London Clinical Senate

Advice on plans for the transition of paediatric services from Ealing Hospital

February 2016

Response to a request for independent advice on plans for the transition of paediatric services from Ealing Hospital

Prepared for:	**NHS England (London)**
Approved by:	**London Clinical Senate Council Chair**
Date:	**22 February 2016**

AIMS OF THE REPORT: To provide the following advice to NHS England (London):

1. Whether the proposed paediatric services clinical model has satisfactorily addressed each of the concerns raised by the London Clinical Senate in its previous review which reported in February 2015
2. Whether any additional concerns have been identified relating to the safety of the proposed paediatric services clinical model
3. The key risks associated with transition to this clinical model so that the assurance process can ensure sufficient action is planned to mitigate them to an acceptable level.

1. Executive summary

In February 2015 the London Clinical Senate provided advice on plans to implement previously agreed changes to maternity, neonatal, gynaecology and paediatric services in North West London. These centre on the transition of services from Ealing Hospital and development of new models of care across other trusts in North West London

Changes to maternity, gynaecology and neonatal services were implemented in July 2015. Changes to paediatric services are due to be implemented in June 2016. Our previous advice identified a number of issues and some concerns about the proposed paediatric model of care and made a number of recommendations. NHS England has asked the Clinical Senate to give further advice to inform the assurance of process for this service change. We were asked to advise on three things:

1. Whether the proposed paediatric services clinical model has satisfactorily addressed each of the concerns raised by the London Clinical Senate in its previous review
2. Whether any additional concerns have been identified relating to the safety of the proposed paediatric services clinical model
3. The key risks associated with transition to this clinical model so that the assurance process can ensure sufficient action is planned to mitigate them to an acceptable level

The Review Team established to provide this advice included several members involved in our previous review and a number of additional members who brought significant and broader expertise in different aspects of children and young people's health services as well as experience of planning and delivering services change at a local and strategic level. The combination of continuity and fresh perspective contributed to the robustness of our deliberations.

I have had the pleasure of chairing both reviews. I am very grateful to my clinical colleagues, and to members from the Clinical Senate's Patient and Public Voice, for the time they committed and the experience they brought. I am also very grateful to members of the *Shaping a Healthier Future* programme for their time in meeting with the Review Team for the open and wide ranging discussions we had. Alongside the comprehensive set of documents we received, this ensured we were able to explore what we collectively identified as the most important issues, with a particular focus on risk, in some depth.

The Review Team concluded that, overall, significant progress has been made in responding to the issues and concerns raised in the Clinical Senate's February 2015 review. We were impressed by the work that has been carried out to date and the level of care, commitment and collaboration that is evident in planning this change and in addressing key risks and issues. There is strong and visible clinical leadership and a robust programme approach. The SaHF team confirmed that service users are involved in all key groups within the programme. Learning from other change programmes is being used to inform transition planning, including the changes to maternity, neonatal and gynaecology services implemented last year.

We believe the SaHF team has identified all the key risks and issues and are clear where further work is needed and have arrangements to address and manage these. The Review Team did not identify any new issues that the SaHF team is not considering though there are some areas that may need more emphasis.

There will need to be a continued focus on delivery against these plans to prepare for the transition. However, there will also need to be a focus on the delivery of care at Ealing and receiving sites immediately following formal transition to ensure the new working arrangements are properly embedded and that staff are supported to deliver the new model of care across North West London.

A clear process for reviewing the transition will help ensure benefits are being delivered and there are no unintended consequences. Importantly this should include experiences of staff at all sites as well as patients and the public. Appropriate review points will include pre- and post-Winter 2016/17.

In this review, the Review Team also explored whether there was any evidence of risks increasing at Ealing to the extent that consideration should be given to accelerating the transition. Whilst there are some risks within current services, maintaining sufficient medical staffing cover is considered the key risk, the SaHF team believe these can be mitigated and they are being monitored. We concluded that the further work required to prepare for the transition, including the need for well-planned and appropriately timed communication with local people, did not support such a case, and is likely to increase risk.

It is essential, however, that the planned transition date at the end of June 2016 is achieved. Significant risks are likely to emerge if there is any slippage including impact on staff morale recruitment and retention, withdrawal of junior doctor's accreditation, which would impact on the viability of the current paediatric model of care at Ealing Hospital, and uncertainty amongst the local community causing significant communication challenges.

Inevitably, there is further work to do in preparing for the transition in four months' time and there are particular risks that will require ongoing attention to ensure they are or will be mitigated to an acceptable level. The SaHF team is very conscious of these.

The report concludes with the Review Team's advice on the key risks that the assurance process should focus on and advice on the assurance that should be sought.

Dr Ian Abbs
Review Team Chair and Member of the London Clinical Senate Council
On behalf of the Review Team

2. Background

In February 2015, the London Clinical Senate provided advice to NHS England (London) and North West London Clinical Commissioning Groups (CCGs) on plans to transition maternity, neonatal, paediatric and gynaecology services from Ealing Hospital, part of London North West Healthcare NHS Trust. The plans were part of a wider set of proposals to transform the way healthcare is delivered for people in North West London, which were agreed following public consultation in 2013. The overall change programme is called *Shaping a Healthier Future* (SaHF). This is a link to the Clinical Senate's previous report.

Changes to maternity, gynaecology and neonatal services were implemented in July 2015. Changes to paediatric services are due to be implemented at the end of June 2016. In the Clinical Senate's previous review, the Review Team concluded that the key elements of the clinical model for paediatrics were appropriate; however felt there was a lack of detail on aspects of the model, particularly for services that will remain at Ealing Hospital. The Review Team therefore highlighted a number of issues and some concerns about both the clinical model at Ealing Hospital and the wider health economy's response to the transition.

3. Scope of advice requested

The Clinical Senate has been asked to give advice on three issues:

1. Whether the proposed paediatric services clinical model has satisfactorily addressed each of the concerns raised by the London Clinical Senate in its previous review

2. Whether any additional concerns have been identified relating to the safety of the proposed paediatric services clinical model

3. The key risks associated with transition to this clinical model so that the assurance process can ensure sufficient action is planned to mitigate them to an acceptable level.

4. Formulation of Advice

4.1 Review Process

The Clinical Senate established an independent Review Team to consider the proposals and formulate the advice requested, chaired by a member of the Clinical Senate Council. The Team included several members involved in the previous review, including the Chair. This continuity was important. Additional members brought significant and broader expertise in different aspects of children and young people's services as well as experience of planning and delivering services change at a local and strategic level. No-one on the Review Team has been involved in developing the proposals that the Team considered. One member was a member of the Independent Reconfiguration Panel that advised the Secretary of State on the proposals following consultation in 2013. Review Team members are shown in section 9.

The Review Team considered a range of documentation provided by the SaHF Programme Team, which members felt to be comprehensive. This included a response to each of the issues and concerns raised in the previous review together with supporting and background information. Documentation received is listed in section 9.

The Review Team then met to share and debate views and findings from the information and evidence provided. This session included a meeting with members of the SaHF Programme (see section 9) providing the opportunity to discuss issues directly with clinicians leading the work to deliver these changes. Whilst all of the concerns in the previous review were considered in this discussion, most attention was given to those issues that the Review Team and the SaHF team identified as the most significant in terms of risk. The Review Team debated issues further after this session prior to formulating its advice.

This report presents the Review Team's findings, conclusions and advice drawing from the overall process. The advice provided is the unanimous view of all members.

The associated changes to the urgent and emergency care pathway for children and young people, in particular future arrangements for managing acutely sick children who self-present at Ealing Hospital, have also been discussed with the London Clinical Director for Emergency Care. This report therefore also reflects his advice.

4.2 Limitations

A significant amount of documentation was provided by the SaHF Programme to inform this review. The Review Team's advice is based on the information seen and discussions with the SaHF team. Wherever possible the Review Team has attempted to triangulate the two.

The advice from this review is intended to provide a clinical and service user perspective to inform the assurance process for the transition of paediatric services. The review was not established to assure the transition plans.

5. Review Findings

This section considers all of the concerns and recommendations from the Clinical Senate's previous review and whether the Review Team felt these have been satisfactorily addressed.

The clinical model of care for children and young people's services at Ealing Hospital – response to issues raised in the February 2015 report

5.1 The clinical model must be specific about the type of daycare remaining at Ealing Hospital

The Clinical Senate strongly advised that daycare for children and young people which continues to be provided at Ealing Hospital when there is no paediatric inpatient unit on site should be restricted to very low risk activity.

The Review Team agrees that the scope of day-care activity is now clearly defined and is content that the associated level of risk is low, based on examples provided.

The proposed 'day care' model described sets out a predominantly outpatient service, continuing existing arrangements, with some planned daycare procedures. Some further definition is required however to ensure that there is a common understanding of "low risk". For example, the Review Team felt that undertaking blood transfusions is appropriate but there must be senior paediatric doctor (competent in paediatric resuscitation) and senior paediatric nurse support when transfusions are carried out. Arrangements should be supported by standard operating procedures (SOP) against which adherence can be audited. These should be explicit about what tests or procedures can and cannot be carried out, e.g. glucose tolerance tests are considered low risk but for endocrine simulation tests growth hormone tests are not, and include any skills/qualifications required by staff who carry out the procedures or who should be available onsite to provide support if required. The SOPs must be in place ahead of the transition so that all staff are familiar with the new arrangements.

The SaHF team advised that the consultant paediatrician present on site will be the consultant running the Rapid Access Clinic (RAC) and that the RAC has been established as a one-year pilot initially with a decision on continuation subject to the outcome of an evaluation (see 5.3 below). Suitable alternative consultant cover arrangements would be required for the day care service if the RAC did not continue.

In addition to a consultant paediatrician, the Review Team emphasises the importance of a paediatric support team being in place, particularly a paediatric nurse. The SaHF team confirmed that a minimum of 2 paediatric nurses will be available across the daycare service and rapid access clinic (see below) and sometimes 3. The Review Team was content with that, but highlights the important role of paediatric therapy staff, including play specialists in such settings.

5.2 No day case surgery requiring a general or significant regional anaesthetic should be provided at Ealing Hospital once the inpatient unit has transferred

The Review Team is satisfied that this will be the case. Planned procedures requiring local anaesthesia will be carried out and, as for daycare procedures, should be supported by SOPs and appropriate staff.

The Review Team understands that there will be one anaesthetist with paediatric training who will cover these cases at Ealing. It is likely that the volume of activity will be relatively low and arrangements should be put in place to ensure anaesthetic expertise is maintained.

5.3 The Rapid Access Clinic (RAC) specification needs to be developed and the business case approved

The previous review concluded that the RAC had the potential to become an innovative, integrated paediatric service for local children and young people, though suggested the proposed operating hours be reviewed to ensure children and young people's needs would be met 7 days a week. At that time, whilst the concept was well described, the specification had not been developed and a business case had not been accepted.

Evidence to this review confirmed that Ealing CCG approved a business case in April 2015 to pilot the RAC for one year and it became operational in November 2015. The RAC provides clinician-to-clinician advice, giving GPs prompt access to non-urgent paediatric consultant opinion, including same day or next day appointments as considered necessary. It does not provide open patient access. At any one time minimum staffing in the RAC will be a consultant paediatrician, a middle grade doctor and 1-2 paediatric nurses. An additional paediatric nurse will be available in the daycare unit.

The Review Team heard that the pilot will develop in three phases. The first phase provides GPs with access to telephone advice from a consultant paediatrician between 11am and 3pm Monday to Friday. Access is deliberately restricted pending the build-up of additional consultant capacity. Phase 2, expected to start in March 2016, will extend the service to 7pm Monday to Friday and 11am-2.00pm, on Saturdays and Sundays. Opening hours reflect peak paediatric attendance times in the A&E department and Urgent Care Centre (UCC) and support the wider development of general practice in North West London with a drive for surgeries to open six or seven days a week. In the third phase, UCC doctors will be able to access the RAC for advice and if agreed to be appropriate the paediatrician will see a child for assessment.

The Review Team welcomed that fact that the RAC was up and running several months prior to the transition and noted there had been 112 telephone referrals in the first eleven weeks. In 38% of cases the GP was given advice on a management plan, 18% led to an appointment in the RAC, 24% were advised to make an outpatient referral and a small number were advised that the child should attend A&E. The RAC pilot will be evaluated after six months of operation.

The Review Team agrees that the service model is clear. However, as the agreed business case is only for one-year at this stage, some concerns remain. The Review Team strongly supports evaluating the RAC and was advised that Ealing CCG is committed to sustaining the

service if evaluation demonstrates it is successful. The evaluation is likely to start only a few weeks before the transition. It will be important to ensure this is early enough to understand its impact. A staged evaluation linked to each phase of implementation could be considered.

It will be important to ensure that the evaluation concludes and decisions are made in sufficient time to implement them effectively before the pilot concludes in November 2016. If the service continues, this will need to be built into plans from 2016/17. The Review Team has not seen the criteria or approach that will be used to evaluate the RAC however believes it will be very important to ensure that any decision about the RAC, particularly a decision not to continue the service, is based on a clear understanding of the role that it plays in sustaining the wider model of children and young people's services at Ealing Hospital and their care in the community, for example in maintaining a level of paediatric expertise on site during day case activity and the extent to which it contributes to a critical mass of staff across the paediatric service as a whole.

5.4 There needs to be more clarity on the approach to managing patients who self-present at Ealing A&E

The Review Team and the SaHF team agreed that this is the most critical issue within the overall model of care and the highest clinical risk. The greater part of the Review Team's discussions, and discussions with the SaHF team, focused on this.

The urgent and emergency care pathway at Ealing Hospital[1], involves the UCC operating as a 'front door' i.e. all patients, of whatever age, who self-present are assessed by an Advanced Nurse Practitioner (ANP) in the UCC and triaged to the A&E department if they require care or treatment beyond the UCC's capabilities. Children under two years of age are immediately streamed for review by a UCC doctor. Data provided shows that in 2014/15 around 24,000 children and young people under the age of 16 attended urgent and emergency care services at Ealing Hospital. 18,000 were managed in the UCC and just under 6,000 were referred to A&E, which is an average of 21 per day

Following transition of the paediatric inpatient unit the A&E will no longer accept children under the age of 16 because of the absence of specialist paediatric staff onsite twenty-four hours per day, which is required to safely look after the most unwell children. The urgent and emergency care pathway will therefore change. Following assessment in the UCC, by an ANP or doctor as now, children under the age of 16 who require care or treatment beyond the capabilities of the UCC will be transferred to one of five hospitals in North West London with an A&E that treats children and a comprehensive 24/7 paediatric service.

This transfer will happen in one of three ways depending on the assessed needs of the child:

- Parents/carers will take the child to another A&E or paediatric assessment unit (PAU) if the child is well enough

[1] This model operates at all sites with an emergency department in North West London apart from St Mary's Hospital where it will be introduced from April 2016.

- Ealing Hospital will arrange patient transport to take the child and parents/carers to another site if the child is assessed to be stable (with a nurse escort if required)
- An emergency ambulance will be called via 999 if the child is acutely unwell, UCC staff will perform paediatric basic life support if required, the child will be taken to a safe place and supported until the ambulance crew's arrives to transfer the child to an appropriate unit

The SaHF team confirmed that all modelling and all pathways assume that other than a role in assisting with stabilisation of a sick child, Ealing A&E is not going to assess or treat any children who cannot be treated within the UCC. Ensuring absolute clarity about the acute care pathway will be essential to delivering a safe, effective service. The Review Team has carefully considered each of these scenarios and explored them with the SaHF team.

The SaHF programme has carried out significant work to review and develop pathways and shared this with the Review Team. A workshop at the end of January 2016 involving clinicians from paediatric services, UCCs, A&E services and the London Ambulance Service (LAS), was reported to have a high level of engagement and reached agreement on two important principles.

- To facilitate an integrated service, smooth patient journeys and positive experiences for children and families, other North West London Hospitals will never refuse to accept a patient transferred or referred from Ealing. To mitigate risk with the first scenario (parent transport), a system will be introduced to inform a receiving unit when a child and parent/carer is advised to go there and for that unit to notify Ealing UCC if the child does not attend. A SOP should be developed with follow-up processes and timescales and include robust safeguarding process for children and young people who do not attend.

- To ensure that transfers lead to children receiving care/treatment required as promptly as possible following initial assessment at Ealing Hospital, there should be no more than two steps in any child's journey (the initial assessment at Ealing being one). The exception to this would be if a child requires access to critical care, which could involve a further transfer via the Children's Acute Transport Service (CATS) as paediatric critical care services are only provided at designated hospitals across London (which includes St Mary's Hospital in North West London) or other specialised services i.e. surgery. The importance of managing parents/carers expectations in these circumstances was acknowledged.

In the second scenario (hospital arranged transport), there may be a need for a member of the clinical staff, usually a nurse, to accompany the child and parent/carer in the hospital transport. This could have implications for staffing. The SaHF team noted that further work is needed in relation to this pathway and a SOP should be developed to operationalise this once agreed. Plans should be developed to mitigate the risk that numbers of transfers may be higher than planned based on worst, mid and best case scenarios, with the worst case assumed at least in initially.

The third scenario (emergency transport) poses the greatest risk. The SaHF team described plans to enhance capability within the UCC through additional paediatric training for staff. In the event of a child being or becoming acutely unwell the pathway will involve calling an

emergency ambulance via 999, administering paediatric basic life support if required, transferring the child to a safe place to wait (the A&E is proposed) and attempting to keep the child stable until the ambulance crew arrives. The LAS has recently agreed that a request from an UCC will receive a Category A 8 minute response time. The SaHF team explained that discussions about this pathway continue to take place including the role of A&E and anaesthetic staff.

Documents about the models of care shared with the Review Team make little reference to standards. The London Quality Standards (February 2013), which are incorporated into the London acute care standards for children and young people (April 2015) and the Urgent and Emergency Care Facilities specifications for London (November 2015) are all relevant. The Review Team considers it important for the SaHF programme to demonstrate how the proposed model of care complies with these standards, clearly setting out the reasons for any variance and showing how an alternative arrangement meets standard, for instance through a networked approach. For example, although Ealing A&E will not treat children under the age of 16 in future, staff may need to deal with children in this age group on occasions and will still routinely see young people aged 16 and 17, for whom, amongst other issues, there may be safeguarding concerns. Identifying a consultant and senior nurse in the A&E who have overarching responsibilities for children and young people e.g. ensuring guidance is kept up to date and that any children and young people attending (up to 18 years of age) are looked after appropriately, will give assurance about the quality and safety of the service being delivered and will mitigate risk.

The SaHF team provided several examples of how learning is being applied from other changes to urgent and emergency care services in London to this transition. These include Chase Farm Hospital in Enfield and Charing Cross, the Central Middlesex, and Hammersmith Hospitals in North West London; changes at the latter two were an earlier part of the SaHF programme. The SaHF team discussed the fact that some of these service models have similarities to Ealing and operate pathways that are shown to be safe and effective. Charing Cross hospital has a UCC that treats children though the A&E has not treated children for many years and the hospital does not provide other children's services. The Central Middlesex Hospital provides some children's services, but has no inpatient unit and has a UCC but no A&E. This does allow learning about protocols for unwell children who self-present and need to be transferred, and about how the population adjusts behaviour. The CCG is keen that the community continues to see Ealing Hospital as a provider of children's services and to encourage local families to utilise the UCC where appropriate to do so, although the A&E will no longer treat children under 16 years of age. This may be a difficult message to get across and the communication around it will be critical.

The SaHF team have clearly given significant thought to these pathways and discussions continue. Review Team makes the following recommendations:

- The February 2015 review suggested considering the establishment of a short-stay paediatric assessment unit (PAU) at Ealing Hospital to support the A&E. The Review Team accepts the SaHF programme's rationale for not having a PAU due to the workforce implications.
- The age group of children and young people treated in different services at Ealing Hospital should be unequivocal.

- Staff in a UCC should be trained in paediatric basic life support and appropriately trained staff should be available at all times.
- The proposed pathway for an acutely unwell child who needs emergency transfer from the UCC to an A&E that treats children is appropriate i.e. call 999, perform paediatric BLS if required, move the child to a safe place, observe and support them until they can be transferred.
- We would expect adult teams (A&E and anaesthetists) to use their best endeavours to assist UCC staff to look after a child pending arrival of an emergency ambulance.
- In considering the role of adult teams, careful thought needs to be given to the level of skill required and how this would be maintained in an ongoing way bearing in mind the expectation that it would be rarely needed; this includes the use and maintenance of appropriate equipment for children
- Arrangements for dealing with a child who exceeds the ability of the UCC should be set out in a SOP, which clearly describes roles and responsibilities, experience/training required, plans for monitoring and review
- The SaHF programme should set out how the model of care following the transition will meet the London Quality Standards and the Urgent and Emergency Care specifications for London, the reasons for any variance and how this will meet an acceptable standard. This should include identifying a lead doctor and a lead nurse with overall responsibilities for the care of children and young people (up to age 18) within the A&E department.
- A SOP should make clear how arrangements for transfers will work, including criteria for determining whether to transfer via parent transport, hospital transport or emergency transport (LAS).
- In the early period of the transition there is a, possibly significant, risk that parents and carers will continue to bring to Ealing Hospital children and young people who need to be treated in an A&E. This could result in a higher number of ambulance transfers (emergency and non-emergency). Staffing levels should take account of this, for example, by having a supernumery children's nurse available to escort children if required.

5.5 Paediatric patients should be redefined as 0-18 years, with 16-18 year olds given the choice of paediatric or adult care

In the previous review, the Clinical Senate noted that the model refers only to children and young people under 16 years of age and challenged the SaHF programme to extend this to young people up to 18 in line with the National Service Framework for Children and Young People (2005). There is increasing recognition that young people aged 16-17 can be significantly disadvantaged by traditional splits between paediatric and adult health services, with 17 year olds often unable to access care in either system. This is particularly the case for young people requiring mental health care as adult psychiatrists will not generally see young people under 18 years old.

The Review Team believes it is important this this remains the overall goal however accepts the SaHF team's view that there should be a phased approach and that effectively implementing the new model of care for 0-16 year olds is the right first step. It is also evident that thought is being given to meeting the needs of the older age group. For example, 16-18 year olds with complex and chronic conditions will continue to be treated in the paediatric

service until they believe they are ready to transfer to an adult service. Discussions are also being held with every child or young person who has a chronic condition to agree where they will receive acute or inpatient care after the Ealing inpatient unit closes. A buddying system with the acute teams is being put in place, including visits to the other hospitals, so that they become familiar before the transition.

The Review Team emphasises the importance of ensuring that there are robust safeguarding arrangements in place for young people in this age group.

The SaHF team confirmed their commitment to ensuring young people aged 16-18 will be given a choice of whether they wish to be treated within a paediatric or adult service, even for a one off attendance, though further work is needed on the process for doing this in practice. The programme to develop children and young people's services will continue after this transition. The Chair of Hounslow CCG will be leading a group, which will aim to better understand and improve care and experiences for 17-18 year olds as well as paediatric critical care, CAMHS and children's community services. This is due to commence in March 2016.

5.6 Particular thought needs to be given to the provision of child and adolescent mental health services and social services for 16/17 year olds in an adult A&E unit

Child and adolescent mental health services (CAMHS) already provide services up to age 18, as does social care. This is important in providing appropriate ongoing support to Ealing A&E. Section 5.4 of this report highlights the importance of identifying a lead doctor and a lead nurse with overall responsibilities for the care of children and young people (up to age 18) within the A&E department and this includes CAMHS, social services and safeguarding.

The Review Team also heard about a new seven day service recently introduced to strengthen the provision of CAMHS out of hours in Ealing, Hounslow and Hammersmith & Fulham, by providing advice and arranging assessments or transfers.

Information provided by the SaHF confirmed that work is taking place with stakeholders to ensure robust CAMHS pathways are in place, including back to Ealing CAMHS for children and young people under who attend A&E or inpatient services at other trusts and need ongoing or follow–up mental health care.

The wider model of children and young people's services across North West London – response to issues raised in the February 2015 report

5.7 System integration

The previous review highlighted a potential risk that the model could lead to more fragmented care for children, young people and their families, particularly in Ealing, because inpatient and outpatient care will be provided on different sites.

The Review Team explored how the model of care would operate as a single integrated system. Some of the processes being put in place are noted earlier in the report, for example the buddying system with other acute teams and the agreement that other units will accept all children and

young people referred or transferred from Ealing. Clear communication with staff about pathways should be developed and agreed and monitoring of the effectiveness of pathways will be important as will managing parents' expectations, for example if a child is sent to a hospital which is not able to meet their needs or requires a further transfer for whatever reason. The SaHF team noted that successful pathways between Ealing Hospital and other trusts exist for other services, which demonstrates that it can be managed well.

IT infrastructure and records access is limited and a paper-based system will support the model of care initially and probably for some time. Clear SOPs will need to be in place for every pathway including information sharing arrangements for safeguarding..

The Review Team did hear about an interoperability project between general practice and secondary care in Ealing using *SystmOne*[2], which is helping to integrate care locally. *SystmOne* has also been introduced into the West Middlesex PAU, enabling electronic communication with GPs.

Existing systems will be used for safeguarding with CP-IS (Child Protection – Information Sharing) due to be introduced to all UCCs and emergency departments during 2016.
The SaHF team also gave an example of further work taking place in Ealing to strengthen integration between primary and secondary care. *Connecting Care for Children* involves consultant paediatricians undertaking joint clinics with GPs in their practice improving access for local families and supporting GPs to enhance their paediatric skills. Groups of GPs can also meet with a paediatrician to discuss and get advice on management of individual cases. The service will start in Acton in March 2016, followed by Southall later in the year.

5.8 High dependency care (HDC)

The February 2015 review highlighted that the lack of understanding about current capacity and demand for paediatric HDC has the potential to increase risk in the system. This was acknowledged as a London wide issue and not unique to North West London.

Ealing Hospital does not currently provide paediatric HDC therefore the transition of inpatient paediatrics is not expected to impact on HDC provision. Evidence submitted to this review confirms however that the SaHF Paediatric Delivery Board recognises the need to address this and has recommended that options for commissioning level 1 critical care at West Middlesex, Hillingdon and Northwick Park Hospitals be explored. An analysis of demand is planned initially to inform recommendations. Paediatric clinical leads in each trust will work with their commissioners to review provision. It is proposed to commission paediatric HDC services at CCG level, in line with RCPCH guidance.

5.9 Workforce

The previous review identified the need to develop a robust plan for the paediatric workforce with a more innovative model than suggested at that time.

[2] SystmOne is a healthcare information system, predominantly used in primary care, to electronically record and share patients' demographic and clinical care information safely and securely across care settings

The SaHF team provided an overview of the plan developed to address workforce requirements for this transition. This draws on lessons learnt from the transition of maternity (and other) services last year. Importantly, there has been early and ongoing dialogue with existing staff at Ealing, to ensure that the service is sustained until the date of transfer whilst giving staff certainty, and choice, about where they would like to work. We are told that nursing staff have all committed to staying within North West London.

There will be an ongoing need for some paediatric staff at Ealing to support the outpatients' clinics, daycare and the RAC. Health Education North West London (HENWL) has advised the SaHF programme that this model will provide high quality training opportunities and, where feasible and appropriate, will rotate postgraduate medical trainees there. The Review Team sees a potential risk in retaining paediatric nursing staff at Ealing and the assurance process should ensure plans are in place to mitigate this, for example, through rotations, and more individualised support.

The new model of care across North West London includes establishment of paediatric assessment units (PAUs) at a number of hospitals, and increases the requirement for paediatric nurses by 8.54WTE. There is a general shortage of paediatric nursing staff across the country. North West London, as for other parts of London, is not immune to this and so there are existing vacancies across most units. The SaHF team described various recruitment initiatives in train or planned, which include recruiting in the UK and overseas, training and education support, including use of bursaries. The programme is working closely with Health Education North West London (HENWL), which is providing significant support. Activities to date seem to have been successful and the need for efforts to be ongoing, with an element of natural staff turnover likely before and following the transition, is recognised.

The Review Team emphasised the importance of new recruits being adequately supported, particularly as the recruits are likely to include both newly qualified and overseas nurses.

The greatest challenge in medical staffing is the availability of middle grade doctors. A reduction in the number of paediatric training posts in London has created more competition to have trainees placed at each site. A key strategy for responding to this is to recruit non-training middle grade doctors. HENWL is also providing significant support and has put together a recruitment and retention package, which includes funded training bursaries.

The SaHF team highlighted recruiting middle grade doctors to Hillingdon Hospital as the most significant concern, despite the offer of bursaries in the range of £5-10,000. Whilst efforts continue, increased consultant cover, including consultants being resident on site, is the strategy to mitigate this risk. Paediatric consultant recruitment is not envisaged to be a problem. The new model of care requires only a small increase on consultant capacity and a recent vacancy at Hillingdon attracted a number of appointable candidates for one post.

Paediatric trainee posts will be distributed across North West London in line with activity flows and plans for the gradual reduction in the number of paediatric training posts. Information submitted for this review advises that plans are not yet final and have not been shared with trusts. To inform overall workforce planning, this should happen as soon a possible. The submission also highlights that the timing of the transition means that trainees will be

redeployed mid rotation, though describes the intention for individualised development plans to mitigate the risk of disruption to training and trainees' development.

The Review Team was also told that the combined increase in maternity and paediatric/ neonatal activity at Hillingdon, and possibly the West Middlesex, has reached a point where split rotas are needed. This was not discussed in detail, as it had not been described in the documents which the Review Team received, however adds complexity to the staffing model, and recruitment, during a period of further change. The assurance process will need to consider this.

5.10 Ensuring capacity is in place

Documentation submitted to the review confirmed that business cases had been developed and approved for the RAC pilot at Ealing (addressed earlier in the report) and to develop additional physical capacity for the expansion of paediatric services at other trusts; in some cases this is linked to wider redevelopment work. An update on progress was also included, confirming work is either complete or is on track to complete before the transition with two exceptions.

At Hillingdon Hospital A&E expansion, including a PAU, is due to complete in June 2016. This will be just before the changes at Ealing Hospital, however progress will need to be monitored carefully between now and June and mitigation put in place in the event of any slippage. Four additional paediatric inpatient beds at Hillingdon are scheduled to be ready for occupancy in September 2016. The SaHF team has advised that current capacity should be sufficient as winter activity levels typically tend to increase from October and mitigation plans for alternative capacity (e.g. use of day beds) have been agreed.

A business case to establish PAU at St Mary's Hospital has been approved however it will not be operational until December 2016. The Review Team was advised that mitigation plans have been agreed involving use of day beds, however there is a risk that these beds could be required to support the Trust's winter plans and further mitigation may be required. The SaHF team also highlighted a potential risk in plans to accommodate an increase in paediatric attendances at St Mary's A&E following the changes at Ealing Hospital. The A&E has no capacity to expand and the plan involves commissioning an enhanced UCC using a common specification in use for other UCCs across North West London. Currently, St Mary's UCC treats around 10% of children on the urgent and emergency care pathway, whilst other UCCs treat 50-60%. A new UCC provider has been commissioned to provide the service, commencing in April 2016 and mobilisation is underway. Given the low volume of anticipated flows to St Mary's (an average of 2 per day) and the potential for the new UCC model, the SaHF team consider this to be low risk and the Review Team would agree with that.

Nevertheless, the assurance process leading up to and following the transition must maintain a clear focus on these issues and ensure plans are in place to mitigate risks of any slippage. The SaHF team noted that learning from the West Middlesex Hospital PAU, which opened in September 2015 has shown that the anticipated impact on A&E flows and on admissions is being delivered in practice, giving confidence to the capacity plans. This is also informing the Royal College of Paediatric and Child Health's updated guidance on SSPAUs. Although

located adjacent to the inpatient unit, whereas other PAUs will be co-located with A&E, the model in practice will inform implementation at other sites.

Overall planned system wide A&E capacity will provide 127% of current paediatric activity at Ealing Hospital A&E to provide contingency. This assumes the current level of paediatric A&E activity will transfer i.e. an average of 21 attendances per day, through upskilling in Ealing UCC and parent choice may reduce this. The new RAC at Ealing is also expected to reduce GP referrals to A&E and if this occurs to the level predicted excess capacity would increase further.

Similarly capacity planning for paediatric inpatient beds assumes the equivalent level of inpatients at Ealing in 2014/15 (2,607 spells) will transfer although the establishment of PAUs at all sites except Chelsea & Westminster (where the function is delivered through the inpatient unit due to the specialist nature of some services) is expected to reduce demand on inpatient beds, and the experience at West Middlesex suggests this is a reasonable assumption, providing contingency here.

The SaHF team confirmed that all modelling and all pathways assume Ealing A&E is not going to assess or initiate any treatment for children who cannot be treated within the UCC. In the early period of the transition, notwithstanding the effort put into the communication with the local communities, there is a risk that parents and carers will continue to bring to Ealing Hospital children and young people who need treatment in an A&E. The SaHF team advised that further work is needed on transfer pathways. This should include criteria for determining whether a child should be transferred by ambulance or by hospital transport and arrangements for escorts. It is not clear what assumptions have been made about the likely volume of transfers that will be required. To mitigate this risk the Review Team strongly advises that provision is made to respond to a higher number of transfers in the early period following the transition than the overall model assumes and ensure that capacity is available within the staffing model to escort children requiring transport if needed. This should be monitored and reviewed in light of experience.

5.11 Peer review to identify lessons learnt

In February 2015, the Clinical Senate recommended that a process of external peer review be set up to support the transition of maternity, neonatal and gynaecology services and strongly recommended a similar approach for the transition of paediatric services. The objective is to support services to transition safely and to develop and deliver the all of the intended benefits and enable learning to be shared. The format would involve plans for Ealing Hospital and receiving trusts being shared and tested with teams of clinical experts from outside North West London and refining them, as necessary, in the light of this. All services impacted by the change should be included, not just core paediatric services. Visits should take place before, during and 12-18 months after the transition and consider benefits delivered as well as lessons learnt.

The SaHF team agreed the value of this approach and confirmed that arrangements will be put in place. Over the next year, the London Healthy Partnership Children and Young People's will be asking trusts to carry out a self-assessment of compliance against the London Acute Standards for Children and Young followed by peer review, to support organisations to meet the standards. It would be sensible for post transition peer-review process to be aligned with this.

5.12 Communications

The proposed scope of the communications strategy was shared with the Review Team. This appears comprehensive and has been developed with the North West London Patient and Public Representative Group.

The strategy rightly identifies the importance of keeping parents and carers in the catchment area for Ealing Hospital informed about the changes, when they will happen, how it will impact on a child's care and what services will remain at Ealing Hospital.

The most critical communication requirement, and challenge, is helping local people to understand that whilst Ealing Hospital continues to provide a range of services for local children, including urgent care, the A&E department at Ealing no longer treats children and young people under the age of 16. This is a difficult message to give clearly.

Patient and public voice members on the Review Team questioned whether parents or carers are being asked to make the choice about the appropriate location to meet their need. However, the SaHF team was clear that this is not the case and arrangements will be in place to respond appropriately to an individual child's assessed need wherever they chose to go.

The communication strategy includes communication with GPs, LAS crews and other health and care professionals. The Review Team would emphasise the importance of ensuring this includes communication about new protocols, SOPs etc supported by any training required. It is as critical for staff working across the North West London health and care system to understand the future model of care for children and young people as it is for parents and carers.

Work is clearly taking place to ensure effective and timely communication with children and young people and their families currently receiving ongoing care at Ealing Hospital, as noted earlier. It was not clear from the documentation submitted however, the extent to which children, young people and parents and carers are involved in the transition planning, in particular development of new pathways. The importance of this was emphasised and acknowledged. The SaHF team described how service users were involved in both co-design and the communication workstreams and offered to provide further evidence if required (the Review Team has not requested this) and noted that service users are represented on all groups within the programme structure. One example provided was the Travel Advisory Group, which considers the impact of changes on access and travel implications for children and families and advises the programme in addressing these.

The Review Team also identified a need to consider the unintended consequences of using different communication channels and to mitigate the risk that these inadvertently exclude some members of the community.

5.13 Conclusion

The Review Team concluded that, overall, significant progress has been made in responding the issues and concerns raised in the Clinical Senate's February 2015 review. Strategic oversight of the transition planning is good, and there is positive collaborative working in delivering the programme and addressing risks and issues. We feel the SaHF team have identified all the key risks and issues and were clear where further work is needed and discussed arrangements to address and manage these. The Review Team did not identify any new issues that the SaHF team were not considering though there are some areas that may need more emphasis.

There will, clearly, need to be a continued focus on delivery against those plans to prepare for the transition however there will also need to be a focus on the delivery of care at Ealing and receiving site immediately following formal transition to ensure the new working arrangements are properly embedded and staff are supported to deliver the new model of care across North West London. The Review Team and the SaHF team were clear that the period of transition will continue well beyond the end of June until such time as pathways and processes are assured to be working effectively and fully embedded.

A clear schedule for reviewing the transition will help ensure benefits are being delivered and there are no unintended consequences. Importantly this should include experiences of staff at all sites as well as patients and the public. Appropriate review points will include pre- and post-Winter 2016/17.

6. Other issues considered

In addition to the specific issues raised about the model of care in the previous review, the Review Team considered a number of other issues and discussed these with the SaHF team.

6.1 Sustainability of the current model of care at Ealing Hospital and timing of the transition

The review carried out in February 2015 concluded that transitioning paediatrics services from Ealing Hospital, coincident with changes arrangements for maternity and neonatal services, without sufficient capacity being available at other sites would lead to increased risk. The rationale for retaining paediatric inpatient and A&E services at Ealing Hospital following the transition of maternity and neonatal services in July 2015 was to mitigate this risk by allowing a longer lead-time for the services and capacity required elsewhere to be developed. The Review Team agreed in 2015 that the inpatient paediatric service would be able to continue independently of maternity and neonatal services for as long as necessary providing a robust plan was in place for the paediatric workforce. It was also acknowledged, however, that risks can change over time and that sustaining quality at Ealing was likely to become more difficult in the months leading up to transition and was concerned that the eventual transition was delayed beyond June 2016

In this review, the Review Team explored whether there was any evidence of risks increasing at Ealing to the extent that consideration should be given to accelerating the transition. Information submitted to the review indicated that some difficulties in maintaining the medical workforce might be emerging. The SaHF team fully recognise that a period of transition can be a difficult time for staff and whilst some challenges are experienced at Ealing believe these reflect the realities that exist in most paediatric units. The Team confirmed that there are a sufficient number of appropriately skilled doctors to sustain the service until the planned transition date. The consultant workforce remains stable, though trainees are spending more time on service delivery than training. The unit also receives support from other paediatric consultants and middle grade doctors across the London North West Healthcare NHS Trust.

The Trust's Paediatric Clinical Director, who also chairs the programme's Paediatric Delivery Board, meets with staff regularly and is comfortable that risks are being mitigated and can be managed until the planned transition date. As noted earlier, discussions are also taking place to give staff certainty about their roles post transition.

The SaHF team further advised that from March 2016 the programme will start to monitor routinely a quality dashboard for all providers which will comprise a set of high level indicators, including staffing, as part of the local assurance mechanism. A similar approach was taken for the transition of maternity services and is reported to have worked well.

The Review Team recognises that although some of the additional capacity needed at other trusts is in place, other capacity will not be ready until nearer the transition date and further work is required to finalise and test some pathways. In addition, whilst a communications strategy has been agreed, the SaHF team advised that a key learning point from other changes to urgent

and emergency care services shows that the timing of communication about changes to local communities is important and there is a risk in this taking place too early.

Taking all of this into account, particularly the importance of comprehensive and well-timed communication with people who use Ealing Hospital, the Review Team concluded that whilst there are some risks within current services, the SaHF team believe these can be mitigated and are being monitored, and plans should focus on achieving the transition date planned.

6.2 The period following formal transition

The SaHF team was clear that planning, governance and monitoring arrangements would continue beyond the end of June 2016, as they have following the transition of maternity services which continues to be subject to regular review following transition last year.

Most of the documentation submitted for this review, however, focused on preparation for the transition of services at the end of June 2016. The Review Team did consider issues and risks relating to the periods during and post transition in discussion with the SaHF team and risks that we believe to most significant are highlighted in this report with some recommendations on issues that should be considered to mitigate these.

6.3 Safeguarding

The Review Team felt that overall the documentation did not make sufficient reference to safeguarding. The SaHF team advised that this was being given appropriate attention and that a workshop focused on safeguarding had been held with keys stakeholders. We are told that arrangements will build on existing processes. The Review Team identified two key areas of risk. Whilst it will clearly be important to ensure that all services have up to date guidance and that staff are appropriately trained, particular attention will need to be given to ensuring this is the case for adult teams in A&E and other services that see 16 -18 year olds.

Notwithstanding the efforts being made to integrate children and young people's services across North West London, some children and young people will have more steps in their pathways and this does increase risk in communication and information sharing, especially as this will largely be paper based for the foreseeable future.

7. Key risks associated with the transition

The overall aim of this transition is to reduce current risk in the sustainability of children and young people's inpatient services at Ealing Hospital by providing higher acuity paediatric services in fewer centres to maintain and improve quality and access and develop a model of care that provides more, lower acuity, care closer to home.

In considering risks associated with the overall transition, and recognising that the period of transition will extend beyond the specific date on which the model of care for children and young people at Ealing Hospital changes, the Review Team discussed risks across four main areas, set out below.

Risks in maintaining the current model at Ealing Hospital until the transition

Maintaining sufficient medical staff is considered to be the key risk. Any sudden reduction in numbers could increase risk significantly.

Risks associated with the timing of the transition

The Review Team considered whether there was a case for the transition happening earlier to further mitigate current risk. We concluded that the further work required, and the need for well-planned and appropriately timed communication with local people, did not support such a case, and is likely to increase risk.

It is essential however that the planned transition date at the end of June 2016 is achieved. Significant risks are likely to emerge if there is any slippage including impact on staff morale and recruitment and retention of staff, withdrawal of junior doctor's accreditation, which would impact on the viability of the current paediatric model of care at Ealing Hospital, and uncertainty amongst the local community causing significant communication challenges.

Risks associated with the transition

The Review Team has identified a number of risks where the assurance process will need to ensure sufficient action is planned to mitigate them to an acceptable level. Advice on the assurance that should be sought is provided in section 8.

The Review Team also recommends that the following risks and mitigating action are added to the SaHF programme risk log:

- The risk that acutely unwell children who will occasionally be brought by their parents to Ealing UCC following the transition will not receive an appropriate, safe and timely response
- The risk of that the model of urgent and emergency care at Ealing Hospital following the transition does not meet the London Quality Standards and the standards set out in the urgent and emergency care specification for London
- The risk that currently there may be a mismatch between demand and capacity for paediatric high dependency care across North West London

Risks following transition

The period of transition will clearly extend beyond the actual date on which the services paediatric inpatient and A&E services move away from Ealing Hospital. Risk is likely to increase in the period immediately following the change requiring a corresponding increase in mitigating action. The Review Team has highlighted advice on areas of assurance below. Careful monitoring will be required to determine when risks have reduced and therefore when mitigating action should be adjusted.

There is a risk that the intended benefits of the change may not be achieved, or it may take longer than envisaged to achieve them. It is important therefore that the impact of the change is evaluated. The approach to this, and the duration, will need to be carefully considered. The SaHF team advised that a quality dashboard will be used in the pre and post transition period, drawing on experience from the transition of maternity services, and adapting as necessary for the paediatric model of care. This should include a clear set of measures aligned to the benefits envisaged.

8. Summary of advice to NHS England (London)

The Review Team's advice on the three areas requested is summarised below.

Advice on whether the proposed paediatric services clinical model has satisfactorily addressed each of the concerns raised by the London Clinical Senate in its previous review which reported in February 2015

Review Team concluded that the SaHF programme has satisfactorily addressed or is addressing issues and concerns about the proposed paediatric model raised in the February 2015 review report, recognising that work in a number of areas is ongoing. The Review Team has provided further advice on some issues.

The Review Team was impressed by the work that has been carried out to date and the level of care, commitment and collaboration that is evident in the planning of this change. Clinical leadership is strong and visible and it is supported by a robust programme approach with frequent meetings, clear governance and risk management. Learning from other change programmes, including the changes to maternity, neonatal and gynaecology services implemented last year, is being used to inform transition planning. Inevitably, there is further work to do in preparing for the transition in four months' time and there are some risks which the Review Team believes require further, and ongoing, attention to ensure they are or will be mitigated to an acceptable level. The SaHF team is very conscious of these.

Advice on whether any additional concerns have been identified relating to the safety of the proposed paediatric services clinical model

The Review Team believes the SaHF team has identified all the key risks and issues, are clear where further work is needed, and have arrangements to address and manage these. The Review Team did not identify any new issues or concerns that the SaHF team is not considering though there are some areas that may need more emphasis.

Advice on the key risks associated with transition to this clinical model so that the assurance process can ensure sufficient action is planned to mitigate them to an acceptable level.

The Review Team's advice on the key risks that the assurance process should focus on and advice on mitigating action that the assurance process should ensure is in place are summarised below. Much of this will involve ensuring effective delivery of work that is currently underway.

Risks and mitigation in maintaining the current model at Ealing Hospital until the transition

1. That arrangements in place to identify, mitigate and monitor risks within the current paediatric model at Ealing Hospital, and ensure it is sustained until 30 June 2016, are sufficiently robust, including arrangements for escalating issues as necessary.

Risks and mitigation associated with the timing of the transition

2. That arrangements in place to identify, mitigate and monitor any risks to implementing the transition on 30 June 2016 are sufficiently robust including arrangements for escalating issues as necessary.

Risks and mitigation associated with the transition

3. That there is a common understanding of "low risk" in relation to paediatric day case procedures and that the specific day case procedures which will be undertaken are clearly defined supported by standard operating procedures (SOP), including skills required, against which adherence can be audited.

4. That the arrangement for treating a child whose needs exceed the ability of Ealing UCC to continue their care is based on a thorough assessment of the options, risks and mitigation regarding airway management of children in the event of a cardiorespiratory arrest without 24/7 paediatric cover. This should be set out in a SOP which clearly and unambiguously describes roles and responsibilities, experience/ training required and plans for monitoring and review. The Review Team recommends that the SOP is reviewed by Dr Tina Sajjanhar, a member of this Review Team, and Dr Simon Eccles, the London Director of Emergency Care. The SOP should encompass all areas where children and young people are treated.

5. That the model of care remaining at Ealing Hospital complies with the London Quality Standards and the Urgent and Emergency Care specifications for London and where this is not the case that the reasons for any variance, and how this ensures an acceptable standard is met, are understood. This should include identifying a lead consultant and a lead senior nurse with overall responsibilities for children and young people (up to age 18) within the A&E department.

6. That there is a SOP which clearly sets out the arrangements for transferring children and young people under the age of 16 years from Ealing Hospital to children's acute services in other hospitals across North West London services, including criteria for use of parent transport, hospital transport or emergency ambulance transfer by the LAS.

7. That a grid is developed which sets out the qualifications, skills and training required by staff in all areas where children and young people will continue to be treated at Ealing Hospital and evidence that proposed staffing plans have been audited against this and will continue to be at appropriate periods.

8. That arrangements to safeguard children and young people are robust, in particular that information sharing arrangements are in place, and clearly set out in new pathways and SOPs.

9. That plans are in place to monitor the effectiveness of the communication strategy and its impact so that it can be adapted if necessary in the light of experience.

10. That all relevant staff across North West London have been made aware of new pathways and procedures in place and have completed any necessary training.

11. That delivery of outstanding capacity is proceeding as planned with mitigating action in place to address any risks of slippage.

12. That staffing arrangements required to deliver the model of care and capacity at all hospital sites across North West London are in line with plan and that action is being taken to mitigate the risk of identified gaps. Particular attention should be given to plans for middle grade doctors and sites where separate medical cover of acute paediatrics and neonatology will be required.

13. That all risks, including additions recommended on page 21 of this report are included in the programme risk register with mitigating action and that arrangements are in place for these to be routinely monitored.

Risks and mitigation following transition

14. That the post-transition arrangements recognise the risk of a higher number of children and young people than predicted attending the Ealing Hospital UCC with needs that exceed its capabilities leading to a higher number of ambulance transfers (emergency and non-emergency) and that staffing levels should take account of this, for example, by having a supernumery children's nurse available to escort children if required. Plans should be informed by an assessment of the worst, mid and best case scenarios for the number of such children likely to arrive with action planned to mitigate the risk for each. The Review Team recommends that plans should be based on the worst case scenario initially then scaled back based on a re-assessment of the risk in light of experience.

15. That the timing of a decision on the future of the RAC following its evaluation ensures it can be effectively implemented before the one-year pilot ends in November 2016 and that the decision has fully considered the role that the RAC plays in sustaining the wider model of children and young people's services at Ealing Hospital. In particular, if a decision is made not to continue the RAC following the pilot, assurance should be sought that the model of care for other children and young people's services at Ealing Hospital remains robust and can be safely sustained.

16. That arrangements are in place to ensure anaesthetic expertise is maintained for paediatric day surgery requiring local anaesthesia.

17. That plans are in place to maximise the potential for Ealing Hospital to continue to attract high quality paediatric nursing staff and that staff are engaged in the development of these plans.

18. That arrangements for peer review are in place or there is evidence of a clear plan and timetable to do so.

19. That there is evidence that the plans to address the needs of 16-17 year olds are progressing as expected.

9. Shaping a Healthier Future Programme

9.1 Members of the Shaping a Healthier Future Team (SaHF)

The Review Team met and discussed plans for the transition of paediatric services with the following members of the SaHF Programme

- Dr Mohini Parmar, Chair of Ealing CCG
- Dr Vijay Taylor, Vice Chair of Ealing CCG and lead commissioner for children and young people
- Dr Abbas Khakoo Clinical Senior Responsible Officer for the Paediatric Transition and Medical Director, The Hillingdon Hospital NHS Foundation Trust
- Nathan Askew, Clinical Senior Responsible Officer for the Paediatric Transition and Divisional Nurse for Women's, Neonataes, Children and Young People's, HIV/GUM and Dermatology, Chelsea & Westminster NHS Foundation Trust
- Dr Susan Labrooy, Medical Director, Acute Reconfiguration North West London CCGs
- Juliet Brown, Programme Director, Acute Reconfiguration North West London CCGs

9.2 Information submitted to the review

The following documentation informed the review

1. Shaping a Healthier Future Paediatric Transition: Update on progress and response to London Clinical Senate Report (February 2016)

2. Shaping a Healthier Future Paediatric Transition: Anticipated benefits of the transition and the proposed model of care (December 2015 Version 2.2)

3. Shaping a Healthier Future Paediatric Transition: Modelling Narrative (November 2015 Version 1.0)

4. Shaping a Healthier Future Paediatric Transition: Review of the timing of the transition of paediatric services from Ealing Hospital (November 2015 Version 1.0)

5. Shaping a Healthier Future Paediatric Transition: Stage 1 implementation plans (November 2015 Version 1.0)

6. Shaping a Healthier Future Paediatric Transition: Update on workforce transition (January 2016)

7. Briefing - Ealing Hospital Site General Paediatric Medical Staffing situation (January 2016)

8. Shaping a Healthier Future Paediatric Transition: Paediatric Transition Risk Log (February 2016 V1.0)

9. Shaping a Healthier Future Paediatric Transition: Paediatric pathway overview – input to the pathways workshop (January 2016)

10. Shaping a Healthier Future Paediatric Transition: Communications strategy (November 2015 Version 1.0)

10. Members of the Clinical Senate's Review Team

Dr Ian Abbs (Chair)*
Ian has been the Medical Director at Guy's and St Thomas' NHS Foundation Trust since January 2011. As a full member of the Trust Board he is accountable for strategic and operational objectives at one of the UK's largest teaching hospitals with a yearly turnover of over £2 billion, 13,000 staff and 2 million patient contacts per year. Ian joined the Trust as a consultant renal physician and honorary senior lecturer at King's College London in 1994, and has had a distinguished clinical and academic career, including a broad range of senior management positions. As Medical Director, Ian's leadership portfolio includes clinical standards, governance, risk management, research and development, and medical education and training. Ian has recently completed his Executive MBA at Judge Business School, University of Cambridge, UK. Ian chaired the review in February 2015 which provided advice on plans to transition maternity, neonatal, gynaecology and paediatric services in North West London. Ian is a member of the London Clinical Senate Council.

Cavette Castillo
Cavette Castillo joined Evelina Children's Hospital London in 2015 as a paediatric ambulatory matron. She is responsible for overseeing the day case unit, outpatients department as well-being lead nurse for the nurse led paediatric pre assessment team.

Before joining the team at Evelina London, Cavette worked at Kings College Hospital (Denmark Hill) as a surgical ward sister for seven years where she identified she had a skill in delivering improvements in challenging environments and was subsequently appointed as a paediatric matron for the neonatal unit, children's inpatient and outpatients services at services at the Kings College Hospital Princess Royal University hospital site.

Cavette has a passion for improving the health of young people especially those experiencing mental heal issues. She is a member of the Children and Young People's Programme Healthy London Partnership group. Cavette's other areas of interest/experience are leadership, staff development and safeguarding children and is co-author of the article "how to turn wad managers into leaders".

Dr Jane Hawdon
Jane's postgraduate medical education was in Newcastle upon Tyne and Liverpool, including a 3-year PhD programme investigating neonatal metabolic adaptation. She has remained interested in this topic, in particular the inter-relationship with infant feeding and has written and spoken widely in the subject. Jane became a consultant neonatologist in 1994 and is now consultant neonatologist and executive director of the Women's and Children's Health Clinical Academic Group at Barts Health NHS Trust, which provides care for women, babies, children and young people across 4 sites, including community health services. Jane is also a qualified coach and facilitator within the NHS. She is a member of the board of trustees of the charity Bliss and of the Independent Reconfiguration Panel, has been a member of a number of NICE clinical guideline development groups, and now chairs the hypoglycaemia working group of the current NHS England Patient Safety programme to reduce admission of term babies to neonatal units. Jane is a member of the Healthy London Partnership Children and Young People's Programme Clinical Leadership Group.

Sally Kirkpatrick*
Sally is as a member of the London Clinical Senate's Patient and Public Voice Advisory Group. Sally retired from being a financial business analyst in the City at the end of 2010. Since that time she has been working on a voluntary basis mainly in the health and wellbeing sector. Sally is a carer, and board member of a mental health and learning disability organisation that gives support to unpaid carers, mental ill health sufferers and those with learning disabilities. She has a particular interest in children and young people's mental health services (CAMHS) and is a Time to Change Champion

Sally has participated in several NHS public consultations and uses this experience to give advice as a patient and public voice. Sally is a volunteer with her local Healthwatch. In this capacity she carries out "enter and view" visits and PLACE Audits in acute and mental health NHS hospitals. Sally is a member of the Pan London End of Life Alliance and the Clinical Senate's Helping Smokers Quit Programme Board. Sally also sits on the procurement panel for integrating NHS111 and GP Out Of Hours services for North Central London.

Dr Mike Lane*
Mike has been a GP for over 20 years and works as a GP trainer and managing partner in an innovative NHS practice providing care for 61,000 London patients. He was elected to the Fellowship of the Royal College of General Practitioners (RCGP) in 2013. Mike has been a commissioner of health and social care in London since 2004, and is a board member of Wandsworth Clinical Commissioning Group. He has provided expert opinion to NICE and the UK Health Informatics Forum, and led a medical team caring for athletes at the 2012 Olympic Games. Mike has been involved in strategic programmes to improve health and healthcare for several years and is currently the Maternity and Newborn Clinical Lead for the South West London Collaborative Commissioning Programme. Mike's clinical interests include expedition, travel and homeless medicine, and he leads a medical team for the charity Crisis to bring care to homeless Londoners.

Christiana Ozoemelam
Christiana is a member of the London Clinical Senate Patient and Public Voice Advisory Group. She is passionate about improving the quality of healthcare service provision, empowering people and reducing inequality. She has a wealth of experience in patient and public engagement, quality improvement and capacity building in the voluntary, public and private sector.

Dr Tina Sajjanhar
Tina has been Consultant in Paediatric Emergency Medicine at University Hospital Lewisham, part of the Lewisham and Greenwich NHS Trust, for 17 years. She is also Divisional Director for the Children and Young People's Division in the Trust. Tina has a sound background in acute and emergency care services for children, in part due to her clinical experience and also by taking an active role in committees that affect acute care services for children and young people, including previously being the Royal College of Paediatric and Child Health's representative on NHS Pathways Governance group. Tina has extensive experience in service transformation, including the Picture of Health consultation, the reconfiguration of paediatric surgical services and development of the urgent care centre locally. She was part of the team that developed the London Quality Standards for Paediatric Medicine and Surgery,

and then as part of the London Strategic Clinical Network for Children, developed the acute care standards for children and young people. Tina is currently the Clinical Lead for the children and young people's stream of the Our Healthier South East London (OHSEL) programme, a five year strategy which aims to improve health and integrated care across south east London, and is also a member of the Healthy London Partnership Children and Young People's Programme Clinical Leadership Group.

Deborah Sanders*
Deborah is Director of Nursing at the Royal Free London NHS Foundation Trust, has worked for the trust since 1994 and also trained at the Royal Free Hospital. She was appointed as the trust's director of nursing in 2010, having previously worked at St Bartholomew's Hospital and the London Chest Hospital. Deborah is also a board member of the Royal Free Hospital Nurses' Home of Rest Trust.

Professor Russell Viner*
Russel is a Professor of Adolescent Health at the University College London Institute of Child Health and a Consultant in Adolescent Medicine, University College London Hospitals NHS Foundation Trust. Russell is currently Clinical Director of the Healthy London Partnership Children and Young People's Programme (from 2015), having held the role of Clinical Director of the Strategic Clinical Network for Children for NHS England (London region) from 2014-15. He is a paediatrician and was clinical director of the Child & Adolescent Division at UCLH from 2013 to 2015.

*Members involved in the previous review.

Additional advice

Dr Simon Eccles, Consultant in Emergency Medicine, Guy's and St Thomas' Hospital NHS Foundation Trust and the London Clinical Director for Emergency Care was consulted on issues relating to urgent and emergency services and pathways.