Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Clinical Senate Review

of the

Care of the Acutely Unwell Child Case for Change

for the

Working Together Programme

Final Version 1.0

November 2016

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

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Yorkshire and the Humber Clinical Senate
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Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	14th October	Based on Working group teleconference, email discussions and September Council meeting	Joanne Poole
Version 0.2	19th October	Amended by Working Group and formatting improved	Joanne Poole and Working Group.
Version 0.3	24th November	Amended following Council discussion	Joanne Poole
Final Version 1.0	28th November		

1. Chair's Foreword

1.1 The Senate thanks the Working Together Programme for inviting us to consider their Case for Change and Scenario Appraisal considering the care of the acutely unwell child.

1.2 The Senate is broadly supportive of the need to address the issues highlighted in the Case for Change and agrees that changes are required to offer a safe and sustainable service to acutely unwell children now and in the future. We recognise that commissioners are at a very early stage in their thinking and engagement with local teams is going to be key to developing a solution. We hope that this report is of assistance in your stakeholder discussions in November 2016 and we look forward to working with you as the detail emerges on a preferred option for the future service.

2. Summary of Key Recommendations

2.1 The Senate is supportive of the need to address the issues highlighted in the Case for Change but currently advises that it does not provide a comprehensive review of the issues facing the service and needs to be strengthened across a range of areas.

2.2 The broader concerns with this work are in relation to the geography, particularly the inclusion of Mid Yorkshire and exclusion of North Lincolnshire which is not reflective of patient flows.

2.3 We have concerns about the handling of the co-dependencies (e.g. neonatal services, maternity services) which whilst acknowledged, are not addressed and these need to be an integral part of the decision making.

2.4 The Senate also advises commissioners that there is merit in setting out the totality of the service change to patients across a range of associated service areas rather than consulting separately on different service aspects, which may lead to patients perceiving multiple cuts in services rather than a coherent approach to a future safe and sustainable model. The Senate also advises further consideration on the scope of the programme.

2.5 In considering the Case for Change in detail, the Senate recommends a number of areas where commissioners may want to consider strengthening the narrative. These include in the analysis of population size and population needs, emergency department and ambulance service information and the consideration of the workforce. In addition, we advise that the Case for Change should make reference to children's mental health services and children with neuro-disabilities. Commissioners are also advised to consider further developing the issues within primary care within this document.

2.6 Broadly, the Senate feels unable to advise on the clinical concerns of the 3 scenarios presented due to the lack of information provided at this point in time. Currently, we are unable to distinguish between scenario 1 and 2 and advise that the scenarios are not assessed consistently against each standard applied. Our recommendation is that scenario 3 needs to be set out in more detail as a theoretical model with differing numbers of hubs and spokes, considering some of the best practice evidence contained within the comprehensive supporting document.

3. Background

Clinical Area

3.1 The Working Together Programme (WTP) is a collaboration of 7 NHS Trusts, 8 Clinical Commissioning Groups and NHS England across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield. The programme has come together to look at how services can be better delivered in a safe and sustainable way across the area.

3.2 This project relates to the care of the acutely unwell child. The project scope is defined as:

- Children and young people, from birth to their 19th birthday, experiencing:
  - Unplanned/unscheduled/non elective incidences of acute illness, or
  - Acute exacerbations of existing chronic conditions
- Encompassing the 36 hour period from onset of illness until the child is either discharged or active management is underway
- Excludes children and young people admitted to adult wards and neonates in neonatal units and maternity wards

3.3 Based upon the 2015 Office for National Statistics data, the Local Authorities most closely relating to the Working Together Programme serve a population of around 487,000 children and young people (ages 0-19). Currently all 7 NHS Trusts within the programme provide an inpatient paediatric service. Nationally, the Royal College of Paediatricians and Child Health have highlighted the issues and challenges facing the provision of children's acute care services in district general hospitals. Many of these same challenges have been identified by stakeholders locally. These are particularly around the availability of a medical workforce sufficient to staff the current service configuration, leading to concerns about timely access to specialist opinion and continuity of care.

3.4 The Working Together Programme have developed Best Practice Guidance which reviews the literature and standards published by the Royal Colleges and other bodies in relation to both the child health service and children's acute care pathway. This document has helped to inform their Case for Change for the Care of the Acutely Unwell Child and their high level Scenario Appraisal to progress this project to the next phase.

Role of the Senate

3.5 The Senate was approached by the Working Together Programme to provide independent clinical advice on their Case for Change and their Scenario Appraisal. This will be used to inform their stakeholder event on the 15th November 2016 and thereafter inform the further development of their options for the service. The specific question the Senate was asked to address is:

Could the Senate advise on the "Care of the Acutely Unwell Child" Case for Change, and whether this provides a comprehensive review of the issues facing the services? The Best Practice Guidance document has also been shared as this has informed the Case for Change.

Considering the case for change, can the Senate review the three proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?

Process of the Review

3.6 The Senate received the request for review on the 8th September 2016 and the associated evidence was received week commencing 19th September. The Terms of Reference were agreed on 15th September and the Working Group was appointed by the 16th September.

3.7 The Senate Working Group held a teleconference to aid their discussions on 30th September and commented also via email discussion. A discussion was arranged with the commissioners for the 3rd October to provide early feedback and at commissioner request, the headlines of our discussion were provided to them by email on 7th October. The report was drafted by the Working Group following all these discussions and the final draft was provided to the commissioners for comment on the 19th October 2016. The report and commissioner comments will be provided to the Senate Council for final ratification on the 17th November 2016.

4. Evidence Base

4.1 The Working Together Programme have developed a Best Practice Guidance for the Configuration and Provision of Children's Acute Care which reviews the literature and standards published by the Royal Colleges and other bodies in relation to both the child health service and children's acute care pathway. The Senate agrees that this provides a comprehensive review of the evidence base and has therefore not referred to any additional evidence within its review.

5. Recommendations

5.1 In developing our recommendations, the Senate has considered the questions provided by the Working Together Programme but first wish to highlight three overarching issues.

i. **The Geography.** We have serious concerns about the boundaries of this piece of work. This is in relation to the North Lincolnshire population which feed into the children's network, but are not listed as members in this plan, and the inclusion of Mid Yorkshire. The Mid Yorkshire patient flows are naturally to Leeds in the North and not to services in the South which questions why they are included in this geography. We also recommend greater clarity about the language used. Wakefield Clinical Commissioning Group is different to the population of Wakefield which is different again to Mid Yorkshire Trust. Commissioners need to be much clearer in defining their population and geography and recognising and reflecting the patient flows. It is also noted that the geography of this proposal does not reflect that of the Sustainability and Transformation Plan (STP) footprint.

ii. **The Co Dependencies.** We also have concerns with how the co-dependencies have been handled. Commissioners have highlighted these co-dependencies and acknowledged them but then they are deliberately left to one side. The Senate advises that they need to be more than just acknowledged but be an active part of this piece of work as these co-dependencies will have a substantial impact on what can be achieved. Maternity and neonatal services for example, are acknowledged as interdependent services but the issue of how these services can be separated out from this review, when the services are staffed by the same people within the district general hospitals, has not been addressed. They are an integral part of the decision making and need to be considered together with the acutely ill child.. This leads to a broader point about the piecemeal approach of the service change within the Working Together Programme. There has already been a public consultation on paediatric surgery and if substantial changes are required to this service, a further public consultation will be required. There is advantage in setting out the whole system change for patients so that it is easier to describe the totality of the change and the reasons for this or you risk the public questioning how open commissioners are being if the changes are presented one by one.

iii. **The Scope.** The Senate has concerns with the scope of the programme which excludes children and young people admitted to adult wards. As admission at Sheffield Children's Hospital is only to age 16 there will be a cohort of 17 – 18 year olds, on adult wards, who will be excluded from this review. We are not clear on the reason for this exclusion. There are young people with developmental delay and mental health issues and there can be big differences in the emotional

maturity of this age group and their ability to cope on an adult ward. Children with mental health issues cannot be admitted to an adult mental health ward until they are 18. We are aware that commissioners have discussed this exclusion and acknowledged that these children will be considered within their work on improving transitional services. We advise that the rationale for this is made clearer in the Case for Change, with reference to the work on transitional services within the Case for Change.

Could the Senate advise on the "Care of the Acutely Unwell Child" Case for Change and whether this provides a comprehensive review of the issues facing the services?

5.2 The Working Together Programme is supported by the Senate in their consideration of this difficult set of issues which are not simple to resolve. Broadly, the Senate agrees that whilst the Case for Change provides a good starting point in considering the issues, it does not yet provide a comprehensive review.

5.3 The Senate advises that commissioners consider developing the Case for Change further, in the following areas:

i. **In the analysis of the population size and population needs:**

- The population of the Working Together Programme is stated as 2.5 million and on page 17 of the Case for Change the under 19s population is stated as 487,000. Our calculations are that the under 19s population equates to 19% of the total population, whereas on page 17 it is referred to as 23% of the total population.
- On page 18, the Case for Change refers to self-reported attendances of 40,801 from the 7 Acute Trusts but acknowledges on page 19 that the hospital episode statistics data total attendances of 61,000. It is difficult for commissioners to plan for their service and understand the impact of their proposals when the variation is so significant. Commissioners will need to have more confidence in the data as they move forward with their proposals, there is opportunity now to pro-actively record activity to help achieve this confidence.
- In the supporting appendices there is no data from Mid Yorkshire Hospitals NHS Trust
- The travel distances and the number of transfers in and out of hours would have been helpful data to assess the scale of the current issues. The impact on families and siblings is key and this information is needed to help assess this.
- The length of stay data is presented as an average only and does not differentiate between secondary and tertiary care and it is not clear what value this adds to the document

ii. **Emergency Department data.** It would be helpful if the Case for Change set out the total and paediatric Emergency Department attendances and admissions rates.

iii. **The bed numbers.** It is useful to see the overview of the bed numbers but this could be improved by more detail on the differing types of beds in order to portray the current reality as accurately as possible. The level of support available

(resident consultant, resident doctor or resident advanced nurse practitioner for example) would help ascertain the service level.

iv. **Ambulance services.** The ambulance services are first responders, their competency and effectiveness are a crucial part of the solution and need to be addressed in more detail within the Case for Change to ensure that children are efficiently and safely transported to where they need to be. This is about maintaining safe patient flows, both inter hospital and between the community services and the hospital and it was felt that their role is not adequately reflected. There is also little detail in regard to the retrieval service, particularly the waiting times. Having a child in paediatric resuscitation for two hours waiting for retrieval has a big resource implication, especially in terms of emergency department and anaesthetics and the availability of the transfer services needs to be considered in more detail within the documentation.

v. **Mental health services.** There is no reference in the material about children and young people's mental health. Their needs should also be reflected and not separated out from acute illness.

vi. **Neuro-disabilities.** Those children with neuro-disabilities are also not mentioned within the Case for Change.

vii. **Workforce.** The medical workforce model re-groups trainee doctors (15 wte) with consultants (8 wte) which confuse the issues. There is also no reference to the nursing workforce which would form a key part of the solution, especially for places where there are non-resident medics.

viii. **Primary care.** Plays a huge role in filtering out those children who do not need admission and recognising quickly and competently those that do. GPs are currently struggling to cope, a national issue, but good local primary care is essential to allow secondary care services to function safely. There is recognition on page 15 that GPs knowledge in the management of acute care of children is variable but this needs to be really well appreciated and understood. The Senate advice is that currently the documentation does not reflect the level of primary care engagement required. There is a greater focus in the documents on secondary care without adequately considering the increasing reliance on primary care to ensure that patients do not default to attending Emergency Departments. The relationship with out of hours and 111 services is also not reflected.

ix. **Financial Pressures.** This section largely only refers to the costs of medical locums with no reference to other financial figures. The capacity issues and implications of change are mentioned but not costed and currently the financial analysis does not appear complete.

Considering the Case for Change can the Senate review the 3 proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?

5.4 Broadly, the Senate feels unable to advise on the clinical concerns of these scenarios due to the lack of information provided at this point in time. The following comments may assist commissioners in further developing their scenarios.

5.5 The Senate is unable to clearly understand the differences between Scenario 1 and 2. Scenario 1 describes a 'do nothing' approach but the current description of scenario 2 does not seem that different. All services are expected to progress and improve quality against standards. We recommend that the differences between these 2 scenarios are more clearly explained or that scenario 1 is retired.

5.6 The scenarios are assessed against 4 areas - quality, affordability, access and deliverability, but all 4 areas are not applied consistently against each scenario. In addition, the quality category is sometimes described as quality and safety and commissioners need to be clear what it is. We recommend that the assessment against each scenario is consistently applied.

5.7 Scenario 3 is not described at all beyond reference to a hub and spoke model. The Facing the Future[1] standards as referenced in the commissioner Best Practice Guidance, describes the needs of different size centres based on number of attendances (<1500, 1500 -2500, 2501-5000, >5000) but this is not modelled in scenario 3 in terms of what the hub and spoke model could look like in this geography. At this point in time the model doesn't need to say which hospital is being considered as a spoke or a hub but to make this scenario meaningful it needs a theoretical model with different numbers of hubs/spokes.

5.8 Scenario 3: Commissioners could make more of this scenario document by incorporating some of the learning which is summarised within the comprehensive Best Practice Guidance. Pages 10 – 20 of this document provide a helpful summary of what has happened in Evelina Children's Hospital, Kings College Hospital and the Wessex Healthier Together programme, to name just a few. It would have been helpful, within the scenarios, to describe how these opportunities have been considered and which of these may be applicable, adapted and/or proposed for South Yorkshire.

Other Issues

5.9 In the Appendix B - CCG response Standard 9, we question the self-assessments and advise that all should be categorised as Red against this standard, unless the access to SystmOne is shared (GP ←→Acute). This leads to a broader point of commissioners needing to have confidence in the self-assessments.

5.10 There is little reference in the report to the possibility of using technology to assist with the solutions to this issue and commissioners may want to consider the potential for how telemedicine may play a part in their future model of service. Airedale NHS Foundation Trust has been considering a range of telemedicine options across a range of services and commissioners may wish to explore some of these further.

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

5.11 Consideration to the support that the children, their families and friends will receive, to cope with any change is an important aspect for commissioners to address and to present to the public. It is also not clear what provision will be made for families who travel.

5.12 Commissioners may also find it helpful to consider the information from the outcomes of the acute care vanguards, a small part of which reflects the care of children.

6. Summary and Conclusions

6.1 The Senate thanks the Working Together Programme for inviting us to consider their Case for Change and Scenario Appraisal considering the care of the acutely unwell child.

6.2 The Senate is supportive of the need to address the issues highlighted in the Case for Change and agrees that changes are required to offer a safe and sustainable service to acutely unwell children now and in the future. Currently however, the Case for Change does not provide a comprehensive review of the issues facing the service and needs to be strengthened across a range of areas.

6.3 We recognise that commissioners are at a very early stage in their thinking but at this point in time we are unable to advise on the clinical concerns of the scenarios due to the lack of information provided and it would benefit from commissioners providing further detail on the hub and spoke model.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Dr Pierre-Antoine Laloë, Consultant Anaesthetist, Calderdale & Huddersfield NHS Foundation Trust

Dr Ben Wyatt, GP, Brig Royd Surgery

Assembly Members

Peter Allen, Public Representative

Jean Gallagher, Public Representative

Co-Opted Members

Dr Lisa Daniels, Consultant Paediatric Anaesthetist, The Great North Children's Hospital

Dr Geoff Lawson, Consultant Paediatrician and Clinical Director – Children's Services, City Hospitals Sunderland

Dr Andrew Simpson, Consultant in Emergency Medicine, North Tees & Hartlepool Foundation Trust

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Jeff Perring	Consultant Intensivist & Deputy Medical Director	Sheffield Children's Hospital NHS FT	At the Senate Council meeting on 21.9.16	The deputy Medical Director of a hospital whose provision of care is under review	At the Senate Council meeting on 21.9.16	To manage this conflict of interest we will need to ensure that Jeff does not take part in any Council or sub group discussions as they relate to this matter
Dr Sewa Singh	Medical Director	Doncaster & Bassetlaw Hospitals NHS FT	At the Senate Council meeting on 21.9.16	The Medical Director of a hospital whose provision of care is under review	At the Senate Council meeting on 21.9.16	To manage this conflict of interest we will need to ensure that Sewa does not take part in any Council or sub group discussions as they relate to this matter

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Care of the Acutely Unwell Child, Case for Change

Working Together Programme

V0.1

Sponsoring Organisation: Working Together Programme (South Yorkshire and Bassetlaw, North Derbyshire and Wakefield Collaboration)

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Will Cleary Gray on behalf of the Working Together Programme

Date: 15th September

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: TBC

Citizen Representative: Peter Allen and Jean Gallagher

Clinical Senate Review Team Members:

Dr Lisa Daniels	Consultant Paediatric Anaesthetist	The Great North Children's Hospital
Dr Pnt Laloë	Consultant Anaesthetist	Calderdale & Huddersfield NHS Foundation Trust
Dr Geoff Lawson	Consultant Paediatrician and Clinical Director Children's Services	City Hospitals, Sunderland
Dr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool Foundation Trust
Dr Ben Wyatt	GP	Brig Royd Surgery
Dr Mark Anderson	Consultant Paediatrician and Head of Department – Paediatric Medicine	Royal Victoria Infirmary & The Great North Children's Hospital

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Could the Senate advise on the Care of the Acutely Unwell Child Case for Change and whether this provides a comprehensive review of the issues facing the service.

Considering the Case for Change can the Senate review the 3 proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario

Objectives of the clinical review: The commissioners are seeking to agree a model for the Care of the Acutely Unwell Child that provides a high quality, safe and sustainable service to their population. The Senate advice will help to assure that the case for change and scenario appraisal are clinically robust, reflecting up to date clinical guidelines and national and international best practice and that the clinical risks, concerns and opportunities within

the proposals are fully explored. The Senate advice will be used in the next stage of the work as commissioners develop a more detailed option appraisal.

Scope of the review

Children and young people from birth to their 19th birthday experiencing:

- Unplanned/ unscheduled/ non elective incidences of acute illness or
- Acute exacerbations of existing chronic conditions
- Encompassing the 36 hour period from the onset of illness until the child is either discharged or active management is underway

Excludes children and young people admitted to adult wards and neonates in neonatal units and maternity wards

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 8th September

Agree the Terms of Reference: 15th September

Receive the evidence and distribute to review team: week commencing 19th September

Discussion at Council: Commissioners to present and have Q and A with the Senate Council on 21st September

Teleconferences:

- Working Group teleconference 30th September
- Commissioner teleconference 3rd October

Draft report submitted to commissioners: 19th October

Senate Council ratification: 17th November meeting

Final report agreed: end November 2016

Publication of the report on the website: end November 2016

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Case for Change: Care of the Acutely Unwell Child V0.3
- CAIC Case for Change V0.3 July 2016 Appendix A – Acute Standards
- CAIC Case for Change V0.3 July 2016 Appendix B – Child Health Standards
- Best Practice Guidance for the Configuration and Provision of Children's Acute Care August 2016
- Children's Acute Care: Scenario Appraisal 06/09/16

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. EVALUATION

The Senate will ask the commissioning sponsor to complete a short evaluation to assess the impact of the Senate advice. This will be emailed to the commissioning lead 3 months following the publication of the report.

9. RESOURCES

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

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

10. ACCOUNTABILITY AND GOVERNANCE

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

The Yorkshire and the Humber 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.

11. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. 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. 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.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable
v. complete the evaluation form issued by the Senate 3 months after the publication of the Senate report.

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.

Clinical 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. 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, and 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.

END

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below

- Case for Change: Care of the Acutely Unwell Child V0.3
- CAIC Case for Change V0.3 July 2016 Appendix A – Acute Standards
- CAIC Case for Change V0.3 July 2016 Appendix B – Child Health Standards
- Best Practice Guidance for the Configuration and Provision of Children's Acute Care August 2016
- Children's Acute Care: Scenario Appraisal 06/09/16