# Facing the Future:

## Together for child health

2015

Royal College of General Practitioners

Royal College of Nursing

RCPCH
Royal College of
Paediatrics and Child Health
*Leading the way in Children's Health*

# Facing the Future: Together for Child Health

2015

# Foreword

The pressures on our unscheduled care services continue to dominate the headlines and are a daily concern for many patients using the services and for the healthcare professionals who work there.

Children make up more than a quarter of emergency department attendances with worrying variation in rates of attendance and admission across the UK. The vast majority of children's illnesses are minor, requiring little or no medical intervention and a significant number of these attendances can be deemed unnecessary or inappropriate. However, each one of these attendances tells us that a parent was worried, and either unable or unsure how to access a more appropriate service.

If we are to get to grips with these pressures, we need to be looking seriously not only at sustained investment in unscheduled care services, but also at the way in which services are set up.

The RCPCH *Facing the Future: Standards for Acute General Paediatric Services* published in 2010 and revised in 2015 addressed some of the changes needed within the acute hospital environment. If we are to really improve outcomes for all children we also need to consider whether some episodes of acute illness could be safely and better managed without a visit to the emergency department or an admission to an inpatient ward.

Indeed, parents' preference for initial advice is their GP and children make up around a quarter of a typical GP's workload. We need to deliver better connected care in the community with more primary care healthcare professionals trained in child health and supported by more paediatricians operating outside the hospital setting.

We believe that these standards will improve healthcare services for children and ensure that specialist child health expertise and support are available to strengthen primary care services, where the needs of the child and their family are known.

There is consensus as to what needs to be done and we are committed to working through our membership and with services, commissioners, planners and inspectorates to support them to implement the changes needed to meet these standards.

**Dr Hilary Cass**
**President, Royal College of Paediatrics and Child Health**

**Dr Maureen Baker**
**Chair of Council, Royal College of General Practitioners**

**Cecilia Anim**
**President, Royal College of Nursing**

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# Executive summary

The Royal College of Paediatrics and Child Health (RCPCH), the Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) have worked together to develop this new set of standards in the Facing the Future suite, *Facing the Future: Together for Child Health*.

The standards apply across the unscheduled care pathway to improve healthcare and outcomes for children, focussing on the acutely mild to moderately unwell child.

They aim to ensure there is always high-quality diagnosis and care (safe, effective and caring) early in the pathway, providing care closer to home where appropriate (right care, right time and right place). The standards will ensure specialist child health expertise and support are available directly into general practice services, where the needs of the child and their family are known. The standards will build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

There are three overarching principles and 11 standards in total.

Standards one to six focus on supporting primary care to care safely for the child in the community, preventing unnecessary attendance at an emergency department or unnecessary admission to hospital.

It will of course be necessary for some children to be cared for in hospital, and standards five to eight focus on reducing the length of stay and enabling these children to go home again as safely and as quickly as appropriate (while preventing unnecessary reattendances and readmissions).

Standards nine to 11 look more widely at connecting the whole system, streamlining the patient journey and improving the patient experience.

*Facing the Future: Together for Child Health* represents a standard of care which children and their parents and carers can expect from the healthcare professionals looking after them. We hope that healthcare professionals will see them not just as standards to strive toward, but as a lever to continue to improve the safety, quality and sustainability of services.

**Dr David Shortland (Chair)**
**Past Vice President, Health Services, RCPCH**

**Professor Nigel Mathers**
**Honorary Secretary, RCGP**

**Fiona Smith**
**Professional Lead for Children and Young People's Nursing, RCN**

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# Case for change

The *United Nations Convention on the Rights of the Child*[1] sets out the minimum entitlements and freedoms that children everywhere have the right to expect; this includes 'the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'.

While children's health has improved greatly in the UK over the last 30 years, the UK continues to lag behind much of Western Europe and performs poorly on several measures of child health and wellbeing, including mortality[2, 3]. The RCPCH's *Why Children Die* report[4] highlights a need to better manage sick children and recommends that measures are taken to improve recognition and management of serious illness across the healthcare service.

The vast majority of children's illnesses are minor, requiring little or no medical intervention, and it can be difficult for healthcare professionals to identify the very few children with serious illnesses, which may have non-specific presentations and clinical features mimicking those of common, non-serious illness. Primary care services must be better equipped to identify children with early signs of serious illness, enabling them to be appropriately managed at first point of contact and ensuring that all children receive the right care at the right time before the illness has the opportunity to escalate.

Parents' preference for initial advice is their General Practitioner (GP)[5] and GPs are the main healthcare providers for children and their parents and carers. Children make up nearly one-fifth of the population and are estimated to account for around a quarter of a typical GP's workload. Yet less than half of GPs are given the opportunity to undertake a paediatric placement during their training. The RCGP and RCPCH are working together to ensure that in future all GP trainees receive specialist-led training in children's health. However, in the interim this leaves many GPs without the skills and confidence to assess and treat children in their surgery, leading many to refer children to hospital for conditions that could be managed in general practice or other community settings.

Reports continue to highlight the growing strain that urgent and emergency care services are under, and within the UK there is wide variation in the rate of emergency department attendances and admissions[6]. More than a quarter of emergency department attendances are by children and the number of children presenting at emergency departments and the number of emergency admissions have increased substantially over the last decade. In England alone there has been a 28% increase in admissions for all children, with a particularly sharp increase for those under five years old[7].

Estimations of the proportion of these emergency department attendances which are unnecessary (patients with low urgency problems which are unlikely to require admission and are more suitable for other services, such as general practice services, telephone advice helplines or pharmacies) and potentially avoidable vary from 15%[8] to 40%[9]. Within these estimates the largest subgroup is children presenting with symptoms of minor illness (highest for one and two year olds but also elevated between mid-teens and mid-twenties)[10, 11]. Some children appear to be bypassing general practice and heading straight to the emergency department, while others are having numerous encounters with different healthcare professionals before also ending up at hospital.

Hospital admissions of less than 24 hours duration (so called zero-day admissions) have also doubled during the last decade[12]. While the reasons behind this rise are complex - for example, some of this change may be accounted for by the increase in short stay paediatric assessment units - high zero-day admission rates may also reflect systems failure in emergency departments, where admission to hospital becomes a default or preferred option, or reduced capacity of general practice to manage children in the community.

Not only are some emergency department attendances and hospital admissions unnecessary, they may even be harmful. Admission to hospital can result in additional morbidity such as hospital-acquired infections as well as distress, disruption and cost to children and their families (separation, school absence, travel time and travel cost). They are an unnecessary and wasteful high-cost intervention in a resource-limited health service. We need to consider whether some episodes of acute illness could be safely and better managed without a visit to the emergency department or an admission to an inpatient ward by using alternative models of care and providing better connected care in the community.

Where children do need to be seen in hospital, finding alternative routes into the hospital which by-pass the emergency department and stream patients according to urgency will release space in the emergency department for the patients who require the most intensive treatment. We need to ensure that children get the right treatment, in the right place and get home again as quickly as is appropriate.

The RCPCH *Facing the Future: Standards for Acute General Paediatric Services*[13], published in 2010 and revised in 2015, addressed some of the changes needed within the acute hospital environment. If we are to really improve outcomes for all children we need to look across the healthcare pathway at all healthcare professionals working with children and consider new ways of working, building connections between services and bringing specialist child health expertise into primary care, to ensure that we are all working to the same shared high standards. We need to help children and their parents and carers navigate the options available to them, including self-care for minor illnesses at home.

# Aims and scope

In addition to revising the original *Facing the Future: Standards for Acute General Paediatric Services*[14] to respond to new evidence and changing needs, the RCPCH continues to look at visionary and innovative models of service provision.

The RCPCH, RCGP and RCN have worked together to develop a new set of standards in the Facing the Future suite, *Facing the Future: Together for Child Health*, which apply across the unscheduled care pathway to improve healthcare and outcomes for children.

The standards build on *Facing the Future: Standards for Acute General Paediatric Services* and the *Standards for Children and Young People in Emergency Care Settings*[15], expanding them into care outside the hospital. They aim to ensure there is always high-quality diagnosis and care (safe, effective and caring) early in the pathway and to reduce unnecessary attendances at emergency departments and admissions to hospital by providing care closer to home where appropriate. Where children do need to be cared for in hospital, the standards aim to reduce the length of stay, enabling these children to go home again as safely and as quickly as appropriate, while preventing unnecessary reattendances and readmissions.

The standards will strengthen services and ensure specialist child health expertise and support are available directly into general practice services, where the needs of the child and their family are known. They will ensure good connectivity between primary care, the hospital and community services.

The standards focus on the unscheduled care of acutely mild to moderately unwell children across the UK.

The standards do not explicitly cover the safeguarding of children in unscheduled care settings. This is covered in detail in existing guidance, for example, the RCGP *Safeguarding Children Toolkit for General Practice*[16].

The Royal Colleges play a leading role in setting and ensuring the highest standards of care for patients. The standards are intended to be a tool and resource for healthcare professionals, commissioners, planners, providers, managers, regulators and inspectorates to help plan, deliver and quality assure children’s healthcare services. Services need to be designed and developed in partnership with children and their parents and carers and other local stakeholders.

# Development of the standards

The standards have been developed to meet the needs of children and have been developed by those with expertise in the system, including children and parents and carers themselves. The development of the standards has been overseen by an Intercollegiate Project Board (see page 45) in consultation with a wide range of stakeholders.

The following key stages have been undertaken in the development of the standards:

## Stage one: analysis

### Systematic literature review

As part of the evidence base for the project a systematic literature review was carried out. The review looked at 'what interventions by paediatricians and child health specialists improve outcomes for children with acute illness presenting in the unscheduled care pathway?'.

Key databases including Medline, Embase, the Cochrane Collection and NHS Evidence were searched in February 2014, returning 7,560 papers. Following a title screen this was reduced to 1,237 papers. An abstract screen was carried out independently by two reviewers using the inclusion and exclusion criteria and 109 papers were identified for inclusion. The full text of the papers selected for inclusion was obtained and a final full text screen carried out, with 81 papers identified to go forward for full appraisal. Each paper was critically appraised by two independent reviewers to ensure its validity and key data was extracted and collated into evidence tables.

### Call for evidence

A call for evidence was issued and a hand search of relevant websites carried out, identifying another six papers for inclusion. Each of these papers was appraised and included in the evidence tables.

### Views of children and parents and carers

The Royal Colleges recognise that children and their parents and carers are not only beneficiaries of healthcare but also key stakeholders with invaluable insights and experiences. The RCPCH worked strategically with the Project Board to ensure the insights of children and parents and carers meaningfully informed and influenced the development of the standards. There was a parent/carer representative on the Project Board from the outset and the principles outlined in *Not Just a Phase: A Guide to the Participation of Children and Young People in Health Services*[17] provided a framework for involving children, parents and carers.

The RCPCH held a focus session with the RCPCH Youth Advisory Panel in March 2014 (14 young people, male and female, aged between 14 and 26 years old from across the UK). A full report was considered by the Project Board on the insights of the young people, including their key issues and messages for quality healthcare improvement to support the development of the standards.

The RCPCH also held a focus session with the RCPCH Parents and Carers Group in March 2014 (six parents and carers from across the UK). A full report was again considered by the Project Board.

### Surveys of current practice

A SurveyMonkey questionnaire was sent to all paediatric clinical directors in the UK to ascertain what interventions by paediatricians and other child health specialists were already in use to improve outcomes for children in the unscheduled care pathway. The survey was sent to clinical directors in February 2014 and the RCPCH received 87 responses.

To complement and triangulate the results from the survey of paediatric clinical directors similar surveys were developed for GPs via the RCGP and for community children's nursing teams via the RCN. The surveys were sent in May 2014 and 358 responses were received from GPs and 70 from community children's nursing teams.

A summary of the results of all three surveys is available on the RCPCH website[18].

## Stage two: formulation of the standards

The evidence from the literature review, call for evidence and surveys and the views of children and parents and carers were evaluated by the Project Board. Drawing on the best available evidence, a set of draft standards was developed. Where there was insufficient evidence, standards were agreed by consensus.

Despite the widespread concern, there is little published evidence to inform the most appropriate method for reducing emergency department attendances and hospital admissions for children and much of the evidence that does exist is of poor methodological quality. There is a need for high-quality, well-conducted research and any future service improvement should be implemented in such a way as to allow objective evaluation.

## Stage three: consultation

### Stakeholders

The draft standards were circulated to key Royal College committees and to external stakeholders to ensure that they are: relevant and achievable; specific and measureable; clear and consistent; to identify any gaps and suggestions for additional standards; and to engage users and key stakeholders.

Key RCPCH committees included: British Association for Community Child Health, British Association of General Paediatrics, Child Protection Standing Committee, Clinical Standards Committee, Executive Committee, Informatics for Quality Committee, Ireland Executive Committee, Paediatricians in Medical Management Committee, Paediatric Mental Health Association, Parents and Carers Group, Remote and Rural Special Interest Group, Scottish Executive Committee, Trainees' Committee, Wales Executive Committee and Youth Advisory Panel.

Key RCN committees included: Children and Young People: Continuing and Community Care Forum.

Key RCGP committees included: Child and Maternal Health Group.

Key cross-college committees included: Children's Surgical Forum, Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings, Neonatal and Paediatric Pharmacists.

Key stakeholders included: Children and Young People's Health Outcomes Forum, Kings Fund, NHS England, Royal College of Physicians, Royal College of Psychiatrists and Strategic Clinical Networks, as well as individual GPs, paediatricians, emergency medicine practitioners, community children's nurses, health visitors, commissioners and allied health professionals.

## Site visits

Based on the results of the surveys, eight sites were identified for further exploration of the models in use, to 'road test' the standards and to develop practice examples for inclusion in the final report. These sites, which were visited during August and September 2014, were:

- Aneurin Bevan Local Health Board (Royal Gwent Hospital)
- Barts Health NHS Trust (Royal London Hospital)
- Calderdale and Huddersfield NHS Foundation Trust
- Hywel Dda Local Health Board (Bronglais General Hospital)
- NHS Lanarkshire (Wishaw General Hospital)
- North Cumbria University Hospitals NHS Trust (West Cumberland Hospital)
- South Eastern Health and Social Care Trust (Ulster Hospital)
- South Tyneside NHS Foundation Trust (South Tyneside District Hospital)

The standards were then refined by the Project Board incorporating the feedback from the consultation prior to endorsement by the RCPCH, RCGP and RCN.

# Key terms and definitions

| | |
|---|---|
| **Children:** | Infants, children and young people under the age of 18 across the UK. |
| **Consultant paediatrician:** | A consultant paediatrician or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota. |
| **Healthcare:** | Throughout the standards we use the terms ‘healthcare’ and ‘health’ to refer to all aspects of health and wellbeing, including physical, mental and emotional health. |
| **Healthcare professional:** | A clinically qualified person who is working within the scope of practice as determined by their relevant professional body and who is registered with that body as competent to practice, for example, the General Medical Council or the Nursing and Midwifery Council. |
| **Parents and carers:** | To identify and acknowledge those who hold parental responsibility but who may not be the biological parent. |
| **Unscheduled care:** | Healthcare which cannot reasonably be planned in advance of contact with the relevant healthcare professional. It follows that such demand can occur at any time and that services to meet this demand must be available 24 hours a day. |

# Standards

The standards are first listed and then presented alongside:

- The rationale and evidence base
- Guidance notes to support implementation of the standards
- Metrics for use both by services to monitor progress towards the standards and by the Royal Colleges in future audits to assess whether the standards are being met
- Practice examples to illustrate how the standards are already being implemented

The metrics are based on information that is currently collected or can be made readily available. Any additional data which services might collect to monitor use of the service is also suggested under the activity data. Outcome measures are being developed in a separate RCPCH project (page 44).

## Overarching principles

- Every child should have timely access to high-quality unscheduled 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.
- 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).
- Service providers, planners, commissioners and users should work together across hospital and community services, primary and secondary care and paediatrics and general practice to design and deliver efficient and effective unscheduled care in a geographical network which is responsive to the needs of local children and their parents and carers.

## Summary of the standards

1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.
2. Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.
3. There is a link consultant paediatrician for each local GP practice or group of GP practices.
4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.
5. Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.
6. There is a link community children's nurse for each local GP practice or group of GP practices.
7. When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.
8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.
9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.
10. Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.
11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

# Standard one

GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.

## Rationale and evidence

If more children are to be cared for in the community without follow-up in the hospital, the child and their parents or carers must have confidence in their GP and the GP must be supported by the local paediatric team, with easy access to specialist child health advice when needed.

If a GP is able to speak directly to a consultant paediatrician about a specific child, the consultant paediatrician can offer immediate specialist advice and support to the GP in caring for the child safely in the community, preventing an unnecessary admission to hospital[19-22]. Some queries will result in a referral, but these will be better directed to the correct service[23]. The discussion may also help to reassure anxious parents and carers and increase their confidence in how children's health services fit into general practice, preventing unnecessary attendances at emergency departments.

## Guidance

The telephone advice, in the form of a hotline or hot phone or using videoconferencing technologies etc., is for GPs to directly access consultant level general paediatric advice and support where this may prevent an admission to hospital. If a GP is unsure whether a child needs admission they can speak to a paediatric consultant who can advise whether admission is needed, if the child can be seen in the rapid-access service (see standard two) or if the child can be managed by the GP safely in the community and provide support to the GP to do this.

Clinical governance responsibility for patients discussed is retained by the GP.

As an exception, level three paediatric trainees approaching consultancy may, as a training experience and following discussion with a consultant, provide advice to GPs.

The telephone advice service is in addition to the established routes of 999 for emergencies or calls through the switchboard where advice is sought on minor ailments, treatment, medication or results of investigations. It is not intended that this telephone advice service be used for safeguarding queries which should continue to follow the well established locally agreed routes.

The hours of the telephone advice service need to be agreed locally between the hospital and general practice (including out-of-hours GPs). We would expect the majority of calls to be between 8am and 10pm. Usage should be monitored locally to ensure that it is being used appropriately.

Services need to determine locally whether the telephone advice service is also open to other healthcare professionals seeing children at first contact outside the hospital, for example, urgent care centres or health visitors.

## Metrics

| Metrics | Activity data |
|---|---|
| • Evidence of GP access to immediate telephone advice from a consultant paediatrician<br>• Hours of operation<br>• GP satisfaction | • Number of GP practices using the hotline<br>• Number of calls received<br>• Types of queries received<br>• Time taken for calls<br>• Outcome of calls |

## Practice examples

**Senior telephone advice**
**Nottingham Children's Hospital, Nottingham University Hospitals NHS Trust**

A project team working on improving the pathway for emergency medical admissions identified that when a GP called with concerns about a child the call was taken by a junior doctor and always resulted in the GP being advised to send the child into the Children's Assessment Unit. The Project Team hypothesised that if the calls were taken by someone senior, with more extensive paediatric knowledge than the GP making the call, it might be possible to have a more proactive discussion and identify some appropriate options that did not involve an on-the-day attendance.

Nottingham already had a 'hotweek' consultant rota for emergency admissions, so the group proposed a trial of having the hotweek consultant take the GP calls to see how many could be diverted from the hospital. Simple paperwork was developed using the Situation, Background, Assessment and Recommendation (SBAR) format.

The trial ran for one week and found that 30% of patients did not need to attend; some were diverted to routine outpatient or rapid-access clinics and some were managed by the GP with advice from a consultant. There was an additional, unexpected, outcome of two patients being escalated as a result of the call and a 999 ambulance called. In some practices, the clinical discussion prompted the GP to change practice or purchase equipment such as a saturation monitor.

The initial trial identified that the idea was worth pursuing and further trials confirmed this. The change in process was fully implemented and has also been rolled out for other specialties. Analysis of the paediatric calls has shown that the outcomes are: 63% sent to the Children's Assessment Unit; 13% referred to a rapid-access clinic; 4% referred to routine outpatients; 15% managed by GP with advice from the consultant; and 4% escalated.

*'I sometimes send people in - particularly children, because I am being cautious. Discussion with a senior paediatrician may give me confidence to keep at home.'* GP using the telephone advice service

Further details: childrenshub@nuh.nhs.uk

**Paediatric Unscheduled Care pilot (PuC)**
**North of Scotland Planning Group**

25% of children in Scotland live in remote and rural settings which present challenges in providing safe, sustainable paediatric care. The PuC pilot trialled a dedicated on-call paediatric consultant model, providing 14 rural general and community hospitals with single point of contact access to paediatric consultants, 24 hours a day, seven days a week, via videoconference with project management being provided by NHS24.

Sixteen on-call consultants were recruited; all were within 10 minutes of secure broadband access and standardised SBAR documentation was used. Within individual rural hospitals, following initial nurse triage, there are two models in place: 1) Assessment by a trainee (foundation year/GP trainee). Many children are then referred on to regional paediatric services, without further evaluation. Rural (adult) physicians have clinical responsibility for the care of the child whilst in hospital until the child reaches definitive care but, in practice, rarely get involved. 2) Evaluation by experienced rural practitioners, who may carry out investigation or initiate active management, prior to referral for advice/transfer.

230 referrals were made to PuC (152 managed locally, 21 retrieved and 57 transferred). An independent evaluation by the Centre for Rural Health noted that videoconferencing enhances clinical assessment and decision support of children in remote locations, with rapid-access to senior advice being valuable in this setting. Parents and carers find videoconferencing helpful which helps improve further the outcome for children. Even in children requiring transfer, early assessment and management adds value. External Expert Review by a rural GP noted that 33% of cases showed improved outcome: *'PuC added value and security to the children seen.'* A paediatric intensive care consultant stated improved outcome in 20 to 25% of cases: *'PuC avoids unnecessary admission/transfer/retrieval and offers significant support to remote and rural locations.'*

Further details: Dr Donald MacGregor, Consultant Paediatrician, donaldmacgregor@nhs.net

## Standard two

Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.

### Rationale and evidence

Parents and carers increasingly will not wait if they are anxious about the health of their child; they want easy access to what they perceive as 'expert enough' advice that they will be happy to follow.

Equally, judgement of the severity of illness in children is often not straightforward, particularly over the phone, and even child health professionals may only arrive at a definitive opinion after physical assessment of the child.

A rapid-access service contributes to right place, right time and senior review of patients. It offers a scheduled appointment for children within an acceptably short time frame, helping to remove children from unscheduled care services and prevent emergency department attendances and admissions to hospital.

Acute assessment clinics have been shown to provide a safe, effective and acceptable alternative to admission for children[24].

### Guidance

The rapid-access service (or hot clinic) is a consultant-delivered service aimed at providing a quick, senior paediatric opinion for children who are not ill enough to be referred to the emergency department but who cannot wait for a routine outpatient consultation.

The majority of children should be seen within 24 hours, but in some circumstances this may be extended to 72 hours according to clinical judgement and the needs of the child. The GP and the paediatrician must agree on the urgency and contact should be made with the child and their parents or carers to explain this and reassure them.

Referrals to the rapid-access service may come from general practice (via the hotline), the community children's nursing service or the emergency department. Clear criteria should be developed locally for referral and referrals should be monitored for appropriateness.

Children may be seen by a senior paediatric trainee (level three) first and then discussed with a consultant paediatrician, who should be available on site to review the child if needed.

### Metrics

| Metrics | Activity data |
|---|---|
| • Evidence of a rapid-access service<br>• Percentage of children referred seen within 24 hours<br>• Percentage of children seen by a consultant<br>• GP satisfaction | • Number of children seen<br>• Number of children admitted<br>• Source of referrals |

## Practice examples

### Rapid-access clinic
### Rotherham Hospital, Rotherham NHS Foundation Trust

A rapid-access clinic was set up in Rotherham Hospital 20 years ago with the aim of providing an immediate consultant appointment for GP and emergency department referrals of children less than 16 years old who are not acute emergencies but who cannot wait for a routine outpatient appointment.

The rapid-access clinic is located within a children's clinic on the hospital site with full access to pharmacy, laboratory and imaging services and to inpatient facilities if these are required. The clinic is run by a consultant paediatrician who is rostered to the clinic on a 1:7 basis. This is identified in the job plan as two hours clinic time with an hour administration time associated with the outcomes from the clinic. Clinics run from Tuesday to Friday between 1.30pm and 3.30pm, with four 30 minute appointments available. Referrals are made by telephoning a dedicated number in the Children's Clinic and bookings are only made 48 hours in advance. If there are no slots, the clinic staff re-direct the GP or referrer to the on-call paediatric registrar who discusses alternatives, for example, children's assessment unit, routine clinic appointment or specialist nurses. The rapid-access clinic has been used to give feedback and complete a mini-Clinical Examination Exercise (CEX) for trainee registrars with the trainee doing the clinic and the consultant observing.

In July 2013, 38 case notes of children referred to the rapid-access clinic were reviewed retrospectively. Of children seen, 55% were under 12 months of age and 29% were between one and five years old. Children were mostly seen for medical conditions; 79% of referrals were from GPs and 8% of referrals were from the emergency department. The rest came from consultants, asthma nurses or other sources, for example, health visitors. The outcome of the consultation was that two children were admitted, seven were discharged, 23 were investigated and/or given medication and 25 had follow-up arranged.

Recommendations for consideration in setting up a rapid-access clinic:
- Consult with stakeholders (GPs/commissioners/clinic staff/consultants/trainees)
- Identify availability of clinic rooms and scheduling
- Write a set of simple guidelines for referral (why, what, where, when and how)
- Ensure a 48 hour booking rule; otherwise the clinic ceases to function as a rapid-access clinic
- Monitor, evaluate, audit, implement change and re-audit
- Consider conducting patient satisfaction surveys to gain feedback on the service

Further details: Dr Sanjay Suri, Consultant Paediatrician, sanjay.suri@rothgen.nhs.uk

## Standard three

There is a link consultant paediatrician for each local GP practice or group of GP practices.

### Rationale and evidence

Strong links between paediatricians and GPs are fundamental to providing more efficient and higher quality care for children in the community.

While the immediate telephone advice service allows GPs to get timely advice on the best approach to treatment or onward referral, the link paediatrician connects hospital-based children's services with local GP practices and community-based professionals to build relationships and share knowledge. This will help to strengthen the paediatric capabilities and confidence of GPs, supporting them to manage children in the community (helping to decrease unnecessary attendances at emergency departments and referrals to hospital).

Outreach or joint clinics with paediatricians and GPs also help to improve links with general practice, building capability and learning, and may help to reduce the need for a referral to hospital, streamlining the patient journey and providing care closer to home.

### Guidance

The link paediatrician is a named consultant paediatrician who acts as a point of contact between the group of GP practices and the general paediatric service. They have a role in coordinating and signposting services and resources to the group of GP practices; for example, this may include answering non-urgent email queries, participating in case discussions and attending multidisciplinary team meetings.

The link paediatrician plays an active role in sharing knowledge and best practice. This includes being available at least twice a year to visit the group of practices for an informal discussion and knowledge exchange which might include cases of interest, new developments in paediatrics, patterns and trends in child health, changes in local services and reviews of frequent emergency department attenders.

### Metrics

| Metrics | Activity data |
|---|---|
| • Evidence of a named link consultant paediatrician for each GP practice or group of practices<br>• GP satisfaction | • Number of contacts between link consultant and GP practices a year |

## Practice examples

**Imperial Child Health General Practice Hubs**
**St Mary's Hospital, Imperial College Healthcare NHS Trust**

The Imperial Child Health General Practice Hubs comprise groups of two to six general practices, within inner North West London, working with paediatric consultants to provide care to practice populations of approximately 4,000 children. The hubs were established in response to high outpatient and emergency department attendances by children.

At the heart of this model is an openness to discuss cases, share ideas and learn together. GPs in the hub practices might have a telephone or email conversation with a consultant to discuss the most appropriate approach for a particular patient. Where patients do not require face-to-face consultant input but discussion by the broader team would be beneficial, the case is brought to a monthly Multi-Disciplinary Team (MDT) meeting in the GP Hub. Any member of the team can bring cases, including health visitors, practice nurses, community therapists, mental health workers and social workers. The majority of cases are resolved within the MDT. The MDT also allows senior triage of patients who require treatment in a paediatric sub-speciality directly to the appropriate clinic, rather than having an initial general paediatric appointment as before. Some patients are seen by the GP and paediatrician together in the joint-clinic that follows the MDT.

A culture of education and learning is key and each MDT meeting includes a short learning session run by the visiting consultant. Following the meeting, a joint outreach clinic is held by a consultant with a hub GP. Clinical governance responsibility for patients referred to the outreach clinic rests with the consultant. Responsibility for patients discussed at an MDT meeting or over email or telephone is retained by the GP. Evaluation of the pre-pilots shows that the hubs have the potential to decrease the number of referrals to hospital outpatients and attendance at paediatric emergency departments.

Further details: www.cc4c.imperial.nhs.uk

**Child HealthCare Closer to Home (C3)**
**Calderdale and Huddersfield NHS Foundation Trust**

Children’s journey into acute care is often fragmented, with the focus being around a specific professional and building rather than the family. Partners from Calderdale and Greater Huddersfield health and social care organisations have worked collectively to deliver improved services for local children, with the overall aim of developing enhanced paediatric provision and expertise closer to the child's home. C3 foundations lie in self-management, empowering families to have the confidence to manage their own health conditions and know when to escalate appropriately.

The C3 model has been to set up two multi-professional care clinics with a paediatric consultant, advanced paediatric nurse practitioner, GP and community nurse. One of the clinics is delivered in a local GP surgery and the other in a local children’s centre, offering users a service in family friendly hours (4pm to 8pm). Referrals are accepted from pre-selected pilot site GPs with user and referrer experience being at the heart of the project. Interventions are recorded via an electronic shared record. This has aided timely communication across primary and secondary care. On the horizon there is a push in primary care to move towards 8am to 8pm and weekend opening, recognising the need for acute care for children closer to home.

The project has led and encouraged communication and shared learning with primary care and ensured health and self-care is high on the agenda of community services, families and children’s centres. C3 is also developing pathways of care, education and expertise for use within primary care.

Recommendations for consideration in setting up a similar service:

- Establish good relationships and buy-in from commissioners and providers at the start
- Change requires tenacity and enthusiasm
- You can never communicate enough
- Strong administration support is required

Further details: http://c3.cht.nhs.uk

## Standard four

Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.

### Rationale and evidence

Around a quarter of patients seen by a GP are children, but currently less than half of GPs are given the opportunity to undertake a paediatric placement during their training. The RCGP and RCPCH are working together to ensure that in future all GP trainees receive specialist-led training in children's health.

Paediatricians' attendance at protected learning time events for primary care doctors and nurses helps to build relationships and improve understanding of child health with positive impacts on clinical practice[25]. This is particularly important given the lack of paediatric training of many GPs, but the learning runs both ways and paediatricians can learn a lot about their patients from discussing cases with GPs and other primary care staff.

### Guidance

In addition to the role of the link paediatrician in supporting informal advice and knowledge sharing, all acute general children's services contribute to local primary care education and training sessions to share updates and best practice and enhance continued professional development. For example, this could include training on and dissemination of the care pathways for common conditions (see standard 10).

The education content should be jointly agreed between paediatrics and primary care and be regularly reviewed to assess its effectiveness. The content should include recognising and assessing the acutely ill child.

To facilitate and support closer working between GPs and paediatricians, GPs are encouraged to take advantage of these opportunities.

### Metrics

| Metrics | Activity data |
|---|---|
| • Evidence of two GP education and knowledge exchange sessions held a year<br>• Percentage of GPs attending one session every two years<br>• Percentage of GPs attending one session every year<br>• GP satisfaction | • Number of GPs attending<br>• Number of paediatricians attending |

## Practice examples

**Up-skilling GPs and nurses in the clinical management of children with acute health problems**
**Partners in Paediatrics**

In October 2010, research at University Hospital North Staffordshire (now known as University Hospitals of North Midlands) identified that the number of children with acute health problems admitted to paediatric wards was about twice the admission rate of other hospitals in similar communities. It also identified the top 10 conditions where children referred into the hospital by a GP were discharged within four hours without active clinical intervention.

An interactive up-skilling programme for primary care was developed through a business case model. The work was supported by Partners in Paediatrics. The main objectives of the programme were to:

- Increase the competence and confidence of GPs and nurses in the clinical management of children with acute health problems
- Reverse the year-on-year rise in inappropriate referrals to the Paediatric Assessment Unit by primary care clinicians
- Improve the patient experience, particularly providing services closer to patient homes

Ten master-class sessions, run by paediatric consultants, were held in spring and summer 2011 to increase competence and confidence in managing acute paediatric conditions in primary care. Approximately 250 clinicians took part, including 114 GPs (40% of the GP cohort), 79 nurses and participants from other clinical backgrounds, including student doctors, clinical educators and community midwives.

Master-class topics included respiratory problems, failure to thrive, gastroenteritis, abdominal pain, constipation, fever management/febrile child, fits, faints and funny turns, mixture of acute admissions, rashes and skin problems. Paediatric pre-referral guidelines and urgent care referral guidelines were produced and made readily available to all clinicians in primary care.

The overall response to the programme was extremely positive. Participants welcomed the wide range of practical tips for managing conditions in the community working with parents and many rated the explanation of the NICE and locally developed urgent care guidelines particularly highly. After 18 months, GPs and nurses who took part in the up-skilling project indicated that they felt more competent and confident in the clinical management of children with acute health problems, that they are retaining more care within general practice and that they are referring more appropriately. They also felt better able to advise and support parents and carers. Of the 28 GPs who responded to the post master-class evaluation, most believed that the master-classes had increased their ability and confidence in the clinical care of children, particularly those with acute health problems. Specific changes in practice identified from attending the master-classes included use of saturation probes to check oxygen saturations in respiratory paediatric cases and use of pulse oximetry for children.

Further details: www.partnersinpaediatrics.org

# Standard five

Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week for advice and support, with visits as required depending on the needs of the children using the service.

## Rationale and evidence

Appropriate help from a community children's nursing service is essential to support parents and carers and to enable them to care for their child at home[26]. Care in the community by Community Children's Nurses (CCNs) provides a safe and acceptable alternative to hospital care for children with acute medical conditions and results in high parental satisfaction, including a reduction in parental anxiety[27-29].

CCN care has the potential to avoid some onward referrals and prevent admissions. The CCN service can provide follow-up assessment and care to prevent hospital admission of the mild to moderately ill child. Parents of children who have long-term conditions or complex needs highly value being able to call the CCN service when their child's condition changes due to an acute illness as an exacerbation or complication of an underlying condition. CCNs familiar with the child are able to assess in the home whether or not they need hospital admission, preventing unnecessary journeys to a GP surgery or hospital[30].

CCN services can not only prevent hospital admission but, for those who need to be admitted, they can enable early discharge, reducing the length of stay (with no significant difference in readmission rates) by providing a continuum of care from the hospital into the home[31].

## Guidance

The CCN service operates 24 hours a day, seven days a week, for on-call telephone advice and support and, as a minimum, provides visits between 8am and 8pm, seven days a week. The CCN service needs to be flexible, working on behalf of GPs and the acute children's inpatient service to accommodate the needs of children.

The CCN service provides services aimed at avoiding admission to hospital, for example, at the request of other healthcare professionals, including GPs (see standard six), the assessment of children with acute problems at home or a designated location (for example, children's centres or GP practices). The CCN also supports the early discharge of children admitted to hospital.

The CCN service provides care for children with acute and short-term conditions (as well as children with long-term conditions, children with disabilities and complex conditions and children with life-limiting and life-threatening illness).

The location of the CCN service will vary, but it needs to have strong links to primary care, hospital and community services to ensure continuity of care. It will also work closely with adult services to facilitate transitions. CCNs also play a key role in educating parents and carers.

## Metrics

| Metrics | Activity data |
|---|---|
| - Evidence of on-call access arrangements 24 hours a day, seven days a week<br>- Evidence of acute visits between 8am and 8pm, seven days a week | - Number of referrals<br>- Source of referrals |

## Practice examples

**Seven day community children's nursing team**
**South Tyneside Community Children's Nursing Team (CCNT)**

The South Tyneside CCNT has grown and evolved according to the needs of service users and providers since its formation in 1998. The CCNT provides a safe and comprehensive seven day service, 8am to 6pm, 365 days a year, with the aim of preventing hospital admission and reducing length of stay. It provides direct nursing care and education in the community to support families with children during acute, chronic and palliative phases of illness. Referrals can come from anywhere, but the child must live within the borough and be within the specified age range.

An example of admission avoidance: Child A was brought to the Urgent Care Centre with symptoms of sepsis. A full septic screening was performed and intravenous antibiotics prescribed and administered. When Child A was clinically stable some hours later, the child was discharged from the Urgent Care Centre to the CCNT. The child was then visited daily for the administration of intravenous antibiotics and clinical review. The parents were encouraged to contact the CCNT if they had any concerns or, if the child deteriorated, to return to the Urgent Care Centre immediately. At the end of the prescribed course of treatment the child was assessed in the rapid review clinic by a consultant.

An example of reduction of length of stay: Child B was brought to the Urgent Care Centre with signs of sepsis and was clinically unstable. A full septic screen was performed and the Child was stabilised, then transferred to City Hospital Sunderland with a diagnosis of meningococcal meningitis for an inpatient episode. On day three, Child B was discharged into the care of the CCNT to continue the 10 day course of intravenous antibiotics. Child B's follow-up was in the rapid review clinic locally.

Further details: Gill Gunn, Team Leader, 01912 022183

**Extended hours community children's nursing team**
**Islington Community Children's Nursing Team (CCNT)**

The Islington CCNT has tripled since its formation in 1997. The team provide a safe and comprehensive service with the aim of facilitating early discharge from hospital and preventing and reducing unnecessary attendances and admissions to hospital. The borough serves an estimated child population of 40,000, which is due to increase by approximately one-sixth by 2030.

The Hospital@Home service began in August 2014 and runs from 8am to 10pm. It has been developed with input from acute paediatricians and a referral criterion is that the child has a working diagnosis and physical signs and symptoms within set parameters. Accountability for the care of the child remains with the consultant paediatrician with a nurse-led discharge. The CCNT provide safety netting information following a visit and parents and carers can call the CCNT for advice from 8am to 10pm (support is provided by the Whittington Hospital outside these hours). GPs can refer directly to the CCNT and the CCNT also run primary care clinics supporting the education of practice nurses.

The CCNT is made up of 17.5 Whole Time Equivalent (WTE) nurses, 1.5 WTE administrative support and 0.5 WTE consultant paediatrician. From August to December 2014, 107 referrals were made with 376 face-to-face contacts. Positive feedback has been received through patient and parent surveys.

Recommendations for consideration in developing a similar service are:

- Be reasonable in your expectations
- Research how other services have developed their service and adapt local pathways
- Find a paediatrician to champion the service
- Consider involving other services such as physiotherapy and dietetics
- Develop a good working relationship with commissioners

*'This is an excellent service; the staff are very professional and friendly. They are really knowledgeable and made me feel confident to look after my child at home when he was unwell. I was so reassured that they did what they said they would do and acted as a link between hospital and home.'* Parent

Further details: Jeanette Barnes, Matron, jeanettebarnes@nhs.net

## Standard six

There is a link community children's nurse for each local GP practice or group of GP practices.

### Rationale and evidence

Referral from GPs to CCN services that can provide care to children at home has the potential to avoid some attendances at emergency departments and admissions to hospital. However, CCN services only receive a minority of referrals from GPs, although referral patterns do vary widely, reflecting differences in location and service design. GPs have an important role in identifying children for whom CCN care would be of benefit and could reduce the need for hospital attendance.

In order to facilitate referral between GPs and CCN services, GPs must both be aware of the CCN services and have confidence in CCNs' ability to safely manage acutely ill children at home[32]. Even where care protocols are agreed, it takes time to build the trust of GPs in making referrals to the CCN service.

A link CCN can increase the visibility of CCN services and help to develop a trusting relationship, supporting GPs and increasing appropriate referrals to the CCN service. GPs' confidence in CCNs' ability to safely manage children at home can also be secured through frequent demonstration of clinical skills and a safety net of rapid-access to assessment facilities and paediatric consultant cover.

### Guidance

The link CCN is a named CCN who acts as a point of contact, providing coordinating and signposting advice and support to the group of GP practices.

The link CCN promotes and acts as a conduit to the CCN service. The link CCN will meet regularly with their group of GP practices to highlight the CCN service, referral mechanisms, clinical protocols and audit of outcomes, including reduction in hospital admissions. This may also include attending multidisciplinary team meetings. The link CCN plays an active role in sharing knowledge and best practice.

The CCN service works with local general practice to prevent unnecessary admissions to hospital, undertaking visits at the request of GPs and other healthcare professionals. This may include holding outreach clinics in GP practices or community settings.

### Metrics

| Metrics | Activity data |
|---|---|
| • Evidence of a named link CCN for each GP practice or group of practices<br>• GP satisfaction | • Number of referrals from GPs<br>• Number of visits to GP practices a year |

## Practice examples

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

COAST is based within the Community Children's Nursing Service and consists of two teams: one based in Portsmouth and one in Southampton. COAST was established in 2008 to facilitate early discharge from hospital and to reduce unnecessary attendances and admissions to hospital.

COAST is a distinct team of nurses within the Community Children's Nursing Service and offers high-quality nursing assessment and follow-up, accepting referrals from GPs, the out-of-hours service, the emergency department and the paediatric in-patient wards. The remit of the team is to assess and monitor a child during an acute episode of illness whilst also providing support and education to the family.

The service operates seven days a week, 364 days a year (not Christmas day). The hours of service are 8am to 10pm, Monday to Friday, and 9am to 6pm on Saturdays, Sundays and bank holidays. The referral criterion is that the child must have had a 'face-to-face' assessment by a doctor/practitioner and a working diagnosis of one of 10 conditions. The key for referral is that the referrer is considering sending the child to hospital, therefore capturing 'genuine' hospital avoidance referrals.

One of the challenges facing the team is providing the assurance that these children, who would otherwise have been sent to hospital for assessment, are safe in their own homes. The development and auditing of robust evidenced-based protocols and ensuring the maintenance and currency of assessment skills of the team has resulted in no clinical safety incidents and no complaints for a total referral rate of over 5,000 children.

Capturing meaningful data to evidence that COAST is making a difference to the local health economy is a challenge, but the commissioners report that there has been a 'flattening' of the number of referrals to hospital when compared to clinical commissioning groups that don't commission COAST.

Throughout its development the team has been faced with some significant challenges. Engaging GPs and primary care generally to ensure they utilise the service appropriately has proved to be an ongoing challenge.

For the future, expanding and enhancing COAST with the right workforce/skill set to take referrals from the ambulance service would be a useful development as well as the ongoing development of paediatric nurse practitioners within COAST to work alongside primary care to support the hospital avoidance agenda.

Recommendations for consideration in setting up a similar service:

- Develop clear and meaningful outcome measures
- Forge strong links with key individuals in primary and secondary care
- Have 'champions' for the service
- Recruit and select staff with right skill set and experience

Further details: Kelly Owens, Clinical Lead COAST, kelly.owens@solent.nhs.uk

# Standard seven

When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.

## Rationale and evidence

If children are to be discharged early from hospital and cared for safely in the community, the relevant information must be sent to the GP and nursing teams who will be caring for the child in the community. This information must be sent quickly, particularly if it involves a change in medication or requires follow-up in the community.

Structured discharge summaries have been shown to improve communication with GPs. Parents prefer to receive this information electronically themselves and for it to be sent electronically to GPs[33-35]. A standardised electronic discharge summary enables the continuous care of children once they have been discharged from hospital, with relevant and accurate information available in the right place quickly.

## Guidance

The discharge summary is provided to the GP and other relevant healthcare professionals electronically within 24 hours of discharge (from the hospital, emergency department or urgent care centre). Ideally, this should be done within 12 hours and, depending on the condition and follow-up needed, may need to be more immediate.

Relevant community-based nursing professionals may include, depending on the child's age, a health visitor, school nurse or community children's nurse, and may in some circumstances also need to include other professionals, for example, social care for safeguarding concerns. Specific consideration should be given to issues of confidentiality when sharing sensitive data disclosed to healthcare professionals by children.

The child and their parents and carers are given a copy of the discharge information (see standard eight for content, language and accessibility of information).

The child's unique patient identifier number (NHS number in England and Wales, Community Health Index number in Scotland or Health and Care number in Northern Ireland) is used on all clinical correspondence.

The Academy of Medical Royal Colleges' standards for the clinical structure and content of patient records[36] set out the clinical information that should be recorded in the discharge summary communication from the hospital to the GP and to the patient.

## Metrics

**Metrics**

- Percentage of discharge summaries received by GPs within 24 hours
- Percentage of discharge summaries received by GPs within 12 hours
- Percentage of discharge summaries received electronically by GPs
- Evidence of copy given to child and parents and carers
- Completeness (against Academy of Medical Royal Colleges' standards)

## Practice examples

### Standards for the structure and content of patient records

**Academy of Medical Royal Colleges**

In order to effectively manage and deliver high-quality care to patients across the health service, there is an urgent need for a standardised electronic health record to capture clinical information and share this securely across the health system regardless of the patient's point of entry.

In response to this, the Academy of Medical Royal Colleges produced a set of standards for the structure and content of patient records. Records cover hospital referral letters, inpatient clerking, handover communications, discharge summaries and outpatient letters.

The standards consist of a list of clinical record headings and a description of the information that should be recorded under each heading. Individual specialties and services will require headings and information in addition to, and different from, these generic standards. The additional heading standards will be developed by those specialties and accommodated under the generic headings. The RCPCH is tailoring the standards for children.

There is a core set of data and then a subset for each of the record headings identifying where they are used: in admission, handover, discharge, outpatients, referral and communications. Every entry on an electronic health record should include the date, time and identity of the person making the entry.

Implementing these standards will facilitate shared care, enable interoperability between locations and contexts and produce comparable data for monitoring and evaluation of services. These standards will help ensure that clinical information is captured uniformly and made available to all relevant healthcare professionals, as well as the child and their parents and carers, in a timely manner.

Further details: www.aomrc.org.uk/doc_view/9702-standards-for-the-clinical-structure-and-content-of-patient-records

## Standard eight

Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.

### Rationale and evidence

With the delivery of more care closer to home, children are being discharged earlier from hospital. In addition to detailed discharge information on self-care so that children and their parents and carers can effectively manage their care at home, safety netting information is required to advise on when and where to seek further help if needed. As well as providing a safe route in the case of deterioration, safety netting advice helps to reduce demands on health services including reducing reattendances by decreasing parental anxiety, improving confidence to self-care and encouraging appropriate follow-up care with primary care[37, 38].

The provision of written in addition to verbal discharge information increases knowledge and satisfaction[39]. There is also a growing demand for information to be provided in different formats, including video and internet-based information[40, 41]. One approach will not be appropriate for all and a variety of techniques are needed to ensure understanding of the information provided.

Any presentation in the unscheduled care system should be seen as an opportunity for health promotion and education on childhood illness and safety practices[42]. Patient information leaflets given during the consultation can modify behaviour and knowledge[43]. Targeted programmes can help to direct children and their parents and carers to ensure they receive timely treatment in the right place and that they know the signs and symptoms they should or should not be worried about. Follow-up phone calls after emergency department attendances advising on the use of services can also decrease future emergency department use[44]. Frequent attendances can also be a marker for child abuse or neglect and young people transitioning to adult services may also be attending the emergency department because of an inadequate specialist response to their changing needs.

### Guidance

The information given at the time of discharge includes the signs and symptoms that should alert a child, or parent or carer, to seek further help and how and where to access this help. This may include a phone number for use within a defined period of time on discharge and for some children with identified ongoing needs may include direct (or open) access for acute relapse. The pathway will vary depending on the condition and type of presentation. If the direct access is to the ward or assessment unit the facilities must include resuscitation facilities and there must be trained members of staff to manage children who deteriorate suddenly. The information should also include a reminder of the use of primary care services in the area where appropriate as the first point of call.

Written discharge information needs to be regularly updated and should be evidence-based. Information needs to be tailored to meet the needs of children and parents and carers with varying levels of ability to read English, either as translations or in audio-visual format. It is important that information is presented in a form that is accessible and understandable by the child and their parents and carers. Their understanding of the information should be checked before they leave. It is good practice to involve local support groups in designing and testing the information provided. All services should promote patient information resources.

## Metrics

| Metrics | Activity data |
|---|---|
| • Evidence that verbal safety netting information is provided<br>• Evidence that written safety netting information is provided<br>• Evidence of other formats provided<br>• Evidence that child and parent/carer understanding of the information is checked | • Number of children with open/direct access |

## Practice examples

**Acutely Sick Kid Safety Netting Interventions for Families (ASK SNIFF)**
**University College London, University of Northampton, University of Oxford, University of Leicester**

The ASK SNIFF programme developed from a shared concern to address the needs of parents for information to help them determine when to seek help for an acutely sick child. Working with parents, clinical and academic collaborators, the team developed the concept of safety netting itself and took an evidence-based approach to developing the resource. A parent panel informs every stage of the project to ensure that the work is developed with, for and by parents.

- ASK SaRA: Acutely Sick Kid Safety-net Review and Analysis (2011): A systematic review to identify the effectiveness of information resources to help parents decide when to seek medical care for an acutely sick child under five. ASK SaRA identified what did and did not work in previous interventions.
- ASK PIP: Acutely Sick Kid Parent Information Project (2012): A qualitative research project to explore parents' and healthcare professionals' use of information resources during decision-making in acute childhood illness at home. Building on ASK SaRA, it asked what information they use, what they like and dislike and what they would like in the future.
- ASK SID: Acutely Sick Kid Safety-netting Intervention Development (2013-14): Funded by Well Child, this is a mixed methods project to co-design the content and delivery methods for a standardised safety-netting intervention tool. Findings of the previous phases are being applied within this project, for example, through its focus on more than one symptom and collaboration with parents and healthcare professionals in every stage of the development.
- ASK VIC: Acutely Sick Kid Video Capture (2012 – ongoing) of sick children presenting to the emergency department: Volunteer health professionals are developing a video library which will be used to populate our intervention with explanatory video clips.

The next step will be the development of a prototype intervention which can then be feasibility tested and clinically evaluated following implementation. The team's vision is that this resource will be freely available to every parent with a child under five years of age.

Further details: asksniff@ucl.ac.uk

**DIY Health**
**Bromley by Bow Health Partnership**

The DIY Health project aims to provide parents and carers of children under the age of five with the knowledge and skills to confidently manage their children's health at home and to know when to seek further help. With funding from Higher Education North Central and East London, the Bromley by Bow Health Partnership worked with University College London Partners, the Bromley by Bow Centre, healthcare professionals, parents and the local community to create an education programme that would give parents and carers the confidence to know when and where best to access health services for children with minor ailments. The project created a curriculum of 12 sessions that focussed on the most common problems in the under-five age group, as well as needs relevant to the local community.

The weekly sessions take a participatory family learning approach and are co-facilitated by a health visitor and an adult learning specialist with support from local children's centres. The sessions place strong emphasis on parents' experiences and the importance of understanding these in order to support and direct self-care for the future, leading to greater engagement and understanding of how to use services most effectively. The project has recorded promising preliminary results and seen positive anecdotal behaviour changes in the attendees; for example, parents attending for coughs and colds are now comfortable seeking advice from a pharmacist. The pilot reported that parents who had participated in the most sessions had reduced attendance, not only for GP appointments, but also for the emergency department.

Next steps include a robust evaluation by the Anna Freud Centre, which will develop outcome measures. The project will also be modelled economically to ensure it is delivering value for money. To facilitate wider rollout a comprehensive training package is being co-produced.

Further details: Emma Cassells, Patient First Project Manager, emma.cassells@nhs.net

# Standard nine

Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.

## Rationale and evidence

Good patient care requires good communication between healthcare professionals. The *Francis Report*[45] emphasised the need for better information and highlighted the risks that increasing service pressures bring to patients. No matter where children are being cared for, their basic health information should be available, as needed, to those looking after them. Information should be recorded once, at the first contact with healthcare professionals, and should flow between systems while keeping confidential information safe and secure.

There are two key routes to achieving this: a shared electronic healthcare record or a patient-held record such as the Personal Child Health Record (PCHR).

An electronic healthcare record provides an efficient means of recording and sharing healthcare information in order to deliver high-quality care and to inform research and drive service improvement[46]. Access to an electronic healthcare record with key details about a child's healthcare would increase the ability of healthcare professionals to make informed decisions, providing them with key medical information to decide on safe treatment without having to wait and refer back to the GP. This is particularly important out of hours when GP practices aren't open or when a patient cannot give information (if they are unconscious), or if they are taken ill away from home and are unable to see their own GP. It also reduces the time, effort and resources needed to obtain medication information directly from the patient's GP practice. Time saved can be reinvested in direct care.

## Guidance

The shared electronic healthcare record includes, as a minimum:

- The unique patient identifier number (NHS number in England and Wales, Community Health Index number in Scotland or Health and Care number in Northern Ireland)
- Name, address, date of birth
- GP's details
- Medications (prescription medication, allergies, bad reactions to any medication)
- Active diagnoses
- Encounters - recent admissions or visits to hospital, emergency department or out-of-hours centres attendances, appointments booked for the future
- Any emergency care plans or personal healthcare plans (for example, for children with long-term or complex conditions)
- Safeguarding information including whether they are on or have been on a child protection plan, are Looked After or are care leavers and the name of the responsible local authority

The information is only used by the healthcare professionals providing direct care to the child.

The diagnoses should be made clear for coding purposes and coding should be regularly audited to ensure quality and consistency. Services should cooperate with national data collections.

All healthcare staff assessing or treating children with unscheduled care needs should ask to the see child's PCHR.

## Metrics

| Metrics |
|---|
| • Percentage of sites able to access electronic health records<br>• Percentage of sites which have a policy requiring staff to ask to see a child's PCHR<br>• Percentage of consultations for which appropriate records are available |

## Practice examples

**Northern Ireland Electronic Care Record (NIECR)**
**Health and Social Care in Northern Ireland**

No matter where they are being treated or cared for in the healthcare service, a child's information should be available, as needed, to those looking after them. Health and Social Care in Northern Ireland is in the process of introducing a new system, NIECR, to make it easier for staff to get the information they need to look after patients and make sure that they get the best, safest and fastest care possible.

The NIECR will contain information from existing electronic record systems from hospitals and clinics throughout Northern Ireland. This will include lab tests, x-rays, appointments and discharge letters. Details of current medication and any known allergies are already captured by the Emergency Care Summary Record and will also be included in the NIECR, unless the patient has opted out of sharing this information electronically in the past.

Only staff caring for the patient will be able to look at their information on the NIECR and the patient's permission will be asked for first with an audit trail in place to check this. In exceptional circumstances where a patient is seriously ill and unable to give their informed consent, the doctor treating them in the Emergency Department would be allowed to access their Emergency Care Summary Record to ensure safe treatment.

By making sure that information is available wherever the patients and those treating them require it, NIECR will help ensure more time and effort can be put where it is needed most – into caring for patients.

*'People have told us they can't understand why the right information isn't available to those making decisions about their care, in the right place at the right time … It will avoid the need for people to tell their story many times to healthcare staff.'* Patient Client Council

Further details: www.nidirect.gov.uk/northern-ireland-electronic-care-record-niecr

**Electronic Personal Child Health Record (ePCHR)**
**RCPCH**

The Personal Health Care Record (PCHR) is the main record of a child's health and development. The parent or carer owns and retains the PCHR, in which they enter their child's health information, access and use information contributed by healthcare professionals and share this record with any organisation or individual they choose to. Healthcare professionals should update the record each time the child is seen in a healthcare setting. The ePCHR is an electronic version of the PCHR which is currently being piloted at two sites across Liverpool and South Warwickshire.

As does the PCHR, the ePCHR supports the Healthy Child Programme, recording details of screening tests, immunisations and reviews as well as signposting to relevant information. With the information kept electronically in a secure system, a child's parent or guardian can have the convenience of managing the child's care online.

Designed for parents and guardians to easily enter information and check their child's health status, these are online records owned by the parent or carer and intended to be used as they would the paper PCHR. Users of a personal health record decide who has access to their information - they are the 'custodian' of the record. Users explicitly give consent to the use of each data item and there is no implicit consent and no global consent. As a custodian, users decide what level of access to grant others. ePCHR has the potential to substantially improve cross-care setting information sharing between primary, community, acute and social care. Developing parental access to and management of their child's health records will lead to new communication models and healthcare delivery models within the NHS.

*'Indications overall are that where we find increased patient involvement in personal healthcare, so we expect to find better health outcomes alongside lower service cost.'*
Personal Health Records: putting patients in control 2020health.org

Further details: www.rcpch.ac.uk/pchr

# Standard ten

Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.

## Rationale and evidence

The majority (85%) of emergency department attendances by children under 15 can be accounted for by the 10 most common presenting problems, with the top three comprising nearly 50% of attendances: breathing difficulty (20%), febrile illness (14%) and diarrhoea with or without vomiting (14%)[47]. The presenting problems are different for older children and the majority of attendances for children aged 13 to 17, excluding injury, are for: abdominal pain (16%), self-harm (11%) and collapse (10%)[48, 49].

Care pathways based on the common presenting problems help to guide healthcare professionals to make safe decisions in specific circumstances, determining who needs to be referred to hospital, and can help to reduce unnecessary attendances at emergency departments, admissions to hospital and the length of stay[50, 51].

Care pathways help to promote high-quality, evidence-based assessment and management of the acutely unwell child when accessing local unscheduled care services[52]. They build consistency across local areas so that all healthcare professionals understand the pathway and can assess, manage and support children and their parents and carers to the same high standard, regardless of where they present. The confidence and resilience of parents and carers to manage their child's illness at home should also increase with the provision of consistent advice[53, 54].

## Guidance

Care pathways are developed, promoted and used for high-volume acute care conditions. As a minimum this includes: respiratory conditions, fever, gastroenteritis, abdominal pain, head injury, seizure and self-harm.

The pathways are based on available guidance from the National Institute for Health and Care Excellence (NICE) and other national guidance and adapted for use locally. The pathways need to be regularly updated. Each pathway should have three elements: advice for parents and carers; pathway for use in primary care and community settings; and pathway for use in acute settings.

Representatives from hospital, community and primary care services as well as representatives of children and their parents and carers are involved in the development of the pathways locally. As required, depending on the pathway, other services including education, social care, ambulance services, urgent care centres, public health, allied health professionals and child and adolescent mental health services should be involved in the development of the pathways.

The possibility of non-accidental injury as a differential diagnosis in any baby presenting with irritability, feeding problems, increasing head circumference, breathing problems, fits and failure to thrive should be considered.

## Metrics

| Metrics |
|---|
| • Evidence of care pathways developed for:<br>• Respiratory conditions<br>• Fever<br>• Gastroenteritis<br>• Abdominal pain<br>• Head injury<br>• Seizure<br>• Self-harm<br>• Awareness of pathways by GPs<br>• Awareness of pathways by hospital staff |

## Practice examples

**Children and Young People's Health Partnership**
**Evelina Children's Hospital, Guy's and St Thomas' NHS Foundation Trust**

The Children and Young People's Health Partnership is a coalition of clinical commissioning groups, local authorities, acute providers, third sector and family and patient representatives, funded by the Guy's and St Thomas' Charity and focused on improving the everyday health needs of children in Southwark and Lambeth. A three-pronged strategy was developed to ensure that general children's services worked closely with primary care to develop better care pathways.

Firstly, a series of guidance covering the most commonly seen conditions in primary care, for example, asthma, fever, constipation and mental health conditions was developed. These consisted of one page flow charts of how to identify conditions, what to look out for (red flags) and top tips. Each piece of guidance was localised with specific information on when to refer and where. The guidance was designed with primary care to ensure they are user friendly and the information sits within the IT system of primary care, making it accessible and functional.

Secondly, a hotline service was developed at the Evelina and King's to ensure there was a strong link to the general paediatric service. This service enables primary care to access real time advice via email or telephone from a consultant paediatrician. Outcomes of a call or email are advice, transfer to the Emergency Department, booking into the next available outpatient slot or a hot clinic appointment. This service helped build a strong relationship between primary care and the hospital and provides a mechanism by which concerns can be directed to the relevant guidance.

Thirdly, by doing in-reach clinics with GPs, a further opportunity to guide people to the new guidance has been created. During in-reach clinics a consultant paediatrician sees children alongside a GP. These children are a mix of children about whom the GP has concerns, those who attend the Emergency Department frequently or those who would otherwise have been referred to the hospital.

Further details: Steven Trowbridge, Programme Coordinator, Steven.Trowbridge@gstt.nhs.uk

**Care pathways**
**Luton and Dunstable University Hospital NHS Foundation Trust**

Luton has long recognised that there are high volumes of children presenting to the Emergency Department and Secondary Care Paediatric Services with common conditions that could sometimes be treated more appropriately elsewhere. The team also recognised the need for consistent assessment and care wherever a child presents and, since 2009, have worked collaboratively across the whole health system to develop shared urgent care pathways for use wherever children present.

The pathways chosen were the highest volume conditions including fever, diarrhoea, vomiting, seizure, asthma, bronchiolitis, abdominal pain and head injuries. Some pathways for conditions with good evidence-based national guidance were easy to develop whereas others were more challenging. The pathway development included workshops with children and parental involvement. Information sheets were developed for families and educational tools with lessons for school-children, exploring their understanding about where to go for illness and the different services available.

An audit of the fever pathway identified that implementation of the pathway changed which patients are referred to the Paediatric Assessment Unit (PAU). It also showed an increase in the number of necessary tests and a decrease in the number of unnecessary tests. Commissioners reported a notable decrease in short-stay and long-stay costs as a result of change in the care pathway. Developing these pathways further enhanced an ethos of collaboration between acute and community services and children’s commissioners. The ongoing challenge has been to embed these pathways into multi-professional practice, particularly into GP surgeries, and also to keep them up-to-date and continuously rolled out to professionals working locally.

Further details: Dr Beryl Adler, Consultant Paediatrician, beryl.adler@ldh.nhs.uk

# Standard eleven

There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

## Rationale and evidence

Critical examination of clinical practice is an integral part of care, but we also need to share learning and expertise across services in order to drive the continuous development of high-quality care. It is important that the local system has a proper process in place to both review and implement improvement.

Regular whole system meetings can both help to build strategic connections across the system and to drive through system-wide improvements. They also provide the opportunity to work together to promote appropriate use of health services by building children's and their parent and carers' capability and confidence to self-care. This is particularly the case for vulnerable and marginalised groups who repeatedly report poorer experiences of care[55, 56]. Interventions should be evidence-based and tailored to inform and empower children and their parents and carers so that they know the signs and symptoms they should or should not be worried about and the healthcare services that they can access appropriately[57].

## Guidance

As a minimum, the meetings are held every six months.

In addition to representatives from the hospital, community services and primary care and representatives of children and their parents and carers, the meetings include commissioners and service planners and, as appropriate, managers, public health, ambulance services, school nurses, health visitors, community pharmacists, representatives from the local safeguarding/child protection team and allied health professionals. Actions and learning points are disseminated widely.

The meetings focus on quality (safety, effectiveness and patient experience), quality improvement and risk. This will include monitoring responses to and discussing system-level critical incidents and complaints, root cause analysis of sudden unexpected incidents and coroner's cases, auditing care pathways, developing and progressing plans for quality improvement, monitoring service use and standards (for example, use of the telephone advice service and rapid-access service), monitoring trends in child health issues, monitoring trends in attendances, admissions and referrals to hospital and reviewing and responding to patient experience measures[58].

Services should also consider wider engagement and schemes to build the capability and confidence of children and their parents and carers to self-care and use health services appropriately, for example, the provision of education interventions in schools and the community.

## Metrics

| Metrics |
|---|
| • Evidence of meetings held every six months<br>• Attendance at meetings by:<br>  • Hospital<br>  • Community services<br>  • Primary care<br>  • Representatives of children and parents and carers<br>  • Commissioners/service planners |

## Practice examples

**Connecting Care for Children (CC4C)**
**Imperial College Healthcare NHS Trust**

CC4C aims to keep children healthy by working in partnership with families and communities and improving the connections between communities, GPs, health visitors, school nurses and other community health professionals, as well as specialists within hospitals. North West London has a higher than average use of unscheduled care with a significant proportion of children presenting with low acuity conditions that could be seen in alternative settings. As a provider of paediatric emergency care, CC4C recognised a need to proactively tackle this challenge.

CC4C collaborated with Puppetsoup, a professional puppet company, to produce Fix Freddie! - a piece of puppet theatre that explores options for families when their child is ill or injured. The puppet show was used to trigger discussion regarding healthcare options, followed by opportunities for families to meet local health professionals and ask questions about any concerns about their child's health. Leaflets were distributed with advice about where to seek advice, self-management and local services.

Key themes surfaced from Fix Freddie! feedback:

- Better understanding of local services available, notably about NHS111
- Improved knowledge and confidence about self-managing minor illnesses and injuries
- Additional awareness raised about safety at home
- General positive feedback for puppet show and events

Local clinical commissioning group commissioners are now funding a wider local tour which has begun in collaboration with local community champion groups. CC4C are putting together a toolkit to share their experience, which Puppetsoup can use to collaborate with other teams across the UK.

*'[What I will take away]: keep children at home rather than rushing to the GP.'* Parent, St Vincent's Primary School

*'[What I learnt:] information of where to take my children if my GP is closed.'* Parent, Queens Park Children's Centre

Further details: www.cc4c.imperial.nhs.uk

**PACE SETTER Award**
**South East Coast Strategic Clinical Network for Children and Young People**

The Strategic Clinical Networks bring together those who use, provide and commission services to make improvements in outcomes for complex patient pathways using an integrated, whole system approach. The South East Coast Strategic Clinical Network for Children and Young People identified a need to make services more family-friendly with a focus on patient-centred care.

The PACE SETTER Award is a new initiative for primary and community care in the NHS. It has been designed by those working within the primary and community care sector and has been adopted into the work programme of the South East Coast Strategic Clinical Network for Children and Young People. It is a voluntary but formal system for recognising, celebrating, promoting and sharing excellence in the provision of health services to children.

A PACE SETTER organisation will be known by its younger patients, and their carers and families, to be committed to the provision of well-designed, consistent, co-ordinated, family-friendly and patient-centred care. The PACE SETTER Award has been designed and launched by an experienced team to highlight and reward great quality children's services. All applicants must complete two key mandatory activities: a self-assessment audit of their safeguarding procedures and a consultation exercise with their child population and families. From these exercises, three additional key activities must be chosen and implemented to complete the application process. These activities must be based on the four PACE elements: Patient and Carer Engagement, Accessing Services, Clinical Pathways Implementation, and Education.

Further details: CWSCCG.cypSECpathways@nhs.net

# Implementation of the standards

These standards are designed to ensure that services are planned and organised around the child with care provided closer to home where appropriate and with quick access to an expert opinion.

The standards should complement a service's assessment of the needs of their service. We want to support and prompt conversations with services that do not meet the standards, including facilitating discussions between neighbouring services on how standards might be met by working as a bigger team in network configurations.

Detailed modelling of the workforce needed to deliver the standards is available on the RCPCH website (www.rcpch.ac.uk/togetherforchildhealth).

The Colleges cannot implement these standards alone and will require support and agreement from other NHS organisations. A detailed implementation plan is available on the RCPCH website (www.rcpch.ac.uk/togetherforchildhealth) which sets out how the RCPCH, RCGP and RCN will implement the standards by:

- Supporting and equipping members across the three Colleges with the information and skills to influence at a local level
- Supporting services to implement the standards
- Continuing discussions and negotiation between the Colleges and key stakeholders at a national policy level
- Ensuring children and their parents and carers know the quality of care they can expect and helping to change behaviours

An audit of the standards is planned for 2016/17. We recognise the need for flexibility locally and will be interested to hear, during the planned audit, of alternatives being implemented and the evidence behind them. This is intended to be a live document and future iterations of the standards should be expected.

# Related work

## Facing the Future: Standards for Acute General Paediatric Services

This set of standards is part of a larger programme of work towards whole system change under the Facing the Future Suite. In addition to this new set of standards, the RCPCH has also revised *Facing the Future: Standards for Acute General Paediatric Services* (originally published in 2010).

*Facing the Future: Standards for Acute General Paediatric Services* sets out 10 minimum standards for acute, general paediatric care. These aim to deliver high-quality, safe and sustainable acute general paediatric services and ensure that every child in hospital is seen in a timely manner by a suitably experienced doctor.

The two sets of standards should be considered together when developing service models and pathways of care across primary and secondary care services.

Visit www.rcpch.ac.uk/facingthefuture

## Outcome measures

*Facing the Future* has been successful at building consensus over the required service standards for acute paediatrics. However, there are currently no reliably evidenced outcomes for acute paediatric care, and so the standards were based upon expert opinion. The lack of evidence of successful outcomes resulting from service change makes it difficult to say for certain that service interventions are having a positive or negative effect.

It has always been the intention of the RCPCH to monitor the impact of the standards set out in *Facing the Future* to evaluate their efficacy in improving the care children receive. As a consequence the RCPCH has established a working group tasked with proposing outcome measures against which to benchmark services and to monitor the effect of service change. This Working Group is projected to make final recommendations in late 2015.

The aim of the Group is to reach consensus agreement regarding five to ten outcome measures for acute paediatric services which are relevant to patients and carers, to clinicians and to service planners and commissioners. In England, the measures will also be aligned with the NHS Outcomes Framework, with formal representation from the Children and Young People's Health Outcomes Forum on the Working Group.

Prior to the final publication of these standards the data collection will be piloted at selected centres to ensure the feasibility of standard measurements. Tools to support data collection at the local level will be included in the final report, with a key aim of the group being to limit the burden upon centres of additional data collection.

Visit www.rcpch.ac.uk/facingthefuture/outcomemeasures

# Project Board membership

| | |
|---|---|
| **Dr David Shortland (Chair)** | Past Vice President, Health Services, RCPCH |
| **Emily Arkell** | Head of Policy, RCPCH |
| **Dr Francesca Cleugh** | Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings |
| **Dr Carol Ewing** | Vice President, Health Policy, RCPCH |
| **Isobel Howe** | Policy Lead, RCPCH |
| **Dr Lisa Kauffmann** | Chair, Paediatricians in Medical Management Committee, RCPCH |
| **Dr Daniel Lumsden** | Chair, Trainees' Committee, RCPCH |
| **Dr Donald Macgregor** | Scottish Executive Committee Representative, RCPCH |
| **Professor Nigel Mathers** | Honorary Secretary, RCGP |
| **Martin McColgan** | Workforce Information Manager, RCPCH |
| **Dr Katherine McKay** | Senior Medical Officer, Scottish Government |
| **Zoe Picton-Howell** | Chair, Parents and Carers Group, RCPCH |
| **Catrin Pritchard** | Policy Assistant, RCPCH |
| **Fiona Smith** | Professional Lead for Children and Young People's Nursing, RCN |
| **Dr Stephanie Smith** | Chair, Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings |
| **Rachel Winch** | Workforce Projects Coordinator, RCPCH |

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