ACT Government | Canberra Health Services

Our reference: **CHSFOI21-22.22**

[redacted]

Dear [redacted],

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on **Friday 18 November 2022**.

This application requested access to:

> *'Any documents, including correspondence and ministerial briefings, held by ACT Health and Canberra Health Services about the decision to table the Resolve Health Advisory - Department of Paediatrics Organisational and Service Plan 2021-2023 in the Legislative Assembly on October 20, 2022. This request also includes any documents about deliberations and the decision making process to release this report'*

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Friday 16 December 2022**.

I have identified two documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions on access

I have decided to grant partial access to the two documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Partial Access

I have decided to grant partial access to the two documents that have been identified containing information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the FOI Act.

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1(a)(i) promote open discussion of public affairs and enhance the government's accountability;
- Schedule 2, 2.1(a)(ii) contribute to positive and informed debate on important issues or matters of public interest; and
- Schedule 2, 2.1(a)(viii) reveal the reason for a government decision and any background or contextual information that informed the decision.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, Schedule 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004*;
- Schedule 2, 2.2 (a)(xii) prejudice an agency's ability to obtain confidential information;
- Schedule 2.2 (a) (xv) prejudice the management function of an agency or the conduct of industrial relations by an agency; and
- Schedule 2.2 (a) (xvii) prejudice the effectiveness of testing or auditing procedures.

The documents are partially comprised of personal information such as an ACT Government employees' mobile number and has not been disclosed as this could reasonably be expected to prejudice the protection of the individual's right to privacy.

Document at reference one also contains partial redactions to staff members names, and I believe this constituted an unreasonable disclosure of individuals' personal information. The release of this information would or could reasonably be expected to have a detrimental effect for the agency's ability to conduct future reviews within the organisation as it may reduce engagement and diminish the honest and truthful participation of staff members contributing feedback.

On balance, the factors favouring disclosure are outweighed by the factors favouring non-disclosure as the information would not provide any government information pertinent to your request. Therefore, I have determined the information identified is contrary to the public interest and would not advantage the public in disclosing this information.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

Cathie O'Neill
Chief Operating Officer
Canberra Health Services

14 December 2022

ACT Government | Canberra Health Services

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	*'Any documents, including correspondence and ministerial briefings, held by ACT Health and Canberra Health Services about the decision to table the Resolve Health Advisory - Department of Paediatrics Organisational and Service Plan 2021-2023 in the Legislative Assembly on October 20, 2022. This request also includes any documents about deliberations and the decision making process to release this report.'*	**CHSFOI22-23.22**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	1 – 63	Email and attachment – Paeds OSP v 2.2	19 October 2022	Partial Release	Schedule 2, 2.2 (a)(ii) Privacy, Schedule 2, 2.2 (a)(xii) obtain confidential information, Schedule 2, 2.2 (a)(xv) management function & Schedule 2, 2.2 (a)(xvii) auditing procedures	YES
2.	64 – 123	Email and attachment – RE: Paeds OSP v 2.2	20 October 2022	Partial Release	Schedule 2, 2.2 (a)(ii) Privacy	YES
Total Number of Documents						
2						

From: O'Neill, Cathie (Health)
Sent: Wednesday, 19 October 2022 6:04 PM
To: Bransgrove, Meagen; Bergin, Catherine
Cc: Bell, Amanda (Health); CHS COO
Subject: Paeds OSP v 2.2
Attachments: Paediatrics OSP v 2.2.pptx

Follow Up Flag: Follow up
Flag Status: Flagged

UNOFFICIAL

Hi

I have attached the editable version – it has had any identifying names, financial information and appendices removed.

I have sent straight through to you given the delays in finalising approach and getting it back to you.

Please PDF prior to release as there are some graphics (ie watermarks) that are hidden but will become messy if not PDF.

Let me know if you need anything else from us

Cathie

Some suggested Talking Points

Paediatric Services Review
I have previously undertaken to table the Paediatric Services Review and Plan and do so now.
Paediatric Expert Panel
As I have previously informed the Assembly, I have instigated an Expert Panel into Child and Adolescent Clinical health Services. I am pleased to announce today that the Chair of that Expert Panel will be Professor Michael Bryden who will be aptly supported by another eminent independent expert Dr Diana Lawrence along with Fiona Tito-Whelan and Karen Toohey. The Panel will meet for the first time this month and one of their first tasks is to go through this Review Report and Plan and determine which of the recommendations have been implement, those that are still relevant and oversight their implementation. This will include coming back to me to prioritise and quantify the amount of investment required.

I will keep the Assembly updated on progress.

Cathie O'Neill
Chief Operating Officer
Canberra Health Services

Mobile: [redacted]
E-mail: Cathie.O'Neill@act.gov.au

EA: Maddy Bartlett 512 42147
EO: Michelle Ramsay 512 45804
BM: Amanda Bell 512 48688

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RESOLVE HEALTH ADVISORY

Department of Paediatrics Organisational and Service Plan 2021 – 2023

Version 2.2 – Final For Release

Version Control

Date	Version	Changes	Pages
01.04.21	1.3	• Updates to paediatric surgery plan following meeting with surgeons: refer new position as 'consultant-level'; update conversion rates for backlog; tighten executive summary • Update to specialised services prioritisation following discussion with orthopaedics	12, 43-50 22
05.04.21	1.4	• Updates to paediatric medicine plan following feedback: clarify CAMHS team as inpatient; update action owners and clarify terminology • Updates to care of the critically ill child to capture feedback received from various • Incorporate leadership development actions in relation to interprofessional care, and clarify terminology • Refine planning horizons summary	7, 31-42, 165 25-30 6, 10, 15, 17, 19 8
05.04.21	1.5	• Update Allied Health section for [redacted] comments ( )(iii)	62-65
05.04.21	1.6	• Update horizons to make clear that endocrinology is covered in paediatric staffing & operating model	8
09.04.21	1.7	• Update for additional feedback from paediatricians • Incorporate issues raised by paediatric surgeons regarding neurosurgery • Incorporate feedback from [redacted] • Incorporate feedback from Steering Committee Discussion • Include Allied Health Executive Summary	3, 8,21,35,37,38,40,98,102,166 12,44,50 9,56,59 19 14
20.04.21	1.8	• Incorporate feedback from [redacted] ( ) • Incorporate feedback from WYCCH and Allied Health • Incorporate feedback from [redacted]	6, 8, 19, 22, 38, 40, 77, 85, 159, 160 4, 7, 8, 13, 14, 18, 19, 63, 64 6, 7, 30, 38,
02.05.21	1.9	• Incorporate residual feedback from WYCCH and Allied Health • Incorporate update from [redacted] ule	25, 27, 34, 39, 40, 42, 52, 53, 54, 56, 58, 60, 62, 63, 64, 65, 74, 75, 76, 81, 82, 84, 85, 86, 108, 109, 110, 112, 113, 115, 116, 117, 118, 119, 121, 122 18, 58
15.05.21	2.0	• Address comments from finance and SteerCo	9, 15, 19, 41, 42, 50, 59, 60, 65, 91, 93, 94,100, 104,110, 117, 119
20.05.21	2.1	• Replace 'interdisciplinary' with 'interprofessional' • Note additional nurse staffing are indirect FTE	Various (find and replace completed) 91
19/10/22	2.2	• De-identified, appendices and financial information removed for public information	

Contents

Organisational & Service Plan

Appendices

Appendices have been removed from this version as they contain detailed operational information for the use of implementation only

Executive Summary: Context and Approach

The paediatrics organisational & service plan covers paediatric medicine (including sub-specialties), paediatric surgery, and community child health at Canberra Health Services. It sets out the scope of services to be provided, the operating principles for delivery of those services, and the actions required to get there

Context

- Canberra Health Services provides paediatric health care services to the population of the ACT, and, for paediatric medicine and surgery, to a significant catchment from Southern New South Wales – and the Centenary Hospital for Women & Children is the only public children's hospital within the ACT.
- Paediatric services are provided to the Aboriginal & Torres Strait Islander community in the ACT and surrounding region, and include dedicated Aboriginal Liaison Officers and health professionals across Centenary Women's & Children's Hospital and Community Child Health.
- This plan sits within a broader set of planning activities underway or completed within both Canberra Health Services and ACT Health, including: the Canberra Health Services Strategic Plan; the Canberra Health Services Clinical Services Plan; the ACT Health Child & Adolescent Clinical Services Plan; the ACT Children's Health Services Plan for the first 1,000 days; and planning for the expansion of the Canberra Health Services campus, including new integrated adolescent ward and Critical Services Building.
- Canberra Health Services has a clear vision - to **create exceptional health care toget**her, underpinned by strong values of being: **reliable** – we always do what we say; **progressive** – we embrace innovation; **respectful** – we value everyone; and **kind** – we make everyone feel welcome and safe, and four strategic priorities: personal health services; a great place to work; a leading specialist provider; and a partner to improve people's health, with consumers firmly at the centre.
- There have been some significant challenges within paediatrics at Canberra Health Services, which have resulted in low levels of employee engagement. The most significant areas of concern raised by staff related to: the structure and model of care, including lack of capacity, and silo working; and management practices/leadership, including excessive administrative tasks/meetings and lack of transparent communication.

Approach

- The organisational & service plan has been developed in consultation with the service, with a view to delivering exceptional health care for children, and embedding Canberra Health Service's organisational values within paediatrics.
- The Health Care Consumers Report, *Consumer and Family Experiences and Expectations of Accessing Interstate Specialist Care*, along with complaints data, was used to identify the key issues from consumers' perspectives that needed to be addressed within the plan.
- Stakeholder engagement was undertaken through 1-2-1 interviews and meetings with professional groups, to develop an understanding of the key issues to be addressed, and service aspirations (see Appendix 1).
- This was supplemented by analysis of available activity, financial and quality data, understanding the current care pathway, and comparison against national standards and benchmarks. (see Appendix 2)
- Together these analyses provided a clear understanding of the current state of services, and the priority issues to be resolved, which informed development of the Organisational and Service Plan. Stakeholder perspectives were largely consistent with the data analysed for the current state assessment.
- The organisational and service plan provides for each section of paediatrics: the proposed outcome measures against which to measure progress; the operating principles to be adhered to; the future state care pathway; forecast activity and workforce requirements to 2025; the proposed team structure; any significant financial impacts; and an action plan. It also addresses issues that impact all sections of paediatrics: care of the critically ill or deteriorating child; prioritisation of specialised services to be strengthened / expanded; and allied health support into paediatrics.

Executive Summary: Defining exceptional care for children

Children's Hospitals Australasia have developed a Charter on the rights of children and young people in healthcare services in Australia, which is based on putting the interests of the child or young person first, hearing and taking seriously all young people, and recognition of the importance of family – this defines exceptional care

Charter of Children's and Young People's Rights in Healthcare Services in Australia

Every child and young person has a right:

1. to consideration of their best interests as the primary concern of all involved in his or her care.
2. to express their views, and to be heard and taken seriously.
3. to the highest attainable standard of healthcare.
4. to respect for themselves as a whole person, as well as respect for their family and the family's individual characteristics, beliefs, culture and contexts.
5. to be nurtured by their parents and family, and to have family relationships supported by the service in which the child or young person is receiving healthcare.
6. to information, in a form that is understandable to them.
7. to participate in decision-making and, as appropriate to their capabilities, to make decisions about their care.
8. to be kept safe from harm.
9. to have their privacy respected.
10. to participate in education, play, creative activities and recreation, even if this is difficult due to their illness of disability.
11. to continuity of health care, including well-planned care that takes them beyond the paedatric context.

CHILDREN'S HOSPITALS AUSTRALASIA

Executive Summary: A shift to interprofessional working

An **interprofessional** approach involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities, and is a critical foundation for delivering holistic, child and family-centred care.

Case for interprofessional working

- Children and families requiring specialist paediatric care often have multiple and complex needs, which may include complex multi-morbidity, social or psychological issues. Delivering against the Charter of Children's and Young People's Rights in Healthcare Services in Australia requires a consultative, collaborative approach to care that actively involves the child and their family.
- An interprofessional approach can improve patient outcomes, healthcare processes and levels of satisfaction, as well as reducing length of stay and avoiding duplication of assessments, leading to more comprehensive and holistic records of care.
- The opportunity for discussion created by interprofessional care planning can be used for the patient, their family and carers to develop their ongoing plan.
- interprofessional service management supports cohesion across staff groups, breaks down siloes and can strengthen staff engagement and morale, through unifying teams behind a common purpose, and creating an environment in which everyone's voice feels valued and heard.
- Implementing interprofessional working within the paediatrics service, should be done with active consideration of creating a psychologically safe working environment, which requires addressing psychological risk factors, including: job demand & control; effort-reward balance; exposure to trauma; organisational justice; psychosocial safety climate; and job security.
- Implementation will be dependent on ensuring there is sufficient capacity in the team from across disciplines.

Implementing interprofessional working

- **Leadership –** positive leadership and management give clear direction and vision for the team, through:
  - Promoting an atmosphere of trust, where contributions are valued and consensus is fostered
  - Ensuring that the necessary resources, infrastructure and training are available, as well as a mix of skills, competencies and personalities amongst team members
- **Child-Centred Practice –** well integrated and coordinated care that is based on the needs of the child, including:
  - Involving the child and family in all aspects of care and decision making
  - Formulating shared, interprofessional care plans
- **Teamwork**- teams with shared responsibilities and some role interdependence, and:
  - Clear goals, shared roles and responsibilities within a team structure
  - Joint assessment, diagnosis and goal setting
- **Communication** – across disciplines, care providers, and with the child and family to set goals that meet the child's specific needs, including:
  - Active involvement of the child's GP
  - Open communication to encourage genuine collaboration

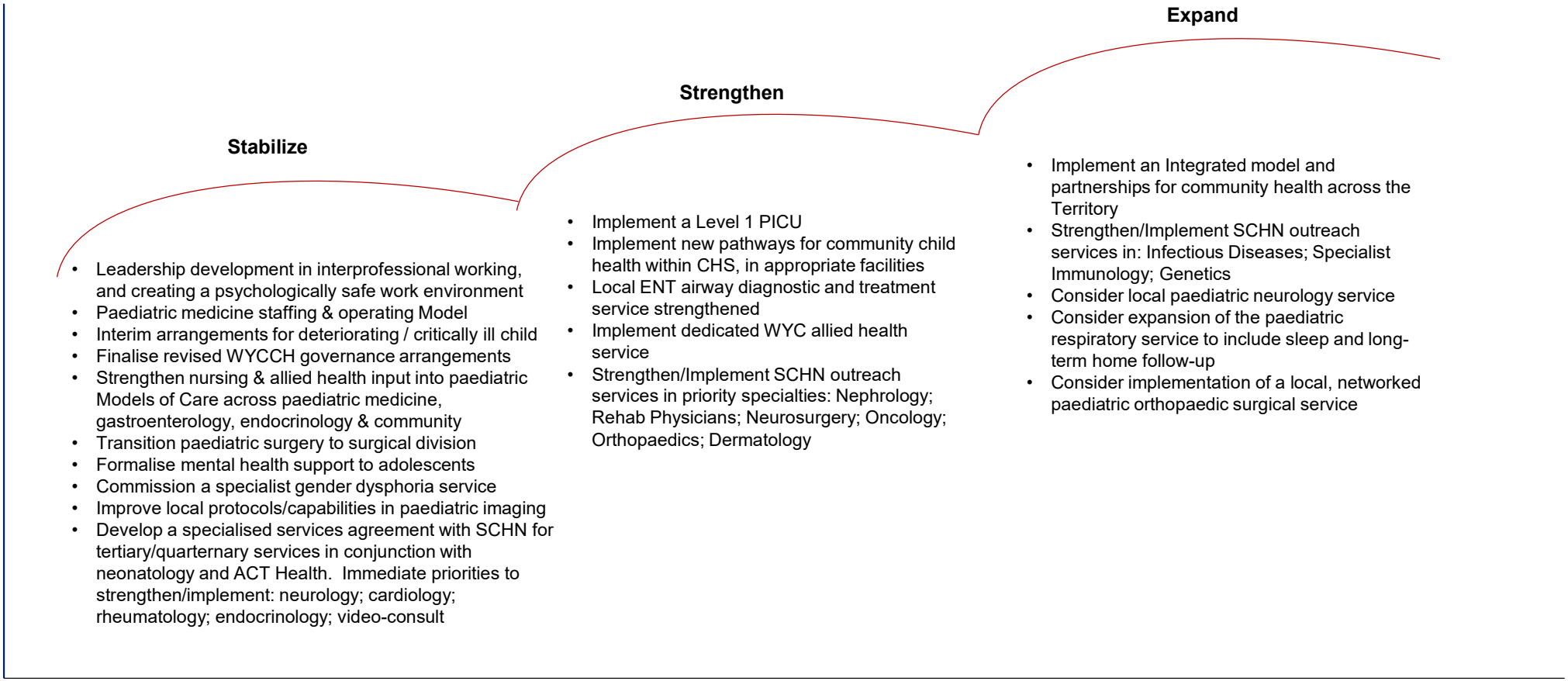
Executive Summary: Addressing the priority issues

Stakeholder engagement identified the most critical issues to be addressed as part of the paediatrics organisational & service plan. These have been systematically addressed through the planning process – as summarized below:

Issue raised during stakeholder engagement	Actions incorporated into the organisational & service plan
Lack of appropriate care setting and formalised protocols for high acuity and deteriorating patients.	A proposal for managing critically ill and deteriorating patients has been developed as part of the plan.
Sustainability of general paediatrics and paediatric endocrinology.	A bottom-up staffing and capacity plan as been completed as part of the paediatric medicine plan.
Lack of agreed prioritisation of the specialist services to be strengthened or expanded locally, and limited formal arrangements in place with Sydney Children's Hospitals Network.	Prioritisation has been completed on all specialist services that are required to support paediatrics at CHS, along with recommended principles for shared care.
Concerns regarding culture & governance, including silo working, and perceived excessive bureaucracy.	interprofessional team working has been incorporated as a key operating principle for each section of paediatrics, with interprofessional leadership and teams.
Workforce, Training & Education challenges, including known workforce gaps and insufficient ongoing training and education.	Specific actions have been included in relation to addressing workforce gaps, training & education in each section.
Concerns regarding the sustainability of Child Health Targeted Support Services and whether the workload justifies 24/7 on-call.	A revised staffing and team structure has been proposed. It is recommended that the 24/7 roster continue until a credible alternative for providing expert paediatric forensic medical advice out-of-hours is identified.
Whether the scope of services provided for children in the community is consistent with population needs, and the role of Canberra Health Services.	A reorganisation of health services for children across the Territory, and across directorates is recommended. Actions to properly commission gaps in service at CHS (both retrospectively and prospectively) have been recommended.
Challenges with interfaces with other services, both internal and external, with lack of communication and inadequate communication and planning in transfers of care.	A number of actions have been proposed to strengthen relationships between paediatrics, other key interfaces at CHS, and the relationship with SCHN.
Insufficient business support and intelligence to enable effective management of the service.	A number of revisions to financial and performance reporting are recommended, including development of an internal performance dashboard for each section, against meaningful outcomes. A project coordinator is recommended to support general paediatrics.
Care of children & adolescent inpatients with mental health issues is not provided in line with best practice, with challenges in accessing timely specialist CAMHS advice and insufficient specialist mental health trained staff.	There is good cover for the wards, with an inpatient team and ED consultant liaison from CAMHS, including 1.4 FTE CAMHS psychiatrist and registrar, and CAMHS worker (vacant). This needs to be formalised. Future staffing for the integrated adolescent ward needs to be defined in line with proposed admission criteria.
The gender dysphoria service is being provided outside of recommended clinical guidelines and poses a clinical and reputational risk to CHS.	A specialist gender dysphoria service needs to be commissioned in line with NSW and international guidelines. This may require commissioning a service outside ACT.

Executive Summary: Planning Horizons

The paediatrics service and organisational plan will need to be delivered over three distinct phases, recognizing that there are critical issues that need to be resolved now, whilst other changes will take time to plan and implement. A 3-5 year timeframe is recommended, with a maximum of 18 months for each planning horizon.



Executive Summary: Divisional Issues

A number of the critical issues identified during stakeholder engagement, and from the current state assessment, will need to be addressed at a divisional level, as they span two or more sections of paediatrics.

Service & Organisational Plan Overview

- The immediate priority for the division is to put in place the management controls to ensure successful delivery of the service & organisational plan.
- This will require:
  - Formal sign-off of the plan, including budget impacts, and setting clear expectations on Directors and Unit Leads for delivery
  - Building foundational capability in interprofessional working and creating psychologically safe working environments, including leadership development in these capabilities
  - Defining and formalising the roles of unit leads, including any associated shifts from clinical to non-clinical time – this should be embedded in job plans
  - Successful recruitment to the Clinical Director role and/or provision of interim senior management support to drive implementation of the plan
  - A full-time, dedicated, ADON role for paediatrics
  - Oversight of the recruitment and job planning actions required for each section of paediatrics, ensuring that capacity expectations are clearly set, and met
  - Initiating work to develop clear information for children, families, referrers and other departments regarding the range of services available at CHS
  - Supporting opportunities for paediatrics sections to interact informally with one another, and with key interfaces (e.g. ED)
  - A review of planned capacity, by age group, against the forecast capacity requirements set out within this plan, and full review of the PDS Model of Care
- The division will also need to lead work to agree the services to be commissioned from SCHN, including any funding implications for ACT Health or CHS. This should involve all paediatric sections, neonatology and ACT Health
- The division will need to take a lead role in coordinating paediatric and neonatology input into the implementation of a Level I PICU, and interim arrangements for care of the critically ill or deteriorating child.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)

Executive Summary: Paediatric Medicine[1]

The paediatric medicine service is not sustainable in its current form, and requires substantial action, investment and support, to transition to a high performing service that is able to deliver exceptional care for children and families of the CHS catchment.

Service & Organisational Plan Overview

- The immediate priority for paediatric medicine is to put services onto a sustainable footing (in particular the outpatient service) and strengthen the operating model.
- This will require:
  - Increasing the number of general paediatricians and paediatric endocrinologists, and strengthening job planning and rostering (incl. VMOs and juniors), to ensure that clinical commitments can be met and share of workload is equitable
    - A robust and strategic approach to recruitment of additional staff, to ensure new appointments will contr bute to strengthening the service
    - Early negotiation with ANU for a 50/50 ANU/CHS funded position, to incorporate a significant proportion of the current substantial teaching workload, and drive research within paediatrics
  - New nursing and allied health roles to support sub-specialty services and complex patients, increase outpatient capacity, and drive service innovation. A greater focus on training & upskilling the existing workforce is also required.
  - Strengthened ways of working, which are truly interprofessional across both inpatient and ambulatory settings, and a clearly defined and streamlined pathway for all paediatric outpatient referrals
  - Strengthened administrative, business intelligence and finance support into general paediatrics, to enable proactive management of the service and reduce the administrative burden on senior medical staff
  - Strengthening the specialist services that general paediatricians rely on to provide holistic care to the CHS catchment, with a view to growing some of these specialist services locally over time.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Improvement in a wide range of other clinical outcome measures (see Appendix 5)

[1] Including paediatric endocrinology and paediatric gastroenterology

Executive Summary: Paediatric Surgery

The paediatric surgery service is currently meeting the needs of the CHS catchment for the casemix that can safely be delivered at Canberra Health Services. The current staffing model is sustainable for the horizons of this plan, but succession planning is needed early, alongside improvements to ways of working.

Service & Organisational Plan Overview

- The immediate priority for paediatric surgery is to improve ways of working, in order to foster a positive team environment across all staff, and meet the Charter on the rights of Children & Young People in Healthcare Services in Australia.
- There is also a need to plan recruitment to a new permanent consultant level position, as part of succession planning for the future. Early recruitment to this position would assist in reducing the ambulatory waiting list to three months.
- This will require:
  - Formalising the Unit Lead role for paediatric surgery, with clear roles & responsibilities
  - Adopting a set of operating principles, which include strengthening relationships, and greater visibility and interaction with other disciplines, particularly paediatric medicine, other surgical specialties operating on children, and the Emergency Department
  - Increasing awareness and understanding amongst the team in relation to creating a psychologically safe work environment, and what it takes to deliver this
- Development of a Level I PICU in the short to medium term (within the next 3 years) will enable more children to have their surgical treatment in Canberra, in particular, those who may require short-term ventilation post surgery.
- Strengthening and formalising specialist input into Canberra Health Services from Sydney Children's Hospital Network, including nephrology and haematology will support delivery of exceptional care.
- There is a need for closer joint working with other surgical specialties with high volumes of paediatric activity, including ENT, Orthopaedics and Neurosurgery. Once a Level 1 PICU is established, ENT can provide a more comprehensive airways service, from their existing team. Over time a dedicated paediatric orthopaedic surgeon, networked into SCHN, is also recommended.
- Adult neurosurgical involvement in children with head injury needs to be reviewed.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to treatment
• Reduced variation from time of referral to treatment by Category
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Proportion (%) of congenital elective orchidopexy procedures performed before the age of 12 months
• Reduced unplanned returns to theatre
• Reduced transfers to SCHN after elective surgery

Executive Summary: Community Child Health

It is difficult to isolate 'community paediatrics' from the wide range of services provided by WYCCH for women, children & family health, due to the significant service interfaces and overlaps. This plan focuses on the current Child Health Targeted Support Services, but within the context of the other services provided.

Service & Organisational Plan Overview

- The immediate priority for Community Child Health is to move to an interprofessional model of community health care for children, with streamlining of pathways to meet the needs of all children, including those with complexity or vulnerability.
- This will require:
  - Investing in new nursing & allied health roles to work alongside the community paediatricians to provide interprofessional triage, assessment and treatment for the current cohort of children referred to the community paediatrician service.
  - Finalising a revised governance model for WYCCH – this includes some amendments to the proposals set out in the current consultation paper, and realignment of resources to sit two functional teams: Neurodevelopmental and behavioural - NBAT (formerly community paediatrician service); and Targeted Support for Children & Families -TSCF (incorporating former CARHU and other early parenting support services)
  - Establishing the care pathways set out within this plan, including developing the inclusion and exclusion criteria for each pathway
  - Identifying suitable space to accommodate the interprofessional teams at both CHS and in the community
- There are also a number of areas where the services currently commissioned are not adequate to meet the needs of the ACT population (e.g. early intervention for developmental delays), and would benefit from expansion. This will require discussion with ACT Health to agree prioritisation and funding of any service expansion.
- There is a significant need to integrate services, service locations and service records for children & families across ACT Government Directorates, to reduce confusion, service gaps and overlaps, and make it easy for children & families to access the services they need. Although beyond the scope of this plan to address, it is recommended that action is taken to progress cross-directorate action, to deliver exceptional care across the Territory (see Appendix for how this model could be delivered)

Target Outcomes

Measure
• Child & Family Reported Experience

• Child & Family Reported Outcomes
  • Social & Emotional Wellbeing
  • Peer relationships
  • Behavioural problems
  • Parent-child relationship
  • Family Functioning

• Staff satisfaction / Engagement
• Time from referral to first contact
• Time from referral to assessment
• Time from referral to treatment commencement
• Prescribing rates for psychotropic medications in children with behavioural/developmental diagnoses

Executive Summary: Allied Health into paediatrics

Options for improving allied health input into paediatrics were considered as part of service & organisational planning. The recommendation is to have a dedicated paediatric allied health team. This will require investment and significant change, and can't be considered in isolation without also considering Women's Allied Health.

Dedicated Paediatric Allied Health: Proposed Model

Integrated

- Allied Health are part of at-scale functional teams (service or cohort focussed) across community, acute and paediatric ambulatory setting:
  - Neurodevelopmental & Behavioural Team
    - Triage, Assessment & Treatment for all relevant referrals from both general and community paediatricians.
    - Provide support, on referral, into acute paediatric wards.
  - Diabetes & Obesity Team
    - Dietician, exercise physiologist
    - Provide support, on referral, into acute paediatric wards. Transfer acute paediatric nutrition FTE into this team
  - Acute & Ambulatory Team
    - Transfer existing physio, social work, speech path and OT team to paediatrics
    - Bid for post-acute rehabilitation service to be part of this team
    - Provide support, on referral, into community paediatrics complex cases
  - Specialist Disciplines
    - Play Therapists
    - Newborn Hearing Screening
    - Genetic Counselling

Key Considerations

1. Inclusion of Women's Allied Health as part of the integrated model

Models for consideration were developed within the scope of the paediatrics service & organisational plan (i.e. paediatrics only), however discussion with the Allied Health Director highlighted that moving to an integrated for paediatrics, but remaining with the existing model for Women's Allied Health, would create challenges, and the case for an integrated model applies equally to Women's Allied Health.

2. Investment in Allied Health to create sufficient scale

The integrated model will require investment in Allied Health roles, to ensure that there are sufficient FTE in each profession to provide a dedicated Women & Children's service. The need to invest in Allied Health positions has already been identified in both Paediatric Medicine and Community Health, in order to provide interprofessional assessment & treatment, and support reducing the outpatient waiting lists.

3. Team working across community, ambulatory and acute teams

The integrated model is based on grouping functionally similar teams together to create scale and move away from small FTE in specific care settings. Teams and disciplines have been aligned to the setting where there is greatest clinical need, but will need to provide out-reach support to other care settings of care. (e.g. there is greatest need for psychology support in the community neurodevelopmental & assessment team, but that team will need to provide psychologist support to acute wards on referral).

Executive Summary: Roadmap for Year One

Divisional Issues

Executive Summary: Divisional Issues

A number of the critical issues identified during stakeholder engagement, and from the current state assessment, will need to be addressed at a divisional level, as they span two or more sections of paediatrics.

Service & Organisational Plan Overview

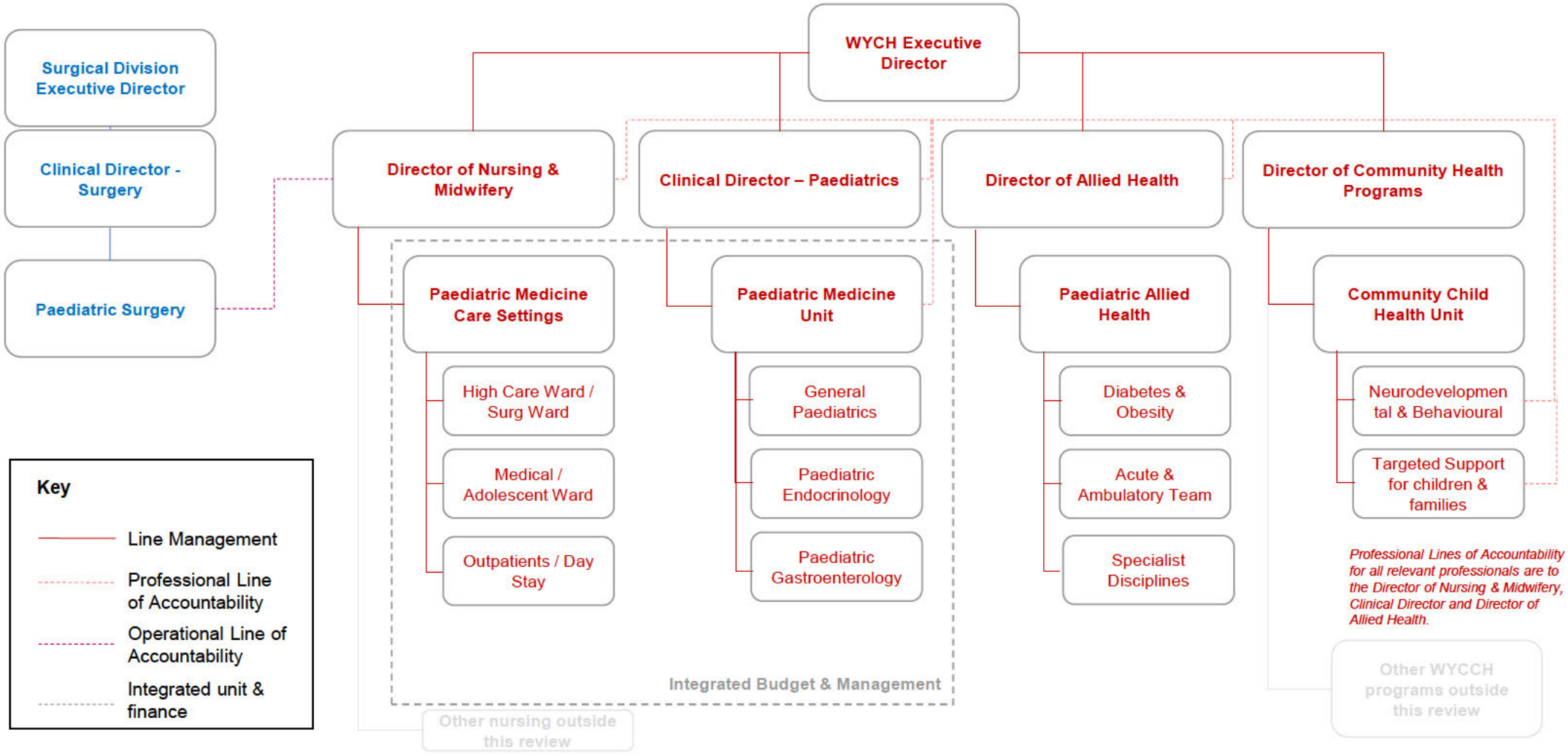
- The immediate priority for the division is to put in place the management controls to ensure successful delivery of the service & organisational plan.
- This will require:
  - Formal sign-off of the plan, including budget impacts, and setting clear expectations on Directors and Unit Leads for delivery
  - Building foundational capability in interprofessional working and creating psychologically safe working environments, including leadership development in these capabilities
  - Defining and formalising the roles of unit leads, including any associated shifts from clinical to non-clinical time – this should be embedded in job plans
  - Successful recruitment to the Clinical Director role and/or provision of interim senior management support to drive implementation of the plan
  - A full-time, dedicated, ADON role for paediatrics
  - Oversight of the recruitment and job planning actions required for each section of paediatrics, ensuring that capacity expectations are clearly set, and met
  - Initiating work to develop clear information for children, families, referrers and other departments regarding the range of services available at CHS
  - Supporting opportunities for paediatrics sections to interact informally with one another, and with key interfaces (e.g. ED)
  - A review of planned capacity, by age group, against the forecast capacity requirements set out within this plan, and full review of the PDS Model of Care
- The division will also need to lead work to agree the services to be commissioned from SCHN, including any funding implications for ACT Health or CHS. This should involve all paediatric sections, neonatology and ACT Health
- The division will need to take a lead role in coordinating paediatric and neonatology input into the implementation of a Level I PICU, and interim arrangements for care of the critically ill or deteriorating child.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)

Future Team Structure

It is recommended that paediatrics is organised into interprofessional functional teams, with professional lines of accountability to the relevant Director. It is recommended that paediatric surgery transfer to the surgical division, but retain operational accountability to paediatrics for high quality inpatient care.



Action Plan

No.	Action	Deadline	Owner
1	Formally sign off the organisational and service plan, including timescales for delivery and associated budget impacts. This includes formally adopting the Charter on the rights of children and young people in healthcare services in Australia		
2	Address real and perceived inequities between the staff specialist and VMO workforces, including remuneration for similar activities and guiding principles. Specifically determine whether VMOs & staff specialists can be on-call for more than one hospital at a time		
3	Agree the organisational metric(s) to be used to measure the impact of, and improvement in, paediatrics at Canberra Hospital and incorporated into reporting to the CHS Executive		
4	Formalise revised arrangements with imaging, to ensure paediatric images are reported on / reviewed by a suitably qualified paediatric radiologist, there is day-time paediatric radiology cover, and radiology nursing staff feel confident to support children & adolescents undergoing imaging at CHS		
5	Leadership and team development in interprofessional working and leadership, and creating psychologically safe working environments		
6	Complete detailed financial analysis against the plan to provide updated estimates (including pro-rata impacts in Year 1), and a budget refresh for paediatrics, aligned to the revised operating model. Strengthen finance support to provide true management accounting capability to paediatrics, which supports operational management and strategic decision making		
7	Formalise the Unit Lead roles, including roles & responsibilities, tenure, and any associated reduction in clinical commitments		
8	Set job planning expectations and timelines for Unit Leads (and/or the Clinical Director), including a principle of equitable workloads, and of meeting the capacity requirements of the plan as a priority.		
9	Finalise interim arrangements for management of the critically ill / deteriorating child, ensuring these are formally signed off		
10	Split the neonatology / paediatrics ADON role into 2 roles (probably 1.5 FTE), including any required consultation and implementation plan		
11	Review opportunities to strengthen pharmacy input into paediatric wards, to mitigate the known risks in the current service		
12	Recruit a senior resource (Clinical Director or other) with overall accountability for delivery of the organisational and service plan		
13	Establish a working group with interprofessional representation from paediatric medicine, paediatric surgery and community child health to develop information for children, families & referrers regarding paediatric services available at CHS		
14	Develop a revised business case for a Level I PICU, including the proposed staffing model and location		
15	Complete a review of day stay and overnight bed requirements against the forecast capacity needs within this plan, including a detailed review of the Paediatric Day Stay Model of Care		
16	Develop a detailed SLA with SCHN, setting out the full range of services to be provided over a 3-year period (including non-clinical services, such as access for CHS sub-specialists to MDTs and professional development)		
17	Develop the detailed roadmap and actions for Year 2 of the Service & Organisational Plan		
18	Review the potential to transition to a single on-call roster within general paediatrics, through prospective audit of on-call workload		

Prioritisation of specialised services

Specialist Services – Prioritisation (1/2)

Providing appropriate specialist expertise for children in the ACT and CHS catchment is a key component of delivering exceptional care – that expertise may be best provided locally, or through networking into SCHN.

Services (in approximate order of priority)	Requirements for delivering high quality care	Required Setting (Must Have)		
		Local	SCHN – Locally Delivered	SCHN – Sydney
Mental Health	Strengthen psychiatry and supporting input for children and adolescents with mental health issues at CHS, ensuring that the staffing model for the integrated adolescent ward is consistent with the proposed admission criteria	Horizon 1		
Level 1 PICU	24-hour mechanical ventilation and simple invasive cardiovascular monitoring in accordance with the Level I PICU proposal. Commence planning immediately, but likely to be realized in Horizon 2	Horizon 2		
Allied Health	Strengthen Allied Health support into all aspects of general and community paediatrics, to provide interprofessional assessment and treatment, including local outreach	Horizon 1		
Gastroenterology	Strengthen the supporting team for paediatric gastroenterology, to including a RN 3.1 Specialist Nurse and better access to Allied Health. Formalise arrangements for consultants from SCHN when the paediatric gastroenterologist is not on-call.	Horizon 1	Horizon 1	
Paediatric imaging	Strengthen the CHS Imaging service to ensure that paediatric images are reported on (in-hours) or reviewed (after on-calls where paediatric radiologists not available) – formalize and document arrangements. Upskill paediatric staff in reviewing images. Develop formal professional links with SCHN for CHS paediatric radiologists	Horizon 1	Horizon 1	
Rheumatology	An outreach service from SCHN needs to be developed. The current CHS adult rheumatologist providing a consult service to paediatrics retires in 12 months		Horizon 1	
Paediatric endocrinology	Formalise arrangements for out-of-hours consult from SCHN when the CHS paediatric endocrinologists are not on-call		Horizon 1	
Neurology	Strengthen relationship with SCHN in the short-term, to include better access for consults (preferably video) on acute patients and outreach (virtual & in person) outpatients	Horizon 3 (Expand)	Horizon 1-2 (Strengthen)	
Cardiology	Strengthen the current arrangement for off-site reviews of PCU and outreach clinics from SCHN. Any shift to a service, rather than individual-based arrangement will need to ensure that current CHS capabilities in PCU are well understood.		Horizon 1-2	
Nephrology	Implement an outreach service from SCHN, to provide both acute consult services and outpatient clinics (blend of virtual / in-person)		Horizon 2	
Respiratory	Occasions of service (c. 400) and population demographics may warrant expansion of this service locally in future years. Expansion should include expertise in sleep, and ability to support infants requiring long-term respiratory support at home.	Horizon 2-3		

Specialist Services – Prioritisation (2/2)

Providing appropriate specialist expertise for children in the ACT and CHS catchment is a key component of delivering exceptional care – that expertise may be best provided locally, or through networking into SCHN

Services (in approximate order of priority cont.)	Requirements for delivering high quality care	Required Setting (Must Have)		
		Local	SCHN – Locally Delivered	SCHN – Sydney
Dermatology	A succession plan is required for the current adult consult support into paediatrics, provided by 2 CHS adult dermatologists.	Horizon 2		
ENT	The CHS ENT service should be strengthened to provide diagnostic and therapeutic interventions for children with airway issues (excluding major/complex). This is dependent on implementation of a Level 1 PICU and some upskilling/reskilling for the ENT surgeons.	Horizon 2		
Rehab Physicians	Strengthen the relationship with SCHN in the short-term, to include better access for consults (preferably video) on acute patients and outreach (virtual & in person) outpatients. Consider a local service for complex orthotics, and complex co-morbid patients (e.g. cerebral palsy) in the longer term.	Beyond Horizon 3	Horizon 2	
Neurosurgery	Strengthen and formalize the specialist service provided from SCHN, to include 24/7 consult (preferably video), and outreach virtual clinics. Clear referral pathways into SCHN.			Horizon 2 (strengthen)
Oncology / Haematology	Strengthen and formalize the specialist service provided from SCHN, to include 24/7 consult (preferably video), and outreach virtual clinics, in addition to the current in-person clinics. Clear referral pathways into SCHN. Explore opportunities to integrate the CHS paediatric trained haematologists into this service.			Horizon 2 (strengthen)
Infectious Diseases	Implement an outreach service from SCHN, to provide both acute consult services (24/7) and outpatient review as needed (virtual outreach / clear referral pathway to Sydney)			Horizon 3
Immunology	Whilst there is good support for paediatrics from 4 adult immunologists at CHS, there may be benefit in implementing a consult and outreach (virtual & in person) service from SCHN, for the cohort currently going to Sydney for care		Horizon 3	
Genetics	Consider a dedicated local paediatric genetics service in the longer term, although noting that the current model of genetic counsellors providing local support and case management works well. The current model is, however, leading to delays in access to a clinical geneticist, particularly for NICU and FMU patients. New genomic technologies are also impacting the ability to provide a safe and timely service – this needs more urgent attention.	Horizon 3		
Orthopaedics	Consider a specialist paediatric orthopaedic surgeon as part of the orthopaedic surgical team at CHS to provide on-site acute consults and clinics, with formal networking into SCHN for major/complex cases and 24/7 cover	Horizon 3		Horizon 2 (strengthen)

Shared Care Principles

Networking arrangements with SCHN and regional hospitals that refer to CHS need to be strengthened. A set of principles are proposed as a starting point for discussion to guide shared care that is patient and family-centred.

- Safe and effective services as locally as possible (not local services as safely as possible)
- Tertiary/Quarternary services provided based on service agreements, which set out activity, quality, access and financial parameters (not based on individuals)
- Clear and equitable funding arrangements based on a principle of 'the funding follows the patient'
- Coordinated care supported by appropriate structures and process
    - Named medical specialist in the quarternary centre with overall clinical responsibility and named specialist at CHS who takes local responsibility at a patient level
    - Identified nursing lead at CHS for care coordination
    - Identified pharmacist lead at CHS for care coordination
    - Written care plans for unplanned admissions / out of hours for patients receiving treatment outside their locality
    - Identified contacts for families
- Regular attendance by local team (interprofessional) at relevant specialist MDTs
- Robust two-way systems of communication
- Written guidelines to support levels of care / inclusion & exclusion criteria
- Written protocols for specialist care carried out locally (e.g. administration of chemotherapy) with defined responsibilities
- Education and training programs for staff in all settings - shared

Care of the critically ill and deteriorating child

Providing care for the critically ill or deteriorating child

Analysis of CHS care settings highlights a gap in care provision for critically unwell children aged between 1 and 12 years old, with no child or adolescent suitable facility with the skills and capabilities to provide organ support, on even a temporary basis, to enable stabilisation and safe transfer to Sydney Children's Hospital Network.

Context

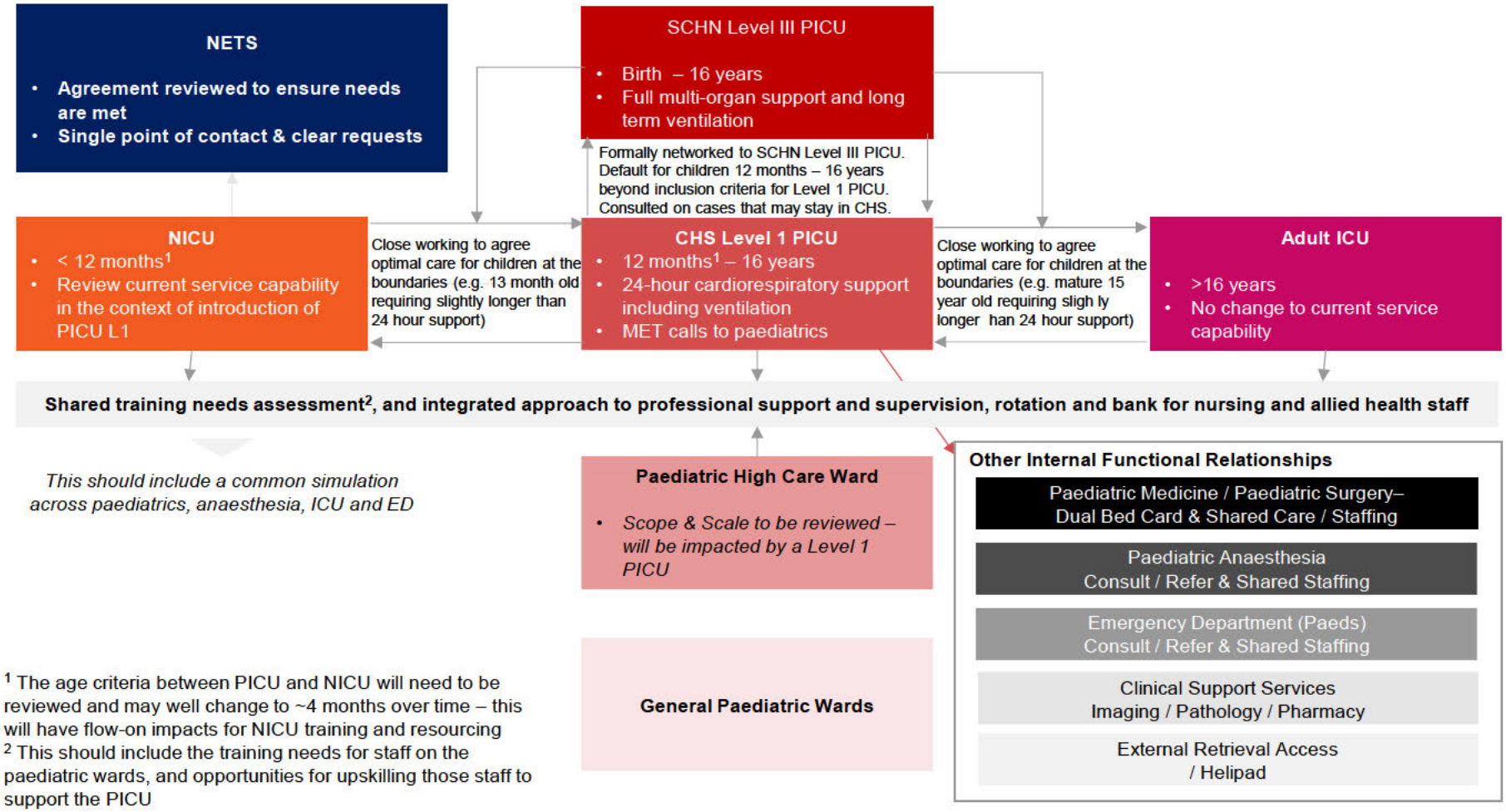
- Canberra Health Services has a well established NICU and ICU capability, to manage critically unwell babies and adults for both short and longer-term organ support. This enables stabilisation and high quality care for these cohorts, irrespective of whether their entire episode of care takes place in Canberra Hospital, or whether they require transfer to/from Sydney Children or Adult Networks for quarternary care (e.g. specialised burns)
- For children between the ages of 4 weeks and 16 years of age, this capability is not currently in place, although NICU will accept children up to 2 years of age (longer stay for <12 months, stabilistation/transfer for 1-2 years), and the adult ICU will sometimes accept children over 2 years old for stabilisation prior to transfer only, but there is often debate regarding the most appropriate care setting and care providers for children between 2 and 12 years old.
- There is currently a 'high care ward' for paediatric patients, but the capability is limited to close observation and CPAP.
- The College of Intensive Care Medicine of Australia and New Zealand (CICM) sets clear minimum standards for Paediatric Intensive Care Units, including the level of throughput required to be a Level III (400) or Level II (200) PICU. The current catchment for Canberra Health Services would not meet these throughput requirements in the short to medium term.
- There is acknowledgement from across disciplines (ICU, NICU paediatric medicine, paediatric surgery, paediatric anaesthetists) within CHS that the current system is sub-optimal and creating unnecessary risks for unwell children in the ACT and surrounding catchment. A number of business cases and alternative Models of Care have been put forward previously, but not adopted.
- The new Critical Services Building includes space for a dedicated PICU, co-located with the adult ICU service.
- The nomenclature in use in describing PICUs has created confusion, as the term PICU has become synonymous with the CICM Level III PICU, which is a highly specialist service that supports multi-organ failure in the most complex of cases.

Characteristics of a Level I PICU

- The current casemix at Canberra Hospital would justify a Level I PICU – a facility recognized by CICM as suitable in a rural/regional and lower volume tertiary context for the stabilisation and short-term single organ support of children.
- **Capabilities** – A Level I ICU should be able to provide:
  - Immediate resuscitation
  - Mechanical ventilation and simple invasive cardiovascular monitoring in the short-term (<24 hours)
  - Monitoring and prevention of complications in 'at risk' medical and surgical patients
  - Established relationship with Level II or III PICU (SCHN)
- **Inclusion Criteria –** Typical inclusion criteria would be:
  - Patients with complex fluid, electrolyte, nutritional and metabolic requirements;
  - Post-surgical patients requiring special observations and care;
  - Unstable medical patients requiring special observations and care beyond the scope of a conventional ward;
  - Patients requiring short-term mechanical ventilation or airway observation;
  - Patients requiring short-term vasopressor support
- **Staffing Requirements** – There is significant flexibility in how Level I PICUs are staffed, but should include:
  - A Medical Director who is a fellow of the CICM, or meets the CPD requirements of the college
  - 1:3 Roster of specialists with experience in intensive care medicine, who meet the CPD requirements of the college (could be dual-trained)
  - At least one registered medical practitioner with an appropriate level of experience rostered to the PICU at all times
  - 1:1 or 1:2 nursing (casemix dependent), with a nurse in charge who has a post registration qualification in intensive care and at least 50% of rostered staff with a post registration qualification
  - At least 2 registered nurses present at all times when there are patients in the unit
  - Access to allied health, including dietician, occupational therapist and speech therapist as required

Proposed Functional Relationships for CHS – Level 1 PICU (end state)

The model below illustrates the proposed approach to providing safe short-term critical care support for children who are at high risk of deterioration or critically unwell.



[1] The age criteria between PICU and NICU will need to be reviewed and may well change to ~4 months over time – this will have flow-on impacts for NICU training and resourcing
[2] This should include the training needs for staff on the paediatric wards, and opportunities for upskilling those staff to support the PICU

Proposed Characteristics of a CHS Level 1 PICU

The core purpose of a Level 1 PICU at CHS should be to provide better care to the current cohort of children and families who receive care at CHS, and reduce harm and adverse events. Patients requiring short-term, lower complexity critical care support will receive it in a more appropriate setting, close to home.

Proposed principles of establishing a CHS Level 1 PICU

- Is child and family-centred, providing a child appropriate and psychologically safe environment
- Supports the existing cohort of children and families receiving care at CHS (i.e. it is not intended to increase overall service complexity in paediatric disciplines) – all 'planned' admissions to Level I PICU must be formally agreed between treating surgeon, anaesthetist and PICU attending clinician
- Supports sustainability of other paediatric services at Canberra Health Services (including paediatric medicine and Emergency Department), including through exploring staffing models that can strengthen these services (e.g. dual-trained general paediatrician / intensivist) – with strong, integrated governance
- Has a strong and formal relationship with the SCHN Level III PICU, including regular case reviews, consultation with SCHN on any variation from agreed inclusion/exclusion protocols
- Is in a physical location which supports strong functional relationships with paediatric teams and beds (including prompt response to MET calls), as well as ED, NICU and ICU and retrieval facilities (ie.helipad)
- Consolidation of staff skills and training appropriate to the clinical requirements and location of services provided

Target Outcomes

- Reduction in mortality for all children requiring ICU support from the CHS Catchment (both transferred and non-transferred)
- Reduced rate of cardiac arrest in children <16 years of age
- Reduced MET call response times
- Reduced transfers to SCHN for children with a total LoS in SCHN of less than 3 days
- Improved child & family experience
- Improved staff satisfaction (patient safety conversations) and staff resources/training

Next Steps

- **Reconvene PICU working group to agree the outline proposal**
- **Develop staffing options, with input from paediatric medicine, paediatric emergency teams and allied health**
- **Agree the most appropriate physical location for the Level 1 PICU considering the significant trade-offs between proximity to different functional relationships, including helipad, and potential cost differences**
- **Formalise and sign-off interim arrangements (see overleaf)**

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for escalation

- Care should be escalated in accordance with the PEWS escalation table (see Appendix)
- Dependent on the PEWS score, escalation is initially to the team leader, followed by Registrar then Consultant
- Nursing staff are responsible for continuing to escalate, via the Nursing Team Leader, to senior medical review, should they have concerns regarding the medical response, or ongoing deterioration of the patient
- Children & Families also have the right to escalate care, should they feel that the healthcare team has not fully recognized the patient's changing health condition – the nursing team should facilitate this.

Criteria for a MET call

- A MET call is made when there are signs of serious clinical deterioration in a child.
- MET calls should be made in accordance with the established PEWS and MET criteria (see Appendix)
- MET calls are everyone's responsibility – the nurse or doctor who identifies that MET criteria have been met, should initiative the MET call.
- There are known instances where the current MET criteria are overly sensitive to children with pre-existing cardiorespiratory conditions. Any exceptions to applying MET criteria for individual patients, must be document in their notes, and approved by the admitting consultant.
- NICU respond to MET calls for children < 1 year
- ED respond to MET calls for children ≥ 1 year

Criteria for a Code Blue

- A Code Blue should be called when there is a medical emergency for a child (e.g. cardiac or respiratory arrest)
- Code Blue's are everyone's responsibility and should be called immediately by the first clinician who identifies the emergency.

It is acknowledged that moving to a Two-Tier system would be a change from current practice, and further work will be required both to refine criteria (including the issue of sensitivity of PEWS in specific cases), and to operationalise

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for admission as a High Acuity Patient[1]

- >10 days and <16 years on admission
- Persistent PEWS >4 but not deteriorating
- Clinically unstable medical or surgical patient requiring, or expected to require frequent observations and/or medical review and a 1:2 nurse to patient ratio

Inclusions

- Patients with respiratory compromise requiring acute non-invasive respiratory support
  - FiO2 <0.5
  - HFNPO ≤2L/kg/min
  - Bubble CPAP <8cm H2O
- Patients requiring infusions such as magnesium sulphate, salbutamol or aminophylline (or 2 or more infusions for pain management)
- Patients with intercostal catheters (chest drains)
- Sepsis with haemodynamic stability. If inotropes are required, admission to an intensive care is required
- Patients requiring continuous monitoring post complex surgery
- Diabetic ketoacidosis with a rising pH which is ≥ 7.0.
- Other children requiring multidisciplinary intervention and frequent monitoring / with potential for clinical instability requiring close monitoring and 1:2 nursing support

[1] These patients will be admitted to the High Care Ward, noting that this ward also accepts lower acuity patients

Criteria for transfer to SCHN

- > 12 months and < 12 years
- < 12 months with complex care needs or who are not responding to short term intensive care in the NICU
- Diabetic ketoacidosis if pH <7 or not rising,
- Patients with severe respiratory compromise
  - pCO2 of ≥50mmHg in the absence of chronic lung disease (and not improving despite treatment over a 2-hour period)
  - required FiO2 of > 0.5
  - require > 2L/kg of HFNPO2
  - require ≥8cm PEEP on CPAP
  - Children needing sedation to maintain HFNPO2 or CPAP
- Apnoea despite respiratory support
- Airway risk such as severe croup or post-operative airway compromise
- requirement for ≥ 40ml/kg fluid bolus with persistent hypotension
- requirement for inotropes
- requirement for invasive blood pressure monitoring

Criteria for transfer to SCHN cont..

- arrhythmias such as severe bradycardia
- multi-organ impairment – all ages
- a child requiring multidisciplinary intervention and frequent monitoring for the following conditions
  - neurological conditions
    - use of ≥2 long acting pharmacological agents to control seizures
    - GCS ≤11
  - gastrointestinal
  - Renal
    - anuria or severe oliguria <0.5ml/kg/hr over at least 6 hours
    - rapidly rising creatinine
- Elective or semi-elective surgery with a high risk of complications requiring intensive care, and over 1 year of age.'
- Children in the post-operative phase at high risk of deterioration
- severe single organ failure requiring super-specialised intervention – all ages
  - Dialysis
  - ECMO
- Multi-organ failure – all ages

NETS should be contacted as soon as the above criteria are met. NICU will provide support to all children < 2 years pending retrieval by the NETS team. Adult ICU will provide support to all children ≥ 2 years pending retrieval by the NETS team

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for admission to NICU

- Critically ill infants presenting to Canberra Hospital <1 year who do not have complex care needs and respond to treatment
- Critically ill infants from <2yrs of age with single organ system condition and clear signs of response to treatment such that NICU care will likely be required for a short duration only (approx. 24hrs) and/or for stabilisation prior to transfer.
- All surgery for patients < 10 weeks corrected gestational age (equivalent to 50 weeks post conception age)
- Abdominal Surgery in ex-premature infants < 1 year of age
- Any other major surgery (elective or emergency) in children <1 years of age, that do not meet criteria for transfer to SCHN
- Thoracic/major surgery in children < 2 years of age, where surgery was an emergency or in elective cases where NICU is deemed a back up for high care in case of unplanned complications or clinician deterioration and do not meet criteria for transfer to SCHN with PICU
- *For those infants <1 year of age who will require a direct NICU admission post-operatively, a face-to-face or virtual planning meeting must be held prior to surgery, co-ordinated by the referring surgeon, involving surgeon, anaesthetist, neonatologist, representative paediatrician and Clinical Nurse Managers (CNM). NICU have the right to veto any admission where there are serious clinical safety concerns.*
- *For those infants >1 year of age who may require NICU admission post-operatively, a face-to-face or virtual planning meeting must be held **prior to booking** the surgery, co-ordinated by the referring Surgeon. NICU have the right to veto any admission where there are serious clinical safety concerns.*

Criteria for admission to ICU

- Critically unwell children over 2 years presenting to Canberra Hospital where the medical situation involves a single organ system and there are clear signs of response to treatment such that ICU care will likely be required for a short duration only (approx. 24hrs), and too unwell for the High Care Ward.
- Children aged over 12 years deemed suitable to continue to receive intensive care at CHS beyond the period of initial stabilisation, by CHS Intensivist on-call, admitting paediatrician/paediatric surgeon, NETS NSW and paediatric intensivist, and too unwell for the High Care Ward
- Any major surgery (elective or emergency) in children > 12 years old, that do not meet the criteria for transfer to SCHN, and too unwell for the High Care Ward.
- Any major surgery (elective or emergency) in children < 12 years old, that are physiologically mature and do not meet the criteria for transfer to SCHN, and too unwell for the High Care Ward.
- *For children > 12 years of age who will require a direct ICU admission post-operatively, a face-to-face or virtual planning meeting must be held prior to surgery, co-ordinated by the referring Surgeon, involving surgeon, anaesthetist, intensivist, representative paediatrician and Clinical Nurse Managers (CNM). ICU have the right to veto any admission where there are serious clinical safety concerns.*
- *For children < 12 years of age who may require ICU admission post-operatively, a face-to-face or virtual planning meeting must be held **prior to booking** the surgery, co-ordinated by the referring Surgeon. ICU have the right to veto any admission where there are serious clinical safety concerns.*

Principles for reaching decisions

- There will always be children who fall outside of the criteria set out within this document, or who have exceptional circumstances (clinical, psychosocial or other), which mean that the agreed criteria may not represent best and safest care for that individual.
- Where this is the case, the treating, or admitting consultant should initiate a multi-disciplinary meeting with the appropriate experts (this should usually involve input from the Level III PICU) to agree a care plan that best meets the needs of the individual child and their family.
- These discussion should always be
  - Consultant-to-consultant
  - Captured in the clinical notes
  - Courteous and acknowledging of differing clinical and risk perspectives
- Where consensus cannot be reached, this should be escalated to the Medical Director if not urgent, or Executive On-Call if time critical.

Paediatric Medicine

Executive Summary: Paediatric Medicine[1]

The paediatric medicine service is not sustainable in its current form, and requires substantial action, investment and support, to transition to a high performing service that is able to deliver exceptional care for children and families of the CHS catchment.

Service & Organisational Plan Overview

- The immediate priority for paediatric medicine is to put services onto a sustainable footing (in particular the outpatient service) and strengthen the operating model.
- This will require:
  - Increasing the number of general paediatricians and paediatric endocrinologists, and strengthening job planning and rostering (incl. VMOs and juniors), to ensure that clinical commitments can be met and share of workload is equitable
    - A robust and strategic approach to recruitment of additional staff, to ensure new appointments will contr bute to strengthening the service
    - Early negotiation with ANU for a 50/50 ANU/CHS funded position, to incorporate a significant proportion of the current substantial teaching workload, and drive research within paediatrics
  - New nursing and allied health roles to support sub-specialty services and complex patients, increase outpatient capacity, and drive service innovation. A greater focus on training & upskilling the existing workforce is also required.
  - Strengthened ways of working, which are truly interprofessional across both inpatient and ambulatory settings, and a clearly defined and streamlined pathway for all paediatric outpatient referrals
  - Strengthened administrative, business intelligence and finance support into general paediatrics, to enable proactive management of the service and reduce the administrative burden on senior medical staff
  - Strengthening the specialist services that general paediatricians rely on to provide holistic care to the CHS catchment, with a view to growing some of these specialist services locally over time.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Improvement in a wide range of other clinical outcome measures (see Appendix 5)

[1] Including paediatric endocrinology and paediatric gastroenterology

Operating Principles for Paediatric Medicine

- A principle of interprofessional team-based care in all our inpatient wards and ambulatory services, and interprofessional management of the service
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 18 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.
- Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged.
- Transition to paediatricians on-call for one organisation at any given time, with formal arrangements in place in the interim to ensure an on-call paediatrician for CHS is always available
- An attending consultant system (ward cover during weekdays, in addition to on-call and post-call activities)
- At least two medical handovers every 24 hours (in person or virtually) involve a consultant paediatrician – all high acuity patients discussed
- First point of escalation for junior doctors should always be the consultant on-call, not direct to sub-specialty consultants who are not on-call
- Consultant paediatricians are available for immediate telephone advice for acute problems for all sub-specialties – it is clearly defined when this advice is coming from CHS or SCHN
- Sustainable general paediatric training rotas, with strong training and supervision, and high staff satisfaction

Future Care Pathway

The future care pathway for general paediatrics will provide exceptional care for children of the ACT and surrounding catchment, with access to specialist advice as needed, and smooth transitions between care settings through strengthened interprofessional team working.

Community

Services / experience

- Transfer of care between acute and community paediatrics, based on a child's needs – clear understanding of respective service inclusion/exclusion criteria
- Comprehensive secondary and tertiary care of children in the community who do not require acute intervention
- Post-acute services provided in the community
- Outreach endocrine clinic provided monthly in Gungahlin
- Paediatric medicine provides a consult service to the community where required.

Ambulatory

Services / experience

- Outpatient appointments via GP or specialist referral
- Consultant triage to allocate referrals in accordance with agreed process (see overleaf)
- Specialist clinics available, with a principle of shared care, in:
  - Cardiology
  - Neurology
  - Gastroenterology
  - Allergy/Immunology
  - Respiratory & Sleep
  - Diabetes
  - Endocrinology
  - Intersex
  - Young Adult Transition
  - Gender Dysphoria[1]
- Expanded use of telehealth for both local and specialist clinics
- PDS for day stay and food testing clinic

Emergency

Services / experience

- Paediatric stream in the ED, moving to fully dedicated paediatric area when the CSB opens
- Paediatric Day Stay (PDS) for known patients requiring urgent, day-only admission

Inpatient

Services / experience

- Patients cared for by an interprofessional team in the most appropriate paediatric ward.
- Dedicated paediatric Allied Health team provide support as needed.
- Wards staffed via general paediatric junior medical staff, with daily consultant on-site cover in-hours and offsite on-call out of hours.
- Specialist consults available 24/7 across all subspecialties, in accordance with the agreed service specification

Intervention

Services / experience

- PDS for day interventions (e.g. chemotherapy infusions)
- Endoscopy capacity increased and provided by an integrated gastroenterology/surgical team, based on clinical priority.

Critically Unwell

Services / experience

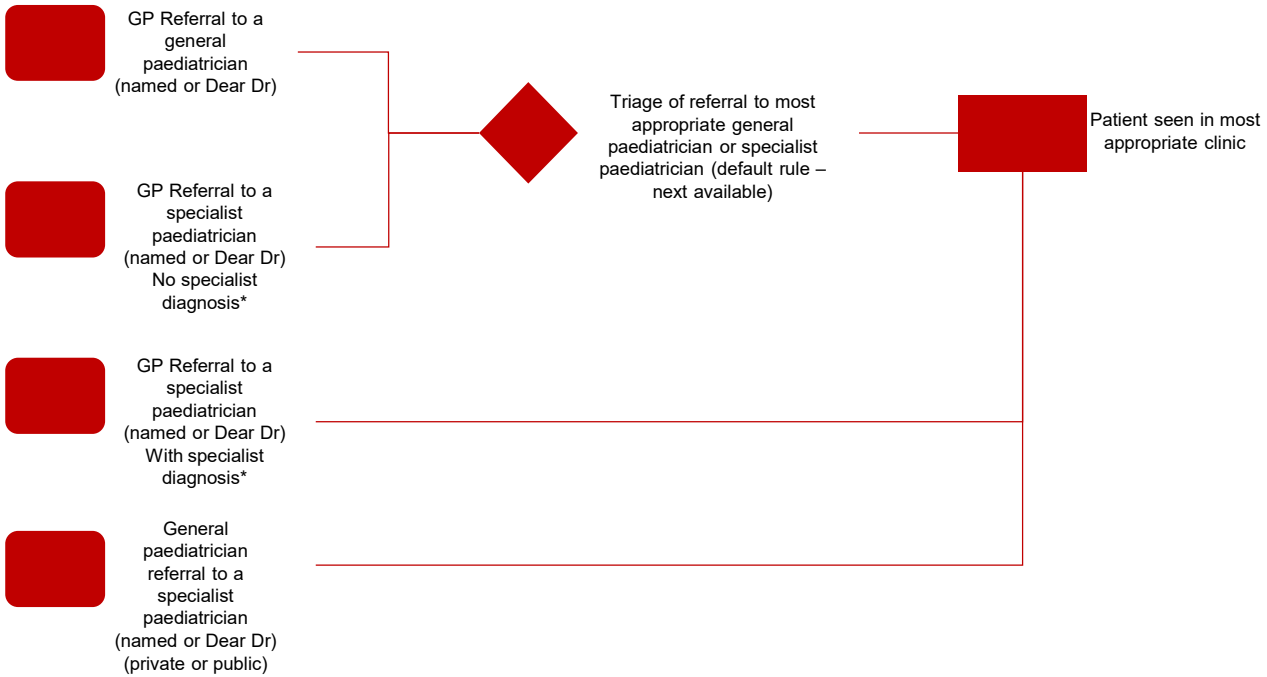
- Level I PICU established to care for children requiring stabilisation and transfer, or short-term mechanical ventilation. MET support provided by the Level I PICU Team.
- High Care Ward for high acuity patients requiring close observation
- Interim arrangements for care of the critically ill / deteriorating child formally adopted.

[1] Subject to resolution of current service commissioning issues

Management of Outpatient Referrals

At the VMO general paediatrician meeting, there was agreement in principle for general paediatrics to be the primary route for GP referrals for paediatric conditions, other than for agreed specialist suspected or confirmed diagnoses.

Referral Flow



Specialist Diagnoses

General paediatricians and specialist paediatricians will need to agree the list of confirmed and suspected diagnoses that warrant direct referral to the appropriate specialist, this may include:

Confirmed

- Cystic Fibrosis
- Sleep Apnoea

Established Referral Criteria

Gastro Referral Criteria

Respiratory Referral Criteria

Endo and Diabetes Criteria

Other Operating Principles

- Transparent and simplified booking rules (2+4)
- Remove barriers to innovation (slot timings)
- Increased use of registrars and fellows
- Optimise available slots (patients contacted via telephone to confirm appointments)

Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Outpatients

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	80	960	960	983	1,007	1,031	1,056
Follow-ups	364	4,364	4,364	4,469	4,576	4,686	4,798
Backlog							
Current Waiting List		1,019					
Reasonable WL		240					
Backlog Clearance		779	200	200	200	179	
Backlog Follow-ups		3,541	909	909	909	814	
TOTAL DEMAND			**6,433**	**6,561**	**6,692**	**6,710**	**5,854**

Inpatients & Day Stay[1]

	Monthly	Annual	2021	2022	2023	2024	2025
Elective		119	122	125	128	131	134
Semi-Elective		1,463	1,498	1,534	1,571	1,609	1,648
Statistical Admission		40	41	42	43	44	45
Urgent		3,220	3,297	3,376	3,457	3,540	3,625
TOTAL DEMAND		**4,842**	4,958	5,077	5,199	5,324	5,452

[1] These numbers will be impacted by changes to the ED Model of Care, including introduction of a short-stay unit, and the establishment of a PICU – this modelling is outside the scope of the plan.

Forecast Capacity Requirements

Outpatients

- Modelling has been completed to estimate the number of clinics required to meet the growing demand in outpatients, and address the substantial backlog.
- This suggests between 1,065 and 1,300 clinics will need to run each year for the next five years, to meet the demand.
- Sufficient capacity needs to be planned to ensure this number of clinics is available, after adjustments for on-call, study leave, annual leave and public holidays.

Inpatients and Day Stay

- Modelling has been completed to estimate the number of beds required for paediatric medicine over the next five years at 85% occupancy. Assuming that patients staying less than 12 hours can be managed through the paediatric day stay unit, this suggests the following bed requirements for paediatric medicine:

	2021	2022	2023	2024	2025
Paediatric Day Stay[2]	7	8	8	8	8
Inpatient Beds - <12 years	18	19	19	19	20
Inpatient Beds - ≥ 12 years	4	5	5	5	5
TOTAL BEDS	**29**	**32**	**32**	**32**	**33**

[2] Calculated as total number of children with a LoS <12 hours ÷ 365 ÷ 0.85. This is a conservative estimate, assuming no more than 1 child per bed per day.

Future Staffing Requirements

Modelling of outpatient demand, and comparison of paediatric medicine against benchmarks, has highlighted the need to strengthen the current service, to provide a sustainable service, address the current substantial waiting list backlog, and deliver an improved working environment for all staff.

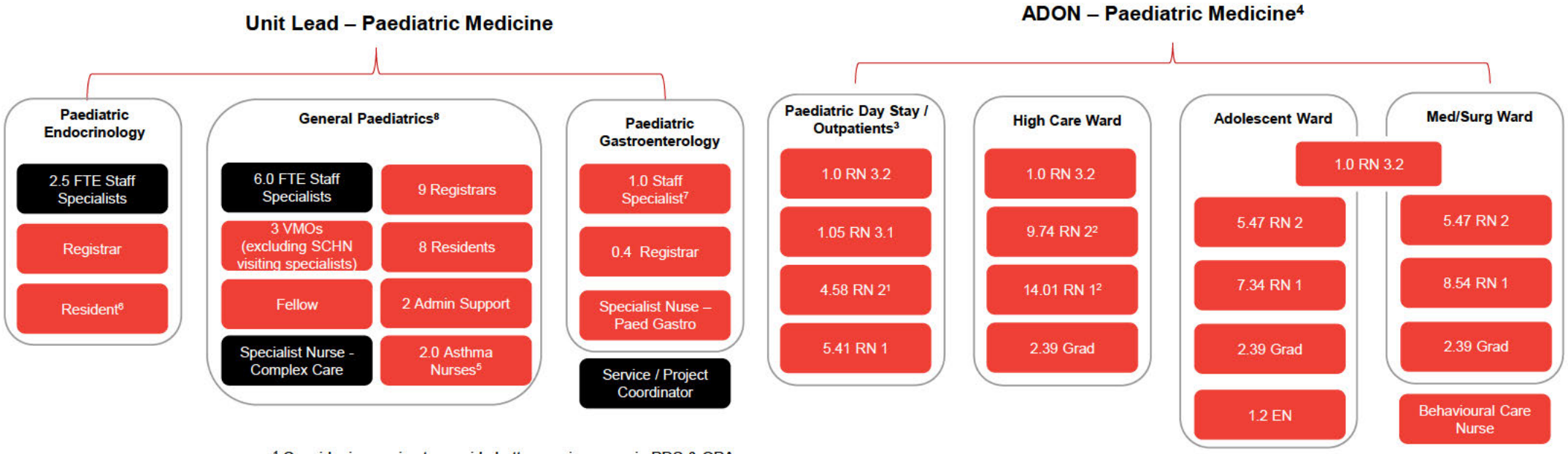
Staff Type	Current FTE	Proposed FTE	Impact
General Paediatricians (Staff Specialists)	3.9	6.0	Moves total paediatric senior medical staffing to accepted benchmarks. Increase in staff specialists provides additional capacity to cover the substantial shortfall in outpatient capacity. (N.B. 6 does not include a Clinical Director for Paediatrics, but does include an assumption of 0.5FTE funded from ANU)
General Paediatricians (VMOs)	3-4[1]	3[1]	Continues to provide capacity for VMOs to provide a valued contribution into the service, and the potential for attractive VMO roles shared with the private sector
Paediatric Gastroenterologist	1.0	1.0	The service will require Nursing & Allied Health Input, along with strong links into SCHN to ensure sustainability
Paediatric Endocrinologist	2.0	2.5	Meets the recommendations of the Endocrine Review 2018 and associated benchmarks. Enables more equitable distribution of workload across all paediatric medicine physicians.
RN 3.1 Nurse Specialist	0.0	2.0	1.0 Gastroenterology; 1.0 Complex Care Patients. Facilitates service innovation, care coordination and a case management approach to complex patients. Supports inpatients. A low-cost approach to addressing the outpatient backlog for clinically appropriate cases.
Allied Health	0.0	3.0	Facilitates service innovation, care coordination and a case management approach to complex patients, in addition to outreach / home visiting where required. A low-cost approach to addressing the outpatient backlog for clinically appropriate cases.
Project Coordinator	0.0	1.0	Provides the senior administrative resource required to deliver against the substantial change program required to deliver against the service & organisational plan

Principles for attracting and retaining a high quality medical workforce

- Retain proportionality between direct clinical care and other duties (min 75/25) across staff specialist and VMO workforce
- Attractive Staff Specialist and VMO roles, which strengthen capability and capacity within the ACT
- Incorporate values & behaviours within the recruitment process, as equally important to clinical skills for new appointments
- Involve senior medical staff in appointment decisions
- Consider fixed tenure for leadership roles, to provide development opportunities and experiences for a greater number of individuals who are suitably skilled and have interest
- Seek to bring in additional expertise to CHS through recruiting / growing general paediatricians, with advanced training in other specialties, including:
    - Adolescent Health
    - Gastroenterology
    - Respiratory
    - Cardiology
    - Neurology
    - Nephrology
    - Mental health (CAMHS to recruit to this)
    - Intensive care medicine (TBC)
- Where recruitment identifies paediatricians with dual-training, clear parameters are set regarding their role in general paediatrics, including: expectation regarding equal contribution to the on-call rota – usually 5 years; contribution to general paediatric outpatient clinics – usually 1-2; referral criteria for specialist clinics; relationship with SCHN MDT – usually formalised; gateways for expansion of specialist components of the service (demand or other parameters)

Proposed Governance

The team structure should support the functional model we are seeking to implement, including collaboration within and across disciplines and teams, sharing of non-clinical tasks equitably amongst medical staff and increased interprofessional working.



Key

- Existing
- Strengthen / New – CHS Funded
- Strengthen / New – If commissioned

[1] Consider increasing to provide better nursing cover in PDS & OPA
[2] Consider decreasing to a NHPPD of 7.5
[3] The new CNC and Allied Health roles should also support paediatric day stay and outpatient activity
[4] There is a case for a dedicated ADON for paediatrics, to work alongside the Allied Health and Medical Lead as part of an integrated MDT leadership team
[5] Recommended that the asthma nurses currently in the community are transferred across to the acute team, to create a larger scale team of specialist nurse input and support both inpatient and ambulatory acute care
[6] The resident is currently informally 'borrowed' from Team B – consideration should be given to formalising the role
[7] Noting that this role also contributes to general paediatrics, including 1:8 on-call
[8] Note that the additional Allied Health staff recommended on page 38 are included in the Allied Health governance on page 64

Action Plan

No.	Action	Deadline	Owner
1	Recruit Project Coordinator team to support operational plan implementation		
2	Early discussions with ANU to agree a 50/50 ANU CHS funded post in paediatric medicine to lead teaching & research		
3	Strengthen interprofessional handover and huddles, and monitor compliance		
4	Implement interprofessional fortnightly unit leadership meeting, with Business Intelligence and Finance support		
5	Formalise and sign-off outpatient protocols, including defined specialist diagnoses, and monitor adherence. Streamline current processes for outpatient booking and autonomise senior staff, and identify opportunities & incentives for revenue generation		
6	Complete consultation on transfer of the asthma nurses to the acute team, including the opportunity to create an acute specialist nursing workforce as part of an interprofessional paediatric medicine team, with input from medical & allied health		
7	Test new handover arrangements, organised by on-call team, and with equipment available for consultants to dial-in		
8	Review nursing ward expenditure to identify total cost saving potential and update financial forecasts accordingly		
9	Formalise the Unit Lead role, including roles & responsibilities, tenure, and any associated reduction in clinical commitments		
10	Identify training leads in each discipline, and complete training needs assessment against aspirations of the organisational plan		
11	Confirm current baseline against proposed outcome measures		
12	Implement improved communication with VMOs in paediatric medicine, including up-to-date mailing lists, and a suitable virtual teaming environment		
13	Implement revised governance arrangements, including consultation as required		
14	Recruit to new staff specialist positions, applying principles for attracting and retaining high quality workforce		
15	Recruit to new nursing positions, including defining job role and focus to meet plan requirements, with input from medical and Allied Health leads		
16	Recruit to new Allied Health positions, including defining job role and focus to meet plan requirements		
17	Implement integrated paediatric medicine budget, reporting and forecasting, with monthly reporting to the leadership team		
18	Implement revised service for Gender Dysphoria in collaboration with ACT Health, against an agreed deadline for improvement or closure of the service. This should include specialist mental health services for gender and alignment to NSW guidelines		
19	Formalise the timetable for CAMHS support into the wards as part of service planning, including who is on-site / on-call. Agree future staffing model for the integrated adolescent ward, in line with planned admission criteria.		
20	Implement a case management approach to complex patients, including transfers to SCHN		
21	Implement revised job plans, staff rostering and on-call arrangements, to meet organisational plan capacity. As part of this, complete a full review of non-clinical 'jobs to be done' transparently with the team, and allocate according to capacity and personal areas of interest/focus		
22	Revise Blue Star Clinic Inclusion & Exclusion criteria to limit paediatric medicine involvement to medical management (weaning) – explore options for more integrated interprofessional support, but with default being discharge to GP		
23	Transition Services Committee to be reconvened to establish transition services for all cohorts and subspecialties, commencing with gastroenterology and general medicine.		
24	Review ROMAC policy and inclusion criteria to ensure these are fit for purpose, and in line with ethical principles, and CHS clinical capabilities		
25	Seek advice from the national specialist advisory group for Adolescent Medicine on the Model of Care that should be considered for CHS in the longer term		

Paediatric Surgery

Executive Summary: Paediatric Surgery

The paediatric surgery service is currently meeting the needs of the CHS catchment for the casemix that can safely be delivered at Canberra Health Services. The current staffing model is sustainable for the horizons of this plan, but succession planning is needed early, alongside improvements to ways of working.

Service & Organisational Plan Overview

- The immediate priority for paediatric surgery is to improve ways of working, in order to foster a positive team environment across all staff, and meet the Charter on the rights of Children & Young People in Healthcare Services in Australia.
- There is also a need to plan recruitment to a new permanent consultant level position, as part of succession planning for the future. Early recruitment to this position would assist in reducing the ambulatory waiting list to three months.
- This will require:
  - Formalising the Unit Lead role for paediatric surgery, with clear roles & responsibilities
  - Adopting a set of operating principles, which include strengthening relationships, and greater visibility and interaction with other disciplines, particularly paediatric medicine, other surgical specialties operating on children, and the Emergency Department
  - Increasing awareness and understanding amongst the team in relation to creating a psychologically safe work environment, and what it takes to deliver this
- Development of a Level I PICU in the short to medium term (within the next 3 years) will enable more children to have their surgical treatment in Canberra, in particular, those who may require short-term ventilation post surgery. (see page 24)
- Strengthening and formalising specialist input into Canberra Health Services from Sydney Children's Hospital Network, including nephrology and haematology will support delivery of exceptional care. (see page 20)
- There is a need for closer joint working with other surgical specialties with high volumes of paediatric activity, including ENT, Orthopaedics and Neurosurgery. Once a Level 1 PICU is established, ENT can provide a more comprehensive airways service, from their existing team. Over time a dedicated paediatric orthopaedic surgeon, networked into SCHN, is also recommended.
- Adult neurosurgical involvement in children with head injury needs to be reviewed.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to treatment
• Reduced variation from time of referral to treatment by Category
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Proportion (%) of congenital elective orchidopexy procedures performed before the age of 12 months
• Reduced unplanned returns to theatre
• Reduced transfers to SCHN after elective surgery

Operating Principles for Paediatric Surgery

- Safe and effective services as locally as possible (not local services as safely as possible)
- A principle of interprofessional team-based care in all our inpatient wards and ambulatory services, and interprofessional management of the service
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Delivery against the nine core competencies of the Royal Australasian College of Surgeons (see overleaf)
- Every unwell child presenting with an acute surgical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) or higher paediatric surgical rota within a clinically appropriate time (typically 4 hours or less).
- Paediatric surgeons on-call for one organisation at any given time
- Two daily surgical rounds, involving the surgical team and and nursing team leader
- Sustainable paediatric surgical training rotas, with strong training and supervision, and high staff satisfaction
- A principle of consultant-to-consultant communication and resolution of issues within and between departments
- Public outpatient capacity reserved for new and follow-up public outpatient activity (e.g. no routine transfers of post-acute follow-up from private to public)
- Equitable access to paediatric surgery for the CHS catchment in accordance with clinical needs

RACS Nine Core Competencies

Medical Expertise

Medical Expertise relates to the acquisition, integrating and application of medical knowledge, clinical skills, and professional attitudes in the provision of patient care:

- Demonstrating medical skills and expertise
- Monitoring and evaluating care
- Managing safety and risk

Judgement – Clinical Decision Making

Judgement – clinical decision making involves making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance, and promotion:

- Considering options
- Planning ahead
- Implementing and reviewing decisions

Technical Expertise

Technical expertise relates to safely and effectively performing surgical procedures conducted in the unit in which they are training or working:

- Recognising conditions for which surgery may be necessary
- Maintaining dexterity and technical skills
- Defining scope of practice

Professionalism and Ethics

Professionalism and ethics involves demonstrating commitment to patients, the community, and the profession through the ethical practice of surgery:

- Having awareness and insight
- Observing ethics and probity
- Maintaining health and well-being

Health Advocacy

Health advocacy involves responding appropriately to the health needs and expectations of individual patients, families, carers and communities:

- Caring with compassion and respect for patient rights
- Meeting patient, carer and family needs
- Responding to cultural and community needs

Communication

All surgeons are required to be able to communicate effectively with patients, families, carers, colleagues and other staff:

- Gathering and understanding information
- Discussing and communicating options
- Communicating effectively

Collaboration and Teamwork

Collaboration and Teamwork involves developing a high level ability to work in a cooperative context to ensure that the surgical team has a shared understanding of the clinical situation and can complete tasks effectively:

- Documenting and exchanging information
- Establishing a shared understanding
- Playing an active role in clinical teams

Management and Leadership

Management and leadership involves leading the team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members:

- Setting and maintaining standards
- Leading that inspires others
- Supporting others

Scholarship and Teaching

As scholars and teachers, surgeons demonstrate a life-long commitment to reflective learning, and the translation, application, dissemination, and creation of medical knowledge:

- Showing commitment to life-long learning
- Teaching, supervision and assessment
- Improving surgical practice

Future Care Pathway

The care pathway for paediatric surgery includes services provided by the paediatric surgeons and paediatric surgical services provided by adult specialties – there is limited overlap / collaboration between these groups. Gaps include care of the critically unwell child, and management of emergency cases when the paediatric registrar is not on call.

Community

Services / experience

- Referral from community into paediatric surgery via written referral (not common)

Ambulatory

Services / experience

- Outpatient appointments via GP or specialist referral
- Surgical clinics available in:
  - Orthopaedics (Fracture Clinic)
  - General
  - Plastics
  - Ophthalmology
  - ENT
- All clinics take place in age-appropriate settings
- General paediatric surgery includes:
  - Paediatric Thoracics
  - Paediatric Urology
  - Paediatric gastroenterology
- Expanded use of telehealth for both local and specialist clinics

Emergency

Services / experience

- Paediatric Surgeon on-call 1:4
- Registrar on-call rota shared between paediatric and general surgery, with the skills necessary to care for acute paediatric cases.
- Specialist clinics (e.g. fracture clinic) provided in an age-appropriate environment

Inpatient

Services / experience

- Paediatric surgical patients looked after in the general paediatric wards, with high consultant visibility
- Shared care of patients in the high care ward, with consultant attendance at daily handovers for high acuity patients.

Intervention

Services / experience

- All inpatient interventions carried out at Canberra Hospital
- Children treated equitably in accordance with clinical need.
- Interventions out of scope:
  - Paediatric cardiac
  - Organ transplant
  - Scoliosis
  - Surgical Oncology
  - Neurosurgery
  - Specialised Burns
- Interventions led by adult teams:
  - ENT
  - Orthopaedics
  - Opththalmology
  - Interventional Radiology

Critically Unwell

Services / experience

- Suitability for surgery at CHS tested through pre-anaesthetic assessment.
- Level I PICU established to care for children requiring stabilisation and transfer, or short-term mechanical ventilation. MET support provided by the Level I PICU Team.
- High Care Ward for high acuity patients requiring close observation
- Interim arrangements for care of the critically ill / deteriorating child formally adopted. (see page 24)

Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Outpatients

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	50	600	600	615	630	646	662
Follow-ups	175	2,100	2,100	2,151	2,203	2,256	2,311
Backlog							
Current Waiting List		450					
Reasonable WL		150					
Backlog Clearance		300	100	100	100		
Backlog Follow-ups		1,050	350	350	350		
TOTAL DEMAND			**3,150**	**3,216**	**3,283**	**2,902**	**2,973**

Inpatients & Day Stay[1]

	Monthly	Annual	2021	2022	2023	2024	2025
Elective		549	549	562	575	589	603
Additional Conversions from Backlog			15	15	15		
Semi-Elective		76	76	78	80	82	84
Statistical Admission		1	1	1	1	1	1
Urgent		724	724	741	759	777	796
TOTAL DEMAND		**1,350**	**1,365**	**1,397**	**1,430**	**1,449**	**1,484**

[1] This is the total backlog, assuming conversion rate remains static – recommend spreading over 3 years

Forecast Capacity Requirements

Outpatients

- The outpatient waiting list is currently longer than desirable – reducing it to 3 months (excluding Cat 1s) would require additional capacity.
- Assuming ~9 patients per clinic[2], an additional 1.5 clinics per week would be required to clear the outpatient backlog and meet future growth.

Inpatients and Day Stay

- Reducing the outpatient waiting list, and meeting projected growth in demand, will generate an additional 90 – 150 inpatient and day stay episodes over the next five years. This equates to a total increase in inpatient/day-stay workload of ~10%

Beds[3]

- Modelling has been completed to estimate the number of beds required for paediatric surgery over the next five years at 85% capacity, assuming that patients staying less than 12 hours can be managed through the paediatric day stay unit.

	2021	2022	2023	2024	2025
Paediatric Day Stay[4]	2	2	2	2	2
Inpatient Beds - <12 years	4	5	5	5	5
Inpatient Beds - ≥ 12 years	4	4	4	5	5
TOTAL BEDS	**10**	**11**	**11**	**12**	**12**

[2] Based on current throughput, although worth noting there is substantial variation between clinicians
[3] This does not include beds for children in other surgical specialties, which equate to c. 6 inpatient beds and 1.5 Day Stay Beds currently
[4] Calculated as total number of children with a LoS <12 hours ÷ 365 ÷ 0.85. This is a conservative estimate, assuming no more than 1 child per bed per day.

Proposed Governance

No changes are proposed to the current paediatric surgical team. A decision needs to be made on whether the team sit under the line management of the Women Youth & Children's Division or the Surgical Division. This should not fundamentally alter ways of working, and strong links to both Divisions will be required.

Lead for Paediatric Surgery[1]

Paediatric Surgery

- 3.5 Consultant Level Staff
- 2.0 Registrars
- 1.0 Resident

Key Functional Relationships

- Paediatric Medicine (interprofessional) — High quality, consultant-directed, ambulatory & inpatient care
- Theatres — Efficient scheduling and management of operating lists
- General Surgery — Consistent high quality out-of-hours paediatric surgical care
- Critical Care — Safe management of high acuity post-operative paediatric surgical patients
- Other Adult Surgical — All children undergoing surgery are cared for in line with the CHA Charter
- Anaesthetics — Key clinical interface for paeidiatric surgical patients

[1] Included within the 3.5 Consultant Level Staff

Action Plan

No.	Action	Deadline	Owner
1	Facilitate discussion amongst the surgical team (including juniors) to identify changes required to create a psychologically safe working environment		
2	Agree the future line management arrangements for paediatric surgery (WYC or Surgical Division)		
3	Confirm current baseline against proposed outcome measures and implement routine reporting against agreed outcomes		
4	Explore options for recruiting to a new part-time consultant-level role within current FTE, through forward planning against planned extended leave and reducing clinical commitments for existing senior staff (where possible in accordance with their preferences)		
5	Review paediatric skills and capabilities required for general surgical registrars to provide high quality on-call cover, and support refresher training in paediatric surgery for each rotation		
6	Improve outpatient coding to enable distinction between elective follow-up and post-acute review, to support better future planning		
7	Formalise the unit lead role, including roles & responsibilities in relation to unit management, adherence to operating principles, teaching & support or junior medical staff, clinical safety & quality monitoring, and oversight of surgery on children outside of the paediatric surgical specialty		
8	Unit Lead to attend paediatric medicine interprofessional meeting monthly, to address any issues relating to surgical patients		
9	Strengthen relationships across surgical specialties providing surgical services to children, to develop common standards, and shared learning across teams		
10	Review adult neurosurgical involvement in children with head injuries and formalise early review and opinion by neurosurgical staff		

Community Child Health

Executive Summary: Community Child Health

It is difficult to isolate 'community paediatrics' from the wide range of services provided by WYCCH for women, children & family health, due to the significant service interfaces and overlaps. This plan focuses on the current Child Health Targeted Support Services, but within the context of the other services provided.

Service & Organisational Plan Overview

- The immediate priority for Community Child Health is to move to an interprofessional model of community health care for children, with streamlining of pathways to meet the needs of all children, including those with complexity or vulnerability.
- This will require:
  - Investing in new nursing & allied health roles to work alongside the community paediatricians to provide interprofessional triage, assessment and treatment for the current cohort of children referred to the community paediatrician service.
  - Finalising a revised governance model for WYCCH – this includes some amendments to the proposals set out in the current consultation paper, and realignment of resources to sit two functional teams: Neurodevelopmental and behavioural - NBAT (formerly community paediatrician service); and Targeted Support for Children & Families -TSCF (incorporating former CARHU and other early parenting support services)
  - Establishing the care pathways set out within this plan, including developing the inclusion and exclusion criteria for each pathway
  - Identifying suitable space to accommodate the interprofessional teams at both CHS and in the community
- There are also a number of areas where the services currently commissioned are not adequate to meet the needs of the ACT population, and would benefit from expansion (e.g. early intervention services for children with developmental delays). This will require discussion with ACT Health to agree prioritisation and funding of any service expansion.
- There is a significant need to integrate services, service locations and service records for children & families across ACT Government Directorates, to reduce confusion, service gaps and overlaps, and make it easy for children & families to access the services they need. Although beyond the scope of this plan to address, it is recommended that action is taken to progress cross-directorate action, to deliver exceptional care across the Territory (see Appendix for how this model could be delivered)

Target Outcomes

Measure
• Child & Family Reported Experience

• Child & Family Reported Outcomes
  • Social & Emotional Wellbeing
  • Peer relationships
  • Behavioural problems
  • Parent-child relationship
  • Family Functioning

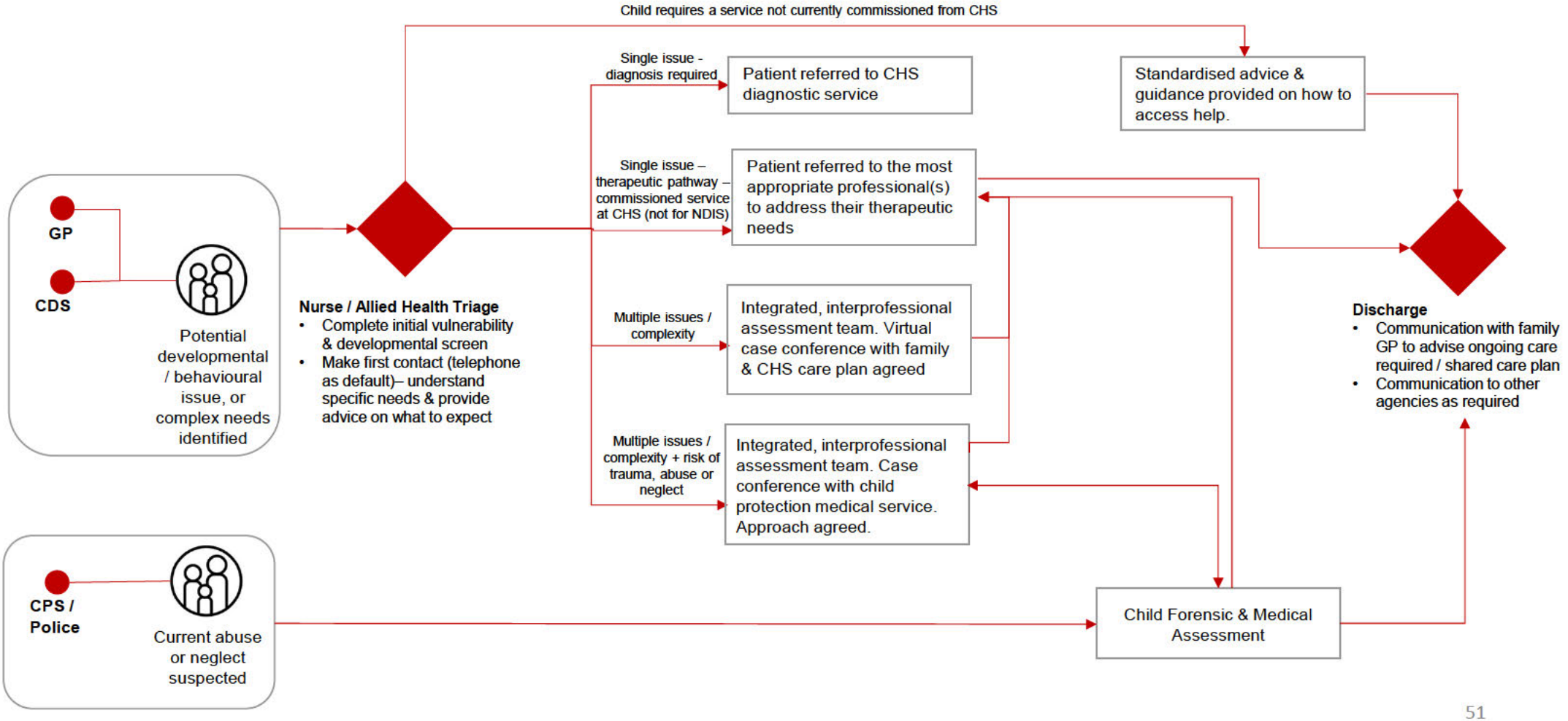
• Staff satisfaction / Engagement
• Time from referral to first contact
• Time from referral to assessment
• Time from referral to treatment commencement
• Prescribing rates for psychotropic medications in children with behavioural/developmental diagnoses

Operating Principles for Community Child Health

- A principle of interprofessional team-based care and interprofessional team-based management of the service
- Integrated teams applying standardised practice, particularly in similar services across NBAT & TSCF (e.g. psychometric testing)
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Clear distinction between services provided by medical teams with NBAT & TSCF, and clarity on roles & responsibilities within the team
- A commissioned services approach, with clear inclusion and exclusion criteria
- Single care record within CHS (prior to a single children's health and care record across directorates)
- Child-centred, family-oriented, holistic care
- Operational lead, who understands fully the day-to-day work, strategic issues, population needs and workforce requirements and can lead and represent the service effectively
- Single paediatric medical lead across Community Child Health to oversee clinical services, medical care and pathways
- Community paediatricians supported to make the best use of their skills and expertise, focussing their time on what only the community paediatrician can do
- A principle of shared care with General Practitioners, with children returned to the care of their GP as soon as it is safe and appropriate to do so
- A strengthened nursing and allied health service to improve access to commissioned services and drive service innovation, including consideration of high-level nursing roles to support the review of children with ongoing complex health needs
- Rotate staff through most challenging roles (e.g. child protection & family violence training) to minimize vicarious trauma and strengthen expertise across the larger team
- Professional Development embedded within/across teams with sufficient capacity to provide ongoing training, education and upskilling
- Ensure services are culturally appropriate and aware including recruitment of Aboriginal Liaison Officers and health workers

Future Care Pathway

CHS could organise its community services for children and families (including vulnerable children & families) to deliver a more integrated, interprofessional and streamlined service, through better integrated working between professionals and teams, and strengthened Allied Health and Nursing capabilities.



Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Neurodevelopmental & Behavioural

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	32	384	384	394	404	414	424
Follow-ups[1]	159	1,908	1908	1,954	2,001	2,050	2,100
Backlog							
Current Waiting List		400					
Reasonable WL (3 months)		96					
Backlog Clearance		304	101	101	101		
Backlog Follow-ups		1,514	503	503	503		
TOTAL DEMAND			**2,896**	**2,952**	**3,009**	**2,464**	**2,524**

CARHU

- CARHU demand is considerably less predictable to model, as it does not align with demographic growth.
- In addition, the workload associated with each child & family referred to CARHU is highly variable, and we know the service has 'latent capacity' by necessity, in order to be able to provide a timely response when needed.
- Time should be created in CARHU diaries each week to contribute to interprofessional case conference meetings.

Forecast Capacity

Resource	FTE	Triage	Psychometric Assessments	Clinics	MDT Case Reviews	Clinical Admin	Admin	Non-Clinical	Total Clinics Adjusted for Leave	Slots per clinic	Total Slots	Total Slots after DNA
Staff Specialist	3.1	0		7	7.5	8.5	8	26%	287	6	1,722	1,435
Registrar / CMHO	2	0		6	3	6	5	25%	246	3	738	615
Allied Health	6	10	12	6	5.5	12	14.5	24%	270	2	540	450
Nursing	2.54	6		3	5.5	5	6	24%	135	2	270	225
												2,725

- Modelling shows that establishing an interprofessional neurodevelopment & behavioural team has the potential to double the current capacity of the service, in addition to creating time and space for interprofessional case conferences and child & family consults.

Future Staffing Requirements

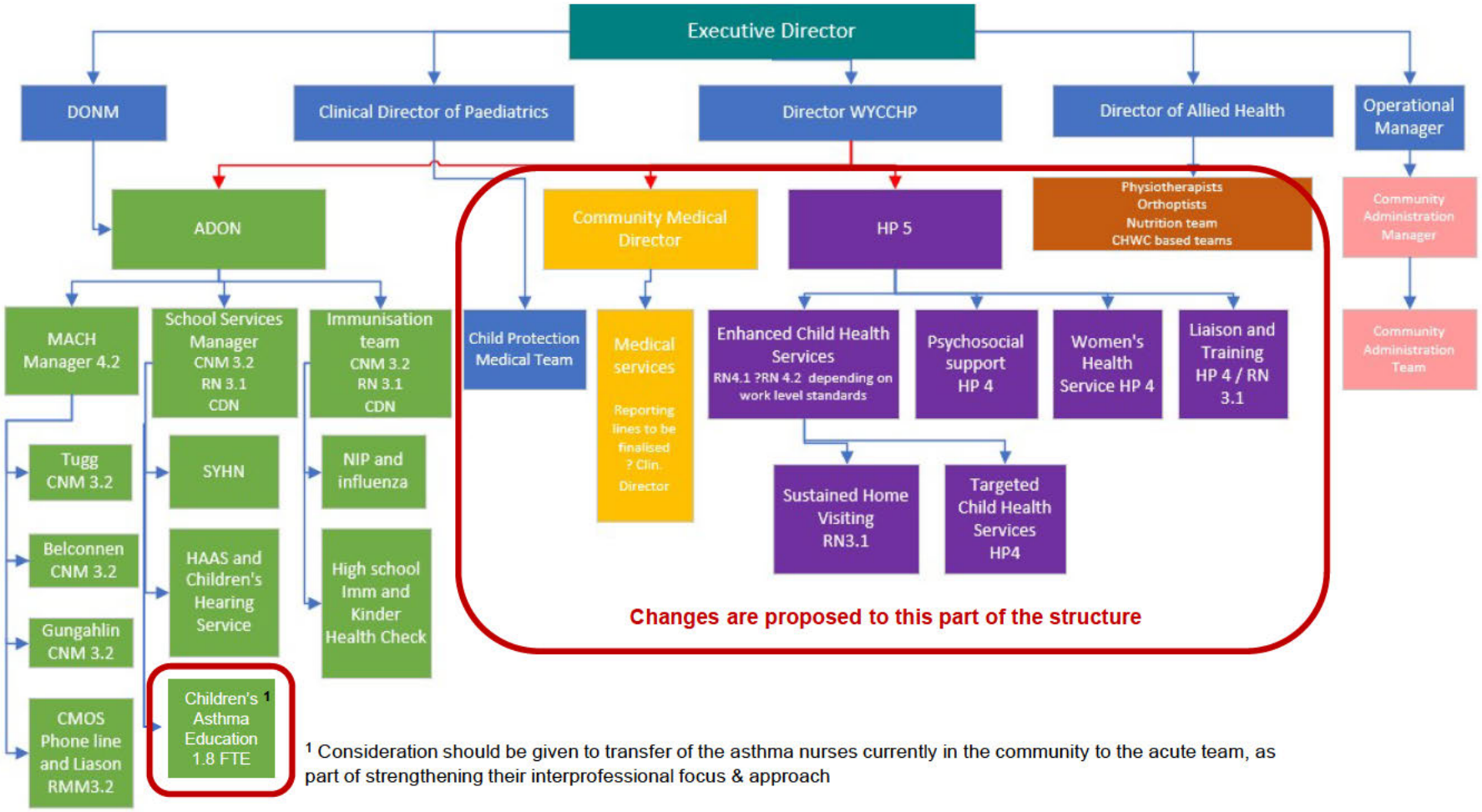
Modelling of outpatient demand, and alignment to the desired future pathway, has highlighted the need to strengthen the current service, and align staffing to functional teams, in order to address the current substantial waiting list backlog, and deliver an improved working environment for all staff.

Staff Type	Current FTE	Proposed FTE	Commentary
NBAT Community Paediatricians (Staff Specialists)	2.6	3.1	Increase community paediatrician capacity to support interprofessional working
NBAT CHMO / Registrar	2	2	No change (1.5 FTE Registrar and 0.5 FTE CHMO)
NBAT Senior Nursing / RN 3.1 Specialist Nurse	0.54	2.54	Increase capacity for nurse-led clinics, triage and MDT assessment
NBAT Allied Health Neurodevelopmental & Behavioural	0.7	6.0	Increase capacity for allied health clinics, triage and MDT assessment
TSCF Medical	2.2	2.2	No change
TSCF Specialist Nursing	1.64	1.64	No change (recommend seeking funding and scope extension to support more comprehensive Out of Home Care nursing)
TSCF Allied Health	6.96	6.96	No change (although there may be some transfer of staff to NBAT as part of implementing the full care pathway)
TSCF Impact / PEP	9.0	9.0	No change (recommend seeking funding and scope extension to support all vulnerable families)
TSCF Early Parenting Counselling	4.2	4.2	No change (recommend seeking funding and scope extension to support all vulnerable families)
TSCF CYPS Liaison	0.84	0.84	No change (position requires review)
TSCF Child Protection & Family Violence Training	4.0[1]	4.0[1]	No change (recommend completing an analysis of statutory training requirements and approaches to ensure this FTE can deliver the training required)

[1] Ongoing funding only in place for 2 FTE

Amendments to the outcomes of the governance review

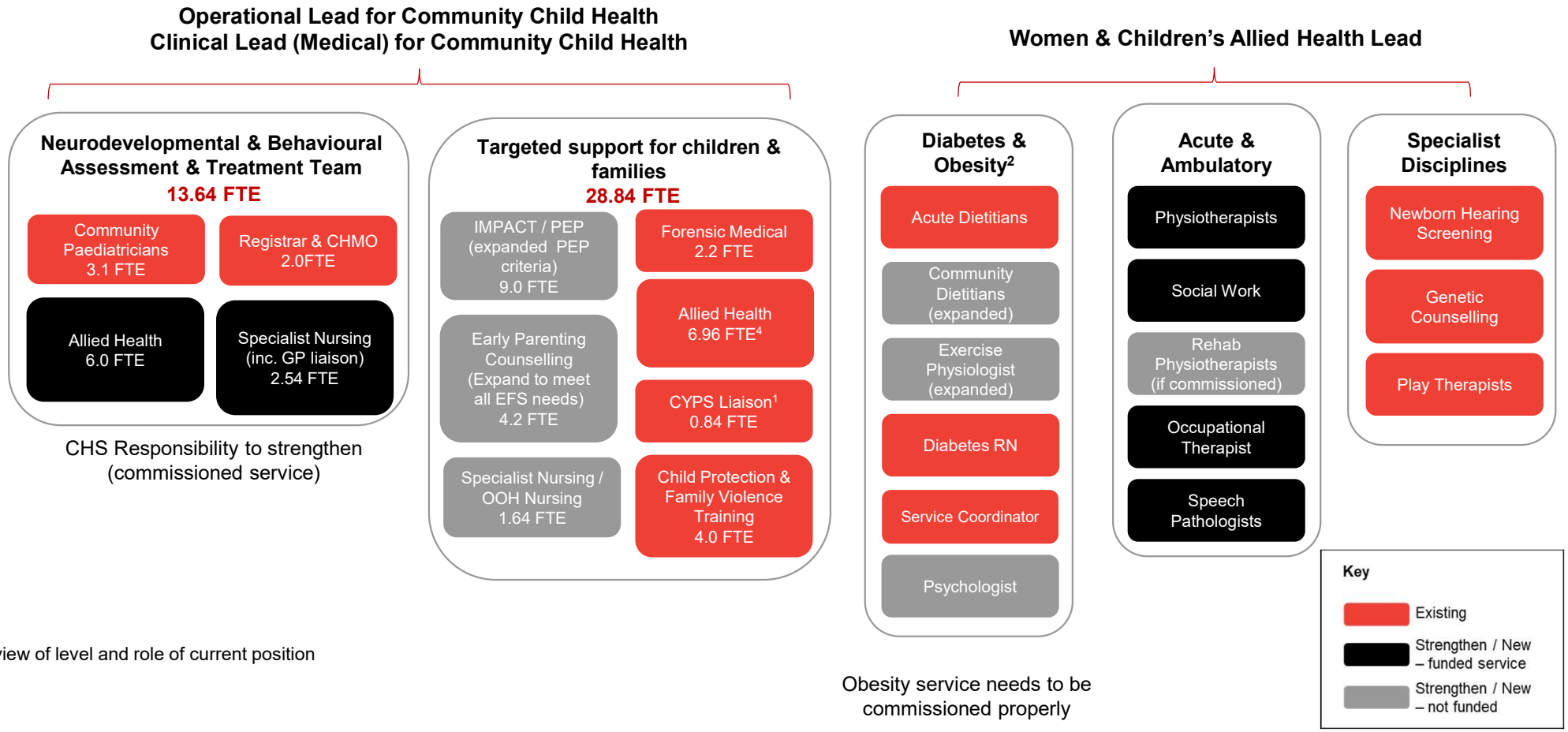
Applying the model and principles proposed, whilst broadly aligned to the outcomes of the governance review, would lend itself to a different team structure than that proposed in the review for a sub-set of the proposed structure, as set out below.



[1] Consideration should be given to transfer of the asthma nurses currently in the community to the acute team, as part of strengthening their interprofessional focus & approach

Proposed Functional Teams

The team structure should support the functional model we are seeking to implement, support collaboration within and across disciplines and teams, and ensure reasonable workloads for senior staff and meeting the needs identified during the previous governance review.



[1] Review of level and role of current position

Action Plan

No.	Action	Deadline	Owner
1	Initiate cross-directorate work to deliver exceptional care for children across the Territory, building on the lessons learned through this approach – develop MoU with the Community Services Directorate as part of this approach		
2	Recruit a fixed term project coordinator / manager to support implementation of the organisational & service plan		
3	Identify training leads in each team, and complete training needs assessment against aspirations of the organisational plan, including opportunities for rotation, and regular interprofessional clinical supervision for high emotional demand roles		
4	Confirm current baseline against proposed outcome measures		
5	Complete detailed staffing estimates and profiles for the revised services, and finalise the consultation and implementation of a revised governance model.		
6	Complete a review of space requirements to accommodate the revised team, including consideration of space available within the community (e.g. Holder)		
7	Recruit to new positions, including appointment to clinical leadership roles within teams, with clearly defined roles & responsibilities		
8	Establish an interprofessional working group within the neurodevelopmental and behavioural team to develop the inclusion & exclusion criteria (and evaluation framework) for triage to allied health and nurse-led clinics		
9	Implement a case management approach and philosophy for all patients, including complex / vulnerable		
10	Develop retrospective business cases for services established but not commissioned, including a clear indication of associated cost pressures, and indication on whether services will cease without commissioning		
11	Develop business cases for extension of WYCCH services, including anticipated impact (clinical & social outcomes and value), set-up and ongoing costs for consideration by CHS / ACT Health		
12	Complete job planning for all staff, aligned to the capacity plan set out within this organisational and service plan, to ensure sufficient capacity to meet demand and implement the future care pathway		
13	Implement the future care pathway for Community Child Health in CHS in full		
14	Incorporate a workstream (if not already in place) in the EPIC roll-out for the integration of community, CARHU and acute records at CHS for children, and for effective interfacing (or integration) with other directorates		
15	Create opportunities to showcase the services provided by Community Child Health and improve knowledge and understanding of service capabilities, inclusion & exclusion criteria across CHS and with key external stakeholders		
16	Progress joint working with the paediatric medicine team to agree transition pathways between the services		
17	Complete a review of training needs across CHS for family violence and child protection, including mandatory/statutory requirements and potential modes of delivery, to assess whether the current FTE is sufficient, and opportunities for alternative modes of delivery (e.g. online)		

Allied Health

Allied Health Challenges and desired Outcomes

The literature highlights the significant benefits that Allied Health can bring to service efficiency and outcomes for children and families across community, ambulatory and acute settings in paediatric healthcare. At present the paediatric Allied Health service is distributed into both professional and care setting siloes.

Challenges

- No dedicated Allied Health team for acute paediatrics within WYC Division – this has led to a decreased service over time and no ability for the paediatric team to prioritise Allied Health input.
- General paediatricians have identified better Allied Health input as one of their Top 5 services areas that require strengthening.
- Very small FTE for Allied Health Teams working in the community, with professionals split off into different teams creating service continuity and sustainability challenges
- Limited true interprofessional working outside of pockets of good practice (e.g. in paediatric endocrinology)
- A number of services not commissioned in line with population needs (e.g. obesity services; post-acute rehabilitation; early intervention child development services)

Desired Outcomes

- True interprofessional working, with nursing and allied-health led and integrated services that drive better child & family outcomes, and higher staff satisfaction
- Sufficient economies of scale within professional teams to manage planned and unplanned absences and provide peer support and learning
- Meets or exceeds the current response times for acute Allied Health support as set out in 'Acute Allied Health Priority Tools' Supports rotation, sharing and learning across care settings, to build breadth and depth in paediatric Allied Health capability
- Aligned to the desired future state for other aspects of the paediatric organisational and service plan
- Sufficient specialist and experienced Allied Health staff to provide out of hours support (0830 - 2130hrs 7 days a week) in NICU/PICU/paediatrics/maternity/ED to facilitate discharge on weekends

Options Considered

- Two options were put forward for consideration by the Allied Health team: 1) To move to functional teams within community and ambulatory care; or 2) To extend these functional teams to include Allied Health in the acute setting. On balance, Option 2 was preferred, as this would enable an at scale Allied Health team for paediatrics, to work across acute, ambulatory and community settings.

Preferred Option

The recommended option is to have a dedicated paediatric allied health team, functioning across community, ambulatory and acute care. This will require investment, and can't be considered in isolation without also considering Women's Allied Health.

Dedicated Paediatric Allied Health

Integrated

- Allied Health are part of at-scale functional teams (service or cohort focussed) across community, acute and paediatric ambulatory setting:
  - Neurodevelopmental & Behavioural Team
    - Triage, Assessment & Treatment for all relevant referrals from both general and community paediatricians.
  - Diabetes & Obesity Team
    - Dietician, exercise physiologist, psychologist
    - Provide support, on referral, into acute paediatric wards. Transfer acute paediatric nutrition FTE into this team
  - Acute & Ambulatory Team
    - Transfer existing physio, social work, speech path and OT team to paediatrics
    - Bid for post-acute rehabilitation service to be part of this team
    - Provide support, on referral, into community paediatrics complex cases
  - Targeted Support for Children & Family
    - interprofessional Allied Health Support into targeted support services
  - Specialist Disciplines
    - Play Therapists; Newborn Hearing Screening; Genetic Counselling; ALO

Key Considerations

1. Investment in Allied Health to create sufficient scale

The integrated model will require investment in Allied Health roles, to ensure that there are sufficient FTE in each profession to provide a dedicated Women & Children's service. The need to invest in Allied Health positions has already been identified in both Paediatric Medicine and Community Health, in order to provide interprofessional assessment & treatment, and support reducing the outpatient waiting lists.

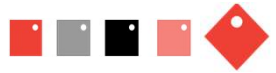
2. Team working across community, ambulatory and acute teams

The integrated model is based on grouping functionally similar teams together to create scale and move away from small FTE in specific care settings. This requires creation of dedicated and sufficient resourced interprofessional teams that work across acute and community care. This will include dedicated community-based allied health positions.

3. Inclusion of Women's Allied Health as part of the integrated model

Models for consideration were developed within the scope of the paediatrics service & organisational plan (i.e. paediatrics only), however discussion with the Allied Health Director highlighted the importance of ensuring that allied health services for women, children and families at CHWC are considered as a package across paediatrics, maternity, neonatology and community

Proposed Functional Teams



Operational Lead for Community Child Health
Clinical Lead (Medical) for Community Child Health

Neurodevelopmental & Behavioural Assessment & Treatment Team
13.64 FTE

- Community Paediatricians 3.1 FTE
- Registrar & CHMO 2.0FTE
- Allied Health 6.0 FTE
- Specialist Nursing (inc. GP liaison) 2.54 FTE

CHS Responsibility to strengthen (commissioned service)

Targeted support for children & families
28.84 FTE

- IMPACT / PEP (expanded PEP criteria) 9.0 FTE
- Forensic Medical 2.2 FTE
- Allied Health 6.96 FTE[4]
- Early Parenting Counselling (Expand to meet all EFS needs) 4.2 FTE
- CYPS Liaison[1] 0.84 FTE
- Specialist Nursing / OOH Nursing 1.64 FTE
- Child Protection & Family Violence Training 4.0 FTE

Women & Children's Allied Health Lead

Diabetes & Obesity[2]

- Acute Dietitians
- Community Dietitians (expanded)
- Exercise Physiologist (expanded)
- Diabetes RN
- Service Coordinator
- Psychologist

Obesity service needs to be commissioned properly

Acute & Ambulatory

- Physiotherapists
- Social Work
- Rehab Physiotherapists (if commissioned)
- Occupational Therapist
- Speech Pathologists

Specialist Disciplines

- Newborn Hearing Screening
- Genetic Counselling
- Play Therapists

Key

- Existing
- Strengthen / New – funded service
- Strengthen / New – not funded

Action Plan

No.	Action	Deadline	Owner
1	Stakeholder engagement with Maternity, Gynaecology and Neonatology teams to test alignment to, and appetite for the proposed change, alongside further discussions with Sam Lazarus		
2	Prospective audit of current acute Allied Health input into WYC wards and outpatients, to inform a discussion with Sam Lazarus regarding appropriate FTE and budget to transfer to WYC		
3	Complete detailed staffing estimates and profiles for the revised Allied Health Model, in liaison with Deborah Colliver and Action 3 on the Community Child Health Service & Organisational Plan, including consultation and implementation plan		
4	Recruit to new positions, in close liaison with Deborah (pending funding for new positions)		

From: Bergin, Catherine
Sent: Thursday, 20 October 2022 2:29 PM
To: O'Neill, Cathie (Health)
Cc: Bell, Amanda (Health); CHS COO; Bransgrove, Meagen
Subject: RE: Paeds OSP v 2.2
Attachments: Consolidated Paediatrics Tabling Speech.docx; Paediatrics OSP v 2.2.1.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Cathie,

Thanks for your help with all of this.

Attached for your records is a copy of the version the Minister will be tabling as well as a copy of her statement.

Thanks,
Cath

From: O'Neill, Cathie (Health) <Cathie.O'Neill@act.gov.au>
Sent: Wednesday, 19 October 2022 6:04 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Bergin, Catherine <Catherine.Bergin@act.gov.au>
Cc: Bell, Amanda (Health) <Amanda.Bell@act.gov.au>; CHS COO <CHSCOO@act.gov.au>
Subject: Paeds OSP v 2.2

UNOFFICIAL

Hi

I have attached the editable version – it has had any identifying names, financial information and appendices removed.

I have sent straight through to you given the delays in finalising approach and getting it back to you.

Please PDF prior to release as there are some graphics (ie watermarks) that are hidden but will become messy if not PDF.

Let me know if you need anything else from us

Cathie

Some suggested Talking Points

Paediatric Services Review
I have previously undertaken to table the Paediatric Services Review and Plan and do so now.
Paediatric Expert Panel

As I have previously informed the Assembly, I have instigated an Expert Panel into Child and Adolescent Clinical health Services. I am pleased to announce today that the Chair of that Expert Panel will be Professor Michael Bryden who will be aptly supported by another eminent independent expert Dr Diana Lawrence along with Fiona Tito-Whelan and Karen Toohey. The Panel will meet for the first time this month and one of their first tasks is to go through this Review Report and Plan and determine which of the recommendations have been implement, those that are still relevant and oversight their implementation. This will include coming back to me to prioritise and quantify the amount of investment required.

I will keep the Assembly updated on progress.

Cathie O'Neill
Chief Operating Officer
Canberra Health Services

Mobile: [redacted]
E-mail: Cathie.O'Neill@act.gov.au

EA: Maddy Bartlett 512 42147
EO: Michelle Ramsay 512 45804
BM: Amanda Bell 512 48688

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ACT Government | Canberra Health Services

Canberra Health Services Paediatric Organisation and Service Plan 2021-2023

An external review of Canberra Health Services' (CHS) paediatric services was finalised in 2021. Resolve Health Advisory conducted this review across an eight-week period with stakeholder consultation to understand issues, identify causes and potential solutions. The purpose of the review was to provide a three-year plan with actions to be implemented to ensure that the Paediatrics Department delivers on the vision of creating exceptional healthcare together. A detailed working document was produced by CHS, known as the CHS Paediatric Organisation and Service Plan 2021-2023.

In the Assembly on 21 September 2022, I outlined work would be undertaken to look at what we could release of that review and I am now tabling a copy of the Executive Summary and main body of review that has been de-identified and with sensitive internal CHS working information removed.

I am committed to ensuring transparency and I want to again reassure the ACT community that the ACT Government takes seriously its role of caring for children and young people. That is why this work was commissioned, to deliver on the vision of creating exceptional healthcare together.

CHS has commenced key actions from the review including governance realignment of paediatric, neonatology and clinical support functions.

A senior project lead has been recruited to oversee the implementation and on-going monitoring of the plan. This senior role continues to oversee key projects for the Division of Women, Youth and Children.

Significant actions to date have included realignment of the Paediatric Surgery speciality and appointment of an Assistant Director of Nursing (ADON) for paediatrics to enhance operational and strategic leadership within paediatrics and neonatology. Committees and working groups have also been established, or where already setup, tasked to undertake work as part of implementing findings of the review. For example, I have outlined previously in the Assembly the considerable work that has been undertaken by the Care of the Deteriorating Child Working Group to ensure care of unwell children is formalised, effective and appropriately networked with NSW.

In the 2022-23 ACT Budget, more than $4.8 million has been appropriated to increase specialist health services for children and young people and over $16 million to increase the number of allied health professionals to support multi-disciplinary teams and expand service provision in the Canberra Hospital and Centenary Hospital for Women and Children.

In the 2021-22 ACT Budget, $6.4 million was invested to implement patient navigation starting with a Paediatric Liaison and Navigation Service (PLaNS) which has been developed with the Health Care Consumers Association and has now commenced delivering services with families.

As part of the $50 million expansion of the Centenary Hospital for Women and Children a new model of care is being developed for the Adolescent Unit. A new model of care is also being developed for a Paediatric Short Stay Unit (PSSU) to enhance the journey for paediatrics. This unit will be eight beds and cater for children who need an admission that is projected to be under 24 hours. The CHS Gender Service is being developed to provide interdisciplinary support for children, young people, adults and their families with gender concerns or gender dysphoria in the ACT and surrounding regions. A governance redesign and overarching model of care for Enhanced Health Services to deliver multidisciplinary, collaborative and integrated services for women, children and families experiencing complex health and psychosocial issues, including child abuse and neglect, family violence and complex trauma was endorsed in July 2022.

As part of the $624 million Canberra Hospital Expansion Project the ACT Government has invested in the establishment of Level I Paediatric Intensive Care capabilities and an expanded paediatric emergency department within the new Critical Services Building. There will be 4 dedicated paediatric beds in the new Intensive Care Unit and a dedicated paediatric stream in the emergency department that will include a separate waiting area and courtyard. Construction on the Critical Services Building is due to be completed in 2024.

On 8 August 2022, the ACT Health Services Plan 2022-2030 was launched that outlines an eight-year roadmap for improving the way our health services work together in the ACT. The ACT Health Services Plan provides direction for more

detailed health system planning for children and adolescents through a Child and Adolescent Clinical Services Plan.

I recently announced the formation of the Child and Adolescent Clinical Services Expert Panel who will bring together this work with other reviews and initiatives to ensure all recommendations remain relevant and monitor progress. I'll shortly be in a position to announce the membership of the Expert Panel that will be independently chaired by Professor Michael Brydon OAM, a leading child health expert who was previously Chief Executive of the Sydney Children's Hospital Network and has provided independent expertise on key ACT Government projects including the First 1000 Days or Best Start Strategy.

In June 2022, independent assessors from the Australian Council on Health Care Standards with significant expertise in health care delivery, governance, leadership and administration assessed CHS as an organisation against the 8 National Safety and Quality Health Service Standards. This included assessment of paediatric services and the work being undertaken as a result of the review. It was found that CHS had met all of the Standards including the comprehensive actions underpinning those Standards that ensure health services are delivering safe, quality care.

RESOLVE HEALTH ADVISORY

Department of Paediatrics Organisational and Service Plan 2021 – 2023

Version 2.2 – Final For Release

Contents

Organisational & Service Plan

Appendices

Appendices have been removed from this version as they contain detailed operational information for the use of implementation only

Executive Summary: Context and Approach

The paediatrics organisational & service plan covers paediatric medicine (including sub-specialties), paediatric surgery, and community child health at Canberra Health Services. It sets out the scope of services to be provided, the operating principles for delivery of those services, and the actions required to get there

Context

- Canberra Health Services provides paediatric health care services to the population of the ACT, and, for paediatric medicine and surgery, to a significant catchment from Southern New South Wales – and the Centenary Hospital for Women & Children is the only public children's hospital within the ACT.
- Paediatric services are provided to the Aboriginal & Torres Strait Islander community in the ACT and surrounding region, and include dedicated Aboriginal Liaison Officers and health professionals across Centenary Women's & Children's Hospital and Community Child Health.
- This plan sits within a broader set of planning activities underway or completed within both Canberra Health Services and ACT Health, including: the Canberra Health Services Strategic Plan; the Canberra Health Services Clinical Services Plan; the ACT Health Child & Adolescent Clinical Services Plan; the ACT Children's Health Services Plan for the first 1,000 days; and planning for the expansion of the Canberra Health Services campus, including new integrated adolescent ward and Critical Services Building.
- Canberra Health Services has a clear vision - to **create exceptional health care toget**her, underpinned by strong values of being: **reliable –** we always do what we say; **progressive –** we embrace innovation; **respectful** – we value everyone; and **kind –** we make everyone feel welcome and safe, and four strategic priorities: personal health services; a great place to work; a leading specialist provider; and a partner to improve people's health, with consumers firmly at the centre.
- There have been some significant challenges within paediatrics at Canberra Health Services, which have resulted in low levels of employee engagement. The most significant areas of concern raised by staff related to: the structure and model of care, including lack of capacity, and silo working; and management practices/leadership, including excessive administrative tasks/meetings and lack of transparent communication.

Approach

- The organisational & service plan has been developed in consultation with the service, with a view to delivering exceptional health care for children, and embedding Canberra Health Service's organisational values within paediatrics.
- The Health Care Consumers Report, *Consumer and Family Experiences and Expectations of Accessing Interstate Specialist Care*, along with complaints data, was used to identify the key issues from consumers' perspectives that needed to be addressed within the plan.
- Stakeholder engagement was undertaken through 1-2-1 interviews and meetings with professional groups, to develop an understanding of the key issues to be addressed, and service aspirations (see Appendix 1).
- This was supplemented by analysis of available activity, financial and quality data, understanding the current care pathway, and comparison against national standards and benchmarks. (see Appendix 2)
- Together these analyses provided a clear understanding of the current state of services, and the priority issues to be resolved, which informed development of the Organisational and Service Plan. Stakeholder perspectives were largely consistent with the data analysed for the current state assessment.
- The organisational and service plan provides for each section of paediatrics: the proposed outcome measures against which to measure progress; the operating principles to be adhered to; the future state care pathway; forecast activity and workforce requirements to 2025; the proposed team structure; any significant financial impacts; and an action plan. It also addresses issues that impact all sections of paediatrics: care of the critically ill or deteriorating child; prioritisation of specialised services to be strengthened / expanded; and allied health support into paediatrics.

Executive Summary: Defining exceptional care for children

Children's Hospitals Australasia have developed a Charter on the rights of children and young people in healthcare services in Australia, which is based on putting the interests of the child or young person first, hearing and taking seriously all young people, and recognition of the importance of family – this defines exceptional care

Charter of Children's and Young People's Rights in Healthcare Services in Australia

Every child and young person has a right:

1. to consideration of their best interests as the primary concern of all involved in his or her care.
2. to express their views, and to be heard and taken seriously.
3. to the highest attainable standard of healthcare.
4. to respect for themselves as a whole person, as well as respect for their family and the family's individual characteristics, beliefs, culture and contexts.
5. to be nurtured by their parents and family, and to have family relationships supported by the service in which the child or young person is receiving healthcare.
6. to information, in a form that is understandable to them.
7. to participate in decision-making and, as appropriate to their capabilities, to make decisions about their care.
8. to be kept safe from harm.
9. to have their privacy respected.
10. to participate in education, play, creative activities and recreation, even if this is difficult due to their illness of disability.
11. to continuity of health care, including well-planned care that takes them beyond the paedatric context.

CHILDREN'S HOSPITALS AUSTRALASIA

Executive Summary: A shift to interprofessional working

An **interprofessional** approach involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities, and is a critical foundation for delivering holistic, child and family-centred care.

Case for interprofessional working

- Children and families requiring specialist paediatric care often have multiple and complex needs, which may include complex multi-morbidity, social or psychological issues. Delivering against the Charter of Children's and Young People's Rights in Healthcare Services in Australia requires a consultative, collaborative approach to care that actively involves the child and their family.
- An interprofessional approach can improve patient outcomes, healthcare processes and levels of satisfaction, as well as reducing length of stay and avoiding duplication of assessments, leading to more comprehensive and holistic records of care.
- The opportunity for discussion created by interprofessional care planning can be used for the patient, their family and carers to develop their ongoing plan.
- interprofessional service management supports cohesion across staff groups, breaks down siloes and can strengthen staff engagement and morale, through unifying teams behind a common purpose, and creating an environment in which everyone's voice feels valued and heard.
- Implementing interprofessional working within the paediatrics service, should be done with active consideration of creating a psychologically safe working environment, which requires addressing psychological risk factors, including: job demand & control; effort-reward balance; exposure to trauma; organisational justice; psychosocial safety climate; and job security.
- Implementation will be dependent on ensuring there is sufficient capacity in the team from across disciplines.

Implementing interprofessional working

- **Leadership –** positive leadership and management give clear direction and vision for the team, through:
  - Promoting an atmosphere of trust, where contributions are valued and consensus is fostered
  - Ensuring that the necessary resources, infrastructure and training are available, as well as a mix of skills, competencies and personalities amongst team members
- **Child-Centred Practice –** well integrated and coordinated care that is based on the needs of the child, including:
  - Involving the child and family in all aspects of care and decision making
  - Formulating shared, interprofessional care plans
- **Teamwork-** teams with shared responsibilities and some role interdependence, and:
  - Clear goals, shared roles and responsibilities within a team structure
  - Joint assessment, diagnosis and goal setting
- **Communication –** across disciplines, care providers, and with the child and family to set goals that meet the child's specific needs, including:
  - Active involvement of the child's GP
  - Open communication to encourage genuine collaboration

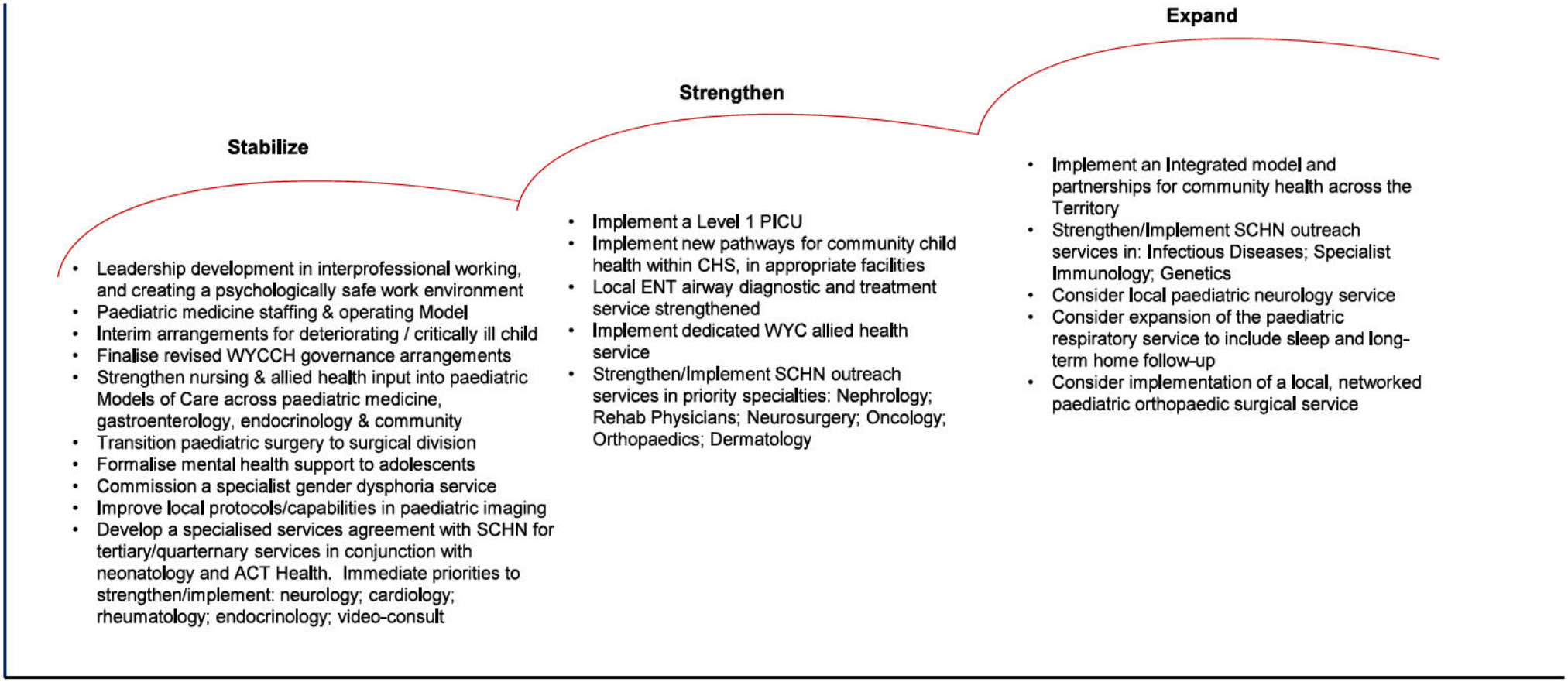
Executive Summary: Addressing the priority issues

Stakeholder engagement identified the most critical issues to be addressed as part of the paediatrics organisational & service plan. These have been systematically addressed through the planning process – as summarized below:

Issue raised during stakeholder engagement	Actions incorporated into the organisational & service plan
Lack of appropriate care setting and formalised protocols for high acuity and deteriorating patients.	A proposal for managing critically ill and deteriorating patients has been developed as part of the plan.
Sustainability of general paediatrics and paediatric endocrinology.	A bottom-up staffing and capacity plan as been completed as part of the paediatric medicine plan.
Lack of agreed prioritisation of the specialist services to be strengthened or expanded locally, and limited formal arrangements in place with Sydney Children's Hospitals Network.	Prioritisation has been completed on all specialist services that are required to support paediatrics at CHS, along with recommended principles for shared care.
Concerns regarding culture & governance, including silo working, and perceived excessive bureaucracy.	interprofessional team working has been incorporated as a key operating principle for each section of paediatrics, with interprofessional leadership and teams.
Workforce, Training & Education challenges, including known workforce gaps and insufficient ongoing training and education.	Specific actions have been included in relation to addressing workforce gaps, training & education in each section.
Concerns regarding the sustainability of Child Health Targeted Support Services and whether the workload justifies 24/7 on-call.	A revised staffing and team structure has been proposed. It is recommended that the 24/7 roster continue until a credible alternative for providing expert paediatric forensic medical advice out-of-hours is identified.
Whether the scope of services provided for children in the community is consistent with population needs, and the role of Canberra Health Services.	A reorganisation of health services for children across the Territory, and across directorates is recommended. Actions to properly commission gaps in service at CHS (both retrospectively and prospectively) have been recommended.
Challenges with interfaces with other services, both internal and external, with lack of communication and inadequate communication and planning in transfers of care.	A number of actions have been proposed to strengthen relationships between paediatrics, other key interfaces at CHS, and the relationship with SCHN.
Insufficient business support and intelligence to enable effective management of the service.	A number of revisions to financial and performance reporting are recommended, including development of an internal performance dashboard for each section, against meaningful outcomes. A project coordinator is recommended to support general paediatrics.
Care of children & adolescent inpatients with mental health issues is not provided in line with best practice, with challenges in accessing timely specialist CAMHS advice and insufficient specialist mental health trained staff.	There is good cover for the wards, with an inpatient team and ED consultant liaison from CAMHS, including 1.4 FTE CAMHS psychiatrist and registrar, and CAMHS worker (vacant). This needs to be formalised. Future staffing for the integrated adolescent ward needs to be defined in line with proposed admission criteria.
The gender dysphoria service is being provided outside of recommended clinical guidelines and poses a clinical and reputational risk to CHS.	A specialist gender dysphoria service needs to be commissioned in line with NSW and international guidelines. This may require commissioning a service outside ACT.

Executive Summary: Planning Horizons

The paediatrics service and organisational plan will need to be delivered over three distinct phases, recognizing that there are critical issues that need to be resolved now, whilst other changes will take time to plan and implement. A 3-5 year timeframe is recommended, with a maximum of 18 months for each planning horizon.



Executive Summary: Divisional Issues

A number of the critical issues identified during stakeholder engagement, and from the current state assessment, will need to be addressed at a divisional level, as they span two or more sections of paediatrics.

Service & Organisational Plan Overview

- The immediate priority for the division is to put in place the management controls to ensure successful delivery of the service & organisational plan.
- This will require:
  - Formal sign-off of the plan, including budget impacts, and setting clear expectations on Directors and Unit Leads for delivery
  - Building foundational capability in interprofessional working and creating psychologically safe working environments, including leadership development in these capabilities
  - Defining and formalising the roles of unit leads, including any associated shifts from clinical to non-clinical time – this should be embedded in job plans
  - Successful recruitment to the Clinical Director role and/or provision of interim senior management support to drive implementation of the plan
  - A full-time, dedicated, ADON role for paediatrics
  - Oversight of the recruitment and job planning actions required for each section of paediatrics, ensuring that capacity expectations are clearly set, and met
  - Initiating work to develop clear information for children, families, referrers and other departments regarding the range of services available at CHS
  - Supporting opportunities for paediatrics sections to interact informally with one another, and with key interfaces (e.g. ED)
  - A review of planned capacity, by age group, against the forecast capacity requirements set out within this plan, and full review of the PDS Model of Care
- The division will also need to lead work to agree the services to be commissioned from SCHN, including any funding implications for ACT Health or CHS. This should involve all paediatric sections, neonatology and ACT Health
- The division will need to take a lead role in coordinating paediatric and neonatology input into the implementation of a Level I PICU, and interim arrangements for care of the critically ill or deteriorating child.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)

Executive Summary: Paediatric Medicine[1]

The paediatric medicine service is not sustainable in its current form, and requires substantial action, investment and support, to transition to a high performing service that is able to deliver exceptional care for children and families of the CHS catchment.

Service & Organisational Plan Overview

- The immediate priority for paediatric medicine is to put services onto a sustainable footing (in particular the outpatient service) and strengthen the operating model.
- This will require:
  - Increasing the number of general paediatricians and paediatric endocrinologists, and strengthening job planning and rostering (incl. VMOs and juniors), to ensure that clinical commitments can be met and share of workload is equitable
    - A robust and strategic approach to recruitment of additional staff, to ensure new appointments will contribute to strengthening the service
  - New nursing and allied health roles to support sub-specialty services and complex patients, increase outpatient capacity, and drive service innovation. A greater focus on training & upskilling the existing workforce is also required.
  - Strengthened ways of working, which are truly interprofessional across both inpatient and ambulatory settings, and a clearly defined and streamlined pathway for all paediatric outpatient referrals
  - Strengthened administrative, business intelligence and finance support into general paediatrics, to enable proactive management of the service and reduce the administrative burden on senior medical staff
  - Strengthening the specialist services that general paediatricians rely on to provide holistic care to the CHS catchment, with a view to growing some of these specialist services locally over time.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Improvement in a wide range of other clinical outcome measures (see Appendix 5)

[1] Including paediatric endocrinology and paediatric gastroenterology

Executive Summary: Paediatric Surgery

The paediatric surgery service is currently meeting the needs of the CHS catchment for the casemix that can safely be delivered at Canberra Health Services. The current staffing model is sustainable for the horizons of this plan, but succession planning is needed early, alongside improvements to ways of working.

Service & Organisational Plan Overview

- The immediate priority for paediatric surgery is to improve ways of working, in order to foster a positive team environment across all staff, and meet the Charter on the rights of Children & Young People in Healthcare Services in Australia.
- There is also a need to plan recruitment to a new permanent consultant level position, as part of succession planning for the future. Early recruitment to this position would assist in reducing the ambulatory waiting list to three months.
- This will require:
  - Formalising the Unit Lead role for paediatric surgery, with clear roles & responsibilities
  - Adopting a set of operating principles, which include strengthening relationships, and greater visibility and interaction with other disciplines, particularly paediatric medicine, other surgical specialties operating on children, and the Emergency Department
  - Increasing awareness and understanding amongst the team in relation to creating a psychologically safe work environment, and what it takes to deliver this
- Development of a Level I PICU in the short to medium term (within the next 3 years) will enable more children to have their surgical treatment in Canberra, in particular, those who may require short-term ventilation post surgery.
- Strengthening and formalising specialist input into Canberra Health Services from Sydney Children's Hospital Network, including nephrology and haematology will support delivery of exceptional care.
- There is a need for closer joint working with other surgical specialties with high volumes of paediatric activity, including ENT, Orthopaedics and Neurosurgery. Once a Level 1 PICU is established, ENT can provide a more comprehensive airways service, from their existing team. Over time a dedicated paediatric orthopaedic surgeon, networked into SCHN, is also recommended.
- Adult neurosurgical involvement in children with head injury needs to be reviewed.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to treatment
• Reduced variation from time of referral to treatment by Category
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Proportion (%) of congenital elective orchidopexy procedures performed before the age of 12 months
• Reduced unplanned returns to theatre
• Reduced transfers to SCHN after elective surgery

Executive Summary: Community Child Health

It is difficult to isolate 'community paediatrics' from the wide range of services provided by WYCCH for women, children & family health, due to the significant service interfaces and overlaps. This plan focuses on the current Child Health Targeted Support Services, but within the context of the other services provided.

Service & Organisational Plan Overview

- The immediate priority for Community Child Health is to move to an interprofessional model of community health care for children, with streamlining of pathways to meet the needs of all children, including those with complexity or vulnerability.
- This will require:
  - Investing in new nursing & allied health roles to work alongside the community paediatricians to provide interprofessional triage, assessment and treatment for the current cohort of children referred to the community paediatrician service.
  - Finalising a revised governance model for WYCCH – this includes some amendments to the proposals set out in the current consultation paper, and realignment of resources to sit two functional teams: Neurodevelopmental and behavioural - NBAT (formerly community paediatrician service); and Targeted Support for Children & Families -TSCF (incorporating former CARHU and other early parenting support services)
  - Establishing the care pathways set out within this plan, including developing the inclusion and exclusion criteria for each pathway
  - Identifying suitable space to accommodate the interprofessional teams at both CHS and in the community
- There are also a number of areas where the services currently commissioned are not adequate to meet the needs of the ACT population (e.g. early intervention for developmental delays), and would benefit from expansion. This will require discussion with ACT Health to agree prioritisation and funding of any service expansion.
- There is a significant need to integrate services, service locations and service records for children & families across ACT Government Directorates, to reduce confusion, service gaps and overlaps, and make it easy for children & families to access the services they need. Although beyond the scope of this plan to address, it is recommended that action is taken to progress cross-directorate action, to deliver exceptional care across the Territory (see Appendix for how this model could be delivered)

Target Outcomes

Measure
• Child & Family Reported Experience

• Child & Family Reported Outcomes
  • Social & Emotional Wellbeing
  • Peer relationships
  • Behavioural problems
  • Parent-child relationship
  • Family Functioning

• Staff satisfaction / Engagement
• Time from referral to first contact
• Time from referral to assessment
• Time from referral to treatment commencement
• Prescribing rates for psychotropic medications in children with behavioural/developmental diagnoses

Executive Summary: Allied Health into paediatrics

Options for improving allied health input into paediatrics were considered as part of service & organisational planning. The recommendation is to have a dedicated paediatric allied health team. This will require investment and significant change, and can't be considered in isolation without also considering Women's Allied Health.

Dedicated Paediatric Allied Health: Proposed Model

Integrated

- Allied Health are part of at-scale functional teams (service or cohort focussed) across community, acute and paediatric ambulatory setting:
  - Neurodevelopmental & Behavioural Team
    - Triage, Assessment & Treatment for all relevant referrals from both general and community paediatricians.
    - Provide support, on referral, into acute paediatric wards.
  - Diabetes & Obesity Team
    - Dietician, exercise physiologist
    - Provide support, on referral, into acute paediatric wards. Transfer acute paediatric nutrition FTE into this team
  - Acute & Ambulatory Team
    - Transfer existing physio, social work, speech path and OT team to paediatrics
    - Bid for post-acute rehabilitation service to be part of this team
    - Provide support, on referral, into community paediatrics complex cases
  - Specialist Disciplines
    - Play Therapists
    - Newborn Hearing Screening
    - Genetic Counselling

Key Considerations

1. Inclusion of Women's Allied Health as part of the integrated model

Models for consideration were developed within the scope of the paediatrics service & organisational plan (i.e. paediatrics only), however discussion with the Allied Health Director highlighted that moving to an integrated for paediatrics, but remaining with the existing model for Women's Allied Health, would create challenges, and the case for an integrated model applies equally to Women's Allied Health.

2. Investment in Allied Health to create sufficient scale

The integrated model will require investment in Allied Health roles, to ensure that there are sufficient FTE in each profession to provide a dedicated Women & Children's service. The need to invest in Allied Health positions has already been identified in both Paediatric Medicine and Community Health, in order to provide interprofessional assessment & treatment, and support reducing the outpatient waiting lists.

3. Team working across community, ambulatory and acute teams

The integrated model is based on grouping functionally similar teams together to create scale and move away from small FTE in specific care settings. Teams and disciplines have been aligned to the setting where there is greatest clinical need, but will need to provide out-reach support to other care settings of care. (e.g. there is greatest need for psychology support in the community neurodevelopmental & assessment team, but that team will need to provide psychologist support to acute wards on referral).

Executive Summary: Roadmap for Year One

Divisional Issues

Executive Summary: Divisional Issues

A number of the critical issues identified during stakeholder engagement, and from the current state assessment, will need to be addressed at a divisional level, as they span two or more sections of paediatrics.

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Target Outcomes

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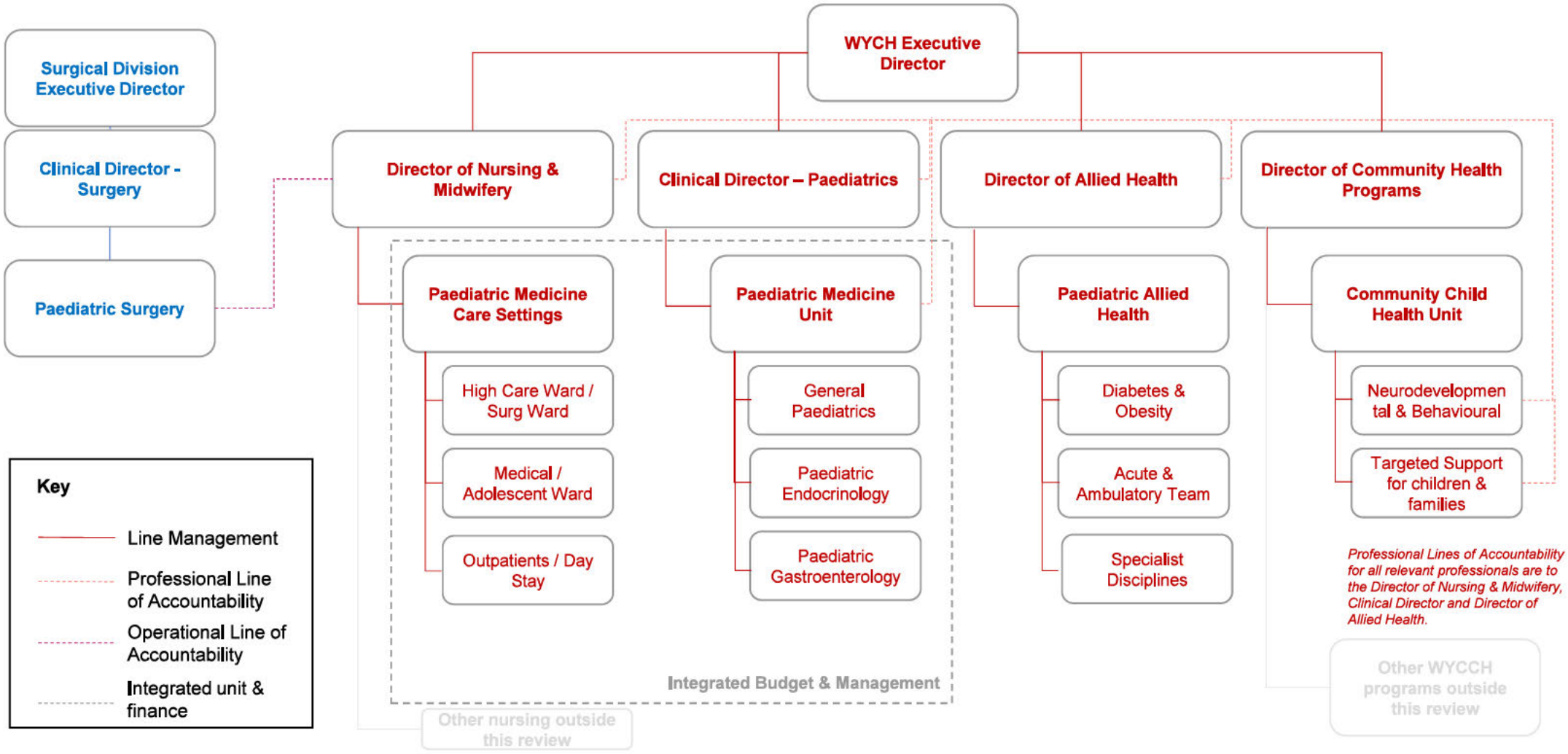
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)

Future Team Structure

It is recommended that paediatrics is organised into interprofessional functional teams, with professional lines of accountability to the relevant Director. It is recommended that paediatric surgery transfer to the surgical division, but retain operational accountability to paediatrics for high quality inpatient care.



Prioritisation of specialised services

Specialist Services – Prioritisation (1/2)

Providing appropriate specialist expertise for children in the ACT and CHS catchment is a key component of delivering exceptional care – that expertise may be best provided locally, or through networking into SCHN.

Services (in approximate order of priority)	Requirements for delivering high quality care	Required Setting (Must Have)		
		Local	SCHN – Locally Delivered	SCHN – Sydney
Mental Health	Strengthen psychiatry and supporting input for children and adolescents with mental health issues at CHS, ensuring that the staffing model for the integrated adolescent ward is consistent with the proposed admission criteria	Horizon 1		
Level 1 PICU	24-hour mechanical ventilation and simple invasive cardiovascular monitoring in accordance with the Level I PICU proposal. Commence planning immediately, but likely to be realized in Horizon 2	Horizon 2		
Allied Health	Strengthen Allied Health support into all aspects of general and community paediatrics, to provide interprofessional assessment and treatment, including local outreach	Horizon 1		
Gastroenterology	Strengthen the supporting team for paediatric gastroenterology, to including a RN 3.1 Specialist Nurse and better access to Allied Health. Formalise arrangements for consultants from SCHN when the paediatric gastroenterologist is not on-call.	Horizon 1	Horizon 1	
Paediatric imaging	Strengthen the CHS Imaging service to ensure that paediatric images are reported on (in-hours) or reviewed (after on-calls where paediatric radiologists not available) – formalize and document arrangements. Upskill paediatric staff in reviewing images. Develop formal professional links with SCHN for CHS paediatric radiologists	Horizon 1	Horizon 1	
Rheumatology	An outreach service from SCHN needs to be developed. The current CHS adult rheumatologist providing a consult service to paediatrics retires in 12 months		Horizon 1	
Paediatric endocrinology	Formalise arrangements for out-of-hours consult from SCHN when the CHS paediatric endocrinologists are not on-call		Horizon 1	
Neurology	Strengthen relationship with SCHN in the short-term, to include better access for consults (preferably video) on acute patients and outreach (virtual & in person) outpatients	Horizon 3 (Expand)	Horizon 1-2 (Strengthen)	
Cardiology	Strengthen the current arrangement for off-site reviews of PCU and outreach clinics from SCHN. Any shift to a service, rather than individual-based arrangement will need to ensure that current CHS capabilities in PCU are well understood.		Horizon 1-2	
Nephrology	Implement an outreach service from SCHN, to provide both acute consult services and outpatient clinics (blend of virtual / in-person)		Horizon 2	
Respiratory	Occasions of service (c. 400) and population demographics may warrant expansion of this service locally in future years. Expansion should include expertise in sleep, and ability to support infants requiring long-term respiratory support at home.	Horizon 2-3		

Specialist Services – Prioritisation (2/2)

Providing appropriate specialist expertise for children in the ACT and CHS catchment is a key component of delivering exceptional care – that expertise may be best provided locally, or through networking into SCHN

Services (in approximate order of priority cont.)	Requirements for delivering high quality care	Required Setting (Must Have)		
		Local	SCHN – Locally Delivered	SCHN – Sydney
Dermatology	A succession plan is required for the current adult consult support into paediatrics, provided by 2 CHS adult dermatologists.	Horizon 2		
ENT	The CHS ENT service should be strengthened to provide diagnostic and therapeutic interventions for children with airway issues (excluding major/complex). This is dependent on implementation of a Level 1 PICU and some upskilling/reskilling for the ENT surgeons.	Horizon 2		
Rehab Physicians	Strengthen the relationship with SCHN in the short-term, to include better access for consults (preferably video) on acute patients and outreach (virtual & in person) outpatients. Consider a local service for complex orthotics, and complex co-morbid patients (e.g. cerebral palsy) in the longer term.	Beyond Horizon 3	Horizon 2	
Neurosurgery	Strengthen and formalize the specialist service provided from SCHN, to include 24/7 consult (preferably video), and outreach virtual clinics. Clear referral pathways into SCHN.			Horizon 2 (strengthen)
Oncology / Haematology	Strengthen and formalize the specialist service provided from SCHN, to include 24/7 consult (preferably video), and outreach virtual clinics, in addition to the current in-person clinics. Clear referral pathways into SCHN. Explore opportunities to integrate the CHS paediatric trained haematologists into this service.			Horizon 2 (strengthen)
Infectious Diseases	Implement an outreach service from SCHN, to provide both acute consult services (24/7) and outpatient review as needed (virtual outreach / clear referral pathway to Sydney)			Horizon 3
Immunology	Whilst there is good support for paediatrics from 4 adult immunologists at CHS, there may be benefit in implementing a consult and outreach (virtual & in person) service from SCHN, for the cohort currently going to Sydney for care		Horizon 3	
Genetics	Consider a dedicated local paediatric genetics service in the longer term, although noting that the current model of genetic counsellors providing local support and case management works well. The current model is, however, leading to delays in access to a clinical geneticist, particularly for NICU and FMU patients. New genomic technologies are also impacting the ability to provide a safe and timely service – this needs more urgent attention.	Horizon 3		
Orthopaedics	Consider a specialist paediatric orthopaedic surgeon as part of the orthopaedic surgical team at CHS to provide on-site acute consults and clinics, with formal networking into SCHN for major/complex cases and 24/7 cover	Horizon 3		Horizon 2 (strengthen)

Shared Care Principles

Networking arrangements with SCHN and regional hospitals that refer to CHS need to be strengthened. A set of principles are proposed as a starting point for discussion to guide shared care that is patient and family-centred.

- Safe and effective services as locally as possible (not local services as safely as possible)
- Tertiary/Quarternary services provided based on service agreements, which set out activity, quality, access and financial parameters (not based on individuals)
- Clear and equitable funding arrangements based on a principle of 'the funding follows the patient'
- Coordinated care supported by appropriate structures and process
  - Named medical specialist in the quarternary centre with overall clinical responsibility and named specialist at CHS who takes local responsibility at a patient level
  - Identified nursing lead at CHS for care coordination
  - Identified pharmacist lead at CHS for care coordination
  - Written care plans for unplanned admissions / out of hours for patients receiving treatment outside their locality
  - Identified contacts for families
- Regular attendance by local team (interprofessional) at relevant specialist MDTs
- Robust two-way systems of communication
- Written guidelines to support levels of care / inclusion & exclusion criteria
- Written protocols for specialist care carried out locally (e.g. administration of chemotherapy) with defined responsibilities
- Education and training programs for staff in all settings - shared

Care of the critically ill and deteriorating child

Providing care for the critically ill or deteriorating child

Analysis of CHS care settings highlights a gap in care provision for critically unwell children aged between 1 and 12 years old, with no child or adolescent suitable facility with the skills and capabilities to provide organ support, on even a temporary basis, to enable stabilisation and safe transfer to Sydney Children's Hospital Network.

Context

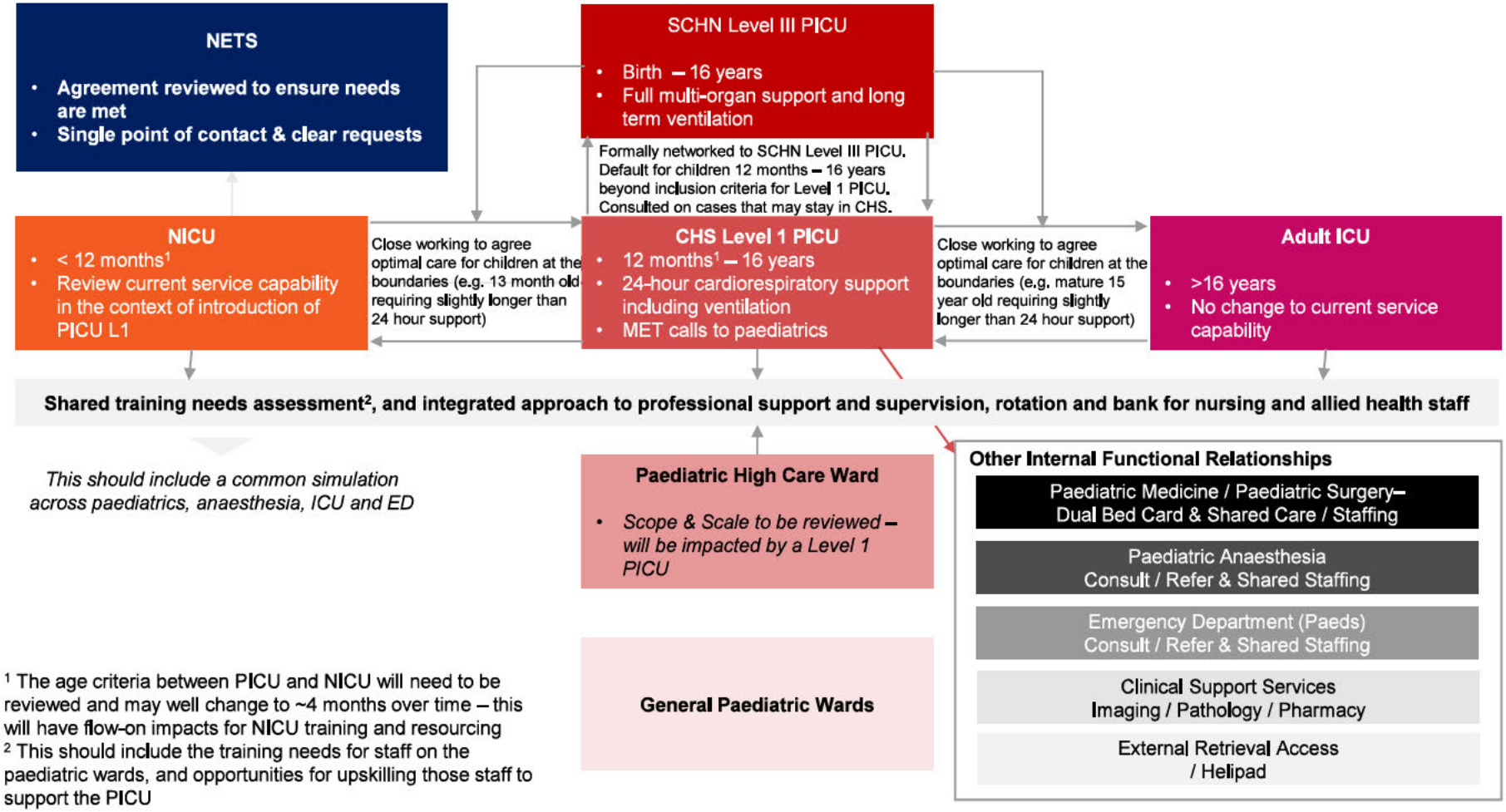
- Canberra Health Services has a well established NICU and ICU capability, to manage critically unwell babies and adults for both short and longer-term organ support. This enables stabilisation and high quality care for these cohorts, irrespective of whether their entire episode of care takes place in Canberra Hospital, or whether they require transfer to/from Sydney Children or Adult Networks for quarternary care (e.g. specialised burns)
- For children between the ages of 4 weeks and 16 years of age, this capability is not currently in place, although NICU will accept children up to 2 years of age (longer stay for <12 months, stabilistation/transfer for 1-2 years), and the adult ICU will sometimes accept children over 2 years old for stabilisation prior to transfer only, but there is often debate regarding the most appropriate care setting and care providers for children between 2 and 12 years old.
- There is currently a 'high care ward' for paediatric patients, but the capability is limited to close observation and CPAP.
- The College of Intensive Care Medicine of Australia and New Zealand (CICM) sets clear minimum standards for Paediatric Intensive Care Units, including the level of throughput required to be a Level III (400) or Level II (200) PICU. The current catchment for Canberra Health Services would not meet these throughput requirements in the short to medium term.
- There is acknowledgement from across disciplines (ICU, NICU paediatric medicine, paediatric surgery, paediatric anaesthetists) within CHS that the current system is sub-optimal and creating unnecessary risks for unwell children in the ACT and surrounding catchment. A number of business cases and alternative Models of Care have been put forward previously, but not adopted.
- The new Critical Services Building includes space for a dedicated PICU, co-located with the adult ICU service.
- The nomenclature in use in describing PICUs has created confusion, as the term PICU has become synonymous with the CICM Level III PICU, which is a highly specialist service that supports multi-organ failure in the most complex of cases.

Characteristics of a Level I PICU

- The current casemix at Canberra Hospital would justify a Level I PICU – a facility recognized by CICM as suitable in a rural/regional and lower volume tertiary context for the stabilisation and short-term single organ support of children.
- **Capabilities –** A Level I ICU should be able to provide:
  - Immediate resuscitation
  - Mechanical ventilation and simple invasive cardiovascular monitoring in the short-term (<24 hours)
  - Monitoring and prevention of complications in 'at risk' medical and surgical patients
  - Established relationship with Level II or III PICU (SCHN)
- **Inclusion Criteria –** Typical inclusion criteria would be:
  - Patients with complex fluid, electrolyte, nutritional and metabolic requirements;
  - Post-surgical patients requiring special observations and care;
  - Unstable medical patients requiring special observations and care beyond the scope of a conventional ward;
  - Patients requiring short-term mechanical ventilation or airway observation;
  - Patients requiring short-term vasopressor support
- **Staffing Requirements –** There is significant flexibility in how Level I PICUs are staffed, but should include:
  - A Medical Director who is a fellow of the CICM, or meets the CPD requirements of the college
  - 1:3 Roster of specialists with experience in intensive care medicine, who meet the CPD requirements of the college (could be dual-trained)
  - At least one registered medical practitioner with an appropriate level of experience rostered to the PICU at all times
  - 1:1 or 1:2 nursing (casemix dependent), with a nurse in charge who has a post registration qualification in intensive care and at least 50% of rostered staff with a post registration qualification
  - At least 2 registered nurses present at all times when there are patients in the unit
  - Access to allied health, including dietician, occupational therapist and speech therapist as required

Proposed Functional Relationships for CHS – Level 1 PICU (end state)

The model below illustrates the proposed approach to providing safe short-term critical care support for children who are at high risk of deterioration or critically unwell.



[1] The age criteria between PICU and NICU will need to be reviewed and may well change to ~4 months over time – this will have flow-on impacts for NICU training and resourcing
[2] This should include the training needs for staff on the paediatric wards, and opportunities for upskilling those staff to support the PICU

Proposed Characteristics of a CHS Level 1 PICU

The core purpose of a Level 1 PICU at CHS should be to provide better care to the current cohort of children and families who receive care at CHS, and reduce harm and adverse events. Patients requiring short-term, lower complexity critical care support will receive it in a more appropriate setting, close to home.

Proposed principles of establishing a CHS Level 1 PICU

- Is child and family-centred, providing a child appropriate and psychologically safe environment
- Supports the existing cohort of children and families receiving care at CHS (i.e. it is not intended to increase overall service complexity in paediatric disciplines) – all 'planned' admissions to Level I PICU must be formally agreed between treating surgeon, anaesthetist and PICU attending clinician
- Supports sustainability of other paediatric services at Canberra Health Services (including paediatric medicine and Emergency Department), including through exploring staffing models that can strengthen these services (e.g. dual-trained general paediatrician / intensivist) – with strong, integrated governance
- Has a strong and formal relationship with the SCHN Level III PICU, including regular case reviews, consultation with SCHN on any variation from agreed inclusion/exclusion protocols
- Is in a physical location which supports strong functional relationships with paediatric teams and beds (including prompt response to MET calls), as well as ED, NICU and ICU and retrieval facilities (ie.helipad)
- Consolidation of staff skills and training appropriate to the clinical requirements and location of services provided

Target Outcomes

- Reduction in mortality for all children requiring ICU support from the CHS Catchment (both transferred and non-transferred)
- Reduced rate of cardiac arrest in children <16 years of age
- Reduced MET call response times
- Reduced transfers to SCHN for children with a total LoS in SCHN of less than 3 days
- Improved child & family experience
- Improved staff satisfaction (patient safety conversations) and staff resources/training

Next Steps

- **Reconvene PICU working group to agree the outline proposal**
- **Develop staffing options, with input from paediatric medicine, paediatric emergency teams and allied health**
- **Agree the most appropriate physical location for the Level 1 PICU considering the significant trade-offs between proximity to different functional relationships, including helipad, and potential cost differences**
- **Formalise and sign-off interim arrangements (see overleaf)**

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for escalation

- Care should be escalated in accordance with the PEWS escalation table (see Appendix)
- Dependent on the PEWS score, escalation is initially to the team leader, followed by Registrar then Consultant
- Nursing staff are responsible for continuing to escalate, via the Nursing Team Leader, to senior medical review, should they have concerns regarding the medical response, or ongoing deterioration of the patient
- Children & Families also have the right to escalate care, should they feel that the healthcare team has not fully recognized the patient's changing health condition – the nursing team should facilitate this.

Criteria for a MET call

- A MET call is made when there are signs of serious clinical deterioration in a child.
- MET calls should be made in accordance with the established PEWS and MET criteria (see Appendix)
- MET calls are everyone's responsibility – the nurse or doctor who identifies that MET criteria have been met, should initiative the MET call.
- There are known instances where the current MET criteria are overly sensitive to children with pre-existing cardiorespiratory conditions. Any exceptions to applying MET criteria for individual patients, must be document in their notes, and approved by the admitting consultant.
- NICU respond to MET calls for children < 1 year
- ED respond to MET calls for children ≥ 1 year

Criteria for a Code Blue

- A Code Blue should be called when there is a medical emergency for a child (e.g. cardiac or respiratory arrest)
- Code Blue's are everyone's responsibility and should be called immediately by the first clinician who identifies the emergency.

It is acknowledged that moving to a Two-Tier system would be a change from current practice, and further work will be required both to refine criteria (including the issue of sensitivity of PEWS in specific cases), and to operationalise

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for admission as a High Acuity Patient[1]

- >10 days and <16 years on admission
- Persistent PEWS >4 but not deteriorating
- Clinically unstable medical or surgical patient requiring, or expected to require frequent observations and/or medical review and a 1:2 nurse to patient ratio

Inclusions

- Patients with respiratory compromise requiring acute non-invasive respiratory support
  - FiO2 <0.5
  - HFNPO ≤2L/kg/min
  - Bubble CPAP <8cm H2O
- Patients requiring infusions such as magnesium sulphate, salbutamol or aminophylline (or 2 or more infusions for pain management)
- Patients with intercostal catheters (chest drains)
- Sepsis with haemodynamic stability. If inotropes are required, admission to an intensive care is required
- Patients requiring continuous monitoring post complex surgery
- Diabetic ketoacidosis with a rising pH which is ≥ 7.0.
- Other children requiring multidisciplinary intervention and frequent monitoring / with potential for clinical instability requiring close monitoring and 1:2 nursing support

[1] These patients will be admitted to the High Care Ward, noting that this ward also accepts lower acuity patients

Criteria for transfer to SCHN

- > 12 months and < 12 years
- < 12 months with complex care needs or who are not responding to short term intensive care in the NICU
- Diabetic ketoacidosis if pH <7 or not rising,
- Patients with severe respiratory compromise
  - pCO2 of ≥50mmHg in the absence of chronic lung disease (and not improving despite treatment over a 2-hour period)
  - required FiO2 of > 0.5
  - require > 2L/kg of HFNPO2
  - require ≥8cm PEEP on CPAP
  - Children needing sedation to maintain HFNPO2 or CPAP
- Apnoea despite respiratory support
- Airway risk such as severe croup or post-operative airway compromise
- requirement for ≥ 40ml/kg fluid bolus with persistent hypotension
- requirement for inotropes
- requirement for invasive blood pressure monitoring

Criteria for transfer to SCHN cont..

- arrhythmias such as severe bradycardia
- multi-organ impairment – all ages
- a child requiring multidisciplinary intervention and frequent monitoring for the following conditions
  - neurological conditions
    - use of ≥2 long acting pharmacological agents to control seizures
    - GCS ≤11
  - gastrointestinal
  - Renal
    - anuria or severe oliguria <0.5ml/kg/hr over at least 6 hours
    - rapidly rising creatinine
- Elective or semi-elective surgery with a high risk of complications requiring intensive care, and over 1 year of age.'
- Children in the post-operative phase at high risk of deterioration
- severe single organ failure requiring super-specialised intervention – all ages
  - Dialysis
  - ECMO
- Multi-organ failure – all ages

NETS should be contacted as soon as the above criteria are met. NICU will provide support to all children < 2 years pending retrieval by the NETS team. Adult ICU will provide support to all children ≥ 2 years pending retrieval by the NETS team

Interim arrangements (current care) for the critically-ill or deteriorating child

A number of attempts have been made to formalise and agree on best care for the critically-ill / deteriorating child in the absence of suitable paediatric critical care capacity. In the interests of children & families, these need to be signed off and agreed in good faith pending establishment of a Level I PICU.

Criteria for admission to NICU

- Critically ill infants presenting to Canberra Hospital <1 year who do not have complex care needs and respond to treatment
- Critically ill infants from <2yrs of age with single organ system condition and clear signs of response to treatment such that NICU care will likely be required for a short duration only (approx. 24hrs) and/or for stabilisation prior to transfer.
- All surgery for patients < 10 weeks corrected gestational age (equivalent to 50 weeks post conception age)
- Abdominal Surgery in ex-premature infants < 1 year of age
- Any other major surgery (elective or emergency) in children <1 years of age, that do not meet criteria for transfer to SCHN
- Thoracic/major surgery in children < 2 years of age, where surgery was an emergency or in elective cases where NICU is deemed a back up for high care in case of unplanned complications or clinician deterioration and do not meet criteria for transfer to SCHN with PICU
- *For those infants <1 year of age who will require a direct NICU admission post-operatively, a face-to-face or virtual planning meeting must be held prior to surgery, co-ordinated by the referring surgeon, involving surgeon, anaesthetist, neonatologist, representative paediatrician and Clinical Nurse Managers (CNM). NICU have the right to veto any admission where there are serious clinical safety concerns.*
- *For those infants >1 year of age who may require NICU admission post-operatively, a face-to-face or virtual planning meeting must be held **prior to booking** the surgery, co-ordinated by the referring Surgeon. NICU have the right to veto any admission where there are serious clinical safety concerns.*

Criteria for admission to ICU

- Critically unwell children over 2 years presenting to Canberra Hospital where the medical situation involves a single organ system and there are clear signs of response to treatment such that ICU care will likely be required for a short duration only (approx. 24hrs), and too unwell for the High Care Ward.
- Children aged over 12 years deemed suitable to continue to receive intensive care at CHS beyond the period of initial stabilisation, by CHS Intensivist on-call, admitting paediatrician/paediatric surgeon, NETS NSW and paediatric intensivist, and too unwell for the High Care Ward
- Any major surgery (elective or emergency) in children > 12 years old, that do not meet the criteria for transfer to SCHN, and too unwell for the High Care Ward.
- Any major surgery (elective or emergency) in children < 12 years old, that are physiologically mature and do not meet the criteria for transfer to SCHN, and too unwell for the High Care Ward.
- *For children > 12 years of age who will require a direct ICU admission post-operatively, a face-to-face or virtual planning meeting must be held prior to surgery, co-ordinated by the referring Surgeon, involving surgeon, anaesthetist, intensivist, representative paediatrician and Clinical Nurse Managers (CNM). ICU have the right to veto any admission where there are serious clinical safety concerns.*
- *For children < 12 years of age who may require ICU admission post-operatively, a face-to-face or virtual planning meeting must be held **prior to booking** the surgery, co-ordinated by the referring Surgeon. ICU have the right to veto any admission where there are serious clinical safety concerns.*

Principles for reaching decisions

- There will always be children who fall outside of the criteria set out within this document, or who have exceptional circumstances (clinical, psychosocial or other), which mean that the agreed criteria may not represent best and safest care for that individual.
- Where this is the case, the treating, or admitting consultant should initiate a multi-disciplinary meeting with the appropriate experts (this should usually involve input from the Level III PICU) to agree a care plan that best meets the needs of the individual child and their family.
- These discussion should always be
  - Consultant-to-consultant
  - Captured in the clinical notes
  - Courteous and acknowledging of differing clinical and risk perspectives
- Where consensus cannot be reached, this should be escalated to the Medical Director if not urgent, or Executive On-Call if time critical.

Paediatric Medicine

Executive Summary: Paediatric Medicine[1]

The paediatric medicine service is not sustainable in its current form, and requires substantial action, investment and support, to transition to a high performing service that is able to deliver exceptional care for children and families of the CHS catchment.

Service & Organisational Plan Overview

- The immediate priority for paediatric medicine is to put services onto a sustainable footing (in particular the outpatient service) and strengthen the operating model.
- This will require:
  - Increasing the number of general paediatricians and paediatric endocrinologists, and strengthening job planning and rostering (incl. VMOs and juniors), to ensure that clinical commitments can be met and share of workload is equitable
    - A robust and strategic approach to recruitment of additional staff, to ensure new appointments will contribute to strengthening the service
  - New nursing and allied health roles to support sub-specialty services and complex patients, increase outpatient capacity, and drive service innovation. A greater focus on training & upskilling the existing workforce is also required.
  - Strengthened ways of working, which are truly interprofessional across both inpatient and ambulatory settings, and a clearly defined and streamlined pathway for all paediatric outpatient referrals
  - Strengthened administrative, business intelligence and finance support into general paediatrics, to enable proactive management of the service and reduce the administrative burden on senior medical staff
  - Strengthening the specialist services that general paediatricians rely on to provide holistic care to the CHS catchment, with a view to growing some of these specialist services locally over time.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to first appointment
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Improvement in a wide range of other clinical outcome measures (see Appendix 5)

[1] Including paediatric endocrinology and paediatric gastroenterology

Operating Principles for Paediatric Medicine

- A principle of interprofessional team-based care in all our inpatient wards and ambulatory services, and interprofessional management of the service
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 18 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.
- Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged.
- Transition to paediatricians on-call for one organisation at any given time, with formal arrangements in place in the interim to ensure an on-call paediatrician for CHS is always available
- An attending consultant system (ward cover during weekdays, in addition to on-call and post-call activities)
- At least two medical handovers every 24 hours (in person or virtually) involve a consultant paediatrician – all high acuity patients discussed
- First point of escalation for junior doctors should always be the consultant on-call, not direct to sub-specialty consultants who are not on-call
- Consultant paediatricians are available for immediate telephone advice for acute problems for all sub-specialties – it is clearly defined when this advice is coming from CHS or SCHN
- Sustainable general paediatric training rotas, with strong training and supervision, and high staff satisfaction

Future Care Pathway

The future care pathway for general paediatrics will provide exceptional care for children of the ACT and surrounding catchment, with access to specialist advice as needed, and smooth transitions between care settings through strengthened interprofessional team working.

Community

Services / experience

- Transfer of care between acute and community paediatrics, based on a child's needs – clear understanding of respective service inclusion/exclusion criteria
- Comprehensive secondary and tertiary care of children in the community who do not require acute intervention
- Post-acute services provided in the community
- Outreach endocrine clinic provided monthly in Gungahlin
- Paediatric medicine provides a consult service to the community where required.

Ambulatory

Services / experience

- Outpatient appointments via GP or specialist referral
- Consultant triage to allocate referrals in accordance with agreed process (see overleaf)
- Specialist clinics available, with a principle of shared care, in:
  - Cardiology
  - Neurology
  - Gastroenterology
  - Allergy/Immunology
  - Respiratory & Sleep
  - Diabetes
  - Endocrinology
  - Intersex
  - Young Adult Transition
  - Gender Dysphoria[1]
- Expanded use of telehealth for both local and specialist clinics
- PDS for day stay and food testing clinic

Emergency

Services / experience

- Paediatric stream in the ED, moving to fully dedicated paediatric area when the CSB opens
- Paediatric Day Stay (PDS) for known patients requiring urgent, day-only admission

Inpatient

Services / experience

- Patients cared for by an interprofessional team in the most appropriate paediatric ward.
- Dedicated paediatric Allied Health team provide support as needed.
- Wards staffed via general paediatric junior medical staff, with daily consultant on-site cover in-hours and offsite on-call out of hours.
- Specialist consults available 24/7 across all subspecialties, in accordance with the agreed service specification

Intervention

Services / experience

- PDS for day interventions (e.g. chemotherapy infusions)
- Endoscopy capacity increased and provided by an integrated gastroenterology/surgical team, based on clinical priority.

Critically Unwell

Services / experience

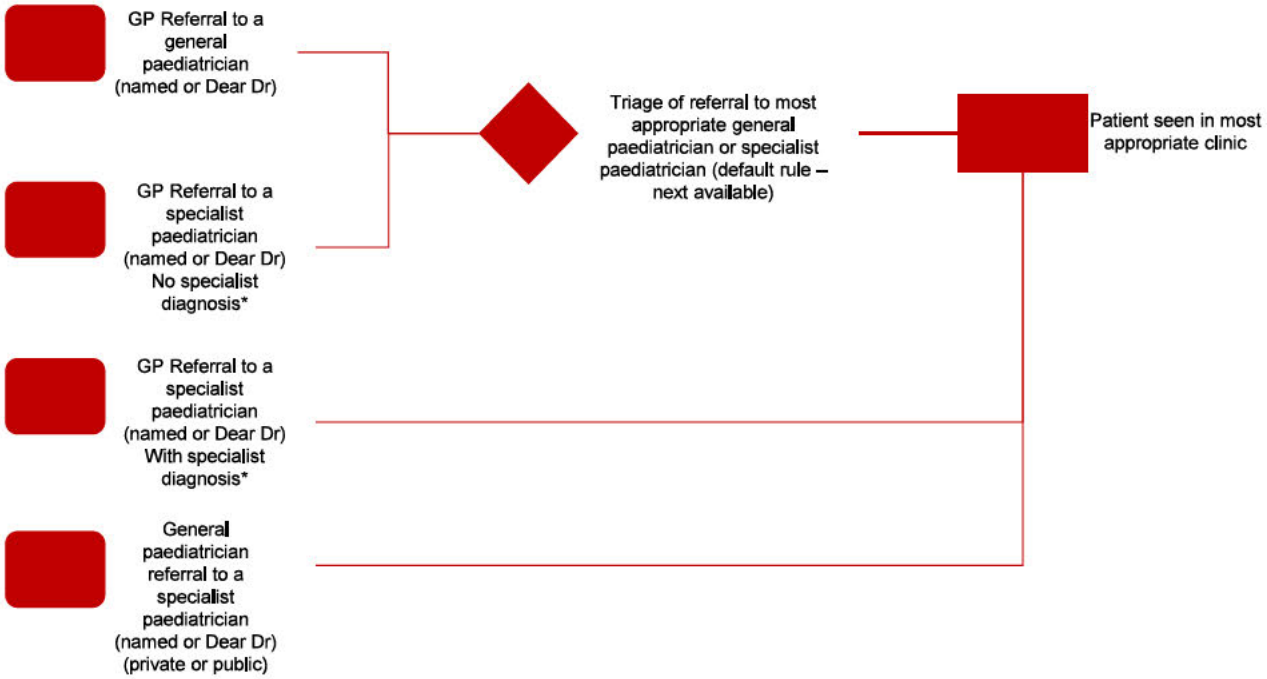
- Level I PICU established to care for children requiring stabilisation and transfer, or short-term mechanical ventilation. MET support provided by the Level I PICU Team.
- High Care Ward for high acuity patients requiring close observation
- Interim arrangements for care of the critically ill / deteriorating child formally adopted.

[1] Subject to resolution of current service commissioning issues

Management of Outpatient Referrals

At the VMO general paediatrician meeting, there was agreement in principle for general paediatrics to be the primary route for GP referrals for paediatric conditions, other than for agreed specialist suspected or confirmed diagnoses.

Referral Flow



Specialist Diagnoses

General paediatricians and specialist paediatricians will need to agree the list of confirmed and suspected diagnoses that warrant direct referral to the appropriate specialist, this may include:

Confirmed

- Cystic Fibrosis
- Sleep Apnoea

Established Referral Criteria

Gastro Referral Criteria

Respiratory Referral Criteria

Endo and Diabetes Criteria

Other Operating Principles

- Transparent and simplified booking rules (2+4)
- Remove barriers to innovation (slot timings)
- Increased use of registrars and fellows
- Optimise available slots (patients contacted via telephone to confirm appointments)

Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Outpatients

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	80	960	960	983	1,007	1,031	1,056
Follow-ups	364	4,364	4,364	4,469	4,576	4,686	4,798
Backlog							
Current Waiting List		1,019					
Reasonable WL		240					
Backlog Clearance		779	200	200	200	179	
Backlog Follow-ups		3,541	909	909	909	814	
TOTAL DEMAND			**6,433**	**6,561**	**6,692**	**6,710**	**5,854**

Inpatients & Day Stay[1]

	Monthly	Annual	2021	2022	2023	2024	2025
Elective		119	122	125	128	131	134
Semi-Elective		1,463	1,498	1,534	1,571	1,609	1,648
Statistical Admission		40	41	42	43	44	45
Urgent		3,220	3,297	3,376	3,457	3,540	3,625
TOTAL DEMAND		**4,842**	4,958	5,077	5,199	5,324	5,452

[1] These numbers will be impacted by changes to the ED Model of Care, including introduction of a short-stay unit, and the establishment of a PICU – this modelling is outside the scope of the plan.

Forecast Capacity Requirements

Outpatients

- Modelling has been completed to estimate the number of clinics required to meet the growing demand in outpatients, and address the substantial backlog.
- This suggests between 1,065 and 1,300 clinics will need to run each year for the next five years, to meet the demand.
- Sufficient capacity needs to be planned to ensure this number of clinics is available, after adjustments for on-call, study leave, annual leave and public holidays.

Inpatients and Day Stay

- Modelling has been completed to estimate the number of beds required for paediatric medicine over the next five years at 85% occupancy. Assuming that patients staying less than 12 hours can be managed through the paediatric day stay unit, this suggests the following bed requirements for paediatric medicine:

	2021	2022	2023	2024	2025
Paediatric Day Stay[2]	7	8	8	8	8
Inpatient Beds - <12 years	18	19	19	19	20
Inpatient Beds - ≥ 12 years	4	5	5	5	5
TOTAL BEDS	**29**	**32**	**32**	**32**	**33**

[2] Calculated as total number of children with a LoS <12 hours ÷ 365 ÷ 0.85. This is a conservative estimate, assuming no more than 1 child per bed per day.

Future Staffing Requirements

Modelling of outpatient demand, and comparison of paediatric medicine against benchmarks, has highlighted the need to strengthen the current service, to provide a sustainable service, address the current substantial waiting list backlog, and deliver an improved working environment for all staff.

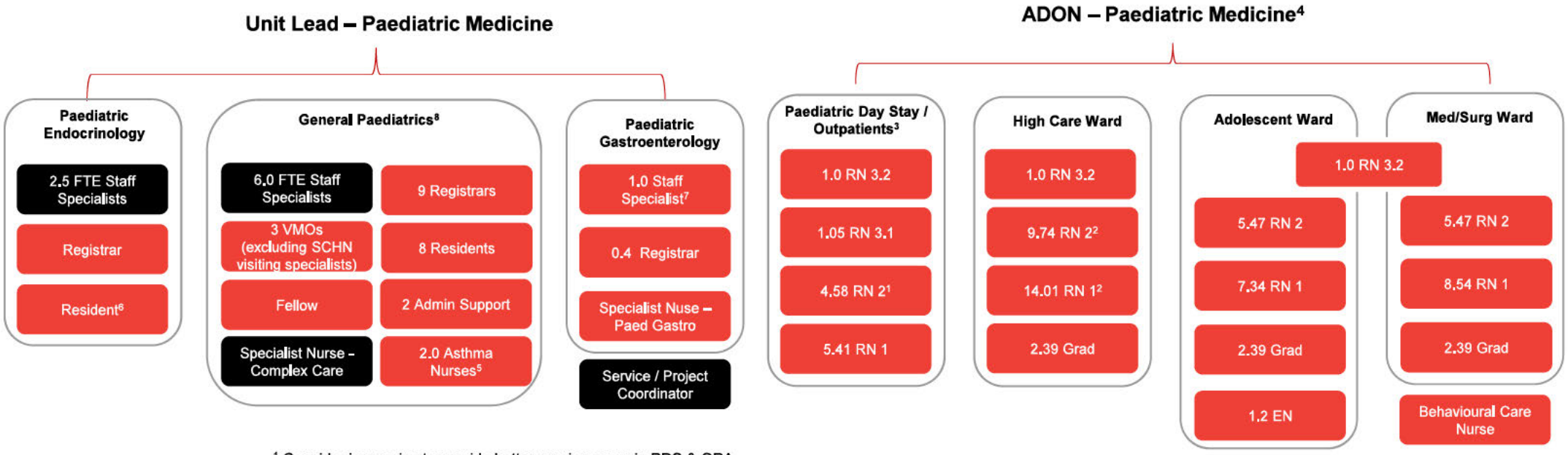
Staff Type	Current FTE	Proposed FTE	Impact
General Paediatricians (Staff Specialists)	3.9	6.0	Moves total paediatric senior medical staffing to accepted benchmarks. Increase in staff specialists provides additional capacity to cover the substantial shortfall in outpatient capacity. (N.B. 6 does not include a Clinical Director for Paediatrics,)
General Paediatricians (VMOs)	3–4[1]	3[1]	Continues to provide capacity for VMOs to provide a valued contribution into the service, and the potential for attractive VMO roles shared with the private sector
Paediatric Gastroenterologist	1.0	1.0	The service will require Nursing & Allied Health Input, along with strong links into SCHN to ensure sustainability
Paediatric Endocrinologist	2.0	2.5	Meets the recommendations of the Endocrine Review 2018 and associated benchmarks. Enables more equitable distribution of workload across all paediatric medicine physicians.
RN 3.1 Nurse Specialist	0.0	2.0	1.0 Gastroenterology; 1.0 Complex Care Patients. Facilitates service innovation, care coordination and a case management approach to complex patients. Supports inpatients. A low-cost approach to addressing the outpatient backlog for clinically appropriate cases.
Allied Health	0.0	3.0	Facilitates service innovation, care coordination and a case management approach to complex patients, in addition to outreach / home visiting where required. A low-cost approach to addressing the outpatient backlog for clinically appropriate cases.
Project Coordinator	0.0	1.0	Provides the senior administrative resource required to deliver against the substantial change program required to deliver against the service & organisational plan

Principles for attracting and retaining a high quality medical workforce

- Retain proportionality between direct clinical care and other duties (min 75/25) across staff specialist and VMO workforce
- Attractive Staff Specialist and VMO roles, which strengthen capability and capacity within the ACT
- Incorporate values & behaviours within the recruitment process, as equally important to clinical skills for new appointments
- Involve senior medical staff in appointment decisions
- Consider fixed tenure for leadership roles, to provide development opportunities and experiences for a greater number of individuals who are suitably skilled and have interest
- Seek to bring in additional expertise to CHS through recruiting / growing general paediatricians, with advanced training in other specialties, including:
    - Adolescent Health
    - Gastroenterology
    - Respiratory
    - Cardiology
    - Neurology
    - Nephrology
    - Mental health (CAMHS to recruit to this)
    - Intensive care medicine (TBC)
- Where recruitment identifies paediatricians with dual-training, clear parameters are set regarding their role in general paediatrics, including: expectation regarding equal contribution to the on-call rota – usually 5 years; contribution to general paediatric outpatient clinics – usually 1-2; referral criteria for specialist clinics; relationship with SCHN MDT – usually formalised; gateways for expansion of specialist components of the service (demand or other parameters)

Proposed Governance

The team structure should support the functional model we are seeking to implement, including collaboration within and across disciplines and teams, sharing of non-clinical tasks equitably amongst medical staff and increased interprofessional working.



Key

- Existing
- Strengthen / New – CHS Funded
- Strengthen / New – If commissioned

[1] Consider increasing to provide better nursing cover in PDS & OPA
[2] Consider decreasing to a NHPPD of 7.5
[3] The new CNC and Allied Health roles should also support paediatric day stay and outpatient activity
[4] There is a case for a dedicated ADON for paediatrics, to work alongside the Allied Health and Medical Lead as part of an integrated MDT leadership team
[5] Recommended that the asthma nurses currently in the community are transferred across to the acute team, to create a larger scale team of specialist nurse input and support both inpatient and ambulatory acute care
[6] The resident is currently informally 'borrowed' from Team B – consideration should be given to formalising the role
[7] Noting that this role also contributes to general paediatrics, including 1:8 on-call
[8] Note that the additional Allied Health staff recommended on page 38 are included in the Allied Health governance on page 64

Paediatric Surgery

Executive Summary: Paediatric Surgery

The paediatric surgery service is currently meeting the needs of the CHS catchment for the casemix that can safely be delivered at Canberra Health Services. The current staffing model is sustainable for the horizons of this plan, but succession planning is needed early, alongside improvements to ways of working.

Service & Organisational Plan Overview

- The immediate priority for paediatric surgery is to improve ways of working, in order to foster a positive team environment across all staff, and meet the Charter on the rights of Children & Young People in Healthcare Services in Australia.
- There is also a need to plan recruitment to a new permanent consultant level position, as part of succession planning for the future. Early recruitment to this position would assist in reducing the ambulatory waiting list to three months.
- This will require:
  - Formalising the Unit Lead role for paediatric surgery, with clear roles & responsibilities
  - Adopting a set of operating principles, which include strengthening relationships, and greater visibility and interaction with other disciplines, particularly paediatric medicine, other surgical specialties operating on children, and the Emergency Department
  - Increasing awareness and understanding amongst the team in relation to creating a psychologically safe work environment, and what it takes to deliver this
- Development of a Level I PICU in the short to medium term (within the next 3 years) will enable more children to have their surgical treatment in Canberra, in particular, those who may require short-term ventilation post surgery. (see page 24)
- Strengthening and formalising specialist input into Canberra Health Services from Sydney Children's Hospital Network, including nephrology and haematology will support delivery of exceptional care. (see page 20)
- There is a need for closer joint working with other surgical specialties with high volumes of paediatric activity, including ENT, Orthopaedics and Neurosurgery. Once a Level 1 PICU is established, ENT can provide a more comprehensive airways service, from their existing team. Over time a dedicated paediatric orthopaedic surgeon, networked into SCHN, is also recommended.
- Adult neurosurgical involvement in children with head injury needs to be reviewed.

Target Outcomes

Measure
• Improved Child & Family Reported Experience
• Improved Child & Family Reported Outcomes
• Improved Staff Satisfaction & Engagement
• Reduced time from referral to treatment
• Reduced variation from time of referral to treatment by Category
• Reduced Hospital Acquired Infections
• Reduced unplanned readmission rates (≤ 30 days)
• Proportion (%) of congenital elective orchidopexy procedures performed before the age of 12 months
• Reduced unplanned returns to theatre
• Reduced transfers to SCHN after elective surgery

Operating Principles for Paediatric Surgery

- Safe and effective services as locally as possible (not local services as safely as possible)
- A principle of interprofessional team-based care in all our inpatient wards and ambulatory services, and interprofessional management of the service
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Delivery against the nine core competencies of the Royal Australasian College of Surgeons (see overleaf)
- Every unwell child presenting with an acute surgical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) or higher paediatric surgical rota within a clinically appropriate time (typically 4 hours or less).
- Paediatric surgeons on-call for one organisation at any given time
- Two daily surgical rounds, involving the surgical team and and nursing team leader
- Sustainable paediatric surgical training rotas, with strong training and supervision, and high staff satisfaction
- A principle of consultant-to-consultant communication and resolution of issues within and between departments
- Public outpatient capacity reserved for new and follow-up public outpatient activity (e.g. no routine transfers of post-acute follow-up from private to public)
- Equitable access to paediatric surgery for the CHS catchment in accordance with clinical needs

RACS Nine Core Competencies

Medical Expertise

Medical Expertise relates to the acquisition, integrating and application of medical knowledge, clinical skills, and professional attitudes in the provision of patient care:

- Demonstrating medical skills and expertise
- Monitoring and evaluating care
- Managing safety and risk

Judgement – Clinical Decision Making

Judgement – clinical decision making involves making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance, and promotion:

- Considering options
- Planning ahead
- Implementing and reviewing decisions

Technical Expertise

Technical expertise relates to safely and effectively performing surgical procedures conducted in the unit in which they are training or working:

- Recognising conditions for which surgery may be necessary
- Maintaining dexterity and technical skills
- Defining scope of practice

Professionalism and Ethics

Professionalism and ethics involves demonstrating commitment to patients, the community, and the profession through the ethical practice of surgery:

- Having awareness and insight
- Observing ethics and probity
- Maintaining health and well-being

Health Advocacy

Health advocacy involves responding appropriately to the health needs and expectations of individual patients, families, carers and communities:

- Caring with compassion and respect for patient rights
- Meeting patient, carer and family needs
- Responding to cultural and community needs

Communication

All surgeons are required to be able to communicate effectively with patients, families, carers, colleagues and other staff:

- Gathering and understanding information
- Discussing and communicating options
- Communicating effectively

Collaboration and Teamwork

Collaboration and Teamwork involves developing a high level ability to work in a cooperative context to ensure that the surgical team has a shared understanding of the clinical situation and can complete tasks effectively:

- Documenting and exchanging information
- Establishing a shared understanding
- Playing an active role in clinical teams

Management and Leadership

Management and leadership involves leading the team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members:

- Setting and maintaining standards
- Leading that inspires others
- Supporting others

Scholarship and Teaching

As scholars and teachers, surgeons demonstrate a life-long commitment to reflective learning, and the translation, application, dissemination, and creation of medical knowledge:

- Showing commitment to life-long learning
- Teaching, supervision and assessment
- Improving surgical practice

Future Care Pathway

The care pathway for paediatric surgery includes services provided by the paediatric surgeons and paediatric surgical services provided by adult specialties – there is limited overlap / collaboration between these groups. Gaps include care of the critically unwell child, and management of emergency cases when the paediatric registrar is not on call.

Community

Services / experience

- Referral from community into paediatric surgery via written referral (not common)

Ambulatory

Services / experience

- Outpatient appointments via GP or specialist referral
- Surgical clinics available in:
  - Orthopaedics (Fracture Clinic)
  - General
  - Plastics
  - Ophthalmology
  - ENT
- All clinics take place in age-appropriate settings
- General paediatric surgery includes:
  - Paediatric Thoracics
  - Paediatric Urology
  - Paediatric gastroenterology
- Expanded use of telehealth for both local and specialist clinics

Emergency

Services / experience

- Paediatric Surgeon on-call 1:4
- Registrar on-call rota shared between paediatric and general surgery, with the skills necessary to care for acute paediatric cases.
- Specialist clinics (e.g. fracture clinic) provided in an age-appropriate environment

Inpatient

Services / experience

- Paediatric surgical patients looked after in the general paediatric wards, with high consultant visibility
- Shared care of patients in the high care ward, with consultant attendance at daily handovers for high acuity patients.

Intervention

Services / experience

- All inpatient interventions carried out at Canberra Hospital
- Children treated equitably in accordance with clinical need.
- Interventions out of scope:
  - Paediatric cardiac
  - Organ transplant
  - Scoliosis
  - Surgical Oncology
  - Neurosurgery
  - Specialised Burns
- Interventions led by adult teams:
  - ENT
  - Orthopaedics
  - Opththalmology
  - Interventional Radiology

Critically Unwell

Services / experience

- Suitability for surgery at CHS tested through pre-anaesthetic assessment.
- Level I PICU established to care for children requiring stabilisation and transfer, or short-term mechanical ventilation. MET support provided by the Level I PICU Team.
- High Care Ward for high acuity patients requiring close observation
- Interim arrangements for care of the critically ill / deteriorating child formally adopted. (see page 24)

Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Outpatients

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	50	600	600	615	630	646	662
Follow-ups	175	2,100	2,100	2,151	2,203	2,256	2,311
Backlog							
Current Waiting List		450					
Reasonable WL		150					
Backlog Clearance		300	100	100	100		
Backlog Follow-ups		1,050	350	350	350		
TOTAL DEMAND			**3,150**	**3,216**	**3,283**	**2,902**	**2,973**

Inpatients & Day Stay[1]

	Monthly	Annual	2021	2022	2023	2024	2025
Elective		549	549	562	575	589	603
Additional Conversions from Backlog			15	15	15		
Semi-Elective		76	76	78	80	82	84
Statistical Admission		1	1	1	1	1	1
Urgent		724	724	741	759	777	796
TOTAL DEMAND		**1,350**	**1,365**	**1,397**	**1,430**	**1,449**	**1,484**

[1] This is the total backlog, assuming conversion rate remains static – recommend spreading over 3 years

Forecast Capacity Requirements

Outpatients

- The outpatient waiting list is currently longer than desirable – reducing it to 3 months (excluding Cat 1s) would require additional capacity.
- Assuming ~9 patients per clinic[2], an additional 1.5 clinics per week would be required to clear the outpatient backlog and meet future growth.

Inpatients and Day Stay

- Reducing the outpatient waiting list, and meeting projected growth in demand, will generate an additional 90 – 150 inpatient and day stay episodes over the next five years. This equates to a total increase in inpatient/day-stay workload of ~10%

Beds[3]

- Modelling has been completed to estimate the number of beds required for paediatric surgery over the next five years at 85% capacity, assuming that patients staying less than 12 hours can be managed through the paediatric day stay unit.

	2021	2022	2023	2024	2025
Paediatric Day Stay[4]	2	2	2	2	2
Inpatient Beds - <12 years	4	5	5	5	5
Inpatient Beds - ≥ 12 years	4	4	4	5	5
TOTAL BEDS	**10**	**11**	**11**	**12**	**12**

[2] Based on current throughput, although worth noting there is substantial variation between clinicians
[3] This does not include beds for children in other surgical specialties, which equate to c. 6 inpatient beds and 1.5 Day Stay Beds currently
[4] Calculated as total number of children with a LoS <12 hours ÷ 365 ÷ 0.85. This is a conservative estimate, assuming no more than 1 child per bed per day.

Proposed Governance

No changes are proposed to the current paediatric surgical team. A decision needs to be made on whether the team sit under the line management of the Women Youth & Children's Division or the Surgical Division. This should not fundamentally alter ways of working, and strong links to both Divisions will be required.

Lead for Paediatric Surgery[1]

Paediatric Surgery

- 3.5 Consultant Level Staff
- 2.0 Registrars
- 1.0 Resident

Key Functional Relationships

- Paediatric Medicine (interprofessional) — High quality, consultant-directed, ambulatory & inpatient care
- Theatres — Efficient scheduling and management of operating lists
- General Surgery — Consistent high quality out-of-hours paediatric surgical care
- Critical Care — Safe management of high acuity post-operative paediatric surgical patients
- Other Adult Surgical — All children undergoing surgery are cared for in line with the CHA Charter
- Anaesthetics — Key clinical interface for paeidiatric surgical patients

[1] Included within the 3.5 Consultant Level Staff

Community Child Health

Executive Summary: Community Child Health

It is difficult to isolate 'community paediatrics' from the wide range of services provided by WYCCH for women, children & family health, due to the significant service interfaces and overlaps. This plan focuses on the current Child Health Targeted Support Services, but within the context of the other services provided.

Service & Organisational Plan Overview

- The immediate priority for Community Child Health is to move to an interprofessional model of community health care for children, with streamlining of pathways to meet the needs of all children, including those with complexity or vulnerability.
- This will require:
  - Investing in new nursing & allied health roles to work alongside the community paediatricians to provide interprofessional triage, assessment and treatment for the current cohort of children referred to the community paediatrician service.
  - Finalising a revised governance model for WYCCH – this includes some amendments to the proposals set out in the current consultation paper, and realignment of resources to sit two functional teams: Neurodevelopmental and behavioural - NBAT (formerly community paediatrician service); and Targeted Support for Children & Families -TSCF (incorporating former CARHU and other early parenting support services)
  - Establishing the care pathways set out within this plan, including developing the inclusion and exclusion criteria for each pathway
  - Identifying suitable space to accommodate the interprofessional teams at both CHS and in the community
- There are also a number of areas where the services currently commissioned are not adequate to meet the needs of the ACT population, and would benefit from expansion (e.g. early intervention services for children with developmental delays). This will require discussion with ACT Health to agree prioritisation and funding of any service expansion.
- There is a significant need to integrate services, service locations and service records for children & families across ACT Government Directorates, to reduce confusion, service gaps and overlaps, and make it easy for children & families to access the services they need. Although beyond the scope of this plan to address, it is recommended that action is taken to progress cross-directorate action, to deliver exceptional care across the Territory (see Appendix for how this model could be delivered)

Target Outcomes

Measure
• Child & Family Reported Experience

• Child & Family Reported Outcomes
  • Social & Emotional Wellbeing
  • Peer relationships
  • Behavioural problems
  • Parent-child relationship
  • Family Functioning

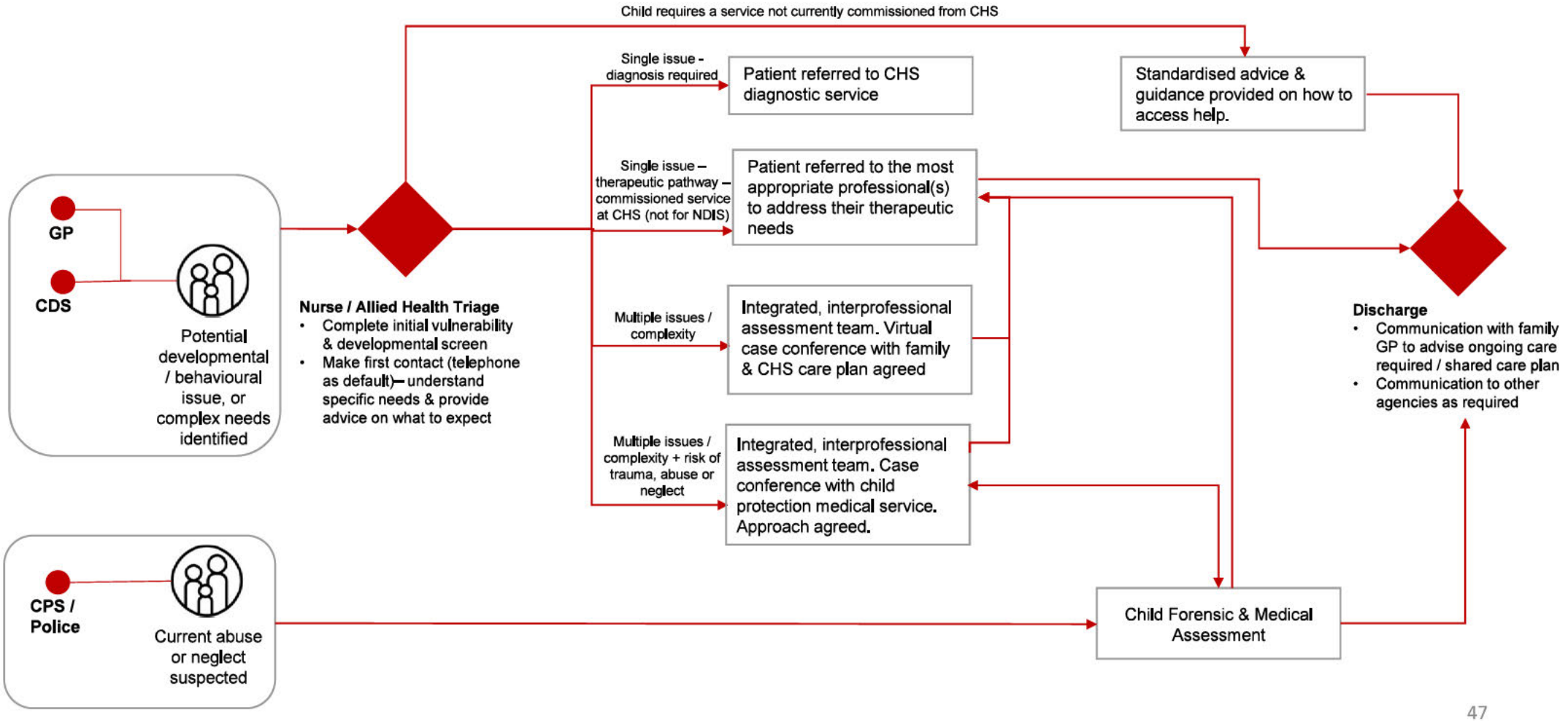
• Staff satisfaction / Engagement
• Time from referral to first contact
• Time from referral to assessment
• Time from referral to treatment commencement
• Prescribing rates for psychotropic medications in children with behavioural/developmental diagnoses

Operating Principles for Community Child Health

- A principle of interprofessional team-based care and interprofessional team-based management of the service
- Integrated teams applying standardised practice, particularly in similar services across NBAT & TSCF (e.g. psychometric testing)
- Robust systems and processes for monitoring quality & safety, and managing issues that arise – regular monitoring of clinical, patient experience and staff outcomes
- Clear distinction between services provided by medical teams with NBAT & TSCF, and clarity on roles & responsibilities within the team
- A commissioned services approach, with clear inclusion and exclusion criteria
- Single care record within CHS (prior to a single children's health and care record across directorates)
- Child-centred, family-oriented, holistic care
- Operational lead, who understands fully the day-to-day work, strategic issues, population needs and workforce requirements and can lead and represent the service effectively
- Single paediatric medical lead across Community Child Health to oversee clinical services, medical care and pathways
- Community paediatricians supported to make the best use of their skills and expertise, focussing their time on what only the community paediatrician can do
- A principle of shared care with General Practitioners, with children returned to the care of their GP as soon as it is safe and appropriate to do so
- A strengthened nursing and allied health service to improve access to commissioned services and drive service innovation, including consideration of high-level nursing roles to support the review of children with ongoing complex health needs
- Rotate staff through most challenging roles (e.g. child protection & family violence training) to minimize vicarious trauma and strengthen expertise across the larger team
- Professional Development embedded within/across teams with sufficient capacity to provide ongoing training, education and upskilling
- Ensure services are culturally appropriate and aware including recruitment of Aboriginal Liaison Officers and health workers

Future Care Pathway

CHS could organise its community services for children and families (including vulnerable children & families) to deliver a more integrated, interprofessional and streamlined service, through better integrated working between professionals and teams, and strengthened Allied Health and Nursing capabilities.



Future Activity Forecasts

The Australian Bureau of Statistics (ABS) forecasts that the paediatric population within the ACT will grow at an average of 2.4% per year between 2020 and 2025. The overall burden of disease in children is declining, but not at rates likely to have a significant impact on referral into secondary care.

Forecast Demand

Neurodevelopmental & Behavioural

	Monthly	Annual	2021	2022	2023	2024	2025
New Referrals	32	384	384	394	404	414	424
Follow-ups[1]	159	1,908	1908	1,954	2,001	2,050	2,100
Backlog							
Current Waiting List		400					
Reasonable WL (3 months)		96					
Backlog Clearance		304	101	101	101		
Backlog Follow-ups		1,514	503	503	503		
TOTAL DEMAND			**2,896**	**2,952**	**3,009**	**2,464**	**2,524**

CARHU

- CARHU demand is considerably less predictable to model, as it does not align with demographic growth.
- In addition, the workload associated with each child & family referred to CARHU is highly variable, and we know the service has 'latent capacity' by necessity, in order to be able to provide a timely response when needed.
- Time should be created in CARHU diaries each week to contribute to interprofessional case conference meetings.

Forecast Capacity

Resource	FTE	Triage	Psychometric Assessments	Clinics	MDT Case Reviews	Clinical Admin	Admin	Non-Clinical	Total Clinics Adjusted for Leave	Slots per clinic	Total Slots	Total Slots after DNA
Staff Specialist	3.1	0		7	7.5	8.5	8	26%	287	6	1,722	1,435
Registrar / CMHO	2	0		6	3	6	5	25%	246	3	738	615
Allied Health	6	10	12	6	5.5	12	14.5	24%	270	2	540	450
Nursing	2.54	6		3	5.5	5	6	24%	135	2	270	225
												2,725

- Modelling shows that establishing an interprofessional neurodevelopment & behavioural team has the potential to double the current capacity of the service, in addition to creating time and space for interprofessional case conferences and child & family consults.

Future Staffing Requirements

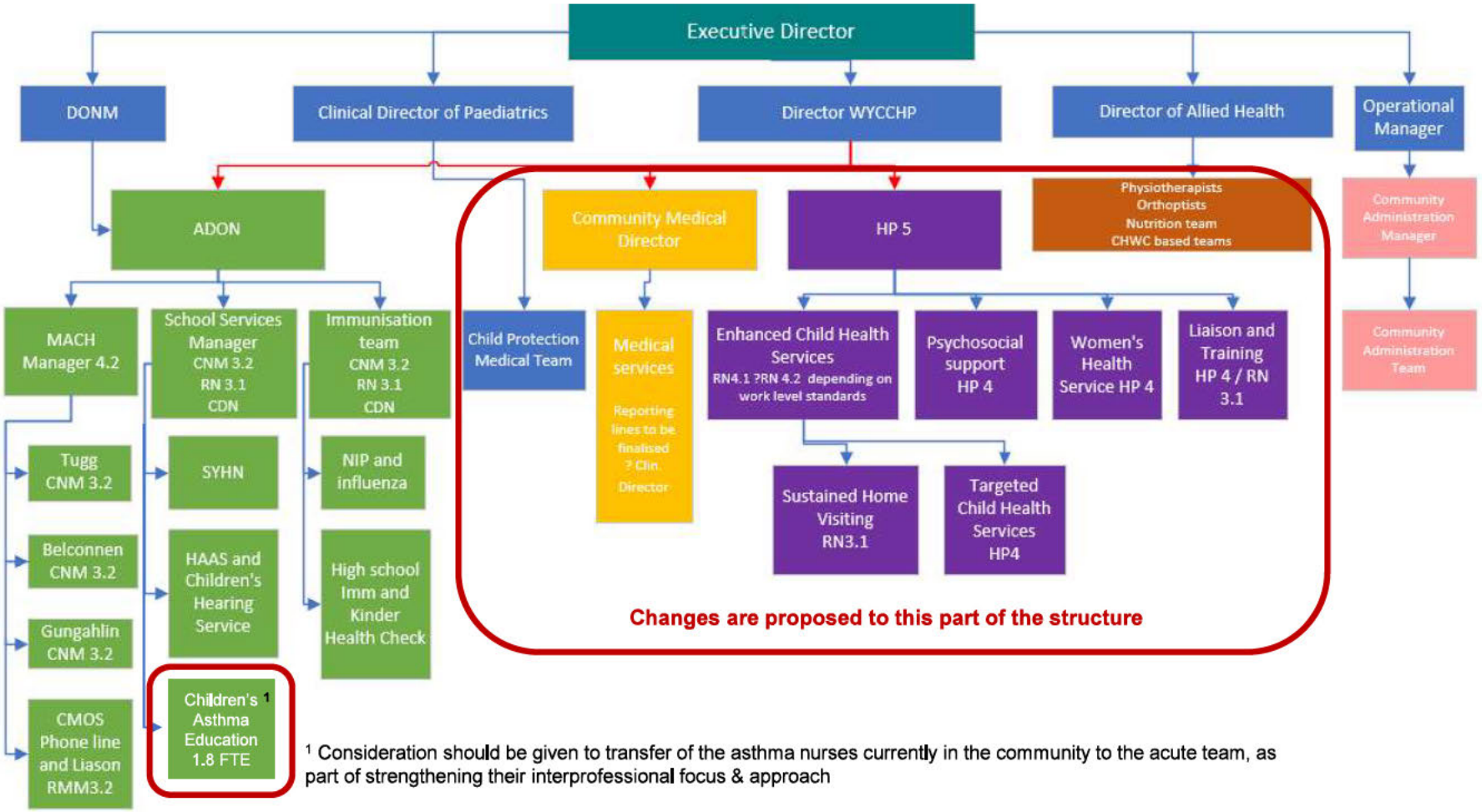
Modelling of outpatient demand, and alignment to the desired future pathway, has highlighted the need to strengthen the current service, and align staffing to functional teams, in order to address the current substantial waiting list backlog, and deliver an improved working environment for all staff.

Staff Type	Current FTE	Proposed FTE	Commentary
NBAT Community Paediatricians (Staff Specialists)	2.6	3.1	Increase community paediatrician capacity to support interprofessional working
NBAT CHMO / Registrar	2	2	No change (1.5 FTE Registrar and 0.5 FTE CHMO)
NBAT Senior Nursing / RN 3.1 Specialist Nurse	0.54	2.54	Increase capacity for nurse-led clinics, triage and MDT assessment
NBAT Allied Health Neurodevelopmental & Behavioural	0.7	6.0	Increase capacity for allied health clinics, triage and MDT assessment
TSCF Medical	2.2	2.2	No change
TSCF Specialist Nursing	1.64	1.64	No change (recommend seeking funding and scope extension to support more comprehensive Out of Home Care nursing)
TSCF Allied Health	6.96	6.96	No change (although there may be some transfer of staff to NBAT as part of implementing the full care pathway)
TSCF Impact / PEP	9.0	9.0	No change (recommend seeking funding and scope extension to support all vulnerable families)
TSCF Early Parenting Counselling	4.2	4.2	No change (recommend seeking funding and scope extension to support all vulnerable families)
TSCF CYPS Liaison	0.84	0.84	No change (position requires review)
TSCF Child Protection & Family Violence Training	4.0[1]	4.0[1]	No change (recommend completing an analysis of statutory training requirements and approaches to ensure this FTE can deliver the training required)

[1] Ongoing funding only in place for 2 FTE

Amendments to the outcomes of the governance review

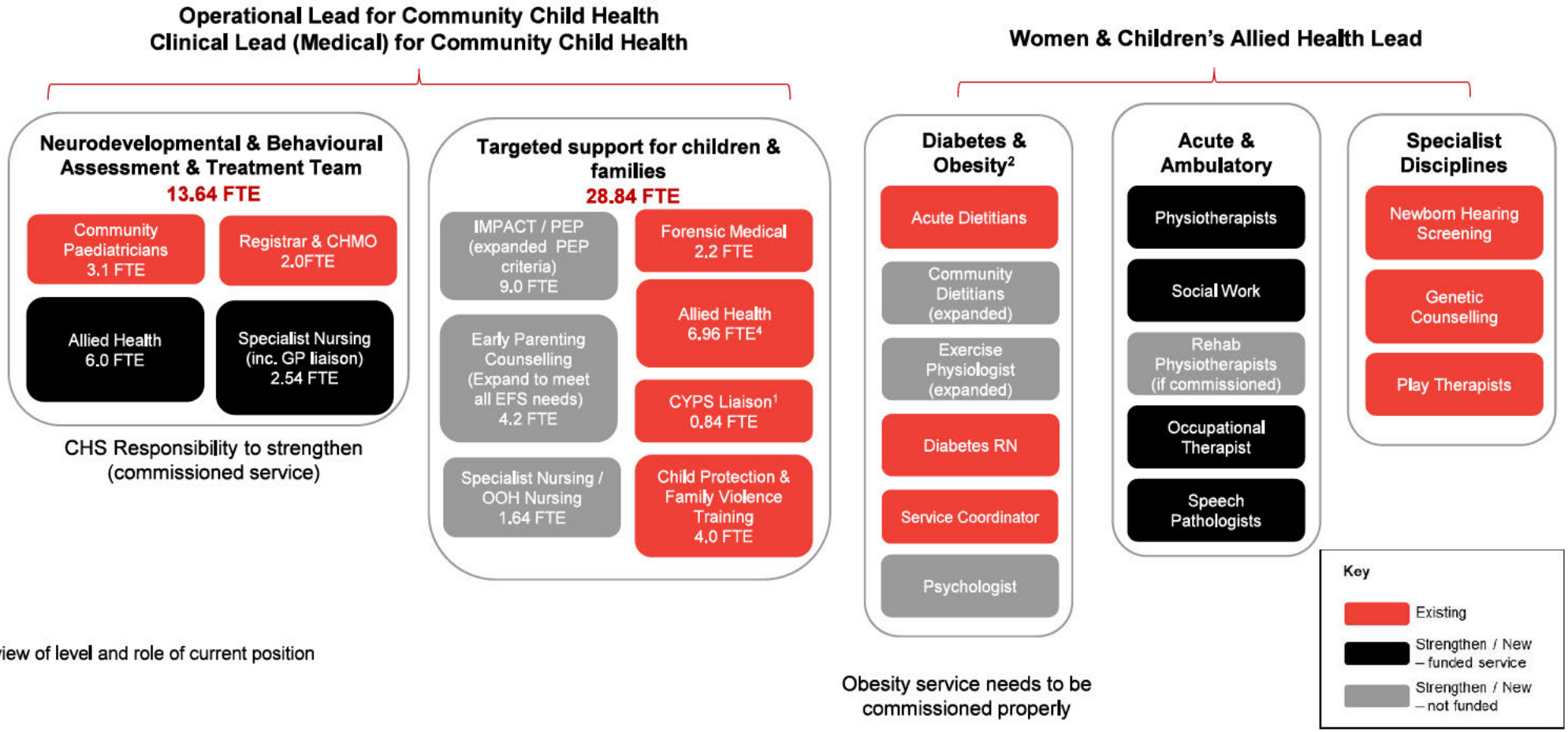
Applying the model and principles proposed, whilst broadly aligned to the outcomes of the governance review, would lend itself to a different team structure than that proposed in the review for a sub-set of the proposed structure, as set out below.



[1] Consideration should be given to transfer of the asthma nurses currently in the community to the acute team, as part of strengthening their interprofessional focus & approach

Proposed Functional Teams

The team structure should support the functional model we are seeking to implement, support collaboration within and across disciplines and teams, and ensure reasonable workloads for senior staff and meeting the needs identified during the previous governance review.



[1] Review of level and role of current position

Allied Health

Allied Health Challenges and desired Outcomes

The literature highlights the significant benefits that Allied Health can bring to service efficiency and outcomes for children and families across community, ambulatory and acute settings in paediatric healthcare. At present the paediatric Allied Health service is distributed into both professional and care setting siloes.

Challenges

- No dedicated Allied Health team for acute paediatrics within WYC Division – this has led to a decreased service over time and no ability for the paediatric team to prioritise Allied Health input.
- General paediatricians have identified better Allied Health input as one of their Top 5 services areas that require strengthening.
- Very small FTE for Allied Health Teams working in the community, with professionals split off into different teams creating service continuity and sustainability challenges
- Limited true interprofessional working outside of pockets of good practice (e.g. in paediatric endocrinology)
- A number of services not commissioned in line with population needs (e.g. obesity services; post-acute rehabilitation; early intervention child development services)

Desired Outcomes

- True interprofessional working, with nursing and allied-health led and integrated services that drive better child & family outcomes, and higher staff satisfaction
- Sufficient economies of scale within professional teams to manage planned and unplanned absences and provide peer support and learning
- Meets or exceeds the current response times for acute Allied Health support as set out in 'Acute Allied Health Priority Tools' Supports rotation, sharing and learning across care settings, to build breadth and depth in paediatric Allied Health capability
- Aligned to the desired future state for other aspects of the paediatric organisational and service plan
- Sufficient specialist and experienced Allied Health staff to provide out of hours support (0830 - 2130hrs 7 days a week) in NICU/PICU/paediatrics/maternity/ED to facilitate discharge on weekends

Options Considered

- Two options were put forward for consideration by the Allied Health team: 1) To move to functional teams within community and ambulatory care; or 2) To extend these functional teams to include Allied Health in the acute setting. On balance, Option 2 was preferred, as this would enable an at scale Allied Health team for paediatrics, to work across acute, ambulatory and community settings.

Preferred Option

The recommended option is to have a dedicated paediatric allied health team, functioning across community, ambulatory and acute care. This will require investment, and can't be considered in isolation without also considering Women's Allied Health.

Dedicated Paediatric Allied Health

Integrated

- Allied Health are part of at-scale functional teams (service or cohort focussed) across community, acute and paediatric ambulatory setting:
  - Neurodevelopmental & Behavioural Team
    - Triage, Assessment & Treatment for all relevant referrals from both general and community paediatricians.
  - Diabetes & Obesity Team
    - Dietician, exercise physiologist, psychologist
    - Provide support, on referral, into acute paediatric wards. Transfer acute paediatric nutrition FTE into this team
  - Acute & Ambulatory Team
    - Transfer existing physio, social work, speech path and OT team to paediatrics
    - Bid for post-acute rehabilitation service to be part of this team
    - Provide support, on referral, into community paediatrics complex cases
  - Targeted Support for Children & Family
    - interprofessional Allied Health Support into targeted support services
  - Specialist Disciplines
    - Play Therapists; Newborn Hearing Screening; Genetic Counselling; ALO

Key Considerations

1. Investment in Allied Health to create sufficient scale

The integrated model will require investment in Allied Health roles, to ensure that there are sufficient FTE in each profession to provide a dedicated Women & Children's service. The need to invest in Allied Health positions has already been identified in both Paediatric Medicine and Community Health, in order to provide interprofessional assessment & treatment, and support reducing the outpatient waiting lists.

2. Team working across community, ambulatory and acute teams

The integrated model is based on grouping functionally similar teams together to create scale and move away from small FTE in specific care settings. This requires creation of dedicated and sufficient resourced interprofessional teams that work across acute and community care. This will include dedicated community-based allied health positions.

3. Inclusion of Women's Allied Health as part of the integrated model

Models for consideration were developed within the scope of the paediatrics service & organisational plan (i.e. paediatrics only), however discussion with the Allied Health Director highlighted the importance of ensuring that allied health services for women, children and families at CHWC are considered as a package across paediatrics, maternity, neonatology and community

Proposed Functional Teams