Witness Statement Ref. No. 266/1

NAME OF CHILD: Claire Roberts

Name: Evan Bates

Title: Mr

Present position and institution:

Self-employed

Previous position and institution:
[As at the time of the child's death]
Director of Development, Information Systems & Patient Records, the Royal Group of Hospitals (the "RGH")

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2012]

During approximately 2004 and 2005, I was a member of the Employment Services Board in the West Belfast and Greater Shankill Taskforce Areas.

Since 2006, I have been a member of the Advisory Group for Disability Action's Centre on Human Rights for People with Disabilities.

From 2008 until 2010, I was a member of the Management Committee for An Munia Tober.

Since 2010, I have been a member of the Management Committee for the Participation and Practice of Rights group.

Since June 2012, I have been a member of the Independent Panel appointed by the Minister for Education to review the Common Funding Scheme for schools.

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

None

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	**Date:**	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) Please provide the following information:

(a) State your qualifications (and kindly provide a copy of your Curriculum Vitae);

MA (Cantab) in Economics

Diploma, Institute of Health Services Management

(b) Describe your career history before you were appointed Director of Development, Information Systems & Patient Records;

Before coming to the Royal Hospitals in 1993, I worked in NHS management roles in England, and in several public sector posts in Papua New Guinea. I was appointed to the post of Director of Corporate Information at the Royal Hospitals in 1993; the title for the post changed at various points, reflecting changes to my role and the scope of my Directorate.

(c) Describe your work commitments at the RGH from the date of your appointment;

- Directorate management (at various stages, ambulatory services in Royal Victoria Hospital, corporate communications and information technology). "Ambulatory services" refers to nursing and secretarial staff in the main outpatient clinic facility in the RVH, and the main library for patient records in the RVH (on Level 4 of the RVH Outpatient Building, along with two subsidiary stores: Kelvin School, and the Swiss Embroidery/Tent Store).
- Promotion of human rights, equality of opportunity, and targeting social need through community involvement and partnership-working on a range of initiatives.
- Policy development in relation to Government consultation initiatives.
- Strategic clinical service planning (at various stages, this included women and children's services, neurosurgery, dental school/hospital).
- Aspects of the Royal Hospitals' major redevelopment programme, including business case development linked to clinical activity projections, performance analysis, and sizing of facilities.
- Analysis and publication of clinical activity patterns and trends, taking account of factors such as age, gender, and social deprivation.

(d) Is there a written job description for your post? If so, please provide copy of the same. If not, what are the functions and responsibilities of the post?

I do not have a copy of a written job description. I have been able to locate some documents

at the Royal Hospitals which may be relevant:

- Director of Corporate Information: Objective setting, 1994/5 (and recorded 'Outcome')
- Director of DISPR: Objective setting, 1995/6 (with my handwritten notes on progress)
- Management Plan 1997/8: Directorate of Development, Information Systems, Outpatients and Record Services.

(e) Describe the accountability of the Director of Development, Information Systems & Patient Records;

I was accountable to the Chief Executive, Mr. William McKee.

(f) When was your post (or similar) created?

In 1993, when I was appointed.

(g) Please name your predecessor and successor to the role;

My post as Director of Corporate Services was not refilled after I retired.

(h) Did you have any involvement with the cases of Adam Strain and/or Claire Roberts and/or their aftermath?

I had no involvement with these cases.

(2) In 1996-1997, did the RBHSC /RGH have guidance, policy or procedures in place which governed the issue of clinical/nursing record keeping?

It may be better to distinguish the collection of clinical and nursing details for each patient from wider issues about the storage and management of patient records. The former issue would have been dealt with mainly through Medical Audit channels, and the Medical Records Committee would also have had involvement - but I cannot be more specific. In relation to storage and management of patient records, the Objective Setting documents which I referred to in Section 1 (d) referred to:

"Through the Medical Records Committee, seek a Record Storage and Destruction Policy consistent with legal requirements, and allowing the closure of Tent Store/Swiss Embroidery." The documents suggest that the policy was in place by the end of 1994/5; but my handwritten notes for 1995/6 state that implementation was delayed, "hindered by sickness absence."

The Management Plan 1997/8 refers to implementation of a "Medical Records strategy, including closure of Library/introduction of case note tracking".

I cannot recall the extent to which the Record Storage and Destruction Policy, and the Medical Records Strategy related to RBHSC; nor any detail of the Policy or Strategy themselves. I have seen a subsequent reference to a 1996 RVH patient records strategy - presumably the same Strategy as referred to in the Management Plan, and if so suggesting its focus was on the RVH,

and not the full Royal Group of Hospitals (which would have included RBHSC).

By way of background, I recall that the RVH Level 4 Records Library was under severe pressure on storage space - hence the focus on agreeing a Record Storage and Destruction Policy. We also wanted to improve the availability rates for patient records when needed in wards and outpatient clinics - hence the focus on introducing computerised tracking of patient records, and restriction of entry to the Level 4 RVH Records Library ("closure" is a misleading word). The Tent Store/Swiss Embroidery was not in active use - the intention was to remove and where appropriate destroy old patient records, to allow eventual demolition.

(3) **If so,**

(a) **Provide a copy of the guidance, policy or procedures;**

I am unable to assist; I have attempted to locate the documents, without success.

(b) **Describe its main features;**

I cannot recall details.

(c) **Was the guidance, policy or procedures adopted by the RBHSC/RGH, modelled on or informed by any published guidance, and if so, identify that guidance;**

I would have thought so, but I cannot recall any details.

(d) **State how the guidance, policy or procedures were distributed to clinical and nursing staff;**

I cannot recall details; again, I have tried to find relevant documentation, without success.

(e) **State how the RBHSC/RGH satisfied itself that the guidance, policy or procedures were being complied with by members of clinical teams;**

In relation the RVH Level 4 Patient Library for which I had direct responsibility, I know that regular exercises to transfer patient records to archive took place; and archived records were filtered for destruction. Also, we commenced monitoring of the availability rates for patient records in outpatient clinics. This was internal, within my Directorate. Probably later than 1996/7, targets for improving the availability of patient records were included in my Directorate Management Plan, and would have been monitored through the Trust's Directorate planning and accountability procedures.

I do not know in any detail how other Directorates which managed their own Patient Record Libraries (such as RBHSC, the Maternity Hospital, the Dental Hospital, and Eyes and ENT Directorate) dealt with the archival and destruction of patient records (I think some may have used off-site commercial storage). I do not recall if other Directorates set targets for the availability of patient records through their Directorate plans.

(4) **In 1996-1997, had the RBHSC established a Medical Records Committee?**

I do not know. There was a Trust-wide Medical Records Committee, and my comments in relation to Section 5 (a) - (e) refer to the Trust-wide MRC.

(5) If so, please address the following:

(a) Who formed the membership of this committee?

The chair was appointed by the Medical Director. During the 1990's the Committee was chaired by Dr. Stanley Hawkins (a neurologist in the RVH), and subsequently by Mr. David Boyle (a gynaecologist in the Royal Maternity Hospital). The members comprised doctors from all Directorates (possibly simply nominated by the individual Directorates). A number of administrative staff also attended (including Mrs. Mary O'Malley, who managed Patient Records in RBHSC). I recall that it was sometimes difficult to get full membership, and low attendance at meetings was sometimes a problem.

(b) Did you play a role in connection with the committee?

I was not a formal member of the Committee, but I attended quite often, especially during the mid 1990's.

(c) Were minutes taken of its deliberations?

The RVH Patient Records Manager, Mrs. Aislinn Carlile, provided support to the Committee, and took minutes. Aislinn managed the RVH Level 4 Patient Record Library, and reported to me.

(d) What was the purpose of the committee?

I cannot recall much detail. The Committee was concerned about issues such as the safe storage of records, and the destruction of records only after an appropriate period. The Committee sought improvements in the availability of patient records when needed in wards or outpatient clinics. In the early 1990's, many charts were bulky, with dilapidated covers. I recall that the Committee was involved with the introduction of a new Medical records chart cover, and a revised sequence for storing clinical notes within the new chart cover.

(e) Was its operation governed by any policy/procedure or rule?

I do not recall formal terms of reference; I am also unclear on the formal accountability arrangements for the Committee.

(6) With respect to the recommendations deriving from:

(a) Department of Health Circular HC (89)20;

(b) Department of Health Circular HSG (94)11;

(c) Circular HMC 75/82- Preservation of Hospital Service Records (Ref: WS-251/1 p.9)

(d) HSC 1999/053- 'For the Record-Managing Records in NHS Trusts and Health Authorities;

(e) The 1995 Audit Commission study 'Setting the Records Straight, a study of hospital health records';

(f) The Royal College of Surgeons of England Guidelines for Clinicians on Medical Records and Notes (1990, revised 1994).

Please state what steps the RBHSC/RGH took to:

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.

In relation to all the documents listed at (a) to (f) above, I have no recollection; and I have been unable to locate any relevant documentation.

(7) **What guidance was provided to medical staff in 1996-1997 in respect of the completion of clinical records?**

I cannot give a comprehensive answer. I vaguely recall that the RVH Patient Records Manager used to attend the induction for new House Officers, to explain how to use the "new" Patient Records chart.

(8) **Please indicate what teaching and/or training was provided to nursing and medical staff in and before 1996-1997 in respect of record keeping?**

I cannot give a comprehensive answer. I vaguely recall that the RVH Patient Records Manager used to attend the induction for new House Officers, to explain how to use the "new" Patient Records chart.

(9) **What procedures or protocols were in place in 1996-1997 for monitoring compliance with professional standards for record keeping?**

The Trust-wide Medical Records Committee was keen to raise standards; and standards would also have been addressed through clinical audit chart reviews. I cannot recall specific procedures or protocols.

(10) **In 1996-1997, what arrangements did the RBHSC/RGH have in place for the audit of clinical records? If none, when was a regular audit first developed and on what basis?**

I have located a copy of a Royal Hospitals strategy finalised probably in 1996 - "Getting it together - a strategy for children's services". I was a member of the Working Group which developed the strategy, and I drafted the strategy document itself.

Section 6.2 of the strategy stated that there was "an active clinical audit programme" within the RBHSC, and it listed 13 "recent assessments". Section 7.1.1 of the strategy set a target "to adopt a clinical audit programme oriented towards the development of clinical guidelines, monitoring variance in the use of guidelines, and assessing the clinical effectiveness of services".

I cannot recall any specific details about the arrangements for audit of clinical records in RBHSC/RGH in 1996/7.

(11) **In 1996-1997, what arrangements were in place for the audit of the management of clinical records? If none please state how the RBHSC/RGH ensured the management of the same was maintained to an appropriate standard?**

In relation to those RVH patient records stored and managed within my own Directorate, some overall monitoring would have taken place as part of the Trust's wider Directorate planning and

accountability arrangements. The Medical Records Committee was also concerned with chart availability issues. I cannot recall if there was ever any involvement with the Trust's internal audit department. The first King's Fund Organisational Audit probably took place in 1996/7 (based on my interpretation of the reference in my Directorate's Management Plan for 1997/8, referred to in Section 1(d) above); the KFOA would have audited some aspects of clinical record management. I have no specific information on audit of the management of clinical records within other Directorates within the Royal Hospitals, such as RBHSC.

(12) In 1996-1997, had the RBHSC/RGH established a Paediatric Audit Committee? If so, please provide all minutes and records of its meetings held during this period.

I have no knowledge.

(13) Please identify the Paediatric Audit Coordinator 1996-1997, indicating where appropriate date of appointment.

I have no knowledge.

(14) Please provide all minutes of Neuroscience Grand Rounds which took place in 1996-1997.

I am unable to assist.

(15) In 1996-1997, did the RBHSC/RGH have guidance, policy or procedures in place governing the retention and/or destruction of records? If so:

(a) Please provide a copy of the same;

(b) Was the guidance, policy or procedure informed by any published guidance and if so what?

In relation to storage and management of patient records, the Objective Setting documents which I referred to in Section 1 (d) referred to:

"Through the Medical Records Committee, seek a Record Storage and Destruction Policy consistent with legal requirements, and allowing the closure of Tent Store/Swiss Embroidery." The documents suggest that the policy was in place by the end of 1994/5; but my handwritten notes for 1995/6 state that implementation was delayed, "hindered by sickness absence."

I have been unable to locate a copy of the Policy; and I cannot recall the detail.

(16) If the procedures relating to destruction of records were governed by unwritten convention, please give details:

(a) How the same was applied to the records of child patients;

(b) Whether different procedures applied to different categories of document;

(c) The basis upon which documents were classified into categories;

(d) If discretion was permitted in that procedure, please describe the criteria upon which that discretion was exercised.

The procedures relating to destruction of patient records were not governed by unwritten convention, as a Records Storage and Destruction Policy was developed and in place in 1994/5.

Implementation within my own Directorate was "hindered by sickness absence", and continuing in 1995/6 - though I guess the delay may refer to the closure of the Tent Store/Swiss Embroidery, and that selection and removal of charts for destruction in Kelvin School may have commenced more quickly.

In relation to procedures for other records (such as general management files), there were varying arrangements. By about 2003, the introduction of controls assurance standards, coupled with the duties arising from the Freedom of Information Act, brought more focus to wider (non-patient) records management issues. During 2004 and 2005 I chaired a small Working Group preparing for implementation of the FOI Act - one strand of this work related to wider record management issues within the Royal Hospitals. I have located some minutes for meetings of this Working Group, including the Group's final meeting on 23 May 2005. At that point, work was continuing to develop a formal Trust-wide records disposal schedule. The minutes record that I was to take forward the establishment of a new Records Management Group; but I cannot recall what action I took prior to leaving the Trust in January 2006.

(17) **Please confirm whether or not you or your predecessor in post received a report in writing of or into the death of Claire Roberts?**

I do not recall receiving a report.

(18) **Did the RBHSC/RGH conduct an internal review in respect of any of the following matters after Claire's death:**

(a) The records arising from and relating to the care and treatment of Claire Roberts;

(b) The records arising from communication with Claire's family;

(c) The records relating to staff rotas and other documentation identifying those members of staff involved in the care and treatment of Claire?

(d) Records relating to audits, reviews or discussions relating to the care, treatment and cause of death of Claire?

I have no knowledge or information about Points (a) - (d) above.

(19) **How was the death of Claire Roberts categorised within the RBHSC/RGH statistical data in 1996-1997?**

I do not know. This information may still be available from archives from the Royal Hospitals' computerised Patient Administration System. In addition, patient-level data was transferred each year to Regional Information Branch within DHSSPS; so the information you are seeking may be available through DHSSPS.

(20) **Was her death re-classified following her Inquest in 2006?**

I do not know.

(21) **Please state what arrangements were in place in 1996 and 2006 to ensure that Autopsy reports were filed with the case notes? If there were none, please explain how Autopsy reports were filed and where.**

In the RVH Patients Records Library, I recall that autopsy reports were to be filed with case notes;

but I also recall some discussion of a backlog (I cannot remember even an approximate date). I am unaware of arrangements elsewhere in the Royal Hospitals.

(22) With reference to document (Ref: 090-006-008), please state:

(a) Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to the initials of Dr. McKaigue? If so, why was this note made? If not, how do you interpret this?

(b) Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?

(c) Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/role role in relation to this matter?

I am unable to clarify any of the Points (a) - (c) above.

(23) Please provide any further comments you may wish to make.

My recollection is regrettably poor. I wish to acknowledge the assistance of staff in the BHSCT who helped me by providing access to storage areas and record management systems. Though unable to locate many documents, I was able to find some documents which I have drawn on in my witness statement. If further documentation becomes available, such as minutes of the Medical Records Committee, the 1994/5 Record Storage and Destruction Policy, or the Patient Records strategy form about 1996, I would welcome an opportunity to review the documentation and extend my comments.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: [signature] Dated: 13/9/2012

Notes of a meeting -

FOI WORKING GROUP
23 May 2005

Present:	Evan Bates Bronagh Dalzell Margaret Best Charlotte McArdle Jennifer Holmes Mary O'Malley Anne Mulvenna
Apologies:	June Champion Aislinn Carlile

1 Notes of last meeting (25 February 2005) were accepted and apologies noted.

2 Matters arising:

2.1 Information governance

Evan Bates mentioned that the information governance paper previously circulated has been discussed at Executive Team. It was agreed that issues will be dealt within four groups.

- Communications (including FOI) by Corporate Communication.
- Records Management
- ICT
- Information Knowledge

Communications

Evan Bates feels that the FOI working group will now become redundant as FOI issues will be dealt within the Communications Group by Corporate Communication. Bronagh Dalzell informed the meeting that the new group may also consider issues of external/internal communications, and also the identity/reputation of the Trust.

Information Knowledge -

An existing group on Information Knowledge is chaired by Mr McKee and he has asked Paul Duffy to co-ordinate and widen the membership of this group.

ICT -

Evan Bates informed the group that he is currently chairing a Trust wide ICT Steering Group – there is now an opportunity to reflect on its role/membership.

Records Management -

It has been agreed that a new group will be established for Records Management. Evan Bates has agreed to take this forward and will try to establish a group. He has not yet decided who should be permanent members of the Record Management Group. He has in the first instance agreed to try and form a small group of people who would be aware of record management issues to discuss a way forward. He will be contacting David Brooker in relation to the Health Records Committee. Data protection, disposal schedule, public records office issues will be some of the topics within this group. A regional group is also being established, and Evan Bates has agreed to join but only on an interim basis.

It was established that any proposals from the four groups should then be brought to Executive Team for approval.
Evan Bates

2.2 FOI requests

Bronagh Dalzell informed the group that the 30th request has been received. The Public Interest Test Panel consisting of herself, Dympna Curley, Evan Bates and Patricia Donnelly have had their first meeting. If we are considering applying one of the qualified exemptions, we then have to decide on the public interest issues. The group then makes a recommendation to William McKee. The Regional Freedom of Information group are constantly monitoring progress and Bronagh Dalzell prepares a report for them on a quarterly basis.

A number of probably patient-related requests have been from solicitors. Requests have also been received in relation to negligence and also from people performing research, for example a request for the number of ultrasounds used in the Royal within the last five years. She has also received requests from staff who are keen to see their notes from interviews as to why they were not successful. Bronagh has been referring them to Human Resources, as FOI is not the appropriate channel for such requests.

2.3 FOI training

Evan Bates informed the group that a trawl has been taken for further decision making training and 15 responses have been received. The cost would approximately be [redacted] Evan Bates has asked that Finance cost it to all the different departments involved. He will therefore contact the divisions/directorates to obtain budget holder approval. Masons will probably be used for the training as they performed the last session and was well received. It was agreed that he will try to arrange this for late June and if this proves difficult will then hold it in September.
Evan Bates

2.4 Records management - disposal schedule

Margaret Best is currently working on a disposal schedule. She informed the group that she plans to meet each head of department such as Estates, Finance, Pharmacy and will be meeting Anne Mulvenna from Human Resources. This schedule will then be brought forward to the new Records Management Group and will then have to be agreed internally.

2.5 E-mails

Bronagh Dalzell queried the recording of e-mails and Evan Bates informed the group that e-mails should be printed if they are significant and part of the decision making process, they should then be filed with the paper record. Evan Bates also felt that a footer should be placed on all external e-mails and Bronagh Dalzell is aware of this. This could be authorised through the Corporate Communication group.
Bronagh Dalzell

3 Last meeting

It was agreed that no further meetings of this group would be required. Evan Bates thanked all participants for their help and support during the past year.

Management Plan 1997/8

Directorate of Development, Information Systems, Outpatients and Record Services

Corporate objective area - Acute services

Task	Outcome	Timescale	Responsibility
To support the implementation of AHRP	Patient charts available as required.	To be agreed	AC
	Patient appointments operate smoothly, in terms of bookings and chart availability.	TBA	AC
	Smooth transfer of outpatient clinics	TBA	PM
To obtain regional commitment to develop Neurosurgical services	Complete and initiate implementation of strategy	June 97	TF/EB
To review strategic issues relating to Dentistry and Oral Surgery	Complete and initiate implementation of strategy	October 97	IS/EB
To initiate and develop programme for theatre service	To establish Theatre Services Group	May 97	JG/EB
	Identify and address priorities	TBA	TSG
To adjust bed management and utilisation to allow easy transfer to new RVH facility	Repeat bed modelling work	October 97	EB
	Convene Bed Management Group, to drive forward agreed changes.	May 97	EB

Corporate objective area - New partnerships

Task	Outcome	Timescale	Responsibility
Develop collaborative arrangements with other health care services	Pilot direct outpatient appointment arrangements with GP's	October 97	HM/EB/AC/ PM (AC to project manage)
	Develop nurse led clinic in leg ulcers in collaboration with Multifund and Eastern Board, following completion of approval of Business Case.	July 97 (to complete Business Case)	PM
Development of provision of services by the Trust to other sites	Resolve Medical Records and PAS issues to support operation of additional outreached clinics	TBA	AC

Corporate objective area - Clinical effectiveness

Task	Outcome	Timescale	Responsibility
Development of streamlined services and concept of 'one stop shop'	Explore opportunities with Clinical Directorates, and ensure development of proposals for one stop services	On going	PM
	Development of nurse led clinics for preadmissions	On going	CD's/PM
Development of care pathways	Co-operate with Clinical Directorates in developing out-patient aspects	On going	PM

Corporate objective area - Organisational effectiveness

Task	Outcome	Timescale	Responsibility
King's Fund Audit	Address all areas of deficiency in Outpatients against A standards with agreed action plans		PM
	Extend new chart for all new patients	June 97	AC
	Secure Library, along with use of secure trolleys	June 97	AC
Responsiveness to patients' needs and requirements	Ensure that staff are appropriately trained in customer care	On going	PM
Develop organisational performance	Complete interim benchmarking reports (Outpatients and Medical Records)	September 97	PM/AC
	Implement Medical Records strategy, including closure of Library/introduction of case note tracking	July 97	EB/AC

Corporate objective area - Staff

Task	Outcome	Timescale	Responsibility
Calman	Identify implications within Outpatients, and identify appropriate training for nursing staff who may fulfil an extended role	?	PM
Implementation of staff development review system	All staff to have a staff development interview, setting objectives	May 97	EB/PM/AC/ST /FB
Reduce absenteeism	Reduce absenteeism to below 1996/7 levels by 20%	Quarterly	EB/PM/AC/ ST/FB

Corporate objective area - Information

Task	Outcome	Timescale	Responsibility
Development and implementation of information strategy	a) Agree revised strategy	August 97	EB/FB
	b) Implement strategy, progressing;	As agreed	EB/FB/ST
	A&E imaging	As agreed	FB
	RICU system	As agreed	FB
	Theatre Management system	As agreed	FB
	Laboratory system	As agreed	FB
	Business Objects	June 97	ST
	Casenote Tracking	June 97	AC/FB/ST
	c) Complete rollout of GP letters to non Uniplex users	July 97	ST
	d) Complete transfer of all Uniplex users to Microsoft Word	March 98	ST
	e) Implement stable electronic mail system for all senior staff	December 97	ST
	f) Reorganise IT Help Desk function	September 97	ST
	g) Implementation of network within RBHSC redevelopment	March 98	ST
	h) Complete risk review of Millennium issues	June 97	ST

Corporate objective area - Securing resources and controlling costs

Task	Outcome	Timescale	Responsibility
Financial viability	Manage services within budget	On going	EB/PM/AC/ ST/FB
Develop budget responsibilities to Clinical Directorates	Devolve responsibility for certain direct goods and services costs and direct income, from Outpatients to Clinical Directorates	April 97	EB/PM
Ensure income targets are met	Establish monitoring mechanisms to ensure that patient details are checked at every outpatient appointment	June 97	PM
	Ensure that PAS data standards are maintained, initiating any necessary corrective action	On going	AC

Corporate objective area - Teaching and Research

Task	Outcome	Timescale	Responsibility
To promote nursing research aimed at extending use of preadmission clinics, subject to appropriate funding.	Improved patient services, with more efficient use of resources	On going	PM
To identify education and training needs resulting from Calman and AHRP	Easy transfer of skills and competencies to support change	On going	PM

Corporate objective area - Buildings and Equipment

Task	Outcome	Timescale	Responsibility
Developments in Outpatients:- GUM clinic alterations Urodynamic clinic alterations Couch replacements	Compliance with health and safety/ improved patient facilities.	Subject to funding, bids already submitted	PM

OBJECTIVE SETTING 1995/96

DIRECTOR OF D.I.S.P.R.

Key Result Areas	Objectives	Timescale	Targets	Outcome
Trust Viability	Contribute to Trust Viability :-	March 1996	1. Agree a budget for Directorate of D.I.S.P.R. and manage expenditure accordingly achieving cost savings where required.	EXPENDITURE RESTRICTED TO PREVIOUS LEVELS, WITH MAJOR SAVINGS FROM ENQUIRY OFFICE/MAINTENANCE.
	- income - control of expenditure - control of IT capital expenditure	On going	2. Control IS Capital Expenditure, within agreed limits for approved schemes.	ACHIEVED
Secure Our Income Base	Build long-term Board/GP Relationships	Nov 1995	1. Extend a PAS/Uniplex facility to simplify the production of GP letters.	UNIPLEX SYSTEM OPERATIONAL; CONVERSION TO ITS WORK IN PROGRESS
	Expand Contracting Horizon	Nov 1995	2. Investigate options to improve outpatient appointment booking.	INVESTIGATED : BEST OPTION TO EXTEND TELEPHONE ACCESS.
		March 1996	3. Facilitate introduction of pilot Telemedicine links.	PENDING WIDER DEVELOPMENT OF TELEMEDICINE PILOT
		Nov 1996	4. Assist Paediatric and Obstetric Directorates to differentiate and charge for services.	ADVISED BOTH DIRECTORATES ON EXTENDED CAPTURE OF ACTIVITY DATA, FOCUSED TOWARDS GP FUNDHOLDING.

Key Result Areas	Objectives	Timescale	Targets	
		Feb 1996	4. Undertake a benchmark exercise for Medical Records services, reviewing procedures, quality standards and costs.	VISITED LEEDS AND UK HOSPITALS. WORKSHOP PLANNED.
	To manage the development and implementation of PAS as the core activity system within the Royal.	May 1995	5. Complete implementation of Clinicom, with associated training.	COMPLETED
	Reduce Absenteeism	March 1996	6. Reduce absenteeism below 2.91%	ABSENTEEISM POLICY FULLY IMPLEMENTED, BUT UNFORTUNATELY IT HAS BEEN IMPOSSIBLE TO MAINTAIN THIS LOW TARGET.
	MISCELLANEOUS.		EXTENSIVE ANALYSIS AND REPORTING ON AHRP	COMPLETED.
			DEVELOPMENT WORK ON RVH – PROJECT ~~TEAM~~ GROUP PARTICIPATION, OVERSIGHT OF PROJECT MANAGER, ANALYSIS OF BED REQUIREMENTS, NETWORK INFRASTRUCTURE	COMPLETED

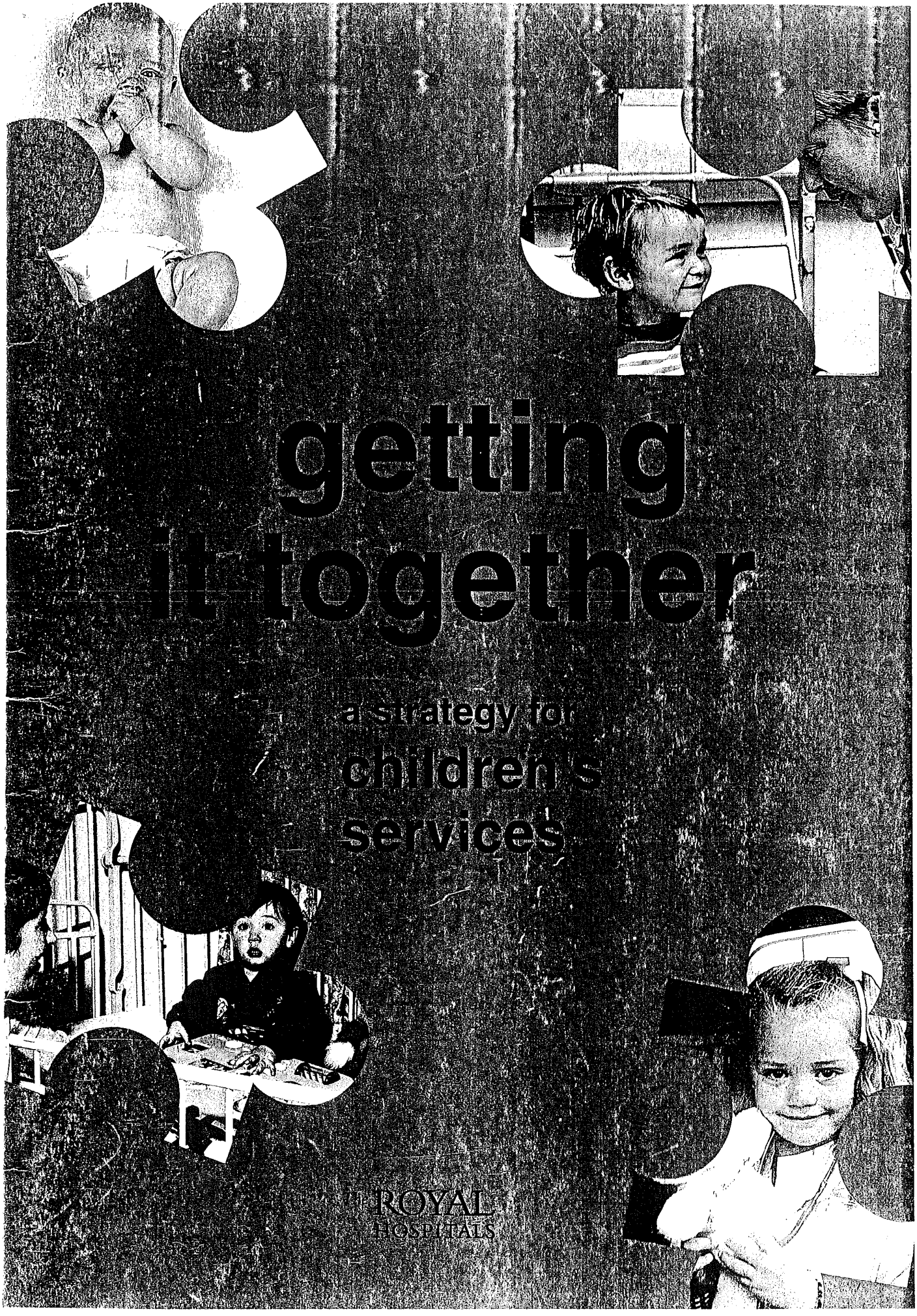
OBJECTIVE SETTING 1994/95 — DIRECTOR OF CORPORATE INFORMATION

Key Result Areas	Objectives	Timescale	Targets	Outcome
Trust Viability	Contribute to Trust Viability :- - income - control of expenditure - control of IT capital expenditure	On-going	1. Provide activity analyses for the Hospital Council and Trust Board, consistent with contracting/billing requirements, and highlighting issues which may threaten income.	Met
		May 1994	2. Agree a budget for Directorate of Corporate Information, and manage expenditure accordingly achieving cost savings where required.	Enquiry Office Saving
		On going	3. Provide resource utilisation reports to Directorates as required, to assist them in managing the resources efficiently.	Met
		On going	4. Control IT Capital Expenditure, within agreed limits for approved schemes.	Met
Secure Our Income Base	Build long-term Board/GP Relationships	July 1994	1. Introduce a PAS/Uniplex facility to simplify the production of GP letters.	Met, but slippage
	Expand Contracting Horizon	August 1994	2. Undertake geographical/GP analyses, identifying pockets of low referral, if possible linking to 1991 census data.	Met

Key Result Areas	Objectives	Timescale	Targets	Outcome
Hospital Process Re-engineering	Strategy development and implementation			
Information Strategy	Strategy Development	July 1994	1. Submit Strategy to Hospital Council for approval.	Met
	Strategy Implementation	To be agreed	2. Implement priority elements of the approved Strategy, using robust procurement and project management techniques.	Met
Cost and Quality	Support Clinical Audit programme.	On-going	1. Provide information derived from PAS to support the Clinical Audit process, as required.	Progress
	Support monitoring and achievement of Patient Charter standards.	On-going	2. Co-ordinate the preparation and submission of Charter returns, highlighting areas where further discussion with purchasers may be needed to ensure compliance.	Met
		June 1994, on-going	3. Raise the profile of waiting list management issues, promoting achievement of the Charter standards.	Met
		November 1994	4. Based on costing project, HRG analysis, and bed usage analysis, provide information to support the 1995/6 contracting round, and the disaggregation of services and costs.	Met

Key Result Areas	Objectives	Timescale	Targets	Outcome
Organisation and Development				
Directorate of Corporate Information :	A cohesive, efficient department, with resources targeted towards the key priorities facing the Royal, and responsive to Directorate requirements	On-going	1. Develop an effective management structure, with proper emphasis on system operation and support, system development and implementation, Information Management, PAS Management and Medical Records functions.	Progress
		On-going	2. Identify skills required, and address priority areas through staff recruitment and development programmes as appropriate, within agreed budgets.	Progress
	Provide an efficient, high quality Medical Records Service	August 1994	3. Through the Medical Records Committee, seek a Record Storage and Destruction Policy consistent with legal requirements, and allowing the closure of Tent Store/ Swiss Embroidery.	Policy in Place
		June 1994	4. Initiate a package of measures aimed at improving the quality and efficiency of services, with demonstrable improvements in service performance.	Progress
	To manage the development and implementation of PAS as the core activity system within the Royal.	On-going	5. Ensure that the PAS Management Group develops a central co-ordination role.	Progress
		April 1994	6. Ensure that all outpatient, daycase, and inpatient activity is recorded accurately and quickly on PAS, excluding Dental outpatients, and outpatients/daycases in Genito-Urinary Medicine.	Met
		On-going	7. Ensure that all PAS users receive formal, up-to-date training in all appropriate areas of functionality.	Met
		Completion by October 1994	8. Co-ordinate a waiting list validation for all patients waiting more than 12 months for admission.	Partially Met

Key Result Areas	Objectives	Timescale	Targets	Outcome
	To improve access to patient information throughout the Royal	On-going	9. Advise and assist Clinical Directorates in the analysis and interpretation of data, particularly in support of the Business Planning Process.	Met
		June 1994	10. Present proposals to Hospital Council aimed at improving standards of clinical coding, implementing such steps as may be agreed.	Met
		December 1994	11. Investigate and report on options which will allow easier and direct access to Clinical Directorate staff to key data derived from PAS.	Met
	Provide efficient IT services	May 1994	12. Arrange the sale and disposal of the IBM 9370.	Met
		July 1994	13. Arrange transfer of PAS from the VAX 8650 to a new VAX 4500A, thereafter minimising system downtime.	Met
		December 1994	14. Develop and implement robust procedures for Directorate of Corporate Information Computer Room and Network Operation.	Progress
		August 1994	15. Implement permanent data communication links with BCH and Queen's University.	Progress


getting
it together
a strategy for
children's
services
ROYAL
HOSPITALS

PREFACE

Children have special needs. They present particular challenges to organisations responsible for promoting health and treating illness among young people.

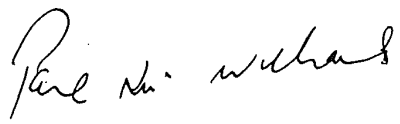
The Royal Belfast Hospital for Sick Children has for many years been the hub of hospital care for sick children in Northern Ireland. It provides secondary care to many children in Belfast, and a range of specialist services for all of the province.

We want to make our services better. To help do this we want to strengthen our links with other health care providers, recognising our complementary roles and responsibilities.

A seamless service for children will require a concerted effort to improve the responsiveness and quality of our services, extending our work into the home and the community, and complementing the services provided by other healthcare organisations. We believe that if we are to achieve these objectives a clear strategy is essential.

This document has emerged following a long period of discussion and consultation. A small multidisciplinary group of staff, mainly working within the Royal Belfast Hospital for Sick Children, developed the key strands of this strategy, prior to wider consultation within the Trust. A number of representatives from other healthcare organisations have taken part in discussions, and I acknowledge, with gratitude, their contribution to the development of this strategy.

The development of this strategy is only the starting point. We trust that it will serve as a useful contribution to the development of a wider regional strategy for children's services. Implementation of the proposals is the real challenge. We in the Royal Hospitals are committed to collaborating with others to achieve our overall objective to improve the wellbeing of children in Northern Ireland.



Paul McWilliams
Chairman

CONTENTS

EXECUTIVE SUMMARY

1. **Children** require comprehensive, holistic, sensitive and responsive services.

2. The strategy is intended to provide a **basis** for the development of child health services in the Royal Hospitals, and to contribute to the **development** of a **regional strategy** for paediatric services. The Royal Hospitals wish to co-operate and collaborate with other providers, so that, from a child and family perspective, the service becomes a seamless one.

3. Eight **principles** are set out dealing with the aims, range, quality, delivery, accessibility and efficiency of the service. These principles underpin the strategy.

4. The strategy takes **cognisance** of the public's rising expectations, clinical and technological developments, and purchasers plans and requirements.

5. The **demand** for services is fuelled by the high proportion of young people in the province, constrained by increasingly rigorous requirements for providers of children's services, and complicated by the rising tide of emergency admissions.

6. Current services within the Royal Belfast Hospital for Sick Children have been **analysed** and **compared** with peer group specialties. Current funding difficulties, and deficiencies in accommodation, are set out.

7. The strategy is **child and family centred**, with particular emphasis on quality, comprehensive and effective tertiary services, linkages with other providers, and the improvement of processes for clinical assessment and care delivery. Specific targets have been set for each of these areas.

8. Progress and implementation will require **an unwavering focus** on the needs of children and a commitment on the part of all providers and purchasers to collaborate in the challenging task of meeting those needs.

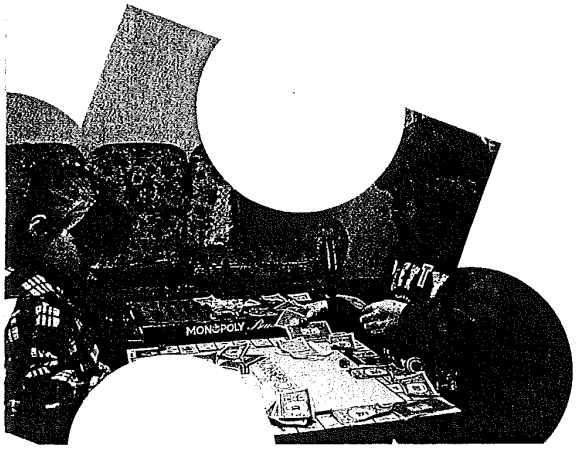
1 the healthcare

1. THE HEALTHCARE NEEDS OF CHILDREN

Most sick children are cared for at home by their parents and family. General practitioners and other community-based clinical workers provide primary care for these children, when appropriate. A relatively small number of children will be referred to hospital-based consultants, possibly leading to hospital admission, for secondary care. An even smaller number of children will require referral, either from GPs or other hospital consultants, to regional specialist services. Many children who require secondary and tertiary level care will also require complementary services from primary care workers. Effective communications and co-ordination between HPSS organisations is essential **to ensure that children and their families receive timely and comprehensive services.**

At a personal level, an illness, and the treatment of that illness, have the potential to frighten and confuse a child, possibly resulting in psychological stress. Children recover more quickly, with minimised long term emotional and developmental side effects, if services are responsive to their overall needs, both physical and emotional. These needs vary, depending on the age and maturity of each child as well as the medical condition.

This emphasis on **sensitivity, responsiveness** and **holistic** care places distinctive demands on children's services.



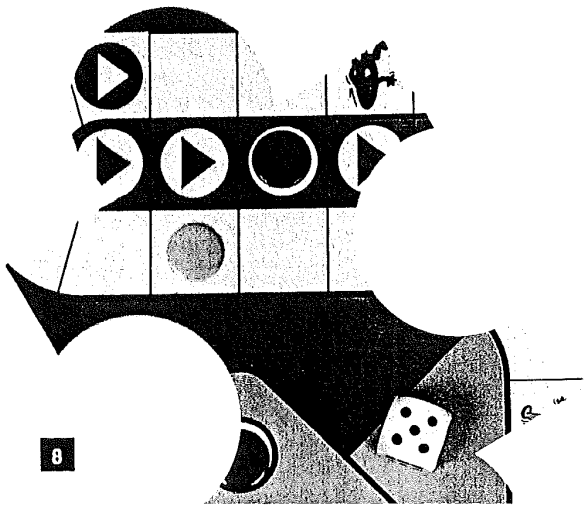
2 role and scope

2. ROLE AND SCOPE OF THE STRATEGY

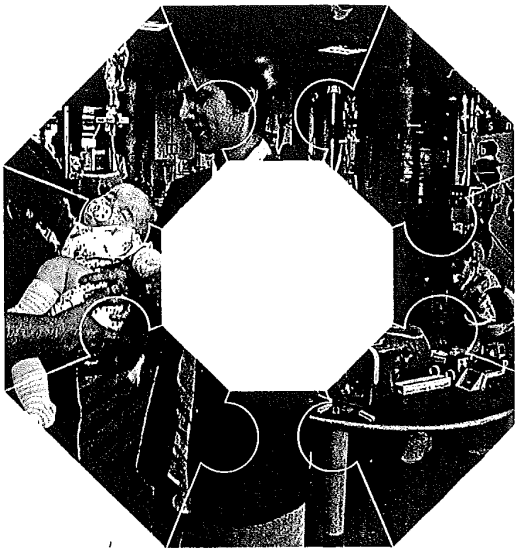
The Royal Belfast Hospital for Sick Children, part of the Royal Hospitals, is the only hospital in the province solely dedicated to the needs of children. It provides acute hospital services and tertiary care, within an environment of professional education and research. Cognisant of a wide range of pressures on services, and of opportunities for improvement, the Trust has developed a strategy for children's services (see Appendix 5). This focuses on **the provision of acute hospital services, and specifically on the role of the Royal Hospitals**. Linkages with other hospitals, and with primary care services, are key issues within the strategy.

The strategy is intended to provide a basis for the development of child health services within the Royal Hospitals, and to contribute to the development of a regional strategy for children's services. Such a regional strategy would build on the broad policy directions already established within the Regional Strategy for Health and Social Wellbeing, 1997 - 2002, relating to acute care, and services for children and their families.

It is not the intention that the Royal Hospitals would provide or control the totality of children's services. Clearly other service providers, based in primary care, in the community and at hospitals, will develop their own strategies within the overall regional strategic context. It will be appropriate in some situations for the Royal Hospitals to take the lead in co-ordinating services; in other situations the Royal Hospitals will fulfil a supporting role. The Royal Hospitals wish **to cooperate and collaborate with other providers and purchasers** to ensure an interlocking of all aspects of paediatric service, so that any sick child and family may move smoothly from one area to another in the process of receiving the best and most appropriate care.



3 principles



3. PRINCIPLES

The Trust has adopted the following eight principles as a framework for the provision and strategic development of paediatric services.

1. Children in hospital need both physical and emotional care and support. Services must be responsive to the needs of each individual child, recognising the benefits to be gained from active family participation.

This is the cardinal principle. Children have holistic needs which vary according to their age, maturity and medical condition. It acknowledges that family members have much to contribute in caring for a sick child, even in hospital.

2. Health care services for children should aim to maximise health gain, within resource constraints. Children throughout society should have easy access to diagnostic services; and health care services should thereafter be allocated in an efficient manner which promotes a more equitable distribution of healthy outcomes among children.

Healthy children are the goal. Some children are already healthier than others. The health of children is affected by a wide range of factors, often outside the control of health care services and resources are limited. "Health for all" is utopian but services can be configured and delivered selectively in a way which moves society towards, rather than away from, that goal. All children should have easy access to assessment services, leading to early diagnosis and a prognosis. The child's capacity to benefit would influence the choice of treatment and care programme, but difficult issues of efficiency and equity would also have to be taken into account.

Current healthcare commissioning arrangements have introduced a further factor. The resources available to a hospital, and hence its capacity to deliver services, are directly affected by the funding arrangements for each episode of care - arrangements which vary between commissioners. There is a need for greater collaboration between commissioners and providers of healthcare to explore the implications for equity and appropriate access to services.

3. Paediatric services in Northern Ireland should be planned to conform with national and clinical specialist guidance.

Relevant contemporary guidance is listed in the Bibliography.

4. The Royal Belfast Hospital for Sick Children should develop its role as the tertiary service centre for Northern Ireland. Continued development of general acute services is necessary as a foundation for lower volume specialist tertiary work. Both general acute and tertiary services should be delivered in close proximity to the home, where practical, on an outreach basis from the Royal Belfast Hospital for Sick Children.

The British Paediatric Association usefully defined tertiary services as those specialist services which are not provided routinely at district general hospitals. The medical condition may be relatively uncommon, or the treatment may be complex, requiring the involvement of specialists and multi-disciplinary teams with expertise both in the care of children and in the specific condition.

The Royal Hospitals document "Vision of Success", released in 1994, made explicit the fundamental purpose of "providing the highest quality cost effective health care, as an outstanding acute general hospital and tertiary referral centre, through exceptional service to our patients, staff and community, in an environment of education, teaching and research". There was a commitment to "sustain our acute services for children, an important component of our acute general role, so that in turn they can complement our wide range of small special tertiary children's services and also provide a solid foundation from which such services can be more community based".

5. Linkages with other healthcare providers should be strengthened in appropriate areas, providing children and their families with comprehensive, integrated packages of care.

Though a sick child of the family may be receiving services from a number of healthcare providers, the interfaces between the service organisations should be transparent to them. Communications and joint planning of service delivery are key factors in providing a complete, co-ordinated service.

6. While ensuring that efficient use is made of scarce specialised resources, hospital care should be used only where it offers diagnostic and therapeutic advantages over care at home.

Other things being equal, it is best for a sick child to be cared for at home, in a familiar environment, and with the support of the family. Wherever practical, hospital-based specialist services need to extend into the community and home, complementing the work of primary health care services. Admission to hospital will be necessary in some circumstances for diagnosis or treatment; efficient ambulatory services can minimise the need for overnight admissions.

7. All children requiring hospital care should be treated in a paediatric environment, by suitably qualified clinical staff.

National and specialist clinical guidance has repeatedly emphasised that children should be treated in a paediatric environment, not in adult facilities. Specialist equipment and consumables to cope with children of all ages should be available. Clinical staff require appropriate paediatric training and experience to provide services of a suitable standard for children.

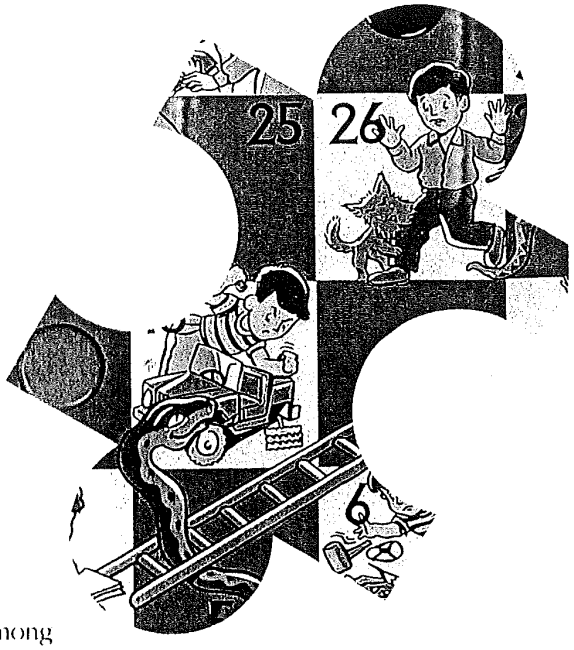
8. Adolescents requiring hospital admission should have a choice between treatment in either an adolescent facility (within a paediatric unit), or in an adult unit.

The needs of adolescents are very different from those of younger children, and separate ward facilities are necessary. Adolescents themselves will vary widely in their maturity and social experience; some may prefer to be cared for in an adult ward.

44

the

strategic



4. THE STRATEGIC CONTEXT

In common with health services for other patient groups, **children's services must anticipate and respond to change**. Though services have never been static, the current pace of change, and the prospects of further change, may be stimulating and challenging yet also threatening. Resource constraints emphasise the perception of change among staff, as there is less opportunity to absorb the consequences of change within existing work patterns.

4.1 Rising expectations

People have become accustomed to rising standards and these present challenges to the health service.

Patients are justified in expecting that health care providers should meet the same standards routinely available in other walks of life - avoiding undue delays, for example. Increasingly, too, patients want to be well informed about their illness and potential treatments, and to be able to influence the choice of treatment.

Children have their own independent rights, and these are increasingly being protected in legislation - notably, the Children (Northern Ireland) Order, 1995. The Order provides a framework for the commissioning and delivery of services to children and their families.

4.2 Clinical and technological developments

The pace of development in diagnostic and treatment techniques **in recent years has been remarkable**, and further acceleration is likely. Diagnostic equipment and techniques are becoming increasingly sophisticated, allowing faster and more accurate diagnoses, often avoiding invasive procedures. Minimal access surgery, more effective drugs, and improved pain control techniques all contribute to more rapid recovery and better clinical outcomes.

There is increasing pressure to justify the introduction of new procedures and techniques with rigorous research into the clinical effectiveness of each innovation.

And, once proven, improved procedures and techniques should be adopted throughout the health service without undue delay.

The rapid development of information technology underpins many of these changes. Diagnostic and treatment equipment increasingly relies on silicon chip technology. Clinical support systems are available, enabling rapid access to patient information, and manipulation of that information; information which can be shared across considerable geographical distances, without delay. Access to up to date clinical guidance based on research has become easier, using document management systems.

4.3 Regional and purchaser plans

The Regional Strategy for Health and Social Wellbeing, 1997 - 2002, emphasised that **quality and safety of acute care should have primacy over geographical accessibility**. It stated that it will be impossible to sustain the current pattern of acute hospitals in Northern Ireland without adverse consequences for clinical quality and efficiency in the use of resources. In the key area of family and child health, the overall thrust of policy is the provision of well co-ordinated, comprehensive services, enabling parents to care for sick children at home, but with admission to hospital when appropriate. Providers are encouraged to agree admission and discharge protocols; and to develop alternative facilities which reduce the need for hospital admission.

In 1995, the HPSS Management Executive endorsed recommendations to unify medical staffing structures between community and hospital services. The Management Executive encouraged co-ordinated postgraduate training, reflecting the requirements of combined child health services. Providers were urged to review their services, determining with other Trusts, if appropriate, how a combined community health and hospital service could be developed in each area.

The Eastern Health and Social Services Board Purchasing Prospectus, 1996/7 - 1998/9, placed emphasis on the implementation of the Children (Northern Ireland) Order, 1995. The Board prepared technical specifications for a number of paediatric services. The Board highlighted as a priority its wish to progress the development of short stay assessment arrangements for acutely ill children.

The Northern Health and Social Services Board Purchasing Prospectus, 1996/7 - 1998/9, again placed emphasis on implementation of the Children (Northern Ireland) Order, 1995. The Board aims to secure access to high quality, co-ordinated services,

delivering care which is centred on the child and family.

The Southern Health and Social Services Board Purchasing Prospectus, 1996/7 - 1998/9, stressed the ongoing need for high quality and co-ordinated services to ensure support for vulnerable children and their families.

The Western Health and Social Services Board's Purchasing Specification for Child Health Services, 1995/6 - 1997/8, commented that the need for hospital inpatient treatment should be reduced by better community, outpatient and day surgery services, including the development of 'hospital at home' models of care. Further detailed quality standards were also identified.

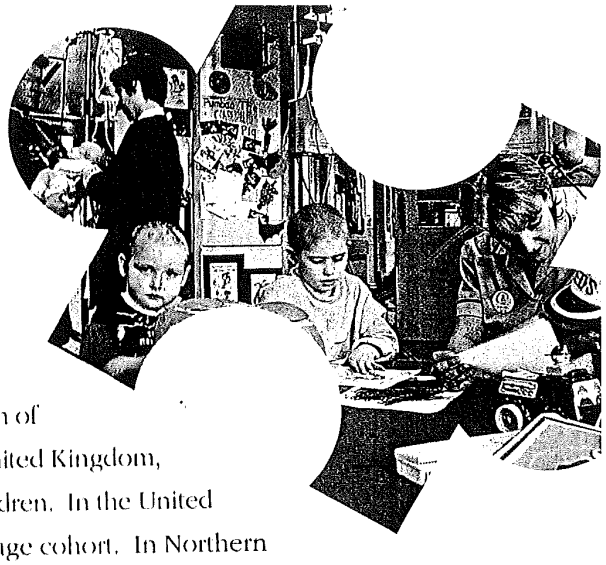
4.4 Staffing

The pressures for change encountered by manufacturing and service organisations, both public and private sector, are leading many organisations to review processes, traditional staffing structures and roles. Many organisations are finding benefit from streamlining processes, from widening and deepening the skills of staff, and from a greater emphasis on team working.

The implementation of Calman proposals for medical training will impact over the next few years on all clinical specialities. As originally proposed, doctors in training will become increasingly focused on the requirements of their training programmes, and operational services will depend more heavily on consultant medical staff and other clinicians. As a result there will be pressure to concentrate services on a smaller number of sites.

Multi-disciplinary collaboration is already well established in relation to children's health services. The prospect of continuing rapid change, in an environment of scarce resources, must also lead to a search for improved processes and procedures, with evolving roles for staff, and further emphasis on teamworking.

55 demand for services



5. DEMAND FOR SERVICES

5.1 The child population

Northern Ireland has a higher proportion of young people than any other region in the United Kingdom, with 25.7% aged under 16 years - 418,500 children. In the United Kingdom overall, only 20.6% are within this age cohort. In Northern Ireland the number of children is expected to fall by 7% over the decade ending 2004, with the proportion of children in the population falling to 23.2%.

Around 33% of children are aged under five years, with a further 33% aged between five and ten years. No significant changes in these proportions are expected in the period up to 2004.

In Northern Ireland 37.4% of children live within the boundary of the Eastern Health and Social Services Board. The Eastern Board has some of the most affluent, and some of the most deprived, areas within Northern Ireland - the province as a whole is one of the most deprived regions in the United Kingdom. The deprived areas are located mainly in urban areas, notably in North and West Belfast - the hinterland of the Royal Hospitals.

Adverse socioeconomic conditions are associated with higher morbidity, and while immunisation programmes have been successful in minimising the incidence of some childhood diseases, respiratory disease, particularly asthma, is on the increase.

5.2 The demand for acute hospital services

Most sick children are cared for at home, with the support of GPs and community health services. Families living close to hospitals with A&E facilities sometimes use these facilities inappropriately, as an alternative to primary care. There is scope for collaboration with GPs to inform and educate the public on the appropriate use of primary care and hospital emergency services.

Children may be referred for secondary acute care to hospitals throughout Northern Ireland, the Royal Belfast Hospital for Sick Children being the largest single centre for secondary and tertiary care. In all specialties, at the Children's Hospital, urgent cases are seen with a minimum of delay. Routine cases are usually seen within 13 weeks of referral with the longest delays in psychiatry and plastic surgery. Most

children will be seen at clinics in the Children's Hospital although there is a small number of regional outreach clinics within cardiology, plastic surgery and neurology.

Children requiring acute hospital care will be admitted either electively, or on an emergency basis. In addition to the Children's Hospital paediatric medical inpatient facilities are also located at Antrim, Craigavon, Daisy Hill, Altnagelvin, Coleraine, the Erne, Omagh and Ulster hospitals. Only two centres, the Ulster hospital and Royal Belfast Hospital for Sick Children, have specialist surgical services. Nevertheless, many hospitals throughout Northern Ireland continue to admit and treat a number of children (see Appendix 1). In these situations, children will be treated and cared for by staff more accustomed to dealing with adults, and possibly without paediatric training, in an environment which may not be tailored to the needs of children. Professional guidance is very clear - **children requiring hospital admission should be treated in recognised paediatric centres, with appropriately qualified and specialised staff.**

In 1995, the Eastern Health and Social Services Board undertook a survey of GP referral patterns, identifying that GPs in East and South Belfast, and in the Down and Lisburn areas, would welcome an opportunity to increase the proportion of their referrals for paediatric medical care to the RBHSC. Almost all GPs responding to the survey would welcome the introduction of short stay assessment arrangements for acutely ill children, where children would be assessed by paediatricians within a paediatric ward, on request of a GP.

Acute services throughout the United Kingdom have seen a rise in emergency admissions. Scotland has experienced an annual growth of 3% in emergency admissions, with some acceleration in the 1990's. Major inner city hospitals have typically experienced the highest rates of increase, with growth rates of 8 - 10% being common in the last couple of years. Paediatric services in Belfast are no exception to the trend as the following table shows.

Annual growth in emergency admissions, RBHSC

Year	1993/4	1994/5	1995/6
Percentage	+12.6%	+13.6%	+4.0%

The number of emergency admissions usually rises during the winter, reflecting the incidence of respiratory conditions such as bronchiolitis. This seasonal fluctuation is partially offset by fracture admissions, which peak during the summer.

Unfortunately, this growth in emergency workload exacerbates the ongoing pressure on facilities and staff. Within the Royal Hospitals, the waiting time for non-urgent elective admission within paediatric surgery and plastic surgery can still be in excess of 18 - 24 months. Though there has been some improvement during the last year, as a result of purchasing board waiting list initiatives, the delays in treatment for some children are very unsatisfactory.

5.3 Future requirements

A number of factors will affect the future requirements for hospital care in Northern Ireland:

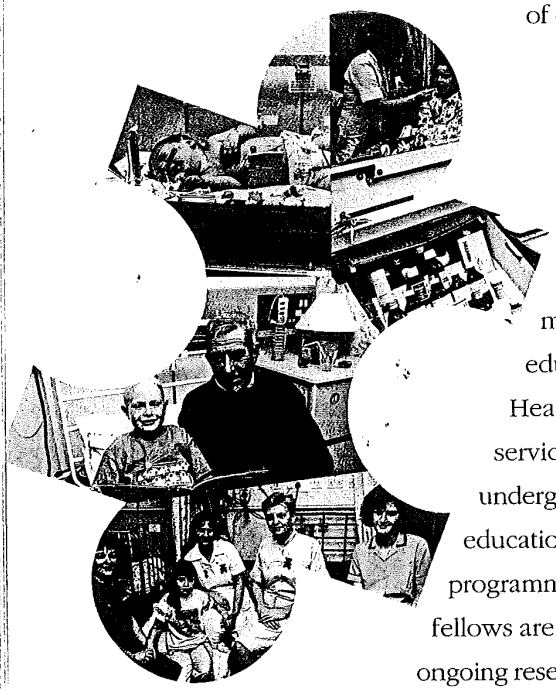
- The expected decrease in the child population.
- Underlying socioeconomic and epidemiological conditions.
- Clinical and technological developments. On the one hand, these developments will allow some services to be provided at home rather than in hospital; on the other hand, new hospital-based diagnostic and treatment techniques will become available. Enhanced foetal scanning techniques, for example, are likely to led to the detection of around 150 additional abnormalities throughout Northern Ireland each year, surgically correctable if treated immediately after birth. It is expected that these mothers will give birth in the Royal Maternity Hospital, with immediate access to surgical facilities in the Royal Belfast Hospital for Sick Children.
- Improved collaboration with GPs will reduce inappropriate referrals. There are also areas where referrals are inappropriately low, and some correction is likely.
- There will be some transfer of clinical services between hospitals, and from hospitals to the community.
- There will be continued movement towards ambulatory care, with a consequent reduction in inpatient elective activity.
- Regional and national analyses of emergency admission patterns indicate a number of causal factors. It seems prudent to expect ongoing growth in emergency admissions, albeit at a reduced level.

6 current services

6. CURRENT SERVICES AT THE ROYAL HOSPITALS

6.1 Description of current services

Children are treated at all parts of the Royal Hospitals, but the Royal Belfast Hospital for Sick Children has a unique role. It provides **acute care for children living in Belfast**, particularly North and West Belfast, **as well as most tertiary care services for children throughout Northern Ireland**. Standards of care benefit from multi-disciplinary working practices within the Children's Hospital, and from collaboration with adult services on the Royal site.



Though the Royal Belfast Hospital for Sick Children has the advantage of having paediatric-trained staff in all disciplines, workload pressures are evident, particularly among nursing staff, and in certain medical areas. Active programmes of continuing medical education are in place. Staff in the Department of Child Health, Queen's University, provide many aspects of clinical services, whilst the Children's Hospital staff share in the undergraduate and postgraduate medical and multi-professional education programmes within the hospital. There is an ambitious programme of multidisciplinary research; three clinical research fellows are employed within the RBHSC, and there are over 40 ongoing research projects.

The Royal Maternity Hospital is adjacent to the Royal Belfast Hospital for Sick Children, and accommodates the regional neonatal intensive care unit. The full spectrum of paediatric expertise is easily accessible when required by sick babies - paediatric specialists undertake over 500 consultations a year in the neonatal intensive care unit, with a smaller number of babies requiring transfer to the RBHSC for surgery.

Summaries of clinical activity for all children's services within the Royal Hospitals including an analysis by Board of Residence are provided in Appendix 2.

6.2 Perceptions and standards of service

In 1994, the Centre for Health and Social Research at the University of Ulster reported on a focus group study among mothers whose children had been inpatients at

the Royal. The study was commissioned by the Royal Hospitals - the first of its kind in Northern Ireland.

Mothers identified both the best and the worst aspects of services. Some commented favourably on the speed and efficiency of care, and praised the efforts of staff in providing care and information. There was criticism of some facilities and accommodation - the need for more single rooms in wards, overcrowding in the A&E department and in outpatients clinics, and limited facilities for parents staying overnight. It was acknowledged that nursing and medical staff are under considerable pressure of work, but there were cases where mothers felt that standards of care were inadequate or insensitive. The first phase of the redevelopment of the Royal Belfast Hospital for Sick Children will alleviate some of these problems (see Section 7.2), but the Trust is concerned that the pressure on staff has continued to intensify.

General practitioners responding to the 1995 Eastern Health and Social Services Board survey also acknowledged the workload pressure on staff within the Royal Belfast Hospital for Sick Children. This was linked to unsatisfactory waiting times and overcrowding in the A&E department. GPs would welcome improved communications from medical staff, following treatment. It was also felt that paediatric services should be available to young people under the age of 16 years, but that adolescents should have a choice of admission to either a paediatric or adult facility.

Informal discussions were held with a number of general practitioners and purchasing board representatives during the preparation of this strategy. There was general support for many of the principles outlined earlier in Section 4; several people commented that 'equality of access' to services should be maintained, even when a hospital is supplying services to a wide range of health care purchasing boards and GP fundholders. A number of GPs would welcome a rapid access paediatric clinic, short stay assessment facilities, and direct referral access to specialist services such as neurology and cardiology. Some general practitioners were willing to work with the Royal Hospitals in developing referral protocols. General practitioners appreciated the difficulties in providing appropriate accommodation for adolescents following admission to hospital; a separate adolescent facility in the Royal Belfast Hospital for Sick Children would be welcomed, but other issues may take priority. Services must also be sensitive to the needs of other groups of children, including those with physical or learning disabilities.

There is an active clinical audit programme within the Royal Belfast Hospital for Sick Children. In addition to regular medical ward audits (involving all members of the ward teams), and interface audits with general practitioners, other recent assessments have included:

- management of asthma in the A&E department
- an assessment of medical and surgical outpatient services
- medication prescribing
- management of children with a fracture, aged less than 15 months
- management of urinary tract infections (follow-up review)
- discharge counselling and medication
- use of radiological screening and ultrasound examinations
- theatre utilisation for emergency operations
- use of intramuscular analgesia
- use of ketamine analgesia in neonates and young infants
- recovery from anaesthesia
- management of children with acute airways obstruction
- evaluation of acute pain service

Recommendations for follow-up action have been made and progress will be kept under review.

In 1995, a 'Junior Monitor' exercise was undertaken in wards throughout the Royal Belfast Hospital for Sick Children. Junior Monitor is a recognised tool for assessing the quality of care given to children and their families in hospital. The survey identified areas of strength, and areas (such as documentation) where there was scope to improve standards. It was reassuring that physical and non-physical care was generally good, showing that nurses are prioritising care appropriately.

6.3 Efficiency and funding

6.3.1 Bed utilisation

The Royal Hospitals have used comparative hospital data held by CHKS to make performance comparisons for most specialities within the Royal Hospitals. Comparisons (at HRG level) are sometimes made to a group of provincial teaching hospitals; a separate comparison is also made between services in the Royal Belfast Hospital for Sick Children and Sheffield Children's Hospital. The Sheffield Children's Hospital comparison shows that the proportion of daycase

activity in the Royal Belfast Hospital for Sick Children is comparatively high - in consequence the average length of stay for inpatients is slightly higher.

A more detailed comparison has also been made, using small peer groups for individual specialities. This exercise has already been used to set challenging bed utilisation targets for adult services which will use the inpatient facilities in Phase 1 of the RVH Redevelopment. The following table shows potential bed savings by speciality, resulting from higher daycase ratios, and shorter turnover intervals and lengths of stay.

Potential bed savings in the Royal Belfast Hospital for Sick Children, based on 1994/5 activity

Paediatric Specialty	Available beds	Length of stay saving	Daycase ratio saving	Turnover interval saving	Net bed requirement
Trauma & Orthopaedic	11.1	-2		+0.3	9.4
Plastic surgery/burns	9.1	-1		+3.3	4.8
Surgery	28.9	-1		+4.2	23.7
Intensive Care	6.0	-1		+0.3	4.7
Cardiology	12.0	-2.8	-0.2	+3.8	6.2
Medicine (1)	43.0	-7	-0.3	+4.9	40.6
Neurology	7.6	-1		+2.9	3.7
Haematology	8.4			+0.6	9.0
Dental Surgery	0.1			+0.1	0.2
Dermatology	1.1			+0.1	1.0
Ophthalmology	0.2			+0.1	0.3
Total	**127.5**	**-15.8**	**-0.5**	**+8.6**	**102.6**

Note (1) 'Medicine' includes Nephrology and Cystic Fibrosis services.

If the Royal Belfast Hospital for Sick Children were to achieve these very high standards simultaneously in all specialities - and no children's hospital in the United Kingdom has yet done so - then a bed saving of 25 beds would result, with an 80% occupancy rate. In practice, it is difficult to achieve the turnover interval targets shown above, for two reasons:

i) clinical activity and staffing levels are reduced at weekends, and
ii) the ward configuration within the Royal Belfast Hospital for Sick Children does not facilitate flexible bed utilisation.

Though the potential reduction in bed capacity shown above are not fully

achievable in the short term, the overall target saving of 25 beds is acceptable for strategic purposes, conditional on the provision of more flexible ward accommodation. Obviously, any changes in activity patterns after 1994/5 will also affect bed requirements.

6.3.2 Benchmarking

The Royal Hospitals have initiated a benchmarking exercise with leading children's hospitals in the United Kingdom. The exercise will not simply focus on performance measures of productivity of staff, or use of facilities; it will consider wider issues of process and service standards.

6.3.3 Funding

Funding for paediatric services is obtained mainly through contracts with health care purchasers - boards and GP fundholders. Contracts with boards have been slow to respond to rising activity. The Royal Hospitals are steadily seeking to move towards contracting arrangements which reflect the full range of services, and which more fairly share the risk of unplanned and unavoidable changes in activity levels.

The Royal Hospitals have recently reviewed staffing levels and cost pressures within the Royal Belfast Hospital for Sick Children, on the basis of current activity levels. Key conclusions were:

Medical staff: Junior medical staff in post exceed current funded staffing levels - a shortfall equivalent to at least four whole time equivalent Senior House Officer posts. Given current activity levels, there is no scope to reduce the medical staff complement.

Nursing staff: A review of nurse staffing, current work practices, and standards of care was recently completed by a project team. The review confirmed that services are under-resourced, and that an increase of at least 18.2 wte nursing staff is required to sustain service levels.

Clinical professions: A shortfall in staffing across the range of clinical professions continues to inhibit the provision of comprehensive assessment, treatment and rehabilitation

services in a number of specialities the shortfall is estimated at 6.8 wte posts.

Clerical staff: A review of current staffing and workload has indicated a staffing shortfall equivalent to 9.7 wte posts.

These estimates of staff shortfalls exclude 14.5 wte posts funded from a range of charitable and private sources. The Cystic Fibrosis and the Paediatric Oncology/ Haematology services are very dependent on such sources of funds, even for core services. Funding for these posts will gradually be discontinued, beginning in 1996/7.

In order **to maintain services at current levels of activity**, and with acceptable standards of service, **additional funding** through contracts **amounting to £1.032 million will be required**. This includes £0.309 million relating to the current reliance on charitable and private funding sources.

6.4 Accommodation and facilities

The main building and much of the ward accommodation in the Royal Belfast Hospital for Sick Children was built in 1934.

Estate appraisals were carried out be the Estate Services Directorate of the DHSS in 1988 under the headings:

- functional suitability
- space utilisation
- statutory standards
- energy performance

The results of these appraisals are set out in Appendix A. If the appraisals were to be updated, it is expected that further deterioration in standards would be evident. The main building was indicated as having the most unsatisfactory accommodation - many of the facilities within that building will be reprovided in Phase 1 of the major redevelopment underway and discussed in Section 7.2. Ward accommodation is increasingly viewed as unsatisfactory:

- facilities for the families of sick children are also unsatisfactory
- the ward configuration is inflexible, making it difficult to manage changing activity patterns

- extensive structural maintenance is required, including replacement of windows, roofing/flooring repair, and rewiring.

The current configuration of the Royal Belfast Hospital for Sick Children has a number of physically isolated wards and clinical services. Phase 1 of the redevelopment will bring major improvements, but some services such as diagnostic imaging are at risk of becoming isolated in the older part of the building.

7 the strategy

7. THE STRATEGY FOR CHILDREN'S SERVICES

Children in Northern Ireland should have access to services which compare to the best in the United Kingdom. The Royal Hospitals are committed to working towards clinical excellence, recognising that this will be an ongoing dynamic process.

This strategy document has already established some key principles for providing children's services, placing them in a wider strategic context. It has identified factors which will reduce demand for acute hospital care. The current role of the Royal Hospitals in providing children's services has been analysed, based on external perceptions of services, and on internal analyses of service standards and efficiency.

7.1 Strategic themes

Four key themes have emerged from this process, all based on the premise that **services must always place the sick child and family as the central consideration.**

7.1.1 Focus on quality

A focus on quality drives all the proposals in this strategy, and it is the most challenging of objectives. It is too easy to equate "better quality" with "more resources" - more resources can bring real benefits, but there will always be constraints. The search for quality has much more to do with the use of existing resources - responding to a sick child's holistic needs, communicating sensitively and effectively, and basing decisions on sound clinical evidence.

The Royal Hospitals have a range of ongoing quality initiatives, which are pertinent to children's services - achieving full accreditation through the King's Fund Organisational Audit programme is a key corporate objective for the next year. Children services will also benefit from recent corporate decisions to strengthen the management and co-ordination of education, training and research programmes.

Targets

- *To develop a multidisciplinary programme of quality initiatives for children's services within the Royal Hospitals, addressing issues of perceived weakness identified in the Centre for Health and Social Research focus group work. The programme should include a further focus group study within two years.*

- *To prepare and introduce care pathways, multidisciplinary guidelines and standards for the management of the more common clinical conditions, based on analyses of available information on the clinical effectiveness of alternative patterns of care - with a pilot project operational within one year.*

- *To adopt a clinical audit programme oriented towards the development of clinical guidelines, monitoring variance in the use of guidelines, and assessing the clinical effectiveness of services.*

- *An effective clinical information system could facilitate the introduction and implementation of clinical guidelines, supporting clinical decision making processes. Accurate, coded and timestamped computerised data is of great value for clinical analysis and audit, and will underpin many quality initiatives. Children's services will benefit from the implementation of a wider information strategy within the Royal Hospitals, including:*

a) *on-line provision of laboratory results, from 1998, with the introduction of the new laboratory system; and*

b) *implementation of an unique patient identifier throughout the HPSS, led by the Management Executive. This is an exciting development for children services, as it offers opportunities for much more effective communications between healthcare providers, and for analyses of clinical outcomes post discharge.*

- *To establish a Clinical Skills laboratory within two years, developing practical clinical skills for paediatric services. Training courses in advanced paediatric life support are already in demand, among GPs and casualty officers throughout Northern Ireland; these courses would also make use of the skills laboratory. A postgraduate clinical tutor has been appointed, and it is the aim to extend the post graduate education programme.*

7.1.2 Comprehensive services

The Royal Belfast Hospital for Sick Children has an established role as the tertiary centre within Northern Ireland, and it is the objective of the Trust that its services should continue to develop on that basis. The British Paediatric Association acknowledge that most children's specialist services rely heavily on other tertiary services, and regard it as essential that they are located together in large children's units, with access to paediatric intensive care. The British Paediatric Association have identified a range of services as tertiary in nature. These services, and their location in Northern Ireland, are outlined in Appendix 4. In a small region such as Northern Ireland, careful planning is needed to ensure that an acceptable service is provided in the smaller specialities - the management of inborn errors of metabolism, for example.

It is proposed that tertiary services should be developed at the Royal Belfast Hospital for Sick Children, following a **'hub and spoke'** model. This will involve collaboration with GPs, community health services and secondary care services, agreeing and introducing guidelines for appropriate referral to tertiary services, and appropriate roles and responsibilities for diagnosis, treatment and care. Access to tertiary services should be improved, reducing the risk that children may be treated inappropriately in hospitals which lack the necessary facilities and staff.

This strategy document has already commented on the substandard accommodation within the Royal Belfast Hospital for Sick Children, and development work is now underway. The Department of Finance and Personnel approved the capital development plan in late 1993. Following an architectural competition, a design was finalised, allowing building work to commence in August 1995. The building is scheduled to become operational in April 1998. Phase 1 will accommodate A&E services, three outpatient suites of rooms; medical, surgical and orthopaedic services; a three theatre operating suite, and a twelve bed intensive care/high dependency unit.

The new accommodation will replace current overcrowded and substandard facilities. Great care has been taken to ensure that the design, facilities and art work will be appropriate to the needs of children. The new accommodation is an essential foundation for developing acute tertiary and secondary care services in the manner described in this strategy.

Detailed operational plans for use of the new facilities are not yet completed, but some increase in operational costs are anticipated - and justified, in view of the fourfold increase in floor space, and the correction of the current underprovision in paediatric intensive care facilities. Capital charges will also rise, by approximately £850,000 per year.

It has already been planned that a subsequent development phase will allow the transfer of children's otolaryngology and audiology outpatient services from the Royal Victoria Hospital, and provide improved accommodation for the academic department. Staff in the Royal Belfast Hospital for Sick Children have already identified the need for extended diagnostic imaging services, and for improved inpatient accommodation (including suitable adolescent facilities). Future development plans will be influenced by these various requirements, and priorities emerging from this strategy.

Targets

- *In consultation with other healthcare agencies, and based on available clinical evidence, to formulate, promote and monitor referral protocols for appropriate use of tertiary services - to be completed within two years, with regular revaluation.*

- *To clearly define multidisciplinary tertiary service teams, making this information available to other healthcare agencies, and to the families of sick children requiring tertiary care - within one year.*

- *To develop detailed plans for the clinically effective and efficient delivery of service within the new facilities which are currently under construction - within one year.*

- *Linked with a more detailed appraisal of accommodation, staffing and equipment requirements for tertiary services, to complete an outline business case for Phase 2 of the Royal Belfast Hospital for Sick Children redevelopment, within one year.*

7.1.3 Processes

Further centralisation of tertiary services on a single site would facilitate higher standards of care, but it can be difficult for parents and their children to travel long distances - particularly if a child's condition requires regular review and specialist care. There is a number of ways to minimise the impact of these problems. Collaborative care, shared with GP's and local paediatric services, can minimise the need for visits to the tertiary care centre. There are opportunities to transform outreach services; and telemedicine and telecare will also have a role. Visits to the tertiary care centre should be patient focused; co ordination of services is the key, to minimise delays, and to make each visit as effective as possible.

Many tertiary services deal with small numbers of children, making it essential that these services be based on a larger secondary care role. The Royal Hospitals already provide secondary care for many children in Belfast, but there is scope to refine and strengthen some aspects of the service. In collaboration with other hospitals, GP's and community health services, there will be benefit in reviewing roles and referral arrangements, identifying appropriate settings for care; there is already a clearly identified need for a paediatric assessment and observation service.

Effective team working is key, in streamlining these processes - for each element of care, a team member with appropriate skills needs to be available at the right time and place, with access to such equipment and backup services as may be required.

Targets

- *Introduction of a rapid access paediatric clinic within one year.*
- *Development of programmes of ambulatory and outreach care for each specialty, within one year.*
- *Reduction in the amount of emergency surgical activity undertaken out of hours - with a substantial reduction within one year.*
- *Introduction during 1997/8 of a paediatric assessment observation facility, offering a period of extended assessment, and aiming to prevent emergency admissions.*

7.1.4 Linkages

There are opportunities to link services co-ordinated from the Royal Belfast Hospital for Sick Children with those services provided in the community and at home. Many of the proposals in this strategy aim to improve these linkages, so that children and their families receive a more comprehensive and well co-ordinated service. The role of multidisciplinary teams in providing comprehensive services will be enhanced, possibly with lead workers co-ordinating team services for each individual child. A common theme in the proposals outlined in Section 7.5 is the recognition of the potential role for clinical nurse specialists and nurse practitioners. Nurse specialists can provide additional support and training to families, both in hospital and at home, and they fulfil a valuable role in linking and communicating with other hospitals and community-based services.

Targets

- *To review standards of communication with other healthcare agencies, agreeing and introducing key standards for all services - within one year. Standards should be subject to regular audit and revaluation.*

- *To develop the role of nurse specialists and practitioners within multidisciplinary teams, not only improving ambulatory and outreach services, and extending family support, but also in fostering linkages and effective communication between healthcare agencies.*

- *To develop additional consultant posts which straddle hospital and community services. The aim is to have consultant paediatric posts which share a sessional commitment between the Royal Hospitals and local community Trusts - North & West Belfast, South & East Belfast, and Down & Lisburn.*

7.2 Initial Service proposals

Implementation of this strategy will have considerable impact on individual services and specialties. All services will now need to consider how best to give practical effect to the key targets identified in this strategy. Initial proposals have been identified, but they are subject to approval of individual business cases. Outline details are available in an associated document "A Strategy for Children's Services - Outline Service Proposals".

Some common features emerge:

- Developing and strengthening tertiary services through the Royal Belfast Hospital for Sick Children, to ensure that services are comparable in standard to those available throughout the United Kingdom.

- Improving interworking with GPs and other hospitals, with appropriate liaison across the full spectrum of referral, diagnostic, treatment, and support services.

- Extending outreach and ambulatory care services.

- Extending the roles for nurse practitioners and nurse specialists.

- Many proposals have significant implications for diagnostic imaging and laboratory services, and for clinical professions.

As these proposals will be subject to individual business cases, no attempt at prioritisation is necessary at this stage. There should be no doubt, though, that the potential financial consequences are considerable. Excluding the shortfall and revenue funding referred to in Section 6.3.3, additional revenue costs at the Royal Belfast Hospital for Sick Children could exceed £1.5 million per year, partially offset by reduced costs elsewhere. Excluding the capital build consequences of Phase 1/2 of the Royal Belfast Hospital for Sick Children redevelopment, additional capital costs could exceed £3.5 million, including over £2 million for imaging equipment.

Though some additional resources are clearly needed it has been the intention that this strategy would identify opportunities for making most effective use of existing resources.

7.3 Projected future demand

Factors affecting the demand for hospital care throughout Northern Ireland were identified earlier in Section 5.2. The following table shows the projected demand for services at the Royal Hospitals, on the basis of:

- a 7% reduction in the child population in the decade up to 2004, with a proportionate reduction in the demand for healthcare.

- a transfer from elective inpatient work towards daycase work, based on the analysis outlined in Section 6.3.1 for services found in the Royal Belfast Hospital for Sick Children, and extended to include children's services elsewhere in the Royal Hospitals.

- continued growth in the number of emergency admissions, at a rate of at least 2% per year.

- exclusion of the impact of service proposals identified in Section 7.5 at this stage.

Royal Hospitals

Patients under 16 years of age

Projected demand for services 2004-5

Specialty	Finished consultant episodes 1994-5 Daycases	2004-5 Daycases	1994-5 Inpatients	2004-5 Inpatients
Cardiology, RVH	0	0	4	4
Plastic Surgery, RVH	26	24	13	13
Cardiac Surgery, RVH	0	0	120	130
Cystic Fibrosis	24	22	166	168
Dental Surgery, RVH	38	52	64	44
Dermatology, RVH	59	55	0	0
Otolaryngology, RVH	667	682	787	680
Fractures, RVH	8	7	114	128
Gynaecology, RMH	4	4	6	6
Haematology, RVH	12	11	22	22
Paediatric Intensive Care	0	0	316	361
Obstetrics, RMH	0	0	8	9
General Medicine, RVH	22	20	76	87
Metabolic Medicine, RVH	2	2	21	22
Neurology, RVH	0	0	22	22
Neurosurgery, RVH	6	13	200	209
Ophthalmology, RVH	287	441	000	410
Paediatric Plastic Surgery	197	183	304	383
Paediatric Cardiology	5	58	303	351
Paediatric Dental Surgery	1114	1036	23	25
Paediatric Dermatology	53	49	54	56
Paediatric Otolaryngology	124	115	33	35
Paediatric Trauma & Orth.	130	126	027	019
Paediatric Haematology	437	406	325	320
Paediatric Medicine/Nephrology	387	427	3209	3614
Paediatric Neurology	82	76	204	214
Paediatric Surgery	774	720	1739	1921
Rheumatology	1	1	0	0
Regional Intensive Care, RVH	0	0	14	16
Neonatal Intensive Care, RMH	2	2	425	400
General Surgery, RVH	14	13	00	110
Thoracic Surgery, RVH	0	0	9	9
Urology, RVH	1	1	0	0
Vascular Surgery, RVH	0	0	6	6
Total	**4476**	**4547**	**10347**	**10702**

Notes: Paediatric specialties are located at the Royal Belfast Hospital for Sick Children
Excludes the impact of service proposals identified in Section 7.5

8 next steps

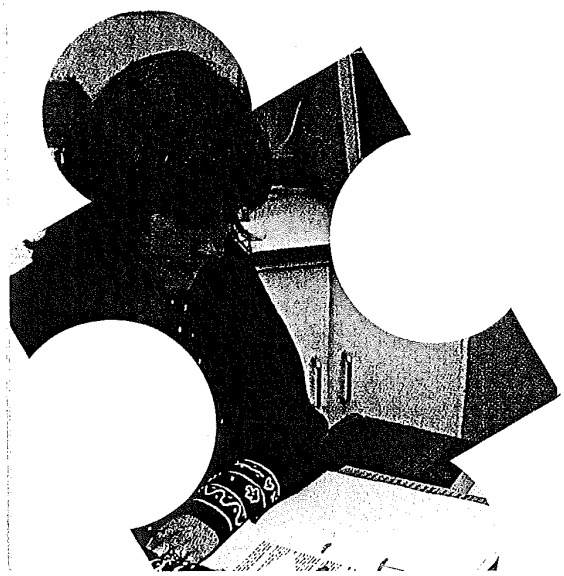
8. NEXT STEPS

The Royal Hospitals will want to collaborate closely with other healthcare agencies in progressing many of the targets and proposals outlined in this strategy.

Recognising current resource pressures, and the competitive environment implementation of the strategy will be difficult; it will require commitment and determination, and the support and co-operation of other healthcare agencies.

It will require participants to acknowledge the primacy of the child's requirements and as they strive to meet these, agreeing their priority over sectional, professional and local interests. It will require participants to ask what is best for the child, how may this be most effectively achieved, who should do it, and where is it best delivered? The challenge is to us all to be flexible and open-minded, so that, without losing what is appropriate in our present approach, we are willing to explore and develop new ways of promoting the health and treating the illnesses of the Province's children.

In its several roles, the Royal Belfast Hospital for Sick Children occupies a pivotal position in Northern Irish paediatrics, but in order to best fulfil these roles it is required to work alongside purchasers and other providers of paediatric services. There must be collaboration of all concerned in order to ensure the interlocking of regional, area, and community strategies, making best use of available resources. Project management techniques will be essential in progressing such a complex and inter-related agenda for change, but we believe that by continuing to place the child at the centre of our service we can achieve this together.



Paediatric Directorate

Service Proposals

Service Proposal	Revenue Cost Non-recurrent £	Revenue Cost Recurrent £	Capital Cost £
A&E medical and nursing staff appointments	3,000	137,200	0
Appointment of anaesthetists	6,000	186,621	0
Transfer of critically ill children	0	150,000	150,000
Intensive care data management system	0	0	250,000
Access to cardiological service	0	110,000	130,000
Child & family psychiatry - access & outreach	3,000	74,231	0
Strengthening of dentistry & oral surgery services	3,000	74,231	0
Strengthening of gastroenterology service	3,000	104,013	60,000
Strengthening of dermatology service	0	29,153	70,000
Strengthening of haematology and oncology services	3,000	74,231	20,000
Extending laboratory services	na	na	na
Extension of nephrology service	0	26,295	0
Establishment of epilepsy service	0	73,971	105,000
Transfer of neurosurgery service	0	18,932	140,000
Transfer of selected ophthalmological workload	0	20,000	50,000
Partial transfer of ENT services	0	34,400	0
Establishment of infectious diseases services	5,000	754,000	840,000
Rapid access paediatric clinic	0	42,565	0
Expansion of paediatric nurse specialist services	0	63,460	0
Paediatric assessment observation facility	0	70,000	20,000
Strengthening inborn error of metabolism services	0	48,000	0
Extension of diagnostic imaging services	3,000	262,000	2,300,000
Expansion of paediatric neurology service	3,000	97,384	0
Extension of paediatric surgical service	3,000	109,231	0
Strengthening of trauma & orthopaedic services	3,000	100,231	0
TOTAL	**35,000**	**2,660,149**	**4,135,000**

Excludes RBHSC Phase 1 and 2 development costs, with the exception of imaging equipment

BIBLIOGRAPHY

Action for Sick Children (on behalf of Caring for Children in the Health Services)	Bridging the Gaps (1993)
Action for Sick Children	Setting standards for children undergoing surgery (1994)
Audit Commission	Children First - a study of hospital services (1993)
British Association of Paediatric Surgeons	A guide for purchasers and providers of paediatric surgical services (March 1995)
British Paediatric Association	Towards a combined child health service (March 1991)
British Paediatric Association	Flexible options for paediatric care (August 1993)
British Paediatric Association	Tertiary services for children and young people; a review of the present position and future needs (September 1995)
British Paediatric Association	The care of critically ill children (December 1993)
British Paediatric Association	Future configuration of paediatric services (May 1996)
Department of Health and Social Services	Regional strategy for health and social wellbeing 1997-2002 (July 1996)
Department of Health/British Diabetic Association	St Vincent Joint Task Force for Diabetes Report (1995)
British Diabetic Association	The principles of good practice for the care of young people with diabetes (April 1996)
HMSO (Clinical Standards Advisory Group)	Standards of clinical care for people with diabetes (July 1994)
HMSO (Department of Health)	Welfare of children and young people in hospital (1991)
Royal College of Nursing	The role and qualifications of the nurse specialising in paediatric diabetes (1993)
Royal College of Pathologists	Service specification for paediatric and perinatal histopathology: Guidance for purchasers (September 1995)
Royal Hospitals	Annual Report on clinical audit (1994/95)
University of Ulster	The Royal Hospitals: A patients view of achievements and problems (February 1994)

APPENDIX 1

Patients under 16 years of age

Finished consultant episodes throughout Northern Ireland by hospital 1994/95

Specialty	RVH	RMH	RBHSC	Mater	Lagan Valley	Downe	Belfast City	Coleraine	Route	Mid Ulster	Whiteabbey	Antrim/Moyle	Musgrave Park	Belvoir Park	Armagh City	South Tyrone	Banbridge	Lurgan	Craigavon	Daisy Hill	Altnagelvin	Erne	Tyrone County	Ards	Ulster	Total
General Surgery				74	101	166	81	491	194	460	105	967			9	526	52		1153	1030	1011	415	521	63	110	7529
Urology	1			1			52												27		427				501	81
Trauma & Orthopaedic	126		959	3	154	29	89					825														3113
Otolaryngology	1449		157	68	102	74	1163		174		262	1470				553			1109	472	870	12	974		1274	10183
Ophthalmology	900				22											1					255					1178
Oral Surgery	101					11	27			98		58				85			36	27	303	3	22		34	805
Paediatric Dentistry			1142			2													105						64	1313
Neurosurgery	212																									212
Plastic Surgery	38		586																						340	964
Cardiac Surgery	120																									120
Paediatric Surgery			2530		68	181											1								1637	4416
Thoracic Surgery	9						1									1										11
Accident & Emergency							92					10							81							183
Anaest's/Intensive Care	14		317							11	43	2							3						6	396
General Medicine	97				39	35	32	79	69	2	672	57	1			41	2		65	80	131	671	696	26	82	2877
Endocrinology	23															9										32
Clinical Haematology	34		772				22												8							836
Cardiology	4		390				3				3								23	3	2				1	433
Dermatology	58		77				171	13			2	4			1	2			4						349	833
Thoracic Medicine							4												3	71	12	70				4
Infectious Diseases																										1494
Neurology			160				30								1494											210
Neurology	22																									22
Rheumatology	1		3733	5		2		558		3	1746		15	110		525	2									130
Paediatrics			257												1			2								2
Paediatric Neurology	425			7	23	43	451		18		346								1732	1249	2061	2			2364	14089
Neonatal Intensive Care												6				5										287
Obstetrics	7			3	15	3	5		11										326	175	819				5	2701
Gynaecology	9			9	9	6	13		5	6	13					10			4	1	12		12	1	9	105
Radiotherapy																			22	11	16	6	9	5	11	160
Other				56											25											25
																			1		15					72
Total	3218	432	11152	271	529	554	2233	1171	404	1256	415	4694	936	1520	10	1755	56	3	4797	3060	6012	1109	2234	100	6893	54814

Source: Regional Information Branch data
Note: Use of specialty definitions may vary between hospitals

APPENDIX 2 Patients under 16 years of age

Outpatient, daycase, inpatient and accident & emergency attendances 1994/95

Specialty	Outpatient attendances			Daycases	Elective inpatients		Non-elective inpatients		Total inpatients	
	New	Review	Total	FCEs	FCEs	Beddays	FCEs	Beddays	FCEs	Beddays
Cardiology, RVH	19	38	57	0	3	5	1	11	4	16
Plastic Surgery, RVH	39	144	183	26	10	28	3	43	13	71
Cardiac Surgery, RVH	6	3	9	0	35	98	85	255	120	353
Cystic Fibrosis	0	37	37	24	104	1093	62	531	166	1624
Dental Surgery, RVH	1359	9305	10664	38	58	99	6	12	64	111
Dermatology, RVH	314	480	794	59	0	0	0	0	0	0
Otolaryngology, RVH	1745	3283	5028	667	743	996	44	82	787	1078
Fractures, RVH	405	1363	1768	8	12	28	102	475	114	503
Gynaecology, RMH	22	33	55	4	2	3	4	3	6	6
Haematology, RVH	16	97	113	12	14	245	8	283	22	528
Paediatric Intensive Care	-	-	-	0	8	70	308	1944	316	2014
Obstetrics, RMH	8	23	31	0	0	0	8	29	8	29
General Medicine, RVH	73	148	221	22	2	10	74	156	76	166
Metabolic Medicine, RVH	49	119	168	2	10	21	11	48	21	69
Neurology, RVH	60	102	162	0	13	44	9	28	22	72
Neurosurgery, RVH	33	467	500	6	92	393	114	883	206	1276
Ophthalmology, RVH	1313	2628	3941	287	530	900	79	150	609	1050
Paediatric Plastic Surgery	509	1189	1698	197	264	995	120	793	384	1788
Paediatric Cardiology	364	1231	1595	5	165	479	218	2290	383	2769
Paediatric Dental Surgery	144	1231	1375	1114	8	15	15	9	23	24
Paediatric Dermatology	1112	1398	2510	53	28	162	26	141	54	303
Paediatric Otolaryngology	835	2522	3357	124	15	26	18	49	33	75
Paediatric Trauma & Orth.	1280	3929	5209	130	122	323	705	2913	827	3236
Paediatric Haematology	0	3373	3373	437	246	1743	79	1254	325	2997
Paediatric Medicine/Nephrology	2392	7443	9835	387	342	1533	2927	9544	3269	11077
Paediatric Neurology	71	556	627	82	95	711	109	684	204	1395
Paediatric Surgery	2150	4525	6675	774	353	1475	1386	5536	1739	7011
Rheumatology	38	68	106	1	0	0	0	0	0	0
Regional Intensive Care, RVH	-	-	-	0	0	0	14	91	14	91
Neonatal Intensive Care, RMH	530	1411	1941	2	3	3	422	6957	425	6960
General Surgery, RVH	50	63	113	14	11	48	87	327	98	375
Thoracic Surgery, RVH	15	23	38	0	5	30	4	10	9	40
Urology, RVH	9	1	10	1	0	0	0	0	0	0
Vascular Surgery, RVH	6	13	19	0	6	36	0	0	6	36
Total	**14966**	**47246**	**62212**	**4476**	**3299**	**11612**	**7048**	**35531**	**10347**	**47143**
A&E attendances:										
RVH (pts<16yrs)		3393								
RBHSC		26506								

Note: Paediatric specialties are located at the Royal Belfast Hospital for Sick Children

APPENDIX 2

Royal Hospitals

Patients under 16 years of age

Finished consultant episodes by Board of Residence, 1994/5

Specialty	Board of Residence					
	Eastern	Northern	Southern	Western	Other	Total
Cardiology, RVH	1	0	1	2	0	4
Plastic Surgery, RVH	15	12	2	9	1	39
Cardiac Surgery, RVH	57	23	19	20	1	120
Cystic Fibrosis	83	49	30	28	0	190
Dental Surgery, RVH	64	25	12	0	1	102
Dermatology, RVH	49	7	3	0	0	59
Otolaryngology, RVH	1050	244	151	7	2	1454
Fractures, RVH	69	24	24	4	1	122
Gynaecology, RMH	6	3	1	0	0	10
Haematology, RVH	16	8	5	5	0	34
Obstetrics, RMH	8	0	0	0	0	8
Paediatric Intensive Care	158	74	39	42	3	316
General Medicine, RVH	87	10	0	1	0	98
Metabolic Medicine, RVH	17	3	2	1	0	23
Neurology, RVH	10	4	2	6	0	22
Neurosurgery, RVH	73	59	29	45	6	212
Ophthalmology, RVH	410	207	257	13	9	896
Paediatric Plastic Surgery	307	132	87	54	1	581
Paediatric Cardiology	169	92	61	65	1	388
Paediatric Dental Surgery	761	259	87	22	8	1137
Paediatric Dermatology	88	15	2	1	1	107
Paediatric Otolaryngology	110	28	15	4	0	157
Paediatric Trauma & Orth.	551	227	155	20	4	957
Paediatric Haematology	274	163	201	120	4	762
Paediatric Medicine/Nephrology	2790	613	136	109	8	3656
Paediatric Neurology	154	62	39	26	5	286
Paediatric Surgery	1610	517	239	137	10	2513
Rheumatology	1	0	0	0	0	1
Regional Intensive Care, RVH	6	4	4	0	0	14
Neonatal Intensive Care, RMH	300	71	33	21	2	427
General Surgery, RVH	97	9	2	4	0	112
Thoracic Surgery, RVH	3	1	1	4	0	9
Urology, RVH	1	0	0	0	0	1
Vascular Surgery, RVH	2	0	0	4	0	6
Total	**9397**	**2945**	**1639**	**774**	**68**	**14823**

Notes: Paediatric specialties are located at the Royal Belfast Hospital for Sick Children

APPENDIX 3

Estate appraisal results

The following table summarises the results of the 1988 estate appraisal. The parts of the estate which are the focus of this option appraisal have been underlined.

The methodology for rating the estate is as follows:

A	=	ideal	1	=	empty
B	=	tolerable	2	=	underused
C	=	tolerable with minor works	3	=	adequate
D	=	tolerable with major works	4	=	overused
DX	=	impossible to remedy			

Block No.	Dept. No.	Title	Functional Suitability	Space Utilisation	Statutory Standards	Energy Performance	Physical Condition
01		Nurses changing	No longer exists				
02		Children's Hospital					
	01	Basement Plant Room	C	3	C	B	C
	02	Kitchens	C	3	C	C	B
	03	Administration	B	3	C	C	C
	04	Theatre & Intensive Care	DX	4	D	D	C
	05	X-Ray	B	3	C	C	C
	06	Outpatients	DX	4	C	C	C
	07	Child Psychiatry	B	3	C	C	B
	08	Nurses Residences	B	2	C	C	C
	09	Speech Therapy	B	3	C	C	B
	10	Doctors Residences	B	3	C	C	B
	11	X-Ray Plant Room	C	3	C	B	B
	12	Intensive Care Plant Room	D	4	D	D	B
	13	Theatres Plant Room	D	4	D	D	B
03		Sir Malcolm Sargent House	B	3	C	C	B
04	01	Barbour Wards	C	3	B	CX	C
	02	Paul & Musgrave Wards	Under Reconstruction				
	03	Day Ward	A	3	A	A	-
	04	Laboratory	D	4	D	CX	C
05	01	Knox Ward	B	2	C	D	C
	02	Allen Ward	B	3	C	D	C
	03	Clarke Clinic	C	2	C	D	C
	04	Haematology Unit	A	3	B	B	-
06	01	Audiology Department	D	4	C	C	C
	02	Child Health	B	2	C	C	C
07	01	Laundry, Porters & Domestics	D	3	C	C	C

APPENDIX 4 - TERTIARY PAEDIATRIC SERVICES

Paediatric Service	Location in Northern Ireland
Cardiology	Royal Belfast Hospital for Sick Children
Cardiac Surgery	Royal Victoria Hospital
Endocrinology/Metabolic Disease	Within Paediatric Medicine, RBHSC
Gastroenterology	Within Paediatric Medicine, RBHSC
Clinical Genetics	Belfast City Hospital
Haematology/Oncology	Royal Belfast Hospital for Sick Children
	Royal Victoria Hospital
Immunology	Royal Belfast Hospital for Sick Children
	Royal Victoria Hospital
Infectious Diseases	Belvoir Park Hospital
Neonatal Intensive Care	Royal Maternity Hospital
Nephrology	Royal Belfast Hospital for Sick Children
	Belfast City Hospital
Urology	Within Paediatric Medicine, RBHSC
Neurology	Royal Belfast Hospital for Sick Children
Intensive Care/Anaesthetics	Royal Belfast Hospital for Sick Children
Pathology	Royal Victoria Hospital
Paediatric Surgery	Royal Belfast Hospital for Sick Children
	Ulster Hospital
Plastic Surgery and Burns	Royal Belfast Hospital for Sick Children
	Ulster Hospital
Radiology	Royal Belfast Hospital for Sick Children
Respiratory Medicine	Cystic Fibrosis at RBHSC
Rheumatology	Musgrave Park Hospital
Specialist Care for Disabled	Forster Green
Child and Adolescent Psychiartry	Forster Green

Notes:

1) Refer to British Paediatric Association; Tertiary Services for Children and Young People - A review of the present position and future needs

2) The British Paediatric Assoication consider that services such as orthopaedics, otolaryngology, ophthalmology and paediatric medicine should be available at a tertiary care centre; but some of these services may also be provided in secondary care hospitals, if appropriate standards can be met.

APPENDIX 5 - DEVELOPMENT OF THE CHILDREN'S STRATEGY

Strategy working group members

Mr Evan Bates, Director of Development, Information Services and Patient Records
Mr Victor Boston, Paediatric Surgeon
Sr Mavis Brush, Acting Nurse Manager RBHSC
Dr Denis Carson, Paediatrician
Mr Gordon Clarke, Directorate Manager
Dr Peter Crean, Paediatric Anaesthetist
Mrs Patricia Donnelly, Clinical Professions Director
Dr Elaine Hicks, Paediatric Neurologist
Dr Connor Mulholland, Clinical Director (Chairman)
Dr Michael Shields, Paediatrician

This multidisciplinary group met on several occasions and drew up a series of principles which underpin the strategy. These were discussed widely within the Royal Hospitals, and also with selected primary and secondary care doctors, community paediatricians and public health doctors.

Subsequently a strategic plan was built up on these principles and extensive detailed discussions were carried out with representatives of all specialities which have a role in paediatric services. A final draft document was then widely circulated in the province to hospital and community paediatricians, general practitioner groups, voluntary bodies and public health consultants. Their comments were for the most part incorporated in the final version. We are indebted to them for their participation.