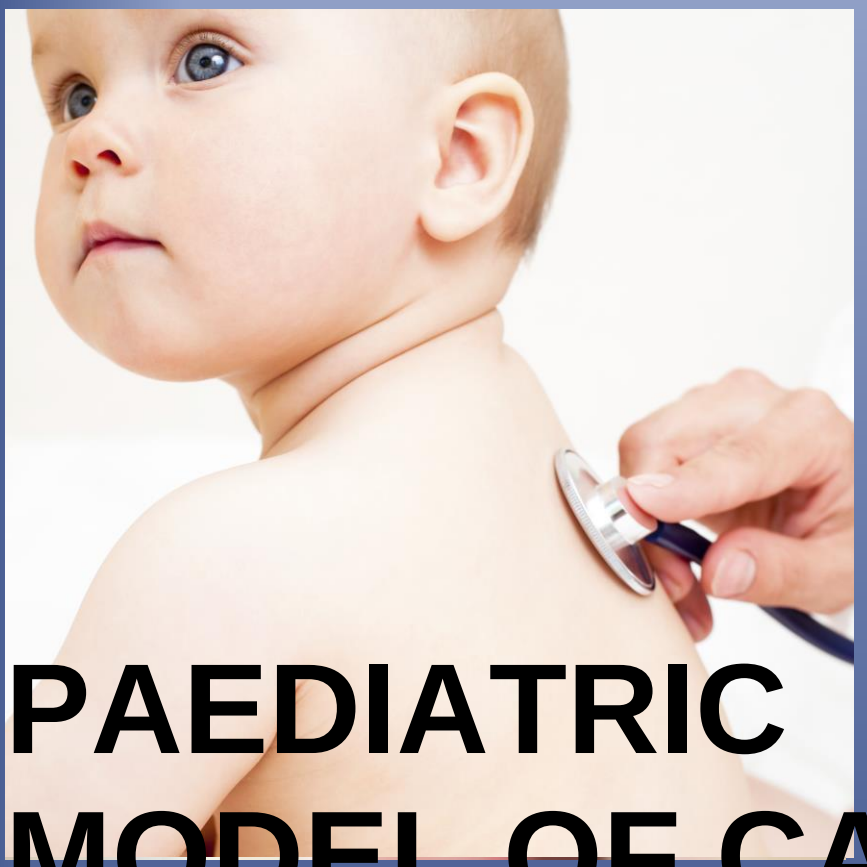
NHS
Northern England Clinical Senate



PAEDIATRIC MODEL OF CARE IN NORTHUMBRIA SPECIALIST EMERGENCY CARE HOSPITAL

North of England Clinical Senate Review

December 8, 2014

Contact Details

Northern Clinical Senate Office
Waterfront 4
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY
Tel: 0113 825 3039
Email: england.northernclinicalsenate@nhs.net
Web: www. nesenate.nhs.uk
Review Chair :Dr. Suresh Joseph
Senate Chair : Prof. Andrew Cant (Contact: gale.roberts@nuth.nhs.uk)
Senate Manager: Lynda Dearden (Contact: Lynda.dearden@nhs.net)
Senate PA: Seema Srihari (Contact: seemasrihari@nhs.net)

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Summary

This report presents the Northern Clinical Senate's suggestions to the NHS North Tyneside and Northumberland Commissioning Groups (CCGs).

Purpose of Clinical Senates

- Support commissioners to make the best decisions about health care for the populations.
- Bring together a range of health and social care professionals, with patients, to take an overview of health and healthcare for local populations.
- Provide a source of strategic, independent clinical advice and leadership on how services should be designed to provide the best overall care and outcomes for patients.
- Provide clinical advice to inform the NHS England service change assurance process

Context/background

Previously when NHS North of Tyne consulted about the services to be provided in the Northumbria Specialist Emergency Care Hospital (NSECH) it concluded that paediatric care would be provided through Accident &Emergency and in an Short Stay Paediatric Assessment Unit (SSPAU) at the Emergency Care hospital at Cramlington, but that its detailed operating model would need further clarification between commissioners and Northumbria Healthcare NHS Foundation Trust (NHCFT). This was the position inherited by the in-coming CCGs in 2012/13.

Work has taken place between the CCGs and NHCFT to agree a service delivery model in preparation for the opening of the NSECH in 2015. It is assumed that the proposed model met with the four tests set out by the previous Secretary of State.

The Clinical Senate was asked to comment (as part of the NHS England assurance process for service change) on a change to the service model already consulted on for the delivery of paediatric care that can provide rapid assessment, short stay assessment and where observation, investigation and treatment can safely be carried out in a child focussed environment at the new Northumbria Specialist Emergency Care Hospital (NSECH) due to open in July 2015. This included an overnight stay but less than 24 hours.

The Review team have considered the information made available in the documents provided, in accordance with the agreed terms of reference.

Based on this the senate review team have identified a number of themes which require further consideration about the model as proposed, and have made some suggestions (page 12) to the CCGs as to how these issues might be addressed.

The Clinical Senate would be happy to offer assistance (if required) at a later date.

Terms of Reference

The process to formulate advice was led by Dr Suresh Joseph, Vice Chair of the Northern Clinical Senate. Draft terms of reference were developed in discussion with the NHS North Tyneside and Northumberland Commissioning Groups (CCGs). The terms of reference were also agreed at Senate Council meeting 6th October 2014.

(Appendix 2 – Terms of Reference)

Review Process

Requiring total objectivity and having an awareness of organisational sensitivity an independent review team was drawn from regional paediatricians and neighbouring senates for their relevant expertise in the area under review to explore the issues and formulate this advice. We are very grateful to everyone involved for the time they committed and the level of enquiry, expertise and objectivity that they brought. We are also very grateful to the CCG's for the information they provided and for the flexibility they showed in making time to see us and for the openness with which they shared their views.

Review Team

Name	Review Team membership	Title	Organisation
Suresh Joseph	Chair of Review Team	Clinical Senate vice Chair and Consultant Psychiatrist	Northumberland Tyne and Wear Trust
Geoff Lawson	Review team member	Clinical Lead for Child Health SCN	City Hospitals Sunderland NHS FT
David Shortland	External Reviewer	Quality lead for Paediatrics , Poole Hospital	Royal College of Paediatrics and Child Health
Richard Parker	External Reviewer	Director of Nursing	Doncaster and Bassetlaw NHS FT
Jeff Perring	External Reviewer	Director of Intensive Care	Sheffield Children's Hospital NHS FT
Lynda Dearden	Review team member	Network Manager	NHS England
Jonathan Smith	Review Team member	GP	NHS Durham, Dales, Easington and Sedgefileld CCG
Fran Toller	External Reviewer	Managing Director Women And Children's Centre	South Tees Hospitals NHS Foundation Trust

Background Information provided by CCG's

A range of documentation was made available to the Senate Review Team by the sponsoring organisations and was presented via email over a period of 4 weeks.

All documents are included in Appendix 1 and Appendix 3

- Paediatric Short Stay Assessment Unit at NSECH , Operating Model April 2014
- Joint Locality Executive Board paper Agenda item 6.2
- Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011.
- You're Welcome: Quality criteria for young people friendly health services, Department of Health, April 2011

Further information was presented at the request of members of the review team.

- NHCFT data analysis of pathways
- NHCFT paediatric admissions information
- NHCFT paediatric activity (01/10/2012 – 30/09/2013)

The review team came together on the afternoon of Monday 8th December 2014 to discuss the information and met with two senior members of the CCGs to ask questions relating to the proposed service. **(Appendix 4 – Agenda of the Meeting)**

The Senate Review panel met with the following people:
Dr Ruth Evans (Clinical Director, NHS North Tyneside CCG)
Ms Julie Ross (CEO, NHS Northumberland CCG)

Timescales

October – December 2014
3 stages
Desk top review of background and supporting information
Identify additional queries
Review team to meet 8/12/14 to collate responses
Report to CCGs end of December 2014

Limitations

Not to revisit work carried out by the previous NHS North of Tyne Primary Care Trust cluster.

Emerging Themes

In addressing the main task identified in the terms of reference the Clinical senate review has identified a number of issues relating to the proposed service model, which we advise should be clarified prior to commissioning the service. These are grouped under a number of themes. The Review Team fully recognised the need to not reopen the consultation undertaken by NHS North of Tyne
It should be noted that the conclusions below are based upon the information provided, as appended in this document. It may be that other information is available to Commissioners that adequately addresses the issues raised by this report.

The themes are as follows:

1. **Limitations of data upon which the planning assumptions appear to be based:**
   Plans for the proposed service appear to be based upon relatively limited data, given the significance of the proposed change, especially in terms of bed numbers and alternative provision: We understand that there are currently 18 beds at North Tyneside, which will close with the opening of the SSPAU at NESCH. Data provided (Paediatric admissions information Nov 12 – Oct 13) indicates that 365 of 397 admissions between 8am and 8 pm over this period were to Northumbria units. Of these 60% were "zero day length of stay" i.e. less than 24 hours. Accepting that these patients will be adequately cared for by the new SSPAU, it is necessary to consider the alternative provision for the other 40% of admissions requiring longer stays. This group of patients use in excess of the 40% of currently available bed capacity owing to their longer lengths of stay.

   No analysis has been made available as to the arrangements for this group of patients, in terms of alternative community provision or bed provision. We are advised that there are currently bed pressures for this group of patients across the region.
   We therefore advise that Commissioners satisfy themselves that alternative measures to cover current demand are in place. The Review team felt it likely that some additional bed provision may be necessary in Newcastle in the wake of the closure of beds at NTGH; the numbers depending upon further analysis of the patient groups currently using the service. It is of course essential that this discussion involve GNCH and the Newcastle Hospitals NHS Foundation Trust.

   Northumbria Healthcare NHS FT has commented as follows: "Further analysis has taken place I relation to those identified as 1 night stay. This data means that they are in bed at midnight and are discharged the following day. It is anticipated that the needs of this group of patients will be met in the SSPAU. The assumption that the needs of 40% of those presenting cannot be met is incorrect. We believe it is about 20%, but with changes in practice and the development of CCN team we hope to reduce that further."

2. **Implications of hours of opening for patient demand**

There is lack of clarity as to the exact hours of opening of the service. This needs to be considered especially in the context of consultant availability, as RCPCH guidance emphasises the importance of consultant presence to the effective functioning of SSPAUs.

The stated staffing model indicates that consultants will be available until 9 pm with a middle grade doctor until midnight and an APNP 24/7 (staffing correction provided by Northumbria Healthcare NHS FT).

Data provided (operating model paper and Northumbria FT paediatric admissions 01/10/12 to 30/09/13) indicate that significant numbers of children arrive at A&E between 6pm and 8 pm and indeed after 8pm. These patients, if referred to the SSPAU, will typically arrive about 2 hours later (source: Paediatric Emergency Activity data 01/10/12 - 30/09/13 provided). Therefore a significant number of children will arrive in the SSPAU after the consultant has left.

There is also conflicting information regarding the hours of operation envisaged. The Operating Model paper states that the unit will close at 11pm. It is the view of the review team, due to the time taken for an assessment, this would mean that effectively the unit would close to new admissions by 10pm at the latest. From the activity data this would be in the middle of the second peak of activity (2000 to midnight) and therefore inadvisable. Consultant availability has also been referred to above.

It is also not clear what procedure will be followed for children who present after 11pm. It is stated that children will be assessed in A&E and either transferred to GNCH or observed in an ambulatory care setting (Operating Model), and NHS 111 and Ambulance will bypass between 11pm and 8 am. However data provided suggests that a number of children self present during these hours and clear guidance needs to be in place for these situations.

3. **Functions of the Unit after 11 pm**

The Operating model envisages that the unit will remain open and staffed between the hours of 11pm and 8 am, though no assessments and admissions will take place. The rationale for this arrangement is unclear. It is the view of the review team that no admissions can take place after 10pm at the latest (for reasons set out above). Children seen prior to 11pm will presumably require assessment as to whether they can safely be managed overnight at the SSPAU or will require transfer to GNCH. No evaluation has been provided as to the likely numbers and types of patients requiring this overnight service. The Review team feel that clear guidance is necessary to cover this aspect of the service. Without such clarity we are concerned that, especially in a context of bed pressures, there may be unplanned extension and development of the functions of the service, resulting in patients with increasing dependency and acuity remaining on the site; this could potentially create difficulties if the unit has to deal with situations other than those for which it is planned and staffed.

Note: Northumbria Healthcare NHS FT has responded to the above, stating that children presenting to A&E after 11pm will still be assessed by A&E staff and the APNP as part of the emergency care pathway.

4. **Staffing of the Unit**:
   It is unclear what the total staffing model for the SSPAU is. CCG representatives who attended felt that this was a provider issue. However the Review team felt that as this was a new service the whole model should be agreed and reviewed in order to ensure appropriate cover and that commissioners may be assured of sustainability of the service. Points relating to consultant availability in the context of demand have already been made above.

5. **Staffing sustainability**:
   The Review team had significant concerns in this regard. Senior Paediatricians on the team expressed concerns about consultants being prepared to work long term in a unit where they would not be able to admit any patients. There are issues about skill loss and resignation of consultants working in this setting. We did not receive any documentation anticipating this or advising how this may be addressed. These concerns would also apply to senior nursing roles such as APNPs. We would strongly recommend a networking arrangement with Newcastle and/or other nearby units to address these issues.

6. **Consultation with partners**:
   No unit can exist in isolation and an SSPAU must be seen as an element within an overall regional pathway that ensures all foreseeable needs of sick children are met. In the case of the proposed unit, it is most important that discussions take place with GNCH regarding capacity, bypass arrangements and rotational arrangements to ensure sustainability of medical and nursing skills and training opportunities. These discussions may well have taken place but we are not aware of such discussions or firm plans, apart from a meeting involving paediatricians from the two Trusts. We believe it is essential, in the interests of continued excellence of provision in the region, that Commissioners and the relevant Trusts facilitate these discussions. NEAS is another important partner and we would suggest the CCG's seek explicit confirmation that appropriate discussions regarding ambulance capacity for transfers, bypass arrangements etc. have taken place.

   Note: Comments and suggestions have also been received from the Clinical Directors at the Great North Children's Hospital. It is anticipated that these comments and suggestions will form part of the ongoing discussions as the model of care is implemented.

Suggestions

The senate would encourage the following steps:

- It would be helpful to have a clear 'visual' and detailed pathway drawn out describing clinical case scenarios/examples

- To have a fully developed workforce model describing staffing numbers, responsibilities, how skills will be maintained including the role of the advanced practitioner. Matching the workforce with the demands of the service and to be sure that there are appropriate numbers of staff to cope with the peaks of workload.

- Liaison with the Deanery to gain their perspective on whether they will still send trainees to this service.

- To clarify and clearly demonstrate an integrated service level agreement with Newcastle Hospitals NHS Foundation Trust

- To develop a network of paediatric clinicians working across Trusts

- To describe how rotas will work and 'on call' cover

- Given reduction in beds how will alternative models operate

- To have a clear understanding of ambulance service provision and diverts

- Clearly map the needs of the service and understand expected activity
    - What proportion of A&E attendances are expected to go to SSPAU
    - What proportion are expected to have an overnight stay at SSPAU
    - How many will be required to go to Newcastle

Glossary of Acronyms

A&E	Accident and Emergency
APNP	Advanced Paediatric Nurse Practitioner
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
GNCH	Great North Children's Hospital
NEAS	North East Ambulance Service
NSECH	Northumbria Specialist Emergency Care Hospital
NHCFT	Northumbria Healthcare NHS Foundation Trust
SSPAU	Short Stay Paediatric Assessment Unit

Review Panel members

Dr Suresh A. Joseph MBBS MMedSc FRCPsych
Vice Chair, Northern Clinical Senate

Dr. Joseph is a psychiatrist who in addition to his clinical role has contributed in the areas of professional and clinical leadership, service redesign and development, and postgraduate training, having held senior positions in NHS management and in the Royal College of Psychiatrists. He was Executive Medical Director of Northumberland, Tyne and Wear NHS Foundation Trust, one of the largest mental health and disability healthcare organisations in the UK, between 2007 and 2014. He led on clinical and quality governance and safety of services, service development and innovation, and the development of the medical workforce. Prior to this he contributed at regional and national levels as Hon. Secretary of the Faculty, RCPsych., Convenor for psychiatric training schemes in Scotland, Programme Director and Postgraduate Tutor for Psychiatry in the Northern Deanery.

He has wide experience of service development and redesign, having led large-scale change projects in Newcastle and Sunderland. He initiated a comprehensive review of service models for his Trust leading to an ongoing service transformation programme. He is trained in change methodology in the North East Transformation System, in association with Virginia Mason Hospital in Seattle, and in the NHS Institute's Large Scale Change programme.
Through his experience as Medical Director and Responsible Officer of a large NHS Trust, he has expertise in establishing and operating medical professional development and regulatory systems, carrying out complex investigations into serious incidents and concerns about professional practice.
He is a medical member of the First Tier Tribunal (Mental Health). He has supported NHS Trusts in improving systems for the Mental Health Act and provides mentoring for clinical leaders.

Mr Richard Parker

Richard Parker is Director of Nursing, Midwifery & Quality at Doncaster and Bassetlaw NHS Foundation Trust and a clinical member of the Yorkshire and Humber Clinical Senate. Richard began his career as a student nurse, qualifying as an RGN in 1985. Richard was appointed Deputy Chief Nurse at Sheffield Teaching Hospitals in 2005, Deputy Chief Operating Officer in 2010 and then Chief Operating Officer in 2013. He held that position until joining DBH in October 2013. Richard has a special interest in ways of ensuring that nurse staffing levels are safe, appropriate and provide high-quality patient care. He gained an MBA (Health and Social Services) in 1997 from Leeds University and the Nuffield Institute for Health and his dissertation was on acuity, patient dependency and safe staffing levels.

Dr David Shortland MB. ChB. MD. DCH. FRCP. FRCPH

Dr. Shortland was appointed as a Consultant Paediatrician at Poole Hospital in Dorset in 1989 having trained at United Bristol Hospitals, Great Ormond Street Hospital, Leicester University Hospital and Queens Medical Centre, Nottingham.

He was dually accredited in general paediatrics and neonatology.

He was appointed as lead neonatologist at Poole and was instrumental in developing the Special Care Unit into the Neonatal Intensive Unit with full supporting facilities. Three years after becoming a consultant , he was appointed as Clinical Director and was responsible for managing the acute, neonatal and community paediatric services. He was the lead clinician for the rebuild of the paediatric department in 1995.

In 2001 Dr Shortland joined the RCPCH Clinical Directors Special Interest Group becoming Chair of the group two years later. In 2006 he was elected to the post of RCPCH National Workforce Officer. He led on the 2007 National Workforce Census and was College lead for developing strategy for the European Working Time Directive.

In 2009 Dr Shortland was elected to the post of RCPCH Vice President (Health Policy) and for five years he has had a central role in developing strategy for Child Health Services in the United Kingdom. During this time 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. He led a national audit of these standards in 2013.

In 2014 he was appointed as Quality Lead for the Paediatric Department at Poole Hospital. He is currently leading a project on behalf of the RCPCH, working with a number of other medical Colleges, to define standards for urgent care services for children in the U.K.

He has an MD thesis (awarded by the Bristol University in 1992) and has 29 publications in Peer Review Journals.

Mrs. Lynda Dearden

Lynda Dearden is the Network Manager for the Maternity and Child Health Strategic Clinical Network (NESCN) She also covers a programme of work around long term conditions and end of life care. Lynda has worked in the NHS for over 30 years, in a variety of clinical settings and senior management roles. She is also the acting Manager for Northern Clinical Senate.

Dr. Geoff Lawson

Dr. Lawson has been a consultant paediatrician in Sunderland since 1991, and Clinical Director for Children's Services since 1994. He was intimately involved with the reconfiguration of acute general paediatric services South of Tyne which was implemented in November 2012. Dr Lawson was the RCPCH regional representative for the Northern Region for five years and College Policy Officer for 3 years during which time he chaired a group leading on reconfiguration of acute services; this work resulted in the core of "Modelling the Future" (2006) which later became an essential strategy within "Facing the Future".

Dr Jeff Perring MB ChB. MD. BSc. MA. FRCA

Dr Perring qualified from the University of Liverpool in 1988 and specialised in Anaesthesia before moving into Paediatric Intensive Care. He became a substantive Consultant Paediatric Intensivist at Sheffield Children's NHS Foundation Trust in September 2002 and

Director of the Paediatric Critical Care Unit (PCCU) in 2007.
Since becoming Director, Dr Perring had led the PCCU through major changes including the development of a High Dependency Unit, the introduction of Advanced Nurse Practitioners, the Trust's designation as a Paediatric Major Trauma Centre and the establishment of Embrace, the Yorkshire and Humber Infant and Children's Transport Service.

He is joint lead for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network and vice-chair of the Yorkshire and Humber Clinical Senate. He is also member of the Paediatric Intensive Care Clinical Reference Group and Honorary Secretary of the Paediatric Intensive Care Society.

Dr. Jonathan Smith, GP

Dr Smith has been a full-time GP in the Easington area since 2008, and has had heavy involvement with quality improvement and pathway work in Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group (CCG) where he is a member of the Governing Body and Locality Leadership team. He is also currently the DDES CCG Clinical Champion for Paediatrics. Dr. Smith has been a member of the Northen clinical Senate since 2012.

Ms. Fran Toller

Fran Toller has been the Managing Director of Women and Children's Centre, South Tees Hospitals NHS Foundation Trust for the past 10 years. She is a trained nurse and midwife; and worked as Head of Midwifery at South Tees NHS Foundation Trust before taking the current post. She had been involved in a lot of change management at the Trust; and had led the trust element of reconfiguration of Children's services at Friarage Hospital; she had also led a number of maternity reconfigurations. She has previous experience in establishment of a SSPAU in line with the relevant RCPCH guidance.

Appendices

Appendix 1

Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011.

You're Welcome: Quality criteria for young people friendly health services, Department of Health, April 2011

Appendix 2

Terms of reference

Appendix 3 Background material

Paediatric Short Stay Assessment Unit at NSECH , Operating Model April 2014

Joint Locality Executive Board paper Agenda item 6.2

NHCFT paediatric activity (01/10/2012 – 30/09/2013)

NHCFT data analysis of pathways

NHCFT paediatric admissions information

Appendix 4

Review Meeting Agenda

Facing the Future:
Standards for Paediatric Services

April 2011

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

Facing the Future: Standards for Paediatric Services

April 2011

(First Published December 2010 and amended by RCPCH Council March 2011)

RCPCH

Royal College of
Paediatrics and Child Health

Leading the way in Children's Health

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1. Introduction

All children and young people who require it should receive high quality care, delivered by trained and competent professionals in a timely manner and in appropriate settings. The purpose of this document is to set out a series of service standards that will ensure that such excellent paediatric care is provided.

It is written against a background of a significant financial crisis in the UK, large-scale workforce pressures in many inpatient paediatric units, relatively poor health outcomes for the UK childhood population,[1] and inadequate provision in many aspects of children and young people's healthcare.[2] Given this backdrop, the Royal College of Paediatrics and Child Health (RCPCH) does not believe that to continue as we are is an option. The College must face the future and so we propose what we consider are a set of minimum standards for paediatric services. Whilst the RCPCH has little influence with the current funding problems for the NHS, it has a responsibility and ability to influence the quality of the service that is provided.

In this document the RCPCH specifies ten service standards, all of which have been approved by the College Council. The College considers the standards to represent a minimum requirement for all acute general paediatric services. Each standard is accompanied by an explanatory text that indicates in more detail what the standard is seeking to achieve, and how it will be implemented.

The RCPCH recognises that the implementation of these standards may cause transitional difficulties for some services. However, the rewards of achieving these standards are considerable. All children and young people seen in paediatric departments will receive high quality consultant delivered care,[3] their health outcomes will improve, there will be greater efficiency, and so some of the problems highlighted by Sir Ian Kennedy's report into children's healthcare will be addressed.

In his report, Sir Ian described children and young people's healthcare as a "Cinderella" service. It is the College's view that unless this crisis in paediatric services is addressed the health of children and young people in the UK will continue to suffer and we will not stand by and let that happen.

1. A*n overview of child well-being in rich countries. (UNICEF: 2007)*. Available at unicef-irc.org (accessed 24th April 2010); *Wellbeing and Child Poverty: Where the UK stands in the European Table?* (Child Poverty Action Group, Spring 2009) Available at: cpag.org.uk (accessed 24th April 2010)
2. Kennedy, Professor Sir Ian, *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs* (Department of Health, September 2010) Available at dh.gov.uk (accessed 1st October 2010).
3. Temple, Professor Sir John, *Time for Training: A review of the impact of the European Working Time Directive on the quality of training.* (MEE: May 2010) Available at mee.nhs.uk (accessed 10th July 2010)

2. RCPCH Service Standards

The following section specifies the 10 service standards that the RCPCH believes should be achieved by all acute, general paediatric services. The College considers these standards to represent a minimum requirement and they are all underpinned by the principle that consultants are responsible and accountable for the children and young people admitted under their care. The standards are first listed and then an explanatory guide to each one is provided in the subsequent section.

The standards were developed using a review of the relevant literature and consultation with paediatricians. Three of these standards have already been adopted by the College and published in its manifesto (Standards 1-3). Standards 7,9 and 10 were developed in consultation with the relevant specialist groups and represent consensus decisions. Standards 4,5 and 6 emerged from our review of the literature. Standard 8 is a recommendation of the Academy of Medical Royal Colleges and is partly based on published evidence.

It is the College's intention to initiate a national audit program against these standards in due course.

1. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.**

2. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care), within the first 24 hours.**

3. **Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.**

4. **All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.**

5. **At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).**

6. **A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.**

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

8. **All general acute paediatric rotas are made up of at least 10 WTEs, all of whom are EWTD compliant.**

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

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

Explanatory Guide to Standards

The Temple report concluded that consultant-delivered, as opposed to consultant led or consultant-based, care was the only viable model for the future of medical care in the UK. There were a number of reasons for this but most importantly the simple fact that consultants "make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality."[4] The Temple report defines consultant-delivered care as "24 hour presence, or ready availability" and it is this model of service that underpins many of the service standards.

1. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.**

2. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first twenty four hours.**

It is important to recognise that these two standards apply to acute rather than elective admissions, and also they refer to admissions to paediatric departments rather than mere attendance at, for instance, emergency departments. The College would expect doctors on the middle grade rota to be those who are judged to have achieved level 1 competences of the *RCPCH Framework of Competences*. This would normally mean those working in posts at ST4 or above. In units where there are just two tiers of medical cover this will not be possible and the consultant should be resident when it is judged that any member of the tier 1 rota e.g. paediatric trainee, GP trainee or advanced children's nurse practitioner, does not have the basic competences of recognising a sick child and being able to initiate treatment for paediatric emergencies. When a resident rota has trainees of ST1 or ST2, who have not yet achieved level 1 competences, our first service standard would ensure that all children and young people admitted with an acute medical problem would be seen by a paediatrician on the consultant rota within 4 hours of admission.

4. Temple, Professor Sir John, *Time for training*, p41.

If the most senior resident doctor is at ST3 level the College would recommend that

the consultant review takes place within 12 hours of admission rather than 24 hours. The admission time is taken to be the official time of admission to the paediatric department rather than, for instance, the time of presentation to the emergency department or the time of referral to the paediatric department.

For SSASG doctors to be considered as "consultant equivalent" they should successfully revalidate at this competency level through the RCPCH or a similar approved partner scheme. The RCPCH encourages SSASG doctors to develop competencies throughout their career and to take the MRCPCH exam if they wish to do so. The RCPCH also supports the provision of at least 1.5 SPAs each week for SSASGs to have adequate time for CPD and preparation for revalidation. In addition, they must have a mutually agreed named consultant who, at least as part of an annual appraisal process, has assessed them as competent to work on the consultant rota.

The RCPCH recognises that implementation of the second of these standards will need consultant rounds at least once per day, and ideally twice per day, seven days per week. However, the College believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality.[5]

3. **Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.**

In contrast to standards 1 and 2, this standard concerns all children and young people referred for an urgent paediatric opinion whether the source of that referral is general practice, the emergency department or an SSPAU. The RCPCH would expect all children and young people to be seen by personnel with appropriate expertise. However, as a minimum the College would expect all cases to be discussed with a senior doctor or nurse as specified. This standard would preclude a less experienced doctor who has not achieved level 1 competences in paediatrics sending a child or young person home who has been referred by a general practitioner without that child or young person being discussed with a more senior colleague.

Standards 1,2 and 3 were arrived at by consensus during extensive discussions by the RCPCH Council and Executive Committee.

4. **All SSPAUs have access to a paediatric consultant (or equivalent)opinion throughout all the hours they are open.**

The RCPCH is aware that not all SSPAUs have consultant presence during their opening hours. However, studies have shown that the availability of consultants can decrease the rate of unnecessary admissions without compromising patient safety or patient

5. McNeill G et al,'What is the effect of a consultant presence in an acute medical unit?', *Clinical Medicine* (June 2009); 9(3):214-8

satisfaction.[6] Therefore, it is our view that all SSPAUs should have consultants (or SSASG equivalents, see explanatory text to Standards 1 and 2) available for advice even if they are not physically present.

The College also would expect that any child or young person who is continuously present in an SSPAU for more than 8 hours will be discussed with a consultant or paediatrician on a middle grade rota to decide upon ongoing treatment and/or transfer.

Standard 4 is based on published evidence.

5. **At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).**

6. **A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.**

Implementation of the EWTD (European Working Time Directive) and the consequent transition to shift patterns of working have significantly reduced the continuity of care that junior doctors used to provide and increased the number of clinical handovers between medical staff. At the same time, junior medical staff have not always yet adopted the kind of structured handover process with which nurses are familiar. There is a growing body of evidence that clinically significant information can be lost during the handover process, and that this can lead to adverse outcomes for patients.[7] It is also well documented that the peak admission time for acute paediatrics is the early evening, 5-10pm, when traditionally the consultant has not been present. Consultant presence during this time would not only improve patient outcomes, but their presence during handovers would provide an excellent training opportunity for junior staff.[8] Hence, the College has specified these two standards in order both to improve patient safety and outcomes as well as facilitate the training of medical staff.

Standards 5 and 6 are based on published evidence.

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

With the introduction of EWTD, continuity of care has become a significant problem for inpatient care. The College believes that the most appropriate system to mitigate the effect of new working practices is to adopt a consultant of the week system in which the consultant has no other clinical duties during that week but is fully available for the management of acute admissions. Anecdotal evidence received by the RCPCH

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6. 'Positive impact of increased number of emergency consultants'. Geelhoed G et al, *Archives of Disease In Childhood* (September 2008); 93: 62-4.
7. Borowitz et al, 'Adequacy of information transferred at resident sign-out (in-hospital handover of care): a prospective survey', *Quality and Safety in Health Care* (2008), 17: 6-10; Clark et al, 'The PACT Project: improving communication at handover', *Medical Journal of Australia* (2009); Ye et al, 'Handover in the emergency department: deficiencies and adverse effects', *Emergency Medicine Australasia* (2007), 19:5:433-441; Carter et al, 'Information loss in emergency medical services handover of trauma patients', *Prehospital Emergency Care* (2009), 13:3:280 - 285
8. Temple, *Time for Training*, pp20,35,52.

has indicated that such systems have contributed towards WTD compliance, improved patient safety, created better continuity of care and better training, supervision and consultant support for trainees.[9] The College recognises that some consultant of the week rotas may include some SSASG doctors if recognised as competent to operate at this level (see explanatory text to Standards 1 and 2).

Standard 7 has a pragmatic base, and was arrived at consensually.

8. All general acute paediatric rotas are made up of at least 10 WTEs, all of whom must be EWTD compliant.

The EWTD mandated that no-one should work more than 48 hours per week on average. The subsequent SiMAP[10] and Jaeger[11] judgements have clarified the implications for junior doctors. The Academy of Medical Royal Colleges have stated that in order to protect adequate training time, as well as to cover for annual leave and recovery periods, 10 WTE doctors in a rota are required.[12] It is possible to design rotas that are compliant with just 8 staff and in relation to neonatal medicine, where there is less daytime outpatient activity, rotas of this size may be entirely appropriate.[13] However, for general acute paediatrics, 8 cell rotas inevitably result in the use of internal locums, and therefore in practice are not sustainable. The College does not believe that relying on junior doctors opting out of the directive is acceptable. An exception to this standard would be where resident consultants form part of the middle grade rota. In this situation, rotas with fewer trainees can be appropriate, sustainable and EWTD compliant provided there are the equivalent of 10 WTE's on the rota.[14]

Standard 8 is partly pragmatic, and partly based on published evidence.

9. *Children's and Maternity services in 2009: Working Time Solutions* (RCPCH, RCO&G, 2008). Available at: http://www.healthcareworkforce.nhs.uk (accessed 4th August 2010)
10. http://theCollegebarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Workforceplanninganddevelopment/Europeanworkingtimedirective/DH_4051942 (accessed 20th August 2010)
11. http://theCollegebarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Workforceplanninganddevelopment/Europeanworkingtimedirective/DH_4068970 (accessed 20th August 2010)
12. *Implementing the European Working Time Directive* (Academy of Medical Royal Colleges, 2004). Available at aomrc.org.uk (accessed 30th April 2010). See also Ahmed-Little, Y, Bluck, M, 'The European Working Time Directive 2009', *British Journal of Health Care Management* (2006) 12:12 pp374-376.
13. *Service Standards for Hospitals Providing Neonatal Care* (BAPM, August 2010)
14. *Delivering Safe Services: Consultant Delivered Care for Maternity, Paediatric and Neonatal Services* (Teamwork Management Services, 2008). Available at: healthcareworkforce.nhs.uk (accessed 13th August 2010). The College do also acknowledge that it is possible to design a compliant middle grade rota comprised of 7 trainees, and the equivalent of 2 consultants.

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

With increasing centralisation of specialist care and in order to facilitate appropriate long term condition management closer to the child or young person's home, it is imperative that local paediatricians have access to appropriate specialist advice in a timely manner, at least if unnecessary referrals and admissions are to be avoided. This standard aims to ensure that the local paediatrician, whether based in the community, an SSPAU or an inpatient unit, can access the specialist opinion that is needed when faced with acute problems in children and young people with complex and specialist needs. It is optimal if such advice is provided as part of a managed clinical network which encompasses all of the local secondary care providers. It is also important to stress that this standard does not apply when the presenting problem is not an emergency, nor does it apply to referrals from non-paediatricians who should, in the first instance, seek the advice of their local paediatric service.

Standard 9 was arrived at by consensus.

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

Standard 10 aims to ensure that any child or young person of 17 years or younger, presenting with child protection concerns, is appropriately assessed at an appropriate time by a competent paediatrician. This service must be available to all units on a 24/7 basis. As with all clinical presentations, the timing of the assessment is determined by the presentation and in child protection, the likelihood of finding and collecting forensic evidence.

An initial strategy discussion (with interagency colleagues) must take place in accordance with local safeguarding policies, as soon as practical and usually within 2 hours. Depending upon the needs of the child or young person (clinical, forensic and safety) the child or young person must be assessed and an opinion provided (which may be provisional depending upon further investigations and discussion) usually within 12 hours of presentation where there are recent injuries. The written medical document should be available within 3 days.

Specialist paediatric and forensic opinion should be available to all units within 4 hours for all acute sexual assaults and all unexpected child deaths. Paediatricians should act as the "single point of contact" for children's social care departments to articulate the concerns of the medical professionals involved with the family. They should attend initial and review conferences whenever there is likely to be a discussion of the interpretation of medical views or findings.

Standard 10 was arrived at by consensus.

3. Conclusion

At the start of this document, it was acknowledged that the current state of children and young people's healthcare in the UK is not adequate. Sir Ian Kennedy's recent report has highlighted a series of concerns about the way children and young people's healthcare is delivered. This document and series of service standards represents our first marker in the ground. Given the relatively poor health outcomes of our childhood population, we simply cannot ignore the problems before us anymore.

We have set out a series of service standards that we consider to be a minimum for acute, general paediatric services. This document is a first in a series of publications. Subsequent ones will explore the implications that these standards have for the configuration of paediatric services and the paediatric medical workforce. We also intend to develop standards for some subspecialty services. Our intention with them all is to fulfill our remit to set standards of safety and quality in an attempt to help raise the standards of care that are currently delivered to our children and young people. When adopted, these standards will ensure that children receive high quality, safe and sustainable healthcare whenever and wherever it is needed.

The College cannot implement these standards without the support and commitment of our members. We accept that some services may have difficulties in achieving all of the standards. However, if we believe that these standards will ensure a safer and better healthcare system for children and young people, we must ensure that all paediatric services are progressively developed to achieve them. The standards call for a greater degree of consultant presence than has hitherto been the case, and this will inevitably mean changes in working practices for some consultants. However, the College believes that adherence to these standards will bring a necessary level of consistency to what is currently quite a variable pattern of practice, and in the process ensure that every child or young person that warrants it receives appropriate review in a timely manner by a suitably experienced doctor.

We therefore do not just draw our members' attention to these standards, but also the government (including those of the devolved nations), commissioners and health boards, and NHS managers for it is their responsibility to ensure that the framework is in place for clinicians to work effectively and safely. It is imperative that some means to improve the quality of children and young people's healthcare is found and the College believes that the standards in this document represent a realistic opportunity to do just that.

Our vision is one where all children and young people who require it receive timely and appropriate care in settings as near as possible to their home delivered by well-trained and competent professionals. If the standards in this document are implemented then it is a vision which in due course could be realised and for that reason we commend them to our members.

Dr David Shortland, Vice President - Health Services, RCPCH
Professor Terence Stephenson, President, RCPCH

Royal College of
Paediatrics and
Child Health

5-11 Theobalds Road, London, WC1X 8SH

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Department of Health

Quality criteria for young people friendly health services

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Quality criteria for young people friendly health services - 2011 edition

Foreword from the World Health Organization

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Foreword

by Director of Child and Adolescent Health, World Health Organization, Elizabeth Mason

Young people: a global public health priority

There is growing evidence that a considerable number of young people are losing their lives every year, largely from preventable causes. In the European region alone, more than 300 young people aged 15-24 years die *every day* and globally the figure reaches 2.6 million per year. In addition to this death toll, substantially bigger numbers of young people experience health problems that affect their physical, mental and emotional well-being. Mental health problems, in particular depression, are the largest contributor to the global burden of disease among young people. In Europe, we estimate that almost one in ten 18-years-olds suffers from depression. Moreover, some risky behaviours that many young people engage in can contribute to health problems later in life. There are very visible examples. Alcohol use contributes to road traffic accidents, the largest cause of death among young people in Europe. Unsafe sex can lead to sexually-transmitted infections (STIs), including HIV, and unintended pregnancy. Seventeen million young women below the age of 20 give birth and an estimated 2.5 million abortions are performed on young women each year globally, many of which are unsafe.

There is also growing recognition that meeting the particular needs of young people needs to be a key component of national public health agendas. A growing number of countries in the World Health Organization's (WHO's) European region are drawing upon the experiences of non-governmental organizations, professional societies and young people themselves to build policies and programmes that address the health needs of young people.

In September 2009, WHO worked with partners to organize a regional meeting on youth-friendly policies and services in Edinburgh, Scotland. This meeting brought together representatives of more than 30 countries in the European region who shared their experiences in developing policies and reorienting health services to meet the needs and fulfil the rights of adolescents.

We are pleased to learn that the Department of Health, England has set out a clear set of quality criteria for youth-friendly health services in a document entitled *You're Welcome*, and is encouraging health service providers within and outside the National Health Service (NHS) to meet those criteria. The quality criteria are helping to provide a framework for change in how resources are allocated, and are helping ensure better health outcomes.

We are also pleased to learn that the Department of Health, England, working with the Royal Colleges of General Practitioners and of Paediatrics and Child Health, has developed an innovative e-learning approach to build the capacity of health workers, especially those who are the first point of contact with adolescents, to respond effectively to their needs.

We welcome this two-pronged approach to making health facilities and the systems they are part of youth-friendly, and to improving the abilities of health workers to respond to adolescents effectively, appropriately and with sensitivity. These approaches are evidence-based, and they have been shown to be effective in systematic reviews undertaken by WHO. They are also in

line with WHO's recommendations, and with the support that the Organization is providing to countries in the European region and beyond.

We are pleased to learn that initial experience suggests that the *Quality criteria for young people friendly health services* are informing and helping to shape decision making by local health authorities and commissioners. Early experiences are showing that the quality criteria are also helping to give young people a voice in the NHS and that their experiences and contribution to the overall health of the nation are valued. The successful pilot of the quality criteria in Primary Care Trust areas has led to their promotion by professional organizations as well as by the Department of Health. The quality criteria are providing a way to improve: the accessibility of services; the delivery of preventative approaches; and young people's ability to be actively involved in their own care. The English experience is showing that the criteria are being adopted by a wide range of healthcare providers. This includes services in the community (e.g. general practice, contraception and sexual health services, pharmacy, mental health services, ante-natal care) and in acute settings (e.g. in-patient and out-patient services, abortion service providers).

We believe that the concerted application of the *Quality criteria for young people friendly health services* will contribute to improving the quality and coverage of health services provided to adolescents in England, and to the reduction of inequities in access to health services.

Elizabeth Mason
Director of Child and Adolescent Health
World Health Organization
Geneva

December 2010

Introduction

All young people are entitled to receive appropriate health care wherever they access it. The Department of Health Quality criteria for young people friendly health services lay out principles that will help health services – both in the community and in hospitals – to 'get it right' and become young people friendly.

Services across England need to take young people's needs into account. This includes primary, community, specialist and acute health services. The Department of Health Quality criteria for young people friendly health services build on the Royal College of General Practitioners' initiative Getting it Right for Teenagers in Your Practice [1], which was supported by the Department.

The quality criteria cover ten topic areas:

- accessibility
- publicity
- confidentiality and consent
- environment
- staff training, skills, attitudes and values
- joined-up working
- young people's involvement in monitoring and evaluation of patient experience
- health issues for young people
- sexual and reproductive health services
- specialist child and adolescent mental health services (CAMHS).

The Department of Health Quality criteria for young people friendly health services are based on examples of effective local practice working with young people aged under 20. They should be applied to general and acute health problems, chronic and long-term disease management (such as specialist care for asthma and diabetes) and health promotion.

To support implementation of the Department of Health Quality criteria for young people friendly health services, a companion self review tool for health service providers will be made available in Spring 2011 at www.dh.gov.uk

[1] www.rcgp.org.uk/about_us/committees/medical_ethics_committee/about_the_committee/publications/policy_statements.aspx

Theme 1: Accessibility

This theme outlines how to ensure that services are accessible to young people. This section links with Theme 2 –Publicity.

1.1 Where there is a choice about service location, the service is accessible to young people by public transport

1.2 Young people can use the service at times convenient to them where possible.

1.3 When making appointments and attending consultations, young people may express a preference about:

a. Where they are seen
b. Who they are seen by
c. Attending with the support of a friend or partner
d. Who and how many people are present during discussion, examination and treatment
e. The gender of the member of staff they are seen by

1.4 Young people are routinely offered the opportunity to be seen on their own without the presence of a parent or carer

1.5 Where appropriate there are opportunities for self-referral and clear lines of referral to specialist services as required

1.6 Where required, arrangements are in place to enable young women with unplanned pregnancies to be seen immediately by another practitioner known not to have objections, to enable impartial discussion of options. Where any member of staff is ethically opposed to abortion, relevant professional guidance for those with conscientious objections is applied.

1.7 This service is provided in accordance with the Disability Discrimination Act (DDA) 2005. The service is easily accessible by people with any form of physical disability or sensory impairment. Disability support aids are fully functional and freely available to assist service users. Reasonable adjustment is made where required.

1.8 Services are provided to marginalised and socially excluded young people. If specialist services are required, young people are referred. Examples may include:

- Unaccompanied asylum seekers who are minors
- Looked-after children and care leavers
- Teenagers living in neighbourhoods where there are high levels of teenage pregnancy and evidence of health inequalities
- Young people from black and minority ethnic communities
- Young people with any form of disability and/or sensory impairment
- Lesbian, gay, bisexual and trans-gendered young people
- Teenage parents
- Young people with long term health needs

Theme 2: Publicity

This theme highlights the importance of effective publicity in raising awareness of the services available and explaining the extent of confidentiality. Effective publicity enhances access.

2.1 The service provides information in variety of languages and formats including leaflets for young people explaining:

- What the service offers
- How to access the service
- What will happen when they access the service
- How the service is linked to other services
- The content and style of the leaflets is appropriate for young people
- How to access other services and get appropriate onward referral
- How to make comments, compliments or complaints about the service
- Who else has access to any information that the young person shares with the service
- Circumstances under which information may be disclosed or shared

2.2 In accordance with the Disability Discrimination Act 2005:

- Service publicity material is available in forms that can be easily understood by young people with learning disabilities.
- The service will provide information for people with physical disabilities or sensory impairments in an appropriate format.

2.3 Service publicity material is available in languages that are used by the local community of young people.

2.4 Service publicity material makes clear the following:

- Young people's entitlement to a confidential service, including any limitations to confidentiality with regard to safeguarding legislation.
- There are routine opportunities for young people to attend a consultation on their own without the involvement of a parent or carer

2.5 All information provided by the service is kept accurate and up-to-date. The service provides information about other local services for young people, in accordance with current DH guidance

Theme 3: Confidentiality and consent

This theme addresses confidentiality, consent and safeguarding and how these are implemented by staff and understood by service users[abcd]. This theme supports and is supported by local Safeguarding arrangements

3.1 There is a written policy on confidentiality and consent to treatment and the policy is consistent with current DH guidance. The policy includes a clear protocol for the Safeguarding concerns and possible breaches of confidentiality. All staff are familiar with the service's confidentiality policy. Processes to ensure regular review of consent and confidentiality policies. The policy supports how staff will work with parents and carers where appropriate whilst respecting the confidentiality of the young person.

3.2 Members of staff routinely receive inter-disciplinary training on the issues of confidentiality and consent and issues pertaining to seeing young people without a parent/carer present. Inter-disciplinary training is undertaken in line with local Safeguarding Children arrangements to ensure that approaches to safeguarding are in line with Working Together to Safeguard Children (WTtSC).

3.3 Confidentiality and consent policies are made explicit to young people and parents or carers supported by appropriate publicity materials. The information makes clear young people's entitlement to confidentiality and any limitations to confidentiality with regard to safeguarding.

3.4 All staff routinely explain the confidentiality policy to young people and to their parents or carers in order to enable them to understand young people's right to confidentiality. The service routinely explains to young people that they have the opportunity to attend a consultation without the involvement of a parent or carer.

Theme 4: Environment

This theme addresses the service provision, environment and atmosphere, with the aim of ensuring that they are young people friendly (at the same time as being welcoming to all service users, regardless of age). The 'environment' is taken to include the atmosphere created by physical arrangements as well as staff attitudes and actions. The environment can contribute to ensuring confidentiality for service users.

4.1 Care is delivered in a safe, suitable and young people friendly environment. Young people are not asked any potentially sensitive questions where they may be overheard for example in the reception, waiting areas, ward environment.

4.2 The reception, waiting, treatment areas are accessible and young people friendly, comfortable and welcoming. There is a range of recreational activities appropriate for young people for example reading material and multi media and these are refreshed regularly. In accordance with Health and Safety Regulations, these are maintained and kept in working order.

4.3 All staff routinely explain who they are, and what they/the service can and cannot provide to help young people. The service considers the physical and cognitive ability of the young people and takes into account the effects of sedation and analgesia and mental health state. The service ensures young people's privacy and dignity are maintained during discussion, examination, treatment and care.

4.4 As appropriate the service ensures pain relief is an explicit part of young people's care and staff are trained in pain management (including use of pain management tools)

- Young people are provided with information and options to enable them to make informed choices regarding pain relief management
- The range of pain relief options are effectively communicated to young people and where possible the young persons views are central to the decisions about their pain relief

4.5 In patient/residential settings the provider should ensure it:

- Supports young people in maintaining contact with siblings, peers and partners during their stay.
- Provides young people with access to an age-appropriate environment, where possible this is separate from younger children. This should be available for recreation, formal and informal learning at appropriate times and supported by appropriate staff.
- Provides young people with access to food and snacks at times which meets their individual needs as well as any cultural and religious requirements. The food and snacks provided have appropriate nutritional value, suit individual taste and are presented in a way that is young people orientated.

Theme 5: Staff training, skills, attitudes and values

This theme addresses the training, skills, attitudes and values that staff need to deliver young people friendly services and ensuring the needs of young people are met. Local Authorities and commissioners of NHS and public health services have an important role to play in providing/ co-ordinating advice on training and safeguarding arrangements.

5.1 All staff who are likely to come into contact with young people receive appropriate training on understanding, engaging and communicating with young people promoting attitudes and values. All staff receive appropriate training in equality and human rights issues for them to be able to engage with confidence with a range of young people.

5.2 Appropriate staff members receive training, supervision and relevant appraisal to ensure that they are competent to:

- Discuss necessary and relevant health issues with young people and understand the health needs of young people in the context of peoples lives and relationships
- Work with parents/carers/family and friends where appropriate in culturally appropriate ways
- Make appropriate referrals when necessary
- Manage sensitive and/or difficult consultations.
- Support young people in making their own informed choices

5.3 Appropriate appraisal, supervision and support are offered to staff who provide services for young people.

Theme 6: Joined-up working

This theme addresses some of the ways to ensure effective joined up delivery.

6.1 Where possible, other relevant services for young people are co-located within the service. Where this is not the case, the service provides information about other local services for young people. All staff are familiar with local service provision and arrangements for referral.

6.2 Information about the service is provided to other relevant organisations and to key professionals working with young people.

Theme 7: Young people's involvement in monitoring and evaluation of patient experience

This theme addresses the importance of capturing of young people's experience of health services as part of service development, monitoring and evaluation.

7.1 Young people are routinely consulted in relation to current services and relevant new developments, and they are included in patient satisfaction surveys. Processes are in place to ensure that young people's views are included in governance service design and development.

7.2 The service invites and encourages all clients to give their opinions of the service offered and whether it met their needs; these are reviewed and acted on as appropriate

7.3 Young people are routinely involved in reviewing local service provision against the Department of Health's *Quality criteria for young people friendly health services*.

Theme 8: Health Issues and Transition for young people

This theme outlines the health needs of young people as they go through the transition into adulthood. It includes universal issues effecting all young people and issues effecting those with specific long term health needs.

8.1 As appropriate, consultations routinely promote healthy lifestyles including:

- Smoking cessation
- Healthy eating and weight management
- Alcohol misuse
- Long term health needs
- Substance misuse
- Mental health or emotional health and psychological wellbeing concerns
- Sexual and reproductive health.

8.2 Staff / the service ensures that the emotional, psychological and spiritual needs of young people are met. A clear referral pathway is identified for young people with identified emotional and mental health concerns. The pathway includes specialised CAMHS (child and adolescent mental health services) input where appropriate.

8.3 The service has a clear procedure to prepare young people for the transition from health services designed for children and young people to adult health services, consistent with current Department of Health guidance. Specific attention is given to the needs of young people with long-term health needs.

8.4 Appropriate staff members are trained to help young people, and their parents or carers, with the transition to adult services from the age of 12 onwards. All young people with ongoing needs have an individual transition plan. This will usually include a named key-worker for each young person who will provide continuity during the transition process.

8.5 The service provides publicity material specifically outlining the transition to adult services. This material is attractive to young people and is presented in a way that is young people friendly.

8.6 The care and support of young people with complex needs are considered in the context of their cognitive ability and chronological age. This should include assessment of physical, psychological and emotional needs.

8.7 In order for parents/carers to discuss health issues with young people, they are provided with relevant information and support, in ways that are sensitive to different cultures and religions.

Theme 9: Sexual and reproductive health services

This theme is only applicable to any type of sexual and reproductive health service, provided either in a specialist setting (e.g. genito-urinary medicine/GUM, contraceptive services) or a more generic setting (e.g. general practice). The criteria in themes 1 to 8 also apply.

It is important that all sexual-health-related work is informed by evidence of effectiveness. NICE guidance will be of particular importance, as will guidance concerning sexual health and HIV from the Medical Foundation on AIDS and Sexual Health and the British Association for Sexual Health and HIV.

9.1 A range of sexual health services is offered, including the following:

- Chlamydia screening: opportunistic chlamydia screening and treatment of young men and women, with referral pathways for partner notification
- Contraception: accurate information about the full range of contraception, including reversible long-acting methods of contraception
- Free condoms: with information and guidance on correct use
- Emergency hormonal contraception
- Pregnancy testing: free and confidential pregnancy testing and the opportunity to obtain accurate and unbiased information about pregnancy options and non-directive support
- Abortion: referral for NHS-funded abortion services
- Antenatal care: referral for antenatal care.

9.2 Sexually transmitted infection (STI) testing and treatment are offered. Where STI services are not available on-site, there are clear, integrated care pathways for seamless referral to other services or clinicians.

9.3 Young people are offered appropriate information and advice to help them develop their ability to make safe, informed choices. This includes advice to help them develop the confidence and skills to delay early sex and resist peer pressure.

9.4 Appropriate, easy-to-understand information is available on a range of sexual health issues, including contraception, STIs, relationships, use of condoms and sexuality. The information makes it clear that prescriptions for contraception are free.

9.5 Appropriate staff receive training, supervision and appraisal to ensure that they are:

- Able to talk to young people about sexual health issues, including delaying sex
- Knowledgeable about the full range of contraceptive options, promoting positive sexual health, preventing pregnancy and STIs
- Clear about what they can and cannot do to help young people
- Clear about who they are able to help
- Able to recognise and respond to different sexual health needs such as those relating to gender, sexual orientation, ethnicity and age.
- Able to recognise and facilitate informed consent and work within Fraser guidelines.

9.6 The service will see young people who are not ordinarily registered with them in order to provide sexual health advice and contraception, including emergency contraception.

Theme 10: Specialist child and adolescent mental health services (CAMHS) and facilities that offer specialist services

This theme is only applicable to providers of specialist child and adolescent mental health services for young people on psychological wellbeing and mental health. This includes specialist services (such as multidisciplinary teams or inpatient services). The criteria in themes 1 to 8 also apply.

It is important that all interventions are based on evidence of effectiveness. NICE guidance will be of particular importance. This section links with criteria 1.5 which includes notes on Fraser/Gillick competency and the Mental Capacity Act 2005.

10.1 The service provides young people, their parents and carers with:

- Advice and information to help informed decision making
- Information materials to help informed decision making.
- Information and advice explaining the roles of staff they might encounter in mental health services.

10.2 All appropriate staff routinely discuss choices with young people.

- Young people and their families are offered information and advice to facilitate informed decision making.
- Discussions take place at the beginning and throughout therapeutic contact.

10.3 The services offers information and advice to help young people and their families to make decisions regarding their psychological wellbeing and mental health support needs, and treatment choices based on informed consent. The service makes routine attempts to provide flexibility about involving other people in the assessment and treatment process.

10.4 Appropriate staff receive training and appraisal to ensure that they are:

- able to talk to young people about mental health issues
- knowledgeable about a range of support and treatment options
- clear about what they can and cannot do to help young people
- clear about who they are able to help
- able to recognise and respond to different therapeutic needs such as those relating to gender, gender identity, sexual orientation, ethnicity and age, disability, religion or belief
- able to recognise and facilitate informed consent.

10.5 Services are flexible about involving other people in the assessment and treatment process, particularly at first contact, and:

- Young people are offered appropriate information and advice to help them understand what can be achieved without parental or family involvement wherever this is considered to be therapeutically beneficial. Refusal of consent to family involvement is accepted unless there is serious risk to the young person's welfare.
- Even when assertive action is needed, there is some flexibility about what choices can be made available and which treatment the young person would like to receive. Even in cases where the overriding serious risks lead to compulsory treatment, young people should always be offered appropriate information and advice to make treatment choices based on informed consent.

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Dr Ginny Birrell	Royal College Paediatrics and Child Health, Young People's Health Special Interest Group (YPHSIG)
Paul Bloem	World Health Organization
Cathy Brammer	South Tees Hospitals NHS Foundation Trust, YPHSIG
Dr Clive Constable	Royal College Physicians
Bev Davison	Northumberland Care Trust
Charlotte Frith	Hospital based youth workers
Catherine Gane	University Hospitals Bristol NHS Foundation Trust
Donna Hilton	Nottingham University Hospitals NHS Trust
Dr Dougal Hargreaves	Department of Health
Julie Johnston	South Tees Hospitals NHS Foundation Trust
Dr Naomi Jones	Royal College Paediatrics and Child Health, YPHSIG
Theresa Maddison	Northumbria Health Care NHS Foundation Trust
Dr Rebecca Sands	Royal College Paediatrics and Child Health, YPHSIG
Dr Angela Robinson	British Association of Sexual Health and HIV
Dr Gill Turner	Royal College Paediatrics and Child Health, YPHSIG
Dr Janet McDonagh	Royal College Paediatrics and Child Health, YPHSIG
Wendy Nicholson	Department of Health
Karen Walker	University College London Hospitals NHS Foundation Trust
Dr Damian Wood	Royal College Paediatrics and Child Health, YPHSIG

References

[a] Seeking Consent: Working with Children. 2004. London. Department of Health www.dh.gov.uk

[b] Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health. 2004. London. Department of Health www.dh.gov.uk

[c] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. 2006. London. HM Government www.dh.gov.uk

[d] Confidentiality: NHS Code of practice. 2003. London. Department of Health www.dh.gov.uk

SENATE CLINICAL REVIEW

TERMS OF REFERENCE

Title: Paediatrics at the new Northumbria Specialist Emergency Care Hospital

Sponsoring Organisation: NHS North Tyneside and Northumberland Commissioning Groups

Clinical Senate: Northern

NHS England regional or area team: NHS Cumbria, Northumberland, Tyne and Wear Area Team

Terms of reference agreed by:

(Name)

on behalf (name) Clinical Senate and

(Name)

on behalf of sponsoring organisation (name)

Date:

<u>Senate Clinical review team members</u>

Chair: Northern Senate Vice Chair Suresh Joseph, Consultant Psychiatrist, Northumbria, Tyne and Wear NHS Foundation Trust

Dr Geoff Lawson, Clinical Lead for Northern Child Health Strategic Clinical Network

Dr David Shortland MD FRCP FRCPCH DCH (external reviewer)

Richard Parker, Director of Nursing, Doncaster and Bassetlaw NHS FT (Yorkshire and Humber Senate - external reviewer)

Jeff Perring, Director of Intensive Care, Sheffield Children's Hospital NHS FT (Yorkshire and Humber Senate - external reviewer)

Julie Flaherty, Paediatric Nurse (Greater Manchester and South Cumbria Senate – external reviewer)

Dr. Jonathan Smith, GP, Durham Dales Sedgefield and Easington CCG

Fran Toller, Managing Director, Women and children’s Services, South Tees Hospitals NHS Foundation Trust

Context/background

When the previous NHS North of Tyne consulted about NSECH it concluded that paediatric care would be provided through A&E and in an SSPAU at the Emergency Care hospital at Cramlington, but that its detailed operating model needed further clarification between commissioners and NHCFT. This was the position inherited by the in-coming CCGs in 2012/13.

As a result of this, Northumberland and North Tyneside CCGs wish to commission a model of service delivery for paediatric care that can provide rapid assessment, short stay assessment and where observation, investigation and treatment can safely be carried out in a child-focused environment.

Work has taken place between the CCGs and Northumbria Health Care Foundation Trust to agree a service delivery model in preparation for the opening of the NSECH in 2015.

This is described in briefing previously received.

A key aspect of the model of care is to ensure that the condition for which the child is being observed or treated is suitable, to make most effective use of the clinical workforce and beds.

SCOPE

CCGs would welcome:

a) Comments identifying if or how this model can be strengthened so that we commission and monitor this appropriately

b) This review should not re-open the previous consultation undertaken by NHS NoT but this will be available as background and context for the reviewer .

Timeline

October – December 2014

Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Methodology

3 stages

1. Desk top review – CCGs to provide background and supporting information and be available to brief/respond to queries
2. Reviewer to identify and refer to current guidance and best practice in this area and identify additional queries for the clinical team and the CCG
3. Reviewers to meet face to face – to collate responses and develop report by November (Date to be inserted)

Report

A draft clinical senate assurance report will be circulated within 48 hours from the face to face meeting by the review team to the sponsoring organisation for factual accuracy.

Comments/ correction must be received within [5] working days.

The final report will be submitted to the sponsoring organisation by [Last week in December 2014]

Communication and media handling

The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

Resources

The Northern clinical senate will provide administrative support to the review team , including setting up the meetings and other duties as appropriate.

Accountability and Governance

The clinical review team is part of the Northern Clinical Senate accountability and governance structure.

The Northern clinical senate is a non statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.

Clinical senate council and the sponsoring organisation will

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

The full Senate council will

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. will endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to

i. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

v. undertake to be objective and not unduly influenced by any 3rd party

END

NHS
North Tyneside
Clinical Commissioning Group

NHS
Northumberland
Clinical Commissioning Group

OPERATING MODEL
April 2014

Paediatric Short Stay Assessment Unit at Northumbria Specialist Emergency Care Hospital (NSECH)

Northumberland and North Tyneside CCGs (Clinical Commissioning Groups) wish to commission a model of service delivery for paediatric care that can provide rapid assessment, short stay assessment and where observation, investigation and treatment can safely be carried out in a child-focused environment.

Children will stay less than 24hours; some of these children's care requirements will be overnight. There may be exceptional occasions where the length of stay exceeds 24hours; these occasions will be determined on a case by case basis, taking into consideration the safety of care, the wishes of the family and the most appropriate clinical environment and team to care for the child.

A key aspect of the model of care is to ensure that the condition for which the child is being observed or treated is suitable, to make most effective use of the clinical workforce and beds.

Protocols and integrated care pathway for transfer to the Great North Children's Hospital where more intensive and longer term care is required already exist, and these will be further developed

The following table highlights some key elements of this approach and model.

Operating parameters

Patient group

The paediatric short stay assessment unit will care for children between the ages of 0 and 16 (older for special needs patients), who arrive at the emergency department of the NSECH or have been referred by a GP or other health professional e.g. midwife. The medical staff will exercise their clinical judgment about how best to meet the needs of young people aged 16 – 18 with some being cared for within the paediatric unit.

Conditions suitable for this unit include breathing difficulties, fever, diarrhoea and vomiting, abdominal pain, seizures and rash, as well as some head injuries and non-intentional poisoning. This would mean (appropriately so) fewer young children with minor to moderate Illnesses being transferred to the Great North Children's Hospital.

Community paediatricians will occasionally admit children for planned care or safeguarding that exceeds 24 hours, e.g. initiation of naso gastric feeding for a child with complex health needs.

Services provided

The unit will provide rapid assessment, treatment and discharge – or following clinical assessment transfer to another service.

The unit will be for short stay assessments, with a maximum length of stay of 24 hours

The unit will be consultant led and staffed by a multi-disciplinary team including children's doctors, advanced paediatric nurse practitioners (APNP), children's nurses and therapy staff.

Opening hours

Children will be seen and assessed in the emergency department regardless of what time they arrive. The paediatric short stay assessment unit will accept patients for short stay assessment from 8am until 11pm, seven days per week. There will be no new paediatric assessments between 11pm and 8am.

Those children who need to be in hospital for more than 24 hours will be transferred to the Great North Children's Hospital.

Following initial assessment a clinical decision will be made to one of six pathways, these are:

I. Send the child home following any required treatment

II. Admit to the paediatric short stay assessment unit for a short period of observation and/or brief clinical intervention (4-6 hours)

III. Admit to the paediatric short stay assessment unit for a longer stay that is not anticipated to exceed 24 hours or more than 1 night stay

IV. Send the child home to return the following day for day case surgery (e.g. simple fractures), a consultant review or regular outpatient slot at a base site

V. Send the child home with community nursing support

VI. Transfer to Newcastle as child does not meet admission criteria for the paediatric short stay assessment unit at NSECH.

From 11pm until 8am, children who self-present at the emergency department will be assessed and either observed in an ambulatory care setting or transferred to the Great North Children's Hospital, whichever is most appropriate.

There will be an ambulance and NHS 111 bypass policy in place between 11pm and 8am.

Children who are admitted by community paediatrics for planned care, will not follow this pathway, as they are not in need of urgent medical care.

Standards

The paediatric short stay assessment unit will meet the standards as laid out in

1. *Facing the Future: Standards for Paediatric Services*, Royal College of Paediatrics and Child Health, April 2011.
2. *You're Welcome: Quality criteria for young people friendly health services*, Department of Health, April 2011.

Additional information

Medical Staffing and APNP 24 hour manpower profile

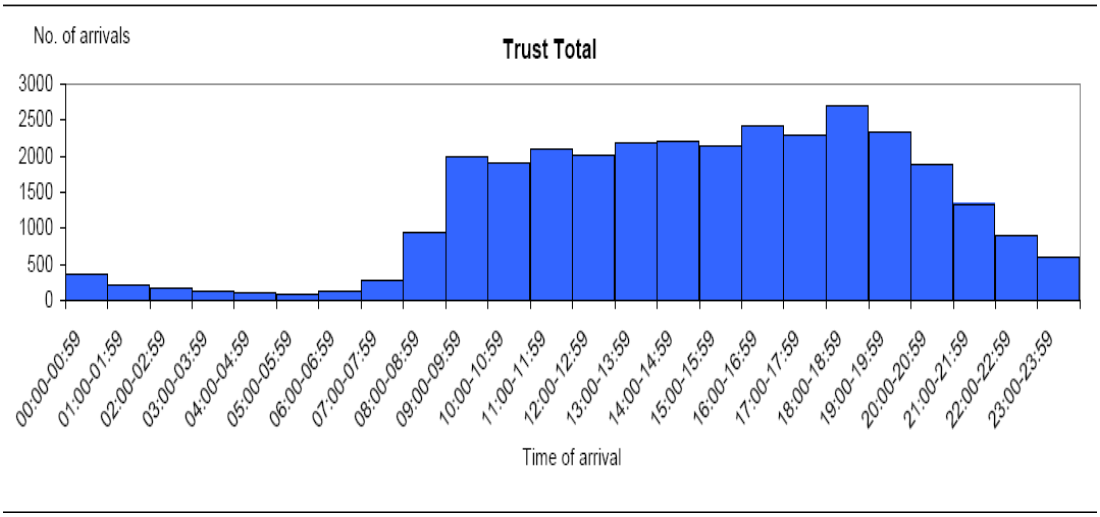
Staff Group (Number on duty)	Mon - Friday				Weekend day	Weekend night
	Morning	Afternoon	Evening	Night		
Consultant	1	1	1 until 20.00	On call	1 until 20.00	On Call
Middle Grade	-	1	1 until midnight	-	1 until midnight	-
Junior (F2/VTS)	2	2	2	-	1 – 2 until midnight	-
APNP	1	1	1	1	1	1
Community nursing	8 hours per day of acute community nursing to pick up children in a 15 mile radius.– the capacity will come from the establishment in the acute nursing team. Existing community nursing team will pick up acute children who live outside the 15 mile radius					

Activity Profile in 24 hour period.

Children and Young people arrive from a variety of sources overnight including 111, NDUC, 999 the majority however self-present.

The table below indicates the arrival time to A&E of children and Young people under the age of 16, over a 24 hour period. The graph includes all children who attended in 2013.
To illustrate a couple of examples - there were 2500 children arrived between 6 & 7 pm – so the average number of children arriving every day at that time is 7

There were 400 children arriving between midnight and 1am so 1 or 2 arrive every day at this time.



Joint Locality Executive Board
23 April 2014
Agenda Item: 6.2
Paediatric model of care at Northumbria Specialist Emergency Care Hospital
Sponsor: Eileen Higgins

NHS
Northumberland
Clinical Commissioning Group

Members of the Joint Locality Executive Board are asked to

1. **Note the work undertaken to date with North Tyneside Clinical Commission Group (CCG) and Northumbria Healthcare NHS Foundation Trust to define the operating model for the paediatric short stay assessment unit.**
2. **Consider the operating model, particularly the opening times and services provided, and endorse it for use at the Northumberland Specialist Emergency Care Hospital**
3. **Agree that Dr Eileen Higgins continues to lead this work and in particular, leads the conversations between the commissioners, Northumbria and Newcastle hospitals in finalising the patient pathways.**

When NHS North of Tyne consulted about the Northumbria Specialist Emergency Care Hospital, it concluded that paediatric care would be provided through A&E and in a short stay assessment unit. The outline operating model was agreed but the detail needed further clarification between the commissioner and provider.
Over the last three months, Northumberland and North Tyneside CCGs have worked with the Trust to describe the model of care that will operate, as described in the attached paper. In headline form:

- A short stay assessment unit will be commissioned at the Northumbria Specialist Emergency Care Hospital (NSECH) that can provide rapid assessment and short stay assessment and where observation, investigation and treatment can safely be carried out in a child focussed environment.
- Children will stay less than 24 hours. Some of these children's care requirements will be overnight. The unit will open from 8am until 11pm.
- The condition for which the child is being observed or treated is suitable to make the most effective use of the clinical workforce and beds
- Protocols and integrated care pathways for the transfer of patients to the Great North Children's Hospital, where more intensive and longer term care is required, already exist; these will be further developed.
- The short stay assessment unit will be supported by a children's community nursing team that will operate on a seven day, extended hours basis.

Northumbria Healthcare paediatricians will conduct some detailed audit work over a three month period (autumn 2014) to provide the CCGs with data and assurance that the new operating model is appropriately described and will deliver high quality care to patients. The trust will also run more 'live' testing days in preparation for opening the new unit.

Staff Group (Number on duty)	Mon - Friday				Weekend day	Weekend night
	Morning	Afternoon	Evening	Night		
Consultant	1	1	1 until 20.00	On call	1 until 20.00	On Call
Middle Grade	-	1	1 until midnight	-	1 until midnight	-
Junior (F2/VTS)	2	2	2	-	1 – 2 until midnight	-
APNP	1	1	1	1	1	1
Community nursing	8 hours per day of acute community nursing to pick up children in a 15 mile radius.– the capacity will come from the establishment in the acute nursing team. Existing community nursing team will pick up acute children who live outside the 15 mile radius					

Paediatric Emergency Activity Data (01/10/12 – 31/09/13)

Length of stay by source of referral

	0 Days	1 Day	2 + Days	Total
A&E	**1414**	**661**	**256**	**2351**
GP	**546**	**191**	**70**	**807**
Total	**1960**	**852**	**326**	**3158**

Percentage of patients admitted by source of referral

	Total	2 or more Nights
A&E	**39**	**11**
GP	**32**	**9**
Total	**37**	**10**

Time of Arrival in A&E and Transfer to Paediatrics

	00:00-08:00	08:00-20:00	20:00-00:00	
A&E arrivals/yr	**1555 (7%)**	**17560 (76%)**	**4012 (17%)**	**23126**
A&E arrivals/d	**4**	**48**	**11**	**63**
Paeds referrals	**168**	**1,766 (+807 GP)**	**426**	**2360 (+807 GP)**
% referred	**11**	**10**	**11**	

(Data on transfers to NTGH CAU not included in hourly breakdown – from previous data 965 added to 08:00-20:00 period)

50% of all A&E attenders arrive in the 6hrs between 15:00 – 21:00 (5 /hr)

There will be differences between weekdays and weekends

Assessment in A&E and transfer (especially from WGH) mean that children arrival time in paediatrics approx. 2 hrs after their arrival in the Trust and this results in more late evening/overnight activity.

Northumbria Healthcare NHS
NHS Foundation Trust

Data analysis of pathways

Between May 15th and 10th July we collected data on pathways of children attending CAU at NTGH or being admitted to ward 10.

In total data was collected for 645 pathways

Some sections of the data are not 100% collected so the analysis reflects this

Pathways analysed

May	June	July
179	391	75

No of pathways indicating less that 24 hour stay

May	June	July
132	310	64
73%	79%	85%

Analysis of pathway information where this was identified based on pathways

May 179			**June 391**			**July 75**		
pathway	total	%	pathway	total	%	pathway	total	%
1	77	43	1	85	21	1	33	43
2	19	10	2	82	20	2	16	21
3	41	22	3	141	36	3	16	21
4	2	1.1	4	1	0.2	4	0	0
5	2	1.1	5	1	0.2	5	0	0
6	26	14	6	31	7.9	6	8	10
No data	12		No data	42		No data	2	

1. Send the child home following any required treatment.
2. Admit for a short period of observation and/or brief clinical intervention (ambulatory care)
3. Admit to the short stay ward for a stay of no more than 1 night. (n.b. there will be no new admissions overnight so if the child arrives very late at night the child will be transferred to GNCH regardless of the severity.)
4. Send the child home to return the following day for day care surgery (e.g. simple #'s),a consultant review or regular outpatient slot at a base site

5. Send the child home with acute community nursing support

6. Transfer to Newcastle as child does not meet admission criteria for children's ward at NSECH. (predicted to recover within 23.59mins and low risk of deterioration)

Source of admission and % of high referrer

Source	May	June	July
A+E NT	65 (36%)	134 (34%)	12 (15.5%)
A+E WGH	17	56 (14%)	3
NDUC		2	1
CAMHS	1		
Community midwife	2	2	
GP	80 (44.5%)	136 (34.5%)	43 (57.3%)
CCN	1		
Open access/home	7	26	1
Health visitor	4	8	
Trauma/clinic	1	5	
Elective		10	3
A+E Ber/Aln		3	
SW		2	

Patients who may be required to go to GNCH in new model because admitted after 11pm and before 7am, or due to LOS or clinical need

	May	June	July
Identified as pathway 6 needing GNCH due to LOS or Clinical need	26	31	6
Recorded as Pathway 6 and admitted after 11pm (included as above)	5	10	1
DSH after 11pm	1	0	1
Admitted after 11pm	28	61	4
Total combined for period where child needs clinical care on path way 6, decision to admit was after 11pm and before 8am, or arrival on CAU was after 11 pm	40	89	13

Reason for admission where recorded

Reason	May	June	July
Abdominal pain	6	19	6
Appendicitis	4	4	1
Chest pain	2	2	1
Respiratory/Wheeze/Asthma	16	31	4
Cough/Croup	9	7	5
D+V and gastro	22	36	7
Seizures/febrile convulsions	6	9	
Head injury	3	8	
fracture	4	31	
Chicken pox	4	2	
jaundice	7	7	1
DSH/ingestion	6	19	2
pyrexia	10	31	9
rash	14	16	5
tonsillitis		9	1
headache	5	4	2
uti	2	6	
viral	5	7	0
other	20	72	20
Unknown/not recorded	24	71	11

Conclusions:

- Majority of patients stay less than 24 hours.
- There's no obvious pattern to admissions across the week in terms of numbers - appear to be spread evenly across weekdays and weekends.
- Majority of patients are classed as either pathway 1, 2, or 3.
- Patients on pathway 6 (transfer to NUTH) do tend to come in late evening/night.
- Doesn’t appear to be anything unusual in the reason for admission - wheeze, pyrexia, abdo pain etc.
- Some evidence to suggest assessment times in CAU have improved - particularly later on in the evening when historically there have been issues with getting CAU "closed" when it was in OPD i.e. some instances where patients are seen and sent home in <2 hours and in some cases less than <1.
- This data excluded WGH CAU unless transferred to NTGH
- In discussions with GNCH we need them to be awrae of potential numbers to be transferred after 11pm or agree bypass policy with NEAS

Further analysis:

Further data collection is planned for October.

Would be useful to look at the difference between time of arrival in A&E and arrival in CAU – for this data collection period we only have partial completion of A&E arrival times. From what we currently have the time averages around <2 hours – though at a glance some longer waits are noticeable - would need to unpick these further to see what/where the delay was.

Paediatric admissions information

From 1st November 2012 to 31st October 2013 there were 4,734 A&E attendances for Northumberland patients aged less than 19 years old. These attendances were at either Newcastle Hospitals or Northumbria, and they were self-referred between 8pm and 8am.

Of these 4,734 A&E attendances, 397 patients went on to have an emergency admission. This was done using the criteria of linking on pseudo NHS number between the A&E and inpatient datasets, where the date of discharge from A&E equalled the admission date of the resulting admission. In summary, 8% of these selected A&E attendances went on to have an emergency admission.

Of the 4,734 A&E attendances, 4,376 were at Northumbria and 358 were at Newcastle Hospitals.

Of the 397 resulting emergency admissions; 365 were at Northumbria and 32 were at Newcastle Hospitals. The 397 emergency admissions cost £319,065, with an average LOS of 0.88 days, with 238 of the admissions having a zero day LOS (60%).

Paediatric emergency admissions from A&E (8am – 8pm), by month.

There are slightly more admissions in winter than in summer.

Month/yr	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total
Admissions	50	49	37	34	23	40	27	23	21	33	28	32	397

Age breakdown – 40% of the admissions are for patients aged 2 years and under, and almost 20% are for patients aged 17 -18 years old.

Age	Number of admissions
0	82
1	52
2	25
3	17
4	17
5	10
6	10
7	8
8	7
9	8
10	12
11	9
12	8
13	9
14	12
15	21
16	13
17	31
18	46
	397

The primary diagnosis group analysis indicates that the most common reasons for admission are infections, respiratory system conditions and poisoning and injury. Types of diagnosis found in the ICD10 R chapter include lower abdominal pain, syncope and collapse.

Chapter	Chapter Description	No. admissions
ICD A00-B99	Certain infectious and parasitic diseases	66
ICD C00-D48	Cancer/Neoplasms	1
ICD D50-D89	Diseases of the blood & blood-forming organs & certain disorders involving the immune mechanism	1
ICD E00-E90	Endocrine, nutritional & metabolic diseases	2
ICD F00-F99	Mental & behavioural disorders	9
ICD G00-G99	Diseases of the nervous system	11
ICD H00-H59	Diseases of the eye	2
ICD I00-I99	Diseases of the circulatory system	3
ICD J00-J99	Diseases of the respiratory system	83
ICD K00-K93	Diseases of the digestive system	21
ICD L00-L99	Diseases of the skin & subcutaneous tissue	6
ICD M00-M99	Diseases of the musculoskeletal system & connective tissue	6
ICD N00-N99	Diseases of the genitourinary system	12
ICD O00-O99	Pregnancy, childbirth & the puerperium	8
ICD P00-P96	Certain conditions originating in the perinatal period	11
ICD Q00-Q99	Congenital malformations, deformations & chromosomal abnormalities	1
ICD R00-R99	Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified	62
ICD S00-T98	Injury, poisoning & certain other consequences of external causes	89
ICD Z00-Z99	Factors influencing health status & contact with health services	3
		397

A&E arrival time for admitted patients, by provider

	Admissions by A&E arrival time												
	20.00 - 20.59	21.00 - 21.59	22.00 - 22.50	23.00 - 23.59	00.00 - 00.59	01.00 - 01.59	02.00 - 02.59	03.00 - 03.59	04.00 - 04.59	05.00 - 05.59	06.00 - 06.59	07.00 - 07.59	**Total**
Newcastle FT	5	5	5	1	4		1	3	1	3	1	3	**32**
Northumbria FT	51	43	46	50	42	18	16	18	22	19	18	22	**365**

Primary diagnosis by age for these admitted patients shows that there is some variation in diagnosis depending on the patient age.

Chapter	Chapter Description	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total
ICD A00-B99	Certain infectious and parasitic diseases	21	13	6	6	5	1	3	2	2				1	1			1	2	2	**66**
ICD C00-D48	Cancer/Neoplasms						1														**1**
ICD D50-D89	Diseases of the blood & blood-forming organs & certain disorders involving the immune mechanism		1																		**1**
ICD E00-E90	Endocrine, nutritional & metabolic diseases	1											1								**2**
ICD F00-F99	Mental & behavioural disorders				1									1	1		1	1	2	2	**9**
ICD G00-G99	Diseases of the nervous system	2											3	1			1		1	3	**11**
ICD H00-H59	Diseases of the eye									1	1										**2**
ICD I00-I99	Diseases of the circulatory system														1			1		1	**3**
ICD J00-J99	Diseases of the respiratory system	18	22	10	4	7	4	1		1	2	4		1			2	4		3	**83**
ICD K00-K93	Diseases of the digestive system	2	1		1						1	2	1		1	1	2		3	6	**21**
ICD L00-L99	Diseases of the skin & subcutaneous tissue	2					2							1						1	**6**
ICD M00-M99	Diseases of the musculoskeletal system & connective tissue		1					1	1				1			1				1	**6**
ICD N00-N99	Diseases of the genitourinary system	2			1	1							1		1		1			5	**12**
ICD O00-O99	Pregnancy, childbirth & the puerperium																		5	3	**8**
ICD P00-P96	Certain conditions originating in the perinatal period	11																			**11**
ICD Q00-Q99	Congenital malformations, deformations & chromosomal abnormalities			1																	**1**
ICD R00-R99	Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified	15	8	3	2	2		3	1	1	2	4	2	3	1	2	5	2	3	3	**62**
ICD S00-T98	Injury, poisoning & certain other consequences of external causes	7	6	4	2	2	2	2	4	2	2	2			3	8	9	4	14	16	**89**
ICD Z00-Z99	Factors influencing health status & contact with health services	1		1															1		**3**

Northern England
Clinical Senate

Northern Clinical Senate

Cramlington Paediatric Services Review by Northern Clinical Senate

A G E N D A FOR MEETING ON 08 12 2014 1-5 PM

BOARD ROOM, WATERFRONT 4, NEWBURN RIVERSIDE, NEWCASTLE UPON TYNE, NE15 8NY

Please report to the reception. Working lunch at 1PM

Item	Time	Items	Lead
Meeting - Part 1 – Review Panel only			
1	13:15	Welcome, introductions and objectives of the review	Suresh Joseph, Review Panel Chair
2	13:20	Confidentiality agreement/ Code of conduct	Lynda Dearden
3	13:25-14:45	Discussion on the papers submitted	All
	14:45-15:00	**Coffee break**	
Meeting – Part 2 – CCG members join the Panel for Q&A			
4	15:00-15:45	Questions to Julie Ross (Northumberland CCG) and Dr Ruth Evans (North Tyneside CCG) arising from the previously received information pack	All
Meeting – Part 3 – Review Panel only			
5	15:45: 16:15	Proposal and deliberation	All
6	16:15	Report back and Conclusion	Suresh Joseph
7	16:50	Any other comments / Reporting Time frame	Lynda Dearden

8	17:00	Meeting finish