

Full Equality Analysis Template

Consolidation of In-patient Paediatrics to Lincoln County Hospital and subsequent impact on Neonatal and Maternity Services

Currently, United Lincolnshire Hospital NHS Trust (ULHT) provide a range of acute and community paediatric services.

With regards to hospital-based services, ULHT provides children's services for children ranging from 0 to 18 years of age, including: an emergency service with links to inpatient beds, elective and day-case services, day assessment unit, a broad range of outpatient service with visiting specialist consultants and Intermittent respite care for specific diseases

At Lincoln County Hospital, a 24 hour paediatric service is provided, which includes: day case, inpatient and outpatient services. Paediatric consultants are available for general paediatric referrals. Current bed configuration is a general paediatric ward which is 19 bedded and an assessment unit which is 8 bedded.

At Pilgrim Hospital, Boston, a 24 hour paediatric service is provided, which includes: day case, emergency and outpatient services. Paediatric consultants are available for general paediatric referrals. Current bed configuration is an 8 bed paediatric in-patient ward, which currently will also undertake assessment activity with 2 assessment beds

At Grantham and District Hospital, The Kingfisher unit is open between 10am and 5pm Monday to Friday and provides an outpatient service only. Children in the Grantham area who have presented at Accident and Emergency that require emergency care and review by a consultant paediatrician are transferred to Lincoln or Boston. Transfer will only take place after review by an accident and emergency doctor or GP (based in the department) and a registered adult nurse. Very few children require this on a daily basis.

Both in-patient services need to comply with the RCPCH's *Facing the Future: Standards for Acute General Paediatric Services – revised 2015*. Standard 5 states:

“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. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner”.

ULHT advise that from July 2018 there will only be 1.0 wte substantive middle grade doctor available to work. ULHT have been continually attempting to recruit middle grades and paediatric consultants (to work as middle grades) since May 2017 with limited success.

Concerns have been raised internally to the ULHT Trust Board by the Women's and Children's Clinical Directorate regarding the fragility of Children's Services particularly at Pilgrim Hospital, Boston resulting in an internal risk summit called by ULHT.

An external, system wide risk summit was held and chaired by the Executive Medical Director on the 10th April 2017 where five potential options moving forward were presented:

- **Option 1:** No change to current model
- **Option 2:** Temporary closure of Paediatric inpatients at Pilgrim Hospital, a Paediatric assessment model in place & retain Consultant led Obstetrics, Gynaecology and Neonatology at Pilgrim Hospital
- **Option 3:** Temporary closure of Paediatric inpatient service, Neonatology and Consultant Led Maternity services at Pilgrim Hospital. Facilitate a midwifery led unit at Pilgrim Hospital as a temporary mitigation and a Paediatric assessment model
- **Option 4:** Maintain two site working for paediatric inpatients, Consultant led Obstetrics & Neonatology, but reduce paediatric bed numbers on each site to align with staff availability
- **Option 5:** With effect from July 1, 2018, providers across the region to support Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology

The general consensus at the system wide risk summit was that the status quo was not an option, and option 2 was considered a safe option. Subsequent to that meeting further refinement to the options have been proposed by ULHT as follows, but should be noted that Option 5 was discounted at the risk summit on April 10th by the external providers who attended the summit. The updated options are shown in the table below.

Option One	<ul style="list-style-type: none"> • Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover children's, maternity & neonatal services <p>Following advice we are currently unable to identify nationally that a middle grade tier run solely by locums is safe and whether it could carry a bigger risk and therefore need to seek assurance as to whether it is safe to do so.</p>
Option Two	<ul style="list-style-type: none"> • Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 4th June 2018 • Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC • Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations • Paediatric support with emergencies in Emergency Department at Pilgrim Hospital • Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks
Option Three	<ul style="list-style-type: none"> • Temporary closure of Paediatric inpatient services at Pilgrim with effect from 4th June 2018 • Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC • Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations • Paediatric support with emergencies in the ED department at Pilgrim Hospital up until July 1st • Retaining Consultant led Obstetrics and Neonatology at Pilgrim until July 1st when medical staffing reduces beyond the ability to support Neonatology. From July 1st Temporary closure of Consultant led Obstetrics and Neonatology at Pilgrim until the staffing gaps could be addressed • Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks • Establish midwifery led birthing unit at Pilgrim Hospital and a co-located midwifery led birthing unit at the Lincoln Hospital to facilitate increased activity on the consultant led unit.
Option Four	<ul style="list-style-type: none"> • Maintain Current Paediatric inpatient services, Consultant led Obstetrics and Neonatology services at Pilgrim & Lincoln Hospital Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital. • Stop all paediatric inpatient and day case elective (planned) activity for all paediatric specialities at both Lincoln and Pilgrim Hospital sites (This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln) • Stop all general Paediatric outpatient appointments
Option Five*	<p>With effect from July 1, 2018, providers across the region to provide Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology.</p>

Who will be affected?

Staff:

ULHT Clinical staff working in Accident and Emergency, Paediatric Wards, Maternity, Neonatal,
East Midlands Ambulance Team
General Practitioners and Practice Nurses
Urgent Care Staff
Health Visitors and School Nurses
Community Paediatric Consultants and Community Paediatric Nurses
Children Centre Staff and neighbourhood teams
Clinical and non-clinical staff at Nottingham University Hospitals NHS Trust, North Lincolnshire and Goole NHS Hospitals Trust, Queen Elizabeth NHS Trust (Kings Lynn), Peterborough and Stamford Hospitals NHS Trust

Patients

Pregnant Women

Children under 16 and under 25 their SEND (Special Education and High Needs)

Neonates and Well babies

Users

Young Carers and Carers

Parents

Families

Evidence

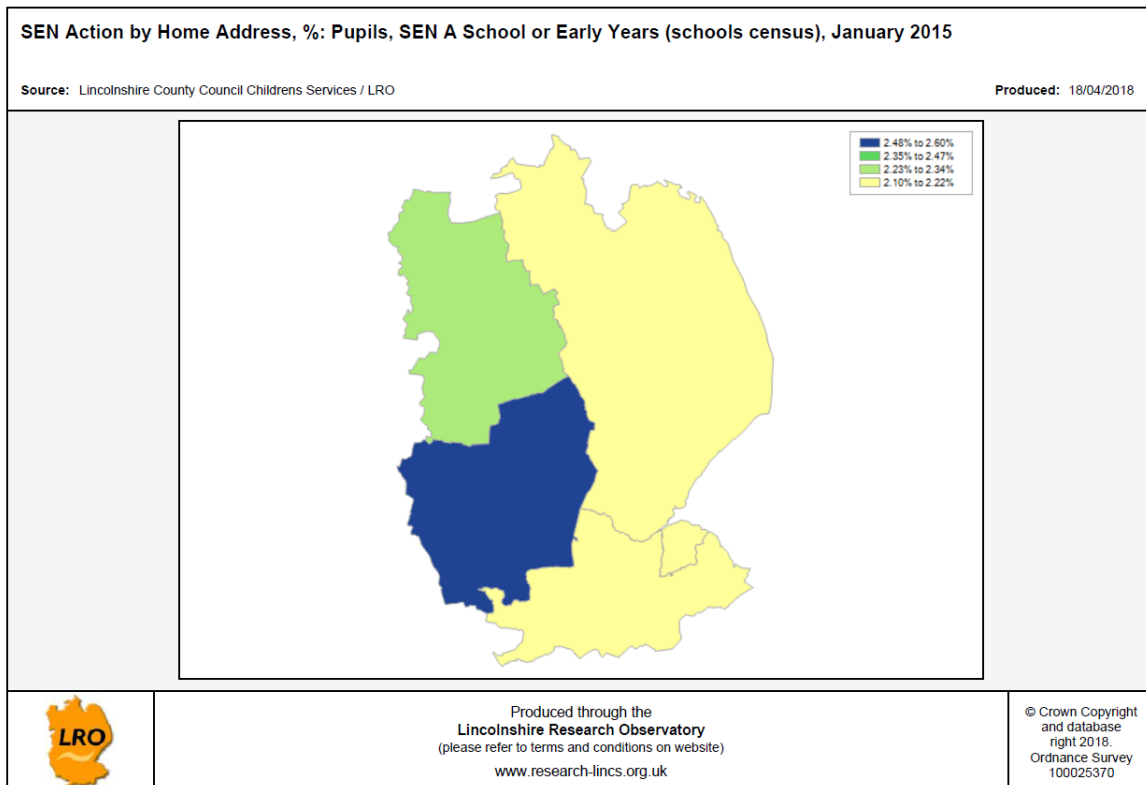
- Public Health – Finger Tips Reports
- Public Health – Child Health Outcome Report – March 2017
- ONS 2013 Census
- ONS Religion in England and Wales 2011
- Joint Strategic Needs Assessment (JSNA)
- Lincolnshire Research Observatory 2011 Census Country of Birth, Ethnicity and Nationality of Lincolnshire Residents
- LRO Schools Population Characteristics (SQL Latest Census) English as an additional Language, 2013
- EMMBRACE Saving Lives, Improving Mothers' Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. December 2017
- SuS Activity Data for 2016/2017
- Emergency Planning Services, Draft Final Report: Lincolnshire STP Obstetric and Paediatric Modelling. April 2018
- Lincolnshire Research Observatory
- Better Births Engagement Results
- ULHT Women's and Children's Engagement Results
- Intercollegiate Guidelines for Safer Childbirth: Minimum Standards for the organisation and delivery of care in labour, 2007

- RCPCH's *Facing the Future: Standards for Acute General Paediatric Services – revised 2015*.
- Defining staffing levels for children and young people's services. *RCN standards for clinical professionals and service managers. 2013*
- Department of Health (2009) *Toolkit for high quality neonatal services*, London: DH.
- RCPH Guidance of Short Stay Paediatric Assessment Units
- Section 11, Children's Act, 2004
- Working together to safeguard children, 2015
- Children's and Families Act, 2014
- Special Educational Needs and Disability Code of Practice: 0 to 25 Years (January 2015)
- Equality Act, 2010
- Public engagement findings from 2021 strategy engagement and targeted engagement carried out by ULHT

Disability

In Lincolnshire in 2014/15, 10.3% of Children in Need had a disability (England average is 12.8%). There are around 250 children and young people open to the Children with Disabilities Social Care team with approximately 40% aged 14-18. All of these children and young people have severe or profound disabilities (Source: LCC MOSAIC case management system). In January 2017 there were 105,806 pupils on the roll in Lincolnshire maintained and academy schools, of these 15.9% (approx. 16,820 pupils) are in receipt of some form of provision for their SEND

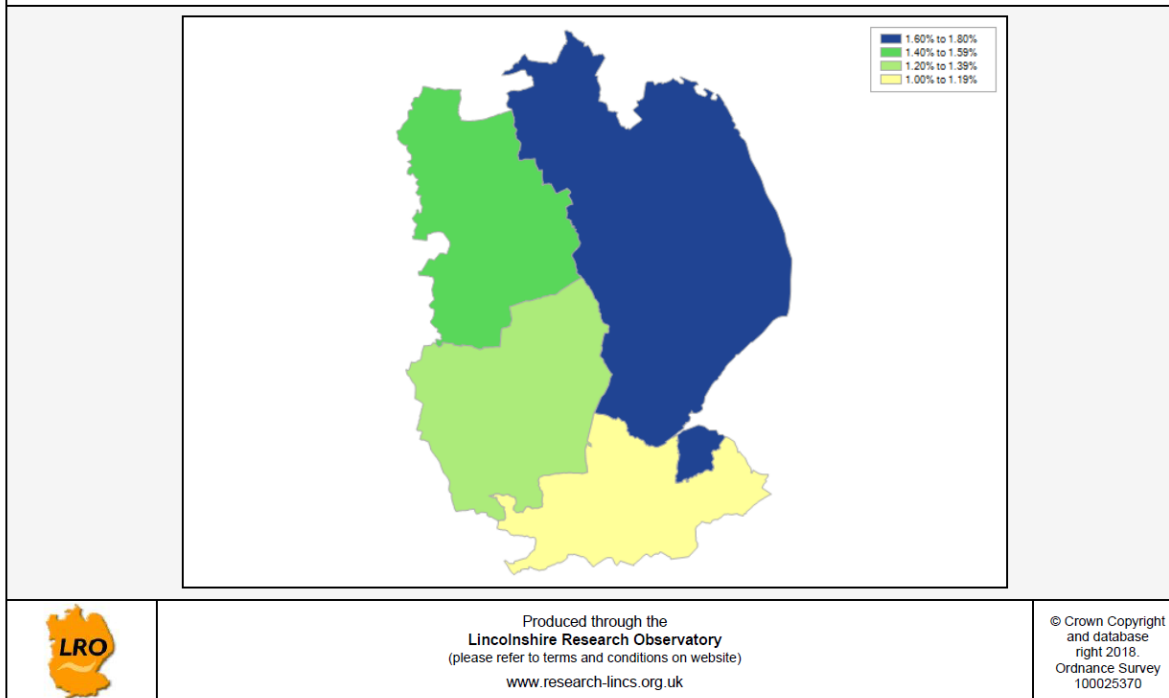
The graph below reports this data by home address of the child and shows higher incidence rates in South West CCG; however the more complex cases are in Lincolnshire East CCG



SEN Action Plus by Home Address, %: Pupils, SEN P School or Early Years (schools census), January 2015

Source: Lincolnshire County Council Childrens Services / LRO

Produced: 18/04/2018



Under the Children's and Families Act 2014, NHS providers and Commissioners have a responsibility that health provision promotes the well-being of children or young people in its area who have special educational needs or a disability. Well-being to include physical, mental and emotional health. Given that Children with physical disability may require ongoing support from their local paediatric unit, consolidation to Lincoln reduces access for this group and has the potential to adversely impact on their clinical outcomes. Greater travelling times will also lead to more time away from education so also impacting on their educational attainment. So consideration regarding assistance with travelling is required.

Children with very complex needs i.e.) with a tracheostomy & with / or without long term ventilation who become acutely unwell should go to PHB A/E, (if nearest), be treated & stabilised (as required) and then be transferred to tertiary hospital – not Lincoln, as they are considered to be HDU patients.

The Equality Act, 2010 outlines the requirement to offer reasonable adjustment and the Trust needs to consider how Children with disabilities receive an equitable service throughout the county as well as ensuring that the decision to consolidate services does not disadvantage this group of children.

Engagement sessions undertaken by the Trust, with parents, report that proper consideration is given to children with speciality needs who require stability and familiarity as well as those children with long term conditions such as heart, epilepsy, chronic asthma who need immediate attention.

Further engagement sessions are required where voices of children with disabilities are gathered. Several forums facilitated by the Lincolnshire County Council as well as a Commissioner led SEND user group are in place and the Trust should give consideration to eliciting views through these groups to satisfy their responsibilities under Working together to

safeguard children, 2015, Children's and Families Act, 2014 and Special Educational Needs and Disability Code of Practice: 0 to 25 Years (January 2015) when redesigning services.

Other considerations that required greater exploration are:

1. Number of disabled parents/ family members required to travel greater journey times to visit or accompany their children to in-patient care at Lincoln rather than Pilgrim
2. What is the impact of consolidation on Young Carer's of disabled parents not only their own access to health but also assisting the access to health for their parents.
3. Impact on disabled mothers and fathers receiving maternity care

Sex

Consideration to the following issues is required:

1. Gender of parent who has the main childcare responsibilities
2. Impact of centralised services and increased travelling times on other family and caring responsibilities
3. Impact of increased time away from work for different genders

Race

In 2011, 7.1% of Lincolnshire residents were born outside the UK; 4.5% hold only a non-British passport. This figure had doubled since 2001 largely due to the new EU accession states. Lincoln, Boston and South Holland have the greatest proportion of foreign-born residents. Boston is the only district in Lincolnshire where proportion of non-UK born (15.1%) is higher than England's rate.

Ethnic Group	Boston		East Lindsey		Lincoln		North Kesteven		South Kesteven		West Lindsey		Lincolnshire	
	number	%	number	%	number	%	number	%	number	%	number	%	number	%
White	62,592	96.8	134,314	98.5	89,379	95.6	105,835	98.2	130,394	97.5	87,600	98.2	610,114	94.9715
White: English/Welsh/Scottish/Northern Irish/British	54,221	83.9	131,717	96.6	83,653	89.4	103,343	95.9	125,261	93.6	85,977	96.3	584,172	90.9
White: Irish	208	0.3	490	0.4	719	0.8	512	0.5	656	0.5	411	0.5	2,596	0.5
White: Gypsy or Irish Traveller	63	0.1	61	0.0	80	0.1	74	0.1	78	0.1	161	0.2	517	0.1
White: Other White	8,100	12.5	2,046	1.5	4,927	5.3	1,906	1.8	4,399	3.3	1,051	1.2	22,429	3.5
Mixed/multiple ethnic groups	664	1.0	937	0.7	1,230	1.3	791	0.7	1,142	0.9	630	0.7	5,394	0.8
Mixed/multiple ethnic groups: White and Black Caribbean	171	0.3	414	0.3	367	0.4	242	0.2	410	0.3	222	0.2	1,826	0.3
Mixed/multiple ethnic groups: White and Black African	114	0.2	87	0.1	189	0.2	91	0.1	138	0.1	58	0.1	677	0.1
Mixed/multiple ethnic groups: White and Asian	167	0.3	261	0.2	372	0.4	256	0.2	304	0.2	205	0.2	1,565	0.2
Mixed/multiple ethnic groups: Other Mixed	212	0.3	175	0.1	302	0.3	202	0.2	290	0.2	145	0.2	1,326	0.2
Asian/Asian British	928	1.4	789	0.6	1,794	1.9	750	0.7	1,580	1.2	728	0.8	6,569	1.0
Asian/Asian British: Indian	374	0.6	231	0.2	522	0.6	217	0.2	509	0.4	370	0.4	2,223	0.3
Asian/Asian British: Pakistani	148	0.2	63	0.0	139	0.1	29	0.0	93	0.1	64	0.1	536	0.1
Asian/Asian British: Bangladeshi	72	0.1	100	0.1	139	0.1	68	0.1	63	0.0	0	0.0	442	0.1
Asian/Asian British: Chinese	130	0.2	198	0.1	452	0.5	215	0.2	436	0.3	130	0.1	1,561	0.2
Asian/Asian British: Other Asian	204	0.3	197	0.1	542	0.6	221	0.2	479	0.4	164	0.2	1,807	0.3
Black/African/Caribbean/Black British	278	0.4	264	0.2	778	0.8	251	0.2	509	0.4	224	0.3	2,304	0.4
Black/African/Caribbean/Black British: African	174	0.3	160	0.1	504	0.5	108	0.1	330	0.2	127	0.1	1,403	0.2
Black/African/Caribbean/Black British: Caribbean	57	0.1	75	0.1	165	0.2	101	0.1	117	0.1	74	0.1	589	0.1
Black/African/Caribbean/Black British: Other Black	47	0.1	29	0.0	109	0.1	42	0.0	62	0.0	23	0.0	312	0.0
Other ethnic group	175	0.3	97	0.1	360	0.4	139	0.1	163	0.1	68	0.1	1,002	0.2
Other ethnic group: Arab	63	0.1	40	0.0	175	0.2	43	0.0	48	0.0	38	0.0	407	0.1
Other ethnic group: Any other ethnic group	112	0.2	57	0.0	185	0.2	96	0.1	115	0.1	30	0.0	595	0.1

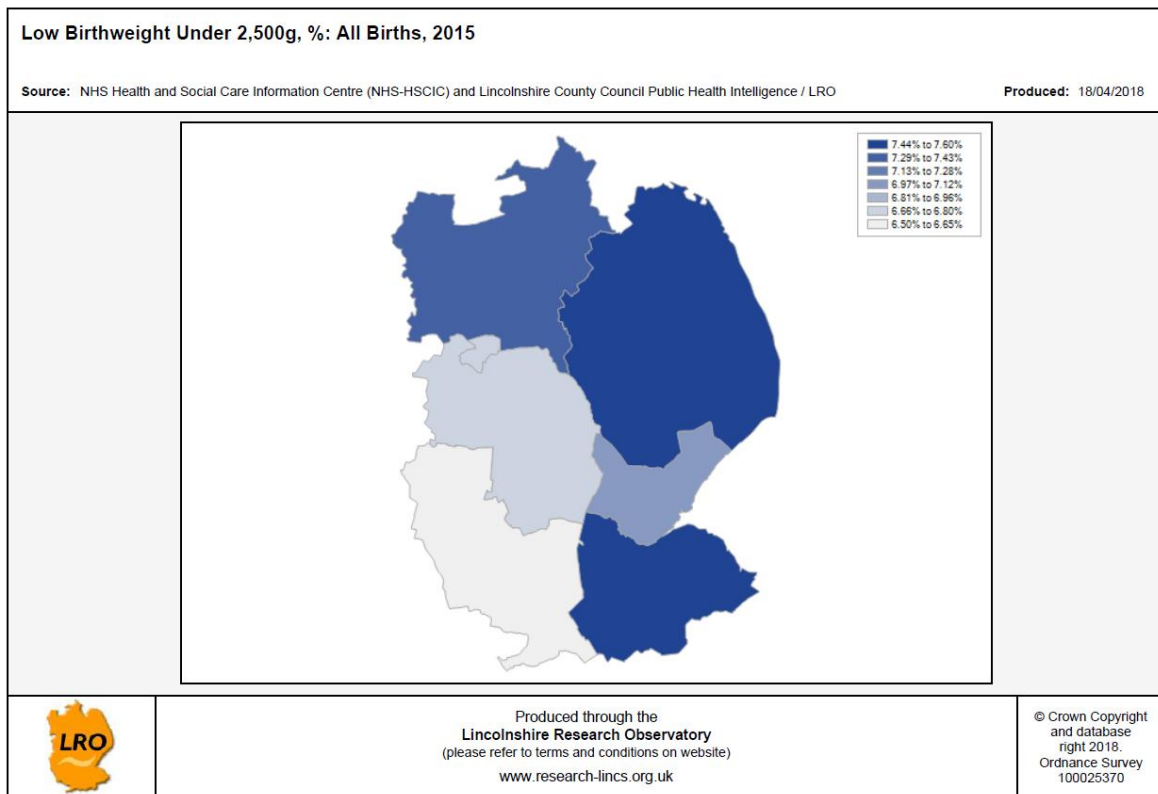
The non-white population make up 2.4% of the total population in 2011 compared to 1.4% in 2001. The proportion of people born in the Middle East and Asia is significantly lower in Lincolnshire (1.1%) than in England (4.8%) or in the East Midlands (3.4%). The proportion of people born in African countries is also much lower in Lincolnshire (0.6%) than in England (2.4%). Over 28,500 people speak a foreign language as their main language with 69.3% of those speaking English well; which is below the national average

People born outside the UK tend to be younger than the general population of Lincolnshire. Over a quarter of people born outside the UK were aged 25-34 in April 2011. The same age group makes up 10.7% of the general population in Lincolnshire. Differences in age structure are even greater in Boston and South Holland districts, where nearly a third of the non-UK born population was aged between 25 and 34 so likely to be parents. This population data suggests higher demand for women's and children services and so will be significantly impacted by the consolidation of paediatric and subsequent neonatal and maternity services to Lincoln

Given the higher concentration of adults being of childbearing age it is not surprising that 12% of school children are from a minority ethnic group. Reviewing the Lincolnshire School data that reports on English as an additional language; the average percentage of children across Lincolnshire is 6% though reviewing this data by economic area and CCG level, there are higher concentration of children speaking English as an additional language in Boston (21%), Lincoln (10%) and Spalding/ Holbeach (10%). This data reinforces that a considerable ethnic group will be adversely impacted through the consolidation of services.

Unsurprisingly, there is a link with deprived wards and higher levels of residents born abroad. The consideration for children’s & young people’s services temporary reconfiguration from the PHB site when considering infant mortality rate for England and Wales, though low, mother’s county of birth and parent’s socioeconomic status are risk factors and services should be designed so health inequalities are minimised. Currently, the Lincolnshire infant mortality is similar to that reported regionally and nationally (2.4-3.6 per 1000 compared to 3.7-3.9). However, low birth rate is a leading contributory factor to infant mortality rates and this is shown geographically across Lincolnshire below.

Additionally 24% of those mothers that died nationally between 2013-15 were born abroad of which 13% were from East Europe particularly Poland – access to maternity care is therefore of paramount importance for the population of Boston which has a high concentration of young East Europeans.



South Holland and East Lindsey report the highest number of low birth with babies so reinforcing the link between ethnicity and poorer health outcomes. The temporary consolidation of children’s & young peoples , neonatal and maternity services will adversely impact on access for this venerable group. . Consideration needs to be given with regarding to continuity of carer maternity models that are known to improve clinical outcomes such as birth weight in these areas as a preventative measure moving forward.

Consideration is also then required regarding travelling for parents to enable access to maternity & neonatal care and if the baby is expected to be born with low birth weight and required to birth at Lincoln or a neighbouring unit with appropriate neonatal support this will potentially negatively impacts on the significant ethnic population in the Boston area.

Engagement sessions with East European mothers reported that they expect to be admitted to hospital earlier to give birth, more availability of c-sections and less focus on natural birth. They also want a doctor present for all births s which is not within current UK maternity standards.

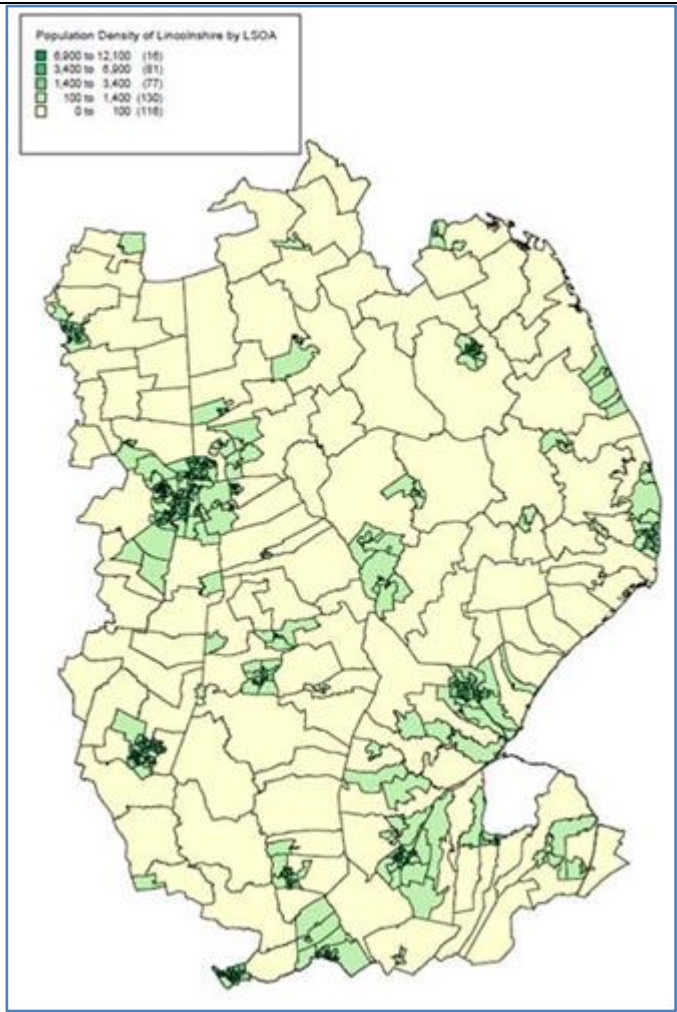
Age

Children and young people under the age of 20 years make up 21.7% of the population of Lincolnshire. 15.8% of the population are aged 0-14, compared with a national average in England of 17.3%.

The number and proportion of children across the four CCGs is illustrated in the table below (based on mid 2014 population figures from ONS for 0-15 year olds):

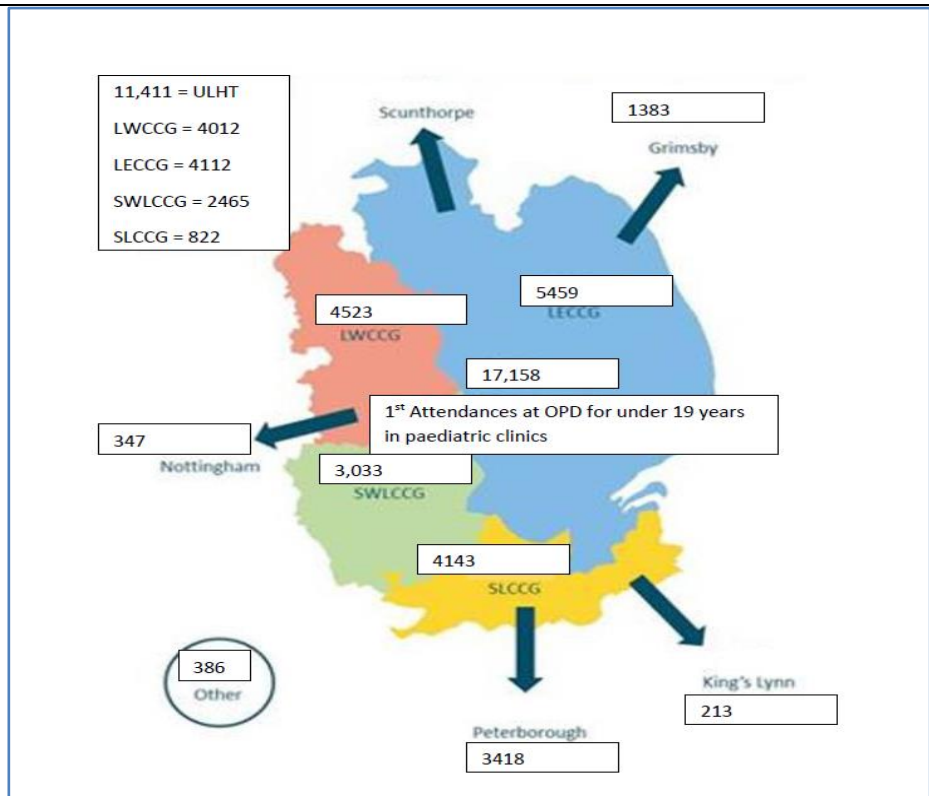
CCG Area	Total Number of Children	Proportion of Children
East Lincolnshire	37,616	16.4%
West Lincolnshire	39,025	16.8%
South West Lincolnshire	21,070	17.3%
South Lincolnshire	26,601	17.9%
Lincolnshire	124,300	17%

Across Lincolnshire there are several areas that have a higher density of children. The highest densities of children are concentrated predominantly in the urban areas of Gainsborough, Lincoln and surrounding neighbourhoods. There are pockets of high-density areas of children in Bourne, Stamford and Boston with the east coast having a much lower density areas.

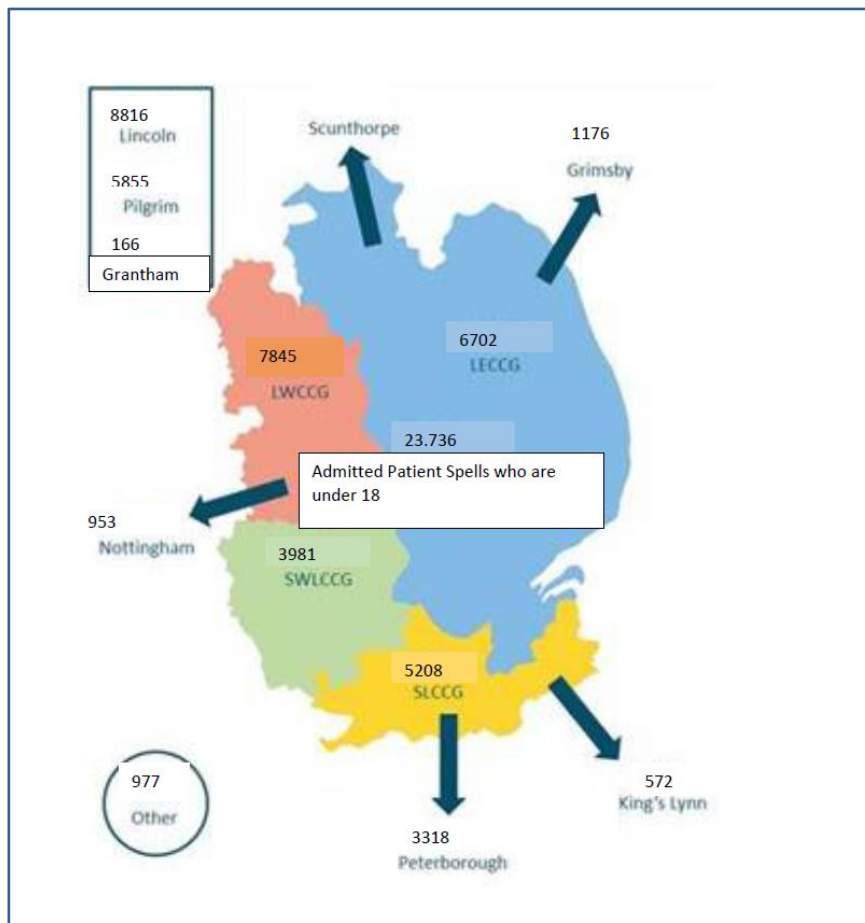


This population data is aligned with the referral activity data by CCG regarding Children under 19. The following graphs illustrate the referrals activity data by CCG and by provider.



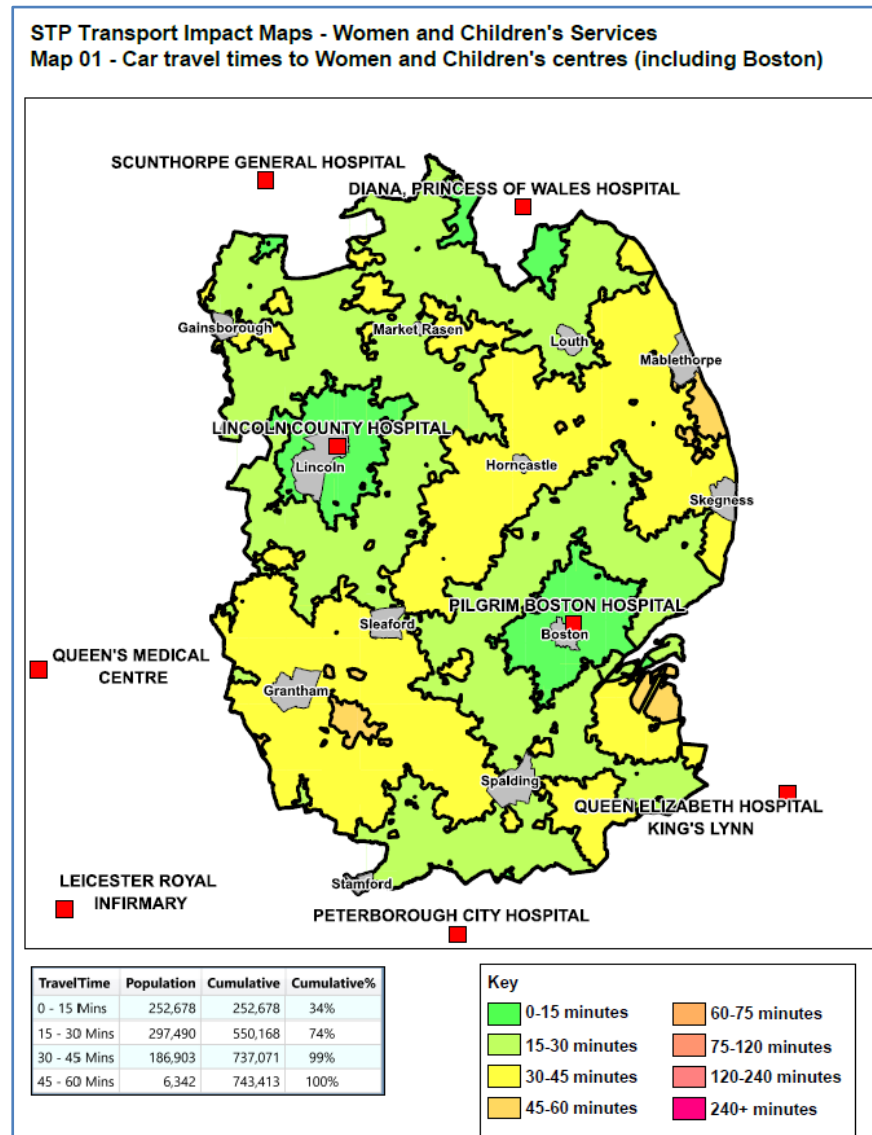


The next graph reports admitted patients spells for children 18



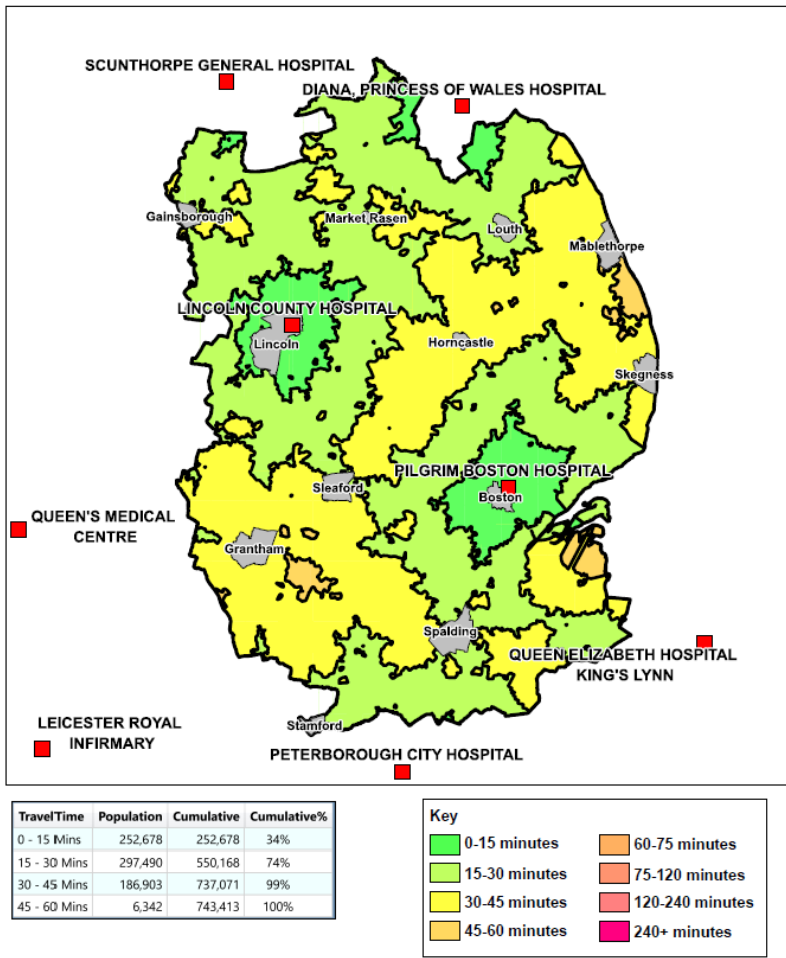
Both graphs highlight the significant number of children being referred to ULHT from Lincolnshire West and East CCG. Consolidation of in-patient services to Lincoln will have a significant impact on the population in Lincolnshire East. Access is then compounded by the lack of public transport infrastructure.

Transport modelling has been completed by the Lincolnshire STP team and the current transport times by car as follows



Transport by car has also been modelled if services are to be consolidated onto the Lincoln site and the following map reports the significant impact of this in reducing access to the population on the east coast. This has the potential to increase clinical risk and disadvantage children on the east coast; so consideration to how this risk is mitigated needs to be considered by ULHT

STP Transport Impact Maps - Women and Children's Services
 Map 01 - Car travel times to Women and Children's centres (including Boston)



The graphs show that in the current configuration of services, a population of 6,342 would be required to travel 30-45 minutes to access a maternity or paediatric site. The consolidation of services to Lincoln County Hospital, leads to a population size of 186,903 travelling 30-45 minutes and 6,342 45-60 minutes to their nearest maternity or paediatric site.

Further modelling by public transport is required for consolidation of paediatrics, neonatal and maternity; however work done to date on access to emergency care report that during the week a population of 42,784 do not have access to public transport to an accident and emergency which rises to 318,216 on a Sunday. This will impact on families visiting children in hospital and accessing emergency paediatric care.

Additionally, if there is no paediatric support at Boston Accident and Emergency, the lack of public transport infrastructure has the potential to place greater demand on East Midland Ambulance Services and neighbouring services. These concerns were raised by parents in the engagement sessions undertaken by the Trust where the following trends emerged:

- Issues with travelling for care if family has no car- public transport can be difficult
- Patient transport needs to keep pace if services are centralised.
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Maternity

- High Reliance on taxis to get to hospital, not affordable for those on low incomes
- Low social-economic backgrounds rely on ambulances alone, so will be disadvantaged

compared to those with transport.

- Number of parents do not own a car therefore they have to rely on public transport.

Deprivation: overall deprivation, measured by the Index of Multiple Deprivation (IMD) in 2015, shows that Lincolnshire ranked 92nd overall (where 1st is the most deprived). However, Districts are varied, with Lincoln ranking 62nd for overall deprivation, and 34th for Income Deprivation Affecting Children Index (IDACI).

The countywide level of child poverty is better overall than the England average of 20.1%, with 18.1% of children aged under 16 year's old living in poverty in 2014. However, this rises to 23.3% in Lincoln and 23.9% in East Lindsey.

Given the higher levels of deprivation in East Lindsey and the higher density of children living in Skegness with poor access to Lincoln by public transport; consolidation of inpatient paediatric unit to Lincoln significantly reduces access thus having the potential to widen health inequalities further; so consideration how this risk will be mitigated is required.

Child Health Outcomes vary across the county with both Lincolnshire West and East having significantly more children compared to the regional and national average attending accident and emergency. The impact of removing paediatric medical cover from Pilgrim hospital requires further thought given that in 2016/2017 approximately 3000 IS THIS CORRECT? children presented at Pilgrim Hospital, Boston Accident and Emergency department. Parents expressed that they tended to access A&E directly rather than going through NHS 111, so these cultural norms of accessing services needs to be considered to ensure that there is adequate paediatric expertise in the Accident and Emergency Department in Boston

Lincolnshire East also have higher rates of obesity in children aged 4-5 and 10-11years which has the potential to increase their risk of developing diabetes. This will place additional demand for hospital services and through consolidation has the potential to delay initiation of treatment in the case of diabetic ketoacidosis or other acute diabetic issues. Lincolnshire South report having more children with one or more missing, decayed or filled teeth than the national and regional average though the number of admissions to hospital for dental procedures is currently in line with the national average.

All NHS provider organisations are required to consider their obligation under Section 11 of the Children's Act 2004 and Working Together to Safeguard Children, 2015; which places duties on NHS Trusts to ensure their functions, and any services that they provide safeguard and promote the welfare of children. This statutory responsibility includes the requirement to listen to children and take account of their wishes and feelings in both individual decisions, and development of services. To date, ULHT have engaged with a range of groups and parents regarding views of paediatric services. Themes emerging from that engagement are:

- Some parents were concerned about safety if they needed to travel in an emergency/ feel that centralising services will cost lives
- No consensus on travelling times for emergency care was gained through the engagement sessions
- In case of emergency, the majority of parents take their children to A&E in Pilgrim
- Majority of parents would expect their child to be admitted to the local (Pilgrim) hospital. Some families had to travel to Leicester or Nottingham. They would expect paediatrician to care for their child at all times.
- Most agreed that emergency paediatric care needs to stay in Boston.
- A handful suggested that if you centralise maternity and paediatric service, there needs to be a way for partners and other children to stay overnight

- There was a concern around lack of paediatric provision for holidaymakers on the East Coast at peak times
- It is very difficult to get a GP appointment so people end up going to Pilgrim A&E.
- Worry that if we centralise, more children will be sent out of county for care as Lincoln won't be able to cope with the increased capacity. Some expressed concern about poor reputation of Lincoln children's & young people's service

However, the Trust needs to consider how they will engage directly with children in eliciting the views to satisfy this responsibility as Children have a right to receive and impart information, to express an opinion and to have that opinion taken into account in any matters affecting them from the early years. Their views should be given due weight according to their age, maturity and capability (Articles 12 and 13 of the United Nations Convention on the Rights of the Child). Additionally, how children's welfare is protected and safeguarding through consolidation of paediatric services and the subsequent impact on Neonates and Maternity requires careful consideration and mitigated action to be developed.

Lincolnshire east CCG have also undertaken a survey where 141 people responded to a question on access to emergency of which 29% expected to be seen the same day and 33% to be reviewed by someone with specialist paediatric training which has impact of the staffing model in Accident and Emergency at Pilgrim. There was support for GP's to extend their services for children (63%).

Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.

Consideration is required regarding

- Children with indeterminate gender
- Parents

Sexual orientation Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.

Consideration is required regarding

- Children who are aware of their sexual orientation
- Same Sex Parents

Religion or belief Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.

National statistics report that for the county of Lincolnshire over 60% of the population report their religion to be Christian – ONS 2011

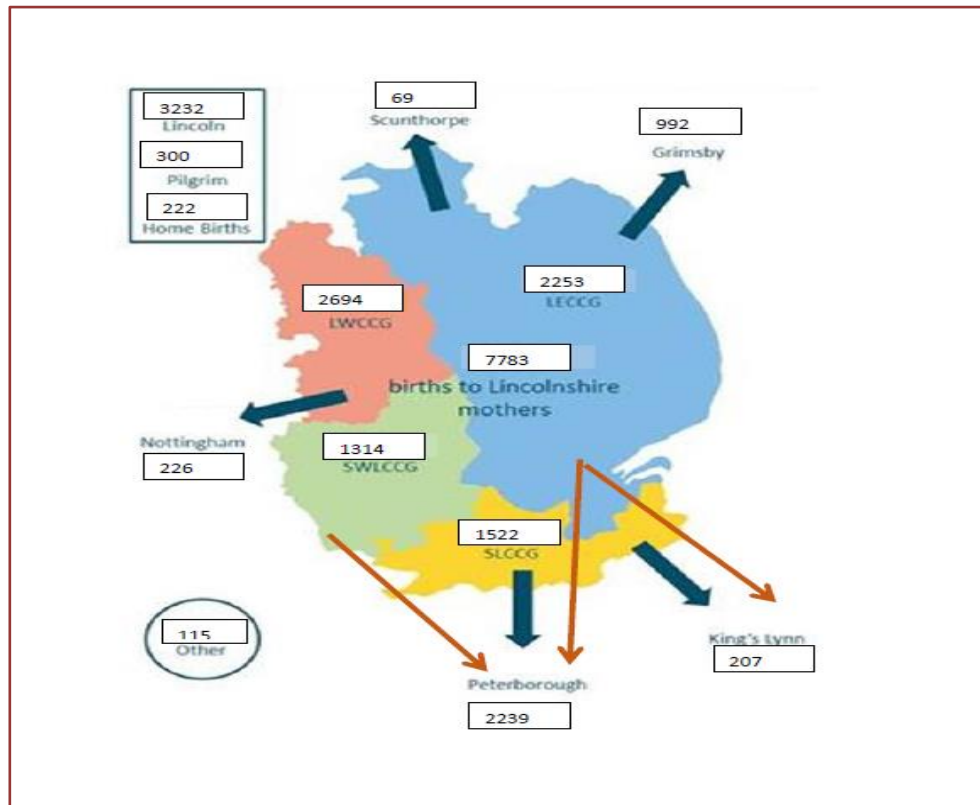
Pregnancy and maternity

Any consolidation of medical staffing in paediatrics that leads to the deficit in the above standards then affects the viability of both the neonatal and obstetric service.

In view of this, the decision to consolidate paediatric services impacts on the wider pregnant population in Lincolnshire. Across the 4 Lincolnshire CCGs there were 7783 women who gave birth in 2016/2017, with 5448 of these births taking place at United Lincolnshire Hospitals NHS Trust, 3278 at Lincoln County Hospital and 1948 at Pilgrim Hospital in Boston. 222 women chose to give birth at home. Boston has the lowest birth rate in the county and Lincoln has the highest .

Population predictions of women aged 15-44 years show a stable or a slight fall in the number of women considered to be of child birthing age within all four CCG areas in Lincolnshire (projected up to 2037). This is against an increasing population projection in general.

Exploratory work regarding anticipated displaced activity as a result of consolidating obstetric units at Lincoln is shown in the diagram below



This would appear to result in ULHT's birth rate reducing from 5448 to 3752 if women then access their nearest maternity unit which will incur longer travelling times.

The latest maternity dashboard reported in January 2108 12 BBA's (Born before Arrival); it is likely that as families have longer to travel to birth in an obstetric unit, this figure could potentially rise.

Family and Friends recommend rate is 94.7% as an average for the past year for feedback on Birth which is rag rated as "red" which is likely to deteriorate further for ULHT if maternity services are consolidated. .

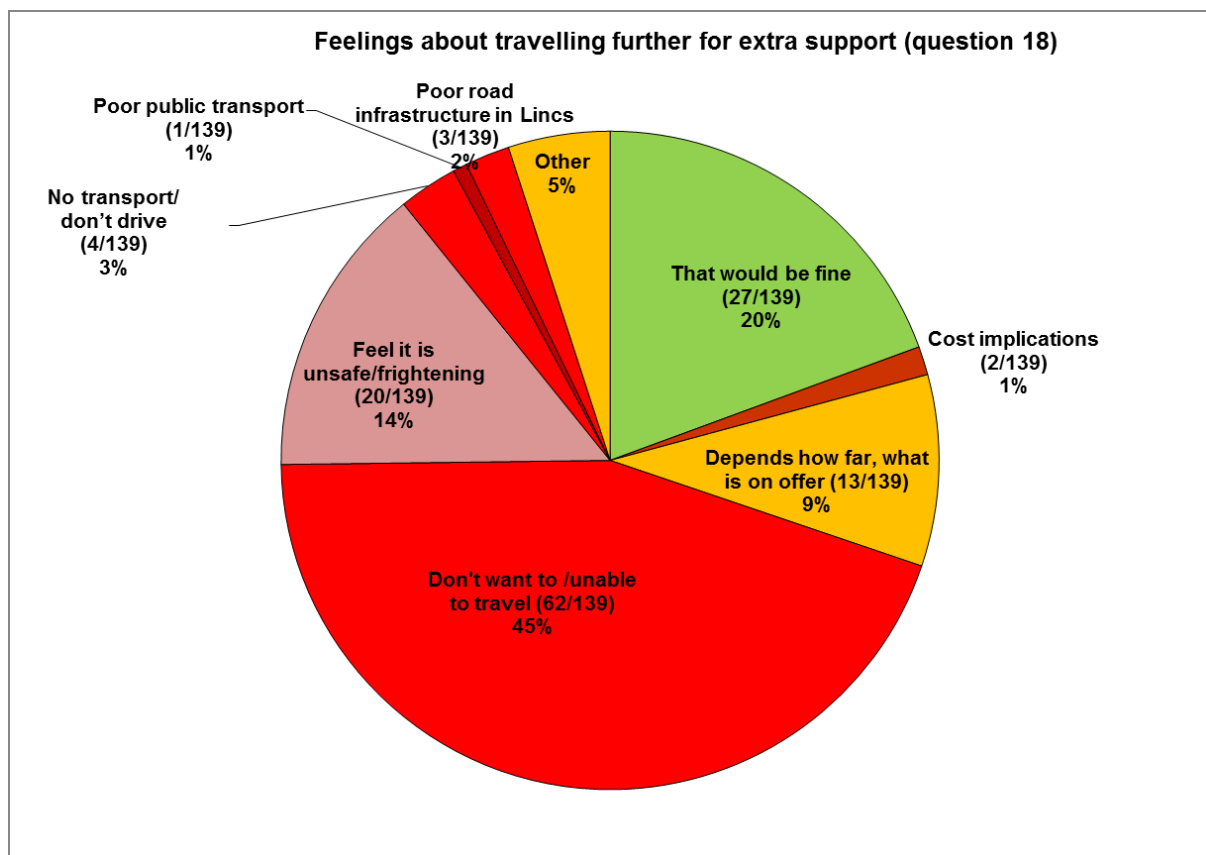
Some women will have to travel further if they choose to have either an epidural or be in an obstetric unit rather than a midwifery led unit as per their choice. This was confirmed in the ULHT engagement sessions undertaken where the following themes were articulated:

- Anxiety from mothers in the Boston area about having to travel for maternity care more often- cost, stress, appointment times (difficult to get to early appointments if they are far away)
- Overall feeling was that Lincoln maternity would not be able to cope if everything was centralised there.

- A large number of women said they would not use a midwifery-led unit at Pilgrim. They reported it would be “too scary and something might go wrong”. Expect pain relief and consultant care close to home.

Additionally, engagement work has been undertaken by Lincolnshire East CCG as part of the STP Women’s and children’s services review. A survey was undertaken with 349 people responded of which 219 were from Lincolnshire East. The following outlines the main findings from the Lincolnshire East area as they are mostly affected by the proposals

- 50% of respondents wanted obstetric services on both sites
- 84% wanted to give birth in an obstetric unit and 10% would birth in a midwifery led unit
- See graph below regarding comments on travelling to a central site



Additionally, the teenage pregnancy rate throughout the whole of Lincolnshire is similar to the England average. In 2015/16, 1.1% of women giving birth were teenage which, whilst higher than the national average, represents a decrease from the previous year. The greatest fall in conceptions has been seen in Lincoln, although this is still the district of the county with the highest rates of conception in under 18s.

Only Lincoln and Boston are significantly above the national average for teenage pregnancy rates, with Lincoln being the highest at 36 per 1,000. The percentage of births to mothers over the age of 35 years is lower than England at 15.7% compared to 21.1%. Delayed booking, poor antenatal attendance are familiar patterns often presenting in labour. Consideration regarding continuity of carer for teenage pregnant young children will be essential to maximise clinical outcomes for young mums.

Marriage and Civil Partnership Consider and detail (including the source of any evidence) on same sex people who are in a civil partnership, and heterosexual people and same sex people who are married.

See above

Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

Potential for children to feel more isolated whilst in hospital if families live further away either due to the journey times, the lack of public transport and caring conflicts with other members of the family whether this is school runs or working.

Increased requirement for carers to stay in services are further away which again impacts on the other caring responsibilities and work commitments

Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.

Engagement and involvement

Risk summits raising and escalating the risks to patient safety have been held internally at ULHT on the following dates:

- November 2015
- 4th January 2016
- 13th July 2016
- 20th July 2016
- 25th July 2016
- 5th December 2016
- 17th August 2017
- 4th December 2017
- 26th March 2018

Multi Agency / external stakeholder risk summits have been held on the following dates:

- August 2016
- 6th September 2017
- 10th April 2018

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the function proposals?

The proposals have not been fully developed – this appraisal has been completed with the assumption that the temporary re-location of the in-patient children’s ward and paediatric medical workforce.

Over the last two years, ULHT and STP partners have engaged the population of Lincolnshire on the future of women and children’s services and support for and impact any potential change may have on them. This included a mix of qualitative and quantitative techniques to reach harder to reach people and a wider representation of the population. It is recognised that engagement with children is required

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

In total, we’ve engaged almost 2,000 people on children’s & young peoples and maternity services. We have spoken to nearly 120 parents in face-to-face meetings specifically about children’s & young peoples and maternity services over the past 18 months, as well as a further 1,000 people about the ULHT 2021 strategy, which has included discussions on maternity, children’s and young people’s services.

The targeted community groups engaged include:

- Maternity groups, Skegness
- Toddlers play groups in Skegness and Boston
- Little SNAPPS (neonates group), Boston
- Children’s Centres in Boston and surrounding area
- NCT groups - Aschoughfee Hall and Black Sluice
- International parents group, Lincoln
- Polish group, Boston

In addition, more than 800 people responded to our 2021 strategy survey in 2017, and comments around paediatrics and maternity in particular were collated.

The main themes from all of this engagement were:

Children’s & Young People’s Services

- Parents generally have no issue with their child being transferred away from their local hospital for specialist non-emergency treatment.
- In an emergency, some would expect child to be stabilised locally first
- No consensus on travelling for emergency care – some expected this to be provided locally, yet others would travel an hour to receive care for their child
- Some are concerned about safety if they needed to travel in an emergency/ feel that centralising services will cost lives
- Generally parents praise the staff, nurses and doctors at Pilgrim. They feel the medical staff are helpful and caring.
- In case of emergency, the majority of parents take their children to A&E in Pilgrim. Few said they called 111 and followed the process. Very few tried to get an appointment at GP surgery, which seemed to have been a challenge.
- In case of emergency, most parents say they wouldn’t mind their child being seen by a nurse or GP instead of consultant as long as they were trained appropriately.

- Outpatients appointments – preferably local hospital however prepared to travel for specialist appointments; to be seen by a specialist with paediatric background.
- Inpatient stay – majority of parents would expect to be admitted to local (Pilgrim) hospital. Some families had to travel to Leicester or Nottingham. They would expect paediatrician to care for their child at all times.
- Most agreed that emergency paediatric care needs to stay in Boston.
- A handful suggested that if you centralise maternity and paediatric service, there needs to be a way for partners and other children to stay overnight.
- There was a concern around lack of paediatric provision for holidaymakers on the East Coast at peak times
- Need proper consideration for children with special needs who need stability and familiarity, as well as those with heart conditions, epilepsy, chronic asthma and bleeding disorders who need immediate attention.
- Worry that if we centralise, more children will be sent out of county for care as Lincoln won't be able to cope with the numbers. Some expressed concern about poor reputation of Lincoln children's services.
- Issues with travelling for care if family has no car- public transport can be difficult
- Patient transport needs to keep pace if services are centralised.
- It is very difficult to get a GP appointment so people end up going to Pilgrim A&E.

Maternity

- Most women said they accept going out of county for very specialist care if baby is born early/ needs a certain level of care.
- Boston mothers said they worry about having to travel for maternity care more often- cost, stress, appointment times (difficult to get to early appointments if they are far away)
- The overall feeling was that Lincoln maternity could not cope if everything was centralised there.
- Many people in the Boston area said they are worried that babies will die if there isn't a consultant presence at Boston.
- A large number of women said they would not use a midwifery-led unit at Pilgrim. "Too scary and something might go wrong". Expect pain relief and consultant care close to home.

Every woman spoken to said they would like maternity scans, antenatal appointments and check-ups locally.

Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

No protected group will suffer discrimination, harassment or victimisation as a result of the changes

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

We will work with community groups representing protected groups who will be adversely affected to develop an action plan to promote equality.

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

As above. Plus ULHT engagement team will continue engage ULHT members who represent all protected groups, patient experience will continue to engage with carers' groups.

What is the overall impact?

Disability – negative impact
Age- negative impact
Sex – neutral impact
Gender reassignment – neutral impact
Sexual orientation – neutral impact
Race – negative impact
Pregnancy and maternity – negative impact
Religion – neutral impact
Marriage and civil partnership – neutral impact
Carers – negative impact

Overall – negative impact

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence. We will work with community groups representing protected groups who will be adversely affected. ULHT engagement team will continue engage ULHT members who represent all protected groups.

Action planning for improvement

This will be developed following Trust board meeting on 27 April 2018.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

There is a requirement to:

- During April, May and June:
 - Undertake engagement with children and young people regarding proposed temporary service changes and future options for the services
 - To undertake specific engagement with children with disabilities, parents and carers and user groups regarding the proposed service changes and future options
- To scope an option that mitigates the significant clinical risk of possible displaced obstetric activity
- Further activity has been included in the action plan

Name of persons who carried out this assessment:

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Mandy L Clarkson: Consultant in Public Health, Department of Public Health, Lincolnshire Council

Date assessment commenced:
18th April 2018

Name of responsible Director/ General Manager:
Neill Hepburn, Medical Director
Date assessment was signed:

