

Transforming Community Services: Ambition, Action, Achievement

*Transforming Services for Children, Young People and
their Families*



DH INFORMATION READER BOX

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Transforming Services for Children, Young People and their Families

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Introduction

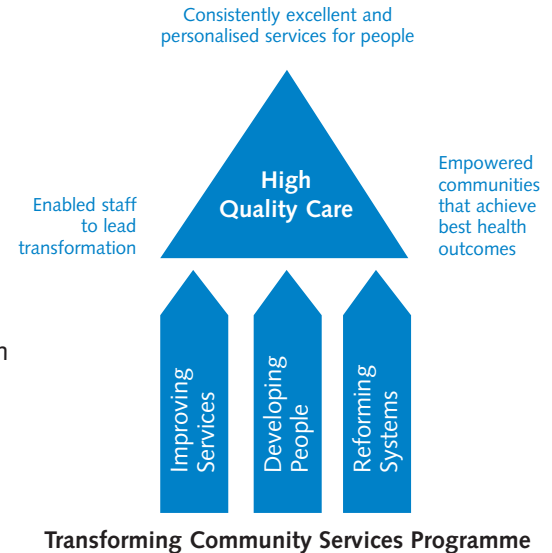
Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. However, we face some major challenges:

- there is great variation in service quality and health outcomes
- much activity and achievement goes unmeasured
- we lack usable data, tariffs and currencies
- there is disparity in quality, productivity and costs
- infrastructure is frequently outdated
- access can be uncertain and confusing.

We recognise that the environment is changing for community services which – like all health services – face the challenge to drive up quality and drive down costs. The Transforming Community Services Programme is therefore about delivering improved quality *and* productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications.

The Transforming Community Services Programme has set out a far-reaching plan to resolve some long-standing issues by harnessing the energy and enthusiasm of everyone to provide consistently high quality care. This will mean that the best, currently available for some, is there for all.

The programme takes a three-pronged approach: improving services, developing the people who provide them, and aligning systems to underpin the transformation.



About the guides

There are six transforming community services guides for frontline staff and their leaders. Many practitioners will be interested in one particular guide and some will be interested in elements of more than one. The guides therefore have a common format and the first sections apply to all service areas and are the same. Subsequent sections cover specific changes and will differ between guides. Four of the guides deal with services for adults and older people. One guide relates directly to services for children, young people and families. The health and wellbeing guide contains information to enable all practitioners and teams to maximise their contribution to good health outcomes and reducing inequalities and is therefore relevant to all.

These best practice guides demonstrate what is considered to be best practice across community services and have been developed in conjunction with experienced and committed health professionals. They highlight a number of actions that people have said make a real difference to patients. They are based on a framework of '*ambition, action and achievement*'. By this we mean:

- Clearly setting out your **ambition**
- Taking **action** to deliver the ambition, using the best available evidence
- Demonstrating and measuring **achievement**

Quality for community services

The Next Stage Review states that high quality care requires a high quality workforce. In keeping with this, the guides describe **six transformational attributes**, which individuals and teams will need to demonstrate in order to meet the requirements of their high-performing 'practitioner, partner, leader' roles. These can be found within the later sections of the guide and are specific to each service area.

The Six Transforming Community Services Reference Guides

- Transforming Health, Wellbeing and Reducing Inequalities
- **Transforming Services for Children, Young People and their Families**
- Transforming Services for Acute Care Closer to Home
- Transforming Rehabilitation Services
- Transforming Services for People with Long Term Conditions
- Transforming End of Life Care

The importance of providing care closer to home, or in the home, for children and young people has been widely accepted as being in the child and family's best interests. This guide sets out some suggested actions which will help practitioners, provider organisations and commissioners working with local authorities, Children's Trust partners and the voluntary sector deliver national policy for improving the quality of services for children, young people and their families.

These guides will be successful if they help deliver the aspirations of *The Next Stage Review* and enable:

Practitioners closest to patients to lead change themselves and realise their own high ambitions for the care that they provide.

Provider organisations to align high quality care to organisational vision and strategy.

Commissioners of children to understand the constituents of high quality care and enable **world class commissioning** decisions to be made that are clinically led and focus on achievements.

Our guidance on the **Quality Framework** for Community Services is part of the overarching quality improvement programme outlined in *High Quality Care for All*. The programme focuses on **bringing clarity to quality and measuring quality** as the foundation for broader quality improvement. It is aimed at all those with a role in providing or commissioning community services.

Useful links and further information on these six transformational guides, national policy, evidence based research and innovation in practice can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

Quality

A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It's when things go wrong they become expensive and inefficient.

Quality Indicators

*More than 70 potential indicators of high quality care have been identified. They cover effective practice, safety and people's experience to help us to **measure what we value**, to benchmark and improve the quality of care we deliver. These are a starting point and more work is needed to refine, develop and pilot them to ensure that they enable practitioners to measure the ambitions set out in the transformational guides. They are not comprehensive and we know there are gaps, which is why we are asking for your views on what are good effective indicators of quality.*

Ambition

1

Getting the basics right – every time

People have urged us to stress how important it is to ensure that the basics are in place – not doing so compromises service users' experience and practitioners' ability to deliver high quality productive services as efficiently and effectively as possible. What follows are recommended actions and how they can be measured through achievements. They are based on evidence and professional consensus

and are for local organisations to consider when planning quality, innovation and productivity improvements.

Actions to deliver the basics for all community services

1. Know about local health needs and plan services accordingly

- Work with your public health observatory (public health team in the commissioning PCT), the Child and Maternal Health Observatory (ChiMat) and Children's Trust partners to access information on the health needs of your population: identifying those who may be disadvantaged or marginalised in society. Target need based on your Children's and Young People's Plan.
- Work with your commissioners to agree the outcome data that needs to be collected for a specific service area to demonstrate effective intervention. Ensure that you have robust systems in place to collect this data. Link this to the quality framework and, if appropriate, contracts including the payment framework for commissioning, quality and innovation ([CQUIN](#)).

2. Create effective health and care partnerships

- Strengthen partnership working across Children's Trusts, health and children's social care. Work with

people using community services and organisations such as ambulance trusts, acute trust, children's social services/children's services, GP practices (and practice-based commissioners), the voluntary and independent sectors so that care and treatment can be aligned along a care pathway and co-ordinated around the needs of the service users.

- For children and young people this includes services enabling their education and access to social activities as described in the *Every Child Matters outcomes*.

3. Implement new services/approaches

- Addressing variability, working efficiently, and demonstrating high levels of productivity and achievement of ambitions for quality are always important and particularly so in an economic downturn. Ensure that your teams use the most up-to-date and appropriate evidence and tools to ensure effective working. This may include the **NHS Institute productive series** or lean management techniques.
- Support teams to develop creative approaches to service provision, which reflect the five *Every Child Matters* outcomes and will improve choice and personalisation for children, young people and their families, efficiency and effectiveness, for example, reducing avoidable admissions to acute hospitals by making the best use of community and social care resources.
- Support and empower practitioners to develop innovative multidisciplinary teams using approaches such as the transformational attributes.

4. Access and availability

- Provide local health information about your services: the access, availability and choices, for patients, the public and professionals. Check against the experiences of those using your services to ensure understanding.

- Provide clear information about out-of-hours service provision to patients, the public and practitioners. This should include the service and current contact details. Use **self-referral** as the optimum route and use new technology, for example, text and email where possible. Audit these services regularly to ensure that they meet the quality standards.
- Provide the right resource, in the right place at the appropriate time in accordance with children and families' needs. This may mean extending the hours of service provision to 24 hours a day, overnight or weekend care. This may also mean working with other partners to ensure systems are in place to access care. This may include capacity management systems, access points and telephone triage. Partners should include the out of hour provider and ambulance trust.
- Provide the right equipment to the right patient in a fast and efficient manner with systems in place to retrieve equipment when this is no longer required. You may need to undertake an equipment audit to ensure that the demand for equipment matches the resource available.

Transforming Community Equipment Service (**TCES**) was launched in 2008. Its aim is to create a new service delivery model that puts users and carers at its heart giving more choice and control.

5. Care planning and case management

- Provide all children and their families with a **personalised care plan** and where appropriate use joint care planning or integrated assessments such as the common assessment framework (**CAF**) or continuing care framework.
- All children, young people, families and carers should have a named key worker or case manager to provide high quality, safe and effective continuity of care.
- Ensure that there are robust systems in place to **safeguard children** and young people and for adult protection.

- Ensure that you are familiar with your PCT's local carers' strategy, providing all carers with a holistic assessment in their own right and giving the appropriate information, support and advice for them to remain healthy and within their own home.

6. Information and technology

- Provide clinicians with appropriate IT and ensure that where safe and practical to do so clinical pathways are interlinked using shared records and joint care plans. This could include investment in IT web design solutions and or portable IT solutions for remote access working such as tablets, laptops and palm tops.

7. Education and training

- Commissioners and provider management teams must be responsible for developing a competent workforce that will deliver current and future services safely, effectively and who have a positive impact on service user experience. This will include thinking about workforce planning aligned to patient need and the commissioning of sufficient education and training places for the future.
- Work with education commissioners and universities to ensure education programmes at all levels and for all disciplines are fit for the future. This will include targeted training around illness and disability.
- Equip staff with a wide range of skills, knowledge and competence to meet the future demands on community services, including the impact of new service models and shifts in care settings, e.g. from hospital to children and young people's homes.
- Provide access to robust training and education, clinical supervision and improved clinical leadership, managerial and business skills to improve health outcomes.
- Use and develop evidence based practice and validated research to improve clinical practice.

Achievement

- ★ Clinical and multi-agency teamwork is supported by a robust infrastructure that enables all staff to deliver high quality care, achieve agreed outcomes, maximise productivity, promote, and measure service user experience.
- ★ There is a reduction in the variation in provision and quality of community services resulting in improved health outcomes.
- ★ Variability in productivity is reduced by efficient, effective systems, clearly described and measured.
- ★ Community services contribute to the efficiency and effectiveness of partner services, for example working with acute trusts, primary care and social care to provide a seamless care model.
- ★ Practitioners have the confidence that these systems will support them when working in the community and allow them to spend the maximum amount of time with individuals and families.

Benefits realisation

With the increasing focus on **quality and innovation with productivity**, it is important to be able to demonstrate that the benefits envisaged (i.e. our ambitions) are actually derived (i.e. our achievements): this is known as **benefits realisation**. Actions to create the change and the delivery of outcomes should be monitored through a plan to track the implementation and the service improvements. The improvement plan should be aligned with the PTC's strategic priorities, focused on delivering improvements in health outcomes for the local population and in line with the aspiration for **world class commissioning**.

Productivity defined

- Productivity is a measure relating a quantity or quality of output to the inputs required to produce it.
- It is the quality of being productive.

Ambition**2**

Making everywhere as good as the best

Actions to achieve the best – ‘high impact changes’

The actions below grouped under seven main headings have gained support from all those who took part in developing the guides as most likely to have the **greatest potential to improve care and achieve the highest quality services**. In all of these guides, we have used the best research evidence available; however, we know that there are significant gaps in community service evidence. We have also drawn on expert professional opinion and service user experience to provide robustness to these **recommended actions and achievements** that practitioners should consider to deliver our ambition.

The examples and principles outlined in this guide are of equal relevance to children and young people's physical, emotional and **mental health** and well being.

Family-centred care is a central philosophy underpinning the delivery of healthcare to children and young people. This includes supporting parents or carers to enable children to reach their full potential. It is therefore important that services are provided in easily accessible settings, for example, children's centres, extended schools and integrated youth centres and, where children are ill or disabled, maintaining access to their education is critical.

Summary of high impact changes

- Individuals and teams are fully conversant with safeguarding arrangements across organisations and contribute to the development of systems and processes to ensure safeguarding systems are effective.
- The voices of children, young people and families are central to the planning and evaluation of services using formal and informal processes.
- Use creative ways to implement public health programmes, such as the **Healthy Child Programme**, to build the foundation for future health, reducing later costs on the acute trust for health issues such as **obesity**, inequalities and negative parenting.
- Adapt the hours that community services are accessible to suit the needs of children, young people and families, especially fathers. Develop new ways of engaging families who find it difficult to connect with traditional service arrangements.
- Offer services in a range of settings and through different media acceptable to children, young people and families, for example, using telephone access points for on-call, texting, email and websites. If it is appropriate and cost effective use new technologies to deliver care, for example, **telehealthcare**.
- Work with commissioners to develop services so that children and young people with support from family members can choose to be cared for at home at all stages of their illness or disability.

We now consider 'Actions to achieve the best' in two parts:

1. *Staying healthy and well: delivering universal services for all children and young people.*
2. *Working with children who have acute or additional health needs addressing the needs of ill and disabled children.*

Staying healthy and well: delivering universal services for all children and young people

1. Know about local health needs and plan services accordingly

- Use public health data, your local children and young people's plan, along with the experience of children and families to map local services. Use interventions that will make a difference to the future health and life chances of all children especially those who are vulnerable, sick or disabled.
- The voices of children, young people and families are central to the planning and evaluation of services. Ensure that there is involvement from Children's Trust partners; existing youth councils and formal or informal community organisations.
- Review the staffing and skill level required to deliver the existing **Healthy Child Programme** in pregnancy, the first five years and plan for the future expansion of the programme for 5-19 years.
- Work with your local safeguarding board to ensure systems are in place to identify children in need of **safeguarding**. Ensure that the current workforce receives the appropriate and ongoing training and that workforce planning takes into account the specific responsibilities for the community child health workforce in respect of safeguarding.

2. Create effective health and care partnerships

- Help children and their families develop their confidence and abilities in choosing what is best for them. This will include developing the communications skills to work directly with children and young people.
- Work collaboratively with others who work with local children and families agreeing and developing a common vision, goals and models of good practice.
- Set up information-sharing agreements across organisations, including levels of access that benefit children, young people and families. Involve parents and young people in these discussions.
- Work with your Children's Trust partners to develop and implement an evidence based parenting strategy. Make the development of **parenting skills** for mothers and fathers a key preventative and **safeguarding** a priority.

3. Implement new services/approaches

- Work with Children's Trust partners including schools and others to create a health enhancing environment for children and young people. Work to ensure that healthy life choices are easier to learn and adopt, for example, housing, safety, equipment, smoking, nutrition, exercise, and safe play environments.
- Capitalise on the personal health and social education **PSHE** curriculum in schools.
- Implement well-researched programmes that can demonstrate a positive impact on vulnerable young families. Ensure that the family nurse partnership programme is tested and lessons learnt are shared with other services.

- Start the Healthy Child Programme (HCP) in pregnancy, and build on the contribution of children's centres and general practice. The programme 'Action on health visiting' will enable practitioners to maximise the impact of the **Healthy Child Programme**.
- Make sure **parents have access to up-to-date information** about the importance of early child development, and how children can benefit from positive parenting.
- Work with parents to develop new and innovative methods for communicating with children in early years. We know that a significant number of children start school with a speech and language delay.

4. Access and availability

- Provide easily accessible information to children, young people and families about local health services and what they can expect. This should include the support available at key life stages, as set out in *Healthy Lives: Brighter Futures – the strategy for children and young people's health*.
- Make sure all families are aware of the 'Healthy Child Programme offer' for their child and how to access services. Ensure that there are arrangements in place for identifying and supporting those families who find it difficult to engage traditional service arrangements and/or preventative services.
- Adopt flexible hours for community services to suit family needs especially those of fathers and young people. Develop new ways of engaging families who find it difficult to connect.
- Offer services in a range of settings and through different media that are acceptable to children, young people and families, using telephone access points for on call, texting, email and websites.
- Offer services in the home when appropriate, ensuring that all staff are competent, and that safety is a priority. Ensure lone worker policies are implemented.

5. Care planning and case management

- Use the Healthy Child Programme (0-5 years) for universal preventive services to assess risk and put into place protective actions for children and families. Each child and family should have a personalised Healthy Child Plan agreed with parents. The Healthy Child Programme (5-19 years) is currently being developed.
- Use a comprehensive approach to assessing, planning and co-ordinating the needs of the child and family using the common assessment framework (CAF).

6. Information and technology

- Explore technological options, such as Contactpoint, for improving engagement with children, young people and families and to maintain contact with mobile families and those in rural communities.

7. Education and training

- Ensure everyone in the team is competent to carry out their role and that all have regular learning opportunities. Ensure individuals and teams have up-to-date training in safeguarding, are fully conversant with safeguarding arrangements across organisations and contribute to development and audit to ensure systems are effective.
- Make sure the team understand biological, social and psychological aspects of child health and development and can work with the whole family from pregnancy onwards.
- Keep up-to-date with new learning especially in neuro-science, genetics and **infant development**. Ensure everyone understands how to promote resilience and has skills to promote positive parenting and attachment.

- Make sure all team members have regular, clinical supervision, take part in reflective discussions and in team learning.
- Develop programmes to improve the knowledge of families and carers and to provide an understanding of their child's health and development. Improve their confidence in managing minor illness and common ailments.

Working with children who have acute or additional health needs: addressing the needs of ill and disabled children and young people

In addition to accessing universal services, children and young people who are ill or disabled and their families, also require the provision of additional healthcare services in their own home or in settings close to home.

Children and their families have expressed how important it is to them that the development of services takes into account their views and experiences, that information is provided in readily accessible forms and that decisions are open and transparent.

1. Know about local health needs and plan services accordingly

- Use public health data about ill and disabled children in your population and work with commissioners to agree the local priorities for the care of sick children at home, planning services accordingly.
- Enable ill and disabled children and young people as well as their family or parent representatives to participate in joint NHS/Children's Trust service planning at every level.
- Work with commissioners to develop and implement national data collection systems, for example, child health mapping and ChiMat for identifying all children locally with additional needs.

2. Create effective health and care partnerships

- Empower parents and carers to deliver healthcare to their ill or disabled child through the provision of adequate training and ongoing support.
- Equip parents with the skills and knowledge to recognise acute exacerbations/deterioration and to treat their child or seek expert help as appropriate.
- Equip other partners such as teachers with the skills and knowledge to recognise illness and exacerbations or deterioration in a child or young person.
- Promote earlier discharge and parental support from hospital. Work closely with acute trust, ambulance trust, out-of-hours providers and Children's Trust colleagues including children's social care, education and housing.
- Work with commissioners and other health and social care partners to ensure that tailored and co-ordinated programmes of care are in place for children and young people who have complex and on-going healthcare needs. Ensure that they have the maximum opportunity to access education and social opportunities.
- Assist in transparent and equitable decision-making for the allocation of services to ill and disabled children and their families, presenting an objective case using an agreed decision support tool, such as that developed for the forthcoming continuing care framework.
- Ensure that individuals and teams are fully conversant with safeguarding arrangements across organisations and contribute to their development. Audit systems and processes to ensure they are effective.

3. Implement new services/approaches

- Integrate and co-ordinate all services that contribute to caring for a child through an illness or disability, making sure universal, preventative services continue to be offered.

- Work with commissioners, acute paediatric service providers, ambulance trusts and local GPs to avoid admission to hospital whenever possible through the development of safe and sustainable care in the community. Develop the skills of community staff to advance their roles and develop alternative referral models to avoid children being admitted to hospital.
- Build comprehensive collaborative teams with a critical mass of expertise to care most efficiently for ill and disabled children.
- Develop and offer 'buddy systems' to support families with a child with a long term or life limiting condition.
- Develop services and approaches to support siblings of children with illnesses or disabilities and for young carers.
- Explore new freedoms with parents to improve choice and personalisation.

4. Access and availability

- Provide easily accessible and transparent information, for children, young people and their families, about the local health services and support available. This will include advice on the assessment processes and how decisions are made, as set out in *Healthy Lives: Brighter Futures – the strategy for children and young people's health*.
- Develop a single point of access or referral whenever possible to enable services to be co-ordinated efficiently and give children and families simple 'one front door' access to services. This may mean partnering with those who may already use these systems eg ambulance trust and out-of-hours providers.
- Work with commissioners to develop services so that children, young people and families with an illness or disability can choose to be cared for at home at all stages of their illness or disability. This should cover acute illness or injury, long term conditions, life-threatening or degenerative conditions including palliative care and end of life.

5. Care planning and case management

- Use a comprehensive approach to assessing, planning and co-ordinating the needs of the child and family using the common assessment framework (CAF).
- Introduce a system to co-ordinate multi-agency care for each ill and disabled child and those with complex needs, for example, lead professional, case manager or key worker.

6. Information and technology

- Use new technology wherever appropriate and economic to do so to support the care of children and families at home.
- Maintain contact with families via telephone, text or email to monitor a child's condition or exchange information, as appropriate.

7. Education and training

- Ensure all staff have on-going joint training for safeguarding children and young people.
- Provide supervision for staff caring for children and families and ensure expert supervision in respect of safeguarding.
- Ensure that all staff are aware of psychological issues for ill and disabled children and their families and are competent to promote their emotional wellbeing.
- Ensure that all team members can recognise the signs of ill health, deterioration and acute exacerbations and know the appropriate action to take.

Achievement

- ★ The Healthy Child Programme is welcomed by families; coverage is high and the quality of delivery good. Parents are helped to build the foundations for a healthy life for their child and benefit from other services in their community.
- ★ Public health priorities, such as **obesity** prevention, are being addressed at a population and individual level.
- ★ Practitioners feel confident and well informed about the latest knowledge on neuro-science infant development and parenting. They are able to use evidence based methods of behaviour change and promoting psychological wellbeing of children and families.
- ★ Community health professionals and their teams are competent in safeguarding children and young people.
- ★ Children and their families are offered preventative services that are tailored to their risks and protective factors with the most vulnerable being offered evidence based intensive programmes.
- ★ Children and young people who are ill or disabled receive efficient, high quality services which improve the management of their condition. Variation in access, quality and health outcomes is reduced.
- ★ Services reduce hospital admission for children whenever possible and new services increase choice and personalisation.
- ★ Children and young people who are ill or disabled have the confidence and ability to monitor, manage or receive care at home, school and other settings.
- ★ Children start school with good communication skills and there is a reduction with language (development) delay.
- ★ Children receive care that is well planned and co-ordinated. Care plans reflect their individual needs, children are supported by case manager/key worker when appropriate and, if they choose, individual budgets should be held.

- ★ Evidence, professional consensus on good practice, experience of children, young people and families and productivity tools are rapidly appraised and adopted to increase efficiency and effectiveness – both for community services and the wider health and social care system.
- ★ Innovation and creativity is nurtured and flourishes. The Transforming Community Services (TCS) innovation and leadership award scheme generates information about what constitutes a high quality service. Lessons learned are implemented rapidly, disseminated and adopted, nationally.
- ★ Measuring quality, continually seeking improvement and demonstrating high quality services to service users, public and commissioners is endemic: we need to move from '**valuing what we measure to measuring what we value**'.

Measuring what we value

Quality indicators for community services will be piloted with clinicians and community providers in Autumn 2009. Indicators for children and families include those within the service specification for the Healthy Child Programme.

Ambition

3

Delivering evidence based practice

Actions to improve the quality of commissioning and provision through implementing evidence

What does the evidence say?

More than 18,000 studies were analysed by the Health Services Management Centre (HSMC) to examine the evidence for a range of community services.

Useful links and further information on all the studies can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

What follows are **recommended actions and their achievements** based on evidence and professional consensus and are for local organisations to consider when planning quality innovation and productivity improvements.

Tailoring services

There are a number of studies outlining why and how to match services to the individual and population needs of children and families. Longitudinal studies enable us to identify the factors that influence a child's later outcomes so that the Healthy Child Programme can be tailored to individual risks and protective factors.

Successful programmes for children and families are those that are aligned to a targeted population of interest, perhaps defined by age bands, ethnic groups, levels of disadvantage or geographic

region. They also tend to be based on a sound understanding of the underlying causes of health problems and are focused on addressing these root causes with the individual or family rather than the broader symptoms.

Information to empower children, young people and families

Clear, comprehensive information and support regarding a child or young person's condition, including sources of further support, enable children, young people and families to retain ownership of their individual lives.

A relationship based on partnership between parents, children and practitioners is the basis for effective health interventions.

New technologies

There is good evidence to suggest that establishing and maintaining contact with children, young people and families using the vast range of electronic tools promotes efficient and flexible models of working for providers, whilst enabling families to live ordinary lives.

Care at home

Evidence suggests that it is in the best interests of children, young people and their families for care to be provided at home in a family-centred environment, reducing admission to hospital wherever possible. Overall, services promoting this approach are deemed by families to best meet their needs.

Improving health and wellbeing

There is evidence to show the importance of prevention and early intervention in childhood to give children a good foundation for life. This evidence has been brought together in the latest version of the Healthy Child Programme.

Safeguarding vulnerable children

Children and young people are protected best when services are integrated, strong partnerships exist, information is shared, and where staff are appropriately trained to recognise warning signs and to act on them in a timely manner.

Choice in receiving care and treatment

Children, young people and families have indicated that they want to be able to make decisions about how, when and where they receive care. This is especially important where the child or young person has a life-limiting or life-threatening condition and is nearing end of life.

Children, young people and parents' voices

Many children, young people and their families are keen to share their experiences of health services to contribute to their development in the future. A strong voice for children, young people and parents in the design and delivery of services, has led to significant improvements in services and made them more family-centred and responsive to their needs.

Strengthening data

Good quality care relies on good quality information. Community services for children, young people and families should be informed by the best possible data and evidence.

Workforce

Evidence suggests that when delivering complex programmes to vulnerable children and families highly qualified health professionals can achieve better outcomes for children and families.

Achievement

- ✦ Community practitioners have access to, use information on evidence based practice, and their audits show that they have delivered successful outcomes to children and families.
- ✦ Commissioners and providers work together to ensure that where good evidence exists, such as the Healthy Child Programme and the Family Nurse Partnership programme this is implemented within local services.
- ✦ The time taken from identifying evidence to community testing and replication is improved.

Achievement: What do transformed community services look like?

Case study

Children's Acute Nursing Initiative: Children's Community Nursing Service; Children's Directorate of Newcastle Hospitals NHS Foundation and Trust

The Children's Acute Nursing Initiative (CANI) team was created to facilitate much earlier hospital discharge for children and young people living in Newcastle with acute illnesses, and exacerbations of chronic conditions. The service creates a 'virtual ward in the community' so that children with stable conditions can be nursed safely at home. This significantly shortens admission periods and facilitates more 'timely' discharge thus reducing family stress and disruption and the economic impact of hospitalisation.

The objectives of the service are to:

- Provide a high quality, flexible and responsive service.
- Shorten admission periods and facilitate timely discharge.
- Increase patient choice and offer care closer to home.
- Improve trust efficiency and effectiveness.

Nursing care by the CANI team include:

- Further clinical monitoring, assessment and continued treatment.
- Intravenous medication for a large number of conditions up to three times a day.
- Support and advice to reduce parental anxiety.
- Further education and information to empower parents to care for their child during the period of illness and recovery.

In the first year the service has facilitated the early discharge of 335 children and freed up to 2,318 acute bed days (1,372 days in cubicles).

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Case study

Diversity, flexibility and responsiveness: transforming services for children and young people in Rotherham

The Complex Health Needs Team is a nurse-led service providing support to children and young people with a long term condition, life limiting illness or complex health need to fit in with the child's everyday life. The team consists of community children's nurses, specialist nurses in diabetes, oncology and palliative care, generic children's healthcare assistants, special school nurses, education nurse advisor, discharge facilitator and children and family counsellor.

Five years ago services looked very different; staff groups were minimal, fractionalised, disparate and working in isolation. Children and families wanted support that fitted around their life, their children to be able to access school with the same ease as a well child, with confident nurses and carers that would walk their path. They wanted services that followed the child 'wherever they may be', spanned 24/7 and enabled access to on call. Many children are technology dependent and cannot access short break provision through social care.

Currently 287 children in schools are being supported. Feedback from children and families indicates that the 'team-around-the-child approach' and the ability to follow the child wherever they may be, has 'significantly improved continuity and quality of care', 'given assurance' and 'enhanced coping'.

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The TCS innovation award winners for services related to the care of those with children and families are listed below. The Department of Health will be working with the leads of these new and innovative services to support the successful development of these pilots. Further information and regular updates can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

The TCS innovation award winners: Children, Young People and their Families

- **NHS County Durham** – Improving quality through multidisciplinary safeguarding
- **Tees PCT** – Development of health visitor role
- **Central Lancashire PCT** – Packs and pounds – social marketing campaign for promoting healthy choices
- **NHS Sefton** – Developing a healthy workforce
- **NHS Warrington** – Public health nursing support to vulnerable families
- **South West Essex Community Services** – Growing an NHS workforce in partnership with Jobcentre Plus
- **South West Essex Community Services** – Web innovation for paediatric diabetes
- **South East Essex Primary Care Trust** – Out of hospital integrated children and young people's asthma services
- **Redbridge PCT** – Reconnect using community resources
- **Hampshire PCT** – Training to enable nutrition screening to identify at risk patients
- **Portsmouth City PCT** – Develop and support 'expert carers' targeting young carers with no access to local services
- **Winchester and Eastleigh Healthcare Trust** – Developing integrated services for children and families
- **Winchester and Eastleigh Healthcare Trust** – Installing telemedicine link to reduce ambulance journeys and hospital admissions
- **NHS Bath and North East Somerset** – New service delivery model
- **NHS Devon** – Development of health hub

- **NHS North Somerset** – Development of generic assistant practitioner
- **NHS Wiltshire** – High quality care for children and families conditions
- **Derby County PCT** – Care home support service
- **Calderdale PCT** – Innovation council
- **Kirklees CHS** – Productive teams and empowering change with service users
- **NHS Wakefield** – Integration in action
- **North Yorkshire and York PCT** – A patient-centred approach to workforce planning in community services

Ambition

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Developing and supporting people to design, deliver and lead high quality community services

Actions to consider in developing a 'social movement approach' to change owned and led by local services and practitioners

Transformational change happens when those delivering care are motivated and inspired to do things differently.

The Next Stage Review emphasised the need for a high quality workforce to deliver high quality care and introduced the healthcare professional for the 21st century being 'practitioner, partner, leader'. Contributors to the programme have built on the concept of practitioner, partner, leader to develop attributes for community practitioners that will generate radical improvement.

Many good initiatives flounder because insufficient attention is paid to the staff themselves and the actions needed to create the climate in which the desired attributes can ensure success. Organisations implementing change will want to consider how they promote such attributes in their own workforce, and the action needed on a number of fronts. How staff are educated and trained, managed and led, how services are commissioned and regulated, and how performance is monitored, can all contribute to the creation of a positive, enabling culture in which staff constantly strive to improve safety, effectiveness and experience of care. Conversely, the same factors can mitigate against empowerment, motivation and personal accountability, reducing the likelihood of success.

Social movement

A group of people with a common ideology who try together to achieve certain general goals; features include:

- Energy
- Mass
- Pace
- Momentum
- Passion
- Commitment
- Spread
- Sustainability

Demonstrating the six attributes in services for children, young people and their families

Practitioners and teams are:

Health promoting practitioners

- Working within a philosophy that promoting and maximising health and wellbeing is part of the role of every healthcare professional.
- Understanding the health needs of children and young people in your community and delivering the evidence based care Healthy Child Programme with additional support to give individual children the best start and improve health outcomes for local communities.

Clinical innovators

- Using new approaches to health and wellbeing for vulnerable children and families.
- Using new technologies to enable children with disability to maximise their potential.
- Developing and applying advanced skills and extending roles to enable children with complex care needs to be able to live at home.

Professional partners

- Listening to and valuing the views of children and young people and supporting decision making appropriate to their age.
- Ensuring that care planning fully includes children and families and is child-centred.

The six transformational attributes for community practitioners

Health promoting practitioners

focusing on health, wellbeing and addressing health inequalities

Clinical innovators and expert practitioners enabling increasingly complex care to be provided at home

Professional partners in an expert to expert relationship with patients and in building teams across organisations

Entrepreneurial practitioners exploring business opportunities including expanding social enterprise and other innovative approaches

Leaders of service transformation individual, organisational and across systems

Champions of clinical quality using new techniques and methodologies to embrace continuous improvement

- Sharing a vision and goals with partners working in cross-sector teams and with children so that services are better co-ordinated, duplication of assessment and gaps in service are reduced and users notice the difference.
- Working in partnership with others: primary care, the ambulance trust, the acute trust, social services and the third sector to join up clinical care pathways and deliver effective care, which will prevent children needing to go to hospital unnecessarily.

Entrepreneurial practitioners

- Seeking out business opportunities to develop new approaches to child health and wellbeing, and/or delivering services for children, young people and families either within existing providers or through new service partnerships or organisations. This may include thinking about **social enterprise** or **integrated care** organisations (ICO).

Leaders of service transformation

- Working with commissioners, managers, cross-sector teams and other partners to redesign services that are really child and family centred and/or targeted to the needs of young people and improve their health outcomes.
- Understanding the business process, the impact of the economic downturn and productivity/efficiency measures and how to put together a business case which can evidence value for money whilst ensuring high quality care and patient safety.
- Ability to lead a team to deliver new programmes or health promotion and/or care home, supporting people as they develop new skills and extend their role.
- Displaying influencing skills and ability to implement change.

- Modelling leadership behaviours such as solution focused, strength based with courage, integrity and excellent communication.

Champions of clinical quality

- Maximising opportunities to promote and deliver child centred care and measuring the quality of this care for safety and safeguarding, evidence and effectiveness and responding to children and families' experience.
- Using new methods and approaches and objective research and data to improve services. Ensuring team is able to measure quality in terms of safety, evidence and effectiveness through involving service users and local people to learn about their experience of services and what quality means to them.
- Using stories to understand and demonstrate the experience of service users and frontline staff.
- Displaying expert clinical skills, values and authority to champion the quality of community-based services locally.

Achievement

- ★ People are developed to be high quality community 'practitioners, partners, leaders' who can clinically own and lead local change.
- ★ Local practitioners (individually and as teams) use the transformational attributes applied to their services together with evidence based practice to become part of the 'social movement' for transformation of community services.

Next Steps: Taking forward the best practice guides

Taking forward the guides: Providers

- Share the guides widely with relevant staff and stakeholders including PCT provider committees, local partners and frontline clinical teams.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Discuss the priorities and agree an action plan for 'Getting the basics right – every time' with relevant staff and stakeholders.
- Discuss and agree with commissioners the priority high impact changes and agree the action plan for taking forward.
- Where an evidence base exists ensure this is accessible to staff and services – audit performance on evidence based service delivery.
- Gain widespread clinical, managerial and commissioning support to take forward agreed service redesign strategies.
- Build agreed priority areas for action into 2010/11 service improvement plans and, as appropriate, through service contracts which may include the **CQUIN** payment framework.
- Consider how to actively involve patients and carers in any proposals to change pathways.
- Consider reviewing the ability of local systems to support data collection and real measurement to support local improvement.

Taking forward the guides: Practitioners and clinical leaders

- Share the guides widely with all members of your team including local delivery partners.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Agree where the team can take action to improve quality based on evidence and good practice. Plan and implement local action.
- Where change requires wider action discuss and agree with senior managers the priority areas for taking forward.
- Consider how to actively involve local people, service users and carers in all proposals to change care pathways.
- Consider how change will be actioned and benefits measured – for example through clinical audit, user satisfaction, improved performance on outcomes.
- Consider the workforce implications and the impact on roles within the team.
- Identify any training and development requirements and agree a plan for addressing.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Taking forward the guides: Commissioners

- Share the guides with relevant commissioning leads including **PBC** colleagues and joint commissioning partners.
- Consider, in line with **world class commissioning**, incorporating changes into local commissioning strategies and, where appropriate care pathway.
- Discuss and agree with community providers the priority high impact changes.
- Build agreed priority areas for action into 2010/11 service specifications and contracts and, if appropriate, consider possible goals to link with, through **CQUIN** payments.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Policy documents: Children, Young People and their Families

Healthy Lives, Brighter Futures – the strategy for children and young people's health (DCSF and DH, February 2009)

Every Child Matters www.everychildmatters.gov.uk (DCSF, 2003)

National Service Framework for Children, Young People and Maternity Services (DH, 2004)

Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. (HM Government, 2006)

The Children's Plan (DCSF, 2007)

Aiming high for disabled children: better support for families (DES and HM Treasury, May 2007)

PSA Delivery Agreement 12: improve the health and wellbeing of children and young people (HM Treasury, 2007)

You're Welcome Quality Criteria: making health services young people friendly (DH, April 2007)

The Child Health Promotion Programme: pregnancy and the first five years (DCSF/DH, 2008)

High Quality Care for All: NHS next stage review (NHS/DH, 2008)

Better Care: Better Lives. Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions (DH, 2008)

Securing Better Health for Children and Young People through World Class Commissioning: a document to support delivery of healthy lives, brighter futures (DCSF/DH, 2008)

Framing the Contribution of Allied Health Professionals: delivering high quality healthcare (DH, 2008)

Modernising Allied Health Professionals (AHP) Careers: a competence-based career framework (Skills for Health/DH, 2008)

Children and Young People in Mind: final report of the national CAMHS review (DCSF/DH, 2008)

Further information on these six transformational guides, national policy, evidence based research, case studies and innovation in practice can be found on the TCS website www.dh.gov.uk/tcs – information relating to Children, young people and families can be found on www.dh.gov.uk/en/Healthcare/Children/index.htm.