WP 08
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol Pediatreg ac Iechyd Plant
Response from: Royal College of Paediatrics and Child Health

Royal College of Paediatrics and Child Health
Submission to the Health, Social Care and Sport Committee's Inquiry into winter preparedness 2016/17
September 2016

1. Introduction

1.1 The Royal College of Paediatrics and Child Health (RCPCH) is pleased to contribute to the work of the Health, Social Care and Sport Committee and it's aims to understand and explore the winter preparedness of health and social care services in Wales.

1.2 The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 550 members in Wales and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of our members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

1.3 For further information please contact Gethin Jones, External Affairs Manager for Wales: [redacted] or [redacted].

2. The current pressures facing unscheduled care services, and how well prepared the Welsh NHS and social services are for winter 2016/17

2.1 While children's health has improved greatly in the UK over the last 30 years, the UK continues to lag behind much of Western Europe and performs poorly on several measures of child health and wellbeing, including mortality[1] [2]. The RCPCH's *Why Children Die* report[3] highlights a need to better manage sick children and recommends that measures are taken to improve recognition and management of serious illness across the healthcare service.

2.2 Infants, children and young people (ICYP) aged 0 to 18 make up around 20% of the UK population[4] and they are high users of healthcare services; accounting for around a quarter of a typical GP's workload[5] and more than a quarter of emergency department attendances.

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[1] Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reform. *BMJ* 2011; 342: d1277
[2] Wolfe et al. Health Services for Children in Western Europe. *The Lancet* 2013; 381 (9873): 1224-1234
[3] RCPCH, National Children's Bureau and British Association for Child and Adolescent Public Health. *Why Children Die: death in infants, children and young people in the UK.* 2014
http://www.rcpch.ac.uk/sites/default/files/page/Death%20in%20infants,%20children%20and%20young%20people%20in%20the%20UK.pdf
[4] 2011 Census, Office of National Statistics
[5] Hippisley-Cox J et al. Trends in consultation rates in general practice 1995 to 2006: analysis of QRESEARCH database 2007. Cited in Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms? *BMJ* 2011.

2.3 The vast majority of children's illnesses are minor, requiring little or no medical intervention and a significant number of these emergency attendances may be deemed unnecessary or inappropriate. Unnecessary attendances are distressing and disruptive to children and families and also a wasteful high-cost intervention in a resource-limited health service, putting additional pressure on the hospital.

2.4 As this winter and the bronchiolitis/flu season approaches, the same pressures as previous years exist with no mitigation. RCPCH members have expressed concerns that the total number of beds, the number of cubicles and the number of Paediatric High Dependency Unit (PHDU) and Paediatric Intensive Care Unit (PICU) beds are all insufficient. As in previous years, services will again face short term periods where they have to compromise care by placing infectious children in wards, not cubicles, manage HDU patients in temporary overflow HDU beds on wards and have to provide intensive care in a DGH setting without specialist staff or equipment as all the UK PICU beds are full.

2.5 The RCPCH has also continued to express serious concerns about the sustainability of the paediatric workforce and services across the UK and the latest data show that gaps on paediatric rotas are increasing[6]. Services are having to be sustained by existing junior doctors and consultants struggling to plug vacancies. 89% of paediatric clinical directors (across the UK) are concerned about how the service will cope in next six months; up from 78% last year.

2.6 From the data received to date from the 2015 Workforce Census[7] (two hospitals outstanding) we estimate that 11% of posts on tier 1 rotas in Wales (junior trainees) and 21% of posts on tier 2 rotas (usually more senior trainees) were vacant over the 2015/16 winter period. These figures are slightly higher than elsewhere in the UK.

2.7 From our previous census in 2013, we reported that there were 153 Whole Time Equivalent (WTE) paediatric consultants in Wales i.e. 27.5 per 100,000 children aged 0-15. This ratio was lower than that in Scotland, London and the North of England but higher than the ratios on Northern Ireland, South of England, Midlands and East of England. However, the RCPCH estimate that across the UK as a whole an additional 800-1000 WTE consultants are needed to meet the standards for acute care such as 12 hour consultant presence in hospital 7 days a week (RCPCH Facing the Future Standards) and British Association for Perinatal Medicine standards for neonatal care.

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[6] RCPCH. *Rota Vacancies and Compliance Survey.* 2016
http://www.rcpch.ac.uk/sites/default/files/user31401/Rota%20vacancies%20and%20compliance%20survey%20-%20FINAL.pdf

[7] RCPCH carries out a biennial census of the UK paediatric workforce and child health services, from which we produce figures for Wales. The latest report (our 2015 census) will be disseminated late in 2016. http://www.rcpch.ac.uk/census

3. **Whether there has been sufficient progress in the fourth Assembly in alleviating pressures on unscheduled care through integrated winter planning across health, social and ambulance services, and lessons learned**

3.1 The pressures on unscheduled care remain a daily concern for paediatricians working in hospitals day to day and for many patients using the services.

3.2 It is disappointing that many of the recommendations designed to ease the pressures have not been acted upon and we are not aware of any specific action taken in relation to children.

4. **The actions needed to produce sustainable improvements to urgent and emergency care services, and the whole system, ensuring the Welsh NHS builds resilience to seasonal demand and to improve the position for the future**

4.1 In the short term, an increase in paediatric trainee and consultant numbers is urgently needed along with better advanced planning of rotas to avoid the costly use of locums. Annualised job planning would allow more senior decision makers to be on the shop floor in winter to maximise chances for senior review and early discharge.

4.2 Figures from the Welsh Deanery show that there are currently (Summer 2016) 148 paediatric trainees in Wales, which represents a fall from an RCPCH estimate of 156 in 2015. Clearly a decline in the number of trainees will impact the number of new Certificate of Completion of Training (CCT) holders who qualify as future consultants. In 2014, only 13 doctors achieved CCT in paediatrics and its subspecialties in Wales.

4.3 Around half of paediatric consultants and over 75% of those recruited to training in recent years are women. As these proportions have grown, so inevitably has time out of programme due to maternity leave. Along with the relatively high rates of less than full time training in paediatrics, this has meant that participation rates are falling. These trends do not appear to have been taken fully into account by the Wales Deanery when determining training numbers. Better mapping of and additional training places are needed to cover expected rota gaps due to maternity leave and less than full time working.

4.4 In addition to an increase in paediatricians, we also need to break down barriers to multi-disciplinary working, an increase in children's nurses and immediate opportunities for our GP colleagues to access child health training. Less than half of GPs are given the opportunity to undertake a paediatric placement during their training. Primary care services must be better equipped to identify children with early signs of serious illness, enabling them to be appropriately managed at first point of contact and ensuring that all children receive the right care at the right time before the illness has the opportunity to escalate.

4.5 In the long term, the demand for beds for emergency admissions can only be managed by better self/family care with early recognition of illness and more care delivered in the community outside of hospital settings. This will require a move away from single institutions towards a systems-based approach with networks of organisations delivering pathways of care and active engagement of children, young people and their families to better understand their needs.

4.6 The RCPCH is clear that closer working between primary and secondary care services is required to ensure that ICYP are getting the right care, in the right place and at the right time. Providing high quality paediatric care in a community setting will also reduce pressure on acute services (throughout the year). We need to help ICYP and their families navigate the options available to them, including self-care at home, with better signposting and safety netting.

4.7 The RCPCH's *Facing the Future: Standards for Acute General Paediatric Services*[8] and *Facing the Future: Together for Child Health*[9] make the case for whole system change in paediatrics to meet the needs of ICYP. The model recommends fewer, larger inpatient units which provide consultant delivered care and are better equipped to provide safe and sustainable care. These units need to be supported by networked services and more care delivered closer to home through community children's nursing teams and better paediatric provision in primary care.

4.8 Where children do need to be cared for in a hospital setting we need to ensure that all those delivering urgent care are following consistent guidelines and make sure that all emergency departments have the appropriate skill mix and workforce to deliver safe, effective and efficient care. The RCPCH is currently revising the Intercollegiate *Standards for Children and Young People in Emergency Care Settings*[10] (last published in 2012) which provide healthcare professionals, providers and service planners with measurable and auditable standards of care applicable to all urgent and emergency care settings.

[8] RCPCH. *Facing the Future: Standards for Acute General Paediatric Services*. 2015 www.rcpch.ac.uk/facingthefuture
[9] RCPCH,RCN, RCGP. *Facing the Future: Together for Child Health.* 2015 www.rcpch.ac.uk/togetherforchildhealth
[10] *Intercollegiate Standards for Children and Young People in Emergency Care Settings*. 2012 http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf