RCPCH Invited Reviews Programme

Service Review

East Kent Hospitals University NHS Foundation Trust

April 2015

Royal College of Paediatrics and Child Health

Leading the way in Children's Health

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Executive Summary

The RCPCH was pleased to be invited to review the paediatric services at East Kent Hospitals University NHS Foundation Trust (EKHUFT). This report examines the current paediatric services for children at the trust, against professional service standards. The report's recommendations are drawn from the review team's findings through interviews on-site with a wide range of clinical staff, together with the analysis of documentation and data submitted by the trust.

The review team felt that the paediatric services within the William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother (QEQMH) and Kent and Canterbury Hospital (KCH) continue to largely function independently of each other. However the review team acknowledged that the nursing leadership has taken a greater step forward towards planning resources with a 'trust vision' rather than for specific sites. Overall the nurses were open to cross site integration and changes to working rotas. However there is still resistance from some consultants to work extended hours, across sites and integrate services. Difficulties in the alignment of medical policies and procedures between hospitals were also apparent.

The paediatric consultants are currently spread too thinly across the service, and modelling the current activity indicated that three more are required to comply with current professional standards. Consultants offer specialist clinics based on their expertise and interest, but these do not always reflect local need or trust priority, thus honorary contract clinics at other trusts need to be reviewed against the EKHUFT acute service needs.

There were at the time of the review visit insufficient middle grade doctors to cover both sites, but the recent decision to separate the neonatal and paediatric rota, should, once fully staffed, result in a safer and more stable middle grade service, and new guidance from RCPCH regarding SAS doctors on middle grade rotas should move the current service towards compliance.

An internal review of nursing has made good progress in developing current nurses to meet activity needs. The review team commends the development of the Advanced Paediatric Nurse Practitioner (APNP) and supports the trust in considering the use of APNP and Advanced Neonatal Nurse Practitioners (ANNP) on the medical rotas.

The recent CQC 2014 report has raised the profile of the paediatric service within the trust's senior management, although it is too soon to know whether subsequent changes have been effective. The involvement of paediatric consultants in, any child health action plans still needs to improve, through active engagement in developing and executing improvement plans for the service, as a result of the CQC inspection and report.

The paediatric emergency service is poor in QEQMH and almost non-existent in WHH. The current service is not compliant with standards, and therefore urgent attention needs to be given to emergency care services for children and young people. The paediatric department needs to have greater influence within the emergency setting, and other trust services for children, to meet the standards for children and young people in emergency care settings and the Facing the Future standards.

Consolidation of services onto a single site may offer the opportunity more comprehensively to address the challenges identified by this review. Consultants should work closely together, with service managers across the sites to map activity and geographical flows, and thus consider different ways of working to support reconfiguration and relocation. The review team considers that a compliant consultant rota with extended hours of working would be achievable, should the child health service be consolidated onto a single site. The emergency pathway could be radically revised within options two and three; a newly built hospital could be designed to meet the standards set for delivering emergency care to children.

It is considered that the short term and long term recommendations outlined by this review, will improve the safety and effectiveness of care for children and young people across EKHUFT.

1 Introduction

1.1 RCPCH was approached in July 2014 by the Associate Medical Director of East Kent Hospitals University NHS Foundation Trust (EKHUFT), [redacted] to review the paediatric services at its three main acute sites.

1.2 A CQC inspection report was published in August 2014 which rated the children and young people's services inadequate and needing improvement in several areas (listed in footnote[1]). The trust has already put in place an internal EKHUFT improvement plan following the inspection, but requested an RCPCH review to provide greater detail of the paediatric services at the three sites, and comment on the implications of a proposed reconfiguration on the workforce and service for children and young people.

1.3 This review is an independent critique, against agreed terms of reference, of the paediatric service based on information provided to the reviewers, and evidence gleaned through an initial pre-visit and a two day review visit to all three sites.

1.4 The services are considered against published policy and standards from RCPCH and other professional bodies, together with the objective workforce and service design experience of two senior consultant paediatricians and an RCN representative on behalf of the College. The report has subsequently been quality assured by two further external consultant paediatricians.

1.5 The report will become the property of East Kent Hospitals University NHS Foundation Trust through the Associate Medical Director and remain confidential between him and those in the RCPCH responsible for producing it.

1.6 RCPCH encourages wider dissemination of the report amongst those involved in the service, but this is the responsibility of the report owners and RCPCH will not itself publish or comment on review reports.

[1] Ensure there is a sufficient number and mix of suitably qualified, skilled and experienced staff across the Trust, including A&E, on wards at night and in areas where children are treated.
Ensure that there is a Board level lead for children and young people (and that staff know who this is) and that, in all areas where children are treated, equipment is safe and there are appropriately trained paediatric staff.
Ensure that all relevant policies and procedures for children reflect best practice / NICE quality standards for paediatrics.
Ensure that staff are fulfilling their roles in accordance with current clinical guidelines and also that children's services audit their practice against national standards.

2 Terms of reference

2.1 The trust required an independent service review of the paediatric service across East Kent Hospitals University NHS Foundation Trust, with specific focus on:

1. Is the paediatric service currently provided at each location operating effectively?
   Particular focus should be on:
   - Adequacy of medical staffing for doctors
   - Meeting the standards for nurse staffing
   - The paediatric emergency pathway
   - Supportive administrative and organisational systems and policies

2. With consideration to the current options for service redesign, the review team will consider:
   - The medical and nursing workforce implications
   - Whether child health services are meeting the acute health needs of the children and young people of East Kent

3. Are there any other issues, positive or negative, relating to safety and quality that arise from the review that are not covered above?

2.2 The report will provide an independent analysis of the services of the Trust based on the College's interpretation of current operational practice and service through application of supplied documentation, and interviews with selected staff.

3 Background Information

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3.1 East Kent Hospitals University NHS Foundation Trust (EKHUFT) manages three acute hospitals: William Harvey Hospital (WHH) in Ashford, Queen Elizabeth the Queen Mother Hospital (QEQMH) in Margate and Kent and Canterbury Hospitals (KCH) in Canterbury. The trust also has two supporting hospitals: The Royal Victoria Hospital, Folkestone and Buckland Hospital, Dover. The trust became a Foundation Trust in March 2009.

3.2 EKHUFT serves a mixed rural and urban population of over 720,000, and the population is spread across a geographical area of over 700 square miles. There is a distance of 37.7 miles between WHH and QEQMH, 20.5 miles between QEQMH and KCH and 14.9 miles between KCH and WHH 22% of Kent households do not own their own transport, and consequently have difficult access to healthcare across East Kent. The population is also forecast by the office for national statistics to increase by 10.6% over the next 10 years.

3.3 In the past two years the trust has been considering reconfiguration of acute services, and for children's services, three strategic options are being explored:

- centralisation onto the specialist surgical hub at KCH
- continue to provide acute services on two sites: WHH and QEQMH
- move to a stand-alone site

The recent EKHUFT strategic plan 2014-2019 suggests that all reconfiguration and relocation of services aims to be complete by 2019.

[2] Map image cited from www.britishservices.co.uk

4 Analysis of the Services

4.1 Current Service Design

William Harvey Hospital (WHH)

4.1.1. WHH provides acute paediatric care through Padua inpatient ward, a Children's Assessment Unit (CAU), outpatient clinic and a Level 3 neonatal intensive care unit.

4.1.2 Padua is a 28-bedded inpatient ward for children and young people, up to 16 years with approximately 3,300 medical and surgical admissions per year. The ward contains two high dependency beds. There is an outdoor 'roof' play area and a good sized indoor 'Sunshine' playroom, with a range of toys and facilities for families. The ward provides a bedside school facility for children who have been admitted on the ward for a minimum of two weeks. There are two adolescent bays, gender divided, each with three beds. There is also an adolescent lounge, which is soon to be revamped following a donation to the ward.

4.1.3 The Children's Assessment Unit (CAU) is a designated area which provides urgent and unscheduled care between 9am and 10pm seven days a week. The review team heard that the CAU improves the emergency flow and reduces the number of children and young people admitted to the ward overnight. The CAU accepts referrals from ED, GPs, walk-in centre nurses, community paediatricians, midwives and health visitors. Currently there are two advanced paediatric nurse practitioners (APNPs) in training in this area, with three posts in total.

4.1.4 GP out-patient referrals are received via the Patient Services Centre, triaged on the Windip system[3] by consultants,. Appointments are booked within the eighteen week pathway. This system is also in place for QEQMH.

4.1.5 General outpatient clinics are provided in a dedicated paediatric area adjacent to the ward. Specialist out-patient clinics are also provided locally by paediatricians across the three trust sites reducing the need for tertiary referral. The Specialist Respiratory Nurse undertakes clinics in these areas and the APNPs do pre-assessment clinics.

4.1.6 The 25-cot Neonatal Intensive Care Unit (NICU) has seven intensive care cots, four high dependency (HDU) cots and fourteen special care

[3] a paperless document handling system, not specifically designed for medical documents

cots. There is also a quiet room, a milk kitchen and laboratory (in the same room) and a breast feeding room.

4.1.7 There is no dedicated Paediatric Emergency Department (ED) on this site, and children are seen alongside adults in ED. Although there are 2.6 WTE qualified paediatric nurses, children are frequently seen by general trained nurses. There are approximately 14,000 paediatric attendances to ED per year which puts the trust just below the threshold for employing a consultant with sub-specialty training in paediatric emergency medicine.

4.1.8 Elective and emergency paediatric day surgery is provided in the Channel day surgery unit. There are no paediatric surgeons; all surgery is performed by adult surgeons with paediatric experience. There are paediatric nurses based in surgery and funded by the surgical division. There do not appear to be nurse led discharge pathways for elective surgery, which has been used by other trusts to expedite patient pathways and improve bed utilisation. Neonatal surgery takes place in London or Brighton.

Queen Elizabeth the Queen Mother Hospital (QEQMH)

4.1.9 The paediatric service at QEQMH is also a combined acute and community medical service. The site consists of the inpatient Rainbow ward, one high dependency bed, a Children's Assessment Unit, Out-patient clinics and a level 1 neonatal Special Care Unit (SCU).

4.1.10 Rainbow ward is a 20-bedded inpatient ward admitting around 4,200 children and young people annually up to 16 years. There is a good size playroom and an outdoor play area with good facilities for children. There is no hospital school, but free Wi-Fi (commissioned by Kent County Council) enables children to link into school work.

4.1.11 The 4-bed CAU adjacent to Rainbow Ward accepts referrals direct from ED and other appropriate referrers, with a consistent referral process for both WHH and QEQMH. The CAU was created from an adolescent bay, consequently there is now no gender-separation as there is just one adolescent bay.

4.1.12 Out-patients includes five consulting rooms and a nurse examining room. General and specialised out-patients are provided at QEQMH, a similar arrangement to WHH. There are no nurse led clinics provided by EKHUFT, but the Specialist Children's Oncology Community Nurse undertakes clinics in this area.

4.1.13 The SCU has eleven cots and one high dependency cot. There is a breast feeding room available, however it was commented that this is too small, and instead mothers are offered one of two rooming in-rooms available. There is a milk kitchen and the ward kitchen which parents are invited to use to make drinks. However there is no quiet sitting room for parents to use. The review team did note that the ward would be cramped at full capacity and space for parents was limited. New born infants requiring more specialised care are transferred to the neonatal unit at Ashford.

4.1.14 There is a four bedded paediatric area in the QEQMH main emergency department with one paediatric resuscitation bay in the adult area of ED. The resuscitation bay is the same set-up and equipment as at WHH, to facilitate safe practice for doctors and nurses who work between sites. Children are sent to the ward (CAU) for assessment. The three paediatric nurses working in ED do not rotate through Rainbow ward.

4.1.15 Orthopaedics day surgery preparation and recovery is on the children's ward, whilst other elective and emergency surgery for children is provided at the day surgery unit in Ashford or the KCH assessment centre. A small number of ENT and Ophthalmology day case procedures are performed by adult surgeons with paediatric experience

Kent and Canterbury Hospital (KCH)

4.1.16 Dolphin Ward, the Children's Assessment Unit (CAU) at KCH is open weekdays from 8am – 5pm with a five bedded medical ward and a five bedded surgical ward with a high dependency unit. There are also four clinic rooms. The CAU provides care for children and young people between the ages of 0-15 years old. This is a highly functional dedicated ambulatory unit, which has achieved and exceeded the goals of ambulatory care; the NHS institute of innovation and improvements has identified areas of similar innovative practice in the area of emergency and urgent care for children and young people (publication cited in the appendices). The review team noted that it was established at a time when such provision was virtually unheard of in the UK, and recognised the service model as a beacon of excellence for the children and young people of Canterbury.

4.1.17 There is one main entrance to Dolphin ward, and a separate entrance for day surgery. Half of the building is also allocated and managed for community work. In addition to the beds and clinic rooms, Dolphin ward

also comprises an occupational therapy room, a sensory children's area and care suite, and the Honey Bears Nursery. It was commented that the nursery provided a good link in for local children with complex needs, but was only available to children in the immediate Canterbury area.

4.1.18 The unit meets the needs of children who require ongoing assessment or a short stay treatment, who are then able to be discharged home, rather than be referred for inpatient admission.

4.1.19 ENT and general surgery lists are performed, and it was confirmed that the unit has designated paediatric anaesthetists for all day surgery. Children are also admitted for elective procedures such as MRIs.

4.2 Staffing and Training

Medical

4.2.1 Staffing at WHH comprises:

- Five consultant paediatricians, plus two who also work in the community. There is consultant of the week (COTW) system and 1 in 7 non-resident on-call out of hours with prospective cover. Consultants are not present after 5pm.
- Four consultant neonatologists, and two paediatricians with neonatal interest cover the NICU with a 1 in 6 on-call rota with a Consultant of the Week system operating in two week blocks. Weekend on calls operate from 3pm on Fridays to Monday morning after handover.
- The Tier 2 rota is made up of five acute specialty doctors who cover acute paediatrics and NICU with a shared rota. There are also two more posts being advertised, this will bring the total number of full time specialty doctors to seven.
- There are also two deanery middle grade doctors who work in acute paediatrics during the day, two deanery middle grades who work in the community during the day, and two middle grades who work in NICU during the day. There is a community specialty doctor who takes part in the WHH on-call rota
- There are separate rotas at Tier 1 with one ST1, seven GP trainees and one F1 for paediatrics and seven deanery trainees in NICU. there are no ANNPs on the rotas..

4.2.2 Staffing at QEQMHH comprises:

- Five consultant paediatricians and one consultant who also works in the community.

- Eight middle grades, on a 1 in 8 rota: three deanery trainees and five specialty doctors for paediatrics, the special care unit at QEQMH and a day rota at KCH. There is a 0.5 WTE specialty doctor shared with community, but this job will move to WHH from 1 March 2015.
- Nine junior trainees: two paediatric trainees, six GP trainees and one F2 doing a 1 in 9 rota for paediatrics and the special care unit. There is also one F1 trainee who is not on the rota, and is scheduled 9am-5pm Monday to Friday.

4.2.3 Staffing at KCH comprises of:

- Four consultants are based at KCH. Two of the consultant paediatricians are shared with WHH and one consultant paediatrician shared with QEQMH.
- Middle grade cover is provided by QEQMH, one middle grade per day is rotated from the QEQMH base, for the 9am-5pm KCH hours.
- One junior trainee from WHH is provided to KCH during the day for the 9am-5pm opening hours.

4.2.4 All middle grade doctors taking part in the out of hours on-call rota and at night are expected to provide cover for acute paediatrics, paediatric needs in ED, and the neonatal intensive care unit (NICU) at WHH or the special care unit at QEQMH.

4.2.5 The review team considered that there were insufficient middle grades at WHH to effectively or safely cover all the clinical areas at night. The trust has agreed to assign two middle grades at night from March 2015, although this consequently requires reducing the middle grades cover at QEQMH. The neonatal intensive care unit should be covered at all times by a separate middle grade rota, which may include ANNPs if they are suitably trained and experienced.

4.2.6 The division has already looked at new ways of working to address deficiencies in the service and a business case had been put forward for extended working of consultants until 9pm (currently their day finishes at 5pm). This is in line with RCPCH ‘Facing the Future’ standards. The proposal had been signed off by the QEQMH consultant lead, but had not been supported by consultants at the WHH.

4.2.7 Both WHH and QEQMH have a consultant led handover at 8.30am and 4.30pm each day, there is a third handover at 8.30pm which is middle grade led. Paediatric consultants that are on a 10PA contract and are expected to do three clinics a week.

4.2.8 The consultant team have a very good skill mix between them, and consultants offer specialised and diverse clinics to the East Kent children and young people, including: diabetes, epilepsy, nutrition, oncology, respiratory and rheumatology. Some consultants are allocated 1 PA a week in their job plan to fulfil honorary contracts with other trusts, helping to maintain their specialist skills but it was not clear how this was balanced against their own trust service..

4.2.9 The review team heard that the trust does not have recruitment difficulties for consultants or middle grades in acute paediatrics. However there have been significant difficulties in recruiting to posts in community paediatrics.

4.2.10 Middle grade and junior doctors reported feeling well supported by their consultants, and feel able to approach them and ask whenever more support is needed. However at night they would feel more confident if there were more middle grade medical staff and experienced nurses present on the wards.

4.2.11 There is currently no overall clinical lead for the neonatal service in the trust, but a post is currently being advertised and interviewed for. This role would support the two neonatal units to work together as a single service within the network and improve neonatal governance arrangements, but staff were concerned that 0.5PA was insufficient to cover the clinical lead role.

4.2.12 The neonatal intensive care unit at WHH is covered at times by consultants with responsibilities in general paediatrics. It is recommended that neonatal intensive care units be staffed at tier 3 level by consultants with higher specialist training in neonatal medicine with responsibilities solely to that service.

Nursing

4.2.13 In 2014 a trust-wide nursing review had resulted in increased nurse staffing in paediatrics, and numbers were meeting the RCN 2013 one to four guidance in the day, although still not at night..

4.2.14 Advanced paediatric nurse practitioners (APNPs) are being developed and trained for the paediatric assessment units, with 2.7 WTE posts at WHH and QEQMH. This should improve career options and enhance retention of more senior nurses. A practice development nurse

works across the service to support newly qualified band 5 nurses and other areas of training.

4.2.15 The children's community nurses (CCNs) are employed by Kent Community Health Trust (KCHT), and relations between the trusts are good.

4.2.16 All nurses on Padua, Rainbow and Dolphin wards are children's trained; there are no vacancies and retention is not a problem, except the more experienced band 5 nurses. They roster 5 or 6 nurses per shift with a healthcare assistant (HCA) to support clinical and non-clinical activity. The trust is also employing Band 4 associate practitioners, with two in children's services where children are following a clearly defined pathway of care such as in day case areas.

4.2.17 The paediatric assessment areas have been staffed separately from the wards since the summer of 2014 and run with a band 5 nurse, an APNP, junior and middle grade doctor on each shift. Padua has two full time play leaders from Monday to Friday, with some weekend hours. Rainbow has a 0.8WTE play specialist and a 0.8WTE play therapist.

4.2.18 Some medical staff consider that there are too few skilled nurses on the wards at times at both WHH and QEQMH. Sample rotas show that on Padua and Rainbow Wards only 75% and 50% of night shifts respectively have a band 6 nurse to supervise less experienced nurses despite the 2013 RCN guidance stating this should apply on all shifts. Extra funding had been secured for nurses during the winter months, although there was still some concern over temporary recruitment, and it is difficult for nurses to cover shortages across sites due to the distances between hospitals. This means that when the ward is busy, especially if high dependency activity is high, the service has to close to admissions, which happens around four times a year.

4.2.19 Nurse staffing in the neonatal unit has recently been reviewed, using the DH neonatal toolkit calculator. Nurse to infant ratios meet the recommendations, except for intensive care cots where the ratios fluctuate between 1:1 and 1:2. There is no supernumerary shift co-ordinator on the neonatal units and no specialist surgical nurses. The surgical service is supported by the neonatal unit at the Evelina London Children's Hospital. The service is currently looking at skill mix and roles. They have a research nurse and special care co-ordinator and are piloting a neonatal outreach service. They are also looking at recruiting advanced neonatal nurse practitioners (ANNP), as these are not currently employed on the unit. The

job description and competencies for this role are currently under development and the trust will initially aim to recruit a trained ANNP from another centre. Nursing staff are supported by nursery nurses and band 2 HCAs.

4.2.20 The review team heard that there has been discussion to add the advanced practice nurses to the junior medical rotas. However it was unclear whether this idea had been fully explored and whether any time frame had been considered to introduce this, as development of APNPs will take two to three years from commencing training.

Safeguarding

4.2.21 The trust-wide safeguarding team includes the designated doctor who has 2PA allocated for this role funded by the CCG and cross charged by the trust, the named nurse for safeguarding children, one full time safeguarding advisor, two part time administration support, and currently two band 6 nurses on secondment. The team reportedly works well together; however, all members expressed concern that it was difficult to meet their many responsibilities within the limited resources allocated to each post. As a consequence they found they were unable to fully address the strategic aspect of their roles. The two nurses on a secondment have provided good additional support, and received valuable safeguarding exposure and development.

4.2.22 There are four named safeguarding doctors to cover: KCH, QE, WHH and Buckland together and the Ashford community, but they have no protected time allocated to this role. Consequently much of the responsibility for supporting the medical staff in their safeguarding roles lies with the designated doctor, which is inappropriate. The review team were also concerned that there is not yet an on-call rota for carrying out safeguarding medical examinations.

4.2.23 CQC raised concerns about safeguarding training for non-paediatric staff working with children. However the review team were shown HR data that confirmed 90% of the child health work force has level 3 training in child protection, but individual training records were not reviewed. Some staff felt there could be more vigorous peer review sessions as currently these are infrequent.

Teaching

4.2.24 Trainees at WHH reported that consultants teach well when opportunities arose, but formal teaching was not integrated into the junior

doctors' working week at WHH and teaching opportunities seemed sporadic, rather than planned.

4.2.25 At QEQMH the trainees commented that teaching is good, with those who have been at the trust over a few years, considering that teaching and support has much improved. A five minute teaching scheme happens each day, which is a valuable learning technique, and the College tutor organises multi-disciplinary organisational training, but it is not clear whether this training was available for WHH trainees also.

4.2.26 Across both sites the review team heard that whilst medical trainees were welcome to attend the many general and specialist consultant led clinics, rota commitments would usually prevent this from happening.

4.2.27 The trust College tutor has 0.5 PA allocated to support trainees, improve the educational environment and attend relevant educational meetings .This is insufficient for development of the education and training responsibilities, especially in view of the additional GMC requirements as college tutors have an essential role in ensuring all trainers are appropriately trained and appraised in their educational and supervisory roles.

4.3 Emergency Care

4.3.1 The ED at WHH does not have a designated area for paediatrics and at present children and young people are seen in areas shared with the adults within ED, unless they are taken to the ward. This is inappropriate, contrary to the national intercollegiate standards and may impact on the safety of patients, staff performance, and quality of care.

4.3.2 QEQMH has a reasonably sized paediatric area within the ED but there is no dedicated children's assessment area. A business case for an assessment area had been rejected and consequently the CAU remains adjacent to the children's ward. As a consequence sick children must be assessed both within the ED and on the CAU, which was reported to stretch medical resources at times.

4.3.3 Responsibility for children is shared between paediatrics and ED at both sites although the paediatricians felt unable to influence the ED management team as much as they would wish. The review team has concerns about governance and quality in these areas, where there is limited paediatric input.

4.3.4 The review team were also given trust HR data, which confirmed that 72% of the child health workforce has completed their resuscitation training. Consequently, if the HR training record is accurate, this means that 1 in 4 staff do not have this required training.

4.3.5 Whilst both sites have some paediatric nurses based in ED, they are employed by ED, and therefore also see adult patients, with some children in ED being seen by adult-trained nurses. There is no nurse rotation with the paediatric wards and the ED does not meet 2013 RCN guidance to have one children's nurse per shift. There are however plans to develop APNPs in ED, due to a revision of the emergency pathway a year ago to improve care.

4.3.6 In May 2014 there had been a serious incident at WHH linked to failure to comply with the NICE feverish guidance in ED. The review team are unclear whether all emergency care guidance for children and young people is now embedded in ED resources and practice.

4.3.7 Overall children in ED do not receive the child and family friendly service they should on either site. The settings are not designed to accommodate their needs and those of their accompanying parents, carers and siblings, with audio and visual separation from all adult areas. All staff grades coming into contact with children and young people should be skilled in communicating with them at an appropriate level. The RCN staffing guidance outlines minimum essential training for nurses working with children in ambulatory care settings including the ED.

4.3.8 Whilst the current service configuration makes it convenient for families and GPs to access emergency care, it results in resources being spread across a number of sites, and this naturally causes difficulties in improving standards. There is also currently the potential risk of encouraging families to bring sick children to the units in Canterbury or Dover, which are not covered by paediatric staff throughout the night. However, when this has happened since opening as a standalone ambulatory unit, the review team heard that the staff have dealt with the cases in what appears to be a satisfactory way.

4.3.9 The review team did not hear evidence of participation with children, young people, parents and carers regarding the ongoing quality and improvement of ED services and facilities. For example UK trusts may use the: *You're Welcome: Quality criteria for young people friendly health services, department of health, 2011,* for guidance in the participation of children and young people for service change.

4.3.10 The review team were given the '*Children Attending A&E and MIU Units'* document which was updated in June 2014. Page five outlines the standards for clinical assessments with ED, however the review team did not hear evidence if these standards were being met or audited, not if the units had been audited against the intercollegiate standards for children and young people in emergency care settings.

4.4 Leadership and Team Communications

4.4.1 The paediatric service forms part of the trust specialist services division, this also includes maternity services. Divisional Strategic Leadership is provided by a divisional medical director, supported by a lead clinician for paediatric services and site based lead clinicians. The divisional medical director and clinical child health service leads have been actively working to secure increased resources for the department. They have successfully increased the medical establishment, indicating that some of the concerns expressed by the CQC have and are being addressed.

4.4.2 The consultants feel they work very well together on individual sites, and support each other to invest in their individual specialities. However, more progress could be made in consultants across the three sites working together with aligned protocols and pathways of care. Consultants appear to be very well engaged in their own site's operational activity, but there was limited evidence of communication between clinicians across sites for which they did not have direct clinical responsibility. Furthermore opportunities for cross site working and the improved deployment of paediatric expertise across the whole trust did not seem to have been fully explored by the consultant body.

4.4.3 There was enthusiasm for the nurse led promotion of cross site working, and a vision for working as one trust. The senior matron, site matrons and ward managers meet regularly to map nurse activity strategically, rather than site specifically.

4.4.4 The review team heard positive feedback about the child health clinical lead and the senior matron, especially from the nurses. Comments suggested that they are working hard for integration across all sites and for all doctors and nurses to work across sites. However the review team heard that although currently consultants are happy to do clinics across sites, there has not yet been agreement for acute work.

4.4.5 Consultants felt a lack of engagement and communication with senior management, saying it was difficult sometimes to get the information they needed from the management team. They were concerned that, since the 2014 CQC visit, a Child Health Board had been formed, but that they, as consultants, were unaware of the membership of this board who been chosen to represent the concerns of the clinical team in Children's Health.

4.4.6 The review team also heard conflicting comments regarding future reconfiguration plans for the trust, and in particular the engagement and involvement of the consultant body. Some consultants appeared to have been invited to working groups, including an evening meeting to discuss potential plans, and evaluate current activity, whilst others were unaware of any of the reconfiguration options, and therefore could not engage at this early stage. Managers indicated, however, that the clinical strategy had been disseminated through a range of communication channels. Those who did want to engage fully were finding it difficult to map activity to reconfiguration plans, due to limited information provided from the senior leadership of the trust.

4.5 Incident reporting

4.5.1 EKHUFT uses the Datix tool, to report concerns and issues of clinical practice, which triggers e-mail alerts to key individuals to keep track of the situation. There are also additional triggers on the system to speed up reporting for neonatal cases.

4.5.2 The junior doctors at WHH were aware of Datix, but did not often get involved in the reporting process, considering it 'a middle grade duty' rather than everyone's responsibility. However, elsewhere doctors and nurses felt comfortable to escalate concerns, and felt that they would be listened to when reporting incidents or risks.

4.5.3 The paediatric and neonatal services use random safety auditing (RSA) and root cause analysis systems to respond to critical incidents and RSA is sent to all staff who were involved.. Staff commented that the RSA is a good way of learning, and could be utilised more across the division.

4.6 Governance

4.6.1 Following the CQC 2014 visit, the trust had put together action plans, including a child health improvement plan. Senior trust staff also confirmed the establishment of a new children's health board, aiming to address the

standard of care for children managed outside the children's service. The director of quality confirmed that membership of the board was currently internal only, as the board has only recently been established. However the board aims to have parental and CCG involvement in the future.

4.6.2 The senior matron confirmed that the department has been working on assessing and reviewing all areas of the trust which provide services to children and young people, following requirements by the CQC. The review team heard that the trust is aware that this is an area of risk that needs to be addressed and developed. The children's health board could provide an excellent forum for the trust to hold to account those within the organisation providing services for children. This includes the ED and other areas where children are cared for outside the paediatric department. There is not yet evidence that the board has made progress in this area.

4.6.3 The 2012-2015 quality strategy is currently being used as a measure for the paediatric services. It outlines the use of benchmarking, clinical audits, research and external regulation as indicators for the quality strategy implementation, in addition to other trust services. There is a monthly divisional quality governance board meeting and clinical leads are all copied into the minutes.

4.6.4 To ensure governance updates and issues are circulated across sites, there are monthly trust child health governance meetings with the clinical leads, senior matron and managers. The protocol is then for sites to have site meetings once a month, where information will be fed down from site leads to medical and nursing staff. Despite a protocol for sharing information, there was not strong evidence that information was clearly being passed down effectively with mixed comments about who would be permitted to attend site meetings.

4.6.5 The review team heard that NICE guidance is discussed at the child health clinical governance meetings. It was confirmed that there is a NICE lead for the trust who will report on these, and if current practice is not compliant with NICE, then an action plan will be put in place.

4.6.6 There were mixed comments from interviewees regarding all guidelines across the trust for paediatrics and neonatal care. The clinical lead confirmed that guidelines are increasingly uniform across the sites, with a cross-trust consultant clinical working group meeting twice a year to help deliver this. However, implementation differs between sites and individual consultants.

4.6.7 The review team heard concerning comments regarding the 'SharePoint' web application system to access guidelines and protocols which all medical staff referred to as extremely poor. Staff commented that many of the guidelines were out of date, for example the review team were told that the jaundice guideline was seven years old. The system was also reported to be difficult to navigate, and that the 'search' button did not seem to work. There was general concern regarding patient safety relating to this, as medical staff commented that they would either try to access other trusts' guidelines or would rely on the folder on the ward. Senior leadership confirmed that each area of SharePoint should have a designated lead responsible for uploading and updating information but it was not clear to the review team who held this responsibility.

4.6.8 From January 2015 there will be an audit half-day every second month with dates circulated well in advance to staff, encouraging their attendance. There is an audit lead for each specialty who is responsible for the audit process, and the division expects to hear of improvements from an initial audit at a follow up audit meeting. There were comments from staff that whilst audit protocols were in place, the feedback from audits could be improved.

4.6.9 Consultants appear engaged with the audit process, but junior doctors and middle grades seemed unsure of their role. At WHH junior doctors acknowledged that they were encouraged to do audits, but they felt it was not clear how one would get involved or lead one, as there did not seem to be any particular organisation or a system for the allocation of audits. The middle grades who had been involved in an audit told the review team that consultants had been helpful and supportive.

4.6.10 Although paediatric governance structures are in place, the review team heard little evidence of proactive joined up governance where all staff had an opportunity to discuss patient safety issues, complaints and guidelines.

4.6.11 The senior matron confirmed to the review team that a business case had been put forward for a child health performance specific dash-board, and there was now one in draft. However she was now relying on support from IT within the trust to implement this.

4.6.12 Medical rotas are administered without any consultation from medical staff working on the rota by a trust administrator. The review team heard that some juniors and trainees are always rostered for certain days,

which consequently means they always miss available teaching. There was also comment that junior doctors and middle grades can find fixed annual leave problematic.

4.6.13 There is a central system for complaints within the trust. The patient experience team coordinate complaints, which they will then forward to the appropriate specialty coordinator and the clinical lead. Responses to the complaints are then reviewed and approved by the matron, checked by individuals within the specialty and with the patient experience team. The review team heard that nearly all complaints were responded to by the trust deadline, and a formal extension would be requested if required. The review team commended the robust complaints and patient experience procedure across the trust.

5 The Implications of the Proposed Service Redesign

The review team heard and saw a presentation, from senior personnel responsible for strategic development, which detailed options for reconfiguration and relocation of paediatric and neonatal services (para 3.3) Whilst the review team appreciate that the trust does not want to confirm a decision on the preferred option to staff until a decision is final, the lack of knowledge surrounding such decisions was causing anxiety for some staff. There was a very significant difference between and within staff groups regarding their perception, knowledge and awareness of trust wide and more local divisional reconfiguration options and plans.[4]

5.1 The medical and nursing workforce implications

5.1.1 Consultants across the three sites had mixed reaction to the reconfiguration plans, but most wanted to be engaged and involved in any long term changes. However the review team were given the impression that consultants across the three sites had not communicated well together and were not working on forward planning and mapping activity as one effective consultant body. Strategic leadership roles should be clarified to avoid conflict amongst the various staff groups and to ensure cooperative and effective operational leadership of the children's health team. The ambition being to forge a service which recognises the need to work together, across the trust, to improve services for children

[4] Presentation referred to is the: Acute Paediatrics and NICU/SCBU overview, Dr Rfidah, 15 January 2015

5.1.2 Whilst the review team cannot comment in detail on the proposed options for a single acute site, a consolidation of services onto a single site may offer the opportunity to address the challenges identified by this review. The consultant body is a significant number, in breadth of skills and in experience. Consequently a compliant consultant rota with extended hours of working would be achievable with consolidation to a single site.

5.1.3 Leaving services as presently constituted would require the trust to make a further significant investment in the services provided for children, including increasing the medical and nursing establishment to meet all RCPCH and RCN standards, and a radical redesign of the emergency pathway to meet the standards for children and young people in emergency care settings.

5.1.4 If all acute services are re-located to a single site, an improved consultant delivered service could be implemented within the current consultant staffing, with greater supervision and development of trainees. Similarly, provision of senior, experienced nurses on all shifts and more flexibility in nurse staffing would be possible.

5.1.5 There is scope to redistribute staff from some sites onto those of greater, more acute activity. For example staff could be moved from the sites at Dover and Canterbury onto the acute sites at Ashford and Margate to mitigate some of the risks identified at the two acute sites but this would not address all the problems identified in the emergency pathway. There must be consultation with the commissioners, as well as mapping of the required competencies for medical and nursing staff to provide the appropriate care.

5.1.6 Once the reconfiguration decision and design has been confirmed, the paediatric consultant body should work as one unit to map and consider how to provide the highest standard of consultant led and delivered acute care for children and young people in East Kent.

5.1.7 The review team would recommend lead appointments for specific patient orientated services in a future reconfiguration and/or relocation, for example consultant leads for urgent and unbooked care, neonatal lead, paediatric lead, governance lead.

5.1.8 Improved teaching and training should be a specific goal in any reconfiguration. Currently trainee attendance at clinics is restricted. The quality of the specialist clinics at a teaching hospital is to be commended,

however if trainees cannot access these due to operational pressures, the benefit of such teaching and development in lost.

5.2 Meeting the needs of the Population

5.2.1 A single site could provide high quality services for the East Kent population, as a single site would enable the trust to become compliant in standards for children and young people. However access issues are likely to be a concern to some patients. The review team would recommend comprehensive analysis and mapping of ambulatory assessment hubs to ensure feasible, reasonable, safe and sustainable models of care.

A&E Attendances

Sum of CountOfPa	AE_Contract_Year			
Local_Site_Code	20122013	20132014	20142015	Grand Total
BHD	2969	3002	2386	8357
KCH	5797	5838	4086	15721
QEH	13654	13473	8957	36084
WHH	12882	12911	8812	34605
Grand Total	**35302**	**35224**	**24241**	**94767**

** aged under 16*

[5]

5.2.2 The ED attendances table exhibits that if the trust were to move to a single site emergency unit; there must be further consideration of the emergency pathway ensuring that in future it meets the standards for paediatric emergency care in a busy paediatric ED department. The 2014/2015 figures are still to be completed, however are likely to follow the 2012-2014 figures. The review team would expect the service to meet the staffing levels stipulated in the Standards for Children and Young People in Emergency Care Settings, 2012.

5.2.3 The review team did not have sufficient detail to judge the adequacy of transport arrangements which would be necessary to be developed for any redesign. The review team would recommend extensive mapping of activity and development to ensure transport options are safe and effective for child health care. Options should consider provision of such services by alternative providers other than NHS ambulance services.

5.2.4 The review team did not hear whether children, young people and their parents were participating in the reconfiguration planning. To meet the DH You're Welcome standards, RCPCH would encourage children and young people involvement from an early stage and the PREM tool may assist in seeking their views.

[5] A&E Attendances image cited from paediatric data, activity report, 2012-2015

6 Recommendations for Current Services

Staffing and activity

a) Increase the scheduled resident consultant presence in the evening and weekends in line with the 'Facing the Future' standards.

b) A review of consultant job plans and honorary contracts for special interest clinics outside the trust should be conducted to ensure the clinics are a resourceful and patient-centred way of maintaining the specialist services the trust requires.

c) The review team commends the nursing development within the trust. There should be continued development of APNP, ANNP and AENP posts with gradual inclusion in junior and middle grade doctor rotas, and consideration of nurse led clinics and discharges.

d) Consultants and junior doctors covering the neonatal intensive care unit should have responsibilities solely to that specialty. This will improve both the quality and safety of the service.

e) The trust should review children's nurse staffing against the 2013 RCN guidance to enable the trust to attain the minimum core standards and standards for education of nurses working in ambulatory care settings.

Emergency Care

f) The EDs at WHH and QEQMH should be adequately staffed with doctors and nurses to provide child centred care throughout the day and night, with staff trained in appropriate competencies. Each should have a lead RN Children's nurse and a lead nurse responsible for safeguarding, with one children's nurse per shift.

g) Paediatric nurses from ED and the ward should rotate to enhance their skill-mix and knowledge. This will require a combined approach between the management teams in child health and the emergency department.

h) The 'children attending A&E and MIU Units' policy should be updated to reflect the intercollegiate standards for children and young people in emergency care settings. The RCPCH can provide a self-

analysis template for the trust to check the emergency care provided against the intercollegiate standards.

i) The child health and ED management should work together to ensure all emergency care national guidelines are embedded into the ED and that medical and nursing staff are aware of how to access such guidelines.

Safeguarding

j) The safeguarding responsibilities of consultants should be reviewed and recognised in job plans. Named doctors need to have protected time with appropriate resources allocated to their role. Alternatively developing one named doctor role supported by colleagues (with protected time) across both sites for operational delivery would rationalise this aspect of the trust safeguarding services.

k) The named doctor needs increased resources to support colleagues and develop a rigorous system for peer review and supervision. The designated doctor role should be ring fenced as an external role in line with statutory and intercollegiate guidance.

l) An on-call rota for safeguarding medicals should be developed and implemented for the child health medical workforce.

m) Child protection peer review sessions should be timetabled for paediatric medical and nursing staff groups, as this can ensure shared learning and exposure to child protection cases.

Procedures and guidelines

n) Urgent attention to the SharePoint system is required. The system either needs to be replaced with a more user friendly system to access governance guidance and protocols, or the current system needs to be improved for user accessibility.

o) Guidelines, pathways, protocols and procedures should be reviewed and if necessary updated. Medical and nursing staff needs to be confident that they can quickly access current and up to date local guidance and protocols through a trust mechanism.

p) The trust should ensure that the designated leads for SharePoint are uploading and updating information for which they are responsible.

Leadership and management

q) There currently seems to be a lack of trust from operational staff regarding the divisional and wider trust strategies. The division should work alongside the EKHUFT HR to improve staff engagement in any service change or/and development.

r) Senior support should be given to developing a child health performance specific dashboard.

s) CCGs representatives should be invited to join the children's health board. Board agendas should be divided to ensure the strategic goals are delivered and operational issues delegated down to the individual operational committees or similar structures.

t) An internal review of paediatric and neonatal teaching time and content should be conducted. Audits should be allocated to junior and middle grades, with a clear expectation of format and timeframe.

Appendix 1 - Abbreviations

ANP – Advanced Nurse Practitioner
ANNP – Advanced Neonatal Nurse Practitioner
CAU – Children Assessment Unit
CCN – Children Community Nurse
COW/COTW – Consultant of the Week
CQC – Care Quality Commission
DH – Department of Health
ED – Emergency Department
ENP – Emergency Nurse Practitioner
EKHUFT – East Kent Hospitals University NHS Foundation Trust
ENT – Ears, Nose, Throat
F1/F2 – Foundation Doctor Year 1 / Year 2
GMC – General Medical Council
HCA – Health Care Assistant
HDU – High Dependency Unit
'Junior Doctors' – SHO's / Tier 1 / ST1-3
KCH – Kent and Canterbury Hospital
Middle Grades – Registrars / Tier 2 / ST4-81
MIU – Minor Injury Units
NICE – National Institute for Health and Care Excellence
NICU – Neonatal Intensive Care Unit
RCPCH – Royal College of Paediatrics and Child Health
RCN – Royal College of Nursing
RCA – Root cause Analysis
RSA – Radom Safety Auditing
QEQMH – Queen Elizabeth the Queen Mother Hospital
SHO – Senior House Officer
SCU – Special Care (Baby) Unit
WHH – William Harvey Hospital
WTE – Whole Time Equivalent

Appendix 2 - Reference documents

The following standards are relevant and/or referenced in the review

Facing the Future – a Review of Paediatric services (RCPCH 2011) details ten service standards relating to clinical cover, expertise and child protection. All units in the UK will have been audited in summer 2012 for compliance against these standards

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

Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services.

The role of the consultant paediatrician with subspecialty training in paediatric emergency medicine' (RCPCH Intercollegiate, 2008) explores the role of paediatricians with subspecialty training in Paediatric Emergency Medicine, and makes recommendations for how their skills can be most effectively utilised.

Defining staffing levels for children and young people, (RCN 2013), this guidance applies to all areas in which infants, children and young people receive care. The standards are the minimum essential requirements for all providers of services for babies, children and young people.

Safeguarding children and young people: roles and competencies for health care staff, (RCPCH, 3rd edition, 2014), this guidance outlines the safeguarding competences that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice.

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 guidance on competence development for nursing staff.

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, A&E departments and the ambulance service.

Guidance on the role of the consultant paediatrician in the acute general hospital (RCPCH May 2009) sets out a range of models of paediatric care including consultant of the week, resident on call and includes information on job planning, rotation and competencies for acute care.

Healthcare service standards in caring for neonates, children and young people (RCN 2014) sets out the standards to be applied when caring for neonates, children and young people in all health care settings. These standards cover employment issues, a multi-agency approach to care, community based services environment and facilities, safety, staffing levels and skill mix, safeguarding and education of the nursing workforce.

Service Standards for Hospitals Providing Neonatal Care, 3rd edition, British Association of Perinatal Medicine, this document complements and provides additional detail relating to the standards, guidelines and principles relating to different aspects of neonatal care.

Toolkit for High Quality Neonatal Services, (DH, 2009), the toolkit is designed to support the delivery of equitable, high-quality specialist neonatal services in England.

Standards for assessing measuring and monitoring vital signs in children and young people, RCN 2012 provides a policy index that outlines the policies that should be in place in organisations that undertake health related care for babies, children, young people and their families

Defining staff levels in children's and young people's services, RCN 2013, provides guidance on staffing levels requires for both general and specialist children's services in a range of healthcare settings.

The Reconfiguration of Clinical Services, The Kings Fund, 2014 provides insight into the drivers of reconfiguration and builds on major analysis commissioned by NIHR and a review of service reconfigurations conducted by NCAT.

Reconfiguring Hospital Services, Lessons for South East London, The Kings Fund, 2011 considers whether reconfiguration of services across hospital sites is an appropriate response to the need to drive up quality and drive down costs in the NHS in England.

Focus on: emergency and urgent care pathway for children and young people, NHS Institute for innovation and improvement, 2010 The NHS Institute for Innovation and Improvement has produced a document which has identified areas of innovative practice that are in the area of emergency and urgent care for children and young people which merit further study. There is no simple solution for all organisations, but there are a variety of valuable service improvement ideas in this document that could be selected and modified for use locally.

A whole system approach to improving emergency and urgent care for children and young people, NHS Institute for innovation and improvement, 2011, this document is designed, primarily, for teams and team leaders who are seeking a whole system approach to improvement which requires working across or outside our traditional organisational and professional boundaries.

You're Welcome, Quality criteria for young people friendly health services, DH, 2011 this criteria for young people friendly health services are based on examples of effective local practice working with young people aged under 20.

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

Audits
Activity (Child Health) and presentation data
Business Cases
Child Health audit plans
Child Health HR data
Child Health organisation charts
Complaints Data
Governance Minutes
Induction plans
Paediatric activity data and report
Staffing Rotas
Safeguarding board minutes
SWOT analysis
Template job plans

Appendix 3 Contributors to the report

The following staff were interviewed on the 14 or/and 15 January 2015

[redacted] – Consultant Paediatrician
[redacted] – Specialist Services Governance Lead
[redacted] – Interim Specialist Services Divisional Director
[redacted] – NICU Matron
[redacted] – Consultant Neonatologist
[redacted] – Head of Safeguarding Children
[redacted] – Specialist Services Divisional Director
[redacted] – Service Manager, Child Health
[redacted] – Consultant Neonatologist
[redacted] – Consultant Paediatrician
[redacted] – NICU Consultant
[redacted] – Senior Matron
[redacted] – Ward Manager, Rainbow and Dolphin
[redacted] – Consultant Paediatrician
[redacted] – Consultant Paediatrician and Designated Doctor
[redacted] – Chief Nurse and Director of Quality
[redacted] – Locum Consultant Paediatrician
[redacted] – Consultant Paediatrician
[redacted] – Child Health Clinical Lead
[redacted] – Consultant Paediatrician
[redacted] – Consultant Paediatrician
[redacted] – Child Protection Advisor
[redacted] – Paediatrics Matron
[redacted] – Consultant Paediatrician
[redacted] – NICU Consultant

Junior doctors and middle grade doctors from WHH and QEQMH were also interviewed during the visit.

Appendix 4 Paediatric Workforce Modelling

Modelling for increased consultant presence in single hospital unit

Assumptions used

1. Resident or present means consultant present in hospital, on-call means consultant at home

2. Current consultant presence = 9am to 5pm/weekdays plus 9am to 3pm at weekends i.e. 52 hours

3. When consultant presence, there is not a consultant on-call

4. On-call hours are paid for at 25% i.e. for a 12 hour on-call shift out of hours, 3 hours (1 PA will be paid)

5. There is tier 2 (middle grade) cover at all hours when consultant present.

6. Extended day working means 9am – 9pm /7 days per week

7. Core PA = 4 hours, Out of Hours PA = 3 hours

8. All other factors remain the same e.g. clinic commitment, number of SPAs undertaken

Modelling

Step 1: Calculate Weekly Resident PAs required for existing and extended models

	Core hours	OOH	Total Hours	Core PAs	OOH PAs	Total PAs
Existing	40	12	52	10	4	14
Extended	50	34	84	12.5	11.33	23.83
Increase	10	22	32	2.5	7.33	**9.83**

Step 2: Calculate decrease in on-call PAs required with increased consultant presence

	Core hours	OOH	Total Hours	Core PAs/4	OOH PAs/3	Total PAs
Existing	20	96	106	1.25	8	9.25
Extended	10	74	84	0.63	6.17	6.79
decrease	10	22	32	0.62	183	**2.45**

Step 3: Deduct reduction in on-call from increase in resident PAS = 7.38. PAs

Step 4: Allow for prospective cover

Consultant will only be present for 42 weeks, approximately 0.8 allowing for annual leave, study leave etc., therefore PAs required = 7.38 * 1/0.8 = 9.225

Step 5: Add SPAs for CPD, educational supervision, management duties, research etc., say 2 PAS

Additional requirement per unit to meet extended opening only = 1.125 consultant on 10 PA contract, i.e. 2.25 WTE consultants when considering 2 sites (William Harvey and QEQMH)

Additional factors for consideration

1. The calculations are based upon the requirement for general paediatrics only and do not include any provision for additional consultant time to undertake community, neonatal duties or work at other sites. For example we are aware that there is a requirement at William Harvey for "general paediatricians" to support the NICU rota (BAPM standards require 8 WTE consultants on a NICU rota, yet there is a 1 in 6 neonatal on-call rota). This would reduce availability for acute paediatrics and needs to be factored in when assessing future requirements

2. The calculations also only estimate the additional WTE required for consultant presence. They do not take account of the possible need to ease pressure on outpatient activity by increasing the number of outpatient clinics undertaken by the team as a whole. It is important that each consultant has an appropriate number of clinics and that they are contracted to undertake no more than 4 PAs of resident on-call duties, in line with the RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital (May 2009).

3. The RCPCH is developing a set of standards (Facing the Future Together for Child Health) due to be launched in April 2015, which among other recommendations, puts forward the development of immediate telephone advice (consultant hotline) systems for GP practices, rapid access clinics and closer, multi-disciplinary working with primary care.

4. Revised Facing the Future standards state that there should be 10 WTE staff on all training rotas. There are three Tier 2 (middle grade) rotas on 1:8, with five specialty doctors on the paediatric rotas. Current guidance states that 'It is possible to design rotas that are compliant with just eight

staff and in relation to neonatal medicine, where there is less daytime outpatient activity, rotas of this size may be entirely appropriate. However, for general acute paediatrics, eight cell rotas inevitably result in the use of internal locums, and therefore in practice are not sustainable.' Updated guidance (due for publication in April 2015) states that Including SAS doctors on a rota allows a rota with 5 SAS doctors and three trainees, therefore the rotas as currently constituted would appear to comply with the new guidance.

5. The model calculates that the requirement for consultant general paediatricians for the existing model of working would be 7.0 WTE. Given that at the William Harvey, there are currently only 5 general consultant paediatricians plus 2 who work in community, and some of these consultants cover at other sites (Kent and Canterbury, existing provision is stretched.

6. The factors in 1-5 all illustrate that there is an additional requirement surplus to the calculation of the extra 2.25 consultant WTE needed for extended working and although it is difficult to precisely quantify, RCPCH would recommend that an additional 3.0 WTE acute consultants would more appropriately reflect current and future demand.