Summary of the intervention at Birmingham Children’s Hospital NHS Foundation Trust

March 2009
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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission’s role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- Be independent, fair and open in our decision-making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission’s work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.
Introduction

On 9 November 2008, the Observer newspaper published a report raising concerns about the quality of services provided by Birmingham Children’s Hospital NHS Foundation Trust (‘the trust’). This report was obtained from the University Hospital Birmingham NHS Foundation Trust (UHB) as a result of a request under the Freedom of Information Act 2000.

The report, entitled ‘Paediatric Tertiary Services Commissioner Review’ was written by staff at UHB, and followed a series of meetings in September and October 2008 between UHB and the trust. The meetings involved management and consultant staff from the trust and UHB, and were to discuss the concerns that UHB and some of the trust’s clinicians had about the quality and safety of paediatric tertiary care services provided by the trust.

The report was not shared or agreed with the staff involved in the meetings, nor was it seen by the trust before it was released to the media. In fact, no final agreement was reached with regards to the record of the meetings between UHB and the trust. The trust had, however, seen an analysis of issues to be addressed following the meetings, received from South Birmingham Primary Care Trust (PCT) and, in response to the concerns, it had provided an action plan to the trust’s commissioners. It had been the understanding of UHB that South Birmingham PCT would circulate UHB’s report to the trust. However, only the analysis written by South Birmingham PCT was distributed and accepted.

The UHB report and the analysis of issues by South Birmingham PCT highlighted concerns about the quality and safety of paediatric tertiary care (that is, specialist healthcare) services provided by the trust in the specialty areas of renal transplants, liver transplants, craniofacial surgery, neurosurgery and interventional radiology.

The Secretary of State for Health subsequently asked the Healthcare Commission to make preliminary enquiries into the concerns that had been expressed in the UHB report about paediatric tertiary care services provided by the trust. On 12 November 2008, we wrote to the trust informing it that we would be considering the following:

- Concerns about poor clinical governance arrangements, including lack of incident reporting and learning.
- Allegations about a lack of capacity affecting treatment for patients, due to insufficient planning of services that included bed-capacity, access to theatres and lack of interventional radiology.
- Claims of a lack of (clinical) leadership at medical and nursing levels.
- Concerns about a lack of action taken by key senior professionals in raising and addressing concerns.
• Allegations about a lack of appropriate arrangements for staffing in terms of:
  o Appropriately trained theatre staff
  o Arrangements for out-of-hours cover
  o The level of support for surgical services by consultants and junior doctors.

• Concerns about a lack, between the trust and UHB, of commonly agreed protocols, policies, procedures, pathways of admission and criteria for selecting patients for services.

• Allegations about a lack of adequate equipment, including equipment for carrying out procedures such as interventional radiology.

We also received a letter on 10 November 2008 from NHS West Midlands, which included concerns in relation to:

• The effectiveness of cross-organisational governance and partnership working between the trust and UHB.

• The responsiveness of all relevant organisations and commissioners, once they became aware of the issues.

These concerns were included in our considerations.

Investigating serious failings in healthcare

The Healthcare Commission is empowered by section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003 to conduct investigations into the provision of healthcare by, or for, an English NHS body. As part of this function we undertake ‘interventions’ when this is considered to be the most proportionate and practical means of identifying the need for, and bringing about, sustainable improvements in the service concerned.

We aim to help organisations to improve the quality of care that they provide, to build or restore public confidence in healthcare services, and to ensure that the care provided to patients is safe throughout the NHS.

Our approach

As the trust had already begun to develop an action plan to address the concerns, in coordination with the bodies responsible for commissioning services from the trust, we considered that an intervention was the most effective way of determining the quality and safety of paediatric tertiary care services provided by the trust, and determining whether these concerns had been properly addressed.

Our remit was to determine what concerns there were about the paediatric tertiary care services provided by the trust, the extent to which they impacted on
the safety of the trust’s services, and the way the trust and other stakeholders had responded to these concerns once they had been made aware of them.

Our focus was, therefore, to identify:

- Concerns about the safety of patients in relation to the trust’s paediatric tertiary care services.
- What action the trust had taken in response to the concerns raised.
- What action the commissioners of the children’s services had taken in response to the concerns.

As part of this process, we called for documents from the trust, UHB and other stakeholders for review, conducted a two-day visit to the trust and interviewed clinicians from a number of specialties.

We carried out a further visit in February 2009 in response to more recent clinical concerns that came to our attention since our previous visit to the trust. We also spoke to other clinicians from the trust and UHB who contacted us to express their views or highlight their concerns regarding paediatric services at the trust. Overall, we interviewed more than 35 staff. We carried out a further visit to interview the commissioners involved.

Our investigation team included a medical director from a trust responsible for providing tertiary paediatric services and a paediatric neurosurgeon, both of whom provided advice and guidance throughout.

As a result of the findings, we have made 12 specific recommendations. They are addressed primarily to the trust but they also refer to the role of other bodies. The recommendations and the rationale leading to them are set out below.
Background

Birmingham Children’s Hospital NHS Foundation Trust is a specialist children’s hospital providing a wide range of general and specialist health services to children and adolescents within the West Midlands and nationally. It became an NHS foundation trust on 1 February 2007. There are three other specialist children’s hospitals in England.

The trust’s services include liver transplants and specialist paediatric liver diseases, renal transplants, neurosurgery, craniofacial surgery, cardiac surgery, neonatal surgery and small bowel transplants. It operates nine theatres and has 189 paediatric inpatient beds and a large paediatric intensive care unit of 20 beds. There are approximately 2,600 staff at the trust, of whom 150 are consultants.

During 2007/08, more than 140,000 children used the trust’s services. Of these, 45,000 children attended the emergency department. The trust’s turnover for 2007/08 was £165 million, and it ended the financial year 2007/08 with a surplus of £2.4 million.

The Heart of Birmingham Teaching Primary Care Trust (PCT) is the lead commissioner for the trust for general paediatric services on behalf of other PCTs in the area, mainly South Birmingham PCT and Birmingham East and North PCT.

The West Midlands Specialised Commissioning Team, hosted by Birmingham East and North PCT, commissions and monitors the provision of a number of specialist services. The contract it holds with the trust covers a range of acute specialist services totalling £61 million. These include renal transplants and paediatric neurosurgery. In addition, the National Specialised Commissioning Group currently commissions eight specialised services from the trust, totalling £12.7 million. These include craniofacial services and paediatric liver transplants.

The trust works with University Hospital Birmingham NHS Foundation Trust (UHB) to provide certain specialised services, including interventional radiology, liver transplants, renal transplants, neurosurgery and craniofacial surgery. Service level agreements detail the responsibilities and requirements for these services. In order to provide specialised services, the trust requires consultants from UHB to undertake surgical work at the children’s hospital. The benefit to the trust and patients is that UHB consultants undertake this specialist work on adults as well as children, and are therefore very experienced in undertaking these procedures.

In the Healthcare Commission’s 2008 annual health check, the trust was scored “fair” for quality of services (down from “excellent” in 2007) and “excellent” for use of resources. The trust declared itself fully compliant with all core
standards, “good” for new national targets, and having “partly met” existing national targets (where it “underachieved” for “cancelled operations and those not admitted within 28 days”). The trust achieved a score of “good” on new national targets for 2007/08.

The role of the commissioning bodies

Heart of Birmingham Teaching PCT
Heart of Birmingham Teaching PCT is responsible for commissioning and providing primary and community health services for people who live in the centre of Birmingham. In addition, it is the lead commissioner for the trust in relation to general paediatric services for the residents of Birmingham. This means that Heart of Birmingham manages the contract with the trust to provide general paediatric services with the trust on behalf of the other 17 West Midlands PCTs. As such, it monitors the contract with the trust through monthly meetings of a review group. Members of this group, which is chaired by Heart of Birmingham, include the trust, associates from the 17 PCTs, and a representative from the Commissioning Business Support Agency, which provides data on key performance indicators.

Prior to July 2008, when it was first informed about the issues raised by UHB consultants, Heart of Birmingham did not have any concerns regarding the safety of patients and the provision of paediatric tertiary services provided by the trust. It held regular contract monitoring and clinical governance meetings with the trust, so that concerns of this nature could be raised and addressed.

South Birmingham PCT
South Birmingham PCT is responsible for commissioning and providing health services for the people who live in the four parliamentary constituencies of Edgbaston, Selly Oak, Hall Green and Northfield. It is also the coordinating commissioner for services provided by UHB.

It became aware of the concerns about the trust in June 2008 through meetings with the chief executive of UHB.

West Midlands Specialised Commissioning Team
West Midlands has longstanding arrangements in place to support the collaborative commissioning of specialised services for the 5.5 million people who live in the region. The team was most recently reconfigured in April 2007 in response to the Carter Review of specialised services, which introduced more consistent collaborative arrangements across the country.

The West Midlands Specialised Commissioning Team (WMSCT) acts, on behalf of the 17 PCTs in the West Midlands, in the commissioning of a range of specialist and non-specialist services at a regional level. The team is hosted by Birmingham East and North PCT. It supports five local collaborative commissioning boards and is supported by a dedicated team of commissioning staff.
Prior to July 2008, when WMSCT was first informed about the concerns raised by UHB clinicians described in this report, WMSCT was not aware of the concerns, nor did it have concerns regarding the provision of paediatric neurosurgery or renal transplant services at the trust, either through its regular monitoring activities or through its networks.

As regards renal transplants, outcomes for patients are routinely monitored by NHS Blood and Transplant. This monitors the performance of individual centres over time and compares the performance of centres against each other. Its routine monitoring of outcomes of renal transplants has not shown any recent cause for concern in relation to short-term outcomes for paediatric patients transplanted in Birmingham. More up-to-date analyses have been carried out in response to the concerns raised about the trust. These again showed no statistical evidence of any difference in short-term outcomes comparing Birmingham with the rest of the UK, and no evidence of any change in performance in paediatric renal transplant results in Birmingham over the last 3½ years.

National Specialised Commissioning Team
The National Specialised Commissioning Team (NSCT) was established to commission services on a national basis for a specific group of extremely rare conditions or very unusual treatments. It works on behalf of the National Specialised Commissioning Group of PCT chief executives. The West Midlands member is the chief executive of Birmingham East and North PCT. Most services commissioned by the NSCT relate to a condition where the national caseload is less than 400 people. The total annual budget is £388.3 million. At present, the NSCT commissions eight services from the trust totalling £12.7 million: craniofacial; paediatric liver transplant; specialist paediatric liver disease; small bowel transplant; retinoblastoma; alstrom; epidermolysis bullosa; and lysosomal storage disorders.

Prior to September 2008, when the NSCT was informed about the issues raised by UHB clinicians, the NSCT did not have any specific concerns regarding the outcomes of tertiary paediatric services at the trust. Outcomes for patients following transplants are routinely monitored by NHS Blood and Transplant. This had not shown any recent cause for concern in short-term outcomes for paediatric liver patients transplanted in Birmingham. More up-to-date analyses have been carried out in response to the concerns raised about the trust. These again showed no statistical evidence of any difference in short-term outcomes comparing Birmingham with the rest of the UK, and no evidence of any change in performance in paediatric liver transplant results in Birmingham over the last 3½ years.

1 Results for kidney transplants are for all patients aged under 18 years and may include some adolescents receiving transplants at the adult unit. Paediatric liver patients are those aged under 17 years at the time of transplant.
2 Paediatric liver patients are those aged under 17 years at the time of transplant.
The role of other external bodies

NHS West Midlands
NHS West Midlands is one of 10 strategic health authorities that came into existence in July 2006. It is responsible, on behalf of the Department of Health, for the strategic development of NHS organisations (excluding foundation trusts) within the West Midlands region. Whereas NHS West Midlands has a role in managing the performance of NHS trusts, it does not have a role in managing the performance of NHS foundation trusts. Prior to June 2008, when it was first made aware of the concerns raised by UHB clinicians, it did not have any specific concerns about the paediatric tertiary services provided by the trust.

Monitor
Monitor was established in January 2004. Its role is to authorise and regulate NHS foundation trusts, making sure they are well-managed and financially strong so that they can deliver excellent healthcare for patients.

Monitor receives and considers applications from NHS trusts seeking foundation status. If satisfied that certain criteria are met, Monitor authorises them to operate as foundation trusts and it then monitors their activities to ensure that they comply with their terms of authorisation. Monitor has powers to intervene in the running of a foundation trust in the event of failings in its healthcare standards or other aspects of its activities, which amount to a significant breach in the terms of its authorisation.

Monitor was first made aware of the concerns raised by UHB clinicians in November 2008, just before the report was published in the media. Prior to this, it did not have any specific concerns about the paediatric tertiary services provided by the trust.

Key events leading up to the release of the UHB report to the media

On 6 June 2008, the chief executive officers and medical directors of the trust and of UHB met to discuss broad concerns that UHB had in relation to the provision of specialist paediatric services at the trust. At the same time, UHB mentioned this meeting during a regular meeting with South Birmingham PCT, its lead commissioner.

The trust wrote a formal response to UHB, asking for evidence of the concerns, and it also wrote to and met the speciality heads concerned to discuss the issues raised.

On 9 July 2008, NHS West Midlands spoke to South Birmingham PCT about concerns that UHB had also raised with NHS West Midlands. South Birmingham PCT informed Heart of Birmingham Teaching PCT and West
Midlands Specialised Commissioning Team, and it was agreed to hold a joint meeting with the two trusts.

This meeting was held on 21 August 2008 between the trust, UHB and the commissioners (Heart of Birmingham Teaching PCT, South Birmingham PCT and West Midlands Specialised Commissioning Team). There it was agreed that the trust and UHB would meet with each of the relevant specialist groups and confirm whether there were any unresolved issues that commissioners needed to be aware of. The trust and UHB were also required to write back to West Midlands Specialised Commissioning Team within four weeks. It was also agreed to undertake a long-term planning exercise across all commissioning bodies to scope the emerging demand, trends and sustainability of children’s specialised services.

Between September and October 2008, a series of meetings were held between management and consultant staff at UHB and the trust, to discuss concerns that UHB consultants had regarding the trust’s services. Following these, UHB wrote a report and sent it to South Birmingham PCT on 14 October 2008. The report was not shared or agreed with the staff involved in the meetings, despite requests from the trust. It was the understanding of UHB that South Birmingham PCT would circulate the report to the trust.

South Birmingham PCT discussed the report with Heart of Birmingham Teaching PCT and agreed that it was not suitable for wider circulation, but that instead it should be used as the basis for an analysis document to describe the concerns. South Birmingham PCT circulated its analysis of the issues from the UHB report to be addressed to the commissioners and NHS West Midlands. On 16 October 2008, it was discussed at a meeting with the commissioners. On the same day, Heart of Birmingham Teaching PCT despatched the analysis document to the trust.

The trust subsequently agreed South Birmingham PCT’s analysis and prepared an action plan in response, which it sent to the commissioners.

On 5 November 2008, UHB received a request from the Observer under the Freedom of Information Act 2000, asking for information relating to the performance, safety, staffing, quality and cancelled operations at the trust, and any report relating to such issues.

On 7 November 2008, in response to the Freedom of Information request, UHB released a copy of their report to the Observer newspaper. UHB felt that it was important to respond to the media request quickly, as it perceived a danger that the story would otherwise run for a longer time if the information came out in stages.

UHB informed the trust about the Freedom of Information request and provided the trust with a copy of the UHB report after it had been released to the Observer. UHB told the Healthcare Commission that they were unaware until this point that the trust had not received a copy of their report. Other
organisations who had also received a similar FOI request, including South Birmingham PCT and West Midlands Specialised Commissioning Team, subsequently released information to the Observer.

On 9 November 2008, the Observer published the report, along with an article raising concerns about the quality of services provided by the trust. Heart of Birmingham Teaching PCT, the West Midlands Specialist Commissioning Group and most of the staff at the trust had not seen the UHB report before this time.

On 10 November 2008, NHS West Midlands raised concerns with the Healthcare Commission regarding cross-organisational governance and partnership working between the trust and UHB. A teleconference of commissioners established that the focus of concerns lay with a limited range of specialist contracts. As lead chief executive for specialised services, the chief executive of Birmingham East and North PCT convened a group, called “The Tertiary Paediatric Clinical Performance Review Group”, of all three levels of commissioning to provide a focus for the development and monitoring of the action plan for the trust.

We wrote to the trust on 12 November 2008, stating that we were making preliminary enquiries into the concerns raised regarding the paediatric tertiary services. On 1 December 2008, the Secretary of State for Health formally wrote to us, asking us to make preliminary enquiries into the concerns that had been expressed about paediatric tertiary care services at the trust in the media and the UHB report. Monitor supported the decision to conduct the review.
Our findings

We have reviewed the concerns raised in the UHB report that was released to the media, and listened to concerns from staff at both the trust and UHB. We have also considered concerns from other stakeholders, including NHS West Midlands.

Here, we set out our findings in relation to each of the areas of concern.

Capacity to deliver paediatric services

The trust has seen an increase in the demand for its services. In the first six months of 2008, the trust admitted over 2,000 more patients than in the same period in 2007. In addition, it received more than 10,000 additional outpatient attendances over the same period. In recent years, there has been a steady increase in referrals to the trust from district general hospitals, across many surgical specialties.

This increase in general surgical workload has put pressure on the entire system in terms of theatre space, wards, beds and admissions. In April 2008, the average bed occupancy at the trust was 98.17% and, for 15 days in that month, bed occupancy was 99% or higher. On a strategic level, the trust is faced with a continuous challenge in finding the right balance between the demands of the expanding secondary care services and the demands of the tertiary services. Some staff expressed a lack of confidence in managers at the trust to assess and meet the demand for both areas of work.

Access to beds

Many of the staff that we interviewed raised concerns about difficulties in admitting patients needing emergency and urgent care due to the unavailability of beds. The lack of access to beds has led to delays in admission, and patients having to be transferred to other hospitals further away from their home. It is noted that no evidence of harm was found as a result of delays or due to hospital transfers.

At the trust's joint operational meeting in October 2008, the trust reported that approximately 70 children a month had to be transferred or redirected to other hospitals for treatment. It was also reported that there had been a rise in the proportion of cancelled admissions due to no bed being available on the wards, from 19.4% of breaches on the day in 2007/08 to 28.4% in 2008/09.

The difficulties in admitting patients can be a special concern for those patients for whom it is particularly important to start treatment urgently, such as liver patients. According to figures from the National Specialised Commissioning Team, there has been an increase in the number of overall referrals of liver patients to the trust, as well as an increase in the complexity of the caseload.
and the number of bed-days (that is, the total number of days patients occupy a bed at the trust). If a bed cannot be made available for these patients, and the patient cannot, therefore, be admitted to the trust, there are only three other trusts nationally to which these patients can be referred. It is noted that the trust has started to review the concerns about the physical capacity to treat, and the ability to admit, liver patients, given the growing demand for services. It is considering various options to address these issues. These include exploring the creation of three additional beds within the new liver unit that the trust is building.

We interviewed staff within various levels of management to see how the trust manages its bed capacity. The majority of managers and clinicians we spoke to thought mainly about increases in capacity in terms of “more beds and theatres”, instead of thinking how to use the existing capacity more efficiently.

The scope to release extra beds by working more efficiently was highlighted in a review of the trust’s capacity by consultancy firm KPMG. The review was commissioned by the trust. It looked at, among other things, bed occupancy, length of stay and use of theatres. The final report was received in March 2008 and concluded that, although the trust was performing adequately overall, “potential spare capacity has been identified in beds, theatres and outpatients if the trust is able to streamline processes, introduce new ways of working and effectively redesign services”. In addition, “benchmarking length of stay indicates there is an opportunity to release bed capacity” of 45 to 85 beds a year.

The trust is in the process of taking forward the report’s findings in relation to streamlining processes and becoming more efficient in order to increase bed capacity. For example, the trust has employed a lead for service transformation and has set up nine workstreams within the ‘capacity to care’ programme. One of these is about optimising stay, and addresses bed management and flow, as well as looking at transferring trust services into community settings.

Some staff told us that not all consultants were fully aware of, or complied with, the trust’s policies in relation to admissions and bed management.

Although the trust has a system for monitoring the time from receipt of a referral to admission into hospital, it does not routinely monitor information on how many referrals to the trust’s specialties cannot be accepted and are therefore referred to other hospitals.

The trust is looking to improve the care of patients with very complex conditions who need a long stay in hospital. These patients require a care team that can support and manage them at home before they are discharged. The trust has recognised that discharges were not uniformly regulated and there was a need to improve interaction with care agencies. The policy for discharging patients

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3 KPMG, Birmingham Children’s Hospital NHS Foundation Trust: ‘Discovery Phase’ Final Report, 19 March 2008
has now been revised. It requires patients with complex care needs to be identified so that the relevant external care agencies are contacted in advance to ensure the patient can be discharged on time.

The trust has been looking into developing a network service with other hospitals around Birmingham, to allow these hospitals to take more of the general secondary care paediatric work that currently takes place within the trust.

The trust is also working with commissioners to understand how demand for paediatric tertiary services will shape its services in the future. In addition, the 17 PCTs in the West Midlands and NHS West Midlands are undertaking a review, to look at demand and capacity for general, community services alongside specialist paediatric services within the West Midlands.

**Recommendation 1**
The trust, with relevant commissioners, needs to ensure that it actively monitors the demand and capacity for children’s services, including information about those patients it has not been able to admit.

**Recommendation 2**
The trust needs to review its strategies and policies to improve its management of admissions and beds, and ensure that staff throughout the trust keep to these. It also needs to work with its consultants to ensure that patients needing urgent care are admitted in a timely manner.

**Recommendation 3**
The trust and commissioners of paediatric tertiary services must continue to work actively to manage the demand and provision of paediatric services at the trust.

**Access to theatres**
Many of the staff that we interviewed raised concerns about increasing difficulties in access to theatres. Most of the staff we interviewed said that this, alongside a lack of access to beds, had led to delays in treatment and patients having to be transferred to other hospitals further away from their home.

Some of the consultants we spoke to said that access to theatres can be a particular problem for cases that are urgent, but not life-threatening. One example of this is neurosurgery, which has two operating sessions on a Monday and two sessions on a Wednesday. This means that, if an urgent neurosurgical case is referred to the trust after Wednesday, the patient can only be treated the following Monday unless they are put on the emergency list within theatres. The trust runs an all-day trauma and emergency list every weekday – trauma surgery is a planned list in the morning and the emergency theatre list starts after 1.30pm.
Staff told us that it is often very challenging to be able to fit in urgent but non-life threatening cases into the emergency list. This has resulted in patients needing to be transferred to other hospitals or experiencing delays in treatment. It is noted that staff identified cases that were regarded as ‘near misses’ and concerns were raised very strongly that the situation represented a risk to patients and had the potential to lead to an adverse incident. The access to theatre for emergency surgery was not seen or raised as a concern by staff.

The review into capacity at the trust, conducted by KPMG, reported that efficiencies in theatre capacity could be achieved by:

- Three theatre sessions a day, to increase capacity and allow some additional emergency surgery to be carried out.
- Improved use of day surgery by improving scheduling, a move to dedicated day theatres and development of a day surgery ward and assessment area.

**Recommendation 4**
The trust needs to review the way it organises capacity and prioritises cases within theatres, to ensure that patients requiring urgent and emergency surgery gain access to theatres in a timely manner.

**Access to interventional radiology**

**Interventional radiology**
Interventional radiology is a form of radiology in which minimally invasive procedures are performed using ‘image guidance’. Some of these procedures are carried out for purely diagnostic purposes; others as part of treatment.

Almost all of the consultants we interviewed, who used interventional radiology within their specialty, raised concerns about the lack of access to interventional radiology. They were concerned that this resulted in poor care for patients, because of:

- Delays in treatment and/or transfers to other hospitals.
- The performance of ‘open’ procedures (that is, where underlying tissue is exposed) when interventional radiology would have been more appropriate.

Currently, interventional radiology is provided within one angiography suite, on a planned basis every Monday morning. Despite an increase in demand over several years, the number of theatre sessions available for interventional radiology has not increased and is therefore not sufficient to meet the demand for the service.

Also, staff from both the trust and UHB expressed concerns that the theatre list for interventional radiology was poorly organised. As a result, the time available
on Monday was not used efficiently. Examples we were given included incorrect information being given to staff, doctors and theatre, and delays in obtaining consent from patients. The lack of access to interventional radiology has resulted in long waiting lists for several specialties; all of the elective Monday morning sessions have been fully booked until June 2009.

Consultants were particularly concerned about the lack of access to interventional radiology for those cases where it was required urgently. This, too, has led to patients being transferred to other hospitals for this treatment. In addition, patients who needed relatively simple procedures had to wait for several days, for example patients needing the insertion of an abdominal drain.

Modern liver transplant and hepatobiliary practice allows for certain procedures and assessments to be done through interventional radiology, thereby avoiding unnecessary open procedures. Some staff raised concerns that a lack of access to interventional radiology slots could have resulted in some cases where the trust was conducting open procedures on patients, where other procedures would have been preferable.

One might reasonably expect that a large paediatric specialist hospital should have a sufficient level of access to interventional radiology so as to ensure that, where interventional radiology is considered to be appropriate and preferable to open procedures, patients are treated without delays.

The trust’s documents show the demand for interventional radiology has increased since 2002/03, from 803 procedures a year to 1,186 procedures so far in 2008/09.

The trust has recognised the above concerns, and has begun to address them. Actions include:

- Revising the service level agreement to increase UHB consultant input and facilitate a daily service for interventional radiology.
- Revising the booking process so it is led by the imaging department, as it is for MRI and CT scans, and is transparent to all.
- Commissioning an interventional radiology suite in the imaging department, with an anaesthetic room and theatre standard air conditioning. This is planned to be in service by the beginning of March 2009.
- Developing a second suite within imaging by the spring of 2009, in order to increase capacity.
- Developing a third suite (which can also be used for cardiac catheterisations) within theatres by late 2009 or early 2010.

Further concerns were received in February 2009 about access to interventional radiology following an incident during a kidney transplant. The incident raised serious concerns regarding the safety of the patient due to lack of information regarding the patient being available before surgery and difficulty in gaining access to interventional radiology out of hours from the scheduled Monday
sessions. Once the concerns had been raised, immediate action was taken by the trust and UHB to put in place support to provide a safe service. This included an emergency rota with regards to access to interventional radiology, considering the option to transfer patients to UHB for treatment and developing expertise at the trust to carry out procedures. The trust is also investigating the incident to identify any further action required.

The West Midlands Strategic Commissioning Team is liaising with the Department of Health and the Academy of Royal Colleges to determine the possibility of a national review of paediatric interventional radiology to determine the standards that should apply to staffing, training, equipment that trusts should adhere to.

**Recommendation 5**
The trust needs to urgently agree a clear plan to ensure that it has the capacity and systems in place to provide sufficient and timely access to elective and emergency/out-of-hours interventional radiology.

**Theatre staff**

The UHB report that was released to the media highlighted a concern about a lack of knowledge among theatre staff of specific procedures and equipment. These concerns were initially raised with the trust on 25 January 2008 by a renal transplant surgeon from UHB, in connection with staff assisting the consultant in performing transplant operations. Renal transplant surgeons from UHB felt that they were not given the level of support in theatres that they should have been.

It took until July 2008 for the trust to complete a root cause analysis to establish the areas that needed to be addressed. This analysis highlighted the challenge in ensuring that staff at the trust could gain the required level of experience and competence, due to the low number of cases performed at the trust (around eight to 12 paediatric renal transplants are performed each year at the trust, compared with around 145 adult cases each year at UHB). This lack of knowledge had resulted in incidents where staff required prompting and were not familiar with vascular instruments, names of instruments and the set-up procedure required.

As a result, the trust has asked the renal transplant surgeons to review the content sheets of the theatre instrument trays, to confirm the instruments required for each procedure and to document the transplant processes, so that this can be communicated to staff through training.

Furthermore, two members of the trust’s theatre staff have attended renal transplant operations at UHB to observe and update their existing skills. In addition, in the short term, UHB surgeons have taken members of their own
theatre team to the trust to assist in the elective renal transplants. As such, renal transplant surgeons felt that things had significantly improved as far as elective cases were concerned. However, some concerns still remain around non-elective transplants, which are less planned.

Further concerns were received in February 2009 regarding the level of support in theatres for neurosurgery. We became aware of several incidents where a lack of appropriately trained theatre nurses for neurosurgery had led to serious concerns about the safety of patients. In these incidents, neurosurgery was performed in complex cases without trained neurosurgical theatre nurses. This led to difficulties in setting up the equipment required for surgery, the surgeon being handed incorrect instruments during surgery and the unintentional jogging of the surgeon’s hands, which potentially could have caused serious harm to the patient undergoing surgery. Concerns were also raised regarding a lost pathology specimen.

The trust has responded to these concerns and is currently investigating the incidents raised to identify any action required. It is noted that some of the incidents raised recently related to cases in November 2008 and were not reported to the trust at that time. The trust is taking further steps to ensure that correct support is given to surgeons operating at the trust; this has included recruiting an agency neurosurgical theatre nurse.

The consultants that we interviewed all pointed out that the existing theatre staff were hard working and competent in their field of work, but were concerned that appropriately trained staff were not always available for these highly specialist clinical areas.

**Recommendation 6**
The trust must urgently ensure that it provides, for all renal transplants and neurosurgery, an appropriate and sustainable level of support within theatres at all times. This needs to be informed by discussions with the surgeons involved about the standards of support required from theatre staff.

**Equipment**

Some of the staff that we interviewed raised concerns about poor availability of equipment at the trust for undertaking interventional radiology and renal transplant procedures.

A key issue highlighted in the UHB report that was released to the media related to the trust not keeping in stock equipment needed for interventional radiology. An example quoted was that no drainage catheter was available when required. As a result, some UHB consultants take their own equipment whenever they have to perform these operations at the trust.
The trust told us that it is necessary for UHB consultants to provide necessary equipment, for example in interventional radiology, due to the unavailability of applicable equipment from manufacturers. For disposable single use equipment, the risk of infection on transfer is very small, since the equipment is packed and sterile. However, some of the consultants said that they were concerned that problems could arise if, for example, unexpected complications occurred for which the consultants did not have the required equipment with them. The concerns raised in relation to renal transplants were about the correct equipment not always being provided on the theatre trays.

We also came across examples in neurosurgery. For example, we were informed about an incident where a specific drill, needed for an urgent procedure, was not functioning and a replacement was not readily available. In this incident, a replacement was found at the trust; the outcome was a delay in the procedure and no harm was caused to the patient. The above incidents are being investigated by the trust to identify any necessary action required by the trust.

The trust has worked with UHB consultants to agree which items it should keep in stock, as well as reviewing the content sheets of surgical instrument trays with consultants to confirm that the trays contain the instruments needed for each procedure.

Recommendation 7
There should be clarity between the trust, UHB and UHB consultants regarding what the UHB consultants will provide in terms of the specialist paediatric service, and what standard of support and equipment these consultants need in order to enable them to provide that service.

Staff rotas and arrangements for out-of-hours cover

A few of the consultants that we interviewed, raised concerns about the clinical risks posed to patients as a result of implementing the “Hospital at Night” programme at the trust. From 2004, the Working Time Regulations (the enactment in UK law of the European Working Time Directive) has required trusts to ensure that they reduce the average number of hours that junior doctors can work to a maximum of 48 hours. This is a reduction from a pattern where employers had to limit junior doctor’s work to 56 hours of actual work a week, but to 72 hours on duty (including time spent resting at hospital).

This is providing to be a challenge to trusts throughout the country, in terms of ensuring that medical cover will meet the requirements of the Working Time Directive by August 2009. The Hospital at Night programme within the trust aims to ensure that these requirements are met.

The trust conducted a risk assessment to identify the risks associated with bringing haematology, oncology, gastroenterology and the liver unit into the
Hospital at Night programme. This identified an increase in the workload of consultants at night and concern around inappropriate assessment due to a lack of experience. The trust put actions in place to mitigate these risks by robust management of consultants’ workload through the consultant job planning process, greater investment in workforce and the appointment of a clinician with lead responsibility for the Hospital at Night programme.

We saw evidence that Hospital at Night had been extensively planned in advance at the trust and had been implemented through a staged approach, reaching full implementation by August 2008. The project was supervised by a steering group that met monthly to oversee the delivery of the work and review the project risks and risk register. All specialty teams were represented on this group. The programme had been audited pre- and post-implementation.

Overall, the trust had managed the staged introduction of the scheme and ensured that it closely monitored and carefully reviewed adverse incidents to pick up any trends. The trust informed us that there had not been any significant incidents to come out of the programme in the last five months of its implementation, including within the above-mentioned specialties. A review of risks is planned for February 2009.

The trust is still working towards identifying a solution that will make sure that the rota for neurosurgical registrars will comply with the Working Time Directive, as well as ensuring that the trust achieves, by August 2009, a 48-hour compliant surgical rota within the liver transplant unit.

Although issues were raised by some of the clinicians involved, they did not feel that the Hospital at Night programme had resulted in a lower standard of care for children. However, the trust clearly did not have the confidence of some of their senior clinical staff in the new process.

Recommendation 8
The trust needs to review urgently the arrangements for Hospital at Night with senior clinical staff, to ensure that any outstanding concerns have been properly addressed.

Leadership
Craniofacial surgeons raised concerns with the trust in September 2008 about a lack of leadership on Ward 10, and the impact that this could have had on safety. Ward 10 is the neurosurgical ward to which patients return after craniofacial surgery. In response, the trust immediately undertook a risk assessment of the ward, which involved the leading clinicians for both craniofacial surgery and neurosurgery. The assessment looked at eight different aspects of the service and delivery of care, which were highlighted as the key areas required for a safe service. This showed that the highest risks related to

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the management of the ward, the communication between the nursing staff and the medical staff, and junior doctors’ knowledge of craniofacial conditions.

Most of the staff that we interviewed in relation to Ward 10, told us that the leadership and the way the ward had been managed since 2006 had been inadequate. This, in combination with a number of experienced ward nurses resigning from the ward, had led to low staff morale on the ward, dissatisfaction among consultants, and strained relationships between the nursing staff (particularly the ward manager) and the medical staff.

Prior to the concerns being raised in September 2008, and the Healthcare Commission’s involvement, the trust had recognised in February 2008 the lack of leadership on the ward and the inadequate support provided by the directorate (directorate 1), and had asked the head of nursing from directorate 4 (a predominantly surgical directorate) to oversee the ward. This was followed by a change in ward manager in May 2008. Since then, the new head of nursing for the ward has focused on recruiting staff, to enable the ward to increase its bed capacity from 12 to 15 beds. Furthermore, the trust has increased the supervision of junior staff by consultants, and introduced specialist teaching sessions that are nurse-led, delivered jointly to junior medical staff and nurses.

Members of staff that we interviewed told us that, as a result of the actions taken by the trust since February 2008, the quality of leadership of nurses had improved, as had communication between consultants and nurses. These improvements had had a positive impact on the overall morale of staff.

**Governance**

We interviewed staff from the trust and UHB, and reviewed documentation, to determine whether staff had been reporting incidents and concerns, and how the trust had responded to these concerns.

Staff from the trust reported a strong culture of reporting of incidents. This was supported by figures for the trust from the 2007 national survey of NHS staff, which showed that only 2% of staff members had said they had not reported the last incident that they had witnessed (compared with an average of 6% for all trusts). In addition, an internal audit conducted by the trust in 2008 had shown that a wide range of incidents were reported by a wide range of staff from all areas of the trust. It noted that a high proportion of incidents were reported by medical staff, which was very positive.

However, consultants from UHB, who worked at the trust only part of the time, told us that they did not often complete incident reporting forms, but preferred to raise any concerns either verbally or by email/letter to different people in the trust. We were told that this was due to a lack of an agreed procedure as to how and where UHB consultants should raise concerns regarding their work at the trust. Consultants at UHB working at the trust on honorary contracts are
contracted to follow the trust’s local policies and procedures. This includes following procedures for governance and mechanisms for reporting of that trust.

We heard and saw evidence that the trust had taken actions in the past in response to incidents and complaints from patients. The trust has recently been successful in achieving the National Health Service Litigation Authority’s (NHSLA) risk management standard level two. Healthcare organisations are regularly assessed against the NHSLA’s risk management standards; these have been specifically developed to reflect issues that arise in negligence claims. The risk management standards incorporate standards relating to organisational, clinical, and health and safety risks. There are three levels: level three is the highest that can be obtained.

However, we also saw evidence of delays in managers responding to issues and concerns raised by consultants, some of which dated back many years. As highlighted above, formal reporting mechanisms were not necessarily followed. An example of this was within craniofacial surgery, where staff had raised problems dating back to 2006.

Craniofacial services are centrally commissioned by the National Specialist Commissioning Team (NSCT). The trust runs one of four designated craniofacial centres in the country. The service has seen an increase in workload since 2005/06, and has struggled to meet this demand within the boundaries of its operating capacity.

This resulted in delays in access to treatment, which was a particular problem for those patients who relied on operations being done at an early age to ensure the best possible outcome. For example, the median age at which transcranial cases were being operated on at the trust had increased to 19 months, which was still within the clinical window of opportunity but was considered significantly later than ideal. The trust, together with the craniofacial surgeons, has not worked effectively together to provide an accurate costing of the service provided. This was a requirement that the NSCT needed to clarify whether the service was appropriately funded or not. It was only in October 2008 that the trust completed this exercise. In addition, the NSCT conducted an assessment of the waiting list at the trust, which confirmed that the trust had around two more patients per month than it had the capacity to deal with. Furthermore, the NSCT has agreed (in principle) to fund additional work for a short-term to enable the trust to reduce its waiting time list.

The trust has agreed to assess ongoing capacity needs and how these will be delivered, and to submit a bid to NSCT for recurrent funding to meet demand on an ongoing basis.
Recommendation 9
The trust must agree, together with relevant consultants and its commissioners, a clear plan setting out actions being taken to ensure that craniofacial patients will be treated at the appropriate age and that any delays will be minimised.

Another issue that was mentioned by staff during our interviews, and which impacted on the trust’s ability to effectively respond to issues raised by various specialties, was the way in which the organisation was structured. The directorate structure of the trust had historically been relatively large, with a wide range of specialties and services combined within directorates. As a result, some directorates were struggling to develop and work towards a common objective. The trust has recognised this, and developed a structure that involves a transition to nine clinical business units (doubling the current number of directorates).

At the time of our visit, services were being transferred to different directorates and combined with services with which they have more in common. For example, the trust recognised that the craniofacial service had received insufficient management input over the years, and that the service had been unable to develop and execute a clear strategy. The trust has undertaken to transfer the service to the surgical directorate, where it has shared aims and objectives with the other services.

Services had also been affected by a combination of vacancies in management roles, high turnover, and a lack of skills within key positions at middle management level. This had resulted in a lack of well developed structures for engaging with consultants (both from the trust and from UHB), addressing their concerns and developing longer-term strategic plans for the tertiary services within the trust. Work was being undertaken by the trust to look into the roles and responsibilities of the key people within the management teams, and job descriptions of lead clinicians, general managers, head of nursing, finance lead and the service managers were reviewed through discussion.

Overall, we found examples of managers at the trust failing to communicate effectively with the UHB consultants providing services at the trust. These managers were not proactive and forthcoming in ensuring that the trust was fully aware of any concerns that consultants from UHB had, and they did not effectively engage with the UHB consultants to alleviate concerns.

Recommendation 10
The trust must develop better, formal communication with UHB consultants undertaking work at the trust, to ensure that any concerns are identified and addressed in a timely manner, and that the views of these consultants are formally incorporated into the trust’s arrangements for governance.
Partnership working

Serious concerns were expressed by NHS West Midlands about the nature and strength of the partnership and relationships between the trust and UHB, that would be necessary and expected for delivering high-quality and safe care, especially given the complexity of paediatric tertiary care services.

We interviewed staff and reviewed a range of documents, including correspondence between the trusts, to establish the way the two trusts had worked together.

Senior managers at both trusts stressed that previously there had not been any concerns about the relationship between the two trusts. We are aware that senior operational staff from the trust and UHB met with their counterparts regularly. However, it was clear that the two hospitals had not been communicating effectively since the concerns were raised by consultants during the first half of 2008. There had not been a culture of sharing information. There were examples of miscommunication about the location for providing paediatric services, which had distracted from the actual concerns of the UHB consultants.

We were very concerned that, when the recent issues regarding tertiary paediatric services came to light, communication between UHB and the trust about action to be taken did not occur.

Team working
Relationships between the trusts at middle management level and between consultants appeared to be generally better, although the overall picture was mixed.

The UHB consultants indicated that they were committed to providing a high standard of service at the trust, but had become frustrated over the years with the way in which the services had been organised at the trust. Although many of the staff we spoke to at the trust said that they were very happy with the support and commitment provided by UHB consultants, some of the UHB consultants we spoke to still felt as if they were outsiders, instead of part of the team, despite having worked at the trust for many years.

Job plans
Interviews conducted with consultants from both trusts showed that the involvement of UHB consultants was perceived as being focused on the technical aspects of the service, and that these consultants were not seen as having a broader role at the trust beyond their specific clinical responsibilities. The consultants that we interviewed were positive about communication with their colleagues. However, there seemed to be little involvement of UHB consultants with the management, clinical governance and planning of services at the trust.

The input of UHB consultants is critically important to the trust’s provision of services. We found no evidence of a structure in place through which UHB
consultants could contribute to the management and governance of the trust. In addition, some of the UHB consultants working at the trust on honorary contracts said that the time spent at the trust was not reflected within their job plans, despite them having raised this as a problem with managers at UHB and the trust for a number of years.

**Recommendation 11**
Job plans that take account of the time spent by UHB consultants at the trust need to be developed by UHB. The trust needs to clarify and agree with UHB the level of input it requires from UHB staff, including time to enable more involvement of consultants in the clinical governance and management structures at the trust. Once the job plans are developed, the trust should be involved in the appraisals and professional development of these consultants.

**Recommendation 12**
The trust and UHB, with the support of the commissioners, must agree on and implement a model of care delivering high-quality paediatric services, in line with the requirements of Monitor, the independent regulator of foundation trusts. Monitor must ensure that both trusts play their part in implementing this new model of care.
Action taken by local health bodies following publication of the UHB report

The commissioners have requested and agreed an action plan with the trust to address the concerns raised in the analysis of issues by South Birmingham PCT. Following publication of the UHB report, Heart of Birmingham Teaching PCT and the West Midlands Specialist Commissioning Team set up a coordinating task force (the Tertiary Paediatric Clinical Performance Task Force), which included a representative from the NCST, to monitor the implementation of actions arising from the trust’s action plan and provide assurance to commissioners that tertiary paediatric services provided were safe and in line with appropriate standards of care. The task force also aimed to agree key clinical performance indicators and ensure that all concerns were thoroughly investigated and resolved.

On 21 November 2008, the chair of the task force sent a letter to the trust that stated that, while the task force did not have concerns regarding immediate risks to the safety of patients at the trust, it requested action in relation to 10 issues that had the potential to represent a heightened clinical risk:

1. Confirmation that a process for reporting and responding to serious untoward incidents (SUIs) is in place, is well-understood and is used by all staff, and that appropriate arrangements exist for reporting to relevant commissioners.
2. Development of a clinical process for renal transplant, including a single protocol for preparation of donors and patients.
3. Training for all theatre staff who may be involved in renal transplant to recognise and use (as appropriate) specialised instruments.
4. A common renal transplant trolley or pack identified and readily available 24/7 at the trust.
5. New on-call arrangements for liver transplant, to minimise the risks associated with reliance on a single individual.
6. Development of, and compliance with, agreed protocols for patient access to interventional radiology, minimising unnecessary open procedures.
7. An agreed inventory and necessary equipment purchased to support safe interventional radiology practice, and trolley or pack identified and readily available at the trust 24/7.
8. Development of, and compliance with, agreed protocols for access to maxillo-facial or neurosurgical procedures within an appropriate clinical window for congenital and other relevant conditions where bone fusion or other physical development may be an issue.
9. Development of protocol and access thresholds for urgent transfer of neurosurgery patients from other units; the work undertaken on urgent inter-hospital transfer in adult cardiac surgery may be useful in this.
10. An agreed inventory and necessary equipment purchased to support safe neurosurgery, and trolley or pack identified and readily available at the trust 24/7.

The trust was asked to take immediate action in relation to these 10 issues, and has since reported progress to the task force. It responded to the satisfaction of the task force and, subject to the trust continuing to implement actions agreed in their action plan, agreed that there was a low risk to patients. It is noted that the task force concerns are similar to the concerns of the Healthcare Commission as stated in this report.

The task force agreed to several streams of additional work, including a formalisation of the trust’s arrangements for reporting SUIs to commissioners, a strategic review of paediatric tertiary services in the West Midlands, a review of capacity with regards to access to paediatric intensive care at the trust, and a review of the use of interventional radiology.

The chair of the review group has also written to the chair of the trust to highlight concerns about a range of leadership and management issues for the trust to address, as a matter of urgency, through its organisational development activity.

Furthermore, the NSCT aims to work with the trust and other commissioners to resolve the issues relating to national contracts highlighted in the UHB report that was released to the media. These include:

- To build and develop an overarching process for reviewing contracts with the trust’s corporate team, and to address trust-wide, operational and financial issues.
- To work with the trust to review numbers of transplant and the potential increase following the Donor Taskforce Report, which details the requirement for a 50% increase in donor transplants by 2012.
- To review information reporting with the trust for accuracy and timing, including a reconciliation with data provided by NHS Blood and Transplant.
- Following the issues that have arisen at the trust, the NSCT will review capacity with the trust for all NSCT-commissioned services.
- To review services that are provided across the trust/UHB and clarify inter-trust service level agreements and capacity.
- To review commissioning arrangements and the relationship with the local PCT and Special Commissioning Group commissioners, building on the existing task force as a forum for commissioners of the trust.
- To review the service crossover between NSCT and locally commissioned services (for example, kidney transplant).
- To make sure that clinical engagement is maintained between NSCT and the trust’s clinicians, to ensure an understanding of service issues, pathways for patients, and service definition.
Conclusions

We were asked by the Secretary of State for Health to examine the trust’s paediatric tertiary services because of a number of serious concerns, which had featured in a report published in the national press.

We have no evidence of any serious incidents causing harm to patients, although there is evidence of less than optimal care being provided to some patients at the trust. There were many serious concerns expressed by some of UHB’s and the trust’s consultants who were responsible for providing paediatric tertiary services at the trust. The concerns related in large part to difficulties in access to beds and theatres, theatre staff not having the required skills to assist in certain specialist procedures, and the arrangements that were in place between the trust and UHB. However, the concerns had not always been formally raised through the trust’s established systems, nor had they always been effectively managed in a timely fashion.

The trust had struggled to ensure that it had sufficient capacity to meet the increased demand for its services, due to a steady rise in referrals from general hospitals, and this had resulted in delays, less than optimum standards of care, and in patients needing to be redirected to other providers. The trust had not, in the past, responded to this increased demand with sufficient urgency, nor were there effective systems to monitor what happened to those patients who were unable to receive services from the trust due to lack of capacity. The trust has now recognised the seriousness of concerns about its inability to meet demand for its services, and has begun to work on a range of actions to address this. It is clear that long-term solutions will require the trust to continue to work closely with the commissioners of these services.

There are a number of specific urgent improvements that need to be made to improve the quality of clinical care provided by the trust. These are highlighted in our formal recommendations, set out below, and we will ensure that the actions, many of which the trust is already putting into place, are closely monitored.

However, it is our view that many of these difficulties have arisen, or at least have not been properly resolved, as a result of poor communication and ineffective joint working between the trust, UHB and UHB consultants working at the trust, in relation to the provision of paediatric tertiary services. Despite the genuine efforts that have been made to make improvements to the quality of care for patients, problems with communication and joint working were evident at a senior level in both trusts throughout the course of our intervention. It is deeply concerning that a situation was allowed to arise whereby, over several months, serious concerns about clinical care were raised but were not properly
or rapidly addressed and may have been the cause of alarm and anxiety amongst patients, families and the public.

Our final recommendation, agreed together with Monitor, the regulator of foundation trusts, aims to ensure that a model of care which is able to deliver high-quality paediatric services is developed between the two trusts and the commissioning bodies as a matter of urgency. We have received a detailed joint proposal on behalf of the two trusts and we will work closely with Monitor to ensure that this is in place without delay.
Summary of recommendations

Recommendation 1
The trust, with relevant commissioners, needs to ensure that it actively monitors the demand and capacity for children’s services, including information about those patients it has not been able to admit.

Recommendation 2
The trust needs to review its strategies and policies to improve its management of admissions and beds, and ensure that staff throughout the trust keep to these. It also needs to work with its consultants to ensure that patients needing urgent care are admitted in a timely manner.

Recommendation 3
The trust and commissioners of paediatric tertiary services must continue to work actively to manage the demand and provision of paediatric services at the trust.

Recommendation 4
The trust needs to review the way it organises capacity and prioritises cases within theatres, to ensure that patients requiring urgent and emergency surgery gain access to theatres in a timely manner.

Recommendation 5
The trust needs to urgently agree a clear plan to ensure that it has the capacity and systems in place to provide sufficient and timely access to elective and emergency/out-of-hours interventional radiology.

Recommendation 6
The trust must ensure that it provides, for urgent renal transplants and neurosurgery, an appropriate and sustainable level of support is available within theatres at all times. This needs to be informed by discussions with the surgeons involved about the standards of support required from theatre staff.

Recommendation 7
There should be clarity between the trust, UHB and UHB consultants regarding what the UHB consultants will provide in terms of the specialist paediatric service, and what standard of support and equipment these consultants need in order to enable them to provide that service.

Recommendation 8
The trust needs to review urgently the arrangements for Hospital at Night with senior clinical staff, to ensure that any outstanding concerns have been properly addressed.
**Recommendation 9**
The trust must agree, together with relevant consultants and its commissioners, a clear plan setting out actions being taken to ensure that craniofacial patients will be treated at the appropriate age and that any delays will be minimised.

**Recommendation 10**
The trust must develop better, formal, communication with UHB consultants undertaking work at the trust, to ensure that any concerns are identified and addressed in a timely manner, and that the views of these consultants are formally incorporated into the trust’s arrangements for governance.

**Recommendation 11**
Job plans that take account of the time spent by UHB consultants at the trust need to be developed by UHB. The trust needs to clarify and agree with UHB the level of input it requires from UHB staff, including time to enable more involvement of consultants in the clinical governance and management structures at the trust. Once the job plans are developed, the trust should be involved in the appraisals and professional development of these consultants.

**Recommendation 12**
The trust and UHB, with the support of the commissioners, must agree on and implement a model of care delivering high-quality paediatric services, in line with the requirements of Monitor, the independent regulator of foundation trusts. Monitor must ensure that both trusts play their part in implementing this new model of care.