United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Dr Neill Hepburn
Date:	25th May 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 as a response to 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 acute service is compromised within the middle grade doctors rota and the consequence of not being able to provide a safe, quality and consistent rota, which will effect the provision of the C&YP, Neonatal and Maternity Services at the Pilgrim Hospital site, Boston.

This paper provides the background of how and why the position has deteriorated and clearly identifies and analyses the issues that are faced in our current Service provision.

The paper goes on to consider the options avaliable to consider and recommend for the immediate mitigation of the imminent risks to the current C&YP Services, until a longer term strategic direction can be confirmed.

The Report is provided to the Board for:

Information	X	Assurance	X
Decision	X		

Summary/Key Points:

- The C&YP Services provided at Pilgrim Hospital cannot be sustained in their current form beyond 31st July 2018 unless additional middle grade doctors can be found to fill significant gaps in the rota.
- The issues with the middle grade rota at Pilgrim for Children's Services will also impact on the Obstetric (Maternity) and Neonatal services at Pilgrim Hospital, which will no longer be sustainable from 31 July 2018 unless additional medical cover can be found to cover the middle grade rota.

- With effect from 31 July 2018, it is expected that there will be only 1.0 substantive whole time equivalent (wte) middle grade doctor on the rota at Pilgrim out of an establishment of 8.0 wte.
- National and international recruitment extensively pursued by the Women & Children's Clinical Directorate (W&CCD) has failed to produce significant results to support the rota.
- The Clinical Directorate are working relentlessly 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.
- There is concern raised by the Consultant Paediatric Medical Team of the safety relating to a potential middle grade medical rota, if recruitment of locums was possible, where 7.0 wte out of an establishment of 8.0 wte are locum/agency doctors. Therefore, the Clinical Directorate are attempting to recruit senior medical staff, including additional consultants, to cover the middle grade rota at Pilgrim.
- This paper puts forward five options to consider as temporary mitigation of the immediate medical crisis until a longer term strategic solution can be implemented.
- The task and finish group consider that Option 1 and Option 3 are viable. Option 2 is a short term mitigation, Option 4 does not release sufficient medical time to maintain the out of hours rota and Option 5 could not be supported by the wider health community.
- The paper includes a Quality Impact Assessment of the options being proposed, and also includes an Equality Impact Assessment for consideration.
- A twice weekly Task and Finish Group, chaired by the Medical Director, has been established 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.
- Assurance is given that the Trust will continue with every option to recruit to the vacant posts to mitigate, as far as possible, the risks to the Service from 31st July 2018, with the intention of sustaining as many Services within Women's and C&YP as safely as possible at Pilgrim Hospital, Boston.
- Clinical Senate forum has been rearranged from Monday 21st May 2018 to 20th June.

Recommendations:

- Trust Board is asked to consider carefully the risks raised in this paper relating to the medical and nursing challenges that will significantly increase over the coming months.
- Trust Board is asked to consider each option that has been discussed in this paper for mitigating the immediate risks relating to the medical staffing challenges, and to offer their recommendations for which option they consider would mitigate the risk to the Service on a temporary basis until a longer term strategic solution can be agreed and delivered.
- The Trust Board is asked to consider recommending Option 1 as the preferred option with development of extensive mitigations to reduce the inherent risk.
- The Trust Board is also asked to consider recommending a full work up of Option 3 with implementation plans as mitigation in the event of a failure of Option 1.

Children & Young People Services at United Lincolnshire Hospitals NHS Trust Risk to the sustainability of the service

May 2018

Contents

Executive Summary

This paper is the culmination of a series of circumstances that have led to the challenging position within our C&YP Departments, specifically at Pilgrim Hospital, Boston. This is not a situation that any health economy wants to find itself in. However, patient safety is, and must always be our first and foremost concern and that is why this paper is being presented detailing the risks and options for discussion and recommendations.

This paper has been developed as a response to the difficulties and challenges faced by the C&YP which also has clinical interdependencies within Neonatal and Maternity services at United Lincolnshire Hospitals NHS Trust. The service will be compromised within the Middle Grade doctors rota in August 2018, (with only 1.0 wte substative middle grade) and the consequence of not being able to provide a safe, quality and consistent rota, which will effect the provision of the children's & young persons, neonatal and maternity services at the Pilgrim Hospital.

The paper provides the background of how and why the position has deteriorated and clearly identfies and analyses the issues that are faced in our current service provision. The paper goes on to consider the options we believe are available to consider and recommend for the immediate mitigation of the imminent risks to the current children's services.

The objectives of the report are:

- To provide the current situation with regards to C&YP care at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital.
- To provide clarity on the potential implicatons to the maternity & neonatal services at the Pilgrim Hospital.
- To identify the options for resolving the C & YP staffing challenges at Pilgrim Hospital.

We have consultant medical staffing commitment to keep Paediatric inpatient services running at Pilgrim Hospital until 31 July 2018. At the time of writing this paper, there is no mitigation in place to continue this commitment beyond this date.

THE CHILDREN AND YOUNG PERSONS SERVICES – CURRENT SITUATION AT PILGRIM HOSPITAL

Background context

Children & Young Persons services at ULHT are provided across three sites (outpatients only at Grantham) and include a community provision. At Lincoln and Pilgrim, the following clinical services are provided and supported:

- Acute Children's Inpatient service
- Emergency Children's Assessment
- Neonatology
- Consultant Led Obstetric service
- Emergency Department
- Outpatients Clinics and Procedures
- Community Children's services
- Children's Elective in patient and Day case Surgery

Over the past three years, the service has experienced both medical and nursing staffing challenges which have been partially mitigated by temporarily closing beds, increased skill mix through the introduction of nursery nurses, adult registered nurses and significant utilisation of both locum and agency medical staff. However, the position is forecast to further deteriorate within both the nursing and medical workforce.

Current staffing position

• Tier 3 (Consultant Grades):	PHB and LCH site	Continuing risk
• Tier 2 (Middle Grades)	PHB Site	Continuing & deteriorating risk
• Tier 1 (Junior Doctors)	PHB and LCH site	Not a current risk
• Registered Children's Nurses	PHB Site	Continuing risk

Where are we now? What has changed to increase the risk

There is significant increase to the risk of identified gaps on the Tier 2 (Middle Grade) rota in addition to the longstanding nursing recruitment and sickness issues on the PHB site. The position had been further compounded due to the short term need to support the Emergency Department (ED) at PHB with Registered Children's Nurses (RNC).

CQC (Care Quality Commission) inspection Feb 2018

Following inspection of the ED at Pilgrim Hospital by the CQC between 15 and 17 February 2018, conditions were placed on the organisation. The Trust was requested to provide assurance that the ED was staffed with appropriate numbers of competent staff to meet the needs of children & young people within the emergency pathway. Due to the staffing numbers of RNC within ED and adult nurses with children's competencies, the Women & Children's Clinical Directorate (W&CCD) were requested by the Executive Team to review the RNCs in post establishment on Ward 4a, to see if it would be feasible to support the ED Registered Nurse establishment with RNC. This action would provide the assurance that on every shift within ED there was 1 RNC able to provide care to CY & P.

The option of providing assurance through providing 3 wte RNC from within the children's ward (4a) at PHB establishment was considered by the Executive team and agreed as a short term option. To facilitate this, the bed capacity had to be reduced from 12 to 8 beds due to the availability of the

registered workforce. The impact was that a temporary stop to children's elective activity was required.

Lincoln and Pilgrim Hospital sites have Children's inpatient wards with 19 bed capacity, however over the last two years; this number has had to be temporarily reduced on numerous occasions due to shortage of nursing staff to safely staff the complement of beds.

Current Workforce Establishment
Consultants – No change

Site	Current Establishment	March 2018	July 1st 2018
PHB	6	5.5 (1.5 Locums)	6.0 (1.5 Locum)
LCH	8	8.0 (2 Locums)	8.0 (2 Locums)
TOTAL	14(*1)	13.5 (3.5 Locums)	13.5 (2.5 locums

**1: The consultants average 11.5 PA's (equating to 16% additional activity) & the equivalent of 16.25 '10PA' Consultants*

- New substantive consultant at Pilgrim Hospital due to commence June 2018
- A consultant establishment of 14 is 5wte below facing the future requirements as recommend by the Royal College of Paediatrics & Child Health (RCPCH). The consultant establishment should be 19 wte. *(21 wte if all had 10PA contracts)*

Middle Grades – Deteriorating position at PHB

- 3.5 wte [out of 8.0 wte] posts available from April (following LT sickness 4 weeks+)
- Short term agency secured 16.04.18 to 06.05.16 temporarily increasing to 4.5wte out of 8.0
- Reduction of 1.0 wte Middle Grade from May 2018, 2.5 wte Middle Grades July 2018 – only 1.0 wte if Middle Grade remains on sick leave
- Inability to recruit following multiple recruitment events / long term substantive staff
- The service has recruited long term Agency Locum staff

RN (Child) - Deteriorating position at PHB (as at 18th April 2018)

- 20.4 wte [out of 28.65 wte] in post
- 16.25 wte RN (Child) in post
- Available to work
  i) 12.95 wte RN(Child)
  ii) 4.23 WTE RN (Adult)
- There is an inability to currently meet the minimum RCN standards for RN (Child) staffing to the bed capacity of 19
- The service has not been successful in recruiting to the PHB site despite numerous attempts
- The service has relied upon block booking Agency RN (Child) staff x 2.0 wte since September 2017 to December 2017, then only 1.0 wte until April 2018, and from April 2018 1.8 wte
- The service has recruited adult nurses in order to mitigate some of the risk with additional paediatric competencies
- The service has also relied upon Children's Community Support for a year.

Summary

The Clinical Directorate team, supported by the Children's multi-disciplinary team at Pilgrim believe that a Children's service at Pilgrim can no longer be supported. The reasons for this are:

- Inability to provide assurance that nursing and medical rotas can be prospectively filled
- Inability to provide assurance that Medical rota's can be filled without the extensive use of Agency Locum staff
- Inability to assure the reliability and quality of the Agency locum medical staff
- Mitigations further work is on-going (**Appendix Six**)
- Further deterioration of staffing numbers expected at Middle grade level without a confirmed pipeline of replacements in the next 6 months.

1. Introduction

1.1 An overview of United Lincolnshire Hospitals NHS Trust

- **Lincolnshire is the fourth largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.**
- **Transport networks are underdeveloped resulting in transport times of around one hour between the respective hospital sites.**
- **Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.**
- **We provide acute hospital care, to around 757,000 residents of Lincolnshire.**
- **Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037.**
- **These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.**
- **In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.**

ULHT is one of the largest acute trusts in the country. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GP clusters. These include: Louth County Hospital, John Coupland Hospital, Gainsborough, Johnson Community Hospital, Spalding and Skegness and District General Hospital

We deliver services across the following specialities:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory Physiology
Breast Services	Diabetic Medicine	Hepatobiliary and Pancreatic Surgery	Oral and Maxillofacial Surgery	Specialist Rehabilitation Medicine
Cardiology	Diagnostic Services	Maternity and Obstetrics	Orthodontics	Rheumatology
Chemotherapy	Dietetics	Medical Physics	Pain Management	Acute Paediatric services
Children's Community Services	Ear, nose and Throat	Medical Oncology	Palliative Care	Therapies
Clinical Immunology	Endocrinology	Neonatology	Pharmacy	Trauma and Orthopaedics
Clinical Oncology	Gastroenterology	Nephrology	Radiotherapy	Urology
Colorectal Surgery	General Medicine	Neurology	Rehab Medicine	Vascular Surgery
Community Paediatrics	General Surgery	Neurophysiology	Research and Development	Paediatric surgical services
Hyper-acute and acute stroke medicine	Gynaecology	Nuclear Medicine	Respiratory Medicine	Vascular services

Whilst ULHT is the leading provider of elective care across all four CCG's (Clinical Commissioning Groups) in Lincolnshire; Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust achieve a significant share of elective care in Lincolnshire East and South Lincolnshire respectively. It is of note that South Lincolnshire CCG commissioners have more than 70% of its elective care from hospitals outside Lincolnshire.

An overview of the services provided at our hospitals

The Lincoln and Pilgrim Hospitals provide a full range of clinical services, with only the following exclusions:

- Neurosurgery
- Cardiothoracic surgery
- Spinal surgery

Specialised services are provided at ULHT either at Pilgrim Hospital or at Lincoln Hospital, and in the case of some services, both hospital sites. The specialised services include: Critical Care level 3 and Stroke Medicine at both Pilgrim and Lincoln hospitals, Cardiology (Cardiac Centre at Lincoln), Specialised Rehabilitation Medicine level 2a at Lincoln and Vascular services at Pilgrim Hospital.

Grantham & District Hospital does not provide any in patient specialised services; there is currently a restricted medical take at Grantham, together with a range of elective surgery and outpatient services. Grantham hosts the Trust's main Cardiac Diagnostic services, including Cardiac MRI and Cardiac Echo both of which see more patients than our neighbouring hospitals in Nottingham and Leicester.

Our hospitals have the following number of beds:

- Grantham: 100 beds
- Lincoln: 540 beds
- Pilgrim 350 beds

An overview of the current Women and Children's services at ULHT

.

Lincoln County Hospital

Consultant led Obstetrics & Gynaecology, Neonatology and Children's services at Lincoln Hospital. Circa 3,200 births per annum. A 19 bed inpatient children's ward, separate children's 8 bed day surgery/assessment unit and outpatient department supported by a Community Children's nursing team.

The Emergency Department at Lincoln provides unrestricted access to ED services 24/7 for C&YP emergencies, direct C&YP GP referrals, significant number of children on the ward receive Paediatric High Dependency Unit (PHDU) Level 1 care. From Mid 2017 ULHT has received additional funding for the provision of this care.

Pilgrim Hospital, Boston

.

Consultant led Obstetrics & Gynaecology, Neonatology and Children's services at Pilgrim Hospital. Circa 2,000 births per annum. A 19 bed inpatient children's ward, currently reduced to 12 due to registered sick children's nurse staffing gaps. Children's Outpatient Department and Community Children's Nursing Team.

The Emergency Department at Pilgrim provides unrestricted access to ED services 24/7 for C&YP emergencies, direct C&YP GP referrals a number of children on the ward receive PHDU level 1 care and from mid-2017 ULHT has received additional funding for the provision of this care.

Grantham & District Hospital

The Grantham & District Hospital provides access to Children's outpatient services. There is a community Children's hub located at the hospital where children can be seen on an outpatient basis by a Consultant Paediatrician supported by Community Children's Nursing Team

2. Children's activity and performance

2.1 Children's activity details

The tables below show the number of patients attending per day and per annum for each point of deliver (data an early cut 2017/18 actuals produced on 9/4/18), e.g. Outpatients, Day Case, Elective admission, Non-elective admission and ward attenders.

Paediatric	Pilgrim Hospital		Lincoln Hospital		Grantham Hospital		Total Activity	
POD	Year	Day	Year	Day	Year	Day	Year	Day
First	2164	9	2612	10	1881	8	6657	27
Follow Up	2689	11	2977	12	1085	4	6752	27
Total	4853	19	5589	22	2966	12	13408	54
Children's & Young Persons & subspecialties of Children's & Young Persons only								

POD	Pilgrim Hospital		Lincoln Hospital		Total Activity	
	Year	1 Day	Year	1 Day	Year	1 Day
Day Case	529	2.1	670	2.7	1199	4.8
Elective *	143	0.6	267	1.1	410	1.6
Non-elective**	2661	7.3	4935	13.5	7596	20.8
Ward attenders	2539	10.2	2903	11.6	5442	21.8
All specialities on the children's wards (See breakdown below)						

Elective (DC & IP)	Pilgrim Hospital		Lincoln Hospital		Total Activity	
Speciality	Year	Day	Year	Day	Year	Day
ENT	236	0.9	291	1.2	527	2.1
Orthopaedics	68	0.3	240	1.0	308	1.2
Children's & Young	122	0.5	78	0.3	200	0.8
Oral Max Fax	68	0.3	119	0.5	187	0.7
Ophthalmology	58	0.2	65	0.3	123	0.5
Urology	50	0.2	56	0.2	106	0.4
Radiology		0.0	82	0.3	82	0.3
Respiratory Physiology [Sleep studies]	48	0.2			48	0.2
General Surgery	22	0.1	5	0.0	27	0.1
Gynaecology		0.0	1	0.0	1	0.0
Total	672	2.7	937	3.7	1609	6.4

Non Elective	Pilgrim Hospital		Lincoln Hospital		Total Activity	
Speciality	Year	Day	Year	Day	Year	Day
Children's & Young	2388	6.5	4303	11.8	6691	18.3
Orthopaedics	153	0.4	292	0.8	445	1.2
General Surgery	103	0.3	196	0.5	299	0.8
ENT	1	0.0	66	0.2	67	0.2
Oral Max Fax		0.0	53	0.1	53	0.1

Urology	15	0.0	19	0.1	34	0.1
Gynaecology	1	0.0	6	0.0	7	0.0
Total	2661	7.3	4935	13.5	7596	20.8

* Elective activity is based on 250 days per annum

** Non-elective activity is based on 365 days per annum

Therefore, this demonstrates from the above activity details that the following number of beds is required:

- 6.5 beds at the Pilgrim site for non-elective activity
- 11.8 beds at the Lincoln site for non- elective activity
- 2.7 beds at the Pilgrim site for elective activity
- 3.7 beds at the Lincoln site for elective activity

The above relates to only Paediatric non elective and does not take into account length of Stay and variation in daily demand.

The table below shows the overall number of beds required at Pilgrim and at Lincoln Hospital for both elective and non-elective activity.

POD	Pilgrim Hospital			Lincoln Hospital			Total Activity		
	Average daily Admissions	Corrected for LoS [Elective = 1] Non elective = 1.4]	Variation in daily admissions (20% increase)*	Average daily Admissions	Corrected for LoS [Elective = 1] Non elective = 1.4]	Variation in daily admissions (20% increase)	Average daily Admissions	Corrected for LoS [Elective = 1] Non elective = 1.4]	Variation in daily admissions (20% increase)
Elective & DC *	2.7	2.7	2.7	3.8	3.8	3.8	6.4	6.4	6.4
Non-elective**	7.3	10.2	12.3	13.5	18.9	22.7	20.8	29.1	34.9
Total beds	10.0	12.9	15.0	17.3	22.7	26.5	27.2	35.5	41.3

*More detailed modelling will be required to fully understand the impact on beds, of peaks & troughs in activity flows

2.2 Length of stay for Children's inpatient activity

The table below shows the average length of stay for children's inpatient activity at both Pilgrim and Lincoln Hospitals.

	PHB	LCH
Elective	1.0	1.0
Non-elective	1.4	1.4

2.3 Children's critical care

ULHT has been newly commissioned to provide Children's critical care level 1 (basic HDU), Patients requiring level 2 or 3 critical care are transferred to a tertiary centre. The table below shows the number of children that required level 1 critical care from September 2017 to current date.

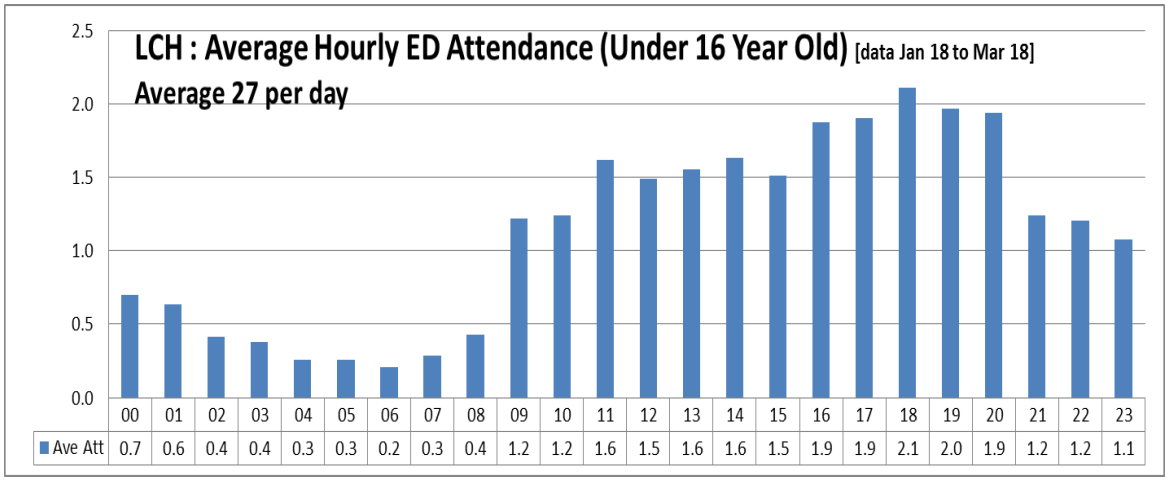
		LCH			PHB			Trust		
Years	start	Patients	Beds Days	LoS	Patients	Beds Days	LoS	Patients	Beds Days	LoS
2017	Sep	44	129	2.9	10	40	4.0	54	169	3.1
	Oct	28	109	3.9	22	52	2.4	50	161	3.2
	Nov	36	117	3.3	31	105	3.4	67	222	3.3
	Dec	30	131	4.4	22	99	4.5	52	230	4.4
2018	Jan	26	128	4.9	18	76	4.2	44	204	4.6
	Feb	21	94	4.5	8	40	5.0	29	134	4.6
	Mar	23	74	3.2	10	48	4.8	33	122	3.7
	Total	**208**	**782**	3.8	**121**	**460**	3.8	329	1242	3.8

2.4 Children's ED activity

2.4.1 Children presenting to ED by the hour at Lincoln Hospital

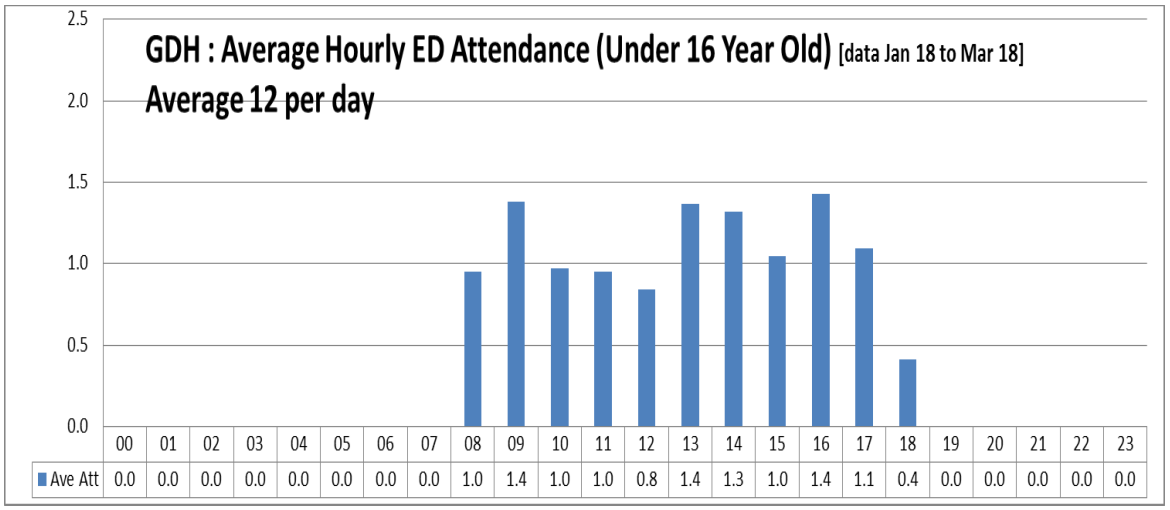
The bar charts below demonstrate the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 at the Lincoln Hospital.

Peak time of attendance is between 16:00 hours and 20:00 hours.



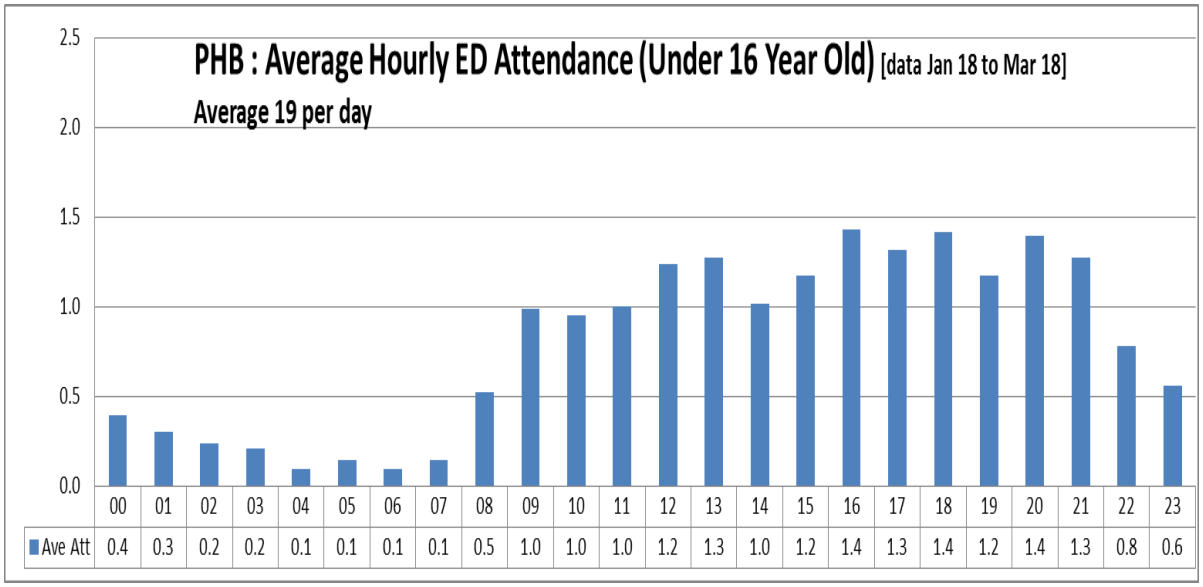
2.4.2 Children presenting to ED by the hour at Grantham & District Hospital

The bar chart below shows the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 at the Grantham Hospital.



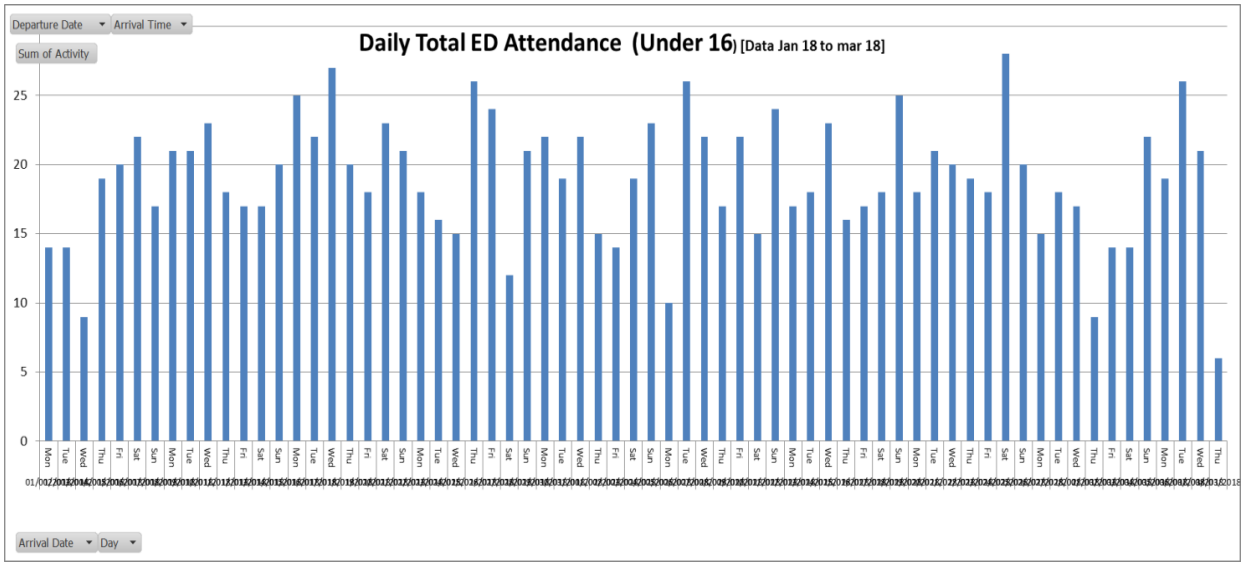
2.4.3 Children presenting to ED by the hour at Pilgrim Hospital

The bar chart below shows the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 for the Pilgrim Hospital. The chart demonstrates that the peak time for attendance at the ED department is between the hours of 16:00 hrs and 21:00 hrs. Peak time of attendance is between 16:00 and 20:00 hours



2.4.4 Children's presentations to ED by day of the week at Pilgrim Hospital

The table below shows children attending the Pilgrim ED department by day of the week, for the period between January and March 2018, an average of 19 children per day attend ED.



Arrival Method

The tables below shows the daily average transportation method for the children who attendended the Pilgrim Hospital for the 67 day period between 4 January and 8 March 2018.

	Grantham Hospital	Lincoln County Hospital	Pilgrim Hospital Boston	Grand Total
Car	**11.00**	**22.93**	**16.42**	**50.34**
999	0.03	**3.72**	**2.28**	**6.03**
Walked in	0.30	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	0.00	0.04	0.03	0.07
Bicycle	0.01	0.01	0.00	0.03
Work Transport	0.03	0.00	0.00	0.03
Helicopter	0.00	0.03	0.00	0.03
Ambulance (not 999)	0.00	0.00	0.01	0.01
Grand Total	11.72	27.18	18.94	57.84

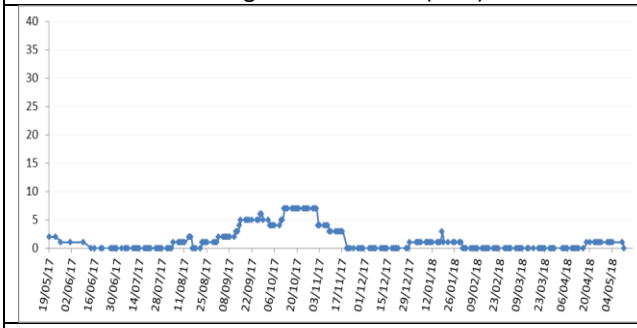
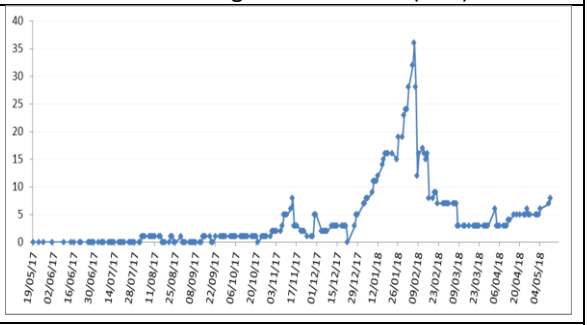
ED Outcome: Arrival by 999 Ambulance	Grantham Hospital	Lincoln County Hospital	Pilgrim Hospital Boston	Grand Total
Home	0.0	**1.9**	**1.0**	**2.9**
I/P (This hospital)	0.0	**1.4**	**1.2**	**2.7**
Out-Patient Clinic	0.0	0.1	0.0	0.1
Fracture Clinic	0.0	0.1	0.0	0.1
Did not wait	0.0	0.1	0.0	0.1
Own GP	0.0	0.1	0.0	0.1
Total	0.0	3.7	2.3	6.0

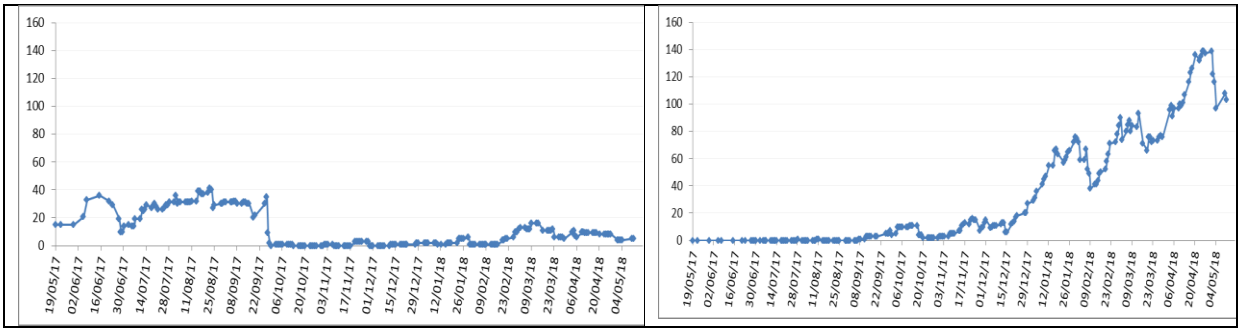
ED Outcome: Self / Other arrival (Non 999)	Grantham Hospital	Lincoln County Hospital	Pilgrim Hospital Boston	Grand Total
Home	**8.7**	**15.4**	**9.6**	**33.8**
I/P (This hospital)	**0.0**	**4.0**	**2.9**	**7.0**
Fracture Clinic	**1.3**	**2.2**	**2.4**	**5.9**
Did not wait	0.2	0.6	0.5	1.3
Out-Patient Clinic	0.2	0.6	0.4	1.2
Own GP	0.1	0.2	0.3	0.6
I/P Other Hosp. in Trust	0.5	0.0	0.0	0.6
A&E Clinic	0.2	0.1	0.3	0.5
I/P (elsewhere)	0.1	0.1	0.0	0.2
Not set	0.0	0.1	0.0	0.2
Out of Hours Service	0.0	0.1	0.1	0.2
Transfer to other ULHT A&E	0.1	0.0	0.0	0.1
Referred to other hospital	0.1	0.0	0.0	0.1
Other	0.0	0.0	0.0	0.1
Total	11.7	23.5	16.7	51.8

2.5 Current performance against national waiting time standards

The children & young person's service is achieving the Referral to Treatment pathway with current performance at 96% [692 out of 720 referrals under 18 weeks]

The charts below shows children's new outpatient appointments waiting over 12 weeks. And overdue follow up appointments . The high number for the period from the end January & beginning of February 2018 reflected the leaving of two Paediatric Consultants on the LCH site. The New OP position recovered following the appointment of two Agency Locum Consultants . The overdue follow up position is taking longer to recover.

New Referrals waiting over 12 weeks (PHB)	New Referrals waiting over 12 weeks (LCH)
	
6 weeks + over due Follow Up appointments (PHB)	6 weeks + over due Follow Up appointments (LCH)



2.6 Current performance against national quality standards for Children's & Young Persons

The tables below show current performance for ULHT against the standards for Children and Young Persons as set by the Royal Colleges of Nursing & Paediatric Medicine.

Acute Children and Young Person's Standards (Medical) RCPCH Facing the Future (2015)		Standard Met?	
Ref	Summary of Standard	PHB	LCH
AP1	A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.	- NO -	- NO -
AP2	Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.	-YES-	-YES-
AP3	Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.	- NO -	- NO -
AP4	At least two medical handovers every 24 hours are led by a consultant paediatrician or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota	- NO -	- NO -
AP5	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	-YES-	-YES-
AP6	Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota	-YES-	-YES-
AP7	All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.	-YES-	-YES-
AP8	All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.	- NO -	- NO -
AP9	Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.	-YES-	-YES-
AP 10	All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.	-YES-	-YES-

Acute Children and Young Person's Standards (Nursing)		Standard Met?	
Ref	Summary of Standard	PHB	LCH
PN 1	Ward to have a minimum of 2 Registered Nurses (Child) on duty at all times #1	PART	-YES-
PN 2	Registered Children's Nurses should make up 90% of trained staff establishment	- NO -	-YES-
PN 3	Meets RCN standards for Nurse to Patient ratio	- NO -	- NO -
PN 4	Provision for a separate adolescent unit	- NO -	- NO -

#1 PHB site: requires significant mitigation; support from LCH, Children's Community nursing team, Matron Presence & sister in numbers

3 Current Service Provision & the Children's Staffing Position

Previous sections of this paper have provided context regarding the current levels of service provided and activity within our Children's departments. This section of the paper will focus on the levels of staffing required to run a safe Children's service, and it will also set out our concerns as a result of a continued reduction in available staffing, both medical and clinical.

3.1 What levels of staff are needed to run Children's & Young People's services across ULHT?

Acute hospital C&YP departments are staffed by a combination of consultants, middle grade and junior doctors, and nurses. In addition, advanced nurse practitioners may also contribute to the workforce.

Utilising the standards as set out by the RCPCH (Royal College Paediatric & Child Health) in the document called "*2011 Facing the future"* it would suggest that in order to provide adequate clinical medical cover, supervision and training, we would require a minimum of 19.0 wte Children's consultants (21.3 wte if all on 10PA contracts) , 18.0 wte middle grades, and 24.0 wte Junior Doctors across the C&YP services within ULHT. The staffing numbers include cover for Obstetric, Neonatal and Emergency Department for a District General Hospital.

The Royal College of Nursing standards 2013 document; "*Defining staffing levels for children's and young people's services"* states that the required number of registered children's nurses required at ULHT to staff a 20 bed children's ward based on a 1:4 nurse to patient ratio, would be 5.0 wte registered children's nurses for provision of direct care, in addition, 1.0 Co-ordinator /Supervisor per shift, and 1.0 wte ward manager. This establishment would change for children under the age of two years, as the ratio of nurse to patient would increase to 1:3.

Our current establishments for each staff group are significantly below those as expected via the aforementioned documents. This is demonstrated in the tables in the sections below.

3.1.1 Medical staff

Lincoln Hospital – Medical Staff

Grade	Facing the future / 7 day establishment/Defining staffing levels for children & young people's services	Current Est. WTE	In post as at April 2018 WTE	In post as at July 1 2018 WTE	Impact of long term sickness/ maternity leave
Consultants	10.5	8(#2)	8(#1)	8(#1)	None
Consultants (on 10PA contract)	11.8	9.3			
Middle grades	10	8	8	8	None
Junior Doctors	8	8	8	8	None
Advanced Neonatal Nurse Practitioner/Junior Doctors	8	6	4	4	None

#1: 2 X Agency Locum
#2: The LCH consultants averaged 11.5 PA's (These additional PA's constitute Direct Clinical Care PA's & SPA's for necessary duties over and above the standard 1.5 SPA's) and effectively result in each consultant undertaking an average of 16% more activity than a 10PA consultant (ie the 8 consultants equate to 9.3 x 10PA consultants)

Pilgrim Hospital – Medical Staff

Grade	Facing the future / 7 day establishment/Defining staffing levels for children & young people's services	Current Est. WTE	In post as at April 2018 WTE	In post as at July 1 2018 WTE	Impact of long term sickness/ maternity leave
Consultants	8.5	6(#7)	5.5(#2)	5.5(#5)	None
Consultants (on 10PA contract)	9.5	7			
Middle grades	8	4.5	4.5(#3)	1.0(#6)	-2.5
Junior Doctors	8	8	7(#4)	7(#4)	None

#2: 1 X Agency Locum & 1 x Bank covering OP clinics only
#3: 1 x Agency Locum Consultant working @ MG plus internal bank and ad hoc agency
#4: 1 x Agency Junior Dr
#5: x0.5 Agency Locum
#6: x1 Deanery position high risk
#7 The PHB consultants averaged 11.2 PA's (These additional PA's constitute Direct Clinical Care PAs & SPAs for necessary duties over and above the standard 1.5 SPAs) and effectively result in each consultant undertaking an average of 16% more activity than a 10PA consultant (ie the 6 consultants equate to 7 x 10PA consultants)

Grantham Hospital – Medical Staff: No Paediatric Medical staff

Only children's outpatient clinics delivered at Grantham Hospital by clinical staff from both Pilgrim and Lincoln Hospitals.

3.1.2 Registered Nursing staff

Lincoln Hospital – Inpatient Service

Band	Registered Nursing Establishment	RN In post	Block Agency	RN In Post But Unavailable to work on ward (includes sickness / absence)	WTE Long-Term Sickness / Absence	Current WTE Available to Work minus sickness/ Absence	Current Vacancies
6	3.73wte **(uplift to 5.48wte)**	5.48wte	0	0	0	5.48wte	1.0wte
5	21.06wte	14.22wte	0.96wte	0.64wte (Maternity leave)	0.64wte (Maternity leave)	13.58wte	6.64wte
Total	**24.79wte (26.54wte)**	**19.7wte**	**0.96wte**	**0.64wte**	**0.64wte**	**19.06wte (with agency)**	**7.64wte**

1.0wte Band 6 now advertised (temp uplift from band 5 budget)

Recruitment
4.0wte offered Band 5 registered nurse posts from cohort recruitment Interviews in November 2017, of which 3.0wte are RN Child and 1.0wte is RN adult. These will be newly qualified ready to commence in September 2018.

In addition a further:

- 2.0wte were interviewed in March 2018, these will be newly qualified and will commence in September 2018. Both are from Sheffield University.
- 1.0wte band 2 currently seconded to do Children's Nursing at Nottingham. Due to qualify and commence in post as a band 5 in September 2018
- 0.4wte interviewed in February Cohort and was the offered post. Currently awaiting DBS, Occupational Health Clearance and references. This is a Registered Children's Nurse

Expected availability End May = 19.06wte

Bank & Agency use
Block Agency Nurse booked until 19th May 2018 0.96wte.
Bank Nurse available to work 2 long nights per week for every 3 out of 4 weeks. Shifts offered at time of doing roster.

Pilgrim Hospital

	Registered Nursing Establishment	RN In post	Block Agency	RN In Post But Unavailable to work on ward (includes sickness / absence)	WTE Long-Term Sickness / Absence	Current WTE Available to Work minus sickness/ Absence	Current Vacancies
6	3.13wte **5.2wte (Includes Uplift)**	4.5wte (0.2wte temp cover)	0	0.0wte	0.0wte	4.5wte	0.9wte
5	23.45wte	RN(C) 12.75wte (inc temp 1wte)	1.88wte (included in RNC figures)	2.6wte	0.6wte	RNC 10.15wte	8.35wte
		RN(A) 5.23wte	0	1.0wte (On Nursing course)	0	RN 4.23wte	
Total	**26.58wte (28.65wte uplift not funded)**	**22.48wte**	**1.88wte**	**3.6wte**	**0.6wte**	**18.88wte**	**9.25wte**

Children's Inpatient Ward Current Nursing Establishment statistics for 19 bed capacity

Royal College of Nursing Children's (2013) recommended staffing establishments for deliverable hands on care are:

- *Children <2 years of age 1:3 nurse-child day and night*
- *Children >2 years of age 1:4 registered nurse-child day and night*

CHILDRENS NURSES IN POST = 17.25wte
CHILDRENS NURSES AVAILABLE TO WORK = 14.65wte

<u>In post but Unavailable to work</u>
<u>Band 5 RNC</u>
1.0 wte Maternity leave
1.0 wte redeployed to clinic
0.6 wte long term sickness
=**2.6 wte**

0.5wte Band 5 – Ward Attender Nurse in ward establishment but not included in the available to work figures for the ward

EXPECTED NEW STARTERS
1.0wte RNC starting 11th June 2018.
1.0wte RNA due to return as RNC in September following Children's Nurse Training

CURRENT RECRUITMENT
x1 potential newly qualified RNC with possible start September – reliant on relocation.
Ward Manager Recruitment – x 1 shortlisted – Interview date to be arranged (3rd attempt to recruit).

RAD completed for 1.0wte Band 6 vacancy

RESIGNATIONS
- 0.5wte RN (Child) resigned and contract ends 20th June 2018.

MATERNITY LEAVE
- 0.6wte Band 5 RN (Child) due to commence maternity leave July 2018 – Date not specified.
- 0.5wte Band 5 RN (Adult) due to commence maternity leave July 2018 – Date not specified.
- 0.64wte Band 5 RN (Child) expected Maternity leave approximately September 2018.
- 1.0wte band 5 RN(Adult) expected Maternity leave approximately September 2018

3.2 What levels of staff do we currently have in our Children's Departments

The previous section has demonstrated and explained the shortfall in medical & nursing posts within our Children's services. As the issues regarding staffing are primarily associated with the availability of Consultants, middle grade doctors and registered sick children's nurses the rest of this section will focus on those issues.

Consultants – No change

Site	Current Establishment	May 2018
PHB	6	5.5 (1.5 Locums)
LCH	8	6 (2 Locums)
TOTAL	14	11.5 (of which 3.5 are locums)

- New substantive Consultant expected to commence at Pilgrim Hospital June 2018
- Establishments 5.0 wte below facing the future requirements

Middle Grade Staff (PHB site)

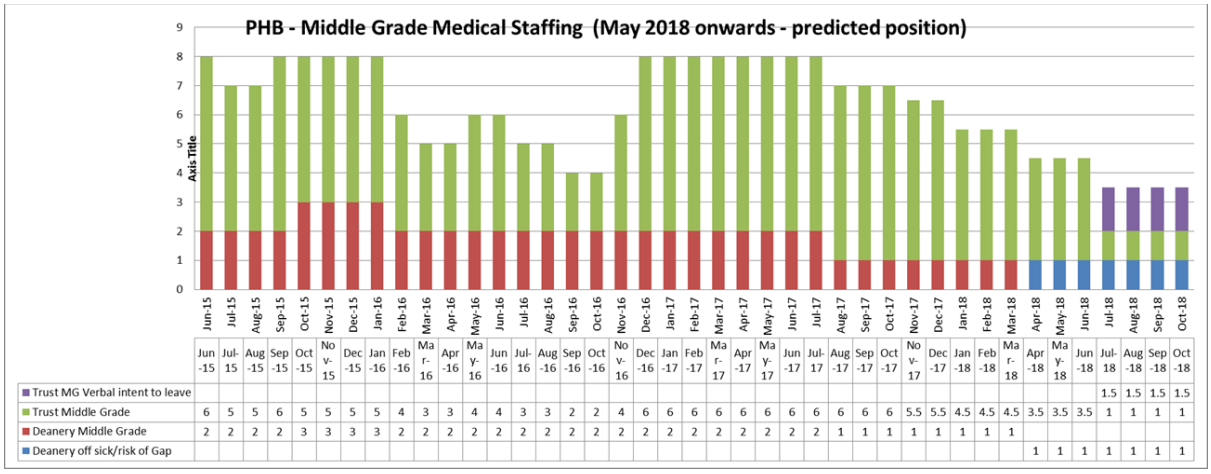
As can be evidenced in the table and chart below there is a steady decline against the compliance of the middle grade rota with the position expected to deteriorate further in July 2018. Since preparing the graph below, the position is changing:-

- Deanery trainee on Long term sickness
- Reduction of 1 wte MG from May 2018, and by 1.5 wte MG July 2018
- Only 1 wte MG will be available in August if the deanery MG remains on sick leave (or is not replaced as currently thought)
- From August 2018, the Deanery has advised they are unlikely to sustain their Middle Grade rota post if the ward does not remain open
- 1 international recruit will be ready for Tier 2 rota Sept-Dec 2018 (visa dependent)
- Inability to recruit following multiple recruitment events / long term Agency locum staff

Role	Comment	Comment 2
Speciality doctor	Full time	Remains in post
Speciality doctor	Full time	Leaves July 18

Speciality doctor	Full time	Leaves 1st July
Speciality doctor	Full time	Leaves 31st March 2018
Speciality doctor	50% Community 50% Paediatrics	Leaves 1st August 18
Speciality Trainee (Deanery)	Full time	Off sick (LT) High risk of not replacing this post from August onwards if the ward is the closed
Middle Grade	Full time	Start date 16/4/18 Agency Consultant to cover Middle Grade gap (for 5 weeks only)
Middle Grade	Vacant	Long Term Agency now potentially in place for MG Gaps

The chart below demonstrates the current position with middle grade medical staff in post from the required staffing as recommended by the Royal College Paediatric Medicine. As a consequence of the deterioration and following the most recent decline in staffing numbers, prospective rotas can no longer be staffed with confidence.



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Trust MG Verbal intent to leave																																						1.5	1.5	1.5	1.5
Trust Middle Grade	6	5	5	6	5	5	5	5	4	3	3	4	4	3	3	2	2	4	6	6	6	6	6	6	6	6	6	6	5.5	5.5	4.5	4.5	4.5	3.5	3.5	3.5	1	1	1	1
Deanery Middle Grade	2	2	2	2	3	3	3	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1							
Deanery off sick/risk of Gap																																		1	1	1	1	1	1	1

This can be further evidenced with the rota as it currently stands for the months of May, June and July. Please see these below and the impact on the shifts that cannot be covered by middle grade doctors.

May 18

Date	Day	09:00 to 17:00	17:00 to 21:00	SCBU (9-5.pm)	Ward/A&E 9-5	Clinic	Night
01.05.18	Tuesday	Agency (One)		Trust (1 - Remaining)	No Cover	No Cover	Trust Olunajo L
02.05.18	Wednesday	Agency (One)	Agency (One)	Trust (1 - Remaining)	No Cover	No Cover	Trust Olunajo L
03.05.18	Thursday		Agency (One)	Trust (2 - leaving)	No Cover	No Cover	(Trust) (Seven) L
04.05.18	Friday		Agency (One)	Trust (2 - leaving)	No Cover	No Cover	Trust (1 - Remaining)
05.05.18	Saturday	Trust (Seven)					Trust (1 - Remaining)
06.05.18	Sunday	Trust (Seven)					Trust (1 - Remaining)
07.05.18	Monday	Agency (Two)		Agency (Three)	No Cover	No Cover	Trust (1 - Remaining)
08.05.18	Tuesday	Agency (Two)		Agency (Three)	No Cover	No Cover	Trust (3 - Agency 7 From 9/7/18)
09.05.18	Wednesday	Agency (Two)		Agency (Three)	No Cover	No Cover	Trust (3 - Agency 7 From 9/7/18)
10.05.18	Thursday	Agency (Two)		Agency (Three)	No Cover	No Cover	Trust (3 - Agency 7 From 9/7/18)
11.05.18/	Friday	Agency (Two)		Vacant	No Cover	No Cover	Agency (Three)
12.05.18	Saturday	Trust 4 - Leaving					Agency (Three)
13.05.18	Sunday	Trust 4 - Leaving					Trust (Seven) L
14.05.18	Monday	Agency (Three)		Trust (1 - Remaining)	No Cover	No Cover	Trust (Seven) L
15.05.18	Tuesday	Agency (Three)		Trust (1 - Remaining)	No Cover	No Cover	Trust 4 - Leaving
16.05.18	Wednesday	Agency (Three)		Trust (1 - Remaining)	No Cover	No Cover	Trust 4 - Leaving
17.05.18	Thursday	Agency (Three)		Trust (1 - Remaining)	No Cover	No Cover	Trust 4 - Leaving
18.05.18	Friday	Agency (Three)		Trust (1 - Remaining)	No Cover	No Cover	Trust (3 - Agency 7 From 9/7/18)
19.05.18	Saturday	Agency (One)					Trust (3 - Agency 7 From 9/7/18)
20.05.18	Sunday	Agency (One)					Trust (3 - Agency 7 From 9/7/18)
21.05.18	Monday	Trust (2 - leaving)	Vacant	Trust (1 - Remaining)	No Cover	No Cover	Trust (3 - Agency 7 From 9/7/18)
22.05.18	Tuesday	Trust (2 - leaving)		Trust (1 - Remaining)	No Cover	No Cover	Agency (Three)
23.05.18	Wednesday	Trust (1 - Remaining)	Vacant	Trust (2 - leaving)	No Cover	No Cover	Agency (Three)
24.05.18	Thursday	Trust (2 - leaving)		Trust (1 - Remaining)	No Cover	No Cover	Agency (Three)
25.05.18	Friday	Trust (2 - leaving)	Vacant	Trust (1 - Remaining)	No Cover	No Cover	Trust 4 - Leaving
26.05.18	Saturday	Trust (Seven)					Trust 4 - Leaving
27.05.18	Sunday	Trust (Seven)					Trust 4 - Leaving
28.05.18	Monday	Trust (2 - leaving)		Trust (1 - Remaining)	No Cover	No Cover	Trust 4 - Leaving
29.05.18	Tuesday	Trust (1 - Remaining)		Trust Olu	No Cover	No Cover	Agency (Three)
30.05.18	Wednesday	Trust (2 - leaving)		Trust (1 - Remaining)	No Cover	No Cover	Agency (Three)
31.05.18	Thursday	Trust (Seven)		trust (1 - Remaining)	No Cover	No Cover	Agency (Three)

June 18

Date	Day	09:00 to 17:00	17:00 to 21:00	SCBU (9-5.pm)	Ward/A&E 9-5	Clinic	Night
01.06.18	Friday	Agency (Five)		Trust (Seven)	Trust (2 - leaving)	Trust (1 - Remaining)	Agency (Three)
02.06.18	Saturday	Agency (Five)					Agency (Three)
03.06.18	Sunday	Agency (Five)					Agency (Three)
04.06.18	Monday	Trust (2 - leaving)	Agency (Four)	Trust (3 - Agency 7 From	Agency (Four)	Trust (1 - Remaining)	Agency (Three)
05.06.18	Tuesday	Trust (2 - leaving)	Agency (Four)	Trust (3 - Agency 7 From	Agency (Four)	No Cover	Agency (Five)
06.06.18	Wednesday	Trust (2 - leaving)	Agency (Four)	Trust (3 - Agency 7 From	Agency (Four)	Trust (1 - Remaining)	Agency (Five)
07.06.18	Thursday	Trust (2 - leaving)	Agency (Three)	Trust (3 - Agency 7 From	Agency (Three)	No Cover	Agency (Five)
08.06.18	Friday	Trust (2 - leaving)		Trust (3 - Agency 7 From	Agency (Three)	Trust (1 - Remaining)	Agency (Four)
09.06.18	Saturday	Trust (2 - leaving)					Agency (Four)
10.06.18	Sunday	Trust (2 - leaving)					Agency (Four)
11.06.18	Monday	Agency (Three)		Agency (Five)	Trust (3 - Agency 7	Trust (1 - Remaining)	Agency (Four)
12.06.18	Tuesday	Agency (Three)	Agency (Five)	Agency (Five)	Trust (3 - Agency 7	Trust (1 - Remaining)	Trust (2 - leaving)
13.06.18	Wednesday	Agency (Three)		Agency (Five)	Trust (3 - Agency 7	Trust (1 - Remaining)	Trust (2 - leaving)
14.06.18	Thursday	Agency (Three)	Agency (Four)	Agency (Four)	Trust (3 - Agency 7	Trust (1 - Remaining)	Trust (2 - leaving)
15.06.18	Friday	Agency (Three)		Agency (Four)	Trust (3 - Agency 7	Trust (1 - Remaining)	Agency (Five)
16.06.18	Saturday	Trust (1 - Remaining)					Agency (Five)
17.06.18	Sunday	Trust (1 - Remaining)					Agency (Five)
18.06.18	Monday	Trust (Seven)	Agency (Four)	Agency (Three)	Agency (Four)	Trust (2 - leaving)	Agency (Five)
19.06.18	Tuesday	Agency (Four)		Agency (Three)		Trust (2 - leaving)	Trsut (1 - Remaining)
20.06.18	Wednesday	Agency (Four)	Agency (Three)	Agency (Three)	Agency (Four)	Trust (2 - leaving)	Trust (1 - Remaining)
21.06.18	Thursday	Agency (Five)	Agency (Four)	Agency (Three)	Agency (Four)	Trust (2 - leaving)	Trsut (1 - Remaining)
22.06.18	Friday	Agency (Five)	Agency (Three)	Agency (Three)	Agency (Four)	Trust (Seven)	Trust (2 - leaving)
23.06.18	Saturday	Agency (Five)					Trust (2 - leaving)
24.06.18	Sunday	Agency (Five)					Trust (2 - leaving)
25.06.18	Monday	Trust (Seven)	Agency (Five)	Agency (Four)	Agency (Three)/(Fi	Trust (1 - Remaining)	Trust (2 - leaving)
26.06.17	Tuesday	Trust (Seven)	Agency (Three)	Agency (Four)	Agency (Three)/(Fi	Trust (1 - Remaining)	Agency (Six)
27.06.18	Wednesday	Trust (Seven)	Agency (Five)	Agency (Four)	Agency (Three)/(Fi	Trust (1 - Remaining)	Agency (Six)
28.06.18	Thursday	Agency (Three)		Agency (Four)	Agency (Five)	Trust (3 - Agency 7 From	Agency (Six)
29.06.18	Friday	Agency (Five)		Agency (Four)	Agency (Three)	Trust (3 - Agency 7 From	Trust (1 - Remaining)
30.06.18	Saturday	Trust (Seven) Locum pay					Trust (1 - Remaining)

July 18

Date	Day	09:00 to 17:00	17:00 to 21:00	SCBU (9-5.pm)	Ward/A&E 9-5	Clinic	Night
01.07.18	Sunday	Trust (Seven) L					TRUST (1 - Remaining)
02.07.18	Monday	Agency (Six)	Agency (Three)	Agency (Five)	Agency (Four)	No Cover	TRUST (1 - Remaining)
03.07.18	Tuesday	Agency (Six)	Agency (Four)	Agency (Five)	Agency (Four)	No Cover	Trust (3 - Agency 7 From 9/7/18)
04.07.18	Wednesday	Agency (Six)	Agency (Three)	Agency (Five)	Agency (Four)	No Cover	Trust (3 - Agency 7 From 9/7/18)
05.07.18	Thursday	Agency (Three)	Agency (Four)	Agency (Five)	Agency (Four)	No Cover	Trust (3 - Agency 7 From 9/7/18)
06.07.18	Friday	Agency (Three)	Agency (Five)	Agency (Five)	Agency (Four)	No Cover	Agency (Six)
07.07.18	Saturday	Trust 4 - Leaving					Agency (Six)
08.07.18	Sunday	Trust 4 - Leaving					Agency (Six)
09.07.18	Monday	Agency (Three)	Agency (Four)	Agency (Seven)	Agency (Five)/(Fou	Trust (1 - Remaining)	Agency (Six)
10.07.18	Tuesday	Agency (Three)	Agency (Five)	Agency (Seven)	Agency (Five)	Trust (1 - Remaining)	Trust 4 - Leaving
11.07.18	Wednesday	Agency (Three)	Agency (Four)	Agency (Seven)	Agency (Five)	Trust (1 - Remaining)	trust 4 - Leaving
12.07.18	Thursday	Agency (Three)	Agency (Five)	Agency (Six)	Agency (Five)	Trust (1 - Remaining)	Trust 4 - Leaving
13.07.18	Friday	Agency (Three)		Agency (Six)	Agency (Five)/(Fou	Trust (1 - Remaining)	Agency (Seven)
14.07.18	Saturday	Agency (Three)					Agency (Seven)
15.07.18	Sunday	Agency (Three)					Agency (Seven)
16.07.18	Monday	Agency (Four)	Agency (Five)	Agency (Six)	Agency (Five)	No Cover	Agency (Seven)
17.07.18	Tuesday	Agency (Four)		Agency (Six)	No Cover	No Cover	Agency (Three)
18.07.18	Wednesday	Agency (Four)	Agency (Five)	Agency (Six)	Agency (Five)	No Cover	Agency (Three)
19.07.18	Thursday	Agency (Four)		Agency (Six)	Agency (Seven)	Trust (1 - Remaining)	Agency (Three)
20.07.18	Friday	Agency (Four)		Agency Khlaifa	Agency (Five)/(Se	Trust (1 - Remaining)	trust 4 - Leaving
21.07.18	Saturday	Agency (Four)					Trust 4 - Leaving
22.07.18	Sunday	Agency (Four)					trust 4 - Leaving
23.07.18	Monday	Agency (Five)		Agency Khlaifa	Agency (Seven)/(I	Trust (1 - Remaining)	trust 4 - Leaving
24.07.18	Tuesday	Agency (Five)		Agency (Six)	Agency (Seven)/(I	Trust (1 - Remaining)	Agency (Four)
25.07.18	Wednesday	Agency (Five)	Agency (Three)	Agency (Six)	Agency (Seven)/(I	Trust (1 - Remaining)	Agency (Four)
26.07.18	Thursday	Agency (Five)		Agency (Six)	Agency (Seven)	Trust (1 - Remaining)	Agency (Four)
27.07.18	Friday	Agency (Five)		Agency (Six)	Agency (Seven)	Trust (1 - Remaining)	Agency (Three)
28.07.18	Saturday	Agency (Five)					Agency (Three)
29.07.18	Sunday	Agency (Five)					Agency (Three)
30.07.18	Monday	Agency (Four)	Agency (Seven)	Agency (Seven)	Agency (Six)	Trust (1 - Remaining)	Agency (Three)
31.07.18	Tuesday	Agency (Four)	Agency (Six)	Agency (Seven)	Agency (Six)	No Cover	Agency (Five)

Therefore, as a consequence of the inability to staff medical rotas with substantive staff, a significant point has been reached where the level of associated risk cannot be mitigated any longer. Further action is required to ameliorate the unacceptable risks to the Women & Children's services at Pilgrim Hospital; this includes services that are inter-dependent with Paediatric services e.g. Maternity, Neonatology and Emergency services.

Nurse staffing (PHB site)

The service has part mitigated some risk by over–recruiting the non-registered workforce and administrative workforce and the employment of adult nurses who complete a competency package of professional development. The key mitigation has been the capping of paediatric inpatient beds at Pilgrim Hospital from 19, to 14, to 12, to 8 and back up to 12 following the recommendations from the CQC in relation to paediatric children's nursing in the emergency department. Nursing colleagues have approached framework and off framework agencies to secure sufficient nurses with the correct skills. This has secured 2 agency nurses to date.

Each Paediatric inpatient ward must have two RNCs on duty at all times to provide a safe service and in line with the national standards. The service is finding it increasingly difficult to fill the rota with the substantive staff and uses significant amounts of additional, bank and overtime hours to maintain the rota. The service is often in the position where there are only two RNCs on a night shift. There is significant risk that when last minute sickness occurs and there are not two RNCs available on duty. The service has managed these occasions with current staff agreeing at short notice to the changing of their shifts to make the service safe. There has now been the necessity for the Lincoln County Hospital RNC staff at short notice (12 hrs) to provide emergency cover for the children's ward at PHB. This is not a medium or long term solution and it is having an impact on the health and well- being of the staff.

- There is an inability to currently meet the minimum RCN standards for RN (Child) staffing.
- The service has not been successful in recruiting to the PHB site
- The service has relied upon block booking Agency RN (Child) staff
- The service has recruited Adult nurses in order to mitigate some of the risk
- The service as relied upon Children's Community Nursing support
- Quality standard recommendations not adhered too

4 Our Response to the Deteriorating Position

The deteriorating staffing position within the C&YP services at ULHT has been carefully monitored over the last few years with a risk assessment on the risk register since 2008, and there have been times for concern on a number of occasions and these have been escalated, with both internal and external risk summits taking place to address the concerns. A timeline of the Staffing Escalation Timeline can be evidenced in **Appendix One.**

4.1 What mitigation actions have we already taken?

Over the previous timeframe, the service has managed to safely staff the Paediatric departments by asking our consultants to work extra shifts, to cover the gaps in the middle grade doctor rota, together with securing as many agency doctors as possible. We have employed long term agency nurses since September 2017, and we have capped the number of paediatric beds at both Lincoln County and at Pilgrim Hospital sites according to the number of nurses available to safely staff the Paediatric inpatient wards. During this period, we have been developing plans to mitigate the issue in the short, medium and longer term as per the STP and to align with the commissioning intent.

4.1.1 Utilising our current workforce

- An agreement with the consultant workforce to undertake additional shifts and to act down into middle grade slots with enhanced pay on an "as required" bases
- Stretched shifts of existing staff to cover vacant shifts resulting in fewer clinicians on the shop floor
- Our nursing staff has absorbed additional hours, bank and overtime.

4.1.2 Recruitment activities

Overview
A number of mid-grade doctors have left the Paediatrics team within Pilgrim, Boston since the beginning of the year with two further due to leave in May/June.

- 8 mid-grade doctors were on the rota in March 2018.
- The rota consists of 6 Speciality Doctors and 2 Registrars (1 of which is long term sick).
- From the 1st August 2018 the rota will consist of 1 Speciality Doctor and 1 Registrar (long term sick). The service has recruited long term Agency locum staff.

A number of recruitment initiatives have been applied to meet the gap:

- Roles advertised through NHS Jobs
- Direct approach to agencies via trusts recruitment specialist
- ULHT independently assessing the English Language skills and supporting candidates through the GMC registration via a two week attachment to the service and a formal assessment of

the candidates English language skills via the process; SELF (Structured English Language Reference Forms. X6 candidates have been assessed
- Business Unit approach to the International Medical recruitment agency known as BDI Resourcing direct, (6 CVs acquired)
- Non PSL (Preferred Supplier list) agencies (quoting 25k rate per appointment)
- MTI (Medical training Initiative) scheme.
- HOLT for a short/medium term solution (requested by the Clinical Directorate until end of October 2018).

There are a number of evident recruitment difficulties, one being around the lead time for the COS (Certificate of Sponsorship)/Visa process. The Trust is currently only obtaining visas for approximately 30% of those doctor's whom the Trust has provided a COS. The Trust understands that Paediatrician posts are likely to be successful with Visa applications

6 international candidates were assessed via the SELF route, between November 17 and January 18, however the GMC did not initially accept the evidence and by February none of the six candidates had been accepted onto the GMC register. Other specialities in the Trust had similar issues with this process and as such the SELF route was halted in February 2018 until the service understood the reasons for the GMC's refusal to accept the SELF evidence provided by ULHT.

There are significant delays and difficulties in international recruitment in terms of obtaining GMC registration for the international recruits who have been assessed and signed off as competent in English language. Once signed off there are further delays in obtaining immigration visas.

There are currently two adverts for middle grade doctors, one for each site, on a rolling basis on the NHS Jobs website.

ULHT process for International Recruitment & Language Assessment

The Women's & Children's Clinical Directorate has supported the C&YP speciality in conjunction with the Trust to embark on an international recruitment process and assessment of the English Language and includes the following actions:

1) 2 week clinical attachment to the Children's Speciality (with 2 year offer letter if successful)
2) Language / Clinical competency assessment
3) Sponsorship by the Trusts Executive Medical Director (to GMC re: Language competence)
4) Support and evidence facilitated by the speciality to enable the relevant medical staff to apply to register with the GMC
5) With successful registration on the GMC register achieved the member of staff initially commences in post at tier 1 level to ensure that a robust orientation and induction into the English Health Care System is facilitated and achieved
6) When assessed as compliant the medical staff move from the Tier 1 to the Tier 2 rota (middle grade), previous experience of this process has seen that the individual achieves the necessary competencies within 3-6 months.

The Clinical Directorate can evidence, as seen below their attempts at International recruitment

Via the SELF Route
- 14 Candidates interviewed via skype (2 were rejected)
- 12 conditional offers sent (Conditional upon attending ULHT for a two week attachment, completing the SELR assessment and subsequent registration with the GMC.

- 6 attended for the two-week attachment/SELR assessment (From Nov 17 to Jan 18)
- The next 6 were not progressed by the Trust following delays and issues with the process as described earlier.
- 6 were assessed as competent in the SELR process and supported in their application with the GMC of these 6 candidates:
    - One candidate decided not to proceed with the process/job offer
    - One candidate have not had the SELR evidence accepted by the GMC
    - Four candidates have now been accepted onto the GMC register and have now had a CoS for their necessary work visa for the UK/ULHT. The Trusts anticipates that the visa's will be applied for at the next round on the 11th May
        - One candidate has experience to work at Tier 1
        - Two candidates have experience to work at Tier 2 following a 3 -6 month orientation period at Tier 1.

Via Other international Recruitment of GMC registered doctors

- 17 doctors CVs submitted
- The directorate interviewed all suitable Drs , usually interviewing within 48 hours on the following dates:
    - 29.10.17
    - 14.12.17
    - 18.12.17
    - 21.12.18
    - 12.01.18
    - 21.01.18
    - 23.02.18
    - 16.03.18

- 7 Drs have been offered employment, to date none have accepted

- As above if appointed these Dr's may be suitable to work at Tier 2 following a 3-6 month orientation period at tier 1

- This is an on-going process and 12 further CVs have been reviewed in April, none of the applicants have a current work visa and not all are GMC registered.

- The service is anticipating offering a one week attachment to suitable candidates who are GMC registered in order to provide further assessment of clinical skills. The service has previous recent experience of recruiting two international Drs who were highly qualified and held senior positions in their previous country, however were not able to demonstrate their competence to PHB clinicians locally to work unsupervised at Tier 1 and Tier 2 levels.

4.1.3 Other Agency Recruitment

The speciality has used the Trust's recruitment specialist to identify other GMC registered candidates. The Speciality has interviewed all doctors that were suitable across 8 dates from 29.10.17 to the most recent 16.03.2018.

Resulting from these interviews there are 7 offers in progress with the recruitment team. None have been accepted to date. If any do accept there would be a 4-6 month process for them to start due to Visa requirements, followed by a period of induction and orientation to the NHS / ULHT whilst on

the Tier 1 rota for 3-6 months. Therefore if any accept our offers it is likely to be 7-12 months before any additional staff would join the Tier 2 rota.

4.1.4 Agency Recruitment

All posts are regularly out to be filled through Holt who manages our agency needs. These posts are also being progressed by all off framework agencies including those that offer resources above the "financial cap" and which are subject to the additional cost of 20% VAT.

4.1.5 Use of Agency staff

Over the last months we have managed to safely staff our Paediatric department service by asking our consultants to work extra shifts, to cover the gaps in the middle grade doctor rota, and securing as many agency doctors as possible. This is not a long term solution, the service were able to safely staff the departments whilst undertaking –other short, medium and long term actions to improve patient flow and ensure that the service was a productive and efficient as possible, including ongoing recruitment activities.

Unfortunately the sheer number of shifts that now require filling via agency staff means that the fill rate has dropped. Despite the commitment from our consultant team and ongoing recruitment drive, we have identified that we are now not able to consistently staff our Paediatric and Nursing rotas at the Pilgrim Hospital. The pressure of Consultants covering extra Middle Grade shifts is now starting to take its toll on the consultant's health and well- being, and this is no longer a sustainable option for covering the gaps in the middle grade rotas.

4.1.6 Use of Community Paediatric Doctors

We have also explored the option of asking the Community Paediatric Doctors to come onto the acute hospital rota; however, this is not a safe option. All of the Community Paediatric Doctors have been working outside of the Acute Hospital for a number of years, the shortest time being away from the acute hospital is three years, and many of the other Community Paediatric Doctors have been away much longer than this.

Working as a Community Paediatrician is very different to working in an acute hospital Children's department, where often the essence is on emergency care, higher acuity of the patient, and children deteriorating quickly. We have asked the Community Paediatric Doctors if they would consider taking a refresher course to enable them to support the acute hospital rota at Pilgrim Hospital, but they do not feel confident about doing this after being away from the acute hospital service, they do not feel it would be safe for the children in the hospital.

In order to facilitate this, the Community Paediatrician would require a refresher course plus would require further training and qualifications in neonatal life support. It is estimated that this would take six months. This would be six months loss of elective activity and would require the trust to stop accepting all new Community paediatric referrals.

However, one of the longer term future options will be exploring the development of combined Community and Acute Hospital Paediatric Doctor roles, where our doctors will work across both the acute hospital and community setting in order to maintain their competencies to look after the sick child both in and out of the hospital.

4.2 Escalation meetings (internal and external)

There have been a number of engagement and risk summits addressing the same issues identified in this paper. The details of these are contained within **Appendix One.** Most recently, the following escalation meetings have taken place, with the outcome shown against each as follows;

W&C Directorate Internal PHB Paediatric Escalation Meeting 21 March 2018

- The outcome of this meeting was that:
    - The paediatric service could not provide assurance that the medical middle grade rotas can provide the required medical cover due to the significant gaps April 2018 onwards
    - The compliance within the medical rota will deteriorate further from July 2018
    - The paediatric service could no longer provide RN (Child) cover to support ED due to the wte workforce available of RN Child
    - The paediatric service could only maintain 8 inpatient Beds (possibly +2 assessment beds) if the RN Child did not have to support the ED on the PHB site
- It was unanimously agreed by the whole multi-professional team that it is not possible in the medium term to provide paediatric in patient services and unanimously recommended the co-location of services in a planned organised way, with a robust plan including a detailed quality impact assessment within the next three months.
- The paediatricians will support Neonatology, Maternity and ED in the short term, providing that the LCH consultants participate in this support by way of joining a combined rota.
- In the medium term, (1 to 3 months) the service will not be able to support the Neonatal and Maternity services and these should therefore also be co-located

ULHT Trust Internal Escalation Meeting with Chief Operating Officer, 26 March 2018 – Outcomes in relation to the Children's services at Pilgrim Hospital

- The Children's service is no longer able to support ED with a RN (Child)
- The Children's service is not able to recommence elective surgery on the PHB site
- The Children's service is committed to provide a medical rota for the Month of April 2018.
    - Current middle grade staff working additional shifts
    - Agency Consultant willing to work as resident
    - Substantive consultants willing to act down at middle grade at short notice
    - Requesting current LCH middle grade staff to cover some shifts

  It was agreed that this is not sustainable and further deteriorates their well being
- From 1st May the paediatric team will not be able to support paediatric inpatients
- From 1st May for a period of two months the paediatric team will support neonatology and the maternity service
- To explore different service models with particular reference to Shrewsbury

External risk summit held on 10th April 2018 – outcomes in relation to the deteriorating staffing position at Pilgrim Hospital

- Representatives from; NHSE, NHSI, Nottingham University Hospitals NHST Trust, North Lincolnshire & Goole NHS Trust, Queen Elizabeth Hospital Trust, Kings Lynne, Lincolnshire Clinical Commissioning Groups, East Midlands Children's and Neonatal Network, Lincolnshire Community Health Service
- Consensus in the room from other providers of Children's services was that ULHT is unable to sustain inpatient Children's services on two sites.
- Options for mitigating the current immediate staffing crisis need to be developed further and a follow up meeting arranged to discuss the options further

4.3 Actions agreed as a result of the escalation meetings detailed in section 4.2

For April 2018

- The PHB paediatric service will endeavour to maintain 8 In Patient beds and will open two additional assessment beds to support ED patient flow
- To maintain a middle grade rota
- To develop hot clinics (emergency appointment slots) to support local GP's
- Develop Standard Operating Procedure including dynamic risk assessment process for balancing risk between the need for RN Child in ED versus the children's ward.
- Development of a Quality Impact Assessment
- The whole workforce will need consulting regarding the development of temporary service models involving participation from all consultants

Actions: Surgery Service in conjunction with W&C CD

- To review children currently on the waiting list and risk asses the delays to listing the patients
- To offer patients alternative sites or alternative providers.
- To look at options for providing surgery for ophthalmology and general surgery (Service where there is currently no children's surgeon who operates on the Lincoln site)

Actions: ED Service

- Review compliance against section 31 notice

4.4 Summary

In summary ULHT has staffing to safely staff the following number of Children's inpatient beds from a nursing perspective:

19 inpatient children's beds at Lincoln Hospital and the Safari assessment unit
12 inpatient children at Pilgrim Hospital

However, from a medical staffing perspective, we have struggled to cover the rota for April at Pilgrim Hospital, from May to July the service has filled the medical rota, but this is with heavy reliance of Agency locum staff. From August 2018 the trust will only have 1 x substantive MG in post. This very high degree of Agency locum usage would result in PHB paediatrics being a significant outlier nationally. This position is not supported by the paediatric consultant body.

The Clinical Directorate and the C&YP multi-disciplinary team believe that a comprehensive C&YP services at Pilgrim Hospital can no longer be supported in its entirety. The reasons for this are;

- Inability to provide assurance that nursing rotas can be prospectively filled
- Inability to provide assurance of the quality and reliability of MG Agency staff
- Further mitigations are being explored with support from NHS Improvement and paediatric consultants.
- Further deterioration of staffing numbers expected at Middle grade level without a known pipeline of replacements in the next 6 months
- Inability to recruit to the Royal College of Nursing and Medical posts currently vacant at Pilgrim Hospital

This deteriorating position is causing concerns on the provision of safe patient care for the existing consultants, middle grade doctors and registered children's nurses. Furthermore, the supervision of trainees and Trust doctors delivering care is becoming increasingly more difficult to provide.
As a result of the recent deterioration in staffing across our Children's Departments, the following issues are now exacerbated;

- Inability to provide compliant nursing rotas at Pilgrim Hospital
- Inability to provide medical rota's without the very high usage of Agency Locum staff
- Inability to provide assurance of the quality, safety and reliability of the Agency locum Staff
- Poor patient satisfaction and experience
- The ability to meet national standards of care
- Difficulty retaining and recruiting Paediatric staff
- Cancellation of elective paediatric surgery
- Longer waiting times in the ED departments for Paediatric patients while beds are located at out of county providers or at Lincoln
- Deterioration in the health and well-being of staff
- Poor experience for doctors and other clinicians in training
- Risk of trainees being removed from the department, thereby exacerbating the risks
- Cost arising from high staff turnover, locums, and performance failure
- Inability to innovate, develop practice, or invest time in basic departmental management and quality improvement

The service has not been able to pursue delivery of the RCPCH facing the future standards until an outcome of the Sustainability and Transformation Plan (STP) and Acute Service Review (ASR) is agreed.

4.5 Immediate Risk Mitigation Proposal

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.

Proposed Children's services short term plan (April 2018 to 31 July 2018)

- Maintain current service to
  - Maternity
  - Neonatology
  - Paediatric ward (12 Beds)
  - Paediatrician support to ED
  - Establishment of multi-professional project team

5 Options beyond July 31st 2018 for consideration

The PHB Paediatric consultants have raised a significant concern about both patient and staff safety, and both clinical and management teams have been concerned about the continued challenges in staffing medical and nursing rota's for a number of years. The previous section 4 has identified an immediate risk mitigation proposal for the period from 4th June 2018 to July 31st 2018, but now we need to consider options for service delivery from 1 August onwards, when once again the staffing situation will deteriorate even further. The options for addressing the immediate crisis position are as follows:

Option One	• Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover paediatric service • Work to mitigate the risk is ongoing (Appendix 6) 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.
Option Two	• Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 31 July 2018 (negotiation/agreement will be needed to go beyond this date as a short term option) • 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 • Paediatric Service to maintain the neonatal and Consultant led maternity service Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks
Option Three	• Temporary closure of Paediatric inpatient services at Pilgrim with effect from 31 July 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 • From August 31st Temporary closure of Consultant led Obstetrics and Neonatology at Pilgrim until the staffing gaps could be addressed • 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	• 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 new routine Paediatric outpatient appointments
Option Five*	With effect from July 31st, 2018, providers across the region to provide Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology.

*****The external risk summit held on 10th April 2018 discounted option five. Whilst our colleagues in the neighbouring organisations were keen to support the ULHT Children's services, they confirmed that they do not have the capacity, and some are facing similar challenges to us.

The following sections are going to provide more detail about options one to four inclusive listed above.

The information provided in sections 5.1, 5.2, 5.3 and 5.4 is based on the following:

- Income includes all specialities for children, not only the general children's activity
- Obstetric data for the midwifery led unit, and repatriation was taken from STP documents and activity movement calculations used in the STP
- All repatriation numbers are based on nearest hospital to the patient adjusted by 5 mins (GEM data)
- Current repatriation data is available for Gynaecology and Obstetrics – we are still waiting on specific Paediatric data

Please refer to the following appendices for more information on each option:-

- Appendix One – Staffing Escalation Timeline
- Appendix Two – Quality Impact Assessment Trust Wide
- Appendix Three – Quality Impact Assessment Per Options – draft multiple clinical review of QIA undertaken, but requires further refinement, to be completed in time for the Clinical Senate Meeting
- Appendix Four – Equality Impact Assessment
- Appendix Five – Activity Data Per Options
- Appendix Six – Recommended Mitigation Plan Per Option

5.1 Option One

Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover C&YP , maternity & neonatal services
(The ULHT Paediatric consultant Body & NHSI have significant concerns about the safety of this option due to the unknown quality and reliability of short term locums and that no other unit operates with such a high % of locums do not support a rota of middle grade doctors populated with 1.0 substantive recruit and the remainder consisting of Agency Locum middle grade doctors without further mitigation).

Disruption to patient activity
There would be no disruption to patients however there is a risk of running a rota with a 1.0 wte substantive middle grade doctor, and agency locum doctors, and this risk is high from a patient safety perspective.

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.

The financial impact is as follows;

- Additional cost pressure due to locum doctor premium rates =
  - May & June 2018 = £115,287
  - Full year effect = £498,740

Impact on Staff

There is a risk on the Consultants in post at Pilgrim to assure safety of medical care from a team of doctors that they do not know and are not familiar working with and addition supervision and support is needed from the Consultant body to the agency locum workforce. This risk is magnified by the higher number of agency locums in place so therefore in this instance with Agency locums and 1 middle grade, the risk would be deemed as very high.

5.2 Option Two

- *Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 1st August 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*

Disruption to patient activity

The majority of Children attending the ED department at Pilgrim are described as "walk in" patients, with a smaller number being brought to the ED department by ambulance.

In this option, c.88% of children currently attending the Pilgrim ED department will continue to present to the department via the "walk in" route. 2-3 (c.12%) children currently attending the department via Ambulance will need to be displaced to another ED department. The number of children who attend could be reduced if supported by an urgent care pathway model via the urgent care centres and extended GP hours of opening.

There are currently on average 22 children that present to the Pilgrim ED department each day (8,030 per annum), from which 4.3 (1.570 per annum), 19.5% of ED attendances are admitted on average per day. In addition, there are on average 3 children admitted per day, (1,095 per annum) following urgent referral from the GP, making on average 7.3 children per day being admitted at the current time. The average length of stay for a non-elective admission is 1.4 days.

Under option 2, the children who are referred to Pilgrim by their GP would be diverted to an alternative provider, and the children who are brought to ED by the ambulance service would be directed to an alternative ED centre. This would reduce the attendances to ED conveyed by ambulance by 2.69 on average per day, and the number of GP urgent referrals by 3 per day. This in turn would reduce the number of admissions by a total of 5.69 on average per day, resulting in the remaining 1.61 children per day requiring admission being transferred to Lincoln Hospital.

Ambulance Transfer

In option 2, the likely average 1.61 children requiring transfer from Pilgrim Hospital to an inpatient bed at the Lincoln Hospital would be transported by ambulance where required.

Additional Children's bed capacity required at Lincoln County Hospital
In option 2 & 3, the Lincoln County Hospital inpatient children's ward will require an additional 2 beds to accommodate the children transferring from Pilgrim Hospital to the Lincoln County Hospital for admission; these are currently available on the ward.

The Financial Impact – currently being modelled following consultation with NHSI and the consultant body

Estates Impact - no perceived impact

Children's outpatient activity at Pilgrim would continue in this option

Impact on Staff

In option 2, the impact on staff is displacement of some staff from the Pilgrim site to the Lincoln site on a temporary basis. Staff will need to be retained on the Pilgrim site to support the outpatient clinics and the emergency department, but this will not require all staff currently working at Pilgrim, and therefore some will need to transfer from Pilgrim to Lincoln to work

This option is not supported by the Consultant body, except for a very short time period to facilitate the implementation of Option 3

5.3 Option Three

- *Temporary closure of Paediatric inpatient services at Pilgrim with effect from 31st August 2018 (negotiation/agreement will be needed to go beyond the 1st August 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 31st when medical staffing reduces beyond the ability to support Neonatology. From August 1st Temporary closure of Consultant led Obstetrics and Neonatology at Pilgrim until the staffing gaps could be addressed*
- *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.*

Disruption to patient activity

The majority of C&YP attending the ED department at Pilgrim are described as "walk in" patients, with a smaller number being brought to the ED department by ambulance.

In this option, c.88% of children currently attending the Pilgrim ED department will continue to present to the department via the "walk in" route. 2-3 (c.12%) children currently attending the department via Ambulance will need to be displaced to another ED department. The number of children who attend could be reduced if supported by an urgent care pathway model via the urgent care centres and extended GP hours of opening.

There are currently on average 22 children that present to the Pilgrim ED department each day (8,030 per annum), from which 4.3 (1.570 per annum), 19.5% of ED attendances are admitted on average per day. In addition, there are on average 3 children admitted per day, (1,095 per annum) following urgent referral from the GP, making on average 7.3 children per day being admitted at the current time. The average length of stay for a non-elective admission is 1.4 days.

Under option 3, the children who are referred to Pilgrim by their GP would be diverted to an alternative provider, and the children who are brought to ED by the ambulance service would be directed to an alternative ED centre. This would reduce the attendances to ED conveyed by ambulance by 2.69 on average per day, and the number of GP urgent referrals by 3 per day. This in turn would reduce the number of admissions by a total of 5.69 on average per day, resulting in the remaining 1.61 children per day requiring admission being transferred to Lincoln Hospital.

Ambulance Transfer
In option 3, the likely average 1.61 children requiring transfer from Pilgrim Hospital to an inpatient bed at the Lincoln Hospital would be transported by ambulance where required.

Additional Children's bed capacity required at Lincoln County Hospital
In option 3, the Lincoln County Hospital inpatient children's ward will require an additional 2 beds to accommodate the children transferring from Pilgrim Hospital to the Lincoln County Hospital for admission; these are currently available on the ward.

Impact on Maternity and Neonatal activity
In option 3 the impact on Maternity and Neonatal activity at Pilgrim is such that:

- Approximately 1,000 women would go out of county to give birth at a hospital closer than Lincoln County
- 28.75% (650 per annum) of births currently taking place at Pilgrim Hospital would transfer to Lincoln Hospital, and
- 11.25% (73 per annum) of these births would result in the baby being admitted to the Neonatal service at Lincoln Hospital.
- Around 300 women would deliver their baby in a midwifery led unit at Pilgrim Hospital

Children's outpatient activity at Pilgrim would continue in this option

The Financial Impact - currently being re-modelled following consultation with NHSI and the consultant body

Estates Plan – Full estates plan has been developed with a start date of June 18 and a completion date of end of August 18 if approved at a cost of £750K – Please see Appendix 7

Impact on staff

In option 3, the impact on staff is displacement of some staff from the Pilgrim site to the Lincoln site on a temporary basis. Staff will need to be retained on the Pilgrim site to support the outpatient clinics and the emergency department, but this will not require all staff currently working at Pilgrim.

5.4 Option Four

- *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 routine new general Paediatric outpatient appointments*

  Disruption to patient activity

  In option 4, all elective (planned) inpatient and day case activity would temporarily cease at both Lincoln and Pilgrim hospital sites. Outpatient clinic activity would also cease at both sites. The impact of this is as follows:

  - Day case procedures; May to July 158 children would not have their procedure, full year affect is 630 children
  - Elective inpatient procedures; May to July 44 children would not have their procedure, full year affect is 178 children
  - Outpatient activity: May to July approximately 2,700 children would not have their first outpatient appointment, full year affect = 10,500 children
  - Outpatient activity: May to July approximately 2,600 children would not have their follow up outpatient appointment, full year affect = 10,300 children

  Option 4 would result in a significant increase in waiting times for children to see a Paediatrician and to have a procedure.

  The Financial Impact – currently being modelled following consultation with NHSI and the consultant body

  Estates Impact - no perceived impact

  Impact on Staff

  The impact on staff in option 4 is similar to that of option 1. There is a risk on the Consultants in post at Pilgrim to assure safety of medical care from a team of doctors that they do not know and are not familiar working with and addition supervision and support is needed from the Consultant body to the agency locum workforce. This risk is magnified by the higher number of agency locums in place so therefore in this instance with 7 locums and 1 middle grade, the risk would be deemed as very high. However, in option 4, the risk is less high than in option 1 because in option 4, the outpatient and elective activity at Pilgrim Hospital would cease, and therefore, the agency locums would have less to do.

  This option is not supported by the ULHT consultant body / NHSi. The consultant time that would be released would be minimal (PHB 4 PA's per week, LCH 8 PA's per week). The loss of General OP appointments would lead to an increase in ward attendances. It is highly likely that retaining existing and recruiting new consultants would be difficult.

6. Quality Impact Assessment of the options

A quality impact assessment has been undertaken to understand the impact of each option. The quality impact assessment is attached as **Appendix Two.**

7. Equality Impact Assessment

An Equality Impact Assessment can be found in **Appendix Four.** This assessment will require more work over the coming weeks, and will require an action plan to mitigate the risks that have been identified.

8. Next Steps

8.1 Governance Process

The Trust has established a formal governance structure for the further work to be undertaken to ensure that our C&YP's Services are delivered in a safe and sustainable manner. A C&YP Task & Finish Group have been established.

The Task & Finish Group have a membership representation from ULHT and major external stakeholders including the local clinical commissioning groups, Lincolnshire Community Health Services, NHSE and NHSI.

The Task & Finish Group have been working to develop each option that has been identified as possible mitigation for the risks to make an informed recommendation on the best option.

The East Midlands Clinical Senate will undertake a review of workforce shortage and the impact on C&YP Services in the Trust and the wider health community in Late May/early June 2018. It is hoped that the Senate report will be available for the Trust Board meeting on 29 June 2018.

The Royal College of Paediatric Child Health is also undertaking a review of the C&YP Services and this is taking place in June 2018.

When the option has been agreed at Trust Board the Task & Finish Group will be responsible for implementation and oversight will be through the Clinical Management Board (CMB)

9 Requests to the Trust Board

The Trust Board is asked to consider carefully the risks raised in this paper relating to the medical challenges that will be heightened further over the coming months.

The Trust Board is asked to consider each option that has been discussed in this paper for mitigating the immediate risks relating to the staffing crisis, and to offer their recommendations for which option(s) they consider would best mitigate the risk to the

service and the wider health community on a temporary basis until a longer term strategic solution can be agreed and delivered.

The Trust Board are asked to consider recommending Option 1 as the preferred option with a full work up, including an implementation, plan for Option 3 as mitigation in the event of a failure of Option 1.

These will then be developed further by the task and finish group and presented to the Trust Board at the meeting on the 29th June 2018.