



**The Integrated Community Children and Young People's Health Services Programme:
Update Report for the Joint Health Scrutiny Committee**

April 2017

1. Purpose of the Report

- 1.1 This report provides an update on the implementation of the Integrated Community Children and Young People's Health Services Transformation Programme, including main achievements and challenges over the first year of operations, and planned priorities for the next year.

2. Introduction and Background

- 2.1 The vision for the Integrated Community Children and Young People's Services Programme is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families
- 2.2 The programme was borne from a concern that a lack of co-ordinated support for children and young people with complex needs and disability and their families was leading to inequity of access and potential safeguarding risks. There were multiple providers and teams working to different processes, policies and procedures leading to duplication and lack of efficiency and effectiveness, which was having a negative impact on children, young people and families. There were too many acute and

emergency attendances and admissions for conditions that could be treated at home or avoided. Furthermore, children were staying in hospital for too long.

- 2.3 A joint programme between the Nottinghamshire County and Nottingham City Clinical Commissioning Groups (CCGs) to develop a new, integrated community health service for children and young people with additional needs and disabilities was established. The aim of the programme was ensuring streamlined access and co-ordinated assessment, treatment and review so that families experience a seamless service that is centred around the child / young person and family, promoting independence and quality of life. The programme sought to secure improved safeguarding outcomes, with children and young people and their families enabled to lead as normal a life as possible, with improved access and equity of service provision and with genuine choice for children, young people and their families.
- 2.4 The programme also sought to secure high quality, cost and clinically effective services with consistent staffing, and satisfied and highly motivated teams ensuring the right skills in the right place at the right time, every time.
- 2.5 Included within the programme were the following community health services for children with additional needs:
- Physiotherapy;
 - Speech and language therapy;
 - Occupational therapy;
 - Special school and community nursing, including end of life care;
 - Phlebotomy.
- 2.6 Following a full procurement, a contract was awarded to Nottinghamshire Healthcare NHS Foundation Trust, commencing from April 2016. Phase 3 of the programme – mobilisation and transformation commenced in October 2015, with the aim of delivering the following objectives:
- Mobilisation and transformation to an integrated model of care delivery.
 - Co-production and collaboration between commissioners, the service provider, partners and children, young people and families.
 - Family friendly name for service.
 - Test, refine and baseline outcomes framework to effectively support the transformation and outcomes focused care delivery.
 - Workforce development.
 - Monitoring and continual improvement.
 - Improved families' experience.

2.7 This report provides an update on progress against the objectives.

3. Progress update

3.1 Mobilisation and transformation to an integrated model of care delivery

- 3.1.1 A rapid period of change has enabled the new integrated services to be established early in year 1 of the implementation programme. Staff transferring from their previous employing organisations were supported to their new bases, and multi-disciplinary staff now work in integrated locality teams. All practitioners in the new service are now recording on a single system, which has enabled all children and young people to have an integrated care record and plan.
- 3.1.2 A single point of access to the service has been established – rather than patients or partners wishing to access community health services for children having to navigate a complex framework of services, this can now be done for all disciplines through a single phone call.
- 3.1.3 As part of the transformation of community nursing, the model requires that support be needs-led, rather than allocated to particular settings. The advantages of this approach are that the needs of children are met equitably and on the basis of clinical need rather than on the basis of what provision is available in their school or setting, and also enables the upskilling of nursing staff in localities through providing support to a wider range of needs and conditions.
- 3.1.4 Transitions from nursing services based at the Caudwell House setting has been positive, with colleagues in the service and within children’s social care collaborating to ensure all staff within the home are competent to deal with the health needs of the children, that care plans are in place and that the expectations of each service are clearly agreed.
- 3.1.5 Concerns were raised by some special school leaders in both the County and City special schools regarding changes to nursing provision. Although most of the 14 special schools in Nottinghamshire had previously been supported by a needs-led community nursing service, in 4 schools (3 county and 1 city) nurses had previously been located on the school site. To ensure careful and collaborative resolution of issues emerging from this change, a joint forum between commissioners and providers of the health services and the special school heads was established. This forum now meets termly and has a terms of reference.

- 3.1.6 Due to specific concerns raised by Oakfield School, health profiling work was undertaken by a Public Health Consultant based in Nottingham City Council. This work is summarised as follows:

Demographics

There are currently¹ 154 pupils on Oakfield School roll which makes Oakfield School the largest special school in Nottinghamshire (including Nottingham City). The number of pupils has increased by 7% since 2010. Oakfield has a ratio of boys to girls of 1:1.5 (95/59).

48% (74/154) of Oakfield pupils are of early years and/or primary school age, 27% (41/154) are of secondary school-age and the remaining 29 pupils are post-16.

50% (77/154) of the pupils at Oakfield School are White British which is broadly in line with the Nottingham City figure of 47.7%. The next most common ethnicity is Pakistani, 12.3% (19/154) slightly higher than the Nottingham City figure of 11.2%.

Diagnoses

45% (70/154) of Oakfield pupils have diagnoses that fit under the broad diagnosis of neurodevelopmental conditions. This is broadly in line with the national picture (any reference to the source of this assertion?). The most common secondary diagnosis in Oakfield pupils is epilepsy with 25% (38/154) of pupils receiving this diagnosis. 62% (96/154) of Oakfield pupils have severe learning disability, see Figure 7, with a further 36% (55/154) having profound and multiple learning disabilities.

Health Needs

81% of Oakfield pupils need some assistance with eating, drinking and/or feeding. This is an increase from the proportion, 72%, identified as needing this assistance in the 2010/11 Special Schools Health Needs Survey (SSHNS).

22% (34/154) pupils require feeding via gastrostomy or NG tube.

The majority (86%) of Oakfield pupils require continence support; 60% (93/154) are doubly incontinent. This is an increase from the proportion, 72%, identified as needing this assistance in the 2010/11 Special Schools Health Needs Survey (SSHNS).

14% (21/154) of Oakfield pupils require suction or oxygen.

32% (50/154) of Oakfield pupils require support with their behaviour and/or emotional health.

59% (89/154) of Oakfield pupils use a wheelchair; a slight increase from the SSHNS figure of 58%.

45% (69/154) of Oakfield pupils need some support to maintain skin health.

¹ October 2016

Therapy Needs

58% (89/154) of Oakfield pupils have identified physiotherapy needs (figure 14). This is a decrease from the proportion, 65%, identified as having physiotherapy in the 2010/11 Special Schools Health Needs Survey (SSHNS). This finding does not reflect local intelligence which suggests pupils therapy needs are increasing and is therefore worth further exploration.

37% (57/154) have 3 or more identified physiotherapy needs.

49% (76/154) of Oakfield pupils have identified occupational therapy needs. This is a decrease from the proportion, 64%, identified as having occupational therapy in the 2010/11 Special Schools Health Needs Survey (SSHNS). Again, this finding does not reflect local intelligence regarding pupils therapy needs and is therefore worth further exploration.

24% (37/154) have an identified sensory need. The SSHNS does not enable an assessment on whether the proportion of pupils with this type of need has increased or decreased.

86% (133/154) of Oakfield pupils have an identified speech and language therapy need. This is a significant increase from the proportion, 71%, identified as having a speech and language therapy need in the 2010/11 SSHNS.

25% (38/154) are identified as having a 1:2:1 session with a speech and language therapist. The SSHNS does not enable an assessment on whether the proportion of pupils with this receiving 1:2:1 support has increased or decreased.

Continuing Care

To be eligible for NHS continuing healthcare, the individual must be assessed as having a "primary health need" and have a complex medical condition and substantial and ongoing care needs. The threshold is based on unpredictability, complexity and severity. When children and young people's complex needs cannot be met by specialist services then they can be considered for continuing healthcare.

5.8% (9/154) of Oakfield pupils have a continuing care package. This question was not asked in the data collection for the SSHNS so no assessment of change in need is possible. In addition, national data sources do not enable an assessment of whether this is higher than the national special school average.

A meeting was held on 31st October 2016 to discuss the needs of Oakfield School and it was agreed that a protocol would be developed between the school and the nursing provider. This is due to be completed by the end of February 2017.

- 3.1.7 The service also provides information prescriptions through 'RECAP'. The e-learning platform, RECAP, enables clinicians to prescribe condition specific materials for

children and young people, such as therapy exercises. The content is audio visual enabling families to see and mirror practice in action, reviewing material as required and reducing clinician needs to retrain families and others. Material is supported by electronic leaflets, fact sheets, media clips and links to relevant websites. This e-platform is now being used by all services.

3.2 Co-production and collaboration

- 3.2.1 The transformation programme was co-produced with families, and the services are underpinned by the 'Families Statement of Expectations' – a commitment to the values and principles which children and families identified as important to them (attached as Appendix A).
- 3.2.2 Providers have worked closely with children and young people, families, carers and staff through focus groups and question sessions to rename the service which is now 'Community Children and Young People's Services' since November 2016.
- 3.2.3 Commissioners and providers have strengthened their collaboration through a monthly Collaborative Partnership Meeting, which provides a forum to work through emerging issues together, track progress against the transformation programme, explore performance and operations in detail and jointly agree next priorities. These feed into the contract meetings, and are viewed positively by both provider and commissioning colleagues.

3.3 Test, refine and baseline the outcomes framework

- 3.3.1 A comprehensive outcomes framework, aligned to the priorities identified by families in their 'Statement of Expectations' underpins the transformation programme, and is attached as Appendix B. To incentivise delivery against the outcomes, a local CQUIN (Commissioning for quality and innovation) has been developed and a process for evidencing progress against the framework to achieve incentive payments has been agreed, with 2.5% of the total contract value linked to achievement of outcomes in year 1, and 4% in year 2.
- 3.3.2 The payment incentives against the outcomes framework are attached to priorities, such as:
- Reduction in avoidable hospital admissions;
 - Patient satisfaction with services;
 - % patients with an integrated care plan;
 - Timeliness of assessment and treatment;
 - Feedback from stakeholders;

- Well planned transition to adulthood.

3.4 Workforce Development

3.4.1 A rapid period of change has resulted in NHFT carrying out organisational development sessions to support staff through this change and enabling staff to shape the new service.

3.4.2 A number of organisational development sessions have been undertaken within the new integrated teams including:

- Communication
- Working in an integrated way;
- Outcome measures.

3.4.3 Feedback from these sessions has resulted in the development of an internal newsletter for all staff. This has resulted in improved and more timely information. These sessions continue to be undertaken.

3.5 Monitoring and continual improvement

3.5.1 In addition to the incentivisation of continual improvement through the outcomes framework and CQUIN payments, performance and outcomes data are analysed and considered each month through routine contract management arrangements. Through this reporting and scrutiny, the following areas of progress and achievement have been identified:

- Excessive waiting lists and times to access speech and language therapy have been addressed, with waiting times for all patients are now within the 13 week target, and for most patients in all services a service specific ambition of 8 weeks is being achieved;
- 100% of patients now have an integrated care record;
- Children are spending less time in hospital;
- Patients have a named professional, whom the family knows;
- The number of referrals which are acknowledged within 1 day has increased.

- Patients who require a routine phlebotomy appointment are seen within 5 days and urgent appointments within 2 days
- Professionals within primary care are able to refer to the service electronically through the SPA.

3.5.2 The accuracy and completeness of data remains an area for development, which the service are prioritising so that plans for future years are based on accurate insights into current service activity.

3.5.3 A quality visit by commissioners was undertaken in November 2016. The visit involved focus groups with staff, home and school visits with practitioners, and interviews with service managers. The visit identified a number of strengths and areas of the service that are going well, including:

- There is plenty of appropriate staff supervision;
- Managers are listening – lots of favourable comments from staff about their managers;
- Managers know the service well, and are reflective – they know what is going well and what isn't;
- Where there are staff performance issues these are being addressed positively and assertively by managers;
- This is a huge transformation programme, and change is being delivered at a pace, with good engagement with both staff and commissioners;
- There have been many successes – locality working and management in place, SPA, growing own staff etc.;
- Nurses are very motivated – recently came from acute Trust and loved being able to share information in community and are relishing having ideas and being able to develop the service. Managers were not sure what they did but came out and watched them so now are appreciative of the role they fulfil;
- Practitioners are finding the new recording system to be beneficial;
- Change has been seamless for families;
- Staff feel listened to, and that managers are taking the time to learn about services;
- Mobile working is working well and enabling improved efficiency;
- The single point of access (SPA) is welcomed.

3.5.4 The quality visit also identified some current challenges for the service, which included:

- The changes have been stressful – initially communications wasn't great and there were problems with technology, however managers have spent time with the staff and listened and things are getting better.
- Some clinical procedures are inconsistent across NHFT and NUH;
- The services are still operating largely separately - as part of mobilisation managers were uncovering work which had been unnoticed, hidden or were creeping developments - these have taken priority to address;
- Physiotherapy vacancies are difficult to recruit to, due to lack of candidates, a national problem;
- Entrenched cultural issues and mindsets in some services are proving difficult to shift, although managers are addressing this robustly.

3.5.4 Commissioners made a number of recommendations which are now being acted upon, as follows:

- More work should be done to integrate functions, process and cultures across professional groups and services, in particular therapies with nurses.
- There are opportunities for services to learn from each other – for example, therapists are experienced in completing Education, Health and Care plans, but nurses less so. Therapists can share templates and approaches to support nurse colleagues.
- Strengthen ongoing communications with staff about how and why things are changing.
- Managers should routinely spend time on the frontline with services – where they currently do this it is appreciated by staff
- Maintaining and developing competency for newly appointed paediatric nurses around enteral feeding/IV care – linked protocols with NUH ideally to enhance seamless care across organisations.
- Clinical supervision of paediatric nurses and access to expertise to aid clinical decision making.
- Acknowledgement by both community staff and commissioners that there were lessons to be learnt around the mobilisation of the new contract – the lessons learned should be logged.

3.6 Improved Families' Experience

3.6.1 There are positive improvements in families experience being evidenced through the routine data collection and monitoring of the service. Some notable achievements are:

- The number of complaints has reduced (there have been none in since October 2016);
- 100% are satisfied with their electronic care plan, are involved in setting their own outcomes and report their history and care plan are well known by those involved in their care;
- 90% of families agreed that they have control over their own care and are involved in decisions about them.

3.6.2 Compliments on the service are also increasing. The following provides some examples of the compliments being received:

Information provision:

'Thank you so much for the information you have provided. I now feel like I have a starting point!' (parent mid Notts seeking nursery place for child with additional needs)

'The information sent was really, really useful, there were lots of things he (child with disabilities) could do'

Feedback comments on Drop In sessions

'With regards to the meeting sessions I find them very useful, I think the sensory sessions are good and also the anxiety related ones, eating & sleeping sessions as I feel this affects nearly every parent & child.'

'I know not everything will be for myself or my son, but it's nice to go and support other parents and know you have that support as there is quite a lack of it '

Personal Support with Disability Living Allowance Independence Payments (drop in provided by family action)

'I had spent weeks on the form - once I saw the advisor the whole form was completed during the appointment - he knew the right boxes to tick'

'Good to speak to someone who knew what they were doing, added reassurance that we were doing it right'

'Appointment very helpful - I was stuck on a few questions and it made it clear what we needed to write'

Authors:

Nicole Chavaudra, Senior Public Health and Commissioning Manager, Integrated Children's Commissioning Hub (on behalf of the following CCGs: Rushcliffe, Mansfield and Ashfield, Newark and Sherwood, Nottingham West and Nottingham North and East)

Charlotte Reading, Head of Commissioning (Children and Learning Disabilities), Nottingham City CCG

Vanessa Briscoe – Divisional General Manager, Community Specialist Services, Nottinghamshire Healthcare NHS Foundation Trust

Sophy Parkin - General Manager, Community Specialist Services, Nottinghamshire Healthcare NHS Foundation Trust

Appendix A ICCYPH Programme Families Statement of Expectations

Our values are...

- Respect
- Collaboration
- Continual improvement

1. “No decision about me without me”.

We are consulted and listened to, heard and treated with respect as experts on our/our own child’s condition and have our views taken into account at all times.

2. Access to information and supplies.

We can easily get information, advice and guidance, and the services and supplies that we need, when we need them, so that our family can enjoy the best possible health and fulfilling lives. This should enable and support our roles, lifestyle choices and aspirations.

3. Whole systems working.

There is collaborative, joined up and timely planning and service delivery, with all parts working as a whole across all organisations and agencies involved in every aspect of our children’s care.

4. Child/young person centred care.

Every child/young person is treated as an individual.

5. Communication and record sharing.

There is timely communication and shared documentation including core essential information about our children, their condition and their support between all those who need to be involved.

6. Capacity, competency and empathy.

We are confident that there are enough staff, who have the right knowledge, skills and expertise for what they are there to do, and they demonstrate this by empathy and understanding in all contacts.

7. Transition.

Children/young people are supported to achieve responsibility for themselves as adults and the family is supported during this period of transition to adulthood and reduced dependence on the family.

8. Continual improvement.

We can see that everyone involved in our children's care is committed to continually improving what they do.

9. Care environment.

Children/young people are seen in age appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.

10. Safety.*

At all times our children are protected from harm.

*Please note this is wider than safeguarding - consider points such as moving and handling training for parents, safe use of equipment etc.