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Joint Commissioner and Provider
Working Together Programmes

Care of the Acutely Unwell Child

Case For Change

February 2017

FINAL

Document Control

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Provider Trust Boards (Private)	January 2017	V0.3	For comment
Joint Committee of Clinical Commissioning Groups	21.02.17	V0.551	Comment on Senate observations; Assurance

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1. Executive Summary

The document sets out the basic rationale for service change in acute paediatrics, recognising that any impacts in acute paediatrics will have wider implications, and tests that rationale in light of national policy, Trust activity and workforce data, and – most importantly – Trust and commissioner self-assessments against the key national standards. Whilst the document works within geographical and clinical service boundaries of scope, it should be read in conjunction with the wider South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) Maternity and Children's (including neonates) work plan, and links with neighbouring STPs are also considered.

The data **corroborates and strengthens the basic rationale**, showing that there are **clear operational risks** (and non-adherence to standards) with particular reference to **senior medical cover**. This suggests significant **sustainability and shorter term resilience issues**, and **cost pressures** from use of agency and additional sessions.

Furthermore, there is evidence of a **lack of joined up working** by primary care, secondary care and community clinicians, and thus **decreased system resilience**, across local health communities – there needs to be strengthened planning and structure in place between the acute, primary care and community sectors.

The paper concludes that "doing nothing" is not an option and that a review of services to ensure sustainability needs to be undertaken through a strong collaborative framework. The document concludes that there is a **clear mandate for further work** and sets out some **initial priorities**, to be ratified by the STP Children's and Maternity Transformation Group, for action. A companion document and project plan to look at the shape for the work going forward have been developed. As part of the development and planning process beyond this document, we will set out the assurance requirements to support transformation and how will articulate the ways in which potential service changes meet the four tests of service reconfiguration.

2. Document Purpose: Introduction and Overview

This document is part of the joint Working Together Programmes' "Care of the Acutely Ill Child" project and sets out the national and local Case for Change in certain areas of children's healthcare services. From the outset it is recognised that any such project has significant co-dependencies, although there is a need to 'uncouple' service change projects into manageable portions.

The basic rationale for changing services is around **sustainability of services:** there are some very **significant challenges** facing children's services in acute (hospital) settings, and which have wider implications both beyond acute hospitals, and in terms of other acute services (including neonates and maternity) – The "Evidence" section (Section 6) goes into detail on this, however issues are particularly around the availability of a medical **workforce** sufficient to staff the current service configuration (including a current shortfall of 28 WTE senior posts across the area), which leads to concerns around **timely access to specialist opinion, continuity of care, and finances** as hospitals are forced to rely on expensive short term agency and locum doctors. There is also evidence to suggest that many children in our area are admitted to hospital when there could be **alternative ways of safely caring for them** nearer to home – hence this Case for Change suggests implications for community and primary healthcare services also. In some of our hospitals, **external review (e.g. CQC) has found significant problems with services**, which have already led to some collaborative working with the main tertiary unit.

This document **brings together the key pieces of evidence to support the above statements, and acts as the mandate to explore options to address our challenges**.

This Case for Change does not exist in isolation, it builds upon existing work and supporting documentation, including earlier work on Children's Surgery and Anaesthesia, and the initial Children's Services Project Initiation Document already agreed by the provider and commissioner Working Together Programme Executive Groups. The project also **sits within continuing work on the South Yorkshire and Bassetlaw (SYB) Sustainability and Transformation Plan (STP)**, and it is through this umbrella structure that links to parallel work on maternity and neonates is maintained. It aims to provide an overview of the current equitability and sustainability of our services, with the intended outcome being to inform an options appraisal document for the improvement of those services.

Specifically, the document brings together material built up through:

1) A survey of local NHS organisations' ability to meet relevant standards (from the Royal College of Paediatrics and Child Health's "Facing the Future" revised 2015 standards set)
2) Activity and workforce data provided by local hospitals
3) The outputs of engagement sessions for NHS organisations held in April and May 2016, and
4) Learning and outputs arising from a parallel project looking specifically at Children's Surgery and Anaesthesia.

This document will inform any resultant Options Appraisal and Outline Business Case (OBC) for proposed changes to children's acute services, and will be included in the OBC as an appendix.

NHS England provides four tests of any potential service reconfiguration, to provide assurance. It is proposed that the project will use the following methodology to meet those tests:

Test 1: Strong Public and Patient Engagement
Building on the pre-consultation and formal public consultation which have formed part of the NHS England Level 2 Assurance process for the separate but related Children's Surgery and Anaesthesia project, this project will utilise, develop and elaborate on that methodology, incorporating any lessons learned.

Test 2: Consistency with Current and Prospective Need for Patient Choice
This will be captured within the remit of the STP work around maternity and neonatal services and will also be a consideration as part of the consultation process.

Test 3: Clear Clinical Evidence Base
Referencing research and appropriate clinical standards, the project will demonstrate that there is strong justification to ensure services are transformed to provide the best outcomes for children.

Test 4: Support from Commissioners
A GP Lead (also clinical lead of a local CCG) is in place, and this supports engagement and leadership within commissioning organisations. Further close collaboration with clinical leads is assured through engagement and involvement at the project's Core Leaders group and the Working Together

Clinical Reference Group, which is led by the Programme Medical Director

3. What is Working Together? Background to our Programme

The Working Together Programmes are two partnerships of NHS organisations which have come together to look at how we can better deliver services in a safe and sustainable way across our area. One programme, the Working Together Partnership Vanguard, is comprised of seven NHS Trusts who deliver hospital services from twelve sites (the "providers"). The other programme, Commissioners Working Together, is comprised of eight NHS Clinical Commissioning Groups (CCGs), who commission services for their local population, plus NHS England, who assure that CCGs operate effectively to commission safe, high-quality and sustainable services within their resources, deliver on their statutory duties and drive continuous improvement in the quality of services and outcomes achieved for patients (collectively, the "commissioners"). The two programmes are working jointly on children's services, and will therefore be referred to collectively as the Working Together Programme (WTP) in this document, unless a distinction needs to be made.

The provider programme comprises the following NHS Trusts:

- Barnsley Hospital NHS Foundation Trust (hereafter BH)
- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH)
- The Mid Yorkshire Hospitals NHS Trust (MYH)
- The Rotherham NHS Foundation Trust (TRFT)
- Sheffield Children's Hospital NHS Foundation Trust (SCH)
- Sheffield Teaching Hospitals NHS Foundation Trust (STH)

The commissioner programme comprises the following NHS organisations:

- NHS Barnsley Clinical Commissioning Group (hereafter CCG)
- NHS Bassetlaw CCG
- NHS Doncaster CCG
- NHS Hardwick CCG
- NHS North Derbyshire CCG
- NHS Rotherham CCG
- NHS Sheffield CCG
- NHS Wakefield CCG
- NHS England

The WTP covers an area stretching from Chesterfield, Bolsover and Worksop in the south to Wakefield and Dewsbury in the north, with a total population of

over 2 million people (the number based on the nearest contiguous ONS data for 2015 is approximately 2.1 million – of these, around 487,000 or 23%, are children)

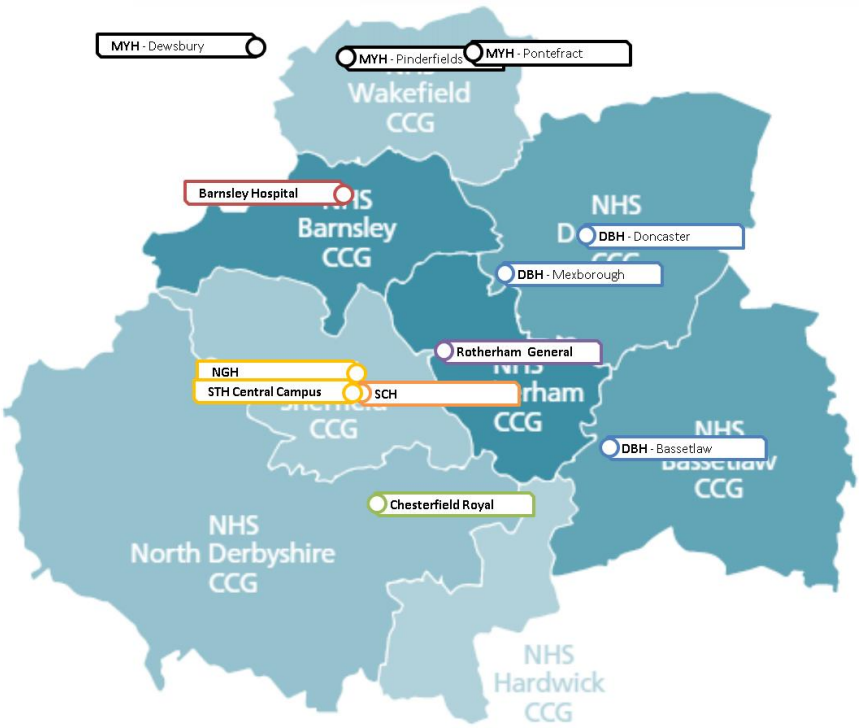


Fig 1: WTP Locations

The geography of the project's work has historically covered the seven WTP Trusts and their local CCGs. It is recognised that setting any geographical boundaries for a project of this nature will raise questions for those patient groups flowing into or out of the area. However the project scope does need to make reference to clear boundaries.

For the boundaries of the project to change, this would require specific agreement from all WTP partners. For an additional non-WTP organisation (e.g. NLAG for North Lincolnshire patients, of whom there is a tertiary flow into Sheffield, and some secondary care flow into Doncaster and Sheffield) to be brought in, this would require agreement from all WTP organisations, as it raises questions about e.g. external access to WTP project management support. Further, it should be noted that NLAG belong to a different STP region (Humber, Coast and Vale).

Given the organisational issues and likely delays inherent in considering inclusion of non-WTP Trusts, expanding the project's membership or boundaries is not currently recommended. However, as an attempt to address the issue of external flows in, the following approach will be adopted:

a) In any service modelling resulting from the Case for Change, an initial assumption will be made that non-WTP patient flows will remain unchanged (unless there is clear intelligence to suggest a change) and that those flows will need to continue to be factored into any capacity projections.
b) At an early stage, prior to detailed modelling, WTP will work with adjacent CCGs from which there is significant patient flow both to inform them of the developing project work, and to gather information on any anticipated service changes in their areas. This does not constitute an invitation for those areas to participate in this work, but it does attempt to provide clear, updated intelligence on likely patient numbers and needs.

WTP's collaborative approach is designed to ensure that patients can continue to receive services that are safe, sustainable, equitable and delivered as close to home as possible. WTP projects cover a wide range of clinical and non-clinical services and all of the projects ensure that the relevant clinicians or other appropriate professional groups are the ones who agree the current state of their service, and the issues facing it, and who design our responses to those issues.

Both commissioners and providers felt that a review of children's services should be considered jointly (see section 5 – "Why Change?") In doing this, WTP recognised that they would need to ensure that they adhere to NHS best practice around change management, competition law and procurement. Governance for this Case for Change, and any work resulting from it, is secured through the WTP children's core leaders group, which reports into the Commissioners Working Together programme board and the provider Working Together Programme Executive/Acute Federation Board.

3.1 Process to date

WTP's work on children's services began in 2014 with work around Children's Surgery and Anaesthesia, an area which has faced some particular challenges. This document covers a different area of children's services (principally unplanned inpatient care, see section 4 "Scope") and this project and Children's Surgery should be taken as two separate entities, albeit projects which do have some significant areas of overlap.

With work on children's surgery services at an advanced stage, this second project was inaugurated in early 2016, building upon learning from the ways in which we had organised our previous work.

In the initial phase, the focus has been upon developing a **baseline**

assessment of the issues facing our local hospital paediatric services. In order to do this, each NHS Trust within the WTP area was asked to complete a questionnaire requesting:

- A summary of the local service's workforce and facilities (beds, etc.)
- A self-assessment against the Royal College of Paediatrics and Child Health (RCPCH)'s "Facing the Future: Standards for Acute General Paediatric Services" on acute paediatric care[1].
- Acute paediatric activity

Separately, Trusts were also asked to complete:

- Self-assessment against the Paediatric Intensive Care Society (PICS) Care of the Critically Ill Child standards (2016)

At the same time, CCGs within the WTP area were asked to complete for their areas the Facing the Future Together for Child Health standards (2015) developed jointly by the RCPCH, the Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN).

Stakeholder feedback: To further inform the baseline assessment, the organisations, providers and commissioners, were brought together at a "Confirm and Challenge" event on 27 April 2016, where the collated evidence was fed back to the group, key themes explored and agreement reached that we, collectively, needed to pursue this work further. This Case for Change document summarises the presented evidence.

A second event was held on 18 May 2016, where the same organisations came back together and began to outline how we could collectively begin to approach the common challenges. This document is not a detailed proposal for further actions, but, because it does conclude that further work is needed to improve children's services, it makes reference to some of the broad potential areas for further action. Information can be accessed via the commissioner WTP website, www.smybndccgs.nhs.uk

This initial phase, which is concluded by the Case for Change, has also offered organisations an opportunity to network and to begin developing a more integrated and system-wide view of the future of children's acute care, as supported by the aims of the local Sustainability and Transformation Plan.

STP: Subsequent to the initiation of this project, all health communities in England have been asked to develop a Sustainability and Transformation Plan (STP) which requires them to consider ways in which they deliver health

[1] RCPCH (revised 2015) Facing the Future: Standards for Acute General Paediatric Services. RCPCH.

(and related) services across their entire geography. The STPs are a collaboration between all healthcare organisations, plus Local Authorities, voluntary sector and research and education organisations within their "footprint" area. The Working Together area is covered mainly by the South Yorkshire and Bassetlaw STP with Chesterfield and Wakefield services included in discussions as "associate members".

The South Yorkshire and Bassetlaw STP contains a clearly-defined Children's and Maternity Care workstream. Work to date on the STP shows correlation in evidence and aims between STP and WTP children's work, and it is envisaged at the time of writing that this WTP project will be the means of delivering some of the STP's aims.

As the Scope section (section 4) below also explains, WTP are highly conscious of the co-dependencies for any work on acute children's services – notably upon maternity and neonatal services, but also upon non-acute children's services and upon social care and public health. The STP workstream, in its current form, covers all of these elements within its scope, with the intention that there is an overarching governance structure to ensure that all co-dependent services are considered appropriately.

4. Scope of document: patients and services covered

The project relates to the "care of the acutely ill child", i.e:

- Children and young people, from birth to their 19th birthday, experiencing:
- Unplanned / unscheduled / non-elective incidences of acute illness, or
- Acute exacerbations of existing chronic conditions,
- **Encompassing the 36 hour period** from onset of illness until the child is either discharged or active management is underway,
- Excludes children and young people admitted to adult wards under the care of clinicians who provide solely adult services (and also due to differences in adult-child transition ages in different locality contracts across the region) and neonates in neonatal units and maternity wards (see below)

It is recognised that any change to acute paediatric services is likely to require an improved or changed offer in terms of community or primary care based services. Consequently, the Project Initiation Document (PID) for the overarching children's services project, of which this is part, suggests that this project should cover care functions delivered both inside and outside hospital:

In-Hospital workstream

Included aspects	Excluded aspects
• Urgent and acute activity for high volume children's and young people's pathways, and non-elective admissions for common childhood diseases with short lengths of stay. • Current and predicted medical and nursing workforce numbers. • Provider initiatives to integrate paediatric practitioners into rotas • Minor injuries/illness units • A&E • Short stay assessment units • Paediatric ward areas	• Obstetric and maternity services • Adult ward areas • Neonatal units • Theatre and recovery areas • Home care / hospices No other element of either specialist or general paediatrics will be considered at this stage unless the evidence base suggests this would be appropriate.

Pre-Hospital workstream

Included aspects	Excluded aspects
• Urgent activity for high volume children's and young people's pathways, and non-elective admissions for common childhood diseases with short lengths of stay. • Outpatient and community-based services aimed at managing demand, reducing admission and supporting discharge • GP practices • OOH/walk in centres • Children's community nursing teams • Community pharmacy	• Obstetric and maternity services • Adult ward areas • Neonatal units • Theatre and recovery areas • Home care / hospices No other element of either specialist or general paediatrics will be considered at this stage unless the evidence base suggests this would be appropriate.

This can involve both medical and surgical conditions (i.e. there are some acute onset conditions which require surgical management), and there is a degree of overlap in medical and surgical cases because both of them may require intervention and/or monitoring by senior paediatric medical staff or their equivalents, and in some cases resuscitation by paediatric-skilled staff may be required. However there are also important areas of distinction – this project (Care of the Acutely Ill Child) does not include within its scope any of the planned / elective surgical and anaesthetic procedures included in the Children's Surgery and Anaesthesia (CS&A) project, and the CS&A project does not include any solely medical conditions (e.g. viral or bacterial illness). Volumes of patients affected by the project are shown in Section 6.1, below.

Whilst initial contact with health services can be through a number of routes (e.g. primary care / GP, A&E, 111, Walk In Centre or direct to the ward or Children's Assessment Unit), there is an assumption under the current models that the large majority of care will be delivered in a hospital setting, either in A&E, a children's ward/inpatient area, or Children's/Paediatric Assessment/Observation Unit (hereafter shortened to CAU for convenience).

This is a useful way of categorising this group of patients based upon existing service use. Whilst this document is a Case for Change relating to those existing services, and whilst it does not make any detailed or binding

proposals for future work at this stage, it is important to note that a major consideration moving forward, based upon the evidence (e.g. provider responses to standards) presented elsewhere in this document, may be that current models of provision are not the best suited to children's needs, and/or may not be sustainable in the longer term.

Therefore, consideration will need to be given to the scope of the project as it progresses into design, OBC and implementation phases – aspects of future models for care might be delivered in other settings than solely hospital based ones (e.g. community facilities, at home with in-reach care, etc.) and might involve a different clinical workforce, or existing staff being used in new ways. Whilst the Case for Change does not make assumptions or recommendations around future service models (which would be developed through a consultative process with local clinicians, managers, commissioners and other stakeholders before a full public consultation), there is likely to be a much greater emphasis upon the role of primary and community care services in screening and / or filtering demand, and potentially in managing and supporting discharge and in coordinating post-discharge care outside of the hospital.

At present, input from NHS providers to the project is almost exclusively from acute hospitals, but given the possibilities above, careful attention will need to be given both to the scope of, and stakeholders in, the evolving project.

Whilst reference to the Paediatric Intensive Care (PIC) standards is made, the project does not include neonatology within its scope. As stated previously, there is a clear recognition throughout this document of the co-dependencies between a paediatric medicine service (comprising in and out of hospitals aspects) and neonatal services, and also by extension, maternity care. There are clear overlaps as paediatric medical rota patterns within individual hospitals may also have to cover neonatal services, and any potential change to acute paediatric rotas will have an impact downstream.

However, in order to break the wider children's and maternity workstream into achievable elements, and because of the overarching governance of the STP as previously described, maternity and neonates are intended to be addressed as separate but parallel projects under the STP.

Similarly, the management in the community and through outpatient services of long term conditions, including Neurodisability, to reduce the numbers of exacerbations and thus demand for unscheduled paediatric care must be a consideration. By extension, this would also extend to the effective management of social factors which impact upon healthcare provision. Prevention, early intervention (including child health surveillance) and

education (including parenting aspects) are highlighted within the overarching STP rationale as key drivers for delivering new models of care. Transition to adult care is also an important consideration.

A particular consideration will be links to CAMHS services, for the longer term management of patients with mental health needs, mental health liaison, and also in terms of crisis care / management of acute episodes and management of mental health aspects in an acute physical care environment.

It might be helpful to view this Case for Change as the 'first 36 hours onset' element within a suite of related Cases for Change for the STP, which are likely to include:

- Maternity services
- Neonatal services and the Neonatal Intensive Care network
- Children's Surgery and Anaesthesia (progressing through consultation)
- Inter hospital transfers both for neonates and paediatrics, including the Embrace service
- Community care services – likely to have one Case for Change per CCG, in common format
- Primary care services for children, with similar considerations to community care
- Specialised commissioning aspects
- Transitional care aspects
- Local authority services, to include screening and surveillance

This Case for Change considers the *rationale* for making changes to acute paediatric services and does not in itself propose models: As work progresses on the project and models of care begin to form, these will need to explicitly consider how a hospital can maintain effective neonatal and maternity (and other co-dependent) services even if it does not maintain 24/7 acute paediatric cover on site. As models develop, best practice examples from within SYB and beyond will be incorporated, and impacts upon co-dependent services will be a key consideration.

It is not envisaged that any decision upon future models for child health services can or should be made without a clear view of the impact upon co-dependent services.

5. Why change? Outline of rationale

The key reason for reviewing and changing our services is that currently, **local Trusts, collectively and individually, are not able to meet national standards for the safe care of acutely unwell children** (RCPCH, Facing the Future 2015), especially with regards to consultant cover arrangements at peak hours. However, there are other pressures on the system at the same time as this.

This is happening at a time of **renewed focus upon quality and safety** right across the acute healthcare sector following the Francis report into failings at Mid Staffordshire Hospitals (2013) and the Keogh report into increased mortality rates and quality concerns in some NHS hospitals (2013). CQC findings on local paediatric services in the WTP area have themselves raised specific quality concerns. NHS policy over the last few years has attempted to address these parallel funding and quality 'gaps' (e.g., the NHS Five Year Forward View, and the Dalton review, both 2014) and has tended to focus considerably on new models for delivering services in the face of this challenge.

Additionally, the acute hospital sector overall faces **unprecedented financial challenges**, with the size of the financial 'gap' in South Yorkshire and Bassetlaw alone expected to be around £300 million over 5 years. This means that, for children's services as well as adult services, it is not possible to continue delivering services as they traditionally have been. This is exacerbated by falls in funding for Local Authority/social care services.

However, aside from the financial and general quality issues facing services there are a number of **specific challenges** which suggest that a more radical approach could be taken in the planning and delivery of children's healthcare services across the WTP area.

Evidence suggests that children's healthcare in the WTP area is under significant pressure on a number of fronts. Paediatrics is by its nature a 24/7 service. As every paediatrician, parent or carer knows, the nature of childhood illnesses is that very often there is rapid progression of symptoms and increasing severity of illness in a very short space of time. This can be coupled with an inability of the child or young person to articulate their symptoms.

As a result of medical advances over the last few decades, **children's services are becoming increasingly complex and intense**, encompassing general and specialist care provision across an age spectrum from neonates to adolescents and young adults. Additionally, an increase of higher dependency nursing care is delivered within hospital wards and a greater amount of acute complex and continuing care is being provided in community and primary care settings, highlighting the importance of having staff with the right knowledge, skill and competence across the child's care pathway.

The ability of providers to deliver such high quality services has come under **significant pressure for a variety of reasons**. Based upon the SYB population, as the largest constituency within the WTP area, key issues include:

a) Health Outcomes

- The UK has one of the worst child mortality rates in Europe, and has amongst the worst morbidity rates for <5 years. Infant mortality rates exceed the England average in several WTP CCGs (PHE Health Profiles by CCG 2016)
- Nationally, 19.1% of Year 6 children are obese; 3 of SYB's 5 boroughs exceed this, and one other is very close to the average (PHE Health Profiles by Borough 2015)
- Child poverty is a factor in healthcare, and 6 of the 8 WTP CCGs score significantly worse on this indicator than the England average of 19.2% (PHE Health Profiles by CCG 2016)
- The UK has been ranked bottom out of 25 industrialised countries for the wellbeing of children

The key Child Health Profiles set for the WTP in 2016 is shown here:

Indicator	Period	England	Y&H Region	Barnsley	Bassetlaw	Doncaster	Hardwick	N Derbyshire	Rotherham	Sheffield	Wakefield
Infant mortality	2012 - 14	4	4.2	4.2	3.6	4.7	2.7	3.8	5.3	4.4	3.8
Child mortality rate (1-17 years)	2012 - 14	12	13.3	16.2	10.6	17.7	10.1	14.5	15	13.4	13.7
MMR vaccination for one dose (2 years)	2014/15	92.3	*	96.3	91.4	92.9	96	95.2	94.2	90.8	94.4
Dtap / IPV / Hib vaccination (2 years)	2014/15	95.7	*	98.1	96.5	97	98.9	98.7	97.1	96.2	97.5
Children in poverty (under 16s)	2013	18.6	20.8	23.8	17.2	23.5	21.6	14.7	22.8	23.5	20.5
Children killed or seriously injured in road traffic accidents	2012 - 14	17.9	25.6	23	23.3	24.9	19.2	16.9	28.2	23.2	23.6
Obese children (4-5 years)	2014/15	9.1	-	-	-	-	-	-	-	-	-
Obese children (10-11 years)	2014/15	19.1	-	-	-	-	-	-	-	-	-
Hospital admissions for dental caries (1-4 years)	2012/13 - 14/15	322	593.8	867.7	462.9	1017.3	219	191.8	1420.2	1023.6	431.6
Teenage mothers	2014/15	0.9	1.3	2	1.3	1.5	1.3	0.8	1.7	1.4	1.3
Hospital admissions due to substance misuse (15-24 years)	2012/13 - 14/15	88.8	-	150.2	139.3	121.1	130.4	140.9	90.1	41.9	164
Smoking status at time of delivery	2014/15	11.4*	15.6	20.4	15.8	20.5	18.6	13.1	18.3	15.1	19.7
Breastfeeding initiation	2014/15	74.3	69.8	67.6	67.9	63.1	*	80.3	62.5	80.1	63.9
Breastfeeding prevalence at 6-8 weeks after birth - previous method	2014/15	43.8	*	28.1	37.3	27.7	*	44.1	*	*	32.8
A&E attendances (0-4 years)	2014/15	540.5	511.3	574.2	482.2	484.8	228	197	487.3	801.8	526.8
Hospital admissions caused by injuries in children (0-14 years)	2014/15	109.6	113.1	95.8	96.5	131.9	105.5	106.2	105.9	80.3	122.5
Hospital admissions caused by injuries in young people (15-24 years)	2014/15	131.7	134.1	161.8	136.3	145.9	151.4	167.6	118	96	232.9
Hospital admissions for asthma (under 19 years)	2014/15	216.1	206.1	183.9	178.4	279.4	182.3	161.6	271.4	137.1	167.1
Hospital admissions for mental health conditions	2014/15	87.4	67.1	90.3	99	58	86.3	126	38.3	80.1	69.2
Hospital admissions as a result of self-harm (10-24 years)	2014/15	398.8	356.1	477	289.7	393.4	682.7	621.2	300.1	296.6	369.1

There is a consensus that child health outcomes should be improved and that location of patients should not impact on provision of healthcare access or quality of care received.

b) Community-Based Provision

- GP knowledge and confidence in the management of acute care of children is variable leading to greater reliance on secondary care services
- In some areas there is poor co-ordination of services between primary/secondary care, with fragmented provision. This is demonstrated by the responses to the RCPCH standards in section 6.
- Community provision, investment and models vary across the patch.

c) Acute Paediatric Services

- There are high levels of A&E attendance and acute admissions, with growth in recent years. Changes in primary care out of hours provision have resulted in increased attendance at emergency care departments[2]. Trusts face serious medical workforce issues, including recruitment problems, thus leading to concerns around the sustainability of individual services. This applies to trusts across the WTP area, as shown in Section 6.
    - The numbers of children's doctors coming through medical schools is expected to drop by 45% between 2012 and 2017
    - The European Working Time Directive (EWTD) - a law which looks after the health and safety of patients and staff by ensuring staff do not work excessively long hours – has impacted on children's services. There is a shortage of medical staff in the service as stated above, making it harder to meet the legal requirements of safe staffing levels. Implementation of the European Working Time Directive (EWTD) has made it

[2] RCN Defining staffing levels for children and young people's services. RCN standards for clinical professionals and service managers .2013

extremely difficult to provide safe and sustainable levels of staffing in many paediatric units[3].

- There is an increase in the number of nursing students and others requiring supervision and support in clinical environments on top of clinical care requirements[4].

- Because of the inability to fill medical rotas through permanent/substantive staff, Trusts are incurring high costs of locum/agency staff at consultant and middle grade levels to support their paediatric units to run 24/7. This is not sustainable, and does not lend itself to a committed workforce. This is evidenced through feedback from stakeholder events for the project.
    - As well as cost issues, heavy reliance upon agency and locum staff brings with it quality concerns, both in terms of a) disrupted continuity of care and lack of effective handover, and b) familiarity of transient or temporary staff with local policies, procedures, facilities and equipment.
- Trusts are not able to meet national standards for the safe care of acutely unwell children (RCPCH, Facing the Future 2015), especially with regards to consultant cover arrangements at peak hours – see Section 6.4, this forms a core part of this Case for Change document.
- Trust services also currently have substantial numbers of 24/7 beds (see section 6.3 below), although throughput to those beds can be low at times (particularly overnight) and lengths of stay are low (see section 6.1 below). Evidence (e.g. the Salford PANDA model) shows that effective triage for admissions avoidance, plus supporting discharge, can reduce demand on those beds. Whilst the Case for Change does not recommend models, one potential cost saving mechanism (in context of the financial gap as described above) might involve a consolidation of acute beds.

The challenges facing children's services are multifactorial, complex and deep rooted. These were presented, along with some of the evidence presented in Section 6 to the Confirm and Challenge event on 27 April 2016. The WTP team had proposed that the factors described here gave a strong rationale to a project aimed at re-evaluating and redesigning services for the acutely ill child. This view was endorsed by stakeholders at the 27 April event.

[3] RCPCH Facing the Future: A review of paediatric services. 2011

Temple, J Time for training: A review of the impact of the EWTD on the quality of training. 2010

[4] RCN Defining staffing levels for children and young people's services. RCN standards for clinical professionals and service managers .2013

6. CONTEXTS AND EVIDENCE: The Case for Change

This section brings together a range of evidence and data aimed at assessing whether the rationale previously discussed is valid, and whether there is indeed an evident case for change.

Data discussed here takes in numerical data (activity, workforce, etc.) but pays particular reference to Trusts' ability or otherwise to meet current standards.

6.1 Demography and activity

Based upon 2015 ONS data, the Local Authorities most closely relating to the WTP area serve a **population of around 487,000** children and young people (ages 0-19, in line with ONS bands).

Region	Local Authority	0-4	5-9	10-14	15-19	Subtotal	LA Total	*0-19 % of LA*
East Midlands	Chesterfield	5776	5676	5049	6029	**22530**	104407	***21.6%***
	Bassetlaw	6385	6253	5989	6731	**25358**	114533	***22.1%***
	Bolsover	4517	4379	4046	4492	**17434**	77780	***22.4%***
	North East Derbyshire	4797	5138	5116	5319	**20370**	99639	***20.4%***
	Subtotal	**21475**	**21446**	**20200**	**22571**	**85692**	**396359**	***21.6%***
Yorkshire & The Humber	Barnsley	14683	14152	12670	13657	**55162**	239319	***23.0%***
	Rotherham	16004	16208	14697	15382	**62291**	260786	***23.9%***
	Doncaster	18794	19224	16714	17145	**71877**	304813	***23.6%***
	Sheffield	33527	33839	29937	38177	**135480**	569737	***23.8%***
	Wakefield	20736	19842	17758	18584	**76920**	333759	***23.0%***
	Subtotal	**103744**	**103265**	**91776**	**102945**	**401730**	**1708414**	***23.5%***
	WTP Area Total	**125219**	**124711**	**111976**	**125516**	**487422**	**2104773**	***23.2%***

Figure 2 : Demography (ONS 2015)

This equates to around 23% of the total population for those areas.

Public Health England's 2015 Health Profiles show a pattern across the WTP of above England-average **deprivation** levels (for the communities as a whole – particular children's indicators are discussed in the rationale section). WTP's Yorkshire areas score worse than the East Midlands areas, with only North East Derbyshire (served largely by CRH) demonstrating low deprivation levels:

National	ENGLAND	20.4
East Midlands	Chesterfield	25.9
	Bassetlaw	27.9
	Bolsover	27.4
	North East Derbyshire	10.3
Yorkshire & The Humber	Barnsley	32.7
	Rotherham	33.4
	Doncaster	37.5
	Sheffield	34.9
	Wakefield	28.7

Figure 3 : Deprivation (PHE 2015)

The acute Trusts within WTP demonstrate a range of activity volumes. The data below shows 1) self-reported non-elective children's admissions data (for all specialties) by Trust, 2) national HES-derived Finished Consultant Episode data for paediatric medical specialties by Trust, and 3) A&E activity by Trust and time band (although data is incomplete for some Trusts on this aspect).

There are some issues in using this comparative data, particularly Trust-derived, as some organisations may count, e.g. short stay assessment visits in different ways. This, therefore, is an attempt to show a best-guess consistent picture, with the HES data as a comparator:

Based upon trust self-reported data, there were **40801** non-elective admissions in 2014-15, corresponding to 8.4% of the total population (but not excluding multiple admissions for the same child):

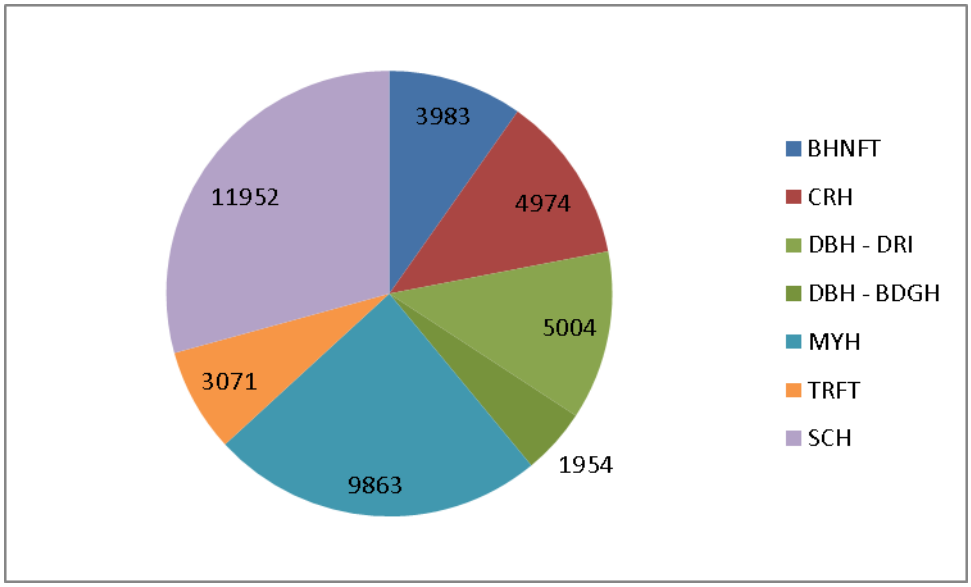


Figure 4 : Non Elective Admissions 2014-15 (Trust Data)

HES FCE data shows a higher number (61414), although there may be multiple consultant events per admission:

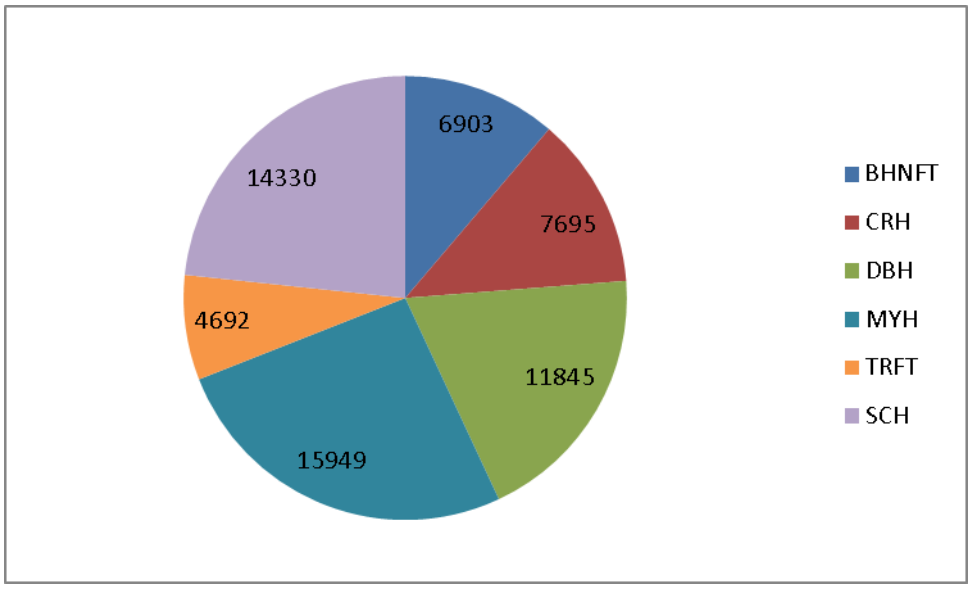


Figure 5: FCEs 2014-15 (HES)

Trusts were asked to provide admissions data for two years, although this has been complicated by counting changes as described above (e.g. in Doncaster). Where year on year data is available, and seems reliable, there are large variances in **growth rate**. An average, however, of available growth data suggests a year on year increase of **6%.**

A&E volumes are high. Although data is missing for several Trusts (MYH and CRH – outside the STP area of this analysis – and BH – not able to identify children within A&E data), volumes in 2015-16 are around 118,000 for the known Trusts (including Sheffield Teaching Hospitals as children present at A&E there on occasion). The end of the year saw a sharp rise in activity:

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	TOTAL
BHNFT													
CRH													
DBH	3213	3333	3597	3341	2819	3349	3161	3015	2720	2800	2802	3341	**37491**
TRFT	1498	1565	1593	1486	1136	1461	1542	1581	1552	1379	1447	1538	**17778**
MYH													
SCH	4801	4682	4792	4406	3590	4365	4728	5188	4703	4594	4681	5493	**56023**
STH	502	491	491	525	503	602	677	633	496	526	537	535	**6518**
TOTAL	**10014**	**10071**	**10473**	**9758**	**8048**	**9777**	**10108**	**10417**	**9471**	**9299**	**9467**	**10907**	**117810**

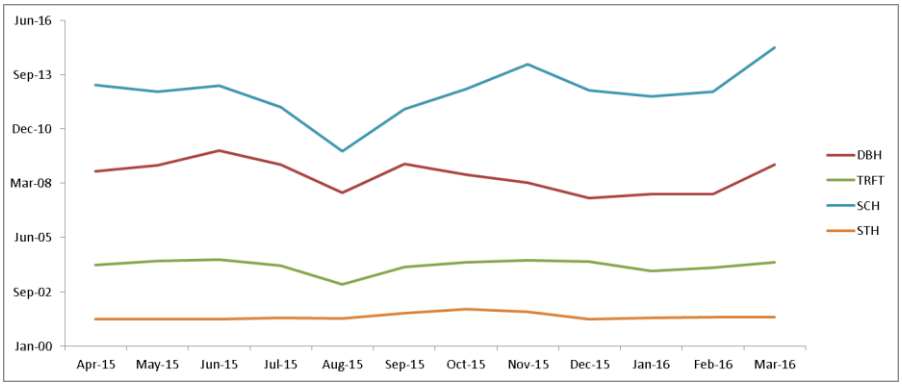


Figure 5a : A&E Activity (via Attain re STP)

Given that BH, CRH and MYH together make up 46.1% of admissions activity, an uplift by this factor in terms of A&E activity would give a WTP-wide picture of around **218,500 attendances**.

In terms of pattern of A&E attendances, this bears out the anecdotal view that overnight activity is very low (in terms of both A&E and admissions):

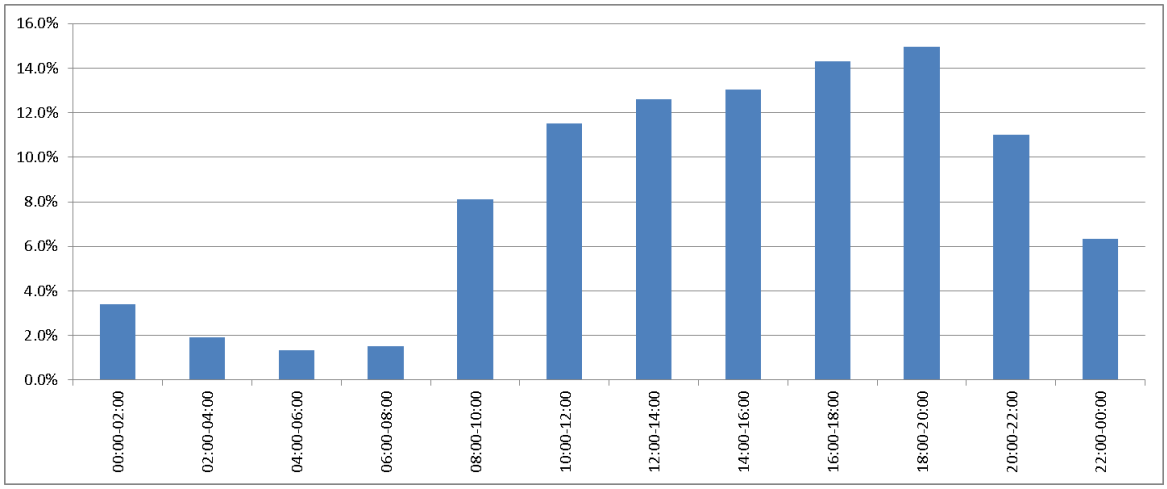


Figure 5b : A&E Activity % by Time Band (via Attain re STP)

There are variances recorded in **average length of stay**, and again these may be complicated by the individual Trusts' counting methodologies / mix of assessments and admissions. Complexity of case mix (e.g. at SCH, the tertiary centre) is also likely to influence this:

BHNFT	1.12
CRH	N/A
DBH	1.49
MYH	1.8
TRFT	2.5
SCH	2.06
Average	**1.79**

Figure 6 : Average Length of Stay (Trust Data)

Most Trusts were able to provide a breakdown of their non-elective admissions by day of the week. Responses were broadly consistent and suggest an average of **76.63% of admissions occurring on weekdays.** Fewer Trusts were able to provide data on time of day, but from available consistent timing data, linked to day of the week data above, an average of **59% of patients present "in hours"** (i.e. Monday-Friday, 08:00-22:00). Irrespective of day of the week, **a range of between 24% and 34% of admissions arrived between 00:00 and 08:00.**

6.2 Policy background

National policy and the political environment have been cited in the "Why Change?" section above. This section looks specifically at policy documents around acute children's care arising from the Royal College of Paediatrics and Child Health (RCPCH), the "Facing the Future" series.

The initial Facing the Future document, published in 2011, states that "The primary purpose of this report is to set out a series of service standards that the [RCPCH] believes are necessary to ensure that high quality healthcare is delivered to all children and young people. It is written against a backdrop of large-scale workforce pressures in many inpatient paediatric units and relatively poor health outcomes for the UK childhood population." As collated evidence shows, it therefore operates in a similar space to this Case for Change.

The 2011 document included a series of standards for delivery of safe, high quality inpatient paediatric services. These were reviewed and amended in 2015, and were accompanied by an additional set of standards from a companion document entitled "Facing the Future Together" – these new standards relate to whole health community aspects. It is these two sets of reviewed/new standards which inform the self-assessment in section 6.4 below, which is the key component of this Case for Change.

Of key importance in the 2011 document, is a **recognition of severe medical workforce shortages** which, the report proposes, **will require a change in service configuration**. The report suggests, as at 2011, a national shortage of 300 junior posts, and problematic consultant: trainee ratios, where the cited figure is 1:21, the ideal would be between 1:3 and 1:4. The paper also requests an increase in consultant WTEs nationally from 3084 to 4625 – a 50% increase which has not yet been attained.

The RCPCH have also advocated moves to enhance primary care training

in paediatrics.

As evidence below shows, these issues of medical staffing shortages at consultant and middle grades relate closely to the current experience of WTP Trusts.

6.3 Local services: Facilities and workforce (Including workforce gaps)

Consultant **workforce coverage**, based on self-declared returns from the Trusts, is as follows:

	Acute Cons in Post	Acute Cons Vacancies	% Vacant	Number on Acute Cons Rota
Barnsley	5.5	0.0	0.0%	6.5
Chesterfield	7.4	0.0	0.0%	7.4
Doncaster & Bassetlaw	12.4	3.0	24.2%	14.4
Mid Yorks	21.9	1.8	8.1%	23.9
Rotherham	5.0	3.2	64.0%	6.6
Sheffield Children's	7.3	0.0	0.0%	7.3
Total	**59.5**	**8.0**	13.4%	**66.1**

Figure 7a: Workforce – Consultant Vacancies (Trust Data, 2016)

(Note DBH are using 2.0 locums to cover rota gaps at present and TRFT are using 1.6) Some Trusts (e.g. BH, MYH) supplement their acute rotas with sessions from Community Paediatricians.

The service shows consultant gaps of 8.0WTE as the Standards section below shows, this is not adequate coverage to meet the revised RCPCH standards.

The Trusts declare larger numbers of middle grade vacancies against expected trainee numbers:

	MG Gaps
Barnsley	0.4
Chesterfield	2.4
Doncaster & Bassetlaw	6.0
Mid Yorks	1.9
Rotherham	2.0
Sheffield Children's	3.0
Total	**15.7**

Figure 7b: Workforce – Middle Grade Vacancies (Trust Data, 2016)

There are also gaps in some services relating to non-training grade middle grade doctors (i.e. Specialty Doctors, Trust Grades, Associate Specialists):

	TG/AS Gaps
Barnsley	0.0
Chesterfield	2.0
Doncaster & Bassetlaw	0.0
Mid Yorks	2.4
Rotherham	0.0
Sheffield Children's	0.0
Total	**4.4**

Figure 7c: Workforce – Trust Grade Vacancies (Trust Data, 2016)

Combining these three numbers, there are therefore **28.1 WTE senior paediatrician gaps or vacancies** across the WTP area at the time of writing. This is a significant number.

This is also shown by expenditure on agency, locums and additional sessions. There were variable responses to trusts in response to this question (including a nil response from DBH – although the data above shows that they do rely upon locum consultants), however, there are some significant figures involved.

In Barnsley, whilst there was no expenditure on or use of additional consultant sessions, the middle grade picture showed 60 additional sessions in 2014-15 at a cost of £34,126. In 2015-16, at the time of submission, data suggested a decrease to 36 locum sessions, but a year-end cost projection of **£36,800** due to a greater reliance upon (internal) additional sessions.

CRH, whilst not specifying cost and relying only upon 2 middle grade additional sessions, note that they have had to cover consultant posts with locums over the last year, to the extent of around **1.5 WTE over the year**, plus the need for additional sessions has been "covered mostly internally."

MYH show very large figures. They do not specify the number of sessions, but for the calendar year from January 2015, they show additional cost for consultant sessions of £255k locum / agency, plus £600k additional sessions. This is added to middle grade locum/agency spend of £591k and a further £10k on additional sessions, giving a Trust total of over **£1.45 million** for the year recorded.
Rotherham also show considerable reliance upon additional medical capacity. Consultant data does not include costs, but shows 22 (internal) additional sessions for 2014-15 rising to 26 sessions plus 3 agency / locum shifts for 2015-16 year to date (projecting to around 32 shifts in total). Locum and agency cover for middle grades is a particular issue, with expenditure of £63,494 on locums in 2014-15 rising to £146,451 in 2015-16 year to date, with an additional £4166 of consultant time covering middle grade shifts – predicting a total spend of **£181,000** on middle grade cover for the year.

SCH note that consultants usually swap and cover shifts internally, rather than having to take on any additional sessions. In winter 14/15 the Trust did put on a number of ad hoc twilight and weekend sessions in addition to the basic rota throughout the winter months to cope with winter pressures. In winter 15/16 this was included as extra sessions within job plans. Going forward the rota will allow for this to happen within extant job plans. The Trust do not usually experience middle grade rota gaps, but had to cover 26 short term sickness rota sessions (of which 14 used agency) over the year, at a total cost of circa **£14,000**.

In terms of sites, care has been delivered from six inpatient wards across the Trusts (with DBH having inpatient beds at only the Doncaster site from February 2017) and 7 CAUs/assessment units (Barnsley's operates 10:00-20:00 on weekdays only, there was a new CAU opened at Bassetlaw from February 2017, and MYH has CAUs at both Wakefield and Dewsbury):

	Beds	CAU Times
Barnsley	20	Mon-Fri 10:00-20:00
Chesterfield	20	None - plans developing
DBH - DRI	41	24/7 - 365
DBH - BDGH*	14	08:00-22:00 7 days
Mid Yorks*	19	24/7 365 @ PGH, DDH reducing hours
Rotherham*	12	24/7 - 365
Sheffield Children's	74	24/7 - 365
Total	**200**	

Figure 8: CAU Facilities (Trust Data, 2016, updated 2017)

However, this situation is evolving: Work is underway between TRFT and SCH on an arrangement which may affect 24/7 bed provision (but which will not diminish CAU provision) at Rotherham. MYH undertook a reconfiguration process with the 24/7 CAU at Dewsbury having reduced hours from 24 to 12 in late 2016. Planned CAU changes in Barnsley and Chesterfield (where there is no current CAU) require clarification.

High bed numbers in Doncaster are explained by the total also including assessment bed spaces on the CAU area, and 2 x higher dependency level beds. SCH bed total shown include only medical and assessment beds – surgical areas are excluded from the total.

6.4 Meeting national standards

Evidence was sought from all local acute Trusts and CCGs with regards to meeting the relevant standards set out in the two 2015 RCPCH "Facing the Future" publications. The following summarises responses in respect of both the provider and commissioner standards and shows the responses by organisation, along with an overall summary showing key areas of adherence or non-adherence. There is a further section in this document relating to the adherence to the Paediatric Intensive Care (PIC) standards.

6.4.1 Provider acute care standards

The ten RCPCH provider standards from Facing the Future (2015) are as follows:

1 A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.*

2.. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.

3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned*

4. At least two medical handovers every 24 hours are led by a consultant paediatrician.*

5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.

6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician.*

7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.

8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

10. All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.

Providers submitted a **self-assessment** against these standards and their self-declared results are shown here. It is important to note that there can be a degree of subjectivity in the responses, and where this is open to challenge, comment has been made at the end of the section.

Sheffield Teaching Hospitals did not respond to this in full, as acute children's services in Sheffield are provided by Sheffield Children's Hospitals (SCH). Results from Mid Yorkshire Hospitals (MYH) have not been received, although prior consolidation of services onto the Pinderfields site might suggest that MYH would have less difficulty complying than smaller Trusts.

This material should be taken in context of the 2015 CQC report into TRFT, which cites a number of concerns around the Children's and Young People's Service (http://www.cqc.org.uk/provider/RFR/reports).

The headline degree of compliance against each standard is as follows:

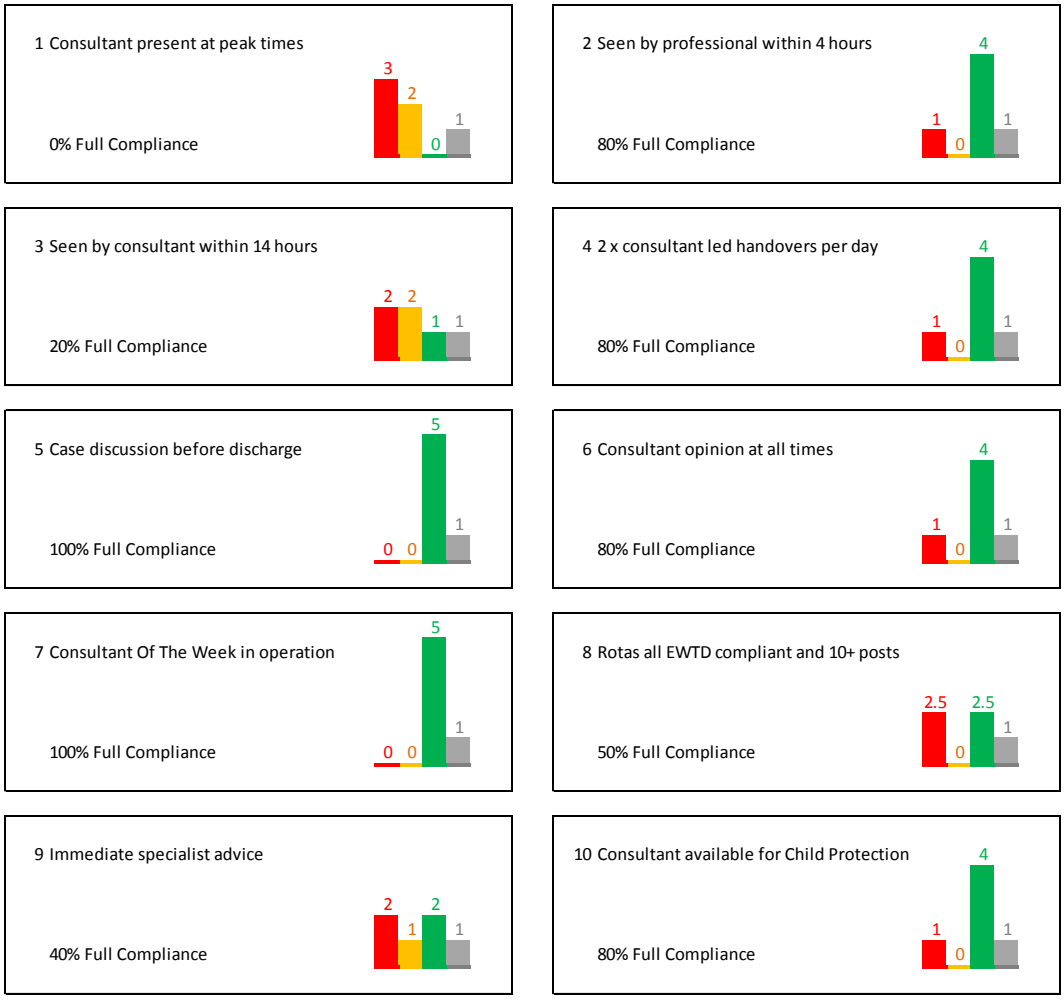


Figure 9: Facing the Future (2105) Acute Provider Standards (Trust Responses, 2016)

There are clear (and unresolved) compliance issues around consultant paediatrician cover.

No Trust is able to guarantee consultant presence at peak times (**Standard 1**). Chesterfield Royal Hospital (CRH) initially submitted a red rating on this measure, but upgraded to an amber on the grounds that they expect to comply by December 2016. SCH similarly rate themselves amber and have plans to achieve this but are not currently compliant. However, compliance is predicated upon recruitments which had not, at the time of self-assessment, come to fruition.

For **Standard 3** (child to be seen by a consultant within 14 hours), only Barnsley Hospitals (BH) self-declare themselves green, however, they note that they cannot meet the standard at weekends and need to recruit to additional posts to achieve that. Therefore, this could more accurately be rated red-amber depending upon their progress towards recruitment.
Doncaster and Bassetlaw Hospitals (DBH) declare themselves red and currently face a similar situation to BH. The situation for CRH and SCH (the two amber ratings) equates closely to the responses for Standard 1 – CRH upgraded from an initial red response and compliance in both cases is predicated upon currently incomplete recruitment processes.

Therefore a revised BH score for this standard might see a 0% compliance rating.

For **Standard 9** (access to specialist consultant opinion), views are split with Barnsley and Doncaster self-declaring themselves green on the basis that specialist advice is available from the tertiary centres – usually (and explicitly in the case of BH) from SCH. However, SCH themselves declare a red rating on the basis that only three specialties offer round the clock immediate advice. Therefore, there is potential challenge to the ability to meet this standard right across the region.

There are also issues around medical cover below consultant level. For **Standard 8** (all training rotas being European Working Time Directive (EWTD) compliant and consisting of at least 10 people), Barnsley and Doncaster (but not Bassetlaw) declare themselves compliant, but both note that they are generally not able to demonstrate this in practice due to gaps in the trainee numbers coming through to them. Doncaster also note that they frequently have difficulty in securing short term locum cover to meet these gaps. As the tertiary centre, SCH are compliant, however CRH and Rotherham (TRFT) self-declare red and TRFT notes difficulties in recruiting to posts which would make them compliant.

Other red ratings across the other Standards are distributed across Trusts. However, from the data described above, it is **clear that medical staffing at both consultant and middle grade levels is not currently compliant,** and that the situation looks even more challenging when some self-declared green ratings are challenged.

A full set of compiled self-assessment returns is included as Appendix A

6.4.2 Facing the Future Together Child Health Standards

The eleven RCPCH Facing the Future Together standards build upon the Facing the Future (2015) acute care standards in the unscheduled pathway, aiming to reduce unnecessary attendances at the emergency department and admissions to hospital by providing quality care closer to home, and are as follows:

1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a:
a) Consultant paediatrician
b) Paediatrician in Training ST6 or above
c) Advanced nurse practitioner

2. Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.

3. There is a link consultant paediatrician for each local GP practice or group of GP practices

4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs

5. Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week for advice and support, with visits as required depending on the needs of the children using the service

6. There is a link community children's nurse for each local GP practice or group of GP practices

7. When a child presents with unscheduled care needs the discharge

summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers

8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.

9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.

10. Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.

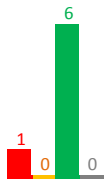
11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

CCGs submitted a **self-assessment** against these, and their self-declared results are shown here. It is important again to note that, as with provider responses, there can be a degree of subjectivity in the responses, and this is potentially open to challenge.

North Derbyshire and Hardwick CCGs submitted a joint response. The headline degree of compliance against each standard is as follows:

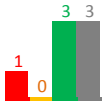
1a GP immediate phone advice - consultant

86% Green Compliance



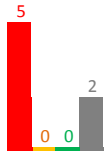
1b GP immediate phone advice - trainee ST6

43% Green Compliance



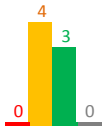
1c GP immediate phone advice - ANP

71% Green Compliance



2 Consutant rapid access service

43% Green Compliance



3 Link consultant

0% Green Compliance

4 Regular acute edication sessions

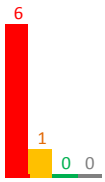
43% Green Compliance

5 Community children's nursing support

29% Green Compliance

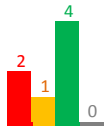
6 Link community nurse

0% Green Compliance



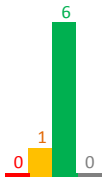
7 Electronic discharge summary

57% Green Compliance



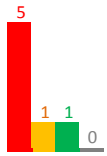
8 Verbal and written discharge info

86% Green Compliance



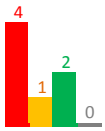
9 Access to shared electronic health record

14% Green Compliance



10 Common care pathways developed

29% Green Compliance



11 Regular formal meetings

0% Green Compliance

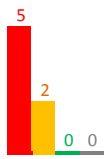


Figure 10: Facing the Future Together (2105) Acute Pathway Standards (CCG Responses, 2016)

In a clear link to the medical staffing concerns prevalent in provider responses, **Standard 3** shows that no CCG area was able to demonstrate a link consultant paediatrician for local practices.

This also resonates with a further theme apparent in CCG responses that there is of a **lack of joined up care planning overall**. As well as the lack of link consultants, no CCG is able to demonstrate a positive response to **Standard 11**, regular/scheduled formal meetings. Whilst Hardwick and North Derbyshire, who score themselves amber, are able to demonstrate some interaction under Children's Locality Partnership Groups, the other amber score (for Rotherham CCG) adjudges itself better than red only because there are plans for a new post (not yet appointed) to pick up the issue.

Similarly, **Standard 10** shows that common/shared care pathways are in place only in Doncaster and North Derbyshire/Hardwick. Again, Rotherham scores amber on the basis of an ambition to do this, although there does not appear to be concrete evidence of progress and so a red score might be more appropriate. The overall lack of a shared electronic health record under **Standard 9** exacerbates this further, although this may have different underlying causes (finance/resources, IT infrastructure, etc.). Sheffield, and to some extent Wakefield, are able to demonstrate the common use of SystmOne, although not all practices use this.

Whilst children's community nursing services exist to some extent in all areas except Sheffield and Wakefield, none of these services have yet been able to demonstrate a clear link back to each practice (**Standards 5 and 6**).

A full set of compiled self-assessment returns is included as Appendix B.

6.4.3 Paediatric intensive care standards

The Care of Critically Ill & Critically Injured Children (2016) standards cover a wide range of factors across numerous areas of acute hospital care for children. There are over 45 standards, which are grouped in specific combinations depending upon the clinical area being assessed. Each organisation is required to fill in assessments for:

hospital-wide factors, ED, Children's Assessment, Inpatients,L1 and L2 critical care and Adult ICU as appropriate.

Standards cover a range of themes, which include: access and involvement for families, environment, staffing levels, information, clinical leadership, policies and protocols and specific clinical teams.

As such, these standards do not lend themselves to an easily digestible visual presentation as do the RCPCH standards. Furthermore, analysis of the WTP Trust returns suggests a less homogenous picture of adherence/non-adherence than to the RPCH standards. Returns had not been received from either TRFT or DBH, but of those who did return data, only Barnsley recorded any red-light non-adherence.

These red lights were in two main areas. Firstly, there is a perceived lack of access to Point of Care testing in both CAU and inpatient areas – this does not represent a systematic issue for the wider WTP area, and is for the Trust to resolve locally. Secondly, there is a lack of an ED liaison consultant and an ED trauma team – the return notes that it is an executive level decision to appoint a new consultant. Clearly whilst this is a local issue, it **links to the wider concerns about medical workforce**. CRH record an amber rating ("Partially meets") in terms of nurse staffing levels in A&E and inpatient areas, with a focus on resuscitation skills in A&E, not all shifts are covered.

Beyond this, there are a small number of amber lights recorded across the Trusts, around a number of areas (family support, data collection, environment, et al.). Emerging themes show that a number of amber ratings relate to either patient and family information, or to operational policies. This suggests that there is **scope to share best practice and to standardise policies and information** in any future WTP-wide service model.

6.5 Summary and Conclusions

Taking current ability to meet RCPCH Facing the Future standards as a key factor, no one provider in primary or secondary care, nor any local health community overall, is able to demonstrate full adherence to all of the standards.

Furthermore, **two strong and highly pertinent themes** emerge from an analysis of performance against standards:

1. **There is a widespread and significant inability of acute providers to meet standards around medical workforce.** Indicators around consultant cover are largely not met, or rely upon incomplete and uncertain recruitments. Trainee rotas largely do not meet the 10-person standard and there are acknowledgements that even compliant rotas are full of gaps, and rely upon short term locums. Data from the RCPCH further suggests that these medical staffing elements will not alleviate in the foreseeable future. Numerical and financial data from Trusts on medical vacancies shows **28.1 WTE senior vacancies** or gaps across the area at the time of writing, and heavy reliance upon agency, locum and additional session capacity across many Trusts, with MYH's £1.45 million expenditure on this in 2015 as the largest recorded figure. Furthermore, there are some specific gaps in terms of, e.g. links to A&E.

2. **There is a clear lack of system-wide/joined up planning and activity between acute and primary care/community services**. This is expressed though a lack of link consultants, no demonstrable joint planning meetings other than in Derbyshire, limited evidence of shared care pathways and very few electronic shared health records.

This suggests that, whilst acute services struggle – and will continue to struggle – with staffing, **there are not currently the structures in place to address this problem.**

These key issues from the self-assessments against standards **validate and strengthen the over-arching rationale** which led the project to be established.

These are **systemic problems**, which cannot be tackled without **integrated approaches**. Furthermore, the lack of medical workforce suggests that a number of issues should be considered, either singly or in combination. Particularly, do we have the right configuration of service both to make best use of the current workforce and to offer the best and most effective service to patients? And, given shortfalls in medical workforce, have we made the best use of all aspects within our overall workforce – nursing, community assistants, et al?

Expressed as **risks**, this suggests clear risks around:

- Service sustainability in individual trusts
- Immediate local service resilience
- Quality and safety (through lack of continuity of care)
- Cost
- Health-community wide systems resilience

These suggest that there is **clear scope, and a mandate**, to consider reviewing and re-modelling approaches to care of the acute child across the WTP area, and that this **review should encompass the nature of the service, the locations where it is delivered, and the workforce to deliver it.**

7. Next steps: Proposals to progress the project

The Case for Change exists primarily as a compilation of evidence and a mandate for further work - it is not a detailed proposal in itself. Nevertheless, the Case for Change does need to make a small number of concrete proposals in order that the project can progress. This section sets out the immediate steps which should be taken in order to move the project on. Developing Project Plan documents are providing further detail some of the direction which the project might take beyond that.

It is proposed that delivery on the steps included here and in the accompanying paper continues to be led via the Working Together Programme's children's project team, responsible to the STP Children's & Maternity Transformation Board. Individual NHS organisations will be represented through their places on WTP executive groups and any task and finish groups set up to support the work.

As stated above, there are some **immediate steps** which should be taken on the back of this document:

1. Sign off of Case for Change at provider and commissioner WTP governing bodies, having taken the document via the appropriate clinical sub group for their comments.
2. Detailed work plan to be updated on the basis of this – referencing other linked projects (e.g. children's surgery and anaesthesia). This should include, as a minimum:
    a. Options development and appraisal
    b. Equality Impact Assessments on options
    c. Financial planning / analysis against options
    d. Public engagement and potential subsequent consultation
    e. STP links
    f. Y&H Senate review of options
    g. NHS Assurance processes
3. Communications and Engagement Plan as an early priority

Appendix A - Facing the Future - Acute Standards, Response Summary

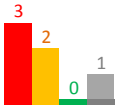
Standard	Barnsley	Chesterfield	Doncaster & Bassetlaw	Mid Yorks	Rotherham	Sheffield Children's
1 A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.*		Paediatric consultant currently on site 9 am to 5 pm 7 days a week. Peak activity 4pm to 9 pm every day. Recent expansion plus one recruitment to one additional post (recruiting at present) brings us to 10 consultants to enable compliant rotas to be in place from December				Plan to achieve. We currently have a resident consultant paediatrician 9.00am – 5.30pm Monday to Friday and 9.00am – 1.00pm Saturday to Sunday. We have a recruitment plan and proposed timetable/rota to achieve by 2019 which will mean increasing resident consultant paediatrician cover until 10pm, 7 days per week (our peak activity in terms of non-elective attendances/admissions is generally 5-10pm). This plan has been taken to the Trust Executive Group, who are supportive of the proposal.
2.. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.	Yes. The Trust does meet this standard however does suffer from deanery gaps at middle grade which can give rise to operational difficulties in meeting this standard 100% of the time	· Current challenges with regard to sustainability: 1WTE trainee on maternity leave until September, 1WTE post filled by 0.6WTE trainee until Feb 2017. Covered by LT locum. Currently reviewing establishment and considering alternative workforce solutions	Yes. Sustainability challenge = Gaps in rotations , shortage of Paeds locum staff and continual difficulty in staffing full rotas on two sites			Yes, with plan to improve. Wed do achieve a 4 hour review in the majority of cases. We currently have 2 middle grade paediatricians available at the busiest times and with the introduction of an additional twilight Consultant Paediatrician and day time acute assessment consultant cover this will become a more robust system.
3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned*	Yes. The Trust currently meets this standard Monday to Friday however although met, this can be a challenge at weekends until additional Consultant posts recruited to	· Expect to have in place by Dec 2016				Plan to achieve. We are not currently compliant as we only have resident consultant cover between 9.00am and 5.30pm so any patients admitted between 5.30pm and 7.00pm will not be reviewed by a consultant within 14 hours. However, we have a recruitment plan and proposed changes in rotas in place to ensure resident consultant cover until 10pm, 7 days per week by 2019. Only risk to this is if we are unable to recruit but this is unlikely to be a problem based on recent numbers of applicants to such posts.

4. At least two medical handovers every 24 hours are led by a consultant paediatrician.*		· Yes. 2 handovers are led by a consultant daily No sustainability issues currently.	Yes. This is sustainable at present		Yes. Morning handover (08:30) and afternoon handovers (16:00) are Consultant led. Night handover (20:30) is between middle-grades, unless consultant called back to deal with emergency. No consultant twilight shift in place to cover night handover. Insufficient consultant staff / funding to achieve this currently.	Yes. We have 2 handovers led by a consultant paediatrician in the week – one at 9am and one at 4.30pm and at the 9 am and 1pm at weekends. We have no issues with sustainability of this as we have just recruited several consultant paediatricians and will be doing further recruitment in the next 2 years. The timings of the handovers may change slightly once we introduce twilight shifts but that will ensure that there at least two medical handovers every 24 hours, 7 days per week.
5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner	Yes	Yes. There can always be a discussion with an appropriate paediatrician	Yes. Sustainability issues = Gaps in rotations, shortage of available Paeds locum staff and continual difficulty in staffing full rotas at two sites		Yes. All patients are seen and / or discussed with middle grade and / or consultant prior to discharge. No sustainability issues, consultant of the week system in place	Yes. We have issued guidance to consultants to ensure that all patients are at least discussed with an appropriate clinician before being discharged. Currently 95% of admissions are reviewed by a consultant and all are reviewed by a middle grade paediatrician. With the additional consultant presence it is increasingly likely that they will be reviewed by a consultant. Unlikely to face issues with sustainability.
6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician.*	Yes		Yes. This is sustainable at present		Yes provided by consultant of the week / on-call consultant	Yes. Access is available 24/7 via telephone from the consultant paediatrician on-call but they are currently non-resident between 5.30pm and 9.00am
7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.	Yes, the Trust operates a 1:6 "hot week" rota	Yes. Currently on a 1:8 rota - moving on to a 1:10 rota from December 2016 .	Yes. This is sustainable but inevitably impacts on clinic capacity, review lists etc as clinics are cancelled for COTW		Yes. Consultant of the week system in place, currently recruiting to vacancies however Consultant of the week is always provided as a minimum	Yes, well established 'consultant of the week' system. The Trust has recently implemented a second consultant ward round in the mornings, 5 days per week in the summer and 7 days per week in the winter so there will be 2 attending consultants at these times. No anticipated issues with sustainability.

8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.	Yes. Although we have an establishment for 10/10 rotas we rarely have this actual number because of gaps at both levels		This is **met at Doncaster** but there are always gaps on the rotations and frequent difficulties in securing locum cover. This is **not met at Bassetlaw**			Yes, we usually have between 17-21 on the level 2 rota and 18-20 on the level 1 rota. All rotas are regularly hours monitored and have been found to be compliant. Only concern around sustainability is the increasing number of gaps on training rotas.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.	Yes. Specialist paediatric advice is available from our Tertiary centre at SCH	Only some specialties supported across current networks. Diabetic advice is available internally for consultant paediatricians through 2 diabetes consultants. PICU/ Neonatal advice available through the network 24/7.Renal advice is available through renal on call consultant from Nottingham 24/7. For all other specialities advice from tertiary consultants is available directly during 9 – 5 hours from tertiary centre at Sheffield and out of hours for any sick patient via the PICU / Embrace team who are able to access all specialist advice needed for us. .	Yes. Specialist advice is sought from tertiary centres if needed_or from our own specialist consultants eg Paed diabetes			
10. All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.	Yes	Yes. We anticipate joining a regional service for CSA at some point when established	Yes. Child Protection clinics held 5 days per week plus out of hours covered on Children's Assessment Unit. CP clinics frequently empty so not best use of consultant time			Yes – general paediatric on-call rota is available 24/7 and staffed by clinicians with the required level of training. No anticipated issues with sustainability.

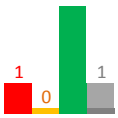
1 Consultant present at peak times

0% Full Compliance



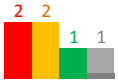
2 Seen by professional within 4 hours

80% Full Compliance



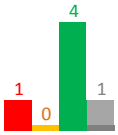
3 Seen by consultant within 14 hours

20% Full Compliance



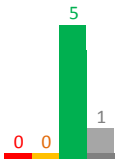
4 2 x consultant led handovers per day

80% Full Compliance



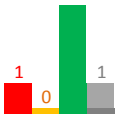
5 Case discussion before discharge

100% Full Compliance



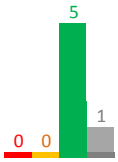
6 Consultant opinion at all times

80% Full Compliance



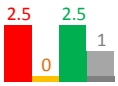
7 Consultant Of The Week in operation

100% Full Compliance



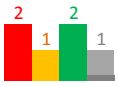
8 Rotas all EWTD compliant and 10+ posts

50% Full Compliance



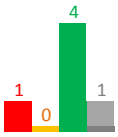
9 Immediate specialist advice

40% Full Compliance



10 Consultant available for Child Protection

80% Full Compliance



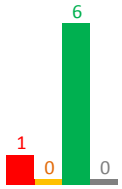
Appendix B - Facing the Future Together: Child Health Data Collection Tool - Response Summary

Mar-16

No.	Standard	Barnsley CCG	Bassetlaw CCG	Doncaster CCG	N Derbyshire & Hardwick	Rotherham CCG	Sheffield CCG	Wakefield CCG
1	GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.	Access to consultant although activity and calls not monitored	GPs can call the on call consultant to discuss urgent paediatric cases.	Access to consultant although activity and calls not monitored	Access to consultant although activity and calls not monitored	GP access available from ward based consultant and on call consultant	On call admission service in place but this doesn't work well as an advice service. Some ad hoc advice from elective consultant paediatricians for GPs where	Consultant paediatrician available
	a) Consultant paediatrician	Consultant paediatrician		Consultant paediatrician	Consultant paediatrician	Consultant paediatrician	Consultant paediatrician	
	b) Paediatrician in Training ST6 or above	Paediatrician in Training ST6 or above	NK	Paediatrician in Training ST6 or above	Paediatrician in Training ST6 or above	NK	Paediatrician in Training ST6 or above	NK
	c) Advanced nurse practitioner	Advanced nurse practitioner	NK	Advanced nurse practitioner	Advanced nurse practitioner	Advanced nurse practitioner	Advanced nurse practitioner	NK
2	Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.	Children can be seen urgently with the CAU between 10 – 20.00 Mon – Friday. Outside of these hours children requiring urgent attendtion would be admitted to the ward. Consultant paediatrician available Mon – Fri 09.00 – 17.00, outside of these hours, resident registrar and on call consultant cover currently reviewing processes within CAU	Following a call with the on call consultant children can be arranged to be seen the same day or next day dependent on need.	Consultant delivered RAC. Activity can be monitored and audited	Consultant delivered RAC but recognise the need to strengthen GP engagement and feedback in the rapid access service. Providers to tackle this as part of developing the service to ensure it is well utilised and for appropriate needs. Activity can be monitored and audited	Consultant delivered 4 days per week 48 hrsbooking rules. Service evaluation in progress	A new Rapid Access Clinic will commence in April 2016. A paediatric consultant or senior trainee will provide a telephone consultation and/or accept the patient for an appointment at the RAC. A paediatric consultant or senior trainee will triage and accept patients for appointment at the RAC for that day or the following day.	No. A registrar led rapid access service with access to a consultant paediatrician exists
3	There is a link consultant paediatrician for each local GP practice or group of GP practices	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist
4	. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs	No such arrangements currently exist	The education session are GP led not Consultant Paediatrician led	DGH currently provides PLT events and this activity can be monitored	No such arrangements currently exist	PLT events currently take place with contribution from CYPS Mainly safeguarding and acute pathways	In 2015-16, a masterclass programme in paediatrics for GPs and practice nurses has been delivered by the CCG in partnership with SC (NHS) FT and Sheffield Hallam University. An evaluation of the programme will be conducted on its completion.	GPs are invited to some education sessions but these are not regular sessions.
5	Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week for advice and support, with visits as required depending on the needs of the children using the service	A community nursing service is available to support the acute general service It operates Monday to Friday 09:00 to 17:00 Oncall arrangements only for Diabetes	There is a community Nursing Team managed by a different provider to facilitate discharge for complex children and those with some nursing needs. It operates 09:00 - 17:00 Mon - Fri	A community nursing service is available to support the acute general service It operates Monday to Sunday 09:00 to 17:00	The CCN team is staffed during "office hours" of 09.00-17.00 and through a pager on-call system out-of-hours to provide 24/7 cover to children and young people who are on the service's caseload. Although data on this aspect of the service is not monitored, the service has recently undertaken an audit of on-call activity.	CCN service is currently provided by the Complex Needs Team operating weekdays and limited hours on a weekend. The focus is upon children with complex disability with limited capacity to deal with acute illness follow up and hospital avoidance	No such arrangements currently exist	No such arrangements currently exist
6	There is a link community children's nurse for each local GP practice or group of GP practices	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist. The service operates on a condition-specific rather than geographical basis, which currently hinders linkage to GPs/localities.	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist
7	When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers	Discharge summary received electronically by the GP Summary received within 24hrs of discharge Parents and carers have copies of this information Can monitor via Lorenzo	Discharge summary received electronically by the GP. Summary received within 24hrs of discharge. Parents and carers only receive copies if requested	No such arrangements currently exist	Discharge summary not sent electronically or received within 24 hrs, parents received copies of this information	RFT working towards these arrangements – timescale for achievement not identified.	Discharge summary received electronically by the GP Summary received within 48hrs of discharge Parents and carers do not consistently have copies of this information	Discharge summary received electronically by the GP, not always within 24hrs of discharge
8	Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.	Discharge advice is provided to parents / carers in written format for some conditions. Discharge advice is provided to parents / carers verbally There is an open / direct access policy in place on the ward	Discharge advice provided verbally, written advice depends on illness and injury. There is open access to the ward	Discharge advice provided to parents verbally but not in written format. Open access to ward. Activity not currently monitored or audited	Discharge advice provided to parents in written and verbal format. Open access to ward. Activity not currently monitored or audited	Condition specific leaflets given at discharge. 48 hour open access given routinely at discharge. Minor illness advice sheet can be modified and used in secondary care for safety netting at discharge	Discharge advice provided to parents verbally not consistently in written format. Open access to ward. Activity not currently monitored or audited	Discharge advice is provided verbally and in written format but not as an individual care plan.
9	Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.	No such arrangements currently exist	No access to electronic record but summary of unscheduled visit shared via Paediatric Liaison pathways	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	Sheffield Children's Hospital has access to Systm1 (not all practices use this system); health visitors and school nurses use Systm1.Record sharing for all under 5 year olds is automatic unless parents have opted out.A summary of the Systm1 record is available to out-of-hours services.	Not all staff have access to System one, some consultant paediatricians do.
10	Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.	Care pathways require developing	care pathway only in place for self - harm	Care pathways in place	Care pathways in place for common acute care condtions. Activity not monitored	Care closer to home and Clinical Referral Management Committee need to scrutinise, approve and embed common acute pathways into practice	Care pathways not in place for common acute care condtions. Activity not monitored	Care pathways not in place for common acute care condtions. Activity not monitored
11	There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.	No such arrangements currently exist	No such arrangements currently exist	No such arrangements currently exist	Unscheduled care needs may be discussed between commissioners and a range of providers and representatives at our children's Locality Partnership groups (which sit under the Derbyshire Children's Trust Board) and at CCG urgent care and systems resilience groups.	Currently no such arrangements exist, new matron to pick this up when appointed	No such arrangements currently exist	No such arrangements currently exist

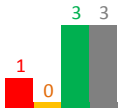
1a GP immediate phone advice - consultant

86% Green Compliance



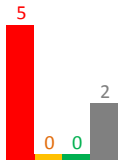
1b GP immediate phone advice - trainee ST6

43% Green Compliance



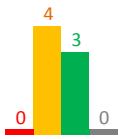
1c GP immediate phone advice - ANP

71% Green Compliance



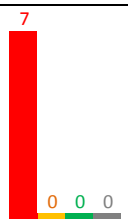
2 Consutant rapid access service

43% Green Compliance



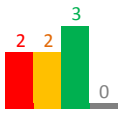
3 Link consultant

0% Green Compliance



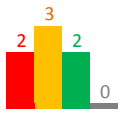
4 Regular acute edication sessions

43% Green Compliance



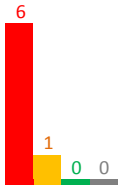
5 Community children's nursing support

29% Green Compliance



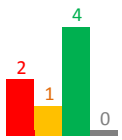
6 Link community nurse

0% Green Compliance



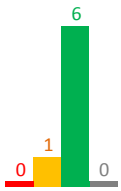
7 Electronic discharge summary

57% Green Compliance



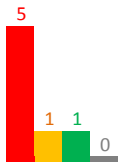
8 Verbal and written discharge info

86% Green Compliance



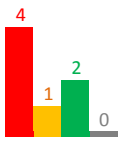
9 Access to shared electronic health record

14% Green Compliance



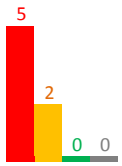
10 Common care pathways developed

29% Green Compliance



11 Regular formal meetings

0% Green Compliance



Best Practice Guidance for the Configuration and Provision of Children's Acute Care.

Owner
August 2016

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Definition:
In this document the term 'children' should be taken as meaning 'children and young people'. The term 'child' refers to all people under the age of 18 years unless separately specified

1.0 INTRODUCTION AND CONTEXT

The Francis report into the events at Mid Staffordshire NHS FT[5] and the subsequent Berwick review into patient safety[6] serve as a reminder of what can go wrong if key standards are not met; patients must receive high quality safe care in every setting in the UK. However, despite significant improvements in child health in recent decades child health outcomes are far from perfect. Compared with other equivalent European countries the UK fares worse for childhood mortality for children between 0 – 14 years of age[7] and according to the NHS Atlas of Variation, wide regional differences exist across a range of indicators.

Despite strong consensus amongst Royal Colleges[8] and the availability of substantial evidence making the case for change in paediatrics, consideration of children's services is limited in current national policy. NHS England's strategic business plan has few explicit priorities for children other than mental health, although the needs of children can be addressed through all of its 10 priorities. The NHS Five Year Forward View (2014) encouraged new models of care to be developed but aside from some aspects of prevention, most do not explicitly focus upon children.

In addition to the need to improve the care delivered, service providers are facing considerable challenges in continuing to provide safe, sustainable services that meet the needs of children and their families. Workforce pressures, medical and technological advances, children's changing care needs in terms of complexity and the economic climate all contribute to the need for change. The Working Together partnerships recognise these challenges and are clear that they are beyond the ability of individual organisations to solve.

1.1 Challenges to the future provision of child health services

Caring for sick babies and children requires specialised knowledge and skills. For several years a number of key documents published by the Royal Colleges (Royal College Paediatrics and Child Health (RCPCH), Royal College General Practitioners (RCGP), Royal College Nursing (RCN), Royal College Emergency Medicine (RCEM), Royal College of Anaesthetists

[5] Report of the Mid Staffordshire NHS FT Public Inquiry (2013) http://www.midstaffspublicinquiry.com/report

[6] Berwick review into patient safety (2013) https://www.gov.uk/government/publications/berwick-review-into-patient-safety

[7] Wolfe I et al (2013) Health Services for Children in Western Europe. The Lancet 381;9873,1224 - 1234

[8] RCPCH,RCGP, RCN (2015) Facing the Future: Together for child health.
Intercollegiate committee for standards for CYP in Emergency Care setting (2012) Standards for CYP in Emergency Care settings.

(RCoA), and Royal College Surgeons (RCS)) have highlighted the issues and challenges facing the provision of children's acute care. These are summarised below:

- *Providing a comprehensive 24/7 range of effective and sustainable acute children's care services.*

Demand for urgent care is growing rapidly, and this is putting a strain on acute children's care services. Whilst the vast majority of children's illnesses are minor requiring little or no medical intervention, more than a quarter of emergency department attendances are for children.[9] The largest sub group of these are for one and two year olds with minor illness.

Hospital admissions of less than 24 hours duration have also doubled during the last decade. The reasons for this may be attributed to:

- Increases in short stay paediatric assessment units.
- Systems failure in emergency departments, where admission to hospital becomes a default or preferred option.
- Reduced capacity of general practice to manage children in the community.

Parents' preference for initial advice is their General Practitioner (GP) and children make up to a quarter of a typical GP's workload[10]. Yet less than half of GPs are given the opportunity to undertake a paediatric placement during their training. Of those GP's who completed a six month paediatric placement some may not be relevant to dealing with children in primary care (e.g. neonatal work). Similarly the expertise gained by hospital-based paediatricians is less transferable when dealing with community management of minor illness or health promotion.

As GPs are responsible for early intervention additional opportunities to improve recognition and management of serious illness presenting non-specifically can only improve outcomes for children.[11] The RCGP and RCPCH are working together to ensure that in future all GP trainees receive specialist-led training in children's health. However, in the interim this leaves many GPs without the skills and confidence to assess and treat children in their surgery,

[9] RCPCH (2015) Facing the Future Together for Child Health.

[10] RCPCH, RCGP,College of Emergency Medicine, NHS Direct, Joint Royal Colleges Ambulance Liaison Committee, University of Leicester and University of Nottingham. To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature). 2010

[11] RCPCH National Children's Bureau and British Association for Child and Adolescent Public Health. (2014)
Why Children Die: death in infants, children and young people in the UK.
http://www.rcpch.ac.uk/sites/default/files/page/Death%20in%20infants,%20children%20and%20young%20people%20in%20the%20UK.pdf

leading many to refer children to hospital for conditions that could be managed in general practice or other community settings.

It is essential that children receive care from the most skilled and experienced practitioners possible. The RCPCH biennial workforce census (2016) indicates a number of trends impacting upon service planning and provision.

A **reducing supply of trainees** through a combination of reducing specialist trainee numbers and evidence that hospital medicine is being seen as a less attractive career choice.

Maintaining compliance with European Working Time Regulations is a further driver for carefully planned workforce numbers as revealed in the Rota Vacancies and Compliance Survey (RCPCH Jan – March 2016):

- There is now a 10% tier 1, and 20% tier 2 rota vacancy rate; averaged across both tiers there has been an increase in the vacancy rate from 12% in January 2015 to 15% in 2016
- The rota vacancy rate is highest on tier 2 general paediatric rotas (28%), a rise from 18% in January 2015
- 60% of tier 1 and 77% of tier 2 rotas comprise fewer than the recommended 10 staff per rota, the standard set in the RCPCH "Facing the Future" report*
- 89% of clinical directors are concerned about how the service will cope in next six months; up from 78% last year
- Consultants are increasingly providing unplanned cover (35% in January 2015 rising to 38% in 2016), an average of 3.1 occasions over the 4 weeks preceding the survey compared to 2.4 in January 2015. Just under half (46.5%) of all vacancies are filled by locum doctors however it is important to consider the potential cost and quality implications of relying on locum cover.

Changes to working patterns is evident with 20% of consultant grade workforce working less than full time, whilst the RCPCH Modernising Medical Careers study cohort of trainees indicates that 48% would like to work less than full time in their consultant careers. This change may be due to the steady move toward a female workforce which tends to increase the demand for more flexible working patterns. The entrants to ST1 in August 2013 are 75% female. The Trainees Committee Survey indicated that many trainees want to train part time suggesting a growing interest in this way of working.

Limited exposure for clinicians to low volume high risk clinical events.

Clinical practitioners (paediatricians, emergency department physicians, anaesthetists, nurses and allied health professionals) within District General Hospitals(DGHs) are key in the initial, often most hazardous, part of stabilisation. The unique challenge faced by practitioners involved in

these high risk infrequent clinical events necessitates regular updating and refreshment of skills. Changes in activity flows from smaller DGH's towards larger centres can lead to de-skilling

Current junior rotas in paediatrics are not solely comprised of paediatric trainees (GP trainees, and FY doctors) and as such the necessary expertise, skills or experience required to provide appropriate services for paediatric inpatients may not be available.

- *Implementation of RCPCH standards lead to challenges that are beyond the ability of individual organisations to solve.*

The suite of standards developed by the RCPCH RCGP, RCN and RCEM are designed to improve the experience and outcome of children throughout the pathway. There is widespread recognition that meeting the standards in full may be a challenge for providers. The view among clinicians is that there are options for addressing these through new models of care (section 2) but that these would require joint working, as well as the development of new roles, etc.

- *Patient experience, expectation and health literacy.*

Some children appear to be bypassing general practice and heading straight to the emergency department, while others are having numerous encounters with different healthcare professionals before also ending up at hospital. Each one of these attendances tells us that a parent/carer was worried, and either unable or unsure how to access a more appropriate service. Engaging and educating parents and carers so they understand the health care system and how to navigate it, as well as how to manage their child's acute and chronic illness where appropriate builds upon their capability and confidence to self-care. The family cares for the child 365 days a year, while the health professionals only have a few appointments a year with them. Hence, there is a need to proactively and continuously work with parent and carers, listen to their needs and views, and support them so they can build trust in their providers as well as the confidence to raise their concerns and self-care when appropriate. Every encounter with the family should be used as an opportunity to provide better support for parents and carers to self-care or signpost to services outside of hospital to get the right advice in the right place, first time.

- *The need to consider clinical interdependencies*

The provision of children's services is dependent on the provision of other acute services and vice versa. Therefore, changes to individual services can have an impact on the overall 'portfolio' of services offered by a particular Trust.

Maternity, neonates, ED, children's surgery, and ambulance services play a significant role as constraints or enablers in the configuration of acute paediatric services. Maternity and gynaecology services are interlinked; in some general hospitals, obstetricians and gynaecologists and their teams are one and the same.

1.2 How do these challenges affect children's acute care?

The Working Together partnerships recognise the challenges facing children's acute care services due to workforce shortages, increasing attendances of minor illnesses to emergency departments and reduced opportunities for paediatric placements for GP trainees.

A baseline assessment and gap analysis of current inpatient children's services has been undertaken, to provide:

- A summary of the local service's workforce and facilities (beds, etc.)
- A self-assessment against the RCPCH's "Facing the Future: Standards for Acute General Paediatric Services" on acute paediatric care[12].
- Acute paediatric activity

At the same time, CCGs within the WTP area were asked to complete self-assessments for their areas with regards to the Facing the Future Together for Child Health standards (2015), developed jointly by the RCPCH, the RCGP and the RCN.

To further inform the baseline assessment, a "Confirm and Challenge" event held on 27th April 2016 invited stakeholders (paediatricians, service mangers, GP's, commissioners) to collectively review the collated evidence and to determine the need to pursue this work further. The resultant Case for Change document summarises the accumulated evidence.

The overwhelming view from stakeholders was that there is a clear need for change as current service provision is not sustainable. The following themes emerged from conversations:

- Workforce data identified acute service rota gaps, with many slots being filled by locum / agency staff, thus highlighting that service provision is not sustainable across the current number of sites.
- Variation in services meeting RCPCH standards (leading to potential inequalities, potentially further exacerbated by deprivation).

[12] RCPCH (revised 2015) Facing the Future: Standards for Acute General Paediatric Services. RCPCH.

- The wider impact of any reconfiguration of services outside the immediate project must be considered, with interdependencies acknowledged as complex. Issues include:
    - Internal initiatives such as pre-existing change programmes (Mid Yorkshire NHS Trust centralisation of inpatient children's services at Pinderfields).
    - Current patient pathways and flows from providers outside WTP into the geography (North Lincolnshire and Goole NHSFT)
    - Sub regional work-streams with similar aims regarding children's services (West Yorkshire –Healthier Futures)
    - National change programmes (Urgent Emergency Care review, GP Five Year Forward View) including specialised services reviews.

Given the 5YFV mandate for new models of care and the increasing pressures on children's acute care services with the WTP geography the following drivers for change are highlighted below:

- Across the geography there is variability to reliably provide permanent staff to deliver children's services to meet the needs of acutely ill children.
- There is variability to meet with permanent staff, the middle and consultant grade rotas in accordance with RCPCH standards.
- The amount of staff required to maintain the service and on-call rotas at all grades is disproportionate to the number of cases in some areas. This is particularly relevant at night where there is felt there are few acute children's admissions after 22:00 hours.

As identified in the Case for Change document there are pressures on our children's acute care services. What is also clear from the Case for Change is the lack of connection between primary and secondary care - and at the stakeholder event there was consensus to strengthen the interface to support primary care services where the needs of the child and family are known.

2.0 THE FUTURE OF CHILD HEALTH SERVICES: NEW MODELS OF CARE.

The RCPCH, RCGP and RCN have worked together to develop a set of standards in the Facing the Future suite; Facing the Future: Together for Child Health (2015), which apply across the unscheduled care pathway of acutely mild to moderately unwell children. The standards build on Facing the Future: Standards for Acute General Paediatric Services (2011 revised 2015) and the Standards for Children and Young People in Emergency Care Settings (2012), expanding them into care outside the hospital to improve health outcomes for children.

There are three overarching principles and 11 standards in total.

Standards one to six focus on supporting primary care to care safely for the child in the community, preventing unnecessary attendance at an emergency department or unnecessary admission to hospital.

Where children do need to be cared for in hospital, standards five to eight focus on reducing the length of stay, enabling these children to go home again as safely and as quickly as appropriate, while preventing unnecessary re-attendances and readmissions.

Standards nine to 11 look more widely at connecting the whole system between primary care, the hospital and community services; streamlining the patient journey and improving the patient experience.

The Royal Colleges play a leading role in setting and ensuring the highest standards of care for children. The standards are intended to be a tool and resource for healthcare professionals, commissioners, planners, providers, managers, regulators and inspectorates to help plan, deliver and quality assure children's healthcare services. Services need to be designed and developed in partnership with children, their parents and carers and other local stakeholders.

The following practice examples compiled by the RCPCH sourced from across the UK illustrate a range of ways standards are being implemented. The examples have been organised under the following sub-headings:

- Strengthening primary and secondary care interface.
- Facilitating discharge and early repatriation home - community children's nursing teams

2.10 Strengthening the primary and secondary care interface

2.11. Children and Young People's Health Partnership - Evelina Children's Hospital, Guy's and St Thomas' NHS Foundation Trust

The Children and Young People's Health Partnership is a coalition of clinical commissioning groups, local authorities, acute providers, third sector and family and patient representatives, funded by the Guy's and St Thomas' Charity and focused on improving the everyday health needs of children in Southwark and Lambeth. A three-pronged strategy was developed to ensure that general children's services worked closely with primary care to develop better care pathways.

Firstly, a series of guidance covering the most commonly seen conditions in primary care, for example, asthma, fever, constipation and mental health conditions was developed. These consisted of one page flow charts of how to identify conditions, what to look out for (red flags) and top tips. Each piece of guidance was localised with specific information on when to refer and where. The guidance was designed with primary care to ensure they are user friendly

and the information sits within the IT system of primary care, making it accessible and functional.

Secondly, a hotline service was developed at the Evelina and King's to ensure there was a strong link to the general paediatric service. This service enables primary care to access real time advice via email or telephone from a consultant paediatrician. Outcomes of a call or email are advice, transfer to the Emergency Department, booking into the next available outpatient slot or a hot clinic appointment. This service helped build a strong relationship between primary care and the hospital and provides a mechanism by which concerns can be directed to the relevant guidance.

Thirdly, by doing in-reach clinics with GPs, a further opportunity to guide people to the new guidance has been created. During in-reach clinics, a consultant paediatrician sees children alongside a GP. These children are a mix of children about whom the GP has concerns, those who attend the Emergency Department frequently or those who would otherwise have been referred to the hospital.

2.12 Supporting Primary Care - King's College Hospital, London

Service development in Ambulatory Paediatrics at King's has evolved over a period of years. The overall vision is to deliver high quality healthcare for children, streamlining their patient journey and thereby optimise their patient experience. This approach has enabled the development of a comprehensive portfolio of clinical services targeted at meeting the needs of children and their families.

GP Education: An annual paediatric GP conference is convened at King's College Hospital. This utilises the expertise of the wide variety of paediatric subspecialties represented at King's to deliver interactive lectures on clinical topics of importance to GPs. The GP feedback collated is proactively utilised to refine the programme content in subsequent years in order to ensure ongoing relevance to a primary care audience. Through collaborative CCG arrangements, a further three formal paediatric educational events are delivered per annum for local GP's.

Paediatric Phone Line: A phone line has been in operation since July 2014, whereby GPs can speak directly to a paediatric consultant between 0800-2200 on weekdays and 0800-1730 at weekends. The aim is to optimise patient care by facilitating timely, reciprocal communication with the most appropriate hospital based paediatrician. This enables acutely unwell children and outpatient referrals to be directed appropriately. It has streamlined the outpatient referral pathway, reduced the numbers of inappropriate paediatric emergency department (PED) attendances and serves to strengthen professional relationships between primary and secondary care. A supplementary function of the phone-line is that it is also used as a means of communication for junior doctors seeking senior advice from the duty

paediatric consultant within the hospital. This has facilitated more timely decision making in the paediatric emergency department (PED) and improved clinical care, as well as directly preventing 26 hospital admissions within the first year of operation.

Rapid Access Clinic: This clinic has been operational for 6 years. In July 2014, there was expansion to facilitate rapid access clinic provision every weekday. Primary care referrals are accepted by phone, email or fax. The aim is to see every patient within two weeks of referral, although this can be expedited on clinical grounds as required.

Email advice: Utilising the facility contained within the established 'choose and book' system, local GPs can send email enquiries for clinical advice to a consultant paediatrician. There is a 24 hour response time during weekdays.

Outreach Clinics: Working in partnership has also facilitated the delivery of paediatric outreach clinics in primary care. A consultant paediatrician delivers a monthly primary care clinic alongside a GP partner. Together, they see patients who would otherwise have been referred to a hospital based general paediatric clinic. Each clinic is preceded by a lunchtime teaching session with the wider primary care team. There is also an opportunity for discussion of specific patients' management following the clinic. These clinics provide reciprocal learning opportunities for both clinicians as consultant paediatricians develop an increased appreciation of the clinical challenges faced in primary care. The patient feedback is overwhelmingly positive.

2.13 Reducing avoidable presentations and admissions and improving the quality of care for children and young people – Wessex Healthier Together SCN

Over the last 10 years, unplanned paediatric admissions have risen by 28% nationally. The rises are most marked for children under the age of 1 (52% increase) and the 1-4 year age group (25%). There are increasing rates of paediatric admissions with acute ambulatory-care sensitive conditions such as upper (URTI) and lower (LRTI) respiratory tract infections and gastroenteritis. Across Wessex there has been a 22% increase in rates of admission of URTI and 40% increase in LRTIs.

Steering groups and project specific groups have been formed consisting of commissioners, clinicians, and other key partners such as Public Health from across Wessex. A governance process has been established with an Oversight and Planning Group, consisting of partner organisations, overseeing the work of all SCNs. This transformational project has been agreed through this process.

The 5 year vision for this project is to strengthen the primary and secondary care interface to improve the management of children and young people in the community to ensure that unwell children and young people are able to

access the ‘right care’ at the ‘right time’ in the ‘right place’ and from the ‘right person’.

This will support a reduction in the number of unplanned hospital presentations and improve the quality of care for children and young people across Wessex.

Objectives- Year 1:

To develop and agree a whole-system model for delivery of high quality, safe, acute paediatric care across Wessex involving primary care, secondary care and community nursing and local authority/ public health England.

Delivery:

- Primary care - model for delivery of acute paediatric care within primary care, including shared working between GP's and community nurses developed. (Inc options for urban and rural settings). Clear pathways for delivery of paediatric care in and out-of hours developed - Oct 2014
- Community nursing - models of working involving primary care, secondary care and delivery at care at home developed. (Staffing requirements and training needs evaluated) - Dec 2014
- Data - shared dashboard across services developed – Jan 2015
- Primary care - education needs evaluated & a primary care education program developed - Mar 2015
- Primary/secondary care interface - model to integrate primary and secondary care and deliver secondary care paediatrics in primary care settings agreed – March 2015
- Secondary care - feasibility and impact of a front-of house model for appropriately triaging children presenting to A+E evaluated. Appropriate triage pathways developed- March 2015
- Commissioning - commissioning models for acute paediatric care delivery to facilitate integrated care across organisation agreed. March 2015

Improved Outcomes:

- 5% increase in the percentage of children and young people being managed in the community.
- 5% decrease in the number GP referred unplanned admissions and A&E attendances.

Objectives- Year 2:

To implement the model developed in year 1 for delivery of high quality, safe, acute paediatric care across Wessex involving primary care, secondary care and community nursing.

Delivery:

- Parent education to address inappropriate health-seeking behaviour - April 2015
- Models of delivery of acute paediatric are in primary care, involving GPs and community nurses, with support from secondary care paediatricians implemented – Aug 2015.
- Primary care education packages introduced – Sept 2015
- Role of community nurses expanded to include the delivery of acute paediatric care. Review of current workforce and delivery of training underway – Dec 2015
- Scope & identify education and pathway modifications required to incorporate NHS 111 & the Ambulance service in clinical decision making – Nov 2015. Commissioners to include appropriate training in contracts.

Improved Outcomes:

- Further 5% increase in the percentage of children and young people being managed in the community.
- Further 5% decrease in the number GP referred unplanned admissions and A&E attendances.

2.14 Imperial Child Health General Practice Hubs - St Mary's Hospital, Imperial College Healthcare NHS Trust

The Imperial Child Health General Practice Hubs comprise groups of two to six general practices, within inner North West London, working with paediatric consultants to provide care to practice populations of approximately 4000 children. The hubs were established in response to high outpatient and emergency department attendances by children.

At the heart of this model is an openness to discuss cases, share ideas and learn together. GPs in the hub practices might have a telephone or email conversation with a consultant to discuss the most appropriate approach for a particular patient. Where patients do not require face-to-face consultant input but discussion by the broader team would be beneficial, the case is brought to a monthly Multi-Disciplinary Team (MDT) meeting in the GP Hub. Any member of the team can bring cases, including health visitors, practice

nurses, community therapists, mental health workers and social workers. The majority of cases are resolved within the MDT. The MDT also allows senior triage of patients who require treatment in a paediatric sub-speciality directly to the appropriate clinic, rather than having an initial general paediatric appointment as before. Some patients are seen by the GP and paediatrician together in the joint-clinic that follows the MDT.

A culture of education and learning is key and each MDT meeting includes a short learning session run by the visiting consultant. Following the meeting, a joint outreach clinic is held by a consultant with a hub GP. Clinical governance responsibility for patients referred to the outreach clinic rests with the consultant. Responsibility for patients discussed at an MDT meeting or over email or telephone is retained by the GP. Evaluation of the pre-pilots shows that the hubs have the potential to decrease the number of referrals to hospital outpatients and attendance at paediatric emergency departments.

2.15 Care pathways - Luton and Dunstable University Hospital NHS Foundation Trust, Luton CCG and Cambridge Community Services

Luton has long recognised that there are high volumes of children presenting to the Emergency Department and Secondary Care Paediatric Services with common conditions that could sometimes be treated more appropriately elsewhere. The team also recognised the need for consistent assessment and care wherever a child presents and, since 2009, have worked collaboratively across the whole health system to develop shared urgent care pathways for use wherever children present. The pathways chosen were the highest volume conditions including fever, diarrhoea, vomiting, seizure, asthma, bronchiolitis, abdominal pain and head injuries. Some pathways for conditions with good evidence-based national guidance were easy to develop whereas others were more challenging. The pathway development included workshops with children and parental involvement. Information sheets were developed for families and educational tools with lessons for school-children, exploring their understanding about where to go for illness and the different services available.

An audit of the fever pathway identified that implementation of the pathway changed which patients are referred to the Paediatric Assessment Unit (PAU). It also showed an increase in the number of necessary tests and a decrease in the number of unnecessary tests. Commissioners reported a notable decrease in short-stay and long-stay costs as a result of change in the care pathway. Developing these pathways further enhanced an ethos of collaboration between acute and community services and children's commissioners. The ongoing challenge has been to embed these pathways into multi-professional practice, particularly into GP surgeries, and also to keep them up-to-date and continuously rolled out to professionals working locally.

2.16 Up-skilling General Practitioners (GPs) and Nurses in the clinical management of children with acute health problems - Partners in Paediatrics (PiP) University Hospitals of North Midlands

In October 2010, research at University Hospital North Staffordshire (now known as University Hospitals of North Midlands) identified that the number of children with acute health problems admitted to paediatric wards was about twice the admission rate of other hospitals in similar communities. It also identified the top ten conditions where children referred into the hospital by a GP were discharged within four hours without active clinical intervention.

An interactive up-skilling programme for primary care was developed through a business case model. The work was supported by Partners in Paediatrics. The main objectives of the programme were to:

- Increase the competence and confidence of GPs and nurses in the clinical management of children with acute health problems
- Reverse the year-on-year rise in inappropriate referrals to the Paediatric Assessment Unit by primary care clinicians
- Improve the patient experience, particularly providing services closer to patient homes

Ten master-class sessions, run by paediatric consultants, were held in spring and summer 2011 to increase competence and confidence in managing acute paediatric conditions in primary care. Approximately 250 clinicians took part, including 114 GPs (40 percent of the GP cohort), 79 nurses and participants from other clinical backgrounds, including student doctors, clinical educators and community midwives.

Master-class topics included respiratory problems, failure to thrive, gastroenteritis, abdominal pain, constipation, fever management/febrile child, fits, faints and “funny turns”, mixture of acute admissions, rashes and skin problems. Paediatric pre-referral guidelines and urgent care referral guidelines were produced and made readily available to all clinicians in primary care.

The overall response to the programme was extremely positive. Participants welcomed the wide range of practical tips for managing conditions in the community working with parents and many rated the explanation of the NICE and locally developed urgent care guidelines particularly highly. After 18 months, GPs and nurses who took part in the up-skilling project indicated that they felt more competent and confident in the clinical management of children with acute health problems, that they are retaining more care within general practice and that they are referring more appropriately. They also felt better able to advise and support parents and carers. Of the 28 GPs who responded to the post master-class evaluation, most believed that the master-classes had increased their ability and confidence in the clinical care of children, particularly those with acute health problems. Specific changes in practice identified from attending the master-classes included use of saturation probes

to check oxygen saturations in respiratory paediatric cases and use of pulse oximetry for children.

2.17 Electronic Personal Child Health Record (ePCHR) - RCPCH

The Personal Health Care Record (PCHR) is the main record of a child's health and development. The parent or carer owns and retains the PCHR, in which they enter their child's health information, access and use information contributed by healthcare professionals and share this record with any organisation or individual they choose to. Healthcare professionals should update the record each time the child is seen in a healthcare setting. The ePCHR is an electronic version of the PCHR which is currently being piloted at two sites across Liverpool and South Warwickshire.

As does the PCHR, the ePCHR supports the Healthy Child Programme, recording details of screening tests, immunisations and reviews as well as signposting to relevant information. With the information kept electronically in a secure system, a child's parent or guardian can have the convenience of managing the child's care online.

Designed for parents and guardians to easily enter information and check their child's health status, these are online records owned by the parent or carer and intended to be used as they would the paper PCHR. Users of a personal health record decide who has access to their information - they are the 'custodian' of the record. Users explicitly give consent to the use of each data item and there is no implicit consent and no global consent. As a custodian, users decide what level of access to grant others. ePCHR has the potential to substantially improve cross-care setting information sharing between primary, community, acute and social care. Developing parental access to and management of their child's health records will lead to new communication models and healthcare delivery models within the NHS.

'Indications overall are that where we find increased patient involvement in personal healthcare, so we expect to find better health outcomes alongside lower service cost.'

2.2 Facilitating discharge and early repatriation home

2.21. Extended hours community children's nursing team - Islington Community Children's Nursing Team

The Islington CCNT Hospital@Home service began in August 2014 and runs from 8am to 10pm with the aim of facilitating early discharge from hospital and preventing and reducing unnecessary attendances and admissions to hospital. The borough serves an estimated child population of 40,000, which is due to increase by approximately one-sixth by 2030.

It has been developed with input from acute paediatricians and a referral criterion is that the child has a working diagnosis and physical signs and symptoms within set parameters. Accountability for the care of the child remains with the consultant paediatrician with a nurse-led discharge. The CCNT provide safety netting information following a visit and parents and carers can call the CCNT for advice from 8am to 10pm (support is provided by the Whittington Hospital outside these hours). GPs can refer directly to the CCNT and the CCNT also run primary care clinics supporting the education of practice nurses.

The CCNT is made up of 17.5 Whole Time Equivalent (WTE) nurses, 1.5 WTE administrative support and 0.5 WTE consultant paediatrician. From August to December 2014, 107 referrals were made with 376 face-to-face contacts. Positive feedback has been received through patient and parent surveys.

Recommendations for consideration in developing a similar service are:

- Be reasonable in your expectations
- Research how other services have developed their service and adapt local pathways
- Find a paediatrician to champion the service
- Consider involving other services such as physiotherapy and dietetics
- Develop a good working relationship with commissioners.

2.22 Healthcare at Home, King's College Hospital London

In April 2014 a novel paediatric ambulatory service was established at King's, with 'Healthcare at Home' (HAH). It is a clinical service providing consultant led, nurse delivered acute paediatric care in the home.

The HAH nurses are integral members of the general paediatrics team. They attend the morning general paediatric handovers 7 days a week and this serves to optimise the referral rate. Once a child has been referred, they meet with the family whilst they are still inpatients and this practice provides continuity of care for children and their families once their care is transferred to the home setting.

The nurses have facility to visit children up to four times a day, to administer medication, provide wound care, perform observations and provide clinical reviews. The care episode notes are all recorded electronically on tablets in the home and these notes are linked to the hospital based electronic patient record. All of the patients are reviewed during a daily consultant-led virtual ward round conducted in person with the HAH nurses. The innovative use of IT facilitates this process and provides an accessible, continuous record of patient care until their discharge date. The initial goal was to enable early discharges from hospital and this has been achieved. The service has subsequently evolved to facilitate direct admission to HAH from the paediatric emergency department (PED) following a paediatric consultant review. This

new pathway thereby completely avoids hospital admission for some children. Children are accepted onto the service based on clinical need and capacity. This therefore ensures equity of the service which is available to children who reside in a range of boroughs.

2.23 *DIY Health - Bromley by Bow Health Partnership*

The DIY Health project aims to provide parents and carers of children under the age of five with the knowledge and skills to confidently manage their children's health at home and to know when to seek further help. With funding from Higher Education North Central and East London, the Bromley by Bow Health Partnership worked with University College London Partners, the Bromley by Bow Centre, healthcare professionals, parents and the local community to create an education programme that would give parents and carers the confidence to know when and where best to access health services for children with minor ailments. The project created a curriculum of 12 sessions that focussed on the most common problems in the under-five age group, as well as needs relevant to the local community.

The weekly sessions take a participatory family learning approach and are co-facilitated by a health visitor and an adult learning specialist with support from local children's centres. The sessions place strong emphasis on parents' experiences and the importance of understanding these in order to support and direct self-care for the future, leading to greater engagement and understanding of how to use services most effectively. The project has recorded promising preliminary results and seen positive anecdotal behaviour changes in the attendees; for example, parents attending for coughs and colds are now comfortable seeking advice from a pharmacist. The pilot reported that parents who had participated in the most sessions had reduced attendance, not only for GP appointments, but also for the emergency department.

Next steps include a robust evaluation by the Anna Freud Centre, which will develop outcome measures. The project will also be modelled economically to ensure it is delivering value for money. To facilitate wider rollout a comprehensive training package is being co-produced.

2.24 Children's Acute Nursing Initiative (CANI) Newcastle upon Tyne Hospitals

CANI stands for Children's Acute Nursing Initiative and is a team of nurses who help with the early discharge of children from hospital. The service looks after children from the Newcastle area who have been unwell in hospital but have improved enough to go home - with the support from CANI's team of experienced children's nurses.

To help children go home earlier, we can:

- support families to administer the child's medication
- provide clinical advice
- monitor things like temperature, oxygen levels and heart rate
- give intravenous antibiotics.

A consultant paediatrician at the hospital will still have overall responsibility for your child's care while the CANI team care for your child. If necessary, the CANI nurse can arrange for your child to be seen again by the doctor at the hospital.

Working in partnership with you

The nurses work in partnership with you to develop a plan of care for your child. We may ask you to monitor and record information about your child's condition on a simple chart. This will be fully explained to you by a member of the CANI team.

Operational hours

CANI nurses work shifts that cover from 8.00am to 10.00pm, seven days a week all year round. You will be given a phone number so you can speak to one of the nurses if you have any concerns. After 10.00pm, you can speak to a doctor.

3.0 ORGANISATION AND PROVISION OF NEW MODELS OF CARE.

The RCPCH[13] believes in order to deliver expected standards and improve outcomes in the future, there needs to be service redesign and reconfiguration, underpinned by a workforce strategy and plans that bring together medical and non-medical education and training for all staff involved in the care of children. The drivers for this redesign i.e reduction and unwarranted variation, childhood mortality and morbidity rates are covered earlier. RCPCH is clear that networks, supported by strong clinical leadership and sound management and service reconfiguration, with a focus on care being delivered closer to home, are fundamental to improving the quality of paediatric care.

3.1 Configuration of services

The original "Facing the Future" publication (2011) recommended a model of fewer larger inpatient units which are better equipped to provide safe and sustainable care supported by short stay paediatric assessment units (SSPAUs), networked services and more care delivered closer to home

[13] RCPCH (2011) Facing the Future Standards for Paediatric Services.

through community children's nursing teams and better paediatric provision in primary care. Modelling assumptions considered hospitals on the following basis:

Unit Description	Activity: Emergency admissions /year	General paediatric consultants
Very small	< 1500	7.7 Whole Time Equivalents (WTE)
Small	1500 – 2500	
Medium	2501 – 5000	9.3 WTE
Large	> 5000	10.9 WTE

The above expression of consultant WTE's required to deliver general acute paediatrics in each size of unit did not include other clinical commitments such as consultant of the week. Since the revision of standards in 2015 the College has revised its modelling assumptions on the basis that the sessional commitment or number of Programmed Activities (PA's) allocated for general acute paediatrics would need to rise.

The following analysis shows the weekly number of general acute PAs required to meet the revised standards for a range of different types of unit. Individual units may need to adapt these models to suit their individual configuration

To undertake the calculations a number of assumptions have been made:

- Prospective Cover is 20% i.e. a consultant is on leave, study leave etc. for one-fifth of a year

- Outpatient clinics last for one PA (four hours) plus one hour for administration (this is a change from the original Facing the Future which allowed one PA per consultant for administration)

- One hour allowed for handover

- Ward rounds will be undertaken by the consultant present in the hospital (this is a change from the original Facing the Future)

- All contribute equally to the resident and on-call rota

- On-call time is calculated at 25% e.g. for a 12 hour on call shift at night the consultant will be paid for three hours (one PA)

Size of unit	Daily consultant presence (hours)	Acute paediatric outpatient clinics per week	Acute PAs per week required
Very small	8	10	48.1
Very small	12	10	56.1
Small	8	15	54.4
Small	12	15	62.3
Medium	12	20	68.6
Large	12	25	74.8
(Very) Large	12 (2 consultants)	25	118.4

The RCPCH expects that a number of the small and very small paediatric inpatient units will either convert to SSPAUs or potentially close. When considering options the College suggests considering the proximity to other providers.

- Proximal within 30 mins drive to another unit
- Distal greater than 30 mins drive to another unit

The likelihood of closure is far more likely for those that are proximal and very small, although decisions to reconfigure are not just based on factors such as workforce sustainability, volume of patients and distance but also local politics and public consultation.

Planners and commissioners will need to consider what kind of SSPAU units are required. The report identified at least two models:

- The 14 hour SSPAU with consultant support
- The 24/7 consultant led SSPAU.

The main advantage of the former is that it would be less expensive; however the lack of senior medical presence would necessitate very clear operational policies and protocols for the treatment of children and options for transfer to units where more senior medical input is available.

For medium and large hospitals, there is likely to be less change, and whilst they will continue to retain their three tiers of staff, the staffing structure of tier 1 and tier 2 rotas will change. The College anticipate that the reduction in ST trainees will be offset by an expansion of GP trainees and advanced nurse practitioners.

3.2 Workforce Implications

The RCPCH standards have workforce implications for three principal staffing groups: children's nurses, paediatricians and general practitioners (GPs).

3.21 Community Children's Nursing Services and Link Community Children's Nurse

Standards five and six will have the most impact upon the nursing workforce and potentially will necessitate the most sizeable increase and/or change. Data is not currently available for the number of children's nurses currently practicing in these roles in the UK, so this analysis concentrates on the workforce implications of implementing the standard for a single service.

The RCN[14] recommends that for an average sized district with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses are required to provide a holistic CCN service1.

The RCN standards[15] on staffing levels state that all Community Children's Nursing (CCN) teams must be led by a registered children's nurse. The RCN standards further state that in the average CCN team the minimum ratio of registered nurses to unregistered staff should not fall below 70:30, with a minimum of 25% of the registered nurse component being CCNs who have completed a recognisable community education and development programme.

The RCN recommendation is reflected very closely by current practice in Islington, London where the CCN team which provides a hospital at home service comprises approximately 17.5 WTE nurses for an estimated child population of 43,000 (prior to setting up the hospital at home service, there were five CCN nurses in the team). However, it should be noted that while the Facing the Future: Together for Child Health standard is for a 24/7 CCN service, the Islington service operates to 10pm with overnight on-call advice provided by the Whittington hospital. The Islington team are also reliant on 0.5 WTE of a paediatric consultant who is closely involved in service development and staff support. In addition, a CCN team needs administrative support and the Islington team has 1.5 WTE staff in these roles. This CCN workforce does not include specialist children's nurses working in community settings such as epilepsy, asthma, diabetes etc.

The CCN service in Islington was expected to see around 400 referrals a year. This represents approximately 15% of children's inpatient admissions at the local hospital. If such a reduction in admissions was matched by a reduction of inpatient beds at the hospital, this could potentially reduce the number of inpatient children's nurses required on the children's ward in line with RCN standards – although a minimum number of registered children's nurses would need to be on duty for a safe service. However, any such reduction would need to be undertaken only after proper evaluation of the impact of the CCN service had taken place.

[14] RCN (2014) The future of community children's nursing: challenges and opportunities.
[15] RCN (2013) Defining staffing levels for children and young people's services

A further example of a CCN team is from the North East (South Tyneside) where the inpatient service has been replaced by a Short Stay Paediatric Assessment Unit (SSPAU) and a strengthened CCN team. This CCN has a team of approximately 9 WTE but as this service only provides a service between 8am and 6pm and covers a smaller child population, the ratio is broadly in line with the RCN recommendation.

The RCPCH is also aware that the relationship between CCN teams and acute hospitals varies across the country and rural areas in particular may need different solutions.

3.22 Standards impacting on the paediatric workforce

There will be a range of impacts on the paediatric medical workforce, particularly from standards 1 to 4 and standards 10 to 11. Calculating the impact or cost is an imprecise art and can only be done presently through drawing on specific practice examples. In many cases it is too early to provide evidence about how increased staffing in one area may mean consequent reductions in services elsewhere.

Standard 1 – Immediate telephone advice from a consultant paediatrician

The introduction of a consultant hotline in a large urban unit in Nottingham was allocated five PAs per week (not as part of the standard consultant of the week (COW) cover, as the COW would not have capacity to undertake this work) and this model is proving successful. Five PAs equates to more than 0.5 WTE consultant time as prospective cover must be accounted for, therefore extra resource would be 0.625 of consultant time. The unit also specified that a full time administrator was required for the operation of this system.

The hours of operation of a hotline will vary according to local need, for example, a unit with fewer admissions in North West London operates their hotline for two hours per weekday between 12-2pm. In units with fewer admissions it may be appropriate for the consultant of the week to provide the telephone advice service, at no extra cost, but this should be subject to regular workload review.

It can also be argued that advice from a consultant to a GP supports and enhances the skill of the latter group, indeed the outcomes of the trial in the Midlands show that 15% of calls were subsequently managed by the GP and that such discussions have given GPs confidence to keep children at home. There are therefore two further benefits; the support for the development of GP skills and the appropriate care of cases avoiding unnecessary admissions which will have a wellbeing benefit to both the patient and their family.

Standard 2- Rapid access service

Rapid access clinic services have been implemented in different ways across the UK. Some rapid access services operate on the basis of appointments being added in an ad hoc manner to existing consultant clinics or the child being seen in the paediatric assessment unit. Elsewhere the rapid access service is formally rostered and included in consultant job plans.

Standards 3 and 11- Link consultant paediatrician and whole system meetings

The implementation of child health general practice hubs in North West London has in effect combined the implementation of these two standards by holding regular multi-disciplinary meetings in GP practice hubs followed by joint outreach clinics run by the consultant and a GP. To hold 10 such meetings per year in each practice hub for a standard District General Hospital (DGH) could mean the investment of approximately 0.45 WTE of consultant time to be added to a team's job plan within a typical DGH area serving 60,000 children. The North West London scheme's business case estimates that to break even on this investment, there would need to be a 20% reduction in outpatient attendances.

Standard 4 – Education and knowledge sessions

The University Hospitals of North Midlands programme to raise skills in primary care in 2011 reached 40% of the GP cohort by providing 10 master class sessions and this would indicate that 25 such sessions a year could potentially reach all GPs within a given district in a year to comply with the standard. If each of these sessions required the contribution of a consultant for one day (including time for preparation of course materials), the average impact on each consultant's workload in a team of 10 consultants would be approximately five PAs per year. Set against this time commitment is of course the increased confidence and ability for GPs in the clinical care of children with acute health problems. The evaluation of this programme did show some reduction in non-elective paediatric admissions.

Standard 10 - Pathway development

Developing care pathways is an important part of improving quality in healthcare services and as such should be viewed as an intrinsic part of healthcare professionals' roles. Therefore, the College do not view this as an additional workforce resource, but that it is important for clinical leaders to prioritise and collaborate on this type of work.

3.23 Standards impacting on the GP workforce

Standards 1 and 2 - Immediate telephone advice and rapid access service

Immediate telephone advice and rapid access services involve GPs working differently, but it is not the view of the College that this will create an additional workload or increased workforce need.

Standards 3 and 11 - Link consultant paediatrician and whole system meetings

Using the North West London hub scheme as a guide would infer that each GP would attend two multidisciplinary team meetings per year and approximately one outreach clinic per year. Broadly this may equate to a commitment on 1.5 to 2.5 days for each GP per year. In this example GP's attendance at multidisciplinary team meetings is paid for from Clinical Commissioning Group (CCG) budgets.

Standard 4 – Education and knowledge sessions

GPs are encouraged to take advantage of these opportunities and the sessions should be factored into GP's job plans.

Standard 6 - Link community children's nurse for each cluster of GP practices

If multi-disciplinary meetings are implemented, the time commitment needed from GPs can largely be incorporated into that calculated for standards 3 and 11. However, it would be advisable to add a small additional element of GP time in order to attend meetings with the CCN team to highlight the CCN service, referral mechanisms, clinical protocols and audit outcomes.

Standard 7 - Discharge summary is sent electronically to the GP

This standard will not have an impact on workforce but may require changes in practice.

Standard 10 - Pathway development

Developing care pathways is an important part of improving quality in healthcare services and as such should be viewed as an intrinsic part of healthcare professionals' roles. Therefore, the College do not view this as an additional workforce requirement, but that it is important for clinical leaders to prioritise and collaborate on this type of work. As per multidisciplinary team meetings in the North West London example, GP time to develop pathways was also paid for by the CCG.

3.3 NETWORKS

The overall intention of networks is to improve the child's journey and their families' experience of services and thereby improve outcomes for both child and family. Integrated care pathways and clinical networks are not new to paediatrics. There are strong examples of this model working well, which are detailed in RCPCH publications[16] However, resources are not infinite and the network also needs to balance the effectiveness, efficiency and equity of service provision for the individual, as well as the whole population covered.

At the heart of the managed network there are three concepts that are fundamental for success.

- The first is assembling the component parts of the pathway, from the many organisations involved, in a way that is seamless from a patient perspective.
- The second is to deliver the pathway in the real world, with attention to evidence, competence of practitioners and the place/environment of delivery.
- The third is to design a system to identify where the pathway is not working optimally and build a system to learn from, and then improve the identified areas.

These three concepts tend to respectively map onto the roles of commissioners, providers and regulators; and in practice all need to work together collaboratively, with the patient voice represented at all levels. Within the network it must be possible to move resources from one part to another, sometimes across organisations, in order to strengthen weak links in the pathway, and thereby achieve greatest health with the resources available.

Successful development depends on the relationships and a common understanding that develops between users, service planners, commissioners, providers and regulators.

The following factors are essential for network development and service improvement:

- A simple model of service delivery in which networks are built around patient pathways
- Pathways based on collaboration not competition

[16] RCPCH (2012) Bringing Networks to Life- An RCPCH guide to implementing Clinical Networks

RCPCH (2006) A guide to understanding pathways and implementing networks.

- Involvement of clinicians and other professionals who are best placed to advise on the care needed at each stage of the pathway
- Joint leadership and working across organisational boundaries - integrated care
- A shared philosophy and principles for all professionals involved
- Clarity of purpose to improve the safety, outcomes and experience of services
- Being patient centred with family engagement and influence on service delivery
- Quality metrics to identify the weakest links in the system
- Innovation and improvement to eliminate any problems identified

A practical example of successful specialist network establishment is the development of neonatal networks in England. Within each network, different hospitals provide a mix and range of levels of care as agreed by that network, based on resources, capacity, geography and the availability of appropriately skilled and trained staff. Each network ensures that every infant has access to the right level of care, with the right resources and that they are cared for by staff with the right skills.

Children's health care crosses many organisational and professional boundaries. Networks support the movement of patients through the healthcare system and can address the boundary issues ensuring good communication across organisational boundaries.

Clinical leadership is crucial to the success of clinical network function and is recognised as an essential component to shape future health policy across the UK.

4.0 SUMMARY

From this review of literature, i.e. Royal College standards and practice based examples, the WTP think that teams locally could work more effectively and usefully utilise the materials in this document. Closer working with primary care, including the regular and out of hours GP service, as well as the community children's nursing team, to develop clearer procedures for referring children for further care or discharging them home is needed.

The following steps should improve compliance with the RCPCH's 'Facing the Future Together for Child Health' standards. It would also help children get the care they need, closer to home, and reduce the demand for hospital assessment and admissions:

- Configuration arrangements of inpatient and SSPAU sites must be supported by networked services, with more care delivered closer to home through community children's nursing teams and better paediatric provision in primary care.
- Review the scope of on-call activity and maximise the role of nurses to help reduce pressure on doctors, including development of a criteria led nurse discharge programme.
- Ensure that there is sufficient outpatient capacity for all local children to be seen in clinics locally as appropriate. This would be for general paediatric and also subspecialty clinics.
- Services need to be available in the community at peak times of activity so that patients receive the right care, at the right time, in the right place. This will require clarifying the governance, decision making and pathway arrangements for paediatric attenders out of hours, particularly the relationships between paediatrics, ED and the Out of Hours GP service. This will help patients, public and referrers be clear about whom to refer to at different times of day, as well as what telephone support is available to diagnose, treat and discharge locally where safe and appropriate.
- Review and develop the CCN services across the geography to ensure links to primary, hospital and community care are strengthened this will include roles of specialist nurses, for example in epilepsy, asthma /respiratory.
- Look across children's healthcare pathways at all clinicians working with children in primary and secondary care and ensure that they are working to shared standards and are supported by training programmes for professionals working in all settings.
- Ensure that there are adequately qualified staff with paediatric resuscitation skills available at all times, potentially through a programme of training and skills development for the anaesthetic team with rotation to other units to maintain skills.
- Ensure that all staff who advise members of the public are aware of the correct clinical pathway to access early treatment and safe transfer.

Working Together Programmes
Children's Acute Care:
Scenario Appraisal
11.10.16

September 2016

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Core leaders	20.9.16	0.1	For endorsement
Senate	3.10.16	0.2	For advice

Commissoiners Working Together SMT	30.09.16	V0.3	For comment
Joint Committee of CCGs	04.10.16	V0.3	Sign off prior to GB consideration
Acute Federation	07.11.16	V0.4	Comment on Senate observations
All WT private Provider Trust Board meetings	December 2016	V0.4	For comments
All WT private CCG GB meetings	January 2017	V0.4	For comments
Joint Committee of CCGs	28.2.16	V0.4	For approval to circulate in public

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Executive Summary

Commissioners need to review and consider the case for change for Children's Acute Care within the South and Mid Yorkshire, Bassetlaw and North Derbyshire (SMYBND) Working Together footprint and consider if provision commissioned is equitable, safe and sustainable for the future.
The case for change and best practice guidance takes into account the quality of current services, draws on national and regional guidance and clinical best practice, which set out the national standards for Child Health services.

If a transformation scenario is supported, then any consideration on location of services will need to be considered from demographic information and take into account the impact of provision in different locations according to access, local need, deliverability, cost and clinical quality.

The purpose of this document is not to provide the detail of the next phase of work but to add to the case for change and provide commissioners with a number of scenarios to consider in progressing the next phase.

It is acknowledged that at this stage consultation and discussion with patient and public members has not taken place.

The scope is consideration of acute care within 36hours of presentation; however the interdependencies and links to community pathways of care provide significant challenge when considering scenarios. This is due to the range of models across community and hospital care pathways and the need to consider demand management on acute services to release pressure from acute setting and manage care through alternative models. This appears to have made this project challenging from the outset as the scope within community services of provision that is an integral part of the pathway is large and varied across geographical areas.

The options to be considered by commissioners are:

Scenario 1.	Do nothing
Scenario 2.	Continue to deliver the services within the current form and from the current sites across the working together footprint, with a focus on improving performance and quality against standards
Scenario 3.	Transform children's acute care provision in the wider context of Working Together footprint and change the service model and pathways to improve performance and quality

1.1 Preferred option

Members of the project team have reviewed high level options and considered the application of them in line with best practice and national models of configuration of Children's Acute Care Services, taking on board feedback from the clinical community and sub groups within the Working Together programmes.

It is the recommendation to the Programme Executive Group to consider option 3 and provide wider transformational change in the context of the vision for this programme of work *Equitable, Safe and Sustainable Services* and the vision for Children's and Maternity Services expressed in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP).

2. Evaluating the high level scenarios

For the purpose of the high level scenario appraisal, Commissioners Working Together have developed evaluation criteria to use as part of the decision making process - highlighting risks, issues and possible benefits with the various scenarios.

These criteria are shown below:

Table 1 – Commissioners Working Together scenario evaluation criteria

Criteria	Indicator
Quality	Impact on premature / avoidable deaths Impact on staffing levels Patient safety – conforming with best practice/guidelines and standards Patient experience including complaints and feedback
Access	Impact on population weighted average travel time Feedback from patients and public – i.e. acceptability, willingness to travel Impact of deprived populations of any potential change in access/ further to travel.
Affordability	Up front capital and other non-recurring costs required to implement reconfiguration Assessment of ongoing financial viability of hospital sites Assessment of affordability within commissioners allocations Total value of each option incorporating future capital and revenue implications
Deliverability	Workforce experience/quality (attractiveness for employment) Site limitation or estates changes Workforce deliverability capacity of skilled workforce Assessment of ease of delivering option in terms of public and stakeholder acceptability Assessment of ease of creating required capacity shifts within timescales (workforce and physical facilities) Degree of integration across acute, primary, and community services

3. Scenario Appraisal

3.1 .

The baseline analysis within the case for change has provided evidence of variation in provision, which can lead to variation in quality, clinical outcomes and performance against standards. The key messages are as follows:

There is significant inability of acute hospital providers to maintain the service and on-call rotas at all grades in accordance with RCPCH standards.

The ability of acute providers to improve and meet standards and performance targets is not likely to improve in the medium term due to clinical workforce restraints.

There are challenges with maintaining and developing workforce skills and expertise to meet the needs of children across the primary / secondary care interface.

Clinicians are identifying that the current service configuration is not consistent, safe or sustainable in the short, medium or long term, and that there are significant variations in the services. This has been raised by Medical Directors and supported by managers of trusts.

The provision of children's services is dependent on the provision of other acute services and vice versa. These interdependencies are complex as changes in one service can impact upon the overall portfolio of services offered by a Trust.

The demand on acute services is also impacted upon by the configuration, quality and capability of community services in meeting need and managing demand.

There is a clear lack of system-wide joined up planning and activity between acute primary / secondary / community services resulting in variation in provider's ability to meet core standards to ensure good quality and sustainable provision of services in future.

There is a need for managerial leadership and clinical leadership across organisations as implementation of standards requires cross-organisational working.

The economic case for change is demonstrated by the flat growth rate in resource and cost pressure within the NHS. It is also demonstrated by the increase in demand on urgent care provision. There is not an option to look to additional investment as a solution. There must be a focus on sustainability of safe care pathways and quality of provision.

We also know that:

- RCPCH workforce census (2016) indicates current workforce trends and shortages will impact upon future service planning and provision
- Primary care are also experiencing considerable challenges due to:

o Undersupply of GPs and Practice Nurses
o Ageing GP/Practice Nurse/Admin workforce
o Shift of work from secondary care into the community driven by policy, finance and technology
o Increased demand driven by population demography: age and morbidity and need

- Configuration arrangements of inpatient and Short Stay Paediatric Assessment Unit (SSPAU) sites must be supported by networked services, with more care delivered closer to home through community children's nursing teams and better paediatric provision in primary care.
- Development of Children's Community Nursing (CCN) services across the geography will strengthen links between primary, secondary, tertiary and community care.
- Services need to be available in the community at peak times of activity so that patients receive the right care, at the right time, in the right place. This will require clarifying governance, decision making and pathway arrangements for paediatrics, ED, and out of hours GP services, so patients and referrers are clear whom to refer to at different times of day, as well as telephone support available to diagnose, treat and discharge.

Risks and Issues - Scenario 1- Do nothing

Category	Risk/Issue	RAG	Mitigation
Quality	Non Compliance with RCPCH standards evident at primary and hospital care levels Lack of continuity of care due to workforce rota gaps supplemented by agency / locum staff There is a correlation between clinical standards and avoidable infant and neonatal deaths, not meeting appropriate quality and		None identified - challenges given the changes in workforce, and the national shortage of specialised staff undergoing training.

	performance standards set out national could pose a risk to infant mortality.		
Access	If no planned alternative models of care are implemented, there is likely to be an increase in demand on hospital care services. We know that there are capacity issues in the current acute services due to workforce and site limitation. If alternative provision is not planned access could therefore be negatively affected. There would be a potential increase in demand and flow to the specialist site This would obviously also mean increased transfers of patients away from local communities.		None identified
Affordability	Current cost pressures from the use of agency / locum staff. Growth in demand on acute services.		None identified

Deliverability	Staffing shortages will mean that ability to respond to clinical need reduces impacting upon local and health community wide systems resilience		None identified

Benefits - Scenario 1- Do nothing

- This would leave provision working in silo and minimal links and joint working
- There would be an anticipated increase in demand on secondary care as community and public health services within community settings become challenged, as the public health grant and Healthy Child Programme Universal offer struggles to be maintained.

Category	Benefit
Quality	None identified
Access	There would be expected change in flows of patients moving to other sites where paediatric skills are available, so the viability of the local service and the local acute hospital trusts would change. Centralisation of provision is not seen as a viable or affordable option.
Affordability	Increase in demand would mean more centralised care in acute settings which is not affordable.
Deliverability	Local hospital services in other areas may be affected if performance and quality is not addressed. This would mean transport services would be affected if pathways changed, more patients could potentially require transfer. Therefore no benefits

Risks and Issues - Scenario 2- Continue to deliver the provision within the current form and with the current providers from existing locations, but develop a network approach and improve quality with a focus on improving performance against standards and strengthening the interface between primary and secondary care.

Category	Risk/Issue	RAG	Mitigation
Quality	Staffing shortages and change in staff skills and expertise		Investment in services – Investment into a Clinical Network and investment into workforce planning and skills development across the primary / secondary interface
Access	This could potentially ensure there are planned thresholds to access care across sites. It would however mean without full transformation that some local areas have variable offer and inconsistencies in access to community support may exist on a local level.		
Affordability	Currently commissioners and providers are required to deliver significant cost savings, and this investment in existing services coupled with the cost pressures associated with locum and agency staff may prove to be prohibitive. To release demand on acute care community services need to be in place and stabilised. Increase in demand on acute care is not		None identified

	affordable.		
Deliverability	Staffing shortages within the provision may continue to be challenging Variation would still exist locally which could impact on flow/demand to acute and effect deliverability.		None identified Even with investment, the workforce development and primary care skills development timeframe will not respond sufficiently to meet growth in need

Benefits – Scenario 2 - Continue to deliver within the current form and with the current providers but develop a managed clinical network to:

- Agree guidelines and protocols are in place across the primary / secondary care interface for referring and managing the full patient pathway and address unwarranted clinical variation.
- Improve access to/from services at the right time.
- Provide a forum and clinical leadership for training and education, sharing best practice and development of the service.
- Ensure processes are in place to identify and monitor network risks and critical incidents.
- Address strategic issues by monitoring and predicting trends in patient flows, matching capacity to demand, workforce and succession planning.

Category	Benefit
Quality	The impact on people from low incomes and deprived areas is assumed to be minimal with this option as it would not involve major changes to their current healthcare provision.
Access	May be variable dependant on location, but should be able to be managed through a network for acute presentation
Affordability	No major investment requirements
Deliverability	Secondary care staff would not have to move to another site – they could continue to work at their local hospital site. Primary care staff would continue to work in their current environment. Maintaining rotas could still be challenging

Risks and Issues - Scenario 3 – Transform children's acute care provision across South

and Mid Yorkshire, Bassetlaw and North Derbyshire, changing the service model and pathways to improve performance and quality. This could mean re-configuring arrangements for children's inpatient and SSPAU sites through a hub and spoke model supported by networked services with more care delivered through community children's nursing teams and strengthened paediatric provision in primary care.

Category	Risk/Issue	RAG	Mitigation
Quality	Ability to skill up staff and develop skills across sites, providing lead skills development from a hub would enhance quality but be challenging. Development of consistent service models, alternative care models outside of hospital, or with an alternative skill mix and consistent standards of care would improve quality		Consider the development of a clinical network for acute care. Consider implementation of new models of care to manage demand differently Ensure collaborative agreements are embedded within contractual arrangements
Access	If services were to be reconfigured, there would be a proportion of patients who may have to travel further. Including possibly longer patient journeys or longer ambulance travel times		This needs to be investigated further as part of the next phase of work looking at possible options. Patients and the public would need to be reassured that travel times by embrace, blue light ambulance are fully understood and planned for.
Affordability	If evidence based consistent model of care is developed and supported across providers as an		The business case to support this assumption needs further development

	alternative to acute hospital care this will manage demand and provide efficiencies.		
Deliverability	There would be a need for extensive patient and public engagement as this would mean a change in where services are delivered but with overall benefits to patients		Overall outcomes will need to be worked on and the impact of changes should demonstrate overall acceptability even though there is significant change

Benefits - Scenario 3 - Transform acute care provision across South and Mid Yorkshire, Bassetlaw and North Derbyshire, changing the service model and pathways to improve performance, quality and sustainability

Category	Benefit
Quality	Reconfiguration of in patient and SSPAU services, to a more hub and spoke model has the potential to deliver improvements to quality and safety to the service. Implementation of new models of care throughout a patient pathway from community to acute settings would ensure consistency of patient pathway and quality across geography. Planning across a larger footprint will also support resilience.
Access	A more specialist site as a hub or several hub configurations fits with the national evidence base for best practice services, which should improve quality and outcomes. This should also contribute to a much improved assessment against standards. Consistent models of care across community to acute hospital care would ensure equitable access is planned across providers.
Affordability	There are economies of scale to be sought from this transformation/reconfiguration. The dependence on agency /locum staff to sustain staff rotas may reduce expenditure, however it should be noted that a full cost benefit analysis should be made available as part of the option appraisal phase of the project.

	Planning across a larger geographical footprint for workforce and developing consensus on models that reduce impact on demand could provide efficiencies
Deliverability	Taking a planned approach to provision of acute care pathways across a larger geographical footprint would support sustained deliverability of acute care. Providing alternative models of care including nursing care and healthcare assistants within community settings as an alternative model supports consistent delivery across.

5. Conclusion and recommendations

This high level options appraisal sets out the options, risks and benefits for Children's acute care services within the Working Together footprint. The project team are reviewing this work, and have undertaken a high level criteria assessment to form a preferred option for phase 2 of the project.

Through consideration of these criteria, and careful review of the benefits and risks associated with service delivery, the project team recommend that Option 3 (Transform children's acute care provision South and Mid Yorkshire, Bassetlaw and North Derbyshire - changing the service model and pathways to improve performance and quality), should be considered by the Children's Core Leaders group and then by the Programme Executive Group (PEG) as the preferred option.

The PEG will be asked to review and endorse the proposal that Option 3 be considered by the Clinical Senate to enable the work to progress.

There is an acknowledgement that further scoping of other services such as neonatal and maternity care would need consideration alongside discussions on proposals for change around acute care.

Appendix C

Key Stakeholder Engagement

Children's services Core Leaders

Name	Role	Organisation
Derek Burke	Clinical Lead	Sheffield Children's Hospital NHS Foundation Trust
Des Breen	Medical Director	Providers Working Together Programme
Fiona Campbell	Clinical Lead – Children and Young People	Strategic Clinical Network
Gail Collins	Medical Director	Chesterfield Royal Hospital NHS Foundation Trust
Chris Cotton	Senior Finance Manager	NHS Sheffield CCG
Will Cleary-Gray	Programme Director	Commissioners Working Together Programme
Linda Daniel	Project Lead	Commissioners Working Together Programme
Chris Edwards	Accountable Officer	NHS Rotherham CCG
Stephen Hancock	Lead Consultant (Paediatrics)	Embrace Transport Service
Helen Kay	Associate Director – Strategy and Transformation	Sheffield Children's Hospital NHS Foundation Trust
Kate Laurance	Senior Commissioning Support	Commissioners Working Together Programme
Phil Mettam	Senior Responsible Officer	Commissioners Working Together Programme
Tim Moorhead	Clinical Lead	Commissioners Working Together Programme
Jeff Perring	Clinical Lead	Yorkshire and the Humber PIC ODN
Mandy Philbin	Programme Lead	Commissioners Working Together Programme
James Scott	Project Lead	Providers Working Together Programme
John Somers	Chief Executive	Sheffield Children's Hospital NHS Foundation Trust
Helen Stevens	Communications and Engagement Lead	Commissioner Working Together Programme
Janette Watkins	Programme Director	Provider Working Together Programme

Working together SMT

Name	Role	Organisation
Jayne Sivakumar	Head of Service Development	NHS Barnsley CCG

Katie Roebuck	Acting Head of Commissioning and Transformation	NHS Barnsley CCG
Rachel Gillott	Deputy Chief Operating Officer	NHS Sheffield CCG
Jacqui Tuffnell	Head of Commissioning	NHS Rotherham CCG
Laura Sherburn	Chief of Partnerships and Primary Care	NHS Doncaster CCG
Lisa Bromley	Executive Lead	NHS Bassetlaw CCG
Gareth Harry	Chief Commissioning Officer	NHS Hardwick CCG
Mark Smith	Director of Finance	NHS North Derbyshire CCG
Esther Ashman	Head of Strategic Planning	NHS Wakefield CCG
Mike Edmondson	Secondary Care Dental Lead	NHS England
Matthew Groom	Assistant Director of Specialised Commissioning	NHS England Specialised Commissioning

Joint Committee of Clinical Commissioning Groups

Name	Role	Organisation
Steve Allinson	Accountable Officer	NHS North Derbyshire CCG
Nick Balac	Clinical Chair	NHS Barnsley CCG
John Boyington	Lay Member	NHS Sheffield CCG
David Crichton	Clinical Chair	NHS Doncaster CCG
Moira Dumma	Director of Commissioning Operations	NHS England
Philip Earnshaw	Clinical Chair	NHS Wakefield CCG
Chris Edwards	Accountable Officer	NHS Rotherham CCG
Andy Gregory	Accountable Officer	NHS Hardwick CCG
Idris Griffiths	Accountable Officer	NHS Bassetlaw CCG
Steve Hardy	Lay Member	NHS Wakefield CCG
Debbie Hilditch	Director	Healthwatch Doncaster
Julie Kitlowski	Clinical Chair	NHS Rotherham CCG
Alison Knowles	Locality Director	NHS England
Steven Lloyd	Clinical Chair	NHS Hardwick CCG
Ben Milton	Clinical Chair	NHS North Derbyshire CCG
Tim Moorhead	Clinical Chair	NHS Sheffield CCG

Jackie Pederson	Accountable Officer	NHS Doncaster CCG
Andrew Perkins	Clinical Chair	NHS Bassetlaw CCG
Maddy Ruff	Accountable Officer	NHS Sheffield CCG
Lesley Smith	Accountable Officer	NHS Barnsley CCG
Jo Webster	Accountable Officer	NHS Wakefield CCG

Acute Federation Board

Name	Role	Organisation
Martin Barkley	Chief Executive	The Mid Yorkshire Hospitals NHS Foundation Trust
Louise Barnett	Chief Executive	The Rotherham NHS Foundation Trust
Des Breen	Medical Director	Provider Working Together Programme
Andrew Cash	Chief Executive	Sheffield Teaching Hospitals NHS Foundation Trust
Richard Jenkins	Medical Director	Barnsley Hospital NHS Foundation Trust
Mike Pinkerton	Chief Executive	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Simon Morritt	Chief Executive	Chesterfield Royal Hospital NHS Foundation Trust
John Somers	Chief Executive	Sheffield Children's Hospital NHS Foundation Trust
Janette Watkins	Programme Director	Provider Working Together Programme
Diane Wake	Chief Executive	Barnsley Hospital NHS Foundation Trust

Clinical Senate

Name	Role	Organisation
Dr Lisa Daniels	Consultant Paediatric Anaesthetist	The Great North Children's Hospital
Dr Pnt Laloë	Consultant Anaesthetist	Calderdale & Huddersfield NHS Foundation Trust
Dr Geoff Lawson	Consultant Paediatrician and Clinical Director Children's Services	City Hospitals, Sunderland
Dr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool Foundation Trust

Dr Ben Wyatt	GP	Brig Royd Surgery
Dr Mark Anderson	Consultant Paediatrician and Head of Department – Paediatric Medicine	Royal Victoria Infirmary & The Great North Children's Hospital

2016 Clinical Workshops

Margaret Ainger	Clinical Director	NHS Sheffield CCG
Emma Andrews	Quality Improvement Manager	Strategic Clinical Network
Tracey Armstrong	Deputy Head of Nursing	The Rotherham NHS Foundation Trust
Lucy Ashall	Commissioning Manager	NHS Sheffield CCG
Pat Barbour	Governing Body GP	NHS Doncaster CCG
Tracy Barker	Senior Matron Children's Services	Chesterfield Royal Hospital NHS Foundation Trust
Nikki Bates	Elected Member	NHS Sheffield CCG
Chris Beattie	Lead Nurse	The Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Sunil Bhimsaria	Consultant Paediatrician	Barnsley Hospital NHS Foundation Trust
Anne Brady	Group Manager	The Mid Yorkshire Hospitals NHS Trust
Des Breen	Medical Director	Provider Working Together Programme
Derek Burke	Medical Director	Chesterfield Royal Hospital NHS Foundation Trust
Tracy Burton	Children's Commissioners	NHS Bassetlaw CCG
Fiona Campbell	Chair Consultant Paediatrician	Leeds Teaching Hospital Trust
David Clitheroe	Consultant Lead – Unscheduled Care and Emergency Centre	NHS Rotherham CCG
Gail Collins	Medical Director	Chesterfield Royal Hospital NHS Foundation Trust
Sarah Cooper	Clinical Strategy and Transformation Lead	The Rotherham NHS Foundation Trust
Sian Cooper	Consultant Paediatric Intensivist	Leeds Teaching Hospital Trust
Naomi Compton	Senior Commissioning Manager	NHS Derbyshire CCG
Linda Daniel	Project Lead	Commissioner Working Together Programme
Ben Dockerill	Nurse Advisor Children and Young Peoples Care/Matron	Barnsley Hospital NHS Foundation Trust
David Gibson	Consultant Paediatrician	The Mid Yorkshire Hospitals NHS Trust
Lee Golze	Head of Strategy	NHS Doncaster CCG
Alison Grove	Consultant Paediatrician – Head of Service	The Mid Yorkshire Hospitals NHS Trust

Stephen Hancock	Lead Consultant	Embrace Transport Service
Isabel Hemmings	Chief Operating Officer	Sheffield Children's Hospital NHS Foundation Trust
Anna Hescott	Commissioning Manager	NHS Sheffield CCG
Lucy Hinds	Consultant Paediatrician	Sheffield Children's Hospital NHS Foundation Trust
Steve Jones	Consultant Paediatrician	The Mid Yorkshire Hospitals NHS Trust
Melanie Kinsman	Nurse Advisor for Children and Young People	Barnsley Hospital NHS Foundation Trust
Kate Laurance	Senior Commissioning Manager	Commissioners Working Together Programme
Stjohn Livesey	Clinical Lead for Urgent Care	NHS Sheffield CCG
Faye Marshall	Service Manager	The Rotherham Hospital NHS Foundation Trust
Helen Moore	Consultant Paediatrician	Chesterfield Royal Hospital NHS Foundation Trust
Tim Moorhead	Clinical Chair	NHS Sheffield CCG
Denise Nightingale	Clinical Lead	NHS Bassetlaw CCG
Daksha Patel	Divisional Director for Family Health	The Rotherham Hospital NHS Foundation Trust
Jeff Perring	Clinical Lead	Yorkshire and the Humber PIC ODN
David Purdue	Chief Operating Officer	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Mary Ryan	Consultant in A&E	Alderhay Children's Hospital NHS Foundation Trust
Matthew Roby	Consultant Paediatrician and Clinical Lead	Chesterfield Royal Hospital NHS Foundation Trust
Emma Royal	Commissioning Manager	NHS Rotherham CCG
James Scott	Project Lead	Provider Working Together Programme
Sally Shearer	Director of Nursing	Sheffield Childrens Hospital Foundation Trust
Rajiv Singh	Consultant Paediatrician	Mid Yorkshire Hospital NHS Foundation Trust
Sewa Singh	Medical Director	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
John Somers	Chief Executive	Sheffield Children's Hospital NHS Foundation Trust
Carmel Stagles	Head of Nursing Children's Services	Chesterfield Royal Hospital NHS Foundation Trust
Sanjay Suri	Clinical Director for Child Health	The Rotherham Hospital NHS Foundation Trust
Conrad Wareham	Medical Director	The Rotherham Hospital NHS Foundation Trust