

## **Bristol Royal Infirmary Inquiry**

### **Phase Two Seminar – Acute Healthcare Services for Children**

#### **Points for Discussion on “*Evidence to the Bristol Royal Infirmary Inquiry: How children’s healthcare services are organised and how to improve access to children’s hospital services*”**

### **Secondary Care**

Secondary care paediatric services should be planned to:

- Be child centred - meet the needs of children and their parents and siblings for local care
- take doctors to the patient where ever possible
- Reduce the need for inpatient admission
- Provide appropriate access to general paediatric expertise and supports primary care whilst ensuring rapid access to specialist skills where these are required
- Make use of the skills of specialist nurses, non consultant grade staff and other expert resources
- Ensure that the model of service enjoys public support and that change minimises disruption to other parts of the health care system
- Ensure that tasks that require specialist expertise are carried out by specialists

Something has gone seriously wrong with the planning of secondary care paediatrics. The model that is emerging may fail these tests in a number of important respects, this appears to be the result of poor planning of the medical workforce. There are an inadequate number of consultants and whilst this is being rectified the number of specialist registrar posts is being reduced to prevent a future surplus of consultants. The approach to planning workforce by the College will lead to a concentration of inpatient care and potentially, the closure of a large number of obstetric units. The evidence that this will improve care is limited and it will certainly have a serious impact on access which is a key consideration for children, their parents and the siblings who do need hospital care. There is a case for a reduction in the number of inpatient units to cope with the shortage of specialists and to ensure that the principle that children should have access to specialists is met. However, it may not be politically possible in some cases.

It will be important to ensure that these changes are managed. Paediatrics should not become more of a hospital-based specialty by default. The UK may be moving in the wrong direction, in many other countries paediatrics is a primary care based activity and if we believe that children should be seen by specialists in secondary care there may be an equally powerful case for this to be true in primary care.

In future it is likely that there will be a need for specialist paediatric support in primary care, particularly as hospitals become more distant and their consultants more specialist. GPs are already too stretched to expect them to provide this enhanced

service and whilst specialist nurses and GPs can fill part of the gap there will be a need for greater access to paediatric expertise in primary care. Expanding the number of paediatricians and basing them with GPs would allow Primary care Groups to provide more local care, reduce admissions, improve access and increase skills in general practice.

Some areas have experimented with ambulatory services - these are generally consultant led services that are open for limited hours (unfortunately, often not at the times when most children present with illness). These may have the problem of being seen as second rate hospital services rather than being first rate primary care. Making these services part of the primary care system would overcome a number of difficulties that these units have experienced, this would require a further expansion in the number of consultant and non consultant career grade posts and the development of more specialist nurses who have an important role to play.

Where hospitals can no longer provide inpatient paediatrics it will be necessary to make arrangements to allow A&E services to continue to treat minor injuries and to deal with minor illness. This will require paediatric expertise available on site. Similar arrangements may be required to ensure that some obstetric care is maintained. This need for staffing needs to be built into College plans, these posts will probably not be suitable for trainees and the College need to be more imaginative about new ways of staffing these units. Work is required to think about how to make the non-consultant grade attractive and to change its rather low status.

Where possible paediatric surgery should be carried out by paediatric surgeons and anaesthetists. However, people expect local access for minor surgery and investigation. We need to develop a culture of taking the team to the patients where there are large numbers of patient journeys involved. This might include having children's days in which hospitals without inpatient paediatrics act as the host to a set of visiting teams working within a child friendly environment. The current increase in the referral of surgery to tertiary centres also needs to be part of a managed process, which it is not at present.

Changing the emphasis of paediatrics over the longer term to make it more a part of primary care would address a number of the issues about the interface with education and social services that bedevil children's services.

## **Tertiary services**

### **Patterns of use**

- Given the pattern of referrals it seems likely that a significant number of children that would benefit from treatment in a specialist tertiary unit are not referred
- I examined 400 referrals to GOS and found that very few were inappropriate. A small but significant number of referrals were later than is optimum or represented requests to revise work done elsewhere – some which we suspected could have been got right first time in a specialist centre. We found significantly less multidisciplinary care than had been claimed. This could have reflected poor record keeping, a failure to capitalise on the advantages of a multi specialty

hospital or that the number of children that need this is less than is usually thought. Many children had a long history of previous admission and therefore developing and sustaining a relationship is very important.

### **Innovation**

- The mechanisms for managing clinical innovation in the current system of speciality commissioning are inadequate and may discourage innovation
- Work with multi faculty adult units is important for research

### **Planning and management**

- The opportunity to bring tertiary services together has not been taken - often as a result of the rivalries of trusts and medical schools and poor relationships at the level of individual clinicians. This is to be regretted.
- Whilst many tertiary services need to be concentrated there are opportunities in large metropolitan areas to take some services to children on an outreach basis. For example routine paediatric surgery for children where the requirement for a tertiary specialist is based only on their age and need for certain surgical expertise.
- Outpatient and shared care offer opportunities for better local access. The system of inter-trust recharging acts as a major disincentive for developing this.

### **Why has planning been so poor?**

Many of these problems are not unique to children's services but they have perhaps suffered more than other services from the poor planning of services because, like older people, they are a diverse group which do not fit the definitions generally used for planning services in the NHS.

A second reason is that, like services for older people, the voice of the advocates of the services have been relatively weak compared with other groups. A particular difficulty is that treating children has often been just a part of the role of an individual or an organisation rather than their whole focus. This tends to mean that are likely to view children as small adults in the way referred to by Professor Aynsley Green, it also means that they are less likely to act as advocates of children's services.

Finally there has been an absence of any coherent approach to planning any hospital services since 1962 and whilst we would not suggest that central planning would help clearer principles, research into what works and much improved human resource planning (particularly of nurses and medical staff) would have made a crucial difference.

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