RCPCH Invited Reviews

Supporting improvement in child health

Service/design review

United Lincolnshire Hospitals NHS Trust - Paediatrics

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RCPCH

Royal College of Paediatrics and Child Health

Leading the way in Children's Health

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Executive Summary

The RCPCH was invited to review the paediatric services at the Pilgrim and Lincoln County Hospitals during a period of extreme challenge to the staffing of the service at the Pilgrim Hospital in Boston. A culmination of factors over several years had led to a high number of medical vacancies at Tier 2 level. Combined with difficulties in recruiting consultants, changes to Tier 1 (junior) doctor deployment and children's nursing vacancies, the Trust could, at the time, see no alternative to closing the inpatient service from 1st August 2018 on the grounds of safety as skilled overnight medical cover could not be guaranteed. Although temporary measures were put in place from 6th August to preserve overnight paediatric medical cover until the end of 2018, closure remains a strong possibility unless an alternative solution can be found.

The implications of paediatric closure on the consultant-led maternity service, as well as on emergency paediatrics are significant; without onsite paediatric and neonatal skills only low-risk, midwife-led births would be offered with all women requiring or choosing obstetric care being transferred to Lincoln County. The Emergency Department (ED) relies on paediatricians for advice and support so more transfers would be required for children attending out of hours, increasing the risk and inconvenience as the hospitals are over an hour's drive apart with minimal public transport.

The catchment population served by the Pilgrim has significant pockets of deprivation, particularly in the coastal areas, without personal transport and with a relatively high proportion of first generation immigrants, many of whom are not fluent with English nor the workings of the NHS. The implications of closure of the service had not been lost on a strong and well-organised campaign lobby group, and staff, politicians and the public were concerned about the way forward and the future safety of the services.

The Trust has made extensive efforts to mitigate the situation, since the scale of the problem became apparent during CQC inspections at the start of 2018. In the absence of a Clinical Director for Women's and Children's services the Medical Director personally led the public engagement and response, supported by NHS Improvement and NHS England, with regular board papers, media updates and an extensive recruitment drive. The appointment of an interim project manager in June has supported development and delivery of a temporary, if fragile, solution which retains paediatric and thus obstetric cover on site but requires transfer of high risk births and any children likely to require traditional inpatient care.

The long term vision (5+ years) articulated in the 2016 Lincolnshire Sustainability and Transformation Plan was for consolidation of services onto one site. This has significantly damaged staff morale and the ability to recruit, despite recent statements by the Trust indicating their intention to continue to provide paediatrics at Pilgrim, and this report considers whether the long-term vision still reflects the requirements for safe care and what the service can deliver.

The remit of the RCPCH review was to examine the current arrangements for paediatrics across both sites and propose an interim solution and longer term viable vision which would be workable, attract new staff and provide the population with the assurance of safety and sustainability, although not necessarily the same provision as they had traditionally received.
The review involved a multi-disciplinary team examining documentary evidence and interviewing a range of staff across the Trust and from other stakeholder organisations. In parallel, a survey of patients, parents staff and the public was carried out which generated over 820 responses.

The review team acknowledges the complexity of the situation, the hard work being done by all stakeholders to ameliorate the current situation and the absolute focus on safety and quality over cost. A number of interrelated factors had led to the current crisis; many of these were the result of previous short-term solutions, the absence of a vision and plan to address long term staffing decline, lack of a modernisation and change management programme in the division and the acknowledged focus on other priorities within the Trust. Whilst the Trust is by no means unique in struggling with paediatric service design, there are a number of short and medium term actions which other units have found helpful in building a workable model and these are listed below and in the main body of the report.

Key to improvement is overt recognition that a 24 hour paediatric service at Pilgrim should stay. Whilst small, its catchment is deprived and remote and the distance to other units is too far to close the unit, particularly due to the implications for consequent downgrading of the maternity service. Uncertainty over the Pilgrim's future continues to impede recruitment but this could be reversed with a strong vision, robust paediatric and nursing leadership and opportunities for staff to feel valued, supported and encouraged to experience new ways of working.

It is important that both Lincoln County and Pilgrim teams need to 'own' the challenges through the new children's board to provide the right care to the whole population. We propose a model of low-acuity overnight paediatrics for the Pilgrim, supported by a guideline-led short-stay paediatric assessment unit, matching demand and minimising the need for transfer of patients whilst providing on-site skilled cover and access to a consultant on call from home. This will still require an increase in substantive medical staff from the current situation and depends upon maintenance

of a daytime Tier 1 junior doctor or equivalent rota. The overnight Tier 2 cover could be supplemented through development of the Advanced Nurse Practitioner role with a mixture of Medical Training Initiative, Trust grade and specialty doctors, Clinical Fellows and consultants working resident shifts. This is not an instant model and will take 3-4 years to complete but once established should be sustainable if the vision is clear. It will require strong leadership across all three sites (including Grantham) and a commitment to and by clinical and managerial staff to work differently with a focus on outcomes, quality improvement, swift clinical decision making and strong teamwork with colleagues across the Trust.

Alongside the acute PAU model a whole-system programme should be implemented to reduce attendance through strengthening community children's nursing, developing rapid-access clinics, building strong links with GPs and the community maternity hubs, and developing telemedicine and other technological solutions to reduce travel and speed consultations. There are clear examples in Scotland and increasing evidence from elsewhere that more can and should be done safely in primary care.

There has been good progress in strengthening nursing competencies through confident leadership and this should continue with greater career progression opportunities such as Advanced Nurse Practitioner roles (ANP) and backfill recruitment encouraged through the development of local degree-level courses. However, this has been achieved through secondment of community nursing leaders to the acute service, so it is important to ensure that there is a strong vision and growth in both the acute and community nursing teams, improving support to primary care and families managing children with long term conditions.

The concept of 'one team two sites' for the paediatricians needs to be explored much more thoroughly as at present this is not embedded in the service, and the Lincoln County team are also facing challenges with recruitment and demand which mean that although willing to 'help out' at Pilgrim they are not sharing the problems. All three hospital sites need to be included in a single plan with shared protocols, guidelines and investment in Quality Improvement to stimulate recruitment and ensure efficient working across both nursing and medical staff. This does not necessarily mean that all clinicians should regularly work across all three sites – indeed the physical distance makes this inefficient - but Lincolnshire deserves a population rather than a site-focussed service with tailored job plans that reflect skills and aspiration, sharing the work and opportunities fairly across the teams. Cultural change such as addressing allegations of bullying, varying the locations of Trust-wide meetings, sharing in training placements and investing in teleconferencing and telemedicine can all serve to bring the teams together and improve morale.

Communication of the changes and options by the Trust could have been better and our survey of patients, parents, staff and the public in Appendix 6 reflects this; issues of concern by those affected have not been addressed within an overall communications strategy, although this has improved in recent months and it is important that staff are fully updated to enable them to reassure their patients.

We suggest that an experienced project manager is appointed to work with the medical and clinical directors and directorate management to develop a clear vision based on the recommendations below and communicate it widely to assist recruitment and encourage innovation. Monitoring of progress against the new model should be rigorous through the Clinical Services Transformation Board to build confidence in the future, demonstrate quick-wins and communicate improvement, and needs external scrutiny and accountability to patients and the public. If there is insufficient progress or the model is not starting to show potential for improvement and sustainability after a period of, say, a year, then the contingency plan of moving all inpatient services to Lincoln County, with its consequent implications for maternity services will need to be planned for.

Recommendations

The following recommendations combine short term enabling actions with a longer-term vision of the future of the service, to retain obstetric and paediatric services across both Lincolnshire sites.

Immediate

Identify an experienced Project Manager/Clinical Director to continue to work with the Clinical Leaders to lead and shape the vision and drive implementation and innovation for the maternity and paediatric teams going forward (5.8.7)

Develop a model and plan for a 'low acuity' overnight service at Pilgrim through development of hybrid Tier 2 working and explore with the medical and nursing teams a migration towards this arrangement (6.3.5)

Appoint a 'Project Board' from stakeholders or use the Clinical Services Transformation Board to monitor progress with the vision and plan and provide external scrutiny (6.3.11)

Actively promote a positive vision backed with a robust communications plan that drives forward change and develops confidence and commitment to a whole-county solution that embeds a sustainable service at Pilgrim (6.3.11)

Introduce a monitoring and outcome analysis process to review admissions transfers and outcomes to demonstrate the model is working safely at the current time and through transition to new ways of working (6.3.10)

Enabling actions

Adopt the RCPCH standards for PAUs at both sites as an approach to managing ambulatory patients not requiring long term stays, with pathways of care and SoPs that focus on discharge and decision making in the ED and PAU and monitor length of stay and outcomes. (6.4.2)

Continue to support and audit use of the dedicated ambulance vehicle for safe transport of sick children and maternity patents who require transfer from Pilgrim (5.6.6)

Actively involve local user groups as well as children young people, parents and those from minority communities to "change the narrative" and improve engagement with the public, including development of written, web based and social media resources. (5.11.9)

Expedite changes to the approach to recruitment including a refreshed and dynamic marketing approach (5.8.5).

Focus on retention and development of existing staff through genuine involvement and listening and acting on their concerns (5.8.6)

Nursing

Recruit a Head of Nursing/ADN with experience of developing and modernising nursing services, to develop the children's nursing service at ULHT to meet the needs of children across Lincolnshire (5.3.2)

Strengthen paediatric nursing competencies in ED and neonatal life support through advanced nursing roles to improve patient care and reduce the demand for medical intervention (5.3.6)

Develop a strategy for children's community nursing to reduce hospital attendance and increase engagement with the NHS through (5.3.12):

- **Expanding the CCN Team**
- **Enabling a seven-day service across the county**
- **Enable early discharge from the Emergency Department and PAUs.**
- **Review referral process to enable direct GP access to community nursing**

Consider recruiting specialist nurses for long term health disorders such as asthma and epilepsy to support the medical team and promote self-management of conditions from an early age. (5.3.13)

Ensure the practice development nurse role is clear to promote an effective impact on recruitment and retention of nurses and good working relationships between the clinical areas and the university. (5.3.6)

Develop nurse led clinics to manage children attending the ward following discharge and to support medical colleagues in managing children with long term conditions (5.3.13)

Medical Staffing

Continue to support MTI recruitment for a steady supply of Tier 2 paediatricians. (5.4.12)

Expedite changes to the approach to recruitment including a refreshed and dynamic marketing approach. (5.8.5)

Explore the benefits of developing advanced practice children's nurses and review how these operate in other services, with a view to establishing the role at both sites to support the medical rotas. (5.4.14)

Conduct an audit review of the quality and implications of the locum provision including incident analysis and risk assessment. (5.4.10)

Work closely with HEEM to Increase the profile for training and compliance with requirements to enable continuing rotation of Tier 1 doctors through Pilgrim (5.4.21)

Rethink the 'offer' for trainees, increase the profile of training through websites and promotional materials to attract more trainees to Lincolnshire's hospitals (6.4.6)

Other recommendations

A focus on Quality Improvement, including working differently, learning from findings and shared whole-team goals should be implemented as soon as possible (5.7.4)

Work with the CCGs to reconsider the future of Pilgrim and opportunities to expand rather than contract the service within the STP. (6.1.1)

Retain and develop a day surgery service at the Pilgrim site with a catchment across the Trust's footprint. (6.4.14)

1. Introduction

1.1. In April 2018 the RCPCH was approached by Dr Neill Hepburn, Medical Director of United Lincolnshire Hospitals NHSFT, to conduct a review of the paediatric services across the two sites. This report sets out the process and findings of the review.

1.2. An RCPCH Invited Review is an independent critique against agreed Terms of Reference, based on information provided to the reviewers, interviews with staff and stakeholders and published regulations, policy and standards from RCPCH and other professional bodies.

1.3. The report belongs to the Trust and remains confidential unless the Trust decides to publish it. The RCPCH does encourage wider dissemination of this report amongst those involved in the service but will not itself publish or comment on review reports without the express permission and agreement of the Trust..

2. Terms of Reference

2.1. The RCPCH Invited Reviews team will conduct a review of the ULHT neonatal emergency and paediatric service provision, focussing particularly on the Pilgrim Hospital, to develop an achievable long-term model of care, examining

a) The current provision of neonatal, emergency and paediatric services within the Trust in terms of

- Staffing and workforce arrangements–medical and nursing teams
- Emergency, urgent and neonatal care pathways for infants and children
- Activity and workload
- Clinical governance, risk, QI and compliance with professional standards
- Operational and strategic liaison with neonatal, emergency and other networks

b) Options for future workforce provision, taking into account

- Progress with the STP and the region's policy drivers and impact of proposals
- The national picture for workforce and new ways of working
- Experience /benchmarking from other equivalent units in the UK
- Any areas that require further exploration that may not have been considered.

3. Background and context

3.1. United Lincolnshire Hospitals NHS Trust is one of the most challenged trusts in the Midlands with three acute hospitals serving a largely rural population including around 160,000 children. A Care Quality Commission (CQC) inspection in October 2016 published in April 2017 rated the Trust as Inadequate and in special measures. This was primarily due to a poor rating on safety, although the children's services were rated 'good'. A follow up inspection in February 2018 raised concerns about the paediatric provision.

3.2. Lincoln County Hospital has a fully staffed ED seeing 71,000 patients a year, with a 19-bed children's ward, 8 bed assessment unit and Level 2 Local Neonatal Unit serving 3700 births a year, caring for infants over 27 weeks' gestation. There are around 3500 acute and 96 elective paediatric admissions, 2700 ward attenders, with 1900 new and 2900 follow up outpatient attendances per year

3.3. Grantham and District Hospital has no paediatric inpatients and a limited emergency service which sees 29,000 patients a year and has been closed overnight since July 2016. Two long term locum consultants provide a weekday presence between 9am and 5pm and a limited service at weekends and the extensive list of exclusions is well understood by the local health community. Following a Clinical Senate review in November 2017 there are no plans to reopen the overnight service.

3.4. Children's services at the Pilgrim Hospital in Boston include an ED seeing around 55,000 patients a year. a children's ward designed for 19 beds, plus an 8-cot special care neonatal unit supporting around 2000 births a year taking infants from 30 weeks gestation[1]. This sometimes includes transfers from Lincoln County when that unit is full. There are around 2700 acute and 90 elective admissions, 2600 ward attenders, with 1500 new and 3000 follow up outpatients annually. The site is 39 miles from Lincoln County Hospital but the roads are not fast, taking around 80 minutes by car to travel between the sites. Public transport is extremely limited between the sites and in the catchment area of the Pilgrim, which extends up to 43 miles to some coastal towns. We heard that sometimes families cannot get home following out of hours' discharge.

[1] this was changed to 34+ weeks in August

3.5. Although the joint Strategic Needs Analysis produced by the local authority[2] did not highlight significant need beyond a raised neonatal mortality[3] it is based on 2016 data for the whole county. The review team was told that the population specifically using maternity and child health services is characterised as high risk. Lifestyle behaviours lead to obesity with high BMIs and a smoking rate of around 21% overall, increasing to 40-50% of the childbearing community from eastern Europe. In addition, many people are not fluent in English, live in multiple occupancy rented accommodation, are in low-paid employment and have a poor understanding of how the NHS works. In their home countries many would not use a GP but go direct to an acute paediatrician and the review team was told that many women choose to have their babies in their home country.

3.6. For the population of Lincolnshire in 2016, 67% of live births took place in Lincolnshire hospitals (42.2% Lincoln County and 24.8% Pilgrim and Grantham[4]). However, in the same period, a high proportion of local women gave birth outside the county; 28% of live births took place at hospitals in counties that border Lincolnshire (13.5% Peterborough, 8.5% Grimsby, 2.9% Nottingham, 2.4% at Kings Lynn and 0.9% Scunthorpe) and 1.5% babies are born in other hospitals. The number of Lincolnshire mothers giving birth at home is increasing with 2.85% being born at home in 2016. However, 0.3% of babies are 'born before arrival' – i.e. neither born at home nor at a hospital, usually en route[4].

3.7. A CQC visit in February 2018 required the Trust to ensure that the Pilgrim ED was appropriately staffed with suitably trained nurses to meet the needs of children and young people. To enable this, three registered children's nurses were transferred there from the 4th floor children's ward. The reallocation of nurses added to the CQC requirement to reduce bed numbers from 19 to 8. However, this added to the risks to children requiring emergency care, placing pressure on decision-making due to the lack of capacity on the ward.

3.8. CQC served a notice of intent of enforcement action on the Trust about Pilgrim in March 2018 under Section 31 of the Health and Social Care Act 2008, requiring the Trust to demonstrate a safe model of care and risk assessment. They cited two previous emergency care incidents and concerns about delays in implementing improvements.

[2] https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-early-years/data#page/7/gid/1938133061/pat/6/par/E12000004/ati/102/are/E10000019/iid/92705/age/23/sex/4

[3] most deprived decile, PHE 2014-6)

[4] Lincolnshire Birth data 2016. At that time Grantham hospital had a birthing unit

3.9. Paediatric surgery at Pilgrim was suspended between March and June 2018 due to staff and bed pressures; CQC was not assured that this had been properly risk assessed. Further actions arising from previous serious incident reports relating to informality of the emergency care pathway had not been implemented to CQC's satisfaction.

3.10. There are currently no reported problems with maternity staffing provision (2 sites 2 teams) but the dependency on neonatal expertise to support a consultant led unit is a concern for obstetric staff, for the women in East Lincolnshire and the midwives who work closely with them and recognise their needs. This is a significant factor in decision making.

3.11. The challenges in children's nursing were compounded by longstanding problems with medical staffing at Pilgrim and increasingly at the Lincoln site. A multi-agency "summit" in April 2018 led to a Board paper in May which set out the risks to the sustainability of the paediatric, and consequently the maternity service. This paper included detailed analysis of activity and performance, staffing levels and outcomes of recruitment initiatives, results of a transport survey, Quality Impact Assessment and five options for consideration as a temporary solution for three months.

3.12. These were set out in Board documents during April 2018:

Option One	• Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover paediatric, maternity & neonatal services
Option Two	• Temporary Closure of the Paediatric inpatient ward at Pilgrim with effect from 1st May • Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest A&E or UCC • Temporary re-direction of GP paediatric referrals to neighbouring organisations • Paediatric assessment model adopted for Children self-presenting at A&E • Retain running of Consultant led Obstetric and Neonatology services on the Pilgrim site (& the Lincoln site) for the foreseeable future, this is reliant on finding additional medical staff from Agencies with effect from July • 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 from May 1st • Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest A&E or UCC • Temporary re-direction of GP paediatric referrals to neighbouring organisations • Paediatric assessment model adopted for Children self-presenting at A&E • Retaining Consultant led Obstetrics and Neonatology at Pilgrim until July 1st when medical staffing reduces beyond the ability to support Neonatology. From July 1st Temporary closure of Consultant led Obstetrics and Neonatology at Pilgrim until the staffing gaps could be addressed

	• Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks • Establish a 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 but reducing paediatric bed numbers on each site to align with available staffing. Achieving this by: Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital. (This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln)
Option Five	With effect from July 1, 2018, providers across the region to provide Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology.

NB the dates quoted were correct as at April 2018

3.13. The Board agreed to pursue Options 1 and 3 as 2 was temporary, 4 did not release sufficient medical time to cover the out of hours rota and 5 was not supported by neighbouring units. A temporary model based on Option 2 was the objective from 1st August 2018 with twice weekly task and finish group meetings and regular reports to the Board and public.

3.14. Current provision from 1st August is twelve assessment and observation beds running 24/7 with any child needing more than 12 hours care being transferred to Lincoln using one of two private ambulances retained on standby. EMAS ambulances are directed past the site and neonates under 34 weeks are transferred (ideally in utero). There is a Neonatal Life Support (NLS) trained midwife or neonatal nurse on every shift.

3.15. The Trust needs to move to a sustainable model that will map to the developing strategic plans for the region and provide a safe, equitable service across the rural communities of Lincolnshire, supported by the Clinical Senate and NHS Improvement. This model needs to address patient flow and demand but can consider new ways of working to tackle recruitment problems with the engagement of the staff involved.

4. The Review Process

4.1. The Trust commissioned an RCPCH Invited Review alongside various other parties (including NHS England/NHS Improvement and other stakeholders) offering immediate planning and interventions to provide a fresh, independent opinion on what is currently being delivered, what works well and what could be done differently. The recommendations should propose how to deliver sustainable, effective services that meet the current and anticipated future demands of the population and makes the greatest use of resources and paediatric and other expertise.

4.2. The RCPCH review team comprised two consultant paediatricians, an experienced children's nurse and a lay reviewer, all supported by a manager from the RCPCH.

4.3. The review team was provided with pre-reading in order to prepare for the review. A pre-visit took place on 14 May and the full team visited both sites to interview staff on 13-14 June 2018. Some additional documentation was requested and received during and after the visits and some telephone calls were conducted after the visits due to people being unavailable to meet the team in person. Contact details for the review team were provided to all interviewees and the review was conducted in a climate of 'confidential openness' to enable staff to share their views freely. Notes were taken at the meetings; these have not been transcribed but have been used alongside the documentation, to inform this report.

4.4. The review team would particularly like to pass on their thanks to all participants for their hospitality, engagement with the process, their openness, and their time.

5. Findings

5.1 Nursing staffing – Pilgrim

5.1. The problem highlighted by the CQC visit in terms of children's nursing presence in the Emergency Department (ED), and consequent reorganisation of children's nurse staffing had been at the time of the visit mitigated temporarily by reducing inpatient bed numbers, alongside training of adult nurses and increasing availability of non-registered staff to provide support. Ensuring at least two RN(C) staff are on shift at all times has been a challenge and at times staff from Lincoln County have supported shifts at Pilgrim and assistance and advice from NHS Improvement has supported development of the service.

5.1.2 As of May 2018 nurse staffing at Pilgrim showed 8.25 wte vacancies against an establishment of 26.65 wte and 17.18 wte available to work, restricting the number of beds available for use. Senior staff explained several measures that have been initiated to build the service through a focus on recruitment and retention alongside dealing with the day-to-day challenges of filling shifts.

5.1.3 Adult nurses have been recruited and trained in paediatric competencies. Funded Band 6 posts have been increased to enable one Band 6 nurse on each shift for supervision and safety. This has mitigated the position but numbers are still insufficient with 0.9 WTE Band 6 vacancy.

5.1.4 The nursing team leader from the children's community nursing service had been temporally assigned as Matron at Pilgrim pending the appointment of a permanent ward manager. This secondment was initially for six months but has lasted 15 months. The Review Team was told that Matron had transformed the nursing service, with improved morale and opportunities for training and development.

5.1.5 Bed numbers had been reduced to 8 whilst three nurses were temporarily reassigned to ED but these have returned to the ward. At the time of the visit there were 12 beds open, with occupancy ranging from five to 13 patients over the course of a week although acuity can be very high. Detailed analysis had shown a need for 16 beds during winter months. Nurses reported that managing the full complement of 19 beds (and also bed capacity as children backed up in ED) had been particularly difficult but 12 was manageable and they felt they could provide good, safe care. There was general enthusiasm for the

development of a PAU to reduce length of stay, work in different ways and take pressure off the ward, although this was seen as an addition to the ward.

5.1.6 There is no HDU and sick children are transferred if they need ongoing level 2 care. Skills to provide Level 1 high dependency care or short-term Level 2 care whilst awaiting transfer should be available on all children's in-patient services[5]. It was reported that funding had been allocated for an additional 5.5 WTE Band 5 nurses to fully staff one level 2 bed. Whilst initially it was thought this would attract nurses it is not practical in the future model to provide this level of care within a PAU at Pilgrim. However, a PAU can be a busy area and a stabilisation bed, ideally in a slightly separate area, should be provided.

5.1.7 In recent months there has been a significant emphasis on training, from developing a robust induction, and strengthening preceptorship to maintaining and improving clinical competencies such as tracheostomy care and ensuring nursing staff are up to date with required training. Essential skills are being reviewed, refreshed and developed including as a priority resuscitation training, with plans to develop paediatric skills in surgical and orthopaedic nursing and provide basic CAMHS sessions to all nurses. Resuscitation training compliance has increased from 45% to 95% in recent months. Staff are valuing this investment in their development, coming in to be trained and appraised in their own time as they cannot be spared from the ward; they are paid for the time and are happy to support the service in this way, with indications that morale is increasing.

5.1.8 Children's nurses are required to cover on the special care unit (SCU) as well as in the ED at the Pilgrim which requires them to have skills in both paediatric and neonatal resuscitation. Although all contracts include a clause requiring cross site working between Boston and Lincoln, discussions about this have not resulted in a formal trial as there is some reluctance on the part of existing nurses to routinely add an additional hour journey to each end of their shifts.

5.1.9 Staff reported good access to allied health professionals, including physiotherapists to reduce lengths of stay and speed discharge although Speech and Language Therapy is more difficult to access. There is a pharmacy technician and an agreement for "TTO" medicine packs on the ward, with paediatric pharmacy support from Lincoln, which can speed discharge.

[5] High Dependency Care for Children – time to move on - RCPCH 2014

5.2. Nursing Staffing – Lincoln County

5.2.1. Nurse staffing on Rainforest Ward in March 2018 comprised 26.54 wte, made up of 5.48 x Band 6s and 21.06 Band 5s. There are 17.26 wte children's nursing staff in post and available to work and 7.64 wte vacancies. It was not confirmed whether there are any adult-trained nurses supporting the service. Recruitment activity was reported to have been successful with all vacancies planned to be filled by September 2018.

5.2.2. Nurse staffing on Safari (Daycase ward) was stable with 5.13 wte in post and 0.6 wte vacancy. The team are discussing establishing nurse-led clinics for ward attenders and are keen to make these work, to improve the efficiency of the unit.

5.3. Nursing Staffing – General and Community

5.3.1. Nursing problems were raised back in November 2015 when a risk summit was held as 41% of nursing staff were unavailable for their shifts due to sickness, maternity and vacancies. Following the appointment of a new Director of Nursing in 2016 and the more recent involvement of NHS Improvement's Head of Children, Young People and Transition, two senior nurses have been moved on a temporary basis from community nursing to lead the acute children's nursing service at each site. They had been in these 'temporary' roles for around 15 months and were making a noticeable difference to morale, competences and development of the nursing staff at each site. However, these are operational roles and are unable to make a significant contribution at senior management level, to influence the development of children's nursing within the trust.

5.3.2. A Head of Nursing or Associate Director of Nursing for children's services would provide the strategic vision and leadership for children's nursing, wherever children are seen. Working with a children's services matron on each site and the Children's Practice Development Nurse, the leadership capacity would enable development at both operational and organisational levels to ensure the proposed model has the nursing resource required to provide high standards of care to children.

Recommendation: Recruit a Head of Nursing/ADN with experience of developing and modernising nursing services, to develop the children's nursing service at ULHT to meet the needs of children across Lincoln county.

Nurse training

5.3.3. Several interviewees explained that some of the problems with nurse recruitment lay with the absence of locally commissioned nurse training – this needs to be embedded in the service strategy to ensure a continuing supply of nurses and support backfill and development of those able to work at more senior levels. The degree-level courses in Peterborough and Nottingham place nurses locally to the faculty so they did not get experience of working in Lincoln and Boston. There is a tendency for many nurses to stay where they were placed after training was complete – although two nurses had just come from Peterborough to join the team which was an exception.

5.3.4. There is a new degree-level course being reintroduced at Lincoln University from September 2019 (awaiting NMC Accreditation) which has potential for supplying the Trust with a steady stream of new recruits from 2022, although numbers will initially be small. This will improve the unit's reputation amongst nurses and, it is hoped, improve retention. There are good relationships with the university including occasional 'exchange' between a lecturer and the acting matron swopping lectures and shifts on the ward.

5.3.5. The induction programme and preceptorship for nurses was reported to require development to help reduce the drain of skilled children's nurses from the Trust. There is a national problem that newly qualified nurses do not stay long unless there is a career structure and development – which is not always the tertiary centres. To provide a focus on education, a Children's Practice Development Nurse is required to build on the university links and focus on staff development in children's and neonatal services at all levels including supporting student placements (in future), induction and preceptorship, the development of competencies in adult nurses and the development of specialist and advanced nursing practice roles. This role would provide effective communication across all children's areas and with the university, supporting the creation of a career framework for nurses within the trust.

Recommendation: Ensure the practice development nurse role is clear to promote an effective impact on recruitment and retention of nurses and good working relationships between the clinical areas and the university.

5.3.6. It is important to ensure development and retention of competencies in other areas of children's work to maintain a broad range of nursing skills on the Pilgrim site, including retention of elective day surgery and advanced skills in emergency care and neonatal life

support as well as the opportunity for Advance Nurse Practitioner (ANP) posts to support the medical rota (see 5.4.14)

Recommendation: Strengthen paediatric nursing competencies in ED and neonatal life support through advanced nursing roles to improve patient care and reduce the demand for medical intervention.

Provision of community nursing

5.3.7. It is important strategically to ensure that the positive investment in development of nurses on the wards does not deplete community nursing leadership. The future of hospital services relies on strengthening community provision to support services aimed at keeping children and young people out of hospital.

5.3.8. Community children's nurses work in three localities, broadly centred around the hospital sites. Each team comprises a Band 7, 3 band 6, a healthcare assistant and administrative support. They work between 9 am and 5 pm, Monday to Friday, covering long term conditions, including long term ventilation. They also aim to provide a 24-hour palliative care service, providing cover for the palliative care rota across the county. They have been able to provide some intravenous antibiotics for children following acute admission. Currently, however their staff numbers are suffering from secondments to the hospital, maternity leave and vacancies: of 11.7 WTE, 6.6 are unavailable. Pending further recruitment, the teams had been merged to two, focusing on long term conditions, complex care, long term ventilation, tracheostomies and home oxygen; they are unable to accommodate acute care including intravenous antibiotics and there is no community neonatal nursing service.

5.3.9. District nurses do not see children and attendance by a CCN has to be authorised by the consultant paediatrician, making it difficult for the GPs to refer directly to the service. As the service is not currently able to cover the whole catchment it would be too thinly stretched to provide a service to GPs to reduce attendance at the acute site. However, this would be possible in the future, if a seven-day service was provided with night-time on call for palliative care and staff told us that this would enable reduction in length of hospital stay for children and young people. Locally, the team have discussed using advanced children's nurse practitioners in both assessment unit and community teams, to establish a rapid response service to provide interventions, education and support to families at home.

5.3.10. In order for the service to minimise emergency attendance and/or the needs for overnight transfers, investment is required in GP liaison and a rapid response acute children's nursing service, which should include palliative care and enable some children to be sent home from the PAU overnight. This should be as described in the RCPCH intercollegiate Publication "Facing the Future: Together for Child Health[6] which sets out eleven standards for reducing attendance and admission to acute services, including strengthening of community nursing services and better liaison between teams.

5.3.11. Community children's nurses need to be able to communicate with the non-English speaking population where required and work closely with GPs, pharmacists and the CCGs on public education about emergency services These are longer term actions to build a strong framework of care in community settings in line with the NHS Five Year Forward View. The current community children's nursing service was reported to be difficult to access by families and is not yet working efficiently as it could with the paediatric and emergency teams to speed discharge and reduce attendance.

5.3.12. There are a number of schemes in the UK which have placed children's nurses in GP practices, reducing pressure on GPs and EDs, with clear governance and SoPs. Given the geography of the region this could be a helpful model for the population and a further opportunity to develop nurses if sufficient supply of appropriately trained children's nurses can be secured. The RCPCH can provide contact details

Recommendation: Develop a strategy for children's community nursing to reduce hospital attendance and increase engagement with the NHS through (5.3.8):

- **Expanding the CCN Team**
- **Enabling a seven-day service across the county**
- **Enable early discharge from the Emergency Department and PAUs.**
- **Review referral process to enable direct GP access to community nursing**

5.3.13. There have been positive developments including appointment of six diabetes specialist nurses across the three sites and a recently appointed cystic fibrosis nurse, which have been built up by the Trust's Children's Nurse leaders. A Children's Continuing Care Team supports community services, undertaking assessments and providing home support.

[6] Facing the Future: Together for Child Health RCPCH 2015

However, there is no specialty support for asthma and Lincolnshire is the only area in the region without an epilepsy nurse.

Recommendation: Consider recruiting specialist nurses for long term health disorders such as asthma and epilepsy to support the medical team and promote self-management of conditions from an early age.

Recommendation: Develop nurse led clinics to manage children attending the ward following discharge and to support medical colleagues in managing children with long term conditions.

5.4. Medical Staffing – Pilgrim

5.4.1. There have been reported problems with medical staffing at the Tier 2 grade since April 2016 with a number of Risk Summits and short-term fixes since then.

5.4.2. At the time of the visit there was a consultant establishment of 14 across the two sites, (8 Lincoln, 6 Pilgrim) of which 13.5 were recruited including 2.5 locum staff, on an average of 11.5PA contracts. The website however shows 16 consultants but states nine are in post. Compliance with Facing the Future standards[7] requires 19 consultants across the two sites (21 if on 10 PA contracts) to include the neonatal cover. Nationally, the average number of consultants on a general/neonatal tier 3 rota is 8.3[8] .

5.4.3. At Pilgrim funding was agreed in June to take establishment to 7.6 wte consultants, with 5 substantive in post, most on 12PA contracts. None of the consultants had been in post for more than 2 years so they were objective about the comparisons with other units and expressed concerns about morale, workload and the expectations on them from management. This had escalated since April 2018 when they felt that decisions were being made without involving them. They reported feeling undervalued despite providing what they considered to be a good standard of care and they were concerned that colleagues are leaving. Morale was reported to be 'flat'.

[7] Facing the Future: RCPCH 2015
[8] Workforce census 2015 https://www.rcpch.ac.uk/resources/workforce-census-2015 RCPCH March 2017

5.4.4. At the time of the visit the consultants were aiming to work to a traditional 3-tier model on both sites with 24/7 tier 2 cover and consultant on call from home overnight. They were not prepared to work resident on call routinely, but since the introduction of the new model of care in August they have been working until 10pm to ensure that patients are appropriately reviewed, transferred or discharged.

5.4.5. At tier 2 there have been long term problems recruiting to posts with just 3.5 wte available at Pilgrim in April out of an establishment of eight.

5.4.6. Until recently the consultants have been providing cover and acting down when required when long term locums were not available. Their goodwill had been exhausted by the time of the review visit as problems with tier 2 recruitment had been long standing and have not improved despite attempts to recruit.

5.4.7. Uncertainty about the future was compounded in June when the Health Education England/Deanery announced that from 1st August tier 1 doctors should no longer work out of hours at Pilgrim suggesting that individual slots are rostered from Lincoln County and cover daytime work only, to ensure quality training and avoid burn-out.

5.4.8. As a result, from October 1st there was predicted to be one whole time equivalent Trust grade doctor and one tier 2 doctor out of an establishment of eight with the rest of the shifts covered by locums when they can be recruited, which is proving increasingly difficult.

5.4.9. The consultants are anxious about the service risks of this arrangement for three reasons:

- locum doctors can cancel with two hours' notice or demand inflated fees and leave the unit without cover,
- although the cost is not a driver in this situation, resources spent on locum staff could be used more constructively elsewhere if permanent staff can be recruited,
- in an emergency having a locum first and second on call leaves a significant amount of accountability with the consultant, and they feel that the level of risk is unacceptably high.

5.4.10. There were significant concerns expressed about the quality of some of the short-term locum cover experienced at Pilgrim, requiring the consultants to cover extra shifts in order to provide supervision. There were reports that some of the locum doctors do not keep

themselves up to date with new guidelines, do not provide a suitable training environment for the tier 1 doctors, such as Journal Club, and can command an inflated fee for working some shifts which undermines the permanent staff. The audit lead was at the time of the visit planning an audit of locum activity. This should be encouraged in order to provide assurance over safe levels of care and cost-effectiveness.

Recommendation: Conduct an audit review of the quality and implications of the locum provision including incident analysis and risk assessment.

5.4.11. The Trust has worked hard to recruit in the UK and overseas. There are challenges recruiting from overseas due to visa and sponsorship problems, but the Pilgrim consultants team feel they provide a good standard of care, high quality training and a rewarding experience. Indeed, we heard that they had the best training feedback in the region.

5.4.12. In October 2017 40 candidates applied including from agencies and overseas. 17 candidates were interviewed, 12 were appointable, six came for the English Language test and the first was due to join the Trust in August. At the time the RCPCH's MTI support arrangements were undergoing change and unfortunately there were some delays in approval of the training and qualifications for UK employment but progress is being made. The local MP has offered to help with obtaining visas and in the medium and long term with a rolling programme of two-year MTI appointments at Tier 2 this could be a source of sufficient doctors to cover a proportion of the out of hours rota.

Recommendation - continue to support MTI recruitment for a steady supply of tier 2 paediatricians.

5.4.13. Despite the success of the advanced clinical practitioner role in the ED and the use of ANNPs and an APNP at Lincoln County, there has been no planning to develop advanced nurse practitioners in children's services at Boston. Staff suggested that Advanced and Specialist Practice Nurses could replace junior doctors and support the medical rota although there were also concerns that these roles would reduce ward nursing numbers further. It is possible, that the development of a clinical career structure for nurses may provide a benefit to recruitment of children's nurses at all bands. Many units are seeing the benefits of developing Advanced Practice and the RCPCH can provide links and practice examples to speed up the programme.

5.4.14. There should not however be reliance on being able to 'buy in' ready trained Advanced Nurse Practitioners as a swift solution as there is a national shortage and a general reluctance to travel for jobs. It will take 2-3 years (depending on experience) as a minimum to develop individuals from the commencement of training to a level where they can support the medical rotas. This will require the commitment of the consultants to 'sponsor' and support their training but this investment is likely to be beneficial in the longer term if the roles can be made interesting enough to challenge and stimulate qualified ANPs. If sufficient mentorship capacity is available, supporting future APNPs to undertake training in one or two cohorts can provide support for learners and aid retention in the long run. In the longer-term future developing one of these roles to a Consultant Nurse can provide leadership and a focus on future service development.

Recommendation: Explore the benefits of developing advanced practice children's nurses and review how these operate in other services, with a view to establishing the role at both sites to support the medical rotas.

Trainee Experience

5.4.15. Trainees report that working at Pilgrim has not been a popular option; it is considered by the Deanery to be not sufficiently busy, with only a small neonatal unit and not much opportunity to gain clinical experience. Tier 1 (ST1) trainees are therefore sent for just six months and Tier 2 (ST4) for a limited time. It is seen as a good placement if they are struggling with exams or need a quieter pace for a period. That said, feedback from trainees about the substantive consultants has been good, with reports of the unit being turned around to make the most of the opportunities available for training.

5.4.16. In April 2018 HEE announced that from 1st June 2018 Tier 1 trainees would no longer be allocated to the Pilgrim site, but travel out from Lincoln to cover some shifts in daytime only. An eight-bed unit in place at the time (now 12 beds) was insufficient for a full training placement and the high proportion of locums also meant that the training experience was reduced significantly despite some good consultant teachers. Consolidating the trainees at Lincoln was considered by the deanery to enable them to receive more complex neonatal experience. The trainees could be assigned to ambulatory care at Grantham and Boston, but not out of hours.

5.4.17. This was unsettling for the staff and management at Pilgrim and was reflected back by the user groups who became worried for the future. The decision was made because the Deanery had for many years requested improvement in the working and learning balance

for trainees at Pilgrim but reported that nothing had changed, and apparently trainees had "threatened to resign their National Training Numbers (NTNs)" if assigned to Pilgrim so radical action was required.

5.4.18. Trainees need 12 weeks' notice of their assignment which can be before their exam results are known, and a large proportion apply for London Trusts leaving fill rates lower in more rural communities like Lincolnshire. There is some longstanding resentment within the Trust about inconsistency and perceived lack of transparency over allocations. It is of note that the Deanery does not include Lincoln on its website[9], citing only Nottingham, Leicester and Derby and the reason for this is unclear.

5.4.19. Trainees spoken to by the review team reported that they did not feel valued or supported by the Trust; they were expected to fill service gaps including unsocial hours and did not receive recognition for this contribution in comparison to how they were treated in other rotations. Their training time was often not protected. There was little surprise that rota gaps were hard to fill as trainees' communications systems are good and consequently there were fewer applications for these posts.

5.4.20. An example was that no trainees attended the slot allocated for them to meet the review team; it had been arranged for a time when they were all on service, courses or leave but nobody had found this out ahead of the visit and the trainees were disappointed to hear that they had missed their chance to participate. We did arrange for telephone input after the visit however.

5.4.21. Since the review visit there has been considerable work with the Deanery and trainees are now working well under the new arrangement (Since 1st August). There is more time for teaching and learning and they are not working overnight. This is a potentially sustainable situation and provides support to the rotas and a positive experience by the doctors of the opportunities available at the Pilgrim site. See also .para 6.4.6

Recommendation: Work closely with HEEM to Increase the profile for training and compliance with requirements to enable continuing rotation of Tier 1 doctors through Pilgrim

[9] https://www.eastmidlandsdeanery.nhs.uk/paediatrics

5.5. Medical Staffing – Lincoln County

5.5.1. Medical staffing at Lincoln comprises eight consultants including 2 locums. At the Tier two level there are currently eight posts comprising five trainees, one Associate Specialist, one Teaching Fellow and one Speciality Doctor. Two further Specialty Doctor /Senior Clinical Fellow posts (ST4+) in neonates and general paediatrics are being advertised to a total of ten posts to enable a 1:10 rota and support out of hours for the emergency department. At Tier 1 there are eleven doctors[10] covering the ward, ED and neonatal unit, including 4 GPVTS trainees, 4 whole time ST1-3s, 1 junior clinical fellow on the neonatal unit and 2 F1 Junior Doctors, all based in Lincoln. There are four Advanced Neonatal Nurse Practitioners rostered to cover the neonatal unit.

5.5.2. The consultants at Lincoln are feeling under pressure and consequently unable to assist their colleagues in Boston; although some conduct outpatient clinics there at least one had never visited the Pilgrim. The concept of 'one team two sites' has not yet become embedded and the Lincoln consultants are concerned that the proposed requirement to cover both sites is hampering their own recruitment process as applicants have pulled out, potentially putting both sites at risk The review team did however hear of Pilgrim consultants covering rota gaps on Lincoln night shifts and the neonatal unit but this was an ad hoc arrangement.

5.6. Emergency Care

5.6.1. The Emergency Department at Pilgrim has been facing its own staffing pressures with just one substantive consultant and two long term locums, and is reliant upon the paediatric service to support attendances.

5.6.2. There is a triaging/streaming service provided by Primary Care Lincoln Community Health service through either a GP or an Advanced Clinical Practitioner (ACP), who can prescribe and order x-rays, located in the new ED front entrance. This arrangement was reported to deal with 20% of attendances but it was not confirmed whether the nurses have children's nursing competencies. All ACPs must complete a range of paediatric competencies for which they are assessed. Each ACP has access to the Royal College

[10] From a current Job description

of Emergency Medicine competencies document[11], which includes paediatric competencies. Two of the four ACPs were reported to have completed these.

5.6.3. The ED consultants reported that the paediatricians arrive swiftly in ED when called and they had not noticed any increased risk despite the current staffing pressures at Tiers 2 and 3. There were two RN(C) on duty when the review team visited with a total of three employed but at least six wte are required to provide one per shift at all times. All anaesthetic staff were reported to have basic competencies to level 4. There is no 24/7 anaesthetist on site but three anaesthetists are paediatric trained and will usually attend if required and available even if they are not rostered on-call. Whilst resuscitation is possible without a paediatrician there would be no diagnosis or long-term planning for attending children if they were not present. All staff in ED have EPLS and 88% of nurses have Level 3a safeguarding training.

5.6.4. The level of support from CAMHS for children with mental health problems has improved and referrals are collected directly from ED where appropriate with no need for the inpatient ward to be used as a place of safety. There is good telephone access to the crisis team who will attend if required. Training for ED staff in managing patients with mental health problems was planed when we visited.

5.6.5. The East Midlands Ambulance Service (EMAS) is currently under significant pressure. Midwives told us that emergency ambulances can take up to four hours to arrive as the unit is considered to be a 'place of safety' and the paediatricians quoted six hours for one retrieval with limited facilities for waiting for transport. EMAS does not have specialist transport for neonates, and the CenTre Neonatal Transport Service will only pick up from neonatal units so would not attend a midwife led unit. The Lincolnshire and Nottinghamshire Air Ambulance based at RAF Waddington can provide some cover but cannot be relied upon in bad weather or at night and sometimes only road access is possible.

5.6.6. Since 1 August two privately-run staffed ambulances have been stationed at Pilgrim to transport women in labour, newborns and children to other units if they no longer meet the new criteria for staying at Pilgrim. Monitoring of their use is essential to map demand and

[11]https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2017/june/pub-005883.pdf

acuity, alongside the numbers of patients travelling direct to Lincoln County and other neighbouring units as a result of the changes at Pilgrim.

Recommendation: Continue to support and audit use of the dedicated ambulances for safe transport of sick children and maternity patents who require transfer from Pilgrim

5.7. Activity Governance and Quality Improvement

5.7.1. Whilst the published Board papers and various summits have provided extensive analysis of the current activity and the staffing required to deliver it, they do not explore the approach to provision of care, whether services are using the latest techniques to maximise efficiency and effectiveness and the overall satisfaction and outcomes experienced by patients and their families. Staff reported in June that they felt the service at Pilgrim was 'unsafe' but were reluctant to say so for fear of it being closed, indeed one member of staff felt the service was 'broken at every point' and there was 'lots of interference from people from outside'. This is explored in 5.9.2..

5.7.2. The review team has not seen the divisional quality report but noticed that the audit data and patient feedback information displayed on boards on the ward was out of date, with some 'monkey' feedback going back to 2016.

5.7.3. There was little evidence of active Quality Improvement within the service. Staff were weary of the pressure and had little time, 'headspace' or senior encouragement to develop innovative techniques or new ways of working. Trainees were limited in their capacity to do audit or QI projects due to the intensity of their roles, but investment in this kind of work is just as important as filling the rota gaps in motivating staff to provide more effective care.

5.7.4. Modern ways of working, use of technology and telemedicine and harnessing the enthusiasm, expertise and innovation often brought by newer members of staff within a robust governance framework are key ingredients to a successful service. This can lead to a climate and culture that attracts high calibre staff and maintains morale whilst enabling significant improvement and efficiency if supported at every level. All doctors are required to demonstrate Quality Improvement activity as part of revalidation and there

is a wide range of tools and techniques available, including from the RCPCH, to help teams improve their systems and outcomes.

Recommendation: A focus on Quality Improvement, including working differently, learning from findings and shared whole-team goals should be implemented as soon as possible.

5.7.5. Whilst there is a high level of confidence and trust in Pilgrim by parents and carers it is essential that there is active monitoring of incidents and outcomes and a climate of continuous exploration as to what could have been 'even better'.

5.7.6. The paediatricians at Pilgrim are all relatively new appointments (less than 2 years) and 25% of medical staff are locums, mainly because they are not yet fully trained to take on a substantive role, but this proportion risks impeding development and growth of the service as substantive doctors are too busy supervising colleagues.

5.7.7. The RCPCH has published a series of standards under the 'Facing the Future' heading with practice examples and metrics that enable a service to assure itself that it is offering safe and effective care. Many units in the UK are now benchmarking against these standards and the audit findings from 2017. Although the RCPCH has not been furnished with the latest governance and quality reports by the Trust there are a number of initiatives which are becoming the norm in other units and which should be actively developed at Pilgrim such as:

- Consultant presence at peak activity – usually 5 - 9pm – seven days a week to speed diagnosis and decisions. 38% of units achieved this in 2017.
- Rapid Response next day clinics for urgent GP referrals to reduce ED attendance
- GP access to immediate telephone advice, (86% of units offer this) plus some units offer an email advice service – responding to queries swiftly to reduce referrals and share learning
- Link consultant paediatricians to GP practices to seek feedback and share information about the service. 7.4% of units had this in 2017
- Community children's nursing service seven days a week– supporting families whose children have complex care needs or are recently discharged from hospital or ED. 14.8% had a 24/7 service in 2017
- Clear care pathways agreed with primary care for common acute conditions. 16.9% had these in 2017

5.7.8. Development of a formal governance structure to accommodate the changes to the service provision at Pilgrim and provide a visible record of progress and priorities will also help to change ways of working and stimulate improvement. This would usually include a dashboard on PALS, Datix, Complaints, Incidents alongside the formal Trust-level targets.

5.7.9. For patients, parents and carers, there is little information on the Trust website about the service, how to access help and the current arrangements for paediatric care at Pilgrim. This makes it harder for parents to self-care and make choices about where to seek advice.

5.8. Leadership and Vision

Perceptions of management intent

5.8.1. Medical and Nurse staffing problems in the paediatric service have been a serious concern at the Trust for almost four years with short-term fixes and summits providing only temporary solutions. In 2014 work by the previous medical director on a Trust wide clinical strategy recognised the continuing failure of both sites to meet RCPCH workforce and other standards and proposed consolidation of all paediatric activity on one site, presumed (but not stated) to be Lincoln. The review team was told that there was little consultation or engagement in development of the strategy, a lack of clarity about the emergency care implications and little or no assessment of population-based risk. However, recruitment activity and subliminal management communications promoted the perception that Pilgrim was set for closure which continues to increase the difficulty of recruiting permanent staff. Despite assurances from senior management and politicians that Pilgrim will not close a previous strategy suggesting it might was at the time of the visit still available on the Trust intranet

5.8.2. More recently an Acute Service Review conducted internally by the Trust aimed to save some £80m and recommended diverting some services, but the review team was told they did not explore where these patients would go nor if there was capacity and the emergency department staff were not involved.

5.8.3. The consultants at Pilgrim are feeling increasingly undervalued which has resulted in their ceasing to cover the tier 2 rotas. They clearly stated that they will not consider resident on call, although there were reports of better staff engagement since April. Many staff

continued to feel alienated and that the Trust was trying to downgrade services at the site. Much more work was required to rebuild their confidence in management.

5.8.4. The leadership of the Trust have stated their current vision of 'Two sites, one team' and strive to explain their commitment to Pilgrim but although the phrase was used many times during our visit it was only by management and we did not see evidence that the clinicians were working this way. Those at Lincoln are reluctant to support their Boston colleagues and the distances make routine shift cover an ineffective use of consultant time except in exceptional circumstances. It was pointed out that almost all the meetings and Risk Summits about the problems at Pilgrim had been held at Lincoln and that words were not underpinned with actions from senior staff; discussions often did not include staff from Pilgrim.

5.8.5. The Trust Board papers of 29 June recognised Trust-wide concern about turnover and vacancy rates which were driving up agency spend, and the recent announcements regarding relaxation of visa rules for doctors and nurses would not resolve the issues. A review of the approach to recruitment was under way to determine what more the Trust can do to improve recruitment rates and change the workforce model and establishment to a lower cost model. Many of the solutions are included in this and the previous section and there must be a focus on why staff should and would choose to work in Lincolnshire over another unit. Indeed even the basic advertisements for the roles lack lustre and energy when compared with other similar jobs advertised elsewhere.

Recommendation: Expedite changes to the approach to recruitment including a refreshed and dynamic marketing approach.

5.8.6. There is less planned to tackle retention, which should perhaps be more of a priority, exploring with staff why turnover is so high and what they see are attractive and less attractive reasons for working at the Trust /unit. The review team identified several corporate behaviours and approaches evidenced and reported which were contributing to the poor morale and consequently may increase the tendency for existing staff to seek jobs elsewhere. For example the high rates paid to locums compared with substantive staff covering similar work, lack of involvement in decision making and development of solutions, delays in engaging midwifery staff, key meetings about Pilgrim being held away from Pilgrim and the ongoing message that the Pilgrim services will close.

Recommendation: Focus on retention and development of existing staff through genuine involvement and listening to and acting upon their concerns.

Going forward

5.8.7. At the time of the visit the Trust had just appointed an interim project manager to focus on the development of a paediatric solution. This appeared to have been a positive move, reducing the pressure on the Medical Director and enabling more involvement of clinicians. The Clinical Director post for the Women & Children's Division, vacant since January 2018 remains unfilled. The Head of Service for Pilgrim has been appointed although as a neonatologist he has strong links to Lincoln County and a Paediatrician from Pilgrim has been appointed as clinical lead for Pilgrim. They are increasingly providing input to discussions but without the authority or time to provide director-level decision making and continuing support is needed to help colleagues improve performance, review pathways objectively and motivate them towards Quality Improvement initiatives. Strong project management and clinical leadership is needed by paediatrics and also surgery/obstetrics/anaesthetics, although support from the Associate Regional Medical Director, NHS Improvement, Midlands and East has been helpful in devising solutions to the current problems.

Recommendation: Identify an experienced Project Manager / Clinical Director to work with the Clinical Leaders to continue to lead and shape the vision and drive implementation and innovation for the maternity and paediatric teams going forward

5.9. Liaison with other units and Networks

5.9.1. When services are being redesigned it is essential to discuss plans with other nearby acute units and stakeholders such as the ambulance service and local GPs. Neighbouring sites including Peterborough, Grimsby, Kings Lynn and Nottingham are themselves dealing with service and some financial pressures and are not in a position in the short term to accept significant extra admissions, and the ambulance service does not have capacity for additional transfers. Although one of the options proposed to address staffing shortages was sharing or rotation of doctors from other units there is insufficient capacity anywhere for this to be considered a viable option and there is a clear indication

that the trust needs to be able to accommodate its own catchment through service redesign and modernising

5.9.2. There has, as previously mentioned been extensive engagement from NHS Improvement, NHS England, CQC, Health Education East Midlands and other stakeholders towards helping to shape a safe and effective model. The Clinical Senate in East Midlands has also been engaged to assist in identifying options for the service. Comprising clinicians and managers from neighbouring Trusts alongside lay representatives, the Senate is meeting on 12th September 2018 to consider the current model and review a longer term plan to further support the Trust.

5.9.3. The neonatal ODN and specialist commissioners have been involved with the neonatal provision and support the unit at Pilgrim as a Level 1 unit from 34 weeks, but would not support provision if the threshold was raised to 37 weeks, as originally proposed.

5.9.4. The STP Expert reference groups established during 2016 covered the major pathways. but this did not result in a clear strategy for maternity, children and young people and this will be discussed at the Clinical Senate on 12th September 2018. Since the STP covered only Lincolnshire, rather than neighbouring counties, large scale cross-county redesign of acute services was outside the scope and there is no strategic agency which is in a position to do that.

5.10. Maternity Services

5.10.1. The interdependency of paediatric and maternity services has been clearly understood by some but not all the local population and there is a strong lobby group demanding to know what the future model of care will be after the paediatric position is resolved. At the time of our visit there were no problems with recruitment to medical and midwifery posts and a two-site full obstetric option was anticipated as there is an expectation that the birth rate will increase. However, neither site had a co-located Midwife Led Unit despite increasing demand nationally for such choices for women, and the model of care was largely obstetric-focussed. There is a new simulation suite for maternity and refurbished ward which women very much appreciate – apparently preferring Boston to Lincoln as a birth environment. Outcomes are reported to be good with no major issues and the staff were reported to be very caring, but, like paediatrics, modernisation of the service and investment in a Quality Improvement culture was reported to be overdue.

5.10.2. The Lincoln better births strategy and implementation plan for Lincolnshire 2017, are founded on engagement with Women and their families through the Maternity Voices Partnership. The strategy sets an ambitious vision over five years to increase the homebirth rate to 10% and midwife led care to 40% and plans for movement to 60%. A range of models for provision have been explored and are being rolled out including 'pop-up' birth centres, four maternity 'hubs' and better links between midwives and health visitors. The review team was told that only 37% of women are currently assessed as having a low risk pregnancy and therefore suitable for consideration for non-obstetric midwifery only care so this is an ambitious target.

5.10.3. Maternity staff were concerned that they had not been consulted or involved in discussions about the paediatric changes which could significantly affect delivery of the better births strategy, and the Trust's maternity webpage does not give details about the changes to service. Midwives are the main point of contact between the Trust and expectant parents who were concerned about the newspaper reports of closure. None of the obstetricians from either site reported having been involved in development of the options; although the Head of Midwifery is involved but the midwives and doctors told us that they felt that the plans were something that was "being done to them".

5.10.4. From April 2018 staff engagement in the decision making had apparently improved and we understand that following the RCPCH visit a more comprehensive communications plan was established which included maternity staff.

5.11. Staff and Public Engagement

5.11.1. In line with the NHSE assurance process for service change are the four tests from the Government's Mandate to NHS England which apply in all cases of major service change.

- strong public and patient engagement
- consistency with current and prospective need for patient choice
- a clear clinical evidence base
- support for proposals from clinical commissioners

5.11.2. Appendix 5 sets out in more detail the range of engagement activity being undertaken by the Trust and the wider health community, and Appendix 6 summarises the RCPCH survey responses from over 800 people. During the visit the review team attended a public meeting to discuss the forthcoming changes to the service, visited the Paediatric Wards at both sites and looked at facilities for play and enriching the environment and experience of children and young people. Whilst the play worker works with children going to theatre, they also support children to feedback on their experiences and there was evidence of patient comments on walls in the ward together with 'feedback clouds'. A lot of the feedback however seemed to have been there for some time. There was not a great deal of evidence from the visit regarding significant engagement with children and young people but this may be available in the engagement strategy, quality report and discussion with Patient Experience and Engagement Manager.

5.11.3. Since April there have been greater efforts to engage with the public and politicians around the potential service changes, initially through the efforts of the 'Save our Hospitals' group who arranged and funded two large public meetings (one of which the review team attended) providing a platform for local politicians and the Trust management to address concerned patients, carers staff and public. Separately, engagement with staff has gradually improved since April and with the appointment of an interim manager further engagement work has taken place with three public meetings planned and regular update newsletters from the Chief Executive.

5.11.4. There have been staffing changes within the communications team which has hampered development of a co-ordinated communications plan, and more could still be done through social media – for example the ULHT Young people Twitter account is cited on the Trust's paediatric webpage but has no mention of the changes.

5.11.5. Our recommendations in this report reflect the emerging themes from the engagement and support the first two tests set out in 5.11.1 as follows:

- Links between maternity and paediatrics are not understood by many women and families at the moment. However, as they are now realising that there will be an impact on Boston based maternity care many women express fears about what will happen
- There is a need for a safe, good quality locally based paediatric service as there are challenges of travel and access for families living in Boston
- Mixed community voices and needs of East European women and families should be understood and addressed; there is high demand for women's and children's services

from this community who have a high proportion of people aged 25-34. There are real difficulties with communication and lack of early connection with services is an issue

- The needs of specific groups such as children with long term conditions or specialty needs must be addressed or health inequalities will widen
- Women are concerned and 'frightened' about not being able to have their baby at Pilgrim maternity service. They are becoming anxious about the impact of travel and they worry as they don't know what is happening
- There are well researched and argued cases from local people about the lack of involvement and communication regarding what has been happening in terms of planning to address staffing issues.

5.11.6. Whilst the Trust has been open and honest in responding to concerns about the future of the Pilgrim, the lack of confidence and enthusiasm to keep it open and the focus on safety has not helped recruitment and retention. It is essential to "change the narrative", to bring families and leaders from the community into the design of the new approach and to co-design based on the needs of the service and local population, building ownership of the solution, rather than design something and put it for consultation.

5.11.7. The Trust website has information on Care Opinion[12] feedback and the Trust launched a children's feedback project at Lincoln County Hospital as a partnership between Patient Opinion and Monkey wellbeing and aims to get more children and young people to give feedback about their health care experiences.

5.11.8. There was a strong presence of 'Monkey' on the ward, posters on doors, staff wearing badges, information in the parents' room and responses are discussed at team meetings the information was out of date, we did not see action as a result of the initiative and the website has no stories.

5.11.9. The Trust reports in its engagement strategy in its Quality Account for 2016-17[13] that it has a robust Patient Experience Committee which oversees the wide range of patient feedback data received within the Trust. However, the information displayed on Pilgrim ward notice board did not suggest engagement with CYP & the feedback was old.

[12] https://www.careopinion.org.uk/blogposts/565/meeting-the-needs-of-our-youngest-patients
[13] https://www.ulh.nhs.uk/content/uploads/2015/06/FINAL-Quality-Account-2016-17.pdf

Recommendation: Actively involve local user groups as well as children young people, parents and those from minority communities to "change the narrative" and improve engagement with the public, including development of written, web based and social media resources

5.11.10. The Trust should review the level and quality of information and communication to ensure it is open and honest so that that women and families have accurate information regarding the services available. Key to the concerns of families in Boston are travel and transport as there are significant challenges for members of the community in the Boston area where car ownership may be low and there are pockets of deprivation. Their view is that some paediatric and emergency services appropriate for children need to be on site so the community will need reassurances about the safety of travelling in an emergency.

5.11.11. In terms of staff engagement, there was mixed feedback from staff about morale and feeling that they could raise concerns and were listened to. Some staff reported morale as good in their area, whereas others were less engaged with the hospital and did not feel as comfortable to raise concerns.

6. Options for Future Provision

6.1 Progress with the STP, the region's policy drivers and impact of proposals.

6.1.1 Lincolnshire Heath and Care brought together the four CCGs in Lincolnshire with the four community ambulance and social care providers, the Local Medical Committee, Health Watch and the Council. Its five-year plan from 2012-3 was the basis of the local STP, involving hundreds of people in the strategic planning meetings and a range of work streams including women's and children's. A systematic process within this review did consider that Pilgrim may be the better site to consolidate given the population and neighbouring units but the scoring did not quite support this option. Whilst current work on the STP has not been shared with the review team nor other partners, the proximity of the scoring did suggest that further consideration be given to expanding the Pilgrim site, not least due to service and capacity pressures at neighbouring units. A review taking suitable weighting of the first two elements of the four tests (strong patient and public engagement and consistence with the need for patient choice) may, if repeated, reach a different conclusion.

Recommendation: Work with the CCGs to reconsider the future of Pilgrim in the light of population projections and opportunities to expand rather than contract the service within the STP.

6.1.2 The Pilgrim site has been the subject of intense scrutiny over several months since the workforce crisis has escalated. The impact of a vociferous and well-informed lobby group, campaigning for retention of the existing model has increased political involvement and scrutiny with a range of stakeholders being involved, including NHS England, Women's and Children's Improvement Board, NHS Improvement, CQC, Heath Education England, the East Midlands Clinical Senate and other key stakeholders supporting summit meetings and offering advice, models and ideas. As one staff member commented 'there are good people involved but decision making is difficult'. Concerns were expressed that the provided service must be able to cope with the "3am moment of a sick child or bad delivery over an hour away from the next acute team".

6.1.3 The concerns of the population are not unfounded and it has been difficult for the management at the Trust to respond to all their questions. This is partly as they have truthfully explained the uncertainty of the position, because they did not yet have answers, which has unsettled the public. The impact of the changes on the provision of maternity services is clear on paper but has not been fully addressed by the proposals in terms of the psychological and emotional impact of indecision and uncertainty on local expectant parents and their midwives.

6.1.4 Whilst the longer-term aim of the STP was consolidation, the review team had not seen the latest draft and details of how it will be achieved safely and the palatability of this option are still uncertain, with a number of enabling projects that must be completed before this can be realistically considered.

6.1.5 The review team considered the two 'viable' options proposed by the Board. Under option 2/3 (closure at night) there were serious concerns about the availability and time taken to transport sick children, expectant women and neonates to an alternative site, although the dedicated ambulance vehicle has alleviated these concerns albeit at a high cost. There remain strong memories of the closure of Grantham hospital and the anxieties that provoked relatively recently and the phrase 'temporary solution' is widely seen as a shot cut to a permanent arrangement.

6.1.6 There remain concerns about the capacity at Lincoln County in terms of staffing and estates to manage additional patients. This would be a transfer of services to an 'already oversubscribed service at Lincoln' and no guarantee that all the staff would willingly transfer too. Capacity in other units which are also stretched must also be considered.

6.2 The national picture for workforce and new ways of working

6.2.1 There are three drivers to the design of a successful, safe paediatric service:
Money – A considerable amount of service redesign is triggered by the need for financial balance within an NHS organisation. The Neonatal Network should facilitate greater sharing of specialist staff to enable skills development and understanding of patient pathways. A service that is reliant on locum cover immediately stands out to a Board as needing review with questions about whether a service is value for money and sustainable in the longer term. Some reconfiguration models can shift the expenditure,

for example introducing a daytime only assessment unit can improve staffing costs but transfer additional activity to ambulance transfer teams; offering pay premiums to attract and retain specialist staff may destabilise other teams in the area's health economy and a lack of strategic investment to develop staff competencies can result in high vacancies and an under skilled workforce.

6.2.2 Standards – For acute paediatrics the RCPCH's Facing the Future standards, RCN-defined nurse staffing levels, BAPM neonatal standards and the Intercollegiate Emergency Care Standards[14] provide a template for design of safe paediatric services (see Appendix 3. They include integrated provision across primary and community-based care to manage acute admissions and reduce emergency presentations through investment in care closer to home and alternative models of urgent care.

6.2.3 Workforce - As predicted in the first Facing the Future in 2011, nationally the paediatric workforce is diminishing as demand increases, and new ways of working are essential to ensure long term provision of safe services nationally[15]. There are an estimated 241 WTE career grade vacancies (133.4 consultant, 57.5 SAS, and 50.5 WTE other non-training grades) and applications for paediatric training have fallen 27% in 2 years. Reconfiguration to cope with the changes is happening in many units and nationally 45% of consultants have resident shifts in their job plan which might include late evenings as well as overnight.

6.2.4 Difficulties recruiting to medical posts and filling rotas has resulted in a range of innovative practice across the UK. Roles such as physician's associates[16] (B7) (or assistants) and Doctors Assistants (B3) to support tier 1 have been introduced to support medical practitioners. The Advanced Nurse Practitioner is the role most commonly introduced to support tier 2 medical roles. Where this role has been introduced successfully, it has brought stability to service provision and aided training of both medical and nursing staff. The role has been used since the early 1990s in neonatal units and is now seen in critical care and emergency departments throughout the country. More recently, it has been introduced into primary care and assessment units, having benefits on both waiting times

[14] Due for relaunch June 2018
[15] RCPCH State of Child Health – the paediatric workforce
[16] https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions/roles-medical-associate-professions/physician-associate

and service delivery. See para 5.4.14-15 which outlines the Trust's current situation with respect to ANPs and recommendations for the future.

6.2.5 Some units are finding opportunities recruiting from overseas either directly or through the RCPCH's Medical Training Initiative scheme. Whilst this can take a period of time to recruit suitable qualified doctors, and ensure their training is sufficient to work in the UK, these two-year placements can provide a steady stream of Tier 2 support so long as the working environment enables time for training and development of skills. See para 5.411 for the Trust's progress with this initiative and recommendations for the future.

6.2.6 Although the implications are still being discussed, the recent GMC case of Dr Bawa-Garba has raised anxiety amongst doctors about working in environments which are significantly understaffed. Although the current model (from 6th August) at Pilgrim is reported to be working well so far, the implications of consistently running a service with insufficient staffing and poor governance processes could potentially result in staff refusing to work at all.

6.3 The proposed way forward

Pilgrim site

6.3.1 The relatively deprived nature of the population, lack of personal transport, high proportion of families without English as a first language and significant comorbidities amongst the childbearing population make it imperative that there are emergency medical and maternity facilities available for mothers and children at the Pilgrim site. Whilst it is clear that Option 1 – continuing as at present - is not sustainable, a 39 mile drive (on top of that to reach the Pilgrim) in an emergency is too far and there is no indication that there will be sufficient ambulance cover to provide transfers for a PAU that closes overnight. A model is therefore required that matches essential demand with a minimum level of competent staffing to ensure safety for patients and adequate support for those staff when they need it.

6.3.2 The review team proposes in the medium and longer-term development of a hybrid medical staffing model for PAU with a low acuity overnight service. This is a model being developed in other areas but is not yet formally working in the UK. The ward would not actually admit overnight as numbers requiring this are low, so the service can manage

with just one paediatrician resident overnight with hybrid Tier 1-2 competencies as minimum and the consultant on call from home.

6.3.3 Consultants should be present 15 hours a day, 8am until 11 pm, with more flexibility at weekends, to ensure that the Facing the Future 14-hour standard is met and a consultant is present at peak times. The model would include a late ward round by the consultant and overnight resident to agree an escalation and treatment plan for each child. This would reduce the need to call the consultant overnight; the service would not be admitting patients so the consultant would be non-resident at home. All paediatricians should work this model unless there are exceptional reasons not to. The consultants should not routinely cover the Tier 2 rota although they could be rostered to work overnight by agreement, and there may be nights when they need to be resident when the minimum competencies could not be achieved with more junior resident staff.

6.3.4 Development of a stronger Tier 2 rota to ensure the resident doctor was confident with sufficient competencies to cover ED, neonates and any urgent resuscitation is key, so a hybrid model of combined competencies would be needed based around those basic principles and the availability of skilled support from midwives and ED staff.

6.3.5 The rota could include some consultant resident sessions as above, (but this should not be compulsory), together with trust grade doctors, a continuing turnover of 2-year MTI trainees, ST4+ paediatricians (in the longer term if the Deanery supports the model) and Advanced Nurse Practitioners. It will take 2-3 years, depending on previous experience, to develop these staff from the commencement of training to ensure that they have the competencies needed to run this arrangement safely.

Recommendation; Develop a model and plan for a 'low acuity' overnight service at Pilgrim through development of hybrid Tier 2 working and explore with the medical and nursing teams a migration towards this arrangement

6.3.6 The model requires the maintenance of a daytime/evening Tier 1 rota, and the current loss of trainees at the Pilgrim site must be addressed, alongside development of other roles such as Advanced Nurse Practitioners to supplement the rotas.

6.3.7 An APNP can cover the neonatal unit as well as the paediatric ward for infants from 37 weeks, but with NLS and assessed competencies could cover from 34 weeks. In children's wards nurses are managing care of ex-premature infants who have been

discharged from neonatal units. Competency assessment is the key to ensuring the role developed meets the needs of the local service.

6.3.9 The whole unit needs to move to have the psychology and philosophy of a PAU whilst supporting those children staying overnight and their families. Whilst some progress has been made to date in redesigning pathways of care to focus on early decision making, there is a considerable shift in attitude and risk assessment required to challenge assumptions and use networks and telemedicine for advice rather than 'wait and see'. It is particularly important to develop assessment criteria and thresholds for admission and early plans for discharge.

6.3.10 Moving to this model will require a clear plan and robust oversight, as it will include development of ANPs, continued recruitment of MTI doctors, and regular review of impact, alongside development of innovative approaches to workforce planning and clinical care.

Recommendation: Introduce a monitoring and outcome analysis process to review admissions, transfers and outcomes, to demonstrate the model is working safely at the current time, and through transition to new ways of working.

6.3.11 A project board with senior leadership and perhaps external challenge should be established which will review progress against agreed success metrics at six-monthly intervals and have the authority to decide whether in the long term the approach will be successful, or revert to option 3. This can continue the work carried out by the fortnightly 'task group' that developed the model during the summer of 2018 and link to the new Children's Board that has been established within the Trust.

Recommendation: Appoint a 'Project Board' from stakeholders or use the Clinical Services Transformation Board to monitor progress with the vision and plan and provide external scrutiny.

6.3.12 It is crucial that the Trust and stakeholders actively change the narrative and language, establishing a positive approach to maintaining the service instead of a focus on the 'unsafe' service, and ensuring that staff 'feel part of it', participants rather than 'victims', with the ideas and solutions of staff being integral to service design and configuration

Recommendation: Actively promote a positive vision backed with a robust communications plan that drives forward change and develops confidence and

commitment to a whole-county solution that embeds a sustainable service at Pilgrim.

Lincoln Site

6.3.13 It was clear that the paediatricians at the Lincoln site are struggling to maintain their own service and do not have capacity or enthusiasm to provide additional support for colleagues at the Pilgrim beyond existing liaison over transfers and cross cover of specialist clinics and occasional shifts. The distance is just a little too far for comfortable cross site working and the benefits do not currently justify the travel time, although Pilgrim consultants will readily cover Lincoln County rota gaps. The management ethos of 'one service two sites' was a long way from reality in Lincoln but a plan should be put in place towards greater joint working, shared protocols and fluency in transfer and cross referrals for specialised review.

6.3.14 For trainees, the experience at Pilgrim provides an important opportunity to work in a rural setting and the challenges that it provides and some cover of twilight shifts should be encouraged along with protected time for training and learning. See section 5.4.15 on.

6.4 Enabling Actions

6.4.1 It is imperative, for the model outlined in the previous section to succeed, that there is strong and committed leadership to take forward what must be a shared and clearly articulated vision that the unit is viable with a long-term purpose, given the population served, which will inspire staff to want to work there. The development of a long term strategy for paediatrics and by association maternity services should be a priority, to prevent the continued lurching from one staffing crisis to the next and enable planned developments to mitigate unmanageable demand for acute service. There are standards and frameworks from the RCPCH and others to provide confident support for such a strategy and a published document will provide potential job applicants with a positive and attractive. message that is more likely to secure their interest.

6.4.2 Key to efficient working, swift discharge and reduction of repeat attendances are the working guidelines for referral and management of patients. Given the high numbers of locum doctors (who tend to make more conservative decisions) it is important that decision algorithms are clear and monitored and that the Assessment Unit operates in a

new way with a focus on discharge. The recently published RCPCH guidance[17] can help with this and should be used in the design of the units at both sites.

Recommendation: Adopt the RCPCH standards for PAUs at both sites as an approach to managing ambulatory patients not requiring long term stays, with pathways of care and SoPs that focus on discharge and decision making in the ED and PAU and monitor length of stay and outcomes.

General practice referrals

6.4.3 There is support from the GP community for a paediatric presence at Boston but there is scope to extend the liaison with GPs once the future is secure to reduce referrals. Facing the Future Together for Child Health[18] recommends the following measures:

> *1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.*
>
> *2. Each acute general children's service provides a consultant paediatrician-led rapid access service so that any child referred for this service can be seen within 24 hours of the referral being made.*
>
> *3. There is a link consultant paediatrician for each local GP practice or group of GP practices.*
>
> *4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs*

6.4.4 The community hub approach, as being developed in the Better Births model, could provide more locally based services for children with a county wide approach to developing primary and community based care including pharmacists and nurses.

6.4.5 Commissioners the review team spoke to were not certain what model they wish to commission but recognised that the uncertainty within the Trust was damaging staff morale and raising anxiety amongst the population.

[17] 2017 https://www.rcpch.ac.uk/resources/standards-short-stay-paediatric-assessment-units-sspaus
[18] https://www.rcpch.ac.uk/resources/facing-future-together-child-health

Trainees

6.4.6 Whilst it is important to ensure protected training time it is also important that trainees are involved with the whole service in an environment of support and encouragement. A well developed and forward thinking ambulatory unit could provide a great training opportunity, with trainees attending on 1:8 rotation to staff it 9-5, or preferably extend into the evening to catch the peak attendance. Better advertising and publicity on the HEE website would help those trainees in post to feel valued and promote the sites to other potential recruits.

Recommendation: Rethink the 'offer' for trainees, and use positive publicity and media to make the posts attractive.

Nursing

6.4.7 To implement a model of nursing which will work for both the hospital and community setting will require considerable investment in recruitment and retention. Full implementation is unlikely to be realised until the first group of ANPs is trained and the first cohort of children's nurses graduates from Lincoln University in 2022. In the meantime, work can be undertaken to develop existing nurses to encourage retention in the service and development of services for local children. See section 5.3 for recommendations.

Neonatal services

6.4.8 Infants under 34 weeks gestation are currently transferred out (from August 2018) – this could be lowered gradually to 32 weeks if midwifery and neonatal staff were trained in neonatal life support and there was confident, substantive Tier 2 support such as ANNPs. the challenge would be persuading ANNPs to stay where the work is not complex so some rotation or even bespoke training to cover both paediatrics and neonates has been developed in other areas. A training programme to develop Advanced Nurse Practitioners on a rolling basis should be part of the nursing and medical workforce strategy to ensure sufficient numbers of ANPs to cover 24 hours and support professional development.

Elective surgical activity

6.4.9 The service undertakes around 1100 surgical procedures per year, and sometimes there is no capacity at Lincoln for them so children are transferred to Boston. There was some concern when bed numbers reduced at Boston as elective surgery was suspended at the end of February but this was restored in June 2018. It is important to retain day surgery

for children on the Pilgrim site to retain nursing staff and the competencies of the anaesthetic team.

Recommendation: Retain and develop the day surgery service at the Pilgrim site with a catchment across the Trust's footprint.

Pure PAU model – making option 3 permanent

6.4.14 It should be part of the plan that if recruitment and mentoring fails to secure sufficient staff or applicants for the new Tier 2 roles within one year then it will not be possible to maintain safe trained overnight paediatric cover. The paediatric service will need to work daytimes only, say from 8am, closing at 11pm with the department emptied through transfer or discharge in the evening.

6.4.15 In such a situation ED and he neonatal unit would lose on site paediatric medical support overnight and the neonatal unit would close, requiring the obstetric unit at Pilgrim to become a low-risk Midwife Led Unit with all births under 37 weeks being transferred to other units. The implications on capacity at other units is being evaluated but in itself would pose considerable risk not least as staff may be unwilling to transfer and a shortage of midwives could compound capacity issues.

7. Conclusion

7.1 This review has been carried out alongside involvement of several other parties focusing on the significant staffing problems at the Pilgrim and challenges to the ULH paediatric service as a whole. During the course of the review an interim model was developed to maintain paediatric services for over 90% of patient activity whilst supporting the staffing problems through locum cover.

7.2 Our proposed solution supports the current model but suggests actions towards greater sustainability, with a step-change in approach and strategy for the Pilgrim. This will need strong leadership and investment in Advanced Nurse training alongside alterative and innovative ways to manage care safely and attract and retain staff within available resources. We will continue to work with the team wherever possible to help with achievement of this objective.

Appendix 1: The Review Team

Lead reviewer:

Dr David Shortland MD FRCP FRCPCH DCH has been a paediatrician for 27 years in Poole, Dorset, including ten years as neonatal lead and twelve as clinical director. David was the lead clinician for the rebuild of the paediatric department in 2005 and currently leads on Clinical Quality for paediatrics.

Following five years as member, then Chair, of the Clinical Directors' Special Interest Group, in 2006 David was elected as the National Workforce Officer for the RCPCH leading the 2007 national workforce census and designing a cohort study of trainees to provide a clearer understanding of the current and future workforce, helping to define how the role of paediatricians can evolve to provide consultant delivered care and hence safe and sustainable services.

David was elected Vice President (Health Services) in 2009 and played a central role in developing strategy for Child Health Services in the UK supporting paediatricians through the challenges of radical reform to the health service, working time legislation and service re-design. During David's five years in post he developed a national template for the resident paediatrician and was lead author for "Facing the Future" standards for acute paediatric services, widely quoted as a template for good practice. David led national audits of these standards in 2013 and 2015 and the steering group extending the standards to care outside hospitals. Since 2014 David has been clinical adviser to the RCPCH Invited Reviews programme and has led a number of high profile reconfiguration, individual and service reviews.

Paediatric reviewer:

Dr John Trounce MD MRCP FRCPCH DCH was a Consultant Paediatrician in Brighton for 25 years, retiring in 2015. He covered general paediatrics and epilepsy, neonatal intensive care in the first ten years and more recently seven years as Named Doctor for Child Protection. He was Clinical Director for Women & Children for five years during which time he oversaw the reconfiguration with a neighbouring service, commissioning of a new Children's' Hospital, transformation to teaching hospital status and innovation such as neonatal nurse practitioners and an ambulatory care service. Dr Trounce was a member of the RCPCH Council for six years.

Nursing Reviewer:

Carol Williams MSc BA (Hons) RGN RSCN RNT is a Nursing and Healthcare Consultant. She works largely in children's services and has led compliance projects and service reviews across a range of health sectors, including community services and complex care, emergency care and hospital based children's services. She has been a Specialist Advisor at CQC and has undertaken a range of work for the RCN including updating guidance documents relating to children's nursing and covering the Children's Nurse Advisor role. She also offers clinical supervision support and training and currently supports groups of school nurses in private schools.

Carol held posts as Consultant Nurse in Paediatric Critical Care, Acting Head of Nursing for Children's Services and Lead Nurse for Children's Critical Care at the Evelina Children's Hospital at Guy's & St Thomas'. She was Area Manager at the Healthcare Commission and the Care Quality Commission. She is a qualified teacher who has taught on both undergraduate and Master's nursing programmes for a number of organisations. She has participated in public inquiries including the Bristol Royal Infirmary Inquiry and more recently as nurse adviser to the Inquiry into Hyponatraemia Related Deaths in Northern Ireland.

Currently, Carol is representing the Royal College of Nursing on NHS England children's workforce and training groups and has previously held a number of national and international roles including Nursing President of the European Society for Paediatric and Neonatal Intensive Care and Chair of the Royal College of Nursing and Paediatric & Neonatal Intensive Care Forum. She contributed to the development of the National Service Framework for Paediatric Intensive Care and was involved in benchmarking national paediatric intensive care standards. She has been invited speaker at national and international conferences and co-edited a children's intensive care nursing textbook.

Lay Reviewer:

Cath Broderick, MSc, BA (Hons) Hon FRCOG is an independent consultant and director of We Consult, and has extensive experience as a professional in the field of patient and public engagement, consultation and facilitation. She has a real passion for working with individuals and organisations to manage change and build patient and public engagement that makes a difference.

Cath was a member of the Independent Reconfiguration Panel until this year and was part of their programme of reviews of contested reconfiguration consultations across the country, including the large-scale reconfiguration of Children's Heart Surgery.

She is Chair of the Royal College of Obstetricians and Gynaecologists Equality and Diversity Committee and until recently chaired the RCOG Women's Network. She has worked with the College to develop its approach to patient and public engagement, is a Lay Examiner for the Part 3 MRCOG and a Lay Assessor for RCOG Invited Reviews.

In the past year she has worked with the Centre for Public Scrutiny on a series of engagement workshops for local authority elected members to understand the health context and drivers of change and also providing targeted advice and support to STPs/ACSs on managing relationships with local government. She is currently leading a review of the development, effectiveness and approach of the ten local Healthwatch organisations in Greater Manchester.

Cath has also supported the development of effective methods and strategy for patient and public engagement in maternity services in a challenging and complex environment across Cumbria and Morecambe Bay. She has worked with the Department of Health, Healthwatch England and the CQC, and at regional level in Greater Manchester and the North West.

Management Support:

Sue Eardley joined RCPCH as Head of Health Policy in January 2011 and now leads the Invited Reviews programme for the College. Sue originally trained as an engineer /project manager in the oil and gas industry but changed career when the first of her three children arrived. Sue spent 13 years as a non-executive and then Chairman of an acute hospital trust in south London, alongside a range of voluntary activities including national and local involvement in user representation and as a Council member of the NHS Confederation. Sue led groups contributing both management and user input to the DH England Maternity National Service Framework and chaired her local MSLC for four years. Before joining the RCPCH Sue spent six years full time heading up the Children and maternity strategy team at the Healthcare Commission and then CQC, overseeing strategy, design and delivery of all inspections and reviews in England of maternity, child health and safeguarding.

QA reviewer: Dr Graham Stewart is a paediatrician/neonatologist in Glasgow

QA reviewer: Dr Frances Ackland is a retired consultant paediatrician from Northampton

Appendix 2: Abbreviations

A(P)NP	Advanced (paediatric) nurse practitioner
APLS	Advanced paediatric life support
CAU	Children's assessment unit
CCG	Clinical commissioning group
CDC	Child development centre
CESR	Certificate of Eligibility for Specialist Registration
CQC	Care Quality Commission
CYP	Children and young people
ED	Emergency department
EPLS	European paediatric life support
FY	Foundation year
GP	General practitioner
GP OOH	General practitioner out-of-hours service
HCA	Healthcare assistant
HEEM	Health Education East Midlands
M&M	Morbidity and mortality (conference)
MTI	Medical Training Initiative
NLS	Neonatal life support (training)
RAC	Rapid access clinic
RCPCH	Royal College of Paediatrics and Child Health
SAS	Specialty and associate specialist
WTE	Whole time equivalent

Appendix 3: Reference documents

Facing the Future – Together for Child Health (RCPCH 2015) was developed jointly by the RCPCH, the RCGP and the RCN. It builds on the Facing the Future: Standards for Acute General Paediatric Services, expanding them to acute care outside the hospital. The standards apply across the unscheduled care pathway and aim to improve health care and outcomes for children and young people with acute illness

Safe sustainable and productive staffing for neonatal care and children and young people's services is a series of improvement resources to help standardise safe, sustainable and productive staffing decisions in neonatal care and children and young people's services

Facing the Future – Standards for acute general paediatric services (RCPCH 2015) updates the original 2011 guidance and details ten service standards relating to clinical cover, expertise and child protection

High Dependency Care for children- Time to Move on RCPCH-PICS 2015 defines Level 1,2,3 Paediatric Critical care (PCC) units and sets out standards for care in Level 1 and 2 units including network working and commissioning arrangements for England.

Short-Stay Paediatric Assessment Unit (SSPAU) (RCPCH 2017) – Standards for this increasingly common component of urgent and emergency care for children and as a hub for the provision and coordination of emergency ambulatory care. These standards have been developed to provide a blueprint for development and for audit of existing services.

Service standards for hospitals providing neonatal care 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit.

A whole system approach to improving emergency and urgent care for children and young people - a practice step by step guide and resource pack (NHSIII 2011) Provides a toolkit of resources and tips to implement the recommendations contained in Focus on: Children and Young People Emergency and Urgent Care Pathway (NHS Institute for Innovation and Improvement 2008). Improvement and Assessment Framework for children and young people (NHS Improvement February 2018) supports and enables senior children and young people's nurses to achieve good and outstanding care standards for children and

young people's health services. It integrates policy guidance with the most frequent reasons the Care Quality Commission (CQC) gives for rating children's services as 'requiring improvement' or 'inadequate', as identified in our review of CQC reports rating these services as such in April 2017 The framework should be implemented using quality improvement methodology, embodying the principle of continual learning. Organisations should adapt it to meet their local population and workforce needs.

The Future for community children's nursing – challenges and opportunities (RCN 2014) sets out the current policy direction in the UK and internationally and the requirements for appropriate services to deliver improved outcomes closer to home

Advanced Nursing practice – Subject Guide (RCN 2017) provides a guide to credentialing and the various standards documents relating to advanced nursing practice, advanced nurse practitioners and the benefits and competencies required for nurses to achieve this status.

Appendix 4: Sources of information

Documents were provided by the Trust relating to the following areas:

- Pilgrim Hospital Children's Services Trust Board papers
- Letters to NHSI re children's services at UHLT
- New PAU models explored by the CCGs
- CQC notification of Section 31 Enforcement Action

The following individuals participated in the review)

Ward Manager Children's ward 4a
Matron Maternity
Consultant paediatricians at Pilgrim
General Manager Women's and Children's clinical directorate
Head of Service Obstetrics and Gynaecology, Pilgrim
Clinical Director, Theatres, Anaesthesia, Critical Care and Pan-Trust chronic Pain
Consultant in Anaesthesia and intensive care
Consultant paediatrician, Lincoln site
Chair and Accountable Officer, Lincolnshire East CCG
Chief Nurse Lincolnshire East CCG, SRO Local Maternity System, Lincolnshire
Consultant paediatrician, Lincoln and College Tutor paediatrics
Medical Director
Matron children's community services and interim Matron Children's Acute Inpatient Services
Consultant paediatrician and Head of Service
Interim Project Manager Women and Children
ED Nurse Band 7
ED nurse
ED Consultant lead (anaesthetics)

Appendix 5: Patients' and Families' perspectives and issues

A 5.1 Initiatives in place across the Trust

A5.1.1 The following is a summary of the way that the local health system finds out what views and experiences patients and families have about services and care. This may not be a complete description of the range of activity but summarises what we found from documented evidence, information heard in evidence and during visits to wards and departments during the review team's visit. We still await sight of the Divisional Quality Report to furnish more detail.

A5.1.2 Information on the FFT comes from the ULHT website. The Board papers include performance monitoring with some more recent data on FFT (23% response re maternity and 97% would recommend ULHT units) however there is no narrative on site specific units or paediatrics.

A5 1.3 It is anticipated that information regarding patient and family feedback from engagement and patient experience activity will be included in the quality report to be provided and identified in discussion with the Communications Lead and the Patient Experience and Engagement Manager.

A5.1.4 The ULHT Equality Impact Assessment (April 2018) has evidence regarding '*Consolidation of Inpatient Children's and Young People's services to Lincoln County Hospital and subsequent impact on Neonatal and Maternity Services'* that engagement sessions with parents were conducted by the Trust (date of engagement is not noted). The methodology is not described and the full report is not appended to the EIA report although relevant emerging themes are highlighted including:

- 10.3% of children in Lincolnshire had a disability and consideration is required about their access to services. those for Young Carers of disabled parents and disabled parents receiving maternity care.
- Proper consideration needs to be given to children with specialty needs who require stability and familiarity as well as those children with long term conditions such as heart, epilepsy, chronic asthma who need immediate attention
- Consider deprivation - some areas are classed as being among the 10% most deprived in the country, with many families relying on public transport, EMAS or expensive taxis

- Centralisation of maternity and paediatric services would require provision for partners and other children to stay overnight and more children will be sent out of the county for care as Lincoln County Hospital will not be able to cope.
- Lincoln, Boston and South Holland have the greatest proportion of foreign-born residents but Boston is the only district in Lincolnshire where the proportion of non-UK born (15.1%) is higher than England's rate. This population group tends to be younger than the general population of Lincolnshire, suggesting a higher demand for women's and children's services. Service change in Boston will have a negative impact on this population group
- Concern around lack of provision for holidaymakers on the East Coast at peak times

A5.1.5 For Maternity services the CQC Patient Survey was conducted in February 2017 with 121 respondents. Results were broadly similar with other Trusts[19]. For children and young people it was conducted between February and June 2017 and overall the service was given a rating of 'about the same' for all categories in comparison with Trust departments across the country. Exceptions were 'Play' which was not applicable (presumably as there were too few responding) and 'Privacy' which was rated 'better'.

A5.1.6 The CQC full report identifies some areas requiring improvement in services used by women and children and where delivery of care would have an impact. These correlate with the findings from our visit and are in the process of being addressed :

A5.2 STP & CCG engagement and feedback

A5.2.1 During our visit we met the Chief Nurse Lincolnshire East CCG & SRO LMS Lincolnshire, who outlined the range of engagement carried out in relation to services for women and children, including work allied to the STP, CCG and Better Births implementation. The LECCG *Patient Engagement and Experience Strategy 2016-19* provides an overview of the broad range of activity and levels of engagement planned and delivered. LECCG also recognises the need to reach a wider group of patients and communities who may not always have opportunities to be involved and give feedback. They are planning to develop a programme of engagement work, including continued Engagement with Children and Young people.

[19] https://www.cqc.org.uk/provider/RWD/survey/5

A5.2.2 The LECCG survey of 141 respondents on access to emergency care indicated 29% expected to be seen the same day. 33% expected to be reviewed by someone with specialist paediatric training and 63% showed support for GPs to extend their services for children. Concerns continue about safety if travelling in an emergency with no consensus on travelling times for emergency care. The majority of parents take their children to ED at Pilgrim in an emergency and expect admission there - there is a 'culture' of using A&E for children's health needs, often because parents say that it is extremely difficult to get an appointment from their GP. They expect a paediatrician to be available.

A5.2.3 The STP has undertaken engagement (predominantly as LHAC) with the public in order to understand their views about services. The STP summary document states that during a period of 3 years over 18,000 people have been engaged and provided feedback. At this stage we have not seen the detailed report of engagement undertaken but it included youth groups and discussions with parents attending weighing sessions with Health Visitors for their babies. *Broad issues have emerged from STP engagement including*

- The difficulty in getting a GP appointment and waiting times for referrals for things like tests, operations and assessments
- The need for services to be more joined up – people are frustrated with having to repeat their healthcare stories several times to different professionals
- Communication needs to improve between professionals and care for patients with lots of different conditions must be coordinated better.
- Not knowing where to go for support and difficulty in accessing a service, often because of the distance to travel
- Wanting services to be as close to home as possible although it was understood that it is not possible to have all services available close to home, all the time
- The importance of services being safe and good quality for all people in the county

A5.3 Better Births

A5.3.1 The nationally-encouraged programme of public engagement and listening events specifically related to implementation of the *Better Births* is described on the Lincolnshire Better Births website which provides information on local listening events and uses the stories of women and families to understand birth experiences, what worked and what can be improved or changed https://betterbirthslincolnshire.co.uk/your-stories/

A5.4 SOS Pilgrim Public Meeting

A5.4.1 The review team attended a public meeting of the SOS Pilgrim group on 14th June. SOS Pilgrim was formed as a 'Focus Group' Autumn 2015 comprising 'concerned Boston Residents who joined a surgery Patient Liaison Group (PLG)' However the group has developed into one with a specific interest in maintaining quality locally based services for children and young people at Pilgrim Hospital. They have undertaken significant research and made many approaches to ULHT to stress the importance of access to services.
The well attended meeting provided an opportunity for health providers, commissioners and the local MP to hear views of families and answer questions on the strategy and approach for the delivery of children and young people's services. Members of the Review Panel also took the opportunity to outline the purpose of the Review and answer questions.

Questions and issues raised

- Concerns about the capacity at Lincoln County in terms of staffing and estates to manage more patients. This would be a transfer of services to an 'already oversubscribed service at Lincoln'
- Queries about whether there will be an adequate number of appropriately trained paediatric nurses to deliver a safe, quality service
- Highlighted challenges of the timeframe of August/September to deliver the options outlined
- Experiences of families given whereby scheduled operations for their children at Pilgrim Hospital had been cancelled and no new date had been given. Queries to the staff about the reason had received the reply 'Have you not seen the paper?'
- Concerns about nursing and midwifery staff having to travel to Lincoln and belief expressed that this was not safe to return home when staff had been working late and long hours
- Women were concerned about where they are going to have their babies from 1st September
- Communications has been poor and members of the audience stressed that it had taken action and pressure from the SOS Pilgrim group to get a dialogue established with the public
- People felt that they had not been engaged to give their views and experience in order to shape any options or proposals
- There was a sense that plans had been in development for some time and that the current situation of 'crisis' was being used to force through change. The situation had not developed overnight and a strategic approach that included engagement should have been developed
- The audience was not clear on how the STP was related to the development of services and criticised the communication at the early stage
- The size and diversity of the Eastern European community was highlighted and their needs and approach to using services needed to be taken into account. The Panel agreed to ensure that the questionnaire was translated into a number of languages such as Polish.

A5.5 Discussion with midwives and obstetricians, Pilgrim

A5.5.1 There was a specific focus on the needs of those using maternity services at Pilgrim in a group discussion with midwives and obstetricians. The approach was informal but the unique insight of the group was valuable as the participants were in regular contact with women and families and their relationships meant that the views and experiences around birth and caring for children were shared with them regularly. In addition, all of the group lived locally, could share their own experience and that of local people who talked to them. Issues raised included

- Women are concerned and 'frightened' about not being able to have their baby at Pilgrim maternity service. They are becoming anxious about the impact of travel and they worry as they don't know what is happening
- There are high levels of deprivation and this impacts on the health of women in Boston. BMI of 50+ common
- Many women don't drive and households may not have access to their own transport. Travel will be difficult for them and also the roads are poor
- Midwives and obstetricians did not feel that they have been involved in discussions about the clinical strategy or development of options 'victims rather than participants'
- Needs of Eastern European women must be addressed. There are real difficulties with communication and early connection with services needs to be addressed. They are used to a medical model of childbirth and expect to come into hospital at the last moment

A5.6 RCPCH Survey

A5.6.1 In advance of the visit a survey was launched as part of the review, as it is important that we listen to the experience and expectations of local people who use or work within the service. Their views provide valuable insight into what people value and what they need, particularly if they have used children's hospital services in the last 18 months or are a member of staff. We highlighted that we wanted to know how families use the services when a child is unwell, and what arrangements in future will ensure that babies and children continue to receive safe, effective care, given the current difficulties in recruiting medical staff with the expertise to provide some of the more complex care. There were 820 submissions to the survey which are analysed in Appendix 6.

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