Purpose of this document
This document has been produced to inform the Clinical Board of commissioning intentions for A&E for children within Central Manchester, and will support the design and delivery team in preparing a project plan outlining strategic and operational priorities for delivery of paediatric urgent care services.

Scope
Data and evidence indicates that Manchester has higher than expected activity levels in paediatrics for both acute activity and A&E attendance, when compared to age, sex and deprivation adjusted benchmarks. Nationally, A&E attendances for children have risen by 6.8% over the past three years. There has also been an increase in lengths of stay of zero days, post admission, which suggests a higher percentage of children could be managed in primary care. Locally, Securing our Shared Future (SOSF) has highlighted reducing A&E attendances and non-elective admissions as a priority.

Recent changes in the provision of urgent care for children in Manchester, i.e. the relocation of Manchester Children’s Hospital to CMFT, have resulted in fewer under 16 patients being seen in PCEC and a higher than anticipated volume of patients being seen in paediatric A&E. Local data suggests that PCEC attendances for paediatrics initially reduced by 40 to 50% on the opening of the new hospital. This equated to between 100 and 150 children per month. The existing PCEC is not co-located with the new children’s hospital and patients are choosing to by-pass this service in favour of the new hospital.

In order to tackle this, there are two areas that need to be considered; firstly, addressing the issue before patients reach A&E, and, secondly, continuing to influence the issue once patients are within the department. The former can be achieved through changing public behaviour and improving awareness so that A&E does not become the default service for urgent care needs; the latter through integration of primary care within A&E. Local data on A&E referrals for children during 2008/09 identifies that GP and self-referral are the main influencing drivers.

Whilst we need to continue to work with primary care colleagues to influence the management of paediatrics within primary care (and the 'just in case' default position that is often held) we also need to recognise the limitations of influencing public behaviour and patient choice (a huge ship to turn around). A local survey showed that 30% of patients attending A&E would have gone to their GP with the type of problem they presented with.

The initiatives outlined in this brief explore opportunities to achieve the above, which should lead to reduced A&E attendances and, subsequently, admissions and length of stay.

Proposal
To improve navigation and triage within A&E to ensure patients are streamed to the appropriate service for their level of need, including streaming patients back out into the community. This would ensure delivery of reduced A&E attendances and associated non-elective (NEL) admissions. Analysis of NEL admissions data indicates that 80% of admissions incurring an overspend in 2009/10 were paediatric admissions. The following pieces of work will need to take place in order to deliver this proposal:
1. **Review of triage**
A full review of the triage protocols in paediatric A&E, including triage categories applied and pathways into the observation and assessment (O&A) unit, how long are patients on the unit for and what treatment/ care do they receive whilst there. This review will complement the Making it Better (MiB) review of the O&A unit, to report in October.

*Timescale: completion by end November 2010*

2. **Integration of primary care services into A&E**
A three to six month pilot during which a GP (and appropriate primary care presence) will be present in the department to assist with triage if necessary, provide primary care advice and treatment and offer education for patients on primary care, in line with the national model which advocates redesign of the paediatric emergency and urgent care pathway.

*Timescale: Pilot start December 2010*

3. **Service models**
Data collected during the review of triage and primary care (GP) pilot will be used to inform consideration of other service models within the department, e.g. a primary care stream/ facility similar to PCEC. Data collection to determine:
- Primary/community care activity
- Secondary care activity
- Tertiary care activity

*Timescale: Revised service proposal spring 2011*

4. **Communication and patient education**
In order to support a sustainable reduction in A&E activity, a clear and consistent message will need to be delivered to the public on the appropriate use of services. These messages will need to be system wide and include:
- Primary care (including the GP in A&E)
- Triage nurses
- Children’s community nurses
- Surestart
- Schools

Patient literature will support the communication of this message, including the NHS Manchester produced ‘Making the right choice’ leaflet and the Choose Well campaign. The use of Choose Well signage within the department will also need to be considered. Links will be made to Manchester City Council’s Total place pilot in Ardwick.

*Timescale: Ongoing; some elements in place Sept 2010*

**Benefits**
- Development and implementation of a single emergency and urgent care pathway for children and young people
- Clinically and cost effective, fit for purpose and equitable service as part of a city-wide pathway
- Standardised assessment based on implementation of guidelines to ensure safe, high quality care across the pathway
- Common referral processes that are consistent across primary and secondary care
- Increased provision and utilisation of urgent care services outside the hospital setting ensuring that services are delivered by competent training professionals sharing a common governance framework
- Increased awareness among health professionals and the wider health economy of the existing system that influences their work and the public's choices
- Reduced A&E attendances, inappropriate presentations non-elective admissions and lengths of stay across the urgent care system
- Reduced occurrence of unscheduled attendance at A & E for patients requiring condition management, by strengthening the use of personalised care plans, information prescriptions and self support (for example, asthma (one of the highest number of presentations for condition management))
- Transition planning to primary/community care services to minimise and deflect admission to acute beds
- An integrated primary and secondary care service model
- More informed patients, parents and carers

Outcomes
- Reduce overall paediatric activity.
- Reduce A&E attendances
- Reduce emergency admissions
- Reduce acute hospital outpatient appointments
- Reduce number of ‘GP urgent’ attending A & E
- Where appropriate, deflect activity away from secondary care and back into primary care
- Maximise the utilisation of existing primary care and community services
- Develop ‘care closer to home’
- Support the development of TCS with an opportunity to integrate children’s services

Metrics

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<tr>
<th>Item</th>
<th>Target</th>
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<tbody>
<tr>
<td>Reduction in Paediatric Attendances at A&amp;E</td>
<td>SOSF Children’s services thematic report advised that re-design could achieve 25% reduction in children and young people attending A&amp;E</td>
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<tr>
<td>Reduction in ‘GP urgent’ to A&amp;E</td>
<td>In proportion to overall A&amp;E attendances</td>
</tr>
<tr>
<td>Reduction in Paediatric Admissions</td>
<td>SOSF estimates potential reduction of 25% in paediatric admissions from A&amp;E</td>
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Links
- **SOSF**
- **Choose Well campaign**
- **GP same-day access**
  Improve urgent and same-day access to primary care to support assessment and treatment in the community. Explore the ability to book GP appointments directly from A&E.
- **Frequent attenders scheme**
  This incentivised scheme involves practices receiving monthly data on children who have attended A&E on two or more occasions in a six month period. Where appropriate, parents are written to and advised of alternatives to A&E.
- **GP ‘hotspots’**
  It is anticipated that data analysis will identify practices with high paediatric A&E attendances. Work to be done with practices to try and reduce this activity through, for example, reviewing referrals and access.
- **MiB Reconfiguration**
The Greater Manchester reconfiguration of children’s services has had, and will continue to have, an impact on activity at CMFT. Any service redesign/pathway improvement for emergency and urgent care of children and young people will need to be implemented in conjunction with, and consistent with, the MiB model.

**Financial Envelope**

*Financial implications of reductions in activity*
- CMFT have 45,732 paediatric attendances per annum (51% of which are registered with a Central Manchester GP), at a cost of £7,023,360. A reduction of 25% in activity could lead to total savings of £1,755,840 for Manchester patients.
- At CMFT 22% of children attending A&E are admitted, equating to 10,061 admissions per annum. A reduction of 25% of those admissions (at a notional cost of £1000, which is below the average) could save at least £2,515,000 for Manchester patients.

**For decision**
The Clinical Board is asked to confirm the brief to mandate the design and delivery team to develop proposals as highlighted above; and to provide an initial report back on progress in November 2010.

**Proposed membership of a design and delivery team**
- Helen Hosker (PBC Urgent care Clinical Lead)
- Ruth Cammish (PBC clinician)
- Stef Cain (PBC Senior Manager)
- Clinical lead, Paediatric A&E
- Managerial lead, Children’s A&E, CMFT
- Children’s A&E Lead Nurse (Rachael Whittington)
- MCH managerial lead
- NHS Manchester Children’s Commissioning representative (Sam Bradbury)
- Manchester City Council Children’s services lead manager