

January 2009



**North East Children's Services Review**  
**Report from the Children's Services Working  
Group**

**January 2009**

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Section 1  
**Executive Summary**



# **1 Executive Summary**

## **1.1 The Children's Services Working Group**

The Children's Services Working Group (CSWG) was established to develop recommendations for a long-term, integrated and sustainable model of children's services, which is safe, of high quality and delivered in an appropriate setting. The creation of the group was prompted by concerns about the future long term viability of the existing service model for children's services provided by Surrey and Sussex Hospitals NHS Trust (SASH) on Jumbo ward in Crawley Hospital and local practice based commissioners' aspirations to develop and improve services for the relatively young and deprived population in the north east of West Sussex.

With these drivers in mind, a multidisciplinary working group of clinicians and lay representatives was established as part of the North East Review. The work of the group has been supported by all the relevant organisations including SASH and West Sussex Primary Care Trust (WSPCT) and has drawn on national developments, most notably the work of the National Integrated Children's Health Collaborative (NICHE). The changes in medical staffing on Jumbo ward and the short timescale available meant that the review focused specifically on the SASH catchment population and specialist, rather than universal healthcare services for children in the area.

The CSWG met twice a month from June to November 2008 and included representation from healthcare professionals, other agencies and parents. The areas of focus included: the Child Development Centre (CDC), Specialist Community Nursing and Child and Adolescent Mental Health Services (CAMHS). The work progressed through the following stages:

- Description and understanding of existing services
- The identification of current gaps in services and their prioritisation for action
- The development of the integrated model of care
- Testing against national guidance and best practice and peer review

The group also assumed responsibility for communicating their work to a range of stakeholders including parents. Working group members from a range of backgrounds attended the North East Review Stakeholder Forum and North East Review Panel and a co-design event was held for members of the public and other stakeholders on 17th November 2008. Feedback from these events largely reinforces the conclusions arising from the CSWG.

A separate review of services is taking place at Crawley Urgent Treatment Centre (CUTC) during 2009. There are links between this report and the review because Jumbo ward has in the past provided paediatric support to CUTC.

## **1.2 Linkage with national initiatives**

An important aspect of the work of the CSWG was to ensure that it took account of relevant national guidance and best practice. Links were established with Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity, who facilitated contact with the NICHE. This work established underlying principles and

structure for the CSWG to draw on and valuable practical advice on how to develop a local model of care.

### 1.3 Description of health services currently available

There are a number of children's services currently being provided in the north east of West Sussex that meet a diverse range of healthcare needs for children in the area:

- **Child and Adolescent Mental Health Services (CAMHS) – Sussex Partnership NHS Foundation Trust**  
This is a multi-disciplinary service which provides assessment, advice and interventions for children and young people with mental health difficulties and their families.
- **Child Development Centre (CDC) – West Sussex PCT**  
The multidisciplinary team at the CDC provides a wide range of specialist medical, assessment and therapeutic services and includes Audiology.
- **Community Children's Nursing (CCN) Team North – West Sussex PCT**  
Currently this CCN Team is part generic nurses and part specialist nurses who work with children who have a range of conditions including Diabetes and Cystic Fibrosis. They play a key role in preventing unnecessary admission to hospital and facilitating discharge.
- **CUTC – West Sussex PCT**  
Paediatric attendances make up 25% of total attendances at CUTC (approximately 12,000 cases per annum) and can be split into primarily medical or injury types; the percentage of medical cases represented approximately 56% while the remaining 44% were of minor injury type.
- **Therapies – West Sussex PCT**  
A range of therapists work with children's services in the north east including: Dieticians, Occupational Therapists, Physiotherapists and Speech and Language Therapists.
- **Paediatric Outpatient Clinics**  
Daily paediatric outpatient clinics held by SASH paediatric consultants at Crawley Hospital.

In addition, there are diagnostics to support the delivery of care.

### 1.4 Key Findings

The following main conclusions arise from the work of the CSWG:

1. There are some serious gaps in current services (identified by the working group and validated by stakeholders), and the highest priority areas to be tackled in the short term are as follows :
  - a) Accommodation - to address outstanding problems at the CDC and provide a base for CAMHS in Crawley. This also underpins the further development of the proposed model of care.
  - b) Integrating paediatric input and facilities within CUTC.

- c) Staff shortages – there are shortfalls across many of the services and ideally all need to be addressed. The CSWG has prioritised the most pressing in each service area.
  - d) Focusing on developing better transitional care (child moving to adult).
  - e) The development of integrated children’s services must be underpinned by the central administration of children’s records and the development of comprehensive information systems that can be accessed by all the relevant services.
  - f) Further work needs to be undertaken to understand the most effective way of engaging with children, their families and carers. Long term solutions that encourage ongoing participation should be established.
2. The services previously provided by Jumbo Ward (supporting children’s services in general at Crawley Hospital) will need to be adapted to ensure that high quality care is provided in the most effective and sustainable way<sup>1</sup>.
  3. The CSWG has developed an outline Integrated Children’s Health Services (ICHS) model, focusing for the time being on specialised health services (planned care) and integrating paediatric input to CUTC.
  4. Waiting times and accessibility are major issues for children and their families, and need to be addressed when developing the proposed model of care. Improving access across all its dimensions, including: waiting times, physical access, and minimising access points to the service is a core part of any sustainable solution and a key enabler of the proposed ICHS model.
  5. Commissioning children’s services needs further development across the spectrum of planning, purchasing and monitoring of services. This would include the identification of specific local commissioning intentions. A new Programme Director for Children, Young People and Maternity Commissioning is now in post at WSPCT.
  6. The proposed ICHS model looks to co-locate the following services at Crawley Hospital: CDC (including the Children’s Sexual Assault Referral Centre (SARC), community specialist nurses, therapies, SASH outpatients and CAMHS all within easy access of CUTC. The model is based on a central Crawley hub and “mini-hubs” at Horsham Hospital and Queen Victoria Hospital, East Grinstead.
  7. There are a variety of very important enablers to the development of the ICHS model and consequent provision of an optimally integrated service for the future, They can be summarised as:
    - a) Organising for integrated commissioning and delivery of services e.g. pooled budgets.
    - b) Improving information and the supporting IT systems and infrastructure at all levels: operational, commissioning and contracting and public health.
    - c) Access and availability management, for instance:
      - Developing efficient referral mechanisms so that professionals can refer to each other without needing a referral from the GP.

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<sup>1</sup> Note that this may or may not involve the use of Jumbo Ward itself.

- Ensuring that all professionals and carers know how to access the expertise available in a timely manner.
- d) Co-ordinating the various individuals and teams so that the optimum delivery of uni-disciplinary and multidisciplinary care is most appropriately and cost-effectively spread across the Crawley, Horsham and East Grinstead populations. A key element of this will be the further development of multidisciplinary clinics for long term conditions and ensuring that the same quality of care is provided, irrespective of geographical location.

## 1.5 Recommendations

### The PCT should:

1. Ensure that accommodation for children's services meets all statutory requirements and provides a safe and high quality environment for children, their families and carers. In particular, the Integrated Children's Health Service (ICHS) model services should be physically co-located at a "hub" in Crawley with possible "mini-hubs" at East Grinstead and Horsham.
2. Implement the recommendations of the recent CUTC report for paediatric nursing, as a matter of urgency.
3. Ensure that the gaps in staffing, including therapy and nursing staff are addressed to efficiently meet the demand, so that families can access services in a timely way and that meets their needs.
4. Carry out a review of current arrangements for the transition from childhood into adulthood.
5. Agree a plan for information sharing systems that includes the management of notes across services, to ensure there is continuity and consistency of care.
6. Ensure the other gaps identified are being, or will be addressed in a co-ordinated fashion according to clearly understood Primary Care Trust (PCT) and Practice Based Commissioning (PBC) priorities, and that this is fed back to the CSWG.
7. Continue to support the redesign of services previously provided on Jumbo ward. This process should be managed with reference to the emerging ICHS model and the ongoing work around the future of the CUTC. For example:
  - a) Minor illness and injury services will continue to be provided at CUTC
  - b) Paediatric surgery will remain at East Surrey Hospital (ESH).
  - c) Review the current phlebotomy service to ensure that it meets the needs of all children, in particular those with more complex needs.
8. Develop local commissioning requirements and priorities for children's services.
9. Develop the proposed integrated health model with co-located specialist health services to improve the experience of children with complex and specialist needs. Specialist child and adolescent mental health services need to be part of this service.

10. Co-ordinate associated developments, for example, an appropriate member of the CSWG should be included on the working group considering issues around CUTC.
11. Support regular dialogue between the ICHS model implementation programme and the NICHE; consideration should be given to becoming a pilot site.
12. Implement arrangements to ensure the voice of children and their families has greater say in the design and delivery of services to ensure the services meet their needs.



Section 2  
Background and context  
for this report



## **2 Background and context for this report**

### **2.1 Purpose of this report**

This document details the outputs of the Children's Services Working Group (CSWG), established as part of the North East Review, chaired by Sir Graham Catto. It presents the drivers for change, the work and findings of the group and the associated recommendations for further action.

An executive summary of this document is included in the full North East Review Report, presented to the North East Review Panel in December 2008 and on the WSPCT Board agenda for January 2009. This is to ensure that issues concerning children's services are reflected in the full report. This document is designed to be a standalone document showing the detailed outputs of the CSWG.

### **2.2 Acknowledgements**

Thanks are extended to all those people who helped with and contributed information to this report, including:

- The Children's Services Working Group
- The Stakeholder Forum
- Attendees at the 17<sup>th</sup> November 2008 Co-Design Event at K2 in Crawley

### **2.3 The Children's Services Working Group (CSWG)**

#### **2.3.1 Background and terms of reference**

The CSWG was established to develop a recommendation for a long-term, integrated and sustainable model of children's services, which is safe, of high quality and delivered in an appropriate setting. The creation of the group was prompted by concerns about the future long term viability of the existing service model for children's services provided by Jumbo ward in Crawley Hospital and local practice based commissioners' aspirations to develop and improve services for the relatively young and deprived population in the north east of West Sussex.

With these drivers in mind, a multidisciplinary working group was established as part of the North East Review. The work of the group has been supported by all the relevant organisations including SASH and WSPCT and has drawn on national developments, most notably the work of the National Integrated Children's Health Collaborative (NICHE). The terms of reference for the working group are presented in Appendix 1.

The CSWG was also asked to consider local commissioning intentions – see sections 2.5 and 5.7.2 for more details.

The executive sponsor for this work was Brian Hughes, Director at WSPCT.

### **2.3.2 Process followed**

The CSWG met fortnightly from June 2008 until the end of November 2008. Individuals also undertook work between the meetings.

The group work consisted of the following stages:

- Description and understanding of existing services
- The identification of current gaps in services and their prioritisation for action
- The development of the integrated model of care
- Testing against national guidance and best practice and peer review

The main tasks of the working group were to map and clarify current service provision, identify and prioritise for action existing gaps in children's services and develop the proposed integrated model of care. The ongoing issue of maintaining sub acute children's services (Jumbo Ward at Crawley Hospital) was addressed separately.

The working group has considered the ongoing work of NICHE, in order to ensure that its findings are in keeping with national thinking and best practice.

### **2.3.3 Membership of the CSWG**

The membership was primarily composed of representatives of the main health services involved and included representation from Community Nurses, Consultant Paediatricians, Child and Adolescent Psychiatrists, GPs, Public Health specialists and Psychologists. There were also two parent representative members. Commissioner representation was also included. The full membership list is included in the terms of reference Appendix 1.

The group was chaired by Amit Bhargava, a local GP representing local Practice Based Commissioners (PBCs). When appropriate, the group called on input and expertise from a wider group including representatives from Education and Social Care.

## **2.4 National drivers for change**

An important aspect of the work of the CSWG was to ensure that it took account of relevant national guidance and best practice. Links were established with Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity, who facilitated contact with the National Integrated Children's Health (NICHE) Collaborative. The purpose of this collaborative is to bring together a range of professionals across providers and commissioners of children's health services in England in the pursuit of a range of sustainable and appropriate solutions for integrated children's health care.

NICHE has identified that the current healthcare model, delivered through geographically and organisationally separate primary and secondary services, is not providing optimum services for children. There are particular problems around out-of-hours unscheduled care and the delivery of long term care for some conditions.

Some of the reasons behind these issues are outlined in *Children's Integrated Healthcare – a New Model for Co-operative Service Provision (2008)*<sup>2</sup>

A major proposal from NICHE is therefore to establish Children's Integrated Healthcare centres that would provide a range of planned and unplanned services delivered by a range of healthcare and other professionals. These centres would focus on developing community based care and a better informed more empowered patient (and carer) population. They would provide local services outside an acute hospital setting and could provide a variety of services, some of which are outlined below:

- Unscheduled care – meeting gaps in local out-of-hours care
- First-line referral clinics – accessible, high quality care for common paediatric problems e.g. asthma, allergies, constipation and eczema
- Follow-up clinics – primarily for long term conditions such as diabetes
- Referral clinics – for additional advice for those conditions generally managed in Primary Care
- Child Development Services
- Mental health clinics
- Health promotion
- Family support

NICHE has identified a range of possible benefits arising from the suggested model and the headline benefits can be summarised as:

- Improved experience for the child and family
- Improved quality and efficiency of clinical care and training
- Opportunity for further integration with associated health partners working with children

Further details on the work of NICHE, particularly around the benefits of the model can be found in Appendix 2.

## **2.5 Local commissioning situation**

Commissioning for children's services appears in the PCT's Strategic Commissioning Plan (SCP) 2009-2014<sup>3</sup>, details of which can be found in its Appendix C.4. However, this commissioning plan tends to refer mainly to national guidance such as Every Child Matters (2004)<sup>4</sup>, rather than detailing specific local intentions. With the new commissioner for children's services now in post at West Sussex PCT, it will be possible to further the development of commissioning in this area.

The CSWG attempted to incorporate some more specific commissioning issues into their work via a sub-group meeting. Particular issues that the sub-group highlighted are shown in section 3.5

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<sup>2</sup> Hilary Cass and Ingrid Wolfe, National Integrated Children's Health (NICHE) Collaborative Steering Group, April 2008.

<sup>3</sup> <http://www.westsussexpct.nhs.uk/about-us/commissioning/>

<sup>4</sup> <http://www.everychildmatters.gov.uk/>

## **2.6 Public health report - the impact of the wider determinants on child health in the north east area of West Sussex**

This section outlines relevant demographic and population risk factors associated with the north east area of West Sussex which should be taken account of when planning or redesigning services for children and is presented in full in Appendix 3. The factors which have been found to have the most significant influence on inequalities of health are widely known as the determinants of health. While health services make a contribution to reducing health inequalities by improving access and health outcomes, most of the key determinants of health lie outside the direct influence of health service providers, for example: education, employment, housing and environment.

Different groups and categories of people have very different experiences of the determinants of health and these different experiences can have an effect on their personal health. Some of the groups and categories involved are well known – in particular, gender, class, ethnic group, age and geographical area. Others might be less obvious – such as disability, single parenthood, quality of school, age of housing stock.

As poverty and social inequalities in childhood have profound effects on the health of children and this continues to reverberate throughout the life course into late adulthood (Spencer 2008), the CSWG has taken the local population structure into consideration during the development of the proposed model of care.

It is acknowledged that to fully address the impact of wider determinants effective links with partner agencies (statutory and voluntary) will need to be established and/or developed to ensure a fully integrated service in the future.

## **2.7 Current Services**

There are a number of children's services currently being provided in the north east of West Sussex. These services provide services for children with a diverse range of healthcare needs.

### **2.7.1 Child and Adolescent Mental Health Services (CAMHS)**

The Child and Adolescent Mental Health Service (CAMHS) is a multi-disciplinary service which provides assessment, advice and interventions for children and young people (up to the age of 16, or sometimes up to 18 if in full time education) with mental health difficulties and their families.

The service aims to promote the emotional, behavioural, social and psychological health of children, young people, their families or carers and to diagnose and treat mental disorders and work therapeutically with young people experiencing mental health difficulties. CAMHS works towards creating a context in which professionals support families in understanding their difficulties and discovering solutions to them. Where solutions cannot be found, the service supports and assists the development of more effective management.

In addition to offering individual, family and group therapy to clients within the CAMHS clinics, CAMHS provides specialist services and also works in collaboration with other agencies, offering consultation, advice and training where appropriate. Currently, the service in the north east of West Sussex is based in Horsham and

includes specialist CAMHS Services and Primary Mental Health Workers who offer a range of services including:

- Consultation, joint work and training to Primary Care Professionals.
- Direct work with children, young people and families.
- Interface between primary care and specialist teams and a specialist CAMHS Services.

### **2.7.2 Child Development Centre (CDC)**

The CDC covering Crawley and Horsham serves a population of 57,000, from birth to 19 year olds which represents almost a third of West Sussex total.

The multidisciplinary team at the Child Development Centre provides a wide range of specialist medical services which include:

- Tertiary epilepsy service
- Botox treatment for cerebral palsy
- Audiology and hearing aid provision, including neonatal hearing screening and follow up
- Neurodevelopmental assessment and management.
- Assessment of
  - Speech and language disorders
  - Autism
  - Complex feeding difficulties
  - Physically, emotionally and sexually abused children, including forensic medical examinations
- Management of
  - chronic neurological disease
  - life limiting conditions
  - children with gastrostomies and tracheostomies
- Medical support for adoption and fostering
- BCG Immunisation programme
- Tertiary Paediatric Neurology Clinic
- Tertiary Paediatric Orthopaedic Clinic
- Paediatric Orthotics
- The CDC also works closely with colleagues in the specialist paediatric community nursing team and helps to keep terminally ill children at home, and reduce admission to hospital in those with chronic conditions. Close working relationships are also maintained with acute paediatricians.
- The CDC also provides medical input to and oversees Holly Lodge Respite Centre.

The CDC team includes:

- Physiotherapists
- Occupational Therapists
- Speech and Language Therapists
- Paediatric Dietician
- Children's Community Nurses
- Audiologists
- Orthotist
- Doctors
- Visiting specialists in neurology, orthopaedics, epilepsy and audiology

- Administrative/clerical staff (including the Child Health Bureau in Chichester)
- Volunteers

There is close liaison with health visitors, school nurses, and all other statutory and voluntary agencies working with children, such as social services, education, police, mental health and voluntary bodies.

### **2.7.3 Community Children's Nursing Team North**

This team is based at Crawley Hospital and covers children in Crawley, Copthorne, Crawley Down, Horsham (and surrounding areas) and East Grinstead. Currently this CCN Team is part generic nurses and part specialist nurses including Diabetes Nurse Specialists, Cystic Fibrosis Nurse Specialists, Complex Needs Nurse Specialists, Allergy Nurse Specialists, Nurse Counsellor and nurses with a special interest in epilepsy, oncology and constipation.

The team's main functions are to:

- Enable safe and effective discharge from hospital.
- Prevent admission or readmission to hospital.
- Enable children to receive quality nursing care at home.
- Maximise the overall well-being of children and to promote optimal health.
- Enhance the quality of life for children and their families.
- Provide or access specialist paediatric equipment to enable the child to be cared for at home.
- Improve communications between community and acute services.

### **2.7.4 Crawley Urgent Treatment Centre (CUTC)**

Crawley Urgent Treatment Centre provides services to a large population area with a relatively high level of deprivation. It is estimated that the total annual attendees is around 49,000 with paediatric attendances representing approximately 25% of the attending population or approximately 12,000 cases per annum. Paediatric attendances can be split into primarily medical or injury types; the percentage of medical cases represented approximately 56% while the remaining 44% were of minor injury type. The emergency nurse practitioners, doctors and nurses working in the CUTC are competent in dealing with children with minor injuries and minor illnesses and are able to discuss cases with the appropriate specialty. They are able to treat when appropriate, recognise the serious conditions, which in turn they will stabilise and transfer accordingly.

### **2.7.5 Therapies**

A range of therapists work with children's services in the north east including:

- Dieticians
- Occupational Therapists
- Physiotherapists
- Speech and Language Therapists

### **2.7.6 Short Break Unit**

Holly Lodge is a residential short breaks unit in the ground of the Queen Elizabeth II School in Horsham, operated by West Sussex Health. It caters for children and

young people from birth to aged 19, who have a severe learning disability together with complex health needs. They are then allocated a set number of nights per month according to the child and family's needs. Holly Lodge comprises a six-bedded unit and provides a range of specialist facilities including specialist beds for a range of needs, overhead tracking for hoists, specially adapted bathrooms, a soft play room and a sensory room. The unit is staffed by qualified learning disability nurses and health care assistants. The service is part of the integrated specialist children's service and receives support from the local Consultant Community Paediatrician and the Community Children's Nursing Team.

### **2.7.7 Diagnostics**

Children's services at Crawley Hospital have access to and use the services below:

- X-ray
- MRI
- CT
- Ultrasound
- ECG
- Echocardiography
- EEG
- Microbiology
- Biochemistry
- Haematology
- Cyto-genetics and DNA lab
- Highly specialised blood and urine tests e.g. white cell enzymes, urine GAGs etc
- Phlebotomy
- IT systems which allow access to results such as APEX and PACS
- Brainstem Auditory Response Measurement as part of the diagnostics in Audiology
- EME for repairs and calibration of equipment
- Pharmacy

## **2.8 Issues concerning Jumbo Ward**

Although this is not the main focus for this report, it is helpful to include a summary of the current situation and background regarding this service.

### **2.8.1 Services provided by Jumbo Ward (before August 2008)**

Jumbo Ward at Crawley Hospital provided a range of services to the population of Crawley and the surrounding area. Outlined below are the main services provided before changes to medical staffing in August 2008:

- Clinical review of sick children (referred by GPs).
- Observation – for example, caring for children with diarrhoea and vomiting.
- Day Surgery - for example, tonsillectomy
- Support to CUTC - staff available to advise on the care of sick children.
- Passport Patients (patients already known to the service).
- Phlebotomy (obtaining blood samples).

In addition, there were consultant outpatient services on most days and the ward was open from 8 am to 6 pm Monday to Friday.

### **2.8.2 Problems with maintaining medical staffing from SASH**

During the summer of 2008, SASH experienced difficulties relating to the appointment of both middle grade training and Trust grade medical staff within paediatrics. There is a significant, national shortage of junior doctors wishing to specialise in paediatrics which has been exacerbated by:

- Changes in the way junior grades of doctor are trained and recruited
- Legislation that restricts recruitment of overseas staff to the European Union.

These constraints posed a particular challenge to SASH in terms of running a compliant rota across both East Surrey and Crawley Hospital sites. As a result, an interim solution – the situation at the time of writing this report – was adopted as outlined below.

### **2.8.3 Services provided by Jumbo Ward (after August 2008)**

The challenges associated with providing medical staffing cover on Jumbo ward meant that an interim solution had to be found by SASH and WSPCT:

- Daily (Monday to Friday) outpatient consultant led clinics at Crawley Hospital that include a number of rapid access slots. These slots are for children who require an urgent review but are not acutely unwell and requiring immediate attention.
- A new paediatric phlebotomy service at Crawley.
- Children who have minor injuries and are not acutely unwell could still be taken to CUTC (24 hours a day, 7 days a week).
- Acutely unwell children should attend A&E at ESH. GPs can refer directly to the Children's Assessment Unit (CAU) at ESH.
- Paediatric surgery at East Surrey.

This is the current configuration of services that remains in place until the proposed integrated model of care can be implemented. The future of the services previously provided on Jumbo Ward is outlined in section 7.

## Section 3

# Gap Analysis



### 3 Gap Analysis

This piece of work was done by the CSWG to identify current gaps in services. Members of the CSWG were asked to identify any gaps in current services when compared against either local priorities or national best practice/guidance for example NICE guidance or national guidance on staffing levels.

#### 3.1 Gap analysis results

Gaps were identified by members of the working group and covered a wide range of services, details of these gaps can be found on WSPCT North East Review website<sup>5</sup>.

#### 3.2 Prioritising the gaps

The number of gaps identified meant that there was a need to highlight the priorities for action for the North East Review Panel (see Section 4). Given that the gaps had been identified by individuals (largely focusing on their own services), it was then important to ensure the prioritisation reflected an objective consensus from the group.

Consequently, a set of five criteria were identified which were used to derive a score for each gap. The importance of the gap – and thus its priority – would be determined by the score.

The five criteria used are:

- risk
- health benefit
- impact on patient experience
- Impact on staff experience
- Improved access

These were also chosen by the working group to reflect what the integrated children's service is trying to achieve.

All criteria were scored from 0 to 10 (where 0 is of no significance and 10 where it is maximally significant to the gap/solution in question). The scores for each criterion were then totalled for each gap out of a maximum of 50 points. The higher the score for a gap (or the suggested solution to address it), the higher the priority.

Scores for each gap were calculated by individual members of the group. Where feedback was provided by more than one member of a service e.g. CAMHS and CDC, an average was used to avoid (as far as possible) the results being biased by having more than one response from one service. A list of gaps in descending order of scores was then collated and the full list is shown in section Appendix 4. The top ten gaps by score are outlined in the table on the following page.

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<sup>5</sup> <http://www.westsussexpct.nhs.uk/about-us/north-east-review/>

<b><u>Number of gap</u></b>	<b><u>Summary of Criteria from Gap Analysis Table</u></b>	<b><u>Average Score out of 50</u></b>
17	Community paediatrics - clinical staff shortages	39
34	CUTC	39
8	Children's and Young People Cancer Care	38
5	Children and young people with epilepsy	38
22	CDC - Accommodation	37
62	Transition from Children's to Adult Services	37
9	Children with challenging behaviour / autistic spectrum in Crawley and Horsham	36
36	Occupational Therapy	36
47	Services for children with learning disabilities	36
11	Children and Young People requiring end of life care	35

It is of note that the top ten gaps cover a relatively small range (39 to 35 out of 50) which indicates the breadth of important issues which need to be addressed. The prioritised gaps were then discussed at the CSWG meeting on 6<sup>th</sup> November and refined into a final top set of priorities for action to be recommended to the North East Review Panel. It should be noted that the CSWG believes all the gaps are important to address, not just those which constitute the priorities for action.

### **3.3 Reviewing gaps and priorities with stakeholders**

The gaps identified and prioritised for action by the group were then discussed at the Integrated Children's Services Model Co-design event on 17<sup>th</sup> November (further detail can be found in section 6). There was a broad consensus amongst the stakeholders attending that the gaps identified by the group were the ones which required the most urgent action. The need to provide support systems e.g. IT and record management systems was another area that was highlighted.

### **3.4 Reviewing gaps against current PCT operational plan**

The gaps identified by the CSWG have been cross-checked with the PCT Operational Plan in order to identify any areas which are currently being, or planned to be addressed as part of other initiatives within the organisation.

### **3.5 Gaps in commissioning**

This was not the focus of the CSWG, but it was considered to be important to the development of the proposed model and was discussed at a sub-group meeting. It was acknowledged that at the present time, there is often a lack of detail associated with commissioning in this area. The process of addressing this and the other issues identified should commence now that the new Programme Director for Children, Young People and Maternity Commissioning is in post.

The subgroup concluded that there should be integrated commissioning to support the development of the proposed model, to enable more detailed planning, purchasing and monitoring of services. The other main points are summarised below and fall under three main headings:

#### **3.5.1 Access to services**

- GPs' made a number of comments about the "high" threshold for accessing CAMHS services, particularly for children with emotional or behavioural difficulties
- Prevention should be included in the proposed model at some point, though this is not the immediate focus
- Demand management should play a role in commissioning, as some groups of children will generate greater or lesser demand for services. For example, should services increase across the board or should investment be targeted on particular groups to generate the greatest health benefit?

#### **3.5.2 Information**

- There is a shortage of information available to inform commissioning planning, purchasing and monitoring (this is also reflected in the gap analysis from the perspective of service providers)
- A significant issue for commissioners is the lack of information on who actually uses services e.g. public health monitoring
- Key data items for public health are postcode, age, GP, ethnicity and gender.
- The need to identify ways of monitoring the effectiveness and quality of the service provided e.g. re-attendance rates.

#### **3.5.3 Principles underpinning commissioning for children's services in the North East**

- The need to account for diverse commissioning requirements in the north east of West Sussex e.g. rural (Horsham) and BME issues (Crawley).

- The need to provide outreach services to populations who may currently not access services and address the reasons for the failure to access services such as culture or geographical location
- Equitable access and addressing inequalities should be principles that underpin the model
- Services should be simple to access and the population should be made aware of how to access services
- Providers and commissioners need to work more closely together, particularly around developing standards of care
- Commissioning in this area needs to account for other associated strategies, particularly the estates strategy for Crawley Hospital.

## Section 4 Priorities for action



## 4 Priorities for action

These are the gaps that scored highest. They are focused on addressing current shortfalls in services. However, there are a number of other important areas that are vital to enabling the ICHS model and the integrated service commissioning, planning and delivery that goes along with it. These areas are highlighted in section 5.7.

### 4.1 Priority One - Accommodation

The CDC has outstanding Health and Safety and Manual Handling reports that detail problems that have to be addressed. The CSWG acknowledged the importance of resolving these outstanding issues in order to ensure the safety of children, their parents and staff working within the department. For example, the department lacks a hoist facility which means that parents and staff have to lift young people from their wheelchairs, in order to undertake their treatment. There is also inadequate space available in the department to allow it to function safely and effectively, examples include:

- Children and their parents waiting in cramped corridors
- A lack of privacy for medical examinations for children subjected to abuse/neglect, as well as an absence of appropriate interviewing facilities

This is also the most important gap identified because a significant proportion of the other gaps cannot be addressed until accommodation issues in general have been resolved. Throughout the process, the group has placed great emphasis on the advantages of co-locating some services which would allow the provision of more holistic and more organised healthcare for children, for example including psychological input to clinics e.g. diabetes. A crucial part of this process would also be to establish a base for CAMHS with existing paediatric services; currently CAMHS has no base in Crawley.

### 4.2 Priority Two – CUTC specialist paediatric staffing

This is a priority because there is currently a lack of specialist paediatric cover within CUTC and this is a core part of the proposed integrated model of care. There are no paediatric trained nurses at CUTC. This is contrary to the National Service Framework for Children<sup>6</sup> which states that specialist staff are required. Nurses and doctors on Jumbo Ward previously partially compensated for this gap, but Jumbo Ward was never designed to provide support for sick children in CUTC. This situation emerged over time, rather than being developed systematically around best practice.

In order to develop the unscheduled aspect of the proposed model and address the current patient safety risks (due to the absence of specialist paediatric cover in CUTC) paediatric staffing needs to be addressed as a matter of some urgency. This is highlighted on page 8 of the recent CUTC review report<sup>7</sup> as follows:

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<sup>6</sup> Department of Health.

<sup>7</sup> West Sussex PCT: Review of Crawley UTC: September 008 -<http://www.westsussexpct.nhs.uk/about-us/north-east-review/>

*“There are no paediatric Emergency Nurse Practitioners (ENP’s) working in the UTC. In view of the significant paediatric workload in the UTC there ought to be staffing with doctors who can assess these children and nurses qualified to nurse them (ideally paediatric ENPs supported by an experienced GP).*

*Recommendation: The optimum model would be to have increased paediatric nurse cover in the UTC (whilst ideally pursuing appointments of paediatric ENP’s), supported by a GP (or General Practitioner with Special Interest (GPSI) in paediatrics – although these are rare and may be too specialised) and consultant paediatrician presence in the UTC e.g. in reach via routine/rapid access clinics”.*

### **4.3 Priority three - Staffing**

The group noted that the majority of the gaps identified were staffing shortages which impact directly on the ability to provide a range of services and meet the associated local priorities and national best practice/guidance. It was agreed that in terms of overall reporting to the North East Review, staff shortages should be considered as one priority gap, but there should be clear guidance on which staffing gaps need to be filled most quickly and why. To facilitate this, each service was asked to prioritise the most urgent shortfalls in staffing and these are outlined below in priority order for each service.

#### **4.3.1 CAMHS**

- 1) Children with Depression -1 x 0.5 WTE Associate Specialist Psychiatrist, 1 x WTE Band 7 Nurse, 2 x WTE Band 6 Nurses, 1 x 0.5 Band 7 Psychologist
- 2) 24/7 Cover - 3 x WTE Band 6 Nurses
- 3) Children with LD/ASD/psychological support to Paediatrics - 1 x0.5 WTE Band 7 Psychologist, 2 x WTE Band 7 Nurses
- 4) BME worker for Crawley - 1 x WTE Band 6 Mental Health Practitioner
- 5) Eating Disorders - 2 x WTE Band 6 Nurses
- 6) Psychotherapy for children needing longer term work - 1 x WTE Band 8a Psychotherapists
- 7) ADHD - 2 x WTE Band 6 Nurses
- 8) Mental health in schools 1 x WTE Band 7 Primary Mental Health Worker, 2 x WTE Band 7 Development Primary mental Health Workers

#### **4.3.2 CDC**

- 1) Clinical staff - Consultant Community Paediatrician 2.0 WTE, Associate Specialist in Community Child Health 1.2 WTE, Staff Grade Paediatrician 1.2 WTE including Audiology
- 2) Secretarial, administrative and clerical staff, 2.0 WTE Band 3 Medical Secretaries and Audiology 1.0 WTE Band 3
- 3) Epilepsy nurse 1.0 WTE

- 4) Lack of other health professionals, for example, speech and language therapists, occupational therapists

### **4.3.3 Community Children's Nursing**

- 1) Allergy Nurse Specialist, 1.0 WTE (band 7/6)
- 2) Epilepsy Nurse Specialist, 1.0 WTE (band 7)
- 3) Generic Specialist Community Children's Nurse, 1.0 WTE (band 7/6)  
(Children and Young People's Cancer care)
- 4) Secretarial support, 0.54 WTE (band 3/2)
- 5) Complex Needs Specialist Nurse, 0.5 WTE (band 7)
- 6) Nurse Counsellor, 0.2 WTE (band 7)
- 7) Bank Hours for the winter months for Bronchiolitis babies, 0.5 WTE (band 6)
- 8) Community Children's Nurse, 1.0 WTE (band 6) (Extend working to provide longer cover for end of life care)

## **4.4 Priority four - Transition from children's to adult services**

It was noted that this was a gap for both physical and mental health/learning disabilities. Done poorly, young people (and society in general) suffer from the complications of their disease. Done well, the transition maintains their health and wellbeing. Poor transitional care can thus have financial and forensic costs. Early planning is needed to prevent this.

A need for a "Young People's Service" was identified to provide continuity of care, covering emotional, as well as mental and physical health needs.



Section 5  
The Integrated Children's  
Health Service (ICHS)  
Model



## 5 The Integrated Children’s Health Service (ICHS) Model

This section focuses on the future and describes what an integrated service will look like. It is important to recognise that there is already a considerable amount of integrated working between the various professionals involved. The model described here aims to build on these arrangements and provide a focus for the health-oriented services.

The proposed model is still very much a work-in-progress and there is much to do in order to deliver an integrated set of services across Crawley, Horsham and East Grinstead. The main workstreams necessary are shown in section 5.7.

### 5.1 Purpose and focus

The scope of children’s services is very broad, including: health, education, social care and voluntary organisations. Given the diversity of services that could be included and the limited timescale, the CSWG decided that its initial focus would be on healthcare aspects of the model. This does not mean that the other elements are any less important but the scope chosen here reflects the urgent need to address healthcare aspects of the model first

The Working Group has created a single statement that reflects the purpose and focus of the desired future service.

*“The **integrated** children’s service (model) provides a **range of services** (provided for the children, families and carers of Crawley, Horsham and East Grinstead) that are **simple to access** and that meet their **health needs** (physical, psychological and emotional) in a **holistic, timely and cost-effective manner.**”*

Certain key phrases within this statement have been highlighted in bold and are explained more fully as follows:

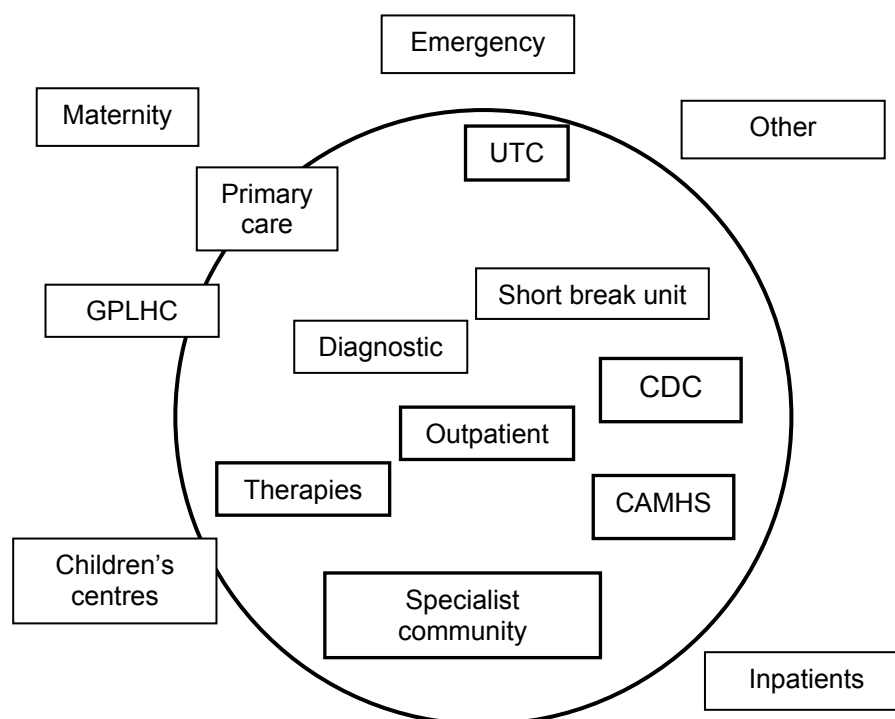
Integrated	<p>The elements work closely and effectively together to provide what patients, their families and carers need, without special efforts being required to make things happen.</p> <p>For each service what professionals need to physically work together at point of interaction with child, why and how much of the activity this represents.</p>
Range of services	<p>The model focuses on health needs and thus comprises health services (physical and mental health). It does not detail other services such as social services, education, housing and the voluntary sector. However, it is acknowledged that the model may well expand to include these agencies.</p>
Simple to access	<p>How we make access easy for those that need it, but also ensure that access mechanisms and information help facilitate effective use of the service e.g. making best use of patient and staff time.</p>

Health needs	What are the highest priority needs that we are catering for in our ICHS model and what information do we need to use and/or generate to help us quantify this?
Holistic	This needs to be described in greater detail, from the perspective of both the child their parents and carers and the professional. This could include care that is targeted to remedy and avoid health problems, as well as taking into account the wider social, educational needs of the individual and family. Service gap analyses should identify where problems and issues with social services and education impact most on health care.
Timely	<p>There are several factors to cover here:</p> <p>Efficiency of process e.g. waiting times, decision turn-round times in order to minimise delays and ensuring all necessary information is present to inform decisions.</p> <p>How to set expectations as to what is timely. The model will explicitly define “timeliness” for each of the constituent services.</p>
Cost-effective	<p>How will the ICHS model and the improvements within it deliver and demonstrate value for money?</p> <p>Quality of care would feature here.</p> <p>Patients, their families and carers should know where they stand in the process/cycle of care at all times</p>

## 5.2 Scope of the model

The scope of the model described in this section is non-acute health services for children. Specifically CAMHS, home care, primary care, community care, outpatients and acute assessment (specialist assessment/observation, urgent treatment centre, and urgent psychological assessment). It excludes acute hospital inpatient services and emergency services at a hospital A&E (where a hospital inpatient admission is likely).

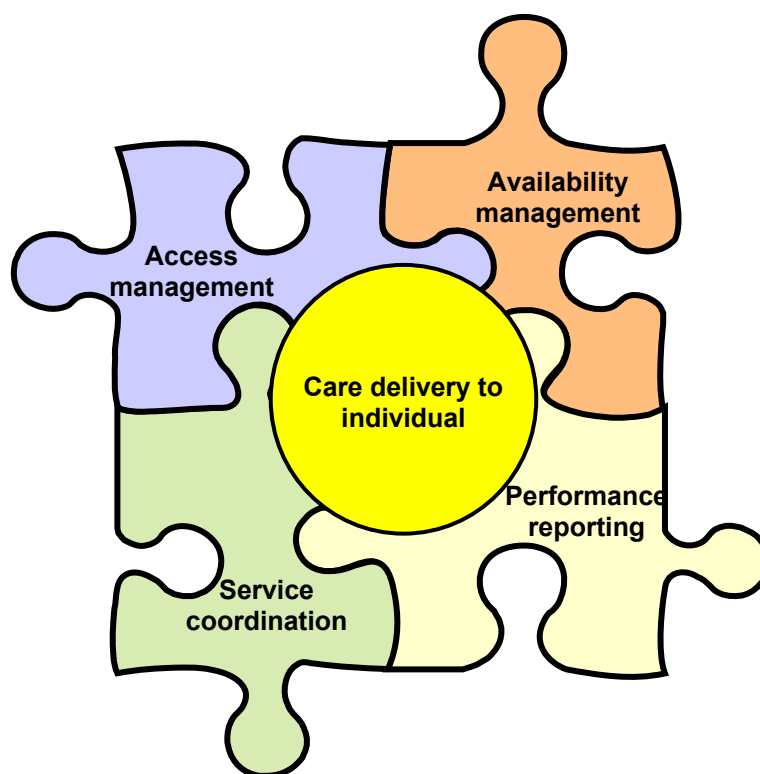
The service elements or facilities shown inside the circle are the focus areas of the ICHS. Within this, the CSWG identified those services that are a priority to co-locate and these are highlighted in bold in the diagram. For scheduled care, the ICHS is focused on specialised services. For urgent care, it is encompassed within universal services.



## 5.3 Integrative elements of the model

The following diagram shows key essential elements that need to “fit together” in order to deliver an integrated service. It identifies areas that need to be managed effectively in order to deliver high quality care which in turn supports care delivery to individual children.

This approach should help to focus on key objectives for improvement, commissioner priorities, and prioritising gaps.



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Essential function	Purpose/Content
Access management	<p>How access to the service is managed. Delivering the “simple to access” principle.</p> <p><u>Example items:</u> Entry points and referral criteria/mechanisms Main pathways Simple (uni-disciplinary) and complex (multi-disciplinary) One-off and ongoing care</p>
(Service) Availability management	<p>Maintaining and communicating an up to date and accurate picture of what services are available for both patients/carers and staff.</p> <p>Directory of services Live availability – what is available now?</p>
Care delivery to individual children	<p>Patient care on an individual basis:</p> <p>Case initiation Diagnosis Treatment and management Discharge</p>

Essential function	Purpose/Content
	What is the best environment to deliver care?
Service co-ordination	<p>Intra and inter-service coordination to enable “seamless” care delivery without families having to make this happen.</p> <p>How and where teams/agencies interwork            Booking appointments            Patient administration and documentation            Service transfers</p>
Performance reporting	<p>Distinct aspects covered here:</p> <ul style="list-style-type: none"> <li>• Patient-related outcome measures to demonstrate the difference that care interventions are having. Integrated care reporting for patients/ carers/ families.</li> <li>• Patient’s logbooks.</li> <li>• Patient/carer experience and satisfaction with services</li> <li>• Service level performance reporting covering outcomes, activity and contract monitoring.</li> </ul>

#### 5.4 What does integrated working look (and feel) like for staff?

- It should be developed around the “Team around the Child” approach.
- Everyone understands their role (and each other’s) and when they need to physically be together.
- There should be a shared purpose, driven by clear outcomes.
- An integrated service would exploit the benefits of both physical and virtual teams.
- At any one time each professional may be part of different teams.
- Anyone can be the lead professional and this would be determined by what is most appropriate to the child’s situation.

#### 5.5 What does integrated working look (and feel) like for children/families?

- Each child would have a key person.
- Children and their parents/carers would feel part of the team with genuine input and influence over their care.
- Children and their parents/carers would have influence the decision over who their key professional.
- Both child and carer perspectives are taken into consideration.
- Service is simple to access and use.
- There should be clear care pathways and all stakeholders should know where the child is on their care pathway at all times.

## **5.6 Enablers**

Enablers are those factors that need to be in place in order to underpin the successful implementation of the ICHS. Two of the key enablers are:

- There should be a shared vision of and ownership/commitment to the service.
- There should also be structural / management enablers such as single provider organisations.

## **5.7 The need for an implementation programme**

This brings together the key recommendations regarding implementing the ICHS model.

### **5.7.1 Phasing the programme**

The programme could be in two main phases. Phase 1 would concentrate on the implementation of the health services aspect of the proposed model, described in section 5.2 i.e. core services working effectively in appropriate premises with defined hub and spoke operations across the 3 main population centres. Phase 2 would extend the core service model to other services including education and social care and the voluntary sector. There could probably be some overlap in these phases.

### **5.7.2 Workstreams**

The implementation programme needs to be comprehensive, as there are many elements that need to come together to create an integrated and working whole. The main workstreams are described below:

#### **Developing the care model / pathways / hub and spoke functionality**

Currently, the model is more structural than functional i.e. it focuses on the service elements themselves e.g. CDC, CAMHS. However, it is the functionality that now needs to be specified in greater detail in order to implement the model, such as the care pathways and inter-working arrangements across the services. As part of this process, it will be necessary to review those services that support the ICHS model, to ensure that they integrate (as seamlessly as possible) with the ICHS; diagnostic services e.g. phlebotomy and specimen collection are two examples of this. Further work is also required on how to design the various types of multidisciplinary team or one-stop type interventions. Multidisciplinary team pathways need reviewing and if necessary designing; potential examples of this include: Autistic Spectrum Disorder (ASD), complex needs, diabetes and obesity.

Significant further work is also needed to define the most effective way of delivering services across the area of Crawley, East Grinstead and Horsham. A hub and spoke (or mini hub) approach will be adopted to ensure equity of access, irrespective of location.

#### **Building the enabling components for integration**

The key essential elements that underpin the proposed model: access management; availability management, service coordination, performance reporting could all be workstreams for the implementation plan.

Access management will be one of the major themes of the implementation plan. The difficulties associated with ensuring timely access to services have been highlighted by the CSWG and reinforced by comments from the Stakeholder Forum and co-design event. Part of this work will include ensuring that all professionals and carers know how to access the most appropriate expertise available, in the timeliest manner. Managing access will also have to tackle the issue of developing efficient referral mechanisms that avoid dependence on GP referrals.

Access management is closely linked to availability management and these workstreams could be merged in an implementation programme. The availability management stream would focus on issues such as extended service hours e.g. CAMHS moving to 7 day working.

A key aspect of the service co-ordination workstream would be organising individual healthcare professionals and multidisciplinary teams to deliver high quality, cost effective care across the Crawley, Horsham and East Grinstead populations. For example, service co-ordination is particularly important in the design and management of one-stop clinics.

### **Commissioning and Finance**

WSPCT and West Sussex County Council (WSCC) need to organise for integrated commissioning and a local commissioning plan needs to be produced, endorsed by the PBCs.

Further work is required on how financial arrangements could support the ICHS. There are finance questions to be addressed, for instance, what is the available finance for services? Should consideration be given to pooling WSPCT and WSCC budgets? Is one or more business cases required for the ICS model or elements of it?

### **Producing a “working together” specification**

In the short term, action is required to ensure that accommodation meets the necessary standards and a location is chosen for the Crawley hub operation base. It will be important to first develop a functional specification for teams working together, from which the functional content and accommodation schedule can be produced. This piece of work will need to link in with the Estates development plan for Crawley Hospital.

### **Information/IT**

This is a key enabler and feeds into all the essential components as well as commissioning. There is a dearth of useful information easily available on which to commission, plan and manage services. This is in part due to poor IT systems. Thus this workstream is necessary in order to co-ordinate improvements to information and IT systems over the next few years. The workstream will need to encompass reviews of information at all levels – operational, commissioning and contracting, and public health.

## **Integration with other service providers**

Phase 2 mainly, but any short term gap-fillers should be addressed too.

Given the impact of Education and Social Care on health services for children, consideration of the interface between these services and the ICCHS should be the first priority.

There is also a need to define how the Children's Centres interface with the ICCHS model. For instance they provide opportunities for:

- Advertising and communication of ICCHS services, an access mechanism and availability.
- Delivery of certain outreach or "spoke" interventions at these locations.

The voluntary sector provides a range of services which may facilitate the further development of the ICCHS model. Work needs to be undertaken with them, to identify how their services interface with the ICCHS model.

Services provided by other local providers need to be identified, in particular paediatric services being delivered in Mid Sussex and East Grinstead by Brighton and Sussex University Hospitals NHS Trust (BSUH). This is of particular importance in order to avoid any unnecessary duplication and should be included in phase 1 of the implementation process.

### **5.7.3 Context of the overall model of care for West Sussex**

The model of care adopted by WSPCT as part of the Fit for the Future programme outlines services provided at the Local General Hospital (LGH+) and the Major General Hospital (MGH). In this model, specialist community paediatric services are co-located at the Major General Hospital. The implication is that specialist children's services such as the ICCHS would be located at East Surrey Hospital. However, given the current location and quality of services and access issues for children, it is appropriate for these services to continue to be provided at Crawley Hospital.

## Section 6 Stakeholder engagement



## 6 Stakeholder engagement

Parent lay representatives were appointed to the CSWG and participated in the identification of gaps and the development of the ICHS Model. Once the working group had developed its ideas, the group assumed responsibility for communicating their work to a range of stakeholders, including parents.

A number of working group members, from a range of backgrounds attended the North East Review Stakeholder Forum and North East Review Panel where there was an opportunity to discuss the work of the group and take on board the views of those attending. In addition, a co-design event was held on 17th November 2008. Its purpose was to:

- Inform stakeholders about the development of the Integrated Children's Services Model.
- Discuss the potential impact of the proposed model on children, their families and carers.
- Discuss the prioritisation of gaps in current services.

This co-design event provided valuable feedback from the general public and other stakeholders further details on which can be found on the WSPCT website<sup>8</sup>. This event agreed a broad consensus that the main gaps identified by the working group should be prioritised. In addition, it was also felt important to prioritise the development of integrated record keeping and information systems to support the proposed model of care.

Discussions also raised a number of other points which participants felt were important in the development of the proposed model for example:

- Safeguarding issues should underpin work in all areas.
- More services should be run locally.
- Better information should be made available.
- There should be better transport and parking facilities.
- There should be equal quality at the hub and spokes of the model.
- Appropriate care pathways should be in place for children with long term conditions, particularly for acute episodes e.g. severe asthma.
- There should be a single point of access.
- Social care needs to be included in the model.
- Dentistry under general anaesthetic has been omitted, it is an important gap.
- The impact on other local service providers needs to be taken into account.
- Support should be provided for the whole family.
- The voluntary sector needs to be involved.
- Assessment needs to be improved.
- Budgets need to be integrated as well.

The positive feedback from the event and depth and breadth of ideas generated will be of value to the group when it comes to working on the more detailed aspects of the proposed model of care. .

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<sup>8</sup> <http://www.westsussexpct.nhs.uk/about-us/north-east-review/>

Parents participated in the working group and attended the co-design event. However, it is acknowledged that more can be done to engage with this group and obtain views on services from children themselves. For various reasons, successful engagement with this group this presents a particular challenge. The next stage in this process would be to identify the most effective ways of engaging with children, their families and carers and obtain their views on the gaps identified and the proposed model of care.

Section 7  
The future of services  
previously provided on  
Jumbo Ward



## **7 The future of services previously provided on Jumbo Ward**

### **Routine outpatient referrals to Paediatrics from GPs**

Outpatient clinics will continue to be provided by SASH paediatric consultants Monday to Friday.

### **Urgent referrals to Paediatrics from GPs**

If children require an urgent review, but do not need to be seen acutely, they can be referred to the rapid access clinic.

### **Clinical review of acutely sick children (referred by GPs)**

Children will be referred to the CAU at East Surrey Hospital.

### **Observation**

Before the changes to medical staffing on Jumbo Ward, observation of sick children was undertaken there, for example, fluid challenges to children with diarrhoea and vomiting and monitoring fever. For those children who would have been observed on Jumbo, SASH continues to provide the same level of care on the CAU at ESH. Parents access care in the same way as previously via their GP or CUTC. The GPs and CUTC then refer to CAU at ESH if necessary i.e. the same service is now being provided at a different site. This is the same site that Crawley patients have always used outside the opening hours of Jumbo Ward (9-4, Monday to Friday).

### **Day Surgery**

Paediatric day surgery previously took place at Crawley Hospital. The draft North East Review report indicates that Crawley Hospital does not at this time meet the criteria to be designated a Local General Hospital plus (LGH+) site, a more appropriate model with better "fit" is the Local General Hospital. Paediatric surgery is not included in the services provided on either the LGH or LGH+ sites and local models of care referenced for the development of the LGH+ model (Princess Royal Hospital, Haywards Heath) do not offer this service at the LGH+ site. The Fit for the Future (FFF) consultation document links the provision of paediatric surgery with the provision of inpatient paediatric services. In addition, the Paediatric CRAG report (2007) draws on evidence from the Royal College of Paediatrics and Child Health (RCPCH) which indicates that daytime services such as day surgery are often provided on hospital sites supported by a paediatric unit with 24/7 facilities. On this basis, following the model of care agreed for West Sussex as part of the Fit for the Future process, it is not appropriate to continue providing paediatric surgery at Crawley Hospital. However, it would be appropriate to run pre and post-operative clinics there. Paediatric day surgery now takes place on the children's ward at ESH; a new six bedded surgical bay is opening in 2009.

### **Support to CUTC - staff available to advise around sick children**

This is outlined in section 4.2 above.

### **Passport Patients (patients already known to the service)**

This service will continue and be expanded on as part of the development of the ICHS Model.

### **Phlebotomy**

A new paediatric phlebotomy service has been established at Crawley and will continue to provide this service. However, concern has been expressed by the CSWG that this service may not meet required standards and the needs of children, their families and carers, particularly when the child has more complex needs.

## Section 8 Next Steps



## **8 Next Steps**

This report will be received and discussed by the Children's Trust Strategy Group during January 2009 and considered for approval by West Sussex PCT Board on 29th January 2009.

A comprehensive commissioning plan for children's services in West Sussex is being developed and this report will form an important element.

A work plan will be developed, led by the Programme Director for Children, Young People and Maternity supported by the Children's Services Working Group.

In particular, there is a need to develop commissioning intentions for the specific needs of the north east of the county which understand the expected outcomes for children, the current resources spent and any associated investment.

Within the overall commissioning plan for West Sussex children, improvements for children's services in the north east will be prioritised and a timeline agreed. Immediate action will then be incorporated into the West Sussex PCT Operational Plan for 2009/2010 and other changes planned for 2010/2011. In particular, developing and implementing the Integrated Children's Health Services model is a top priority.



# Appendices



## Appendices

### 1 Terms of Reference: Review of Children's Services in the North East

#### Context

This review has been prompted in the context of concerns about the long term viability of the current service model for children's services provided by Jumbo ward in Crawley Hospital. Local practice based commissioners in the area have an aspiration to improve and have integrated local children's services because it is an area where significant improvements are needed and the locality is relatively young and deprived within West Sussex. The Urgent Treatment Centre also provides services for a large number of children daily and needs to review their paediatric provision to ensure they remain a safe service that is compliant with guidance. At the same time the North East Review of services by Sir Graham Catto has started and this review necessarily has to inform that work. This will be a clinically lead review following the principles set out in the Darzi Next Stage Review final report.

#### General Objective

Consulting all stakeholders, develop a recommendation for a long-term sustainable model of children's services, which would be of high quality, in the appropriate setting and safe.

#### Scope of the Review

The review will include wider consideration of community paediatric services and not just the medical or urgent caseload. The review will exclude consideration of inpatient services and emergency services likely to result in an inpatient admission.

There will be two main areas of focus for the Children's Services Working Group: sub acute and child and adolescent mental health services (CAMHS) (in particular emotional and behavioural problems).

Sub acute will include, for example, reviewing Jumbo Ward, Crawley Urgent Treatment Centre (CUTC), Child Development Centre (CDC) and community e.g. General Practitioners, Community Paediatrics and Health Visitors.

CAMHS will include reviewing tier 1 to 4 services.

#### Specific Deliverables

- The focus will be to:
- map and clarify current service provision
- identify the gaps in current service provision (with reference to: West Sussex, national standards and best practice).
- make suggestions on the improvements to be made for example, integrated working and measuring and improving patient experience regularly
- provide clear plan for sub acute children's services (including care pathways)

By the 24th November 2008 identify existing gaps in service and produce a plan for establishing an integrated children's service in the north east, including the model of care and main care pathways.

### **Jumbo Ward – Current Situation**

The immediate issue of maintaining current, sub acute children's services i.e. Jumbo Ward at Crawley Hospital will be addressed separately.

### **Key Stakeholders**

Because of the range of potential stakeholders balanced with the need to have very focussed action to meet tight timescales the project will operate with a small working group that calls on the input and expertise from a wider group. In view of timescales all stakeholders will need to input in a timely fashion to the work of the review.

#### **Small Project Team**

<i>Name</i>	<i>Role</i>
Amit Bhargava	Chair, Crawley GP Locality Lead
Patricia Atkinson	Community Paediatrics
Ann Corkery	Public Health
Christine Morris	Team Leader of the Children's Community Nursing Team
Rosie Rowland	Integrated Clinical Service Manager, Children's Services (Northeast)
Debbie Pullen	Paediatric Consultant, SaSH
Catherine Greenaway/Patricia Davies	SaSH
Michaela Maloney	Comms, SaSH
Peter Adams	PM/Data Analyst
Alison Hempstead	Commissioning, PCT
Lyndon Johnson	CUTC
Alfred Perera	CAMHS
Linda McEntaggart	PCT Head of Children's Services
Janet Armstrong	GP, Crawley
Veryan Nicholls	Crawley Locality Manager, Secretariat
Liz Costigan	Programme Manager
Vanessa Forster	Lay Representative
Marion Mitchell	Lay Representative
Social Services/ Education	Carole Aspden

### **Larger Project Reference/Consultation Group**

As required additional people may be called to attend the meeting to provide insight on a particular aspect of children's services.

### **Administrative Support**

Secretariat support will be provided by the NE area office of the PCT. Specific Project Management expertise will be required.

Commitment from Surrey and Sussex Healthcare (SASH) and Primary Care Trust (PCT)

SASH as the current provider of acute services and the PCT as both commissioner and provider of CUTC services commit to working jointly and collaboratively on the optimum model of care.

## 2 Outline of the findings of the National Integrated Children's Health (NICHE) Collaborative

An important aspect of the work of the CSWG was to ensure that it took account of relevant national guidance and best practice. Links were established with Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity, who facilitated contact with the National Integrated Children's Health (NICHE) Collaborative. The purpose of this collaborative is to bring together a range of professionals across providers and commissioners of children's health services in England in the pursuit of a range of sustainable and appropriate solutions for integrated children's health care.

NICHE has identified that the current healthcare model, delivered through geographically and organisationally separate primary and secondary services, is not providing optimum services for children. There are particular problems around out-of-hours unscheduled care and the delivery of long term care for some conditions. Some of the reasons behind these issues are outlined in *Children's Integrated Healthcare – a New Model for Co-operative Service Provision (2008)*<sup>9</sup>

In addition to the shortfalls in paediatric-trained therapy, nursing and medical staff which are beginning to emerge locally, the other significant driver for change are the relatively unsatisfactory outcomes for children. A major proposal from NICHE is therefore to establish children's integrated healthcare centres that would provide a range of planned and unplanned services delivered by a range of healthcare and other professionals. These centres would focus on developing community based care and a better informed more empowered patient (and carer) population and would be underpinned by the following key principles of optimum care delivery:

- Children should be seen by appropriately trained healthcare professionals.
- Children should be seen in a child-friendly environment.
- Care should be delivered as close to home as possible but skills and experience are more important than distance, Shribman (2007)<sup>10</sup>.
- Children with long term conditions should have integrated healthcare services and be enabled to participate as fully as possible in home and school life.
- Paediatric provision should be closely integrated with other services, to address social care, mental health and educational needs.

This approach aims to offer a constructive alternative to the reconfiguration of services which may in some cases exacerbate rather than alleviate staffing problems (e.g. establishing double rotas for medical staff). Reconfiguration may also reinforce the provision of centralised services at secondary care level (based on acute sites).

The Children's Plan – *Building Brighter Futures*<sup>11</sup> advocates an integrated model of delivery organised around three levels of provision universal, targeted and specialised. The proposal for children's integrated healthcare centres is consistent with this guidance. GPs will continue to play a key role in universal and targeted healthcare for children and a more flexible interface between targeted and specialist

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<sup>9</sup> Hilary Cass and Ingrid Wolfe, National Integrated Children's Health (NICHE) Collaborative Steering Group April 2008.

<sup>10</sup> Shribman S (2007) Making it Better for Mother and Baby: Clinical Case for Change DoH.

<sup>11</sup> Department for Children, Schools and Families (2007).

services can be developed through the children's integrated healthcare centres. These centres would provide local services outside an acute hospital setting and could provide a variety of services, some of which are outlined below:

- Unscheduled care – meeting gaps in local out-of-hours care
- First-line referral clinics – accessible, high quality care for common paediatric problems
- Follow-up clinics – primarily for long term conditions such as diabetes
- Referral clinics – for additional advice for those conditions generally managed in Primary Care
- Child Development Services
- Mental health clinics
- Health promotion
- Family support

A range of sites might be a suitable location for these centres, including hospital sites or Children's Centres; however this would be dependent upon the range and types of services provided. To achieve maximum advantage these centres should be established as a joint venture, this could include a number of group practices, the hospital and the Primary Care Trust (PCT). This type of structure may help to counteract the likelihood of "winners and losers" depending on where the child is seen and encourage further integration of services. NICHE concludes that this type of model would break new ground in terms of provider and commissioner arrangements.

NICHE has identified a range of possible benefits arising from the suggested model<sup>12</sup> and the headline benefits can be summarised as:

- Improved experience for the child and family
- Improved quality and efficiency of clinical care and training
- Opportunity for further integration with associated health partners working with children

### **Improved experience for the child and family**

The model of integrated healthcare offers the following benefits:

- One-stop-shop for care, fitting the system around the child and family rather than expecting the child and family to move around an immovable system.
- Capability for urgent primary care and/or co-location with A&E to stream minors into 'see-and-treat' facility and 'majors' into appropriate specialist care.
- New models of care for long term conditions.
- Attendant services could be attracted to work as a partner in the integrated care centre, for example paediatric dentistry.
- Shared development of the service with local community using local children services professionals, for example teachers.
- Meaningful patient satisfaction measures imbedded in performance management of the system, in line with the expectations of the Children's Plan Child Health Strategy (due Winter 2008).

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<sup>12</sup> National Integrated Children' Healthcare (NICHE) - DRAFT Benefits Realisation Framework October 2008

- Fully integrated care with access to a single shared and standard system of records and clinical notes.
- Shared use of protocols/clinical guidelines (and associated care pathways).

### **Improved quality and efficiency of clinical care and training**

- Opportunities for paediatricians and general practitioners to work side by side.
- Enhanced opportunities within training for paediatricians and for GP trainees wishing to gain more experience in paediatrics.
- General practice could benefit in 'any willing provider' models of care by being able to divert work from hospitals, re-provide at the appropriate level in integrated care centres and reinvest savings in primary care practice.
- Paediatricians as a workforce should benefit from less concentration of specialist skills in hospital as European Working Time Directive (EWTG) compliance is already demonstrating a workforce deficit.
- Paediatric careers could change significantly with newly qualified consultants taking responsibility for front line services across the integrated practice and the acute sites and more mature consultants continuing to develop specialist services.
- Clinical network development in respect of care pathway development and treatment protocols where all professionals are represented and are able to input, in a Team around the Child approach.
- Traditional secondary care given a conduit to providing care closer to home whilst preserving specialism.
- Resource will need to be transparent and will clearly be attracted to the most clinical efficient approaches through service improvement.
- Opportunity for standardised record systems ensuring that all healthcare professionals are aware of medical history and thereby improving outcomes.
- Support the training and Common Professional Development of the full range of professionals working at the centre and increase access to diverse and advanced training opportunities.
- Provide a setting where paediatric and CAMHS services can work more closely together to deliver holistic care.

### **Opportunity for further integration with partners working with children and families**

Integrated health care could also benefit from further incorporation with local authority and voluntary sectors providers, particularly for vulnerable families being targeted in the community.

### **Practical steps to developing children's integrated healthcare centres**

The National Collaborative for Children's Integrated Healthcare (NICHE) Steering Group guides this initiative and has initiated work in a number of areas to take the project forward, for example:

- Collaborating with and guiding the three "demonstration" site communities: West Cumbria, West London and Cheshire and Merseyside.
- Establishing a national forum, focused on child health services (and delivering national workshops)
- Developing a virtual and actual network between those children's health services across the country, which were striving to innovate and improve, but which were operating in isolation.

- Modelling future workforce requirements
- Developing the meaningful participation of children, their families and carers.

The work of NICHE therefore provides cohesive underlying principles and structure for the Children's Services Working Group to draw and valuable practical advice on how to develop its own model of care.

### **3 Public Health Report: the impact of the wider determinants on child health in the north east area of West Sussex**

This paper identifies relevant demographic and population risk factors associated with the north east area of West Sussex which should be taken account of when planning or redesigning services.

The factors which have been found to have the most significant influence on inequalities of health are widely known as the determinants of health. While health and social services make a contribution to reducing health inequalities by improving access and health outcomes, most of the key determinants of health lie outside the direct influence of health and social care, for example, education, employment, housing and environment.

Different groups and categories of people have very different experiences of the determinants of health. These different experiences can have an effect on their personal health. Some of the groups and categories involved are well known – in particular, gender, class, ethnic group, age and geographical area. Others might be less obvious – such as disability, single parenthood, quality of school, age of housing stock.

Poverty and social inequalities in childhood have profound effects on the health of children and their impact on health continues to reverberate throughout the life course into late adulthood. (Spencer 2008)

#### **Examples of Impact**

Children from lower socio economic groups are more likely to be born prematurely, be of low birth weight and are more likely to experience physical illness and dental carries (Shaw et al 1999).

Children from lower socio economic groups are more likely to suffer disability and chronic illness and are more likely to be admitted to hospital during childhood.

Children from lower socio economic groups are more likely to experience mental health problems and to suffer the consequences of parenting failure associated with chronic stress, debt and depression induced by economic disadvantage. (Spencer 2008)

The educational achievement of a child's parent is recognised as one of the most powerful predictors of child health. Education can act as a buffer against physical and mental illness in childhood as it appears to strengthen practices and behaviour conducive to child health.

Housing is also an important determinant of health. Housing exists in a social context, and poor housing is often situated in deprived neighbourhoods, where people have increased needs and at increased risk for poor health.

An increasing body of evidence has associated housing quality with morbidity from infectious diseases, chronic illnesses, injuries, poor nutrition, and mental disorders

With the above in mind, five 'Local Neighbourhood Improvement Area's' (LNIA) have been identified as areas which require targeted action by all agencies to improve the quality of life and health outcomes of those who live in these West Sussex communities.

Current priorities have been identified as:

- Parenting
- Education
- Health inequalities
- Financial Inclusion
- Anti-social behaviour
- Community cohesion
- Local environments

Within the North East area of West Sussex, Broadfield North and South, Bewbush and Langley Green electoral wards of Crawley have been identified as one of these LNIA's. The intention of identifying LNIA's is to reduce the causes and consequences of multiple deprivation in these areas.

To clearly demonstrate that inequalities of health are being addressed and vulnerable groups are being reached by services, activity data categorised by age, gender, ethnicity, postcode needs to be collected, collated, analysed and fed back to service providers so evaluation of effectiveness can be conducted.

### North East Demographics

The population relevant to the North East Review are those children and young people who reside in Crawley, Horsham and East Grinstead. Crawley and Horsham are Local Authority areas but East Grinstead is a town within Mid Sussex Local Authority (LA).

Although each local area will have some characteristics which can make it unique from their neighbouring towns, East Grinstead appears to reflect the demographic make-up of Mid Sussex reasonably well. For the purpose of this exercise and to ensure comparables can be made between the areas, Mid Sussex LA has been used as a proxy for East Grinstead.

### Child and Adolescent Population

**Table One. Mid Year Population Estimates 2006 (000's)**

	<b>0-4 yrs</b>	<b>% of LA population</b>	<b>5-14yrs</b>	<b>% of LA population</b>	<b>15-24 yrs</b>	<b>% of LA population</b>
<b>Crawley</b>	6.1	6.1%	12.7	13.0%	12.8	12.8
<b>Horsham</b>	6.7	5.2%	17.4	13.6%	12.9	10.1
<b>Mid Sussex</b>	7.6	5.9%	16.7	12.9%	13.6	10.5

**Source: West Sussex DPH Report 2007**

When comparing the three areas, Horsham LA has the highest number of children and young people and Crawley as a LA has a higher proportion of children and young people.

Projections to 2016 have estimated that the numbers of 0-4yr olds in Crawley are to decrease (-7.9%) from the 2005 baseline. In Horsham and Mid Sussex the numbers are projected to increase, 12.7% and 6.4% respectively. This could be because of the projected decrease in the % of fertile female population expected to reside in Crawley and the expected increase in the % of fertile female population expected to reside in Horsham between 2005-2016. (see table two) However, in the 5-19 yrs old age group there is an expected decrease in numbers in all three areas. (Crawley - 6.2%, Horsham -13.2%, Mid Sussex -11.4%)

It is important to remember that parts of Crawley have been identified as a LNIA which as described before would mean a higher need for health services. So if services are truly accessible to the more vulnerable populations, there will be evidence of poorer health and higher demand for services will be generated from this population. A reflection of this can be seen in the following tables. E.g. Higher % of Low Birth Weight babies in Crawley. (See table Two)

**Table Two. Vital Statistics by Local Authority of Residence 2005.**

	All births	General Fertility rate per 1,000 15-44 yr population	Projected Change in % of fertile female population 2005-2016	Total period fertility rate	% of all births under 2.5kg
<b>Crawley</b>	1318	56.1	-7.9%	1.8	9.0%
<b>Horsham</b>	1296	58.9	3.4%	1.76	5.9%
<b>Mid Sussex</b>	1432	61.3	-1.2%	1.83	6.0%
<b>West Sussex</b>	8087	57.6	0.9%	1.83	6.9%
<b>E&amp;W</b>	649,094	58.4	-	1.77	7.9%

Source: ONS

**Table Three. Ethnicity by Local Authority of Residence (2005)**

	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>
<b>White (White British, White Irish and other White)</b>	88.5%	97.8%	97.4%
<b>Mixed</b>	1.4%	0.7%	0.9%
<b>Asian (Asian British, Indian, Pakistani or Bangladeshi or other Asian)</b>	8.3%	0.6%	0.9%
<b>Black (Black British, Caribbean, African or other)</b>	1.1%	0.3%	0.3%
<b>Chinese</b>	0.3%	0.2%	0.3%
<b>Other</b>	0.3%	0.4%	0.3%
<b>Total</b>	100%	100%	100%
<b>% Population Black &amp; Ethnic Minority</b>	11.5%	2.2%	2.6%

A lower proportion of the population in West Sussex is from a Black or Minority Ethnic (BME) background than the national picture. However, there are differences within West Sussex with Crawley having a high percentage of non-white British. The proportion of people in West Sussex with a BME background is projected to increase. In 2005, 14.4% of all births in West Sussex, where ethnicity was known, were from BME communities. However, in Crawley this proportion was 33%.

### Population risk factors

The following information provides an insight into the prevalence of some of the causes and consequences of poor health locally.

### Low Income

**Table Four. Number of Children Living in Low Income Households.**

	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>	<b>WEST SUSSEX</b>
<b>Children (Number) in Low Income Households</b>	3349	1965	1977	18,065
<b>% of Children (Under 16) in Low Income Households</b>	15.8%	7.8%	7.7%	12.5%

Low income is a key indicator of living in poverty and could be expected to impact negatively on the health the whole family. When we consider the wards within the LNIA in Crawley 32.4% of households in Broadfield South have children living in a family with a low Income, this is the second highest in West Sussex. For Broadfield North it is 31.9% which is the 3rd highest in West Sussex and in Bewbush ward it is 27.4% which is the 7th highest in West Sussex.

### Employment

Although there are higher levels of economic activity in Crawley, the levels of education attained are lower which could suggest lower paid employment.

**Table Five. Economic Activity**

	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>	<b>WEST SUSSEX</b>
<b>% working age economically active</b>	83.5%	82.2%	82.5%	81.1%
<b>% 25-34 economically active</b>	85.7%	86.7%	86.5%	85.1%
<b>% 35-49 economically active</b>	87.7%	87.2%	87.4%	86.3%
<b>% of working age women economically active</b>	77.8%	75.6%	76.6%	75.2%

### Education

**Table Six. Levels of Education**

<b>ADULTS</b>	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>
<b>% with no qualifications</b>	25.4%	19.4%	18.7%
<b>% qualified to level 1</b>	21.7%	17.0%	17.4%
<b>% qualified to level 2</b>	23.4%	24.5%	24.8%
<b>% qualified to level 3</b>	8.0%	9.5%	10.0%
<b>% qualified to level 4 / 5</b>	14.6%	23.3%	22.9%
<b>% unknown or with other qualifications</b>	6.8%	6.2%	6.3%

## Housing

**Table Seven. Homeless households in priority need in temporary accommodation at 31st March in West Sussex**

	Totals				of which: with dependent children or a pregnant woman			
	2001/02	2002/03	2003/04	2004/05	2001/02	2002/03	2003/04	2004/05
<b>Crawley</b>	211	314	448	483	154	204	276	325
<b>Arun</b>	91	77	228	241	47	37	166	170
<b>Adur</b>	250	243	212	156	150	203	174	125
<b>Worthing</b>	185	216	169	132	127	172	143	106
<b>Horsham</b>	83	77	81	88	65	54	45	71
<b>Chichester</b>	73	66	69	62	62	63	65	59
<b>Mid-Sussex</b>	75	89	61	53	50	44	28	27

Source: WSCC

**Table Eight. Statutory homeless household acceptances by local authority**

LA data are reported figures.	Statutory homeless household acceptances							
	Households accepted as homeless and in priority need during the year							
	Totals				of which: with dependent children or a pregnant woman			
	2001/02	2002/03	2003/04	2004/05	2001/02	2002/03	2003/04	2004/05
<b>Crawley</b>	267	282	184	250	162	205	110	151
<b>Arun</b>	242	204	282	148	185	325	196	95
<b>Horsham</b>	210	170	140	130	129	111	84	75
<b>Adur</b>	181	134	113	141	104	86	81	92
<b>Mid Sussex</b>	174	166	120	89	124	108	72	59
<b>Worthing</b>	138	170	121	110	88	124	80	75
<b>Chichester</b>	137	140	39	62	91	123	35	57

Source: WSCC

## Mortality

**Table Nine. Infant Mortality Rate by LA of Residence. (2003-2005)**

Infant Mortality	Local Authority	
	Number	Rate per 1,000 births
<b>Adur</b>	7	3.9
<b>Arun</b>	14	3.5
<b>Chichester</b>	14	4.7
<b>Crawley</b>	13	3.2
<b>Horsham</b>	11	2.8
<b>Mid Sussex</b>	23	5.4
<b>Worthing</b>	12	3.6

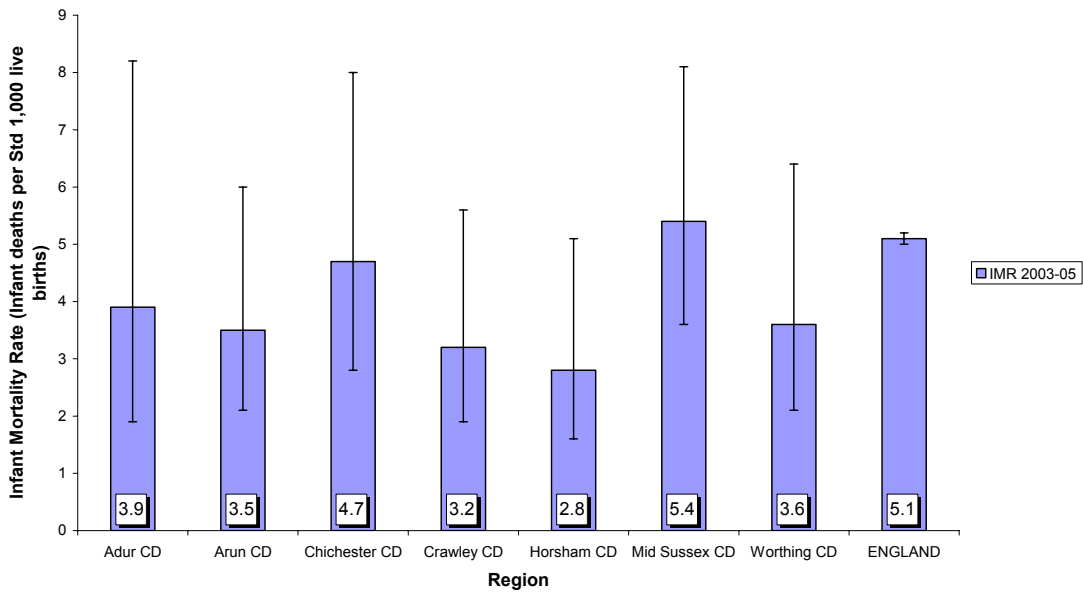


Figure One: IMR 2003-2005

Although Mid Sussex LA has a higher infant mortality rate than the other LA's, figure one demonstrates this is not significantly higher and is comparable to the figure for England as a whole.

Morbidity

Table ten demonstrates that Mid Sussex and Horsham are relatively healthy when compared to other areas in West Sussex. It can be assumed this would have a positive influence on the health of their children. Tables ten to twelve reflect that the population of Crawley report and experience poorer levels of health when compared to the other areas in the North East.

**Table Ten. Standardised Ratio for People with a Limiting Long-term Illness in West Sussex**

Local Authority	Standardised Limiting Long term illness Ratio
England and Wales	100
Adur	90.3
Worthing	88.7
Crawley	86.9
Arun	86.5
Chichester	75.5
Horsham	69.4
Mid-Sussex	68.9

Source: National Centre for Health Outcomes Development (NCHOD) West Sussex JSNA

Table Eleven. Proportion living with Long Term Limiting Illness by Residence of LA.

	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>	<b>WEST SUSSEX</b>
% of Children (Under 16) with a LTLI	3.9%	3.1%	3.2%	3.8%
% of People aged 16-64 with a LTLI	10.7%	8.9%	8.9%	11.1%

Table Twelve. Self Report of Health by Residence of LA

	<b>CRAWLEY</b>	<b>HORSHAM</b>	<b>MID SUSSEX</b>	<b>WEST SUSSEX</b>
% Under 16 in "GOOD" health	90.6%	92.7%	92.8%	91.4%
% Under 16 in "NOT GOOD" health	1.0%	0.8%	0.9%	1.0%
% 16 - 64 in "GOOD" health	72.6%	76.3%	76.7%	73.0%
% 16 - 64 in "NOT GOOD" health	6.0%	4.6%	4.7%	6.0%

### Teenage Pregnancy

Table Thirteen. Rate of conceptions per 1,000 female population aged 15-17, in 2002-04 (pooled) West Sussex

Area	Number	Rate per 1,000 female population aged 15-17	95% CI Rate LL	95% CT Rate UL
<b>Crawley CD</b>	250	44.2	39.2	49.9
<b>Horsham CD</b>	141	20.4	17.3	24.0
<b>Mid Sussex CD</b>	153	21.4	18.3	25.0
<b>West Sussex county</b>	1194	30.1	28.5	31.8

Source: Compilation of compendium of clinical and health indicators. ONS Health and Social Care Information Centre

The teenage conception rate in Crawley is significantly higher than the other two areas and West Sussex as a whole.

### Indicators of Poor Mental and Physical Health

Table Fourteen. West Sussex Survey of 14-15 year olds 2007

% responded	<b>Crawley</b>	<b>Horsham</b>	<b>Mid Sussex</b>
<b>Never smoked</b>	72	<b>69</b>	70
<b>Regular Smoke</b>	9	7	<b>10</b>
<b>Parent Smokes</b>	<b>40</b>	31	35
<b>Never drank alcohol</b>	43	29	<b>28</b>
<b>Regularly drink alcohol</b>	12	13	<b>16</b>
<b>Never taken a high risk drug</b>	60	55	<b>48</b>
<b>Regularly taken a high risk drug</b>	8	8	<b>14</b>
<b>Have used cannabis</b>	14	<b>19</b>	<b>19</b>
<b>Never used cannabis</b>	86	<b>81</b>	83
<b>Regularly use cannabis</b>	<b>2</b>	<b>2</b>	1
<b>Eat no fruit and veg a day</b>	<b>4</b>	1	3
<b>Eat five fruit and veg a day</b>	<b>9</b>	18	14

<b>% responded</b>	<b>Crawley</b>	<b>Horsham</b>	<b>Mid Sussex</b>
No physical exercise a week	<b>4</b>	3	3
>5 episodes of physical exercise a week	<b>30</b>	34	32
Consider selves to be very active	<b>33</b>	39	36
Consider selves not to be very active	<b>9</b>	<b>9</b>	8
Perceive self to be very overweight	<b>2</b>	1	1
Perceive self to be very underweight	<b>10</b>	8	7
Never feel depressed	<b>49</b>	51	52
Regularly feel depressed	7	<b>8</b>	6
Never feel stressed	43	40	<b>39</b>
Regularly feel stressed	<b>12</b>	10	<b>12</b>
High self esteem	<b>20</b>	24	21
Low self esteem	<b>15</b>	12	14
Ever been bullied	17	<b>19</b>	<b>19</b>
Have been a bully	15	16	<b>19</b>
Ever been kicked/attacked	<b>30</b>	28	27
Ever played truant	20	<b>22</b>	<b>22</b>
Think it is wrong to hit someone	<b>59</b>	64	61
I like school strongly agree	<b>8</b>	11	14
I like school strongly disagree	<b>14</b>	7	10
I don't care what teachers think of me – strongly agree	<b>24</b>	16	19
I don't care what teachers think of me – strongly disagree	<b>9</b>	10	11
Going to do my GCSE's before I leave school	<b>95</b>	98	96
I feel safe after dark	<b>37</b>	55	46
I don't feel safe after dark	<b>17</b>	6	8
I feel safe during the day	<b>68</b>	84	77
I don't feel safe during the day	<b>3</b>	1	2

Responses from the West Sussex Survey of 14-15 year olds (2007) found that Mid Sussex children are more likely to participate in unhealthy lifestyle choices, such as alcohol consumption and smoking. This is considered a reflection of poor mental health and will have an adverse effect on physical health.

Crawley children more likely to feel unsafe, enjoy school less and more likely to participate in unhealthy lifestyle choices such as not eating healthily or exercising. This is considered a reflection of poor mental health and will have an adverse effect on physical health

Horsham children are more likely to make healthy lifestyle choices. This is considered a reflection of good mental health and will have a positive effect on physical health.

## 4 Full List of Gaps in Score Order

This section references the detailed list of gaps provided on the WSPCT North East Review website which can be found at <http://www.westsussexpct.nhs.uk/about-us/north-east-review/>

	<u>Summary of Criteria</u>	<u>Average Score out of 50</u>
17	<b>Community paediatrics - clinical staff shortages</b>	39
34	<b>CUTC</b>	39
8	<b>Children's and Young People Cancer Care</b>	38
5	<b>Children and young people with epilepsy</b>	38
22	<b>CDC - Accommodation</b>	37
62	<b>Transition from Children's to Adult Services</b>	37
9	<b>Children with challenging behaviour / autistic spectrum in Crawley and Horsham</b>	36
36	<b>Occupational Therapy</b>	36
47	<b>Services for children with learning disabilities</b>	36
11	<b>Children and Young People requiring end of life care</b>	35
48	<b>Children with depression</b>	35
37	<b>Physiotherapy</b>	34
18	<b>Specialist epilepsy nurse</b>	34

35	<b>Therapist support for long term conditions</b>	34
38	<b>Dietetics</b>	33
52	<b>24/7 service</b>	33
54	<b>Staffing issues in social care</b>	33
10	<b>Children and young people with special / complex needs</b>	33
39	<b>Speech and Language Therapy</b>	33
61	<b>Absence of multidisciplinary working</b>	33
26	<b>Children's SARC</b>	32
55	<b>Absence of a team base in Crawley</b>	32
42	<b>Health Visitors</b>	32
21	<b>6 week audiology target</b>	32
51	<b>Work in schools</b>	31
19	<b>Lack of allied health professionals restrict opportunities for multi-disciplinary working</b>	31
32	<b>Assessment unit for emergency referrals</b>	31
6	<b>Children's and young people allergy care including eczema, asthma, aero and food allergies</b>	31
49	<b>Psychotherapeutic support to paediatrics</b>	31
56	<b>Multi-agency working</b>	31

57	<b>Services for Children with ADHD</b>	31
15	<b>Commissioning Arrangements</b>	30
23	<b>CDC - Computers, printers and IT support</b>	30
7	<b>Children's and young people cystic fibrosis care</b>	30
1	<b>Introduction of diabetic pumps</b>	29
13	<b>Babies with Bronchiolitis [Respiratory Synsttial Virus]</b>	29
46	<b>Working with ethnic minority services in the Crawley area</b>	29
14	<b>Counselling Service to Children, Young People and their families</b>	29
20	<b>CDC - Administration and secretarial staff shortages</b>	29
50	<b>Eating Disorders</b>	29
31	<b>Phlebotomy</b>	28
4	<b>Paediatric incontinence service</b>	28
41	<b>School Nurses</b>	28
2	<b>Dietician support for diabetic clinics</b>	27
53	<b>Work with children needing psychotherapeutic support</b>	27
3	<b>Psychological support for diabetic clinics</b>	27
28	<b>GP awareness of services</b>	26

40	<b>Communications</b>	26
24	<b>CDC - Management of notes</b>	26
45	<b>Obesity</b>	26
16	<b>Community Nursing - Administrative Support</b>	26
12	<b>Children with other conditions requiring nursing in the community:</b>	25
60	<b>Psychological therapy support for CUTC</b>	23
29	<b>GP – Discharge administration</b>	22
59	<b>CAMHS - General staffing</b>	22
27	<b>GP appointments</b>	21
25	<b>Remote management of school health records</b>	21
58	<b>Psychotherapy</b>	21
30	<b>Outpatient Services</b>	18
63	<b>Stakeholder Engagement</b>	16
33	<b>Paediatric surgery</b>	12
64	<b>BME</b>	11
43	<b>Queen Victoria Hospital</b>	0
44	<b>Horsham Hospital</b>	0

## 5 Abbreviations

A&E – Accident and Emergency

ASD - Autistic Spectrum Disorder

BSUH - Brighton and Sussex University Hospitals NHS Trust

CAU - Children's Assessment Unit

CDC - Child Development Centre

CAMHS - Child and Adolescent Mental Health Services

CSWG – Children's Services Working Group

CUTC – Crawley Urgent Treatment Centre

ENP - Emergency Nurse Practitioner

ESH – East Surrey Hospital

GPSI - General Practitioner with Special Interest

ICHS - Integrated Children's Health Services Model

LGH+ - Local General Hospital + (the model of care provided by a local hospital, developed as part of the Fit for the Future programme)

MGH - Major General Hospital (the model of care provided by a more specialist, centralised hospital, developed as part of the Fit for the Future programme)

NICHE - National Integrated Children's Health Collaborative

PBC - Practice Based Commissioning (involves GPs and other front line clinicians in the commissioning and redesigning of healthcare services to better meet the needs of their patients).

RCPCH - Royal College of Paediatrics and Child Health

SARC - Children's Sexual Assault Referral Centre

SASH – Surrey and Sussex Hospitals NHS Trust

WSCC – West Sussex County Council

WSPCT – West Sussex PCT

WTE – Whole Time Equivalent (A figure that reflects the actual numbers of hours worked e.g. a part-time worker who works half the full-time hours is 0.5 WTE).









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