

Delivering Quality and Value

**Focus on: Children and  
Young People Emergency  
and Urgent Care  
Pathway**



Focus on: Children and Young People Emergency and Urgent Care Pathway

High Quality Care

## DH INFORMATION READER BOX

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# Foreword

## By Sheila Shribman



Children and young people in England require high quality emergency and urgent care when they are ill or injured. Prompt access to face to face consultation with a skilled, competent and confident professional is expected by families.

Whilst there has been significant improvement in emergency and urgent care services since the publication of the National Service Framework for Children, Young People and Maternity services and there are more child friendly facilities with more staff trained to care for children, there is further improvement needed. The Healthcare Commission reviewed progress and found there was more to do, particularly in departments whose focus was not principally on children or young people.

The NHS Institute for Innovation and Improvement has produced a document which has identified areas of innovative practice that are in the area of emergency and urgent care for children and young people which merit further study. There is no simple solution for all organisations, but there are a variety of valuable service improvement ideas in this document that could be selected and modified for use locally.

The key to providing high quality emergency and urgent care for children and young people are staff trained and skilled, clear patient pathways, using best practice and supported by a network. The commissioners and providers of services should work together ensuring coordination between GP services, urgent care and out of hours services, walk-in centres, ambulance services, emergency departments and paediatric departments.

The optimum configuration and location of services should be determined locally, based on the needs of the population and after consultation with users of the service, aiming to avoid unnecessary admissions and inappropriate delays in discharge and ensuring high quality and safety, the optimum use of skills in the workforce, seamless care, efficiency and value for money.

I am pleased to hear that the NHS Institute for Innovation and Improvement has produced a number of products to accompany this document that should help to turn some of the ideas into practical solutions. I hope that this report will be widely read and contribute to improvements in services for children, young people and their families ensuring best clinical outcomes and optimum child and family experience at what can be a challenging time.

A handwritten signature in black ink, appearing to read 'Sheila Shribman'.

**National Director for Children,  
Young People and Maternity Services**

# 1. Introduction

This document focuses on the emergency and urgent care pathway for children and young people with the most common illnesses and injuries.

The programme is based on the concept that, by focusing on a limited range of high volume pathways, the NHS Institute can help the NHS make the maximum impact on improving the quality and value of care for NHS patients.

To do this it has been essential for the programme to:

- be clinically led
- engage with a wide range of clinical and managerial professionals
- be co-produced with the NHS
- be integrated with other NHS initiatives.

The aim is a paradigm shift in clinical efficiency and effectiveness, resulting in local health systems being able to provide clinically effective and cost efficient, safe healthcare for the benefit of children and young people.

## About the Focus on series

This document is one of a series published by the NHS Institute for Innovation and Improvement as part of our High Volume Care programme. Produced by the Delivering Quality and Value Team, the aim of the **Focus on** series is to help local health communities and organisations improve the quality and value of the care they deliver.

The areas we are focusing on in the programme have been selected because: they are high volume (and therefore high consumers of NHS resources), they show variability in their use of resources and they represent a range of clinical areas.

To find out more about the programme and the **Focus on** series see the Delivering Quality and Value pages at: [www.institute.nhs.uk](http://www.institute.nhs.uk)





## The approach

A literature review was undertaken of the recognised evidence in delivering optimised care for children requiring emergency and urgent care. The 'References' section at the end of this document gives further detail of the documentary evidence.

A thorough data analysis was undertaken using nationally available data from the Hospital Episode Statistics. This data was used to rank and identify the highest performers, using average length of stay spell as a proxy indicator ('spell' refers to the length of time a patient stays in an acute hospital setting).

There is limited data available regarding the pathway outside the hospital, for example the number of attendances in walk-in centres and primary urgent care facilities. To look at the whole pathway we used 'soft' intelligence from various sources, including professional networks, to identify innovative practice. This approach allowed us to identify organisations who were delivering high quality and efficient care.

## Verifying the selection of organisations

Having identified the local health and social care communities, we approached organisations to visit and observe how they manage this group of patients. The 'Acknowledgements' section at the end of this document lists the organisations we visited. The information contained within this pathway was only possible because health and social care communities allowed us to see their practice.

We then undertook visits, ensuring that at least 50 per cent of our time was spent observing the flow and processes of care, including clinical decision making and the use of information to aid clinical and non-clinical decision making. The remaining time was spent conducting a series of semi-structured interviews with key members of staff across the pathway of care (including a range of doctors, nurses, ambulance staff, pharmacy staff, primary care staff, community services staff, information staff, executive teams, managers and commissioners). In total we interviewed at least 150 staff and observed over 300 staff in 115 different areas (clinical and non-clinical) for this pathway.

The knowledge we gained from these visits and the co-production events<sup>1</sup> was then consolidated, and the optimised pathway of care, illustrated later in the document, was identified.

We worked in partnership with the NHS throughout this project to validate the pathway and to identify improvement measures that would be helpful indicators for evaluating the impact of change.

Prototypes have been identified and tested with the NHS to maximise adoption. Some of these will follow on from the publication of this document, such as a toolkit to help providers engage children, young people and families in all aspects of planning and delivering the services, as well as seeking feedback from them. The key characteristics for delivering optimal care in the NHS have been tested with the organisations and others to ensure that the change in practice is understood, is relevant and appropriate and that measuring the improvement is possible within a short time frame.

<sup>1</sup> Co-production with the NHS, involving all sites visited and national bodies and experts relevant to the pathway.

## How to use this document

The content of this document has been developed with the help of NHS staff for the benefit of any organisations and stakeholders that play any part in the children and young people emergency and urgent care pathway.

***Key characteristics have been developed with the expectation that they will be widely adopted across the NHS so that children and young people receive a high quality experience irrespective of where they receive their care***

Implementation will have numerous benefits for children and young people and all their health services because managing emergency and urgent care processes well will have a knock-on effect on all other processes.

The improvements in the emergency and urgent care processes described in this document have the potential to result in a significant increase in the number of children and young people managed in ambulatory settings. Ambulatory care is defined as inpatient care provided in non-inpatient or community settings.

In each section of the document there is a list of useful measures that may be used in order to assess your current performance in providing a successful emergency and urgent service for children and young people. It is important to regularly monitor performance, as this provides useful feedback on any changes you make to the pathway.

Most of the data for the measures described can be obtained from your information department. Other 'softer' data, such as surveys, will need to be developed inhouse/locally.

## Context

Children and young people have unique emergency and urgent health care needs. They are different from adults in anatomy, physiology and psychology. They present with a different range of clinical problems and symptoms, which may not be familiar to professionals who work only with adults.

Children and young people's ability to communicate depends on their age and stage of development. However, as a general rule, children and young people tend to act younger when they are unwell.

***It is often quoted that children are not just mini adults needing smaller beds and smaller sized portions of food in the hospital, yet their needs are often not taken into account***

Children and young people should be cared for in environments that are specifically designed for their needs which are separate from adult care settings. Play is seen as a right for all children and young people and they need access to age appropriate play facilities and recreational activities wherever they are looked after.



*States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.*

Source: 'United nations convention of the rights of the child' article 31

<http://www.unhcr.ch/html/menu3/b/k2crc.htm>

Every professional who is involved in the care of a child and/or young person, should, as a minimum, be competent in:

1. \* recognition of the sick child
2. \* basic life support skills
3. \* initiation of treatment using protocols for the management of common conditions
4. \* recognition of rare but treatable conditions
5. effective communication
6. recognition of and response to any concerns about safeguarding
7. understanding the need for play and recreation activities.

The majority (80%) of episodes of illness in children are managed by their families without coming into contact with any health

professionals.<sup>2</sup> Children, young people and families nowadays use a variety of sources, such as NHS Direct or the Internet, to access information and support.

If children and young people need face to face consultation, they may visit a range of settings such as a pharmacy, GP practice, walk-in centre, emergency department, or children's assessment unit. Care is provided by a number of professionals, for example, GPs, practice nurses, children's nurses and paediatricians. When developing services there needs to be effective workforce planning between children's services, commissioners and providers of education and training to ensure the supply of an affordable and sustainable workforce for the future.

***Skilled assessment by an experienced and trained professional, sometimes coupled with a short period of observation, is needed to differentiate a minor condition from a life-threatening condition***

Children and young people in need of emergency and urgent care present initially with undifferentiated problems, with non-specific symptoms.

\* Royal College of Paediatrics and Child Health (RCPCH) 'Modelling the Future - A consultation on the future of children's health services' (September 2007) p35 <http://www.rcpch.ac.uk/Health-Services/ServiceReconfiguration/Modelling-the-Future>

2 'Getting the right start: National Service Framework (NSF) for Children, Young People and Maternity Services: Standard for hospital services' (April 2003), Standard 6, 2.1, p6.





There is a small sub-group of vulnerable children and young people who have very specific needs and are likely to be at risk of repeat admissions and, either stay for a long time on a children's ward, or wait for a bed in a specialist unit. This group includes those with severe neuro-disability, complex co-morbidities, mental health needs and also those in need of palliative care. The care of many of these children and young people could be improved by having proactive community children's nursing teams who can predict and respond to emergency and urgent care needs.

A small but significant minority of children and young people are seen by healthcare professionals who have concerns about their safety. This could be because of intentional injury, sexual harm or physical and emotional neglect.

Recognising and responding to concerns about safeguarding is an integral part of any system that is set up to deal with this pathway.

Appropriate management in the community setting, close to a child's home, will prevent unnecessary travel, unnecessary admissions and, potentially, long waits. Good quality care, delivered closer to home, is good for the children, good for the family and is often cost effective.

This approach where children and young people are looked after at home whenever it is possible and safe to do so, and are only admitted where there are clinical reasons, fits well with the ambulatory model of care.

This model can only be delivered through a children's emergency and urgent care clinical network with a clear pathway, shared

guidelines and standards, integrated commissioning, monitoring and inspection. All children's health systems need to be integrated with education and social care.

The National Service Framework for Children, Young People and Maternity Services (2003) sets clear standards for children's health services. The Health Care Commission<sup>3</sup> conducted a review of services for children in hospital in 2006 and found that even though progress is being made in improving services, only 4% of organisations (n=6) were rated as excellent, 21% as good (33), 70% as fair (110), and 5% as weak (8) highlighting the need for further improvements in this area.

3 'Improving services for children in hospital', the Healthcare Commission (February 2007).



## 2. Understanding the variation

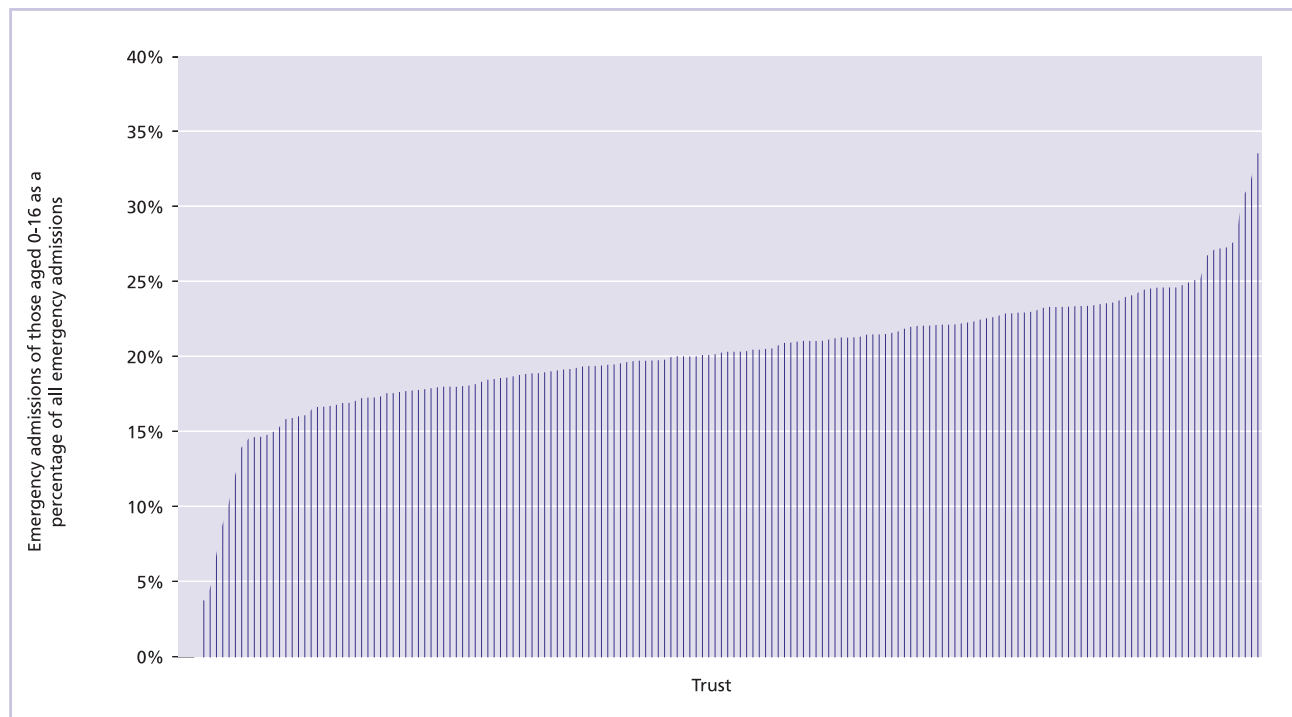
### Understanding the variation in emergency and urgent care for children and young people.

More than three million children (equivalent to 28% of all children in England aged 0-16) attended emergency departments in 2006/7, accounting for more than 25% of all patients seen.

The number of children and young people aged 0-16 years being admitted through emergency departments is over 350,000 and has risen by 6.8% over the last three years.

The following graph (Figure 1) shows a significant variation in the percentage of emergency admissions by trust for children 0-16 years of age for 2006/7.

Figure 1: percentage of emergency admissions by trust for children 0-16 years of age for 2006/7

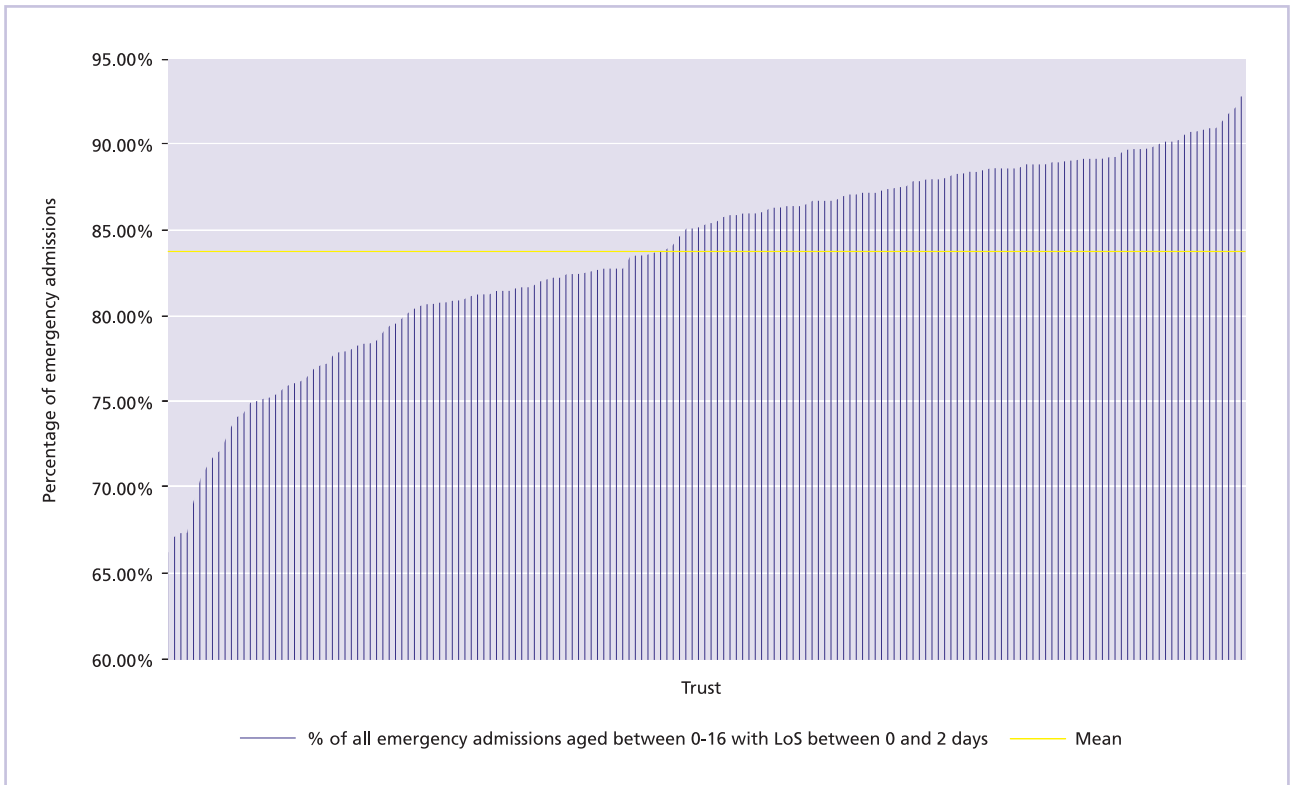


There has been an increase in the number of children with a length of stay (LOS) of zero (an episode of care without an overnight stay). In 2004/5 the number was 320,874, and by 2006/7 it had

risen to 369,690 (an increase of 15%)<sup>4</sup> suggesting that a proportion of these children could be managed in the community if appropriate skills and facilities to assess, treat and

observe them were available. Figure 2 shows the variation for LOS of 0 - 2 days as a percentage of all emergency admissions (excluding obstetrics and gynaecology) by trust.

**Figure 2: variation for LOS of 0-2 days as a percentage of all emergency admissions (excluding obstetrics and gynaecology) by trust**

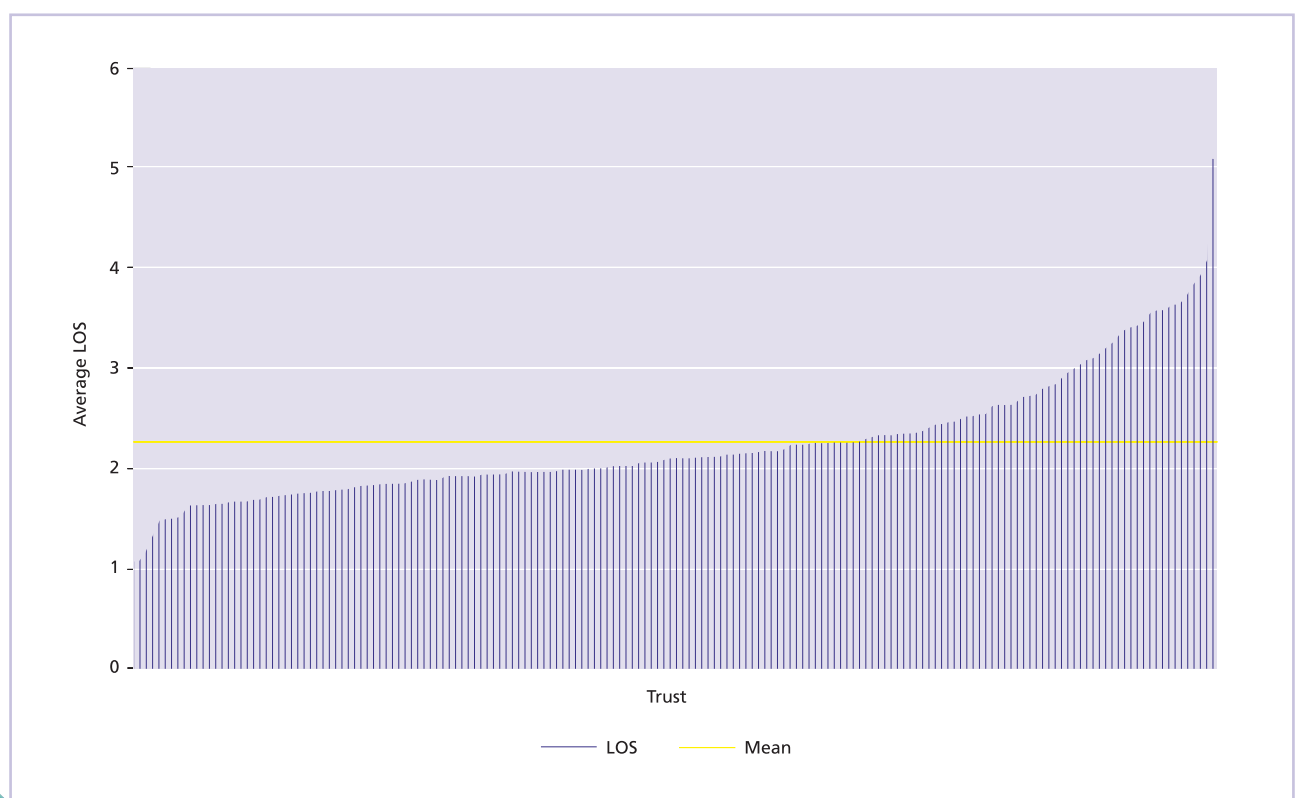


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4 Source: Hospital Episode Statistics for calendar year 2006/2007.

In 2006/7 the mean LOS was 2.26 days, but the following graph (Figure 3) shows there is still significant variation in length of stay between organisations across the country, ranging from 1.06 to 5.08 days.

**Figure 3:** variation in length of stay between organisations across the country, ranging from 1.06 to 5.08 days.



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In 2006/7, 304,458 emergency admissions had a LOS of between one and two days and 113,602 had a LOS over two days.

The increasing high volume of children and young people needing emergency and urgent care, coupled with the significant variation in the LOS, offers an opportunity for some organisations to provide better care more efficiently.

By reducing the LOS of patients who stay between one and two

days (by an average of half a day), there are potential savings of at least £53 million (excluding length of stay of zero). This can be achieved through a variety of mechanisms, some of which are detailed in this document. The savings could be at least £161 million if the LOS for patients staying more than two days is reduced by one day.<sup>5</sup>

Organisations can further reduce costs associated with zero length of stays by developing ambulatory services. However,

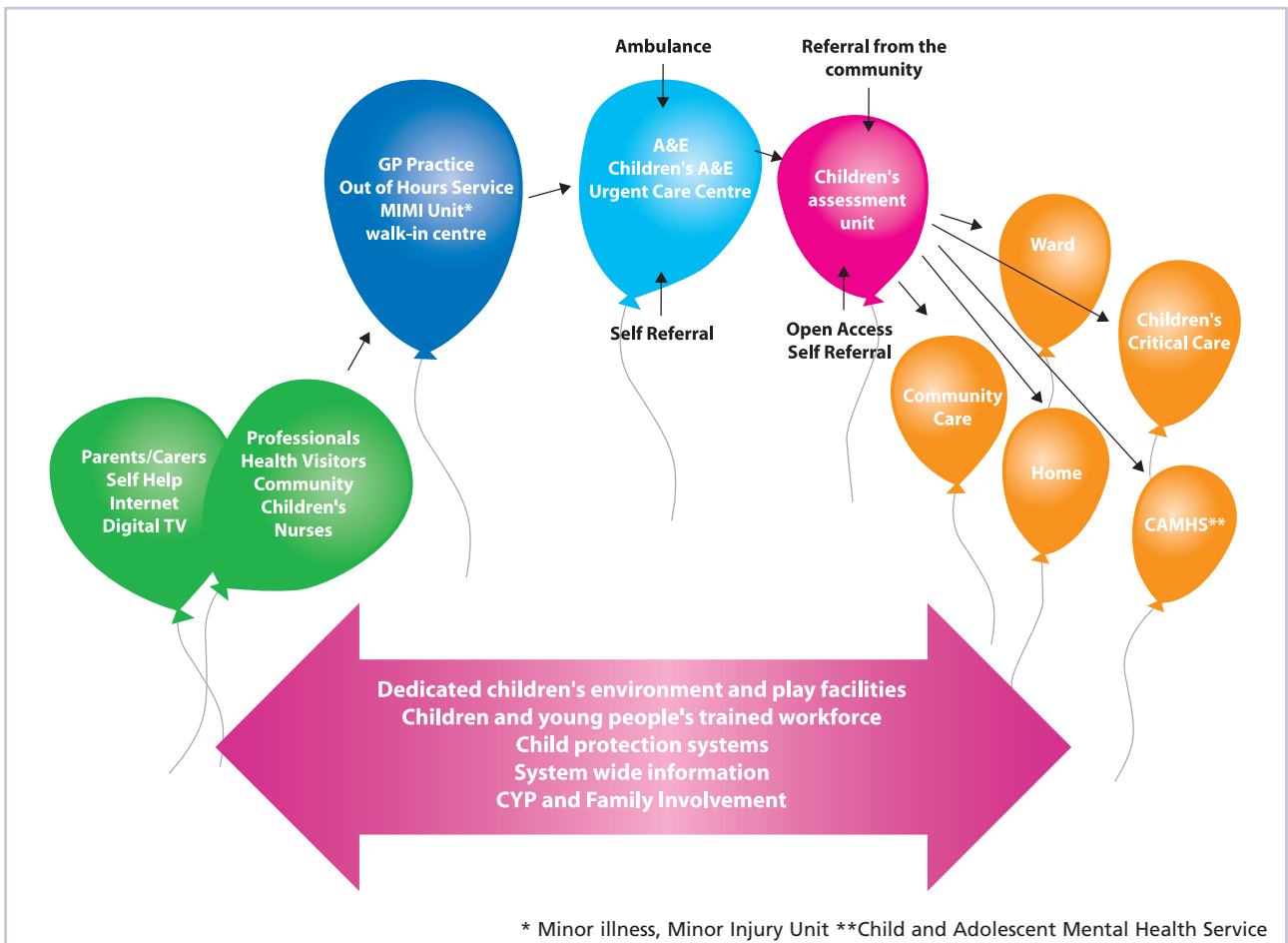
organisations need to consider the potential costs involved in delivering these alternative services.

***The savings could be at least £161 million if the length of stay for patients staying more than two days is reduced by one day***

<sup>5</sup> Figures calculated by Dr Foster Intelligence using data from Secondary User Services (SUS), using £228 as excess bed day tariff.



### 3. Children and young people emergency and urgent care pathway



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For simplicity, the pathway starts after the point at which children and young people should be accessing services delivered by primary care's urgent care processes (such as local pharmacists, NHS Direct, out of hours services, GPs and walk-in centres). However, the key to delivering effective emergency and urgent care is ensuring that

the whole system is designed to support self care and community care at home, thereby avoiding unnecessary hospital admissions and facilitating timely early discharges.

Once children and young people present in secondary care every attempt should be made to minimise admission rates and LOS

by providing early comprehensive assessment and treatment by experienced and competent children's nurses and doctors. To achieve this, the interface between hospital and community care is crucial and should be supported by an integrated information system across the pathway.



## 4. The overarching characteristics of organisations providing high quality care and value for money

The following characteristics have been found to be the key features for delivering quality and value for emergency and urgent care services for children and young people. They are illustrated by case studies from the health communities visited.

The case studies are followed by some suggested measures for improvement which have been co-produced with our stakeholders. These are offered as a prompt to encourage organisations to benchmark their current practice against the characteristics described, and to further improve their services.

Some of the data described can be obtained from local information departments. However, organisations may need to develop new systems for collecting and using relevant measures. To measure qualitative information, surveys will have to be designed and the responses analysed.

### Overarching characteristics

**Key characteristic 1:**  
Clinical leadership is empowered and there is an enlightened executive team.

- A high profile children's service which is led by clinical and non-clinical leaders
- The executive team engages with staff in clinical areas
- Collaborative leadership between managers and clinicians is promoted throughout the organisation
- The trust board understands the unique challenges facing children and young people's services by recruiting a young person as a trust board governor.



*'We are encouraged to collect accurate data, analyse patient flows and find any problems that affect the quality of care and delays in treatment. We are encouraged to find long term sustainable solutions to improve patient care rather than to attempt quick fixes to hit performance targets'*

A&E consultant lead, Homerton University Hospital NHS Foundation Trust

*'We often see our chief executive in the emergency department during periods of significant change'*

Nursing staff, Children's A&E Department, Homerton University Hospital NHS Foundation Trust

### Key characteristic 2:

The lead clinician works with the trust executive team, primary care team and users to champion clinically led service redesign.

- A primary care trust (PCT) lead who understands the pathway is engaged in children's service redesign, information sharing and including children and their families
- Regular meetings between the PCT children's commissioner and lead clinician
- Clinical leaders engage with the local community to seek the views of children and families
- Clinical leaders have a goal and mission for developing the service.

### Useful measures:

- Staff survey on leadership behaviours would be a good indication to assess how engaged your executive team is with your services. For help with developing this survey, see the Healthcare Commission's National NHS staff survey 2007 (see 'References' section at the end of this document)

- Joint working between primary and secondary care, for example, the number of shared care pathways developed to avoid inappropriate admissions
- Percentage of correct transfers/referrals between primary and secondary care, based on agreed criteria so that more children and young people are managed in an ambulatory manner
- Measuring children's and families' experience, for example, by using questionnaires to gather information from a representative sample of the community will help organisations provide a responsive service.







**Key characteristic 3:**  
Effective and safe emergency and urgent care can be delivered without on site inpatient beds.

- Inpatient facilities are centralised to a small number of sites, coupled with the development of neighbouring ambulatory units in other sites
- The availability of a critical mass of trained professionals to provide safe round the clock inpatient care on one site and appropriate cover for the other ambulatory site.

### Case study East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust runs two hospitals with 24/7 accident and emergency services and inpatient facilities for children.

There was a duplication of medical and nursing staff covering two separate facilities, with a small number of

admissions. There were not enough nurses or medical staff to provide safe and high quality service on both sites. The lead clinician worked with the management team, other staff and stakeholders in the local health economy and users of the service, to provide all inpatient services on one site and an

ambulatory paediatric unit on the other site. This has resulted in a decreasing number of admissions and only a small fraction of children who used to be admitted to the Queen Elizabeth site are transferred to the Lister Hospital site (which is the inpatient site).



	1997	2007
<b>Emergency medical paediatric admissions per year</b>	3000	900 (700 ambulatory overnight admissions plus 200 transferred to the inpatient ward).
<b>Number of beds</b>	44 inpatient beds	6 ambulatory beds 22 inpatient beds

In 2007 the service had its lowest transfer for admission and overnight stay rate ever, despite the increasing complexities of the medical and social issues

now encountered in paediatrics. The clinical lead recommends early redeployment and adjustment of consultant job

plans to reflect the increasing consultant led decision making required when operating an ambulatory unit.

**Useful measures:**

- Number of transfers from an assessment unit to a ward to monitor a reduction in number of inappropriate admissions

- Changes in number of inpatient beds utilised for children and young people
- Benchmarking performance on LOS using the national best 25% performers (upper

quartile) as a measure - (1.86 days, based on HES data 06/07).



**Key characteristic 4:**  
A fully integrated children's service delivers high quality and seamless care for children.

- One team of management and administrative support across acute and community paediatrics
- Fully integrated and co-located teams (clinically, managerially and financially) encompassing, doctors, nurses, safeguarding staff, school nurses, therapists, play specialists, health visitors and community children's nursing teams
- Consultants work across community and hospital settings providing continuity for the family and avoiding fragmentation and duplication of care
- One set of integrated medical records.

## Case study

### Basingstoke and North Hampshire NHS Foundation Trust

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Basingstoke is a fully integrated service - clinically, managerially, financially and geographically. The hospital paediatric service, community service, children in care, safeguarding services, therapy services, school nurses and community children's nurses are all co-located and managed as one service.

Every child has a named consultant and a community

children's nurse. There is no artificial separation between services provided for children in the community and in the hospital, with the care supported by a single set of medical records and the same professionals working across the traditional boundaries. This also reduces duplication of management systems and creates a better flow of information. This integrated

approach also cuts costs as fewer staff are needed. The working relationship between teams is better as they have the greater opportunity to agree a consensus approach over priorities. In essence, this approach enables a range of services for children and young people to be dealt with in a more co-ordinated way.

#### Useful measures:

- Percentage of services (acute and community) that perform against jointly agreed operational frameworks (financial, managerial and

clinical) ensuring children and young people are managed efficiently and effectively

- Evidence of multi-agency collaboration and improvement action, for

example, joint funding and joint development of services along the pathways across primary and secondary care.

**Key characteristic 5:** Jointly developed children and young people’s emergency and urgent care clinical networks (spanning primary and secondary care) provides a seamless high quality service.

- Clinical lead attends practice-based commissioning groups and develops shared pathways, e.g. respiratory, UTI
- Clinical lead attends GP consortium meeting monthly to design pathways of care and to identify services that need developing.

## Case study

### Homerton University Hospital NHS Foundation Trust

An ambulatory paediatric service was developed for a population of more than 54,000 children under the age of 16 years. This was done in an area of high deprivation and need with a multicultural population and a high proportion of refugee and migrant communities who are not registered with a primary healthcare team. Previously, an accident and emergency department existed which predominately served teenagers with trauma and minor injuries. But there was no formal paediatric service and hence no paediatric trained personnel on site (informal support being provided by the neonatal team for true emergencies and advice being given from a

neighbouring children’s hospital).

A children’s accident and emergency, children’s assessment unit and an observation unit have been developed with a limit on length of stay of 24 hours. There is a telephone hotline through which advice is provided to the primary care staff, and, if face-to-face consultation is needed, this is arranged in the daily urgent care clinic.

The care is delivered by a multidisciplinary team with hands on care delivered by experienced children’s nurses and consultants.

With 24 hour ambulatory support, transfer from Accident and Emergency to other paediatric units fell from 8.4% (which is 405 transfers out of 4814 attenders) attendees (which is 529 transfers out of a total of 14,965). Activity increased by 213%, and 94.9% of children are now totally managed in the ambulatory service without transfer.

High dependency support was available prior to transfer for those requiring it, and senior clinical assessment facilitated transfer to a definitive unit of care was available where supraspecialist care was required.



#### Useful measures:

- Percentage of GP enquires and potential referrals managed by a telephone hotline by the paediatric staff
- Number and percentage of transfers from assessment unit/observation unit to an inpatient ward to monitor a reduction in the number of inappropriate admissions
- Percentage of transfers achieved within two hours of decision to transfer from the ambulatory unit to an inpatient ward on other sites.



**Key characteristic 6:**  
Integrated information provision across a whole system facilitates patient care and flow.

- There is real time provision of clinical patient information for all teams involved
- A central information analyst within children’s services, helping staff identify what they need, record and analyse data on all aspects of the service.

## Case study Basingstoke & North Hampshire Foundation Trust

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There is a full time information officer based within the children’s services. The officer works with the teams to encourage the use of information and to educate staff on how to use data to inform day to day service provision and longer term commissioning of services. Additional support has also been provided to:

- influence casemix, volume and impact of the work undertaken by the community nursing team on preventing admission and facilitating earlier discharge for key groups of children

- assist the play specialist team in demonstrating their activity within the service
- help the physiotherapy and occupational therapy teams understand their wait times and identify case load volumes across the acute and the community service
- assist the ambulatory unit by collating and summarising more detailed clinical information such as blood tests and sweat tests.

This support has meant that they are in a better position to understand their integrated service, both from a volume and demand perspective, as well as identifying key trends such as referrals and wait times.

### Useful measures:

- Percentage of staff using information to understand their caseload and casemix and inform service planning, for example assessing individual appraisals

- Measuring children and young people’s and their families’ experience, for example using national surveys
- Number of bed days saved as a result of facilitated earlier discharge, using performance

indicators such as bed days occupied, correlated with number of delayed discharges.

**Key characteristic 7:**  
There is competent decision making by senior clinical staff.

- Appropriate staff have the skills and experience to undertake comprehensive assessments, initiate investigations and treatment
- Education and training is regarded as an equal priority amongst all other responsibilities
- There is a standardised assessment process used by all professionals.

*'A child presenting with a rash could have either a self-limiting viral illness needing reassurance or meningococcal septicaemia needing advanced life support and admission to a paediatric intensive care unit'*

Dr Venkat Reddy, Consultant Paediatrician and National Clinical Lead, NHS Institute for Innovation and Improvement

## Case study

### Basingstoke and North Hampshire NHS Foundation Trust

The emergency department at Basingstoke Hospital provides a programme of multidisciplinary teaching and training sessions led by the emergency medicine consultant.

Once a month the session is dedicated to children's emergency and urgent care. This arrangement has resulted in a common understanding and improved joint working among the professionals in the paediatric and emergency departments and the transfer of skills between the two.

A standard operating procedure for paediatric critical care has been agreed between the emergency physicians, paediatricians and anaesthetists to ensure consistent care is provided by the three specialties who are working together to a common policy. This standard operating procedure has been ratified by the regional Paediatric Intensive Care Forum and been recommended to other hospitals in the area.

A key component to the success at Basingstoke has been the maintenance of advanced airway skills by the emergency medicine

consultants. This has the added advantage of enabling procedural sedation to be undertaken on children in the emergency department, resulting in fewer children who require suturing or fracture manipulation having to be admitted to inpatient beds, reducing costs and length of stay. Several emergency medicine registrars from other regions have arranged secondments at Basingstoke in order to acquire experience in safe paediatric procedural sedation.

#### Useful measures:

- Percentage use of a standardised assessment process that improves the quality of the assessment process
- Percentage of staff demonstrating relevant competencies through appropriate assessment, for example through individual staff appraisals
- Evidence of joint working between the paediatric department and the emergency department, for example joint meetings with collective action plans
- The trend in the number and percentage of children and young people referred from the emergency department to the paediatric department
- Time to brief clinical assessment (percentage achieved within 15 minutes)\*
- Time to clinical decision made by a competent professional (percentage achieved within two hours).



**Key characteristic 8:**  
Recognising and responding to concerns about child protection is fundamental to any system that is set up to deal with children's and young people emergency and urgent care needs.

- An integrated safeguarding team that works across primary and secondary care and in all departments where children and young people are treated, ensuring a safe, effective and timely response to any concerns about safeguarding.

## Case study

### The Medway NHS Trust

Approximately 25,000 children attend the Medway NHS Trust Accident and Emergency Department. Following the Victoria Climbié Inquiry (Lord Laming, HMSO, January 2003), the trust decided that a more integrated team consisting of the named nurse, paediatric liaison advisor and a child protection co-ordinator, should be co-located to work closely and address the ongoing and demanding safeguarding agenda.

The full time paediatric liaison advisor is managed by the primary care trust. The post was jointly funded by the Medway PCT and Medway NHS Trust. The named nurse, paediatric liaison advisor and child protection co-ordinator are based in a central child protection office. Co-location improves communication, facilitates quicker access to medical records and ensures a more prompt response to enquires. The team have improved databases on child protection referrals and audit child protection activity.

The trust has a safeguarding forum chaired by the named nurse. This is attended by the leads in paediatrics, maternity, school nursing, learning disability teams, children's home care, the general manager and the named doctors. Cases are shared where there are lessons to be learned, there is discussion on working practices and information from local safeguarding boards is cascaded.



#### Useful measures:

- Percentage of staff with appropriate level of child protection training (95% of staff should be trained)
- Degree of compliance with a selection of recommendations from the Laming enquiry\* for healthcare organisations.

\* 'Services for Children in Emergency Departments', April 2007, Report of the Intercollegiate Committee for Services for Children in Emergency Departments p13, Section 9, no. 2  
<http://www.rcpch.ac.uk/Health-Services/Emergency-Care>

## 5. Pathway specific characteristics

### Integrated urgent care centre

This section describes the integration of processes between ambulance services, out of hours care, primary care, NHS Direct, child and adolescent mental health services, social care, community children's nursing teams and the acute trust.

Many systems have multiple access points for children and young people with acute problems. Each can cause confusion. One access point for all urgent care needs, with assessment and streaming to the most appropriate service could help avoid confusion. These options could include telephone advice or primary care attendance

(out of hours response or daytime service such as a walk-in centre), emergency care practitioner attendance, community nursing attendance, intermediate care, urgent access clinic appointments and paramedic attendance - with or without transfer to an integrated emergency care centre for more detailed assessment.

**Key characteristic 9:**  
Enhanced primary services for children's and young peoples urgent care prevent unnecessary attendance at hospital emergency departments.

- Advanced children's nurse practitioners deliver care in a dedicated children's walk-in centre in primary care
- Joint development of referral and management pathway between a walk-in centre and the hospital
- A service level agreement (formal arrangement) between a walk-in centre and the hospital for advice and training
- An advanced nurse practitioner in walk-in centres provides supervised practice and peer support to practitioners in other walk-in centres across the strategic health authority.





## Case study

### Smithdown Walk-in Centre, Liverpool Primary Care Trust

Smithdown Children's NHS walk-in centre is the UK's first (and only) NHS walk-in centre devoted specifically to children. The centre is located approximately four miles from Liverpool city centre and is open Monday to Friday from 8am to 8:30pm and 10am to 4pm at weekends.

It serves a diverse, inner-city population. Minor illness and injury assessment and management is provided by a team of advanced paediatric nurse practitioners (APNPs) in collaboration with paediatric nurse practitioners (PNPs) and practitioner's assistants. There are x-ray facilities available Monday to Friday (with the diagnosis confirmed by consultant radiologists) and access to off-site diagnostics that include haematology and microbiology.

Smithdown was reconfigured in April 2006 to provide both minor illness and injury management. Key considerations in the service redesign were:

1. Education and training issues - seven nurses completed the MSc Advanced Paediatric Nurse

Practitioner programme in paediatric ambulatory care and an additional five nurses undertook a short course in paediatric minor illness

2. Formalisation of the links to the local children's tertiary care hospital (achieved through a service level agreement).

Attendances at Smithdown since the reconfiguration have increased 72% (8,462 children in 2005/06 and 14,549 children in 2006/07). In addition, 36% of families (n=2,949) state they would have attended the children's A&E department (or called 999) if the walk-in centre was not there. Although there is no quantifiable data available to assess the impact on GP attendances, 48% of families (n=3,945) state they would have sought care from their GP for their child's illness if the services at Smithdown were not available.

Minor illness completion rates currently exceed 85%. The impact of the reconfigured Smithdown services on minor illness and injury attendances in the children's A&E department is difficult to

ascertain. There has been (essentially) no increase in new A&E attendances since the redesign (60,851 children in 2005/06 and 61,083 children in 2006/07; an increase of 232 children). This is despite the national trend of a year on year increase in attendances to the department. A telephone (follow-up) audit is currently in progress at Smithdown to further validate the data.

(See Figures 4 & 5)

Interim feedback from Smithdown families participating in this study (n=85) consistently rated the APNP consultations as 'excellent' with regard to their overall satisfaction, and, more specifically, to indicators such as: the degree to which the APNP involved the parent/carer in the child's care; how well the APNP explained their child's health problem; the APNP's patience with questions or worries; the parent/carer's understanding of and ability to cope with their child's health concern (post-consultation) and parent/carer's perceived ability to keep their child healthy (post-consultation).

In addition, the interim report<sup>6</sup> concludes that there have been:

***'Positive patient outcomes from all of the APNP roles and there are many examples in the data where APNPs have added value to the patient episode and have successfully diagnosed complex problems through clinical assessment.'***

***'In addition, because of the holistic approach in the APNP role, patients have benefited from the wider care approach, for example APNPs can offer health education, advice and parental education that impacts positively on the child's condition and wider well being.'***

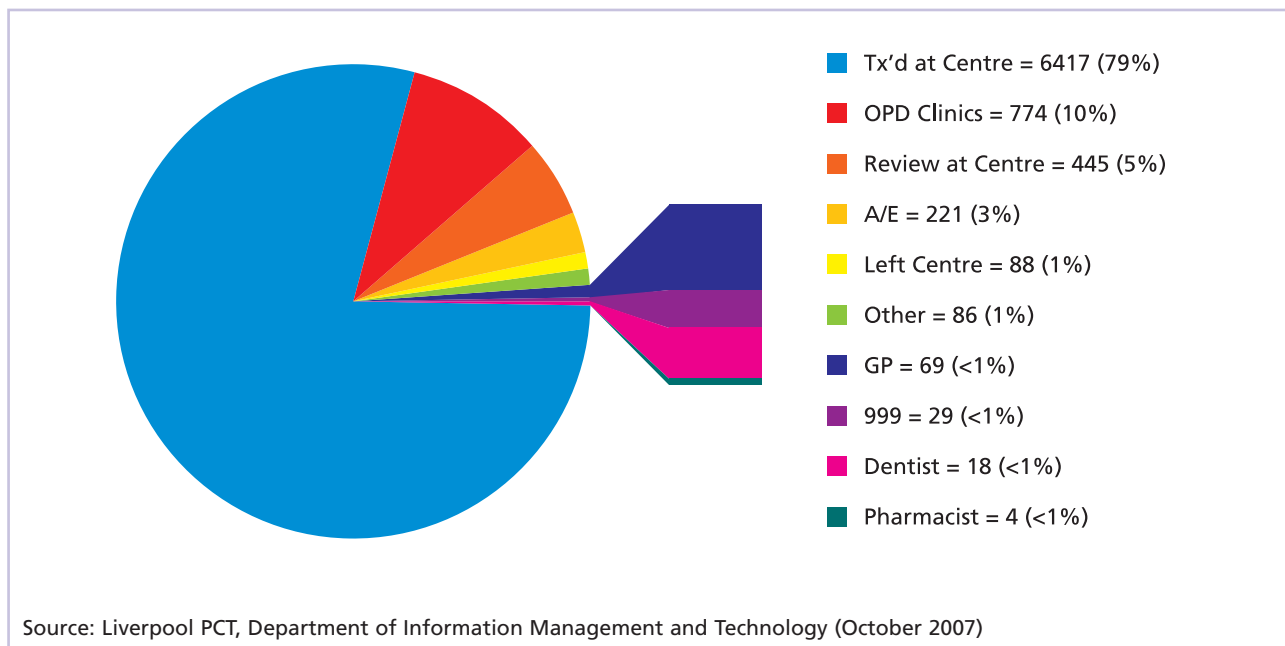
(Taken from interim report, Holborn, A. p. 43)

<sup>6</sup> 'Evaluation of the Implementation of Advanced Paediatric Nurse Practitioner (APNP) Role in Ambulatory Paediatrics: Interim Report Year 2' Holborn, A. [www.hopstreetcentre.com](http://www.hopstreetcentre.com)



**Figure 4: Smithdown Children's NHS Walk-in Centre transfers**

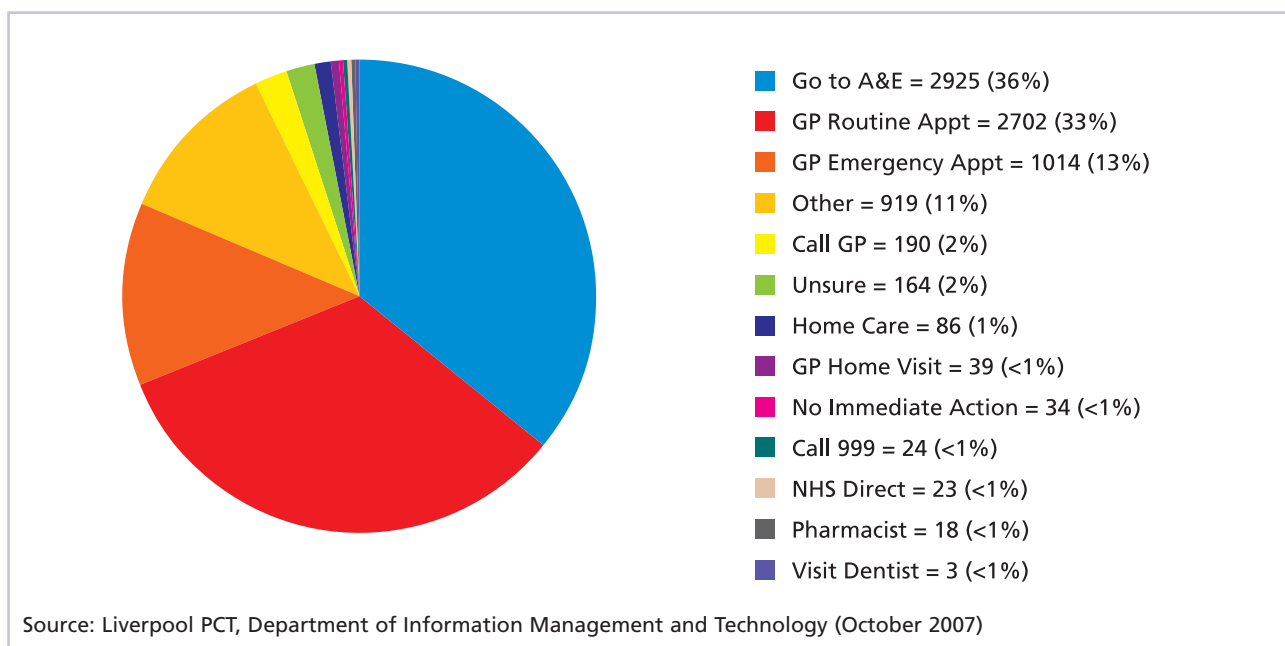
Total attendances = 8141 children  
1 April – 30 September 2007



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**Figure 5: Smithdown Children's NHS Walk-in Centre Access Data**

Visit intention: 'What would you have done if Smithdown was closed?'  
1 April 2007 – 30 September 2007





**Useful measures:**

- Percentage of correct transfers/referrals between primary and secondary care based on agreed criteria so that more children and young people are managed in an ambulatory manner
- Number of children and young people deflected from emergency department by monitoring the trend of children and young people attendances over a sufficient period of time
- The primary care team should have systems in place to collate attendance data from different urgent care providers\*. This can be accessed by the commissioners from the different providers
- Measuring children's and families' experience, for example by using questionnaires to gather information from a representative sample of the community will help organisations provide a responsive service.

\* 'Services for Children in Emergency Departments', April 2007, Report of the Intercollegiate Committee for Services for Children in Emergency Departments p10, Section 3, no.9 <http://www.rcpch.ac.uk/Health-Services/Emergency-Care>

## Case study

### Medway Primary Care Trust

- A local information tool is used by a PCT to identify inappropriate users of A&E and to proactively prevent further attendances to the emergency department.
- PCT lead tracks referral rates by GP and shares the data with all GPs which leads to a change in practice.
- Same day treatment centre co-located with emergency department deflects approximately 20% of children through an appointment system.

Medway Primary Care Trust assumed responsibility for out of hours services after the introduction of the new GP contract. The PCT now provides both a GP out of hours service and booked daytime admissions into same day treatment centres. One centre is located a few miles from the hospital, whereas the other is located on site at the acute hospital next to A&E.

These two centres are known locally as Medway On Call Care (MedOCC) and are managed by a common managerial, financial and clinical governance framework. A multidisciplinary team consisting of GPs and nursing staff operates across the two sites. The same day treatment centre and the department staff have developed good working relationships and support each others' caseload in and out of hours.

Any child presenting at the accident and emergency department with symptoms of minor illness, rather than accident or trauma, is triaged back to the same day treatment centre within 15 minutes in line with an agreed exclusion criteria. In 2006/07, MedOCC managed over 5,500 children referred on this pathway, representing an actual saving to the PCT of over £300,000 on the A&E attendance tariff. The pathway also ensures that these children are more appropriately managed in a primary care setting.

Details of all consultations are transferred electronically to the patient's GP surgery the following morning. MedOCC monitors and provides benchmarking data to the PCT demonstrating the percentage of practice populations which have attended A&E rather than

their own surgery, or who have been managed within the out of hours period. This helps inform improvements in local GP services.

MedOCC has also recently adapted its call taking system to enable specific reporting, by practice, of those patients who contact the service, having already been in touch with their own surgery but were unable to secure an appointment, or were dissatisfied. Any unregistered children are given help to register with a GP.

Approximately 20% of A&E attenders have been triaged back to the same day treatment centre.

#### Useful measures:

- Number of attendances for children and young people in emergency departments as a percentage of total registered by GP practice
- Evidence of multi-agency collaboration and

improvement action, for example, joint funding and joint development of services along the pathways across primary and secondary care

- Percentage of total population of children and young people registered with a GP

- Percentage of children and young people unable to secure an urgent appointment with their GP practice. This data can be accessed from the commissioners of the service.



## Emergency care centre

An integrated front-of-house emergency care centre reduces the number of steps in the delivery of care. This centre should include primary care, secondary care, social care and child and adolescent mental health services.

There needs to be an assessment process that includes appropriate diagnostics and definitive diagnosis. This would allow children to be streamed to the appropriate setting. The range of alternatives available would be 'see and treat', triage to primary care, children's emergency department, paediatric

assessment unit or paediatric ward. Some of these children could be discharged home with input from a community children's nursing service. These alternatives could be collectively known as the 'transfer of care process' since they are provided during the transitional period of altered health.

### Key characteristic 10:

An integrated common front of house emergency and urgent care facility provides seamless streaming of children and young people to the most appropriate service.

## Case study

### Homerton University Hospital NHS Foundation Trust

Previously, there was an existing primary care led unit and dedicated children's accident and emergency facility within an established busy emergency department. In addition there was an on site, 24 hour children's unit which provided assessment, observation and short stay capacity. Despite this there was a large number of children presenting to the A&E department for their primary care needs. There was no integrated emergency centre in the area.

A purpose built A&E department, with an integrated primary urgent care centre from which daytime and out of hours primary care services are

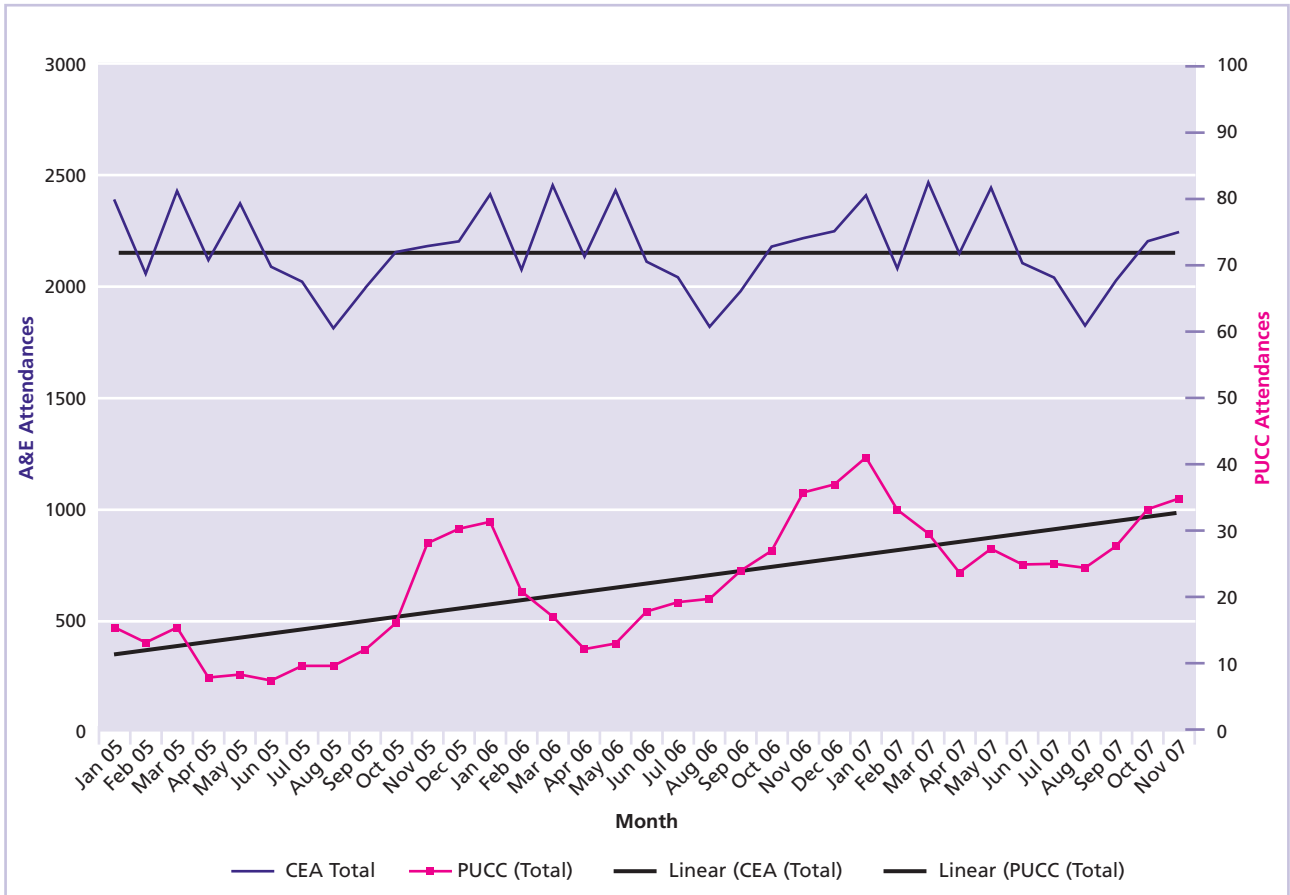
provided, was developed in 2006. The main purpose was to ensure that children were appropriately assessed to receive ongoing care and management from the best equipped clinical team. This follows the 'right child, right place, right personnel, right time' principle.

A child presenting here is triaged by a children's nurse either to the primary urgent care centre, or children's A&E, or referred to the children's assessment unit. The criteria for triage to primary care were developed collaboratively between the primary urgent care centre, the A&E department and the paediatric department. The pathway and flow of

children between these areas is constantly monitored and as the experience and capacity of the centre continues to improve as more and more children are assessed to receive care within this facility.

The following graph (Figure 6) shows there has been an increase in the percentage of children triaged to the primary urgent care centre month by month and challenging targets are set to increase the number of children triaged back to this facility. There is also a slight decrease in the number of attendances in the emergency department.

**Figure 6: Percentage of children and young people triaged to the PUCC and the number of attendees to the emergency department**



**Useful measures:**

- Number of dedicated cubicle or trolley spaces for children and young people per 5000 annual children and young people attendances in the emergency department\*
- Percentage of complete and accurate correct-on-assessment streaming (for example, the percentage of children and young people re-directed from emergency departments to the primary urgent care centre)
- Time to brief clinical assessment (percentage achieved within 15 minutes)\*
- Time to clinical decision made by a competent professional (percentage achieved within two hours)
- Percentage of clinical staff trained in appropriate levels of paediatric life support\*
- Evidence of joint working between paediatric department and the emergency department, including a named emergency department liaison paediatrician and joint meetings with collective action plans
- Measuring children's and families' experience, for example by using questionnaires to gather information from a representative sample of the community will help organisations provide a responsive service.

\* 'Services for Children in Emergency Departments', April 2007, Report of the Intercollegiate Committee for Services for Children in Emergency Departments, p10, Section 3, no. 3, p11, Section 5, no. 2, p11, Section 6, no.2. <http://www.rcpch.ac.uk/Health-Services/Emergency-Care>





### Key characteristic 11:

Availability of advice whenever needed for primary care professionals from senior medical and nursing staff, reduces presentation of children and young people to secondary care and also decreases the chances of admission after presenting through out of hours service.

- Consultant led urgent care clinic every morning with a consultant manned GP hotline
- Senior review clinics (consultant and registrar level).

## Case study

### Homerton University Hospital NHS Foundation Trust

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In keeping with the ambulatory model of providing emergency and urgent care for children, it was recognised that an urgent care clinic and a GP hotline service was required, so that the primary care team could obtain direct and immediate advice from the paediatric consultants.

There are daily consultant run urgent care clinics with booked slots for children with urgent healthcare needs. In addition, there is a hotline for the primary care team so that they can obtain advice from the paediatric consultant about the

management of children, the need for referral; and the most appropriate route of referral. This assists in the triage of children to the most appropriate assessment route and allows ongoing care in the primary care setting with senior paediatric support.

The Urgent care clinic is run from the main children's outpatient department within the paediatric unit and is distinct from the primary urgent care clinic in A&E. On average, approximately 10 calls each week from GPs are received and

the hospital sees approximately 80 patients each month in the urgent care clinic.

This approach provides the right support for the primary care team, giving them confidence to avoid unnecessary referrals out of hours to the A&E department as a senior opinion is readily available the following day.

This has reduced the number of children being referred to the children's A&E department, the children's assessment unit and routine children's outpatients.

#### Useful measures:

- Percentage of GP enquires and potential referrals managed by telephone advice by the paediatric staff

- Satisfaction survey of primary care staff about the service
- Percentage of services (acute and community) that perform against jointly agreed operational frameworks

(financial, managerial and clinical) ensuring children and young people are managed efficiently and effectively.





**Key characteristic 12:**  
The development of innovative roles designed to provide urgent assessment and treatment.

### Case study East and North Hertfordshire NHS Trust

<p>Paediatric emergency nurse practitioners (PENP) in the emergency department provide age specific care by staff who are educated specifically in the assessment and management of children, including pain management.</p>	<p>The role benefits children and young people as they can be seen and treated more quickly with fewer professionals involved in each care episode and timely pain relief administered. The impact of the role in the emergency</p>	<p>department has reduced the wait time from three hours to two hours and pain relief is now given within approximately 10 minutes. Previously it was a 45-minute wait.</p>
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### Key characteristic 13:

Co-location of emergency department, children’s accident and emergency and children’s assessment units improves the efficiency of the pathway and enables skill sharing and joint working.

## Case study

### East and North Hertfordshire NHS Trust

A children’s assessment unit is located next door to the children’s accident and emergency department enabling very close, integrated working and shared learning between these areas.

This approach maximises the number of the children that are discharged back to the

community without being admitted to the children’s ward. This has resulted in significantly improved waiting times, appropriate pathways of care being followed and improved patient satisfaction. This service has no difficulty recruiting into nursing roles, to the point where demand has outstripped supply.

The clinical lead recommends close working practices between all specialities involved in the care of the child who presents through the emergency department with not just medical paediatrics, but specialty surgery as well.

#### Useful measures:

- Time to brief clinical assessment (percentage achieved within 15 minutes)\*
- Time to clinical decision made by a competent professional (percentage achieved within two hours)
- Percentage of children and young people with a pain

score included in the initial assessment where appropriate\*

- Time taken from triage to receiving pain relief
- Measuring children’s and families’ experience, for example by using questionnaires to gather information from a representative sample of the

community will help organisations provide a responsive service

- Number and percentage of transfers from assessment unit/observation unit to an inpatient ward to monitor a reduction in the number of inappropriate admissions.

\* ‘Services for Children in Emergency Departments’, April 2007, Report of the Intercollegiate Committee for Services for Children in Emergency Departments p11, Section 5, no. 2, p11, Section 5, no. 4. <http://www.rcpch.ac.uk/Health-Services/Emergency-Care>

### Key characteristic 14:

Ambulatory paediatric units without on-site inpatient beds will only work effectively if there are the facilities to transfer children to the nearest children's ward.

- St. John Ambulance delivers an integrated service with clinical teams including transfer between two units.

## Case study

### East and North Hertfordshire NHS Trust

This hospital trust manages two hospitals 12 miles apart and the children's inpatient beds are located in one of these.

The trust employs the St. John Paramedic Ambulance Service to provide dedicated transfer between the two units. Children and young people needing high dependency care are accompanied by appropriately competent nursing or medical staff. Children and young people who need transfer to a tertiary paediatric intensive care unit are transferred by a central retrieval

team. There have been no adverse clinical incidents since the St. John Ambulance Service began to transfer children and young people.

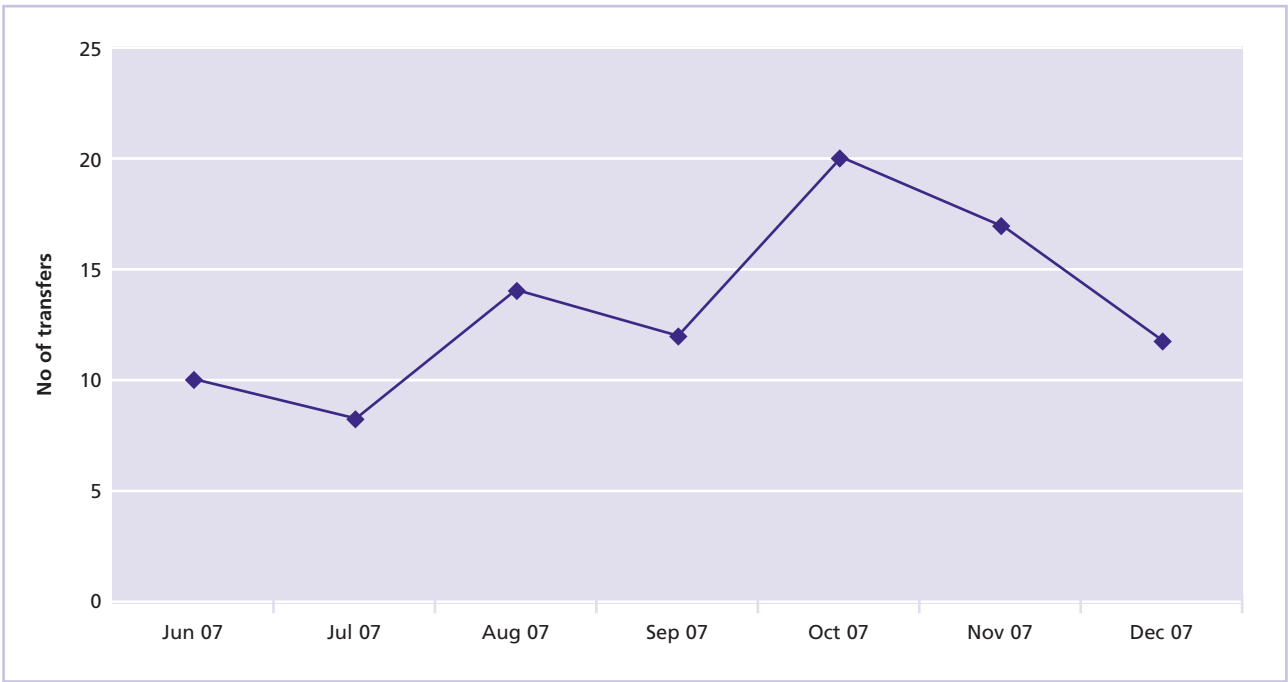
The ambulance technicians are part of the clinical team and are based at the paediatric assessment unit in one of the hospitals. They provide a clinical service when they are not involved in the transfer of children and they operate Monday to Friday between 1pm and 7pm.

Their aim is to be able to transfer patients in a safe caring environment as speedily as possible to anywhere that is deemed necessary. This has built public confidence in the local community that there are quick and reliable arrangements in place for the transfer of a small number of children who might present at one hospital but need to be transferred to the other hospital site.

(see Figure 7)



Figure 7: A graph showing the relatively small numbers of monthly transfers between the two sites in 2007



**Useful measures:**

- Number and percentage of transfers from an ambulatory unit to an inpatient facility to monitor a reduction in the number of inappropriate admissions

- Decreasing the length of time from decision to transfer to actual transfer
- Measuring children’s and families’ experience, for example by using questionnaires to gather information from a representative sample of

the community will help organisations provide a responsive service

- Response times for the children and adult mental health services (CAMHS), 24 hours a day seven days a week.



## The inpatient ward

All decisions to admit will have a prescribed case management plan with identifiable necessary investigations, interventions and a monitoring process. This plan will include timelines for the investigations and interventions to be delivered with an estimated date and time of discharge and the clinical criteria for discharge identified at the time of admission.

The majority of children can be managed without any investigations if they are assessed early by appropriately trained paediatric doctors and nurses. If investigations are needed they should be performed and interpreted by staff who have the appropriate knowledge and skills in dealing with children and young people. Case management up to the time of discharge requires daily multiple senior

reviews to discharge as soon as it is safe to do so. Early liaison with the community children's nursing team will ensure early discharge plans are in place to support children and families in the community.

### Key characteristic 15:

Senior competent staff ensure timely clinical assessments and clinical decisions, with a prescribed case management plan.



<p><b>Useful measures:</b></p> <ul style="list-style-type: none"> <li>• Percentage of expected discharge date and time (EDD) set by the consultant at the time of the clinical decision</li> <li>• Percentage of EDDs delivered</li> <li>• Audit the use of criteria-led discharge</li> <li>• Percentage of discharge summaries following emergency attendance</li> </ul>	<p>received by the primary care team within 48 hrs</p> <ul style="list-style-type: none"> <li>• Number of early facilitated discharges with follow-on support from a community team</li> <li>• Percentage of children and young people presenting for re-assessment following discharge home</li> <li>• Measuring children's and families' experience, for</li> </ul>	<p>example by using questionnaires to gather information to form a representative sample of the community will help organisations provide a responsive service</p> <ul style="list-style-type: none"> <li>• Benchmarking performance regarding length of stay and re-admission rate using the national best 25% performers (upper quartile) as a standard - (1.86 days, based on HES data 2006/07).</li> </ul>
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### Key characteristic 16:

Senior nurse leaders focus on improving quality standards through a system of audits and weekly reporting.

## Case study

### The Medway NHS Trust

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The director of nursing set up the Nursing and Midwifery Audit System (NMAS) in 2004. The clinical nurse lead in paediatrics developed the audit tool for the children's assessment and inpatient area. The data is entered by the lead nurse onto an online system. At a weekly forum all matrons, together with the head nurses and the director of nursing acknowledge achievements and develop action plans to address existing challenges.

Weekly audits of the following takes place trust wide: MRSA CDIF (those admitted with, or acquired); bed days lost through bed closures; wearing of correct

uniform; pressure sores; lost hours through sickness; study leave; maternity leave; carer's leave and flexi bank hours used. In the children's unit, they have developed and implemented a specific daily documentation audit.

- Daily documentation audit in paediatrics led by the senior nurse on duty covers:
  - baseline observations documented within 30 minutes and full nursing assessment documented within two hours
  - care plans and Kardex entries are accurately recorded and signed

- TPR (temperature, pulse and respiration) charts
- fluid balance charts
- discharge checklists.

The documentation audit has led to improved record keeping and the senior nurse believes the greatest impact has been on:

- individual nurses documenting their evaluation of care plans throughout each span of duty as an ongoing process
- individual nurses taking responsibility to accurately record care delivery.

#### Useful measures:

- Multidisciplinary medical records audit with peer review
- Evidence of multi-specialty collaboration and

improvement action, for example, the development of services along the pathway

- Reduction in number of errors/near misses, for example, drug errors

- Reduction in number of serious adverse incidents.

**Key characteristic 17:**  
Play specialists are integrated with all aspects of children's services.

- Play specialists are recognised as key to providing a high quality experience within a child friendly environment
- Play specialists are involved in acute and ambulatory care team meetings
- Play specialists are on the bleep system for emergencies and safeguarding examinations
- Highly visible play specialist team improves the hospital-wide physical environment
- Play specialists provide extended outreach into other areas i.e. personal, social and health education and distraction boxes in different areas
- Play specialists provide access to play and preparation for healthcare interventions.

## Case study Derby Children's Hospital

The play specialist team has been established for 15 years and has developed into a seven day, 7.30am to 6pm, service providing support wherever children are in the hospital.

There is a team of 10 of which six are qualified to an Edexcel level 4, and all are qualified to a minimum diploma level in child care. All members of the team are trained to level 3 (the highest level) in safeguarding children. They are key members of the safeguarding team and are managed by the child protection nurse lead.

The play specialists join paediatricians, health visitors, social workers and police in the child protection clinics, both in the community and in the hospital. In these clinics they use play to explore concerns and are available to support each child as well as parents and carers. They saw 332 children and young people in the child protection clinics between January 2006 and December 2007.

They operate a rotational system (planned six weeks ahead) working in the emergency departments, wards, clinics,

diagnostics and theatres. They prioritise their workload each day, are integrated with the clinical teams and work closely with nurses, physiotherapists, occupational therapists and paediatricians.

The team are part of the Hospital Art and Design Group which has responsibilities to ensure donated funds are used to maintain the appropriate environment for children and young people.



## Case study

### East and North Hertfordshire NHS Trust

Play specialists are part of the multi-disciplinary team whose responsibilities include organising daily play and art activities in the playroom or at the bedside; providing play to achieve developmental goals; helping children cope with anxieties and emotions and using play to prepare children for hospital procedure.

Through their play based observations they are able to provide additional information to support professionals in making clinical judgements. They also teach the value of play to other staff groups. The team provide a seven day service to the children's wards, paediatric assessment unit and the children's A&E department with

additional cover to outpatients, theatre, diagnostics and day surgery on appropriate days. The team also support families and siblings.

All of the play specialists are supported through mentorship and monthly meetings with the team manager.

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#### Useful measures:

- Measuring children and young people and their families experience, paying particular attention to the physical environment from a 'child's and/or 'young person's eye'
- Percentage of children and young people who spent time with play specialists in all other non-paediatric environments (for example, emergency department)
- Percentage of children seen each day by a play specialist.





**Key characteristic 18:** Safeguarding children is everybody's business. Any emergency and urgent care pathway should have a system for safeguarding children embedded within it.

- Safeguarding service has adequate resources with necessary administrative support to deliver a responsive service
- As part of the initial triage and assessment of children, a child protection questionnaire is completed
- Liaison nurse identifies children at risk in emergency department and uses 'youth at risk forms' and informs school nurses
- Community liaison nurse experienced in mental health audits attendances in emergency department, analyses trends and informs a network of agencies across health communities.

### Case study

#### Homerton University Hospital NHS Foundation Trust

The trust identified the need for a paediatric liaison nurse role to address the complexity of safeguarding concerns and the other social needs of children and young people who were attending A&E in increasing numbers. The liaison nurse has a highly visible presence within the A&E department as well as paediatric and adult areas. This is highly valued by the staff.

The A&E department is now identifying more safeguarding issues and concerns, for example, child trafficking, private fostering and female genital mutilation. There are increasing numbers of children referred to community services that would have previously been unidentified. There has been an increase of 31% in referrals to educational services for children not at school, and an increase of 35% to social services.

A domestic violence policy ensures appropriate referrals of children living in homes where there is domestic violence. This system now indicates to social services and school nurses if there are children in the home of adult patients who have been admitted to A&E following domestic violence at home.

The paediatric liaison nurse and community liaison health visitor deliver joint educational sessions on safeguarding issues for a wide range of staff including health visitors, school nurses, community children's nurses and public health co-ordinators.

When the paediatric liaison nurse noticed a trend of increasing numbers of children presenting to A&E with burns and scalds, she worked with the PCT public health team to identify the reason. It was discovered, following an investigation, that children were using empty oven cleaner bottles as water guns. A public health education campaign was launched which led to a dramatic reduction in children presenting with oven cleaner burns and scalds. (See Figure 8)



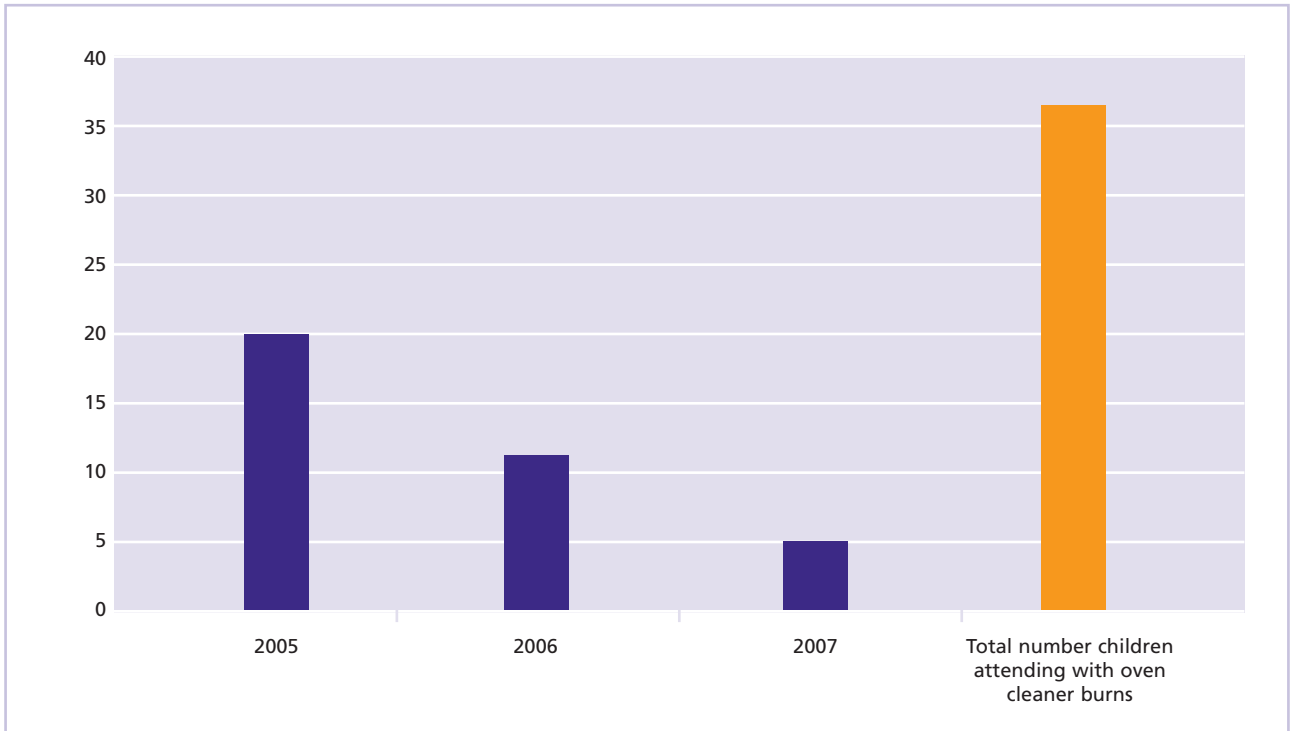
*'I feel more confident dealing with child protection and social issues since the paediatric liaison nurse came into post.'*

Children's A&E nurse

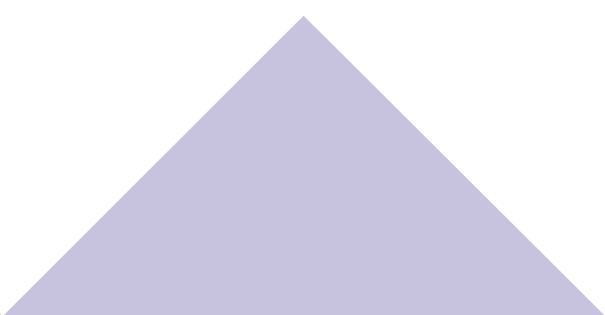
*'The paediatric liaison nurse is very supportive to the department and I like being able to discuss concerns with you.'*

Paediatric registrar

Figure 8: Reduction of the numbers of children attending A&E with oven cleaner burns



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**Key characteristic 19:**  
Plans are in place to develop one stop child protection examination centre which includes police and social services.

## Case study

### East and North Hertfordshire NHS Trust

<p>The East and North Hertfordshire Child Health Services Safeguarding Team (made up of designated named doctors and nurse and a trust executive representative) has successfully bid for half a million pounds through the Child Protection Capital Funding Scheme.</p>	<p>The team has put together a successful business case to convert one of their wards, which is no longer needed, into a state of the art integrated multidisciplinary child protection examination suite. There are facilities for social care and police to be based here and children and young people with</p>	<p>suspected physical and sexual abuse will be examined here. The centre is scheduled to be opened shortly.</p>
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|---|---|---|
| <p><b>Useful measures:</b></p> <ul style="list-style-type: none"> <li>• Percentage of children and young people seen on the same day for child protection medical examinations</li> </ul> | <ul style="list-style-type: none"> <li>• Percentage of staff dealing with children and young people with appropriate level of child protection training (95% of staff should be trained)</li> </ul> | <ul style="list-style-type: none"> <li>• Evidence of multidisciplinary and multi-agency collaboration and improvement action, for example, joint initiatives as illustrated above.</li> </ul> |
|---|---|---|



## Transfer of care function

The transfer of care function implied within this document includes all community based services, including emergency care practitioners, community children's nursing services, child and adolescent mental health teams and social care teams.

The principle behind the concept of transfer of care is the recognition that patients can require the service at any point in their journey in order to prevent unnecessary hospital admission or to shorten the length of stay in hospital. All services need to be

integrated and co-ordinated across the whole system, enabling them to be responsive and accessible.

**Key characteristic 20:**  
Community children's nursing teams are an essential part of the emergency and urgent care pathway as they prevent admissions, support care at home and facilitate early discharge.

- Community nursing teams facilitate choices of where treatment can be received
- Community nursing teams electronically capture and report activity to understand the trends and demands for the service
- Community nursing teams work 24 hours, seven days a week, with an identified named nurse for every child
- Community nursing teams can access a paediatric consultant at any time.



## Case study

### Derby Hospitals NHS Foundation Trust



At Derby Children's Hospital the 'Kids In their Own Environment' (KITE) Nursing Team provides a seven day 'Hospital at Home' service. The team offers a 24 hour service for palliative care and for some children care during the period of transition between the hospital and home – for example the first night a child goes home on enteral nutrition.

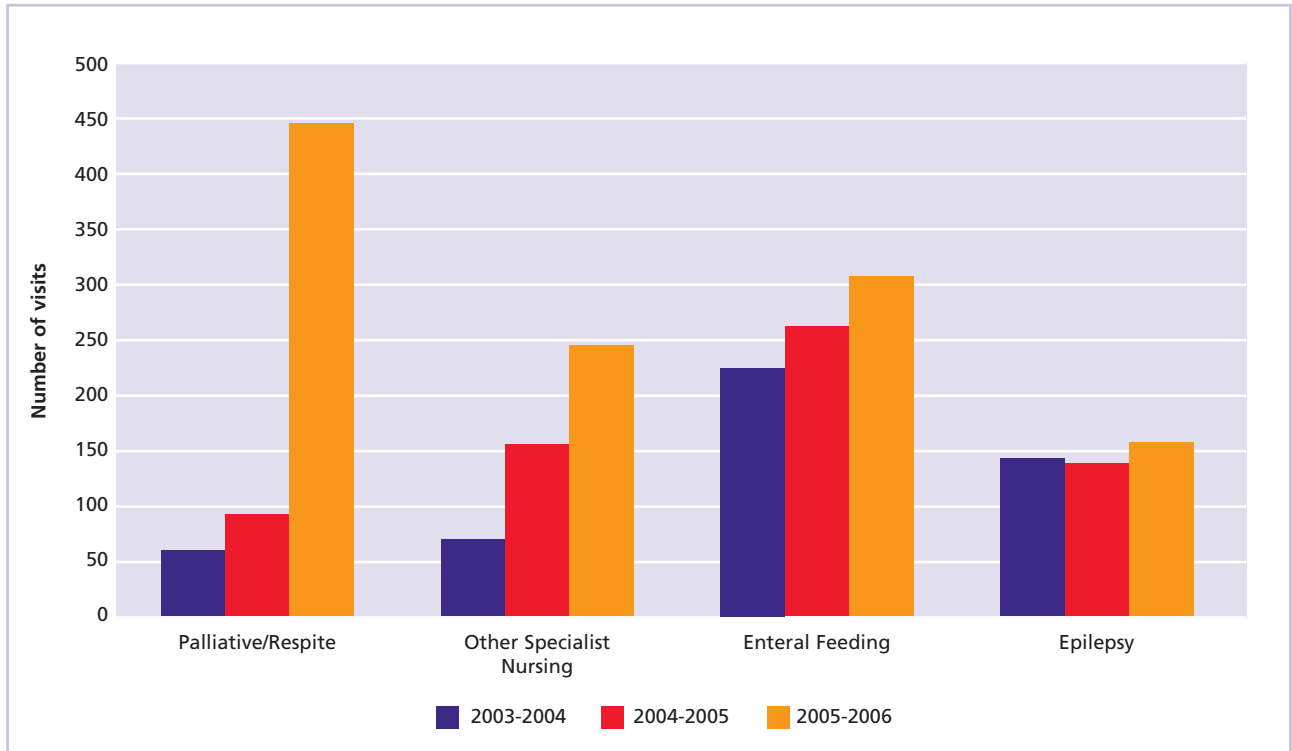
The members of the team have a variety of qualifications and experience, including qualifications in community children's nursing and respiratory management. Continuous professional development is provided by links to tertiary centres and by working closely with colleagues from other centres.

The team captures information about their visits and other activities which enables them to demonstrate changes in both demand and casemix. The bar graph on the next page (Figure 9) shows the increases in visits to children and families, especially

for those with palliative care needs (the trend in 2006/07 indicates an increase in the number of children who have died in the community as their preferred choice), as well as an increase for those with complex health care needs and other specialist nursing needs. This model of care supports families in caring for these children at home.



Figure 9: increases in visits to children and families, especially for those with palliative care needs



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**Useful measures:**

- Number of community children’s nurses per 100,000 children and young people population compared with other similar units.

- Number and casemix of children and young people looked after at home by the children’s community nursing team
- Number of early facilitated discharges with follow on support from a community team

- Measuring children’s and families’ experience, for example by using questionnaires to gather information from a representative sample of the community will help organisations provide a responsive service.



## 6. Benefits

Delivery of high quality care achieves a wide range of benefits. Figure 10 shows that, by delivering quality for children's emergency and urgent care, a number of common benefits can be realised. The benefits apply to the following three dimensions:

### Children, young people and families

- Safe, high quality local care
- Prevention of unnecessary admissions
- Care in dedicated environments
- Cared for by staff trained in the care of children and young people
- Support for families
- Early discharge
- Reduced school absence
- Community children's nursing support
- Access to play facilities and staff
- Improved health outcomes
- Children and Young people involvement

### Staff

- Increased satisfaction
- Decreased absence rates
- Sustainable workforce development
- Collaborative relationships across departments
- Joint working with education and social care
- Participation in service transformation
- Making a difference
- Reputation for safe and high quality care
- Access to appropriate education and training

### NHS organisations

- Implementation of the Children's NSF
- Achievement of the goals of 'Every Child Matters'
- Reduction in emergency secondary care attendances
- Reduction in number of 'zero length of stay' admissions
- Decreased length of stay
- Decreased readmission rate
- Decreased mortality and morbidity rate
- Better value for money
- Reduced critical incidents
- CYP involvement

## 7. Conclusion

Optimal delivery of high quality emergency and urgent care for children and young people is an achievable goal. The opportunities for quality improvement in this area are immense and include:

- improved outcomes for children and young people supported by clinical evidence
- increased ambulatory care and reduced use of inpatient beds.

Good quality care costs less than sub-optimal care as admission rates, length of stay, readmission rates and complication rates are reduced.

The contents of this report are based on the Delivering Quality and Value Team's observations of the practices of NHS organisations that are judged to be delivering high quality care and value for money. While all of these observations have been tested thoroughly, it should be recognised that they may not be the only way of delivering high quality care and value for money.

However, we believe that they will give valuable guidance and direction to those seeking this goal.

To improve services, organisations should utilise this guidance and take the following steps:

1. Understand how your organisation performs when compared with the key measures and benchmarks suggested.
2. Generate a locally integrated programme for improvement.
3. Integrate the local change management programme with the health community integrated service improvement plan and local delivery plan.

While this report offers suggestions to care providers and commissioners on how they might optimise their own provision of care, it is, of course, intended to be a first step on the journey to improvement. It will be followed by practical tools to help organisations make those improvements happen locally.

In particular, the Delivering Quality and Value Team expects to produce the following resources to support the children's emergency and urgent care pathway:

- **A toolkit** for providers about how to involve children and young people in all aspects of planning, delivering and receiving feedback on emergency and urgent care services
- **A guide** to help children and families navigate the emergency and urgent care pathway.

We will develop, prototype and test these products and tools based on what we have observed during this project and what we have learned from the people providing the most innovative care.

They are expected to be available by the end of summer 2008.





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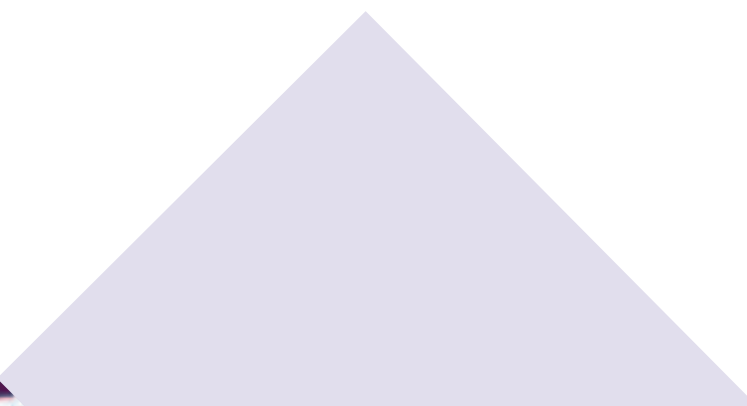
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