Haringey NHS
Teaching Primary Care Trust

Discussing Haringey changes for 2006

DISCUSSION PAPER ~ CHILDREN'S SERVICES

1. Introduction

This paper sets out proposals for making financial savings from within the TPCT's directly provided Children's Services.

Two options are presented and we are seeking the views of staff, partner organisations and local stakeholders as to which option to proceed with.

Option One:

Reconfigure specialist child health services currently provided from the CDC at St. Ann's Hospital (£280k) + some reductions in management and clinical posts within early years and schools services (£170k): Total: £450k

Option Two:

Specialist child health services remain as currently configured within the CDC at St Ann's with the majority of savings identified through clinical post reductions in early years and schools services. (£430K)

Both options will present risks and will need to be carefully managed to minimise the impact on clinical service delivery. Stakeholders are invited to contribute their views as to how risks can be reduced and clinical service delivery maintained in the context of this financial savings plan.

2. SAVINGS TARGET

The service's savings target is £450K per annum. This is in addition to savings already identified as part of the original 2006/7 budget setting round that focused primarily on reductions in management costs.

As identified above, there are 2 options within Children's Services to meet this savings target. Each option is discussed below.

3.0 Options for achieving the required savings

3.1 OPTION 1

3.1.1 REPROVISION OF SPECIALIST CHILD HEALTH SERVICES

The Specialist Child Health Service currently provides a range of services to children with developmental difficulties, disabilities, specialist immunisation needs, those who are Looked After and those requiring child protection medical examinations, from the Child Development Centre at St Ann's Hospital. These services are primarily medical although allied health professionals also contribute to assessment and diagnosis of some groups of children as well as providing some intervention for children from the St Ann's site.

The Specialist Child Health Service medical staff are already employed by Great Ormond Street Hospital. Under this proposal, the focus of provision of community paediatric medical services within the Specialist Child Health Service would be co-located and integrated with the paediatric medical services provided by GOSH at the North Middlesex Hospital (NMUHT) through the North Central London Children's Partnership for Health.

This option would provide integrated, single management of medical staffing through GOSH @ NMHUT reducing the numbers of managers required and providing opportunities for development of integrated care pathways for children and better joint working between community and hospital medical staff. Medical staff would be based at NMH with service provision divided between clinics provided from the hospital or in the community depending upon individual service requirements and best practice guidelines.

There would be a single point of entry for community paediatric medical referrals from primary care, community services and other professionals and a single point for assessment, diagnosis and provision of some medical interventions. Whilst the NMUHT would be the hub of delivery for community medical services the doctors would continue to provide clinical interventions and consultation to children in community settings e.g. special schools and would work jointly with other staff working with children with additional needs in the community. This would provide clarity for professionals wishing to refer children for medical assessment and reduce duplication of appointments for families.

Children's services (health, education, social services) more broadly in Haringey are being developed on the basis of 3 geographical networks each of which will provide a range of universal and targeted services to children and families. Each network would have a named consultant

responsible for the coordination of medical services to children within the network. Specialist services will be provided on a borough wide basis.

The non-medical (allied health professional) services i.e. physiotherapy, speech & language therapy, clinical psychology, dietetics and specialist health visiting which are currently provided by a co-located health team would be provided through integrated working with the TPCT's Early Years team & the local authority's Children's Service staff in particular and also the Schools team. Points for service delivery would include the child's home, Children's Centres and mainstream and special schools.

The TPCT will need to discuss this proposal with The Whittington Hospital (WHT) who provide hospital based paediatric services to children and families living in the west of Haringey. Opportunities for the co-location of some services with WHT will also need to be explored.

3.1.2 Proposed Service Model

Provision of medical services to children would be arranged with the NMH as the hub together with a range of services being delivered in community settings within the 3 networks. Each consultant holds borough wide responsibilities in regard to their clinical specialism. In addition a borough wide collocated multi disciplinary team would provide for children with disabilities.

Services Provided from GOSH @ NMUHT

It is envisaged that the following services would be provided from NMUHT**:**

(1) Child Protection

Currently child protection medicals for children with suspected or actual evidence of neglect, emotional or physical abuse are carried out at the CDC at St Ann's, 5 days a week 9-5. All other medical examinations (sexual abuse, acute physical abuse) are carried out at NMH and for acute sexual assault at The Haven.

It is proposed that all Child Protection medical assessments are undertaken at NMUHT. Again this would provide a clear care pathway for this group of children and reduce confusion for professionals requesting Child Protection advice or assessment. The availability of suitable forensic and clinical equipment at NMUHT would be an added advantage to this arrangement.

The designated doctor role would remain unchanged and the named doctor role would need further discussion.

(2) TB and Infectious Diseases

The consultant lead for this specialty will shortly be vacating his post (pending receipt of formal resignation letter). The children's TB clinic has already been relocated from St Ann's to the NMUHT during the course of the year and there will be a need to identify suitable medical input from within the sector.

The TPCT currently provides a specialist advisory clinic for immunisation at St Ann's, staffed by the lead Consultant for infectious diseases and a nurse. This clinic could be relocated to the NMH or a community facility such as The Laurels, space permitting. Medical input is currently being discussed with GOSH.

(3) Assessment & Diagnosis of Children with Disabilities and Neurodevelopmental Disorders

Initial assessment and diagnosis for children with developmental delay, developmental disorders, neurodisabilites and communication/autistic spectrum disorders would usually be carried out at the hospital enabling tests and investigations to take place in an appropriate clinical setting. Where assessment and diagnosis requires joint working by a multi disciplinary team, this could take place either at the hospital or in a community setting. Medical intervention for these children can also take place either within the hospital or the community depending upon the child's individual needs.

Services Provided in the Community

Medical services in the community would be either borough wide specialist services or services which can be delivered within the Children's Services Networks.

Borough wide Specialist Services

(1)Population Health

Support for the TPCT's Immunisation & Vaccination committee would be available from the lead community clinician at GOSH and responsibility for oversight of the Child Health Promotion Programme would need to be reallocated. This is a borough wide responsibility.

(2) Health of Looked After Children (LAC) and Behavioural Paediatrics

The lead consultant for this group of children would continue to provide this borough wide specialty at the most appropriate location for the child and family. The current clinic for LAC at The Laurels would continue. The consultant would be based partly at NMUHT and partly collocated with the LBH Children's Service LAC Team.

(3) Treatment & Intervention for Children with Neurodisabilites and Neurodevelopmental Disorders (Child Development Team)

Services for these children are generally multi disciplinary and multi agency in nature and would be provided by a collocated, core multi disciplinary team with appropriate input from the consultants. The team would require an administrative base where it is envisaged that the consultants will work jointly with therapists and the specialist Health Visitor to arrange allocation of cases, multidisciplinary assessment, care planning, review and monitoring of children's care.

Therapy and dietetic services for young children aged 0-5 years are currently provided by both the Child Development Team (CDT) located at St Ann's and, where children are placed in Children's Centres, by the Early Years therapy team for children with complex needs. Older children are seen in the main by the Schools therapy team, with some additional services provided by the CDT e.g. joint assessment (doctor, SLT, psychologist)) of children with social communication disorders and dietetics. In addition the CDC provides a physio led orthotics clinic for all children aged 0-19 years.

The majority of children referred to the CDC are young children and it is therefore proposed that the Early Years (complex needs) staff and the current CDT staff integrate to form the health professional core of the Children with Disabilities Service. This would be an interim arrangement with a requirement to develop a multi agency specialist team for these children being implicit. School age children will continue to be seen by the schools team with additional specialist support from the CDT as and when required. Specialist clinics such as orthotics would continue to be provided by the physiotherapist based within the CDT, as would the dietetic service to school age children.

The majority of intervention programmes by the Early Years & Schools teams for these children already take place in the child's home, within Children' Centres and schools and it is proposed that the CDT would also primarily deliver services in these locations. Where this is not appropriate suitable community accommodation will be sought. The latter would include services led by allied health professionals such as

the orthotics clinic and the social communication group and consultant led review clinics which could be located within primary care facilities or an appropriate space within a school or Children's Centre.

(3) Paediatric input to Special Schools
The consultant team would need to review current job plans to ensure appropriate medical provision to Haringey's special school population. This could include the development of clinical protocols to enable School Nurses to undertake additional roles as well as considering the use of an appropriately experienced Registrar.

(4) Special Advisory Clinic
The current out patient Special Advisory Clinic could be provided from a clinic located within each of the 3 networks or at the hospital.

<u>Role of the Consultant in a Network</u>

Each consultant would be the named lead for one of the 3 Children's Network areas. This would provide expert medical advice to staff within each network, including primary care and facilitate a better understanding of each other's roles, better multi disciplinary team working and information sharing. This arrangement would also enable the consultant team to provide initial advice regarding management of children with the most complex needs and engage at a more local level in the strategic planning of services.

Over time, some services which are provided from the hospital could be developed on a network model.

3.1.3 Opportunities and Risks

There are a number of potential advantages to this service model:

- **Administrative & Management**

The current SCHS delivery from St Ann's has long standing problems related largely to administrative infrastructure. Whilst some of these difficulties are being addressed, issues remain with a lack of electronic patient systems for appointments, reviews, reports, waiting times management, activity monitoring and no medical records management by a dedicated medical records team. A move to NMUHT would largely resolve these problems as access to integrated patient management systems are already in place.

- **Clinical**

The relocation of the community paediatric team to NMUHT would provide opportunities to integrate medical services for children in

Haringey. This would also provide a wider number of clinical specialisms within the hospital supporting the development of integrated medical care pathways for children.

The medical team would have immediate access to facilities for tests and investigations for children, such as path labs, radiology and other clinical specialisms again reducing the number of appointments and locations to which children and families would have to travel.

The community paediatricians would also have access to a wider range of clinical expertise for joint assessment of complex children, a bigger peer group and junior doctor community rotas could be better managed. Teaching and training for medical students and junior doctors would be more coherent as it could be planned and delivered together with colleagues within the hospital.

- **Integration with local authority services**

Services provided by allied health professional staff (the Child Development Team) and the specialist Health Visitor for children who currently attend the CDC could be reprovided in locations that are more appropriate for children and families. The majority of children with disabilities and special needs have either part or full time additionally resourced places in Children's Centres and schools within the borough and are already receiving services within these settings from therapists within the Early Years and Schools teams.

Providing services to children within their natural setting reduces travel for families and affords greater opportunities for integrated working with colleagues in The Children's Services (LBH). This arrangement would enhance joint working between health professionals and early years colleagues in Children's Centres and facilitate better information sharing and multi agency planning and monitoring for some of Haringey's most vulnerable children. This in itself should help to avoid duplication of services and facilitate more effective use of resources. For example, family support services that will be available through Children's Centres will be able to work together with therapy and other CDT staff helping to support families through the assessment, diagnosis and intervention process. A further benefit of this model would be the opportunity to provide ad hoc training and demonstration of therapy techniques to non-health professional staff working with children within schools and Children's Centres enabling better carry over of therapy programmes into the child's daily routine.

There are also a number of potential risks / challenges within this model.

Risks include the possible fragmentation of joint working between the consultant team and the rest of the CDT. It will be important to ensure that dedicated time for the consultants to work together with the team is agreed and protected and that the team have an appropriate location in which they can work together. A particular risk is the loss of opportunity to share incidental information about children and families and to opportunistically ask a doctor to see a child who is attending a therapist/dietitian led clinic. This will need to be managed through more rigorous planning of case discussion meetings and planning of timetabled opportunities for information sharing; the latter could take the form of a regular "surgery" when the medical staff would be available for consultation by phone, electronically or face to face.

Appropriate clinical facilities will need to be identified for the community medical staff at NMUT as well as identifying potential clinical space at a Children's Centre. Similarly, an appropriate administrative base for the CDT will need to be identified with an additional requirement for some clinical space preferably within Children's Centres.

The model also carries risk associated with the transport of medical records to community settings where doctors may provide clinics. Arrangements will need to be made to ensure that records are available for appointments. Similarly, non-medical members of the CDT may require access to the child's medical records. Again arrangements will need to be put in place to ensure that staff have the information they require in order to manage children appropriately and effectively.

An additional challenge will be the coordination of the service. In terms of developing integrated therapy services for young children, it is proposed that the CDT service manager also manages the early years therapy team thus providing single management of those working with babies and young children with disabilities. This will provide the CDT with a wider range of clinical expertise and a broader peer group affording more opportunity for support and development.

Coordination of the whole service (medical and other staff) will require better links to be developed with the NMH, building on joint work already undertaken by GOSH / North Central London Children's Partnership for Health.

3.1.4 Estimated Savings from remodelling specialist child health services

Savings will be released through the reconfiguration of the service. There will be **a reduction of 4.01 wte management, administrative and support staff posts and a reduction of 1.68 wte clinical staff. This would include reduction by 1.00 wte of**

consultant paediatrician time (current post holder recently appointed to new post in neighbouring PCT; awaiting formal resignation).

Relinquishing use of the current facility on the St Ann's site will also make additional savings.

Sub Total: £280,000

3.1.5 EARLY YEARS & SCHOOLS SERVICES

In addition to the savings set out above related to the remodelling of specialist child health services the following areas for saving are also proposed

1. Paediatric OT

The current establishment is 4.60 wte Occupational Therapists and there will be no substantive post holders in place by May 2006. It is therefore timely to review the service and consider options for providing this service in a different way. The TPCT is currently working together with Hackney PCT OT service to undertake a full review of the service and develop an appropriate model of service delivery.

It is proposed to delete 1.00wte Band 7 post and this has been taken into consideration in the above review.

2. School Nursing

The School Nursing Service will need to increase targeting of their services to the most vulnerable children and young people.

It is proposed to delete 2.00wte Band 6 posts.

3. Health Visiting

The service has recently been remodelled and is now preparing to deliver a revised Child Health Promotion Programme and additional targeted services for the most vulnerable young children and their families. The current structure includes 3 Clinical Coordinator posts which, with the redistribution of the service into 6 teams, 2 within each of the 3 Children's Network areas, will enable us to reprofile these posts.

It is proposed to delete 1.00wte vacant Clinical Coordinator post.

3.1.6 Savings from early years and schools services

3 x clinical posts + one x clinical management post = £170k

3.2 OPTION 2

The alternative option to remodelling the Specialist Child Health Service in order to reach the savings target is to considerably reduce staffing levels within the Early Years and Schools Services. This would mean **a reduction of 10 wte clinical posts and 1.00 wte management post.**

For School Nursing this would mean an even greater requirement to target services towards the most vulnerable children and would reduce capacity to address the broader public health agenda in relation to obesity, sexual health and relationships and immunisation.

For Therapy Services this would necessitate raising the threshold for access to children's therapy services in order to manage the large numbers of children with special needs and complex disabilities. Criteria for referral to and intervention from children's therapy services in Haringey are already vigorous and in effect this would deny many children with developmental delays and disorders access to appropriate health care. It would also mean that preventative and early intervention services for children with developmental delay (and its associated social, emotional and academic consequences) would be significantly reduced.

£88k 2.00wte Occupational Therapists
£88k 2.00wte Physiotherapists
£88k 2.00wte Speech & Language Therapists
£110k 3.00wte School Nurses
£40k 1.00wte Health Visitor
£44k 1.00wte Health Visitor Coordinator

Total saving: £429,125

Alternatively the 1.00 consultant paediatrician vacancy (highlighted above ~ option one) could be deleted allowing for a 2.5 wte reduction in posts lost (as listed above) equivalent to £100k.

4.0 How to give feedback on the issues raised in this paper

A meeting for **Specialist Child Health Service staff** is scheduled on 25th April, 3.30 pm, A2 meeting room.

A meeting for **partner organisations** is scheduled for 10-12 am 27th April 2006. Please contact Cynthia Arthur for further details and to confirm your attendance.

Cynthia Arthur 0208 442 6159 cynthia.arthur@haringey.nhs.uk

For further information on the proposals set out within this discussion paper please contact:

Jane Elias
Assistant Director of Children's Services (Operations)
G1, St Ann's Hospital, London N15 3TH
jane.elias@haringey.nhs.uk
0208 442 6159 / 6877

Or

Helen Brown
Director of Strategy, Performance and Children's Services
B1, St Ann's Hospital, London N15 3TH
helen.brown@haringey.nhs.uk
0208 442 6857

Written comments on this proposal are welcomed and should be addressed to either Jane or Helen contact details as above.

The closing date for comments to be received is 5th May 2006.

5.0 Next Steps

Final proposals and a formal consultation document for staff affected by these changes will be published at the end of the discussion period.

Jane Elias
Assistant Director
Children's Services
April 2006