



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





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# 1. Executive summary

**Since the creation of the NHS over 50 years ago there has been a revolution in health care within the UK. Advances in technology have seen rates of survival for serious illness climb dramatically with people living for many years with previously fatal, chronic illnesses.**

However, although health outcomes for infants, children and young people in Wessex generally compare favourably with the national picture, the UK is lagging behind many European comparator countries in rates of stillbirth and deaths from common conditions. In the last decade, the 'all cause' mortality rate for under 18s dropped from average to the worst in Europe with higher death rates for conditions amenable to medical treatment such as meningitis, asthma and pneumonia.



“Too many health outcomes for children and young people are poor, and for many, this is involved with failures in care. Despite important improvements - for example, reductions in the number of young people smoking and of teenage pregnancies - in some areas of specialist healthcare more children and young people under 14 years of age are dying in this country than in other countries in Northern and Western Europe. There is enormous and unexplained variation in many aspects of children's healthcare and the UK is worse than other countries in Europe for many outcomes that could be improved through better healthcare and preventative interventions.”<sup>(1)</sup>

Improving health outcomes for children must be seen as a priority. A whole life course approach is needed as key interventions to improve maternal physical health, such as diabetes and smoking or mental health before birth, will impact on the future wellbeing of children and throughout their adult lives. Inequality and deprivation are clearly linked to poorer physical and mental health with lifelong implications on wellbeing, social and economic potential. Although we are primarily addressing how health services are provided, close working and alignment with public health and social care objectives will be fundamental to any sustained improvement in outcomes.

Children make up over 25% of emergency attendances for care. Many of these presentations will be for relatively minor or self-limiting illnesses and may be deemed 'unnecessary' and inappropriate. We must recognise that these visits tell us that parents are worried and are either unable or unsure how to access the reassurance or advice they need in other ways.

“Children, young people and their families struggle to get their voices heard and to be involved in decisions about their own health. This makes it difficult for them to take responsibility for their treatment and care. They know what needs to be done to improve the services they use. Their voices must be heard throughout the health system.”<sup>(1)</sup>

<https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results>

Satisfaction with the NHS remains extremely high. Access and waiting times have fallen and outcomes have continued to improve in many areas despite the financial challenges that have been faced. Population demographics are changing and the rise in the numbers of those living with chronic health challenges mean that financial and human resources within the NHS are stretched in a way previously unrecognised. In 2014, Simon Stevens, Chief Executive Officer of NHS England, published the 'Five Year Forward View'<sup>(2)</sup> which outlined a strategy to fundamentally change the way that health care is delivered. The focus is on prevention, alteration of lifestyle factors which contribute to ill health and to the delivery of health care in a number of different models, with the focus on provision of care in the community.

“The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.”

<https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/>

Seven new models of care are suggested, six of which have particular relevance to healthcare for children and young people. It is recognised that England is too diverse for a 'one size fits all' approach and a number of different approaches are required:

- Multispecialty providers
- Primary and Acute Care Systems
- Urgent and Emergency Care Networks
- Acute Care Collaborations
- Specialised Care
- Modern Maternity Services

Recognising the need to take a systems-wide approach to how health care is provided for children and families, the Wessex Maternity, Children and Young People Strategic Clinical Network was invited by local Clinical Commissioning Groups (CCGs) to review current service provision and to provide a vision of how future health services for children and young people could be provided across Wessex. This work followed on from the previous vision and strategy document for maternity services published in 2015 and will help to inform the regional Sustainability and Transformation Plans (STPs).



# 1. Executive summary

A number of overarching principles were identified which inform the suggested models of care.

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. They will be delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Supporting good physical and mental health is key to improving the outcomes for children with long term physical illnesses, who may suffer more complications if they also develop mental health problems.
4. Services will be integrated and care will be coordinated around the individual. Those young people who require ongoing health and care in adult life, based on an assessment of their need, should have an optimal experience of the transition to adult services.
5. Every child should have timely access to high-quality urgent care services. These should be safe, effective and caring and should promote good health and wellbeing to 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.

The framework provided by these overarching principles is critical in shaping the new models of care which are required to deliver positive outcomes for children and families. All of this needs to be achieved at a time where the NHS is facing significant workforce pressures in both primary and secondary care and in the context of unprecedented financial challenges.

New models of care therefore must consider the following:

- A. Providing as much care as possible in the community and close to home
- B. Closer integration of primary and secondary care services for children and young people and also between secondary and tertiary care
- C. The development of innovative workforce models which can support both primary care and secondary services
- D. The enhancement of children's community nursing services to support urgent and emergency care
- E. The development of key workers to support children and families with long term conditions
- F. Effective transition to adult services for those whose conditions persist into adulthood
- G. Equity of access and consideration for those with mental health problems and a recognition that emotional well-being and good mental health is everyone's business
- H. Consideration to the current provision of inpatient paediatric services and how these will be impacted by delivering care in a different way
- I. Further development of hub and spoke models of specialist care to support care as close to home where possible and centrally when necessary

**There is an expectation that commissioners and providers will produce an action plan for delivery of the recommendations and expectations of this document within 6 months of publication which will include key performance indicators against the expectations.**

# 2. Foreword

**It is 12 years since the National Service Framework for Children was published in 2004<sup>(3)</sup> which was the culmination of Professor Sir Al Aynsley-Green's achievements as National Clinical Director for Children.**

This landmark document set out a mandate to stop treating children as mini-adults and focus on providing family centred, age appropriate care for children. Much has moved on since this time but have we moved as far and fast as we might have liked?

Families tell us that it is difficult and confusing to navigate care within the NHS particularly for a child with complex or chronic needs. How many of our services are truly family centred and age appropriate? How often do organisational and professional boundaries prevent us providing seamless care to children and their families? How effective are we in addressing the inequalities which we know impact on health and development?

We have seen many advances in care over the last 20 years with notable improvements in the survival of children with cancer and of the most premature of Neonates. Despite this, the UK still has much to achieve in terms of health outcomes for children and potentially avoidable deaths when compared with our European peers.

The Royal College of Paediatrics and Child Health published 'Facing the Future'<sup>(4)</sup> standards for those providing urgent and emergency care for children in 2011. Even now, many trusts are struggling to meet the associated workforce challenges. In response to these problems, new models of care with closer integration of primary, secondary and tertiary care are suggested in 'Facing the Future Together.'<sup>(5)</sup>

It seems obvious that children and young people should be cared for by appropriately trained professionals in child friendly environments. It is easy to forget that hospital admission is not a benign experience for children and families even when it feels the 'safe' option. Even a short term admission can be distressing for children and disruptive to families. Best practice must involve caring



for children with minor illnesses in their own home. Developing support systems to facilitate this model will significantly impact on admission rates for children with less severe illnesses and also, by earlier intervention, help prevent repeat admissions in those living with long term conditions.

Equally we should expect that children with more severe or significant illness are cared for in dedicated child and family centred environments by specially trained paediatric staff.

The challenges have been set out in the Five Year Forward view.<sup>(2)</sup> We have an opportunity for our local health and social care community to develop truly integrated services through the vehicle of the Sustainability and Transformation plans. Now is the time to consider how we can develop the high quality and safe services to deliver the best improvement in outcomes for the families who depend on our care.

**Professor William Roche**

Chair, Wessex Clinical Senate, NHS England



## 3. Acknowledgements

We wish to thank all of the stakeholders and their supporting teams who took time out of their busy schedules to review the document in its various stages and provide valuable feedback. Also, all those who attended the workshops and participated with such enthusiasm and for bringing enormous expertise together with a passion for improving the experience and outcomes for children and young people. Dr Sanjay Patel requires specific acknowledgement. As clinical lead for the Wessex Healthier Together project he enabled wide stakeholder engagement and input to the document and, in particular, to setting the expectations for service delivery.

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## 4. Introduction

The NHS in Wessex is justifiably proud of its services. The changing NHS landscape offers opportunities to develop sustainable services that deliver safe, high quality care, in the right place, that meet the needs of our patients in new ways. Most children, young people, parents and carers using paediatric services across Wessex receive excellent care from dedicated staff, but despite this significant variation exists in access and outcomes. Further work is required to address areas where we fail to meet local and national standards for safety and quality.

### 4.1 Purpose and scope of the document

This document provides Clinical Commissioning Groups (CCGs) and the Maternity, Children and Young People Strategic Clinical Network (MCYP SCN) with a strategy and vision to enable the development of plans to ensure safe and sustainable integrated paediatric services across Wessex. The strategy provides a framework to realign paediatric services to provide safe and high-quality care across primary, community, secondary and tertiary care.

This document does not replace or act as a detailed clinical guideline and should be read in conjunction with national guidelines for individual conditions such as those from the National Institute for Health and Clinical Excellence (NICE).<sup>(6)</sup>

### 4.2 What is the role of the Maternity, Children and Young People Strategic Clinical Network (SCN)

Strategic Clinical Networks support areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in healthcare quality and positive outcomes of care for patients. SCNs work in partnership with commissioners, supporting their decision making and strategic planning. Our overall aim is to address local variation and inequalities in health outcomes and experience across the domains which are identified in the NHS Outcomes Framework, as areas where major health challenges and inequalities exist:



SCNs are tasked to bring about:

- Large scale change across very complex pathways of care, involving many professional groups and organisations
- Best approaches to planning and delivering services
- Coordinated, combined improvement approaches to overcome healthcare challenges, which have not responded previously to other improvement efforts

In this way, the SCNs will:

- Reduce unwarranted variation in health and well-being services
- Encourage innovation in how services are provided now and in the future
- Provide clinical advice and leadership to support their decision making and strategic planning



## 5. Background – case for change

In 2014 the Maternity, Children and Young People Strategic Clinical Network (MCYP SCN) was asked by Dorset and Hampshire wide CCGs to advise on the preferred 'clinical case for change' of maternity services across Wessex. This led to the publication of a 'Vision for Maternity Services across Wessex' which was considered and approved by the Wessex Clinical Senate in June 2014.<sup>(7)</sup>

During this process it became clear that many of the issues identified as pertinent to the future shape of maternity services also applied to paediatric services. The MCYP SCN was therefore asked to take a similar approach by the Chair of the Commissioning Assembly. This strategy has been developed in response to this request.

There are a number of significant challenges for paediatric services across Wessex, namely:

- The need to identify and care for vulnerable families in partnership arrangements with Health Visitors, Local Authorities (LAs), General Practitioners (GPs), charities and the voluntary sector
- Equitable access to child and adolescent mental health (CAMHS) pathways
- Changing demographic of the childhood population
- Increasing numbers of children living with complex chronic disease and disability into adulthood
- Apparent decreases in the confidence of parents and professionals in managing acute illness, particularly for children under five years old
- Ensuring effortless multiagency working to meet the safeguarding needs for vulnerable and at risk families

This five year strategy sets out the strategic vision and framework for paediatric services across Wessex to meet these challenges. The strategy will support CCGs in developing plans to ensure safe and sustainable paediatric services across Wessex in line with the national priority to deliver more care in the community.



The strategy acknowledges the need for any proposals to take account of the financial implications of any changes to both the local and wider economy, including those of partner agencies. It should be expected that any scheme which requires significant outlays of funding will be required to demonstrate improvements in patient outcomes and associated savings as a consequence. In the instance that financial outlay is required, revenue streams will need to be identified at the earliest possible stage.

The strategy will consider the impact on co-dependent services such as neonatal and maternity services.<sup>(8)</sup>

## 6. Current configuration of Acute Paediatric Services across Wessex

**Figure 1: Regional map of CCGs and hospital services**

Wessex is a cluster of three counties in the south of England encompassing Hampshire, Dorset and the Isle of Wight. Wessex has nine Clinical Commissioning Groups.



## 6. Current configuration of Acute Paediatric Services across Wessex



Acute paediatric services are provided in seven sites across Wessex:

- Dorset County Hospital, Dorchester
- Poole Hospital, Poole
- Southampton Children's Hospital, Southampton
- Royal Hampshire County Hospital, Winchester
- Basingstoke and North Hampshire Hospital, Basingstoke
- Queen Alexandra Hospital, Portsmouth
- St Mary's Hospital, Newport, Isle of Wight

Southampton Children's Hospital, Queen Alexandra Hospital Portsmouth and Poole Hospital are large inpatient paediatric units. The paediatric service on the Isle of Wight is small with particular challenges related to its relative isolation serving an island population.

Currently, Southampton and Portsmouth are designated as Neonatal Intensive Care Units (NICU) with Southampton providing surgical and cardiac care in addition to supporting the range of paediatric sub-specialities. All other services are currently designated as Local Neonatal Units providing some intensive and high dependency care. However, a recent Royal College of Paediatrics and Child Health review has suggested the re-designation of Dorset County Hospital to become a Special Care Baby Unit with implications for the designation of a number of other services of similar size.

There are additional NHS units on the periphery of Wessex providing paediatric services to the local population:

- Yeovil District Hospital, Yeovil
- Salisbury District Hospital, Salisbury
- Royal Berkshire Hospital, Reading
- Frimley Park Hospital, Frimley
- St Richard's Hospital, Chichester

Two key service reviews are likely to significantly alter the provider landscape over the coming years. The Dorset Clinical Services review is currently reviewing all acute service provision in Dorset. This is likely to lead to a pan-Dorset solution for the provision of maternity and paediatric care with the Royal College of Paediatrics and Child Health review team recommending a more ambulatory/community based model of service for the Dorchester population. In addition, following the merger of North Hampshire Hospital and the Royal Hampshire County Hospital into the Hampshire Hospitals Trust, a single site solution is proposed for inpatient paediatric and maternity services.

<http://www.dorsetsvision.nhs.uk/childrens-services-and-the-rcpch-review/>

### 6.1 Urgent and emergency care

There are a number of challenges in the provision of urgent and emergency care for children. There has been an explosion in the number of ways that families can access urgent support when their child is ill with a move away from the historical model of family doctor GP provision. There are now many ways to access help with the development of telephone triage services, out of hours GP services, walk in centres, urgent care centres and minor injuries units, in addition to secondary care services such as the Emergency Department. Parents' voices tell us that this is a difficult system to navigate.

At the same time the demand for services continues to grow with a 50% increase in Emergency Department attendances by children (0-16) years between 2006 and 2010. There has been a 28% increase in the number of children below 5 years admitted to hospital for less than 24 hours.

An increasing body of evidence is emerging (NHS England 2014)<sup>(9)</sup> which associates timely consultant input to patient care with improved outcomes. Children presenting to inpatient paediatric services, out of hours and at weekends have poorer outcomes. The 2013 Royal College of Paediatrics and Child Health report '*Back to Facing the Future*'<sup>(10)</sup> reported that only a quarter of hospitals had a paediatric consultant present during their self-defined peak hours during weekdays and only 20% at weekends.

At present most units across Wessex rely on medical trainees to provide the bulk of service cover, particularly out of hours. However, a number of units have already implemented partial resident consultant models of care to compensate for the lower number of middle grade doctors in training.

### 6.2 Drivers for change

The MCYP SCN believes that the current configuration of acute units across Wessex is not sustainable going forward. The drivers for change fall into a number of central themes:

- Increasing complexity and acuity of patients requiring specialist care
- National workforce shortages for children's nurses, allied health professionals and a reduction in the number of paediatric training posts
- Increasing requirement for consultant/senior availability and decision making in acute services as part of seven day services
- Affordability of current staffing models with a shift of current work to primary care and the community
- Recognised challenges nationally and locally in primary care recruitment

This is supported by the 'Facing the Future: A review of Paediatric Services' published in 2011<sup>(11)</sup> with a 5 to 10 year time frame to implement the following recommendations:

1. Reduce the number of inpatient paediatric sites
2. Increase the number of paediatric consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Any changes to existing services may have a significant impact on the current provider landscape and on clinical pathways. All partners will therefore need to support the strategic case for change.

It is apparent that some degree of amalgamation of inpatient services is required to allow safe staffing and delivery of care to the sickest children. The increasing drive to provide consultant delivered care in acute paediatrics requires a large volume of activity to be both financially viable and also to avoid occasional practice. This will, however, need to be balanced by the development of integrated primary, secondary and community care for children with milder illness to allow them to safely be managed at home during times of ill health.

The financial implications of any change in service models must be considered to avoid the de-stabilisation of acute services or disproportionate impact on individual organisations particularly during any transition period. Alternate models of service commissioning may need to be developed to remove the barriers to fully integrated care.



## 7. Paediatric workforce

The provision of high-quality, safe paediatric care requires the presence of appropriately skilled staff. This includes not only medical, nursing and support workers but also wide varieties of additional support staff including therapists and radiographers who require appropriate paediatric training. All staff involved in the care of children must have accessed appropriate level 3 safeguarding training and hold enhanced Disclosure Barring Service clearance.

There are currently challenges of compliance with the Royal College of Paediatrics and Child Health recommendations on workforce across all professional groups. Despite this few organisations are signalling an intent to increase staffing numbers.

### 7.1 Paediatric Medical Workforce

In the 2013 Royal College of Paediatrics and Child Health report <sup>(10)</sup> only 28% of hospitals had the required number of doctors available across all rotas. Although a number of units have introduced partial resident consultant models of care these posts replace posts previously occupied by middle grade doctors in training or non-training posts. In the most recent national survey (2012)<sup>(12)</sup> there were 3,825 paediatric doctors in training. It is a female dominated workforce (69%) with over 10% of trainees 'out of training' at any one time and 12.3% in less than full time training, meaning that significant gaps in rotas exist. The impact and scale of the national proposal to decrease trainee numbers is yet to be realised but will put further pressure on rotas. It is also likely to change the distribution of training posts across units as there is a need to achieve a critical mass of paediatric workload to ensure safety, retain accreditation, to assure professional competency and to avoid occasional practice.

New roles will need to be developed to undertake tasks previously delivered by junior and middle grade doctors in training (tier one and tier two posts) either by extending Consultant delivered care or by the development of advanced nursing roles.

Gaps also exist in other areas with around 80 unfilled Community Paediatric Consultant posts nationally. The reasons for this are not clear but are thought to be due, at least partly, to the focus on the provision of safeguarding services within these roles which may be seen as onerous.

### 7.2 Children's Nursing Workforce

Children's nursing is an attractive career but, despite this gaps remain in filling posts nationally. Since 2013 it has been a degree only profession and current limits on training numbers for Registered Sick Children's Nurses (RSCN) within Universities have contributed to the national shortfall in the numbers of children's nurses. Nurses in training will no longer be eligible for a bursary while they train and it is unknown whether this will affect the number of applicants. However, as most RSCN courses are currently oversubscribed, it is possible that market place demands will increase the number of training places available.

Positively, there is also no expected bulge in retirement for this group of nurses.

<http://www.cfwf.org.uk/publications/practice-nurses-workforce-risks-and-opportunities-education-commissioning-risks-summary-from-2012>



However, significant challenges exist in maintaining and building the nursing workforce:

- The drive to increase Health Visitor numbers predominantly affects the cohort of experienced children's nurses
- Numbers of experienced bedside nurses will be impacted by the need to further develop Advanced Nurse Practitioner roles to support:
  - Acute Paediatric tier one and two medical rotas
  - Emergency departments and other acute areas caring for children
  - Enhanced Community Children's Nursing teams
  - School nursing services
  - GP practices/Primary Care
  - Recruitment from overseas has been affected by the recent financial caps for non-EU migrants

### 7.3 Primary Care

A review of primary care services within Wessex is currently underway with a move towards federated primary care. Concerns exist about future staffing gaps with an increasing proportion of the GP workforce working less than full time. Locally 34.2% of current GPs are over the age of 50 with a significant number signalling their intent to reduce hours or retire in the next 5 to 10 years.

Currently around 40 to 50% of the General Practice Vocational Training Scheme (GPVTS) trainees undertake a paediatric placement as part of their placement. It is recommended that further training opportunities are made available to GPs in training.

Scope exists for the development of Paediatric Advanced Nurse practitioner roles to support primary care. Although Wessex benchmarks closely to the national average for current numbers of practice nurses, the availability in different CCG areas varies.





# 8. Local Authorities

Abundant evidence exists for investment in preventative strategies to improve mental and physical health and reinforces the need for investment in early years and early intervention. Local authorities have identified key strategies for Children and Young People recognising the importance of the early years in setting a child’s trajectory for physical, emotional and mental wellbeing in adulthood. This, in turn, will potentially impact on social and educational success.

The expansion of Health Visiting numbers and the development of the Family Nurse partnership are fundamental to the early identification of need and the provision of support to vulnerable families.

Health, Education and Local Authorities must work together to develop systems which:

- **Tackle behaviours which impact adversely on physical health:**
  - Childhood obesity
  - Physical inactivity
  - Smoking rates
  - Teenage pregnancy
- **Take initiatives which will positively impact on mental health:**
  - Hidden harm
  - Good maternal mental health particularly in the perinatal period
  - Support positive parenting and attachment
  - Build resilience in young people
- **Take initiatives which improve life chances for children:**
  - School readiness
  - Support for language and communication skills
  - Support for families living in poverty



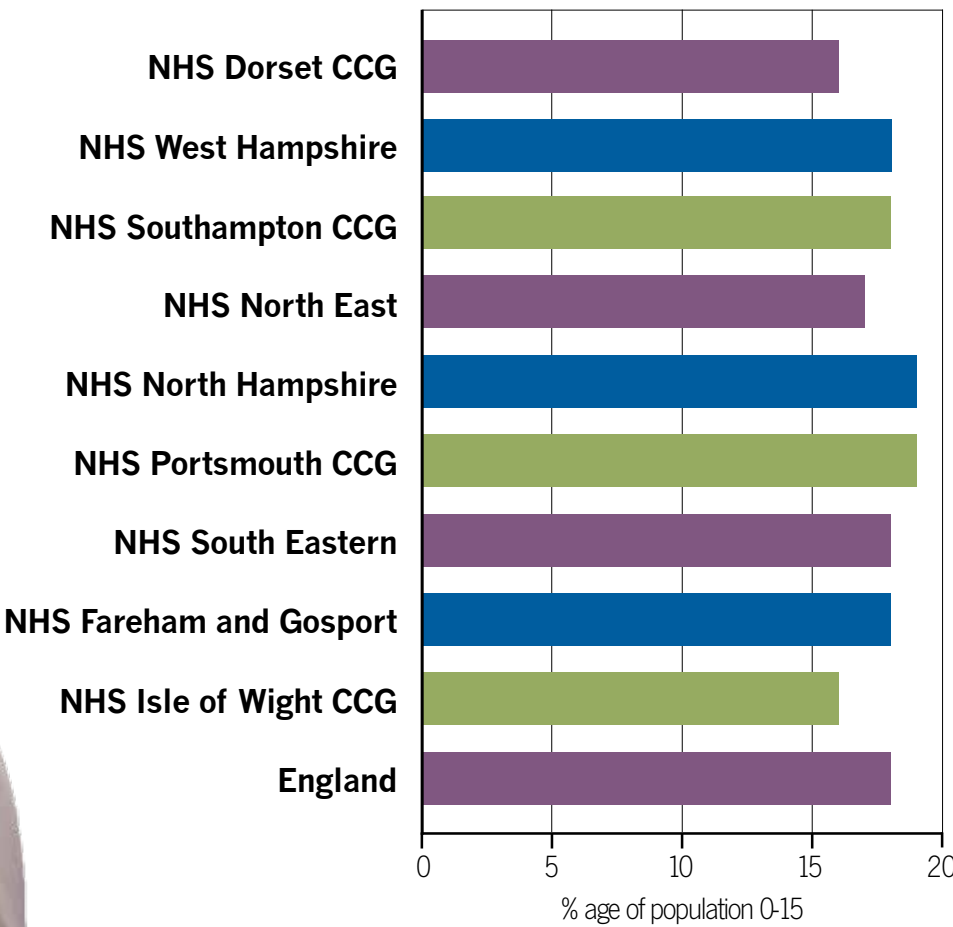
# 9. Paediatric Demographic

Children aged between 0 to 18 years make up 22.4% of the UK population (Office of National Statistics 2013)<sup>(13)</sup> and 18.9% for 0 to 15 year olds. Wessex has fewer children than average with 17.8% in the latter group. This means there are approximately half a million children in Wessex. The paediatric population is expected to grow until 2025.

Health outcomes in Wessex often appear good when compared with national averages, which is potentially attributable to the relative wealth of our non-urban populations. There are just under 72,000 children aged under the age of 16 living in poverty within Southampton, Portsmouth and Havant, higher than the average for England. This pattern would appear likely to continue. Between 27 March 2011 and 30 June 2011 there were fewer live births per head of population in the Wessex region compared to the national average.

Figure 2: Population of Wessex aged 0 to 15 years

Public Health England, 2014





# 10. Variations of Service

The ‘Atlas of Variation in Healthcare for Children and Young People’ shows continuing wide and unwarranted variations around the country in service provision, care and outcomes. Whilst paediatric services across Wessex are safe and of high quality, more needs to be done and the national picture of significant variation is reflected in the local context. Wessex outcomes often appear favourable when compared with national averages, which is potentially attributable to the relative wealth of our non-urban populations. However, we do not compare well with European outcomes which may be a more appropriate target for our health system to aim for (NHS Atlas of Variation 2012).<sup>(14)</sup>

## 10.1 Contracting

The current payment systems for services are complicated both in how services are commissioned and paid for:

CCGs	NHS England	Local Authority
GP services	Specialist Paediatric services	Health Visitors
Secondary care general paediatrics	Neonatal Care	School Nurses
Community children’s services including safeguarding	Inpatient mother and baby units (national)	Tier 1 to 2 CAMHS
Tier 3 to 4 CAMHS services	Some Specialist CAMHS services	Social Workers
Maternity Services		
Perinatal Mental Health Services		

It is apparent that a number of different commissioners potentially contribute to a single pathway of care. This is further complicated by the fact that different providers may be paid by a block contract, payment by results tariffs or year of care bundles amongst other mechanisms. This inevitably leads to ‘blocks’ in the pathway of care for individuals and can lead to fragmentation of care or different thresholds for access.

New models of care will require new models of funding and potentially shared resource to remove organisational barriers to providing the most effective care for children and their families.



## Data showing variations in service

### Acute Paediatric Services

Results taken from survey performed by Dr Sanjay Patel (project lead for Wessex Healthier Together)

#### Graph 1

### Rapid Access Clinics

	Dorset County Hospital	Queen Alexandra Hospital	St Mary's Isle of Wight	Southampton Children's Hospital	Basingstoke & North Hampshire	Royal Hampshire County	Salisbury
Do you have rapid access clinic?	✓	✓	✓	✓	✓	✓	✓
Number of clinics per week	1	3	1	3	1	1	6
Number of patient slots per clinic	6	3	3	2	3	3	4

### Integrated Care

	Dorset County Hospital	Queen Alexandra Hospital	St Mary's Isle of Wight	Southampton Children's Hospital	Basingstoke & North Hampshire	Royal Hampshire County	Salisbury
Do you have a dedicated consultant phone line for GPs?	✗	✓	✓	✓	✓	✓	✓
If yes, what hours of operation?	N/A	10.00 - 15.00 Mon - Thurs 10.00 - 13.00 Friday	24 hours	N/A	24 hours	08.30 - 20.30 Weekdays 08.30 - 13.00 Weekends	09.00 - 17.00 09.00 - 12.00

### Paediatric Clinics in Primary Care

	Dorset County Hospital	Queen Alexandra Hospital	St Mary's Isle of Wight	Southampton Children's Hospital	Basingstoke & North Hampshire	Royal Hampshire County	Salisbury
Do you have paediatric clinics in primary care settings?	✓	✗	✗	✓	✗	✗	✓
If yes, how often?	Monthly	N/A	N/A	Fortnightly	N/A	N/A	Monthly

### Discharge Summaries

	Dorset County Hospital	Queen Alexandra Hospital	St Mary's Isle of Wight	Southampton Children's Hospital	Basingstoke & North Hampshire	Royal Hampshire County	Salisbury
Are discharge summaries sent electronically to GPs/relevant healthcare professionals within 24hrs?	✓	✓	✓ Yes but not always within 24 hours	Unsure	✗	✗	✓

### Dialogue Between Areas

	Dorset County Hospital	Queen Alexandra Hospital	St Mary's Isle of Wight	Southampton Children's Hospital	Basingstoke & North Hampshire	Royal Hampshire County	Salisbury
Is there a formal process in place for regular dialogue with community and primary care providers and patient representatives to review Paediatric unscheduled care services?	✗	✗	✗	✓	✓	✓	✓

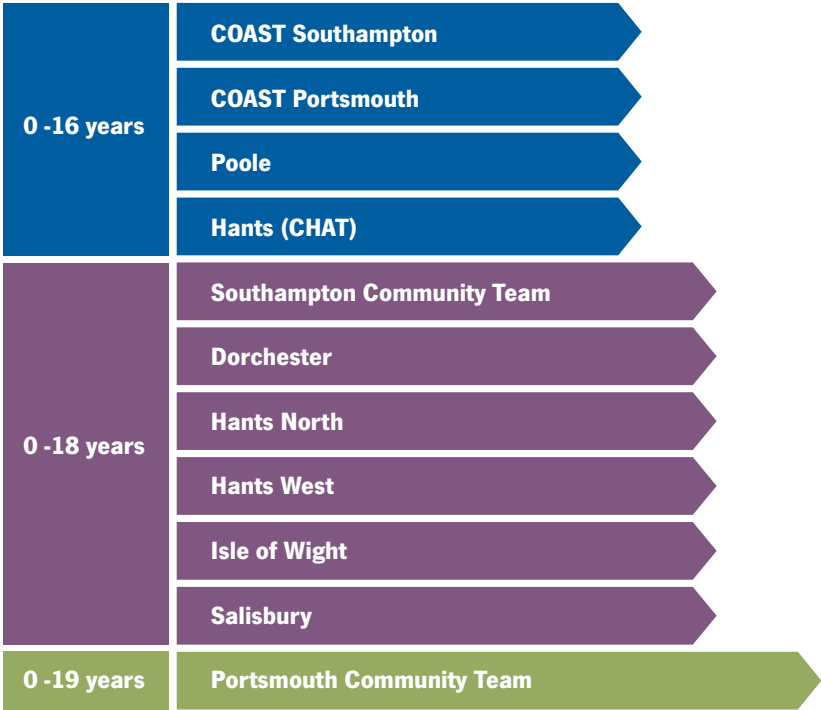


# 10. Variations of Service

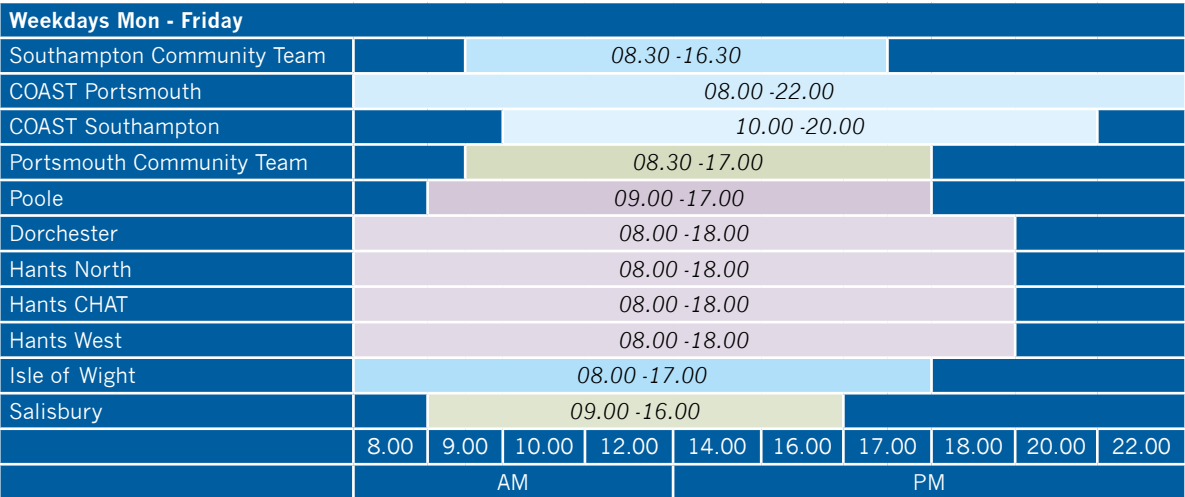
## Community Paediatric Nursing Teams

Results taken from survey performed by Rebecca Hepworth (lead for Wessex Paediatric Community Nursing network)

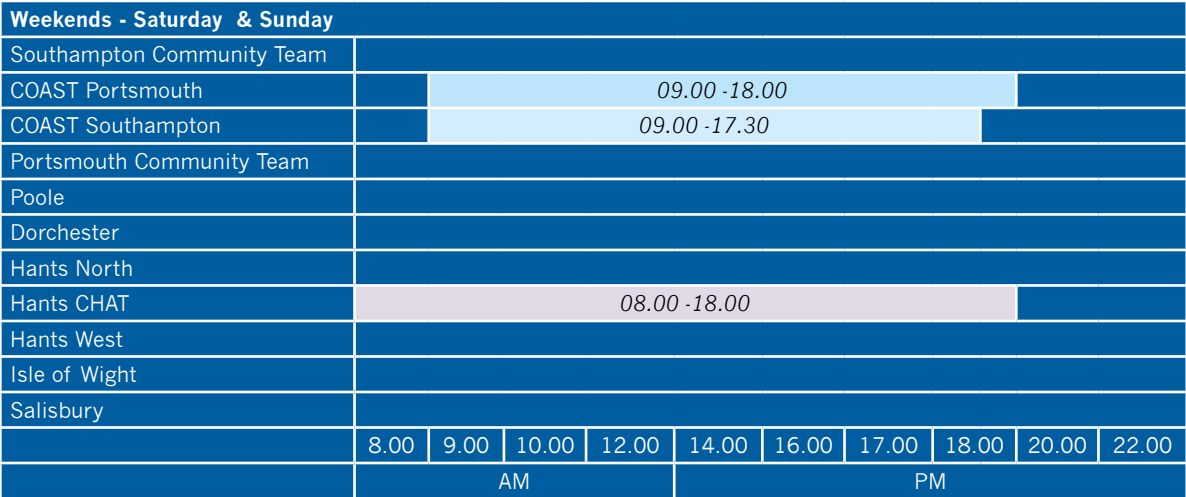
Graph 2  
Age Range



Graph 3  
Hours of service – weekdays



Graph 4  
Hours of service – weekends

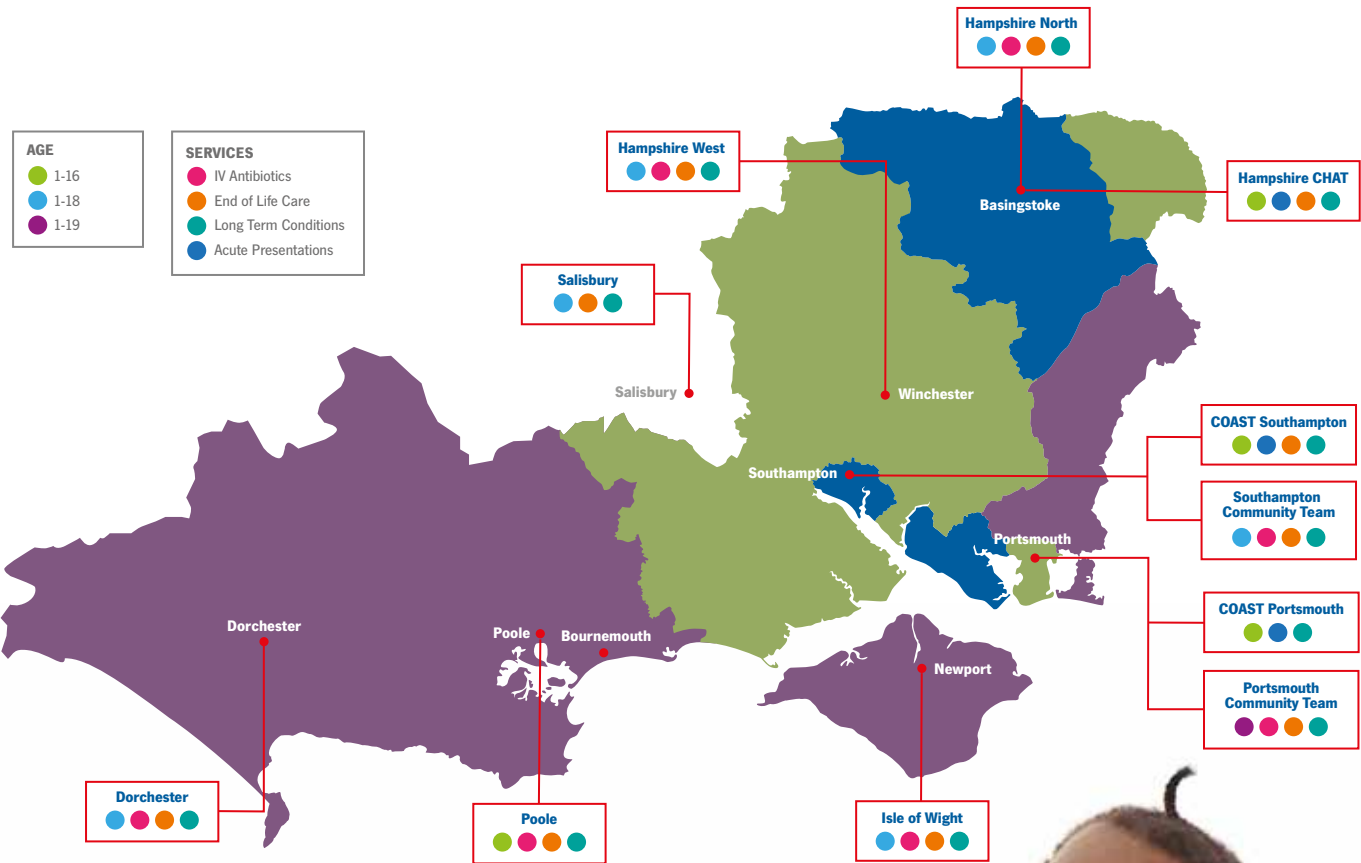




# 10. Variations of Service

**Graph 5**

**Variation in service provision for IV antibiotics, End of Life Care, Long Term Conditions, Acute Presentations**



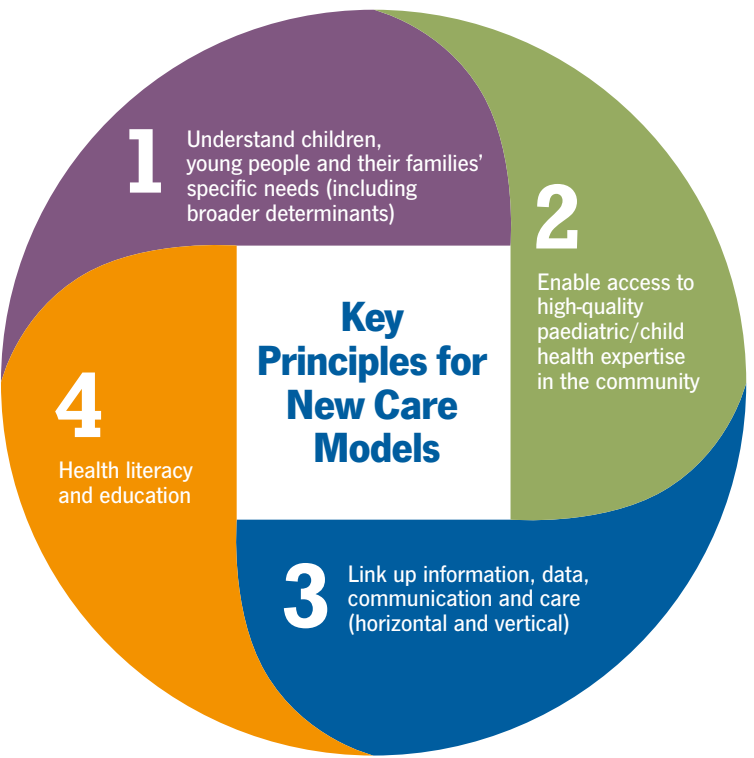
# 11. The Vision for Paediatric Services across Wessex

The NHS in Wessex is passionate about providing the best possible care for children, young people and their families.

Our vision is that services offered to children, young people and their families:

- Are high quality with excellent outcomes for all patients
- Are developed in line with the best available evidence
- Can be sustained, despite future challenges
- Are accessible and delivered as close to home as possible
- Offer a good experience to all children, young people and their families

**Key principles of the ideal model/system – taken from Nuffield Trust report <sup>(15)</sup>**



## 11.1 Workshop Event

From mid-2014, comprehensive stakeholder engagement was undertaken. This generated many suggestions for proposed models of care. In order to test these, a workshop event was held in March 2016 to confirm the optimal models for local care in Wessex.

The initial intent was to consider three broad categories of care

- Long term conditions
- Urgent and Emergency Care
- Child and Adolescent Mental Health Services

A strong message was heard that CAMHS services should not be considered separately to those for physical health. As a result, two models were developed to cover all aspects of good health.



# 11. The Vision for Paediatric Services across Wessex

## 11.2 Outputs from the Urgent and Emergency Care Workshop

- The vision: A Specialist Children's Hub – which provides accessible paediatric/child health expertise in the community and puts children, young people and their families at the heart of the services
- Easy and timely access – with information being provided over the phone, face to face or using the latest technology such as telemedicine
- Shared data – healthcare professionals involved in the care of the child or young person to have access to comprehensive electronic patient records
- Integration between Primary/Community and Secondary Care
- Strong links with other professional services: Education, Local authorities and Voluntary services
- Consistent messaging and information, which plays a key part in early intervention and prevention and provides empowerment for parents and carers
- Enhanced Children's Community Nursing services to provide inreach/outreach services between primary and secondary care and to facilitate support of acutely unwell children in the community
- Children with conditions which persist in to adulthood require effective transition to adult services or to primary care. Use of a transition programme such as Ready, Steady, Go should be considered best practice.
- It is recommended that the '3 questions' campaign is used for transition to help children and young people become more involved in their treatment and care:
  - What are my options?
  - What are the pros and cons of each option for me?
  - How do I get support to help me make a decision that is right for me?

<http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx>

### Emotional and Mental Health Wellbeing is everyone's business



## 11.3 Outputs from the Long Term Conditions workshop

- The vision: To provide a 'professional person' / 'key worker' / 'care navigator' to act as a family link between all the services
- 'Key worker role' to help support children, young people and their families and improve communication between clinical staff, mental health workers, social workers, local authorities and teachers so they can work together better to provide efficient and appropriate care
- Care plans to be in place that all health care professionals have contributed to and have access to via shared electronic data and which stays with the child and young person into adult services
- Patient 'Health Passports' that accompany the patient in all settings; primary, secondary and community, to include physical and mental health conditions
- To be able to provide a flexible response when children with Long Term Conditions become ill
- Continuity of care between health care professionals with no referral necessary

### Long term conditions



### The voice of children and young people



“ This vision and strategy has been developed based on the principles outlined in the Five Year Forward View, the current government pledges for children (Better Health Outcomes for Children and Young People: Our Pledge)<sup>(16)</sup> and the national standards for care developed by Royal Colleges.

The recommendations and expectations in this document reflect national guidance and service specifications where these exist. Where these do not exist for individual services a consensus view was reached by the expert groups.

These have been tested in wide stakeholder consultation and have formed the basis of the Wessex Healthier Together project (<http://www.what0-18.nhs.uk>)<sup>(17)</sup> led and developed by Dr Sanjay Patel, Consultant in Paediatric Infectious Diseases and Immunology.

The key drivers are the delivery of high quality integrated care by an expert workforce with seamless transitions between services. For most children and their families

this will allow care to be provided close to home in the community with concentration of expertise for children who are acutely ill or require specialised care.

This document must be considered in the context of the recommendations of the national Better Births Maternity Transformation Programme<sup>(18)</sup> and the co-dependencies of maternity, neonatal and paediatric services.

The draft document has been included in the Sustainability and Transformation Plans to help frame services for children and it is anticipated that commissioners and providers will use the expectations as the framework in designing services going forward.”

**Alyson O'Donnell**

Clinical Director for the Wessex Maternity, Children and Young People Strategic Clinical Network

- **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 specialised 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** – Specialised 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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# A Strategic Vision for Integrated Healthcare for Children and Young People in Wessex







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