Our Ref: NG/JLS

1 August 2011

Sent via email

Councillor Bill Wearing
Chairman
Cumbria Health and Wellbeing Scrutiny Committee
Scrutiny Unit
Lonsdale Building
The Courts
Carlisle
CA3 8NA

Dear Cllr Wearing

RE: CHILD AND FAMILY HEALTH SERVICES

Thank you for the chance to respond to the Cumbria Health and Well-being Scrutiny Committee’s concern and general sense of frustration with the slow pace of change following the review of children’s services carried out by Dr Mitchell. The Trust shares some of your frustration and welcomes the request of the committee on the current position to ensure we collectively bring about the necessary changes and improvements to children’s health services in Cumbria.

We welcomed the appointment of a Clinical Lead for Children’s Services across Cumbria and the formation of Health Builders (in which we have played a full part). We were however, disappointed that the necessary financial support for the management of the project did not materialise to give the full support to the Lead, Dr Paul Gibson.

We also welcome the efforts of the PCT to improve the safeguarding arrangements. We are in the process of changing the way our Named Doctor and Nurse function operates, with increased funding to provide a wider safeguarding team, within the Trust, to improve safeguarding of both Children and Adults.

You have asked that we indicate what steps our Trust intends to take to deliver the recommended changes highlighted in the report. I have listed below the recommendations that affect the Trust and what we are doing to address these.
- Commissioners and providers should formulate a common vision that incorporates recent policy initiatives and achieves strategic coherence. The aim for children in Cumbria should be not only that their health is improved, but also their social and educational outcomes.

The Trust continues to support the vision for healthcare in Cumbria:

“To work together to provide accessible and appropriate healthcare that improves the lives of and effectively meets the needs of mothers, children, young people and their families. In Cumbria – the best for every mother, child, young person and their family; to enable them be healthy; to stay safe; to enjoy and achieve; to make a positive contribution and to achieve economic well being”

- Clinical leadership roles should be established so that all areas of the county receive support; clinical leaders should take responsibility for both in-patient and community service design, and contribute at senior level to commissioning boards.

The Trust has an Associate Medical Director (AMD) for Family Services who has been working with the commissioning GPs and their designated leads for Children. Together they have been working to redesign children’s services and identify the necessary workforce changes. The Trust has supported the development of two Clinical Advisory Groups (CAGs) to support and inform locality commissioning (Allerdale and Copeland – West, Carlisle and Eden – East). The CAG includes lead Clinicians from acute and community services and the commissioning leads for each of the localities. These CAGs report to a Clinical Leaders Team, whose aim is to agree, support and prioritise the delivery of the clinical models – with outcome of debate then used to inform the PCT Clinical Senate and divisional structures within the Trust.

The Clinical Leader’s team includes the Medical Director from NHS Cumbria and NCUH as well as all AMDs from the Trust, all commissioning GPs in North Cumbria and management support from both organisations. This should provide clarity regarding the commissioning decisions that are required to enable the necessary workforce changes to happen more rapidly.

- There should be integration of acute and community services in a manner which best meets the needs of children and families. There should be a guarantee of the future security of isolated in-patient units.
- There should be expansion of the consultant body as a whole, acting mainly in support of services in the community, and adaptation of consultant working patterns such that there is senior capacity available at times of peak demand to reduce numbers of short stay admissions which may be occurring inappropriately. The ‘generic’ model of consultant practice, with a greater emphasis on outreach and community practice should be further developed, with a requirement to develop locality working alongside primary care.
- There should be an increase in consultant and senior nursing time devoted to the leadership of local educational development.
The Clinical Leaders team has agreed a Clinical Strategy for Paediatrics that includes the recommendations immediately above. The Clinical Leaders will agree how the necessary, but challenging, work force changes will be enabled. Changes have already started with a change in the way, for example, new referrals are undertaken. A locality based multi-disciplinary team (GP, Consultant and community based nurse) review all potential referrals and agree a management plan.

Many children can then be managed without recourse to a hospital visit, while providing education to the primary care team. The Consultant therefore spends less time seeing patients but more time supporting other people to manage patients effectively.

The Strategy includes the recommended increase along with a significant change in focus for Consultant Paediatricians, which is currently being worked through with the consultant team across the two hospital sites. Consultants will always be available on the Hospital sites at peak times (including those “out of hours”).

The aim of reducing hospital admissions will require, not only the presence of this senior advice at the ‘front door’ but also the Paediatrician providing advice and education to staff managing children in A&E, GP surgeries, minor injury units and CHOC. Consultant Paediatricians primary responsibility will be the locality they are linked to. The change will be an “in reach” into hospital from a locality base to cover the needs of acutely ill children, rather than the “outreach” service, that they currently provide from the hospital base, while supporting acute care on both sites. The Clinical Strategy includes time in the consultants job plan for not only education within the locality but also leadership for areas that are important for children (e.g. respiratory disorders, epilepsy, continence, ADHD) with the Consultant Leading (with a nominated GP and nurse) the improvement and development of pathways of care, as well as leading the education programme in managing and following the specific pathways of care.

The model requires investment to enable nursing staff to develop extended skills to work across traditional boundaries and in a different way (for example as a Nurse Practitioner). The Trust’s Head of Nursing has been in discussions with the lead for the Children’s Community Nursing team and they work closely together supporting each other, however there needs to be more commitment to developing a single, integrated, children’s nursing team.

It is our impression that this has become more difficult since the community services moved to the Partnership Trust, with key positions potentially not being fully linked to the overall vision for children’s services or within the wider team of health builders.

- **Locality teams in the community should be both multi-agency and multi-disciplinary. They assume both a provider and commissioning role. To promote integration at the primary-secondary care interface there should be formal engagement with local general practitioners and commissioners to consider any primary care training requirements and to determine pathways of care for children that incorporate increased outreach practice.**
Allerdale and Copeland localities have been at the forefront of developing such teams and the Trust has been actively involved in these groups. Paediatricians have provided specific training to GPs, particularly in the area of the management of acute illness and respiratory illness, key reasons for admission. The Trust has supported Health Builders in the development of pathways (specifically constipation and respiratory illness) that incorporate increased outreach practice. The Trust intends to continue to support this work.

The Trust is also working with GPs and locality groups to improve its Directory of service, especially trying to highlight where actions can be taken in the community without recourse to referral. The model agreed (which is based on a Consultant and Paediatric Nurse Practitioner delivered service) also incorporates specific time allocated to a Consultant job plan to provide advice and education for primary care.

- There should be a commitment to enhancement of the nursing role such that they take more responsibility for front line assessment and management of sick children and neonates, with non-resident consultant support

The Clinical Strategy supports the development of frontline roles for nurses. We need to agree with the commissioners how this will be funded. We plan to address this through the CAGs and Clinical Leaders team. The Trust will focus on reducing admissions and improving their new to follow up ratios to enable some release of funds to support this training.

I hope this letter provides the committee with a helpful update on what the Trust has been progressing to deliver the recommendations made in Dr Mitchell’s report. Clearly, the committee will want to review the collective responses to your letter, however we would welcome the opportunity to have a wider discussion with health and scrutiny colleagues on the progress we have made to date and the milestones we have set for the future if you feel this would be of benefit.

Yours sincerely

Dr Neil Goodwin
INTERIM CHIEF EXECUTIVE

Cc Dr Deb Lee, Consultant Pediatrician and Associate Medical Director
Mr Mike Walker, Medical Director