



A Strategic Vision for Integrated Healthcare for Children and Young People in Wessex

Expectations for Delivery and Implementation



A Strategic Vision for Integrated Healthcare for Children and Young People in Wessex

The voices of children and young people

A national survey of children and young people informs us that they want: ⁽¹⁾

- to have a say and to be listened to in decisions about their health and wellbeing, and to be actively involved in how services are designed;
- information to be presented in a child friendly way;
- care by professionals who have had training in working with children and young people;
- care in environments appropriate to their age and needs;
- appropriate and efficient systems for transfer from children's to adults services;
- good, child friendly information about what is available and how they can access it;
- to receive information directly from health staff, as well as from parents and carers who are important providers and translators of information;
- knowledge of health issues to extend beyond health professionals – for example, to teachers and social workers and early help practitioners – particularly so that they can support those who do not have parents and carers to help them to access and translate health information and advice;
- to give their own views about their health needs and the care they receive; and
- healthcare staff to show respect and recognition of their right to be involved in decisions about their health and care.

Children and young people and their families have concerns about:

- a lack of join up around health, local authority children's services and education;
- poor and delayed diagnosis of conditions impacting on outcomes;
- general practice, the key and most frequent point of contact, is not meeting the needs of children and young people;
- outcomes taking a whole family approach, because the health and wellbeing of families (carers) directly impacts on children and young people and affects their resilience;
- outcomes being measured for different ages along the life cycle; and
- transition to adult services which is often disjointed, and planning needs to involve the young person and their family.

With regard to both their physical and their mental health needs, children and young people want:

- care to be delivered by competent professionals who communicate well with them;
- to be involved in decisions with regard to their care and make informed choices;
- care to be in environments which are appropriate to their age and needs; and
- appropriate and efficient systems for the transfer from child to adult services.

With regard to mental health, children and young people want:

- to have a voice in the development and delivery of mental health services; and
- to have the stigma surrounding mental illness to be tackled as a block to seeking help.

Overarching principles

The vision for Wessex is aligned with current government pledges for children and young people (Better Health Outcomes for Children and Young People: Our Pledge https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf):

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life, based on an assessment of their need.
5. Every child should have timely access to high-quality urgent care services that are safe, effective and caring, that promote good health and wellbeing and that reduce the impact of illness on the child and their parents and carers.
6. No child should be in hospital when care can be provided to an equivalent or better standard outside the hospital in their locality and closer to their home if appropriate (right care, right time and right place).
7. There will be clear leadership, accountability and assurance, and organisations will work in partnership for the benefit of children and young people.



Expectations for Delivery and Implementation of the Vision

A. GENERIC

- 1) **PARTNERSHIP, INTEGRATION AND ALIGNMENT** – There should be documented, regular meetings within each clinical commissioning group (CCG) attended by senior healthcare professionals from hospital, community, pharmacy and primary care services, local authority children's services and the voluntary sector, as well as commissioners and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local healthcare services. Evaluation of adverse events and benchmarking against equivalent services across Wessex forms a core activity of this group.

Health and local authority children's services agendas should be coordinated in order to improve health outcomes for children and young people and to realise efficiencies across the system. This requires integrated working between CCGs and local authorities.

Active participation by children, young people, siblings, parents and carers regarding ongoing quality and improvement of services or facilities should be considered mandatory.

Promote and ensure direct face to face working between primary care/community based staff and secondary care staff (GPs, consultant paediatricians, advanced paediatric nurse practitioners, community paediatric nurses). Commissioners should provide incentives to encourage this. This will include GPs and paediatricians working alongside each other in community urgent care hubs, GP practices, emergency departments, paediatric assessment units/short stay units, hospital based paediatric clinics or paediatric outreach clinics.

- 2) **BENCHMARKING** – all data about children and young people to be presented in standardised age bands through childhood and the teenage years (<1, 1-4, 5-9, 10-14, 15-19 years). Allowing relevant international comparisons of key outcomes as well as national or local comparisons of outcomes at significant transition points, such as joining secondary school and transition to adult life.

Although the NHS Outcomes Framework ⁽¹⁴⁾ has a number of outcome measures relevant to children and young people, local healthcare systems must develop additional measures that reflect the range of health issues affecting children and young people including:

- childhood mortality
- school absence
- time to definitive diagnosis/start of treatment from first symptomatic presentation or contact with NHS services for children for conditions such as epilepsy, diabetes and cancer
- an indicator of the provision of integrated care for children and young people with a long-term condition, disability or complex needs
- an indicator of the quality of transition taking place between child-centred and adult-centred health care.

- 3) **WORKFORCE DEVELOPMENT** – All healthcare staff managing children and young people (GPs, GP out-of-hours services, GP trainees, practice nurses, advanced nurse practitioners, emergency department staff community nurses, paramedics/ambulance crews, pharmacists, paediatric trainees and paediatricians) have access to regular training in the clinical assessment and management of children and young people presenting with unscheduled care needs, emotional and mental health needs or safeguarding issues.

Training packages should be delivered to meet the needs of the workforce. This teaching can be delivered within a workplace based setting, embedded within local training days, and offered as a stand-alone paediatric course, as part of an e-learning package through a variety of mediums.

- 4) **CONSISTENT STANDARDS OF CARE** – Standardised clinical care pathways for common acute, chronic and emotional/mental health conditions should be in place to promote consistent management. All healthcare staff managing children and young people should be familiar with these pathways. Parents and carers and children and young people require high quality care and consistent messages about their health and wellbeing. This will be delivered by standardised clinical pathways for common conditions across all health and local authority settings.

Commissioners should ensure that all healthcare staff managing children and young people know when and how to promptly access more senior or specialist advice.

A clear strategy for effective transition between children's and adult services involving health and local authority children's services should be implemented for all children and young people with on going health needs. Health and local authority children's services providers must ensure that gaps do not exist between the timing of discharge from paediatric services and the provision of adult services.

- 5) **SAFEGUARDING** – all staff working with children and young people have a safeguarding responsibility. Collaborative working and data sharing between healthcare professions, children's services and education will ensure safeguarding issues are identified more quickly and addressed more effectively.

The introduction of a unified child protection information system that enables effective information sharing between agencies should be strongly considered. At the present time multiple information systems currently exist across the numerous agencies involved in safeguarding.

- 6) **DATA SHARING** – Healthcare professions looking after children have access to comprehensive patient records including those from primary care (including out-of-hours GPs), urgent care services, community services, emergency departments, secondary care, mental health services and safeguarding teams. The NHS number should be used as the unique identifier to bring together health, education and local authority children's services data for all children and young people.

- 7) **TECHNOLOGY AND COMMUNICATION** - Technology should be adopted to improve timely communication and integration between local authority children's services, primary care, community paediatric services, secondary care and tertiary care, as well as to enable effective remote communication with families.

Expectations for Delivery and Implementation of the Vision

B) URGENT AND EMERGENCY CARE

Parents



- 8) Parents and carers have access to clear, accurate information about common illnesses in children and young people, promoting self-care when appropriate.

These resources should be standardised across Wessex to ensure they receive consistent messages. One such example is the material developed through the Healthier Together Wessex initiative: www.what0-18.nhs.uk.⁽¹⁵⁾
- 9) Clear signposting is in place to assist parents and carers and children and young people in accessing the right care at the right time, so as to minimise delays to care, reduce repetition of assessment, and avoid unnecessary transfer between organisations.
- 10) Parents and carers receive consistent and appropriate advice from healthcare staff across the unscheduled care pathway.

What healthcare professionals say, their active listening skills and their ability to signpost parents to appropriate resources, is likely to have more influence over subsequent health-seeking behaviour compared to other modalities of information transfer.
- 11) Parents and carers are routinely offered education about appropriate health-seeking behaviour and safety-netting during every unscheduled care contact with a healthcare professional (primary care, secondary care, community nursing and pharmacy).

One such example is the material developed through the Healthier Together Wessex initiative: www.what0-18.nhs.uk.⁽¹⁵⁾

NHS 111



- 12) NHS 111 call handlers providing paediatric advice are supported by clinical staff trained in paediatrics (GP with a specialist interest in paediatrics, advanced paediatric nurse practitioner (APNP) or paediatrician/senior paediatric trainee).
- 13) Clinical staff working within NHS 111 should receive training in how to assess and manage the emotional and mental health needs of children and young people, including deliberate self-harm and substance abuse, and are aware of local policies for those individuals at immediate risk, whilst still remaining mindful of their wider safeguarding responsibilities.
- 14) Clinical staff working within NHS 111 are able to book urgent appointments in primary care and in rapid access paediatric clinics if required.
- 15) The advice provided to parents by NHS 111 is consistent with the information given by healthcare staff across the unscheduled care pathway.
- 16) The opportunities of telemedicine should be used to remotely assess and triage children and young people at home by clinical staff trained in paediatrics within NHS 111.

The Royal College of Paediatrics and Child Health (RCPCH) is currently evaluating parent experience and use of services following contact with NHS 111.⁽¹⁶⁾

Pharmacists



- 17) Parents and carers should be encouraged to draw upon the expertise of pharmacists when seeking advice about the unplanned care of their child. The advice provided to parents by pharmacists should be consistent with the information given by healthcare staff across the healthcare pathway.

The accessibility of community pharmacies and access to medicines for the symptomatic relief of self-limiting conditions in children and young people should be promoted to parents and carers by organisations and health care professionals as a credible alternative to seeking advice and support from elsewhere in the NHS.
- 18) Community pharmacists should be able to access up to date information and advice on children and young people relevant to the types of childhood illness likely to present in a pharmacy setting.
- 19) The continuing professional development needs of community pharmacists should be considered by the agencies delivering training in paediatrics across Wessex (Health Education Wessex) and access to appropriate training to enhance their skills made available.
- 20) Community pharmacists presented with a patient demonstrating symptoms that in their opinion require immediate attention by a doctor, should have the ability to access expert guidance and advice and to fast-track the referral.
- 21) In order to ensure good communication pharmacists should know who is the named designated lead for children and young people within each GP practice or cluster and be able to call upon their expertise in order to enhance the care provided locally to this group.



Expectations for Delivery and Implementation of the Vision

General practice



- 22) Primary care services must be responsive to the needs of children and young people, enabling them to be seen the same day if clinically indicated. Systems should be in place to facilitate urgent review in primary care of children and young people discharged from the emergency department (ED)/short stay paediatric assessment unit (SSPAU) or in-patient facilities.
- 23) GPs assessing or treating children and young people with unscheduled care needs should have access to telephone advice from a consultant paediatrician or senior paediatric trainee.
- 24) Clinical pathways and safety netting approaches used by GPs should be aligned with those used across the rest of the unscheduled care pathway.
- 25) GPs should receive training in how to assess and manage the emotional and mental health needs of children and young people, including deliberate self-harm and substance abuse.
- 26) There is a GP within each practice/cluster of practices who is the designated lead for paediatrics. This role will provide clinical leadership to the practice on issues and services for children and young people.
- 27) There is a named link consultant paediatrician for each group/cluster of GP practices. This role will provide a contact point for local GPs regarding clinical queries, outreach activities and workplace based training and continuing professional development (CPD).
- 28) Out-of-hours GPs must be competent in assessing and managing children and young people and must be aware of local clinical resources, including acute community nursing services and local referral pathways.
- 29) All children and young people presenting frequently to primary care or emergency department or requiring frequent admission to hospital are identified and discussed within a formal multidisciplinary forum. This forum can either be based at individual GP practice level or can involve a cluster of GP practices. The core membership of such a group should involve a GP, a mental health practitioner, a health visitor and, where appropriate, a local authority children's services representative. Best practice would be to involve a paediatrician in these meetings. The input of multi-agency colleagues working with the family at the time should also be sought.
- 30) Summary care records will be completed on all children and young people with complex needs and co-morbidities, including crisis plans and treatment escalation.

The enhanced summary care record can be accessed by paramedics, ambulance crews and NHS 111, providing them with clear instructions for the appropriate management of these complex patients.

Urgent care services (walk-in centre, minor injuries unit, or urgent care centres)



- 31) Staff seeing children and young people within urgent care services with unscheduled care needs have access to telephone advice from a consultant paediatrician or senior paediatric trainee.
 - 32) Staff seeing children and young people within urgent care services are competent in assessing and managing them and are aware of local clinical resources, including acute community nursing services and local referral pathways.
- Clinical pathways and safety netting approaches used by staff in urgent care services are aligned with those used across the rest of the unscheduled care pathway.
- 33) Staff seeing children and young people within urgent care services should receive training in how to assess and manage their emotional and mental health needs, including deliberate self-harm and substance abuse, and are aware of local policies for those individuals at immediate risk and whilst remaining mindful of their wider safeguarding responsibilities.

Paramedics/ambulance service



- 34) Paramedics assessing or treating children and young people with unscheduled care needs should have access to immediate telephone or video-call advice from a healthcare professional with experience in paediatrics (GP with a specialist interest in paediatrics, Advanced Paediatric Nurse Practitioner, paediatric emergency department staff or paediatrician/senior paediatric trainee).
- 35) Clinical pathways and safety netting approaches used by the ambulance service are aligned with those used across the rest of the unscheduled care pathway.

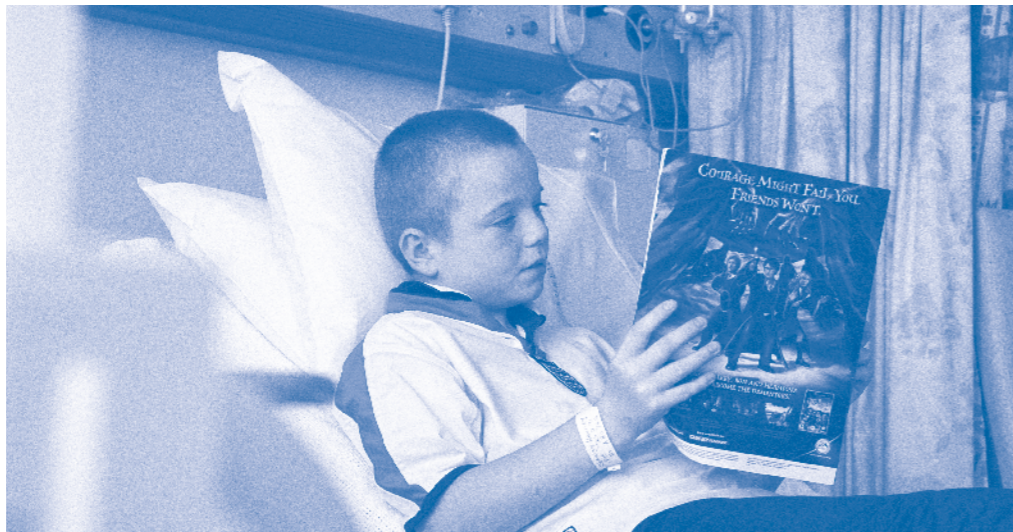


Expectations for Delivery and Implementation of the Vision

Emergency Department (ED)



- 36) In hospitals with dedicated paediatric emergency departments and co-location with short stay paediatric assessment units, acute community nursing teams should be integrated within these units to facilitate admission avoidance or early discharge strategies.
- 37) Emergency departments seeing children and young people must meet the standards set out in the Royal College of Paediatrics and Child Health 'Standards for Children and Young People in emergency care settings.'
- 38) Clinical pathways and safety netting approaches used by the emergency department staff are aligned with those used across the rest of the unscheduled care pathway.
- 39) The advice provided to parents by emergency department staff is consistent with the information given by healthcare staff across the unscheduled care pathway.
- 40) If paediatric on-site support is unavailable, the paediatric skills of the emergency department staff must be enhanced by regular training or additional paediatric-trained staff employed.
- 41) Emergency department clinicians with responsibility for the care of children and young people should receive training in how to assess and manage their emotional and mental health needs, including deliberate self-harm and substance abuse and support their family and carers. Local policies should be in place for the involvement of a mental health practitioner for those individuals at immediate risk.
- 42) A paediatric liaison health worker should be available in each emergency department to improve access to information, education and clinical expertise in managing children and young people with emotional and mental health needs.
- 43) Strategies developed through collaborative working between health and Local Authority children's services, Local Authority Public Health and Children's Services should be in place to manage young people presenting to emergency departments with alcohol and substance misuse.



Hospital based paediatric services



- 44) Inpatient services must meet the standards set out in the Royal College of Paediatrics and Child Health 'Facing the Future – Standards for Acute General Paediatric Services' ⁽⁵⁾
- 45) Secondary paediatric services should provide a consultant-led rapid access service which enables any child referred to be seen within 24 hours if clinically appropriate. This could either be in a dedicated rapid-access clinic or on a Short Stay Paediatric Assessment Unit/paediatric ward.
- 46) Parents and carers and children and young people presenting with unscheduled care needs should be provided, at the time of their discharge, with both verbal and written and electronic safety netting information, in a form that is accessible and that they understand. The advice provided to parents by paediatric staff is consistent with the information given by healthcare staff across the unscheduled care pathway.
- 47) There is a named link consultant paediatrician for each group/cluster of GP practices.
- 48) Clear pathways and protocols are in place to enable paediatricians across Wessex to appropriately access a full range of sub-speciality advice. Networked models of care should be set up for all sub-specialities, following the principles and governance set out in the national guidance on Operational Delivery Networks.⁽⁴⁾

Acute community children's nursing



- 49) The unscheduled care pathway (GP and hospital based services) should be supported by an integrated community children's nursing service.

Acute community children's nursing services are able to take referrals from across urgent care (GPs, emergency department clinicians and paediatricians) for specified paediatric conditions, using standardised clinical pathways.
- 50) Community nursing and local authority children's services must be coordinated effectively and delivered seven days a week to support children and young people presenting to urgent and emergency care services.

Expectations for Delivery and Implementation of the Vision

Information sharing



- 51) Healthcare professionals assessing or treating children and young people with unscheduled care needs in any setting (primary care, GP out-of-hours services, urgent care services or within hospital) have access to comprehensive patient records including those from primary care, emergency department, secondary care, mental health services and safeguarding teams.

A nationally delivered common health record, requiring appropriate IT infrastructure and confidentiality safeguards, is likely to be required to achieve this.
- 52) Unscheduled care providers (urgent care services, out-of-hours, GP services, emergency department and paediatric services) must send details of all out-of-hours consultations, including appropriate clinical information, to the GP practice where the patient is registered by the next working day.

An integrated IT platform would allow this information to be sent out routinely after every patient contact.
- 53) If deemed in the best interest of the child or young person, they should be encouraged to provide consent to share information about an admission to hospital/emergency department presentation with their school or college. This information should then be sent to the Head of Safeguarding within the school/college and would enable them to provide appropriate support as well as to be aware of any potential signs of further risk.

Benchmarking and service improvement



- 54) All providers of urgent and emergency care must monitor the care provided for children and young people using nationally defined indicator sets in order to benchmark themselves against similar providers and to plan service improvement. This includes GPs, GP out-of-hours services, emergency departments, paediatric short stay units/paediatric assessment units and in-patient paediatric units. Health and Children's Services commissioners should include measurable standards for children's services, including the use of care pathways within provider contracts.

The Royal College of Paediatrics and Child Health 'Standards for Children and Young People in Emergency Care Settings' ⁽³⁾ provide an example of an indicator set to enable benchmarking. Paediatric outcome data can be found on the Public Health England National Child and Maternal Health Intelligence Network. ⁽¹⁷⁾
- 55) Regular audits of patient experiences is mandatory for all providers along with action plans to address any highlighted issues.

Education



- 56) Training in the use of standardised clinical pathways, promoting integrated care across the unscheduled care pathway and delivering consistent healthcare messages to parents and young people, should be embedded within undergraduate and post-graduate training for all healthcare professions (health visitors, nurses, midwives, paramedics, pharmacists and doctors).
- 57) All GP trainees should have exposure to hospital-based paediatrics and all paediatric trainees should have exposure to children and young people being managed in primary care settings.
- 58) GPs should receive regular training in paediatrics, including management of acute illness and long term conditions in children and young people.

To forge closer working between GPs and hospital based staff, training should be delivered by local paediatric consultants and trainees.

C) CHILDREN AND YOUNG PEOPLE WITH CHRONIC MEDICAL NEEDS

Written in conjunction with Dr Catherine Tuffrey, Consultant Paediatrician in consultation with community paediatricians from across Wessex.

- 59) All services providing care to children and young people with special educational needs and disabilities must meet the requirements of the special educational needs and disabilities (SEND) reforms to provide support to meet their health needs up to the age of 25 years.

Local authority children's services



- 60) Healthcare, community based care and local authority children's services must be coordinated effectively and delivered seven days a week to support children and young people with chronic medical needs in order to prevent avoidable admissions to hospital.

Primary care



- 61) All children and young people with chronic conditions should have a nominated GP within primary care.

Expectations for Delivery and Implementation of the Vision

Acute Trusts



- 62) When a child with chronic conditions is admitted, the named consultants managing their out-patient care (Acute Trust paediatrician and/or community paediatrician if applicable) should be informed within 24 hours. The other agencies involved in supporting the patient/family should be informed and involved in developing a support plan for the child whilst in hospital as well as to support discharge home.

In areas where community and acute paediatricians are in different trusts it can be particularly challenging to ensure good communication is maintained for patient safety. When a child under the care of a community paediatrician is admitted to hospital, the community paediatrician and other agencies involved in their care should be informed in order to develop a support plan and facilitate supported discharge.

- 63) When a child with a chronic condition or conditions is discharged from hospital, the named consultants managing their out-patient care (Acute Trust paediatrician and community paediatrician if applicable) and their GP should be provided with the discharge paperwork within 24 hours.
- 64) A clear strategy for effective transition between paediatric and Children's and Adult Services should be implemented for all children and young people with chronic diseases.

The Ready Steady Go programme is an example of a system that assists in the process of effective implementation.

Community nursing teams



- 65) Community nursing teams should be in place which work in partnership with primary and secondary care, offering a safe, responsive service including managing children and young people with long term conditions, delivering palliative care and supporting mental health, whilst also remaining flexible to local population needs and accessible seven days a week.⁽⁶⁾

Community paediatrics



- 66) All outpatient letters from community paediatricians must be available to the hospital team if a child is admitted.
- 67) Children and young people presenting with global developmental delay and those with complex neurodisability, for example cerebral palsy, should have their specialist medical care overseen by paediatricians trained in neurodisability.

Initial and follow-up appointments should be of an adequate length to enable this assessment. The care of these children and young people is complicated and often involves multiple teams. For this reason, they will need at least one hour for their initial appointment and 45 minutes for follow-up appointments.

- 68) Children and young people with neurodisability are treated on a defined care pathway with multi-professional input and close professional liaison. Where possible, joint assessments should be carried out to improve efficiency for professionals and families.
- 69) Children and young people presenting with social communication difficulties have timely access to diagnostic services as described in the NICE guidance for the assessment of possible Autism Spectrum Disorders (CG170).⁽¹⁹⁾ Services must be funded to provide structured assessments, for example, Autism Diagnostic Observation Schedule (ADOS) and the Autism Diagnostic Interview (ADI) for children and young people who need these assessments for a diagnosis to be reached.
- 70) Children and young people who present with possible Autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD) have timely access to assessment from either CAMHS or community paediatrics.

Regardless of which service takes the lead for the assessment and management, systems should be in place to ensure input can easily be obtained from the other service where necessary. An example would be where a child with possible autism spectrum disorder is managed by community paediatrics but input is required from CAMHS to exclude a mental health diagnosis as part of the diagnostic process. Such assessment should be available without the need for lengthy additional delay and in close liaison with the paediatric team.

- 71) Where parents are in agreement, Advance Care Plans should be put in place for all children and young people with life-limiting neurodisabling conditions as early as possible. Changes made to these plans following paediatric intensive care unit or hospice admission should be discussed with the community paediatric team.
- 72) Looked After Children have their medical assessments carried out by health professionals (doctors or nurses) with appropriate paediatric skills to perform a holistic examination. This will include developmental screening where necessary using tools such as Schedule of Growing Skills as well as an assessment of their emotional and mental health.
- 73) Children and young people with sensory impairments have access to appropriate diagnostic and assessment services (paediatric audiology and ear, nose and throat; paediatric ophthalmology and orthoptics).

They should also have access to developmental assessment as required from community paediatric services. For children and young people with visual impairment this also includes access to a team able to undertake functional assessment of vision. Time needs to be available for professional liaison between the different community and hospital teams to ensure good quality care.

Expectations for Delivery and Implementation of the Vision

D) SAFEGUARDING

- 74) There is a nominated lead for child safeguarding within all organisations caring for children and young people.
- 75) Appropriate safeguarding training is statutory and mandatory for all staff caring for children.
- 76) All staff in unscheduled care settings should be able to access child protection advice 24 hours a day from a safeguarding children team or a paediatrician with experience in child protection. They should be aware of the pathways/processes that need to be followed and the services/agencies that need to be involved.
- 77) Medical assessments on children and young people suspected of having been physically abused may be carried out by community or acute general paediatricians depending on time of presentation and area to which they present. All professionals doing this work should take part in regular peer review. Where an area has both acute and community paediatricians doing this work, joint peer reviews should be established.
- 78) Medical examinations in cases of suspected child sexual abuse should be carried out in appropriate facilities by doctors with appropriate skills and knowledge. Practitioners should be seeing sufficient cases (current Royal College of Paediatrics and Child Health recommendation is for a minimum of 20 cases per year) to maintain their competence.

In Wessex this may mean centralising services and reducing the number of doctors doing this work.

E) NEONATES

Written in conjunction with Dr Victoria Puddy, Consultant Neonatologist and Teresa Griffin, Network Manager Thames Valley and Wessex Neonatal Operational Delivery Network.

- 79) There should be capacity to provide high quality specialist neonatal care, in an appropriately designated unit as close to home as possible, for at least 95% of babies born to women booked for delivery in the Thames Valley and Wessex Neonatal Operational Delivery Network (ODN).
- 80) All Trusts providing neonatal care should have capacity planned on an average 80% occupancy.
- 81) Local neonatal units (LNUs) and special care units (SCUs) should only care for babies appropriate to their designation. Any baby not being cared for in the correct location for the level of care it requires should be discussed with a Consultant Neonatologist at a Wessex designated Neonatal Intensive Care Unit and exceptions reported to the Thames Valley and Wessex Neonatal Operational Delivery Network (ODN).
- 82) The Network should have a commissioned 24/7 dedicated Neonatal Transport Service. Transfers/classifications and response times for neonatal transfers should meet national transport group and British Association of Perinatal Medicine recommendations.⁽⁷⁾
- 83) All Trusts providing neonatal care should have appropriate staffing levels in line with their designation and national standards.⁽⁸⁾



- 84) All Trusts providing neonatal care should have a nominated practice educator who is qualified in neonatal speciality.
- 85) The ethos of all Trusts providing neonatal care should centre around Family Centred Developmental Care. All units should be working towards attaining/maintaining BLISS FFAS ⁽²³⁾ (Family Friendly Accreditation Scheme) Accreditation.
- 86) All babies with antenatal diagnosed fetal malformations requiring early surgery should be booked to be delivered at the designated Network surgical centre.
- 87) All neonates admitted to a neonatal unit should be entered onto the BadgerNet data system. All Trusts providing neonatal care should provide data to the Thames Valley & Wessex Operational Delivery Neonatal Network dashboard.
- 88) All neonates should be kept with their mother where possible. Parent accommodation/facilities should be available for those whose babies are admitted to a neonatal unit.
- 89) All parents should be fully involved with the decision-making around the care of their baby. They should be kept fully informed of any changes to their baby's condition and have easy access to parent information.
- 90) Parents and carers are provided, at the time of discharge, with both verbal and written/electronic safety netting information, in a form that is accessible and that they understand.
- 91) Referral pathways are in place to ensure that following discharge of the baby, all parents and carers are contacted by a community professional in primary care within one week and that follow-up arrangements are made for higher risk babies.
- 92) Through collaboration between health and local authority children's services, a clear process should be in place to meet the additional needs of more vulnerable parents such as teenage parents or those with learning difficulties.

Expectations for Delivery and Implementation of the Vision

F) EMOTIONAL AND MENTAL HEALTH

Written in conjunction with Liz Winburn (Consultant Child and Adolescent Psychiatrist, Basingstoke CAMHS) and Dr Jonathan Prosser (Consultant Child & Family Psychiatrist, Portsmouth CAMHS).

- 93) Primary and secondary care preventative services should be available for children and young people and parents and carers.
- Collaboration between health and local authority children's services must ensure that strategies to improve resilience and positive emotional wellbeing in children and young people are in place. This should include the identification and appropriate intervention for maternal mental health problems during pregnancy and the promotion of good parent/carer-child relationships through effective delivery of the healthy child programme.
- Information promoting babies' emotional development should be provided to all parents. Additional targeted support should be provided for vulnerable parents.
- 94) Schools have a central role in destigmatising mental health issues and developing resilience and emotional well-being. Staff in schools, primary care, local authority children's services and third sector agencies should possess enhanced knowledge of common emotional and mental health problems and neurodevelopmental disorders in order to signpost individuals to appropriate services.⁽¹⁰⁾
- Training should enable staff to identify children and young people with emotional and mental health issues, as well as how best to support these individuals and their parents and carers.
- 95) Clear, standardised clinical pathways should be in place to identify children and young people requiring urgent and routine referral to Child and Adolescent Mental Health Services services for acute mental illnesses, psychological problems, eating disorders and neurodevelopmental disorders/differences.
- These outcome orientated pathways should be collaboratively developed with input from primary care, third sector, health and local authority children's services agencies.⁽¹¹⁾
- 96) Children and young people referred to Child and Adolescent Mental Health Services must be reviewed within 18 weeks. Children and young people meeting criteria for urgent referral to Child and Adolescent Mental Health Services must be reviewed within two weeks.
- Through primary care, local authorities and the voluntary sector, services should be in place to ensure appropriate support and self-help during any waiting periods.
- 97) Front-line community staff, including school nurses, emergency department and paediatric inpatient staff should receive regular training on common acutely presenting emotional and mental health problems in young people.
- Training should include differentiating between the needs of mentally ill young people, young people in acute psychological distress and young people in whom neuro-developmental disorders and differences have precipitated the crisis. In addition, clinicians should receive training in how to identify, assess and manage their emotional and mental health needs and support their family/carers.⁽¹²⁾

- 98) Local policies should be in place for the involvement of a mental health practitioner for those children and young people at immediate risk from mental health problems.

An on-site paediatric liaison advice and consultation service should be available in every hospital seeing children and young people, as well as rapid access to Child and Adolescent Mental Health Services assessment for young people at risk of significant harm to self or others, where a mental disorder is suspected.⁽¹³⁾ Professionals in acute hospitals should have, at minimum, access by telephone to specialist advice and treatment on a 24/7 basis for young people in their care with a suspected mental disorder.

- 99) Extended hours support, crisis resolution and home treatment should be available for those young people otherwise at risk of psychiatric admission.

Young people in a mental health crisis and their families should be able to access specialist advice and treatment which is not limited to the working day and not dependent on a hospital or clinic setting. Providing specialist, easy-to-access care in a timely manner to those who are at significant risk to themselves or others, particularly if there are engagement difficulties, usually contains a crisis much more effectively than if a young person and family have to wait until services resume in normal working hours. In turn, this may prevent hospital admission. An example would be providing a home visit to a young person with severe depression and suicidal urges in order to monitor risk and work collaboratively on strategies to improve mood and prevent self-injury. Along with effective multi-agency working, increased funding to expand young peoples' crisis care/home treatment teams would be needed to meet this standard universally.

- 100) For children and young people thought to require admission due to mental health issues, all agencies and professionals involved in the child's care should be included in decision-making about whether admission is in the best interest of the child and family and, if so, where best to place the child. Where admission is considered in the best interests, CCGs need to monitor out of area placements and mechanisms need to be in place for step down care and repatriation to tier three services.

- 101) Transition services should be provided up to the age of 25. Age appropriate mental health and wellbeing services should be available for 16-25 year olds based on a holistic local assessment of their needs.

Joint planning with local authority Children's and Adult Services and other relevant agencies should occur well before transition, particularly for the most vulnerable groups, for example, learning difficulties and children and young people in care. There should be flexibility around the age of transition. Young people with mental health difficulties are often not emotionally and socially developed to the extent of their peers by the age of 18.

- 102) For children presenting to emergency departments or admitted to hospital with emotional and mental health issues such as deliberate self harm, an overdose or following a suicide attempt, if deemed in the best interest of the child or young person, they should be encouraged to provide consent to share information about the presentation with their school or college. This information should then be sent to the Head of Safeguarding within the school/college and would enable them to provide appropriate support as well as be aware of any potential signs of further risk.

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G) LOCAL AUTHORITIES AND PUBLIC HEALTH / WELLBEING

Written in conjunction with Dr Debbie Chase, Consultant in Public Health, and Lin Fergusson, Hampshire County Council District Manager, Children and Families.

- 103) Health and Local Authority services must ensure a collaborative, multidisciplinary approach in order to assess and support children and young people, especially those that are more vulnerable and have unmet health needs. Local authority children's services' professionals have a key role in identifying vulnerable children and young people.
- 104) Schools play a key role in supporting the wellbeing and health needs of children and young people. Nursing services, particularly school nurses, should promote good health in all educational settings. Working collaboratively across education and healthcare should ensure that children and young people and parents and carers receive consistent healthcare messages from health and local authority children's services providers.
- 105) Schools should be supported in providing high quality education about healthy living, health seeking behaviour, emotional and mental health issues and sexual health.
- 106) Child public health doctors should work closely with commissioners within the NHS as well as with commissioners within education and local authorities to ensure children and young people's best interests are met and that services improve.
- 107) All parents and carers should have access to health education providing clear and accurate information about common illnesses in children and young people, appropriate health seeking behaviours, antibiotic resistance and accident prevention.

The development of health literacy is important to help people understand and interpret for their own circumstances, the information about common illnesses and where to seek support.
- 108) Parents should be offered evidence based parenting classes within early year's settings. Health visitors play a central role in supporting parental health literacy.
- 109) Local authority children's services staff should have an awareness of healthy conversation skills, are aware of locally available resources and feel confident in signposting parents to appropriate settings.



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Glossary

- **Acute** – Acute conditions are severe and sudden in onset.
- **ADHD** – Attention deficit hyperactivity disorder.
- **Autistic spectrum disorders** – is a serious neurodevelopmental disorder that impairs a child's ability to communicate and interact with others.
- **Chronic** – A chronic condition is a condition or disease that is persistent or otherwise long-lasting in its effects.
- **Clinical care pathways** – also known as care pathways, critical pathways, integrated care pathways, or care maps, are one of the main tools used to manage the quality in healthcare concerning the standardization of care processes.
- **Co-morbidity** – is the presence of one or more additional diseases.
- **Community Care** – The phrase 'community care' is used to describe the various services available to help people manage their physical and mental health problems in the community.
- **Global developmental delay** – (GDD) is the general term used to describe a condition that occurs during the developmental period of a child between birth and 18 years.
- **Health literacy** – Health literacy is the ability to obtain, read, understand and use healthcare information to make appropriate health decisions and follow instructions for treatment.
- **Healthy Child Programme** – HCP is the early intervention and prevention public health programme.
- **Healthy conversation skills** – health professionals with skills to support patients to change behaviours for a healthier lifestyle.
- **NHS 111** – a free-to-call single non-emergency number medical helpline operating in England and Scotland. The service is part of each region's National Health Service and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours services.
- **NHS outcomes framework** – a document issued by the Department of Health which sets out the outcomes and corresponding indicators that will be used to hold NHS England to account for improvements in health outcomes.
- **Neonates** – a new born child or infant less than 4 weeks old.
- **Neurodisability/neurodevelopmental disorders** – a disorder of brain function that affects emotion, learning ability, self-control and memory and that unfolds as the individual grows.
- **NICE Guidance** – National Institute for Health and Care Excellence.
- **Outpatient Care** – Outpatient care describes medical care or treatment that does not require an overnight stay in a hospital.
- **Palliative care** – a multidisciplinary approach to care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness—whatever the diagnosis.
- **PAU** – paediatric assessment units.
- **Primary Care** – health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.
- **Ready, steady go programme** – a programme designed to assist children and young people transition into adult care.
- **Safety netting** – is a systematic approach to the investigation of symptoms that ensures appropriate follow up.
- **Schedule of growing skills** – SGS is an invaluable tool for professionals who need to establish the developmental levels of children from birth to 5 years.
- **Secondary Care** – medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill, or equipment than the primary care physician can provide.
- **SSPAU** – short stay paediatric assessment units.
- **Telemedicine** – the use of telecommunication and information technologies to provide clinical health care at a distance i.e. SKYPE.
- **Tertiary Care** – Specialized consultative care provided by specialised services or units usually on referral from primary or secondary medical care.
- **Unscheduled care** – any unplanned health or social care.



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