Children and Young People
Clinical Working Group Report

*Transforming Services, Changing Lives*
Note on methodology

As part of their discussions, the Clinical Working Groups had access to available data from local providers and national sources. Whist due to different coding and submission practices amongst providers there will always be limitations to this data, it was still felt helpful evidence for participants to have access to it and use it to help inform discussions.

The available data has highlighted that there is variation in care and practice across East London. They have helped the Clinical Working Groups identify potential areas for improvement but the future planning work in which more specific and detailed change plans and options are determined will require more detailed work to be undertaken to overcome some of the limitations associated with available data sources.

The sources of data used include (but are not limited to):

Local Data sources:
- Greater London Authority
- Secondary Uses Service (‘SUS’) data
- Service Level Agreement Monitoring (‘SLAM’) data
- Local clinical audits
- Trust self-assessments against London Quality Standards

National data sources:
- Public Health England
- CHKS benchmarking
- NHS Better Care, Better Value indicators
- Indicators from the Health and Social Care information Centre portal
- Quality and Outcomes Framework
- Mental Health Minimum Data set
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1. Introduction

1.1. Context

In February 2014, Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups agreed to work in partnership to establish *Transforming Services, Changing Lives*. Local providers, commissioners and patient representatives were invited to participate.

The organisations shown below joined the programme, providing expertise and representation on committees and clinical working groups. Local organisations such as City and Hackney Clinical Commissioning Group were also key consultees. Whilst the majority of discussions have focused on Barts Health services, both Barts Health NHS Trust (BHNT) and Homerton University NHS Foundation Trust (HUHFT) took an active part in discussions.

The purpose of the programme is to develop a clinically-led Case for Change and develop a clinical community for change in east London to improve the clinical and financial viability of local services.

The first phase of this work which ran from February to June 2014 was to undertake a baseline assessment of the drivers for change in the local health economy. Six clinical working groups (CWGs) were established to ensure that the programme and emerging case for change were shaped and underpinned by strong clinical leadership. In addition, a clinical reference group (CRG) comprising of the clinical chairs of each of the CWGs was formed to consider the overarching clinical and demographic issues.

Each of the clinical working groups produced an interim report in June 2014 based on their discussions, analysis and findings to date. Over the summer months we engaged with local clinicians to further test these findings. The clinical working groups continue to meet to develop the evidence base for their case for change. A summary of the clinical engagement undertaken can be found at Appendix C.
This final report is one of six reports developed by the clinical working groups, and its findings have influenced and are detailed in the *Transforming Services, Changing Lives Case for Change* and future work programme.

Alongside the clinical engagement detailed above, we engaged with patients, carers, NHS staff, the public and key stakeholders such as local authorities to gather feedback to enhance the overall *Case for Change*. This *Case for Change* and additional information about the programme can be found at: [www.transformingservices.org.uk](http://www.transformingservices.org.uk)

A summary of the patient and public engagement undertaken can be found in Appendix D.

### 1.2. Purpose of this paper

This paper provides a summary of the discussions of the Children and Young people CWG (CYP CWG’). The group consisted of the following membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna Riddell</td>
<td>Co-chair</td>
<td>Barts Health NHS Trust</td>
</tr>
<tr>
<td>Tonia Myers</td>
<td>Co-chair</td>
<td>Waltham Forest CCG</td>
</tr>
<tr>
<td>Abdul Moodambail</td>
<td>Member</td>
<td>Barts Health NHS Trust</td>
</tr>
<tr>
<td>Elizabeth Goodyear</td>
<td>Member</td>
<td>Newham CCG</td>
</tr>
<tr>
<td>Gabrielle Laing</td>
<td>Member</td>
<td>Homerton University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Helen Page</td>
<td>Member</td>
<td>London Borough of Newham (Public Health)</td>
</tr>
<tr>
<td>Julia Thomson</td>
<td>Member</td>
<td>Barts Health NHS Trust</td>
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<tr>
<td>Kirsteen McDonald</td>
<td>Member</td>
<td>Barts Health NHS Trust</td>
</tr>
<tr>
<td>Nair Parvathy</td>
<td>Member</td>
<td>Redbridge CCG</td>
</tr>
<tr>
<td>Neil Douglas</td>
<td>Member</td>
<td>Tower Hamlets CCG</td>
</tr>
<tr>
<td>Sherry Manning</td>
<td>Member</td>
<td>Barts Health NHS Trust</td>
</tr>
<tr>
<td>Sarah Webb</td>
<td>Member</td>
<td>Homerton University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Birgit Westphal</td>
<td>Member</td>
<td>East London NHS Foundation Trust</td>
</tr>
</tbody>
</table>
The content of this report was developed through a series of meetings taking place throughout April to September 2014.

These clinical working groups were established to ensure that the programme and emerging Case for Change were shaped and underpinned by strong clinical leadership and a strong local understanding to develop the emerging evidence base. In developing this Case for Change, the group considered:

- **Patient experience**, gathered through engagement over the summer months.
- **Review of best practice, policy and guidance**, which included information such as the relevant NICE guidance, London Quality Standards, guidance from the Royal Colleges and other professional bodies, reports from Care Quality Commission (CQC) and other regulatory bodies as well as health policy bodies such as the King’s Fund and Nuffield Trust.
- **The best available local data on current performance and activity** from local providers and national sources. Whist due to different coding and submission practices amongst providers there will always be limitations to this data, it was still felt helpful for participants to have access to this information.
- **Their shared clinical experience**, including context on local performance, initiatives and plans.

These groups also engaged with over 350 local clinicians across all health care settings in order to test and validate their work.

Based on the above sources of information the groups were asked to consider:

- An overview of services that are currently available
- The impact of local population changes and demographics on the services
- The implications of local strategies and plans
- What high quality, sustainable care looks like, for the future
- How current services compare to this vision
- What obstacles exist to achieving this
- The emerging model of care and potential next steps
2. Where are we now?

2.1. What are the population challenges?

East London has a higher than average proportion of children and young adults. Approximately 217,000 children, aged 0-19, represent 27% of the population in Newham, Tower Hamlets, Redbridge and Waltham Forest. In line with overall projected population growth rates, the number of children and young people within the four boroughs will continue to rise rapidly with approximately 8% growth expected over the next five years (representing an additional 16,000 children and young people)¹. Forecast growth is particularly high in the 10-14 years age group.

The population of children and young people is culturally diverse, with between 80.2% (Waltham Forest) and 92.8% (Newham) of school children from a minority ethnic group and higher than average rates of non-English speakers². There is a high level of ‘churn’ in the local population, (the movement of residents in and out of a borough) as high as 30% annually in Newham³.

Deprivation is a significant factor within east London with high child poverty and poor nutrition rates expected to contribute to the demand of health services. The rate of child poverty and family homelessness in the area is higher than the England average with between 23% (Redbridge) and 43.6% (Tower Hamlets) of children under 16 years living in poverty (against an England average of 20.6%⁴). Levels of childhood obesity are also above the England average for the four boroughs, contributing to a predicted earlier onset of health complications related to long term conditions, potentially increasing the demand for health services in the future.

Despite good practice being observed in Tower Hamlets, public health data indicates that significant parts of east London are in the bottom national quartile for rates of immunisation of children. All east London boroughs exhibit higher rates of low birth weight babies (under 2.5kg) compared to

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¹ Office for National Statistics (ONS) and Greater London Authority (2012)
³ Newham CCG (2013), Primary healthcare strategy 2013-18
⁴ Public Health England (March 2014), Child Health Profiles
the England average with 9.1% in Redbridge and 10.2% in Newham⁵, suggesting that children in the area are not getting the best start in life.

Estimates vary, but research suggests 20% of children have a mental health problem in any given year, and about 10% at any one time⁶. 2012 Public Health population estimates predicted just over 24,000 children and adolescents (5 – 16 years) will have a mental health disorder in the area. Emergency admissions data reveals the number of admissions for children and young people for self-harm ranges from 0.66 per 1000 in Redbridge to 1.21 per 1000 in City & Hackney.

2.2. How is the system currently performing?

Acute paediatric services are provided at all four of the main Barts Health NHS Trust sites at and Homerton University Hospital (see figure 3.). Barts Health NHS Trust has one of the largest combined paediatric departments in the UK and The Royal London Hospital is one of London’s busiest paediatric accident and emergency (A&E) departments. The Royal London provides complex and non-complex paediatric services whilst Homerton University Hospital, Newham University Hospital and Whipps Cross University Hospital provide less complex paediatric services. All sites provide paediatric emergency services with varying degrees of formal and informal network arrangements to the Royal London.

There are also specialist outreach services provided by the teams from The Royal London Hospital and Great Ormond Street Hospital across the CCGs.

<table>
<thead>
<tr>
<th></th>
<th>Royal London (RLH)</th>
<th>Whipps Cross (WCUH)</th>
<th>Newham (NUH)</th>
<th>Homerton (HUH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>Serves the most critically ill children, and provides a range of in/outpatient services with referral to GOSH for the most specialised conditions</td>
<td>Serves emergency cases and provides in/outpatient services for less complex cases with referral to RL (and other providers) for specialised conditions</td>
<td>Serves emergency cases and provides in/outpatient services for less complex cases with referral to RL for specialised conditions</td>
<td>Serves emergency cases and provides in/outpatient services for less complex cases with referral to RL for specialised conditions (and other providers)</td>
</tr>
<tr>
<td>Annual planned admissions⁷</td>
<td>8,320</td>
<td>2,555</td>
<td>1,139</td>
<td>1,179</td>
</tr>
<tr>
<td>Annual unplanned admissions⁸</td>
<td>6,294</td>
<td>5,182</td>
<td>3,132</td>
<td>3,067</td>
</tr>
<tr>
<td>Annual A&amp;E attendances⁹ (includes UCC)</td>
<td>35,336</td>
<td>24,231</td>
<td>21,537</td>
<td>30,490</td>
</tr>
<tr>
<td>Annual Outpatient appointments (includes St. Bartholomew’s)</td>
<td>49,772</td>
<td>29,830</td>
<td>18,254</td>
<td>19,467</td>
</tr>
</tbody>
</table>

Figure 3. Paediatric services at the main hospital sites October 2012 to September 2013
Source: SUS activity data

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⁵ Public Health England (March 2014), Child Health Profiles
⁷ SUS activity data, Oct 2012-Sep 2013
⁸ SUS activity data, Oct 2012-Sep 2013
⁹ SUS activity data, Oct 2012-Sep 2013
The Royal London Hospital A&E is used predominantly by its local population with 78% of attendances from Tower Hamlets and some patients travelling from City and Hackney (7%) and Newham (8%). Whipps Cross University Hospital is used largely by its local Waltham Forest population with 20% of attendances also travelling from Redbridge. All other A&E sites treat mainly their local populations – see figure 4 and Appendix B, page 4.

St Bartholomew’s and The Royal London Hospitals provide significant levels of planned inpatient care to City and Hackney, Newham, Tower Hamlets, Waltham Forest, Redbridge and Barking and Dagenham residents. In addition to the local Waltham Forest population, Whipps Cross University Hospital also provides some inpatient care to Newham and Redbridge residents. Homerton University Hospital and Newham University Hospital provide inpatient care almost exclusively to their local populations – see figure 5 and Appendix B, page 13. This highlights potential variance in clinical pathways.

Paediatric attendance and admission by CCG and hospital site

Examples of where things are working well

There are several areas where services for children and young people are working well. The following examples have been identified by the CYP CWG themselves and through engagement with a broader set of clinicians at TSCL engagement events:

- The Children’s Hospital at Barts Health NHS Trust offers a wide range of regionally recognised **specialised medical and surgical services** including paediatric intensive care within close reach to the children of east London

- An innovative pilot project in Tower Hamlets has developed a **virtual ward** for children with complex needs
• The Newham University Hospital Paediatric Clinical Decision Unit which operates in A&E, provides important observation facilities and is contributing to reduced admissions.

• Homerton University Hospital’s integrated ambulatory model incorporates rapid access to consultants, short stay observation and assessment and care at home from a seven day community children nursing team. Clinicians report that this new model is proving successful at reducing length of stay, reducing emergency admissions for children and readmissions.

• The ‘best start in life’ pilot project in Waltham Forest is a monthly integrated care style meeting of GPs, midwives, children’s centres, health visitors and early intervention and prevention teams for children 0-5 years. Outcomes are currently being evaluated by Public Health.

• The integrated children’s division at Homerton University Hospital NHS Foundation Trust has facilitated the development of multi-disciplinary pathways across neonatal, general and community services. Examples include pre-term infant follow up, continence and epilepsy.

• The short stay A&E model operating at The Royal London Hospital is supporting shorter waits and improved patient experience.

• The liaison health visitor service at Whipps Cross University Hospital is providing a good safeguarding service.

• An advice hotline and email service for GPs in Tower Hamlets has been established enabling specialist paediatric advice and is receiving positive feedback from GPs. Similar schemes at Newham University Hospital and Whipps Cross University Hospital are currently being evaluated.

However, there are also a number of ways in which care for children and young people could be improved to better meet the needs of children and young people in east London. The diagnosis of the CYP CWG on current performance is outlined further in section three.

3. What does good look like?

Following an initial review of the data pack and policy review at the first meeting the CWG decided to frame their discussions around four models of care. These captured the principle concerns that emerged from the launch event and CWG members. The four models discussed in more detail at the subsequent meetings were:

- Transitions of care
- Integration of community care
- Hospital care pathways and
- Urgent care.

These were developed to provide a picture of what good care for children and young people should look like. It includes a principle for each model of care and a number of principles that should be met in order to provide good care – see figure 6. Central to these are the overarching principles of
public health, prevention and safeguarding that are a consistent feature of good care for children and young people.

**Early intervention.** Early intervention refers to general approaches, specific policies and programmes which help to give children aged 0 – 3 the social and emotional bedrock they need to reach their full potential. It is widely recognised that providing early identification and intervention can help prevent adverse childhood experiences and developmental delays\(^\text{10}\) from manifesting into longer term health and social care problems. Promoting social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Early intervention can help to prevent criminal behaviour, drug and alcohol misuse and teenage pregnancy\(^\text{11}\) (a significant issue in some parts of east London). The economic benefits of early intervention are clear and consistently demonstrate good return on investment.

**Safeguarding.** The *Munro Review* asserted that safeguarding children is ‘everyone’s responsibility’. Professor Munro raised concerns in her review of progress (2012) that ‘the radical reform of the health service may lead to a loss of attention being paid to safeguarding children in the health sector’\(^\text{12}\) (p11.). The CYP CWG were cognisant of this risk and highlighted the need for professionals from a range of agencies to collaborate and create a culture that places the child at the centre. The CYP CWG also reiterated the need for safeguarding to be a central tenant of any service redesign activity and that this would need to link with other clinical working groups in future work to ensure this is covered.

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\(^{10}\) A developmental delay is a term used to describe a child’s condition if they are not progressing as expected (individually, not a diagnosis)

\(^{11}\) Early intervention: Next steps (2011)

\(^{12}\) Munro, E. Progress report: Moving towards a child centred system (2012)
Access to universal services\textsuperscript{13}, early identification and intervention of problems (including social and emotional) and robust safeguarding must be the cornerstone on which to develop services for children and young people.

In order to build a case for change the current has state has been contrasted against these principles.

**Building upon Health for North East London**

The CYP CWGs vision for good children and young people’s care underpins and builds on the *Health for North East London* (Health for NEL\textsuperscript{14}) transformation programme proposals – see figure 7. As part of the analysis of local current service provision, consideration was given to how far the Health for NEL proposals have been met. The CWG asked Barts Health NHS Trust and Homerton University Hospital NHS Foundation Trust to undertake a self-assessment of their progress in implementing these proposals. Since Health for NEL, some London Quality Standards (LQS)\textsuperscript{15} have also influenced service provision and where applicable these standards were also considered.

<table>
<thead>
<tr>
<th>Health for North East London, summary proposals:</th>
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<tbody>
<tr>
<td>• Build on The Royal London’s current role as a specialist paediatric centre and see Queen’s Hospital further develop its services for children, so that more children could be cared for nearer their home</td>
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<tr>
<td>• Whipps Cross, Homerton and Newham to retain 24/7 paediatric services but transfer children with specialist surgical or high dependency medical care needs to The Royal London</td>
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<tr>
<td>For medical care:</td>
</tr>
<tr>
<td>• All A&amp;E services should have 24/7 paediatric facilities, managed by paediatric staff, with clear protocols for transfer of children with complex conditions to Queen’s Hospital or Royal London Hospital when appropriate</td>
</tr>
<tr>
<td>• A focus on individualised assessment and treatment of children and young people to ensure care is provided by the service best placed to meet their needs, in discussion with the child and family</td>
</tr>
<tr>
<td>• Early senior clinical assessment and review to determine the appropriate clinical treatment pathway, with an emphasis on reducing admissions and minimising clinically unnecessary lengths of stay</td>
</tr>
<tr>
<td>• Stronger links need to be developed between hospital and community-based services for children to facilitate community-based care wherever clinically appropriate. In some areas community-based services for children will need to be further developed to support this model of care</td>
</tr>
<tr>
<td>• All children requiring inpatient care should be under the care of a designated paediatrician, even when admitted to an adult ward</td>
</tr>
<tr>
<td>For surgical care:</td>
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<tr>
<td>• Management of all children who require surgery in an appropriate environment by staff with the requisite skills and training</td>
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</table>

\textsuperscript{13} Universal services are those services provided to all children, young people and their families from health, education and other community services

\textsuperscript{14} Health for North East London was a transformational change programme, clinically led and with extensive public engagement, to reconfigure hospital services within North East London. The recommendations emanating from this programme (and endorsed by the Secretary of State for Health in 2010) provide a key point of reference for planning and service development of hospital services in North East London.

\textsuperscript{15} Emerging from the quality and safety programme, the LQS have been developed by a multi-disciplinary clinical panel, with input from both patients and service users, from across London. The majority of the standards are national recommendations from Royal Colleges and other clinical bodies, and represent the minimum quality of care that patients attending an emergency department or admitted as an emergency should expect to receive in every acute hospital in London. Hospitals were asked to self-assess their adherence to these standards across the seven days of the week to determine if there is variation in the service arrangements both in hours and at weekends.
Figure 7. Health for North East London proposals for children and young people care

 Whilst significant progress has been against the Health for NEL recommendations and the London Quality Standards, there are some points of variance that indicate areas of challenge in providing a consistent high quality experience for children and young people in east London. A summary of the key highlights of this self-assessment for Bart’s Health NHS Trust sites and Homerton University Hospital is provided below\(^\text{16}\).

**Medical care (including A&E and urgent care).** Whilst all facilities provide 24/7 services, with the majority staffed by paediatric trained staff, *paediatric consultant cover* is a challenge. Whilst senior medical cover is good, ensuring early senior clinical assessment, this standard is not met 100% of the time with a small number of children being assessed by ST4 level clinicians at times, as specified by the London Quality Standards. Newham University Hospital and Whipps Cross University Hospital identified that they have emergency consultants ‘experienced’ in paediatrics but not formally trained.

Some *urgent care* facilities experience long delays in assessing and treating children which sometimes results in cases being streamed into A&E. There is consensus that links between hospital and community-based services continue to be an area for improved integration. Whilst urgent care services provide advice and support to primary and community based services, greater integration would facilitate an emphasis on community based provision.

All sites have a *paediatric ‘early warning tool’* in place to help identify and manage the acutely unwell child. However this is not standardised across the sites. Members of the CYP CWG highlighted that whilst the protocol to transfer acutely unwell children was in place, in reality this was reliant on appropriate beds at the receiving site being available at the time of transfer. Appropriate transport to convey children who require transfer to another site was also cited as another complicating factor.

**Surgical care.** Barts Health NHS Trust recognises that currently, the anaesthetic and surgical teams at Newham University Hospital have *limited exposure* to paediatric cases to retain appropriate competence. Based on this Newham University Hospital do not meet requirements for delivery of paediatric surgery and transfer to Royal London Hospital should be in place. As yet, this has not been operationalised. Although this may represent lower numbers than children at other sites, the CYP CWG membership felt strongly and raised concerns that this was incongruous with the population profile of Newham (having one of the *youngest populations*), and represented a potential inequity of service provision of care ‘closer to home’. Furthermore, transfer to specialist

\(^16\) This analysis is drawn from the self-assessments undertaken by both Barts Health NHS Trust (incorporating The Royal London, Newham and Whipps Cross hospital sites) and Homerton University Hospital
centres for surgical cases was also dependant in some instance on the availability of suitable beds at the receiving facility.

This assessment against Health for NEL recommendations is also discussed in the relevant sections of this report.

**CWG Principles of good care for children and young people**

Each of the CYP CWG’s four principles will now be addressed in turn focusing on what good looks like against each of the principles, what this means for patients and how the current system matches up to this model of good care.

### 3.1. Principle 1: Seamless transitions of care

“*Young people should be well supported into adult services and should receive individualised care in environments that are appropriate to their age*”

**What does good look like against this principle?**

- Adolescents should be **supported to take more ownership of managing their healthcare** and taught how to access and engage with adult services with plenty of time for them to adjust.

- The transition to adult services should be **joined up and seamless** for the patient. Different teams and service providers should link up to consider and treat the whole patient in a coordinated manner.

- Transitions between different health and non-health services should be **simple and easy for patients**. A single and consistent threshold for adult health, education and social care services would support a seamless transition for adolescents with multi-professional contact.

- Children and young people should be cared for in **age appropriate environments in line with the Children’s Act**. The group felt that although each patient should be treated as an individual, they agreed in general the aspiration should be: no child or young person should be cared for on adult wards and adolescents should not be treated on wards for very young children. Décor and facilities should respect the age of adolescents so that they are not treated like young children.

**What does this mean for patients?**

*Adolescents should be treated like young adults in environments that respect their age. Moving to adult services should be simple and easy to adjust to.*

**How is the system currently performing against this principle?**

*We need to do more to support young people transitioning into adult services to ensure they don’t fall through the gaps*
Preparation for adult services. The CYP CWG reflected that children and young people are not being adequately prepared for adult services. Too many young people are struggling to effectively function in adult systems where there is a general expectation that they take more control of their own health (self-care). There are insufficient safety mechanisms to ensure that young people transitioning to adult services do not fall between the gaps in services. This is a particular risk for people transitioning with long term conditions (LTCs) and poses a real risk that a patient’s health suffers.

The CWG members have seen too many first-hand instances where an adolescent’s health has suffered as a consequence of them not effectively engaging with adult services at the point of transition. This is a particular issue for young people with mental health issues transitioning into adult mental health services. Fragmented child and adolescent mental health services (CAMHS) services often have poor links to mainstream adult services and the level of support experienced as a young person suddenly ends when they become older and no longer meet acceptance criteria for CAMHS. It is noted however that commissioners in Tower Hamlets and Newham are working to address this through extending CAMHS eligibility form 0 – 25 years (in line with recent changes to statutory requirements) to allow better support and planning for smooth transition.

Consistent and simple transitions.
Varying cut-off and acceptance ages for different services and providers can result in staggered and overly complex transitions across a number of different care pathways for children and young people with complex needs. Young people with mental health and special educational needs (SEN) are often not meeting adult service acceptance thresholds when they transition, and can therefore immediately drop out of a care system at a vulnerable age.

Children who require contact with a number of different healthcare professionals experience particularly challenging transitions, with a lack of a lead professional taking responsibility for the coordination of care. This impacts patient experience and can lead to gaps in access to services that are needed.

Neonatal transitions to paediatric services. In the experience of the clinical working group, discharge and handover arrangements are often too simplified in a single letter to a GP with a loss of valuable knowledge and expertise. Existing information technology systems do not support easy access to medical records across providers. The group highlighted that there is a risk that high complexity babies, once discharged from neonatal units, who subsequently attend or are admitted to paediatric services, will see staff who have no prior knowledge of their needs.
The Children and Families Act (2014) has seen the development of education, health and care (EHC) plans for children and young people with SEN and disability. These co-ordinated assessments and plans, between the different agencies should reflect the needs of the child or young person – not the services that are available. A feature of these plans is their extension up to the age of 25, enabling the successful transition of a young person into adulthood. A guiding principle, reiterated by professional bodies, is that services need to be flexible and based on the needs of the young person, rather than focused on the needs of the service. This represents a significant shift and challenge for providers and commissioners alike to ensure that services are enabled to collaborate effectively and provide support to the young person transitioning into adult services.

3.2. Principle 2: Integration of community care

“Children and young people should receive coordinated care across teams, within and between acute, community and primary care. Care should be provided with as few contacts as possible and close to home or education settings where possible.”

What does good look like against this principle?

- Patients should be seen in as few appointments as possible including multi professional appointments where patients are seen by different specialists to consider and treat their needs holistically
- Mental health and physical health should have parity of esteem, where mental health is considered within every patient contact with greater recognition of physical symptoms related to mental health issues
- Appointments should be offered as close to home or school as possible. These should better utilise existing health estate but could also extend onto school sites
- Clinical advice and expertise should be provided over the phone 24/7 for clinician to clinician advice allowing quick, informed and higher quality diagnosis and decision making
- Safeguarding should be on every clinicians mind at every child contact. Hospitals, primary and community care should be linked up with each other and with local authorities to identify and act on safety concerns
- A directory of services should be developed to aide transparency of all services available, improve and facilitate communication between professionals, parents and carers
- A greater emphasis on early intervention and the provision of effective universal services to improve public health outcomes.

What does this mean for patients?

Patients should have their care dealt with closer to home or school where possible with more flexible access and fewer appointments
How is the system currently performing against this principle?

More children should be cared for closer to home through the provision strong support in primary care

Managing referrals in a different way. 117,000 outpatient appointments were conducted across the three Barts Health NHS Trust sites and at Homerton University Hospital from October 2012 to September 2013. On reviewing the data, there is an indication of significant variance (62.5%) in the rate of first outpatient attendances (numbers of referrals) for 0 – 18 year olds (figure 8.) Patients should have their care dealt with closer to home or school where possible with more flexible access and fewer appointments.

Figure 8. First outpatient attendances, per 1000 population, by CCG, October 2012 to September 2013
Source: SUS data extracted 26/08/2014 for patients under the age of 19 all NELCSU CCGs. Data analysed locally.

This high rate of attendance may be attributed to the Rapid Assessment unit at the Homerton

Figure 9. First outpatient attendances by speciality (treatment function code) for City and Hackney, Newham, Tower Hamlets and Waltham Forest CCGs, October 2012 to September 2013.
Source: SUS data extracted 26/08/2014 for patients under the age of 19 all NELCSU CCGs. Data analysed locally. Excluding unknown site
Clearer pathways for children would reduce the burden on general paediatrics and mean that more children will see the right clinician the first time

Over a third of these attendances take place within a ‘paediatrics clinic’ setting with the greatest volume concentrating at Homerton University Hospital and Newham University Hospital (figure 9.)

The CYP CWG reflected that in their experience there is significant variation in the referral pathways and processes for each of the hospital sites across east London. Variations in referral criteria, thresholds for acceptance and triage at the different sites where also highlighted as a challenges to the referrer navigating the pathway. For paediatric services, a first out-patient referral with no follow up may be seen as a potential indicator of an inappropriate referral

![Referral source paediatrics 1st Attendances, NELCSU CCGs, 0-18, Oct 12 to Sep 13](image)

Figure 10. Referral source for paediatric first outpatients, City and Hackney, Newham, Tower Hamlets and Waltham Forest CCGs, October 2012- September 2013.
Source: SUS data extracted 30/09/2014 for patients under the age of 19 all NELCSU CCGs. Data analysed locally.

Improving the appropriateness of referrals. The Kings Fund identified three dimensions of referral:

- Necessity (should the patient be referred)
- Destination (where should the patient be referred to)
- Quality/ process (how should the referral be carried out – supporting investigations, tests)\(^\text{17}\)

Whilst the complexity surrounding individual referral decisions is recognised, there is evidence to support that the use of standardised, structured referral forms, consistent processes and access to decision making tools all improve the appropriateness of referrals from primary care, especially in areas of high volume.

Reducing new to follow-up outpatient rates is often seen as an effective way of achieving productivity and efficiency gains in adult outpatient’s settings. However, the CYP CWG highlighted that there should not be the equivalent focus for paediatric services. For paediatric services, a first out-patient referral with no follow up is seen as a potential indicator of an inappropriate referral. We need to make sure that contractual incentives are not having perverse effects on the model of care that we are delivering for children and young people.

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Access to specialist advice and guidance. The evidence suggests that sustaining changes in referral behaviour requires a multi-faceted approach. The CYP CWG acknowledge that there is significant variation in the skills, confidence and formal training of primary care clinicians in paediatrics. Only half of all GP associates in training have the opportunity to work within secondary care paediatric services to gain experience of identifying and managing the sick child\textsuperscript{18}. Improving access to specialist paediatrician advice and guidance (via telephone or email) has been highlighted as an effective mechanism to support the management of children in community settings whilst also providing a learning opportunity to share knowledge and improve confidence. Multidisciplinary case reviews in the community, decision making support tools (e.g. Map of medicine, paediatric pearls) and structured GP education were all seen as key enablers in improving primary care confidence and competence. Improving the relationship between primary and secondary care clinicians, fostering a collaborative and developmental approach to providing care, is recognised as an effective long term strategy to reduce the number of inappropriate referrals and increase the quality of primary care.

Other strategies that the CYP CWG identified to support community based integrated management included; increasing the skill mix of specialist nurses and therapists in the community; developing a community hub paediatrics clinic (building upon the idea that has been working in maternity clinics); and increasing the use of voluntary sector services. The CYP CWG was keen to explore alternative models of community care including integration with school health and early year’s settings and family based approaches focusing on the wider determinates of health.

There is the opportunity to provide more joined up care for children and young people with complex needs

Joined up care. Children and young people with complex needs are often given multiple appointments with a broad range of teams to deal with a set of issues. The members of the clinical working group report that there is often little coordination of the numerous contacts with specialist teams, resulting in a poor patient experience. This results in variation and inconsistencies of care pathways, influenced by local procedures and variation in individual clinical decision making, which can be seen across the local geography. Clinicians report that they often struggle to provide a coordinated service, in large part because they simply do not know about the different services available and the acceptance criteria required.

Commissioning and referral systems often disincentivise hospital clinicians and services from directly coordinating and joining up with other clinical specialists within and beyond their hospital. Community paediatric services are commissioned differently by CCGs and provision of specialist skills is inconsistent. GPs and hospital clinicians often do not know what services are available to patients, particularly out of area.

Child and adolescent mental health services (CAMHS) has been highlighted as specific area for attention. Children and young people in east London do not experience prompt diagnosis and effective, timely management of their mental health conditions. Mental health problems in children and young people are frequently not identified or managed effectively. Emergency hospital admission rates with a self-harm diagnosis have risen by 13% between 2007/08 and 2013/14

\textsuperscript{18} Andrews.K. 'Fundamentals of commissioning health services for children', (2011) page 13, Child Health and Maternity Partnership
The CYP CWG believe that we are not making the most of every contact with the patient to identify and address mental health needs.

### 3.3. Principle 3: Consistent hospital care pathways

Children & young people should have equal access to surgery, medical and specialist care based on clinical need. Children & young people should receive consistent, evidence based standards of hospital care regardless of where they live. This should be supported by effective clinical networks.

**What does good look like against this principle?**

- **Consistent and agreed pathways of care** ensuring equal access to care for all children and young people.

- Children and young people should be cared for **at a hospital with the skills and facilities to provide safe, high quality care**. This should be close to their home where possible and at specialist centres where it is clinically more appropriate.

- **Timely access to high quality elective care**, with day case seen as normal and separation of emergency and elective surgery.

- **Standardised, evidence based protocols for care**, supporting consistent standards of care for all children and young people.

- **Clinical advice line**, with high quality specialist advice supporting clinicians to make informed clinical diagnosis and treatment decisions.

**What does this mean for patients?**

*All children and young people should receive high quality hospital treatment, at a nearby hospital where possible and specialist centres where this can provide better quality care*

**How is the system currently performing against this principle?**

*We need to develop consistent standardised pathways across east London, regardless of clinical setting.*

**Equitable access.** The CYP CWG have observed that children and young people do not have equal access to hospital care in east London. Health for NEL recommended establishing clinical networks across the hospital sites in east London. The CWG support this recommendation and recognise the important role of clinical networks, yet found that we have failed to establish robust

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19 SUS. Analysed locally.
networks with a formal governance structure for paediatric specialist care, medical care, elective surgery and emergency surgery. The nature of working with children and young people is that there is a tendency towards being risk averse.

Without standardised pathways there is scope for variation in clinical decision making and ultimately the quality of patient care. With representation from four hospital sites the CWG shared experiences which highlighted the variations in the pathways of care and treatment protocols.

Right care, right place. The CYP CWG members do not believe that all patients are getting the right care in the right place. There is significant variation in the admission rates of children and young people ranging from 44 per 1,000 0-19 population in Redbridge to 64 per 1,000 population in Waltham Forest – see figure 11. There is also variance in the onward admission to specialist services with 19% of City and Hackney children, 15% of Newham children and only 3.5% of Waltham Forest children admitted to the Royal London20 (figure 12 and Appendix B page 11.)

This highlights the variance in urgent care and inpatient models at each site and suggests potential variance in the experience and quality of care across east London.

The group commented that, there are no standard pathways and protocols across sites and poor visibility of different services and access routes. This makes it challenging for clinicians to navigate the system. Access to the right care at the right hospital is too often dependent upon individual clinician’s knowledge of services and with doctor training rotations across London this can be very limited. The CYP CWG also reported that capacity issues at The Royal London Hospital impact how effective network arrangements are operationally.

Consistent care. The Royal College of Paediatrics and Child Health (RCPCH) states that, wherever possible, children should be treated by paediatric specialists in separate, dedicated or child-focused facilities21. As evidenced in the Health for NEL self-assessment and the London Quality Standards, paediatric surgical and anaesthetic expertise is not provided consistently across

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20 SUS data
21 Royal College of Paediatric and Child Health (RCPCH) (2011): Facing the future: A review of paediatric services
all sites and therefore fails to meet this standard. This will result in variance in the quality of care. The Care Quality Commission (CQC) has expressed concerns that children at Newham University Hospital were receiving orthopaedic surgery without input from the paediatric team. The CQC also noted that emergency surgical procedures on children under 10 were being carried out at low volume and that there were no pain protocols in use and children were not seen by the pain team\textsuperscript{22}.

The rates of long lengths of stay (classed as the patient staying longer than the PBR trim point) vary across east London sites ranging from just over 4% above trim point at Homerton University Hospital and 4.3% at Newham University Hospital, exhibiting more long lengths of stay against total admissions, compared with 2.1% at Whipps Cross University Hospital and 2.8% at The Royal London. This suggests variance in the discharge processes and availability of community services across the boroughs.

The CYP CWG highlighted some examples of variance in the delivery of care for children and young people which suggests variance in the quality, examples include:

- Although all sites vary in their performance, no one site meets the London Quality Standard that all emergency admissions being seen and assessed by the responsible consultant within 12 hours of admission
- In diabetes care there is significant variation across east London for children with HBA1c (glycated haemoglobin) under 7.5% (58mmol/l) which is an indicator of good control. At The Royal London Hospital 30.1% of patients have HBA1c levels under 7.5%, significantly better than Newham University Hospital (17.3%) and Whipps Cross University Hospital (23%).
- The national average is 15.7% and the UK compares quite poorly to the rest of Europe (e.g. Germany where the average is over 40\%\textsuperscript{23}).

### 3.4. Principle 4: High quality and appropriate urgent care

*Children and young people should be supported to get to the right urgent care advice, in the right place, first time. Specialist paediatric expertise and observation facilities should be available at all urgent care sites.*

**What does good look like against this principle?**

- Urgent care should provide people with clear and consistent urgent care pathways with a single point of access available 24/7 so that they can access the right care quickly and easily.

- Services for urgent, non-life threatening needs should be delivered in, or as close to people’s homes as possible.

- Urgent / emergency centres should treat serious or life threatening needs, and they should be equipped with the best expertise and facilities to reduce risk, and maximise survival and good recovery.

\textsuperscript{22} Care Quality Commission (January 2014), Barts Health NHS Trust - Newham General Hospital Quality report

\textsuperscript{23} National Paediatric Diabetes Audit (NPDA) (2013), NPDA report 2011-2012
• All urgent / emergency centres should be supported with **specialist paediatric expertise at all times**.

• Urgent care should make best use of skills and resources by operating under a **networked model of urgent and emergency care**.

• Ambulances should have the means to **treat all ages of children and young people at the scene where appropriate** and transfer patients to the right emergency centre with the necessary facilities if required.

• **Patient clinical advice lines should be available 24/7**, with good self-care advice and knowledge and understanding of local care services for appropriate signposting.

**What does this mean for patients?**

> All children and their families should be able to easily access urgent care advice and care so that they can have treatment at, or as close to home as possible, only needing to attend A&E for more serious needs

**How is the system currently performing against this principle?**

*We need to develop consistent pathways that are easy to navigate and that enable children and young people to access urgent care support*

**Right place first time.** The CYP CWG felt that too many children and young people are attending A&E when they could be safely cared for at, or closer to home. Attendances for children and young people across Barts Health NHS Trust and Homerton University Hospital A&Es account for 28% of total attendances against a national average of 23%\(^24\). Between October 2012 and September 2013 73,555 attendances across the Barts Health NHS Trust and Homerton University Hospital sites resulted in no diagnosis or treatment\(^25\). The CYP CWG felt that this indicated that with better support outside of hospital there was potential to have provided these children with care closer to home more effectively.

A high level mapping exercise of the paediatric urgent care services available across the geography revealed inconsistent provision (including range of services and hours of operation) and in some instances the existing provision is set to close (i.e. walk in centres). There are no services offered across the areas that provide **clear and consistent urgent care pathways with a single point of access**, available 24/7, enabling access to the right care, quickly and easily’. Refer to Appendix A.

The CYP CWG shared their experiences from working in different parts of east London and concluded that prevention and planning is too variable across different boroughs. Tower Hamlets were cited as good at educating families in first line care, yet elsewhere it was felt that not enough is being done to promote **self-care**. With a transient migrant population (who culturally may be

\(^24\) SUS 09/05/2014 covering October 2012 to September 2013. Analysed locally.

\(^25\) SUS 09/05/2014 covering October 2012 to September 2013. Analysed locally.
unfamiliar with accessing primary or urgent care) and a trend for ever changing services, it is difficult for patients and clinicians to navigate to the right place, first time. There was consensus within the CWG that more can be done to promote alternative points of care, with initiatives such as the pharmacy first programme. The CWG acknowledge that it is not an easy problem to resolve, with a perceived lack of expertise within primary care and a lack of visibility of alternatives, it is often simpler for patients to access visible A&E services where ‘the lights are always on’.

London Ambulance Service (LAS) protocols mandate that all ambulance call outs for children under two years of age must be conveyed to A&E regardless of the severity of the condition. This is contributing to numerous attendances at A&E for minor ailments that could have been treated at the scene or directed to more appropriate services. The CWG feel that robust protocols for treatment at the scene and access to suitable alternative service, could provide better patient experience and alleviate pressures within A&E.

**Consistent standards of care.** The A&E and UCC services at Barts Health NHS Trust and Homerton University Hospital NHS Foundation Trust operate different models and there are notably inconsistent observation facilities across A&E sites. There is high variance in non-elective admission rates across CCGs and sites from 47 per 1,000 population to 64 per 1,000 in different CCG populations. All sites were judged to have strengths and weaknesses that could provide opportunities to share good practice.

The CYP CWG highlighted that in their experience too many children and young people are being admitted to hospital, particularly for a day or less, when many could be treated in a different setting and avoid being admitted.

**Staffing.** A&E attendances for 0-19 year olds account for 28% of total A&E attendances at The Royal London Hospital A&E paediatric consultant staffing is not sufficient to provide consistent high quality care at all sites, 24 hours a day and seven days a week. There are 22 adult consultants covering A&E but only two paediatric consultants. As evidenced by the London Quality Standards self-assessment there are insufficient paediatric consultants to cover A&E and there is a consequent reliance on the paediatric acute team to support A&E, diverting clinical care away from inpatients.

With multiple budgets feeding into emergency care the CYP CWG recognise the commissioning difficulties to ensure consultant cover at all sites, but feel this should be overcome to achieve consistent, high quality care, for all children and young people. East London does not have specialist paediatric services at each emergency care site resulting in inconsistent care for sick children. Future urgent work will need to consider pathways to and from specialist services to ensure the highest quality care for children with complex health needs.

In addition, emergency paediatric mental health provision is variable, with differences ‘in’ and ‘out of hours’. In some settings young people are being assessed by adult psychiatric staff ‘out of hours’ (it was noted however, that paediatric psychiatric support was available over the phone with on call arrangements).
4. Contributing challenges

The CYP CWG identified a number of potential obstacles to achieving the future vision for children and young people's care as described in the principles above. These included:

**Perverse commissioning incentives.** The current commissioning arrangements do not incentivise joint working and can create barriers to optimal patient care. The CWG discussed the barriers caused by the current arrangements and discussed the impact that multiple commissioners and multiple providers of care can have on the delivery of integrated and joined up care. Examples such as block contracts and cost per case and payment by results (PBR) were highlighted as not appropriately supporting consistency across the geography, joint working, reducing unnecessary referral or care close to home in as few appointments as possible. The WELC Integrated Care programme does not currently include integrated care for children and young people and there isn’t currently any means to address these perverse commissioning incentives.

**Workforce.** At present there are insufficient numbers of acute staff with the correct skills and expertise to meet children and young people activity whilst complying with the European working time directive (EWTD) and this is not forecast to improve. There was a 1.4% reduction in consultant training posts and staff speciality and associate specialist grade (SSASG) numbers between 2009 and 2011. This contributes to high rates of locum and agency staff where a high turnover of staff leads to clinicians lacking knowledge of local services. The trend for specialisation of training is leading to a narrow focus for clinicians and does not encourage or enable enough consideration to the whole patient, including mental health. In primary care there is insufficient community and primary care paediatric training to accommodate any potential shift in activity. In many parts of the country 40-50% of GPs will have no formal paediatric/child health training. This is in spite of the fact that 25% of their patients are children and up to 40% of [GP] consultations are with children and families. Locally, the exact rate of GP training rate is undefined, but there is a recognised shortage of training posts. This has been recognised nationally and local education and training boards will be working with general practice to ensure a greater focus on paediatric skills and competency.

**Communication and IT systems.** IT systems vary across different teams and services in primary, community and secondary care settings. This makes access to relevant patient information difficult, it impedes quick and informed decision making and presents safeguarding risks with a vulnerable population. East London lacks a central point of health information that identifies services and access routes. Clinicians and patients find it difficult to navigate the complex array of health services in east London meaning that patients have imperfect information and unequal access to services.

**Listening to children and young people.** We are not effective at capturing the views of children and young people through appropriate methods and language. This means we are often designing services based on adult’s perceptions of children’s views and risk designing services that do not maximise outcomes.

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26 Royal College Paediatric and Child Health (2013), Workforce census 2013
27 Royal College Paediatric and Child Health, response to Our Children, Our Future
**Primary care.** GP appointments are restricted in length with insufficient flexibility to observe child behaviours for better diagnosis. Paediatric training is limited and access to specialist clinical advice and second opinions is variable across east London meaning that diagnosis and treatment is delayed and more referrals are made to secondary care.

**Estates and infrastructure.** There are limitations with the number, location and quality of existing estate across east London. The CYP CWG advocates more community based care to provide access closer to schools and homes. Accessing existing NHS facilities and other community facilities such as schools presents an opportunity for improved patient experiences.

**5. The emerging model of care and potential next steps**

This report puts forward a number of statements to present a case for change in this clinical area. These statements and the proposals for addressing them are:

1. **Young people should be well supported into adult services and should receive individualised care in environments that are appropriate to their age**

To address this, we would need to:

- Develop simple, consistent yet flexible transitions for young people that respond to their individual needs rather than the parameters of service provision
- Improve communication between professional and agencies to ensure patients’ needs are not missed
- Improve co-ordination of care through the use of lead professionals to help young people navigate their way into adulthood
- Develop a directory of services to support young people, parents, carers and professionals to navigate care pathways and available services.

To achieve this we would:

a. Begin to map the current transition points across services and identify areas to harmonise transition
b. Work with community and local authority partners to articulate the principles of consistent standardisation
c. Extend and enhance the work being undertaken to build a local offer and create a directory of services

2. **Children and young people should receive coordinated care across teams, within and between acute, community and primary care. Care should be provided with as few contacts as possible and close to home or education settings where possible.**

To address this we would need to:

- Explore alternative models of service delivery (such as the community hub), utilising a **skill mix** approach and **integrating** with services across agencies, sectors and where
appropriate geographical boundaries. This may be considered in relation to enhancing existing integrated care programmes to include children and young people

- Develop **consistent pathways** across east London that are operationally viable and standardise models of care, exploring top 10 high activity areas as a starting point
- Establish paediatric specialist care, medical care, elective surgery and emergency surgery **networks** to share best practice, develop shared protocols and actively manage capacity, resources and demand across the geography
- Explore the use of the lead professional model to coordinate and navigate care for children and young people with complex needs and mental health problems
- Link with the WELC integrated care collaborative to explore the potential links and models of integrated care for children
- Building upon existing programmes and develop initiatives to help primary care improve the **appropriateness** of referrals. Examples of good practice include:
  - Standardising referral processes and forms
  - Access to clinical decision making tools
  - Telephone or email advice and guidance with secondary care
  - Primary care education programmes
  - Peer review
  - Establishing forums and opportunities to foster relationships between primary and secondary care clinicians
- Maximise the potential of universal services to achieve good outcomes through early identification and intervention and deliver a strong preventative approach to supporting good child health in partnership with local authorities.

To achieve this we would:

a. Explore how care can be better co-ordinated between professionals, services and agencies, drawing upon existing examples of good practice (i.e. the lead professional model)

b. Review the provision of universal services across the geography, noting examples of good practice and identify opportunities to collaboratively commission to strengthen outcomes

c. Work with CCGs to understand their current demand management approaches and identify where they are having success

d. Create opportunities to build relationships between clinicians

3. **Children & young people should have equal access to surgery, medical and specialist care based on clinical need.** Children & young people should receive consistent, evidence based standards of hospital care regardless of where they live. This should be supported by effective clinical networks.

To address this we would need to:

- Develop effective and operationally viable clinical networks to share best practice, develop shared protocols and actively manage capacity, resources and demand across the geography
- Develop standardised, evidence based protocols for care across east London, to support the delivery of consistent quality of care
- Develop standardised consistent pathways, with clear policies and suitably staffed by paediatric specific clinicians.
To achieve this we would

   a. Support the development of clinical networks, identifying appropriate governance arrangements, membership and defining their remit.

4. **Children and young people should be supported to get to the right urgent care advice, in the right place, first time. Specialist paediatric expertise and observation facilities should be available at all urgent care sites.**

To address this we would need to:

- Further map the full range of facilities that provide paediatric focused urgent care, including their location, hours of operation and level of acuity
- Develop alternative models of urgent care with consistent entry points to reduce confusion of the service offer. This in particular should focus on an investigation of an enhanced ambulatory care offer for children as part of the unplanned care provision
- Further develop consistent primary care extended hours schemes
- Develop an urgent care directory of services that clearly sets out what is available to patients in the local area and how to access them.

To achieve this we would:

   a. Undertake a detailed mapping exercise of the urgent care capacity across the geography. Mapping needs to include
      - Access routes and hours of operation
      - Location
      - Inclusion/exclusion criteria
   b. Engage with patients and clinicians to consider alternative models of urgent care
   c. Explore a paediatric focused, enhanced ambulatory care model

6. **Conclusion**

The next steps for the programme will be:

- To seek formal endorsement of this case for change and proposal for emerging models from the *Transforming Services, Changing Lives* sponsoring organisations
- If approved, to develop a clinical strategy that will set out how the changes that have been identified in this document can be delivered.
## Appendices

### Appendix A. Map of urgent care facilities/services

#### Newham

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Hours of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Hours - Hub Practices. Newham GP Co-Operative</td>
<td>10 'hub' practices providing extended hours primary care access to some Newham practices</td>
<td>Various</td>
</tr>
<tr>
<td>Extended Hours - Sir Ludwigg Guttman</td>
<td>Extended hours primary care access for registered patients only</td>
<td>08:00 – 20:00 M- F 10:00 – 16:00 Sat / Sun</td>
</tr>
<tr>
<td>Out of Hours</td>
<td>Approximately 50 practices have opted into provide primary care out of hours 'in house' (as part of the GP Co-Operative). Newham CCG holds the contract for the remaining 10 practices to receive primary care out of hours from the GP Co-Operative</td>
<td></td>
</tr>
<tr>
<td>DMC Vicarage Lane Walk in Service</td>
<td>Walk-in primary care service offering emergency slots. Operates a triage system to prioritise patients. Service proposed to close.</td>
<td>08:00 – 20:00 Monday–Sunday</td>
</tr>
</tbody>
</table>

#### Tower Hamlets

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Hours of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended hours DES</td>
<td>National incentive programme for practices to provide additional out of hours primary care access</td>
<td>varies</td>
</tr>
<tr>
<td>Out of hours</td>
<td>Out of hours primary care for minor illnesses and ailments</td>
<td>18:00 – 08:00 Monday– Sunday</td>
</tr>
<tr>
<td>Barkentine WIC</td>
<td>Walk in primary care service for minor illnesses and ailments for registered and unregistered patients</td>
<td>08:00-20:00 Monday–Sunday</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Hours of operation</td>
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<tr>
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</tr>
<tr>
<td>St. Andrews WIC</td>
<td>Walk in primary care service for minor illnesses and ailments for registered and unregistered patients</td>
<td>08:00-20:00 Monday–Sunday</td>
</tr>
<tr>
<td>Royal London Urgent Care Centre – co-located with A&amp;E at the RLH</td>
<td>Primary Care triage and assessment service Redirection to primary care for those that are registered with a GP and whose GP has capacity to see them. Patients are directed to the UCC from the Royal London reception - non clinical triage to the right service</td>
<td>08:00-22:00 Monday–Sunday</td>
</tr>
</tbody>
</table>

**Waltham Forest**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Hours of operation</th>
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</thead>
<tbody>
<tr>
<td>Orient practice Walk In Centre</td>
<td>Walk in primary care accepting unregistered patients including children. Service proposed to close</td>
<td>08:00 – 20:00 Monday–Sunday</td>
</tr>
<tr>
<td>Whipps Cross Urgent &amp; Emergency Care Centre -GP-led streamer model. All patients that present at A&amp;E are streamed through the UCC.</td>
<td>Accept self-referring patients, registered or unregistered with a local GP (including children). Those patients with minor illnesses or ailments, whose GPs have open clinics and available appointments at time of self-referral, will be booked an appointment with their GP, unless the case is deemed urgent. EUCC staff will book patient an appointment before they leave the centre.</td>
<td>08:00 – 24:00 M-F 09:00 – 24:00</td>
</tr>
</tbody>
</table>

**City and Hackney**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Hours of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended hours scheme for primary care</td>
<td>Extended hour’s scheme up to 9pm on weekdays, flexible on weekends. Service commencing in October</td>
<td>18:00 - 21:00 M-F Varies on the weekend</td>
</tr>
<tr>
<td><strong>CHAPS Service</strong></td>
<td>Paediatric assessment service. Children seen in the PUCC. GP with specialist interest in paediatrics. No under 1s</td>
<td>17:00 - 01:00 Monday–Sunday</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td><strong>Primary Urgent Care Centre</strong></td>
<td>Urgent care service co-located with HUH ED. Booked in by reception (shared with ED) and assessed and streamed by ANP</td>
<td>08:00 - 03:00 Monday–Sunday</td>
</tr>
<tr>
<td><strong>Non-Clinical Navigators</strong></td>
<td>5 x non-clinical navigators - 4 in ED at HUH and 1 in Hackney Service Centre (council). Help to navigate health and social care services, sign posting and register patients with practices</td>
<td></td>
</tr>
</tbody>
</table>

**Appendix B. Data summary sheet**

**Appendix C. Report on clinical engagement**

**Appendix D. Patient engagement summary**