Appendix Six - Mitigation

Meeting with:

- Paediatric Consultant medical body (PHB & LCH)
- Rao Kollipara; Consultant Paediatrician, Head of Service; Paediatrics
- Melanie Iles; Consultant Paediatrician, Associate Medical director NHSi
- Jane Williams; Consultant Paediatrician, Maternity & Children Network Clinical Director, East Midlands Strategic Clinical Network & Senate

Option 1

This remains a high risk option. The paediatricians have significant concerns about;

- The safety of this option due to the unknown quality and reliability of short term agency locum doctors.
- The fact that PHB would be a outlier nationally running a middle grade rota with such a high proportion of agency doctors.

Mitigations that should be implemented;

The immediate appointment of two consultant paediatricians to facilitate;

Implementation of facing the future standards
Increased consultant presence for senior decision making
Increased supervision and evaluation of the Agency MG's
Increased supervision and training of the Tier 1 (to minimise the risk of these being removed by HEEM
Reduced risk in the event of Agency withdrawal
Reduce the demand and unpredictable stresses on the PHB consultant body

Name	WTE	Post	Comment
Munish Kumar	1	Consultant	
David Broodbank	1	Consultant	
Giri Gantasala	1	Consultant	
Ajay Reddy	1	Consultant	
Nandita Danda	0.6	Consultant	Commence 11/6/18 on a 6PA contract
Bogaram Setty	0.4	Locum Consultant (NHS)	OP clinics only
Vijay Samual	1	Locum Consultant (Agency)	Additional Post 1 To be retained :
Additional Post			Additional post 2

Ideally this would be to implement a the full facing the future 'consultant presence' standards. However until agreement / consultants are in post this would rely on the recruitment of temporary consultants willing to provide ward cover

Incentivising of NHS MG posts (Immediate)

Consideration of bonus upon appointment with 2 year tie in.

Increasing gestational age from 30 to 34 weeks (Must be in place by 1st August): This will need support from O&G consultants – both site

This will bring the service into line with a level 1 neonatal unit (The service currently accepts gestational ages of 30 weeks as this is the standard for a local NNU in a rural area)
This will part mitigate the risk of Agency Locum's providing on site presence

Annual Activity (Post meeting information – Gestational age Admissions to the PHB NNU 2017/18)

Under 30 weeks	30 to 33(+6) weeks	34 to 36 (+6) weeks	37 week & over
5	27	60	142

This would affect 32 patients per year (approx. 3 patients per month)
Consider moving higher acuity patients with a longer Length of Stay from PHB to LCH

If appropriate the service should consider transferring higher acuity longer length of stay patients from PHB to the LCH site.

Progression of specialist nurse posts (Agreement required by Trust)

- Respiratory
- Neurology

These posts reduce demands upon the medical team, avoid admissions, facilitate discharges
These posts would part mitigate the risk of the trust not having / being able to recruit and retain the Consultant with interest in neurology

Continued frequent Executive oversight and review, until such point that nursing and medical risk is mitigated
Continued support and involvement from Melanie Ilies / Jane Williams

With the above mitigations option 1 is still considered a high risk and the Clinical senate / RCPCH and trust board will need to accept the risks.

In the event that option 1 continues beyond August, the service requires a 'safety huddle' approach to reviewing safety over the previous 24 hours.

If the above can-not be implemented then option 3 should be implemented

Option 2 : This was considered a very high risk option and not supported by the paediatricians, Unless this is for a very short period (weeks) as part of a phased approach to the implementation of option 3.

Rationale;

- This was only considered an option in the period prior to August 18 when the service had more MG staff & only even then only as part of a phased implementation of Option 3.
- The tier 1 medical staff would be transferred to other units
- Three of the Agency Locums have stated that they would not stay as first on call (This could be tested as this would be a very low intensity job and high hourly rate may attract agency locum staff)

Option 3

This was supported in the event that option 1 could not be maintained. There was agreement that the PHB consultants would move to LCH and participate in the emergency cover, however the option was not discussed in detail.

Option 4

This option would release approx. 4 PA's PHB site 8 PA LCH site
This option was not supported:

This would result in a poor quality of service for children with little time benefit.
There is no support from consultant staff
The period where the PA's were released (Mon – Fri office hours) are not the hours that would be required to mitigate the risks.
The 12 PA's released would provide cover for approx. two overnight shifts (Travel, day off previous and next day)

Consultants agreed that they will always be flexible and supportive of either site in an emergency unforeseen situation

Any pressure to implement a resident system for existing staff is very likely to lead to the loss of the substantive consultants as this would not be a desirable post

Nursing:

The meeting did not discuss nursing issues in detail apart from requesting that the service opens up to 19 beds again.

The Trust is now receiving the PHDU payments and the uplift in nursing numbers should be funded as per business case of 5.5 nurses per site.

An advert going out stating recruitment to 5.5 nurses to support the delivery of PHDU (Level 1 care) would send out a good message to the site

Approval to recruit to the additional nursing numbers should be sought.

Further Development

The service should obtain approval to implement the mitigations as described above and reconvene to discuss the option following RCPCH & Clinical Senate review.