NHS Lanarkshire

# APPENDIX 2

# CASE STUDY – CONCENTRATION OF PAEDIATRIC INPATIENT SERVICES

## 1. BACKGROUND

1.1 In 2001 the New Deal for Junior Doctors was introduced. This new banding system had three main objectives which were:

- Support the modernisation of working practices
- Provide a simpler, targeted system for rewarding Junior Doctors, offering the highest rewards to those in the highest intensity posts, working the most unsocial hours
- Provide clear incentives to NHS employers to secure compliance with the New Deal, reduce hours and intensity of work in line with the commitment to implement the Working Time Directive over a period of time.

1.2 Additionally, the New Deal required that all training posts were approved by the Post Graduate Deanery and Royal College of Paediatrics and Child Health, as well as the Scottish Advisory Committee for Medical Workforce.

1.3 Within General Paediatrics at Monklands and Wishaw and Neonatology at Wishaw there were an insufficient number of approved training posts and this led to an inability to recruit sufficient SHO's for the August 2001 or February 2002 rotations.

1.4 As a consequence, an increased demand was placed on the five Consultant staff covering acute General Paediatrics and Neonatology. Concern was expressed by the Consultant staff in relation to the safety of patient care, particularly out of hours, where three acute clinical services were being covered (General Paediatrics at Wishaw, Neonatology at Wishaw and General Paediatrics at Monklands) by one Consultant.

1.5 Consultant expansion had been approved and was in the process of being implemented. However, due to the relatively small number of Consultant staff involved and the subsequently limited sub-specialisation, the necessity to cover three acute clinical sites could not be overcome.

1.6 Applications were made to SACMW for additional SHO1's and SHO3's for General Paediatrics on both the Monklands and Wishaw sites and for Neonatology. These applications were declined as there were no Royal College (RCPCH) recommendations of the posts to accompany the applications.

1.7 In November 2001 the Primary Care Trust considered the representations made by the Consultant Paediatricians and Neonatologists and decided that in view of the shortage of medical staff, unsafe system of care and inability to recruit staff to posts which did not have approval as training posts, a temporary closure of the Paediatric Ward at Monklands would take place with all inpatient services being concentrated in Wards 19 and 20 at Wishaw General Hospital. This was implemented from 1st December 2001.

1.8 In recognition of this withdrawal of service from Monklands it was agreed to establish a Paediatric Assessment service in the vacated Paediatric ward area. This service was manned mainly by the Staff Grade Doctors who had been employed in General Paediatrics at Monklands. The service was designed to assess G.P. and Accident and Emergency referrals and to filter out those that would require inpatient care, who would then be transferred to Wishaw, with the others being discharged home.

1.9 The closure of Ward 3 at Monklands was initially planned to last until 1st April 2002 to ensure that the General Paediatric service could manage the increased activity which occurs during the winter months. During this period of closure intensive efforts were made to recruit the additional medical staff who would be required to allow the Monklands inpatient service to recommence. This involved advertising on a world wide basis for SHO's, Trust appointments and Staff Grade doctors. In total:

- 15 adverts were placed
- 50 applicants were invited to interview (not all attended)
- 22 successful candidates were appointed (not all accepted the post)

The numbers appointed and taking up post were only sufficient to populate the General Paediatric and Neonatology rotas at Wishaw.

1.10 Due to the inability to recruit a further 12 SHO posts before April 2002, it was agreed that the General Paediatric inpatient service remain concentrated on the Wishaw site. This was subsequently considered and endorsed by the Lanarkshire NHS Board and Ministerial approval was sought and received to this change in service provision.

1.11 Due to the extremely limited activity in the Paediatric Assessment service established at Monklands Hospital (approximately two patients per day) this service was withdrawn around June 2002 and all Paediatric inpatient services were provided through Wards 19 and 20 at Wishaw.

## 2. EXPERIENCE/BENEFITS/ADVANTAGES

2.1 There were a number of benefits and advantages for patients, staff and the service which accrued from concentrating Paediatric Inpatient services on a single site. These are detailed below and are set out in terms of: immediate, short term, medium term and long term.

2.2 The impact of the concentration of services on a single site was an area of concern for NHS Lanarkshire and, consequently, an audit of patients and parents was undertaken during the initial four month service transfer period. This audit, which was conducted by a Specialist Registrar from NHS Lanarkshire Public Health Department, was wide ranging and through patient/parent questionnaires gathered information on issues including:

- Access to the service
- Mode of transport
- Travel time
- Source of referral
- Patient/parent satisfaction

The findings from this audit were that patients and parents were generally prepared to travel to access high quality care. The travel times to the Hospital were a little longer, on average, but that this did not have a detrimental effect on the condition of the child. Most people travelled by private care, although those using public transport did not report any significant difficulties or delays. The majority of patients/parents found the service accessible and that referrals were being received from G.P.'s across Lanarkshire. There were very few negative issues raised within the audit report.

2.3 Subsequently, periodic audits of patient travel and patient/parent satisfaction have been undertaken. The return rate of questionnaires on the latest audit of travel was extremely low, which in itself could be regarded as an indication that travel is not perceived as being problematic. Most comments made on the questionnaires related to parking at Wishaw which again reinforces that the majority of individuals access the hospital by private car.

## 3. IMMEDIATE BENEFITS

3.1 A safer, more efficient and effective system of working was implemented. Consultant staff were only covering two acute clinical services, on the same site, rather than covering three acute clinical sites, two of which were eleven miles apart. Doctors were no longer in the "wrong place" at the "wrong time", particularly when on-call out of hours.

3.2 Junior Doctors working arrangements were New Deal compliant with legal rotas being implemented on the single site.

3.3 The necessity to recruit a further twelve medical staff at SHO1, SHO3, SpR or Staff Grade was negated, removing a significant service pressure.

## 4. SHORT TERM BENEFITS

4.1 Within Wards 19 and 20 at Wishaw General the service was redesigned to ensure that only children who absolutely required admission as an inpatient were admitted. This reorganisation of patient flow utilised Ward 19 as an assessment and short stay facility with Ward 20 functioning as an inpatient ward. Ward 19 also accommodated children admitted for day surgery and other diagnostic tests which would not require overnight stay. In times of peak activity Ward 19 can be used as an inpatient ward. This flexibility ensures that the General Paediatric unit never closes.

4.2 The redesigned service ensures that no child remains in hospital longer than they absolutely have to. Consequently, the average length of stay has reduced to 1.2 days, with many children coming in to Ward 19 only remaining for around four hours.

4.3 Referral flow has also improved significantly with many G.P.'s who would have previously referred children to Monklands referring directly to Wishaw. This was evidenced by the fact that when the Paediatric Assessment unit was functioning at Monklands it was only receiving an average of two children per day. When it was pulled back to Wishaw a further cost and service pressure was removed and the requirement to send two medical staff to Monklands on a 9 a.m. to 5 p.m. basis, seven days per week, was removed.

4.4 Combining the medical and nursing workforces onto a single site facilitated harmonisation of practices and the establishment of shared standards of practice and care.

4.5 Consultant expansion has progressed significantly with an additional three Consultant Paediatricians and two Neonatologists being recruited. This recruitment of four of these posts was in train when the service was initially concentrated. It is unlikely that we would have been as successful in the recruitment of Consultant staff if the Paediatric service was split over two acute clinical sites and the out of hours cover was over three acute clinic sites.

## 5. MEDIUM TERM BENEFITS

5.1 Activity levels on both the Monklands and Wishaw sites were running at around 2,000 admissions per site prior to the concentration of the inpatient service. This level of activity was unlikely to secure educational approval for Junior Doctors as these would be reduced clinical experience at that level of activity. Within the concentrated inpatient service there are currently around 6,000 admissions to the Paediatric Unit at Wishaw. As a result there has been no difficulty in gaining educational approval for Junior Doctor posts.

5.2 The RCPCH have carried out two visits to the concentrated inpatient service and have recognised, in the reports of these visits, that there is a very high level of training delivered to Junior medical staff within the service, both in terms of the academic and clinical elements of their training.

5.3 Due to the expansion in Consultant numbers further sub-specialisation has been introduced and the out of hours on-call rotas for Paediatrics and Neonatology have been split. Both services now run on a 1 in 5 basis and the on-call service is subsequently much safer for both Paediatrics and Neonatology as it is staffed by Consultants from appropriate disciplines.

5.4 Significant reversal in cross boundary flow has been effected with fewer patients from Lanarkshire being referred to Yorkhill for secondary care. This has resulted in care in certain sub-specialties such as Diabetes, being delivered much closer to the patients and been more accessible for children and their families.

5.5 Wishaw has received an increased number of transfers from Hairmyres. It is probable that in the past many of these would have gone into Yorkhill. This is a recognition of the developing high quality Lanarkshire Paediatric service from other health professionals, including the Accident and Emergency service.

5.6 Referrals from G.P.'s across Lanarkshire are now routinely received within the General Paediatric service. Again this is in recognition that the Lanarkshire service is developing and can provide a wide range of secondary Paediatric care.

5.7 Reconfiguration of the Paediatric Inpatient service has also facilitated further service redesign in areas such as Paediatric Ambulatory Care Teams which prevent unnecessary admissions and facilitate early discharge by intervening with children in their home settings to monitor, assess and provide follow up care.

## 6. <u>LONG TERM BENEFITS</u>

6.1 Recruitment at all levels has now become more achievable and credible both in Paediatrics and Neonatology, at all levels. The regional standing of the Neonatal Unit has resulted in an ability to recruit additional Consultant staff when other Units within Scotland have had considerable difficulty.

6.2 No significant events have occurred as a result of concentrating inpatient Paediatric services. No untoward incidents, child deaths or exacerbation of any condition have arisen during the five years since the service moved onto a single site providing services across Lanarkshire.

## 7. <u>SUMMARY</u>

7.1 The concentration of medical Paediatrics has delivered and facilitated a number of direct service benefits for patients and staff. There however remains a significant level of service redesign that remains to be addressed in relation to surgical children's services and the provision of support services to both medical and surgical Paediatrics. The configuration of adult services arising from the implementation of a "Picture of Health" should ensure that children's services provision is fully recognised and considered.