RCPCH Invited Reviews Programme

Service Review

Worcestershire Acute Hospitals NHS Trust

January 2014

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

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Published by:
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The Royal College of Paediatrics and Child Health (RCPCH) is a registered charity in England and Wales (1057744) and in Scotland (SC038299)

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1 Introduction

1.1 RCPCH was approached in September 2013 by Dr Mark Wake, Medical Director to conduct an invited review of maternity and paediatric services at Worcester Acute Hospitals NHS Trust. This report provides an independent critique of the current service and future proposals against agreed terms of reference, based upon information provided to the reviewers and evidence gathered through a two-day site visit on 20/21st November 2013.

1.2 The review takes into account adherence to published policy, guidance and standards developed by the RCPCH, RCOG, other professional bodies and the Government, where these are available, together with the workforce and service design experience of the Review Team.

1.3 The report is the property of Worcestershire Acute Hospitals NHS Trust and remains confidential between the Trust and those appointed by the RCPCH to produce it unless the Trust chooses to circulate or publish it. The RCPCH encourages dissemination of the findings amongst those involved in the service

but will not itself publish or comment on review reports without the permission and agreement of the review client.

2 Terms of reference

To review the paediatric and obstetric services at Worcester Royal Hospital, Alexandra Hospital, Redditch and Kidderminster Treatment Centre, under the Invited Review mechanism.

To consider concerns about the service with specific reference to:

- Quality of out of hours and emergency paediatric care
- Current arrangements for neonatal care
- Quality of birth experience with an emphasis on high risk births
- Sustainability of services
- Current workforce
- Team working and dynamics

To review the way in which the paediatrics and obstetrics services are currently delivered.

To make recommendations for the consideration of the Chief Executive and Chief Medical Officer of the hospital:

- Whether there is a basis for concern about the paediatric and/or obstetric services in light of the findings of the review

- Possible courses of action which may be taken to address any specific areas of concern which have been identified

- Whether the Trust proposals for reconfiguration are appropriate

3 Background Information

3.1 Worcestershire Acute Hospitals NHS Trust was formed in 2000 by merger of three small district general hospitals with a combined catchment of around 560,000, primarily from the county of Worcestershire.

3.2 The Worcester Royal Hospital (Royal) is located centrally and comprises a 12 year old PFI hospital, built to accommodate the population of Worcester. The hospital functions as a medium sized DGH providing type one[1] Emergency Care, a 35 bed paediatric inpatient and assessment unit, trauma services, routine paediatric surgery, outpatients and an obstetric unit with around 4,300 births per year. There is also provision of high dependency care and level 1 shared oncology (with Birmingham Children's Hospital). There is a co-located Urgent Care Centre run by Worcester Health and Care NHS Trust and local GPs.

[1] See www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp?shownav=

3.3 The 27-year old Alexandra Hospital in Redditch (the Alex) also operates as a full DGH serving a population of around 130,000 covered by Redditch and Bromsgrove CCG which extends eastwards into South Warwickshire. It also provides type one emergency care, paediatric inpatients and assessment unit, trauma services, routine paediatric surgery, outpatients and an obstetric unit with around 1,900 births per year. It has a co-located GP- led walk-in centre.

3.4 The Alex and Royal hospitals are around 24 miles apart, taking about 40-50 minutes by car or around 2 hours by public transport during the day, although bus services are sporadic and train connections go via Birmingham. The Alex is 12 miles from Birmingham with a direct train to the children's hospital and the maternity unit close by. Birmingham Heartlands and South Warwickshire NHSFT are relatively close too.

3.5 Kidderminster Treatment Centre ceased being an acute hospital site with closure of the Emergency Department (ED) and inpatient beds in 2000. It provides day surgery (including a children's list), assessment clinics and outpatients. There is a Minor Injury Unit (MIU) run by the community trust and local GPs which serves the local population of around 120-150,000 but other services are provided at the Royal or the Alex.

3.6 The trust links with the three Birmingham Foundation Trusts for specialist services, namely University Hospital Birmingham, the Birmingham Women's Hospital and the Birmingham Children's Hospital and there are also links to Coventry, Wolverhampton, Hereford and Gloucester in relation to specialist services.

3.7 There are three Clinical Commissioning Groups serving the population that attends the Trust hospitals, South Worcestershire CCG, Wyre Forest CCG and Redditch and Bromsgrove CCG.

4 Context of the review

4.1 Since the loss of inpatient services at Kidderminster in 2000, further consolidation of services between the sites is now needed to provide sufficient numbers to justify specialist medical expertise and avoid attrition of services to larger acute trusts such as Birmingham.

4.2 Public engagement during 2012 considered seven options for reconfiguration (including doing nothing) with a view to identifying those to for formal public consultation and two options emerged. The Trust's preferred option (Option 1) proposed centralising maternity and inpatient paediatrics on the Royal site with a new paediatric assessment unit (PAU) supporting a modified ED at the Alex site.

4.3 This model was presented to the Clinical Senate in January 2013 but support from all three CCGs was not achieved and one CCG proposed an alternative model (Option 2) suggesting that services at the Alex could be linked to the three Birmingham Foundation Trusts. At the time of the RCPCH visit an Independent Clinical Reconfiguration Panel (ICRP) appointed by the Local Area Team for NHS England was considering these options. It reported in January with a modified Option 1 which will be consulted upon in 2014.

5 The current service for paediatrics and maternity care

5.1 Kidderminster

5.1.1 There is no paediatric inpatient service at Kidderminster, although outpatient clinics and a weekly paediatric surgery list take place. The Kidderminster site offered a good example of a county-wide service where staff and patients had 'bought into' the redesign despite the politically challenging process of reconfiguration that preceded it.

Maternity services

5.1.3 There is a daily obstetric and gynaecological presence with day-care and outpatient facilities for gynaecology and an antenatal clinic service including services for high-risk pregnancies and fetal medicine. Specialist midwives are available for young and/or vulnerable parents together with specific clinics for diabetes (jointly run with a specialist nurse) and other high-risk conditions.

5.1.4 Day-care assessment is available Monday to Friday together with ultrasound for dating and anomaly scans. Most women are booked to deliver at the Royal, which is around 25 minutes away by ambulance, although 5-10% of women choose the Alex, to which they are transferred for antenatal care at 36 weeks.

5.1.5 The midwifery team reported good governance, peer support and supervision. Band 5 midwives rotate between services across the three trust sites and all sites use the same guidelines, procedures and notes.

5.1.6 There is good user involvement at Kidderminster with strong breastfeeding support and the establishment of a team of new mothers as peer breastfeeding supporters.

5.2 The Alexandra Hospital

Paediatrics

5.2.1 The Alex's 19-bed inpatient ward (Ward 1) includes six cubicles and two six-bedded bays, one for those aged under twelve and one for over twelves. It accommodates surgical and medical patients. There is a high dependency cubicle with separate resuscitation trolley, piped gases and ensuite facilities. There are reclining chairs/folding beds for parents to stay overnight and free TV till 7pm, plus a small parents sitting room with kitchen facilities. There is a large playroom staffed by a play specialist 7am-3pm weekdays and separate adolescent 'den' with Wii, table football, etc. There are two assessment beds used for stays up to 23 hours to which GPs can refer through the ED. Demand for this assessment area is relatively high due to local GP referrals, but the service is effective and the average length of stay for all paediatric admissions is just 1.2 days.

5.2.2 Ward bed occupancy levels are 40-50% and activity is relatively low particularly in summer, although there is pressure on cubicle availability. During the winter the capacity of the Alex is better utilized with 'overflow' patients from Birmingham being accommodated on the ward. The children's outpatient clinic comprises four consulting rooms.

5.2.3 The consultant team comprises six consultants and one locum providing 6.1 whole time equivalent (WTE) posts. Recent appointments include specialists in allergy and CF who are developing county-based services from the Alex. Since 2008-9 newly-appointed consultants have provided resident on call on weekday nights 2100-0930 for 4PA of their 12PA contract 'acting down' to cover the middle grade.

5.2.4 The Tier 1 paediatric rota comprises 8 slots including GP trainees and Foundation doctors. At Tier 2 there are six posts on the rota fully funded by the Trust. Two are deanery-appointed ST3 paediatric trainees[2] (one part-time) and there are two clinical fellows (one teaching) and two staff grades. Gaps in the rota are covered by locums (with 29 placements in a 12 month period). There have been 17 unsuccessful attempts to recruit to middle grade posts in the year to September 2013 and staff reported that they could not recall a time when there were more than 2 permanent staff at middle grade.

5.2.5 Locums are appointed for a month at a time but in 2012 sixteen per cent were replaced sooner than this. The turnover of middle grade locums is a significant concern, which is currently mitigated by consultants 'acting down' to ensure services are safe. The Review Team were told that there has never been a situation with no consultant or registrar cover, but staff reported the quality of locum cover puts pressure on nursing staff, especially out of hours.

5.2.6 Trainees reported that consultant teaching is good but low activity means there are too few complex paediatric cases, with the assessment unit being the most interesting placement. Educational supervision from an external tutor is very accessible and mostly delivered face to face which was much valued over virtual or electronic communication.

5.2.7 All trainees working at the Alex must have completed training in Paediatric and Neonatal Intensive Life Support (PILS/NILS) before starting work.

Nursing

5.2.8 The nursing team is strong across the unit and some nurses rotate between the Royal and Kidderminster to cover sickness. There are plans for more formal rotation in 2014. At the Alex there are three trained nurses per shift and one Healthcare Assistant, and it is easy to recruit although there is around 1 WTE vacancy at any one time. Around 80-90% of nurses have safeguarding training to level 2 and bands 6-7 are encouraged to complete level 3 online, and EPLS and oncology training are encouraged.

5.2.9 There are no Advanced Children's Nurse Practitioners (ACNP) on the ward. The consultants reported that ACNPs were difficult to recruit and may be

[2] Usually Tier 2 doctors would be ST4 but since the site is relatively quiet the Deanery supports the placement of ST3s who receive good experience and build confidence

limited in their versatility given the need for medical trainees to maximise their experience. There are also no paediatric ENPs although one nurse is funding her own training. A paediatric assessment course is offered at the University of Western England in Bristol and a number of staff anticipate taking the course to enable them to manage the PAU after the transfer.

5.2.10 The Orchard Service is a team of community children's nurses funded jointly by the Trust and Worcester Health and Care NHS Trust. The team provides a 7-day a week Hospital at Home service including palliative care and care for children with acute and complex needs including intravenous antibiotics. There was a suggestion that the Orchard Service would also be used to staff the PAU and there are plans to train nurse practitioners and give them time to develop appropriate skills prior to transfer of in-patient services.

Neonatal service

5.2.11 There is an 8-cot Special Care Unit (SCU) adjacent to the postnatal ward which comprises two rooms with 2-3 cots each and a resuscitation room with appropriate equipment. The unit cares for babies over 34 weeks gestation if they are well and will retain babies undergoing continuous positive airway pressure (CPAP) for up to 24 hours but uses discretion for sicker babies. During 2013 there were 21 days of intensive care activity, 55 days of high dependency activity and 1576 days of special care activity. 163 days of activity were transitional care, giving an overall unit occupancy of 62%.

5.2.12 In 2006 a report by Professor Alan Craft (unseen by the Review Team) stated that maternity and neonatal services at the Alex were unsafe due to insufficient staffing levels and expertise at consultant level. A range of staffing options was considered by Worcestershire PCT as part of the commissioning strategy in 2008[3] and the risks were ameliorated through an injection of additional funding to boost recruitment. This funding ceased when the local PCT was replaced by three CCG's.

5.2.13 The unit is staffed by two registered nurses, one with neonatal training and there is a weekday Neonatal Outreach service between 9am and 5pm supporting early discharge. Nurses rotate between the two hospital sites and when the unit is quiet they may assist in maternity, as paediatrics is relatively quiet. Some nurses can cannulate but none intubate. Some midwives are trained to conduct new-born examinations. All nurses are skilled in neonatal life support and undertake four yearly training to maintain skills.

5.2.14 Although the SCU at the Alex is relatively quiet and the staffing appears to be compliant some concerns were expressed to the Review Team about the experience of some of the doctors to cover the neonatal unit on-call at middle grade. The resident consultant on call model provides support, and staff do liaise with the Royal consultants for advice but the lack of rotation through busier sites and the low incidence of sick neonates may result in attrition of skills; for example immediate intubation and stabilisation of a neonate was required just 14 times in 2013 In 2008 the PCT recommended that all consultants and non-training middle grades participate in a skills maintenance programme

[3] See http://www.worcestershire.gov.uk/cms/idoc.ashx?docid=dc34ef40-8b7d-4e41-b6b6-5b0885812339&version=-1

with Birmingham Women's Hospital. This training programme ran once for newly appointed medical staff but was not repeated.

Emergency care and assessment

5.2.17 The ED at the Alex sees over 10,000 children annually and as a trauma centre, this includes a number of children and young people from motorbike and horse riding accidents in the summer. The pathway from reception to a children's waiting area through to the bays was short and separate from the adult pathway. There are three decorated paediatric cubicles with toys, piped gas and suction although they can also be used for adults. The 2-bed resuscitation area had capacity for a third bed but no dedicated paediatric bed or small child resuscitaire. The area was cluttered and paediatric resuscitation algorithms were not visible, although a dedicated children's emergency trolley was available.

5.2.18 There are nine consultant Emergency Physicians working across both sites. All consultants are APLS instructors and all middle grades are Advanced Paediatric Life Support (APLS) trained. It was reported that all consultants, middle grade and long term locums (over 18m) have appraisals up to date. All staff are trained to Level 3 in children's safeguarding and all including band 6/7 nurses have APLS/EPLS training. There was less certainty about whether staff were trained in other areas outlined in the Intercollegiate ED standards[4].

5.2.19There is only one WTE children's nurse employed in the ED and ward staff expressed concern regarding the nursing skills in ED due to the lack of children's nurses. There is an anaesthetist as part of the children's cardiac arrest team and support is good.

Obstetric services

5.2.20 The Alexandra Hospital offers a full obstetric service. There is a 26 bed antenatal/postnatal / transitional care ward plus a day assessment unit and clinic facilities. Delivery suite comprises 8-beds and a single obstetric theatre handling 2,300 births from 34 weeks gestation. There are around 500 in utero transfers into the Alex from other units including Birmingham Women's and Heartlands which become full and the obstetric unit at Solihull which has recently converted to a midwife led unit.

5.2.21. There is a birthing pool 'in a box' supporting 30-35 pool labours and 25 births per year.

5.2.22 The caesarean section (CS) rate is 28-30% but has been variable, dropping as low as 21% at times. The Trust-wide rate is around 25.6% and appears to be loosely dependent upon the number of locum staff in post. Proposals to establish Midwife Led Units (MLU) within the county to reduce the CS rate and increase normality have been delayed by the 2012-3 consultation.

5.2.23 A recent audit of babies needing cooling apparently indicated greater need at the Alex site – 1.8/1000 compared with 0.7/1000 at Worcester and

[4] RCPCH (2012) Standards for children and young people in emergency care settings

expected rates between 0.5 and 1 per 1000nationally, but numbers are very small; the review team did not see the audit.

5.2.24 There are five consultants providing 40 hours labour ward presence. There is anaesthetic cover from 24 hour registrar and also ITU support.

5.2.25 The Tier 2 rota comprises eight doctors (6 speciality registrars and two specialty doctors) and at the time of the visit there were five in post including one ST5. Tier 1 establishment is eight junior posts (3xFY2, 5 GP trainees) with seven in post at the time of the visit. It is difficult to attract clinical staff and remaining slots and gaps in the rota are covered by locum staff on 2-6 month appointments. During 2012 there had been sixteen O&G locums working at the site.

5.2.26 The number of trainees allocated by the Deanery varies due to few trainees choosing the site. Since August 2013 the programme for both sites is managed through the RCOG tutor based at the Royal, but most trainees at the Alex are not shared or rostered with the busier Royal which reduces the breadth of experience and complexity to which they are exposed. There is one rotating post which began in August.

5.2.27 The Alex had been under scrutiny from the Deanery visit in 2012/3 following concerns around supervision, cancellation of Gynae operations and trust-wide training but these issues were resolved prior to the September 2013 intake. The environment for trainees is good but the tight centralised rota can affect relationships and there was reported to be some variability of consultant opinion which can make decisions difficult. Trainees explained that they had been asked on occasion to carry out inappropriate administrative tasks and there were some tensions in working with the midwifery teams. The trainees had been offered simulations but these had not been arranged although consultants had been very encouraging when involved in serious events.

5.2.28 In terms of governance there are junior doctor forums every 4 weeks which include audit. There is governance and audit meeting for obstetricians and midwives every third Friday afternoon which includes examination of Serious Incidents. Around 40 have been reported over two years, each of which have been proactively discussed at a round table within 4 weeks.

5.2.29 The consultants interviewed at the Alexandra Hospital site explained that the uncertainty over reconfiguration was damaging morale. They feel they are a strong team working increasingly hard to cover a one-in-five rota and although they recognise that the work is currently less intensive than in most DGHs they are anxious that any transfer of services to the Royal will result in fully integrated medical teams.

5.2.31 There was a strong feeling that a midwife led unit would be welcomed at the Alex for low risk births given the difficulties of travel to the Royal. The current service links with Solihull, Warwick, Birmingham Women's and Heartlands with women transferring if any of the units is full. There is an estimate that around 500 women will deliver outside the Trust if the Alex obstetric unit closes.

Midwifery services

5.2.32 The ratio of midwife to mother was a commendable 1:30 with aspirations for 1:28 – there are no vacancies and the midwifery sickness rate is a very low 2.4%. The maternity unit is compact and runs like a small DGH or cottage hospital with a friendly, homely feel that did not appear to be busy. Feedback from the women who use the service was generally positive and the morale of the midwives seemed very high. Both women and midwives felt that the service was of a high quality standard.

5.2.33 There is good liaison with midwives across the trust, with trust-wide combined training scheduled up to a year ahead. All teams use the same notes and the same labour ward protocol which is good practice. There appears to be constructive midwifery team working between both units and this may be reflected in the positive relationships that both sets of the management team have There is an 'on call matron' countywide at all times. Midwives from Alex work closely with Royal team, with all band 5 starters rotating for 6 months in each unit and this is incorporated in their contracts.

5.2.34 Both sites offer an after birth advisory service (ABAS) for women who have experienced loss, preeclampsia or other problems offered a debriefing with the consultant. All women undergoing emergency caesarean sections are debriefed the next day and a letter is sent to the GP.

5.2.35 Lengths of stay at both sites are between 6 hours and 3 days, (2-4 days for caesarean section) and there was a view expressed that discharge could be swifter for some new mothers and length of stay could be audited against national data. The midwifery team is running a Birth Rate Plus analysis to examine the needs and acuity of women using the service in order to determine appropriate midwifery staffing levels. Lengths of stay are shown to reduce if normal birth rate is increased and a Midwifery Led Unit (MLU) would lend itself well to this concept. Midwives on all sites are very open to this idea and would welcome an MLU within the Trust regardless of its location.

5.3 Worcester Royal Hospital

Paediatrics

5.3.1 The paediatric ward (Riverbank) is for children up to 18 years old. It has 31 beds including 15 cubicles with en suite facilities, plus a four bedded assessment bay, a treatment room and two high dependency cubicles, one of which is also suitable for young people with mental health problems. There is an adolescent room (being refurbished at the time of the visit), a sensory room, a play room and a milk room for preparing infant formulas. Parents staying overnight with their sick child may have a camp bed with the child or there is a small parents' en-suite sleeping room. There is a parents' day room with tea/coffee making facilities. The ward is child friendly with appropriate pictures, posters and mobiles and there is an outside play area. Two parents in the ward at the time of the visit spoke highly of the staff and the care being provided. A child on the ward said that the nurse was nice and he/she felt comfortable being there. There is a paediatric early warning system in operation.

5.3.2 Activity is approximately 4000 emergency admissions per year, with an average length of stay of 1 day and occupancy levels of 50-60%. There is one bay used for day case surgery, with up to 6 children per day and occasional Saturday lists.

5.3.3 Medical staffing remains a challenge at middle grade level. There are 8 consultants, 7.3 WTE, with one retiring and one community paediatrician who has recently left the on call rota. Two more consultants will be recruited with special interests in cardiology and respiratory in line with plans to develop the managed clinical network with the tertiary centre in Birmingham, but it is not clear whether this was a commissioner requirement. The Review Team was advised that in future all new consultants will have a defined special interest in order to develop more local services for the population.

5.3.4 The 8-doctor middle grade rota covers paediatrics and neonatology and comprises seven Deanery trainees (2xST3, 4xST5, 1xST6) and one international training fellow. The trainees include three community doctors and four acute but in practice deanery rotation slots are not always filled so the gaps are covered by internal shifts and locums. Concerns were expressed about the quality of this arrangement, particularly the use of locums.

5.3.5 The Tier 1 rota comprises 10 doctors with 3x FY1-2 and GP trainees . With the exception of maternity leave long term locums are rarely required for the Tier 1 rota.

5.3.6 The Deanery regards the Royal as a good place to send ST3s to 'step up' to middle grade. Recruitment problems are met head on with good consultant backup and effective HR support and the trainees intimated that the placement was good with plenty of experience and activity and good 24-hour support from the consultants.

5.3.7 The service runs a consultant of the week arrangement and meets eight of the ten 'Facing the Future[5]' standards. There are fewer than the required ten doctors on each rota (standard 8) and consultant presence is not recorded at all busy times (standard 6). There is an evolving managed clinical network with Birmingham Children's Hospital with visiting consultants in cardiac, neurology, endocrinology. Some Worcestershire consultants also have sessions within the tertiary unit.

5.3.8 GPs locally have a good understanding of children's issues and referrals are usually direct to the children's ward (rather than through ED). The CCG is reviewing the increase in less-than-one day admissions, and a system where two GPs will provide an assessment in the community is being piloted from 1st December. There is innovative working with 'EMIS[6]' on i-pads and a central point for 10 practices to refer to decide on referral and follow ups.

5.3.9 There were no reported problems with recruitment of children's nurses – although they are normally at Band 5. Nursing services are integrated with the Alex and guidelines are trust-wide, but nurses generally work in the unit closest

[5] See www.rcpch.ac.uk/facingthefuture
[6] Egton Medical Information Systems Limited, known as EMIS – the software company that supplies computer systems to general practices

to their home. There are normally five or six nurses during the day and four at night for 35 beds. However, due to low occupancy levels, this normally results in four patients for each nurse, which just meets RCN minimum standards if all children are over 2 years of age[7]. There is one Advanced Children's Nurse Practitioner (ACNP) working in a practice development/education role, which gives her limited opportunity to practise her skills. There are two more interested in training, but nurse practitioners are currently unable to contribute to the Tier 1 rota as it is combined with the neonatal service.

5.3.10 Worcestershire Health and Care NHS Trust provides community nursing and paediatric services for the county including in-hours safeguarding medicals for possible CSA and the Orchard Community Children's Nursing service The Orchard service provides care for children with acute and complex care needs, including those requiring palliative or end of life care.

5.3.11 Community paediatric services liaise closely with the acute team, with many patients under joint care and some community paediatricians performing outpatient clinics within the acute trust.

Emergency care and assessment

5.3.12 The Review Team was unable to visit the department in the time available but was told by the consultants at the Alex that the Royal ED does not have the capacity to take all the patients from Redditch. Staff at the Royal explained there are two paediatric cubicles in the ED, with no children's nurses employed that there were plans to develop a separate PAU to be located alongside ED to operate on a 24 hour basis following reconfiguration. However, the service currently operates as a four – bed assessment area within the ward, and is staffed as part of the ward. .

Neonates

5.3.13 There is a level 2 Local Neonatal Unit (LNU) at Worcester linked to the Special Care Unit (SCU) at the Alex. It includes 6 combined high dependency/ intensive care cots, plus 12 special care cots, and cares for infants born in Worcestershire and Herefordshire. There is close working with West Midlands Newborn Network and all babies born below 27 weeks gestation are swiftly transferred to a level 3 unit, usually within Birmingham. Those still receiving intensive care after 48 hours are discussed with the lead centre and may be transferred for ongoing care. A mother and baby unit has been created for low level specialist care and transitional care which is led by a neonatal nurse and a nursery nurse and a neonatal outreach team facilitates early discharge home. In 2013 there were 328 days of intensive care activity, 775 days of high dependency activity, 4338 days of special care and 1390 of transitional care. Cot occupancy rates during 2013 were 82%.

5.3.14 There is a separate daytime (9-5) neonatal rota shared by four consultants with neonatal interest but out of hours the neonatal unit is covered by the general paediatric middle grade/consultant on call. There is a separate Tier 1 rota operating 12 hours a day, which is a requirement of the BAPM standards for a Local Neonatal Unit require a separate tier 1 rota 24 hours a day.

[7] RCN (2013) Defining staffing levels for children and young people's services

5.3.15 Neonatal nursing is shared across the Alex and Royal sites and the need of two trained staff at the Alex irrespective of activity results in nurse staffing at the Royal sometimes falling below the requirements of the neonatal toolkit[8]. The Qualified in Specialty (QIS) nurses have needed some support to build their skills but they are now working in extended roles, running a shift and working to shared guidelines. The Trust has increased nursing skills across the team to include skills such as cannulation rather than train Advanced Neonatal Nurse Practitioners (ANNPs), as the consultants feel there is insufficient work for advanced practitioners. Some concerns were raised by trainees about undermining behaviour which had been alerted through internal systems and was being addressed. In addition, there are concerns regarding the quality of middle grade cover on both sites, as the standard of locums is variable.

Obstetric Services

5.3.16 There is a full high risk obstetrics service with a 10-bed delivery suite accommodating around 4,300 births per year. There is a 35 bedded antenatal/postnatal ward encompassing a transitional care facility. The unit was newer than at the Alex and well laid out. The Trust has achieved CNST level 2. The caesarean section rate is 24-25% and specialist services offered include interventional radiology, Cell salvage, fetal and maternal medicine and a twins clinic and services appeared to be well run and of high quality. The level of serious incidents is not high (0.3%) with 28 over the last 2 years, 13 occurring at the Alex and 4 classified as grade 3's. .

5.3.17 There are nine consultant obstetricians (2 obstetrics, 6 O&G, 1 locum) with eight providing 60 hours presence on labour ward, increasing soon to 9 plus a locum. A unit of this size would usually require at least 98 hours consultant cover[9] although less than 50%of units nationally have yet achieved this standard.

5.3.18 There are eight-doctor rotas at both Tier 1 (7 GP trainees, 1 specialty) and Tier 2 (5 specialty registrars and 3 specialty doctors). There have been attempts to boost staff cover at middle grade through nurse practitioners and there is some rotation of trainees between sites with a registrar rotating through the Alex. There remain, however an average of four middle grade vacancies covered by locums (double the contractually acceptable level and contrary to RCOG standards).

5.3.20 There was a Deanery visit last year at both sites which required a number of actions. There is one tutor across the trust overseeing all trainees but numbers of births at each site are relatively small and with eight trainees there are fewer opportunities for gaining hands-on experience.

Midwifery Services

5.3.21 The midwifery service at the Royal appeared to be relatively well staffed compared with national averages with a current ratio of 1 midwife to 33 women although the contractual target is 1:30. Newly appointed (Band 5) midwives

[8] DH 2009 Neonatal Toolkit
[9] RCOG Standards

rotate through both sites and supervision of midwives across the trust met the standard of one supervisor to 15 midwives. One to one care in labour was reported to be an impressive 92% but readmission rates were higher at the Royal than at the Alex. There is no consultant midwife. Home births were around 2%, and the birthing pool is popular and fully booked.

5.3.22 Significant efforts have been made within the midwifery team to bring both sites together and this is reflected in the midwifery management structure which demonstrated a genuine desire for excellence across the service.

5.3.23 Maternity staff at the Royal are anticipating that most midwives and around 1500 births will transfer if the Alex obstetric unit is closed, with the remainder choosing Birmingham if there is sufficient capacity to accommodate them.

5.4 Cross-cutting issues

Paediatric surgery

5.4.1 Paediatric surgery was outside the scope of this review beyond its interaction with paediatrics for very young children and paediatric inpatient wards

5.4.2 There is a weekly day surgery list for the County at Kidderminster including dental and ENT across 4 theatres. The waiting area is cramped but welcoming and comfortable with carpet[10] and toys. A play leader works between the Kidderminster and Royal sites and there is also provision at the Alex. Children's surgery takes place at the Alex and the Royal and the Review Team were told there is some concern at the level of surgery being carried out at the three sites and whether anaesthetic exposure is sufficient to maintain skills. Children less than 2 years old go to Birmingham from both sites and those under 5 are jointly managed with paediatricians.

Involving users

5.4.3 The Review Team found little evidence of systematic involvement of paediatric patients or their families. Although proud to have been running and publishing the results of the 'Friends and family' test since August 2012 the survey does not include the paediatric or neonatal wards at either site and was introduced to maternity in October 2013 as a national requirement. Patient feedback on individual consultants is collected for obstetric consultant appraisal purposes.

5.4.4 In terms of maternity engagement there is a labour ward forum and district-wide maternity services liaison committee/forum (MSLC) chaired by a lay person. However, at the time of the visit, not all the consultant obstetricians (at the Alex) knew about the MSLC and one (at the Royal) believed that it had ceased to operate but was being supported to restart.

5.4.5 Users of maternity services reported a good experience generally through the 2010 and 2013 CQC maternity surveys which indicated satisfaction as

[10] Risk assessed for infection and cleaned regularly

similar to national data. Patient representatives spoken to by the team at the three sites were generally positive about maternity and paediatric services, including the open access arrangements, home visits from the respiratory nurse for a child with complex needs and the breast feeding support group (Baby latte*).* Breastfeeding counsellors do survey women but there has been poor publicity to date. User feedback and complaints regarding maternity care tend to highlight postnatal care and continuity of carer as the main concerns.

5.4.6 A lay person is involved in the governance group and surveys are carried out county wide. The Picker survey for maternity services showed the trust as average for patient experience across the range of criteria, with the service users at the Alexandra Hospital showing greater satisfaction than those at the Worcester Royal.

Reconfiguration consultation

5.4.7 At the time of the visit the services were under review with a proposal for reconfiguration to move all obstetric and children's inpatient services to the Royal site. An independent review panel established by NHS England on behalf of the CCGs reported in mid January 2014 recommending that the proposals, with some amendments. proceed to consultation.

5.4.8 Medical and nursing staff gave varying reports regarding difficulties with transport between the two sites which is a significant issue in terms of reconfiguration but outside the scope of this review.

Safeguarding

5.4.9 Safeguarding across the Trust is consultant led. The Designated Doctor is employed by the Community Trust and community paediatricians cover the daytime CSA rota with physical abuse medicals and out of hours CSA medicals being conducted by acute paediatricians at the Royal. Child Sexual Abuse (CSA) medicals are rarely conducted out of hours as most can wait to see a community paediatrician the next day in the local SARC.

5.4.10 There is a Named Nurse and a Named Doctor for safeguarding on each site. The Sudden Unexpected Deaths in Infancy (SUDI) service was covered by a full rota led by a community nurse and health visitor, but the service was rarely needed so now cover is provided by the SUDI nurse and the acute consultant on call overnight. There is no hospital social worker at the Alex.

5.4.11 There is a serious case review currently in process relating to a toddler death with questions being raised over the safety of the service, and it is expected that the Trust will take forward any recommendations arising from the report. There is information regarding adult safeguarding on the Trust website including how to report concerns, but there is no information available to the public regarding safeguarding children.

Governance

5.4.12 Governance systems within obstetrics and gynaecology appeared sound and processes were in place for audit, learning from complaints, incidents and,

compliments. Meetings with the trainees to discuss these areas are held every six weeks. There are roundtable discussions when things go wrong, plus monthly clinical governance meetings. Risk and patient safety meetings were held at the Royal with teleconference links to the Alex. There were reports of good medical supervision but again this was not evidenced and the team also heard that there was no audit committee.

5.4.13 Within paediatrics the governance systems are under review following a recent senior management restructuring. There is a 2-monthly paediatric cross-site Clinical Governance meeting which includes medical and nursing attendees joining by video conference and feeds to the trust-wide Patient Safety Group. For 2014 these will become monthly meetings attended by the Clinical Director, consultants, nurses, the General Manager and a representative from risk. These meetings follow a specific template including serious incidents, complaints and guidelines etc. There is no risk governance manager in paediatrics although the 'will' is there and there is one for maternity.

5.4.14 There is a 4-6 weekly meeting between the consultant responsible for risk management and senior nurses for neonates and children's services at which recorded serious incidents are discussed. The most common issue arising is delayed discharge, with neonatal transfer delays, medication errors and safeguarding issues also being frequently discussed.

5.4.15 Although there is a non-executive director as Children's Champion on the Trust Board, staff were not familiar with this position. A recent management restructure has taken place and there is now also a named executive director with lead responsibility for children. The 2012-3 annual report contains only one reference to children's services as part of the reconfiguration and no mention of neonatal issues.

6 RCPCH Comment and Analysis

6.1 Paediatrics

6.1.1 The paediatric services at both Alex and Royal sites are operating under considerable medical staffing pressure with the Alex in particular running with significantly non-compliant rotas and high usage of locum staff. The review team did not discover any specific serious incidents or unsafe practice but the pressure on staff with the current rotas raises the risk of harm and services appear to be safe in the short term only due to consultant staff 'acting down' when locums are not available and good working relationships at each site.

6.1.2 Trainees at the Alex were very supportive of the service and received excellent support which was also reflected in the GMC survey results. However the limited opportunities for exposure to complex cases, and the inability of the Deanery to fill all the slots implied that the quality of training was generally of a lesser standard than may be available elsewhere.

6.1.3 These arrangements are not sustainable and there has been an increasing difficulty in recruiting junior staff due to the uncertain future of services and low levels of activity at each site, further raising the level of clinical risk. There was

at the time of the visit no formal plan to develop cross-site working amongst the medical teams.

6.1.4 Options available to ensure services are safe and sustainable for those families currently using the Alex include a more formal two-tier model of resident on-call consultants, which is expensive and challenging to recruit to without sessions at tertiary centres built into the job plan, or the proposal (Option 1) supported by the ICRP which moves the whole inpatient service to the Royal and maintains an assessment unit, minor injuries service and outpatient clinics for children at the Alex.

6.1.5 In this scenario it should be noted that considerable work will be required to ensure smooth integration of the teams and services. It is not yet clear how the consultant bodies will work together, for example, whether there will be full integration across both sites or whether the Alex consultants would largely cover whatever services are provided there and maintain their skills through participation in the Consultant of the Week system at the Royal. It is likely that some up-skilling of the Alex consultants to contribute to the out of hours neonatal rota will be needed together with recognition by the Royal team of the additional travelling required to deliver clinics and support the PAU in Redditch.

6.1.6 Although appropriately trained in life support skills, it was not clear that staff in the ED at the Alex have been trained in additional areas such as pain assessment and communication with children, measurement and monitoring of vital signs or child development. There does not appear to be a structure for assessing competence in non-paediatric staff and there appears to be heavy reliance on paediatric input for the management of infants and children in ED. Emergency physicians stated they would call in a paediatrician to review cases out of hours, particularly where children were being admitted via the ambulance service. Under the new proposals there will need to be clear protocols and public communication to divert children (except those will minor injury) either to the ED at Worcester or during opening hours to the PAU.

6.1.7 With the current configuration of services, the nursing numbers meet minimum standards for children over 2 years, due to the low bed occupancy. When beds are full, current staffing levels will be insufficient to provide safe and effective care. There does not appear to be a problem recruiting nurses, although the majority are newly qualified nurses with minimal experience. There is some concern among the nurses at both sites that there are too many children staying in hospital longer than required. There were reported to be good links with the Orchard Community Nursing Team and further development of this relationship across the child's pathway of care could speed up discharge and also ensure children are only admitted when necessary.

6.1.11 It is important to explore utilising nurse practitioners on the junior and middle grade rotas in the future. There is no need to increase the numbers of staff as there could be far more activity with the same team. Although reconfiguration to one site as proposed will allow the development of a separate Tier 1 rota staffed by foundation doctors and GP specialty trainees, more advanced practice nurses would provide an opportunity to supplement the Tier 1 rota and provide resilience should trainee numbers reduce in future.

6.2 Neonatal care

6.2.1 There are four consultants with neonatal expertise at the Royal but none at the Alex. Whilst relationships are good and advice is readily available, the Alex doctors (both consultants and trainees) are not receiving sufficient neonatal experience to confidently provide cover to the SCU in an emergency and there are no rotations in place for them to gain experience and maintain skills. At the Royal, although the LNU occupancy is relatively low the unit is breaching standards by not operating a separate Tier 1 rota. Reconfiguration with centralised inpatient services will address both of these problems

6.2.2 Neonatal nursing works well – there is tight teamwork across the two sites with clear guidance and rotation but a central LNU would enable more flexible staffing.

6.3 The Maternity Service

6.3.1 The Review Team found the Alex consultants increasingly disenfranchised by the long-running reconfiguration plans and despite some limited cross-site working there is little integration of maternity teams across the Trust. It is important that a decision is made soon on the future of the service at which point the Review Team felt that with a clear maternity strategy and strong leadership both sets of medical teams would work towards provision of an effective trust-wide service.

6.3.2 The junior doctors interviewed found the Alex an extremely pleasant place to work, the amount of practical training that they receive is extremely limited. The Review team inferred that they were often used as 'scribes' and none of them had even seen a normal delivery. There would seem to be a considerable amount of work that needs to be done to improve the experience of the GP trainees to enable them to be suitably trained and informed to work with a reasonable knowledge of obstetrics in general practice in the future.

6.3.3 The middle grade doctors interviewed at the Royal felt that their experience was extremely good and their training was excellent. However the GP trainees did not gain practical experience and the similar concerns apply to them as for the Alex trainees. The Review Team fed back to the RCOG tutor, about concerns with regard to GP training.

6.3.4 At all three sites the midwives appeared to the Review Team to be well motivated and of good calibre. The units offered an extremely happy working environment reflected in low turnover and sickness levels and the joint guidelines and notes improved integration and reduced risk.

6.3.5 The Review Team was given to believe that there were some concerns about maternity outcomes at the Alex. The only evidence provided was a concern about third degree tears and also a slightly increased incidence of babies with HIE severe enough to warrant transfer for cooling. However, there was no objective evidence provided to suggest that there was an immediate clinical risk currently at either of the units.

6.3.6 Maternity staff on both sites are keen to develop a low-risk midwife-led birth centre; they are ambivalent where it is located and there are repercussions about the historic situation at Kidderminster but times have moved on and development of a new unit is important for staff morale and importantly the availability of choice for women. The midwifery team is extremely competent, well led and effective and there are good relationships with medical staff.

6.4 Workforce and Sustainability of Services

6.4.1 The Review Team's biggest concern is the middle grade doctor rotas across both obstetrics and paediatrics. For both services these are currently designed as eight-cell rather than ten, and on both sites the Deaneries are unable to fill even these slots resulting in significant use of locums or variable quality. The number of junior doctors varies on the two sites from year on year and sometimes there are more locums at the Alex than the Royal and vice versa. Rotas running with 'permanent' locums expose the service to clinical risk and a solution needs to be found to resolve this problem. It is not going to be possible to resolve the problem through the Deanery and therefore amalgamation of the two units would provide an opportunity to rationalise the staff on the middle grade rota and hopefully increase the number of posts occupied by substantive appointments.

6.4.2 A combined obstetric service would enable a 10-consultant rota and raise the opportunity for 98-hour consultant presence on labour ward. Trainees would be exposed to increased complexity and the calibre and quality of middle grade doctors would improve, resulting in the unit being more attractive to future trainees seeking a placement.

6.4.3 The paediatric service does not currently meet all ten 'Facing the Future' standards due primarily to the inability to recruit permanent middle grade doctors and the cost of fully compliant rotas on each site. The situation (as set out in that document) Is unlikely to improve in future given the reducing numbers of available trainees and affordability of fully compliant staffing for relatively low levels of paediatric activity. Combining the medical teams and consolidating inpatients on one site would enable consultant presence at peak times (usually evenings) and rotas to be designed with ten doctors as well as compliant staffing for the LNU.

6.5 Team working and dynamics

6.5.1 There are some challenges to joint working and professional unity between the teams of doctors at each site. There have been some efforts to engage and integrate the teams through educational meetings, cross-site sessions and joint perinatal meetings but attendance was cited as poor.

6.5.2 There appeared to be a lack of a clear strategic direction on the Alex site but this may now be mitigated with the ICRP decision. There are some enthusiastic new consultants who should be mentored and encouraged to develop leadership skills. Overall, management needs a clear pathway to an end point with dates that can be shared with the clinical teams to enable then to plan and communicate clearly with patients.

6.5.3 Midwife morale remains high and. 70-80% of midwifery staff would apparently transfer to the Royal. There is, however, a general feeling of lack of investment at the Alex and development of a MLU and other replacement services may reemphasise the importance of the site to local patients and staff.

6.5.4 It is important now that the ICRP Panel as offered a way forward, subject to consultation. to move swiftly so staff can plan, communicate clearly with patients and families and develop their services to suit. Staff at the Alex are generally accepting that the only decision that will be made will be one that moves them partially or completely to the Royal, and they are willing, in general, to make the move and hopefully become integrated with their colleagues at Worcester Royal.

7 Summary and Recommendations

7.1 Is there is a basis for concern about the Paediatric and/or Obstetric services in light of the findings of the review

7.1.1 Yes. In the current configuration both the obstetric and paediatric/neonatal services are unsustainable and are coping through the appointment of locums to cover middle grade rotas and the goodwill and energy of consultants covering where this is not possible.

7.2 Are the Trust proposals for reconfiguration appropriate?

7.2.1 Yes. The review team looked at the proposals whilst acknowledging that the ICRP was expected to make a decision, and that has now been published. There are benefits for patients in the new models, particularly the quality of care received, the availability of senior paediatricians during times of peak activity, increased junior doctor cover and increased obstetric cover for labour ward and the neonatal unit. The change provides the opportunity for two middle grade obstetricians to be on call overnight and fewer Tier 1 doctors receiving better training.

7.2.2 There are a number of considerations, however, that emerged during the interviews that would need to be worked through during detailed design

Paediatrics

7.2.3 The proposed reduction in total number of beds from 48 to 31 will require integrated working with primary care and the hospital at home service. The current capacity of the Alex to accommodate local fluctuations and ‘overflows’ from nearby overstretched units will be lost which provides an improved basis for planning but may affect income and require contingency discussions with neighbouring trusts.

7.2.4 The capacity, capability and future of the Alex emergency department is not yet fixed at present given the IRP proposal to revise the service to an adult-only model with a MIU for children. It is important that any provision proposed is

compliant with the Standards for Children and Young People in Emergency Care Settings[11] .

Obstetrics

7.2.6 The physical capacity of the Royal site is insufficient to handle all the activity currently provided at the Alex and will require construction of theatre capacity and ward space and the development of an MLU on site. There is widespread support for the development of a midwife-led unit at the Alex which may mitigate some demand. The presence of consultants doing antenatal clinics and gynaecology clinics at the Alex and a carefully thought out booking policy could increase feasibility of this arrangement. It would be wise for the clinical management team to use a successful MLU model from elsewhere in the country as the starting point for working up a solution for an MLU at the Alex. The Trust will need to satisfy itself and the CCGs that appropriate robust governance is in place following the experience in Kidderminster, but the overwhelming desire from staff for an MLU might be what is needed to bring the CCGs together with a shared vision.

Generally

7.2.7 Looking beyond the Trust, it was reported that Birmingham is already running close to full capacity and it is important to consider the effect on the wider population of the proposals for the Alex to reconfigure.

7.3 Possible courses of action which may be taken to address any specific areas of concern which have been identified

7.3.1 Explore the development of a Midwife Led Unit at the Alex site (see 7.2.6)

7.3.2 Given reports of capacity issues at neighbouring trusts there is potential to examine greater use of the Alex site through improved network links and provision of specialty outpatient services similar to those running at Kidderminster. The current initiative within paediatrics to identify special interests within the consultant team and target recruitment towards strategically valuable specialisms is to be encouraged in order to develop the capability and profile of the service, keeping more care within the Trust and utilising the three sites for county-wide services.

7.3.3 The community paediatric service was outside the review terms of reference but appears to be variable across the county. Relationships are generally good and until very recently Worcester community paediatricians contributed to the acute hospital on call rota. The CCG is keen to use them more within the service so we would recommend exploring integration of the paediatricians and nursing services.

7.3.4 The maternity services forum chair was impressive and informed but largely through her own efforts. She reported that she was not made aware of local strategic developments despite being a member of some governance committees. User involvement is particularly important given the changes that

are proposed and although more could and should be done to engage with the existing self-established patient groups, a proactive strategy to build genuine involvement and patient voice into planning and design of services is important to enable buy-in, effective communications and services that meet local needs.

7.3.5 Governance systems need strengthening in terms of structure given the recent changes of responsibility at senior level. It is not clear who represents children on the Trust Board and staff were inconsistent in describing the processes for safety and quality management

7.3.6 It may be helpful to reconsider the use of APNP/ANNPs. Many paediatric units are starting to invest in these roles. Once a decision is made it is recommended that a thorough design is carried out to review all proposals and determine the detail based on the current staff, developments elsewhere in the country and modelling of patient flows.

7.3.7 The challenge of transport has been covered in the ICRP report, but Is an important consideration for patients when services are being consolidated

8 Conclusion

8.1 The team were very impressed by the attitude of staff and the enthusiasm and openness with which they approached the review and spoke candidly to the review team. The trust, like many, faces three core challenges

- Meeting Standards - for safety and workforce and striving to be the best
- Resources – recognising the challenge of maintaining quality within reducing budget
- Workforce – ensuring that there are sufficient, suitably skilled staff with good morale and retention in short and longer term

8.2 RCPCH reviews services under broad themes of vision, structure, process and outcome. Although for obstetric and maternity services there is a greater range of indicators, evidence-based outcomes can be hard to measure in paediatrics so this review focussed more on vision, structure and process.

8.3 We found during the course of the interviews that there appeared at times to be a lack of consideration of the patient and which models were, holistically in their best interests taking into account choice, access/ transport, lifestyle and affordability.

8.4 Staff at the Alex gave a clear and consistent recognition that things needed to change with the Worcester site being preferred for service continuity and, they presumed, employment security. The overriding message was for clear decisive information with timescales against which they could plan and also reassure patients. There remains a lack of clarity over the PAU proposed at the Alex and its likely duration and leadership/staffing structure.

8.5 This independent review and critique of the proposed model of paediatric services was commissioned by Dr Mark Wake, Medical Director. It was carried out by Dr David Shortland, Dr David Milligan, Ms Carol Williams, Mr D Keith Edmonds, Ms Anna Shasha and Ms Susan Bentley with additional support and

verification from Dr Alastair Campbell FRCPH and Dr Christopher Magier, FRCPCH, members of the RCPCH Reviewer Pool.

8.6 It satisfies the terms of reference set out in section 2 above and we hope provides useful information and rationale for future decisions by the partners over the structure and design of paediatric services in Worcestershire.

Appendix 1 Information sources and reference documents

A1.1 The following standards are referenced in the review

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

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

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

The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – " Tanner report") details issues around anaesthesia and other services available. It has 42 clear service and competence recommendations and provides a clear checklist when reviewing urgent care services

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

The Emergency Medicine Operational Handbook (The Way Ahead) CEM 2011 This guidance is for clinicians, managers and commissioners involved in the delivery of Emergency Medicine in the UK and the Republic of Ireland

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

Specialist Neonatal Care Quality Standard (NICE 2011) addresses care provided for babies in need of specialist neonatal services including transfer services. Specialist neonatal services are those delivering special, high dependency, intensive or surgical care to babies. Compliance will be measured by collection of data against the Neonatal National Quality Dashboards

Service standards for hospitals providing neonatal care 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit.

Toolkit for High Quality Neonatal Services (DH 2009) includes eight principles for high quality neonatal services and a framework to assist commissioners. The principles cover the major areas of activity within the neonatal care pathway and aim to provide standardization in neonatal care:

Standards for Children's Surgery (Children's Surgical Forum, 2013) supersedes Surgery for Children: Delivering a First Class Service and provides fresh guidelines for children's surgical service provision, outlining clear procedures for all those involved in commissioning, planning and delivering services.

NHS at Home; Community Children's Nursing Services (DH 2011) shares the findings of a Department of Health review of the contribution community children's nursing services, as a key component of community children's services, can make to the future outcomes of integrated children's services.

Defining staffing levels for children and young people's services (RCN 2013) updates the 2003 guidance by providing minimum standards and standards relating to workforce planning and workload monitoring.

A1.3 Documents were provided by the Trust relating to the following areas

- Commissioning strategy 2008 and current reconfiguration proposals
- Handbook for paediatric trainees
- Risk Management and clinical governance reports and minutes
- Safeguarding Policy and list of other policies
- Deanery visit reports for paediatrics

Appendix 2 – List of Abbreviations

ACNP/ANNP – Advanced Children's/Neonatal Nurse Practitioner
E/APLS – European / Advanced Paediatric Life Support (course)
ED – Emergency Department
ENP – Enhanced (skills) Nurse Practitioner
ICRP – Independent Clinical Review Panel
IV – Intravenous
MIU – Minor Injuries Unit
PAU – Paediatric Assessment Unit
PILS / NILS – Paediatric/Neonatal Immediate Life Support
QIS – Qualified in Specialty (neonatal nursing)
SUDI – Sudden Unexpected Death in Infancy
TDA – Trust Development Authority
WTE – Whole Time Equivalent