



# Peer Review of Acute Care Services for Children and Young People

Overarching report

September 2017

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*Supported by and delivering for London's NHS, Public Health England and the Mayor of London*

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## Purpose

This paper summarises the findings from the peer reviews of London's 26 acute hospitals which provide services for children and young people (CYP). The reviews were conducted between July 2016 and March 2017 and were based on Healthy London Partnership's (HLP) London Acute Care Standards for Children and Young People<sup>1</sup>

A great many people were involved in the process, both at the trusts and as a peer reviewer. HLP is hugely grateful to all of them; without their support, the process would not have achieved the depth of insight it did and much valuable learning would not have been gained.

## Executive Summary

A quarter of the population in London is made up of CYP ≤ age 20 years. Throughout the course of the peer review process we heard that in many areas this population, particularly in terms of children under five years of age, is anticipated to increase significantly in the next five years. Our hospitals are often the first port of call for these CYP; emergency department (ED) presentations by children have increased by 20% in the last decade<sup>2</sup>.

HLP's CYP programme undertook a supportive peer-led review in 2016 -17 of the 26 sites in London that deliver acute medical care to CYP. The process began with each Trust assessing itself against the London Acute Care Standards for CYP (Appendix A: the process). Information provided by trusts was reviewed by a team of clinicians from across London, together with local commissioners, who then spent a day at each site walking key clinical pathways - from the ED to the paediatric wards - and meeting clinical and managerial teams. Each review concluded with a report identifying areas of good practice and suggested areas for improvement, with the findings jointly owned by the trusts and local Clinical Commissioning Groups (CCGs).

### ***Much to celebrate was observed over the course of the year.***

Reviewers were of the opinion that CYP, and their families, were largely well served by the 26 hospital sites visited: their voices were heard and appropriate and often highly innovative care was provided. It was clear that every child and young person mattered.

***Achievement of the London Acute Care Standards for CYP was quite variable; in every category.*** However, trusts reported that they saw them as being important and were striving to meet them. Reviewers felt that full achievement of the may be a significant challenge on some sites.

***Much good practice was seen in the district general hospitals (DGHs);*** innovation and excellence was not limited to the specialist and academic centres.

***Paediatric staff across disciplines were clearly passionate about the services they provide.*** On numerous occasions, reviewers commented that staff were often working under a great deal of pressure, whether due to demand or lack of resource, but were seen to be highly committed to their work - and to the children and young people for whom they care.

***The process raised the profile of paediatric services in many trusts,*** as reported by children's and young people's divisions reported that. Many senior leaders and Board

*The review was conducted by people who understand the services and therefore were able to really see areas of good practice but more importantly areas that we could improve upon.*

**Consultant  
Paediatrician and  
Children's Clinical  
Business Unit Lead,  
Croydon University  
Hospital**

<sup>1</sup> [London Acute Care Standards for Children and Young People](#). First published February 2015; revised August 2016

<sup>2</sup> Nuffield Quality Watch: [Emergency hospital care for children and young people](#) April 2017

members gave a high degree of support to the process; this was both important from the point of view of service quality and staff satisfaction.

***The relationships between commissioners and providers varied hugely across London.***

Many trusts work with a number of CCGs, constantly juggling different local priorities. At times, it was observed that this resulted in inequity of care being delivered by trusts to CYP depending on their CCG of origin. Reviewers saw this as being hard for staff and unfair to the CYP the trusts looked after. The delivery of Sustainability and Transformation Plans (STPs) should help to deliver a more joined up approach.

***Where commissioner/provider collaboration was strong, a whole-system approach was taken to the provision of services for CYP; silos were broken down and CYP were seen to be at the centre of service design.*** Reviewers also remarked upon those areas where there was joint commissioning, which enabled consideration of the needs of the child or young person both in terms of health and wellbeing.

*Learning has been used to help identify STP Priorities.*

**Children's  
Commissioning  
Lead, NHS  
Haringey CCG**

***The process facilitated a constructive dialogue in relation to specific acute care issues between commissioners and providers - and amongst providers - despite the variability in relationships.*** The development of CYP networks in line with STP footprints to help maintain this dialogue post review was urged by reviewers.

***Reviewers were of the view that there are a number of key areas upon which providers and commissioners need to focus,*** despite the many examples of good practice highlighted in this report.

***More could be done to facilitate dialogue amongst all providers - and commissioners - to explore and develop new models of care.*** Some good examples were observed but not enough.

***Reviewers observed that CAMHS<sup>3</sup> provision for CYP in crisis presenting to local trusts is inadequate and represents a system failure.*** A mental health emergency can be as devastating and as life-threatening as a physical health emergency, and the long-term effects of failing to provide effective mental health care in childhood are well recognised.

***Unfortunately the care provided to CYP in London presenting in mental health crisis is often fragmented and delayed.*** It does not address their needs and adds to their feeling of stigma; which can lead to a worse outcome. Their care can also be challenging for staff, many of whom have little training in how to deal with such young people. It is imperative that collaborative commissioning and local transformation planning should look at how the additional funding for delivering [Future in Mind](#) can be directed to these frontline services.

***In terms of acute care service provision for CYP, there were times when reviewers questioned if it was acceptable that the level of provision available to adults was not available to CYP.*** By way of example, standard 40 of the London Acute Care Standards for CYP states that *a consultant paediatrician being present and readily available in the hospital to cover extended day working, up until 10pm, seven days a week*; not all trusts meet this requirement.

<sup>3</sup> Child and Adolescent Mental Health Services (CAMHS)

Reviewers also noted that **staff in some hospitals were often under a great deal of pressure to maintain the quality of care required. In others, the demand for service did not always warrant the level of provision.** Consequently, this raised questions to the viability of all 26 sites as emergency sites, especially as the achievement of the London Acute Care Standards for CYP is variable.

**A final, overarching observation is that resources for children's services are spread thinly across London; at times in ways that appear unequal.**

## Background

HLP brings together the NHS in London and partners to deliver better health and care for all Londoners. Partners include the Mayor of London, Greater London Authority, Public Health England, London Councils and Health Education England. HLP believes that collectively it can make London the healthiest global city in the world by uniting all of London to deliver the ambitions set out in [Better Health for London: Next Steps](#) and the national [Five Year Forward View](#).

HLP works to deliver the changes best done once for London. It is also in the unique position to support the delivery of the STPs in the five areas across London with strategic advice, resources and staff embedded in the areas.

One of the key aims of HLP's CYP programme is to reduce the variation in quality of acute care services that CYP experience. The London Acute Care Standards for CYP seek to achieve this by setting out the minimum requirements which should be delivered in acute care services for CYP across London.

The London Acute Care Standards for CYP are based on the numerous standards already in existence from bodies including the Royal Colleges and NICE. Aimed at commissioners and providers of acute care services for CYP, they can be used to validate, challenge and quality assure service provision.

In 2016, HLP's CYP board agreed that a measurement of the baseline of delivery of the London Acute Care Standards for CYP across London should be established and that this should be undertaken through a clinical peer review process, in conjunction with trusts' local commissioners for CYP; including NHS England specialised commissioning - where relevant. The process was designed to be formative; helping to identify where services were meeting the London Acute Care Standards for CYP and providing supportive feedback to enable them to be met.

Consequently, 26 sites in London, where there is an in-patient facility for CYP were peer reviewed between July 2016 and the end of March 2017. The 26 sites are managed by 18 trusts; a list of the sites visited is included at Appendix B. Panels were made up of clinicians and local commissioners - and chaired by a senior paediatrician.

After each review, a summary of the feedback was provided to the trust's Chief Executive, as well as the Chief Officers of local CCGs. It was requested that this should be shared with their boards.

Both providers and commissioners have been asked to state how the findings have been addressed at executive level within their own organisations and how they are helping to inform delivery of local STPs.

*Preparation for the inspection was a good housekeeping exercise which prompted us to finish some things which we had been meaning to complete for some time and to develop clarity on some key issues where we had become 'stuck'*

**Divisional Head of Nursing, Children's Services, Outpatients and Diagnostics, Homerton University Hospital NHS Foundation Trust**

The process also identified areas where the HLP CYP programme could work to support the delivery of the London Acute Care Standards for Children and Young People across London.

In addition to thanking the each and every one of the trusts who participated in the review process - all of whom were most supportive – the HLP CYP programme would like to thank all those who acted as a peer reviewer. In particular, thanks must go to clinical staff who gave of their time so willingly.

Credit must also go to Royal Free London NHS Foundation Trust and to Lewisham and Greenwich NHS Trust for having acted as pilot sites at short notice. These visits helped to refine the process going forward.

## Key findings

- **Close collaboration between commissioners and providers - and amongst providers – helps achievement of the London Acute Care Standards for CYP**

The peer review process identified that achievement of the London Acute Care Standards for CYP is variable but that it is recognised that they are important. CYP divisions are striving to meet them but in many instances the standards require a whole system response; not all of the solutions lie within the gift of the trusts. For instance, many trusts struggle to meet the huge demand for emergency care services they face; a demand that can be driven by lack of provision in the community.

Noticeable differences were apparent in the strength of collaboration between providers and their commissioners.

In the best cases, provider and commissioner have developed a close working relationship; both formal and informal. In these instances, it was clear that a 'them and us' culture had been broken down. Good examples noted were the relationships observed between North Middlesex University Hospital NHS Trusts and NHS Haringey CCG and between Lewisham and Greenwich NHS Trusts, the local authority and NHS Lewisham CCG.

It was noted that the consistency of acute care provision across multiple sites can be reduced in cases where the trusts is working with different CCGs at each site; each of whom has different funding arrangements, local priorities and desired outcomes.

This can lead to apparent inequalities in care provided. At some sites it was noted that trusts were only able to provide certain types of care and support for CYP from certain CCGs due to varying commissioning arrangements; this was largely related to integration of acute care with primary and community care. In certain trusts which have more than one acute site, inequality of actual provision of care to inpatients was observed due to variable commissioning arrangements; for example, in the availability of after-hours CAMHS support from site to site. In each of these cases, the inequality of care was distressing to the paediatric team and to the review team.

Commissioners commented on the work that the HLP CYP programme has been undertaking to strengthen CYP commissioners' capabilities - and consequently the relationship between provider and commissioner. It was noted that the HLP CYP Commissioning Development Programme had actually carried out a simulation of an acute care peer review in order to prepare commissioners for actual site visits.

*Lots of positive effects from peer review process: helped highlight our own strengths to department, trust and CCG - and helped reinforce to trust and CCG areas we knew needed improvement. Scored the process as 9/10 as the self-assessment paperwork was a bit laborious. However, it did help to highlight areas we hadn't considered looking at.*

**Consultant in Paediatric  
Emergency Medicine,  
Whittington Health NHS Trust**

It is hoped that local STPs will help to deliver greater consistency but there is a concern that services for CYP are not a high priority in such plans.

A similar variance was noted in the relationships between local general practice providers and the hospital; at its best, there was open and clear communication; including an accessible directory of services and advice lines open seven days a week.

Reviewers noted that there is a move to establish regional CYP networks/alliances in line with the STP footprint. It is believed that these will provide an opportunity for wider dialogue and collaborative planning that puts CYP at the centre of service design and service delivery.

- **Acute care services for CYP benefit from strong institutional commitment**

It was clear that the board of a number of trusts give significant attention to the acute care services for CYP they provide. Many peer reviews were attended by members of the Executive Teams, including the Chief Executive, and by the Non-executive Director (NED) who has responsibility for CYP services; if such an appointment had been made. HLP and peer reviewers would like to applaud this demonstration of commitment.

Where the “golden thread” running from children’s ward to board was evident, there appeared to be a greater opportunity for innovation - and for closer collaboration with commissioning partners. For instance, business cases appeared to be viewed more favourably where the relationship between board and division was strongest. Paediatric staff felt motivated to explore new ideas and ways of working because their views would be considered.

However, it was evident that some boards view services for CYP as having a lower priority, as they are less contentious than some other areas. Annual reports and quality accounts (and hence quality plans) typically make little specific reference to CYP. Consequently, reviewers were of the view that more should be done to ensure that all boards have oversight for the quality of the service being delivered.

Reviewers felt that such oversight should extend to those urgent care centres on site that were managed directly by the trust. Urgent care centres were not part of the peer review process but they often shared the same front door and reviewers felt that it would be beneficial to patients and their families if processes could be aligned.

No matter how engaged their boards, the leadership at divisional level was viewed to be strong - for the most part. Paediatric teams were seen to be close knit and supportive; performing well despite the wider challenges being faced by their trusts. Personal relationships were seen to be hugely important in terms of service delivery. Whilst this is admirable, trusts are encouraged to consider succession planning; identifying the leaders of tomorrow.

In terms of the audit arrangements, reviewers proposed that these should be extended more widely within a trust - and be consistent in delivery. Safeguarding was consistently strong; for instance, it was noted that many trusts held daily ‘huddles’ and ‘druggles’, ensuring both the safe handover of CYP from shift to shift but also the safe dispensing of medication.

This said, it was noted that CYP cared for outside core paediatric service areas could be less visible and the impact of governance was less tangible. For instance, standard 3 of the London Acute Care Standards for CYP states that there should be *a programme of audit across all elements of the service*; we did not observe that this was common practice. This was particularly true of older children and adolescents cared for in surgical divisions within trusts.

HLP's CYP programme has produced a number of standards<sup>4</sup> - in addition to those collated into the London Acute Care Standards for CYP - by which trusts could measure their own performance. The acute care self-assessment process provided a methodology for doing this. It was noted that multi-disciplinary CYP boards have been established at a number of trusts to ensure all CYP within the trust (i.e. within or outside the paediatric divisions) receive the same quality of care; for instance, at University College London Hospitals NHS Foundation Trust, King's College Hospital NHS Foundation Trust and Hillingdon Hospitals NHS Foundation Trust. A number of other trusts indicated that they planned to set up a CYP board; a move commended by reviewers.

As many CYP divisions do not have the authority to influence wider service design for CYP, all CYP boards are encouraged to make sure that membership is drawn from all specialities that deal with CYP – and that local GPs are represented. Some CYP boards include young people or have an advisory panel made up of users; a move reviewers applauded.

- **Service provision for CYP designed around them is to be encouraged**

It was noted that organisational structures within trusts tend to be vertical and quite siloed in relation to children. A disconnect - both physical and cultural - between different departments was perceived; for instance, between those who manage the emergency department and the paediatric staff working there. Examples of close collaboration were noted that help to minimise the risk; for instance at Newham University Hospital. Reviewers commented on the fact that more collaborative working resulted in paediatric decision making being moved close to the front door. An example of collaborative working was observed at Northwick Park Hospital, where the triaging of CYP in the urgent care centre is done by paediatric nurses employed by the trust.

*The review prompted and supported us to revisit the standards that had been released, have access to them in one place and get a really good oversight of how our services were performing*

**Divisional Director of  
Nursing, Chelsea and  
Westminster NHS  
Foundation Trust**

It was clear that efforts are being made to create cross-divisional working groups but more evidence as to the effectiveness of these is required. The emerging CYP boards need to drive cross-departmental involvement; focussing on key issues and monitoring quality and effectiveness of services for all CYP on behalf of the main board.

These boards are a key forum for putting CYP at the heart of service design and delivery, complementing the work of CYP fora or networks established at STP level.

- **Progress has been made to strengthen acute paediatric consultant out-of-hours cover**

Standards 37 - 46 of the London Acute Care Standards for CYP stress the importance of senior clinical input to the acute care of a child or young person; such care to be provided in a timely fashion. All trusts had increased the level of paediatric consultant cover available and many met standard 40 which states that *a consultant paediatrician is to be present and readily available in the hospital to cover extended day working (up until 10pm), seven days a week*. Some have even exceeded the standard; for instance The Hillingdon Hospitals NHS Foundation Trust, where a paediatric consultant is on duty overnight. In delivering this level of cover, the

<sup>4</sup> [London asthma standards for children and young people](#); [Paediatric critical care standards for London: Level 1 and 2](#); [Out-of-hospital care standards](#); [Paediatric assessment unit standards](#)

Trust has taken great care to ensure that those registrars on duty overnight do not feel disempowered; they manage the service, the consultant is there to advise.

Reviewers saw the achievement of standard 40 as a genuine commitment from Executive Teams – and local commissioners - to the care of CYP, as all trusts face competing demands for investment.

Where standard 40 was not met, management teams indicated that there was either a lack of resource or that cover until 10.00 pm would make the scheduling of rotas difficult under a number of the current contractual arrangements. In many places, instituting seven-day service provision will require a cultural shift.

Reviewers were of the view that where a trust does not meet standard 40, the board needs to consider the rationale and assure itself that the quality of care has not been compromised.

Of more concern to the peer review panels was the relatively light medical cover that many sites had overnight and at weekends. Relatively junior staff – ST4s (Speciality Trainees) and Senior House Officers - were reported to be on duty and covering a wide agenda; for instance, the emergency department, paediatric wards and neonates. Reviewers felt that there was an inherent risk in this; albeit that paediatric consultants were on-call. Again, boards need to assure themselves that the quality of care is not compromised due to a lack of senior decision makers on site.

- **Emergency Departments are the first port of call for many CYP**

Many trusts operate in challenging urban environments: high levels of deprivation and differing cultural expectations of populations as to how a health service operates. This, together with a view that GP appointments can be difficult to get, mean that many families turn to a hospital and its ED as a first port of call. As noted earlier, ED attendances have increased across England by 30% in the past decade. In London they are very high - with a total of about 573,000 attendances for those under the age of 16 across London in 2015/16<sup>5</sup>.

It was noted that ED attendance is extremely variable for those under the age of 16. In 2015/16 this ranged from 11,374 ED attendances at the Princess Royal University Hospital to over 42,000 at the North Middlesex University Hospital.

Reviewers applauded the fact that many trusts had established a paediatric emergency department (PED) and a short stay paediatric assessment unit (PAU); often called a paediatric assessment and short stay unit (PASSU). Together with triaging by a paediatric nurse at the front door, this meant that CYP are seen by the right person quickly - and that admissions are reduced.

Reviewers were of the view that the links between paediatrics and broader ED services were a very good example of how collaboration between departments should work. For instance, on the University Hospital Lewisham site the panel noted the positive interaction between the staff in the adult ED and those in the PED. In particular, collaborative decisions were seen to be made as to how and where to treat young people aged 16 years plus. Similar collaboration was noted at Kingston Hospital, where the paediatric lead for emergency medicine was employed by the ED; the panel felt that this strengthened the relationship.

Where paediatric staff are employed by the ED, it was felt that it was vital that it should be clear who the senior responsible paediatric clinician was. Some confusion was noted with advice being sought by junior staff from ED clinicians and then referred to a paediatric consultant; an unnecessary delay.

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<sup>5</sup> Source: Sum of trust attendance data provided as part of the peer review self-assessment process.

It was noted that urgent care centres (UCC) have been colocated with an ED/PED in many trusts. Reviewers were particularly impressed by the arrangements at the Homerton, where the ED runs the centre. Where UCCs are run by external providers, relationships were largely positive. For instance, at Northwick Park Hospital (London North West Healthcare NHS Trust) it was noted that the Trust provided the paediatric nurses who worked in the UCC.

Where difficulties were noted - for instance, when the emergency clock starts again when a child is referred from a UCC to ED – it was felt that commissioners could play a larger role in defining the responsibilities from the outset. This would ensure a much more effective clinical pathway. A GP presence on site was seen to be beneficial but concerns were raised about the level of paediatric skills GPs have – both in the UCC and in Primary Care. Reviewers wondered what more Trusts could do to train GPs on site. For instance, it was noted that GPs from 13 local practices were working in the ED at Epsom Hospital over the weekends (10.00 am to 10.00 pm). No data is yet available as to the impact of this but HLP's CYP programme will follow this up.

Many of the CYP who attend an ED are frequent attendees; it is important to understand why this is the case – how genuine is the need? Consequently, reviewers were impressed by the work being done by a number of trusts to monitor such attendees more closely; for instance, at both St George's Hospital and Barts Health NHS Trust.

- **The safety of local children's surgery needs to be assured**

The peer review process demonstrated that there is a clear need to ensure that local children's surgery functions in a safe and supported way. Formally constituted networks in each STP area could facilitate this. However, it is recognised that skills might deteriorate quickly if patient numbers are low.

There was some evidence that surgical networks are beginning to emerge but the arrangements tend to be informal. Examples of good governance were observed but reviewers were of the opinion that the journey to effective system design is only just beginning. The collective view was that all parties need to agree the approach that suits their STP region and put in place formal governance arrangements. Whichever arrangements are put in place, it will be vital to make sure that all staff, not just those involved in surgery, understand them.

Few trusts meet all of the Standards relating to surgery and anaesthesia (S71 – 86). For some, the number of procedures carried out does not warrant dedicated theatres or recovery bays. Where CYP are to be operated on, they tend to be scheduled before the adult lists.

Larger trusts tended to have dedicated spaces and staff, at all levels. For instance, Chelsea and Westminster Hospital has four state of the art theatres dedicated to paediatric surgery, as well as a large recovery area; this has nurse-led cubicles where CYP requiring special care can be looked after. Reviewers also noted an exemplary testicular torsion pathway at King's College Hospital, Denmark Hill which enables delivery of surgery effectively for this time-critical pathway.

S78 states that *all hospitals admitting emergency surgery patients have access to a fully paediatric- competent staffed emergency theatre, and a consultant surgeon and a consultant anaesthetist with appropriate paediatric competencies are on site within 30 minutes at any time of the day or night*. In light of this, questions were raised about the deskilling of surgeons in DGHs, as increasing numbers of CYP requiring surgery are transferred to specialist centres.

However, as noted by the Royal College of Surgeons, all clinicians caring for children and young people in a surgical or anaesthetic context should undertake an appropriate level of paediatric clinical activity that is sufficient to maintain minimum competencies (as defined by their respective medical royal colleges) and consistent with their job plans.<sup>6</sup>

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<sup>6</sup> Standards for Children's Surgery: Children's Surgical Forum, The Royal College of Surgeons of England 2013

It is acknowledged that it is for each trust to decide what service it is going to deliver, in consultation with its commissioners, and ensure that necessary competencies are maintained in all staff groups. An excellent example of this in practice was seen at Barnet Hospital, Royal Free London NHS Foundation Trust. However, reviewers were of the view that clinicians who operate primarily on adults need to have the confidence and capability to operate on CYP as well if surgical networks are to be effective.

Larger, multi-site trusts were seen to be balancing the demands of emergency and elective work – and their specialist work. Reviewers felt that they needed to prioritise their work; identifying a single site where paediatric surgery can be done safely at some volume.

It was noted that trusts often failed to meet standard 73 of the London Acute Care Standards for CYP: *where children are admitted with surgical problems they are jointly managed by teams with competencies in both surgical and paediatric care, which includes having a named consultant paediatrician and a named consultant surgeon*. This did not always happen, especially in relation to day-case surgery. Joint responsibility would help to ensure that CYP are discharged in a timely fashion following surgery. Delays were noted due to a lack of surgical review.

In terms of anaesthesia, the peer review process questioned the adequacy of provision was; particularly in regards to the management of acutely ill CYP requiring intubation. Most trusts were confident that the appropriate skills were available, and cited the support they get from the retrieval services - CATS (the children's acute transport service) and STRS (South Thames retrieval service)); both in terms of actual provision and training. However, reviewers were of the opinion that boards need to assure themselves that the quality of care is not compromised.

- **The management of acutely ill CYP needs a London-wide response**

Reviewers were of the view that the management of severely ill CYP was variable; trusts need to do more work in order to achieve both the London Acute Care Standards for CYP and [Level 1 and 2 Critical Care Standards \(April 2016\)](#). In particular, the level of staffing - and the skills mix - available, particularly in DGHs.

Recognising this, the HLP CYP programme has been granted funding by Health Education England to develop an online hub for L1 and L2 paediatric critical care education. This development is being supported by a clinical lead working within the HLP CYP programme and a local STP lead for each area. Once they have completed the online educational element, staff in DGHs will receive scenario-based training to enable them to reach the level of competency required.

The peer review process identified that a number of trusts had opened high dependency units to cope with demand. Standard 60 of the London Acute Care Standards for CYP states that *all hospitals admitting children should be able to deliver Basic Critical Care (CC) in a defined critical care area, classified as a Level 1 Paediatric Critical Care Unit*. Level 1 Critical Care provision must be recognised as a part of the core acute care provision; it is not an additional service. It is acknowledged that a commissioning framework for delivery of this standard is not yet in place. HLP has undertaken initial work to develop this and work is now going on at national level to try to develop this framework.

In terms of critical care transfers, children deemed by the local trusts to need transfer to a Level 2 or 3 facility were not always judged to be so by the retrieval services; for instance, CYP who

*The process provided focus within the service, helps to engage colleagues from elsewhere in the organisation and adds credibility to requests for support from the senior management of the organisation*

**Divisional Manager,  
Women's & Child Health,  
Barking, Havering and  
Redbridge University  
Hospitals NHS Trust**

do not require intubation but are deemed to require a higher level of care. The transport review being undertaken by specialised commissioning should help to ensure a more consistent response to this issue.

Staff also noted the difficulty in finding high dependency beds; a lot of time is spent phoning around, taking staff away from direct patient care, sometimes for hours. It was noted that paediatric critical care networks had been proposed as part of the Level 1 and L2 Critical Care Standards. The configuration of these networks is currently under discussion in the London Paediatric Critical Care Forum and it is anticipated it will be determined later this year.

- **Coordination of care for CYP with long-term conditions and those with complex needs could be better**

The London Acute Care Standards for CYP state that local pathways are in place for all children with chronic disease and long-term conditions and that such CYP have access to psychological support and CAMHS. Some excellent examples of services for these CYP were observed.

For CYP with asthma, consultants at the Hillingdon Hospitals NHS Foundation Trust provide community clinics, run out of GP hubs; they also go into schools. Reviewers also noted the award-winning diabetes work that the Trust does, which includes multi-disciplinary school clinics and a 24/7 diabetes hotline for GPs, as well as for families.

In the day surgery unit at the Royal Free Hospital, Royal Free London NHS Foundation Trust, reviewers remarked upon the specific provision made for CYP with learning difficulties and autistic spectrum disorder to ensure that the experience was as non-threatening as possible.

*Life Force* - a service run by Whittington Health NHS Trust – consists of a team of specialists who provide care and support to families who have a child with a life limiting or life threatening condition living in the boroughs of Camden, Haringey and Islington. The aim is to provide enhanced support to families and ensure choice in place of care, especially at end of life. Reviewers were particularly impressed by this model.

Pockets of good work were also seen in other trusts but the overall conclusion was that more needed to be done to ensure that written care plans were in place for CYP with long-term conditions or complex needs and that the appropriate community/primary care professionals were involved in its development - and delivery.

- **Care for CYP experiencing a mental health crisis needs to be more accessible, consistent and effective**

Despite some areas of excellent practice in parts of the acute mental health pathway, in no hospital was the entire pathway functioning adequately, particularly timely access to Tier 4 inpatient beds. The mental health compact currently being drafted by NHS England should help with this issue but it currently remains a key matter for senior managers in terms of quality and safety.

Some excellent models of in-house psychiatric liaison were noted. For instance, Whittington Health NHS Trusts employs two consultant psychiatrists, one family therapist and a child psychotherapist; all of whom have therapeutics training. A specialist nurse also works in the team. The team is a key element of the CYP's Services Division and is distinct from community CAMHS.

Reviewers also remarked upon the provision at University College Hospital (UCH), where a similar level of psychiatric and other mental health professional support is provided and a CAMHS registrar is on call 24/7 in the ED.

In addition to in-house provision, it was noted the support that trusts in North East London receive from the North East London Foundation Trust (NELFT). Cover is provided at weekends to young people aged 12 -18 through the adolescent outreach team - Interact. CYP who self-harm also receive dedicated support from psychiatric social workers and nurses.

At Evelina London Children's Hospital, Guy's and St Thomas' NHS Foundation Trust, Reviewers remarked upon what was judged to be very high quality mental health provision; from South London and Maudsley NHS Trust (SLaM) and the Trust itself. On-site provision is led by a consultant child psychiatrist - and a CAMHS clinical nurse specialist who is available on site Monday to Friday. Psychologists, employed by the Trust, are to be found throughout the hospital; both in general and specialist services.

SLaM was also seen to provide good crisis care support to Croydon Hospital, where a psychiatrist is available 9.00 am to 10.00 pm Monday to Friday and from 9.00 am until 5.00 pm over the weekend.

Despite the number of good examples seen, CAMHS provision continues to be a challenge, particularly out of hours for CYP in crisis; ED staff are left to cope with such young people, often with no training in how to do so. The overarching observation is that CAMHS provision for acutely unwell CYP presenting to local trusts is inadequate and represents a system failure. It is imperative that collaborative commissioning and local transformation planning should look at how the additional funding for delivering [Future in Mind](#) can be directed to these frontline services.

To support the development of accessible, consistent and effective care for CYP experiencing a mental health crisis in London, the HLP CYP programme has published [Improving care for children and young people with mental health crisis in London](#).

This guide contains seven recommendations, alongside indicative timelines, for commissioners and providers to implement to improve care for children and young people with mental health crisis in London. Providers and commissioners are strongly recommended to integrate its key points into their planning.

There is a particular issue with access to specialist services - typically a Tier 4 bed - in a crisis. Though small in number, inability to access an appropriate service is very distressing for all involved. There is an opportunity for collaborative commissioning to address this issue in particular.

- **Engagement with CYP and their families could be more innovative**

Generally, reviewers felt that the patient and family experience was adequate: CYP and their families receive sufficient information, education and support to encourage and enable them to participate actively in all aspects of their care and decision making.

However, examples were noted of greater innovation. For instance, patient partners are involved in service design at Barking, Havering and Redbridge University Hospitals NHS Trust. Reviewers also commented upon the Youth Forum set up by Chelsea and Westminster; chaired by a young person with hands-on experience of the care provided by the trusts.

At Evelina London, reviewers noted that a series of applications for CYP were being developed to explain various pathways, using the Evelina Gang, cartoon characters who welcome young patients and their families and help them find their way around the hospital; an early example of how new media was being used. Reviewers also commented on the short films on the St Mary's Hospital's website which explain what happens when you come into hospital.

Younger children having surgery at Epsom & St Helier University Hospitals NHS Trust on the St Helier site were able to follow the Elmer the Elephant trail; this was viewed as a charming and effective distraction.

- **Estate reconfiguration needs to consider the needs of CYP**

By and large, sites were child-friendly and good use had been made of charitable support to enliven tired estates. However, many areas were viewed as being more suited to younger children; adolescents were not catered for as well. Given this, reviewers made particular note of the demarcation at University College Hospital, which provided teenagers with their own age-appropriate ward.

Reviewers also expressed concerns that line of sight had been sacrificed in some trusts as estates were reconfigured to allow for critical care and short stay units. Reviewers wondered how safe this was. Leadership teams need to assure themselves that there are no issues in terms of safeguarding.

An example of innovation in updating the estate was noted at Queen's Hospital, Romford, Barking Havering and Redbridge University Hospitals NHS Trust. Fingerprint controlled stock cupboards had been installed on the children's ward; totally secure and usage could be measured electronically.

- **Transition to adult services is difficult for all**

There is wide variation in the quality of provision, from some exemplar services - often with specific well-recognised single long-term conditions, such as diabetes - to those with more long-term, complex multidimensional problems where the adult care cannot be mapped to a single specialty.

It is known that this is a challenge across London; effective transition requires integration across primary, secondary and community care. It was noted that St George's University Hospitals NHS Trust had appointed a paediatric consultant as the lead for transition, as well as a nurse coordinator. Working with a youth work charity and local social workers, this team has been tasked with developing a strategy for CYP across the Trust.

Reviewers also remarked upon the fact that King's College Hospital NHS Foundation Trust had received an excellent Care Quality Commission judgement in terms of the transition of young people with liver function problems and that the aim was to replicate the model across all complex conditions.

North Middlesex University Hospital NHS Trust also involves youth and social workers in transition planning and that the Homerton University Hospital NHS Foundation Trust runs transition clinics from the age of 14 years of age.

However, more needs to be done. There are good processes that can be implemented; processes that often exist in the same organisation. The CYP boards could help to ensure a consistent approach. HLP's CYP programme has brought together many resources that providers and commissioners could use; these can be found at [Transitioning to adult services](#)

- **Care for adolescents must not be overlooked**

The London Acute Care Standards for CYP define the term children or child as meaning children and young people under the age of eighteen years. They also take into account young people aged 16 – 25 who are undertaking transition to adult services, including those with more complex needs. These young people need to understand who is looking after them.

Care for 16-18 year olds is hugely variable; many are given the option to be treated in adult settings but have little oversight from paediatricians, especially if they are not known to services. Reviewers felt that 16 – 18 year olds are at risk of slipping through cracks in service provision.

Reviewers noted this as a potential safeguarding risk and asked that trusts ensure that departments work closely together to ensure appropriate care is provided. This should be a matter for CYP Boards to address.

However, reviewers were very impressed by the ward configuration at University College Hospital, which provided teenagers their own age-appropriate ward, and by the fact that Whipps Cross University Hospital had appointed an adolescent champion.

- **Clinical support services may need to align more with wider healthcare**

Whilst good examples were seen of some clinical support services, such as 24/7 radiography provision, many paediatric clinical support services are only available 9.00 am to 5.00 pm, Monday to Friday. This does not align with healthcare provision that is 24/7. In some instances, this requires a significant cultural shift if CYP are to be discharged as quickly as appropriate or cared for in the community.

- **Play and education were seen to be vitally important elements of paediatric provision**

The significant input that play therapists/specialists were seen to be making to the care of CYP needs to be acknowledged. Many good examples were noted; for instance, at the Princess Royal University Hospital. Reviewers were also impressed by the fact that medical students at St Mary's Hospital were offering their time out of hours having been trained by the play specialists. St Mary's advised the panel that they had first seen medical students being trained in this way at King's College Hospital.

Although, business cases have to be made for play therapy support, reviewers were of the opinion that such support would be an investment well made.

- **IT systems are a limiting factor**

Few examples of an integrated system were seen; whether within a trust or across Primary, Secondary and Community care borders.

Staff time is wasted transferring data from one system to another - and from paper to a digital platform. In addition, information is not transferred in a timely fashion; between departments or to/from community and primary care providers. One example of good practice reviewers noted was the use of the Local Care Record in Lambeth and Southwark. This allows secondary care clinicians to review the primary care record and vice versa.

Trusts working with a number of CCGs cannot always access the same information from each; for instance, the Child Protection - Information Sharing (CPIS) platform.

Reviewers applauded the bespoke internal solutions seen at Homerton University Hospital. Clinical teams had worked with Cerner, a technology support company, on the development of electronic patient documentation for their inpatient units. This development was driven by a steering committee made up of clinical employees; one that took account of the current and future requirements. Some of the developers had a clinical background and still support the system today.

Integration of clinical systems can be very complex, especially since clinical system suppliers were not facilitated to collaborate at scale until recently in London. Reviewers advised trusts

and commissioners that work is ongoing within HLP to develop patient-focussed, digital interoperable solutions. For instance, across London 23 separate child health departments have been consolidated into four hubs, fitting the strategic maternity footprint, as part of the delivery of [NHS England Children's Health Digital Strategy](#).

The four hubs have drafted new Data Sharing Agreements which allow them to jointly operate a single integration platform that contains 130 data points on every child in London, including demographic, GP registration, responsible health visitor, new born screening results and all immunisation data. This digital record can also flag if a child has a child protection order. These summary records, linked to the Healthy Child Programme outcomes, can be accessed by community clinicians, health visitors and school nurses. The records can also be shared – securely - with parents who choose to launch their child's Sitekit eRedbook project. More information on the project can be found at <https://www.sitekit.net/#products>

- **Workforce is an ongoing challenge**

Reviewers were of the view that a number of the London Acute Care Standards for CYP cannot be met without sufficient staff numbers being in place. For instance, not all trusts met standard 40 which requires that a consultant paediatrician to be present and readily available in the hospital to cover extended day working (up until 10pm), seven days a week. Many trusts also found it difficult to ensure that the nurse in charge overnight was supernumerary.

In terms of nursing, many of the trusts reviewed were doing well in terms of recruitment. However, there are difficulties in recruiting to peripheral DGHs due to the differential pay for outer London hospitals. In addition, there has been a request for training funding to be available for nursing and allied health professionals; similar to that available to medical staff. The [Capital Nurse Programme](#) seeks to secure a sustainable nursing workforce for London. Findings will be shared with the Capital Nurse team.

As so many trusts have to rely on 'adult' nurses to fill paediatric rotas, it was noted that some had looked at how the paediatric skills of these nurses could be increased. For example, Barts Health NHS Trust has been running a *Managing the Sick Child* course for adult nurses since February 2017.

Reviewers also noted that trusts have been looking at how best to deploy other professional such as paediatric advanced nurse practitioners (PANPs) and clinicians' assistants. PANPs could bring a wealth of knowledge and experience to paediatric services; it was noted how effective they had been in neonatal services.

Work is being done to break down barriers between secondary and community care but the funding flows often hamper this. Integrated care organisations are well placed to lead the way; for instance, we noted that that some staff employed by Whittington Health NHS Trust already work across secondary and community care.

Throughout the peer review process it was noted that the effectiveness of acute care services for CYP came down to the strength of leadership, at all levels. Staff were seen to go above and beyond what was required of them because of a commitment to each other – and because of the support they received from senior paediatric clinical leaders.

The HLP CYP programme is undertaking work on how to support workforce mapping and development at STP level. The findings from the peer review process will inform this work.

- **The implementation of new models of care for CYP were viewed as a priority**

All involved in the peer review process recognised that a whole system approach is needed to move health care for many CYP out of hospitals. Services need to be redesigned to allow caring for CYP within community settings.

For instance, large numbers of CYP attend emergency departments who could be treated elsewhere; in some cases this reflects a lack of capacity and capability in primary care, as well as cultural norms for the local population.

Good examples of new ways of working were observed in Lambeth and Southwark. The focus of the children and young people's health partnership (CYPHP) is the better management of long-term conditions, with the aim of keeping CYP in the community and reducing hospital attendance. A four-year programme, CYPHP is responsible for 120,000 CYP across the two boroughs.

Reviewers also felt that the community nursing service in the same area, running from 8.00 am - 10.00 pm seven days a week, was one of the most comprehensive seen during the course of the review process. Evelina London is a major partner in the CYPHP programme; a testament to the strong collaboration and cooperation between provider and commissioner.

Reviewers also made particular note of Kingston Hospital's Paediatric Outreach Nursing Team (PONT) which provides nursing care and advice for children under the care of a Kingston GP who are at home, school and nursery. Hours of operation were noted as being 8.00 am to 6.00 pm Monday to Friday, 8.00 am to 4.00 pm weekends.

Another service noted was the Connecting Care for Children (CC4C) programme run by paediatricians at Imperial College Healthcare NHS Trust. Working with local GPs, commissioning leads and social care partner, the Trust is developing pathways of integrated care with primary care services to address the high rates of paediatric ED and paediatric outpatient attendance across the region.

Other new models of care are being explored across London; for example, ambulatory care and consultant-led community clinics. However, provision is variable and often were seen to differ across boroughs served by the same trust; for instance, community nursing provided to one side of a street and not to another due to commissioning arrangements. This was seen to be confusing for staff who were trying to discharge children as quickly and safely as possible – and for patients themselves. An interesting example of how discharge can be supported was seen at University College Hospital: families are provided with a consultant hotline which not only supports discharge but also has helped to reduce readmissions.

Community nursing was viewed as being a particular gap in service provision. Examples of good practice were seen; for instance, Haringey and Enfield benefit from community nursing services provided by North Middlesex University Hospital NHS Trust.

By and large there are too few staff to cope with demand; both in terms of the number of CYP needing support and hours of service delivery. Community nursing is generally a Monday to Friday, 9.00 am to 5.00 pm service. Consequently, CYP with long-term conditions can be hospitalised because there is no specialist nursing care in the community and discharge can be delayed.

*The peer review was really worthwhile from a commissioner's perspective. It enabled a more in depth view of our local secondary care provision and the services that are being provided. It was also really useful to read through the audit to understand the areas that both hospitals are doing well and the areas that need improvement. It is important however that what was learnt from the peer review is implemented.* **Children's Health Commissioning Manager (joint), for Islington Local Authority and NHS Islington CCG**

HLP's CYP programme has worked with a range of London health professionals, young people and their families to produce materials that support commissioners and providers of out of hospital healthcare services. Recent publications include:

- [London's out of hospital standards for children and young people](#)
- [Compendium: New models of care for acutely unwell children and young people](#)

Providers and commissioners are encouraged to look at these.

## Next Steps

This first round of peer reviews has concluded. Each trust - and its associated CCGs - has received a summary of the feedback that was provided to them at the end of the peer review process. Each has been asked how the findings have been addressed at executive level within their own organisations and how they have helped to inform the delivery of local STPs.

The feedback from this request will be made available to HLP's CYP Transformation Board when available. In the meantime, and with the permission of the trusts, the peer review reports are being made available to STP leads to aid local planning.

Some initial feedback received from both commissioners and providers is of concern. It indicates that progress has been slow; in particular, the findings have not been shared with CCG boards. This needs to be verified, as the concept of peer review - which has been so well supported - will be undermined if people see that findings are not shared or acted upon.

## Appendix A: Peer review process

Each trust completed a self-assessment against the Standard. The self-assessment used a RAG rating:

- Red: The standard is not met and - to date - no plans are in place that will help to meet it
- Amber: Plans in place to meet and working towards achievement of the standard
- Green: Standard is met



CYP acute care  
self-assessment

In addition, trusts were asked to provide evidence to support their rating.

Before each site visit, each trust was provided with key lines of enquiry; these reflected their self-assessment.

During the peer review itself, each trust gave a short presentation that covered:

- a brief overview of the trust and of its catchment area;
- what works well;
- key challenges; and
- future plans for achievement of the London Acute Care Standards for CYP.

The quality of these presentations was very good and we would like to thank each and every trust for the time and effort that went into preparing them.

Following a period of discussion, the peer review panel then visited the site; visiting all areas where CYP were seen. Particular pathways were not followed but members of the panel did ask about:

- 4 year old presenting repeatedly with mild exacerbation of asthma
- 8 year old presenting with testicular torsion
- 14 year old presenting with signs of self-harm
- 16 year old presenting with abdominal pain

Other than a young person presenting with self-harm, few concerns were raised.

Initial feedback was presented to the trust at the end of the peer review; such feedback confirmed by way of a report sent to the Chief Executive – copying local commissioners and STP leads.

## Appendix B: Site visits

Peer review of acute care services – visits			
Site	Chair of peer review panel	Date	STP region
Royal Free London NHS Foundation Trust: Royal Free Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme <sup>7</sup>	13 June 2016	North Central London
Royal Free London NHS Foundation Trust: Barnet Hospital		13 June 2016	North Central London
Lewisham and Greenwich NHS Trust: University Hospital Lewisham	Russell Viner Clinical Lead, HLP's CYP programme	28 July 2016	South East London
Lewisham and Greenwich NHS Trust: Queen Elizabeth Woolwich		28 July 2016	South East London
North Middlesex University Hospital NHS Trust	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	31 August 2016	North Central London
Kings College Hospital NHS Foundation Trust: Denmark Hill	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	12 September 2016	South East London
Kings College Hospital NHS Foundation Trust: Princess Royal University Hospital		13 September 2016	South East London
University College London Hospitals NHS Foundation Trust: University College Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	29 September 2016	North Central London
St George's Healthcare NHS Trust: St George's Hospital	Russell Viner Clinical Lead, HLP's CYP programme	5 October 2016	South West London
Chelsea and Westminster Hospital NHS Foundation Trust: Chelsea and Westminster Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	13 October 2016	North West London
Chelsea and Westminster Hospital NHS Foundation Trust: West Middlesex University Hospital		13 October 2016	North West London
Croydon Health Services NHS Trust - Croydon University Hospital	Tina Sajjanhar Consultant in Paediatric Emergency Medicine and Divisional Director for Children and Young People services Lewisham and Greenwich NHS Trust	11 October 2016	South West London
Barking Havering and Redbridge University Hospitals NHS Trust: Queen's Romford	Karen Daly Consultant Paediatric Orthopaedic Surgeon, St George's University Hospitals NHS Foundation	20 October 2016	North East London
Barking Havering and Redbridge University Hospitals NHS Trust: King George Hospital		20 October 2016	North East London

<sup>7</sup> Former and now current Medical Director of Alder Hey Children's NHS foundation Trust

	Trust		
Whittington Health NHS Trust: Whittington Hospital	Tina Sajjanhar Consultant in Paediatric Emergency Medicine and Divisional Director for Children and Young People services Lewisham and Greenwich NHS Trust	16 November 2016	North Central London
Barts Health NHS Trust: Royal London Hospital	Sara Hanna Medical Director and consultant in children's intensive care, Evelina London Child's Healthcare, Guy's and St Thomas' NHS Foundation Trust	28 November 2016	North East London
Barts Health NHS Trust: Whipps Cross University Hospital		8 December 2016	North East London
Barts Health NHS Trust: Newham University Hospital		12 December 2016	North East London
Kingston Hospital NHS Foundation Trust: Kingston Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	11 January 2017	South West London
The Hillingdon Hospitals NHS Foundation Trust: Hillingdon Hospital	Simon Broughton Paediatrician and Deputy Clinical Director, King's College Hospital NHS Foundation Trust	24 January 2017	North West London
London North West Healthcare NHS Trust: Northwick Park Hospital	Russell Viner Clinical Lead, HLP's CYP programme	9 February 2017	North West London
Imperial College Healthcare NHS Trust: St Mary's Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	21 February 2017	North West London
Homerton University Hospital NHS Foundation Trust: Homerton University Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	22 February 2017	North East London
Guy's and St Thomas' NHS Foundation Trust: Evelina London Children's Hospital	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	1 March 2017	South East London
Epsom & St Helier University Hospitals NHS Trust: St Helier Hospital and Queen Mary's Hospital for Children	Steve Ryan Strategic lead for CAMHS Transformation, HLP's CYP programme	21 March 2017	South West London
Epsom & St Helier University Hospitals NHS Trust: Epsom General Hospital		21 March 2017	South West London

## Appendix C: Glossary

CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CYP	Children AND Young People
DGH	District General Hospital
ED	Emergency Department
HLP	Healthy London Partnership
NED	Non-Executive Director
PANP	Paediatric Advanced Nurse Practitioners
PASSU	Paediatric Short Stay Assessment Unit
PAU	Paediatric Assessment Unit
STPs	Sustainability and Transformation Plans
UCC	Urgent Care Centre
UCH	University College Hospital, University College London Hospitals NHS Foundation Trust