ASSESSMENT OF THE IMPACT OF THE TIMING OF THE MATERNITY TRANSITION ON PAEDIATRIC SERVICES AT EALING HOSPITAL

Ealing CCG Governing Body
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1 PURPOSE

The purpose of the paper is to:

- Set out the impact of the proposed maternity transition on paediatric services at Ealing Hospital;
- Describe the rationale for completing the implementation of the transition of in-patient paediatric services from Ealing Hospital on 30 June 2016, and the impact that these changes will have on inter-dependent services;
- Articulate a post-transition paediatric model of care for Ealing Hospital;
- Set out the service design and implementation planning work completed to date, and describe the programme of work that will be undertaken prior to 30th June 2016 to ensure that the paediatric changes can be implemented successfully.
2 CASE FOR CHANGE

The ‘Shaping a Healthier Future (SaHF)’ programme, led by local clinicians, proposed changes to services in North West London (NW London) that would safeguard high quality care and services for the local population. The principles behind this are about putting the patient at the centre of the NHS, providing more accessible care and establishing centres of excellence so that more expertise is available more of the time.

These changes have the unanimous support from all medical directors in NW London, who have written to the Health Secretary setting out that ‘there is a very high level of clinical support for this programme across NW London’ and that these changes will ‘save many lives each year and significantly improve patient’s care and experience of the NHS.’

A clear rationale for reconfiguring the way in which paediatric in-patient care is delivered in North West London (NW London) was identified as part of a sector wide review. This rationale is set out in more detail in the SaHF Decision Making Business Case, however, the main elements can be summarised as:

- Some children can be provided with care at home or in an ambulatory setting as appropriate.
- Staffing levels are variable out-of-hours and there are too few paediatric doctors to staff rotas to safe and sustainable levels.
- For high quality care, units need to be staffed properly. This could be done by concentrating in-patient paediatric care and neonatal care into a smaller number of units.

In response to this, SaHF proposed the consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay/ambulatory facilities. The five sites are aligned to the five major Trusts to allow a full array of support services including diagnostics and surgery:

- Chelsea and Westminster hospital
- St Mary’s hospital (part of Imperial Trust)
- Hillingdon hospital
- West Middlesex hospital
- Northwick Park hospital

Consolidating paediatric services at fewer sites will enable Trusts to improve levels of consultant cover. Consistent presence of senior clinicians will:

- Enable NW London to provide consistent 7 day services
- Reduce paediatric Serious Untoward Incidents (SUIs) / Incidents
- Reduce paediatric emergency admissions
- Reduce mortality rates
- Increase patient satisfaction
- Expose trainees to a wider range of complex cases
- Provide platform for Out of Hospital services
Following a 14 week public consultation, in February 2013 the Joint Committee of Primary Care Trusts (JCPCT) agreed that maternity, paediatric in-patient and neonatal in-patient services should stop at the Ealing Hospital site, with this activity re-provided by the remaining providers in North West London. The JCPCT decision was reviewed by the Independent Reconfiguration Panel (IRP) on 13 September 2013, who made the following recommendations:

“Commissioners and providers of acute hospital services across north west London must ensure that changes required to secure safety and quality for patients are made without delay.”

“Maternity and paediatric inpatient services should be concentrated on the sites identified by Shaping a Healthier Future.”

“The NHS’s implementation programme must demonstrate that, before each substantial change, the capacity required will be available and safe transition will be assured.”

There was no recommended timescale for implementation of the proposals.

The Secretary of State accepted the recommendations of the IRP in his statement to Parliament in October 2013 and the SaHF programme are now implementing these recommendations.
3 PAEDIATRIC MODEL OF CARE AND CLINICAL INTER-DEPENDENCIES

3.1 Interdependency between paediatric in-patient and neonatal services at Ealing Hospital

Detailed implementation planning for the maternity and neonatal transition explored the dependencies between maternity and paediatric services at Ealing Hospital. Specifically, neonatal care is essential to the delivery of maternity services, but is staffed by paediatricians. The transition of neonatal services (and associated staff) therefore has the potential to destabilise the paediatric workforce at Ealing Hospital. The Paediatric Project Delivery Board is satisfied that paediatric services at Ealing Hospital will remain stable for the proposed transitional period of up to twelve months, however, it is clear that maintaining paediatric services on-site in the absence of neonatology is not sustainable in the long term. As such, whilst a phased approach to implementation is seen clinically as the ‘lowest risk’ option, it is clear that the maternity, neonatology and paediatric service transitions need to be considered collectively in order to avoid the long term destabilisation of paediatric services in Ealing.

3.2 Proposed paediatric model of care

3.2.1 Paediatric services identified for closure at the Ealing Hospital site

Under SaHF proposals, paediatric in-patient services will close at Ealing Hospital, with activity redistributed to other hospitals in North West London.

3.2.2 Retained paediatric services at the Ealing Hospital site

Most paediatric care will continue to be provided at Ealing Hospital after the transition has taken place. In line with the Shaping a Healthier Future (SaHF) commitment to provide patients with a choice of services as close to their home as possible, lower acuity services accounting for the vast majority of current paediatric activity at Ealing Hospital will be retained and expanded. The following paediatric services will be available at Ealing Hospital, post-transition:

- Urgent care provided by the Urgent Care Centre (UCC);
- Non-emergency, low-acuity day-care services;
- Outpatient services;
- Consultant-led Rapid Access Clinic (RAC)

Non-emergency day-case services will continue to operate at Ealing Hospital, as follows:

- Day Care Unit;
- Existing general and paediatric Outpatient services (i.e. clinics on site plus community delivery of diabetes, asthma);
- Sickle Cell and Thalassemia Service;
- Paediatric Physiotherapy;
- Paediatric Speech and Language Therapy;
• Paediatric Orthopaedics (mainly trauma follow-up);
• Ear, Nose & Throat Clinic;
• Adolescent Sexual Health Services;
• Liaison Children and Adolescent Mental Health Services
• Visiting Tertiary Referral Specialist Paediatric Clinics.

3.2.3 New paediatric services available at Ealing Hospital

Ealing CCG has committed to commissioning a consultant-led Rapid Access Clinic at Ealing Hospital. The Rapid Access Clinic will be an extended hours, 7 day, referral-only service co-located with the existing paediatric day-case unit. Its purpose is to support primary care by providing same-day access to specialist paediatric opinion. There is evidence that GPs in Ealing have often referred patients to A&E for rapid assessment, risking unnecessary admission. In future they will have the option of referring patients to the Rapid Access Clinic as an alternative. This will result in the following benefits for patients:

• **Improved patient experience**: treating a higher proportion of patients in a setting appropriate to their clinical need will improve patient experience of care. The RAC will offer timed appointments, reducing the number of paediatric patients expected to wait for up to four hours in A&E before they are seen.

• **Rapid local access to specialist paediatric opinion**: Ealing residents will benefit clinically from rapid access to specialist paediatric opinion.

The purpose of the Rapid Access Clinic (RAC) is to support primary care by providing same-day or next-day access to specialist paediatric opinion.

It is proposed that the RAC is:

- Consultant led
- Co-located with the current Ealing Day Care Unit and run in parallel
- Staffed by one (1) consultant, one (1) nurse and one (1) training post (senior level – weekdays only).
- Open from 11am – 7pm on week days and a minimum of three hours per day on weekends. These opening hours have been chosen in order to allow the RAC to pick up referrals from morning and evening GP surgeries and enable the most efficient use of human resources.

The service is not intended to manage urgent and emergency cases. Those cases should appropriately be referred to A&E.

To start with, GPs working at Ealing UCC (Urgent Care Centre) will be unable to refer patients to the RAC directly. The RAC service will be evaluated after three months of operation, and the introduction of direct referral from UCC may be considered this stage if the service is proven to be effective.

A paediatric consultant or senior trainee will provide a telephone consultation and/or accept the patient for an appointment at the RAC.

A paediatric consultant or senior trainee will triage and accept patients for appointment at the RAC for that day or the following day.

Clinical criteria for acceptance to the Rapid Access Clinic will follow the ‘Manchester traffic light system’ for identifying serious childhood illness. The RAC will see patients meeting green criteria,

1. *Feverish illness in children*, NICE clinical guideline 160 (May 2013)
most children meeting amber criteria, and no children meeting red criteria, who will be referred to A&E in a site with an inpatient paediatric service.— initially Ealing

RAC clinicians will be responsible for ensuring follow-up takes place for any diagnostic tests requested. As such, RAC clinicians will be able to refer on to paediatric out-patient services where this is clinically appropriate.

RAC clinicians will provide formal and informal training to Ealing UCC staff during periods of low activity. The aim here is to support the UCC to manage more children on-site, reducing the volume of children transferred from the UCC to RAC or A&E over time.

**RAC referral pathway.**

### 3.3 Inter-dependency between paediatric in-patient and A&E services at Ealing Hospital

There is a clear consensus among clinicians that without cover from specialist paediatric staff (including consultants and anaesthetists with appropriate paediatric training), Ealing A&E would bear potentially unsafe levels of clinical risk for the most unwell children (‘Right Care, Right Place, First Time?’).

The Shaping a Healthier Future (SaHF) Paediatric Project Delivery Board (PDB) is cognisant of Royal College of Paediatric and Child Health (RCPCH) guidance that in the absence of a paediatric in-patient department, A&E departments can continue to treat paediatric patients safely if supported by an appropriately staffed Short Stay Paediatric Assessment Unit (SSPAU). In their view, a SSPAU would not be suitable for Ealing Hospital for the following reasons:

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2 ‘Right Care, Right Place, First Time?’ JOINT STATEMENT by the Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN), Royal College of Paediatrics and Child Health (RCPCH) and the College of Emergency Medicine (CEM) ON THE URGENT & EMERGENCY CARE OF CHILDREN AND YOUNG PEOPLE. December 2011.

3 *Standards for Children and Young People in Emergency Care Settings*; Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings, 2012.
To operate safely, the SSPAU would require a specialist paediatric workforce, including oversight from paediatric consultants at the level defined by London Quality Standards. In the absence of a paediatric in-patient department, this would result in significant inefficiency and additional cost, and would negate the benefits achieved from the consolidation of services set out in the SaHF case for change.

Pan-NW London shortage of paediatric clinicians - exacerbated by the need to increase levels of consultant cover - is one factor influencing the consolidation of services proposed by the SaHF programme. It is therefore unlikely that an Ealing SSPAU could be staffed appropriately, should Ealing CCG decide to commission the service.

The SaHF Paediatric PDB therefore recommends that when inpatient paediatric services close:
- Paediatric 'blue light' LAS (London Ambulance Service) conveyances should be re-routed to alternative sites;
- Children (0-16 year olds) that attend Ealing A&E should be assessed, stabilised and transferred as necessary;
- Ealing A&E would continue to provide care to unstable children for whom unsupported transfer would represent a clinical risk. A&E clinicians are therefore required to maintain the competences required to treat children safely. This is enabled by the rotation of staff to the Northwick Park site.

This approach is based on the model employed successfully at Charing Cross Hospital.

The UCC at Ealing Hospital (provided by Care UK) will continue to provide care for paediatric patients, as it does currently. As the provider of A&E and other support services at Ealing Hospital, London North West Healthcare Trust will continue to supply clinical governance and emergency backup for both services.

### 3.4 Inter-dependency between paediatric in-patient and High Dependency Unit (HDU) services

There is currently no Paediatric High Dependency Unit (HDU) at Ealing Hospital, meaning the closure of Ealing Hospital in-patient services is unlikely to have a significant impact on HDUs at receiving Trusts. Having said this, the Paediatric PDB recognises that HDU capacity is serious issue in NW London that needs to be addressed. Specifically, the PDB recommends that options for commissioning Level 2 Critical Care at WMUH, Hillingdon Hospital and Northwick Park Hospital should be explored.

In line with recent Royal College guidance, the PDB recommends HDU services should be co-commissioned locally, rather than on a pan-NW London (or pan-London) basis. As such, the PDB recommends that HDU co-commissioning should be taken forward on a CCG by CCG basis and should therefore be out of scope for the SaHF reconfiguration. Paediatric clinical leads from each of the Trusts have committed to working with local commissioners to review HDU provision in their area.

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4. *High Dependency Care for Children - Time To Move On; Royal College of Paediatrics and Child Health, October 2014.*
3.5 Definition of paediatric age cohort and impact on CAMHS

All Trusts in NW London currently define paediatric patients as 'patients who have yet to reach their 16th birthday'. The London Clinical Senate recommends that this definition should be expanded to included patients up to the age of 18. The Paediatric PDB gave this issue serious consideration and believes that now is not the right time to implement such a change.

Implementing this expansion would require a NW London-wide review of capacity, clinical pathways and operational procedures. In the view of the PDB, widening the age-range at the same time as implementing the reconfiguration of paediatric services in NW London would introduce too much change into the system at the same time, and would therefore entail an unacceptable level of clinical risk. The definition of the paediatric age-cohort will be kept under review at the pan-NW London level, however, for the purposes of the transition, the current '0-16' definition will be retained.

Retention of the '0-16' definition has specific implications for the Child and Adolescent Mental Health Service (CAMHS). This is because the CAMHS age cohort is 0-18 years old (rather than 0-16). As a result, the closure of Ealing in-patient services may fragment care for these vulnerable patients. The PDB considered this issue in detail, and makes the following recommendations:

There are no plans to close the Ealing CAMHS service. Ealing CAMHS will continue to receive referrals from Ealing Hospital.

Post-transition, 0-18 year old patients presenting at Ealing Hospital requiring both mental health emergency physical and care (e.g. over-doses) will be managed in two ways:

- **0-16 year olds**: Will be transferred to an alternative A&E as Ealing A&E will no longer treat paediatric patients. If admitted, they will be referred to the CAMHS covering the receiving A&E. They will then be referred to the Ealing CAMHS for follow-on care. If discharged from A&E without being admitted, the patient will be referred to the Ealing CAMHS for follow-on care. This process is near identical to the current pathway for Ealing patients who present at an A&E elsewhere in NW London.

- **16-18 year olds**: Will receive treatment at Ealing A&E and referred to the Ealing CAMHS.
There is a compelling case for implementing the transition of paediatric in-patient services as soon as is practicable.

**Improved quality and experience of care for patients:** The London Clinical Senate and Independent Reconfiguration Panel reviewed the paediatric case for change in detail. Both endorse the proposed changes and recommend that the changes are implemented as soon as practicable in order to improve the quality of care received by paediatric patients in North West London.

“There is a compelling reason to transition the inpatient paediatric service as soon as feasible, subject to assurance that required capacity is in place. This could take place earlier than June 2016 if circumstances allow. Unlike maternity services, the paediatric service at Ealing Hospital is not experiencing risk in the short-term, however this situation is likely to change over time and sustaining quality is likely to become more difficult in the months leading up to transition. The Review Team strongly recommends the need for assurance that the transition will not be delayed beyond a year and that actions required to enable the timetable to be met are adhered to.”

**Advice on plans for the transition of maternity, neonatal, paediatric and gynaecology services from Ealing Hospital; London Clinical Senate, February 2015**

**Interdependency between neonatal and paediatric services:** Neonatal services at Ealing are provided by paediatric medical staff, and experience in neonatal care is a key element of the paediatric registrar training rotation. The transition of neonatal services calls into question the long-term viability of Ealing Hospital as a centre for Paediatric training. Working in close collaboration with Health Education North West London, a plan has been developed to ensure that paediatric training is still possible, for those paediatric trainees who do not want to maintain neonatal competency, at Ealing Hospital after the transition of neonatal services, however, this is not sustainable indefinitely.

**Consultant cover:** Consultant cover at Ealing Hospital is already substantially below the standard recommended by the Royal College of Paediatrics and Child Health and The London Quality Standards (LQS). The Royal College of Paediatrics and Child Health and LQS recommend that all general acute paediatric rotas are made up of at least 10 (WTE) consultants, all of whom are European Working Time directive (EWTD) compliant. EHT currently employ 5.7 (WTE) consultants, significantly below the Royal College standard. Whilst there is no suggestion that the service is clinically unsafe, the lower number of consultants at Ealing means that there is less senior paediatric cover out of hours (including weekends) than at comparable departments elsewhere, and is thus carrying higher clinical risks and less able to support paediatric trainees than other units. Consolidating paediatric care (and therefore, staffing) at fewer sites will help us to meet the minimum levels of consultant cover needed to achieve this goal. The implication here is that the quality of care received by patients would be improved if paediatric services were transitioned to alternative sites. This position is supported by the London Clinical Senate.

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5 Advice on plans for the transition of maternity, neonatal, paediatric and gynaecology services from Ealing Hospital; February 2015
“Common experience across London’s paediatric units is that a minimum of 10 WTE acute paediatric consultants are needed to achieve standards set out in Facing the Future and the London Quality Standards across a 7 day service. Consultant cover at Ealing Hospital remains markedly below this. The hospital’s paediatric unit currently has 5.7 WTE consultants and is almost alone in north London in making no progress in increasing consultant numbers in the past 1-2 years to meet these challenges.”

Advice on plans for the transition of maternity, neonatal, paediatric and gynaecology services from Ealing Hospital; London Clinical Senate, February 2015

Workforce destabilisation: Uncertainty for staff during this period of transition at Ealing Hospital was also considered, and it is understandable that some staff will harbour uncertainty about their futures. Providing staff with clarity about when the transition of paediatric services will take place is fundamental to effective staff retention.

Safe transition is only viable if receiving sites possess sufficient capacity to absorb the additional activity (both in-patient and A&E).

Ealing Hospital currently provides 16 paediatric in-patient beds and treats 7,800 paediatric patients pa. in A&E (on average just over 21 each day) . The Ealing RAC is expected to reduce Ealing A&E activity by 1,900 pa. before the transfer takes place. However, to ensure that we do not underplan for capacity in receiving hospitals the SaHF Clinical Board has agreed that 127% of current Ealing paediatric in-patient and <16 A&E activity will be re-provided elsewhere and no capacity efficiency savings will be sought over the transition (Please refer to Paper 8.0 for more detail on patient flow analysis).

Receiving Trusts have indicated that they will need to undertake infrastructure enhancements to absorb the additional activity, and will require lead-in time in order to complete building works. The transition cannot take place without comprehensive assurance that the required physical capacity at receiving trusts is in place. To do otherwise has the potential to compromise patient safety.

Sufficient capacity within the system will not be in place until winter 2015/16

To implement a planned closure without certainty that sufficient capacity exists in the system would put an unacceptable level of additional pressure on the sector’s A&Es. Because of the capital build (and associated lead-in times) required to provide the additional capacity needed, the physical capacity needed will not be in place until winter 2015/16, after the onset of winter pressure.

The paediatricians have told us that the transition should not take place during the period of A&E winter pressure (December - February) or peak seasonal paediatric activity (March - May).

The Paediatric PDB therefore recommends that the changes should take place during June - September, when activity is comparatively low (see Figure 1 below).
Having considered the capacity and workforce issues, the Paediatric Project Delivery Board recommends that the defined range of paediatric services should transition from the Ealing site on 30th June 2016.

The SaHF Paediatric Project Delivery Board is strongly of the opinion that the paediatric transition should take place as soon as possible after the transition of maternity, neonatal and gynaecology services, however, after careful consideration of the balance of risk, they recommend that the transition of paediatric services is postponed until 30th June 2016 on the grounds of clinical safety.

The rationale for this recommendation is as follows:

Additional in-patient and A&E physical capacity is needed at receiving sites to enable them to absorb paediatric activity from Ealing safely. Implementing the transition before the new physical capacity is in place would put unnecessary additional pressure on A&E services in NW London.

Lessons learned from the recent A&E reconfiguration suggest that service transition could proceed more smoothly if the revised model of care is given time to bed in before services are closed. In the context of the paediatric transition, this means implementing the proposed consultant-led Rapid Access Clinic and other ambulatory care pathways during Quarter 1 2015/16.

Transition on 30th June 2016 requires us to put in place plans to ensure a safe service can be maintained at Ealing Hospital for up to 13 months after the closure of maternity, neonatal and gynaecology services.

Ealing Hospital offers high quality, paediatric care, covering neonatal, A&E and paediatric (in-patient and out-patient) services. We are committed to ensuring that these services are sustainable at the same level of quality throughout the transition period. The key elements of maintaining a sustainable service at Ealing Hospital are:

1. **Ensuring that the paediatric workforce at Ealing Hospital is stable**, such that a rota can be maintained. Specifically, reaching agreement with Health Education North West London (HENWNL) that existing paediatric training posts will be retained at Ealing Hospital for up to 13 months after the maternity transition. There are currently no concerns about the stability of the nursing workforce.
2. **Ensuring that appropriate mitigations are embedded as early as possible to minimise the impact of unplanned closure or unplanned activity shift.** Specifically, commissioning a consultant-led Rapid Access Clinic and working with Ealing UCC to reduce the number of children passing through Ealing Hospital A&E and support and develop the Urgent Care Centre, such that most children can continue to be seen at Ealing hospital and the overall amount of activity to be re-distributed across NW London in the event of an unplanned closure will be minimised. This approach is part of North West London’s wider strategy to shift emphasis from unplanned care to planned care as a way of reducing reliance on A&Es.

3. **Ensuring that additional capacity is created at receiving sites as rapidly as possible.** Specifically, ensuring that Trust capital investment business cases are progressed at pace to ensure that physical capacity is in place to receive Ealing paediatric patients before transition.

The programme is on-track to deliver all three elements within agreed timescales. The Paediatric Project Delivery Board has reviewed the plans in detail and is satisfied that a safe service can be maintained at Ealing for up to 13 months after the maternity transition. They have written formally to the programme to confirm this. The relevant excerpt is provided below:

> “We are confident that a safe paediatric service can be maintained at Ealing Hospital as a transitional measure in the absence of maternity, gynaecology and neonatal services, contingent on the implementation of a number of safeguards. These safeguards are designed to ensure that paediatric services are sustainable at Ealing in the medium-term and that robust mitigations are in place to minimise clinical risk in the event of unplanned closure:

Agreement with Health Education North West London (HENWL) that paediatric trainees can be retained at Ealing Hospital during the 13 month transitional period.

Sector-wide initiative to increase the availability of paediatric and neonatal medical staff to stabilise the paediatric workforce at Ealing Hospital and ensure that receiving Trusts have sufficient staff to cover increases in neonatal activity.

Establishment of a consultant-led paediatric Rapid Access Clinic at Ealing Hospital to reduce the volume of paediatric activity managed at Ealing A&E. This measure will reduce the amount of emergency paediatric activity requiring redistribution in the event of an unplanned closure, reducing the pressure on receiving A&Es.

Investment in infrastructure at receiving sites to ensure that the physical capacity is in place to absorb re-distributed Ealing activity in the event of an unplanned closure. We recommend that this capacity is in place before winter 2015.

Robust monitoring is put in place to track lead indicators of unplanned closure at Ealing (for example staff attrition, unplanned activity shifts to other sites).”

Dr Abbas Khakoo, Chair, SaHF Paediatric Project Delivery Board / Medical Director, The Hillingdon Hospitals Trust.

Dr Abbas Khakoo, Chair, SaHF Paediatric Project Delivery Board / Medical Director, The Hillingdon Hospitals Trust.
5 PAEDIATRIC ACTIVITY AND CAPACITY MODELLING

5.1 Paediatric activity model

Paediatric activity modelling has focussed on demonstrating that there will be sufficient capacity within the system to absorb activity from Ealing safely under every credible scenario. To this end, modelling is based on ‘highest case’ scenario activity flows involving the re-provision of 127% of existing paediatric activity at Ealing Hospital. The intent here is to provide assurance that it is safe to agree a date for the transition of paediatric services without putting additional pressure on paediatric services across NW London.

The current model has been reviewed in detail by the SaHF Paediatric PDB, Clinical Board and Programme Board, and has been used to inform the development of the Trust paediatric business cases.

Further work is required to quantify the precise volume of activity we expect to transfer from Ealing Hospital. For example, the model will be refreshed with new data as this becomes available. Due to the new services we are implementing (such as the RAC and improvements to Ealing UCC), we anticipate that the true volume of paediatric activity redistributed from Ealing Hospital will be significantly less than that set out in the analysis below (and in Paper 8.0). Further analysis will be tested robustly via existing SaHF governance mechanisms.

Under SaHF proposals, the majority of existing paediatric activity will remain at Ealing Hospital post-transition.
• At minimum, 79% of current Paediatric activity will remain at Ealing Hospital (UCC, day-care, OPD and Rapid Access Clinic).

• All paediatric in-patient activity (6% of total paediatric activity at Ealing Hospital) will move to sites elsewhere in NW London.

• Ealing Hospital A&E will continue to treat paediatric patients. These patients will be assessed, stabilised and where necessary transferred for further specialist care elsewhere in NW London. <16 activity at Ealing Hospital A&E currently comprises 20% of total paediatric activity on-site (7,800 attendances). Post-transition, 5% (1,900 attendances) of this activity will be managed in the RAC. To ensure that sufficient contingency exists across the system, our activity modelling assumes capacity for all 7,800 current <16 Ealing A&E attendances - plus a further 27% additional contingency - will need to be re-provided across NW London (9,900 attendances in total).

Detailed modelling has been undertaken to identify the likely flow of patients to receiving sites upon closure of Ealing paediatric services. This modelling is set out in detail in Paper 8.0 of this document. To ensure that ample contingency is built into the system, receiving Trusts have been asked to base their capacity planning on the 'highest case' scenario. The 'highest case' scenario rests on a number of cautious assumptions about patient flow:

1. Capacity equivalent to 127% of existing paediatric activity (A&E and in-patient) at Ealing Hospital will be re-provided system-wide. The 127% figure was arrived at by combining two different approaches to modelling patient flow (provider proximity to patient's home and a clinical audit conducted by LNWHT). Receiving Trusts were asked to plan capacity based on the scenario that resulted in the most additional activity for them (please see Paper 8.0 for more detail)
2. Assumption that the proposed Rapid Access Clinic will have no impact whatsoever on A&E attendance. In practice, it is anticipated that the RAC will reduce A&E attendance by 1,900 pa. (24% of existing <16 A&E activity at Ealing Hospital).

3. Assumption that all existing <16 A&E activity at Ealing Hospital will require transfer to alternative sites. In practice, it is anticipated that the real number of transfers will be considerably lower than this due to a combination of the RAC, enhanced UCC and the ability of Ealing A&E to continue to treat some paediatric patients in the absence of paediatric in-patient or PAU services.

4. Assumed average length of stay for Ealing paediatric in-patients of 1.8 days. In practice, 69% of Ealing paediatric in-patients are discharged within 24 hours of admission.

5. Ealing paediatric activity re-distributed activity is calculated using the 2013/14 baseline. In practice, we know paediatric activity at Ealing is falling year on year (e.g. 34% drop in <16 activity at Ealing Hospital A&E, 2011/12 - 2013/14).

The figures below set out the anticipated volume of additional Ealing paediatric activity each receiving Trust will be expected to accommodate. Trust planning assumptions are based on the 'highest case' scenario (please refer to Paper 8.0 for more detail on how these activity flows were derived).

**Paediatric in-patient activity flow assumptions**

The figures below set out the anticipated volume of additional Ealing paediatric activity each receiving Trust will be expected to accommodate. Trust planning assumptions are based on the 'highest case' scenario (please refer to Paper 8.0 for more detail on how these activity flows were derived).

*1.8 day average Length of Stay is a cautious assumption – the majority of Ealing in-patient admissions are <24hrs.*
The closure of the paediatric in-patient services at Ealing Hospital will mean that, in some cases, Ealing A&E will be required to stabilise, assess and transfer paediatric patients as paediatric specialist input will no longer be available on-site. To ensure that sufficient contingency exists across the system, our activity modelling does not take into account Ealing A&E’s retained ability to manage children, or the benefits of new services (such as the RAC and improved UCC). Patient flow assumptions are based on a scenario in which activity is significantly higher than current <16 Ealing A&E activity (127% of current activity). In practice, the true volume of transfers will be lower.

### LOS Distribution

<table>
<thead>
<tr>
<th>LOS</th>
<th>Number of inpatient episodes (April/May 2014*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-8 h</td>
<td>188</td>
</tr>
<tr>
<td>8-24 h</td>
<td>99</td>
</tr>
<tr>
<td>24-48 h</td>
<td>79</td>
</tr>
<tr>
<td>48-72 h</td>
<td>32</td>
</tr>
<tr>
<td>72 h+</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>419</td>
</tr>
</tbody>
</table>

Ranged distribution of Ealing Hospital Paediatric in-patient Length of Stay (source: EHT data, April/May 2014 (April/May is time of peak activity))

**5.2 Receiving Trust capacity planning**

The All five remaining Trusts have confirmed that they will be in a position to absorb additional paediatric activity from Ealing Hospital by 30 June 2016. The majority of Trusts are able to make new physical capacity available by winter 2015, ensuring that the space exists to support the transition of paediatric services prior to 30th June 2016, should this become necessary.
Three Trusts (West Middlesex University Hospital Trust (WMUH), The Hillingdon Hospitals Trust (THH) and London North West Healthcare Trust (LNWHT)) indicated that they would require capital investment to create the additional capacity needed. All three have submitted business cases to the SaHF programme, which have been approved. The SaHF programme has confirmed formally that it will fund all three capital builds. In response, all three Trusts have commenced building work and have confirmed that new physical capacity will be available by 30th June 2016 and in most cases much earlier.

The Paediatric PDB has reviewed the clinical and operational models proposed in each business case and confirm that they comply with PDB recommended requirements.

Table summarising new capacity created as a result of capital investment

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>Capacity recommended by Paediatric PDB</th>
<th>Capacity proposed by Trust</th>
<th>Capacity in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon Hospital</td>
<td>In-patient: 3 in-patient beds</td>
<td>• 4 in-patient beds</td>
<td>January 2016</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: 1,800 attendance pa.</td>
<td>• 4 PAU beds co-located with A&amp;E</td>
<td></td>
</tr>
<tr>
<td>Northwick Park Hospital</td>
<td>In-patient: 3 in-patient beds</td>
<td>• 3 in-patient beds</td>
<td>November 2015</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: 1,700 attendances pa.</td>
<td>• N/A no capital investment required</td>
<td></td>
</tr>
<tr>
<td>WMUH</td>
<td>In-patient: 6 in-patient beds</td>
<td>• 4 PAU cubicles co-located with A&amp;E</td>
<td>November 2015</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: 3,900 attendances pa.</td>
<td>• 6 ED cubicles (inc. 1 HDU cubicle)</td>
<td></td>
</tr>
<tr>
<td>Chelwest</td>
<td>In-patient: 2 in-patient beds</td>
<td>• Able to absorb activity without expansion</td>
<td>June 2016</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: 1,100 attendances pa.</td>
<td>• Able to absorb activity without expansion</td>
<td></td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>In-patient: 2 in-patient beds</td>
<td>• 2 in-patient beds</td>
<td>June 2016</td>
</tr>
<tr>
<td></td>
<td>A&amp;E: 1,400 attendances pa.</td>
<td>• Expansion of existing A&amp;E</td>
<td></td>
</tr>
</tbody>
</table>

Chelsea and Westminster Hospital Foundation Trust (Chelwest) has confirmed that they will be able to provide the capacity needed at Chelsea and Westminster Hospital by 30th June 2016 without additional capital investment. The Business Case for capital works at St Marys is near completion and would also allow capacity prior to June 2016.
Chart showing when in-patient physical capacity will become available (127% of current Ealing paediatric in-patient activity)

These figures relate to the availability of physical space – NOT the presence of the workforce needed to manage redistributed Ealing activity.

Chart showing when A&E physical capacity will become available (127% of current Ealing <16 A&E activity)

These figures relate to the availability of physical space – NOT the presence of the workforce needed to manage redistributed Ealing activity.
6 IMPLEMENTATION PLANNING

We will undertake significant further work to prepare the system prior to implementation. Over the next twelve months, efforts will be focussed in the following areas:

1. Implementation and evaluation of the Rapid Access Clinic at Ealing Hospital
2. Clinical pathway re-design and testing
3. Workforce planning (including formal consultation)
4. Capital building work at four hospital sites
5. Communications and engagement with patients (including hard to reach groups) and clinicians (including GPs, ED clinicians and condition-specific specialist services such as sickle-cell anaemia).
6. Work with Ealing UCC provider to clarify UCC specification such that it is able to manage as many children on-site as possible,
7. Ealing CCG, NHSE and TDA assurance

Plans for - and progress against - each of these areas is summarised in the remainder of this section.

6.1 Rapid Access Clinic implementation and evaluation

The Rapid Access Clinic service has now been commissioned formally by Ealing CCG. Work is underway with the CCG and LNWHT to flesh out the service specification, implementation plan and communications plan such that the service goes live in summer 2015.

The service will be evaluated after six months of operation, with a view to expanding the service to accept direct referrals from Ealing UCC. The outcome of this evaluation will feed into Ealing CCG and NHSE assurance processes.

6.2 Clinical pathway redesign and testing

The clinical model for paediatric care in Ealing is broader than services provided at Ealing Hospital alone. In order to ensure clinical safety, pathways for the movement of paediatric patients into and out of Ealing must also be considered. The Paediatric Project Delivery Board (in collaboration with A&E clinicians, the LAS, Ealing UCC and Ealing Children’s Community Nursing Service) has developed and approved a set of revised paediatric pathways for Ealing, post-transition. Specifically:

Emergency pathways:
- Pathway for the transfer of urgent or emergency activity from Ealing UCC or GP to alternative A&Es.
- LAS protocols for the re-direction of paediatric ambulances to sites other than Ealing hospital.

Non-emergency pathways:
- Clinical pathways for referral into Ealing paediatric ambulatory care services, including repatriation of patients receiving in-patient, observation or ED care elsewhere and requiring ongoing ambulatory care in Ealing post-discharge.
These pathways are based on approaches that have already been implemented successfully elsewhere in NW London. For example:

- London Ambulance Service (LAS) protocols already in place at Central Middlesex Hospital (CMH) and Charing Cross Hospital (CX);
- UCC to A&E transfer protocols already in place at CX. Charing Cross A&E does not currently treat paediatric emergency patients and has proven processes for the safe transfer of emergency patients to alternative sites.
- GP referral pathways already in place in Hammersmith and Fulham, enabling referral of paediatric patients for in-patient care outside of the borough.
- Repatriation pathways already in place in Hammersmith and Fulham, enabling paediatric patients who have received acute care outside the borough to receive on-going ambulatory care closer to home.

Further work on pathways will be undertaken before implementation. Specifically:

- Development of pathway collateral (Eligibility criteria, pro-formas, clinical/ information governance, IT enablers).
- Pathway testing, following the approached used successfully during A&E reconfiguration (table-top scenario testing workshops involving patients and stakeholders from all of the providers affected).

6.3 Workforce planning

Informal engagement and formal consultation with the Ealing Hospital paediatric and nursing workforce and unions will be undertaken to develop robust workforce redeployment plans. Comprehensive engagement will commence immediately after Ealing CCG’s decision on the timing of the transition to ensure that staff are aware of the changes and have the opportunity to help shape the plans. Formal consultation on workforce redeployment is expected to commence in January 2016. Lessons learned from the maternity work-stream suggest that commencing formal consultation too early results in confusion and uncertainty for staff.

6.4 Capital building work

Building works intended to expand paediatric capacity are underway at Northwick Park Hospital, West Middlesex University Hospital and Hillingdon Hospital. It is anticipated that all building work will be complete by 30th June 2016 and in most cases much earlier. The Business Case for capital works at St Marys is near completion and would also allow capacity prior to June 2016. SaHF liaison officers have been appointed for all three Trusts, enabling the Paediatric PDB and SaHF Programme Board to monitor progress. As with maternity implementation planning, NHSE and commissioner site visits will be scheduled on completion of the building works to ensure that the new facilities are fit for purpose.

6.5 Communication and engagement with patients and clinicians

A robust communications and engagement plan is under development to ensure that all affected groups are aware of the proposed changes and have the opportunity to contribute to the implementation planning process. There will be a particular focus on hard to reach groups, groups who typically make disproportionate use of Ealing paediatric services and condition-specific groups who may be particularly impacted by the changes.
Paediatric services have numerous complex interfaces with other services (especially A&E, CAMHS, Children's Social Services and specialist provision such as sickle-cell anaemia services). These interfaces will be articulated in detail as part of the pathway development work. The Paediatric PDB will work closely with stakeholders and patients and clinicians from linked services to ensure that they have an input into the design of the new interfaces, and are fully aware of the changes and their implications.

6.6 Ealing UCC specification review

Ealing CCG is in the process of re-procuring the UCC at Ealing Hospital. The Paediatric PDB will work closely with commissioners and the UCC provider to ensure that the service is able to manage as many children as possible on-site and without recourse to transfer. This work will include clarifying the range of paediatric conditions in-scope for the UCC (for example, the ability to manage some types of trauma) and reviewing UCC staff minimum paediatric competences to ensure that they continue to be appropriate in the absence of a paediatric in-patient department on site.

Further clarity is also required on the exact mechanism used to assess, stabilise and transfer children who are unsuitable for UCC care. Whilst this process is clear for LAS conveyances, non-emergency transfer protocols need to be developed in more detail and agreed with Ealing CCG and the relevant providers.

6.7 Ealing CCG, NHSE and TDA assurance

Significant further assurance activity will be undertaken as the implementation planning process progresses. Checkpoints are built into the process to provide commissioners with opportunities to review progress and assure themselves that implementation is on-track. The transition of paediatric services will not take place until implementation and operational readiness plans have been reviewed by Ealing CCG, NHSE and the TDA; and the assurance information is considered in public by Ealing CCG.

The proposed paediatric assurance timeline is set out in more detail in the implementation plan below, however the key elements are as follows:

- **Ealing CCG assurance:**
  - Private and public Ealing CCG Governing Body meetings to review progress and approve clinical model, operational model and Trust readiness.
  - Site visits by commissioners to ensure that Trusts are operationally ready for the transition.
  - Ealing CCG Safety Committee meeting immediately prior to transition to examine whether any unforeseen impediments should prevent the transition from proceeding as planned.

- **NHSE/ TDA assurance:**
  - Formal assurance of proposed clinical and operational models. It is anticipated that this will include a review of the clinical model by the London Clinical Senate and an external review of activity modelling assumptions in addition to NHSE's own internal review.
  - Formal assurance of Trust operational readiness. It is anticipated that this will include a TDA review of plans and TDA challenge sessions with the Trusts in addition to NHSE's own internal review.

- **Provider assurance:** Trust Boards will be asked to meet in public to formally confirm readiness for transition.
6.8 Paediatric implementation plan

The implementation plan is included as Paper 7.1 and represents current thinking. It will be reviewed, managed and updated on a regular basis through the Paediatric PDB.
7 PAEDIATRIC RISKS

7.1 Risks to the sustainability of paediatric services at Ealing Hospital during the transitional period

Transition on 30th June 2016 requires us to put in place plans to ensure that a safe paediatric service can be maintained at Ealing Hospital for up to 13 months after the closure of maternity, neonatal and gynaecology services. Though the Paediatric Project Delivery Board consider the likelihood of unplanned closure of paediatric services at Ealing Hospital to be low, there is a risk that staff attrition or unplanned activity shift could destabilise Ealing Hospital paediatric services prior to the planned transition date of 30th June 2016.

The following sections set out the mitigations that have been put in place to ensure that paediatric services are sustainable at Ealing Hospital during the transitional period (or minimise the potential impact, should the services become destabilised):

7.1.1 Ensuring that the Ealing paediatric workforce is stable

An unplanned closure will arise if there is a risk to either patient or staff safety. The most likely cause of this is an inability to maintain the in-patient paediatric workforce during the transitional period. This could happen for a number of reasons:

- Closure of neonatal services reduces scope for paediatric training at Ealing Hospital.
- Employee awareness of the closure results in staff seeking roles elsewhere (though workforce transition plans are less mature than those of maternity, where staff already have destinations in mind).

Staff availability is the key to ensuring that paediatric in-patient services are sustainable at Ealing. Steps have been taken to ensure that the service is staffed appropriately. The aim here is to retain paediatric trainees at Ealing whilst in parallel reducing Ealing’s reliance on trainees to staff their rota.

Retaining paediatric trainees at Ealing Hospital

Agreement has been reached with HENWL that existing paediatric training posts will be retained by Ealing Hospital for at least the duration of the transitional period. HENWL have written formally to the programme to confirm this. The relevant excerpt is provided below:

“We are satisfied that as a result of the recent merger of North West London Hospital Trust and Ealing Hospital Trust, coupled with the expansion of community-based paediatric service provision in Ealing, Ealing Hospital will continue to be a suitable centre of paediatric training after the closure of neonatal services on-site. We are therefore happy to confirm that we have no plans to withdraw paediatric trainees from Ealing Hospital in advance of the closure of paediatric services in summer 2016.”

Dr Julia Whiteman, Postgraduate Dean, Health Education North West London.

London North West Healthcare Trust (LNWHT) has confirmed that the paediatric nursing and medical workforce at Ealing Hospital is now sustainable for the foreseeable future. They added that the the proposed transition date of 30th June 2016 has reduced uncertainty for existing staff, resulting in a
number of Middle Grade doctors withdrawing their resignations and signalling their desire to remain for at least a further 12 months.

Reducing reliance on trainees

In the context of a planned reduction in the number of neonatal trainees across the sector, stakeholders from across NW London agree that providers need to move away from a reliance on trainees to maintain rotas.

In collaboration with HENWL and the Trusts, the SaHF programme is working to establish a pan-NW London pool of Trust grade paediatric and neonatal resources to reduce vacancy rates and reliance on trainees across NW London. These roles will feature a strong training element, including enrolment on an 18 months leadership development programme and the opportunity to build paediatric experience across settings of care (including in the community). HENWL’s experience with similar projects elsewhere gives us confidence that these roles will be attractive to applicants. The scheme will enable us to establish a new model of paediatric training better able to meet the future needs of the NHS. This is an opportunity to work with partners across the sector to cement NW London’s reputation as a centre for high quality, innovative training and education.

Whilst there are no concerns about the stability of the nursing workforce currently, LNWHT are working with HENWL to explore more extensive use of paediatric nurse practitioners to augment the existing workforce.

7.1.2 Minimising the impact of unplanned closure or unplanned activity shift

Contingency plans have been developed to mitigate the small risk that unplanned closure or unplanned shifts in activity could take place before planned closure is implemented on 30th June 2016.

In the context of total emergency paediatric activity managed across NW London’s A&E departments, the volume of emergency paediatric activity that will be redistributed from Ealing in the event of unplanned closure is relatively small. Despite this, there is a risk that even a relatively small increase in activity at receiving A&Es has the potential to compromise the system. Unplanned closure of paediatric services at Ealing Hospital could therefore potentially have significant consequences on patients’ experience of care.

The impact of unplanned closure on emergency paediatric services will be minimised by implementing measures designed to reduce the volume of paediatric activity currently flowing through Ealing A&E. The volume of emergency paediatric activity that would be redistributed to alternative A&Es in the event of unplanned closure would consequently be lower as well. This reduction could be achieved in two ways:

Provide GPs with an alternative to referring paediatric patients to A&E. Anecdotal evidence suggests that GPs often refer paediatric patients to A&E to secure specialist paediatric opinion rather than because they believe the patient’s need is urgent. The data is consistent with this: 46% of current paediatric activity at Ealing A&E is made up of GP referrals (3,600 pa.). Of these, over half (1,900 pa.) are discharged without the need for on-going treatment. The establishment of a consultant-led Rapid Access Clinic able to receive direct referrals from Ealing GPs therefore has the potential to reduce paediatric activity at Ealing A&E significantly.

Support Ealing UCC to safely and confidently manage children within their existing service specification. This will be achieved by supporting Ealing UCC to safely manage more children on site, reducing the number of transfers to A&E. The establishment of a consultant-led paediatric Rapid Access Clinic will, in time, also provide UCC GPs with an alternative to referring low acuity paediatric patients to A&E.
To have the greatest effect, the Rapid Access Clinic should be implemented as soon as possible after Ealing CCG’s decision on the timing of the transition. This measure must be allowed sufficient time to have an effect on paediatric activity at Ealing A&E before there is any immediate risk of an unplanned closure paediatric services.

**Ealing Hospital Rapid Access Clinic**

Ealing CCG has committed to commissioning a consultant-led Rapid Access Clinic at Ealing Hospital. The Rapid Access Clinic will be an extended hours, 7 day, referral-only service co-located with the existing paediatric day-case unit. Its purpose is to support primary care by providing same-day access to specialist paediatric opinion. GPs in Ealing will have the option of referring patients to the Rapid Access Clinic as an alternative to referring them on to A&E. The specification is set out in more detail in the section on ‘Paediatric model of care’.

In 2013/14, there were 3,600 paediatric GP referrals to the Ealing A&E. Of the 3,600, 1,900 were discharged from A&E without onward referral. The implication here is that the majority of these referrals were for a paediatric second opinion, rather than due to a proven emergency need (this is borne out anecdotally by Ealing GPs). This is therefore the target cohort for the Rapid Access Clinic (RAC).

Additionally, 2,400 patients were transferred from the UCC to A&E in 2013/14. Though the RAC will not accept referrals from the UCC in the first instance, this position will be reviewed after three months and again on completion of the one-year pilot. It is therefore likely that a proportion of UCC to A&E transfers will also be in-scope for the RAC by the time the paediatric transition takes place.

**Supporting Ealing UCC to manage more children on-site**

Ealing CCG is working with the current UCC provider to reduce the volume of UCC to A&E transfers. There is strong evidence to suggest that the presence of clinicians with a strong paediatric skill-set can impact the number of transfers through to the A&E. For example, GP with a special interest in paediatrics is currently employed by Ealing UCC during weekends, and has a demonstrable impact on the volume of activity passed through to Ealing A&E.
Despite handling more paediatric activity during weekends, the overall percentage of UCC to ED transfers drops noticeably during the GP specialist’s shifts (10% referral rate on weekends vs an average 14% referral rate during the week). If the same effect could be achieved on weekdays, it is anticipated that over 500 UCC to A&E transfers could be avoided annually, ensuring more children receive care in a setting appropriate to their need and reducing the pressure on Ealing A&E.

**Patient and public engagement/ communications plan**

Engagement with user-groups indicates that the public do not perceive maternity and paediatric services to be closely linked. Feedback from these groups indicates that the proposed closure of maternity services at Ealing Hospital will not result in the public drawing the erroneous conclusion that paediatric services will close at the same time. This could be changed by misleading press coverage of the CCG decisions.

Reactive communications materials (such as ‘Frequently Asked Questions’ sheets and ‘Q&A’ scripts for senior stakeholders) have been developed to ensure public messaging about the paediatric changes are clear and that Ealing residents continue to use Ealing Hospital paediatric services as normal. The aim here is to reduce the likelihood of unplanned activity shift as a result of confusion about the date of the paediatric transition.

Comprehensive patient and public engagement is planned as part of the detailed implementation planning work, which will be initiated immediately after Ealing CCG’s decision on the timing of the transition.

**Impact of mitigations for unplanned closure or unplanned activity shift**

Taken together, the RAC and reduced UCC to A&E transfer could reduce paediatric activity at Ealing A&E by 2,300 attendances pa. (30%), reducing the volume of activity to be redistributed to other sites in the event of unplanned closure. The table below sets out how much activity each receiving A&E would have to absorb under the ‘highest case’ scenario (i.e. 127% re-provision of existing Ealing activity – significantly more than is needed).
Table to show the volume of paediatric activity each receiving A&E would be expected to absorb from Ealing, once the impact of the RAC and changes to Ealing UCC have been factored in.

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>Average daily A&amp;E activity received from Ealing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>127% re-provision of remaining A&amp;E activity once RAC and changes to UCC are factored in</td>
</tr>
<tr>
<td>WMUH</td>
<td>8 cases</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Northwick Park Hospital</td>
<td>3</td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Chelsea and Westminster Hospital</td>
<td>2</td>
</tr>
</tbody>
</table>

Even in the unlikely event of full unplanned closure, the impact on most receiving A&Es is therefore expected to be minimal, and in most cases within existing daily variation.

Unlike maternity services, we have no evidence to suggest that unplanned activity shift is likely among Ealing paediatric patients. Significant unplanned activity shift is consequently thought to be unlikely, however, even under the worst case scenario of a 20% activity shift, the impact on receiving A&Es would be minimal.

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>Average daily A&amp;E activity received from Ealing ('highest case' 127% re-provision)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5% unplanned activity shift</td>
</tr>
<tr>
<td>WMUH</td>
<td>0.4 cases</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>0.2</td>
</tr>
<tr>
<td>Northwick Park Hospital</td>
<td>0.2</td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td>0.1</td>
</tr>
<tr>
<td>Chelsea and Westminster Hospital</td>
<td>0.1</td>
</tr>
</tbody>
</table>

*’Highest case’ scenario (127% of current Ealing activity) used for consistency with patient flow analysis elsewhere in document.

7.1.3 Ensuring additional physical capacity is created at receiving sites

Receiving Trusts will need to provide additional capacity to support the proposed paediatric transition on 30th June 2016. To ensure that sufficient resilience exists within the system in the event of
unplanned closure or unplanned activity shift, Trusts have been asked to ensure that all building works are completed as soon as possible.

The SaHF programme has formally agreed to underwrite the funding of three capital building programmes (WMUH, THH and LNWHT) on condition that work starts immediately and that the required capacity is in place no later than winter 2015/16. The Business Case for capital works at St Marys is near completion and would also allow capacity prior to June 2016. Furthermore, spare physical capacity is currently available within the system that could be used at short notice (e.g. Chelwest and Northwick Park A&E paediatric capacity).

There are well established processes to ensure that Trusts are operationally ready to respond to an unplanned closure of any kind, enabling staff to be re-deployed rapidly to where they are needed. In practice, physical capacity is the key limiting factor in any response to unplanned closure due to the lead-in times needed to create additional space. By making use of existing spare capacity and investing in new physical capacity across the sector, we will ensure that NW London will be in a position to respond quickly, should unplanned closure occur.

7.1.4 Approach to monitoring and early identification of issues

A robust system for monitoring paediatric services at Ealing Hospital has been developed. It will enable senior decision-makers to identify the potential warning signs of the need for unplanned closure and respond in a timely way. Data will be collected from NW London Trusts on a weekly basis, covering paediatric activity at A&E, paediatric in-patient activity, staff attrition and Serious Untoward Incidents. A representative group of senior managers, clinicians and commissioners from across the sector, reporting to the Clinical Board will meet regularly to review the data, with a specific mandate to intervene if there is a reasonable risk of unplanned closure. Lead indicators for unplanned closure include:

Substantial reduction in paediatric activity at Ealing Hospital, coupled with unplanned increases in paediatric activity at other sites (indicating that patients are choosing to go elsewhere);

Unmanageable increase in paediatric staff attrition rates at Ealing Hospital (indicating that Ealing’s workforce is no longer stable).
### 7.1.5 Key risks identified for paediatric transition

<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Risk Description</th>
<th>Inherent Severity</th>
<th>Inherent Likelihood</th>
<th>Inherent Risk Rating</th>
<th>Residual Severity</th>
<th>Residual Likelihood</th>
<th>Residual Risk Rating</th>
<th>Avoidance / Mitigation Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ri001</td>
<td>Governance &amp; Decision Making</td>
<td>There is a risk that the decision on the timing of the paediatric transition will not be taken on 20th May (either no decision on mat and paeds, or paeds decoupled from matony). Uncertainty could result in paediatric staff resignations, potentially destabilising the service.</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>Communicate importance of making a decision on maternity and paediatrics together on May 20th to Ealing CCG, NHSE and others. Engagement with Ealing staff to provide them with certainty about the decision-making timeline.</td>
</tr>
<tr>
<td>Ri002</td>
<td>Stakeholder Comms &amp; Engagement</td>
<td>There is a risk that poor/ inconsistent communication with Ealing paediatric staff before and after Ealing CCG’s decision will increase uncertainty and result in resignations. Potential destabilisation of Ealing paediatric services due to lack of staff.</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>SaHF communications team working with LNWHT to develop communications plan and materials for Ealing paediatric staff. Staff will be informed of the decision on 20th May (if made) and re-assured that a full, formal staff consultation is planned in early 2016.</td>
</tr>
<tr>
<td>Ri003</td>
<td>Infrastructure &amp; Estates</td>
<td>There is a risk that capital building projects at receiving sites will not deliver additional capacity in time to support the transition in summer 2016. The paediatric transition will be delayed as a result.</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>SaHF programme, embedded Trust project managers and TDA monitoring progress to ensure work remains on track.</td>
</tr>
<tr>
<td>Code</td>
<td>Category</td>
<td>Risk Description</td>
<td>Inherent Severity</td>
<td>Inherent Likelihood</td>
<td>Inherent Risk Rating</td>
<td>Residual Severity</td>
<td>Residual Likelihood</td>
<td>Residual Risk Rating</td>
<td>Avoidance / Mitigation Action</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>Ri004</td>
<td>Stakeholder Comms &amp; Engagement</td>
<td>There is a risk that poor communication around the maternity transition will leave patients with the mistaken impression that paediatric services are closing at Ealing Hospital too. Drop in paediatric activity at Ealing Hospital, potentially leading destabilisation of the service.</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>SaHF communications team developing paediatric communications plan/ materials to complement the maternity transition communications.</td>
</tr>
<tr>
<td>Ri005</td>
<td>Activity</td>
<td>There is a risk that post-transition paediatric patient activity flow modelling is inaccurate and that additional capacity is being created in the wrong places. Insufficient capacity at some receiving sites to cope with post-transition demand.</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>Trust capacity plans based on ‘highest case’ scenario, building in 127% of current Ealing paediatric activity.</td>
</tr>
</tbody>
</table>