Covering all bases

Online directory of innovative practice models or pathways

The innovative practice section of the CCH website presents a range of good practice examples which were submitted via the national call for evidence and the national Community Child Health survey. They key information from these submissions has been categorised and summarised into relevant sections so the submissions can be easily accessed and searched. The completed forms are available online on the CCH website to other CCH professionals to support and inspire innovative service models or new clinical pathways.

Contents

Summary of the innovative CCH submissions 3

Detailed submissions 7

1. Ann White - Cross Sussex Paediatric SARC 7

2. Ben Marsh - Plymouth citywide school age ASD assessment pathway 9

3. Cliona Ni Bhrolchain - Performance dashboard to monitor performance in WUTH 11

4. Cliona Ni Bhrolchain - 'Listening into Action' project to reduce DNAs in WUTH 12

5. Cliona Ni Bhrolchain - Skill mix in ADHD assessments in WUTH 13

6. Cliona Ni Bhrolchain – Recording activity on electronic records in WUTH 15

7. Jane Williams - Rapid response to child death in Nottinghamshire 16

8. Elizabeth Marder - Referral guidelines for paediatric outpatients from primary care in Nottinghamshire 17

9. Krutika Patel - Pharmacist review of ADHD patients in Leicester 19

10. Laraine Dibble - CAMHS and commissioner appointed ADHD nurse in South Devon and Torbay 20

11. Laraine Dibble - designated doctor in the CCG 21

12. Lesley Ross - triage system for cases referred for ASD assessment 23

13. Lesley Ross - centralisation of child protection service 25

14. Ratna Sundrum - Children and Young People's Weight Management Clinic 26

15. Serena Haywood - ADHD team skill mix 28

16. Sian Bennett - experienced nurses undertaking initial health assessments for LAC 30

17. Wendy D'Arrigo - Jointly run child behaviour assessment clinic 31

18. Hilary Smith - Advanced Nurse Practitioner role within the paediatric medical service 32

19. Susan Ozer – developed an integrated ADHD pathway 34

20. Dawn Wade - Standard Operating Procedure for EHCP 36

21. Dr Lilias Alison (Original contact Dr Asha Ravi - now retired) - Sexual assault referral centre at Sheffield children's hospital 37

22. Indrani Banerjee - Joint orthopaedic clinics for complex neurodisability in Harrow 39

23. Wei Liang Yap - Child Behaviour Assessment Clinic in Weymouth 41

24. Bratati Bose-Haider – Weekly joint triage meeting between community paediatrics and CAMHS in Bury 43

25. Alison Livingstone - Partial booking to reduce DNA rate in conjunction with a new Paediatric triage in North of Northern Ireland 45
26. Udayanthi Mahamithawa - Conner's assessment via online forms in West Lancashire. 47

Summary of the innovative CCH submissions

	Intervention	Region	Contact name	Description
1	Cross Sussex Paediatric SARC	Sussex	Ann White	Cross Sussex Paediatric SARC with doctors participating in a rota - community paediatricians and GUM physicians. The service sees all Sussex children requiring a forensic CSA medical examination and is available daily.
2	Plymouth citywide school age ASD assessment pathway	Plymouth	Ben Marsh	New citywide school age ASD assessment pathway - established to ensure more efficient and timely assessment. There are now 2 distinct pathways in CDC and CAMHS, with clear acceptance criteria.
3	Performance dashboard to monitor performance in WUTH	Wirral	Cliona Ni Bhrolchain	Using BEST standards and NHS standards, the Wirral has constructed a Performance Dashboard to monitor performance. It is reviewed monthly at their management meeting and RAG-rated according to set criteria.
4	'Listening into Action' project to reduce DNAs in WUTH	Wirral	Cliona Ni Bhrolchain	Through the 'Listening into Action' project they have re-introduced partial booking and started an automated telephone reminder system to improve attendance at clinics for both new and follow up patients.
5	Skill mix in ADHD assessments in WUTH	Wirral	Cliona Ni Bhrolchain	Established a skill mix in ADHD assessments. Two school nurses have developed expertise in assessing ADHD, doing school observations during assessment. This means that CYP can be diagnosed at first appointment if all elements are complete.
6	Recording activity on electronic records in WUTH	Wirral	Cliona Ni Bhrolchain	The Wirral is now recording nearly all activity on electronic records - including peripheral clinics, MDT meetings, Safeguarding medicals and CLA medicals. They code their consultations and have developed a diagnostic register. This information is now used to negotiate with CCG.
7	Rapid response to child death in Nottinghamshire	Nottingham	Jane Williams	The child death / rapid response rota is populated by two Trust teams covering the county of Nottinghamshire and has a range of paediatricians (community, general, ED) with lead nurses doing a large percentage of the work. Nottingham have a shared single point of access for all paediatric / general / community referrals with a single point of vetting where children's problems according to referral need are allocated to the most local clinic site.
8	Referral guidelines for paediatric outpatients from	Nottingham	Elizabeth Marder	In Nottinghamshire secondary care paediatrics is offered as an integrated service with Community paediatrics being part of the acute hospital trusts. It has not always been clear to GP's which part of the service referrals should be directed to, and the secondary care team have been keen to offer their services in a more integrated

	primary care in Nottinghamshire			manner.
9	Pharmacist review of ADHD patients in Leicester	Leicester	Krutika Patel	A pharmacist reviews stable ADHD patients alongside the consultant in the clinic. The pharmacist can change medication. The patients are discussed after the clinic and the pharmacist liaises with schools. Patients are seen in a timely way and the pharmacist has more time with patients.
10	CAMHS and commissioner appointed ADHD nurse in South Devon and Torbay	South Devon and Torbay	Laraine Dibble	Paediatric services have taken referrals for ADHD due to limited capacity in the CAMHS service. The CAMHS service and commissioners worked together to appoint an ADHD nurse to support this. The ADHD nurse does a joint clinic with specific paediatricians at an agreed point in the pathway, does school and home observations where indicated, supports joint diagnostic decision and can access CAMHS records/ facilitate referral if indicated.
11	Designated doctor in the CCG	South Devon and Torbay	Laraine Dibble	Designated doctor in CCG had commissioning support and that of Designated Nursing team to work across 2 providers to improve pathway for assessment of LAC. This allowed embedding of LAC competencies for staff, flagging system for children on the provider notes, better day to day management of timeliness of medicals and a clear business case for increased capacity and starting succession planning discussions.
12	ASD service, co-triaging referrals with CAMHS	Lothian	Lesley Ross	Across Lothian, 3 different areas (Edinburgh, East/Midlothian, West Lothian) operated 3 different waiting lists for ASD assessment, plus had differing rates for ADOS. No uniformity of patient pathway, no equity of service provision. Jointly with SLT and CAMHS a triage system for cases referred for ASD assessment was implemented.
13	Child protection service, working with Child Protection Advisors	Lothian	Lesley Ross	Lothian CCH service forced to centralise child protection service. Due to shortage of SAS grades, no longer able to staff 3 bases (Edinburgh; East/Midlothian; West Lothian) during office hours. Centralisation proved to increase efficiency, maintained service so improved patient safety but has been unpopular with SAS grades required to travel from usual bases to Edinburgh.
14	CYP weight management clinic	Sussex	Ratna Sundrum	A Children and Young People's weight management clinic targeting complex children with neurodevelopmental or social difficulties (LAC, child protection plans, children in need). CYP are offered an individualised programme with input from an MDT comprising hospital paediatrician, dietician, school nurse and trainer.
15	ADHD team skill mix	St Georges, London	Serena Haywood	ADHD team with 2 consultants (8 PA ADHD time), 2 nurses and a PT associate psychologist working to support a population of approximately 500 children with ADHD. See all children with attention problems up to secondary school (for new referrals). The skill mix has reduced the waiting time from over 18 weeks to 11 weeks, and cut the number of complaints and DNA.
16	Experienced nurses undertaking LAC	Sussex	Sian Bennett	Used experienced nurses (since 2000) with a background training of health visiting and paediatric nursing, to undertake initial health assessments for LAC, with supervision by the consultant community paediatrician. All cases are discussed,

	initial health assessments			children can be referred through for prompt review with the paediatrician and all babies under 12 months see the paediatrician for follow up review if they remain LAC. There have been no incidents or complaints about the process. Due for external evaluation autumn 2016
17	Jointly run child behaviour assessment clinic	Dorset	Wendy D'Arrigo	Child behaviour assessment clinic run jointly by a general paediatrician and a community paediatrician. (Dorset County Hospital) and a child psychiatrist (Dorset Healthcare Foundation Trust). Also a member of the incredible years parenting team available to meet families for advice, support and signposting. There is an allocation meeting to consider new referrals with triage to the appropriate clinician. The aim is to assess children whose behaviour is likely to be related to underlying neurodevelopmental issues and to offer advice regarding ongoing management.
18	Advanced Nurse Practitioner role within the paediatric medical service	Southampton	Hilary Smith	The aims of the project are to assess the benefits and potential outcomes of an Advanced Nurse Practitioner role within the paediatric medical service in order to maintain the capacity of the team, contain costs and increase the skill mix and diversity of the service.
19	An integrated ADHD pathway	East and North Hertfordshire	Susan Ozer	In 2011 developed a robust integrated ADHD pathway, which helped to identify service gaps leading to various service improvements including expanding the ADHD Nurse Specialist service, developing a robust transition pathway to adult services, improving communication with service users and professionals by developing a dedicated ADHD website and a service liaison email service, with good results.
20	Standard Operating Procedure for EHCP	Wirral	Dawn Wade	Developed a Standard Operating Procedure for Education Healthcare Plans (EHCP). This standardises all requests received on EHC plans.
21	Sexual assault referral centre at Sheffield children's hospital	Sheffield	Lilias Alison / Asha Ravi	A SARC (sexual assault referral centre) was established at Sheffield children's hospital to provide SARC services for the children and young people of South Yorkshire.
22	Transition Clinic for CYP with physical disability and PMLD	Harrow	Indrani Banerjee	Joint orthopaedic clinics for complex neurodisability. Transition clinics for physical disability and PMLD: started 3 years back. Innovative approach in trying to ensure safe handover of care and empowering CYP and families with information
23	Child Behaviour Assessment Clinic in Weymouth	Dorset	Wei Liang Yap	Co-located clinic model in the Weymouth locality called the Child Behaviour Assessment Clinic
24	Weekly joint triage meeting	Bury, Greater Manchester	Bratati Bose-	Community paediatrics and CAMHS have a joint triage meeting every week for an hour to make a decision regarding which team is in best position to see a child usually

	between community paediatrics and CAMHS in Bury		Haider	these are for ASD and ADHD and thus duplication of referrals to both services are avoided.
25	Paediatric triage for acute and community paediatrics in North of Northern Ireland	North of N. Ireland	Alison Livingstone	Introduced partial booking in the last 6 months and DNA rate has fallen dramatically to almost zero in some areas.
26	Conner's assessment via online forms in West Lancashire	West Lancashire	Udayanthi Mahamithawa	We now do the Conner's assessment online forms being completed by school and parents via e-mail.

Detailed submissions

1. Ann White - Cross Sussex Paediatric SARC

Innovative practice questions	Details
Name of innovation (and contact)	Cross Sussex Paediatric SARC
Organisation	Sussex Community Foundation Trust
Department	Children's SARC
Area of CCH	Safeguarding
How the new service arrangement fits into the organisational structure(s) and pathways	Relates to more than one organisation working together and working across professional boundaries: Multi-agency involving - community paediatricians or GUM doctors - the police force - social services - counselling services
Length of time	Under 12 months
Brief description of the new service arrangement	The Sussex Children's SARC (Sexual Assault Referral Centre) opened on 1st April 2015. The service is for children 13 years and below (and up to 19 years for those with severe learning difficulties). The service sees all Sussex children requiring a forensic CSA medical examination and is available daily between 10am and 4pm (with administrative staff available 9-5 week days). Forensic medicals can be arranged as soon as appropriate for the child. Non-acute appointments are offered at the family and social workers convenience usually within 2 weeks, Monday to Friday. The work is labour intensive requiring 2 highly skills doctors who are either community paediatricians or GUM doctors to be available. Recently we have trained LAC (looked after children) nurses to support the medical examination with either 1 or 2 doctors. Over the last 6 months an improvement has been seen in multi-agency working but challenges remain. For children where there is a CSA SW / police investigation (below 14 years of age). Service delivered in dedicated unit at Brighton General hospital.
The type and number of health care professionals involved (from which teams and which speciality)	Multi-agency working with Sussex police and 3 separate social services departments over a large county. Onwards referrals link with local GUM and counselling services. There is one SARC manager and a secretary. We have 10 Community paediatricians, 2 GUM doctors, 1 forensic GP. One of whom is the Clinical Lead. There are 4 nurses (LAC) who support the medical examinations on a rotational basis, who have recently attended courses to enhance their skills to support the medical examination with 1 doctor. We have a psychologist who supports reflective practice 1.5 hrs every 6 weeks. We have links with the local GUM and counselling services nearer to the child as is needed.
Ways in which the new service arrangement has made a difference	Bringing all the work to one unit has allowed investment in a dedicated building. Investment has allowed dedicated doctor and nursing time. The SARC doctor now attends the Strategy discussion for each case and is part of the planning of a medical when needed. The unit has helped embed the local CSA pathways and given support to the SW and police forces. The doctors feel more supported and have regular peer review of all cases. Training has been easier to organise as there is a clear team and base.

Published documents	Service specification with NHS England
Lessons learned from undertaking the new service arrangement	Dedicated time is needed to do this work. Nurses play a necessary role in preparing the family / child for the medical. We have trained SW and police about CSA and this is necessary and ongoing.
Contact name for further information	Ann White (office email) SC-TR.PaediatricSARC@nhs.net
Evidence / links / further information	RCPCH now has service outline for children SARC

2. Ben Marsh - Plymouth citywide school age ASD assessment pathway

Innovative practice questions	Details
Name of innovation (and contact)	Plymouth citywide school age ASD assessment pathway
Organisation	Plymouth Hospitals NHS Trust
Department	Plymouth Child Development Centre
Area of CCH which the new service arrangement relates to	• Neurodevelopment/neuro disabilities/ complex health needs • ADHD/ASD • Service evaluation and improvement
How the new service arrangement fits into the organisational structure(s) and pathways	- Relates to more than one organisation working together - Relates to working across professional boundaries - Involving CDC and CAMHS, and a wider multi-disciplinary team
Length of time the service arrangement has been running	12 months to 2 years
Brief description of the new service arrangement	New citywide School age ASD assessment pathway - established to ensure more efficient and timely assessment. There are now 2 distinct pathways in CDC and CAMHS, with clear acceptance criteria (CAMHS only seeing children with suspected ASD with comorbid mental health concerns). There are weekly telephone calls and a monthly face to face meeting with CAMHS to ensure patients can transition between the 2 services efficiently and correctly. A multi-disciplinary team assesses each case and then this is discussed at a multidisciplinary meeting. From that meeting the outcome is either to give an ASD diagnosis or not, or identify the need for further assessment through either an ADOS, or specific Clinical Psychology assessment regarding for example attachment. The diagnosis is then given to the family by the consultant, supported by further contact from the specialist Learning Disability Nurse.
The type and number of health care professionals involved (from which teams and which speciality)	The MD team includes specialist community paediatricians, specialist speech and language therapists and a specialist learning disability nurse (who also coordinates the pathway) and Educational psychologists from the City Council who are seconded to take part in the pathway. Also a Clinical Psychologist and LD Nurse if needed.
Ways in which the new service arrangement has made a difference	Audit of 1st year of new pathway (over 100 completed assessments) currently nearing completion
Published documents	
Lessons learned from undertaking the new service arrangement	
Contact name for further information	Ben Marsh benmarsh@nhs.net

Evidence / links / further info	A flowchart is attached to summarise the pathway  Plymouth school-age ASD pathway.pdf

3. Cliona Ni Bhrolchain - Performance dashboard to monitor performance in WUTH

Innovative practice questions	Details
Name of innovation (and contact)	Performance dashboard to monitor performance in WUTH
Organisation	Wirral University Teaching Hospital (WUTH)
Department	Community paediatrics
Area of CCH which the new service arrangement relates to	• Service evaluation and improvement
How the new service arrangement fits into the organisational structure(s) and pathways	Managing Performance
Length of time the service arrangement has been running	12 months to 2 years
Brief description of the new service arrangement	Using the BEST standards and NHS standards, WUTH has constructed a Performance Dashboard to monitor their performance. This is reviewed monthly at the management meeting RAG-rated according to the set criteria
The type and number of health care professionals involved (from which teams and which speciality)	The dashboard monitors performance for community paediatricians only
Ways in which the new service arrangement has made a difference	Provides information 'at a glance' on how the service is performing
Published documents to provide evidence	While there are no published examples in community paediatrics to our knowledge, performance dashboards have been promoted by the RCOG: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-7/
Lessons learned from undertaking the new service arrangement	The BEST standards can be monitored using standard management tools. However translating the standards into SMART objectives requires some thought.
Contact name for further information	Dawn Wade dawn.wade@nhs.net
Evidence / links / further info	There were attached figures and a presentation help to illustrate – do we want to include these online? If so, Cliona would like to review them first to make sure she has permission to publish

4. Cliona Ni Bhrolchain - **'Listening into Action' project to reduce DNAs in WUTH**

Innovative practice questions	Details
Name of innovation (and contact)	'Listening into Action' project to reduce DNAs in WUTH
Organisation	Wirral University Teaching Hospital (WUTH)
Department	Community paediatrics
Area of CCH which the new service arrangement relates to	• Service evaluation and improvement
How the new service arrangement fits into organisational structure/ pathways	Managing performance
Length of time the service arrangement has been running	12 months to 2 years
Brief description of the new service arrangement	Improving attendance rates through a 'Listening into Action' project using partial booking and an automated telephone reminder system. WUTH used Listening into Action, a recognised NHS leadership tool (http://www.listeningintoaction.co.uk/) to introduce new management approaches to improve attendance rates for both new and follow up patients.
The type and number of health care professionals involved	Community paediatricians; clerical and admin staff particularly the booking office; information technology – to link the PAS system with telephone reminders
Ways in which the new service arrangement has made a difference	Through the 'Listening into Action' project partial booking i.e. asking the patient to ring to arrange an appointment rather than just sending one, reduced non-attendance from 16.7% in 2013 to 7.9% in 2016-7 for new patients. Using an automated telephone reminder system follow up non-attendance at clinics improved from 16.8% 2013 to 14.9% in 2016-7.
Published documents to provide evidence	We are not aware of published examples for community paediatrics but NHS guidance on booking is available: http://www.gov.scot/Publications/2005/11/04112142/21441 http://www.wales.nhs.uk/technologymls/cymraeg/resources/pdf/tools/service_dev/Guide%20to%20Good%20Practice%20Outpatients.pdf http://www.nhsimas.nhs.uk/ist/referral-to-treatment-a-guide-for-managing-efficient-elective-care/ https://www.england.nhs.uk/resources/rtt/ NHS evidence on SMS reminders: https://www.evidence.nhs.uk/Search?ps=30&q=patient+reminders https://www.gov.uk/government/publications/reducing-missed-hospital-appointments-using-text-messages/a-zero-cost-way-to-reduce-missed-hospital-appointments
Lessons learned from undertaking the new service arrangement	The methodology worked well. For new patients, partial booking has been extremely effective in maintaining good attendance for general patients. Attendance for Initial Health Assessments for Looked After Children is still a problem. SMS reminders have been less effective for follow ups and we believe partial booking for follow ups

	too would improve attendance.
Contact name for further information	Dawn Wade dawn.wade@nhs.net
Evidence / links / further info	

5. Cliona Ni Bhrolchain - Skill mix in ADHD assessments in WUTH

Innovative practice questions	Details
Name of innovation (and contact)	Skill mix in ADHD assessments in WUTH
Organisation	Wirral University Teaching Hospital (WUTH)
Department	Community paediatrics and school nursing
Area of CCH	• ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	Working across professional boundaries
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	WUTH has well-established skill mix in their ADHD assessments. Two school nurses have developed expertise in assessing ADHD, doing school observations during assessment. As school nurses already do Conner's questionnaires, this means that children and young people can be diagnosed at first appointment if all elements are complete. Over time we have extended their roles with nurse-led ADHD follow up clinics alongside consultants. We are now progressing with extending this model to ASD assessments, using the specialist nurses to take developmental histories, follow up clinics and participate in ADOS assessments. Two new posts have been created for nurse prescribers working alongside paediatricians to meet current demand.
The type and number of health care professionals involved	Two nurse prescribers with expertise in assessing ADHD and ASD
Ways in which the new service arrangement has made a difference	We estimate that about one third of follow up patients can be reviewed by the nurses, alternating with the paediatrician.
Published documents to provide evidence	
Lessons learned from undertaking the new service arrangement	There needs to be careful vetting of patients suitable for the nurses. We have produced written criteria for follow up to ensure this.
Contact name for further information	Dawn Wade dawn.wade@nhs.net

Evidence / links / further info	

6. Cliona Ni Bhrolchain – Recording activity on electronic records in WUTH

Innovative practice questions	Details
Name of innovation (and contact)	Recording activity on electronic records in WUTH
Organisation	Wirral University Teaching Hospital (WUTH)
Department	Community paediatrics
Area of CCH which the new service arrangement relates to	• Service evaluation and improvement
How the new service arrangement fits into the organisational structure(s) and pathways	Relates to more than one organisation working together
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	WUTH is now recording nearly all activity on electronic records - including peripheral clinics, MDT meetings, Safeguarding medicals and CLA medicals. They code their consultations and have developed a diagnostic register. This information is now used to negotiate with the CCG.
The type and number of health care professionals involved (from which teams and which speciality)	Paediatricians and specialist nurses
Ways in which the new service arrangement has made a difference	Having better information available to plan services, workforce and job planning
Published documents to provide evidence	R. Gallagher, C. Ni Bhrolchain. Can you construct a disability register using routine hospital IT systems? Presentation at BACCH ASM. http://www.bacch.org.uk/conferences/documents/ASM%202013%20full%20programme%20(final).pdf (Page 15)
Lessons learned from undertaking the new service arrangement	Using a 'favourites' pick list is particularly useful to avoid lots of different codes for the same condition. We expect the mandatory data set will eventually supersede this system
Contact name for further information	Dawn Wade dawn.wade@nhs.net
Evidence / links / further info	

7. Jane Williams - Rapid response to child death in Nottinghamshire

Innovative practice questions	Details
Name of innovation (and contact)	Rapid response to child death in Nottinghamshire
Organisation	Nottingham University Hospitals Trust
Department	Family health / paediatrics
Area of CCH which the new service arrangement relates to	• Safeguarding • Child death pathway • Neurodevelopment/neuro disabilities/ complex health needs • ADHD/ASD • Long term medical conditions • Palliative care • Other general paediatrics
How the new service arrangement fits into the organisational structure(s) and pathways	Relates to more than one organisation working together. Relates to working across professional boundaries. The rota is populated by a range of clinicians (eg general paediatrics, Community child health, neurodisability, ED) and specialist nurses from two Trusts, working collaboratively, using same guidelines. It has been running for several years and responds to the unexpected deaths in CYP that occur in our area. Population 181,000 0-19 yrs.
Length of time	Over 4 years
Brief description of the new service arrangement	Rapid response to a child death (according to national guidelines)
The type and number of health care professionals involved (from which teams and which speciality)	The child death / rapid response rota is populated by two Trust teams covering the county of Nottinghamshire and has a range of paediatricians - community, general, ED contributing to this with lead nurses doing a large percentage of the work.
Ways in which the new service arrangement has made a difference	- Inter-trust working between paediatric teams has benefits - Families get a 365 day service when most distressed - Allied agencies – police, social care partners
Published documents	Wollf and Flanigan, BMJ Quality Improvement Report 2015;4:DOI:10.1136/bmjquality.u208552
Lessons learned from undertaking the new service arrangement	Collaborative inter Trust working is successful and facilitates populating this Rapid response rota allowing a whole population receive a service, two Trusts have trained staff and competency is maintained amongst a wider pool of clinicians
Contact name for further information	Jane Williams jane.williams2@nuh.nhs.uk Helena.clements@sfh-tr.nhs.uk , Dilip.nathan@nuh.nhs.uk
Evidence / links / further info	

8. Elizabeth Marder - Referral guidelines for paediatric outpatients from primary care in Nottinghamshire

Innovative practice questions	Details
Name of innovation (and contact)	Referral guidelines for paediatric outpatients from primary care
Organisation	On behalf of the Nottingham and Nottinghamshire Children and Young People's health Network
Department	Nottingham Children's Hospital, Nottingham University Hospitals Trust With Paediatric department, Sherwood Forest Hospitals NHS trust , and Children's leads from Nottingham/Nottinghamshire CCG's
Area of CCH which the new service arrangement relates to	• Service evaluation and improvement • Safeguarding • Neurodevelopment/neuro disabilities/ complex health needs • ADHD/ASD • Long term medical conditions • Other general paediatrics
How the new service arrangement fits into the organisational structure(s) and pathways	Relates to navigation of referrals from primary care to secondary paediatric services , ensuring referral are appropriate and are seen at the Right Place , Right time and by the right person To help GPs manage more children safely and confidently in primary care To ensure children are seen in a timely manner, in an appropriate clinic To support paediatricians to reject and redirect referrals to paediatric outpatient services
Length of time the service arrangement has been running	Since November 2015
Brief description of the new service arrangement	In Nottinghamshire secondary care paediatrics is offered as an integrated service with Community paediatrics being part of the acute hospital trusts. It has not always been clear to GP's which part of the service referrals should be directed to, and the secondary care team have been keen to offer their services in a more integrated manner. In addition there was a recognition from GP leads in primary care , and the paediatricians that many referrals did not need to be seen in secondary paediatrics at all and could be safely and effectively managed in other ways. A set of guidelines were developed through workshops attended by paediatricians from both local hospitals, and community paediatric services, children's leads from local CCGs with review and endorsement by the Nottingham/Nottinghamshire Children and Young People's Health Network which includes clinicians from all local Children's health providers, public health professionals, and commissioners. The guidelines include advice on 100 conditions/presentations. Alongside guidance on when to refer and with what urgency, the document links to national and local condition specific guidelines on management, suggests alternatives to referral, and provides links to parent information. The guidelines have been used since November 2015, but have recently been updated and will be re-launched in January 2017 with presentations planned at GP Learning Events. It will be published on the Nottingham care navigator, with links from various other resources – including the service information on the electronic referral system. Audit of use and impact, and arrangements for regular update are planned.

The type and number of health care professionals involved (from which teams and which speciality)	• All primary care teams in Nottingham/Nottinghamshire • Secondary care community ,general and specialty paediatrics at Nottingham Children's Hospital , and Sherwood forest hospitals
Ways in which the new service arrangement has made a difference	Since November 2015, the guidelines have been used by GPs when considering referring and by paediatricians when ''vetting'' referrals. After a year, the rejected referral rate has increased from 8% (November 2015) to 19% (November 2016) despite total referrals remaining relatively constant. (552 referrals in November 2015, 575 in November 2016). This suggests that referral guidance has not yet changed GP referral patterns.
Published documents	Not yet. Paper submitted for presentation at RCPCH Annual meeting 2017
Lessons learned from undertaking the new service arrangement	• There is a general consensus from GP Leads and paediatricians as to what should be referred • Primary care teams are receptive to information, advice and resources that can avoid referrals • There is anecdotal evidence of the potential to impact on referral numbers, not yet shown in data collected • Ensuring that the information is widely disseminated to potential referrers is a challenge and still being worked on • There is interest in extending this guidance to be used in other specialties who see children eg, ENT, orthopaedics, and adopted in other area
Contact name for further information	Elizabeth.marder@nuh.nhs.uk
Evidence / links / further information	The Referral guidelines for Paediatric outpatients from primary care can be viewed via the following links http://www.nuh.nhs.uk/handlers/downloads.ashx?id=62270 http://midnottspathways.nhs.uk or for Nottingham/ Nottinghamshire GPs and other health professionals https://portal1.nuh.nhs.uk/carenavigator/app.

9. Krutika Patel - Pharmacist review of ADHD patients in Leicester

Innovative practice questions	Details
Name of innovation (and contact)	Pharmacist review of ADHD patients in Leicester
Organisation	Leicester
Department	Community paediatrics
Area of CCH	ADHD/ASD
How the new service arrangement fits into the organisational structure(s)	Relate to working across professional boundaries
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	Pharmacist review of ADHD patients alongside the consultant community paediatrician in clinic. A pharmacist reviews stable ADHD patients alongside the consultant in the clinic. The pharmacist is a prescriber so can change medication. The patients are discussed after the clinic and the pharmacist liaises with schools
The type and number of health care professionals involved	A pharmacist working with a consultant community paediatrician ADHD nurses
Ways in which the new service arrangement has made a difference	Patients are seen in a timely way and the pharmacist has more time with patients that they find invaluable. It has kept the follow up list in check and families find the pharmacist invaluable as shown by feedback that has been received. The pharmacist has had a review of this published in a pharmacy journal. It has improved all outcomes - quality, safety, cost
Published documents to provide evidence for the new service arrangement	(Vol 292) 21/28 June 2014 www.pjonline.com
Lessons learned from undertaking the new service arrangement	Lessons learnt – another pharmacist is needed
Contact name for further information	Contact name and email: Krutika Patel - krutika.patel@leicspart.nhs.co.uk
Evidence / links / further info	

10. Laraine Dibble - CAMHS and commissioner appointed ADHD nurse in South Devon and Torbay

Innovative practice questions	Details
Name of innovation (and contact)	CAMHS and commissioner appointed ADHD nurse in South Devon and Torbay
Organisation	
Department	
Area of CCH which the new service arrangement relates to	ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	Fits both options: Relates to more than one organisation working together. Relates to working across professional boundaries e.g. Paediatricians with CAMHS
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	Paediatric services have taken referrals for ADHD due to limited capacity in the CAMHS service CAMHS had capacity issues so the CCH service has taken referrals for ADHD. The CAMHS service and commissioners worked together to appoint and ADHD nurse to support this. The ADHD nurse does a joint clinic with specific paediatricians at an agreed point in the pathway, does school and home observations where indicated, engages with parents for placement on an education course, supports joint diagnostic decision and can access CAMHS records/ facilitate referral if indicated (for ADHD and non ADHD).
The type and number of health care professionals involved	ADHD nurse - does a joint clinic with specific paediatricians
Ways in which the new service arrangement has made a difference	No published documents but anecdotal reports of better parent engagement in the areas where we have an ADHD nurse compared to the areas where no nurse. Also Consultant Paediatricians feel more confident in diagnosis (from peer review).
Published documents to provide evidence for the new service arrangement	In the process of doing a piece of work to try and evidence this.
Lessons learned from undertaking the new service arrangement	Commissioner from neighbouring area has also now facilitated a wider meeting to look at service spec/ standards across 2 CCGs (4 paediatric services) and further meeting planned. Aim to build in outcomes if possible.
Contact name for further information	Laraine Dibble laraine.dibble@nhs.net
Evidence / links / further info	

11. Laraine Dibble - designated doctor in the CCG

Innovative practice questions	Details
Name of innovation (and contact)	Designated doctor in the CCG
Organisation	South Devon and Torbay CCG and Torbay and South Devon Foundation Trust
Department	CCG quality team and provider child health team
Area of CCH which the new service arrangement relates to	Looked after children/adoption and fostering
How the new service arrangement fits into the organisational structure(s)	Relate to more than one organisation working together
Length of time the service arrangement has been running	12 months to 2 years
Brief description of the new service arrangement	Designated Dr sitting in CCG had commissioning support and that of Designated Nursing team to work across 2 providers to improve pathway for assessment of LAC. This has been a series of meetings ongoing. This allowed embedding of LAC competencies for staff, flagging system for children on the provider notes, better day to day management of timeliness of medicals and a clear business case for increased capacity and starting succession planning discussions.
The type and number of health care professionals involved	Designated doctor in the CCG and a designated nursing team
Ways in which the new service arrangement has made a difference	The arrangement was brokered with a clear service level agreement (SLA) within the commissioning framework. This facilitated both a named person with sufficient competency and support (sitting in a standalone position which can be very challenging to the person and organisation) but also stronger identity of the team with the necessary freedom to work across organisation boundaries as necessary for the roles (such as supervision, appraisal and revalidation). A good understanding of the local systems and knowledge of people across different organisations facilitated development of clearer health outcomes for Looked After Children locally and use of the best parts of data analysis across the system to measure progress. This also facilitated early warning/ detection of drift/ difficulties and gave the Designated Doctor more robust information to empower the role both in CCG and at corporate Parent Board.
Published documents to provide evidence for the new service arrangement	None
Lessons learned from undertaking	Due to the success of this model the arrangement has been adopted in neighbouring area. I

the new service arrangement	think this has allowed more robust succession planning for the role at a time of considerable recruitment difficulties in community paediatrics. It has also supported clearer planning/ contracting around hosting (or direct employment) discussions for key nursing posts as well. Since this example was originally submitted the situation has become more unstable with retirement but the arrangement footing allowed rapid assessment of risk and accountability and hopefully will come to an early resolution without local parties backtracking from a successful model.
Contact name for further information	Laraine Dibble laraine.dibble@nhs.net
Evidence / links / further info	

12. Lesley Ross - triage system for cases referred for ASD assessment

Innovative practice questions	Details
Name of innovation (and contact)	Joint triage system for cases referred for ASD assessment
Organisation	NHS Lothian
Department	Department of Community Child Health, 10 Chalmers Crescent, Edinburgh EH9 1TS
Area of CCH which the new service arrangement relates to	ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	Relate to working across professional boundaries e.g. Paediatricians with CAMHS
Length of time the service arrangement has been running	Since January 2015
Brief description of the new service arrangement	Across Lothian, 3 different areas (Edinburgh, East/Midlothian, West Lothian) operated 3 different waiting lists for ASD assessment, plus had differing rates for ADOS. No uniformity of patient pathway, no equity of service provision. Dr Sarah Clegg leading on work working jointly with SLT and CAMHS colleagues re implementation of triage system for cases referred for ASD assessment.
The type and number of health care professionals involved (from which teams and which speciality)	Community paediatricians, Speech and Language Therapists, Child and Adolescent Mental Health Services.
Ways in which the new service arrangement has made a difference	Still in implementation phase. Should result in equity of service, single patient pathway and reduced waiting times as less duplication. Data collection for 12 months (Jan – Dec 2015) demonstrated reduction in waiting time for initial ASD assessment from 9 months to 23 weeks in Edinburgh, and further analysis in April 2016 demonstrated waiting time reduced to 13 weeks from referral being received to diagnosis being given. Current waiting time is about 5 months in Edinburgh, which looks very favourable when compared across Scotland.
Published documents to provide evidence for the new service arrangement	Rutherford, M., McKenzie, K., Forsyth, K., McCartney, D., O'Hare, A., McClure, I., & Irvine, L. (2016). Why are they waiting? Exploring professional perspectives and developing solutions to delayed diagnosis of autism spectrum disorder in adults and children. Research in Autism Spectrum Disorders, 31, 53-65.
Lessons learned from undertaking the new service arrangement	Difficulty of engaging CAMHS in joint working due to limitations of CAMHS resources
Contact name for further information	NB. Dr Sarah Clegg is leader for this work, along with SLT Morag Burns and Dr Lesley Ross Dr Sarah Clegg, Consultant Paediatrician.

	sarah.clegg@nhslothian.scot.nhs.uk
Evidence / links / further information	

13. Lesley Ross - centralisation of child protection service

Innovative practice questions	Details
Name of innovation (and contact)	Centralised child protection service
Organisation	NHS Lothian
Department	Dept of Community Child Health, 10 Chalmers Crescent, Edinburgh EH9 1TS
Area of CCH which the new service arrangement relates to	Safeguarding
How the new service arrangement fits into the organisational structure(s)	Relate to working across professional boundaries e.g. Paediatricians with CAMHS
Length of time	3 years
Brief description of the new service arrangement	Lothian CCH service forced to centralise child protection service. Previously 3 geographical bases in Edinburgh; East/Midlothian; West Lothian. Due to shortage of SAS grades, no longer able to staff 3 bases during office hours. Child Protection Advisors (Nurse) had been gradually implemented taking calls from 2013, but new model required transfer of funds to CPA and increased nursing role in Child Protection services. Centralisation of service has increased efficiency, maintained service so improved patient safety but has been unpopular with SAS grades required to travel from usual bases to Edinburgh.
The type and number of health care professionals involved (from which teams and which speciality)	Child Protection Nurse Advisors Community Paediatricians (SAS grades)
Ways in which the new service arrangement has made a difference	Improved efficiency. Saved money. Increased patient safety as there are significant workforce shortages but acute child protection service maintained by this centralised model. By April 2017, the CPA staffing level will have increased to the point where there will be 2 CPAs and 1 SASG in Hub on 4 days/week and 2 SASG and 1 CPA in Hub on the 5th day. This has created an increase in time for other specialist and generic work within SASG job plans.
Published documents to provide evidence	
Lessons learned from undertaking the new service arrangement	With ongoing workforce difficulties across the Lothian Community Child Health service, the centralisation of Child Protection services has allowed the maintenance of first line child protection services despite gaps in other areas of the service provision. Need to involve HR in Organisational Change Policy management as move caused significant distress to SASG doctors required to travel to Hub.
Contact name for further information	lindsay.logie@nhslothian.scot.nhs.uk (Lindsay Logie has confirmed she is happy to be main contact.)
Evidence / links / further information	

14. Ratna Sundrum - Children and Young People's Weight Management Clinic

Innovative practice questions	Details
Name of innovation (and contact)	A Children and Young People's weight management clinic targeting complex children with neurodevelopmental or social difficulties (LAC, child protection plans, children in need)
Organisation	Sussex Community NHS Trust
Department	
Area of CCH which the new service arrangement relates to	• Child public health • Safeguarding • Looked after children/adoption and fostering • Neurodevelopment/neuro disabilities/ complex health needs • Mental health • Service evaluation and improvement
How the new service arrangement fits	Relates to more than one organisation working together. Relates to working across professional boundaries e.g. Paediatricians with CAMHS
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	We have run a Children and Young People's Weight Management Clinic targeting Complex Children with Neurodevelopmental or Social Difficulties (LAC, Child protection plans, Children in need) as they are often unable to access mainstream interventions that are available. Children and young people 5-19 who meet the criteria are offered an individualised programme with input from a multidisciplinary team comprising hospital paediatrician, dietician, school nurse and trainer. The service is commissioned by Public Health located in the Council, the clinic is based in the local child development centre and staff are employed by the hospital NHS Trust (paediatrician, dietician), Community NHS Trust (school nurse, community paediatrician) and the Council (trainer). Evaluation of the clinic shows that BMI centile was reduced or maintained in 69% of those seen which is comparable with other interventions despite targeting complex children and families- see attached summary of evaluation.
The type and number of health care professionals involved	Multidisciplinary team comprising hospital paediatrician, dietician, school nurse and trainer
Ways in which the new service arrangement has made a difference	See question 9 for summary of unpublished evaluation. In addition, clinic provides a service which is not available in most areas.
Published documents	
Lessons learned	
Contact name for further information	ratna.sundrum@nhs.net

Evidence / links / further information	(Has been provided on a separate document)

15. Serena Haywood - ADHD team skill mix

Innovative practice questions	Details
Name of innovation (and contact)	ADHD team skill mix
Organisation	St Georges University Hospitals NHS Foundation Trust
Department	Department of Child Neurodevelopment (SANDPIT)
Area of CCH which the new service arrangement relates to	ADHD (and associated comorbidities including medical and behavioural support of ASD in association with CAMHS)
How the new service arrangement fits into the organisational structure(s)	Relates to working across professional boundaries
Length of time the service arrangement has been running	Since September 2014
Brief description of the new service arrangement	Our ADHD team is made up of 2 consultants (8 PA ADHD time), an additional consultant with ad hoc ADHD clinics and junior doctors, 2 nurses and a PT assistant psychologist working to support a population of approximately 630 children with ADHD at a rate of approximately 100 new patients a year. We see all children with attention problems up to secondary school (for new referrals) but see all children we have started to see through to transition. All children with attention difficulties at any age referred via the consultant of the week are discussed at a weekly triage meeting with the full team with a completed school or early education form including SNAP and Social Responsiveness questionnaires. Initial recommendations for referrals to other services including CAMHS, specialist autism team or education can be made at this time. The family are send details of the service which includes a timeline. The majority are sent first to the specialist nursing clinic where they are seen within 6-10 weeks, a full history is taken including family and social and psychosocial/behavioural advice is given. They are then seen by a consultant within 18 weeks and diagnosis and/or definitive management is carried out. The psychology team may be asked to do a school observation prior to diagnosis or in rare cases a home visit especially when eating is a problem and a witnessed meal can be carried out. The team discuss 'tricky' cases at the weekly meeting and have guests including the teen pregnancy advisory service, the early years behavioural team and CAMHS. The meetings are minuted and outcomes all reviewed at the next meeting. The nurses offer Webster Stratton based parenting support groups on a rolling programme, weekly telephone clinics including ad hoc and emergency clinics and there is a daily parent-consultant email service. All prescribing is done or supervised by the senior doctors and the admin

	team have a form to complete for each parent conversation to track communication and prescriptions which are also monitored by the Trust pharmacy. There is a good working relationship with local SENCOs and further involvement with local GPs planned for 2017 to accompany the already well-functioning shared care agreements.
The type and number of health care professionals involved	ADHD team with 2 consultants (8 PA ADHD time), 2 nurses and a PT associate psychologist and co working with CAMHS, hospital pharmacy, a close relationship with CAMHS, junior medical staff and a close relationship with acute paediatric services including safeguarding.
Ways in which the new service arrangement has made a difference	We have reduced the waiting time from over 18 weeks to 11 weeks when fully staffed Feedback from parenting group has been very strong.
Published documents to provide evidence for the new service arrangement	There is a project in process on use of Goal Attainment Scoring in Outcomes to be validated alongside the SNAP questionnaire.
Lessons learned from undertaking the new service arrangement	
Contact name for further information	Serena Haywood serena.haywood@stgeorges.nhs.uk
Evidence / links / further information	Website designed by our team with children for children https://www.stgeorges.nhs.uk/service/childrens-services-2/childrens-medicine/adhd-kids-zone/ Website for the families of children with ADHD https://www.stgeorges.nhs.uk/service/childrens-services-2/childrens-medicine/adhd-service/

16. Sian Bennett - experienced nurses undertaking initial health assessments for LAC

Innovative practice questions	Details
Name of innovation (and contact)	Experienced nurses undertaking initial health assessments for LAC, Sussex
Organisation	
Department	
Area of CCH which the new service arrangement relates to	Looked after children/adoption and fostering
How the new service arrangement fits into the organisational structure(s) and pathways	Relates to working across professional boundaries
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	Since 2000 we have used experienced nurses (background training of health visiting and paediatric nursing) to undertake initial health assessments for looked after children, with supervision by the consultant community paediatrician. All cases are discussed, children can be referred through for prompt review with the paediatrician if necessary and all babies under 12 months see the paediatrician for follow up review if they remain LAC. There have been no incidents or complaints about the process.
The type and number of health care professionals involved	Experienced nurses (background training of health visiting and paediatric nursing Consultant community paediatrician
Ways in which the new service arrangement has made a difference	Our own audits of quality of the reports have not identified any issues of safety. The reports are of good quality and receive good feedback from social workers and from carers. The process was subject to joint CQC/OFSTED inspection in 2011 (as part of LA safeguarding inspection) and was graded as Outstanding. B&H CCG are currently commissioning an external review of the model to endorse the practice.
Published documents to provide evidence	
Lessons learned from undertaking the new service arrangement	In the context of significant difficulties in recruiting to consultant posts in the community, we have to look realistically at what the medical role is going to be in the future. Appropriately experienced nurses, working alongside consultants, can provide good quality assessments for children in care.
Contact name for further information	Sian Bennett sian.bennett1@nhs.net
Evidence / links / further information	

17. Wendy D'Arrigo - Jointly run child behaviour assessment clinic

Innovative practice questions	Details
Name of innovation (and contact)	Jointly run child behaviour assessment clinic run by a general paediatrician and a community paediatrician
Organisation	Dorset County Hospital NHS Foundation Trust
Department	
Area of CCH which the new service arrangement relates to	ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	Relate to more than one organisation working together. Relate to working across professional boundaries.
Length of time the service arrangement has been running	12 months to 2 years
Brief description of the new service arrangement	Jointly run child behaviour assessment clinic run by a general paediatrician and a community paediatrician from Dorset County Hospital and a child psychiatrist from Dorset Healthcare Foundation Trust. There is also a member of the incredible years parenting team available to meet families for advice, support and signposting. There is an allocation meeting to consider new referrals with triage to the appropriate clinician. The aim is to assess children whose behaviour is likely to be related to underlying neurodevelopmental issues and to offer advice regarding ongoing management. Long term follow up can be undertaken in this clinic or they can be transferred to the care of the paediatrician looking after their geographical patch.
The type and number of health care professionals involved (from which teams and which speciality)	Involves a general paediatrician and a community paediatrician from Dorset County Hospital and a child psychiatrist from Dorset Healthcare Foundation Trust, also a member of the incredible years parenting team
Ways in which the new service arrangement has made a difference	New development - currently being audited
Published documents to provide evidence for the new service arrangement	
Lessons learned from undertaking the new service arrangement	
Contact name for further information	Wendy D'Arrigo wendy.d'arrigo@dchft.nhs.uk
Evidence / links / further information	

18. Hilary Smith - Advanced Nurse Practitioner role within the paediatric medical service

Innovative practice questions	Details
Name of innovation (and contact)	A community-based consultant-led paediatric medical service for children who are vulnerable to illness, developmental delay, disability and/or disadvantage, in Southampton CCG and some adjacent areas of West Hampshire CCG (New Forest, Test Valley South and Eastleigh South)
Organisation	Solent NHS Trust
Department	
Area of CCH which the new service arrangement relates to	•Neurodevelopment/disabilities
How the new service arrangement fits into the organisational structure(s) and pathways	•To deliver a consistent high quality community paediatric service across a variety of clinic settings enabling care as close to home as possible •To review and assess children and young people referred to the service •To undertake child protection medical assessment and examination of children including relevant investigations and to provide medical opinion that will inform multiagency planning processes regarding the significance of findings. •To enable early identification of children with special needs and disability and provide timely response to requests for medical assessment and reports •To promote psychological, physical and social wellbeing of children •To ensure the service is evidence based through an effective clinical governance framework •To work as part of a whole systems approach to supporting children's development and wellbeing across primary, community (health, education and social care) and secondary care by ensuring access to timely, high quality assessment, diagnosis, treatment and support according to local and nationally agreed best practice •To work with UHSFT to deliver a high quality integrated model of acute and community general paediatric services facilitated through integrated care pathways •To develop strong links with primary care which support the development of skills and confidence within the primary care workforce •To achieve positive evaluation of the service by service users
Length of time the service arrangement has been running	
Brief description of the new service arrangement	The aims of the project are to assess the benefits and potential outcomes of an Advanced Nurse Practitioner role within the paediatric medical service in order to maintain the capacity of the team, contain costs and increase the skill mix and diversity of the service. (Further details included in attached documents) • Paediatric clinics will be delivered in a variety of community based locations across the city. • Children will be seen in child and family friendly environments. • Wherever possible, families will be given choice of clinic location, date and time wherever

	possible, with information made readily available to support their choice
The type and number of health care professionals involved (which teams and which speciality)	Advanced Nurse Practitioner
Ways in which the new service arrangement has made a difference	The service will contribute towards the following outcomes: •Early diagnosis, treatment and ongoing follow up to minimise/prevent longer term problems •Better management of children in the community and fewer unnecessary referrals to acute secondary care •Reduction in infant mortality •Improved school attendance and educational outcomes through early and appropriate, timely intervention •Long term improvement in health inequalities •Beneficial health outcomes on general health and wellbeing, growth, development and nutritional status. •Accurate, comprehensive medical information that informs good safeguarding assessment and planning, and therefore good outcomes for children subject to safeguarding procedures •Health contribution to multiagency assessment and care planning that enables a child's needs to be considered and addressed in the round, thereby enabling them to achieve their potential
Published documents to provide evidence for the new service arrangement	
Lessons learned from undertaking the new service arrangement	
Contact name for further information	
Evidence / links / further information	

19. Susan Ozer – developed an integrated ADHD pathway

Innovative practice questions	Details
Name of innovation (and contact)	Integrated ADHD pathway which helped to identify service gaps
Organisation	East and North Hertfordshire NHS Trust
Department	
Area of CCH which the new service arrangement relates to	ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	
Length of time the service arrangement has been running	Over 2 years
Brief description of the new service arrangement	Developing a robust integrated ADHD pathway in 2011, helped identify service gaps leading to various service improvements including expanding the ADHD Nurse Specialist service, developing a robust transition pathway to adult services, improving communication with service users and professionals by developing a dedicated ADHD website and a service liaison email service. We have also developed high quality parent information leaflets and booklets and a monthly ADHD parent psychoeducation workshop in North Hertfordshire.
The type and number of health care professionals involved	ADHD Nurse Specialist
Ways in which the new service arrangement has made a difference	Our referral statistics indicate that less ADHD referrals are being declined (23% in 2011 versus 14% in 2013/2014). Paediatricians generally assess less complex secondary school age children requiring CAMHS input- Audit (53% 2010/2011 versus 28% 2013/2014. the ADHD nurse specialist provides more input and support post ADHD pathway (0% 2010/2011, 16% 2013/2014.The biggest improvement is the reduction of time taken from referral to diagnosis due to the quality of information and input prior to an assessment by a Specialist. On average children were seen in 2 consultations or more before a diagnosis was made (2010/2011). In 2014, majority of children assessed received a diagnosis in one setting. Development of information tools like the ADHD website (www.addmore.org.uk) has contributed to providing a robust support framework for parents, patients and Professionals. Monthly ADHD Psychoeducation workshops for parents also inform and support families regarding understanding ADHD and how best to support their child.
Published documents to provide evidence for the new service	ADHD website details given. Books and information literature are published mainly by support grants are mainly targeted at children to help them understand their disorder better.
Lessons learned from undertaking the new service arrangement	
Contact name for further	

information	
Evidence / links / further information	

20. Dawn Wade - Standard Operating Procedure for EHCP

Innovative practice questions	Details
Name of innovation (and contact)	Standard Operating Procedure for Education Healthcare Plans (EHCP).
Organisation	Wirral University Teaching Hospital
Department	
Area of CCH which the new service arrangement relates to	
How the new service arrangement fits into the organisational structure(s) and pathways	
Length of time the service arrangement has been running	
Brief description of the new service arrangement	Request received on EHC referral proforma. Proforma to be emailed using standard subject: Child's First Name, Surname and DOB. Clerical Officer Acknowledge all requests via standard email: PR1 – Not known to Community Paediatrician – standard email to be sent. Request still to be sent to SALT, CAMHS and Physio to check their database. PR1 – Known to service } 1P - } – standard email 1S - } Proforma received by Clerical Officer and entered onto Education Healthcare Plans Tracker. Clearly indicating type of request and all other healthcare agencies to be involved. Weekly meetings to be held with admin and secretarial teams to discuss referrals on EHC tracker
The type and number of health care professionals involved	
Ways in which the new service arrangement has made a difference	
Published documents to provide evidence for the new service arrangement	
Lessons learned from undertaking the new service arrangement	
Contact name for further info	
Evidence / links / further information	

21. Dr Lilias Alison (Original contact Dr Asha Ravi - now retired) - Sexual assault referral centre at Sheffield children's hospital

Innovative practice questions	Details
Name of innovation (and contact)	Sexual assault referral centre at Sheffield children's hospital
Organisation	Sheffield Children NHS Foundation Trust
Department	Paediatric Medicine
Area of CCH	Safeguarding
How the new service arrangement fits in	Relate to more than one organisation working together
Length of time	Over 3 years
Brief description of the new service arrangement	Sexual assault referral services for children aged 0 - 16. Service is for children from South Yorkshire (Sheffield, Barnsley, Rotherham, Doncaster) and Bassetlaw. Forensic medical assessments are undertaken by a single doctor (one of 6 consultant paediatricians) trained in safeguarding, sexual abuse examination and forensic assessment. Referrals are taken from the police. The service is also offered to children aged 16-17 with vulnerabilities eg learning difficulties. Facilities also contain police video interview suite. The SARC also has a child psychologist, support workers and safeguarding nurses.
The type and number of health care professionals involved (from which teams and which speciality)	Consultant paediatricians x 6 (general and community, including named and designated doctors for safeguarding) who have been trained to perform historical and acute forensic single doctor child sex abuse examinations. Examinations are performed with a support worker. Psychologist within the team supports the child's aftercare following sexual assault. Links developed with paediatricians and safeguarding teams at local DGHs to assist with aftercare. Links with local GUM departments, children's ISVA (independent sexual violence advisor), Victim support.
Ways in which the new service arrangement has made a difference	Children in South Yorkshire now have access to a local commissioned paediatric SARC service. The service provides timely forensic medical examinations within child-friendly hours following acute sexual assault. The service aims to be holistic meeting forensic, medical and psychological needs, as well as sexual health and safeguarding. Children no longer need to travel out of region for an ad hoc forensic medical, or be examined inappropriately in the middle of the night. Pathways of care have been developed to give the child access to local after-care, with appropriate sharing of information. The service aims to provide a one-stop shop, with forensic medical and police interview on same day, same site where required. As this service is now within the NHS, it is subject to NHS clinical governance, and can be audited, measured and meet quality standards.
Published documents to provide evidence	Service specification for the clinical evaluation of children and young people who may have been sexually abused. RCPCH and Faculty of Forensic and Legal Medicine, September 2015.
Lessons learned from undertaking the new service arrangement	Ensure staff get early training in forensic medicine eg attending FMERSA, and have access to practical training eg speculum examinations. Market the service so that eg Safeguarding services fully aware of the importance of the service for children. Have access to someone who with FFLM

	accreditation to provide educational supervision and support. Good managerial support is essential eg for commissioning with NHS England. Get support and advice from Forensic Regulatory Authorities and local forensic labs. Ensure links with local providers formally established.
Contact name for further information	Dr Lilias Alison, Consultant Community Paediatrician - lilias.alison@sch.n.hs.uk
Evidence / links / further information	

22. Indrani Banerjee - Joint orthopaedic clinics for complex neurodisability in Harrow

Innovative practice questions	Details
Name of innovation (and contact)	Indrani Banerjee – Transition Clinic for CYP with physical disability and PMLD
Organisation	Harrow CCH
Department	Department of Paediatrics, Northwick Park Hospital
Area of CCH which the new service arrangement relates to	Neurodevelopment/ Neuro-disabilities/ Complex health needs, ADHD/ASD, Long Term Medical Conditions, Teaching and Training
How the new service arrangement	Relate to working across professional boundaries e.g. Paediatricians with adult LD psychiatry team, CAMHS, Local authority education and social care.
Length of time	Over 2 years
Brief description of the new service arrangement	Transition clinics for physical disability and PMLD: started 3 years back. Innovative approach in trying to ensure safe handover of care and empowering CYP and families with information.  RSM poster_Transition_CP  PhyDis_transclinic_MM_2017.pdf  TransitionClinic_PMLD.pdf
The type and number of health care professionals involved (from which teams and which speciality)	SLT/PT/OT Adult LD psychiatry team, Paediatric CWD Social service team, Adult social care (As of 2016 they are now a joint team 0-25) Education: Deputy head teacher, family liaison workers, Connexion team
Ways in which the new service arrangement has made a difference	We have not done any cost benefit analysis. Quality, safety and efficiency is improved and reflects in feedback from PMLD transition clinic : •100% of the parents felt there was adequate information provided during the clinic, and 100% of the parents also replied that there was enough time to ask questions. •100% of the parents felt clear about what the next stage would be after clinic. •100% of the parents felt that the Therapists had helped them prepare for adulthood •100% of the parents said that all the people they needed to ask questions from in clinic were there to help them. Feedback from Physical Disability Transition Clinic: •100% of the YP and parents said they understood why they were being seen in clinic. •100% of the YP and parents felt there was adequate information provided during the clinic, and 100% of the YP also replied that there was enough time to ask questions. • 90% of parents replied yes to having enough time to ask questions. •100 % of YP felt clear about what the next stage would be after clinic

Published documents	Poster publication in BACD Annual Scientific meeting  Transitionposterfinal 1.pdf
Lessons learned	Need to unsure user involvement
Contact name for further information	The following contacts can be used: Indrani Banerjee Indrani.banerjee@nhs.net Madhumita Mukherjee and Jodi Mirelman - Community Child Health Team
Evidence / links / further information	

23. Wei Liang Yap - Child Behaviour Assessment Clinic in Weymouth

Innovative practice questions	Child Behaviour Assessment Clinic in Weymouth
Name of innovation (and contact)	Dorset County Hospital NHS Foundation Trust (for paediatrics) and Dorset Healthcare University NHS Foundation Trust (for CAMHS)
Organisation	Community paediatrics, Acute (General) paediatrics, and Child and Adolescent Mental Health
Department	ADHD/ASD
Area of CCH	Relate to working across professional boundaries e.g. Paediatricians with CAMHS
How service arrangement fits	12 months to 2 years
Length of time	Co-located clinic model in the Weymouth locality called the Child Behaviour Assessment Clinic : Paediatricians, parent specialist, and child psychiatrist discuss all referrals for behavioural difficulties of those aged under 18 years at the start of the clinic. The referrer and the family are informed about who they have been allocated to, and a contact given to them for the right department. We will signpost rather than offering appointments on occasion. For the younger children our parent specialist may see the family first to assess parenting capability and engagement, together with gathering information and referring onto available parenting services. The CAMHS clinician is more likely to see the family where there are significant risks to child/others secondary to their mood or behaviour. If the child is in care they may pass the family to the Looked After Child Protocol that is run through the CAMHS service. The clinicians then run their clinics alongside each other and meet at the end to discuss issues raised. We have a consistent nurse who can give informal advice in waiting room. Our parent worker occasionally offers short focused work on specific issues like anger, sleep, constipation. Cases can be passed between the clinicians depending on risks and comorbidity.
Brief description of the new service arrangement	• One acute paediatrician • One community paediatrician • One Associate specialist child psychiatrist • One Parent specialist (nurse specialist, band 7) • Out-patient clinic nurse provided by paediatrics (incl. checking Height, Weight, BP, etc) • Facilities at CAMHS • Administration done by relevant teams
The type and number of health care professionals involved (from which teams and which speciality)	Staff in the clinic feel very positive about the support received from each other. There is less transfer between departments as all our skills are improving. Medical advice is easily available re ECGs or physical comorbidities. Paediatric trainees have been positive about being able to access CAMHS input

	The audit suggested that patients seen in the clinic are more likely to be signposted to other services because of the sharing of resources than previously when they had been reviewed in a lone community clinic
Ways in which the new service arrangement has made a difference	An audit cycle has been completed which mainly looked at whether the clinic met the standards agreed by the relevant trusts such as time to assessment etc. A survey of GPs prior to starting the clinic suggested that it would be perceived as useful
Published documents to provide evidence for the new service arrangement	We have generally had increasing number of younger patients referred and are concerned that the threshold for consultant assessment may be too low. We are looking to develop a referral guide so that community resources can be accessed prior to referral
Lessons learned from undertaking the new service arrangement	Dr Chrissy Boardman Associate Specialist Child Psychiatrist (DHUFT) chrissy.boardman@nhs.net
Contact name for further information	
Evidence / links / further information	

24. Bratati Bose-Haider – Weekly joint triage meeting between community paediatrics and CAMHS in Bury

Innovative practice questions	Details
Name of innovation (and contact)	Weekly joint triage meeting between community paeds and CAMHS in Bury
Organisation	Pennine Acute Hospitals NHS Trust
Department	Bury -Community Paediatric medical service
Area of CCH which the new service arrangement relates to	Safeguarding Neurodevelopment/ Neuro-disabilities/ Complex health needs ADHD/ASD Paediatric Audiology/ Audio-vestibular Medicine
How service arrangement fits	Relate to working across professional boundaries e.g. Paediatricians with CAMHS
Length of time	12 months to 2 years
Brief description of the new service arrangement	Community paediatrics and CAMHS have a joint triage meeting every week for an hour to make a decision regarding which team is in best position to see a child usually these are for ASD and ADHD and thus duplication of referrals to both services are avoided. We also have opportunity to discuss other difficult or complex cases with CAMHS. In general children up to the age of 9th birthday are seen by paediatrics and 9 + are usually seen by CAMHS though exceptions can happen. This pathway was started in October 2015 at the instigation of Bury CCG – No extra money was given but simply reorganising the pathway between the 2 organisations. The pathway is being revised to include local education authority at this point in time –April 2017)
The type and number of health care professionals involved (from which teams and which speciality)	Community Paediatrics: Consultants, Associates, ST4 to ST8 Trainees, - **all employed by Pennine Acute Trust** CAMHs (now known as Healthy Young Minds-HYMS) – Consultant Child Psychiatrists, Associate Specialist and CAMHS Nurse specialist- **all employed by Pennine Care NHS Community Trust**
Ways in which the new service arrangement has made a difference	• Streamlined the referrals appropriately therefore better patient experience • More efficient and effective –avoids writing detail letters of referrals – much simple referral process following the joint triage meetings and avoids duplications • Cost analysis is beyond our scope but no extra money was given or any extra PA time
Published documents to provide evidence for the new service arrangement	This was initiated at the effort of clinicians who requested the commissioners to do something about the pathway. The division of

	Paediatrics seeing up to 9 years and CAMHS after 9 years has no science behind other than experience that 9 + children's presentation tends to be more complex emotional and hence and arbitrary joint decision of who is in the best place to initiate assessment.
Lessons learned from undertaking the new service arrangement	That appropriate funding should be acquired and the pathway should be properly costed – a specific PBR should be agreed with CCG so that support services could be developed
Contact name for further information	Dr Bratati Bose-Haider, Consultant Paediatrician, Bratati.BoseHaider@pat.nhs.uk Fairfield General Hospital, Bury BL9 7TD
Evidence / links / further info	

25. Alison Livingstone - Partial booking to reduce DNA rate in conjunction with a new Paediatric triage in North of Northern Ireland

Innovative practice questions	Details
Name of innovation (and contact)	Paediatric triage for acute and community paediatrics
Organisation	Northern Health and Social Care Trust Community Paediatric Medical Service
Department	Community Paediatrics Team
Area of CCH which the new service arrangement relates to	Service Evaluation and Improvement
How the new service fits	
Length of time	Under 12 months or still in planning
Brief description of the new service arrangement	Partial booking as mentioned overleaf in conjunction with a new Paediatric triage for acute and community paediatrics jointly. All new referrals come into a single point. There are discussed at a multi-disciplinary triage meeting and every effort is made to redirect to the most appropriate service
The type and number of health care professionals involved (from which teams and which speciality)	Consultant Paediatrician acute sector (represents ADHD referrals as well as general acute paediatric referrals) Associate Specialist Community Paediatrics (considers community type referrals and also referrals which may best be managed by specific ASD team); Senior nurse manager who considers referrals which should go to an enuretic service (nurse led), Behavioural Assessment service, Health visitor etc. Referrals to AHP and audiology services are also considered
Ways in which the new service arrangement has made a difference	Referrals are channelled to the most appropriate service following triage (at triage, consideration is also given to what service the child may be open to and whether, indeed, this service may be able to manage this apparently 'new' referral). Result: More appropriate referrals being channelled to Community Paediatric Medical Service. Parents phone in to make an appointment thus they have some ownership over the timing of the appointment (partial booking). Partial booking for new referrals and partial booking also simultaneously introduced for review appointments has resulted in a dramatic fall in DNA rate and therefore an increase in capacity with an anticipated resultant reduction in waiting time to first appointment (when the service is fully resourced)
Published documents	A paper was produced within the Trust following the pilot of this process for a period of 6 months
Lessons learned from undertaking the new service arrangement	The process is ongoing however acute paediatrics have moved to etriage from GPs and only those referrals that they do not deem appropriate for the acute sector are discussed at community triage. Vice versa, if some referrals into community triage are deemed more appropriate for the acute paediatrician the children will be redirected there. Currently the triage meeting does NOT include all referrals into every service for children in the community. There are plans to develop this single point of referral into other services eg ASD service to ensure the child is being seen by the most appropriate

	person at the outset. Lengthy waiting lists in the ASD service can result in children not being referred to education services in a timely fashion, particularly true for the very young child. Community etriage has recently been introduced for GPs but has not been rolled out to other services. This single point of referral/triage continues as work in progress
Contact name	Dr Alison Livingstone, CHILD DEVELOPMENT CENTRE, Spring House, Ferrard Site, Station Road, Antrim BT41 4AB
Evidence / links / further info	

26. Udayanthi Mahamithawa - **Conner's assessment via online forms in West Lancashire**

Innovative practice questions	Details
Name of innovation (and contact)	Conner's assessment via online forms in West Lancashire
Organisation	Southport and Ormskirk NHS Trust
Department	
Area of CCH which the new service arrangement relates to	ADHD/ASD
How the new service arrangement fits into the organisational structure(s) and pathways	We now do the Conners assessment online forms being completed by school and parents via e-mail. We generate the analysis using computer software when we have received both responses. This has saved admin time, is cheaper and more accurate removing human error
Length of time the service arrangement has been running	Under 12 months or still in planning
Brief description of the new service arrangement	The online version has to be purchased (it is half the price of the paper copy) and each assessment has a unique reference number and a link to the questionnaire which is e-mailed to the parent and school. On receipt of the email the recipient has to click on the link which gives access to the questionnaire which can be completed online and returned. Once both questionnaires are returned a detailed comparative report (similar to the paper report but more detailed) can be generated at the click of a button. This is then uploaded to the patient's records. It is cheaper, saves time and removes the possibility of human error in the analysis.
The type and number of health care professionals involved	The Medical officer responsible for the patient is the only person involved. It is in a common system which can be accessed by any member of the team who can generate the report.
Ways in which the new service arrangement has made a difference	The online version is half the price of the paper version. The report is generated in a few minutes. There is no paperwork, postage cost or admin work/staff involved. The analysis of the paper version is very tedious, time consuming and there is a possibility of errors being made.
Published documents to provide evidence for the new service arrangement	None as far as we are aware. Not certain whether this is applicable in this instance as the facts are obvious.
Lessons learned from undertaking the new service arrangement	Nothing as the system is working well. Only issue is that e-mails have to be monitored to ensure forms are completed and returned. The system does not have a way of alerting you if form completion is delayed.
Contact name for further information	
Evidence / links / further information	https://www.mhsassessments.com/