United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Dr Neill Hepburn
Date:	26th October 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 is to provide an update regarding the interim Paediatric service model in place at the Pilgrim hospital and also the continuing work to address the significant challenges faced by the Children & Young Peoples Services (C&YP), which also have clinical interdependencies within Neonatal and Maternity Services at United Lincolnshire Hospitals NHS Trust (ULHT).

The interim service model described in previous Trust Board papers is in place and remains operational. The medical Trust wide rota continues to operate the interim model at Pilgrim.

In addition, the paper provides an update on the contigency options available , as well as recommendations for the immediate mitigation of the imminent risks to the current C&YP services associated with the interim service model until a longer term strategic direction can be confirmed.

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

The Report is provided to the Board for:

Information	X	Assurance	X

United Lincolnshire Hospitals NHS Trust

Summary/Key Points:

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

- The interim service model described at previous Trust Board remains in place and is operational.

- As in previous months the workforce remains heavily dependent on locum and agency doctors to provide weekend and shifts. There is now one substantive middle grade doctor and six agency locum middle grade doctors within the current rota.

- National and international recruitment continues by the Women's & Children's Clinical Directorate (W&CCD). The Consultant paediatric medical team remain, as in previous months, concerned about the safety of a potential middle grade medical rota consisting almost entirely of locum / agency doctors.

- During the first ten weeks of operation of the new service model, 6th August – 12th October 2018, 601 patients have been seen in the paediatric assessment unit with 82 patients transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

- The gestational age for delivery at Pilgrim Hospital has been increased from 30 to 34 weeks; however as at 12th October only 6 transfers had taken place due to the increase in gestational age alone. Other transfers occurred but they did not cover the gestation age of 30 34 weeks.

- The dedicated transport provision has been reduced and the contract extended until 31st December 2018. Under the extended contract, there is 1 x ambulance on each 12hr shift and an additional ambulance on a 12hr shift from noon to midnight to assist with potential peaks in demand. As reported last month, this reduction in ambulances was decided upon following analysis of the first six weeks data, which showed there were no instances where two ambulances were needed at the same time. The provider is, however able to increase this number of ambulances at short notice, should it become required during any unpredicted demand. The ambulance resource continues to provide the ultra-safe provision for patients, whereby transfers required can be completed in the shortest possible timeframe.

- Transport needs for level 1 patients. A further meeting was held on the !6th October to review provision. It was agreed that a blended solution should be developed that would include the following:

    - An option appraisal based on a mapping exercise to be held on 18th October 2018

    - Agree review and update our SOPs and guidelines based on SOPs we have received from NUH. Comet have agreed to provide details of training and the required skill set for our nursing staff that they require to become compliant

- Relevant equipment required to support high flow patient transfers will be identified and procured.

- The contingency plan has now been written encompassing the changes in the estates building work, required as a result of the fire plan and asbestos removal work. The original build and subsequent contingency plan has been altered to reflect the changes in build. The contingency plan applies in the event that the current interim, model fails, focusing on the possible centralisation of some services to Lincoln.

- Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group. A summary of the risk register is included in the body of the report and a copy of the register is included in appendix 1

- Incidents continue to be tracked through Datix. 114 x IR1 reports have been submitted and relate largely to length of stay exceeding 12 hrs. 2 x IR1 for low harm have been reported this month. The Task and Finish group reviews all Datix reports and escalates any issues, identifies any changes to operating procedures and provides assurance and governance to the Directorate in this regard.

- Stakeholder meetings, chaired by NHS Improvement and involving key stakeholders from the Trust, NHSI, NHSE, CCG, GMC, HEEM, CQC have now ceased as it is considered that there is a high level of assurance that the interim model is safe and operating effectively. Oversight is to be provided via the monthly System Improvement Board (SIB). NHSI convened a meeting on Friday 12th October with the intention of gaining final assurance that the temporary solution is operating safely and remains viable.

- As reported last month, the clinical senate met this and gave an indication that the Sustainability and Transformation Partnership (STP) plan to develop a long-term model for women's and children's services across the county for the future is provisionally accepted. The STP team are currently working will now continue to refine the model and develop proposals for the future plan. Although the plan is now moving ahead, it remains at this time that there is still a lack of a confirmed plan at this time, the concern remains for patients and their families until the detail and timeline of a plan is known.

- The comms plan remains in place with regular stakeholder and staff newsletters, social media messaging, public and staff engagement sessions.

Recommendations:

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

- Trust Board is asked to note that the contingency plan to centralise consultant-led

maternity onto the Lincoln County Hospital site if necessary continues to be developed.

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

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

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REPORT TO TRUST BOARD – 26th October 2018

Background

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

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

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

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

Purpose of the Report

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

Body of report

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

3.1 Mobilisation

The Paediatric Assessment Unit (PAU) commenced on Monday 6 August at 9am. The internal operational group continue to meet on a weekly basis, attended by the Paediatric clinical leadership team, directorate team and internal support functions to update on progress, review and resolve the risks and cross divisional issues.

The formal oversight arrangements have changed to reflect the level of assurance that NHSI now have regarding the operation of the interim model. The stakeholder meetings, chaired by NHS Improvement and involving key stakeholders from the Trust, NHSI, NHSE, CCG, GMC, HEEM, CQC have now ceased as it is considered that there is a high level of assurance that the interim model is safe and operating effectively. It has been formally requested, and agreed that oversight is to be

provided via the monthly System Improvement Board (SIB) from September onwards. A stakeholder meeting was convened by Kathy McLean, Medical Director, NHSI, on 12th October in order to gain a final assurance that the temporary model is in place and operating safely for all patients and staff.

NHSI have arranged for a follow up meeting on 12th October chaired by Dr Kathy McLean, Medical Director. The key focus will be reviewing the progress of the interim model and future long term models.

3.2 Workforce

As in previous months, the recruitment activity continues at pace, the requirement for a full complement of consultants at Pilgrim for Paediatrics has not changed and remains at 8 x whole time equivalents and the service currently has 4 x full time consultants and 2 x agency locums, making a complement of 6 x whole time equivalents.

The middle grade workforce remains heavily dependent on locum and agency doctors to provide weekend and shifts. To assist in the mitigation of this risk, an additional middle grade doctor to support the rota was agreed last month. There is now one substantive middle grade doctor to complement the six agency locum middle grade doctors within the current rota.

The medical staff rota, with named doctors on each shift, is in place and under constant review regarding fill rates as the proportion of locum and agency staff required to sustain the service remains high. The rota remains as in previous months with Tier 1 doctors on a 1:16 and Tier 2 (middle grade) doctors on a on a 1:10 on call.

Recruitment activity is continuous, as reported last month, one doctor started on the 6th August, an additional six doctors are still going through the recruitment process;

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

Dr Kollipara, Head of Service, has written new job descriptions now that the interim model is in place and the requirements are clearer. Discussions to gain consensus with the Consultant body regarding the revised job descriptions are in progress. Once agreed, these adverts will be published.

The junior doctors contractual pay issue reported last month is near completion in terms of resolution and is being managed by directorate HR. The HR team have a comprehensive list of those junior doctors affected and are calculating the number of weekend and overnight shifts that the juniors had not undertaken and the projected loss of earnings until the 1st February. HEEM have offered to match fund the gap in pay. The directorate finance team are working with HR to ensure that the funding is received and payments made to individuals.

3.3 Transport Solution

The original 2 x ambulances on each 12hr shifts has been reduced until 31st December 2018, to 1 x ambulance on each 12hr shifts with an additional ambulance on a 12hr shift from noon to midnight to assist with potential peaks in demand. The reduction in numbers of ambulances has been validated and as there were no instances where two ambulances were needed at the same time over this time period and in line with the volumes being experienced.

The provider has given assurance that, should it become necessary, that additional paramedic led crews and ambulances could be provided at short notice to assist in the management of unpredicted peaks in demand.

3.4 Activity

As reported in previous months, the new service model commenced at 9am on Monday 6 August. Clinical pathways have been developed in line with the interim service provision and will be made available following ratification through the Trust Governance process.

Volumes of patients attending either Pilgrim or Lincoln have been very low since the commencement of the interim service model. During the first nine weeks of operation of the new service model, 6th August – 12th October 2018, 601 patients have been seen in the paediatric assessment unit with 82 patients transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

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

3.5 Risk management

The project risk register has been maintained and updated, a copy of the register is included in appendix 1.

In summary:

- At the commencement of the project, 22 risks have been identified with scores 20 and above,
- Mitigations against these 22 risks were implemented, reducing the number with a score greater than 20 to 3 risks

- Further mitigations to arrive at the best possible score for each risk have been identified which identify a single remaining risk scoring 20 as “risk to reputation if service is not returned to previous model at PHB in 12 months”.

The change in Directorate leadership has been added as a risk to the project risk register, although short term, the experienced General Manager left the business on 21st September, an interim General Manager has been appointed. This risk is partially mitigated through the appointment of the Directorate Managing Director and a new management structure which increases the level of managerial cover within the directorate as a whole and will, going forward, be able to provide the Directorate with clear triumvirate based management processes in the medium term. The dedicated project manager left early, at request of NHSI, on 5th October and a replacement is being sourced.

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

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

3.7 Management of incidents

The Datix system has been configured to include a new mandatory field relating to the new service model. Each incident can be identified readily and managed appropriately. Incidents are being reviewed weekly at the operational task and finish group meeting each Monday.

3.8 Contingency and future capacity plan

The contingency plan is to centralise paediatric services from the Pilgrim site onto the Lincoln County Hospital site if services cannot be maintained at the Pilgrim site.

The extensive reconfiguration and building update managed through estates build programme dictates the timeline for which any contingency area is available for use in extremis.

Over the next six months, there are three, incremental, plans dependent on build.;

1) Immediate capability - At the beginning of October 2018, the following areas will be available should they be required;

- An increased bed capacity on Rainforest ward from 19 to 24 beds,
- Side rooms available on Nettleham ward to use as birthing rooms to accommodate any displacement of birthing rooms at Pilgrim,
- Nettleham ward can accommodate 8 x maternity beds displaced from Pilgrim,

2) Short term capability - During November 2018, the enabling works continue to enable;

- An additional 5 x Neonatal cots from Pilgrim to Neonatal unit at Lincoln (space exists currently for the additional cots),
- 12 x Paediatric beds to be available on 1st Floor Maternity tower block (resulting in the total Paediatric bed base at Lincoln site to be 36 beds)

3) Long term capability - The enabling works will continue from November to May 2019, which will further result in further space being made available;

- Relocate Breast services from 4th floor tower block to refurbished old microbiology block in order to create additional space / potentially create space for a Midwifery led unit,
- Vacated maternity wing on 4th floor, tower block, the space on this floor will be configured with ward facilities, but not designated as additional beds to allow for a fluid designation to be undertaken dependent on the needs of the service at the point when contingency plan needs to be invoked.

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

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

3.9 Health Scrutiny Committee

An update paper will be presented to the November meeting which addresses the points raised by HOSC at the September meeting, namely;

- Additional details around the communications plan and communications processes which included feedback and output from the engagement events.
- The capacity on Rainforest Ward at Lincoln in light of the interim model and transfer activity,
- Wait times at Pilgrim for transferring patients,
- Journey times,
- Feedback on patient experience of those patients transferred,

- Details regarding the length of stay for transferred patients,
- How many children have been put on adult wards and if this number had increased under the interim model.

The Project Director will respond with a paper as requested for the November meeting which will provide details to the specific questions raised at the meeting.

3.10 Communications and Engagement Plan

Communication around the current service model, ongoing engagement activity and addressing any public concerns continues through the execution of the communications and engagement plan.

In addition, engagement activity continues as per the plan. This includes public engagement sessions, regular staff engagement meetings and a planned patient survey .

In addition, engagement continues to be carried out with the general public, including face-to-face discussions with affected and interested groups across the East Coast area, and public engagement in Boston marketplace, schools and children's' centres and in local supermarkets.

The findings of all engagement activity is fed directly into the Directorate team, for consideration as part of continuing monitoring and development of the interim model.

This is also reported back in a 'you said, we did' format in newsletters and at public engagement events, to enable participants to see what is being done with their feedback.

Among the issues raised at the public engagement events include concerns about the advice given by NHS 111 about the availability of services at Pilgrim, the current low levels of activity, a wish to return to a 24/7 full ward at Pilgrim and the difficulties of attracting doctors to work at Pilgrim. The next engagement session is planned for 6th November 2108.

3.11 Project Plan

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

Actions Required

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

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

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

Dr Neill Hepburn
Medical Director

Appendix 1

Project Risk Register

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

Operational																	
7	Risk that standards could deteriorate	7.1	Change in service provision and practice could have a detrimental short term effect on maintaining standards.	3	4	12	Oversight group to monitor compliance with standards and oversee the development and implement of any RAPs	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	2	2	4	Oversight group ceases and management of operation reverts to business as usual.	1	2
8	Communication of Information	8.1	Lack of IT communication integration between sites could impact on patient discussions / decision making.	4	5	20	Safety huddles 3 x daily and communicaton between sites post huddles. Information team to create dashboard and distribute	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	3	3	9	IT integration across all sites is in place and operational	2	2
9	PHB / LCH does not have adequate staffing levels to mobilise the contingency plan	9.1	Nursing staff	2	5	10	Off duty produced until November. Some risk exists in being able to open all beds at Lincoln site due to ability to obtain an increased number of nursing staff - Lincoln site currently have beds closd due to staff sickness / unavailability.	Wednesday, 11 July 2018	Paul Hincliffe / Sue Bennion	2	3	6	Off duty in pace with no gaps and any sickness covered, business as usual stance	1	2
		9.2	CNS	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.3	Health Care Assistant	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.4	Consultants and other grades of medical staff	2	5	10	Recruitment of medical satff at all grades continues.			2	5	10	Full compliment of medical staff is unlikely given national staffing levels and national recruitment issues.	2	3
		9.5	Administrative	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6			
10	Physical Space	10.1	Capacity to accommodate demand resulting from change in service configuration at PHB	2	4	8	Demand and capacity model data being validated	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	3	6	Demand and capaity managed as business as usual	1	2
		10.2	Capacity to accommodate demand resulting from change in service configuration at LCH	2	4	8	Demand and capacity model data being validated, indications that sufficient beds are avaialble at the LCH site to accommodate patients.	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4		1	2
		10.3	There is the risk that 19 beds may not be an adequate number of inpatient beds for sick children requiring treatment / inpatient care	4	4	16	Management of demand by Matron through regular staff huddles and ward round discharge activity.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Proactive bed management and balancing of capacity across the network.	2	3
		10.4	A reduction in staffing levels due to staff sickness or a loss of agency nurses.	4	4	16	1) Capping of beds to below 19 for patient safety. 2) Local children from Lincoln, Pilgrim and Grantham sites being transferred out of county to another hospital to receive care.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	1) Dedicated private transport / transfer team required to facilitate and support transfers to ensure ward staffing is not compromised on either site. 2) Immediate temporary uplift of nurse staffing by increasing agency nurses to open additional beds on Rainforest to 20 - 24 beds. 3) Ongoing recruitment plans in place to increase substantive posts to support a further increase in bed numbers.	2	3
		10.5	There are times when the service is likely to require more than 19 inpatient beds for the population of children in the county.	4	4	16	There are currently insufficient Childrens nurses to staff above 20 beds on the Lincoln site on every shift. Occasional 24 beds but needs close monitoring as would need to flex back down due to staffing levels.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Regular review of all inpatients to identify discharges and facilitate flow by Hot week Consultant, including Fast Track pharmacy for TTO's – supported by Ward Manager, Deputy Matron and Matron.	2	3
11	Patients will have difficulty accessing the LCH service if resident in Boston	11.1	Some patients will have to travel further to LCH	5	2	10	If the child requires a nurse to accompany them on this transfer, this will further impact on nurse staffing levels at the Lincoln and Pilgrim	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4	No further mitigations	1	2
		11.2	Patient Journey to PHB is more difficult due to transport links.	4	4	16	1) Patients and families with low incomes may have to reply on charitable means of transport to get to LCH. 2) Patient choice may indicate preference, due to transport, of patients being referred to neighbouring Trusts.	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	3	3	9	No further mitigations	3	3
12	Recruitment and retention of nursing staff at PHB	12.1	Retention of Nursing staff to continue to work at PHB if service becomes unattractive	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
		12.2	Recruitment of new staff to work at PHB given no inpatient beds.	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
13	Contingency Plan	13.1	Emergency relocation of service enacted under emergency powers.	5	5	25	1) Trust required to enact emergency powers to relocate service in extremis within an extreme timescale 2) Trust to escalate to Department of Health, Regulator, Commissioners, HEEM, GMC, RCP and other key stakeholders.	Monday, 9 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	5	5	25	Short term change to provision of service to ensure safe service for patients in place and operating.	3	3
		13.2	Estates work in place to ensure service can be consolidated at LCH with appropriate beds, assessment areas and outpatient facilites	5	5	25	1) Provision of sufficient clinical and bedded space at LCH 2) Enabling works for Breast patients to move to Digby ward with minimal estates work required to enable paediatrics to move to 4th floor maternity block, this in extremis and in contingency. 3) Enabling works for Neonates and Maternity is 6 months 4) Configuration for split services to operate required	Friday, 6 July 2018	Rob Game / Richard Mather / Paul Boocock	3	3	9	1) Digby ward hosting Breast patients in the short term. 2) Digby forms part of the winter plan to house increase in demand of patients across the Trust, risk that breast patients may have to be decanted to a.n.other area before peak demand in the run up to winter.	2	3
		13.2	Staffing rotas for both medical and nursing staff created to enable service provision post 1st August	5	5	25	1) Moving medical and nursing staff to a consolidated site at LCH requires a re-write of rotas and on call arrangements.	Friday, 29 June 2018	Rao Kollipara / Ajay Reddy	5	5	25	"Two sites, one team" approach achieved in the medium and long term.	3	3
		13.3	Pathways and referral processes in place at consolidated site	5	5	25	1) Pathways meeting scheduled for 6th July at Sleaford involving all specialities 2) Pathways to be analysed to ascertain if any changes to existing pathways are required as a result in change to service. 3) Requirement to demonstrate that pathways and processes can be implemented and communicated.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	3	9	Pathways agreed and in place	2	2
		13.4	Communications plan reflecting emergency	5	5	25	1) New communications strategy and plan to be devised and implemented 2) Key stakeholders, both internal and external, to be engaged 3) Media strategy to patients, families and general public to be initiaated	Monday, 16 July 2018	Anna Richards	3	3	9	1) Comms strategy deployed 2) Patient and staff survey report positive results.	2	2
14	Recruitment and retention of medical staff PHB	14.1	Retention of Consultants to continue to work at PHB if service becomes unattractive	5	5	25	1) Potential of creating a site operating with less pressure than LCH which could facilitate an environment that is conducive to consolidation of learning. 2) Link with ties with Medical school in 2019/20. 3) Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 1 August 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) HEEM formally agreeing that the training provided at PHB meets or exceeds training requirement for trainees. 2) Medical school involvement positively incorporated to training.	2	2
		14.2	Recruitment of new staff to PHB may become problematic	4	4	16	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
		14.3	HEEM unable to identify trainees who are willing to be placed at PHB, trainees may not wish to select or accept places due to type of service on offer at PHB.	5	5	25	1) HEEM to continue to promote training viability at PHB and assure trainees of viability of the service at PHB in the medium and long term. 2) Potential to reverse the negative view of the placement as being able to experience a "blended" workforce solution to Paediatrics (which is a potential long term outcome of the speciality given continuing decline in numbers of Paediatricians nationally). 3) Resulting service provision could become a vanguard type offering.	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	4	12	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
15	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	15.1	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	5	5	25	1) Children will not be able to receive care Inpatient care at Pilgrim Hospital as there are no inpatient beds.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	5	3	15	1) Children with PEWS 5 or less may, following assessment, meet level 1 criteria to be transferred in parents own vehicle as documented within the Safe Transfer of Children and Young People from Emergency Departments and Children's Services-CESC/2014/126 Version 3	2	3
		15.2	There may not be a transport service in place by 01/08/2018 to transfer the children to an inpatient bed which would impact upon patient flow from ED to the assessment unit resulting in extended waits / breaches and the unit remaining as an inpatient ward	5	5	25	1) Extended waits within the Emergency Department and on the assessment unit over 12 hours if patients have to wait for return ambulances.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) EMAS will transport children 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.3	The two proposed dedicated ambulances are for all of Women and Childrens Services i.e.) to transfer pregnant women and children, therefore the demand for transport is currently unknown and there is a risk a vehicle may not be available for a sick child when required.	5	5	25	1) The child may face a longer journey and may deteriorate whilst travelling 2) The family will have to endure longer journeys and may have increased periods of separation from their child.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Comet will retrieve children requiring level 2 and 3 dependent upon criteria. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.4	The private ambulance crew may not be trained in the paediatric equipment e.g. Infusion pumps and therefore children will not be able to receive intravenous fluids / drugs throughout the journey from Pilgrim Hospital to Lincoln County Hospital resulting in treatment potentially being stopped prior to the journey resulting in a delay in	5	5	25	1) Treatment being stopped / delayed due to lack of training of private ambulance crew in equipment such as infusion pumps could result in deterioration of child's condition	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Training of Paramedic team in infusion pumps if required. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.5	The private ambulance may not be equipped with all of the equipment required to treat children during the transfer if their condition should deteriorate on the journey	5	5	25	Paediatric Equipment (Paediatric grab bag) provided to transport team.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.6	The turnaround time for the transport travelling from Pilgrim Hospital to Lincoln County Hospital is likely to be longer than 3 hours due to poor road networks and vast geographical area and unknown delays on arrival at the destination.	5	5	25	1) Telematic vehicle tracking to enable acute staff to identify optimum transfer time and turnaround. 2) Double up on ambulances availability during first six weeks of the interim model to ascertain actual future demand.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Policy and Procedure for Patient Transfer Trust Wide CESC/2011/040 Ver 4.6	2	3

16	Change in Directorate Leadership	16.1	The organisation is undergoing a restructure impacting on the existing specialty designation in the directorate.	3	3	9	1) Part of the organisation wide restructure but will come into full effect in the new year by which time, the service model will have been operational for 6 months.	01 June 2019	General Manager	2	2	4	No further mitiagtions	2	2	4
		16.2	Appointment of a Directorate Managing Director and Paediatric Lead Nurse	3	3	9	1) Provision of a strengthened leadership team 2) Ability to focus on the converting the temporary model to a business as usual status. 3) Ensure performance of the unit is incorporated into the assurance and governance process for the Directorate	10 September 2018	Directorate Managing Director	2	2	4	No further mitigations	2	2	4
		16.3	The General Manager has left the organisation	5	4	20	1) Interim Geeral Maager appointed 2) Interim is internal and has a good level of experience and knowledge in Paediatrics and the Directorate	10 September 2018	Directorate Managing Director	3	3	9	The General Manager post is filled on an interim basis.	2	3	6
Financial																		
17	New service may be an unaffordable financial pressure for commissioners	17.1	Change in tariff of assessment based model with no in-patient beds at PHB	4	3	12	Financial model to be delivered and agreed with commissioners to ensure that service remains financially viable.	16 July 2018	Rob Game / Vanessa Treasure	2	2	4	Commissioners agree and commission service with acceptable financial outcome for Trust.	1	1	1
		17.2	Potentially funding travel costs for patients	3	3	9	1) Transport solution to be designed and delivered which remains financially viable.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		17.3	Any funding of travel costs for patients could set a precedence which Commissioners are unlikely to create.	4	3	12	1) Locally agreed tariff which incorporates private transport facility. 2) Work with charitable organisations to create a partially funded service.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		17.4	ULHT may request funding beyond tariff to implement contingency plan	4	3	12	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure	4	3	12				0
		17.5	Cost of communication to patients and staff in relation to the transfer	5	3	15	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure			0				0
		17.6	Request to underwrite consultant recruitment costs (International)	5	3	15	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure			0				0
		17.7	Implementation of the contingency plan results in stranded costs at PHB	5	5	25	1) Reworking of income based on assessment based model and no in-patient beds for Paediatrics. 2) Potential increased outpatient income 3) Potential for "One stop" approach to some parts of the service via Outpatient clinics.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	1) If needed, Contingency in place and working providing safe care for patients and staff.	2	2	4
Commercial																		
18	Negative impact on the viability of PHB		Transfer of this service may not align with the long term STP plan	4	4	16	Mitigation to be identified	01 August 2018	Neill Hepburn			0				0
Patients and Stakeholder																		
19	Access		Patients will have inconvenience/change of travelling to a different site.	5	3	15	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
20	Risk to reputation of NHS bodies	20.1	Reputational as Trust, NHSI have previously stated they would not move the service from PHB to LCH	4	3	12	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
		20.2	Reputational if the service is not returned to previous model at PHB in 12 months	4	5	20	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
21	Lack of support from Patient and Public voice	21.1	Patients will not want to see service move from their local hospitals	4	4	16	Communications plan to explain rationale for change	31 July 2018	Neill Hepburn	4	4	16	Communicaton strategy deployed and in place	2	2	4
		21.2	Lack of patient/public engagement about this issue	5	3	15	Develop evidence of case for change and engage with local stakeholders	31 July 2018	Neill Hepburn	3	3	9	Communicaton strategy deployed and in place	2	2	4
22	Increase in young people aged between 14-16 years being cared for within adult wards due to the new temporary Childrens Assessment Unit (CAU) service model on the Pilgrim Hospital Site.	22.1	Due to the change of ward 4A, Pilgrim Hospital, to an Childrens Assessment Unit (CAU) there will be a potential increase in young people aged between 14-16 years being cared for on Adult Wards at Pilgrim Hospital.	5	4	20	1) Children and young people will not be cared for by the appropriately trained nursing staff as Registered Adult Nurses on Adult Wards have not received competency based training in the nursing care of children and young people aged 14-16 years and therefore will not have the knowledge, specialist skills and competencies to care for adolescents including level 3 safeguarding children. 2) Adult nurses have not completed competency assessments and workbooks in Paediatric Early Warning Score (PEWS) or Children's Sepsis 6 and parameters for the recognition of the deteriorating child are different to that of the early warning score for adults (NEWS) 3) Children will also receive treatment in line with Adult guidelines and policies which may be detrimental to their treatment and recovery. 4) Patient experience could potentially be poor due to children and young people being nursed next to sick adults and exposing them to potentially traumatising scenes. 5) RNA's may feel vulnerable and undervalued and this has the potential to eventually impact on morale and staff retention	03 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12	1) All staff who work within adult areas who may care for young people aged 14-16 will have received some safeguarding training 2) Policy for the Admission of Young People Aged 14- 18 years into Adult In-Patient Areas- CESC/2011/058 3) Adolescent Admission Risk Assessment Screening Tool completed for all admissions of 14-16 year olds to adult areas 4) Urgent Identification of adolescent area / ward to ensure right staff provide right care in the right area. 5) Communication / notification of when young person admitted to adult areas. 6) Datix completion to help monitor admission rates to adult areas 7) Competency based training could be offered to RNA's	3	2	6
		22.2	As Rainforest Ward will be the only inpatient Childrens ward, there may also be an increase in young people aged between 14-16 years being cared for on Adult Wards at Lincoln County Hospital.	5	4	20		03 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12		2	3	6