United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Dr Neill Hepburn
Date:	31st August 2018

Title:	**Children & Young Peoples Services at United Lincolnshire Hospitals NHS Trust (ULHT) Risk to the sustainability of the Service**

Author/Responsible Director:

Dr Neill Hepburn, Medical Director

Purpose of the Report:

This paper has been developed to provide an update regarding the continuing work to address the significant challenges faced by the Children & Young Peoples Services (C&YP), which also have clinical interdependencies within Neonatal and Maternity Services at United Lincolnshire Hospitals NHS Trust (ULHT).

The temporary service model described at the June and July Trust Board is in place and is operational. A new Trust wide rota is in place to operate the temporary model at Pilgrim and is populated for August and early September 2018.

In addition, the paper describes the contigency options available to consider and recommend for the immediate mitigation of the imminent risks to the current C&YP Services, associated with the interim service model until a longer term strategic direction can be confirmed.

The Trust Board is asked to note progress and to consider the current position and options.

The Report is provided to the Board for:

Information	X	Assurance	X
Decision	X		

Summary/Key Points:

In order to update the Board, the paediatric directorate reports that:

- The temporary service model described at previous Trust Board is in place and is operational.
- A new Trust wide rota is in place to operate the temporary model at Pilgrim and is populated for August and early September 2018.
- Stakeholder meetings, chaired by NHS Improvement and involving key stakeholders from the Trust, NHSI, NHSE, CCG, GMC, HEEM, CQC continue.
- National and international recruitment continue to be pursued by the Women & Children's Clinical Directorate (W&CCD), one overseas doctor has commenced, with the first two weeks acting in a supernumery role.
- The Clinical Directorate continue to work with medical agencies, irrespective of financial cost, to find agency and locum medical staff to support the rota at Pilgrim in order to keep Children's Services running safely.
- The Consultant paediatric medical team remain concerned about the safety of a potential middle grade medical rota consisting almost entirely of locum / agency doctors.
- The current position remains, as in previous months that over 60% of weekend and night shifts would be covered almost entirely by the locum / agency doctors. This equates to 108 hours of the 168 hours of the week. To mitigate this risk an additional middle grade doctor to support the rota has been agreed.
- The transport solution for patients from Pilgrim to Lincoln for children has been commissioned for the first six weeks with 2 x ambulances on 2 x 24hr shifts. This to ensure, in the first instance, an ultra-safe provision whereby transfers required can be completed in the shortest possible timeframe. During this initial period accurate demand can be identified and will inform a further short-term model following the initial six weeks with reduced resources whilst ensuring patient safety at all times.
- During the first ten days of operation of the new service model, 6th – 18th August 16 patients have been transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported.

  A full financial assessment for the project has been completed, the total impact of the new service model until December 2018 is £1.75m, with loss in income accounting for 21%, pay accounting for 53% and non-pay accounting for 26% of the projected costs. The assessment details are included in the body of the report with the breakdown included in appendix 1.

- Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group. A summary of the risk register is included in the body of the report and a copy of the register is included in appendix 2

- Incidents are being tracked through Datix. A mandatory field has been added to the system which requests users to identify if the incident being reported is due to the new service model. In this way, all incidents can be easily identified and filtered in order for action and reporting.

- Contingency plans continue to be developed. Currently under consideration is a six-stage plan decanting to the former microbiology building, Safari and Rainforest wards in order to create space on the 4th floor of the tower block which will provide future capacity for the service.

- The comms plan remains with regular newsletters, public engagement and staff engagement sessions weekly.

- A twice weekly Task and Finish Group continues to develop the work required to mitigate the current risks and ensure the safe and sustainable running of C&YP, Obstetrics and Neonatal Services at ULHT. Oversight of this work will be through the Clinical Management Board.

Recommendations:

- Trust Board to acknowledge the performance of the temporary model over the first weeks of operation, the number of transfers completed, activity on each site, the issues encountered, and actions undertaken to resolve those issues.

- The contingency options continue to be developed and are detailed in appendix 3, the contingency to centralise consultant led maternity onto the Lincoln County Hospital site continues to be developed.

- Current and future capacity requirements for part of the contingency plan, details of current capacity management processes are included in the body of the report, but feature robust daily management processes and escalation policies.

- Trust Board is asked to consider carefully the risks raised in this paper relating to the medical and nursing challenges that remain during the operation of the temporary model and also for the likely future model in the coming months.

- Trust Board is asked to consider each element of the model that has been discussed in this paper for mitigating the immediate risks relating to the medical staffing challenges.

- A dedicated transfer ambulance solution is in place for the initial six weeks of the service model. The solution is based on 2 X IHPC Paramedic lead Ambulances for 24 hours per day, 7 days per week. This level of cover has been dictated by the

unknown potential demand resulting from the change in service and the requirement to be able to assure maximum levels of safety for patients at all times. A business case for the future solution will be presented following analysis of the initial six-week period. The Board is asked to endorse this methodology.

- The Board is asked to acknowledge the full financial assessment for the project in line with the total impact of the new service model until December 2018 of £1.75m. The cost pressures and assumptions should be noted in line with the expected impact on the Trusts overall financial position. It is recommended that the Board approve the continuation of the model despite the financial impact.

- The Trust Board is also asked to consider the proposed contingency plan with implementation plans as mitigation in the event of a failure of delivery of the proposed model.

REPORT TO TRUST BOARD – 31st August 2018

Background

The Women & Children clinical directorate have managed the significant medical and nursing staff vacancies for a number of years within paediatrics.

The medical staffing issues have escalated in recent months resulting in the Trust, in conjunction with stakeholder partners, being required to develop plans to change staffing models and clinical pathways to ensure the continuing safe service at both Lincoln County Hospital (LCH) and Pilgrim Hospital Boston (PHB).

Paediatric nursing and medical staffing rotas remain fragile with a number of consultants 'acting down' both in and out of hours to ensure adequate medical cover due to vacant middle and junior doctor posts on both sites. The number of operational, in-patient beds at PHB remains 12, since being reinstated to 12 in May 2018. This model is not sustainable and continues to operate as a short-term measure. A medium and longer-term solution is required, albeit with a different model to maintain Paediatric services at both locations.

Due to the importance of messages reaching a wide public audience, the Trust and directorate, a comprehensive communications plan has been developed to ensure that a single, accurate message goes into the public domain.

Purpose of the Report

This report is intended to update the Trust Board of progress to date and the potential impact of the changes in services and in staff deployed across the Trust.

Body of report

To update the Board regarding progress of the project is summarised:

3.1 Mobilisation

The Paediatric Assessment Unit (PAU) commenced on Monday 6th August at 9.00am. The internal working group continues to meet on a weekly basis and is attended by the Paediatric clinical leadership team, directorate team and internal support functions to update on progress, review and resolve the risks and cross divisional issues.

3.2 Workforce

Recruitment activity continues at pace, a full complement of consultants at Pilgrim for Paediatrics would ideally require 8 x whole time equivalents (or at least 7 consultants covering the PA's of 8). We currently have 4 x full time consultants and 2 x agency locums, making a complement of 6 x whole time equivalents. In addition to this 1 x part time substantive consultant (0.6 wte) was due to start on 20/08/18, but did not attend at the last minute and has not started in position.

The medical staff rota, with named doctors on each shift, is in place and under constant review regarding fill rates as the proportion of locum and agency staff required to sustain the service remains high. The rota results in Tier 1 doctors on a 1:16 and Tier 2 (middle grade) doctors on a on a 1:10 on call. The rota is included in appendix 5 for information and details the arrangements for any gaps in the rotas.

For clarity, the rotas encompass:

- Three Tier 1 doctors at Pilgrim during day time shifts.
- One Tier 1 doctor on a long day covering the assessment unit, one covering SCBU and one covering the Labour ward.
- The SCBU or Labour Ward Tier 1 doctors will go to clinic from 1300 - 1700.
- The clinics, additional consultant support and the opportunity to attend and lead in teaching programme at Pilgrim Hospital are providing an excellent training opportunity.
- All the long days are 12.5 hours and do not have early start or late finish. (0900 start is standard compared to 0800 or 0830 start which are early starts). This is EWTD compliant.
- If needed, overnight accommodation can be arranged at Pilgrim to avoid travel. This overnight period of rest will not be not included in calculating their working hours.

Recruitment activity remains high, one doctor started on the 6th August, an additional six doctors are currently going through the recruitment process;

	Clinical attachment	**Start Date**	**Site**	**Comment**
Dr 1	Completed	Started 06/08/18	PHB	Tier 1 for 3 months then Tier 2
Dr 2	Completed	01/10/18	PHB	Tier 1 for 3 months then Tier 3
Dr 3	Completed	01/10/18	LCH	Tier 1 only
Dr 4	02/07 – 13/07/2108	Unknown		
Dr 5	30/07-11/08/2018	Unknown		
Dr 6	25/08-08/09/2018	Unknown		
Dr 7	Completed	10/10/18	PHB	Tier 1 for 3 months then Tier 3

In terms of continuing adverts;

CPB-04-18 B Community Paediatrics (Pilgrim) - advert closes 18th September (AAC 9 October) - re-advertisement

CPB-21-17A Consultant in Paediatrics (Pilgrim) - advert closes 17th September (AAC 1st October 2018)

CLN-20-17 Consultant in Paediatrics (Lincoln) - to advertise (awaiting AAC date form t department)

The Lincoln post above has been advertised three times with no interest received, therefore the job description has now changed to general paediatrics and will be re advertised following college approval, approval expected in two weeks.

In addition, we are exploring other models to recruit to fill vacancies. We received a number of CVs from NW Anglia trust following a visit they made to Greece but none unfortunately proved suitable.

We are also negotiating with two other agencies for a different supply model and expect to conclude this in September.

3.3 Transport Solution

EMAS were approached with a view to providing dedicated ambulances for the duration of the temporary service model, however, EMAS were unable to assist.

We have therefore gone to market and have been able to secure dedicated transfer ambulances for the next six weeks based on 2 X IHPC Paramedic lead Ambulances 24 hours per day, 7 days per week. This level of cover has been dictated by the unknown potential demand resulting from the change in service and the requirement to be able to assure maximum levels of safety for patients at all times.

As part of an initial project assessment, after four complete weeks of operation through the task & finish group, the provision of ambulance cover required will be assessed using the actual demand, in terms of transferred patients and this will inform the procurement process for services following the initial six-week contract. A business case will accompany the recommendation.

3.4 Activity

The new service model commenced at 9.00am 6th August. In order to be specific regarding the volumes of transfers of patients, data is gathered, and analysis undertaken weekly covering the period of 9.00am each Monday to 9.00am the following Monday morning.

Clinical pathways have been developed in line with the temporary service provision and will be made available following ratification through the Trust Governance process.
During the first twelve days of operation of the new service model, 6th – 18th August the following patients were transferred:

14 x paediatric medical patients
1 x paediatric general surgical patient
1 x paediatric ENT surgical patient

All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported.

3.5 Financial

In order to ascertain likely costs of the temporary service model, a financial appraisal has been undertaken to understand the cost pressures based on a series of assumptions for this new model.

These cost pressures and assumptions need to be recognised and the expected impact on the Trust overall financial position noted, it is recommended that the Board approve the continuation of the model despite the financial impact.

The Financial appraisal has been broken down into two main periods to represent the change in service provision over time;

- May 2018 to July 2018 the period prior to going live with the new service model,
- August to December 2018, the introduction of the temporary short-term plan,

In order to provide the Board with a clear forward view, the financial assessment includes a projection of the monthly and weekly average costs by month and by week, should the service model extend past December 2018.

The total impact of the new service model until 31st December 2018 is £1.75m, the cost per month thereafter is £310,655, thus, if the model continues to the end of the financial year 18/19, an additional cost of £931,965 would be incurred, the total cost 18/19 would be £2.68m

Appendix 1 further details the breakdown of costs and assumptions for the financial assessment.

3.6 Risk management

The project risk register has been maintained and updated, a copy of the register is included in appendix 2.

In summary:

- At the commencement of the project, 22 risks were identified with scores 20 and above,
- Mitigations against these 22 risks were implemented, reducing the number with a score greater than 20 to 3 risks
- Further mitigations to arrive at the best possible score for each risk have been identified which identify a single remaining risk scoring 20 as “risk to reputation if service is not returned to previous model at PHB in 12 months”.

The project risk register feds directly into both the directorate and the corporate risk register.

It is worthy of note that the directorate and corporate risk scores differ in scoring against each of the risks identified as the impact changes in relation wider issues as the scale broadens. The likelihood is also affected, but to a lesser degree.

The corporate team, via Paul White, are sighted on the project risk register, receive updates to the project risk register to ensure continuity and enable updating as appropriate.

3.7 Management of incidents

The Datix system has been configured to include a new mandatory field relating to the new service model. Each incident can be identified readily and managed appropriately. Incidents are being reviewed weekly at the operational task and finish group meeting each Monday. No incidents related to the new service model have been reported in the first two weeks of operation.

3.8 Contingency and future capacity plan

The contingency options continue to be developed and are detailed in appendix 3, the contingency to centralise consultant led maternity onto the Lincoln County Hospital site continues to be developed.

The plan is a six-stage build which decants to the former microbiology building, Safari and Rainforest wards are moved in order to create space on the 4th floor of the tower block.

Future capacity will be realised in terms of bed numbers and space requirements through the build process and illustrated below;

During August and September 2018;

- Increase bed capacity on Rainforest ward from 19 to 24 beds,
- Existing side rooms on Nettleham ward converted to birthing rooms to accommodate the displacement of birthing rooms at Pilgrim,
- Convert Nettleham ward to accommodate 8 x maternity beds displaced from Pilgrim,

During November 2018;

- Relocate Breast services from 4th floor tower block to refurbished old microbiology block in order to create additional space / potentially create space for a Midwifery led unit,
- Addition of 5 Neonatal cots from Pilgrim to Neonatal unit at Lincoln (space exists currently for the additional cots),
- Vacated maternity wing on 4th floor, tower block (maternity bed numbers and configuration to be advised by clinical team).
- Digby ward alterations to potentially create a 28 bed decant ward with provision for isolation beds.

Daily ward safety huddles are being undertaken three times each day at both Pilgrim and Lincoln hospitals where capacity and bed status are discussed. Each site ward lead contact each other and identify demand, capacity and any resourcing issues. A daily capacity plan is decided upon and communicated.

Where required, medical staff are requested to ensure that all discharges and planning of discharges are undertaken with efficacy to ensure flow. If required, nursing staff may be sent to Lincoln in order to open additional beds (Rainforest thus opening to 24 beds).

During the first week, on one occasion, Rainforest was at 20 beds, full capacity, however discharges were realised quickly which negated the need to send for additional staff to open additional beds. The utilisation of beds is monitored and tracked daily as part of the ward metrics.

Consideration has been given to the existing winter capacity plan, in order to create the best fit for the changes needed should the contingency plan be required, whilst enabling the Trust to concurrently manage winter bed pressures.

3.9 Health Scrutiny Committee

Concerns have been raised by the Health Scrutiny Committee (HSC) regarding the service. As the concerns and questions cover many of the subsections of this paper, for ease of reading and to ensure that each point is clearly answered, the original questions with appropriate responses have been provided in appendix 4.

3.10 Communications Plan

General and individual staff meetings and sessions are being held, in line with the detailed communication plan and these will continue throughout the period of change with support from HR. The Key messages and dates are at appendix 2.

The communications strategy is specifically aimed at:

- Patients – to emphasise that the service will remain at Pilgrim, albeit with a different model of care
- Staff - to emphasise that the service will remain at Pilgrim
- Partners – all stakeholders (health partners, local Councillors / MPs, public, education institutions).

3.11 Governance

The project oversight group, with external partners that includes CCGs, EMAS, NHSI and HEEM representatives has continues to provide strategic oversight and to discuss impact and continues to agree mitigations for the identified risks.

3.12 Project Plan

The formal, strategic project plan and audit trail are updated. Additionally, all relevant risks, mitigations and impact of costs in relation to the Trusts financial position are cross referenced to the risk register in order to “close the loop” in terms of governance assurance.

Actions Required

- The Trust Board to recognise and endorse the progress of the project to date, the update in workforce risk management and incident tracking methodology that are in place to provide assurance to all stakeholders

- The Trust Board to recognise and endorse the transport solution in place with associated costs and during the first six weeks of operation and the methodology proposed post the initial six-week period.

- The Board is also asked to review in detail the financial cost pressures and assumptions regarding the impact of the change in service which need to be recognised and continuation of the model approved by the Board.

- The Trust Board are appraised of the operational capacity plan, the contingency plan and the methodology in place to ensure capacity is managed effectively to ensure patient safety.

- The Trust Board is asked to note the fragility of the situation and request an update in September with details of activity and any amendments to the service model in light of further operations experience.

Dr Neill Hepburn
Medical Director

Appendix 1

Financial Impact Assessment of the Interim Paediatric service model at Pilgrim Hospital.

In preparation for the Board paper due at the end of the August 2018, which will update the Trust Board on the progress of the model for the first four weeks of operation, a financial assessment has been undertaken. This assessment will form part of the overall update, however in order to provide the Board with the opportunity to review the assessment ahead of the Board meeting, this paper details the costing and assumptions for the model to date.

In order to ascertain likely costs of the temporary service model, a financial appraisal has been undertaken to understand the cost pressures based on a series of assumptions for the new model. These cost pressures and assumptions need to be recognised and approved by the Board.

The Financial appraisal has been broken down into two main periods to represent the change in service provision over time;

- May 2018 to July 2018 the period prior to going live with the new service model,
- August to December 2018, the introduction of the temporary short-term plan,

In order to provide the Board with a clear forward view, the financial assessment includes a projection of the monthly and weekly average costs by month and by week, should the service model extend past December 2018.

The financial impact and cost pressures of the new service model is summarised in figure 1, 2018/19 Financial Appraisal;

	2018/19 Financial Appraisal								
Type	April to July 2018	August	September	October	November	December	**Total**	Average month	Average week
Income	0	74,190	74,190	74,190	74,190	74,190	370,950	74,190	16,753
Pay	310,570	163,563	183,053	195,053	184,325	196,673	922,668	154,295	34,841
Non Pay	0	122,711	93,609	82,169	79,570	82,169	460,227	82,169	18,593
Total Expenditure	310,570	286,274	276,662	277,223	263,895	278,843	1,382,895	236,465	53,433
Total Financial Impact (surplus)/ Cost pressure	310,570	360,464	350,852	351,413	338,085	353,033	**1,753,846**	310,655	70,186

Figure 1 – 2018/19 Financial Appraisal

The total impact of the new service model until 31st December 2018 is £1.75m, the cost per month thereafter is £310,655, thus, if the model continues to the end of the financial year 18/19, an additional cost of £931,965 would be incurred, the total cost 18/19 would be £2.68m

Loss in income accounts for 21%, pay accounts for 53% and non-pay accounts for 26% of the projected costs.

A further breakdown of the impact on income and cost pressures is illustrated further in figure 2 below;

In order to cost the financial impacts of the interim model some assumptions have been made.

Assumptions

Income

Income in A&E will decrease by 12.26% based on the repatriation information as described in previous papers, the impact is centred on ambulance 999 and police attendances. N.B. The pathways in place for the new model include an ambulance stop and stabilise process which will mitigate some of this loss of activity.

All A&E streaming, car and walk in activity is expected to remain the same, figure 3 below, as present;

	Grantham Hospital	Lincoln County Hospital	Pilgrim Hospital Boston	Grand Total
Car	11	22.93	16.42	50.34
999	0.03	3.72	2.28	6.03
Walked in	0.3	0.28	0.07	0.66
Other	0.31	0.09	0.06	0.46
Bus	0.03	0.07	0.06	0.16
Police	0	0.04	0.03	0.07
Bicycle	0.01	0.01	0	0.03
Work Transport	0.03	0	0	0.03
Helicopter	0	0.03	0	0.03
Ambulance (not 999)	0	0	0.01	0.01
Grand Total	**11.71**	**27.17**	**18.93**	**57.82**

Figure 3

Day case activity will be risk assessed, and changes will be made to the clinical practice and pathways for activity to remain at Boston. if patients cannot subsequently remain at Boston then the pathway transfers them to Lincoln by exception. Therefore, income for day cases will not change.

The assumption has been made that the few numbers of elective care estimated at approximately 144 children will be moved to Lincoln as per the pathway, and therefore again no loss of income will be incurred.

Outpatient clinics continue to be provided at Boston and therefore also have no change to income and activity.

However, non-elective care will be impacted. Data provided at the time of the STP modelling process some months ago, identified that potentially 1,733 children may be displaced, due to patients requiring more than 12 hours care within an assessment unit.

In order to estimate the impact, based on that data set, potential repatriation of postcode of GP / Home adjusted by 5 minutes has been used, it is calculated that 52.4% of these patients will be nearer to a neighbouring trust for example Peterborough and NLAG.

Using this methodology, it is estimated there will be a loss of income to ULHT of approximately 76 elective patients a month.

The reduction of gestational age to 34 weeks at Boston assumes no loss of income for the Trust as a whole as the pathway for all patients is to transfer to the Lincoln site.

Pay

Consultant and medical staffing have been calculated using agency premiums and extra duty to cover all rotas, this has been negated by current funding available for substantive vacancies.

The junior rotas include three International recruitment posts that are supernumery for three weeks and on the junior rota for maximum of six months before they can operate at middle grade. The costs also include the agreement with the Deanery to operate junior posts based at Lincoln and transfer them daily into Boston, agency cover has been calculated on top of substantive to cover this.

Nursing and midwifery costs illustrate the uplift from 19 to 24 beds on Rainforest ward at Lincoln, based on agency premiums. Ward 4A at Boston retains the same staffing levels for the interim to allow for the transition and maintain quality of care, however, this level of staffing will be reviewed for future staffing needs.

Project Management costs have also been included.

Non-pay

The costs for dedicated transport have been included, ambulance costs are based on 2 x 24 hours a day for the first six weeks from the go live date. This is designed to be in excess of the actual perceived requirement, but assures, on grounds of safety for patients, that transfers can be made at any time, during the six-week period.

Learning from actual activity for the dedicated ambulance for the initial six weeks will be reviewed and a robust procurement process will be commenced using the updated demand. An assumption has been made regarding ongoing financial cost of ongoing delivery of this service.

Costs have been assumed relating to the agreement with the Deanery, regarding the junior doctors offered accommodation at the trusts cost, when on rota at Boston and the taxis from Lincoln to Boston.

Capital Investment

The interim model currently costed does not require any capital investment, however there is some limited funding available if the need arises.

Appendix 2

Project Risk Register

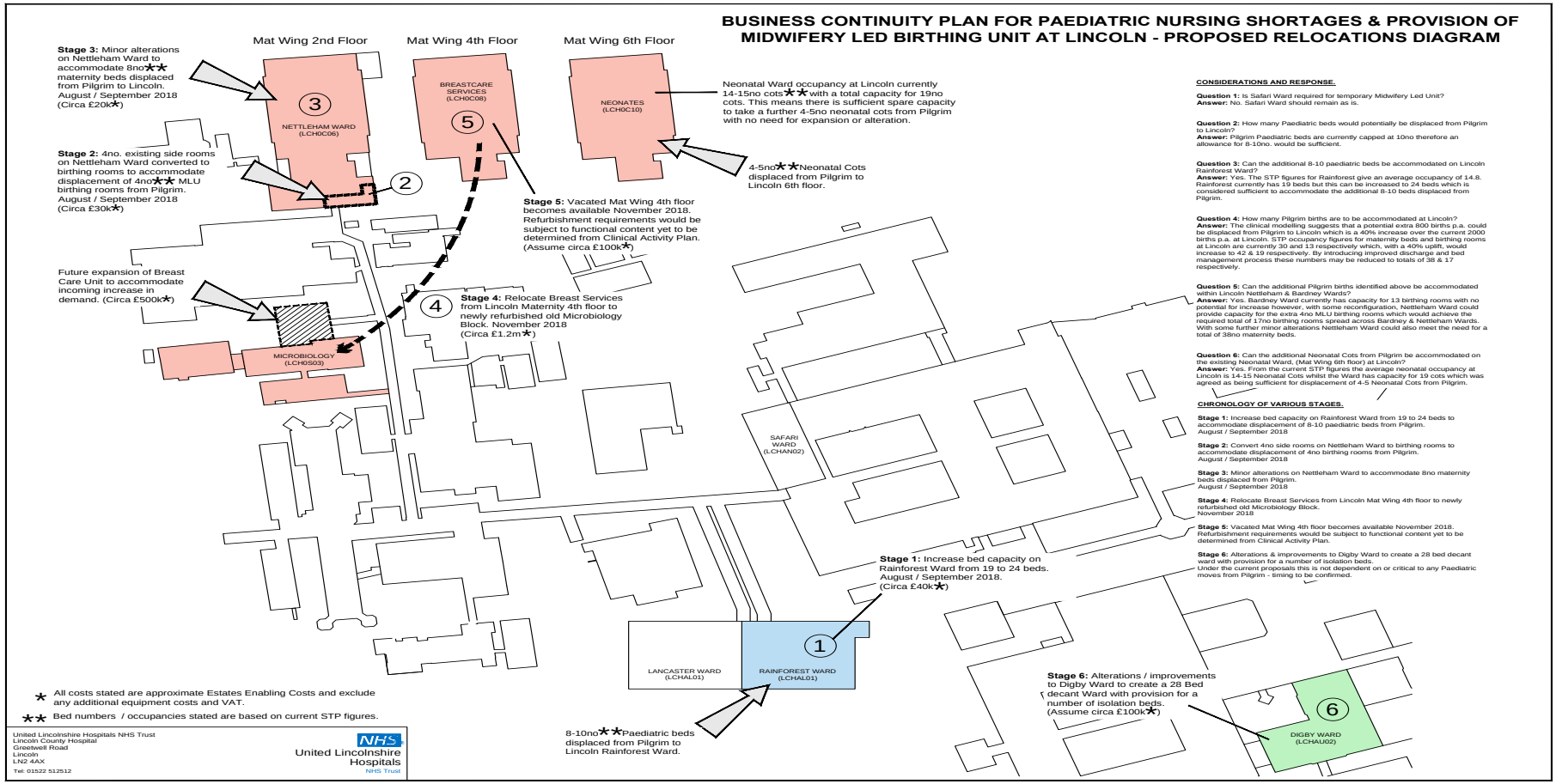
Paediatric Project - Risk Log								Key		L	Likelihood		Maximum mitigated score			
Updated 5th July 2018					Version - 2.0					I	Impact					
										RR	Risk Rating					
UID	Risk		Risk	Risk Assessment			Mitigation	Due Date	Lead	Mitigated Risk			Mitigation	Mitigated Risk		
				L	I	RR				L	I	RR		L	I	RR
Clinical																
1	Paediatric medical workforce has a high proportion of Locum staff	1.1	High percentage of workforce are locum or agency who may opt to leave service with no notice period	5	5	25	1) Consultants continue to "act down" or increase level of remote on call in order to provide cover if required. 2) Recruitment of substantive staff.	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	3	12	1) Percentage of Locums within workforce to be reduced to manageable levels. No prospect however of all vacancies being filled with substantive workforce due to continuing national shortage of Paediatricians	3	2	6
		1.2	Supervision of Tier 1 & 2 Drs potentially compromised as Locums can not provide required standard and HEEM may not endorse trainees on site.	3	5	15	1) Rotas to be created and populated to provide assurance to HEEM that appropriate levels of supervision and training are provided to all trainees 2) Once assurance provided, HEEM to endorse trainees on the PHB rotation. 3) NHSI to provide oversight and agreement to rotas	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	3	12	1) Rotas continue to mitigate against lack of supervision and training	2	2	4
		1.3	There will only be one middle grade doctor available out of hours and at weekends to support the neonate / sick child / young person / Women within the Emergency Department, Maternity Services, Special Care Baby Unit and Children's Assessment Unit from 1st -10th August 2018	5	5	25	1) There will only be one middle grade doctor available out of hours and at weekends which is insufficient medical cover for all specialities. 2) There is potential that there is a delay in the medical assessment of children which will mean treatment is not commenced in a timely manner which may impact upon recovery and length of stay. 3) There is a potential risk that there will be no timely medical support following escalation of a deteriorating child due to only one doctor being available for all specialities as the doctor could be dealing with another sick patient . 4) There could be a delay in the timely response of medical support to emergency call-outs for cardiopulmonary resuscitation and other emergencies. This will result in delays in commencing advanced life support, history taking, medical examination and prescribing of emergency drugs 5) Attendance at unplanned high risk deliveries may be compromised 6) The nurses and unregistered workforce will feel vulnerable and unsupported which will impact on morale and staff retention	Monday, 23 July 2018	Ajay Reddy / Debbie Flatman	4	4	16	1) Consultant Paediatrician on call from home – Consutant stepping down but not sustainable. 2) Nurses are able to recognise and escalate the sick child to the medical team. 3) In utero transfers			0
		1.4	Referral pathways may not be clear to clinicians due to any change of service	5	5	25	1) Pathways to be analysed to ascertain if any changes to existing pathways are required as a result in change to service. 2) PHB will need to demonstrate that they have implemented and communicated pathways and referral protocols across all sites. 3) Confirm MDT scheduling ensures attendance at all MDTs by Consultants to sign off any changes to pathways.	Friday, 6 July 2018	Paul Hinchliffe / Sue Bennion	3	2	6	1) Complete patient pathways which reflect safe and sustainable service provision, 2) MDT agreement that pathways are safe and sustainable	2	2	4
2	Service will not be safe or responsive	2.1	Risk to sustainability of a safe service at PHB.	4	5	20	Trust to confirm service arrangements to ensure a safe and sustainable service	Saturday, 2 June 2018	Neill Hepburn	2	2	4	No further mitigations identified	2	2	4
		2.2	EDs patient who become acutely unwell would not have access to review and advice from a Paediatrician 24/7 365	3	3	9	1) Need to provide further details of proposed pathway for patients who become unwell. 2) PHB ED to confirm the support they need from Paediatricians to ensure a safe service	Wednesday, 6 June 2018	Rao Kollipara / Ajay Reddy	2	2	4	No further mitigations identified	2	2	4
		2.3	ED experiences unplanned attendances which require an overnight bed which results in capacity issues and performance breaches	4	4	16	1) PHB to confirm that they have plans in place to prevent increased unplanned A&E attendances which require an overnight bed due to the implementation of the increased assessment area. 2) Confirmed and agreed escalation processes and action cards	Friday, 6 July 2018	Paul Hinchliffe / Sue Bennion	2	3	6	1) Inclusion in Trust capacity operational plan 2) Winter plan to reflect changes in demand at both PHB and LCH due to change in model (no inpatient peadiatric beds at PHB).	2	2	4
3	Future viability of service	3.1	Paediatric service at PHB will no longer be viable	3	5	15	Trust to confirm future arrangements for a safe and sustainable service.	Wednesday, 11 July 2018	Neill Hepburn	4	4	16	Long term STP plan to ensure that service at PHB is maintained and planned for.	2	3	6
4	Timescales	4.1	Insufficient time to safely implement new service configuration	3	5	15	Ensure that medical and nursing rotas and pathways are agreed by 11/06/18	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	4	16	Ensure that rotas and pathways are sustainable and future proof.	2	2	4
5	Unclear and inconsistent referral pathways	5.1	Patients pathways not clear from 1st August	3	4	12	Definition of pathways and agreement with all specialities in relation to patients to be discussed and agreed at pathway meeting on 6th July at Sleaford.	Friday, 6 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Changed pathways in place and working	1	2	2
		5.2	Change / increased complexity of transfer of care from PHB to LCH may lead to confusion for staff and patients.	3	2	6	Need to confirm that adequately defined and agreed process for both sites has been implemented	Wednesday, 18 July 2018	Paul Hinchliffe / Sue Bennion	2	2	4	Operational with both sites working to the defined safe standard across all specialites for all patients	1	2	2
		5.3	Lack of clinical criteria for transport of patients from PHB to LCH	2	5	10	Clinical criteria to be developed and agreed during pathway meeting.	Friday, 6 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Pathways and clinical criteria agreed and in place	1	2	2
		5.4	Lack of transport solution in relation to transition of patients from PHB to LCH	3	4	12	Transport solution to be developed and implemented before 01/08/18	Wednesday, 11 July 2018	Paul Hinchliffe	2	4	8	Patient transport solution in place and active from go live	1	2	2
6	Clinical relationships	6.1	Poor relationships between PHB and LCH could impact on service delivery	3	2	6	Oversight group facilitates and monitors effective collaboration between sites	Wednesday, 25 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Oversight group ceases and management of operation reverts to business as usual.	1	2	2

Operational																	
7	Risk that standards could deteriorate	7.1	Change in service provision and practice could have a detrimental short term effect on maintaining standards.	3	4	12	Oversight group to monitor compliance with standards and oversee the development and implement of any RAPs	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	2	2	4	Oversight group ceases and management of operation reverts to business as usual.	1	2
8	Communication of Information	8.1	Lack of IT communication integration between sites could impact on patient discussions / decision making.	4	5	20	Safety huddles 3 x daily and communicaton between sites post huddles. Information team to create dashboard and distribute	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	3	3	9	IT integration across all sites is in place and operational	2	2
9	PHB / LCH does not have adequate staffing levels to mobilise the contingency plan	9.1	Nursing staff	2	5	10	Off duty produced until November. Some risk exists in being able to open all beds at Lincoln site due to ability to obtain an increased number of nursing staff - Lincoln site currently have beds closd due to staff sickness / unavailability.	Wednesday, 11 July 2018	Paul Hincliffe / Sue Bennion	2	3	6	Off duty in pace with no gaps and any sickness covered, business as usual stance	1	2
		9.2	CNS	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.3	Health Care Assistant	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.4	Consultants and other grades of medical staff	2	5	10	Recruitment of medical satff at all grades continues.			2	5	10	Full compliment of medical staff is unlikely given national staffing levels and national recruitment issues.	2	3
		9.5	Administrative	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6			
10	Physical Space	10.1	Capacity to accommodate demand resulting from change in service configuration at PHB	2	4	8	Demand and capacity model data being validated	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	3	6	Demand and capaity managed as business as usual	1	2
		10.2	Capacity to accommodate demand resulting from change in service configuration at LCH	2	4	8	Demand and capacity model data being validated, indications that sufficient beds are avaialble at the LCH site to accommodate patients.	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4		1	2
		10.3	There is the risk that 19 beds may not be an adequate number of inpatient beds for sick children requiring treatment / inpatient care	4	4	16	Management of demand by Matron through regular staff huddles and ward round discharge activity.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Proactive bed management and balancing of capacity across the network.	2	3
		10.4	A reduction in staffing levels due to staff sickness or a loss of agency nurses.	4	4	16	1) Capping of beds to below 19 for patient safety. 2) Local children from Lincoln, Pilgrim and Grantham sites being transferred out of county to another hospital to receive care.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	1) Dedicated private transport / transfer team required to facilitate and support transfers to ensure ward staffing is not compromised on either site. 2) Immediate temporary uplift of nurse staffing by increasing agency nurses to open additional beds on Rainforest to 20 - 24 beds. 3) Ongoing recruitment plans in place to increase substantive posts to support a further increase in bed numbers.	2	3
		10.5	There are times when the service is likely to require more than 19 inpatient beds for the population of children in the county.	4	4	16	There are currently insufficient Childrens nurses to staff above 20 beds on the Lincoln site on every shift. Occasional 24 beds but needs close monitoring as would need to flex back down due to staffing levels.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Regular review of all inpatients to identify discharges and facilitate flow by Hot week Consultant, including Fast Track pharmacy for TTO's – supported by Ward Manager, Deputy Matron and Matron.	2	3
11	Patients will have difficulty accessing the LCH service if resident in Boston	11.1	Some patients will have to travel further to LCH	5	2	10	If the child requires a nurse to accompany them on this transfer, this will further impact on nurse staffing levels at the Lincoln and Pilgrim	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4	No further mitigations	1	2
		11.2	Patient Journey to PHB is more difficult due to transport links.	4	4	16	1) Patients and families with low incomes may have to reply on charitable means of transport to get to LCH. 2) Patient choice may indicate preference, due to transport, of patients being referred to neighbouring Trusts.	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	3	3	9	No further mitigations	3	3
12	Recruitment and retention of nursing staff at PHB	12.1	Retention of Nursing staff to continue to work at PHB if service becomes unattractive	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
		12.2	Recruitment of new staff to work at PHB given no inpatient beds.	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
13	Contingency Plan	13.1	Emergency relocation of service enacted under emergency powers.	5	5	25	1) Trust required to enact emergency powers to relocate service in extremis within an extreme timescale 2) Trust to escalate to Department of Health, Regulator, Commissioners, HEEM, GMC, RCP and other key stakeholders.	Monday, 9 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	5	5	25	Short term change to provision of service to ensure safe service for patients in place and operating.	3	3
		13.2	Estates work in place to ensure service can be consolidated at LCH with appropriate beds, assessment areas and outpatient facilites	5	5	25	1) Provision of sufficient clinical and bedded space at LCH 2) Enabling works for Breast patients to move to Digby ward with minimal estates work required to enable paediatrics to move to 4th floor maternity block, this in extremis and in contingency. 3) Enabling works for Neonates and Maternity is 6 months 4) Configuration for split services to operate required	Friday, 6 July 2018	Rob Game / Richard Mather / Paul Boocock	3	3	9	1) Digby ward hosting Breast patients in the short term. 2) Digby forms part of the winter plan to house increase in demand of patients across the Trust, risk that breast patients may have to be decanted to a.n.other area before peak demand in the run up to winter.	2	3
		13.2	Staffing rotas for both medical and nursing staff created to enable service provision post 1st August	5	5	25	1) Moving medical and nursing staff to a consolidated site at LCH requires a re-write of rotas and on call arrangements.	Friday, 29 June 2018	Rao Kollipara / Ajay Reddy	5	5	25	"Two sites, one team" approach achieved in the medium and long term.	3	3
		13.3	Pathways and referral processes in place at consolidated site	5	5	25	1) Pathways meeting scheduled for 6th July at Sleaford involving all specialities 2) Pathways to be analysed to ascertain if any changes to existing pathways are required as a result in change to service. 3) Requirement to demonstrate that pathways and processes can be implemented and communicated.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	3	9	Pathways agreed and in place	2	2
		13.4	Communications plan reflecting emergency	5	5	25	1) New communications strategy and plan to be devised and implemented 2) Key stakeholders, both internal and external, to be engaged 3) Media strategy to patients, families and general public to be initaiated	Monday, 16 July 2018	Anna Richards	3	3	9	1) Comms strategy deployed 2) Patient and staff survey report positive results.	2	2
14	Recruitment and retention of medical staff PHB	14.1	Retention of Consultants to continue to work at PHB if service becomes unattractive	5	5	25	1) Potential of creating a site operating with less pressure than LCH which could facilitate an environment that is conducive to consolidation of learning. 2) Link with ties with Medical school in 2019/20. 3) Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 1 August 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) HEEM formally agreeing that the training provided at PHB meets or exceeds training requirement for trainees. 2) Medical school involvement positively incorporated to training.	2	2
		14.2	Recruitment of new staff to PHB may become problematic	4	4	16	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
		14.3	HEEM unable to identify trainees who are willing to be placed at PHB, trainees may not wish to select or accept places due to type of service on offer at PHB.	5	5	25	1) HEEM to continue to promote training viability at PHB and assure trainees of viability of the service at PHB in the medium and long term. 2) Potential to reverse the negative view of the placement as being able to experience a "blended" workforce solution to Paediatrics (which is a potential long term outcome of the speciality given continuing decline in numbers of Paediatricians nationally). 3) Resulting service provision could become a vanguard type offering.	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	4	12	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
15	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	15.1	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	5	5	25	1) Children will not be able to receive care Inpatient care at Pilgrim Hospital as there are no inpatient beds.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	5	3	15	1) Children with PEWS 5 or less may, following assessment, meet level 1 criteria to be transferred in parents own vehicle as documented within the Safe Transfer of Children and Young People from Emergency Departments and Children's Services-CESC/2014/126 Version 3.	2	3
		15.2	There may not be a transport service in place by 01/08/2018 to transfer the children to an inpatient bed which would impact upon patient flow from ED to the assessment unit resulting in extended waits / breaches and the unit remaining as an inpatient ward	5	5	25	1) Extended waits within the Emergency Department and on the assessment unit over 12 hours if patients have to wait for return ambulances.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) EMAS will transport children 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.3	The two proposed dedicated ambulances are for all of Women and Childrens Services i.e.) to transfer pregnant women and children, therefore the demand for transport is currently unknown and there is a risk a vehicle may not be available for a sick child when required.	5	5	25	1) The child may face a longer journey and may deteriorate whilst travelling 2) The family will have to endure longer journeys and may have increased periods of separation from their child.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Comet will retrieve children requiring level 2 and 3 dependent upon criteria. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.4	The private ambulance crew may not be trained in the paediatric equipment e.g. Infusion pumps and therefore children will not be able to receive intravenous fluids / drugs throughout the journey from Pilgrim Hospital to Lincoln County Hospital resulting in treatment potentially being stopped prior to the journey resulting in a delay in	5	5	25	1) Treatment being stopped / delayed due to lack of training of private ambulance crew in equipment such as infusion pumps could result in deterioration of child's condition	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Training of Paramedic team in infusion pumps if required. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.5	The private ambulance may not be equipped with all of the equipment required to treat children during the transfer if their condition should deteriorate on the journey	5	5	25	Paediatric Equipment (Paediatric grab bag) provided to transport team.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.6	The turnaround time for the transport travelling from Pilgrim Hospital to Lincoln County Hospital is likely to be longer than 3 hours due to poor road networks and vast geographical area and unknown delays on arrival at the destination.	5	5	25	1) Telematic vehicle tracking to enable acute staff to identify optimum transfer time and turnaround. 2) Double up on ambulances availability during first six weeks of the interim model to ascertain actual future demand.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Policy and Procedure for Patient Transfer - Wide CESC/2017/040 Version 4.0	2	3

Financial																		
16	New service may be an unaffordable financial pressure for commissioners	16.1	Change in tariff of assessment based model with no in-patient beds at PHB	4	3	12	Financial model to be delivered and agreed with commissioners to ensure that service remains financially viable.	Monday, 16 July 2018	Rob Game / Vanessa Treasure	2	2	4	Commissioners agree and commission service with acceptable financial outcome for Trust.	1	1	1
		16.2	Potentially funding travel costs for patients	3	3	9	1) Transport solution to be designed and delivered which remains financially viable.	Monday, 16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		16.3	Any funding of travel costs for patients could set a precedence which Commissioners are unlikely to create.	4	3	12	1) Locally agreed tariff which incorporates private transport facility. 2) Work with charitable organisations to create a partially funded service.	Monday, 16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		16.4	ULHT may request funding beyond tariff to implement contingency plan	4	3	12	Mitigation to be identified	Monday, 16 July 2018	Rob Game / Vanessa Treasure	4	3	12	Mitigation to be identified	4	3	12
		16.5	Cost of communication to patients and staff in relation to the transfer	5	3	15	Mitigation to be identified	Monday, 16 July 2018	Rob Game / Vanessa Treasure	5	3	15	Mitigation to be identified	5	3	15
		16.6	Request to underwrite consultant recruitment costs (International)	5	3	15	Mitigation to be identified	Monday, 16 July 2018	Rob Game / Vanessa Treasure	5	3	15	Mitigation to be identified	5	3	15
		16.7	Implementation of the contingency plan results in stranded costs at PHB	5	5	25	1) Reworking of income based on assessment based model and no in-patient beds for Paediatrics. 2) Potential increased outpatient income 3) Potential for "One stop" approach to some parts of the service via Outpatient clinics.	Monday, 16 July 2018	Rob Game / Vanessa Treasure	3	3	9	1) If needed, Contingency in place and working providing safe care for patients and staff.	2	2	4
Commercial																		
17	Negative impact on the viability of PHB		Transfer of this service may not align with the long term STP plan	4	4	16	Mitigation to be identified	Wednesday, 1 August 2018	Neill Hepburn	4	4	16	Mitigation to be identified	4	4	16
Patients and Stakeholder																		
18	Access		Patients will have inconvenience/change of travelling to a different site.	5	3	15	Mitigation to be identified	Tuesday, 31 July 2018	Neill Hepburn	5	3	15	Mitigation to be identified	5	3	15
19	Risk to reputation of NHS bodies	19.1	Reputational as Trust, NHSI have previously stated they would not move the service from PHB to LCH	4	3	12	Mitigation to be identified	Tuesday, 31 July 2018	Neill Hepburn	4	3	12	Mitigation to be identified	4	3	12
		19.2	Reputational if the service is not returned to previous model at PHB in 12 months	4	5	20	Mitigation to be identified	Tuesday, 31 July 2018	Neill Hepburn	4	5	20	Mitigation to be identified	4	5	20
20	Lack of support from Patient and Public voice	20.1	Patients will not want to see service move from their local hospitals	4	4	16	Communications plan to explain rationale for change	Tuesday, 31 July 2018	Neill Hepburn	4	4	16	Communicaton strategy deployed and in place	2	2	4
		20.2	Lack of patient/public engagement about this issue	5	3	15	Develop evidence of case for change and engage with local stakeholders	Tuesday, 31 July 2018	Neill Hepburn	3	3	9	Communicaton strategy deployed and in place	2	2	4
21	Increase in young people aged between 14-16 years being cared for within adult wards due to the new temporary Childrens Assessment Unit (CAU) service model on the Pilgrim Hospital Site.	21.1	Due to the change of ward 4A, Pilgrim Hospital, to an Childrens Assessment Unit (CAU) there will be a potential increase in young people aged between 14-16 years being cared for on Adult Wards at Pilgrim Hospital.	5	4	20	1) Children and young people will not be cared for by the appropriately trained nursing staff as Registered Adult Nurses on Adult Wards have not received competency based training in the nursing care of children and young people aged 14-16 years and therefore will not have the knowledge, specialist skills and competencies to care for adolescents including level 3 safeguarding children. 2) Adult nurses have not completed competency assessments and workbooks in Paediatric Early Warning Score (PEWS) or Children's Sepsis 6 and parameters for the recognition of the deteriorating child are different to that of the early warning score for adults (NEWS) 3) Children will also receive treatment in line with Adult guidelines and policies which may be detrimental to their treatment and recovery. 4) Patient experience could potentially be poor due to children and young people being nursed next to sick adults and exposing them to potentially traumatising scenes. 5) RNA's may feel vulnerable and undervalued and this has the potential to eventually impact on morale and staff retention	Friday, 3 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12	1) All staff who work within adult areas who may care for young people aged 14-16 will have received some safeguarding training 2) Policy for the Admission of Young People Aged 14- 18 years into Adult In-Patient Areas- CESC/2011/058 3) Adolescent Admission Risk Assessment Screening Tool completed for all admissions of 14-16 year olds to adult areas 4) Urgent Identification of adolescent area / ward to ensure right staff provide right care in the right area. 5) Communication / notification of when young person admitted to adult areas. 6) Datix completion to help monitor admission rates to adult areas 7) Competency based training could be offered to RNA's	3	2	6
		21.2	As Rainforest Ward will be the only inpatient Childrens ward, there may also be an increase in young people aged between 14-16 years being cared for on Adult Wards at Lincoln County Hospital.	5	4	20		Friday, 3 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12		2	3	6

Appendix 3

Contingency Plan



Appendix 4

HSC Questions on Contingency Plan

The Committee's questions relate to the contingency plan, previously referred to as Option 3.

Paediatrics

(1) Can the impacts on paediatric services be more clearly set out? *[Pages 39- 40 of the report to the ULHT Board – 25 May 2018]*

It has been possible to retain paediatric services at the Pilgrim Hospital site through extensive work to fill doctor rotas over the next few months. The rota is heavily dependent on the use of agency and locum doctors which does come with a level of risk for these doctors to present for duty when scheduled.

Through this "covered" rota, it has been possible to maintain 97% of services under a temporary service model.

During the first two weeks of operation an average of one paediatric patient per day has been transferred to Lincoln hospital. This is significantly less than the estimation in May 2018.

(2) Throughout Appendix A1 to the 25 May Board paper, there are lists of 'questions to answer'. Have they been fully answered? For reference, some of these questions are listed:

- Numbers of referrals, outpatients, inpatients, births and other activity that will be displaced under each scenario

Each scenario has been modelled, with numbers of patients and activity. The implementation of the temporary paediatric assessment unit solution has seen vastly reduced numbers of patients being displaced.

- What are the workforce and rota implications?

The workforce plans and rotas for the implemented temporary solution are included in the Board paper.

- Which organisation is it proposed will take this activity?

The activity has been contained within UHLT with only two patients being transferred to other hospitals, (these transfers being due to clinical reasons, not capacity issues)

- Have agreements been made with these organisations that they can take this activity?

The Chief Executive and medical Director have written to and contacted all surrounding Trusts to gain support and agreement regarding any transferring patients.

(3) Where children and young people are displaced to other hospitals, is there certainty that these hospitals have the capacity?

The Chief Executive and the Medical Director have written separately to their counterparts in all local hospitals, describing the issues faced at Pilgrim and Lincoln and requesting assistance if required. Those that have replied have given support and where possible, assurance that the predicted small numbers of patients can be accommodated.

(4) How much impact will there be on patient choice?

Patients will of course retain choice with regard to their care and treatment.

Maternity

(5) Does Lincoln County maternity have the capacity to handle an additional 650 births per annum (twelve extra births per week)? *[Page 40 of the report to the ULHT Board – 25 May 2018]*

This refers to the contingency model, the clinical modelling undertaken suggests that a potential additional 800 births per annum could be displaced and managed from Pilgrim to Lincoln.

(6) Do out of county maternity departments have the capacity to handle an additional 1,000 births per year (twenty extra births per week)? [*Page 40 of the report to the ULHT Board – 25 May 2018]*.

The Chief Executive and the Medical Director have written separately to their counterparts in all local hospitals, describing the issues faced at Pilgrim and Lincoln and requesting assistance if required. Whilst the physical capacity exists, it would be dependent upon transfer of some workforce to support.

(7) The figures in Appendix A1 of the report to the ULHT Board (25 May 2018) suggest that 1,150 births (22 per week) might be displaced to Peterborough City Hospital? Does Peterborough City Hospital have the capacity for this? *[The table in Appendix A1 is entitled Obstetric Move – Original STP Calculation.]*

This refers to the contingency model, the clinical modelling undertaken at that time suggested high numbers. Bookings for births at both Lincoln and Pilgrim have stayed stable at previous levels during May, June, July and August 2018.

(8) How much impact will there be on patient choice?

Patients will of course retain choice with regard to their care and treatment.

Transport and Travel

(9) Have all patient transfer arrangements been fully explored? Will private ambulances be used?

The Trust has implemented a dedicated transport solution for paediatric, maternity and paediatric surgical patients that ensures an ultra-safe solution for any patients that may need to be transferred to Lincoln or other local providers.

(10) Have all the impacts on EMAS been fully explored? For example, longer journey times for ambulances taking children to Lincoln instead of Boston.

EMAS have been, and remain, part of the weekly task groups and have been fully involved in the development of the solution, any changes to patient pathways and processes.

Workforce / Organisational

(11) Has ULHT had any discussions with your peers around running the department with a higher number of locum doctors as well as the substantives? Or have you conducted a risk assessment around this option side by side with those displacements that will be caused by option 3?

The temporary solution is reliant on the use of locum and agency doctors, so that we are able to maintain 97% of the service at Pilgrim for patients. The risk register details all appropriate risks associated with the reliance on this mix of workforce.

Estates Plan

(12) There is reference to an estates plan in the ULHT 25 May Board paper, with reference to a start date of June 2018 and a completion date of August 2018. What is the status of the estates plan?

The estates plan is undergoing final planning and agreement, details of the current plan with timelines are included in the 31st August 2018 Board paper.

Appendix 5 - Rotas

		Dr 1	Dr 2	Dr 3	Dr 4	Dr 5	Dr 6	Trainee Reg	SHO	SHO	SHO	Trainee PAU/LD	Trainee SCBU	Trainee LW		Notes
Wed	01/08/2018	PAU/LD	OFF		*LOC NIGHT*	SCBU/LD	OFF	VACANT	PAU		Loc Night	VACANT	VACANT	VACANT		2 x SHO short for day
Thu	02/08/2018	PAU/LD	OFF		*LOC NIGHT*	OFF	LD	VACANT	PAU		Loc Night	VACANT	VACANT	VACANT		2 x SHO short for day
Fri	03/08/2018	PAU/LD	OFF		Loc NIGHT	OFF	*LD*	VACANT	PAU		Loc Night	Locum	VACANT/MONA	VACANT		1 x Sho short for day
Sat	04/08/2018	PAU/LD	OFF		OFF	NIGHTS	*LOC NIGHT*		PAU/LD							No gaps
Sun	05/08/2018	PAU/LD	OFF		OFF	NIGHTS	*LOC NIGHT*		PAU/LD							No gaps
Mon	06/08/2018	SCBU	OFF		PAU/LD	NIGHTS	*LOC NIGHT*	VACANT	OFF	PAU/LD	SCBU/LW	VACANT	VACANT	Locum		No gaps
Tue	07/08/2018	PAU/LD	NIGHT	PAU	SCBU	OFF	OFF	VACANT	NIGHT	SCBU	PN/LW	Locum	VACANT	Locum		No gaps
Wed	08/08/2018	OFF	NIGHT	PAU	SCBU	PAU/LD	OFF	VACANT	NIGHT	PAU/LD	SCBU/LW	VACANT/MONA	VACANT	Locum		No gaps
Thu	09/08/2018	OFF	NIGHT	SCBU/LD	CLINIC	PAU/LD	PAU	VACANT	NIGHT	OFF	SCBU/LW	VACANT/MONA	VACANT	VACANT		No gaps as covered by Reg
Fri	10/08/2018	SCBU/LD	OFF	NIGHT	PAU/LD	NIGHT	PAU	VACANT	OFF	LW/PN	SCBU/LW	Locum	VACANT	VACANT		No gaps as covered by Reg
Sat	11/08/2018		PAU/LD	NIGHT		NIGHT				LEAVE	PAU/LD					No gaps
Sun	12/08/2018		PAU/LD	NIGHT		NIGHT				LEAVE	PAU/LD					No gaps
Mon	13/08/2018	OFF	SCBU	NIGHT	PAU/LD	NIGHT	A/L	VACANT	PAU/LD	LEAVE	OFF	VACANT/MONA	Locum	Locum		No gaps
Tue	14/08/2018	OFF	NIGHT	OFF	SCBU/LD	OFF	PAU	PAU/LD	NIGHT	LEAVE	SCBU	VACANT/F2	Locum	Locum		No gaps
Wed	15/08/2018	SCBU	NIGHT	PAU	CLINIC	OFF	SCBU/LD	PAU/LD	NIGHT	LEAVE	SCBU/LW	VACANT	VACANT	Locum		No gaps
Thu	16/08/2018	SCBU	NIGHT	PAU	CLINIC	PAU/LD	SCBU	VACANT	NIGHT	PAU/LD	SCBU/LW	VACANT	VACANT	VACANT		No gaps
Fri	17/08/2018	NIGHT	OFF	PAU	SCBU	PAU/LD	CLINIC	VACANT	OFF	NIGHT	SCBU/LW	Locum	VACANT	VACANT		No gaps as covered by Reg
Sat	18/08/2018	NIGHT	OFF	PAU/LD		PAU/LD				NIGHT						No gaps as covered by Reg
Sun	19/08/2018	NIGHT	PAU/LD	PAU/LD		OFF				NIGHT						No gaps as covered by Reg
Mon	20/08/2018	NIGHT	SCBU	SCBU	PAU	OFF	OFF	PAU/LD	PAU/LD	NIGHT		VACANT	VACANT	VACANT		No gaps as covered by Reg
Tue	21/08/2018	OFF	SCBU	NIGHT	SCBU	OFF	NIGHT	PAU/LD	PAU/LD	OFF		VACANT	VACANT	VACANT		1 x Sho short for day
Wed	22/08/2018	OFF	SCBU	NIGHT	NIGHT	SCBU/LD	OFF	PAU/LD	PAU/LD	OFF		VACANT	VACANT	VACANT		1 x Sho short for day so reg covering late also
Thu	23/08/2018	SCBU	OFF	NIGHT	NIGHT	SCBU/LD	A/L	PAU/LD	PAU/LD	OFF		VACANT	VACANT	VACANT		1 x Sho short for day so reg covering late also
Fri	24/08/2018	SCBU	NIGHT	OFF	OFF	SCBU/LD	A/L	PAU/LD	PAU	NIGHT		VACANT	VACANT	VACANT		1 x Sho short for day so reg covering late also
Sat	25/08/2018	OFF	NIGHT	PAU/LD		PAU/LD				NIGHT						No gaps as covered by Reg
Sun	26/08/2018	OFF	NIGHT	PAU/LD		PAU/LD				NIGHT						No gaps as covered by Reg
Mon	27/08/2018	OFF	NIGHT	SCBU	PAU	OFF	A/L	PAU/LD	LW/PN	NIGHT		Locum	Locum	VACANT		No gaps as covered by Reg
Tue	28/08/2018	NIGHT	OFF	SCBU/LW	SCBU	NIGHT	A/L	PAU/LD	PAU/LD	OFF		VACANT	Locum	VACANT		No gaps as covered by Reg
Wed	29/08/2018	NIGHT	SCBU	PAU	CLINIC	NIGHT	A/L	PAU/LD	PAU/LD	LW/PN		VACANT	Locum	VACANT		No gaps as adequate reg
Thu	30/08/2018	NIGHT	SCBU	PAU	A/L	NIGHT	A/L	PAU/LD	SCBU	PAU/LD		VACANT	Locum	Locum		No gaps as adequate reg
Fri	31/08/2018	OFF	NIGHT	SCBU	A/L	OFF	A/L	PAU/LD	Nights	PAU/LD		VACANT	Locum	Locum		No gaps
Sat	01/09/2018	OFF	NIGHT	PAU/LD		PAU/LD			Nights							No gaps
Sun	02/09/2018	OFF	NIGHT	PAU/LD		PAU/LD			Nights							No gaps
Mon	03/09/2018	Leave	NIGHT	SCBU	A/L	PAU	PAU/LD	VACANT	Nights	OFF	LW/LD	Locum	Locum	VACANT		No gaps
Tue	04/09/2018	Leave	off	SCBU	A/L	NIGHT	PAU/LD	VACANT	OFF	PAU/LD	NIGHT	VACANT	Locum	Locum		No gaps
Wed	05/09/2018	Leave	off	SCBU	A/L	NIGHT	PAU/LD	VACANT	OFF	PAU/LD	NIGHT	VACANT	Locum	Locum		No gaps
Thu	06/09/2018	SCBU	PAU/LD	OFF	A/L	NIGHT	OFF	VACANT	SCBU	PAU/LD	NIGHT	VACANT	Locum	Locum		No gaps
Fri	07/09/2018	PAU/LD	SCBU	NIGHT	A/L	OFF	NIGHT	VACANT	SCBU	OFF	PAU/LD	VACANT	Locum	Locum		No gaps
Sat	08/09/2018	PAU/LD		NIGHT			NIGHT				LD					No gaps
Sun	09/09/2018	PAU/LD		NIGHT			NIGHT				LD					No gaps
Mon	10/09/2018	OFF	SCBU	NIGHT	A/L	PAU/LD	NIGHT	VACANT	OFF	LW/LD	PAU	VACANT	Locum	VACANT		No gaps
Tue	11/09/2018	NIGHT	SCBU/LD	OFF	A/L	PAU	OFF	VACANT	NIGHT	LW/LD	PAU	VACANT	Locum	VACANT		No gaps
Wed	12/09/2018	NIGHT	SCBU	OFF	A/L	PAU/LD	OFF	VACANT	NIGHT	LW/LD	PAU	Locum	Locum	VACANT		No gaps
Thu	13/09/2018	NIGHT	OFF	SCBU	A/L	OFF	PAU/LD	VACANT	NIGHT	OFF	LW/LD	Locum	Locum	VACANT		No gaps
Fri	14/09/2018	OFF	SCBU	PAU	A/L	NIGHT	PAU/LD	VACANT	OFF	NIGHT	LD	VACANT	Locum	Locum		No gaps
Sat	15/09/2018		PAU/LD	Leave		NIGHT				NIGHT	LD					No gaps
Sun	16/09/2018		PAU/LD	Leave		NIGHT				NIGHT	LD					No gaps
Mon	17/09/2018	PAU/LD	OFF	Leave	OFF	NIGHT	SCBU/LD	VACANT	PAU	NIGHT	OFF	Locum	Locum	Locum		Locum SHO/Reg to take bleep at 1430 from Trainee Tier 1
Tue	18/09/2018	PAU/LD	NIGHT	Leave	NIGHT	OFF	SCBU/LD	VACANT	PAU	OFF	OFF	Locum	Locum	Locum		Locum SHO/Reg to take bleep at 1430 from Trainee Tier 2
Wed	19/09/2018	PAU/LD	NIGHT	Leave	NIGHT	OFF	SCBU/LD	VACANT	OFF	OFF	OFF	Locum	Locum	Locum		Locum SHO/Reg to take bleep at 1430 from Trainee Tier 3
Thu	20/09/2018	OFF	NIGHT	Leave	NIGHT	SCBU/PAU	SCBU/LD	Trainee Reg	OFF	PAU/LD	OFF	Locum	Locum	Locum		PAU REG LATE START 1130/so covered by locum from 0900 AM
Fri	21/09/2018	NIGHT	OFF	Leave	OFF	SCBU/LD	OFF	Trainee Reg	NIGHT	PAU/LD	Study leave	Locum	Locum	Locum		TIER 1 LEAVE AT 1430 so 1 Tier 1 short and covered by Reg
Sat	22/09/2018	NIGHT	PAU/LD	Leave	BCG clinic		PAU/LD		NIGHT							No gaps
Sun	23/09/2018	NIGHT	PAU/LD	Leave			PAU/LD		NIGHT							No gaps
Mon	24/09/2018	NIGHT	SCBU/LD	Leave	PAU	SCBU/PAU	OFF	Trainee Reg	NIGHT	OFF	study leave	VACANT	Locum	Locum		PAU REG LATE START/covered by locum
Tue	25/09/2018	OFF	SCBU/PAU	Leave	PAU	SCBU/LD	NIGHT	Trainee Reg	OFF	NIGHT	study leave	VACANT	Locum	Locum		PAU REG LATE START/covered by locum
Wed	26/09/2018	OFF	PAU	Leave	PAU	SCBU	NIGHT	Trainee Reg	SCBU/LD	NIGHT	study leave	VACANT	Locum	Locum		PAU REG LATE START/covered by locum
Thu	27/09/2018	PAU/SCBU	OFF	Leave	PAU	OFF	NIGHT	Trainee Reg	SCBU/LD	NIGHT	study leave	VACANT	Locum	Locum		PAU REG LATE START/covered by locum
Fri	28/09/2018	SCBU/PAU	NIGHT	Leave	PAU	NIGHT	OFF	Trainee Reg	SCBU/LD	OFF	study leave	VACANT	Locum	Locum		PAU REG LATE START/covered by locum
Sat	29/09/2018	PAU/LD	NIGHT	Leave	PAU/LD	NIGHT										
Sun	30/09/2018	PAU/LD	NIGHT	Leave	PAU/LD	NIGHT										