NHS
South East London
Clinical Commissioning Group

Protected Learning Time Event

Thursday 17 of March 2022

CYP service delivery in Southwark's PCNs Service transformation and case based learning

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Agenda

Welcome and Introductions – Dr Robert Davidson

PCN Child Health Team, Perspectives from a Neighbourhood CYP GP Lead - Dr Nicola Hanson, Villa Street Medical Centre and Walworth CYP Team

Constipation Case study and Nursing Overview, Emma Matthews, Patch CCN Nurse

Failure to thrive- what to do next - Diana Stan, Paediatric Consultant, KCH

Bite sized learning: Top tips for common clinical scenarios in child health, Dr Chloe Macaulay, Patch Paediatrician B&R

PCN Child Health Team

Perspectives from a Neighbourhood CYP GP Lead

Dr Nicola Hanson
Villa Street Medical Centre
Walworth CYP Team

Nicola.hanson1@nhs.net

Aims

- Overview of the PCN Child Health Model
- What happens when you refer to the Child Health triage meeting
- Paediatric referring guide
- Child Health MDT
- MDT Topics/Speakers
- My reflections on the process/role
- Tips on how to make best use of the service

Each local Primary Care Network or Neighbourhood has:

A PCN or Neighbourhood Child Health team, which includes:

- An identified GP CYP lead
- A dedicated Patch Paediatrician
- A patch Children's Community Nurse

Holds a **weekly** triage meeting of CYP referred in from across the PCN / neighbourhood

1

Child Health Team: Triage meeting

2

In-reach clinic

In-reach clinic on a **4-6 weekly basis**

- Led by patch paediatrician
- Attendance by GPs is encouraged for training and education purposes

CYPHP specialist nursing service

4

- Specialist children's nurses
- Look after the child's physical and medicine management issues
- Work in conjunction with primary care providers
- Treat diagnosed conditions (asthma, eczema and constipation)
- Active case finding using EMIS call/recall for early intervention or patients can self-refer

Multi-disciplinary Team meeting (MDT)

3

Monthly MDT meeting, for all interested GPs and partners in the PCN / neighbourhood who care for CYP, such as:

- Child Health Team
- Any interested GP or nurse in primary care
- Health Visitors
- School Nurses
- Mental Health professionals

1. Child Health Team: Triage meeting

ATTENDANCE

Patient visits a primary care provider to understand more about their health issue.

REFERRAL

GP refers patient to PCN or Neighbourhood Child Health Team via email and/ or puts patient straight onto the triage list on EMIS

CHILD HEALTH TEAM TRIAGE MEETING

PCN or Neighbourhood Child Health Team discusses in detail all clinical queries and referrals, either virtually or in person.
This happens on a weekly basis.

RECOMMENDED TREATMENT

The Child Health Team recommend the best treatment for the patient:

Advice and guidance : The triage team make a recommendation to the referring clinician on further management or investigation. This is provided through 'tasks' within EMIS.

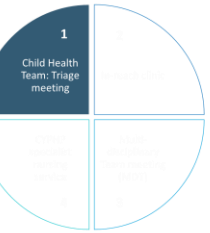
Specialist community nursing service: the child is reviewed by a CYPHP specialist nurse

In-reach Clinic: a paediatric specialist and GP work together at a local GP practice, age-appropriate site (e.g. school) or virtually to look after children's health and wellbeing

A specialist team: where specialist input is deemed appropriate, the GP is asked to refer on to a specialist team. If possible, the paediatrician will refer on behalf of the GP.

Multi-disciplinary Team meeting (MDT): Complex cases may be reviewed during a monthly MDT discussion and a recommendation provided

Paediatric Referring Guide for GPs in Southwark and Lambeth



Patient presents at GP surgery, with condition that requires secondary care input

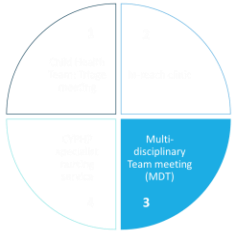
Urgent

- Immediate telephone advice required → **Consultant Connect:**
  - **Evelina:** 9:00-19:00 weekdays
  - **King's College Hospital:** 8:30-20:30 weekdays 8:30-17:30 weekends
- Advice required within 24-48 hrs → **e-RS:** Urgent advice & guidance or **PCN / neighbourhood Child Health Team** triage list if within next 2 days

Non-urgent

- Behavioural or neuro-developmental → Referral via email: gst-tr.evelinacommunityreferrals@nhs.net
- Surgical or ENT → **e-RS**
- Mental health → **CAMHS**
- Any other paediatric problem* → Your weekly **PCN / neighbourhood Child Health Team** triage list on EMIS

*(including asthma, eczema and constipation patients for nursing input)



3. Multi-disciplinary Team meeting

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

What is it?

Monthly MDT meeting, lasting one hour.

Co-ordinated by the CYP GP lead for each PCN or neighbourhood, but usually led by the patch paediatrician.

Develops relationships between patch paediatricians and local GPs.

Involves a combination of clinical discussion, review and education.

Clinical reviews: Discuss in detail more complex cases and clinical queries.

Education: Includes shared education and training sessions to help improve primary care knowledge, skills and abilities of GPs in managing CYP in primary care.

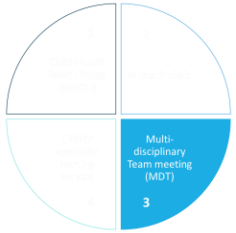
Who can attend?

For <u>all</u> interested GPs and partners in the PCN or neighbourhood who care for CYP, such as:

- Child Health Team
- Any interested GP or nurse in primary care
- Health Visitors
- School Nurses
- Mental Health professionals

All GPs within the PCN or neighbourhood are encouraged to attend.

Attendance of referrer or nominee requested if their patient is being discussed.



3. Multi-disciplinary Team meeting

GP feedback: What works well?

"The monthly meetings are excellent as we get to know the consultants and the educational aspect relevant and clear"

"Easier to have dialogue and learning opportunity"

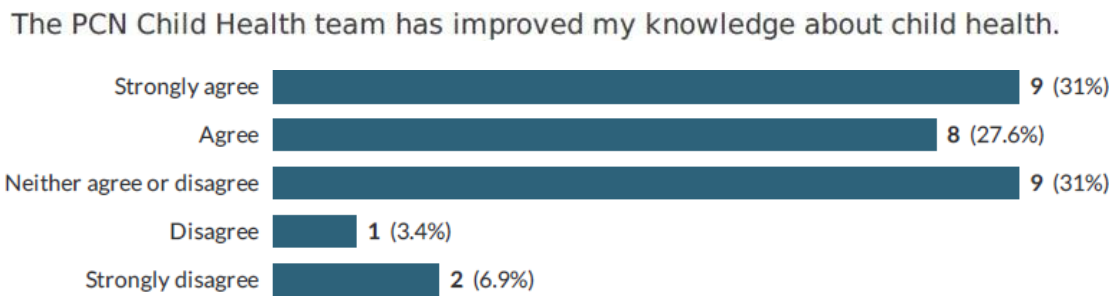
"Having a named consultant for queries and questions. Teaching sessions tailored around our learning needs."

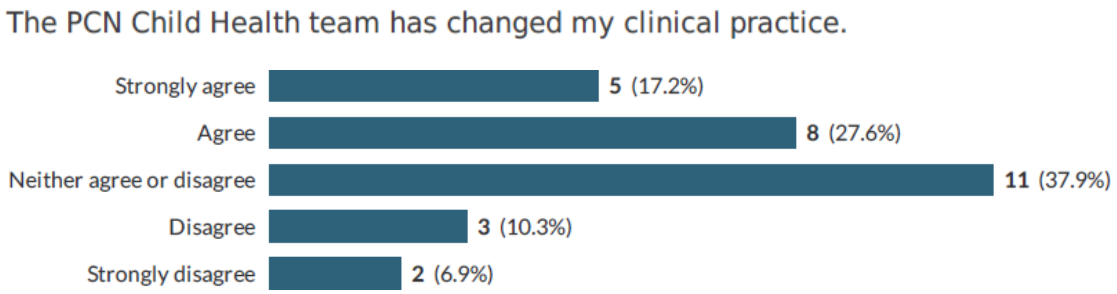
"Having lunch and learn sessions covering hot topics - this has upskilled my knowledge of CMPA and constipation management"

"Teams meeting that GPs can access during lunchtime"

"Educational presentations useful and relevant"

"Excellent learning opportunities coming to clinics / attending MDTs"





Examples of MDT Themes/Topics

Guest speakers

School Nursing Team
Community Paediatric Physiotherapy
Community Paediatric Consultant
Consultant Liaision CAMHs Psychiatrist
Children's Hospital @ Home Team
Paediatric Dietician
The Nest
Alive 'N Kicking
Community Paediatrician

Topics for Teaching

Headache
Chronic Abdominal Pain
Chest Wall Deformities
Making your practice more YP Friendly
First Few Weeks of Life
Rashes in Darker Skin Tones
Constipation

Reflections of a CYP GP

Positives

- Builds relationships
  - PCN/Neighbourhoods
  - Community teams
- Better patient care
- Encourages conversations
  - Across specialties
  - Between GPs/primary care teams
- Represent primary care to secondary care
- Collaborative thinking and working
- Learning from experienced colleagues
- Improving own practice/knowledge
- Chairing virtual meetings
- Wider interaction with allied health professionals

Challenges

- MDT attendance often small numbers
- Hosting the paediatric inreach clinics at practices
- Finding the right way to engage when everyone is busy/distracted/pulled in many directions
- Change /New service ‘itis’
- Admin

Tips to make best use of the service

- Please come and join us – either in a triage meeting or in an MDT or sit in with the paediatrician in clinic
- Particular interest/value for trainees
- Make sure you are on the email list for MDTs
- Ask for MDT topics of your interest / email your question so we can raise on your behalf and feedback
- Feedback – what works/what doesn't/how can we improve?
- Keep the cases you refer to triage as a task to r/v outcome of the triage – useful to learn from and you can enter into dialogue about that patient as needed with us.
- Cascade the learning
- Invite all allied team members to be involved

Constipation Case study and Nursing Overview

Emma Matthews
Patch CCN Nurse

Nursing Service Overview

- 1x Band 7 Clinical Team Leader, 1x Band 7 Asthma Nurse Specialist supported by 4 Band 6 Patch CCN nurses
- Health education and support for eczema, asthma, constipation
- Poor control, lack of understanding of condition or medications
- Mon- Fri 9-5 with late clinic Mon-Thurs until 6pm

Asthma	Eczema	Constipation
- Diagnosis of Asthma/Suspected Asthma** - Not under Respiratory/ tertiary care - Age 2-16yrs ***We do not offer spirometry, this is available through secondary care if required***	- Diagnosis of eczema - Not under dermatology/ tertiary care - Age 0-16yrs	- Diagnosis of constipation - Not under Gastro/ tertiary care - Age 6mths- 16yrs

Nursing Service FAQs

How do I refer?

- Refer via PCN triage or email: gst-tr.cypasthma@nhs.net OR

gst-tr.paediatricprimarycarenurses@nhs.net Please ask families to complete a healthcheck as well!

Via email- we don't have a referral form but do need to know DOB, NHS no. and overview of condition and medications.

What is your wait time and follow up?

- 6-8 week waiting time. 45 mins initial appts f2f then virtual/ tel follow up frequency dependent on patient.

How do you communicate with GPs?

- Mostly via nhs.net email for medication and patient review requests/ via telephone if urgent. We document on EMIS and notes are under All Records. We don't provide clinic letters but do send a discharge letter with treatment plan and DNA letters/ notifications.

A note on DNAs:

- If x2 initial appt DNAs or x2 failed encounters then opt in letter sent with 4 weeks to respond.
- We are an optional service so if DNA we will notify GP. If you have safeguarding concerns re engagement please let us know so we can flag to referring GP if not-responding.

What we can't do:

- We are a nurse-led service so do not diagnosis conditions and are unable to prescribe medications. Patients should already have a diagnosis on referral (or refer to PCN if unsure) and we rely on the kindness of GP prescribing! Please let us know if email is not the best method of contact
- We only see children with asthma/ eczema/ constipation as primary condition (not enuresis, VIW, allergies)

Constipation Case Study

16 year old referred via PCN triage meeting Oct 21

Background: Long hx of constipation and abdo pain, fluctuating between loose and hard stool. Previous ED attendance and GP appts, stool samples and bloods incld coeliac screen NAD.

ASD. Parental concern re length of symptoms. Previously tried Macrogol, buscopan and peppermint capsules

Patient Journey:

1. ***Oct 2021. Triaged: abdominal x-ray requested and faecal loading seen. PCN team advised GP to commence disimpaction regime with macrogol and complete gastro referral for long term follow up as patient 16***
2. ***Dec 2021. Appointment with nurse-led constipation clinic – Mum and Alex able to attend from separate locations as VC. 45minute appointment to allow for in depth education and advice. Concerns raised re diet as excluding lots of foods due to abdo pain. Reassurance given re long-term use of macrogol and how to titrate, maintenance plan given. Mum reports also on gaviscon re reflux.***
3. ***Dec/ Jan: Nursing team liaised with gastro team and referral to gastro dietitians also requested. Liaised with Paeds consultant and GP re use of gaviscon and appropriate treatment for reflux.***
4. ***Feb 2022: Seen by Gastro team***

Outcomes: Patient able to be seen quickly and plan put in place ahead of referral to tertiary team. Nursing service able to provide longer appointments so can address wider education and concerns. Quick communication between primary, secondary and tertiary care means smoother patient journey and all professionals in the loop.

Failure to thrive- what to do next

Diana Stan- Paediatric Consultant , KCH

17/03/22

DR

- DCDA
- Twin 1
- Emergency C/S for failure to progress
- BW 3.4 kg (49^{th} centile)
- Lost 400 g in 5 days (11.7%)
- Mixed fed, mainly breast, 1 top up bottle
- Frenulotomy week 4-5 , some improvement with feeding
- In 4 months gained 1 kg
- No vomiting, BO normally, no signs or symptoms of reflux or CMA

DR

- Seen her 16/09 – weight 4kg (below 0.4th centile)
- After previous discussion, already started extra top up
- Now 6-7 bottles of 45 ml SMA each (67-78ml/kg), plus breast feeding every 2 hrs
- Gained 300 g in last 8 days

DR

28/09 – 4.5kg

12/10 – 5kg

20/10- 5.34 (1st centile)

02/11- 5.5

16/11- 5.81(3rd centile)

7/02- 7.15 (13th centile)

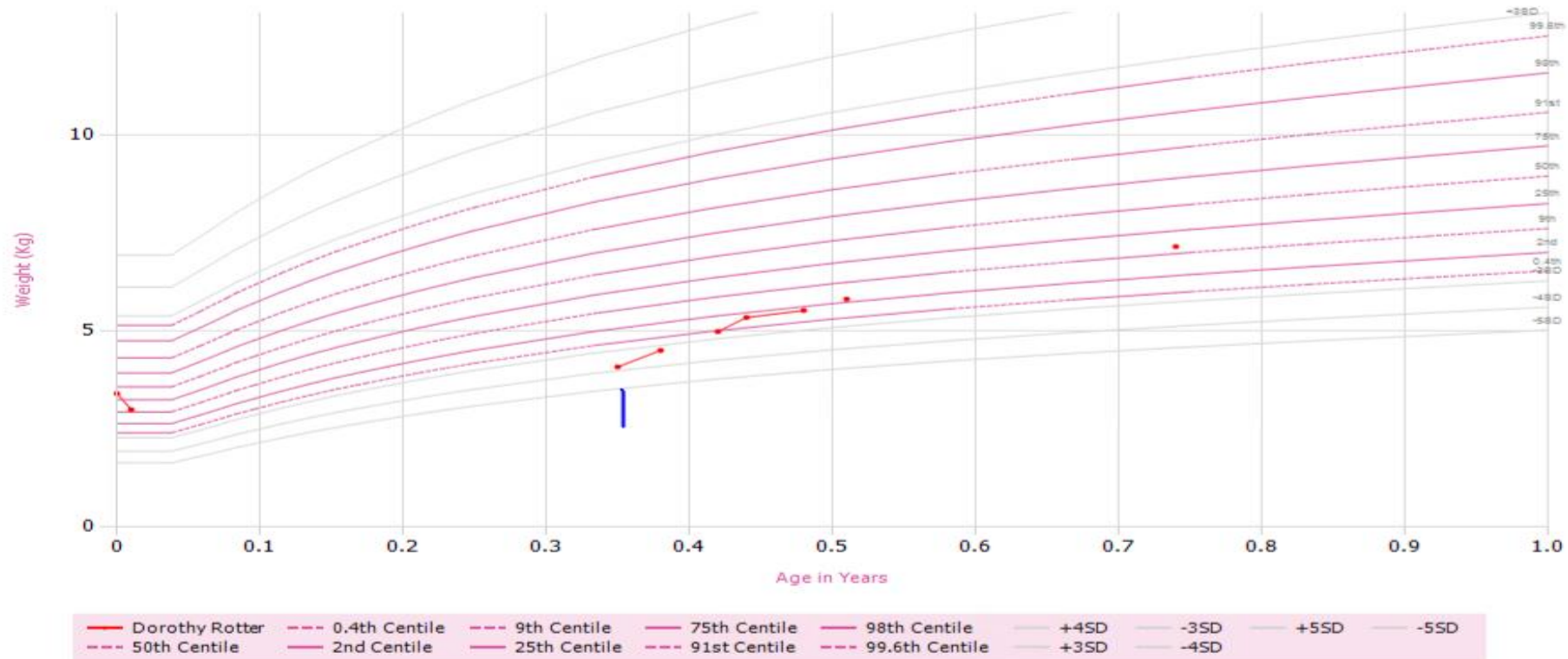
NULL

Find | Next

Weight (Kg)

[redacted]

WHO-UK growth chart



Elegant Solutions for Kings Health Partners. SC, GM, JB 12 Feb 2022 04:56 PM

CR

- DCDA twin 2
- Emergency C/S for failure to progress and transverse lie
- BW 3.7 kg (63rd centile)
- Lost 360 g in 5 days (10%)
- Mainly breast fed, 1 extra top up bottle
- Gained 1.2 kg in 4 months
- No vomiting, BO normally, no signs or symptoms of reflux or CMA

CR

Clinic day- 16/09

4.5 kg (below 0.4th centile)

Started on 6-7 bottles SMA , 60 ml each, plus freast feeding every 2 hrs

Frenulotomy week 4-5, with some improvement

CR

28/09 – 5kg

12/10 – 5.5kg

20/10 – 5.8 kg (1st centile)

2/11- 6kg

16/11-6.2kg

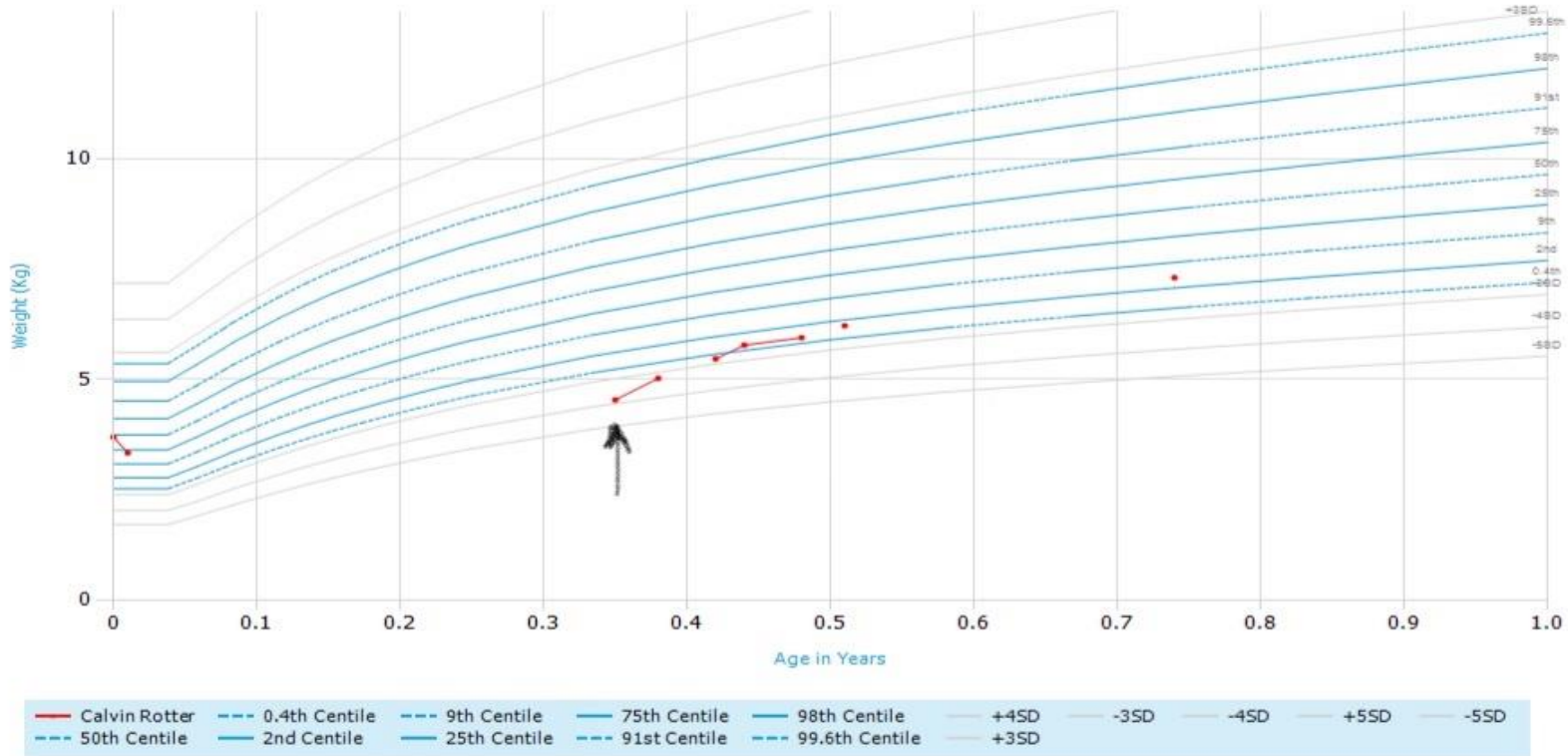
7/02- 7.3 kg (4th centile)

Next

Weight (Kg)

[redacted]

WHO-UK growth chart



Calvin Rotter | 0.4th Centile | 9th Centile | 75th Centile | 98th Centile | +4SD | -3SD | -4SD | +5SD | -5SD

50th Centile | 2nd Centile | 25th Centile | 91st Centile | 99.6th Centile | +3SD

Summary

- Consider starting top up sooner, especially when are twins, C/S, tongue tie , more than 10% weight loss initially
- If clinically well, usually main reason is reduce supply
- Refer for paediatric review sooner
- Consider other factors
  - Unwell/infections (UTI)
  - Vomiting (pyloric stenosis)
  - Tongue tie
  - CMA
  - Reflux

Bite sized learning:
Top tips for common clinical scenarios in child health

Southwark PLT March 2022
Dr Chloe Macaulay
Patch Paediatrician B &R

September 25, 2020

Case based top tips

Cases

- Anaemia
- Abdominal pain
- Diarrhoea
- Headache
- Epigastric pain
- Asthma

Top tips

- Interpreting abn fbc
- When to reassure
- When to investigate
- Importance of weight/height/exam
- New guidance

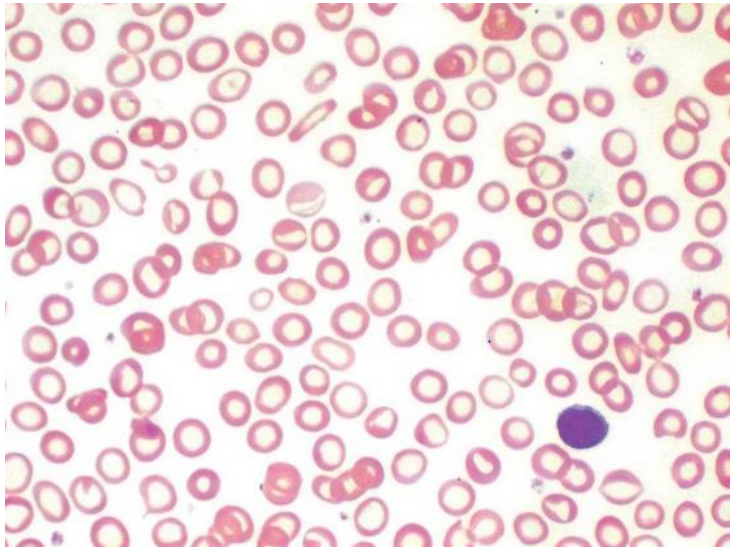
Case 1: Amelie

- Amelie 3 yrs presents to you with tiredness , needing to be carried.
- She has a normal examination
- Recent viral illness
- Review 2 weeks later – still the same

- Extra history – picky eater
- Weight is progressing along centile

Case 1: Amelie - anaemia

Bloods:	Hb 103	↓
	MCV 72	↓
	WCC 7.4	
	Lymphocytes 2.9	↓
	PMNs 1.8	↓
	Ferritin 50	



Microcytic anaemia is iron deficiency until proven otherwise

Treat with 3 months of iron

Case 1: Amelie - anaemia

Bloods:	Hb 103	↓
	MCV 72	↓
	WCC 7.4	
	Lymphocytes 2.9	↓
	PMNs 1.8	↓
	Ferritin 50	

Ferritin is acute phase reactant
Not helpful if recent viral illness
Do complete iron studies

Microcytic anaemia is iron deficiency until proven otherwise

Treat with 3 months of iron

What about the rest of the fbc?

- **High platelets** – due to incurrent illness / after infection
- Don’t worry unless very high >1000

- **Low WCC** – due to incurrent illness / after infection
- **Low PMNs**– due to incurrent illness / after infection
- **Low lymphocytes** – due to incurrent illness / after infection
- As long as child clinically well, watch and wait
- Rarely need to repeat unless neutropenia <1

Key points and learning: anaemia/fbc

- **She has a normal examination and normal weight**

- Microcytic anaemia = iron deficiency anaemia (usually)
- Ferritin can be helpful if low, misleading if normal
- Iron studies more helpful – same cost
- Abnormal fbc (with exception of very high WCC, pancytopenia or low platelets) usually self-limiting and related to viral infection

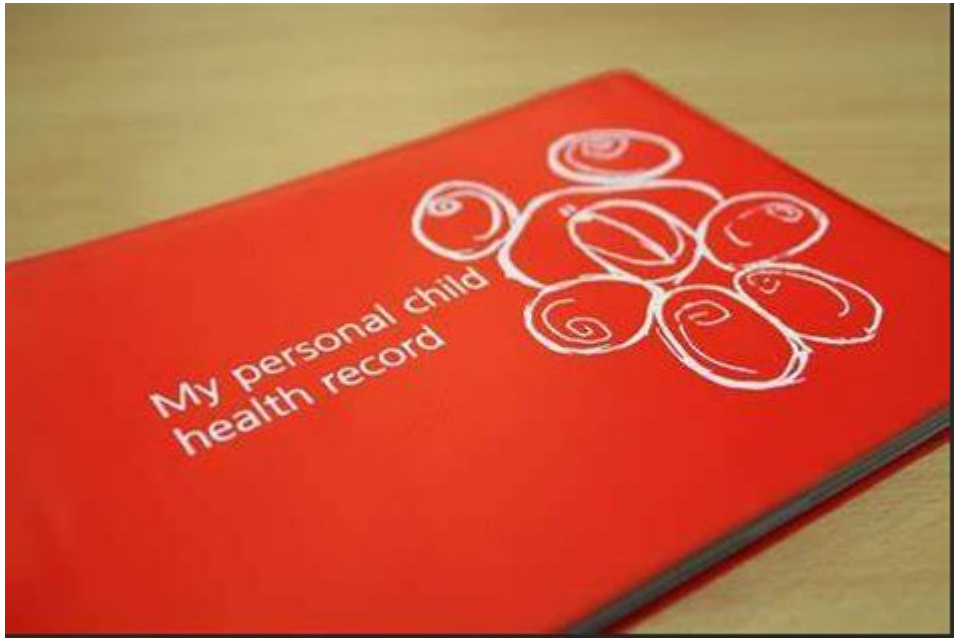
- Do not do B12 – high B12 not important

Case 2: Bilal – abdominal pain

- 5 year old boy, complaining of abdominal pain, on and off for months
- Mum “wants a scan”

- BO every 2 days, not hard, no blood, mucus
- Normal examination, normal weight
- Always around the belly button

- Should we investigate?



Abdo pain – when to worry

Rarely!

Reassuring features: normal growth, no red flags (blood, mucus), periumbilical, not localised, normal examination (often palpate faecolith LIF)

Red flags

- Faltering growth or weight loss
- Haemetemesis
- Blood or mucus mixed in with stool
- Chronic severe diarrhoea or vomiting
- Unexplained fever for more than 14 days
- Family History of Inflammatory bowel disease
- Abnormal clinical examination: pubertal delay, anal fissure, organomegaly, extra intestinal manifestation or jaundice
- Previous abdominal surgery
- Urinary symptoms/back/flank pain

Do not do "routine" investigations

USS does not help – only visualise solid organs, thickened bowel wall.

Faecal calprotectin – often raised in viral infections, often much higher than adults with acute infection

Consider coeliac disease screening *only*

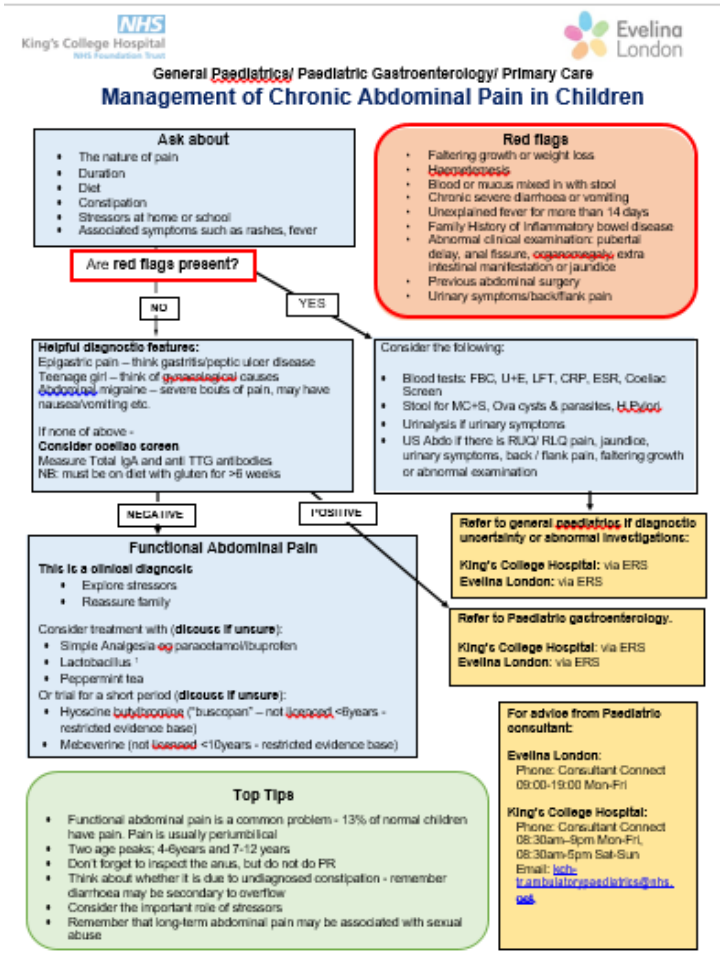
Case 2b: Bilal – abdo pain + diarrhoea

- **15** year old boy, complaining of abdominal pain
- Passing lots of **loose stool**
- Interrupting schooling – missing lots of days
- Normal examination, normal weight

- Should we investigate?
- Could we be “missing” inflammatory bowel disease?

Practical approach to abdominal pain

- Common – up to 70% children
- Commonly related to constipation
- If normal examination, normal growth – reassuring
- Diaries can help
- **Periumbilical pain** more likely functional, LIF Constipation
- Not helpful to do investigations/USS (Exception of coeliac disease)
- If diarrhoea present, may be overflow
- Do not do use faecal calprotectin to “rule in”



Case 3 Viktor - headache

- 7 year old
- 2 month history of headache, on and off, most days
- Normal eye check
- Usually in afternoon, better in holidays
- No associated visual disturbances, nausea, vomiting
- Sleeps well
- Normal examination (fundoscopy)

- 6 hours screen time weekends/3 hours weekdays

Headache – top tips

- Is this primary or secondary headache?
- Ask about associated symptoms including sleep and SCREEN TIME
- Red flags – for SOL – see one page guidance/Headsmart
- Common secondary headaches
  - Sinusistis
  - Secondary to sleep disturbance – snoring, OSA etc
- Migraine has associated features – can start younger than often thought

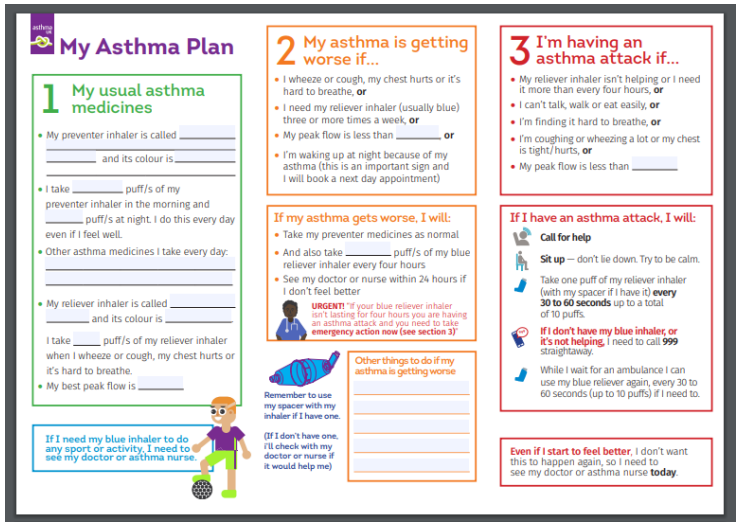
Case 4 Johnny – suspected asthma

- 3yrs old
- Recurrent episodes of wheeze with viral infections.
- Responds to salbutamol inhaler
- Never been admitted
- Coughs with change in weather

- Should I start on a preventer?

Asthma guidance

- All children with asthma should be started on preventer
- Step up and step down but step 1 involves a preventer
- All children should have an asthma UK plan
- Needing >6 puffs 4 hourly should attend ED
- No longer use weaning plans
- All children with asthma should have a spacer – never MDI alone


My Asthma Plan

1 My usual asthma medicines

- My preventer inhaler is called _____ and its colour is _____
- I take _____ puff/s of my preventer inhaler in the morning and _____ puff/s at night. I do this every day even if I feel well.
- Other asthma medicines I take every day: _____
- My reliever inhaler is called _____ and its colour is _____

I take ____ puff/s of my reliever inhaler when I wheeze or cough, my chest hurts or it's hard to breathe.

- My best peak flow is _____

If I need my blue inhaler to do any sport or activity, I need to see my doctor or asthma nurse.

2 My asthma is getting worse if...

- I wheeze or cough, my chest hurts or it's hard to breathe, **or**
- I need my reliever inhaler (usually blue) three or more times a week, **or**
- My peak flow is less than _____ **or**
- I'm waking up at night because of my asthma (this is an important sign and I will book a next day appointment)

If my asthma gets worse, I will:

- Take my preventer medicines as normal
- And also take _____ puff/s of my blue reliever inhaler every four hours
- See my doctor or nurse within 24 hours if I don't feel better

URGENT! 'If your blue reliever inhaler isn't lasting for four hours you are having an asthma attack and you need to take **emergency action now (see section 3)**'

Remember to use my spacer with my inhaler if I have one.

(If I don't have one, I'll check with my doctor or nurse if it would help me)

Other things to do if my asthma is getting worse

3 I'm having an asthma attack if...

- My reliever inhaler isn't helping or I need it more than every four hours, **or**
- I can't talk, walk or eat easily, **or**
- I'm finding it hard to breathe, **or**
- I'm coughing or wheezing a lot or my chest is tight/hurts, **or**
- My peak flow is less than _____

If I have an asthma attack, I will:

Call for help

Sit up — don't lie down. Try to be calm.

Take one puff of my reliever inhaler (with my spacer if I have it) **every 30 to 60 seconds** up to a total of 10 puffs.

If I don't have my blue inhaler, or it's not helping, I need to call **999** straightaway.

While I wait for an ambulance I can use my blue reliever again, every 30 to 60 seconds (up to 10 puffs) if I need to.

Even if I start to feel better, I don't want this to happen again, so I need to see my doctor or asthma nurse **today**.

Case 5 Sara – epigastric pain

- 9 year old epigastric pain
- Not related to foods/diary
- Normal examination and weight

- How should I manage?
- Should I do investigations? What about H pylori?

Epigastric pain – practical approach

- Trial of gaviscon/H+ blockers for 4-6 weeks

- **If no improvement – probably needs referral to gastroenterology – add to EMIS triage list for review**
- **Do not do stool tests for H pylori**
- **Do not treat with triple therapy without discussion**

H pylori disease in children

- A third of children are positive (up to 50% in developing world)
- Infection in children is largely **asymptomatic**
- Complications very rare
- **Antibiotic resistance** increasing

…. ESPHGAN guidance….

Avoid “test and treat” strategy (no stool tests)

Should only treat based on **invasive testing** with antibiotic sensitivities

Bite sized extras

- Plagiocephaly
  - Normal variant – craniosynostosis very rare
  - Monitor HC
  - No “treatment” works eg helmets
  - Reassure

- Glycosylated Hb - HbA1C
  - Do not use to diagnose diabetes in children
  - Only in overweight/obese adolescents YP looking for Type 2…

Learning points:

- **Abnormal fbc** – iron deficiency, ferritin, abnormal fbc, Vit B12
- **Abdominal pain** - High threshold of investigation
- **Stool tests** - Do not routinely do calprotectin or H pylori in stool
- **Asthma** - all asthmatics should be on preventer
- Headache – red flags, primary vs secondary headache

- Examination and weight are key.
- Use red flags to guide investigation
- Don’t forget one page guidance and your friendly PCN Child Health Team!

CYPHP'S SERVICE ARMS

THE CYPHP MODEL INVOLVES TWO DIFFERENT SERVICE ARMS

Specialist Nursing Services

- specialist children's nurses and mental health professionals
- Provide **holistic care** by looking after the child's physical, medicine management and emotional or behavioural issues
- **Specialists** in their area of care
- Work in conjunction with primary care providers
- Treat **tracer conditions – asthma, constipation, eczema**
- Active case finding using **EMIS call/recall** for early interventions or patients can **self-refer**

In-reach Clinics/Patch Paediatricians

- Relationships developed between patch paeds and local GPs
- Patch paeds (aka hospital child health specialists) and GPs (aka primary care colleagues) **run joint clinics**
- Includes **shared education and training sessions** to help improve their knowledge, skills, and abilities
- young people only sent to hospital when they need specialty
- Treats **undiagnosed patients**
- Refers patients referred via email or **ERS**

Before Covid, these two service arms were distinct but have since been brought together under the PCN model

LOCAL PCN CHILD HEALTH TEAM

IDENTIFYING LOCAL NEEDS AND PRIORITIES

A JOINED-UP APPROACH TO CARE FOR CHILDREN AND YOUNG PEOPLE

Each PCN Child Health team includes
(1) an identified GP CYP lead,
(2) a dedicated patch paediatrician,
(3) primary care paediatric nurse

ROLES AND RESPONSIBILITIES OF PCN TEAM

- Identify local needs, priorities and children who need further support or input
- Support primary care teams to manage children
- Redirect referrals and/ or queries to the most appropriate place or see patients jointly with primary care colleagues
- Ensures those that need specialist input are seen by the hospital

Meet your team:
GP CYP Lead
Patch Paediatrician
Primary Care Paediatric Nurse

THE EVOLVED PCN MODEL

A JOINED-UP APPROACH TO CARE FOR CHILDREN AND YOUNG PEOPLE

*The **evolved PCN model** will provide a joined-up approach to care for children and young people. This new model will bring together the in-reach clinics and specialist nursing services so that children and young people with complex health conditions including asthma, eczema and constipation are managed via the same team.*

DIAGNOSIS

Patient visits a primary care provider to understand more about their health issue

REFERRAL

GP refers patient to PCN Child Health Team via EMIS

PCN CHILD HEALTH REFERRAL MEETING (weekly)

PCN Child Health Team discusses in detail all clinical queries and referrals virtually

RECOMMENDATION

PCN team determines next steps for patients

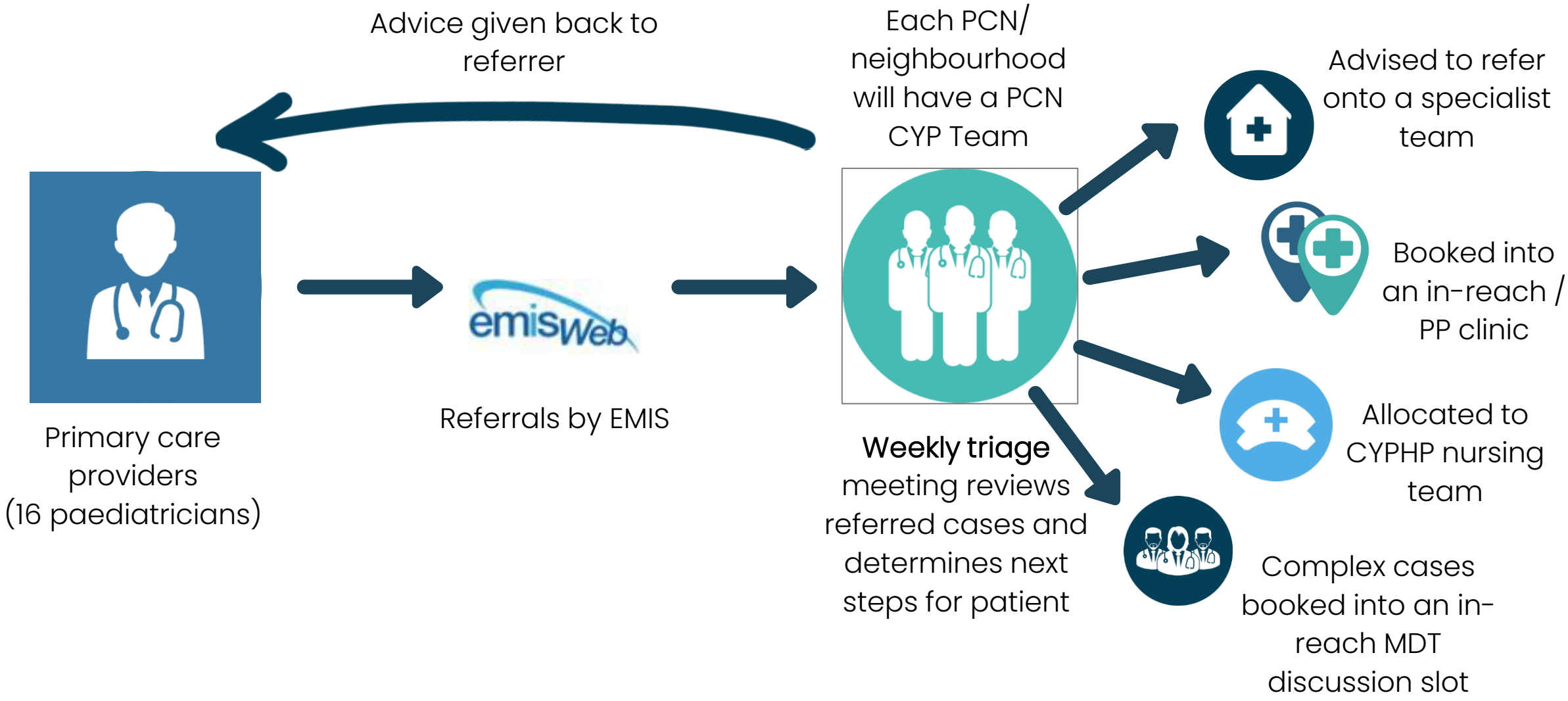
MANAGEMENT

Patient is referred for treatment to one of the following:

- A specialist team
- An in-reach clinic
- Specialist nursing service
- MDT discussion slot; or,
- Advice back to referrer

THE INREACH STORY - POST PCN/ COVID

AN INTEGRATED CHILD HEALTH MODEL, DELIVERED AND OWNED BY PCN



HOW DO I REFER/ASK A QUESTION?

- Search for “Cross organisational slot” on EMIS
- Select …
- Put clinical query in notes
- We will discuss every …. in triage meeting and write a plan in EMIS
- Then the referrer/and or admin is tasked with the outcome

THE PCN TEAM AND WIDER MDT

IDENTIFYING LOCAL NEEDS AND PRIORITIES

Each PCN Child Health team includes
(1) an identified GP CYP lead,
(2) a dedicated patch paediatrician,
(3) primary care paediatric nurse

PURPOSE OF MONTHLY MDT MEETINGS

- Discuss in detail more complex cases and clinical queries
- Attendance of referrer or nominee requested if their patient is being discussed
- Members of the wider MDT (e.g., community team, health visitors, CAMHS, etc.) are encouraged to attend
- Involves a combination of clinical reviews and education