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

RCPCH Invited Reviews Service

# Invited Reviews: The first four years

2012 - 2016

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# FOREWORD

I am delighted to introduce this report having played a part in the establishment and ongoing success of the RCPCH Invited Reviews Service.

As RCPCH Workforce Officer I was often invited to visit paediatric units and comment upon the services that they were providing. Whilst delighted to support my colleagues, at times the questions asked were very specific and the risk and implications of advising a department inappropriately concerned me as they could have far reaching consequences. I remember thinking that "things really should be done better than this". Fortunately senior college officers and staff agreed and we began to develop the Invited Review process.

Professor Hamish Wallace, as the RCPCH Registrar, was asked to lead on the development of this process in 2011, working with Jacqueline Fitzgerald, the RCPCH Director of Research and Policy to initiate a more formal process for taking this work forward. After Hamish stood down from his role, I took over as the Lead Clinician for the service, working with Sue Eardley as the RCPCH staff lead to develop and formally establish the programme we now have in place.

From the outset we have engaged with other colleges, sharing our approaches, learning from theirs and involving their experts in relevant reviews. We are also continually adapting and improving our systems and learning from colleagues with every visit. The programme board comprising officers, clinical reviewers, external experts and RCPCH staff, provides strategic direction but importantly, we have received enormous support from paediatricians throughout the United Kingdom who have undergone training to become reviewers alongside other professional and lay colleagues.

We have completed over 60 reviews in four years. We have learnt much about child health services in the UK and this document shares our experiences and learning more widely. I believe that the service has enhanced the reputation of our College and, crucially, supported our colleagues to deliver better, safer care. The strong College team leading this work enables us to have a high quality, standardised approach to undertaking the reviews and in the reports we write. This structure and learning from earlier reviews, alongside the knowledge and experience of our reviewers enables us to share practice and provide advice and recommendations to current reviews. From the reviews themselves we have learnt a lot about the current state of paediatric services and what the RCPCH must do to improve them, such as seeking to influence policy makers, review and campaign for specific increases in workforce numbers and develop and audit our suite of service standards.

Success is always a team effort and this programme of work is succeeding, not just because of the sterling work of the College team, but because clinicians across the UK are working with us support our colleagues to deliver a children's health service that we can be proud of and that serves the children, young people and families who deserve it.

**Dr David Shortland, MD FRCPCH**
**Clinical Adviser for Invited Reviews**
**RCPCH Immediate past Vice President Health Services**

# EXECUTIVE SUMMARY

The RCPCH provides a unique review service by bringing together clinical and policy expertise to work with local teams to identify and resolve issues of concern. Our work is underpinned by published evidence and standards together with practical understanding of how services work drawing on the RCPCH's health policy, clinical standards and workforce teams. The service launched over four years ago and has undertaken over 60 acute, community, neonatal, emergency and individual reviews. Over 75 RCPCH members have been involved with reviews alongside lay representatives and nominees from other clinical disciplines.

Reviews are bespoke, depending upon the issue being examined, but broadly fall within six main categories: acute service/reconfiguration; neonatal service; emergency and critical care; community paediatrics; individual reviews; and service specific reviews. We work uniquely alongside paediatricians, other medical and nursing Royal Colleges and regulators to ensure appropriate information sharing and consistency in approach.

Reviews can be initiated by managers, commissioners, clinical team members or through a network but always take place with the agreement of all parties involved including the Medical Director.

Emerging themes from the reviews to date include tackling clinical resistance to change, the integration of primary and secondary pathways and problems with covering Tier 2 medical rotas. It is important that clinicians are fully involved in the development of new ways of working, they must be clear about the benefits for children, and they must have confidence in clinical leadership.

Most reviews have recommended greater engagement with children and young people, involving them and their families in the design and operational policies of paediatric services. The establishment and assurance of adequate networks to support arrangements for escalating the care of very sick children must be prioritised.

Over three quarters of reviews received positive feedback with evidence of action planning and change occurring following the RCPCH's involvement. The Invited Reviews team are committed to developing our pool of reviewers with evidenced competencies and skills and further strengthening the branding and reach of reviews so they continue to contribute to practical improvement in children's health in the UK.

# 1. INTRODUCTION

## 1.1 Purpose of the report

The RCPCH Invited Reviews Service is over four years old and has completed over 60 reviews of acute, community, neonatal, emergency and individual activity. Almost all the reviews are confidential except where the client has agreed to publish the report or mention the review in published papers, so locations in this report will usually be anonymous.

The programme approach has evolved over time and we are increasingly taking on more complex reviews, whilst retaining contact and following up with previous clients. There is a steady stream of new enquiries and requests for advice and signposting to keep the team busy, and strong links with the RCPCH health policy, clinical standards and workforce teams provide the framework of standards and evidence underpinning our work.

Throughout the period there has been an enthusiasm from within and beyond the College to understand more about the review service and whether there are any core themes emerging from our findings. We have attempted in this document to provide a `state of play` of the service together with recommendations for future service design, workforce planning and support to our members and paediatrics in general.

## 1.2 Brief history of the service

Whilst the RCPCH has responded to requests for reviews for many years, before the Invited Reviews Service was launched in 2012 these had been relatively informal and delegated to individual members selected by the president and officers of the College. In 2009 the External Clinical Advisory Team (ECAT) process was developed by the then Registrar, Dr David Vickers. Self-nominated reviewers were matched to requests by the College and terms of reference and indemnity arrangements were established. Reviews were organised and conducted directly between reviewer and Trust and the College was not involved in governance or quality. In 2012 a six-month project headed up by the then Registrar, Professor Hamish Wallace developed a governance framework around the process which launched the current service, and Dr David Shortland, former Vice President for Health Services took over as Clinical Advisor to the service in 2013.

## 1.3 Summary of processes

The scope of a review can range from examining an individual case or doctor`s practice, to a theme, pathway, service or network of services. Fundamentally the process is the same and is set out on our webpage. Review teams comprise, as a minimum, two paediatricians and a staff administrator; they have agreed terms of reference and reviews are conducted with tact, diplomacy and discretion. Two additional reviewers provide a quality assurance review of the draft report; the client has a chance to comment on the draft and is encouraged to share the final report as widely as possible. The RCPCH charges a single fee for each review which covers reviewer day-rates, expenses, office and staff costs and a contribution to development and support of the service.

# 2. FACTS AND FIGURES

## 2.1 Activity

From launch in spring 2012 to the end of August 2016 the Invited Review Service has completed 61 reviews. These have covered the range of paediatric services.

| Reviews by Sector | Count | Percentage |
|---|---|---|
| Emergency and critical care | 17 | 28% |
| Community paediatrics | 17 | 28% |
| Service reconfiguration | 10 | 16% |
| Neonatal services | 6 | 10% |
| Service specific reviews | 6 | 10% |
| Case note and individual reviews | 5 | 8% |
| Total | 61 | |

Visits are usually made between six and 12 weeks from enquiry dependent upon agreement of the scope and terms of reference which set out the aims of the review and issues that the review team will be helping with. Most of the reviews undertaken to date have been completed within four months from client enquiry to final report.

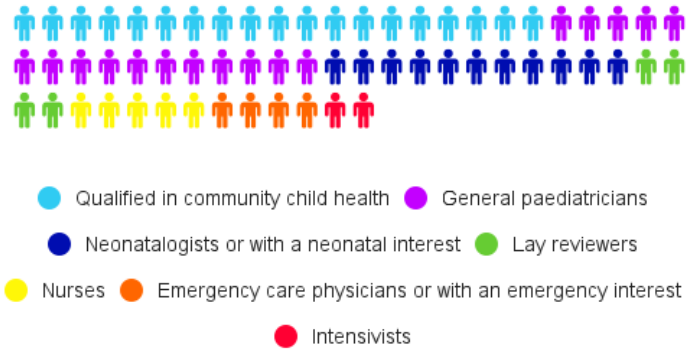

Alongside the service there is a steady stream of enquiries for other advice, such as nominees for local review panels, individuals who can provide second opinion reviews and early conversations about workforce options or comparative sites.

Over the four years there have been 51 enquiries formally seeking individual expertise, and the team has been able to signpost or `connect` almost all of them with one or more members willing to help. Another 24 enquirers have discussed their local service at some length including possible reconfiguration and the benefits of a service review, but for various reasons (we do follow up!) have not gone ahead at the time. Sometimes this may be because the enquirer was an interim or in a couple of cases went off sick, several localities are undergoing larger-scale change and the impact of CQC visits has influenced whether trusts also commission a more bespoke review from the RCPCH,

A proportion of these peripheral enquiries will ultimately develop into full review work and maintaining contact and encouraging dialogue is a vital part of the College's service both to support members and encourage development of a better NHS for children – one of the College`s strategic priorities.

## 2.2 Reviewers

Since the launch of the service an open invitation for RCPCH members to apply to be reviewers has been in place, with specific recruitment drives in 2012, 2014 and 2015. We have received a total of 112 formal applications to join the reviewer `pool` (including lay and specialist reviewers) and 117 reviewers have attended the four induction and development days hosted by the invited reviews team. Some have come more than once and some were 'experts' who were invited to assist with reviews but did not formally 'apply' to be reviewers (see chapter 7).




## 2.3 Deployment

Over the four years the service has benefitted from 69 individuals who have conducted reviews and 53 reviewers who have contributed to the quality assurance process. There are eight trained reviewers who are yet to conduct their first review.

The Invited Reviews Service is advertised through its own College webpage and channelled through events such as the RCPCH Annual Conference and the Clinical Leads Day which is organised on behalf of the Paediatricians in Medical Management Committee. We regularly post items in College bulletins and speak at external events explaining the service and relevant findings yet many of our new clients have been unaware that the service exists. A key objective for the service in 2017 is to develop a communications and marketing strategy for the service, to make it more visible to clinicians, services and the RCPCH membership.

## 2.4 Financial arrangements

Review charges are based upon an algorithm that takes into account the complexity of the review, its scope, the composition of the proposed review team and whether any additional input or activity such as public engagement or detailed workforce modelling is required. The sum charged is designed to cover all identifiable costs (reviewer fees, accommodation and travel, staff time required in terms of salaries, service evaluation and reviewer development). The service delivers an appropriate contribution to RCPCH corporate overheads, but recognises the pressure on paediatric budgets in the NHS. We aim to offer an affordable service particularly for community paediatric teams where there appears to be great need but also significant challenge to available resources.

In four years the income has grown steadily and the staff establishment has increased from one full-time member of staff initially to a team of three (2.5 whole time equivalent).

The range of RCPCH reviews, which has included major reconfiguration advice as well as small community paediatric teams, requires a flexible costing arrangement to reflect affordability and complexity. The single cost arrangement is welcomed by the RCPCH reviewers as they are reimbursed promptly, and clients are clear from the outset of the cost of the review. There are no instances where the RCPCH has not been paid for review work, although NHS finance systems can sometimes result in delays in processing invoices.

# 3. GOVERNANCE AND QUALITY

## 3.1 Programme Board

A Programme Board provides oversight and guidance to the review service, meeting three times a year and reporting through the RCPCH Executive Committee to Council. The Programme Board comprises:

- Chair – Dr David Shortland, immediate past Vice President for Health Services
- Vice President Health Policy
- Six experienced reviewers including nursing and lay reviewer representatives
- Directors of Corporate Services and Research & Policy
- Head of Invited Reviews
- Head of Health Policy (non-voting)
- Operational Lead for Invited Reviews (non–voting)

It has recently been agreed that a representative from the National Clinical Assessment Service (NCAS) will be invited to become a full member of the Programme Board in line with arrangements with other Colleges.

## 3.2 Process, indemnity and quality assurance

The overall process followed in a review is set out in published guidance, but the nature of paediatrics and the enquiries received mean that each review is individually designed to meet the needs of the client organisation and the service under review. Occasionally requests do not fit within the scope of the service, for example

- Investigation of longstanding complaints where legal action is contemplated – in such situations the Invited Review team can put clients in touch with individual reviewers who would be willing to take this on independently.

- Ongoing development or facilitation work – our reviews may recommend that a team has external support to implement changes to working practice - we can provide names of experienced practitioners who can assist independently with this work

All reviews and reviewers are covered by a deed of indemnity which limits the liability of the RCPCH should litigation follow the implementation of a review's recommendations. This is standard practice for all reviews undertaken by royal college and follows very similar wording for each college. To date there have been no challenges, although we are aware of Freedom of Information (FoI) requests for reports being made to two clients.

Before they are sent to the client in draft all our review reports are checked and critically appraised by at least two experienced paediatric reviewers. This provides a 'fresh eyes' challenge to ensure that the reports are readable, rational and comply with the overall policy and standards of the College. The Invited Reviews staff team is responsible for ensuring all reports are consistent in their recommendations, and reflect the latest policy and standards. The invited reviews team is supported by the evidence and expertise within the workforce, health policy, research and clinical standards teams, and draws on advice from the Education and Training, &Us and media/communications teams in its work.

## 3.3 Working with other colleges

An informal group of the Invited Review managers across the medical royal colleges meets three times a year and liaises regularly between meetings. This helps to ensure consistency of the various approaches seen by Medical Directors commissioning reviews. The group also provides a forum for development of induction and development programmes for reviewers, sharing ideas about project documentation and follow up and support for new administrators and programme managers. Increasingly royal colleges are working together to share expertise. For example, the RCPCH has conducted four reviews where obstetrics and midwifery colleagues joined the paediatric team and we have taken reviewers nominated by the Royal College of Anaesthetists (RCoA) and the Royal College of Emergency Medicine (RCEM) on three reviews each.

The group has been supported throughout by the Academy of Medical Royal Colleges. Following the Kirkup[1] report on the Morecambe Bay problems, the Academy commissioned and published in 2015 `A Framework for Operating Principles for Managing Invited Reviews in Healthcare`[2] and the RCPCH Programme Board has reviewed the College`s processes to ensure alignment.

## 3.4 Working with the Advisory Bodies and Regulators

The National Clinical Assessment Service (NCAS) has been undergoing review over recent years but is now emerging more confidently as the body to investigate complex individual performance concerns about doctors. The RCPCH staff team has maintained a constructive relationship with NCAS, and several reviews have resulted from NCAS staff referring clients to the RCPCH when they are unable to assist directly. The Programme Board recently invited NCAS to nominate an adviser to join the Board with a view to strengthening still further the relationships and communications.

The general medical council (GMC) is strengthening its fitness to practise arrangements and has assigned employer liaison advisers (ELAs) to work with trusts in identifying where individual practice or services may be falling below acceptable standards. The RCPCH links with the GMC both through the Invited Reviews Service and the Education and Training Division.

The patient safety arm of NHS England has supported the development of the Healthcare Safety Investigation Branch and we are working with them and the Academy to help this new body to integrate and communicate effectively with College reviews and other regulatory activity.

The Care Quality Commission (CQC) has completed its first round of inspections of all NHS trusts in England and we have been working with them throughout, both in encouraging our reviewer members to apply to be specialist inspectors and providing expertise where specific queries have arisen in their work. A former Programme Board member is now the CQC`s national paediatric adviser and we have contributed extensively to their inspection guidance in terms of relevant standards. In line with other colleges we have taken a firm stand that the RCPCH will not routinely share review reports with the CQC as they are the property of the client trust. Should serious safety concerns be made during a review, we would advise the trust urgently and expect them to report the issue to the CQC. If we do not have verification that the issue has been

[1] The Report of the Morecombe Bay Investigation March 2015 accessed 04/01/2017
[2] AoMRC Operating principles for managing invited reviews within healthcare January 2016

resolved swiftly and/or CQC is not aware then we do reserve the right to contact CQC directly, first notifying the trust and programme board of our intended action.

## 3.5 Using the College resources

A significant benefit to clients of RCPCH reviews over independent consultancy is the breadth and depth of data gathered and available within the College which is available to the Review team. For example the biennial workforce census and other member surveys provide comparative and longitudinal benchmarking data to support recommendations and strategic recruitment planning. Health policy intelligence and public affairs contacts enable our reviews to be sensitive to the political and local environment of a review; we can draw on policy positions and previous consultation responses to shape localised recommendations and ensure they will be acceptable to staff and the public.

# 4. KEY THEMES BY SECTOR

## 4.1 A time of change for paediatrics

In the last eight years paediatric services, alongside other NHS specialties, have undergone a rapid period of change due primarily to various policy initiatives but also through the increasing use of technology and business principles to better manage a highly complex yet emotive service. Change is always difficult but particularly within the NHS; in recent years the focus has been on the development of management and performance monitoring systems with relatively limited investment in developing doctors and clinical teams as strategic leaders to understand the changing nature of services. Medical staff in the NHS have generally invested a high level of emotional capital in their service which can result in phenomenal tolerance of poor working conditions. In the units which the Review teams have visited there was often a resistance to new approaches to problems, and sometimes a 'silo' culture focussing on doing things as they have always been done.

There is a large number of clinical and service standards and guidelines, many developed, supported or endorsed by the RCPCH, which the IR team use as the basis for reviews. Most regularly used are the Facing the Future series, the intercollegiate child protection and emergency care guidelines, BAPM neonatal and PICS high dependency standards, and there is a clear demand for new community workforce and paediatric assessment unit guidance (both under development by the RCPCH).

## 4.2 Acute service reconfiguration

### Policy background

The RCPCH Facing the Future[3] standards for acute services were launched in April 2011, setting out measurable expectations for paediatric care but also the implications for current and future staffing models and a national strategy for service reconfiguration to achieve them. In 2013 the RCPCH published details of progress in the UK towards achieving the standards followed by publication in 2015 of revised standards to reinforce their importance and relevance.

On a more strategic level the Francis report on the Mid Staffordshire enquiry, the Berwick report on patient safety and the Kirkup report on Morecambe Bay have had far-reaching impact on NHS Boards and stressed the importance of appropriate organisational culture, sound working practices and supportive clinical networks to improve the experience and outcomes for patients and their families.

Since the publication of `Facing the Future` the RCPCH has advocated consolidation of smaller proximal paediatric inpatient services into larger units in order to meet the challenges of middle grade (Tier 2) staffing levels. The predictions in that report are playing out six years on with insufficient medical staff numbers being one of the key triggers for reconfiguration reviews, both in urban and extremely remote parts of the UK. The RCPCH`s `Rota Compliance and vacancies survey` report[4] (August 2016) highlighted a national shortage of middle grade staff. The availability of alternative skilled staff such as advanced nurse practitioners, advanced or consultant allied health professionals to support local provision remains limited due to a number of factors including:

[3] www.rcpch.ac.uk/facingthefuture
[4] http://www.rcpch.ac.uk/news/concerns-child-health-paediatric-units-struggle-fill-rotas

- a major shortage of registered children`s nurses / therapists who would be eligible for the programme
- difficulty in obtaining post registration funding and the loss of bursaries
- the absence of a consistent multidisciplinary strategy for workforce and education
- the absence of a co-ordinated national programme for training and development of these important roles.

However the Royal College of Nursing is working towards the development of standards for accreditation of advanced practice programmes.

In parallel work on urgent care pathways out of hospital resulted in intercollegiate 'Facing the Future Together for Child Health[5]' standards for better management of children and young people requiring urgent care, and paediatric assessment unit standards are due.

For nine out of the ten reconfiguration reviews, by the time the RCPCH became involved there had been months (and in some cases years) of business cases, strategies, consultations and workshops led by managers in order to persuade clinicians and the public of the need to reduce the number of inpatient sites. There was usually resistance from some of the more experienced paediatricians to considering alternative ways of working or proposing solutions which complied with the standards from their own professional body. In some cases substantive doctors were themselves providing locum cover with remuneration rates up to three times the basic rate.

Where reconfiguration was resisted there had usually been concerns expressed in the media by public and political spokespeople, often encouraged by disaffected or retired clinicians, which suggested (without evidence) that reconfiguration would be `unsafe`. Campaigners have cited numerous examples of situations where a family had unhelpfully been told by a health professional that their child `had been lucky the unit was so close` or their baby `would have died`. Such powerful assertions and the media`s enthusiasm to report dramatic statements can unhelpfully instil widespread anxiety and concern rather than celebrating the improved levels of care available if reconfigured units are properly staffed and equipped.

When a child is sick or a baby is due to arrive the parents primarily want the best care. Whilst 'local would be nice`, having confidence in the staff caring for them and their child, and clarity about what happens (and how they get home/visit from a distance) appear from patient feedback to be paramount.

Our ten reconfiguration reviews were commissioned with the expectation that the RCPCH would provide an external unbiased opinion of the current and future arrangements for acute paediatric care that would be compliant with professional standards and achievable given the team and trust structures in place. Four of the reviews were conducted fully in the public domain and included public surveys, wide stakeholder engagement and frequent mention in local and sometimes national news. All four have been positively reported in the media (see Appendix 1) and appear to have provided the client organisation with the material to implement step-change in service provision.

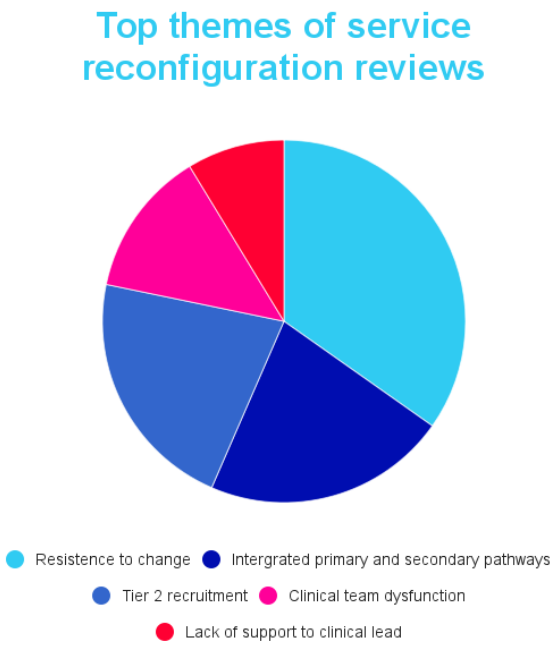
[5] http://www.rcpch.ac.uk/facing-future-together-child-health

## Review triggers

There are three key elements which are characteristics of the services that have requested help with reconfiguration.

**Disengagement of the clinicians:** Clinicians must be fully involved in the development of proposals for new ways of working, must be clear about the benefits for children and themselves and must have confidence in the clinical leadership. Without these ingredients, there can be a climate of disengagement or active resistance to change which can undermine and destabilise strategic plans, preventing improvement, sapping morale and damaging the reputation of a Trust as a good place to work.

Most clinicians are inherently anxious about any changes, particularly if this may mean learning new skills, exposing their own need to learn or working with new colleagues. It is almost unheard of, however, for reconfiguration to result in job losses amongst medical staff.




It is easy to cite reasons not to change, but many of the arguments we have heard from doctors were not evidence based. Though some were valid yet had not been heard by managers.

Reconfiguration has been successfully achieved by trusts who have approached service issues through a combination of consistent performance management (such as ensuring attendance at meetings) alongside listening to concerns and dealing with them systematically, respectfully and responsibly.

**Strength of external communication:** Intuitive management of the wider community is essential to mitigate anxiety and avoid the media peddling mis-information about any change to services. Reconfiguration is usually referred to as 'degradation', 'downgrade' or 'closure', focussing usually on increased distances to travel but never on the quality of care and outcomes resulting from a more skilled and experienced clinical team. This is much more pronounced for children and maternity than for adult services, perhaps because parents feel a responsibility to transport their child themselves rather than calling an ambulance.

Effective change requires close working with communications professionals to place positive news and build public confidence so changes can be accurately described for the benefits they offer. Local media and politicians can be strong allies and influencers but relationships must be strong well before change is mooted.

**Network impact:** Recent reductions in NHSE support for Strategic Clinical Networks and Operational Delivery Networks so soon after their establishment under the Health and Social Care Act has reduced the expertise available for services to draw upon. Given that paediatrics and neonatal services often already struggle to build traction with senior management, with few national targets and little financial authority the absence of

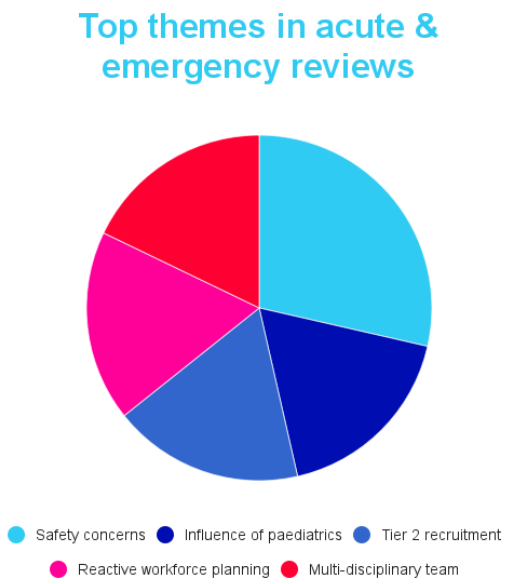
network support is serious. For most of the seven reconfiguration reviews in England we did not see clear strategic input from NHS England, and clinical network and Senate leads were engaged but felt relatively powerless to implement change assertively and articulate performance indicators.

Changes to acute services increase the need for ambulance cover and transport, and increase the burden on families getting home from a centralised unit. Without network support and traction, ensuring all elements of the service work effectively is now more difficult, particularly in England as there is no single organisation responsible for all healthcare in a given area.

## 4.3 Emergency and critical care

### Policy background

The management of emergency paediatrics is covered in most of the acute reviews as part of the pathway for children and young people and 16 reviews have considered emergency services either wholly or due to concerns raised about the pathway as part of a wider acute services review. There are measurable intercollegiate standards for emergency care in hospitals[6] but we did not see evidence that services had been audited against them nor that they were being cited to negotiate development of emergency units. The recent launch of 'Time to Move On[7]' which sets standards and a classification system for paediatric high dependency and intensive care provided helpful material to support reviews.




### Findings

We have generally found medical rota gaps both at trainee and consultant level in emergency departments (ED) and high numbers of staff with insufficient paediatric experience. Overseas recruitment to middle grade posts does not prioritise paediatric expertise, causing delays. Nurse staffing has been a significant concern in EDs, once again increasing staffing levels with suitably trained individuals is a regular recommendation, and few units have the recommended seven children's nurses required to ensure a 24/7 presence. Where this is unachievable we recommend rotation of nursing staff through the children's ward and/or assessment area in order to develop and maintain skills and competencies.

Our reviews of emergency pathways have involved transport teams and network arrangements for escalating the care of very sick children. In several cases reviews have exposed gaps in protocols, absence of a clear pathway and unclear decision making especially when transport teams are on site.

[6] Standards of care for children and young people in emergency care settings.
[7] http://www.rcpch.ac.uk/sites/default/files/page/HDC%20for%20web.pdf

## 4.4 Community Paediatrics

### Policy background

In terms of community services, there is an increasing recognition of the importance of out of hospital care but in the context of this report we consider those teams delivering elements of the community paediatrics specialty rather than acute general paediatrics in a different setting. Due primarily to the persistence of block contracts we have found that despite a significant national concern about staffing levels and pressure on service delivery there remains a perception that community services for children are not a priority for commissioner or provider attention, especially when a small team is working within a large provider trust.

The changes to the assessment of children with special educational needs were rolled out in September 2014 under the Children and Families Act, resulting in increasing numbers of referrals from parents and schools seeking an autism assessment to identify resources for educational support. Each clinical commissioning group (CCG) is required to identify a Designated Health Officer for special educational needs, usually a senior community paediatrician, to support the contribution to the Education, Health and Care Plans.
Child and adolescent mental health services are increasingly pressured and with tight contracts many services are handling referrals for emotional and behavioural concerns through a 'single point of access' and against clear referral thresholds. This can lead to accepting only children and young people with the most severe symptoms or clear mental health need, referring any with suspected attention deficit hyperactivity disorder (ADHD) or autism (ASD) back to an already stretched paediatric team for initial assessment.

### Findings

Of the community services we have visited seven have been part of acute trusts, five in former mental health trusts and six in standalone community trusts. Where community paediatrics has formed part of a larger acute/mental health trusts we have frequently found the strengths and needs of small specialist services and the range of services and skills they contribute are poorly understood and their contributions to the wider trust not sought.

Nationally community paediatrics has had a historically low profile. Trusts have invested minimally in data and outcomes recording and the block contract nature of many community services has provided little motivation for them to pay attention to services which do not generate activity-based income. Increasing demand (from rising ADHD and ASD referrals, for example) fails to be met by matched increase in resources leaving services overburdened with long waiting lists and clinical staff unable to engage with service development. The absence of national standards/guidelines/benchmarks has also proven challenging for trusts attempting to address these issues, although the RCPCH is in the process of developing guidance in this area which is due to publish in Spring 2017.

With small community teams increasingly becoming part of large trusts, and the reported difficulties of many members finding time to attend regional community networks, the voices of the community paediatricians are often lost in an increasingly business and outcome-focused climate within the NHS. These factors appeared in the teams we visited to have combined to leave small community medical teams organisationally separated from paediatric colleagues in their trust and across their region. We found many community paediatricians in the sites we visited had experienced professional isolation restricting capacity for peer review, support, and

external insight to inform service development. Issues with clinical governance and oversight are also not uncommon, as are challenges delivering appraisal, personal development and job planning.

At a regional level, despite some high profile joint commissioning initiatives there remain challenges to real co-ordination between trusts, local authorities, public health and commissioners. As a result we have seen:

- Multiple IT systems across (and sometimes within) organisations with little or no interoperability, inhibiting the delivery of multidisciplinary working and proving a potential safeguarding concern
- Poor management of clinical pathways, which can be confusing for families and delay care
- Lack of clarity over accountability when signing off education, health and care plans on behalf of CCGs, particularly if care is to be delivered by another trust
- Gaps in services for certain groups, for example follow up of children diagnosed with, ASD, lack of clarity about which service sees children with behaviour problems
- Loss of liaison health visitors and other key individuals who `join the dots` for safeguarding
- Poor commissioning to private sector – one community service was transferred and the equivalent sum withdrawn from the NHS provider contract without any funding for the community paediatric team which covered all the usual services in the catchment area.

It is important to note that reviews are only invited by clients with concerns about a service, and there undoubtedly some excellent, well-resourced services in the UK. However presenting the above findings to colleagues at the British Association for Community Children`s Health (BACCH) annual scientific meeting there was a high level of identification with the problems and a strong desire to support colleagues to overcome them.

## 4.5 Neonatal services

### Policy background

The British Association for Perinatal Medicine (BAPM) maintains service standards for neonatal care. The charity BLISS reports on staffing services across the UK based on survey and research from the perspective of infants and their families. National data collection (including audits and the mortality and morbidity studies) and the existence of defined neonatal networks, a clear national service specification in England and similar Standards in Wales provide a sound basis for assessing neonatal units. A total of eight neonatal intensive care units (NICUs), five local neonatal units (LNU) and 15 specialist care units (SCU) have been reviewed either specifically or identified for comment as part of overall paediatric provision in a trust.

### Findings

Our findings exposed the challenges of compliance with BAPM staffing standards, particularly at middle grade and nursing, but also issues in some NICUs around team working. The principles of networked care are sound but become compromised when organisational economics and financial targets are allowed to influence capacity and decision making. There were examples of very premature infants who could not be transferred due to a lack of capacity at the NICU and insufficiently skilled and confident

doctors staffing LNUs. Pressures on transport services and a natural reluctance of families to agree to transfers exacerbated this. The payment and tariffing systems for neonatal care were not always clearly defined, sometimes being wrapped within an overall contract. Poor links between clinicians and contracts negotiators were cited as why commissioners seemed unable to influence capacity and staffing decisions within strong foundation trusts.

Two of our reviews proposed significant reconfiguration of NICU provision and both were requested and funded by senior, influential commissioners of the service. In North Wales, ministerial support and government investment has resulted in concrete plans to proceed with development of the recommended Sub-Regional Neonatal Intensive Care Centre (SuRNICC). Yet for the other the commissioners and network appeared to be unable to influence change due to alleged contractual intransigence of the host trusts, and our recommendations have been shelved pending further local consultation about wider acute care.

## 4.6 Service specific reviews

As well as one ED and three neonatal reviews, six of our reviews have focussed on specific or services within a larger paediatric department. The terms of reference for each were carefully developed in order to be constructive and significant reassurance and time was built in to ensure that the process to be followed and the findings and recommendations were appropriately set out and communicated. Ensuring the review team `fits`, is acceptable to the service and has an approach that is tuned to identify and communicate perhaps unexpected findings makes these reviews both complex yet satisfying. In each case we secured for the Review team a tertiary service paediatrician to provide specific advice, combined with an experienced clinical lead. The support of the RCPCH`s affiliated specialty groups in providing advice and suggesting reviewers has been much appreciated.

## 4.7 Individual reviews

Although other colleges regularly conduct investigations of individual practice and casenote reviews these have not been in great demand from the RCPCH. We have conducted five such reviews, but in nine other `service` reviews the behaviour or practice of an individual has clearly been a significant concern within a department and may be hindering improvement or confident practice.

In such situations the review team would usually feed back their concerns to the medical director whilst they are still on site. Depending upon the nature of the concerns a swift, confidential letter may also be sent within a week to formally document what the Review team reported, and we would take advice on the wording of this letter.

A characteristic of most of the individual reviews is the length of time that the problem has been identified without formal action, despite there being clear NHS procedures and guidance in place to support responsible officers and medical human resource departments.

Our review reports are written carefully with the presumption that they may at some stage be shared in the public domain. We expect that all those involved in a review would in most cases see the report or at least the recommendations and executive summary.

There is a regular stream of enquiries to the review team seeking expert advice on individual cases or complaint resolution. Unlike some Royal Colleges the RCPCH takes a pragmatic view on whether these should be dealt with as:

- Full invited review with a team of at least two paediatricians and a two-day visit.
- Limited-scope reviews, with one expert reviewer supported by the RCPCH process.
- Privately commissioned reviews: The RCPCH can supply details of willing, suitably qualified independent experts but the arrangement is direct between the reviewer and the client, without the backup and support of the RCPCH`s resources and advice. The RCPCH indemnity would not cover reviewers undertaking this type of work and they would need to make their own arrangements.

The latter two are usually much swifter and cheaper for the client but have limited scope. They are offered as a service to the client and our members in order to resolve concerns without delay. Privately commissioned reviews may also be suggested if a request is out of scope or the review team is unable to take on further work in an appropriate timeframe.

# 5. OTHER THEMES

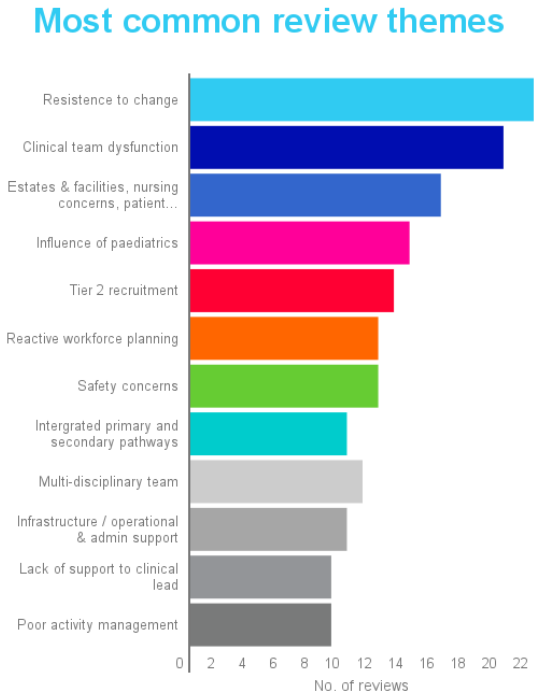
## 5.1 Children and young people's involvement

Involvement of children, young people and families in the design and operation of paediatric services is a fundamental expectation of clinical teams. Apart from the increasing statutory introduction of the Friends and Family Test[8] in England (some with quite innovative approaches as to how data was collected) only a handful of services visited demonstrated active engagement of those who use their services. A few had evidence that things had changed as a result of engagement. One unit had a 'Tops and Pants' line onto which youngsters could attach their praise or criticisms of the unit on specially cut cards. Several units had bright playrooms and a few had a separate adolescent room; in one case largely funded through cancer charity money.

In most reviews we have recommended greater investment in engagement with children and young people and for many of the acute services in particular we have suggested the identification of a board member as a 'champion' for children alongside establishment of a cross-division 'children's board'.

## 5.2 Clinical leadership

In a significant proportion of reviews the Review team identified problems with the clinical leadership either at team, divisional or organisational level. Most clinical leads felt they had insufficient time to do the work expected and several were experiencing unresolved problems with team working, poor behaviour in colleagues, recruitment problems or unrealistic expectation from management of the capacity and resilience of the paediatric team. This was particularly evident in smaller community paediatric teams where PAs for leadership have often been removed and allocated to a divisional post that may not be a paediatrician. In such a situation it is crucial that the incumbent takes time to fully understand the specific issues around paediatrics. In several cases we found there was an expectation that clinic templates, new to follow ups, patient records and other operational activity could directly follow that of, for example, an adult psychiatric model.




In several units the clinical lead role had changed either through resignation or rotation, with the incumbent often taking the role as a duty rather than eagerness to develop. Most had not received training, mentoring or coaching in the role and found the 1 to 2 PAs assigned for leadership duties insufficient for the requirements of the role.

[8] https://www.england.nhs.uk/ourwork/pe/fft/

As a consequence of some of these findings there are plans to develop the support available from the RCPCH for paediatric clinical leads through a range of media, events and potentially support for the establishment of a network or special interest group

## 5.3 Commissioner-requested reviews

Nine reviews in England have been requested by CCGs rather than by trusts themselves, comprising four community (one of these was multi-team), two to provide assurance about emergency pathways and three involving multi-site reconfiguration.

Commissioner-requested reviews require a slightly different approach due to the commercial nature of contracts and (sometimes) issues over expectation and resourcing responsibilities. Whilst commissioners are keen to understand the service being provided, and we ensure that the provider is comfortable about the review taking place, some of the findings have been inappropriate to share with the commissioner until the trust has had an opportunity to consider them. Examples include issues around team working, governance systems and areas where the service provided does not appear to adequately meet the specification or contract. As a result of such experience we now confirm at the outset the process of reporting and sign-off so there is clarity amongst all involved.

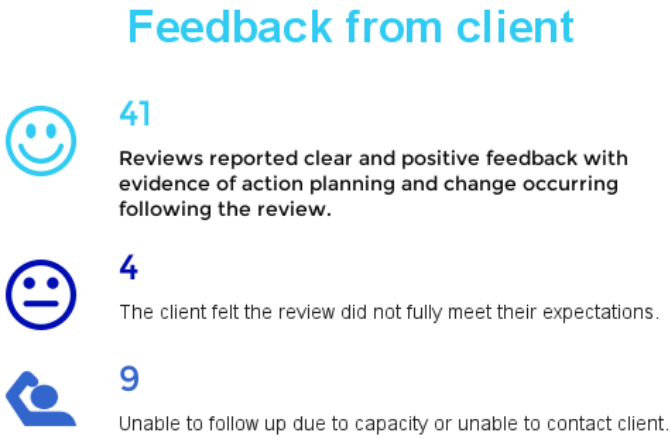
# 6. MAKING AN IMPACT – Where reviews have made a difference

## 6.1 Approach

After each review visit a short survey is circulated to all those interviewed which provides feedback on the team's approach, review preparation and offers the opportunity for the individual to share any further comments about their service with the review team. This enables any misunderstandings to be corrected and can sometimes draw out useful additional information about a service or team.

More systematic follow up is conducted three to six months after the report's completion, and a visit or telephone call is arranged to discuss the action plan and provide any additional support needed.

Feedback from 54 of our clients is summarised in the infographic on the right; seven of them are relatively recently completed so formal follow up has not taken place yet. For these seven however there has been informal positive feedback.




The four reviews for which we inferred that the report was not as expected by the client have been reflected upon in order that we can identify similar risks and avoid them in future.

- One was in a small and remote location with an expectation that the RCPCH could develop a bespoke medical staffing arrangement. We did this, and made a number of other important comments on how services could be more effective, but the costs to implement were considered too high. In a similar situation we would be clearer at the pre-visit as to our approach to standards of care.

- One had a scope that ultimately extended far beyond the initial brief, with a high number of stakeholders expecting engagement and consequently insufficient time to triangulate all the findings. A lack of clarity over the `lead` client and confusion over circulation of the draft report compounded the issues. The review team is now much more astute in spotting potential problems, and we have strengthened the quality assurance and report writing briefs to ensure all the statements in reports are evidenced and constructive. Good relationships with those involved have now been restored and perhaps strengthened as a result.

- One review of an acute trust was commissioned at the same time as an NHSE panel was considering reconfiguration. We were considering maternity and paediatric provision across a catchment that had undergone several actual or attempted reorganisations and public relations had been strained. Our report did not provide for the client the clear decision that had been expected, as we felt that there were concerns around management and engagement of clinicians – although it did correlate largely with the findings of the NHSE review. We

maintain contact with the new Medical Director and our main report recommendations have in fact recently been implemented.

- One review found that there were difficulties at senior level which were impeding the development of the service. The team considered very carefully all aspects of the service and the implications of the findings and recommendations, and a significant level of dialogue and support was required around completion and handover of the report.

Of the nine for which we do not have formally recorded feedback:

- Four were not effectively followed up due to pressure of work at the time.
- Three faced difficulties in contacting the client representative.
- Two reviews were swiftly followed by a CQC inspection or regional reviews which changed the requirements and superseded our report.

We have no indication from these reviews that the client was not happy, and for each they provided timely comments on the draft report and did not question its approach.

We have drawn out below four examples of successful reviews which have shaped the way we will work in future.

## 6.2 Specialist surgical hospital

This Trust had received critical reviews by CQC and was under new management. There were concerns about whether protocols and staffing, particularly on the high dependency unit, were sufficiently robust for children.

The Review team, comprising a paediatrician, an anaesthetist and an experienced children`s nurse found that despite close links with a tertiary children's hospital there was a lack of organisational focus on children. Although there had been some investment in nursing, it was clear more was needed, and governance and accountability for children, particularly out of hours, was unclear. Significant investment and a change of culture was required if the unit wished to continue to care for children, yet the specialist nature of the work and capacity limitations elsewhere reduced the options for alternative provision.

The Review team worked hard to establish the underlying causes for the situation and set out clearly for the clinicians and senior management the importance of meeting the specific needs of children. They highlighted the responsibilities of commissioners and other providers working together around the child`s pathway to ensure risks were identified quickly and safe escalation processes were established and understood.

Following the review the Trust made significant changes to its procedures, invested in appropriate staff and negotiated with the commissioners and tertiary service safe arrangements for medical cover communications and transfer.

The CQC and NHS Improvement hosted a quality summit with all stakeholders (including the RCPCH) and all recommendations have been or are being implemented within six months of the final review report.

## 6.3 Reconfiguration

Hywel Dda University Health Board had centralised its obstetric and paediatric inpatient provision in summer 2014 from the Withybush Hospital in Pembrokeshire to Glangwili Hospital in Carmarthen. The Withybush site retained a midwife led unit and a paediatric assessment unit (open from 9am to 10pm), with various temporary arrangements for emergency cover and transport.

The consultation and implementation of these plans, whilst made for reasons of safety and sustainability, had not been handled well by the previous management of the Health Board and there was vigorous opposition to the proposals from a wide variety of stakeholders. The Health Minister had approved the changes subject to external review after 12 months of operation, and the new management team invited the RCPCH to carry this out.

The review team included two paediatricians (one a neonatologist), an obstetrician, midwife, children`s nurse, lay reviewer and RCPCH management support. The week-long visit explored all aspects of the maternity, neonatal and paediatric services including the team dynamics, governance, risk and incidents. The review was conducted in the public domain with the support of the Community Health Council. Direct engagement activities through surveys and a public meeting with around 450 staff and members of the public were organised to understand their views and to explain the review process.

Our review found the decision to reconfigure was sound but that there were a number of processes which needed to be streamlined or reviewed to improve the experience for women and their families. In particular the reconfiguration had not sufficiently addressed the complexities of merging the groups of professionals (midwives, nurses, doctors) from two sites to one team. The two units had worked in very different ways, and found it difficult to work confidently alongside each other on one site without explicit support and facilitation, which undermined their confidence and raised concerns about safety.

*Health Minister Mark Drakeford said: "It [the report] concludes that, despite all the persistent claims to the contrary, the changes are safe, sustainable in the long-term and have led to improved outcomes for mothers and babies. There is also better compliance with professional standards and more women are being cared for in the Hywel Dda area than under the previous arrangements. These findings will provide reassurance to people in Pembrokeshire and Carmarthenshire. It makes it clear that it would make no clinical sense to return to the previous arrangements"*

**BBC Wales Online 22nd September 2015**

The management of the Health Board was very responsive to the report, recognising the importance of transparency and engagement with parents, staff and those who represent them. Significant steps have been put in place to strengthen the confidence of staff, build positive messages about the new arrangements, tackle the identified problems and enhance the facilities in the combined unit. The lobby group continues to raise concerns but it is reassuring to know that since the reconfiguration there have been no reported serious incidents as a result of the distances.

There were some unresolved issues around the neonatal unit so the Review team is returning to the Health Board in September 2016 to follow up on progress.

## 6.4 Emergency pathway

This Trust was under new management and had been criticised in a CQC report for inadequate staffing in its ward-based high dependency suite, where young people are stabilised. The Trust was seeking external assurance that the processes in place were sufficient to meet standards and called upon the RCPCH to assist.

The review team comprised a paediatric intensivist, a general paediatrician and a children's nurse adviser, supported by a College staff member.

Overall we found that the high dependency unit (HDU) area was reasonably well maintained and staffed but nursing levels on the rest of the inpatient ward were below recommended safe standards. There were a small number of other governance and team concerns identified by the review team which had not been picked up by internal processes.

The combined neonatal and paediatric retrieval team had viewed the unit as one of the safer sites in their catchment which had reduced prioritisation of support, resulting in longer than expected delays for expert assistance. The physical distance between the emergency department (ED), the HDU facility and the surgical ward reduced the opportunities to share skilled nursing staff, and whilst the ED was about to be provided in improved accommodation, there were some process difficulties in staffing the facility appropriately with children's nurses at all times.

The review team's report set out 17 recommendations across nursing, medical staffing, ED, HDU, strategy, vision and governance. As a result of the review the trust developed a detailed action plan which has resulted in a great deal of positive action. A Children and Young People's Board was established and will be reporting on delivery of the action plan in September 2016.

## 6.5 Community team

This review was the second undertaken for a former mental health trust that has taken over community paediatric teams under the Transforming Community Services policy. Local campaign groups had complained about the service for several years. The Trust had found it extremely difficult to recruit and retain consultant and specialty and associate specialist (SAS) doctors and there had been repeated management and organisational change.

The complement of three consultant and three SAS posts (not all full time) was insufficient to deliver a safe service for the child population, but the review team also found that they were working inefficiently and inequitably, and significant concerns about safeguarding arose which were escalated immediately for action by the Medical Director. There were concerns about the use and availability of administrative support and electronic patient records, and problems with behaviours and culture that stifled innovation and hampered team and individual job planning.

As a result of the review some adjustments were made to staffing roles and team job planning was initiated. The RCPCH was invited to assist with support of an 'away day' workshop for the paediatric team to develop an action plan that could be supported by all involved. RCPCH reviewers have continued to be involved with the team for some months after completion of the report.

The journey towards a safe and effective service has been difficult, but the catalyst for turnaround was the review. Gradually progress is being made to build a strong and effective service of which the staff can be proud.

> *"We found a group of doctors hungry to deliver a service which they could be proud of and learn more from peers and colleagues but who were suppressed by a number of different influences and perceptions (some of their own making) into delivering what they felt to be a barely 'good enough' service. We found effective and enthusiastic managers, recently appointed to the service who were keen to support delivery of a modern and efficient service. We found families who were confounded by the complexity of the service and the extent of support needed by the medical team. We saw external stakeholders keen to work with the team and support them but frustrated by the lack of opportunity for joint working and sharing ideas."*
>
> Feedback from Review Team 2016

# 7. DEVELOPING OUR MEMBERS

## 7.1 Recruitment

Currently medical reviewers (consultant and SAS paediatricians) are recruited to an outline role description, and apply to join the service by submitting a short application form and along with a brief CV of relevant experience. All applications are assessed by the programme board to ensure they meet the minimum criteria for the role.

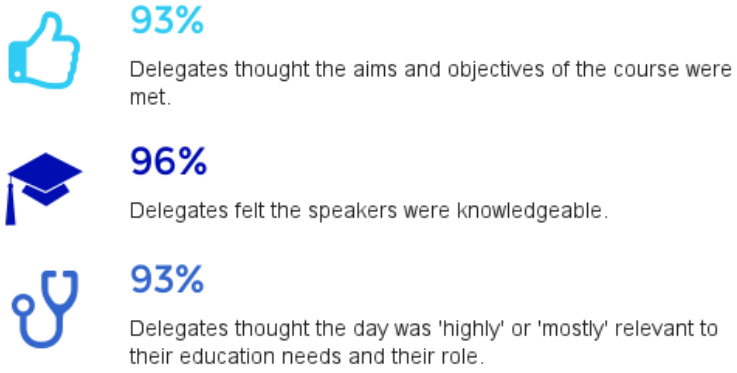
## 7.2 Inducting and refreshing reviewers

Successful applicants are invited to attend an induction/development day. These days are mandatory for all new applicants, and must be attended every two years by existing reviewers.

The days are an opportunity to:

- Introduce new applicants to the College's Invited Reviews process
- Update reviewers on key standards and policy guidance
- Help enhance relevant skills and knowledge
- Introduce reviewers to other members
- Help all reviewers share their knowledge and experience
- Assess applicant's suitability for the role

> *"I liked the practical sessions with the scenarios, as it gives the chance to 'get things wrong' in a safe environment."*
> Delegate February 2016




The agenda includes a mix of presentations, workshop sessions, case study exercises and group discussions. The days are facilitated by experienced reviewers and members of the programme board, and are accredited for CPD points.

In 2016 days were held in both London and Manchester, and were attended by 43 reviewers including 6 members of the programme board, 12 community paediatricians, one nurse reviewer, three lay reviewers, one Royal College of Obstetricians and Gynaecologists reviewer and a guest attendee from the Royal College of Ophthalmologists.

> *"An excellent day..... The workshops and table top discussion were a really good way to simulate a review and the room wide discussion and engagement of the audience was good. Good to have representation from other colleges.... A good opportunity to calibrate my decision making with others."* Delegate February 2016

# 8. NEXT STEPS

There are a number of specific objectives agreed for the service over the next year which align with the RCPCH's corporate objectives. Specific plans include:

- A rolling programme of evaluation and review feedback, working with services that have been reviewed to support sustainable improvement

- Developing our reviewer pool- through competency assessment and a comprehensive programme of training and development, building on the current induction, including all regular reviewers and increasing the diversity of skills.

- Strengthening the brand and raising awareness of the review service to wider audiences so their role and function is widely known

- Increase the efficiency of reviews by better marshalling of resources and data

- Enhance the breadth and depth of the links to other RCPCH services and tools such as quality improvement, paediatric care online, augmentative and alternative communication support, training, events and development.

**For further information, please see the Invited Reviews webpage www.rcpch.ac.uk/invitedreviews or contact the review team on 020 7092 6091.**

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