RCPCH Invited Reviews Programme

# Service Review

## Review of Children's Emergency Services at County Hospital, University Hospitals of North Midlands NHS Trust

**January 2017**

Royal College of Paediatrics and Child Health

Leading the way in Children's Health

RCPCH Invited Reviews Programme
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# Executive Summary

## Background

The RCPCH was invited to conduct a review of urgent and emergency care for children in Staffordshire following the temporary suspension of services of the Children's Emergency Centre (CEC) at County Hospital Stafford in August 2016.

The RCPCH is an independent professional organisation which sets standards of training and service delivery for children's medical services in the UK. Following study of a range of documentation and data the review team visited County Hospital (Stafford) and Royal Stoke University Hospital (Stoke) on 3-4 November 2016 to interview staff who worked in and with the Trust's children's emergency and urgent care services. Alongside the review visit the views of patients, their families, the public and other staff were sought through a short online survey which was publicised widely by the Trust and local media.

## The changing nature of healthcare

The reconfiguration of hospital services at County reflects the modernising of healthcare in the UK. There is an increasing move away from inpatient (hospital) care except for the very sickest patients and centralisation of expertise and complex care to make best use of skilled staff. Most children who are ill can and should be seen and treated by their pharmacist, health visitor, GP, NHS111, or a children's nurse local to home who is suitably qualified to recognise more serious conditions in children and get them to the right care swiftly. It is however important to ensure there is swift identification of more serious illness, and good support for parents and carers.

Standards published by professional bodies and the government ensure that acute (hospital) and emergency care is safe and equitable for children, and these take into account staffing levels, skills needed and how various services should communicate and measure the quality of care.

South Staffordshire families had come to accept the consolidation of children's inpatients at Stoke but valued the Children's Emergency Centre (CEC) arrangements at County. They are aware of the opening times and acknowledging that emergency transfer was available for very sick children. Most of children seen at the CEC were able to go home the same day with some being seen by a paediatrician at County the next day and only small numbers being referred to the Royal Stoke for urgent, surgical or inpatient care.

In July 2016, the West Midlands Quality Review Service (WMQRS) highlighted major safety concerns relating to staffing levels and skills at the CEC, and the arrangements for identifying and managing children with serious medical conditions. The Trust acted immediately to close the unit, which was an appropriate initial response, although the sudden change to services came as a surprise to some staff, partner organisations and members of the public. A limited service for children's minor injuries only (CMIU) was then opened in October 2016, pending the recommendations of this review.

## Our findings

At County we found an enthusiastic and committed team of children's nurses working on CMIU, and heard and saw reports of a local population who are passionate about their local hospital and dedicated to maintaining local services.

The WMQRS did not consider the CEC at County to be working safely and the review team supports this assessment. Re-opening the service as a Children's Minor Injuries Unit seems to have been misunderstood by the local population; on average, 45% of patients

are still attending with minor illness rather than minor injuries as was intended, and are not seeing their GP or using children's services at Stoke. These patients continue to be assessed on site by CMIU staff, despite the fact the unit is not set up to safely manage these types of conditions.

A programme of training and rotation has been introduced for nursing staff to enable them to develop skills for minor injuries and care of ill children; however most of the concerns raised by the WMQRS, including the absence of suitably trained paediatric staff for the majority of shifts, have not been addressed. As the unit at County continues to perform much the same role as the CEC, there remains a significant risk that seriously ill and sick children will not be identified quickly enough to receive timely and appropriate care.

There is a good community nursing service across Staffordshire, which was strengthened in recent years, although there are pressures on primary care with a notable shortage of GPs in the north of the county. A pilot project to support primary care with a 24-hour paediatric advice line in Stoke is being evaluated and there is some potential to better integrate the primary care/paediatric pathway at both sites.

**A vision for the future**

A clearer vision is required for the County site including a cross-trust strategy for children's services. County is an important hub for the South Staffordshire community and as many walk-in ('ambulatory') services as possible for children should be provided there to minimise the need for travel.

There is clear demand for a local service at the County site which can manage minor illness and minor injuries over an extended day but a return to the CEC model of service would be unsafe and unsustainable as the staff do not have appropriate training to safely manage all attendees.

The RCPCH recommends an 'Urgent Care Centre' model is established as soon as possible at County that provides GP-led services to treat minor injury and illness in children and young people, with sicker children being diverted to Stoke. Such a service could be provided largely by advanced practice or specialist nurses and would meet the majority of demand from the local population. Migration to this model would require a period of time to recruit and train suitable staff so other measures are required in the short term towards this vision. We therefore recommend that:

- The CEC at County Hospital is **not** reinstated
- The Children's MIU remains operational alongside ED in the short-term, **BUT:**
    - Nursing cover must be strengthened with Emergency Nurse Practitioners and APNPs
    - All clinical staff must have appropriate, up-to-date paediatric resuscitation (i.e. PLS or equivalent). At least one member of staff with advance paediatric resuscitation training (i.e. APLS or equivalent) must be available at all times (as long as the CMIU remains there will be a risk these skills will be required, this can be reviewed if and when an UCC is introduced)
    - Minor illness must be proactively managed through 'front door' primary care
    - More serious illness is referred directly to Stoke or New Cross
    - The out-of-hours GP service is promoted and strengthened to support the CIMU
    - GPs across Stafford continue to have rapid access to paediatric telephone advice and next-day local clinics

- There is absolute clarity about referral and transfer arrangements.
- A number of other 'enabling' actions are also set out as recommendations in section 5

We recognise GPs are in short supply, particularly in North Staffordshire, but the South of the county has no alternative walk-in, urgent care or minor illness service. The local population's use of current services at County indicates that a UCC would meet most of the demand in a cost-effective way and provide a sustainable service irrespective of the future of County's other services.

**Moving towards the new model**

It will take time to implement a new model of care at the County site, and the quality and safety of services delivered in the meantime must be ensured. Trust-wide governance must be strengthened across both sites to include shared processes and procedures, staff training and risk management. Staff working regularly at County need to maintain their skills in paediatrics and the staff across both sites must increasingly come together as one team despite historical differences in philosophy and approaches to practice. There are also a number of issues around the delivery of safeguarding training across the region, which must be addressed as a matter of priority (see para 3.8.6).

Responsibility for implementing these changes must be clearly identified within the Trust and the paediatric team and commissioners should be closely involved with developing clinical pathways as well as strategic planning, drawing upon published standards where applicable and proven practice models, with focused audit where new arrangements are being developed.

Throughout, there must be a clear communications strategy to ensure the proper engagement of those who use the services, including parents' groups and young people themselves. This strategy must not be an 'add-on' but a fundamental part of designing the new services and ensuring they are fit for purpose and meet the needs of the local population.

**A note on terminology:**

- Throughout the report the term 'children' is used to refer to infants, children and young people up to 18 years of age
- '**C**ounty' refers to County Hospital in Stafford, and '**c**ounty' applies to the geographical region; 'Stoke' to Royal Stoke University Hospital in Stoke-on-Trent
- Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals

# 1. Introduction

1.1. Following the temporary suspension of children's emergency services at County Hospital (Stafford), in August 2016 the RCPCH was invited to conduct an independent review of emergency health services in Staffordshire for children, to provide options for provision of sustainable, high quality care that matches the need of the local population.

1.2. Following agreement of scope and terms of reference, the RCPCH assembled a review team matched to the issues being considered which comprised two consultant paediatricians, a consultant anaesthetist with an interest in paediatric anaesthesia, and a paediatric nurse consultant, all nominated by their respective Royal Colleges, as well as a lay reviewer. The team was supported by a member of the RCPCH's Invited Review service staff.

1.3. The review team was provided with pertinent data and information by the Trust ahead of a two-day site visit on 3-4 November 2016. Interviews took place with key staff who worked in or with the paediatric emergency service at both County Hospital and Royal Stoke University Hospital. Additional information was requested and received during and after the visit and some telephone calls were subsequently conducted with individuals who were unavailable on the visit dates. All those interviewed were provided with contact details of the review team should they or their colleagues wish to contribute information in confidence.

1.4. Given the nature of public and staff interest in the reconfiguration of paediatric services, the review team was keen to hear the views of all those with an interest in the service, not just those they were able to meet. To this end a survey was launched alongside the review for staff, patients, parents-carers and their representatives to contribute their experiences and opinions. Their contributions are detailed in appendix 5.

1.5. In writing this report the review team has taken into account published regulations, policy and standards from professional bodies, government, and third sector organisations, together with national data and evidence from the RCPCH's own audit, census and health policy intelligence.

1.6. The report belongs to University Hospitals North Midlands Trust (UHNM), through the Medical Director and Chief Executive. It remains confidential between the Trust and those appointed by the RCPCH to produce the report. The RCPCH encourages wider dissemination of this report by the Trust amongst those involved in or using the service. The RCPCH will not itself publish or comment on review reports without the permission and agreement of the review client.

1.7. The review team would particularly like to pass on their thanks to all participants for their hospitality, engagement with the process, their openness, and their time.

# 2. Background and context

## 2.1. University Hospitals of North Midlands NHS Trust

2.1.1. University Hospitals of North Midlands NHS Trust (UHNM) was established in November 2014 following the integration of the former Mid Staffordshire NHS Foundation Trust with the University Hospitals of North Staffordshire. The Trust provides the full range of general acute hospital services for approximately 700,000 people living in and around Staffordshire as well as a wide range of specialist services for three million people in neighbouring counties and across Wales.

2.1.2. There are two main hospital sites, County Hospital in Stafford (County) and Royal Stoke University Hospital (Stoke), approximately 18 miles apart. Travel between the two sites takes around 30-40 minutes by car, or 60-90 minutes by public transport.

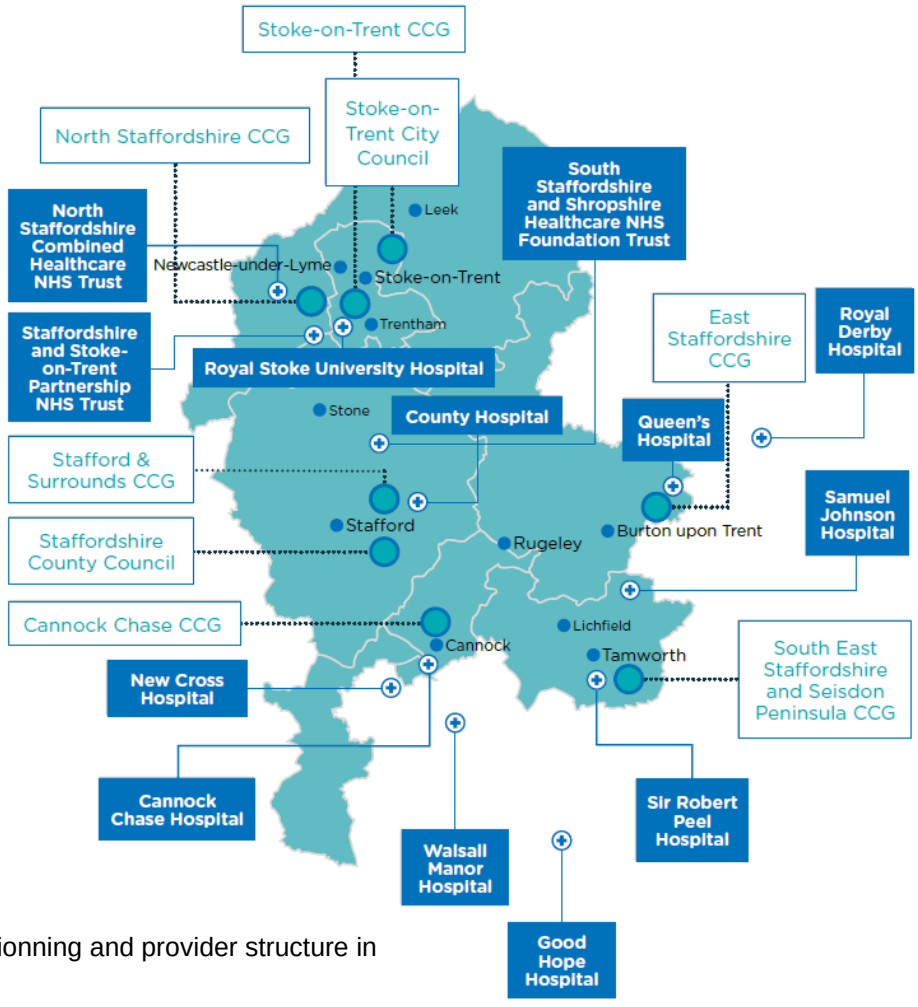


Figure 1 – Comissionning and provider structure in Staffordshire [1]

2.1.3. Upon the recommendation of the Trust Special Administrators, a number of services across the constituent Trusts were reconfigured when UHNM was created in November 2014, including:

- All surgery, consultant-led maternity services and paediatric inpatient services were transferred from County to centralised and expanded services at Stoke
- A new freestanding midwifery birth unit was developed at County

- The paediatric assessment unit (PAU) at County remained open for several months; in May 2015 it was transformed into the Children's Emergency Centre (CEC) which was run in conjunction with the hospital's 14-hour a day Emergency Department (ED)

2.1.4. The current paediatric services at the acute sites following the merger are outlined in sections 2.2 – 2.4 below.

## 2.2. Royal Stoke University Hospital (Stoke)

2.2.1. Stoke serves a population of around 450,000 locally and provides tertiary services to North Wales. It was reported that around a third of GP posts were vacant in the Stoke area, with some reluctance for GPs to work in larger centres. It was suggested that the CCGs are likely to amalgamate in the future and there is a need to expand 'hospital at home' services in order to modernise care provision.

2.2.2. Redevelopment of the Stoke site completed in 2015, with the expanded children's services centralised in the Cheethams Children's Centre. This comprises a separate state-of-the-art Emergency Department with support from a Children's Assessment Unit (CAU), 8-bed intensive care unit, high dependency unit, wards, outpatients, treatment rooms, play areas and school room.

2.2.3. Planned and day case paediatric surgery is also provided on site, with specialists in paediatric orthopaedics, ENT, maxillofacial, dentistry, spinal injuries and deformity, ophthalmology and plastic surgery.

2.2.4. There is a 56-bed maternity unit with around 5600 births per year, and a level 3, neonatal intensive care unit with 26 cots. The 11-room Midwife Birth Centre is located onsite and delivers approximately 1,500 babies per year.

## 2.3. County Hospital Stafford (County)

2.3.1. The hospital was built in 1983 and is being redeveloped following the merger. It hosts a range of paediatric outpatient services delivered by a single paediatric team for the Trust. Following merger, daily consultant-led paediatric Rapid Access Clinics (RAC) were established to see referrals from GPs and CEC follow-ups where children required rapid input from a paediatrician, although these slots were underutilised (see also section 3.3).

2.3.2. The Children's Emergency Centre (CEC) has a separate entrance with video surveillance. There is a large waiting area with toys, which is overseen by the reception, and a triage room, three cubicles and two assessment beds. Like the ED it is open between 08:00 – midnight (last new attendance 22:00).

2.3.3. The CEC offered emergency medical care and advice for around 30 children a day referred in from their GP or the 111 service. Children could be admitted for observations, investigations or initial treatment during opening hours. Staff comprised two registered children's nurses (one with APLS training) covering 07.00-19.30 and 11.30-00:00 respectively, with support from ED doctors, and an ED nurse with PILS training. There was local acceptance of the night time closure and awareness of the alternative hospitals accepting children. Individual profiles and

care plans are in place for children with special, long term or complex needs using the County Hospital, so they are directed to Stoke if they become seriously unwell.

2.3.4. Paediatricians attending the on-site Rapid Access Clinics would also provide evening support in CEC between 18:00 – 22:00 in order to upskill ED doctors in paediatrics. However due to the high proportion of locum ED doctors on site there was little engagement with training, the paediatricians reported they were providing service cover instead and these sessions were eventually terminated.

2.3.5. Since the merger, ambulances with paediatric emergencies have been diverted to Stoke, and 'out of hours' patients are directed either there or to New Cross Hospital (Wolverhampton). Two dedicated, staffed ambulances are based at the County site for emergency transfer of adults, children or women in labour.

2.3.6. The children's outpatient department has a large waiting area with toys for younger children and a 'teen zone'. The four consulting rooms are not always fully utilised. A range of clinics are provided by consultants working out of Stoke as well as some visiting consultants. These clinics include audiology, diabetes, child psychology, dietetic and respiratory outreach clinics from Stoke. There are nurse-led allergy, phlebotomy, BCG and jaundice clinics. Ophthalmology and ENT clinics for children are provided elsewhere within the hospital.

### 2.4. Closure of County Hospital Children's Emergency Services

2.4.1. In July 2016, the West Midlands Quality Review Service (WMQRS) reviewed services for critically ill and injured children attending County Hospital. The review highlighted a number of immediate risks within the CEC relating to clinical safety and clinical outcomes, including:

- Availability of senior paediatric and resuscitation expertise throughout the opening times
- Lack of clarity about resource for time-critical transfer
- Uncertainty about prioritisation of care, use of early warning systems and safeguarding training
- Inconsistency about ambulance presentations, clinical responsibilities, operational policies and overall governance

2.4.2. Alongside this review, the anaesthetists at County, who are mostly middle grades, had expressed concern about their ability to maintain their experience and competency managing children. Since the reconfiguration, the site mainly provides adult elective care and anaesthetists do not currently rotate out to other centres.

2.4.3. In light of these concerns, the Trust made the decision to temporarily suspend services at the County Hospital CEC from 25 August 2016, although outpatient clinics would continue, and children aged 16-17 years of age could attend adult ED. Patients with minor illness and injuries were advised to use primary care services, and those with urgent care needs were diverted to Stoke and New Cross Hospital. The decision was widely publicised and the hospital continued to provide immediate care to children arriving at ED until transfer could be organised.

**Summary of West Midlands Quality Review Service Care of the Critically Ill & Critically Injured Child – site visit to Children's Emergency Centre (CEC), County Hospital**

The WMQRS noted the pleasant and clean environment of the CEC, and highlighted the warm and welcoming atmosphere for families. Staff were reported to be dedicated and enthusiastic, working hard towards achieving the necessary competencies for work on the unit. However the review found the Centre to be an 'immediate risk to clinical safety and clinical outcomes', the reasons for which are outlined below:

1. A member of staff with Level 1 Royal College of Paediatrics and Child Health (RCPCH) competences was not available in the CEC for the majority of shifts
2. Approximately only half of all advertised Consultant-led paediatric rapid access clinics took place, and the paediatricians running them had no involvement with CEC
3. An appropriately staffed paediatric resuscitation team was not available. Not all Emergency Department Consultants received the necessary paediatric life support training. Information on resuscitation training for 'middle grade' doctors was not available, with many posts filled by locums. Whilst the nurses within CEC had completed appropriate training they were making little use of the competences gained and may not feel confident in an emergency.
4. There was no evidence that on-site anaesthetists had up to date competences in the care of children, with a significant proportion not having any paediatric involvement for many years. Policies on airway management did not appear to be in place and it was not clear that appropriate equipment for difficult airway management in a child was available.
5. The service was not prepared to undertake a time-critical transfer, should this be required. A transfer policy had not been finalised and there was a lack of awareness amongst staff that although rarely, they may be required to undertake a time-critical transfer. A 'grab bag' with appropriate drugs and equipment was not available for use.
6. The Safeguarding Policy was not clear and there was confusion as to whether CEC staff had been provided with training at the correct level.
7. A lack of clear policy had resulted in confusion amongst County Staff, ambulance staff and the public as to whether ambulances should bring children to the CEC.
8. Arrangements for prioritising the needs of the sickest patients presenting to the County Hospital were not robust. As a result, medical staff could be caring for a lower priority patient in another area, unaware that a higher priority child was in CEC. Nursing staff in CEC had no guidance or systems to enable them to call a doctor to see a child and reviewers were told that medical staff sometimes did not respond when requested.
9. A robust system to provide early warning of the deterioration of a child was not in place. Initial observations were taken and a Modified Early Warning Score calculated by the computer and the information then put onto a Paediatric Early Warning System chart, with the potential for error and confusion.
10. Children admitted to the Assessment Area were not visible on the computerised screens of Emergency Department patients and medical responsibility for these patients was not clear.
11. Guidelines for the care of children with asthma were not being followed as Trust posters advised different dosages of prednisolone compared to national guidance.
12. Arrangements for review of children prior to discharge were not clear, due to a lack of clear policy, and it appeared possible for an FY2 doctor to discharge a child with only informal systems in place.
13. Governance responsibility for the Children's Emergency Centre did not appear to be functioning effectively. Incidents were recorded on the Datix system but these were not always discussed. The Emergency Department held mortality and morbidity review meetings, but

these meetings did not include staff from the Children's Emergency Centre. Robust mechanisms for involvement of consultant paediatricians in training, guideline development, audit and review and learning were not evident. It was not clear that staff of the main Emergency Department and Medicine Directorate had appropriate understanding of the needs of children and the risks inherent in caring for children. This view was reinforced by comments, when asked about deteriorating or critically ill children, that "it doesn't happen here".

# 3. The current service

## 3.1. County hospital – children's emergency centre (CEC) and children's minor injuries unit (CMIU)

3.1.1. The Children's Minor Injuries Unit (CMIU) opened on 10 October 2016. It occupies the same area as the CEC, utilising the 4 cubicles and waiting space although not the two observation and assessment beds. Opening hours remain as for CEC and the service aims to see the majority of the previous CEC activity (i.e. that relating only to minor injury and not minor illness). This includes head and limb injuries, wounds, sprains, bruises and fractures. The webpage explains that for other illnesses, such as rashes, vomiting and coughs and colds a GP or NHS 111 should be consulted.

3.1.2. The CMIU is staffed by nurses rotating through the ED and provides treatment for children with minor injury where the children can be treated in less than one hour. A medical 'early warning' score is used with this group of children to detect signs of deterioration, as ED staff are familiar with this tool, but it is not designed to be used for paediatric patients. This was raised as a concern by WMQRS but had yet to be addressed at the time of our visit.

3.1.3. All children with illness such as respiratory infection or wheeze are seen by a doctor who decides if the child can be managed locally or should be transferred to Stoke.

3.1.4. There is currently no receptionist on CMIU, so nurses are responsible for booking children in as well as triage and treatment, which can delay recorded assessment times. Numbers seen on the unit vary; in the three months since opening as CMIU an average of 15 patients attended each day (range: 3-31).

Activity at County Hospital

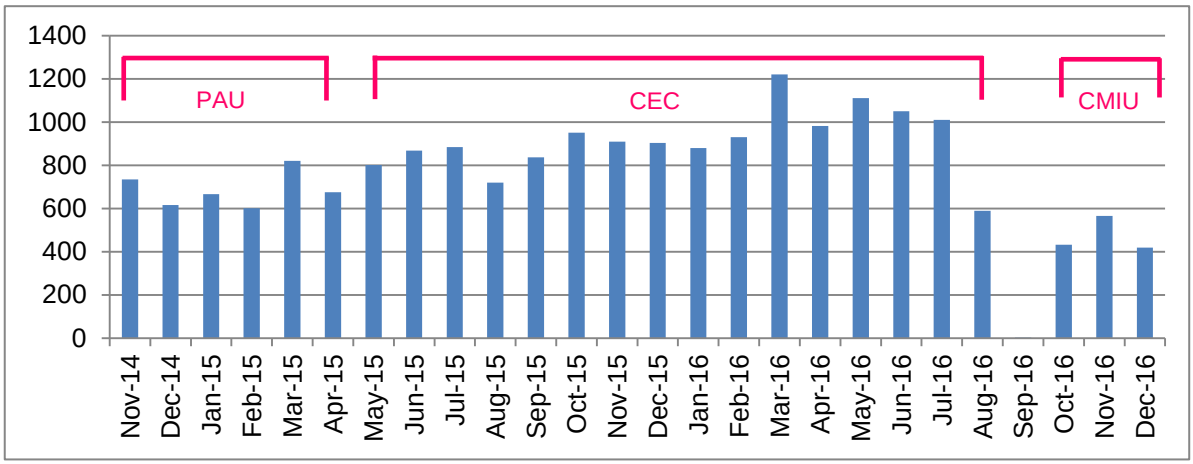


Figure 1 - Patients aged 17 and under attending County Hospital (ED/PAU/CEC/CMIU)

3.1.5. Total paediatric attendance at County hospital rose gradually from January 2015 (when there was still a paediatric assessment unit) to July 2016 (just prior to the closure of the CEC); attendance ranged from 601 (Feb 2015) to over 1200 in March 2016, averaging around 30 patients per day during that period. Following the

change from PAU to CEC, the admission rates did understandably drop from around 20% to around 2% of attenders and transfers to another hospital increased from approximately 1% to around 4-5%.

3.1.6. Although the CEC was closed between August and October 2016 there was little noticeable increase in paediatric attendance at Stoke, although some families may have gone to Burton or Wolverhampton. The CCG did not have destination data. During this period Healthwatch received five letters with concerns from the public, mainly citing additional travel time to, and delays at, Stoke. These were forwarded to the Medical Director and were awaiting response at the time of the visit.

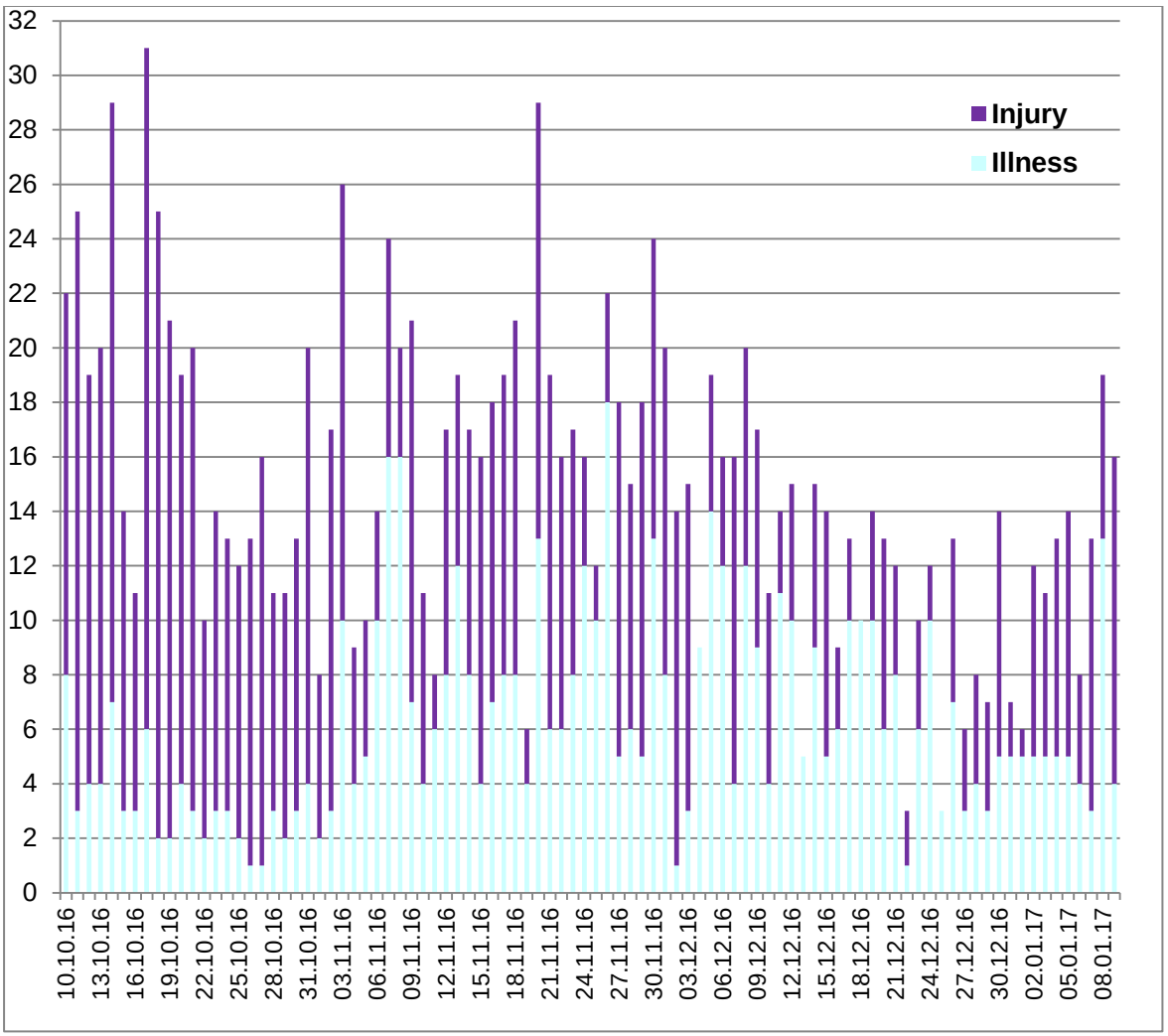


Figure 2 – Number of patients presenting each day to CMIU with minor injury vs illness

3.1.7. Despite weekly communications with the public, at the time of the review visit, local parents appeared uncertain as to the criteria for attendance at the CMIU and continue to bring children with minor illness as the unit is convenient and staff are helpful.

3.1.8. There was also a suggestion that some local GPs were not sufficiently accessible for families to avoid them attending the CMIU. There is a risk that seriously unwell children and acute emergencies might still present to the current CMIU which is not staffed by medical and nursing staff with the skills required to identify and safely

manage a sick unwell child. The Trust did not appear to have involved local GPs in the decision to close the CEC, which meant that the local GPs had no chance to plan for increased activity to reduce hospital attendances.

3.1.9. The review team was told by many of the clinical staff we met with that around 80% of those attending County hospital (before and after the closure) had minor injuries and could, in their opinion, be easily managed by the clinical team. It should be noted however that this precludes consideration of other factors such as safeguarding (see 3.7 and 3.8). The remaining 20% apparently attended with minor illness which required paediatric expertise. These figures were widely reported, but data indicated the proportion with minor illness was much higher - since the CMIU opened an average of 45% of patients attended with illness rather than injury (range of 2-100%). It should be noted that overall numbers attending CMIU are lower than for CEC.

3.1.10. Despite the stated policy that ambulances do not take children to County, the WMQRS reported that ten children had been brought in by ambulance between June 15 and April 16. Data shows that in 2016 a total of 82 children under 18 years of age were brought to County by ambulance (presumably these were 16-17 year olds being seen within the adult ED, although we cannot be certain from the data provided).

**Minor injury vs Minor illness**

Research shows that 80% of episodes of illness in children are managed by families without contacting health professionals[1]. Where parents or carers are concerned about a child there are a range of options available.

**Minor Illness** - should be seen in primary care - these are illnesses that are not life-threatening. Primary care includes pharmacies, NHS111, health visitors and the GP (including the GP out-of-hours service). Where the child has a long term or chronic condition there should be arrangements in place to help parents decide whom to contact.

**Minor Injuries** - should be seen by a GP or in a minor injury unit. For infants and children this includes sprains and strains, broken bones, wound infections, minor burns and scalds, minor head injuries, insect and animal bites, minor eye injuries and injuries to the back, shoulder and chest - the ED department at County can provide assessment and treatment.

A minor injury service is **not** staffed or equipped to diagnose and treat illness.

[1] 'Focus On: Emergency and Urgent Care for Children and Young People'. NHS Institute for Innovation and Improvement ISBN No. 978-1-907045-78-3 March 2010.

## 3.2. Emergency Medicine

3.2.1. Following the creation of the new Trust, ED is led by the Clinical Director for Emergency Medicine, who works across the Trust, with a clinical lead at each site.

Stoke site

3.2.2. The Adult Emergency Department at Stoke faces increasing challenges over capacity, with rising demand. The Trust is one of the worst performing Emergency Services in the country in terms of waiting times to be seen and compliance with national 4 hour targets. The ED often sees over 400 patients per day, with long waits in 'the corridor' outside ED and many patients with medical conditions stay overnight in ED waiting for treatment (30 the day before our visit). Some changes to the management of patient flow within adult ED were due to be implemented shortly after the review visit in November 2016, to allow patients to be assessed more quickly.

3.2.3. At the time of the visit Stoke typically had around 200 – 210 medically fit for discharge adult patients at any one time, reflecting a lack of capacity in the community. This increases the pressure on the ED as patients cannot move swiftly through the department. Consultant recruitment to ED at the Stoke site was not however considered a problem; the service is almost at full establishment at consultant level, and there are a number of military consultants on the rota. They aim to have four consultants on each shift, one is the consultant in charge and one is the minors and children's consultant who provides senior decision making for those areas, since they are not consistently meeting the former 95%/four-hour target[2]

3.2.4. There are significant gaps at Tier 1; whilst there were high numbers of applicants for posts, many were not suitable or failed to materialise for interview. Gaps at middle grade were apparently subject to proactive recruitment, with CESR and clinical fellow posts being introduced. These can take time to get someone in post once they've been appointed. There is an expectation that the CESR programme which is working well in Derby could assist in the longer term and develop middle grades to consultant level.

County hospital

3.2.5. County has had one dual accredited ED/paediatric consultant (who was on long term sick at the time of the review team's visit), one associate specialist and eight Tier 2 posts of which 2.5 were filled substantively and the rest were long-term locums. The unit lost Emergency Medicine GRID trainees several years ago, and then further reductions to the Tier 2 rota occurred with implementation of DRE-EM[3] programme.

[2] The 95% target was replaced by operational performance trajectories in July 2016

[3] IN 2013-4 the GMC and RCEM approved the Defined route entry – Emergency Medicine (DRE-EM) pathway as a run-through 5 year training programme

3.2.6. There is daily ED consultant cover between 8am and midnight with Tier 2 cover at other times. Cover is also provided by Physicians Assistants who see children with minor injury and illness in the CMIU. These medical staff have no formal paediatric education. The review team was told that all staff had ALS/PLS training but the evidence provided indicated that this was out of date, and it was unclear whether they were confident and competent in managing the different presentations and needs of children compared with adults. None of them were rotating to Stoke paediatrics ED where they would work alongside paediatricians, as they were needed on site. The review team are concerned about the ability of Physicians Assistants to maintain their skills in relation to children and that they appear to rely on paediatric trained nurses and consultants for support.

3.2.7. There is a team of Emergency Nurse Practitioners at County, three of whom rotate between sites, and all have paediatric experience. They see children from two years upwards and prescribe analgesia and antibiotics using the paediatric formulary. All new nursing posts planned for County would include rotation through Stoke. The adult ED nurses see children and they should have as a minimum PLS (one day) training in the management of children as set out in the Intercollegiate emergency care guidance[4].

3.2.8. The training records for paediatric life support training of ED doctors (EPLS / APLS) at the County hospital site indicated that most training had expired or there was no qualification date for many of them. It was concerning that the governance system did not appear to have picked this up and it was unclear how the board was assured of the safety of the service. The Intercollegiate standards[4] require consultants, Tier 2 doctors, and ED nurses at band 6 and 7 to be up to date in Advanced Life Support (EPLS/APLS or equivalent).

### 3.3. Paediatrics

3.3.1. The current paediatric workforce for UHNM is:

| | Tier 3 | Tier 2 | Tier 1 |
|---|---|---|---|
| | Establishment / In post / Vacant | | |
| Community Paediatrics | 9 / 9 / 0 | 4 / 3 / 1 | 0 / 0 / 0 |
| Neonates | 7 / 7 / 0 | 7 / 7 / 0 | 8 / 6 (incl 3 ANNP) / 2 |
| Intensive care | 5 / 5 / 0 | 7 / 5.5 / 1.5 | 0 / 0 / 0 |
| General Paediatrics | 18 / 18 / 0 | 7 / 6 / 1 | 11 / 9 / 2 |

3.3.2. Since the reconfiguration there has been a single paediatric team working out of Stoke, with most paediatricians based entirely or largely there, as intensive care consultants would not be expected to cover County Hospital, and the Trust only provides Community Paediatric services to the north Staffordshire.

3.3.3. Three general paediatric consultants rotate through County Hospital. Initially this was to provide dedicated paediatric rapid access clinics (RAC) every day for

[4] RCPCH (2012) Standards for children and young people in emergency care settings (4th edition, currently under review)

children referred by a GP or ED. At weekends they were located in the CEC, whereas during the week they used to be further away.

3.3.4. Dedicated RACs eventually stopped, due to underutilisation making the service unsustainable, but there were suggestions that they were not sufficiently publicised as an option for referral. 20-22 single slots a month are now added to the end of general paediatric outpatient clinics. These slots are still not all filled and better communication is needed about them to GPs, emergency and urgent care staff.

3.3.5. The RAC paediatricians also provided evening CEC support between 18:00 – 22:00 in order to upskill ED doctors in paediatrics, and provide skills/scenario drills to staff, but their hands-on expertise was increasingly being relied upon by inadequately trained or temporary ED staff so this ceased with the changes in August. The paediatricians reported dissatisfaction on being called out of clinics for advice/input on the CEC which was not the reason for them being on site, and posed challenges given the distance from the CEC. There was no information available as to how frequently this occurred and the review team were not shown any Datix or incident reports completed for such events.

### 3.4. Anaesthetics

3.4.1. UHNM has a large anaesthetics department, comprising:

| | Establishment WTE | Vacancies WTE |
|---|---|---|
| Consultants | 73 | 12 |
| NCCGs | 31 | 6 |
| Trainees | 50 | 3 |

3.4.2. The consultants in particular were reported to work effectively as a single team with lists across both sites. Although anaesthetic trainees are present at County for their ambulatory / day care module, there is no formal rotation. There are five theatres and a further one opening soon although these are all for adult and day case activity. Anaesthetic cover at County is provided by a core of six middle grade specialty doctors or staff grade anaesthetists, none of whom have a paediatric special interest. The remaining cover is provided by locum anaesthetists, usually the regular doctors who are familiar with the service.

3.4.3. Out of hours cover at County is provided by a resident Tier 2 doctor, with a non-resident consultant on-call, who will become resident should the Tier 2 need to attend a transfer. The team do not provide support for urgent and emergency transfers due to limited resources, so this is provided by the KIDZ team in Birmingham.

3.4.4. Paediatric skills should be maintained through APLS and ongoing scenario training similar to that for ED doctors, but due to the absence leave by the lead Paediatric ED consultant, this has not been put in place. The Tier 2 doctors have reportedly resisted attempts to introduce rotation to Stoke but there are plans to address this during the next round of job planning in April 2017.

3.4.5. It should be acknowledged, however, that full paediatric skills are difficult to maintain if the anaesthetists are not carrying out regular lists; occasional supernumerary practice at another unit is unlikely to enable them to remain confident or competent to support the critically ill child. The system should not be set up with the expectation that anaesthetists will be able to offer a full paediatric service.

## 3.5. Nursing

County hospital

3.5.1. The current nursing workforce at County is:

County Nursing staffing Adults & Paeds

| Band | Establishment WTE | Vacancies WTE |
|---|---|---|
| 2 | 28.57 | 2.48 |
| 4 | 2.69 | 1.89 |
| 5 | 44.33 | 5 |
| 6 | 13.89 | 0 |
| 7 | 10.75 | 0 |
| 8 | 3.0 | 0 |

County Nursing staffing Paeds

| Band | Establishment WTE | Vacancies WTE |
|---|---|---|
| 2 HCSW | 2.69 | 1.69 |
| 4 Play Specialists | 2.69 | 1.89* |
| 5 | 4.03 | 1.39 |
| 6 | 4.03 | 0 |

*including 1WTE seconded

3.5.2. There are ten children's nurses (8.06 WTE) based at County ED (seven Band 6 and three Band 5), each with at least ten years children's nursing experience. All but two are APLS trained and one is recertifying as an APLS instructor. There is an Emergency Nurse Practitioner with 15 years' experience, who is currently working as a Band 6 Sister. The team are enthusiastic, dedicated to the unit at County and feel that they provide a unique service, as they deal with all aspects of management including administrative work, safeguarding and liaison health visitor role and clinical care.

3.5.3. Nurse staffing in the CMIU is rostered from the combined Adult and Children's ED nursing team. The original plan for CEC was to have two registered children's nurses on duty at all times, however this was not achieved and for CMIU there is one children's and one adult nurse or clinical support worker. These adult trained nurses would usually work in adult ED, so working in CMIU may not be the best use of their skills.

3.5.4. When the CEC closed, County nurses were rostered for six weeks in supernumerary roles at Stoke before being required to take leadership in the Stoke ED commensurate with their grade. Since the CMIU opened, all the County nursing team, including HCAs and play specialists, continue to work at Stoke for 50% of their hours to maintain clinical skills, including the management of seriously ill children. Although the Stoke team has been welcoming and tried to accommodate rota requirements, some County nurses have found the rotation difficult, as Stoke is around an hour away; some have no car and others with children have found the transition to cross-site working difficult. There is no reciprocal arrangement with Stoke nurses rotating to the County; such an arrangement, even for a short time should be considered and discussed with staff in order to build team cohesion and consistency of procedures. Given the small size of the County CMIU, orientation would be swift.

3.5.5. All nurses have a competency document to be completed to ensure they can deliver the full range of CMIU skills. However not all nurses were able to complete required competencies despite opportunities being available during the rotation at Stoke. For some situations, such as rare injuries, opportunities had not arisen so the Trust should discuss with staff how to enable them to gain these competencies, if required, perhaps by short term rotation to a larger ED.

3.5.6. There appears to be a significant difference between the perceptions of the nurses working in CMIU and managers regarding the difficulties the nurses are encountering or creating. Whilst the managers perceive nurses as resistant to change and not performing to the expected standard, the nurses report being unrealistically expected to manage the children's ED at Stoke, often with insufficient staffing (due to a recent high turnover of Band 6 nurses).

3.5.7. The play specialists similarly rotate to Stoke with no reciprocal return of staff. They undertake similar work to the HCAs such as recording observations and cleaning wounds. In addition, they clean beds and cubicles and help with triage. HCAs are also taught to plaster limbs and undertake other CMIU skills once competency is achieved. Play Specialist training does not cover these skills and the review team was informed that competency training was in place to ensure patient safety.

<u>An integrated team</u>

3.5.8. Some nurses at County have understandably found the recent changes to their working arrangements difficult to accept and feel that this has not been recognised. More work and time is required to build a single nursing team across the two sites, encourage more flexible ways of working, provide opportunities for career development and recognise the cost of transport for those for whom the free shuttle bus service does not work - and the impact on family life. Nurses are usually drawn from the heart of the communities they serve and those based at County could be considered 'ambassadors' for the new arrangements, helping the Trust understand the needs of the population and helping the community recognise the benefits of new models of care.

<u>Royal Stoke University Hospital</u>

3.5.9. In the evenings, there are two nurses and an HCA or play specialist in the paediatric ED, seeing 25 to 30 children. One nurse may be required to manage a child in the resuscitation bay in the Adult ED, which can lead to delay in treatment and cause problems with medicines administration in children's ED. This is often the busiest time in Children's ED.

3.5.10. Review of the rota provided for the month to 4 December 2016, indicated that there were some shifts where a third nurse worked a twilight shift (i.e. from 12 noon to 00.30) and other days when there were three nurses on a long day and night, supported by one or two support workers and a play specialist. There were six days during this 28 day period when there were only two registered nurses on the day or night shift, including a day with only one nurse rostered and one night with one nurse. It is unclear whether there was sick leave during this period which would have reduced nursing numbers further.

3.5.11. On most days there were two support workers and a play specialist with a support worker at night. An audit of the number of times a CAU nurse is required to go to resuscitation over a six month period (including the winter months) may identify whether staffing requires adjusting to increase the ratio of registered nurses to support workers, ensuring sufficient people with appropriate skills are available in all areas.

Advanced Nursing Practice

3.5.12. There are no Advanced Paediatric Nurse Practitioners (APNP) working at County, although there are adult ANPs working within the hospital.

3.5.13. At Stoke there is one APNP in Children's ED but none in CAU. There are three emergency nurse practitioners across Children's ED and CAU who have some expertise in managing children's illness but these individuals are also responsible for adult care so are stretched too thinly to provide full-time cover.

3.5.14. Although there is currently no national programme for training, many Trusts are developing the APNP role to fill specific needs and provide an opportunity for career development. Details of the opportunities and practice examples can be found in guidance from the RCN[1]. There is the potential for current nursing staff across the Trust to be offered this training which can take two years including study off-site but will increase the potential for staff retention and improve decision-making within the urgent care pathway.

3.5.15. Nationally, the development of advanced paediatric nurse practitioner (APNP) roles has been shown to reduce the number of admissions of children to hospital[5]. When combined with a community children's nursing team, able to manage acute conditions in the home, this has an impact on education and support for parents of sick children at home and prevention of readmission. The role provides support for ED or urgent care centre staff with less experience of children and diverts activity, leaving hospital doctors to deal with the sickest children. In addition, there are demonstrated financial benefits for both primary care and the acute trust in managing children out of hospital[6].

3.5.16. Nurses who step up to APNP roles provide a highly skilled service and will be keen to use all their expertise. Whilst there is likely to be a loyalty to the Trust that supported their training, there is high demand for APNPs nationally so the Trust needs to ensure these roles offer sufficient challenge to retain them and ensure they are used efficiently and effectively. This may include an element of rotation, strategic involvement or leadership opportunities.

[1] https://www2.rcn.org.uk/__data/assets/pdf_file/0009/580725/004579.pdf
[5] Egerton L (2012) Role of Advanced Paediatric Nurse Practitioners; Emergency Nurse, 20 (4); 30 – 34
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459414/Moving_healthcare_closer_to_home_financial_impacts.pdf

### 3.6. Transfers and transport

3.6.1. The original Standard Operating Procedure dated April 2015 outlined provision for ambulance attendance at County hospital and management of paediatric resuscitation and stabilisation by ED staff, but a 'draft' amendment changed this and all children should be diverted to Stoke or New Cross. Despite this, a small number of ambulance-borne children continue to be brought in which is a breach of policy (see also para 3.1.10).

3.6.2. An average of 33 patients a month were transferred from CEC to Stoke in the year to August 2016, some travelling by ambulance and some in parents or carers' private cars, compared to around 10 per month when there was a PAU at County. The protocol for which mode of transport was appropriate was not clearly understood by some staff the review team heard from, and there was confusion, for example, as to the intended use of the two ambulances at County and how to access them.

3.6.3. There are two fully equipped paramedic-staffed ambulances on the County site which are contracted from the Ambulance Service at around £700,000 annually. One is designated for the midwife birth centre and the other for general emergencies arising at the Trust. The review team heard varying accounts from staff, on how these ambulances were to be used, with many believing both were for the sole use of the Midwife Birth Centre (MBC), which may mean they are underutilised.

3.6.4. The RCPCH has been unable to obtain data relating to the utilisation of these vehicles but were told that 999-vehicles were called in emergencies and few staff could remember the standby vehicles taking a sick child to Stoke. There is significant scope for a joint review with the ambulance service of the use and benefit of these standby vehicles as the resources are likely to be much better utilised with a more flexible arrangement. There is also an opportunity for work with the ambulance service to ensure they recognise the level of care that is provided at the County and the similarity of calling 999 from the community versus the County.

3.6.5. Parents, staff and public consider that it is a long way to travel from County to Stoke with a sick child. In fact with effective engagement of primary care there should be very few children needing to make this journey in an urgent or emergency situation, in which case ambulance transfer may be appropriate.

3.6.6. Due to poor public transport between the sites an hourly shuttle service operates between the County and Stoke sites from 06:00 – 22:00 on weekdays and two-hourly at weekends. Originally intended for staff the service now also takes patients and carers. The service must be booked a minimum of 24 hours in advance, either through phone or email, and costs £5 for a return ticket. There was no information available about patient/carer usage or public awareness about the service

### 3.7. Governance

3.7.1. The quality, safety and compliance department is responsible for health and safety, quality systems, managing Datix, serious incidents, clinical audits, information governance and M&M reviews. The teams report to the Chief Nurse, Medical

Director, the Quality and Safety Forums and the Quality Assurance Committee, which is a sub-committee of the Board chaired by a non-executive.

3.7.2. Each division should also have regular governance meetings with issues reported directly to the associate chief nurses, and from there to the Chief Nurse and the Quality Assurance Committee. Minutes of the meetings provided indicated limited information relating to CEC/CMIU, with no evidence of action taken in response to specific incidents that had been raised with the review team. These included two examples

- a child being discharged with full thickness burn - where usual practice would be for immediate surgery rather than dressings and discharge, to prevent complications such as contractures and damage/infection to other structures,
- ongoing problems with transfers from the high dependency unit (see 3.3).

3.7.3. Despite the issues highlighted by the WMQRS report, the review team was advised that no trends/issues relating to ED, Children's Services or the changes to services at County Hospital had been presented to the Quality Assurance Committee in recent months. Analysis of incident reports from County Hospital indicated a number of reports relating to delayed transfer which could indicate that risks are not being appropriately escalated through the system. The systems for reporting governance issues upwards did not appear to be robust; further incidents raised with the review team which did not appear on the incident data provided are being addressed with UHNM separately to this report.

3.7.4. The focus on integrating the two sites has resulted in activity and staffing data only being available Trust wide, which poses a potential governance risk as it may mask issues at one or other site.

3.7.5. At the time of the visit IT systems across the Trust were not yet integrated with different software operating in County and Stoke. This makes rotational working more challenging as staff adapt to using different systems, and makes it difficult to access information, results, images and notes from patients seen across the two sites.

> "Safe and efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. This is particularly important in the urgent and emergency care system where, by definition, the patient is accessing care from outside of their routine care providers." **NHS England**[7]

3.7.6. We understand the implementation of a new Trust-wide IT system is planned for early 2017 and this should be addressed as a matter of urgency, with consideration for integration with other systems outside the trust (e.g. primary and social care).

[7] Page 51 - Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care: A guide for local health and social care communities (NHS England)

### 3.8. Safeguarding

3.8.1. The Trust nurse-led safeguarding team, based at Stoke provides advice, guidance and training as well as statutory functions across the Trust for adult and child safeguarding. Every month they receive requests for assessment and/or decisions for about 250 children and send 30-50 multiagency referrals about children, with all referrals reviewed by the Named Nurse. The majority of their workload relates to maternity and adult ED. Concerns were raised regarding provision and consistency of safeguarding arrangements across the county, as arrangements for child protection medical assessments and multi-agency working differ in different parts of the county.

3.8.2. The safeguarding arrangements at Stoke were reported as 'very strong and consistent' with high confidence in the ability of the ED team and midwives to recognise and address safeguarding issues, and good use being made of the support and advice available from the safeguarding team.

3.8.3. Concerns were raised about the low level of safeguarding alerts from County. Management could not confirm whether this was lack of recognition of children in need or lower prevalence and there was a risk that the service was 'over there and out of sight'. Attempts by the previous Named Nurse to visit County and offer advice and support were reportedly not embraced by the team there, and there were reported to be low levels of safeguarding training. The recent appointment of a Named Midwife from Stafford has provided additional capacity and training expertise and should begin to improve engagement, supervision and liaison with health visitors in the community, through supporting the ED link nurse.

3.8.4. Across the Trust there is a 97% achievement of statutory and mandatory training, which includes an e-learning package on safeguarding. A 'comprehensive' intranet site has also been developed which includes relevant guidance and links to the two LSCBs (Staffordshire and Stoke on Trent) although the review team did not have sight of this.

3.8.5. From trust data available, the uptake of level 2 and 3 intercollegiate training was less across all 3 directorates dealing with children. The Training strategy 2015-8 includes a needs analysis and defines the levels and competencies required but recorded take-up for intercollegiate level 2 ranges between 31-56% across the directorates which falls well below the 85% target of the local LSCBs.

| | Jul 16 | Aug 16 | Sep 16 |
|---|---|---|---|
| **Child Health Directorate** | 59.8% | 60.0% | 56.6% |
| **Dir of Emergency Medicine** | 28.9% | 30.9% | 31.9% |
| **Obs & Gynae Directorate** | 38.6% | 41.1% | 42.0% |

Figure 3: UHNM trust wide staff training at Safeguarding Level 1 (level 2 intercollegiate)

3.8.6. The situation is complicated by the variation in how safeguarding training is described locally compared to the intercollegiate standards. We were advised that Staffordshire 'level 2' training, maps onto intercollegiate 'level 3' training, however upon review of the Trust safeguarding policy and descriptors of the training

elements this does not appear to be the case. This is likely to mean that some staff requiring Intercollegiate Level 3 training do not receive it, which is a significant risk.

3.8.7. The Trust recognises that the competencies required are broader than simply attendance at training course, but additional experience and acquisition of required skills is not monitored or recorded formally by the individual sites or central safeguarding team. Decentralising of records to improve local ownership and management is too recent for meaningful site-based data although maintenance of safeguarding training records and competencies is a key requirement of CQC and the responsibility of the Named Nurse and Doctor. Training is discussed at the Trust Safeguarding Children Working Group with representatives from across the Trust and safeguarding concerns have been recorded on the Risk Register, but poor attendance by some key individuals has hampered progress. It is important that the situation is reviewed at senior level in order to monitor training levels and perceived under-reporting of concerns, particularly at County.

3.8.8. These issues have been exacerbated by a lack of IT integration, with records at County Hospital still paper based and a number of queries remaining unresolved. Implementation of the 'Medway' joint system has been delayed until January 2017, but whilst encouraging, it will not address poor staff knowledge or under reporting, which pose a significant risk to patient safety.

3.8.9. In a wider safeguarding context there is a lack of clarity over roles, responsibilities, information sharing and accountability between health and social care organisations with respect to child safeguarding concerns and medical assessment. This is a national issue with the increasing fragmentation of children's community health services.
In Staffordshire there are a number of providers involved in addition to UHNM.

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) a mental health and community trust employs community paediatricians across south Staffordshire
- Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) – employs health visitors, district nurses
- Birmingham community health trust – has the contract to run school nursing across Staffordshire

3.8.10. The loss of the assessment beds at County requires all South Staffordshire children requiring medical assessment for safeguarding concerns to be transferred to Stoke, which is served by a different social care locality team, and different designated doctor / LSCB increasing the upheaval for families and bureaucracy for health and social services. Social care staff who are locality-based struggle to understand which organisation is responsible for the health assessment and information sharing. There are a number of important issues relating to accountability and governance which need to be addressed across the three CCGs, multiple health providers and two local authorities.

### 3.9. Leadership and integration

3.9.1. There was no clearly identified 'lead clinician' for children and young people's urgent care in the Trust at the time of the visit. The organisational structure of the Trust

means that paediatrics and emergency care are managed through separate divisions and there does not appear to be a single forum, or lead role, with oversight of the whole paediatric pathway. Indeed paediatricians, who would usually lead development and delivery of children's services, seem largely disengaged with the delivery of the CEC/CMIU at County Hospital, presumably as this falls, organisationally, within emergency medicine.

3.9.2. This has led to confusion over accountability with the result that staff training and maintenance of standards have ceased to be a priority. For example, there is one consultant dual qualified in paediatrics and emergency medicine but whilst she has been on long term sickness absence neither division has taken responsibility for training monitoring and championing the paediatric pathway.

3.9.3. Whilst the review team heard a lot of vision emerging from the individuals we met with, there is no apparent trust wide strategy for the development of children's services. This combined with governance and safeguarding issues outlined in the previous sections, give the impression that children's services at County Hospital have relatively low priority within the Trust.

3.9.4. The introduction of the Children's Hospital Board in April 2016 was a positive development, raising the profile of children's services within the Trust. However the focus so far has been on strategy and service development, particularly relating to tertiary services. The Trust requires a whole system approach to the pathways for children (see figure 4 below), liaising with CCGs, the multidisciplinary team, primary care clinicians and ambulance services; working across the two sites, using information and data to model demand and better engaging the families who use the services. This should include the introduction of a trust wide 'Children's champion' and it would be sensible to expand the terms of reference for the 'Children's Hospital Board' to give them overall oversight and responsibility for reporting progress to the Board and stakeholders on this work.

3.9.5. The NHS Institute for Innovation and Improvement published a helpful toolkit[8] setting out evidence based approach and it is suggested that the Trust and CCG use these materials to engage relevant stakeholders and develop their strategy.

[8] A whole system approach to improving emergency and urgent care for children and young people - a practice step by step guide and resource pack (NHSi 2011)

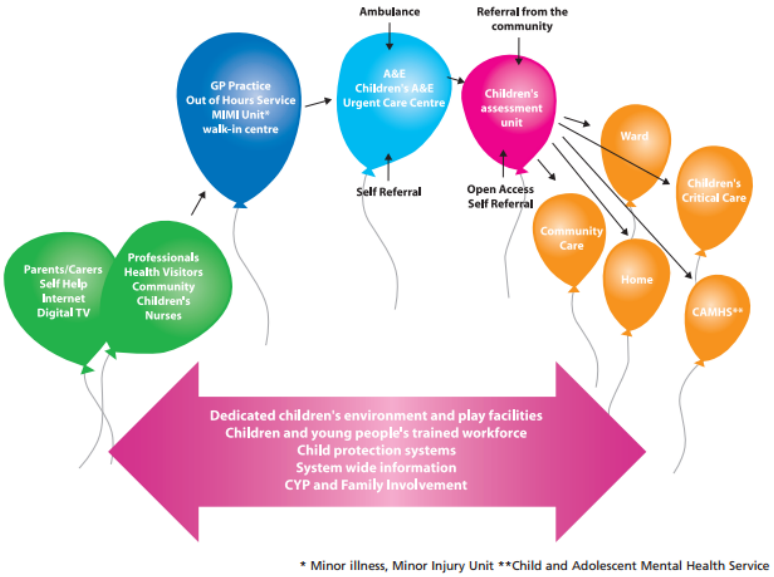


Figure 4 - Children and young people emergency and urgent care pathway[9]

## 3.10. Related services

Primary care

3.10.1. Paediatric skills in primary care were reported to vary across the county; there are 30% GP vacancies around Stoke with high numbers of single-practitioner practices and many partners approaching retirement. The paediatricians at Stoke reported high numbers of inappropriate referrals from GPs coming into the CAU/ED whereas the quality of GP referrals in Stafford appeared to be higher, with fewer queries relating to 'low level illnesses' although no audit data or evidence was seen confirming this.

3.10.2. The Trust and the CCG have previously organised teaching sessions for GPs, who were incentivised to attend, but despite positive feedback this did not appear to have made a difference to the number or quality of referrals. The suggestion was that those GPs attending were those already skilled / interested in paediatrics, whereas the 'bottom 25$^{th}$ centile' who are most in need of upskilling did not attend. Staff did not articulate any plans to incentivise attendance from those GPs who would gain most benefit and we would recommend that the Trust and CCG address this together for the benefit of local families (and GPs).

3.10.3. However at the time of the visit the support and advice available for GPs was also variable. In south Staffordshire GPs are able to refer directly into paediatric Rapid Access Clinic slots at County Hospital, whereas a similar service is not available at Stoke. A recent initiative to manage inappropriate referrals will see all paediatric GP referrals triaged by a consultant paediatrician at Stoke 14 hours a day, alongside a telephone advice line which will be available to GPs across Staffordshire 24 hours a day. The paediatricians were hopeful this would go some way to addressing the

[9] Source: Delivering Quality and Value Focus on: Children and Young People Emergency and Urgent Care Pathway, NHS Institute for innovation and improvement (NHSi 2008)

number of inappropriate referrals from GPs, however it was too early for the review team to assess this.

3.10.4. The review team also heard that army personnel and families at the local army base were not registering with GPs and were using the CEC/CMIU/ED as walk-in centres. The CCG estimated this had cost them £1 million in the last year, however neither the CCG nor the Trust articulated plans to address this issue Although formally a CCG responsibility, senior Trust and CCG management should work together with the local army base on registering all staff and their families with local GPs so they can access the care most appropriate to their need. Information sheets advising families on how to register should also be available at both hospitals, along with details of local walk-in clinics where available.

GP out of hours

3.10.5. At County hospital the GP out-of-hours service is being moved into two dedicated consulting rooms co-located with ED. It runs between 18:30 – 08:00 weekdays and 20:00 – midnight at weekends with 4-5 appointments per hour and a peripatetic model with GPs travelling to patients as needed.

3.10.6. Whilst busy, the service has spare capacity and could expand further to reduce pressure on ED if additional medical and ANP staff could be recruited. Locums or agency GPs are not currently used.

3.10.7. Currently the service can only be accessed through 111, and despite being co-located with the ED there is no pathway or sharing of patient records between ED and the GP OOH service. It is anticipated that this will be addressed once the service is co-located with ED following refurbishments, however it should be considered to allow GPs to provide a greater role in the management of minor injury and minor illness as part of a whole system approach. Follow up after attendance is usually with the patient's own GP.

3.10.8. Unusually, South Staffordshire does not have any walk-in or GP urgent care centres so when GPS are unavailable families use the hospital. In Stoke there are several GP-led services open into the evening and at weekends, including a GP presence at ED to which patients can be directly referred on arrival. If there were urgent care GP services available in South Staffordshire attendance at the CMIU may be lower.

3.10.9. Provision of GP triaging at the entrance to the CMIU could provide assessment and divert/accept/signpost patients with minor illness to their GP or pharmacist. There are a number of models in the UK offering this, for example Alder Hey Children's

Community Services

3.10.10. Community child health services across Staffordshire are delivered through a number of providers (outlined below). In Stoke, Community and acute paediatrics are both provided by UHNM and are reported to have integrated well, with a CDC on the Stoke site, whereas in Stafford the two providers (UHNM and SSFT) have little to no integration which can result in children receiving overlapping care from both services.

**Community services in Staffordshire**

| | CCNs | Community paediatricians | Therapies |
|---|---|---|---|
| **Stafford** | SSSFT | SSSFT | SSSFT |
| **Stoke** | SSOTP | UHNM | SSOTP |

Merged (i.e. cross-county) services:
- Diabetes nurses (SSOTP)
- CF and asthma nurses (UHNM)

3.10.11. Children's community nursing is provided by the 'Hospital@Home' team (SSOTP) in North Stafford/Stoke and the Children's community nursing team (SSSFT) in South Stafford. Both services are staffed by registered children's nurses 7 days a week 08:00-22:00 and support early discharge from hospital, and work to avoid admission. The SSSFT team recently received a financial uplift to expand the range of services offered out of County (previously only early discharge) to prevent admission in children with minor illness and to manage complex needs at home. This reportedly had a noticeable impact on attendance at Stoke.

3.10.12. The review team heard the CCN services are highly valued across the acute paediatric team and was accessible to both them and primary care. Whilst both CCN teams reportedly work and communicate well together there are still benefits to commissioning a county-wide service through a single provider.

3.10.13. There is a palliative care service providing respite and end of life support for approximately 120 children with complex care needs but this service operates on weekdays only.

## 3.11. Public perception and patient experience

Local voices

3.11.1. Given the history of the services in Stafford it is recognised that County Hospital has forged a firm place in the community's infrastructure. A high proportion of staff live locally and regard Stoke as a distant and expensive place to visit. There is a strong and longstanding public campaign, backed and encouraged by local politicians and media, to support the County hospital against any proposed reconfiguration.

3.11.2. The RCPCH's review team was keen to hear the views of patients and their families, staff and their representatives. Recognising that access to public and stakeholder meetings could be difficult, an online survey ran alongside the review, which were publicised widely through the media, campaign groups and UHNM itself. The survey received over 350 responses and a summary of the submissions is provided in Appendix 6.

Engaging and involving patients and families

3.11.3. Following the CEC closure the trust have undertaken a range of ongoing activities to keep the local population updated on service changes, including:

a) weekly press releases to key stakeholders including regional MPs, regional media, local councillors and NHS staff
b) facilitating the national and local media (TV, Radio, Print and Online) to cover the closure and ongoing service changes, and promote the news to local and national communities
c) holding a 'media day' where local media (print, TV and Radio) attended and promoted the news that the CMIU for Under-16s was now open
d) making a clinician available for media interviews (TV and Radio) every two weeks since the services were suspended, to talk about the latest situation
e) utilising the trust's website and social media pages to communicate weekly updates; as the majority of the trust's followers on these platforms come from the local area, this is a key platform for reaching and informing

3.11.4. These initiatives are positive first step, and ensure the public are being provided with the correct information. However activity data (para 3.1.9) shows that CMIU continues to see a significant number of children with minor illness. Our survey showed that not only many families but even some staff, remain confused over the difference between injury and illness, and which services to use when their child is unwell, particularly out of hours. Whilst this problem is not peculiar to Staffordshire (the national GP Patient Survey in July 2015 found that only around 56 per cent of people said they knew who to contact out-of-hours[10]), assessing the impact of communication activities and actively involving families will help the trust to consider innovative ways of sharing information to maintain impact.

3.11.5. On-going engagement is also essential to service development and must be an integral part of future service planning; the NHSIII Resource Pack[11] provides practical advice on how to do this.

[10] https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters
[11] A Whole System Approach to Improving Emergency and Urgent Care for Children and Young People - A Practical Step by Step Guide and Resource Pack (NHS Institute for Innovation and Improvement)

# 4. The way forward

## 4.1. Arrangements at County Hospital

4.1.1. The review team heard a clear journey from the decision of the Trust Special Administrator to where the service is today, and supports UHNM in their decision to suspend paediatric services at County Hospital following concerns raised by the WMQRS.

4.1.2. The WMQRS recognised there were insufficient paediatric-trained staff available in the CEC at County to safely assess and manage critically ill children who require resuscitation (should that be required). Guidelines, communications and escalation protocols were not clear or not always followed and the identification and management of risk was insufficiently robust. Although a children's minor injury service opened in October, which can deal many attendances (i.e. those relating to minor injuries), the core issues about capability to deal safely with sick children remain and the Trust faces a decision over the future of urgent paediatric medical care at County Hospital.

4.1.3. There are important safety issues raised by the WMQRS that must be addressed immediately to ensure children with medical conditions are seen and treated appropriately. This must involve primary care and/ or appropriately trained nursing staff where paediatricians are not available – the rebadging of the unit as minor injury unit (MIU) has not addressed the problems highlighted by the WMQRS review.

4.1.4. The issue at stake is not only the specific service model chosen but core management processes around governance, incident reporting, workforce management, training and integration. We have identified a number of 'quick wins' alongside considering the direction of national policy and workforce planning, the importance of ensuring high quality care for children as close to home as possible, and the extremely high cost of duplicating services at both County and Stoke - resources which could be better used to benefit more patients.

4.1.5. There is a risk that the public expect County hospital will have the capability to manage children attending with acute medical conditions as the current staff training and expertise in recognising and dealing with the seriously ill child is insufficient to guarantee safety. A clear pathway is required to deal with the rare occasion where a critically ill child attends 'in arms'

## 4.2. A vision for the future

4.2.1. Longer term staffing problems, national health policy and professional standards around children's urgent and emergency care indicate that a return of inpatients or the CEC to County hospital is not sustainable in the short or longer term due to the financial and workforce resources required. In the UK many families travel 20-25 miles to access specialist paediatric services on the rare occasions that their child needs hospital inpatient care so the journey from Stafford to Stoke is not unsafe with appropriate assessment, primary care and public information. Although the CMIU was reported to be working well in the short term measures must be put in place

swiftly to ensure that children with safeguarding or medical needs can also be safely treated as close to home as possible. Given the relatively low attendance, in the longer-term sustainability, even with these measures, is questionable in terms of the ability of medical professionals to maintain the necessary skills and competencies, and the cost of delivering a service which is only able to provide care for a limited range of conditions.

4.2.2. The RCPCH therefore recommends that as soon as possible an 'Urgent Care Centre' model is established at Stafford that provides GP-led services to treat minor injury and illness in children and young people, with sicker children being diverted to Stoke. This would work alongside urgent and emergency provision for adults. Such a service could be provided largely by specialist nurses and would meet the majority of demand from the local population. Migration to this model would require a period of time to recruit and train suitable staff so other measures are required in the short term towards this vision. We therefore recommend that:

- The CEC at County Hospital is **not** reinstated
- The CMIU remains operational alongside ED in the short-term, **BUT:**
  - Nursing cover must be strengthened with Emergency nurse practitioners and APNPs
  - All clinical staff must have appropriate, up-to-date paediatric resuscitation (i.e. PLS or equivalent). At least one member of staff with advance paediatric resuscitation training (i.e. APLS or equivalent) must be available at all times (as long as the CMIU remains there will be a risk these skills will be required, this can be reviewed if and when an UCC is introduced)
  - Minor illness is proactively managed through 'front door' primary care
  - More serious illness is referred directly to Stoke or New Cross
  - The out-of-hours GP service is promoted and strengthened to support the CMIU
  - GPs across Stafford continue to have rapid access to paediatric telephone advice and next-day local clinics
  - There is absolute clarity about referral and transfer arrangements
  - A number of other 'enabling' actions are also set out as recommendations in section 5

## 4.3. Rationale

4.3.1. The National Urgent and Emergency Care review[12] launched in 2013 proposed a radical shift to a 24/7 integrated service that involves Emergency Departments, NHS111, GP out of hours services, urgent care centres and rapid access clinics. The publication of 'Safer Faster Better'[13] in 2015 set out for local health and social care communities ideas for managing the 'flow' of patients through a network of provision according to need.

[12] http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf
[13] https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

> "For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.
>
> For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery."
>
> **Transforming urgent and emergency care services in England - End of Phase 1 report**

4.3.2. The Sustainability and Transformation Plan for Staffordshire[14] and the engagement document developed by Healthwatch Staffordshire and Healthwatch Stoke-on-Trent in conjunction with the STP partner organisations describe a future that includes "simplification of Urgent and Emergency Care through increasing community based urgent care and reducing A&E attendances……. and providing better access to more urgent care closer to home ….better information about where to go for treatment and safe alternatives to admission to hospital." It also states "This is likely to mean fewer hospital beds, [less] staff working in a hospital setting and more specialist services in fewer hospitals."

4.3.3. The current arrangement at County Hospital is non-compliant with many of the RCPCH 'Intercollegiate standards for children in emergency care settings' and to comply would be prohibitively expensive, limiting funding which could be better used by expanding the range of outpatient and community based services aimed at reducing hospital attendances. Specialist paediatricians running clinics should not be expected to cover ED/minor injuries from clinic as that perpetuates the running of a service with huge safety gaps which so many of the clinicians were clearly concerned about. Similar issues apply to the ED medical workforce who are currently middle grades and Foundation doctors; There are insufficient permanent staff in ED trained to an appropriate level of paediatric care to be able to safely cover the opening hours of the unit and the absence of trainee staff working at middle grade means that in the longer term the viability of the emergency department as a whole is uncertain. Demand for local urgent care will not diminish so development of Emergency Nurse Practitioner and Advanced Paediatric Nurse Practitioner roles must continue without delay at both sites.

4.3.4. The RCPCH standards for the care of children with urgent medical needs[15] focus on improving access to GPs, community children's nursing and rapid access to paediatric advice to reduce the need for inpatient assessment or even ED attendance for minor illness and urgent care of children. The Trust and commissioners have made good progress with these standards but there is more that can be done to support and encourage GPs to manage common medical conditions within primary care.

[14] http://www.twbstaffsandstoke.org.uk/index.php/document-library/5-161215-transforming-health-and-care-for-staffordshire-stoke-on-trent-stp/file
[15] Facing the Future Together for Child Health

4.3.5. Nationally the paediatric and emergency care workforce is diminishing, at the Tier 2 or Middle Grade "Registrar" level due to changes to training and national workforce planning. Large numbers of these posts in Emergency Departments are unfilled or covered by locum appointments who may not have the training and skills required to treat children with serious illnesses. It is better for children with minor illness to be seen by a GP or specially trained children's nurse who can more confidently diagnose and treat or refer a child for specialist investigations and care

4.3.6. The 'Urgent Care Centre' model is set out in a number of NHS England publications usually operating as part of a wider clinical network with clear transfer arrangements and shared clinical governance. UCCs are usually staffed by GPs and nurses on a 'see and treat' arrangement with a maximum target treatment time of two hours.

### 4.4. Integrating the Trust's approach to children's urgent care

4.4.1. We clearly recognise the serious capacity issues at Stoke, particularly for adult emergency services, with high ED attendances, difficulty meeting 4 hour targets, and delays in transfers of care so it is important to avoid increasing pressure on that service through alternative arrangements for managing demand and/or consolidating services (and staff) to improve efficiency.

4.4.2. The development of UHNM did not just affect provision at County hospital; staff and services at Stoke needed to change to accommodate the patients, move other provision to County and integrate the workforce. Two years on from the reconfiguration, although there has been progress with integration, services for children still seem to operate in 'silos' depending on their work base and function. This is explored in section 3.9 which recognised the absence of an identified 'Champion' for children across the Trust who would ensure the pathways of care for families are patient-focussed and integrated. This individual would not usually be an ED physician but could be a senior manager supported by the lead paediatrician and the 'Children's Hospital Board'' This will help to clarify the overall pathways of care for children, strengthen Trust-wide procedures, develop a strategy for staff recruitment and retention and take forward the practical recommendations from this report.

### 4.5. Workforce

4.5.1. Staff have faced a difficult journey through reconfiguration, although there have been some positive aspects, such as the consultant anaesthetists working together as one team right from the start. In other areas, such as nursing, progress has been slower and some staff continue to face silo working and tension with some nurses from County feeling they have been poorly treated or shunned by Stoke staff and rostered to 'fill gaps' rather than use and develop their skills. Such an approach risks staff seeing their future career outside the Trust. Building a truly integrated team requires staff rotating both ways across sites, although we do appreciate the challenges with this due demand at Stoke.

### 4.6. Approach to primary care and outpatients

4.6.1. The RCPCH 'Facing the Future Together for Child Health' standards focus on arrangements for two-way information and advice flows between GPs,

paediatricians and community nursing teams. The model of immediate telephone advice to GPs from a paediatrician at Stoke is showing positive benefits.

4.6.2. The community children's nursing and hospital at home teams are a real strength. Both providers offer comprehensive services with extended hours, and there is potential to increase the use of those and care for more children closer to home. The two services are commissioned separately and a single county-wide provision would be ideal.

4.6.3. Whilst outside the scope of the current review, there are opportunities at County to enhance the current provision and reduce travelling times for families. These include increasing outpatient services such as cardiology, genetics or neurology, allowing patients to be repatriated from Birmingham, and offering other tertiary outreach services across either hospital site rather than all of them at Stoke, reducing the distances families are required to travel.

### 4.7. Governance and information systems

4.7.1. Our focus has been integration of services and staff using both sites as effectively as possible to serve the local population. This will require integration of the IT systems across sites, and we strongly support this as well as greater integration of the ambulance and transport services so sick patients can be treated in the best place for them whilst ensuring that resources are utilised as efficiently as possible.

4.7.2. In governance terms there were some areas which need tightening up across both sites, particularly around training records for safeguarding and life support, and there were different policies and procedures at the two different sites. It is important as part of integration to develop brand new policies and procedures with contribution from staff at both sites.

### 4.8. Communication with families and referrers

4.8.1. There are practical issues around communication and management of patients and families attending the CMIU, despite the enormous efforts to communicate service changes to the public, they are still using County inappropriately. This may be partly because people don't understand why illness can't be seen, so ignore that advice, and partly because when people do turn up with illness they are being treated and then others hear about that. The review team noticed that many road signs have AE in large type and much smaller underneath 'not 24 hour' with little/no mention of children's services until very close to the hospital site – giving the impressions it's a full ED. Locally there appears to be disengagement with the 111 urgent care service helpline and a reluctance to call an ambulance, (both of which would recommend to the most appropriate care) so they instead arrive at the hospital in private cars or taxis.

4.8.2. The local Sustainability and Transformation Plan refers to the potential for moving from three to two A&Es and an urgent care centre within Staffordshire, however this is predicated on an enhanced model of primary and community care. No sites have been specified, and this would be subject to public consultation . Locally There was a sense from most people we met with that the current situation is temporary and more change will happen, and people are either 'braced' for that, looking

forward to it or seeking an opportunity in it. This is an important part of the journey to reassure those who are concerned that the current and future services are safe and release money that can be used for other services. Therefore no time should be lost in moving to a sustainable arrangement. The recommendations below summarise the steps required to deliver an achievable and long-term solution.

# 5. Recommendations

**Focusing on Children across the Trust (immediately)**

a) Identify a senior level 'champion' for children across the Trust to work with the Children's Hospital Board in taking forward the recommendations of this review. (3.9)

**Make the current arrangements at County Hospital safe (within 3 months of final report being issued)**

b) All clinical staff must have appropriate, up-to-date paediatric resuscitation training (i.e. PLS or equivalent) and at least one member of staff with advance paediatric resuscitation training (i.e. APLS or equivalent) must be available at all times (4.22). There should be a paediatric-specific early warning tool with all CMIU and ED staff trained on its use (3.12). All staff must be clear about time critical transfer arrangements until a sustainable alterative model is in place and medical patients no longer routinely attend.

c) Work with the CCG and primary care to monitor and reduce attendance of medically ill children through:

- GP Advice line to a paediatrician (3.10.3)
- GP (or equivalent) presence in County CMIU (3.10.9)
- Strengthened out of hours service
- Developing a plan for record-sharing between primary care/out of hours GP and Trust systems (3.7.5)

d) Introduce a receptionist at the County CMIU to free up nursing time for triaging and treating patients (3.1.4)

e) Plan, implement and monitor a clear, penetrating, communication programme in partnership with the CCG including:

- Guidance for families to use alternative services for medical problems
- Guidance for GPs about referrals and the Rapid Access Clinic (3.3.3)
- Guidance for staff about what conditions should and should not be accepted
- Guidance for staff about emergency ambulance transfers (with WMAS) (3.1.10, 3.6)
- Installation of consistent signage within and on approach to the site
- (longer term) Establish a comprehensive programme of engagement of children and families to contribute to service development, communication and monitoring (3.11)

**Developing a longer term sustainable model (within 6 months)**

f) Develop with commissioners a strategy and action plan for urgent and unscheduled care for children **across the whole trust**, towards fully integrated services. This links to the

Sustainability and Transformation Plan and compliance with Facing the Future Together for Child Health[16] standards and should include:

- Strengthening links with community children's nurses and GPs so services are more accessible, reducing use of ED for primary care (4.3.4, 3.1.8)
- Developing the Hospital at Home teams towards providing a 24 hour service, with focus on both admissions avoidance and early discharge across the service (3.10)

g) Develop a 'one team' nursing strategy to encourage learning and development, recognising the challenges for some to accept change, and building a team culture. This could include:

- Rotation both ways across CAU, ED and paediatric medical wards to develop their knowledge and skills,
- The opportunity to work towards APNP for those that are interested (3.5)
- Ensuring children's ED at Stoke is appropriately staffed at busy times (3.5.10 )
- Developing the APNP role in County towards long term provision of an UCC (3.5)

h) Plan for introduction of a GP Urgent Care Centre at the County Hospital site, staffed with GPs and Advanced Paediatric Nurse Practitioners (APNPs) who can manage both minor injury and minor illness in children (4.2)

i) Expand the children's outpatient clinic service at County Hospital to provide additional multidisciplinary services locally for families who require follow up in outpatients (4.6.3)

**Governance and safeguarding (within 3-6 months)**

j) Review existing governance structures and communication pathways to:

- Ensure risks/issues/trends from County hospital are being appropriately fed up the system (3.7)
- Include a standing item at risk and governance meetings relating to children's emergency care at both sites until the recommendations of this review have been addressed (3.7)
- Develop Trust-wide protocols and procedures and audit adherence (3.9, 4.7.2)
- Strengthen documentation of training and skills (3.2.6, 3.9)

k) Conduct an internal review of child safeguarding across both sites to ensure:

- Trust-wide consistency of indicators,
- Trust-wide criteria for raising concerns and the process for dealing with them.
- Consistent safeguarding training arrangements that align with the Intercollegiate guidance
- Documented achievement of relevant competencies for all staff.

[16] http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/service-standards-and-planning/facing-future-together-c-1

The Named Midwife and Stafford Named Nurse may be best placed to carry out this work (3.8)

l) The accountability pathway and information sharing arrangements for children who are the subject of child protection concerns presenting at each site must be addressed through the LSCBs and safeguarding team in conjunction with the designated professionals and the CCGs (3.8)

# Appendix 1 – Terms of reference

The RCPCH Invited Reviews team conducted an independent review of the Children's Emergency Services at County Hospital, University Hospitals of North Midlands NHS Trust, following the process set out in the 'RCPCH Guide to Invited Reviews (August 2016)'; addressing the following areas:

a) Consideration of options and required resources, in terms of staff and environment, to deliver a safe, sustainable emergency service for children across the two hospital sites compliant with current guidelines and anticipated future changes

b) Barriers to implementation of such a service (e.g. cost, recruitment, ongoing retention of skills) and assessment of their likely impact

# Appendix 2 - The review team

**Lead reviewer: Dr Melanie Clements MB BS, MRCPCH, FRCPCH** is the Medical Director for Hinchingbrooke Health Care NHS Trust. She has an interest in improving quality and transformational change and will be working to support the collaboration between Hinchingbrooke and Peterborough Hospitals. She was previously Deputy Medical Director for NHS England – Midlands and East, and has been a Consultant Paediatrician at West Suffolk Hospital NHSFT since 2004, with current experience of the daily challenges facing paediatric teams in a busy DGH.

Melanie is the Clinical Chair for the children and young people's work stream of the Cambridge and Peterborough CCG System Transformation plan development. She has led paediatric service improvement across the region for several years, and has been involved in peer review of children's emergency and urgent services in the East of England for two consecutive years.

Locally Melanie has led the development of the Children's Assessment Unit, resident consultant working and Children's Advanced Nurse Practitioner scheme. She is passionate about leadership and improving systems and quality for children, young people, their families and the child health workforce. Melanie was previously, National Clinical Lead for The Children & Young People's Emergency and Urgent care Programme, NHS Institute for Innovation and Improvement and was Clinical director for the Maternity, Newborn, Children and Young People Strategic Clinical Network for NHS England

**Paediatric reviewer: Dr Vipan Datta** is a paediatric consultant at Norfolk and Norwich University Hospitals. He has been a consultant since 1997 and specialises in general paediatrics and diabetes and endocrinology. He is currently a senior RCPCH examiner, assessing candidates both in the UK and overseas.

In previous roles Vipan has been LNC chair within his trust; a college tutor and, until summer 2016, was training programme director for Health Education East of England (HEEoE).

**Anaesthetist reviewer: Dr Clare VanHamel** has been a consultant anaesthetist at the Great Western Hospital, Swindon since 1997. Working in a department without fixed lists she is fortunate to have a diverse anaesthetic portfolio including paediatrics and obstetric anaesthetic cover. Clare has a keen interest in medical education and has been Severn Foundation School Director since 2009. Clare is Clinical Advisor to the UKFPO since 2012, and an important component of her education role is participating in Quality Assurance visits and reviewing Quality data submissions.

**Nursing reviewer: Carol Williams MSc BA (Hons) RGN RSCN RNT** is a Nursing and Healthcare Consultant. She works largely in children's services and has led compliance projects and service reviews across a range of health sectors, including community services and complex care, emergency care and hospital based children's services. She is a Specialist Advisor at CQC and has undertaken a range of work for the RCN including updating guidance documents relating to children's nursing and covering the Children's Nurse Advisor role. She also offers clinical supervision support and training and currently supports a group of school nurses in a private school.

Carol spent a large part of her career at the Evelina Children's Hospital at Guy's & St Thomas' NHS Foundation Trust, London, where she held posts as Consultant Nurse in Paediatric Critical Care, Acting Head of Nursing for Children's Services and Lead Nurse for Children's Critical Care. She has also been an Area Manager at the Healthcare Commission and the Care Quality Commission. She is a qualified teacher who has taught on both undergraduate and Master's nursing programmes for a number of organisations. She has participated in public inquiries including the Bristol Royal Infirmary Inquiry and more recently as nurse adviser to the Inquiry into Hyponatraemia Related Deaths in Northern Ireland.

Currently, Carol is on the Nursing Advisory Committee of the WellChild charity and has previously held a number of national and international roles including Nursing President of the European Society for Paediatric and Neonatal Intensive Care and Chair of the Royal College of Nursing and Paediatric & Neonatal Intensive Care Forum. She contributed to the development of the National Service Framework for Paediatric Intensive Care and was involved in benchmarking national paediatric intensive care standards. She has been invited speaker at national and international conferences and co-edited a children's intensive care nursing textbook.

**Lay reviewer: Sally Williams MA** conducts invited reviews of NHS services on behalf of the Royal College of Surgeons of England, the Royal College of Paediatrics and Child Health, and the Royal College of Physicians. She is a Lay Assessor with the National Clinical Assessment Service and is an Education Associate with the General Medical Council (GMC) and a member of its Quality Scrutiny Group.

Sally is an experienced health policy analyst and health service researcher, with particular expertise in professional regulation; the quality assurance of post-graduate medical education and training; and governance within the NHS and private healthcare. She has worked on projects for a variety of clients, including regulators, think-tanks and NHS organisations. She has authored and co-authored a range of reports, most recently: *A question of balance: The extended surgical team* (Royal College of Surgeons of England, 2016); *Vet Futures – Taking charge of our future: a vision for the veterinary profession for 2030* (Royal College of Veterinary Surgeons and the British Veterinary Association, 2015); *The Francis Report: one year on* (Nuffield Trust, 2014).

Sally Williams is Principal Adjudicator with ISCAS (Independent Sector Complaints Adjudication Service), and decides upon complaints about private healthcare.
She has a background in consumer research and advocacy, having formerly worked for the Consumers' Association/Which? as Principal Health Policy Researcher. She has gained national board level experience (for the Council for Healthcare Regulatory Excellence, now the Professional Standards Authority), and also has experience of NHS Commissioning (Cambridgeshire and Peterborough PCT). She has an MA in Health and Community Care from Durham University.

**Management Support: Jenni Illman** is the Operational Lead for Invited Reviews at RCPCH. She has a background in project management and since joining the College in 2014 she has been involved in the development of clinical guidance for the management of children with a decreased conscious level, and the introduction of the new patient voices platform, RCPCH *& Us*. Previously she worked at The Royal College of Physicians and the Worshipful Society of Apothecaries in examination management roles with a focus on process improvement. Jenni is particularly interested in improving education and well-being

for children and young people around mental and sexual health, and has been an active volunteer with both SANE and Brook.

**Quality assurance reviewer: Dr David Shortland MD FRCP FRCPCH DCH** has been a paediatrician for 26 years in Poole, Dorset, including ten years as neonatal lead and twelve as clinical director. David was the lead clinician for the rebuild of the paediatric department in 2005 and currently leads on Clinical Quality for paediatrics.

Following five years as member, then Chair, of the Clinical Directors' Special Interest Group, in 2006 David was elected as the National Workforce Officer for the RCPCH leading the 2007 national workforce census and designing a cohort study of trainees to provide a clearer understanding of the current and future workforce, helping to define how the role of paediatricians can evolve to provide consultant delivered care and hence safe and sustainable services.

David was elected Vice President (Health Services) in 2009 and played a central role in developing strategy for Child Health Services in the United Kingdom supporting paediatricians through the challenges of radical reform to the health service, working time legislation and service re-design. During David's five years in post he developed a national template for the resident paediatrician and was lead author for "Facing the Future". This document defined 10 quality standards for acute paediatric services and is widely quoted as a template for good practice. David led a national audit of these standards in 2013 and currently chairs a steering group extending the standards approach to care outside hospitals. Since 2014 David has been clinical adviser to the RCPCH Invited Reviews programme and has led a number of high profile reconfiguration, individual and service reviews.

**Quality assurance reviewer: Dr Stephanie Smith BMedSci BM BS MRCP FRCPCH** is an Emergency Paediatrician with dual accreditation for paediatrics and emergency paediatrics, and is Clinical Director for Nottingham Children's Hospital (within Nottingham University Hospitals NHS Trust). She has a broad paediatric experience and works with the general team to deliver care for all acute paediatric admissions.
She has recently been appointed as Deputy Medical Divisional Director with responsibility for the 'Front Door' Pathway in the Trust.

Stephanie was a Named Doctor for safeguarding for the Trust from the time of appointment until 2 years ago, leading on strategic issues for the Trust as well as training and advising staff regularly on safeguarding issues. She has undertaken a number of external clinical reviews of services both individually and on behalf of RCPCH. As Assistant Director for the Trent Clinical Skills and Simulation Centre Stephanie takes medical responsibility for the local and regional training faculty and recognises the importance of including Human Factors training into teaching. Stephanie leads for the paediatric resuscitation (APLS) and Instructor courses run in the Trust and is a member of the ALSG Working Party for APLS.

Stephanie chaired the Intercollegiate Committee for Children & Young People in Emergency Care Settings hosted by the RCPCH which published in May 2012 the updated Standards for Care. She has also been the Project Lead for a multicentre National Audit of Children with Decreased Conscious level, funded by the Reyes Foundation and published by RCPCH in early 2012. Stephanie has recently been invited to join the Clinical Effectiveness Committee for the College of Emergency Medicine to represent paediatric care.

# Appendix 3 – Abbreviations

| | |
|---|---|
| A(P)NP | Advanced (paediatric) nurse practitioner |
| APLS | Advanced paediatric life support |
| BCG | Bacillus Calmette-Guérin (tuberculosis) |
| CAU | Children's assessment unit |
| CCG | Clinical commissioning group |
| CDC | Child development centre |
| CEC | Children's emergency centre |
| CESR | Certificate of Eligibility for Specialist Registration |
| (C)MIU | (Children's) minor injuries unit |
| CQC | Care quality commission |
| CYP | Children and young people |
| ED | Emergency department |
| ENT | Ear, nose and throat |
| EPLS | European paediatric life support |
| FY | Foundation year |
| GP | General practitioner |
| GP OOH | General practitioner out-of-hours service |
| HCA | Healthcare assistant |
| KIDZ | Kids intensive care decision support and neonatal transfer service |
| LSCB | Local safeguarding children's board |
| M&M | Morbidity and mortality (conference) |
| NLS | Neonatal life support |
| P(I)LS | Paediatric (immediate) life support |
| RAC | Rapid access clinic |
| RCPCH | Royal College of Paediatrics and Child Health |
| SAS | Specialty and associate specialist |
| SSOTP | Staffordshire and Stoke-On-Trent Partnership NHS Trust |
| SSSFT | South Staffordshire and Shropshire Healthcare NHS Foundation Trust |
| UHNM | University hospitals North Midlands NHS Trust |
| WMQRS | West Midlands Quality Review Service |
| WTE | Whole time equivalent |

# Appendix 4 - Reference documents

The following standards and guidelines apply to the services in Staffordshire and were used by the review team in making their judgements and recommendations.

**National Policy**

Transforming Emergency Care Phase 1 review (DH August 2014 ) – Phase 1 of Keogh review proposes three types of care settings and provokes reconfiguration.

NHS England Five Year Plan (NHSE October 2014) sets out in 39 pages a succinct vision for modernisation and integrated working including a scheduled review of maternity provision and solutions for centralisation and healthcare provision for remote communities.

Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care: A guide for local health and social care communities (NHS England, RCEM, 2015) sets out progress against the Urgent Care Review and is designed to help frontline providers and commissioners collaborate in Urgent and Emergency Care Networks to deliver best practice. It sets out design principles but is not a list of instructions or new mandatory requirements and implementation depends on financial implications and local context.

**Urgent and emergency care**

Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

Children's Attendance at a Minor Injury/Illness service (Intercollegiate 2002) sets out managerial, accountability and service considerations together with details of clinical network and staffing arrangements for ensuring that MIUs offer appropriate care for U16s which is integrated with the emergency services. Much of this document's content is incorporated into the 2012 standards but there is additional detail specific to MIUs so it remains applicable

Spotting the Sick Child is an interactive tool commissioned by the Department of Health in England to support health professionals in the assessment of the acutely sick child.

Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, 2010) sets out measurable standards for care from arrival at hospital ED through reception, assessment, inpatient, HDU/ITU and general care across services. Sections on anaesthesia, retrieval and transfer complete the pack.

Appendix of guidance to the Standards for care for Critically Ill Children (Paediatric Intensive care Society, 2010) supports the standards with checklists and tools to enable clinicians and managers to establish effective arrangements are in place. These include details of knowledge and skills required, guidance on resuscitation training, referral information, and support for families

Core Competencies for the care of acutely ill and injured children and young people (NHS Scotland 2006) details for emergency and urgent care settings the procedures and expectations of staff.

Chapter 10 - Paediatric anaesthesia service (RCoA 2015) Guidance of the provision of anaesthetic services - one chapter of the RCoA suite of standards.

Acute and Emergency Care -Prescribing the Remedy - RCEM/RCPCH/RCP/RCS 2014 - This report co-authored by the Royal College of Emergency Medicine, Royal College of Paediatrics and Child Health, Royal College of Physicians and Royal College of Surgeons sets out 13 recommendations for Government, national bodies, commissioners, providers, professional bodies and clinicians, to take forward at local and national levels. Implementing these measures will help build an urgent and emergency care system that is sustainable and resilient to cope with future service demands.

The Urgent and Emergency Care Clinical Audit Toolkit *(*RCGP) 2011 is a learning tool to support the quality of urgent and emergency care services for patients. It has been extensively piloted and will help provide a seamless approach to promote quality care across a range of NHS services.

A whole system approach to improving emergency and urgent care for children and young people - a practice step by step guide and resource pack) (NHSi 20111) Provides a toolkit of resources and tips to implement the recommendations contained in Focus on: Children and Young People Emergency and Urgent Care Pathway (NHSi 2008)

**Paediatrics**

Facing the Future – a review of Paediatric services (RCPCH 2015) updates the original 2011 guidance and details ten service standards relating to clinical cover, expertise and child protection.

Facing the Future Together for Child Health (RCPCH 2015) sets out eleven standards to reduce pressure on hospital services in improve the quality and effectiveness of care closer to home.

**Anaesthesia**

The Anaesthesia Team (AAGBI 2010 3rd edition) sets out requirements for staffing training support facilities and practice in anaesthetics and is supported by RCoA but does not explicitly apply to or reference paediatric care

Chapter 10 -Paediatric anaesthesia service (RCoA 2015) Guidance of the provision of anaesthetic services - one chapter of the RCoA suite of standards

**Nursing**

Defining staffing levels for children and young people's services (RCN 2013) updates guidance for clinical professionals and service managers regarding optimal staffing levels in areas where children and young people are nursed, by providing minimum standards and standards relating to workforce planning and workload monitoring.

Safe staffing levels – a National Imperative (RCM, 2013) sets out nurse staffing levels and contributed to NICE guidance in development

Healthcare service standards in caring for neonates, children and young people (RCN 2011) sets out the standards to be applied when caring for neonates, children and young people in all health care settings.

Evidence Based Nurse staffing levels (RCN 2010) sets out essential elements to planning or reviewing nurse staffing, regardless of the specific tools used.

Maximising Nursing Skills in Caring for Children in Emergency Departments (RCN, RCPCH 2010) is for emergency department managers, lead consultants and lead nurses. It provides detailed guidance on competence development for nursing staff.

Specialist and advanced children's and young people's nursing practice in contemporary health care: guidance for nurses and commissioners (RCN 2014) looks at children's nurses roles and their practice. It is aimed at those developing services for children and young people (CYP), for both commissioners and service providers.

Career, education and competence framework for neonatal nursing in the UK (RCN 2015) is informed by numerous influential drivers, from a variety of sources, and will be updated regularly.

Advanced Nurse Practitioners - An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation (RCN 2012) sets out the benefits and competencies required for nurses to achieve this status.

Specialist and Advanced children and young people's nursing practice in contemporary health care (RCN 2014) provides guidance for nurses and commissioners

**Involvement and participation**

Not just a phase (RCPCH 2010) sets out mechanisms and tools for meaningful involvement of children and young people.

You're Welcome Quality Criteria – making health services young people friendly (DH 2007 and 2011) provides voluntary standards of care for ensuring facilities and services are accessible and young-people-focussed.

Patient Reported Experience Measure for urgent and Emergency Care (RCPCH 2012) is a tool developed intercollegiately by the RCPCH with Picker Institute Europe to measure the experience of paediatric patients 0-16 years in all urgent and emergency care settings including; GP practices, out-of-hours centres, EDdepartments and the ambulance service.

# Appendix 5 - Sources of information and contributors

Documents were provided by the Trust relating to the following areas:

- **Workforce** - medical and nursing staff lists, staffing structures and rotas, Statutory and mandatory training figures
- **Clinical activity** - attendances, admissions, transfers, referrals, waiting times, RTT
- **Clinical governance materials** – agendas, papers and minutes from divisional and governance meetings; governance structures, risk registers, incident reporting, incident summaries and complaints
- **Strategy** - Strategic planning documents
- Reports from external reviews / inspections
- protocols /policies for CEC
- Information about patient feedback and involvement

The following individuals and groups participated in the review:

- UHNM Management
    - Chief Executive
    - Executive Medical Director
    - Chief Nurse
    - Clinical Director – Paediatrics
    - Clinical Director – Emergency Department
    - Divisional Chair – CWD
    - Associate Director (CWD)
    - Head of Quality, Safety & Compliance
    - Associate Chief Nurse / Head of Midwifery
    - Deputy Associate Director – Medical Division
    - Directorate Manager – Emergency Medicine
    - Clinical Director – Anaesthetics
    - Business Manager – Emergency Department
    - Matron – County ED

- Safeguarding
    - Designated Doctor for Safeguarding
    - Named doctor for safeguarding
    - Named nurse for child protection

- Clinical staff
    - Paediatricians
    - Emergency physicians
    - Physicians associates
    - Paediatric nurses
    - ED nurses
    - HCWs
    - ANPs

- External bodies / other stakeholders
    - CQC
    - WMQRS
    - Healthwatch
    - Stafford and Surrounds Clinical Commissioning Group
    - West Midlands Ambulance Service
    - GP Out of Hours, Staffordshire Doctors Urgent Care
    - Children's Hospital at Home service
    - Local MP