

# Paediatricians in management

## G241 IS THE PRACTICE OF GENERAL PAEDIATRIC SURGERY VIABLE IN THE DISTRICT GENERAL HOSPITAL SETTING? AN AUDIT OF STANDARDS BY PROVIDERS ACROSS THE WEST MIDLANDS

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**Background:** In 2002 Partners in Paediatrics, a paediatric clinical network in the West Midlands registered concerns about the future of paediatric general surgery. A subsequent formal review by the regional specialised services agency found that some surgeons were operating on children infrequently. The report considered whether it would be necessary to concentrate surgery in a small number of specialised centres, but a strategy of improvement across the local provider units to ensure compliance against standards was preferred.

**Methods:** To support the improvement process, an audit of standards was initiated in 2004, and repeated 3 years later. 25 NHS Trusts participated, reporting whether or not they achieved compliance with 64 standards, in six categories. In 2007, data were loaded directly into a totally online audit system: this allowed different professional leads to provide specialist input and provided immediate feedback on Trusts' relative performance.

**Results:** The second audit revealed improvement. Paediatric on-call rosters for surgery and anaesthetics were in place in 54% of Trusts (18% in 2002). Dedicated paediatric induction/recovery areas were in place 85% (45% in 2002). Multidisciplinary care planning 89% (58% in 2002) and succession planning for surgeons was there in 80% cases (30% in 2002). Standards still showing limited compliance in 2007 were "regular multidisciplinary audit", "advanced paediatric life support training in key departments", "nurses with a paediatric qualification in recovery areas", and "child friendly outpatient clinics".

**Discussion and conclusions:** Self-reported compliance against standards indicates an improvement in provision, but a follow-up conference still revealed concerns about compliance on certain standards and the viability of general paediatric surgical services. General surgeons with the necessary skills in paediatrics are retiring and the ability to maintain expertise in a district general hospital setting is limited. There is a significant task for commissioning to address if services are not to remain a quality concern or to disappear by default.

## G242 THE PAEDIATRIC PHYSICIAN ASSISTANT: AN EVALUATION OF NON-MEDICS IN A MEDICAL ROLE

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**Background:** The European Working Time Directive (EWTD) 2009 will increase pressure on the NHS workforce as it strives to deliver high-quality care. The problem is particularly acute in paediatrics. One potential solution is to utilise new types of workers, such as physician assistants (PAs). PAs are paid at band 4 on the Agenda for Change pay scale, below trained nurses. They are able to perform most of the non-clinical roles of junior doctors. Although no formal medical training was required in the original person specification, both of our PAs have healthcare experience. There is a Department of Health Competence and Curriculum Framework for the Physician Assistant.

**Aim:** To conduct a qualitative evaluation of the impact of a pilot PA's role in a large district teaching hospital.

**Method:** Two different questionnaires were distributed among the medical team, 2 months after the introduction of the PAs.

**Results:** 21 questionnaires were returned by junior and senior paediatricians. Overall, the responses were very positive. A significant reduction in clinical workload was noted, in some cases by up to two-thirds. Valuable suggestions were received, including possibilities for development of the role. Other findings included: a significant improvement in continuity of care; more time for junior doctors to assess and communicate with patients. Consultants reported safer working. For example, PAs have taken responsibility for chasing results of investigations on children who have been discharged. For maximum effectiveness, it is important to explicitly define the boundaries of the role.

**Conclusions:** The introduction of paediatric PAs has been very positive. They have remained motivated by being valued and they learn from regular clinical skills training. We have encouraged them to develop the role continually, under appropriate supervision. The PA has become an independent practitioner of basic clinical skills. These have enabled them to act as a workload buffer for various clinical and administrative tasks. This has contributed to the overall improvement of quality of care for paediatric patients. Although difficult to quantify statistically, anecdotal and questionnaire-based evidence suggests that this new role is highly valued by doctors and other health professionals. Its impact has encouraged serious consideration of its continuation, not only due to the benefits, but also as an effective strategy for the EWTD 2009.

## G243 CREATION OF A FAMILY LIAISON GROUP USING THE MODEL FOR IMPROVEMENT

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**Background:** Lord Darzi's Next Stage Review states that "quality must be the basis of everything we do in the NHS". The NHS defines quality as safe, effective and patient-centred care. Although patients are central to our purpose, how much do we really understand about the impact of our service on them? Patients are rarely equal partners in the design of the structures, processes and training in healthcare, if partners at all. There are many examples of good practice worldwide that could be applied locally.

**Aim:** To create a family liaison group using The Model for Improvement.

**Method:** The Model for Improvement is a tool that allows small tests of change to drive improvement. Each change has an aim, specific measures and a Plan-Do-Study-Act cycle. The key to its success is that the first test of change uses a single person or patient. After studying the outcome, the change is developed and tested on larger groups before being spread, accelerating sustainable change.

**Results:** The initial plan took an hour and decided aims, measures, participants, location and a time to meet. We began with one parent and three staff in a local café. It was a great success. The feeling of elation from this early win motivated us to address the issues raised in the meeting. We designed an information leaflet for families admitted to the ward. We also transformed the recovery area by making small, but significant changes. Our second meeting had two parents. When we studied the effectiveness of the group at that stage, we realised there was a danger it would lose focus. Our concern was that there was too much discussion, too many ideas and no time/personnel to address them. Our action was to develop subgroups that would connect to our steering group. One subgroup is staff, seeking consultation from parents. Others include a support group and a focus group to generate ideas. Communication flows both ways.

**Conclusion:** Learning from children, young people and families is central to developing a high-quality service. The Model for Improvement is an easy technique to apply. We use it for all the innovations we introduce to our unit.

**G244 CAN NEW TO FOLLOW-UP RATIO MEAN ANYTHING? A STUDY OF THE MOST FREQUENT ATTENDERS TO A COMMUNITY PAEDIATRIC SERVICE**

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**Aim:** To ascertain reasons for very frequent clinic attendances (over six times in a 12-month period) and whether these could be predicted and/or avoided.

**Method:** The service activity data for the year 2007–08 were analysed to select the most frequent attenders and ascertain main diagnoses.

**Results:** The service had a total of 4652 clinic attendances for a total of 3672 NHS numbers; the overall new:follow-up ratio was 1:1.5. Reattendances ranged from 0 to 12 per case. 19 children (0.5%) were found to have attended six times or more, with a total number of attendances of 142 (3%). 10 of these 19 children had hyperactivity, four constipation, three learning problems, and one child each complex multisystem physical problems and behaviour/social problems.

**Discussion:** These cases had diagnoses typical of long-term conditions, and a predictable need for sustained follow-up, but it

is not possible to determine from these data alone whether these very frequent re-attendances were all appropriate. It is possible that some of the care could have been delivered by specialist nurses rather than doctors, eg, for hyperactivity and constipation, which are known to require frequent monitoring over a sustained period of time. We currently do not have access to such nursing staff, though we are aware of services that do so, with clinical success and better efficiency.

**Conclusions:** Frequent attenders “worsen” a service’s statistics in terms of new:follow-up ratio in the eyes of many managers. However, such a ratio is completely meaningless in the absence of speciality specific case mix data. We suggest that accurate outpatient diagnostic coding is essential to make sense of new:follow-up ratios to confirm which conditions are more likely to result in higher follow-up rates and determine whether the service’s rate “for that condition” is at variance with a national average, “for the same staff skill mix”. There is also a simultaneous need to determine the ideal follow-up method (attendance, telephone, text, email) and the best staff skill mix necessary to deliver it (probably as part of a condition specific pathway). Only then will the new to follow-up ratio mean anything useful to both clinicians and managers. Until then it is merely a cipher.