United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Dr Neill Hepburn
Date:	March 2019

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 Pilgrim Hospital, Boston and also the continuing work to address the significant challenges faced by the children and young people's 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 and is being developed to integrate the site-based teams.

In addition, the paper provides an update on operational performance of the service.

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

Summary/Key Points:

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

- A review of the Governance arrangements has taken place. It is considered that as the paediatric service is now stable, although fragile, monitoring should move to the Quality Governance Assurance Committee every 3 months, who provide updates to the Trust Board.

- The interim service model described at previous Trust Board meetings continues to be in place. The workforce remains heavily dependent on locum and agency doctors to provide weekend shifts. The international recruitment has been successful and after an initial period of induction and supervision these doctors are playing an increasingly important part in the service. We will continue to recruit through this process. We are also offering other incentives around training and personal development.

- The Tier 2 rotation of doctors to Lincoln reduced in February putting additional pressure on recruitment and meaning we will require additional agency staff. Every effort is being made to fill these vacancies however the consultants remain very concerned over the impact on the service.

- Since the interim arrangements were implemented in August the Paediatric Assessment Unit (PAU) at Pilgrim hospital has seen, assessed and treated 1,869 children, of which 203 have been transferred to other hospitals using one of our dedicated ambulances. This is far fewer than was originally estimated. Whilst these transfers were mainly to Rainforest Ward at Lincoln County Hospital, 53 were transferred to other hospitals - 21 of whom were transferred elsewhere for further specialist care.

- The gestational age for delivery at Pilgrim hospital has been increased from 30 to 34 weeks under the interim model; however as at Monday 25 February only 10 in-utero 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. Bringing the total number of transfers since the implementation of the interim model to 213.

- The reduction in the Trust commissioned additional ambulances on 17th September 2019 there have been no instances where an ambulance has not been available to meet the needs of the service.

- Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group.

- During the first few months of the interim model being in place, there have been a number of occasions when children have stayed longer on the unit than the agreed 12 hour guideline. Decisions are made to allow children to exceed the specified time limit on an individual basis only when it is safe to do so and in the best interests of the child. The 12 hour limit is also used flexibly when the transfer would be for a short time period required to complete observations or tests. The range of condition based protocols continues to be increased resulting in more individualised care plans that result in patients staying beyond the 12 hour guideline. However the 12 hour guideline remains appropriate for the majority of our children. Whilst feedback

from parents has been generally positive the impact of transfer remains a major topic of discussion at public engagement sessions.

- In keeping with the original criteria for the interim service, there has been no change of referral or ambulance conveyance arrangements. Each occasion where a patient stays on the PAU in excess of 12 hours continues to be recorded on Datix and will be used to inform our deliberations at the Task & Finish Group about reviewing pathways.

- The Programme Director, Clive Brookes, met with parents from the Skegness area on Tuesday 19 February and a meeting is also being planned for the Spalding area.

- The six month review of the interim service, including progress on actions as a result of the Royal College of Paediatrics and Child Health (RCPCH) report will be presented to the April Trust Board.

Recommendations:

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

- The Trust Board to acknowledge the improvements to the patient experience for children and their families whilst undergoing assessment on the CYPAU at Boston and the commitment of staff at Lincoln to support the interim model.

- The Trust Board agree that as the paediatric service is now stable, although fragile, and monitoring should move to Business as Usual by the Quality Governance Assurance Committee every 3 months who provide updates to the Trust Board.

REPORT TO TRUST BOARD – March 2019

1. 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.

2. Body of Report

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

2.1 Mobilisation

The Children and Young Persons Assessment Unit (CYPAU), previously referred to as 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.

2.2 Workforce

Medical Workforce

The recruitment activity continued 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. The service currently has 4 x full time consultants and 2 x agency locums, making a complement of 6 x whole time equivalents.

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.

	Establishment		Substantive in post		Locums in place	
	LCH	PHB	LCH	PHB	LCH	PHB
Consultants	8.0	8.0	6.0	4.0	0	2.0
Middle Grade	10	6.0	9	1.0	1	6.0

The international recruitment has been successful and after an initial period of induction and supervision these doctors are playing an increasingly important part in the service. We will continue to recruit through this process and are also offering other incentives around training and personal development. There has been a successful outcome from discussions with HEEM to allow juniors to undertake additional locum

work to fill some of the gaps in the rota.

The Tier 2 rotation of doctors to Lincoln reduced in February putting additional pressure on recruitment and require additional agency staff. Whilst an active plan is in place the consultants remain very concerned over the impact on the service.

The consultant paediatric medical team remains concerned about maintaining the safety of the middle grade medical rota including the current level of locum / agency doctors.

Agreement has been reached to increase the consultant establishment by two to facilitate the introduction of “one team – two sites” in paediatrics commencing with the new arrangements for ‘hot weeks’ in March 2019.

Nursing Workforce

The recruitment of children’s trained nurses continues to be a challenge. The latest HR scorecard for child health shows an improvement of a full 1% in vacancy rate and turnover. There has also been a reduction in both the overall and short term sickness rates. However there is now evidence to show any relationship to the change in service. A staff survey is to be undertaken in March.

A number of initiatives to improve nurse recruitment are underway;
- Revamped recruitment material
- Recruitment of existing Advanced Paediatric Nurse Practitioners
- In-house programme for trainee Advanced Nurse Practitioners
- Advert for Clinical Educator closed 18th January
- Advert for band 5 registered children’s nurses closed 16th January
- Case being finalised for range of specialist nurses

CYPAU NURSING STAFF SUMMARY							
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	5.2 (INC uplift)	4.5wte	0	1.0wte	0.0wte	3.5 wte	0.9wte
5	28.71wte (inc HDU)	RN(C) 11.04 wte	2.0 wte	1.6wte	1.4wte	RNC 8.04wte	13.43 wte
		RN(A) 4.24 wte	0	1.64 wte	0	RN 2.6 wte	
Total	33.91	19.78wte	2.0wte	4.24wte	1.4wte	16.14 wte incl agency	14.33wte

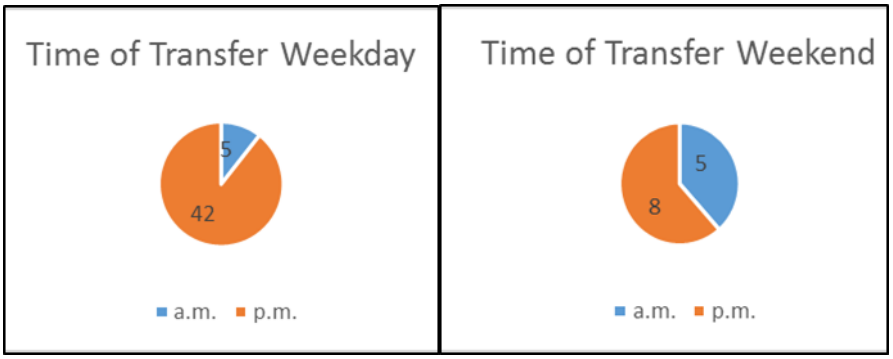
RAINFOREST WARD NURSING STAFF SUMMARY

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	4.73wte (uplift to 5.48wte)	5.48 wte	0	0	0	5.48wte	0
5	25.68wte	11.14w te	0	0.64wte (Maternity leave)	0.64wte (Maternity leave)	11.14wte	14.54wte
Agency			6.0wte			6.0wte	
Total	**31.16wte**	**16.62w te**	**0**	**0.64wte**	**0.64wte**	**18.62wte (plus 6.0wte agency =24.62wte)**	**14.54wte**

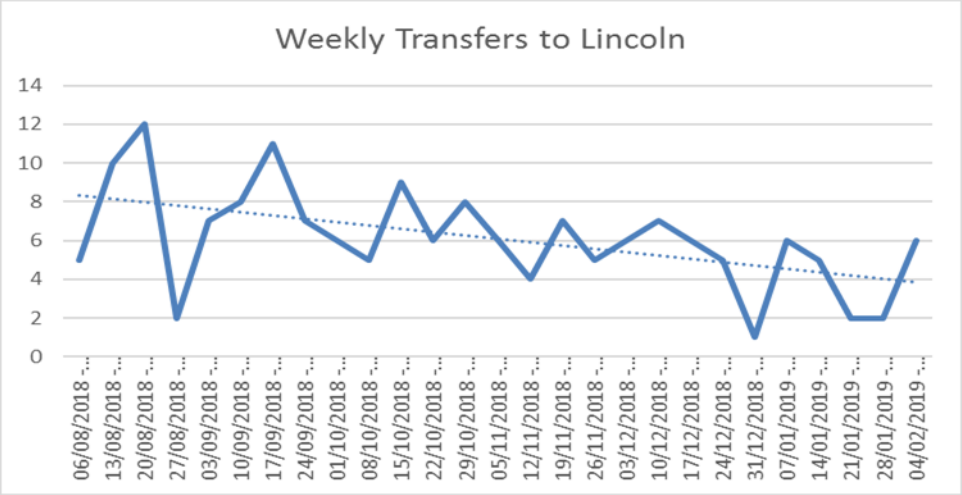
2.3 Transport Solution

Since the introduction of the dedicated ambulance transfer service there have been no instances where an ambulance has not been available to meet the needs of the service. The maximum number of children transferred to Lincoln on any single day has been three. The original contract was to provide two ambulances on site at Pilgrim hospital with a third on standby. This was subsequently reduced to one ambulance on permanent standby and a second for peak periods on 17th September 2018.

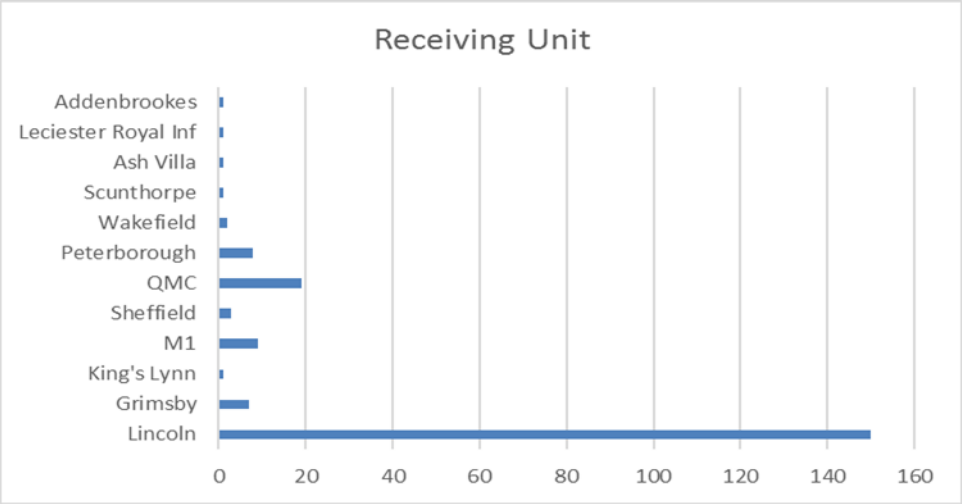
Analysis of the time of transfer over a twelve week period supports the planning assumption on journey times.



The cause of the sharp decline in transfers seen in December is being explored as this corresponds with expected winter pressures.



53 children were transferred to other inpatient units rather than Rainforest Ward at Lincoln County Hospital. 21 were to specialist centres for ongoing treatment (as per agreed protocols), nine were transferred internally to ward M1 at Pilgrim, 21 because beds were not available at Lincoln and 2 were repatriated closer to home. The ambulance resource continues to provide an ultra-safe provision for patients, whereby transfers required can be completed in the shortest possible timeframe. No incidents have been reported as a result of delays in the transfer of patients under these arrangements.



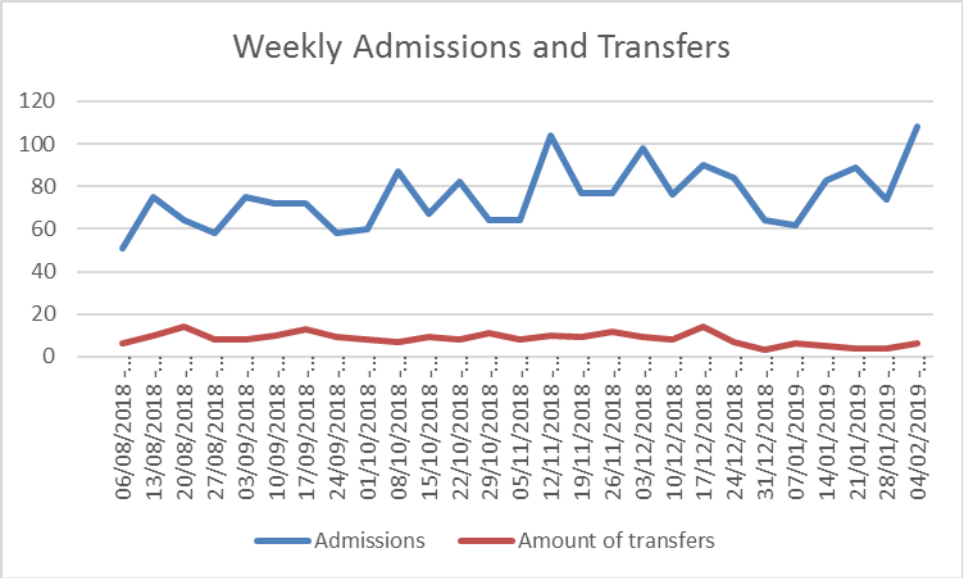
2.4 Activity

Since the introduction of the interim model at Pilgrim hospital there has been a significant improvement in throughput at the same time as improving the patient experience.

During the first twenty six weeks of operation of the new service model, 1,869 patients have been seen in the paediatric assessment unit with 203 patients transferred to other units. Ten mothers have been transferred with babies in utero.

All transfers were undertaken using the dedicated ambulance. One complaint has

been received and is being investigated. The difficulties faced by some families when a transfers is necessary is a major cause of concern raised at public meetings. The programme director is exploring ways to mitigate the impact.



Referrals

A breakdown of source of referral is given below.

Referral Source	Number of Referrals
Emergency Department	479
Direct from General Practitioner	572
Direct Access (those with long term direct access)	64
Midwife (mainly babies with prolonged jaundice)	31
Community Children's Nurses	1
Out of Hours Primary Care	43
Direct from the Urgent Care Centre	19

The other attendances to the PAU are day patients e.g. surgery and MRI.

- Emergency department referrals-
  A system of 2 hourly calls has been introduced between EDs and the wards which is helping to reduce delays in patients being transferred from ED and to help anticipate high volume activity in the Department.

- Direct from GP-
  In order to reduce delays in the GP referral system, dedicated phones have recently been provided allowing direct access for the GP to a senior decision maker in the paediatric service.

- Direct access (those with long term direct access)-
  The system of open access for some children with ongoing health needs

has continued at Pilgrim hospital under the interim service model. Whilst it has been necessary for some patients to be transferred to Lincoln hospital if they require a prolonged length of stay, access to the staff and support remains freely available through the pre-existing channels.

SoS Pilgrim have been instrumental in helping identify issues being faced by families with direct access. Families have now been contacted directly by a consultant to clarify the position and improved patient information has been issued.

Length of stay

During the first six months of the new way of working, there have been a number of occasions when children have stayed longer on the unit than the agreed 12 hour guideline. Decisions have been made to allow children to exceed the specified time limit on an individual basis only when it is safe to do so and in the best interests of the child. The 12 hour guideline is also used flexibly when the transfer would be for a short time period required to complete observations or tests.

Practical experience and international best practice have highlighted a number of conditions and circumstances where it would be sensible for children to stay longer than 12 hours. This has included cases of children who have high dependency needs and require more lengthy periods of hospitalisation for stabilisation, such as patients requiring high flow oxygen therapy for respiratory relief and newly diagnosed diabetics. The 12 hour guideline is still appropriate for the majority of our children and feedback from parents has been very positive.

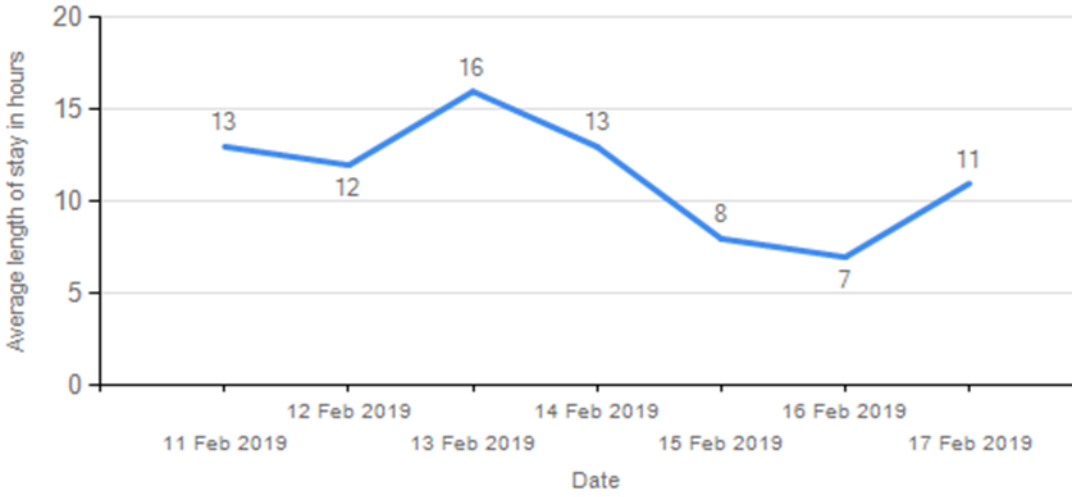
Individual condition specific clinical guidelines will be added to the Standard Operating Procedure for the unit as evidence dictates.

The impact of additional guidelines is shown in this snap short of length of stay.

Date	Min LoS in hours	Avg LoS in hours	Max LoS in hours	Number of discharges
11 Feb 2019	7	13	18	5
12 Feb 2019	1	12	26	14
13 Feb 2019	0	16	53	11
14 Feb 2019	1	13	30	13
15 Feb 2019	1	8	20	10
16 Feb 2019	1	7	18	9
17 Feb 2019	2	11	23	5

Whilst these figures show significant variation in length of stay the average remains below 12 hours.

CYPAU Average Length of Stay in Hours



Outliers are discussed by the clinical team at the bi-weekly Pilgrim hospital 12 hour model group under the new governance arrangements described later in the paper.

2.5 Management of incidents

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

2.6 Lincolnshire Health Overview and Scrutiny Committee (HOSC)

An update paper was presented to the February HOSC meeting which addressed the points raised at the previous meeting.

2.7 Communications and engagement plan

The Trust is increasing its efforts to ensure a clear and consistent narrative is shared with all stakeholders to minimise the risk of confusion and of messages and proposals being misinterpreted. This is supported by providing regular written briefings and the use of agreed campaign materials, including a powerpoint presentation.

Following the successful meeting at Boston the programme director met with members of SoS Pilgrim, interested parents, local people and councillors in Skegness on Tuesday 19 February, which was very positive. A further meeting will be held in the Spalding area.

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

2.8 Governance arrangements

The existing paediatric task and finish oversight group was established to act as the forum for reviewing and agreeing all required actions for the immediate review of the

children's services at Pilgrim hospital on the grounds of safety due to the deteriorating position relating to medical staff and nursing staff workforce. It was also responsible for monitoring the effect on children's and young people's services across ULHT.

Concern has been expressed that there is a lack of oversight of the whole paediatric pathway for children and young people. As a consequence the service could be hitting a 12 hour target for PAU in Pilgrim but missing a very important point regarding the speciality and our patients.

New arrangements have therefore been put in place to strengthen governance arrangements. This is also in keeping with the RCPCH recommendation to establish a programme board.

1 The Programme will report into the children and young people's (CYP) transformation board led by Tracy Pilcher, as many of the new and key pieces of work will flow from the community and out again.

2 The Trust CYP steering group will oversee internal projects

3 The programme will be split into 3 overarching workstreams with 8 key projects all with project leads.

Project leads have already identified core people who they need to work with and will be setting up meetings in the next week.

4 All outstanding actions from the task and finisah group will move to the relevant project for review and action. Each project team will have terms of reference, anagenda and action log. Each month they will be expected to complete a project template and submit two days in advance to the CYP steering group. The group will oversee actions and support any issues and escalations. Finally, they will use these reporting templates to inform the CYP transformation board. Within each project we will cover finance, workforce, pathways and mental health.

5 The leads below are temporary as ideally we would like clinical leads in place of management.

Core workstream 1 Pre hospital

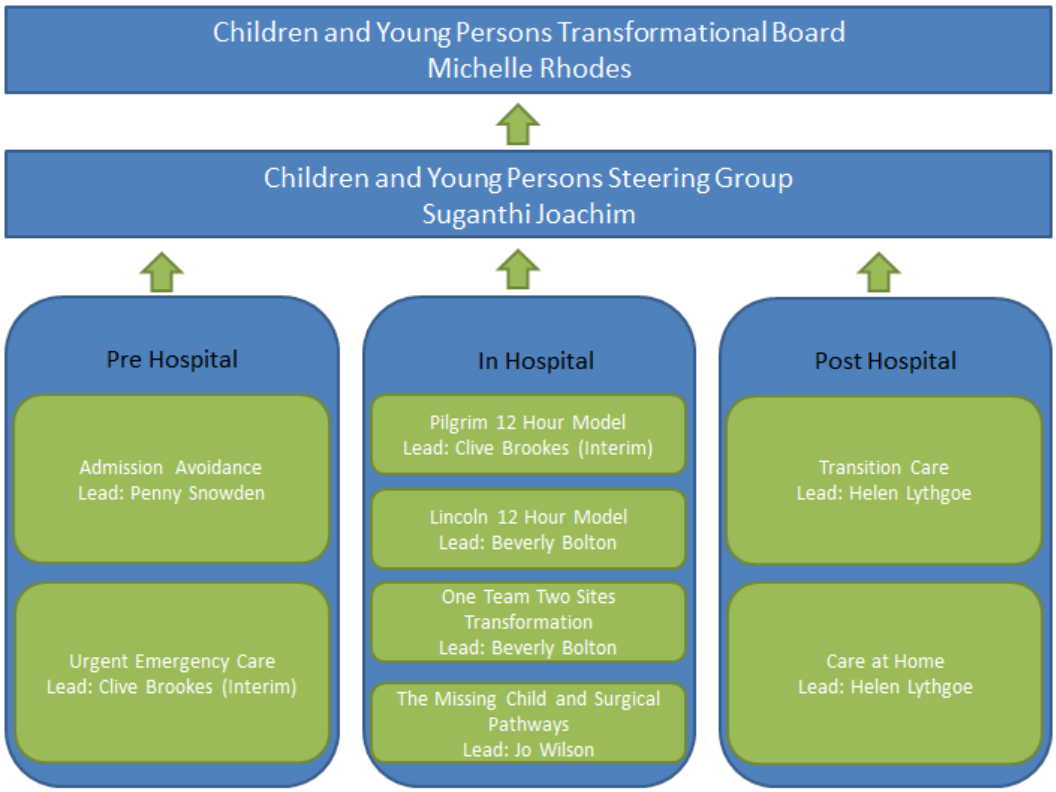
- Admission avoidance – Lead: Penny Snowden
- Urgent Emergency Care – Lead Clive Brookes (interim until end of March)

Core workstream 2 In hospital

- Pilgrim model 12 hour (Lead Clive Brookes (interim until end of March)
- Lincoln model 12 hour(Lead Beverly Bolton)
- One team two sites standardisation and reduction in variation (Beverly Bolton)
- The Hidden Child and surgical pathways (Jo Wilson)

Core workstream 3 Post hospital

- Tertiary and transitional care (Lead Helen Lythgoe)
- Care at home (TBA)



It is considered that the paediatric service is now stable, although fragile, and monitoring should move to Business as Usual by the Quality Governance Assurance Committee every 3 months who provide updates to the Trust Board.

3. Six Month Formal Review and RCPCH Independent Review

A formal review of the first six months of the interim arrangements being in place is now underway and will include a progress report on the response to the RCPCH Independent Review of the Paediatric Service.

Findings will be reported to the April Trust Board

4. Actions Required

4.1 The Trust Board to acknowledge the performance of the interim model over the first six months of operation, the number of transfers completed, activity on each site, the issues encountered, and actions undertaken to resolve those issues.

4.2 The Trust Board to acknowledge the improvements to the patient experience for children and their families whilst undergoing assessment on the PAU at Boston and the commitment of staff at Lincoln to support the interim model.

4.3 The Trust Board agree that as the paediatric service is now stable, although fragile, and monitoring should move to Business as Usual by the Quality Governance Assurance Committee every 3 months who provide updates to the Trust Board.

4.4 The Trust Board note that a formal review of the first six months of the interim model being in place will be presented to the April Trust Board.

Dr Neill Hepburn
Medical Director