Update to Health Overview and Scrutiny Committee, July 2024
Paediatric Care in the Emergency Department (ED) at Eastbourne District General Hospital

1. Summary

1.1 This update report forms part of the briefings that we agreed to share with colleagues for assurance purposes following the HOSC review into the new model for paediatric care at Eastbourne District General Hospital. Another update is due in December this year.

We are pleased to report positive progress with the model for paediatric care. This update covers two broad areas:

- Supporting data from the new model.
- Additional actions undertaken following the HOSC Review recommendations.

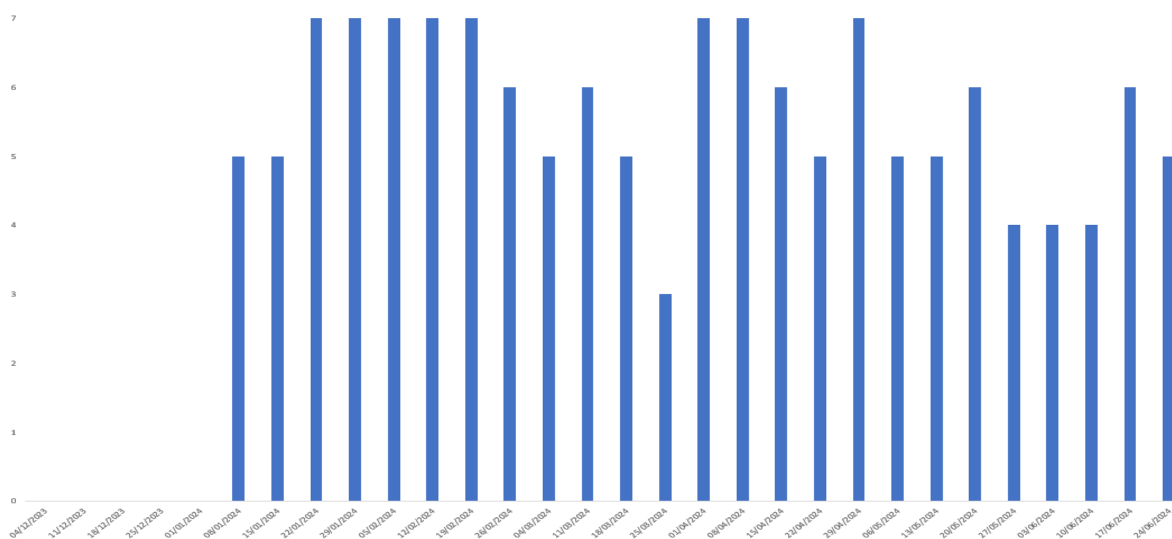
2. Supporting data

2.1 We have now had the benefit of almost five months of activity through the paediatric hub. As the graphs below indicate, we have a regular presence in ED, improving activity levels and a decreasing number of children needing referral to the Hastings site.

2.2 Figure 1 below shows that coverage has been consistently between 5 and 7 days per week. On these days, any paediatric presentation to ED where a paediatric opinion is required, has immediate access to the service. As HOSC members will recall, prior to the new model, there was no paediatric specialists in ED.

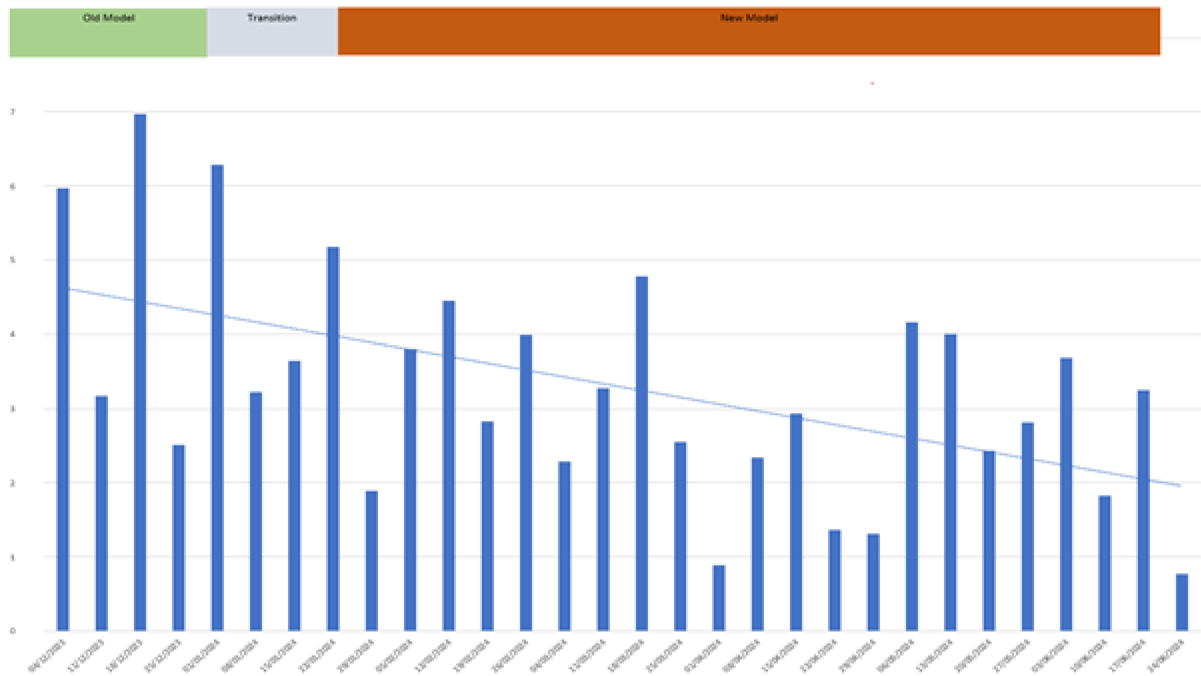
2.3 Members will recall that under the previous model, we regularly closed the assessment unit at short notice (weekends and during staff shortages) so the current has increased access and has brought less unpredictability to the planning of staff rotas/departmental cover.

Figure 1: Days per week with paediatric cover in the (ED) emergency department (max. 7)



2.4 Figure 2 shows that, since implementing the new model in early January, there has been a small reduction in the number of children waiting over four hours, approximately three fewer per week.

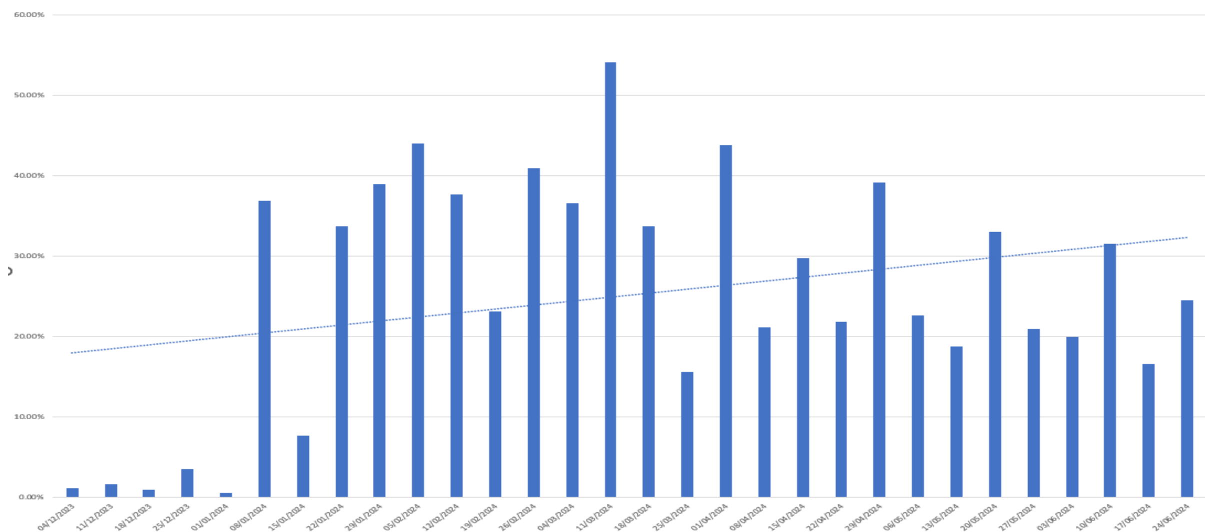
Figure 2: Numbers of children breaching the 4-hr ED standard



2.5 Members will recall that only a very small number of children (3%-4% typically need paediatric care/opinion in the ED, with the majority covered by ED nursing and/or consultant intervention) and for those who did, historically this would have taken place in another part of the site.

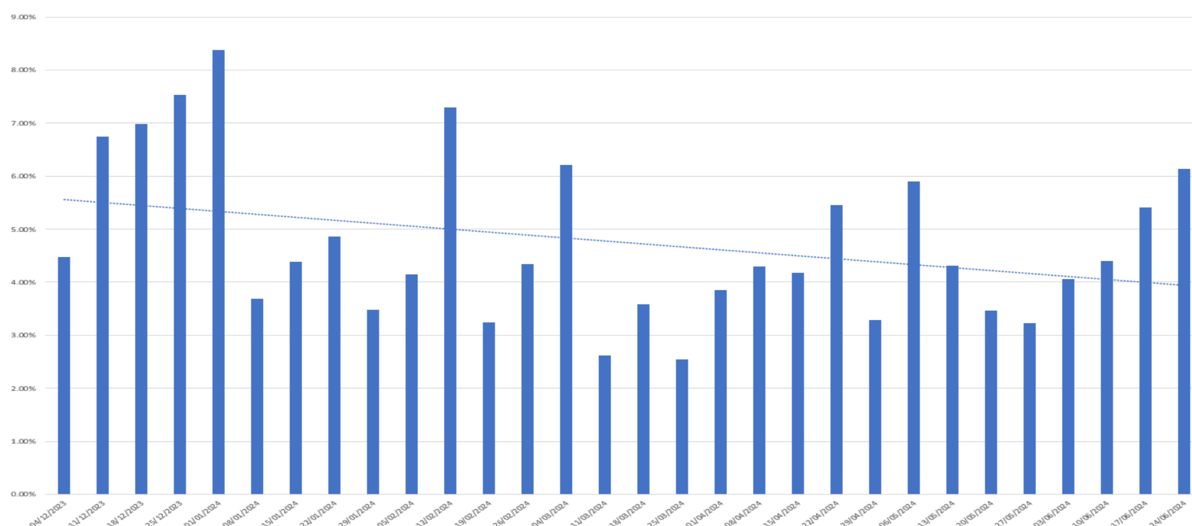
2.6 Figure 3 shows that, over the period covered, we are seeing a steadily increasing number of children directly in ED, supporting the improvement in access to paediatric opinion that the model affords to local parents. This initial increase in numbers is more recently seeming to stabilise and we will continue to monitor the numbers coming through ED.

Figure 3: Percentage of children seen in ED by paediatrics



2.7 Members will recall that one of the concerns put forward with regard to the new model is that it would result in an increase in paediatric cases going to our Hasting site. As Figure 4 shows, this has not been borne out by the results, with the trendline showing a reduction from around 5.5% to 4% a week.

Figure 4: Percentage of children transferred for care in Hastings



3. Additional actions since April relating to the HOSC recommendations

3.1 ***HealthWatch:*** HOSC members will recall that recommendation 3 of the HOSC review requested that Healthwatch and Young Healthwatch be asked to visit and assess the new dedicated paediatric space/service, and we are happy to confirm that the Trust hosted this visit on 11 May 2024.

3.2 Feedback from the Healthwatch/Young Healthwatch visit was overwhelmingly positive. The visit was undertaken by a HealthWatch volunteer and a teenage member of Young HealthWatch. The report notes the calm environment that was out of the more frenetic pace of an emergency department. It reflected the observation that APNPs were evidently experienced and kind with the patients and the environment was clean, tidy and pleasant. Overall, the visit was positive and supportive of the new model in place, which it believes is working well.

3.3 ***Elective care:*** As per recommendation 5, although there have been no changes to elective surgery or radiology services for children at EDGH, new pathways have been developed for children to have food allergy and endocrine testing in outpatients at EDGH, and these will be shared with HOSC colleagues in due course. There are a small number of children (5) with complex needs who are currently having their elective medical care at conquest hospital.

3.4 ***Paediatric consultant base:*** Members will recall that, in response to Recommendation 7 (the location/base of the paediatric consultant managing the GP triage phone line), we agreed to commission an independent clinical review of this matter and to consider the specific question of the clinical model being supported by locating a consultant permanently at the EDGH site.

3.5 For the purposes of transparency we have included the full report from the independent paediatric consultant Dr Moya Dawson as an appendix to this update. Dr Dawson is a Consultant in Paediatric Emergency Medicine at the Oxford University Hospitals Foundation Trust, where she is the clinical Lead for Resuscitation and Chair of the Trust Resuscitation and Paediatric Resuscitation Committees. She is also the Southeast Regional Clinical Advisor for Paediatric Urgent and Emergency Care, NHS England.

3.6 Regarding the independence of the review, we would add that Dr Dawson does not otherwise know the Trust nor any members of the Paediatric service leadership nor the colleagues she spoke to on her visit. We were introduced to Dr Dawson by Dr. Vaughan Lewis, the Southeast Regional Medical Director for NHS England. Dr Dawson was not paid by ESHT for her review or visit. This is considered a feature of her role as Southeast Regional Clinical Advisor for Paediatric Urgent and Emergency Care NHS England.

3.7 With regard to the HOSC recommendation that the consultant be based permanently at Eastbourne DGH, as opposed to the current arrangement which bases the consultant at whichever site is more practical at that point: The Consultant body, including all Consultants based at Eastbourne DGH, has discussed this recommendation. Their view is that this is not necessary or beneficial at this point in time, noting that we routinely review and adapt consultant presence according to demand and population risk (e.g. viral infection patterns) across the year.

3.8 We note that Dr. Dawson's review does not suggest there would be a benefit in implementing this recommendation at this point. She notes:

"Addressing the HOSC board's specific recommendation that EHST permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site: within the paediatric consultant job plan, 1PA of consultant time is dedicated to triaging and managing online GP referrals and 1 PA to holding the advice phone line for both Conquest Hospital and EDGH as well as undertaking the consultant's own SPA work. These two PAs will count largely as remote direct clinical care and as such a) do not include the additional work of providing an input into the new service model and providing additional assurance to address concerns about the level of consultant presence in the hospital and b) can be safely done remotely and would not have to be permanently on site."

Therefore, we do not intend to implement this recommendation. We will continue to keep the amount and role of consultant presence on each site under review as we already do.

3.9 ***Future plans for paediatric services:*** As per our response to recommendation 4, we will be working with colleagues over the next six months to decide how to use the Scott Unit to further improve the quality of care we provide for children in Eastbourne.

3.10 Following recommendation 9, we have recruited two further trainees advanced nurse practitioners, when all our trainees are trained, we will have seven advanced nurse practitioners. We are developing plans for a virtual ward and primary care MDT to reduce the number of children needing to come to either of our hospitals.

3.11 As per our response to recommendation 4, we will be working with colleagues over the next six months to decide how to use the Scott Unit to further improve the quality of care we provide for children in Eastbourne.

Dr Matthew Clark
Clinical Chief of Division, Women's & Children and Sexual Health

Ms Kaia Vitler
Divisional Director of Operations, Women's & Children and Sexual Health

Appendix: Visit of Eastbourne District General Hospital on 18.3.24 by Dr Moya Dawson

I am a consultant in Paediatric Emergency Medicine based at the John Radcliffe Hospital in Oxford. I am the Trust Clinical Lead for Resuscitation, and the Chair of the Trust Resuscitation and Paediatric Resuscitation Committees. I am the lead for the RCPCH Grid and the RCEM training programmes in Paediatric Emergency Medicine at the John Radcliffe. I am the Regional Clinical Advisor for Paediatric Urgent and Emergency Care NHS England for the Southeast.

During my visit to the hospital, I was able to visit the Emergency Department including the area dedicated to paediatrics, as well as the Paediatric Outpatient Department. I had to opportunity to speak with the following staff members whom I felt gave me a broad, fair and balanced view of how acute paediatric care is delivered at EDGH. I did not feel at the time that I needed to speak to more members of staff but did make it clear that of course I would be more than happy to going forward should there be an appetite for this.

- Simon Dowse – Director of Transformation, Strategy and Improvement
- Matthew Clark - Chief of Division for Women's and Children's
- Nadia Muhi-Iddin - Clinical Lead Paediatrics
- Utham Shanker – Clinical Lead Emergency Medicine
- Kate Morrison – PANP in ED
- Joe Chadwick-Bell – Chief Executive Officer

The EDGH paediatric service sees children and young people aged 0 to 15 years included.

1. General Paediatric planned and elective services

EDGH does not have a paediatric inpatient unit but does have outpatient services, a small Paediatric Emergency Department (PED), and did have a small Short Stay Paediatric Unit (SSPAU) until recently.

The SSPAU accepted the following:

- children referred by the ED (2.5% of paediatric attendances)
- children attending for day case surgery
- children scheduled for testing such as allergy or endocrine testing
- children scheduled for blood transfusions, pamidronate infusions and shared care chemotherapy

The SSPAU number of daily attendances was low, it was closed on weekends and after 7pm.

The elective services previously provided by the SSPAU are now being provided by the OPD (allergy testing, endocrine testing), by the surgical day case unit who has allocated one day a week for paediatric elective day cases, and, for a small number of children needing transfusions, infusions and chemotherapy, by Conquest hospital.

Those children who may have been transferred to the SSPAU from PED for a paediatric review or a period of observation are now being managed in one observation bed in the PED by paediatric trained staff (see further details in Section 2).

Hot clinics for GP referrals are being accommodated in the OPD. Follow up reviews, prolonged jaundice clinics and virtual wards are currently presenting an evolving picture with details still being determined by the paediatric team.

These changes are still undergoing review to ensure safety and sustainability, and Dr Muhi-Iddin holds two-weekly meetings with her consultant colleagues to ensure this.

There are consultant paediatricians on site who work primarily in the Outpatient Department (OPD), who manage the GP referrals that are received via email and who hold the GP advice phone line.

Paediatric consultants are on call for both EDGH and Conquest Hospital, which is based in Hastings.

There are no trainees at Eastbourne DGH.

2. Paediatric Urgent and Emergency Services

The Emergency Department (ED) sees approximately 13,500 children a year aged 0-15.

Of these children, in 2022- 2023, prior to the dissolution of the SSPAU, 2.5% were transferred to SSPAU for general paediatric review, 2.3% were seen in the PED by a paediatrician, and 3.5% were transferred to Conquest Hospital for admission to the ward. Overall the acuity of presentations to EDGH is low, as all children conveyed by ambulance will be taken to conquest. The exception for this is for children who are peri-arrest or in cardiac arrest, when they will be conveyed to the closest hospital. In total, approximately 92% of children attending the PED were seen, managed and discharged by an ED doctor.

Currently the ED has a small audio-visually separate PED which runs seven days a week, from 8.00am to midnight. It includes a small bay with two chairs, a bed and a cot. This bay is used for triage as well as treatment. There is no available piped or tanked oxygen in this bay, but there is portable suction.

There is a separate room with a bed which can be used for isolation of patients or for children and young people with mental health or sensory difficulties. This room is currently awaiting renovation to make it more patient friendly and less office-like.

There is a large paediatric bay in the resus area and there is one smaller neonatal resuscitation bay with a *resuscitaire* in situ and ready for use.

Children attend the PED by registering in main reception and moving to the PED area. Here they are assessed by a paediatric ED nurse and seen and managed by a paediatric ANP, and ED middle grade or occasionally a paediatric middle grade covering the shift. Some children are streamed to urgent care.

The PED is primarily staffed by highly skilled Paediatric ANPs, paediatric nurses and HCAs. When fully staffed the PED will have 1 PANP, two nurses and 1 HCA every day.

There are currently three qualified PANPs, one who is nearly qualified, two who are training and one in her first year of training. The paediatric ANPs work from 8.30am to 9pm, they see and manage all patients during their shifts; they are fully registered prescribers and are fully IRMER registered, they have no restrictions on what they can prescribe and what imaging they can order. They, alongside the paediatric ED nurses and HCAs have the following clinical skills: venepuncture, cannulation, suturing, glueing, plastering.
The PANPs will refer to the paediatricians at Conquest Hospital should a child need admission, using the STOPP form (Safe Transfer of the Paediatric Patient).

An ED doctor will see children when the PANPs are not present in the day or at night. 25% of paediatric attendances are between 9pm and 8am the following day.

The presence of paediatric ANPS has all but obviated the need for paediatricians in the PED, but there is always an on-call paediatrician available on the phone for advice. The full ED team is also always available for help and advice.

The EDGH is supported by the South Thames Retrieval Service (STRS) in case of paediatric retrieval need, and by Kings College Hospital for trauma management. It is otherwise supported by Conquest Hospital.

3. <u>Purpose of the review</u>

1. Are the changes safe?
2. Do the changes represent an improvement both in access and quality of urgent care pathways and in use of resources?
3. Are the changes offer sustainable access to high quality care?
4. Does the Consultant Paediatrician staffing the GP triage phone need to be permanently located at the EDGH site?

The urgent care pathways that are currently in place feel safe. Children are managed by appropriately trained and skilled staff, and, where there is need, the same staff have access to appropriate senior decision maker advice over the phone – be this a consultant paediatrician or the STRS retrieval service – or in situ with the ED team.

The ED team report feeling much better supported by having consistent paediatric support in situ rather than having to liaise – with some reported difficulty – with an inconsistent off-site team.

The ED clinical lead reports that having paediatric support in situ also enhances emergency medicine training as, going forward, FY2 trainees will be doing a 4-hour shift with the paediatric ANPs daily.

For this reason, the provision of urgent and emergency care appears to be both improved and sustainable, not only in terms of appropriate use of skilled and knowledgeable resource within the ED but also in terms of career progression and training for doctors, ANPs, paediatric nurses and HCAs. This nurturing and forward-thinking environment is likely to attract high quality career seeking candidates and is also much more likely to retain staff through job satisfaction and opportunity to progress. This in turn will lead to high quality care presently and in the future.

The planned and elective services offered by the Paediatric team under the leadership of Dr Muhi-Iddin also feel safe. She has thought through the change process in detail and has ensured that it continues to meet the need of the children of Eastbourne and that it does not compromise on safety. Given the low numbers of children attending the SSPAU historically, the changes would also seem to be a wiser use of resource both in terms of workforce and financially.

Addressing the HOSC board's specific recommendation that EHST permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site: within the paediatric consultant job plan, 1PA of consultant time is dedicated to triaging and managing online GP referrals and 1 PA to holding the advice phone line for both Conquest Hospital and EDGH as well as undertaking the consultant's own SPA work. These two PAs will count largely as remote direct clinical care and, as such, a) *do not* include the additional work of providing an input into the new

service model and providing additional assurance to address concerns about the level of consultant presence in the hospital and b) can be safely done remotely and would not have to be permanently on site.

4. Looking ahead

I observed many areas of good practice and forward thinking within the PED at EDGH. I would be happy to assist in any upcoming plans for expansion or improvements to the service in the PED.

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