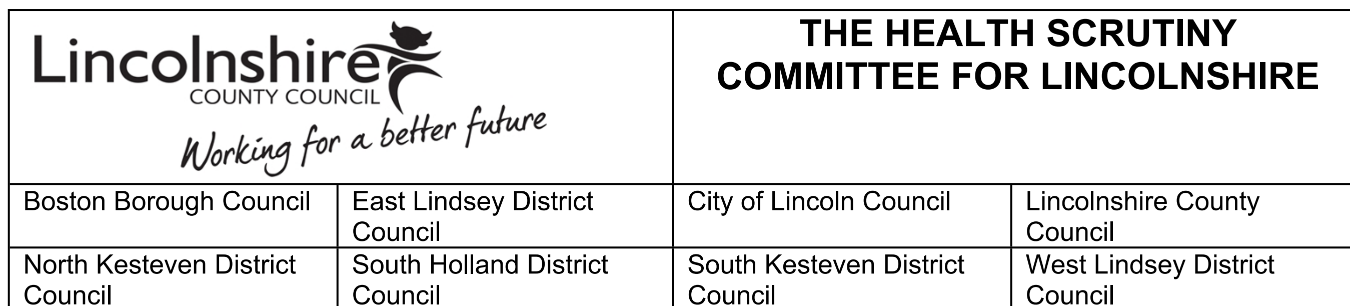
Public Document Pack



| Lincolnshire County Council — Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
|---|---|---|---|
| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |


Direct Dialling: 01522 552104

E-Mail: katrina.cope@lincolnshire.gov.uk

Democratic Services
Lincolnshire County Council
County Offices
Newland
Lincoln LN1 1YL


**A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 16 May 2018 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL**

**MEMBERS OF THE COMMITTEE**

County Councillors: C S Macey (Chairman), Mrs K Cook, M T Fido, R J Kendrick, Dr M E Thompson, R H Trollope-Bellew, M A Whittington and R A Renshaw

District Councillors: P Gleeson (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council), P Howitt-Cowan (West Lindsey District Council) and 1 Vacancy (City of Lincoln Council)

Healthwatch Lincolnshire: Dr B Wookey

## AGENDA

| Item | Title | Pages |
|---|---|---|
| 1 | **Election of Chairman** | |
| 2 | **Election of Vice-Chairman** | |
| 3 | **Apologies for Absence/Replacement Members** | |
| 4 | **Declarations of Members' Interests** | |
| 5 | **Minutes of the Meeting of the Health Scrutiny Committee for Lincolnshire held on 18 April 2018** | 3 - 16 |
| 6 | **Chairman's Announcements** | 17 - 20 |
| 7 | **Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Risk to the Safety of the Service** *(To receive a report from Jan Sobieraj (Chief Executive United Lincolnshire Hospitals NHS Trust), which provides the Committee with background information as to the issues faced by the Children and Young Persons Services)* | 21 - 104 |

| Item | Title | Pages |
| --- | --- | --- |
| 8 | **Patient Access to Primary Care - Lincoln Area**<br>*(To receive a joint report from Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG) and Wendy Martin (Chief Nurse, Lincolnshire West CCG), which provides an update to the Committee on the development of primary care services to meet the patient need following the closure of the Lincoln Walk-in Centre on Monks Road)* | 105 - 146 |
| **LUNCH 1.00PM - 2.00PM** | | |
| 9 | **Winter Resilience Review 2017/18**<br>*(To receive a report from Ruth Cumbers (Urgent Care Programme Director and Senior Responsible Officer, STP Urgent Care Programme) and Simon Evans (Director of Operations, United Lincolnshire Hospitals NHS Trust) which provides the Committee with an update on the system resilience during Winter 2017/18)* | 147 - 156 |
| 10 | **Health Scrutiny Committee for Lincolnshire - Work Programme**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer), which invites the Committee to consider and comment on the content of its work programme)* | 157 - 160 |

Richard Wills
Head of Paid Service
8 May 2018

**HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**
**18 APRIL 2018**

**PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)**

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, Dr M E Thompson, R H Trollope-Bellew, R A Renshaw and R Wootten.

Lincolnshire District Councils

Councillors P Gleeson (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and Mrs R Kaberry-Brown (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Karen Brown (Director of Finance, United Lincolnshire Hospitals NHS Trust), Mike Casey (General Manager, TASL), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Dr Sunil Hindocha (Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group (LWCCG)), Martin Kay (Head of Commissioning, Lincolnshire West CCG), Jan Sobieraj (Chief Executive, United Lincolnshire Hospitals NHS Trust), Kirsteen Redmile (Lead Change Manager, Integrated Care, STP System Delivery Unit) and Derek Laird (Chief Executive, Thames Ambulance Service Ltd).

County Councillors L Wootten and M A Whittington attended the meeting as observers.

Melissa Darcey and Liz Wilson attended the meeting as members of the public and gave statements to the Committee as set out in Minute Number 86.

82 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor M A Whittington and P Howitt-Cowan (West Lindsey District Council).

It was noted that the Chief Executive, having received notice under Regulation 13 of the Local Government (Committee and Political Groups) Regulations 1990, had appointed Councillor R Wootten to replace Councillor M A Whittington on the Committee for this meeting only.

An apology for absence was also received from Councillor Mrs S W Woolley, Executive Councillor for NHS Liaison and Community Engagement.

83 DECLARATIONS OF MEMBERS' INTERESTS

Councillor Mrs P F Watson advised the Committee that she was currently a patient of United Lincolnshire Hospitals NHS Trust.

84 MINUTES OF THE MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 21 MARCH 2018

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 21 March 2018 be agreed and signed by the Chairman as a correct record, subject to the meeting closed time being amended to read *'3.25 pm'.*

85 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised that since the despatch of the agenda for the meeting, emails had been received concerning the orthopaedic service at Grantham Hospital. In response to the emails the Chairman advised further that he had written a joint letter to Jan Sobieraj, the Chief Executive of United Lincolnshire Hospitals NHS Trust and John Turner, Senior Responsible Officer for the Lincolnshire STP to ask for further clarification regarding this and other matters. The Committee noted that once responses had been received they would be circulated to all members of the Committee. It was reported that this matter would also form part of the Acute Services Review, which would be considered by the Committee at its 16 May 2018 meeting.

As Jan Sobieraj, the Chief Executive of United Lincolnshire Hospitals NHS Trust was present at the meeting; the Chairman invited him to provide a brief statement concerning Grantham orthopaedics.

The Committee was advised that Professor Tim Briggs, National Director for Clinical Quality and Effectiveness, NHS Improvement had assisted United Lincolnshire Hospitals NHS Trust with the issue of orthopaedic service provision in Lincolnshire to improve quality and standards going forward.

It was reported that the Acute Service Review was still in its early stages; and that no firm decision had been made regarding service provision. It was highlighted further that any changes to services would be subject to consultation as part of the STP.

Some concern was expressed regarding the proposed removal of services from Grantham Hospital; particularly when further housing development was proposed, which would increase the size of Grantham. Reference was also made to the methodology of a review. The Committee was advised that there would be a wide review, and all options would be looked at and considered. It was clarified that the review was still at an early stage. Further clarification was given that the review was not being driven as a result of staff shortages. It was highlighted that the review was part of a national programme which would improve the quality of services provided.

It was highlighted that some services were very fragile as a result of staff shortages; and that a report would be presented to the Committee in due course.

In conclusion, the Chief Executive of United Lincolnshire Hospitals NHS Trust advised that he was not aware of the changes specifically identified in the said emails; and that any substantial changes to services would be subject to full public consultation, as well as consultation with the Committee.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 17 to 25; and the supplementary verbal update provided by the Chairman at the meeting be noted.

86 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - FINANCIAL SPECIAL MEASURES UPDATE

The Chairman introduced this item, and advised that attached to the report for the Committee's information were two Appendices. These Appendices related to:

- Appendix A - Update on Quality Special Measures; and
- Appendix B – Mortality rates at United Lincolnshire Hospitals NHS Trust.

The Committee were asked to primarily focus on the issue of Financial Special Measures at ULHT.

The Chairman advised further that he had received requests from two members of the public to speak on this item. The Committee was advised further that the requests had been received from Melissa Darcy and Liz Wilson.

The Committee was advised that it was proposed that each speaker would be allowed a maximum of three minutes to speak on the issue of Financial Special Measures first; this would then be followed by a presentation from Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust and Karen Brown, Director of Finance, United Lincolnshire Hospitals NHS Trust.

In their presentations to the Committee, the two presenters made reference to: the emails and letters from United Lincolnshire Hospitals NHS Trust staff; the continued overnight closure of the A & E Department at Grantham Hospital and to the continued lack of any progress towards its re-opening on a 24 hour basis; the proposed

intention to remove Orthopaedic trauma from Grantham Hospital and the effect that would have on the survival of the Grantham Hospital A & E. Reassurance was sought that consultation would be undertaken before the removal of Orthopaedic trauma from Grantham Hospital; the record of ULHT and its approach to public information and consultation; and due to the small amount of progress made by ULHT, what was the Trust Board's recovery plan; and what action the Health Scrutiny Committee would be taking to ensure that accurate, and timely information was provided, and that consultation occurred to ensure that services were preserved.

The Chairman of the Health Scrutiny Committee for Lincolnshire advised that United Lincolnshire Hospitals NHS Trust had stated that no changes to orthopaedic trauma had taken place at Grantham Hospital, or were planned to happen in the near future. This particular item was not for discussion as part of the agenda, but would be discussed further as part of the Lincolnshire Acute Services Review; and that the Committee would consider any proposals for Grantham Hospital following that stage. It was also highlighted that if any changes were implemented on the grounds of the health and safety of patients, the public or staff, these would be considered by the Committee as a matter of urgency, and as yet no such changes had taken place or were planned. It was also highlighted that the Committee had made two referrals to the Secretary of State in relation to the Grantham Hospital A & E Department. The Committee also noted that the Acute Service Review would be considered by the Committee at its 16 May 2018 meeting.

In response to the issues highlighted, the Chief Executive of United Lincolnshire Hospitals NHS Trust advised the Committee that closure of the Grantham A & E service was as a result of patient safety, and not as a result of financial measures. The Committee was advised further that it was the intention of the Trust to provide a better orthopaedic service at Grantham, similar to that being provided at Louth County Hospital.

The Chief Executive of United Lincolnshire Hospitals NHS Trust introduced the Financial Special Measures Update, which advised the Committee of the financial position of United Lincolnshire Hospitals NHS Trust, and the steps that were being taken to become financially sustainable.

The Committee was advised that a Turnaround Director had been appointed; and KPMG had been engaged to provide support in delivering a recovery plan to become financially sustainable; and to exit Financial Special Measures.

The Director of Finance, United Lincolnshire Hospitals NHS Trust advised that the recovery plan agreed with NHS Improvement was to deliver £16m of efficiencies in 2017/18. It was highlighted that the Trust was forecasted to deliver an £82.4m deficit for 2017/18. This figure was £5.4m greater that the revised control total of £77m agreed with NHS Improvement in December 2017. Paragraph 1.4 of the report identified the items that were responsible for the increasing deficit, which included winter pressures; contract challenges; additional cost of external support, and interest changes due to Financial Special Measures loan rate. It was noted that winter pressures had also had an effect on the amount of elective surgery being carried out; which had resulted in a loss of income for the Trust.

The Committee noted that the Trust had identified £19.7m of efficiencies for 2018/19.

Paragraph four of the report provided details relating to the three required elements to be completed to exit Financial Special Measures. Paragraph five highlighted the support being given to the Trust.

It was reported that the Trust had an ambition to deliver £30m of efficiencies in 2018/19; and was working to identify and implement additional schemes to increase the already identified £19.7m. Paragraph 6.4 provided details of the High Level 18/19 Financial Turnaround Programme.

Note: Councillor R A Renshaw wished it to be noted that he was an outpatient with Lincoln County Hospital.

During discussion, the Committee raised the following issues:-

- The support for the campaign to keep Grantham Hospital A & E open. It was reported that a signed petition with some 60,000 signatures was due to be delivered to the Prime Minister on 5 July 2018;
- Whether there was a plan in place to keep track of the money being spent. The Committee was advised there was a spreadsheet and tracker identifying where all the money was being spent;
- Reduction on agency staff – The Committee was advised that there had been a recruitment problem for many years; and there had been a reliance on locum and agency staff. It was reported that in the previous year there had been a positive recruitment campaign, which had resulted in a more positive position;
- Costs – It was confirmed that the Trust had to cover the cost themselves. Confirmation was also given that the Trust had to pay interest on the loans; and that there was a higher interest rate applied as a result of being in special measures. The Committee was also advised that external support was also an additional cost. One member requested the total cost associated with non-medical management. Some members felt that there needed to be a group looking at costs in more detail;
- The need to promote that the NHS Trust was improving its quality of care. Page 35 and 36 of the report detailed some of the achievements made during the year;
- Confirmation was given that the Trust was spending £2.5m a month to improve fire safety of their building for staff and patients. The Committee was advised that this was capital money being actively spent to improve the working environment;
- The need to establish what was happening with the STP;
- Paragraph 2.2 - breakdown of costs – Reference was made to the need to ensure that efficient buying was practised. The Committee was advised the Trust used the Purchase Price Index Benchmarking Tool, which was used by the whole of the NHS. Confirmation was given that the NHS pursued all opportunities;

- Some concern was expressed as to the costs associated with Senior Manager level;
- Further concerns were expressed to the neglect of patients and staff with regard to Fire Safety, to warrant the issue of two Fire Enforcement Notices;
- An explanation was provided as to the definition of Hospital Standardised Mortality Ration and Summary Hospital-level Mortality Indicator; and
- The need to lobby MPs for fairer funding for Lincolnshire's health services. Confirmation was given that Lincolnshire was unique; and that any support from the Committee would be greatly appreciated.

In conclusion, the Committee agreed to the setting up of a Working Group to have an in-depth look into the financial position of United Lincolnshire Hospitals NHS Trust.

The Chief Executive of United Lincolnshire Hospitals NHS Trust advised the Committee that paediatric services at Lincoln Hospital and Pilgrim Hospital Boston had become very fragile, but at the moment were safe; and that efforts to recruit suitable staff were continuing. It was noted that there had been a reduction in the number of children's beds at Boston. The matter would be considered by the Trust Board on 27 April and it was agreed that a paper would be presented to the 16 May 2018 meeting for the Committee's consideration.

The Chairman extended thanks on behalf of the Committee to the two presenters.

RESOLVED

1. That the information presented on the Financial Special Measures of United Lincolnshire Hospitals NHS Trust be noted.

2. That the update on Quality Special Measures (Appendix A to the report) would be subject to a further report to the Committee on 13 June 2018.

3. That the update on Mortality Rates at United Lincolnshire Hospitals NHS Trust (Appendix B to the report) be noted.

4. That a Working Group be set up to have an in-depth look into the financial position of United Lincolnshire Hospitals NHS Trust. That the above said Working Group comprise of Councillors C J T H Brewis, P Gleeson, Mrs R Kaberry-Brown, C S Macey and M A Whittington.

87 LINCOLNSHIRE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP - GP FORWARD VIEW UPDATE

The Chairman welcomed to the meeting Martin Kay, Head of Commissioning, NHS Lincolnshire West CCG and Dr Sunil Hindocha, Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group.

Consideration was given to a report from the Lincolnshire Sustainability and Transformation Partnership (STP), which provided information on the development of

GP Forward View as part of the Lincolnshire STP. It was noted that the GP Forward View was one of the four current priorities in the Lincolnshire Sustainability and Transformation Partnership, which the Committee had decided to look at in more detail.

It was reported that Lincolnshire CCGs were accountable for the delivery of the GP Forward View Programme of work. It was highlighted that the Primary Care Programme was influenced by the General Practice Five Year Forward View (GPFV), which brought together GP Federations, practices, CCGs and the Lincolnshire Local Medical Committee.

The Committee was advised that in addition to local initiatives, Lincolnshire had through the Local Medical Committee been successful in recruiting 26 GPs from abroad; and a second bid had been successful for a further 39 international recruits, which would enable Lincolnshire to reach its required target. As well as the recruitment Lincolnshire was also working with NHS England and others to achieve greater working flexibility to retain current GPs. Lincolnshire also had a target to increase the number of other staff in primary care, the target was to recruit a further 53 additional posts by 2020.

Paragraph 2.2 (1) and (2) of the report provided information as to the Primary Care Workload and Redesign. Particular reference was made to ensuring that existing capacity was being used appropriately; a number of initiatives being developed in primary care were shown on page 46 of the report presented; and to the fact that GPs were key contributors to the development of integrated neighbourhood working.

The Committee noted that significant change was required across general practice; and page 47 of the report identified 10 High Impact Actions, which included active signposting; developing practice teams; partnership working and developing self-care support.

The Committee noted further that with the workforce working differently in different areas would mean that improved infrastructure support would be required to enable them to be effective. This would be achieved by changes to information management and technology. Also, as services changed, some buildings would also need to change so that services could be delivered in a more appropriate environment. It was highlighted co-locating services would provide synergy and benefits for patients and staff; and that this factor would be particularly significant with the development of Neighbourhood Teams.

It was reported that many general practices were now working as part of federations or super practices, but some practices still remained independent.

In conclusion, the Committee was invited to provide feedback on the GP Forward View Update.

Note: Councillor K Cook advised the Committee that she was a Lincolnshire Partnership NHS Foundation Trust Governor; and a Lincolnshire NHS Foundation Trust service user.

During discussion, the Committee raised the following points:-

- The need to ensure that GPs continued to see patients in the first instance, to prevent conditions being missed. Reassurance was given that a patient would always been seen by an appropriate professional. Some members expressed their concerns regarding the national evidence that identified that 25% of appointments for GPs were avoidable. Reassurance was given that a number of pilots were being undertaken, one of which was Care Navigation Training, which would help practice staff signpost patients to the relevant health professional; and also help practice staff provide a better service. One member enquired as to whether mental health was part of the Care Navigation training and this was confirmed;
- Some concern was expressed to the number of people not attending scheduled appointments;
- A concern was raised regarding repeat prescriptions; and to the fact that prescriptions could only be collected by the patient, or their spouse;
- One member enquired as to why no consultation had been undertaken on the proposed changes implemented. The Committee was advised that engagement was ongoing relating to the changes, and that any significant change to a service would be subject to consultation;
- Increase in capacity – It was highlighted that practices working together provided increased capacity to patients. It was highlighted that the Sleaford Medical Group were extending their opening hours from October 2018; which would enable patients to be seen in their locality;
- One member requested information relating to GP practices with extended hours; and a question was asked as to whether pharmacies were extending their opening times as well. A further observation made was that GP practices had not been included in the Pharmaceutical Needs Assessment;
- Staff retention – The Committee was advised that there were a number of schemes operating to help retain staff, such as career breaks and part-time working. One member enquired as to whether medical insurance was something still provided to GPs; and
- A comment was made on the GP Forward View Update and the Integrated Neighbourhood Working as two separate items, as they were both very closely linked.

RESOLVED

That the Lincolnshire Sustainability and Transformation Partnership – GP Forward View Update be received and that a further progress report be received at a future meeting of the Committee.

88 INTEGRATED NEIGHBOURHOOD WORKING

The Chairman welcomed to the meeting Kirsteen Redmile, Lead Change Manager – Integrated Care, STP System Delivery Unit.

The Committee gave consideration to a report from the Lincolnshire Sustainability and Transformation Partnership (STP), which provided an update on the progress that had been made in the collaborative design and implementation of Integrated Neighbourhood Working. The report highlighted the key successes and the links to the GP Forward View programme. The Committee was reminded that Integrated Neighbourhood Working was one of the four priorities in the Lincolnshire Sustainability and Transformation Partnership.

In guiding the Committee through the report, particular reference was made to the national context behind Integrated Neighbourhood Working; the four characteristics that make up a Primary Care Home; the Lincolnshire context; Integrated Neighbourhood Working – 2017 onwards; Better Care Funding; and Integrated Neighbourhood Working Programme; and the progress made to date.

The Committee was advised that each Neighbourhood had identified a GP lead to support their local programme. It was noted that Phase 1 sites had plans in place; and had identified their next steps to ensure that by 1 April 2018; they would all have to be able to start to demonstrate Integrated Neighbourhood working in their area; and Phase 2 sites would start to implement planning and delivery of Integrated Neighbourhood Working from 1 April 2018.

It was noted that the progress of each Neighbourhood was being managed through the Countywide Learning and Development Forum and that each area was accountable to the Integrated Neighbourhood Working Strategic Group.

It was highlighted that the report was not a statutory consultation item within the scope of the 2013 Regulations; this was because the direct service impact on patients in terms of accessibility of services was not substantial enough to warrant a statutory consultation.

Detailed at Appendix A for the Committee's was a copy of the 'Neighbourhood House'.

The Committee had also received two further supplementary reports prior to the meeting, which provided details of the outcomes and impact on individuals who had been supported through the Integrated Neighbourhood working; and a making a Difference Case Study from the Gainsborough Neighbourhood Team.

During a short discussion, the Committee raised the following issues:-

- How the patient experience would be affected. The Committee was advised that the introduction of the Integrated Neighbourhood working would be a positive experience for the patient. The two supplementary reports provided confirmation that this was the case;
- The need for any structure to be clear. Acceptance was given that any changes would need to be communicated very clearly to patients;
- The need to ensure that all GPs become involved. It was noted that some GPs were more engaged than others; and that there was particular challenges in the east of the county and also Gainsborough. The Committee was advised

that East Lindsey District Council had been involved with Neighbourhood Teams since 2013. Officers confirmed that the district councils had a role to play with regard to Integrated Neighbourhood working;

- Some members still expressed concern at the lack of consultation that had taken place. The Committee was reminded that a lot of engagement and participation events had taken place in relation to Lincolnshire Health and Care, the predecessor of the STP;
- A question was asked as to whether GPs were aware of the voluntary mental health organisations that were able to assist them and ease the pressure on services. The Committee was advised that GPs were aware of these organisations; and that the Gainsborough case study was a good example;
- The Committee was advised that Sleaford at the moment was work in progress. Details relating to Phase 1, and Phase 2; and the three key roles that were identified as a must for each neighbourhood to have were shown on page 52 of the report presented;
- Some members agreed that a progress further report should be received by the Committee in 3 to 6 months' time and that a plan should be provided to identify the Integrated Neighbourhood areas and their designation. The Committee was also advised that work was ongoing across county boarders, as some Lincolnshire residents received their health care out of county;
- Vanguard – The Committee was advised that there were 50 Vanguards across the country delivering the new care model as part of the Five Year Forward View;
- The Grantham integrated working solution. The Committee was advised further details of the model to be adopted was shown on page 57 of the report; and
- Developer and Planning Contributions for NHS Provision. The Committee was advised that this item because of its wider ranging implications had been passed to the councils Overview and Scrutiny Management Board to consider as a future scrutiny review.

RESOLVED

That the Integrated Neighbourhood Working report be received; and that a further progress report be presented to the Committee in six months' time.

The Committee adjourned at 12:55pm and re-convened at 2.00pm.

Additional apologies for absence for the afternoon part of the meeting were received from Councillors M T Fido, Dr M E Thompson and Dr B Wookey (Healthwatch Lincolnshire).

89 NON- EMERGENCY PATIENT TRANSPORT - REPORT FROM TASL

The Chairman welcomed to the meeting Derek Laird, Chief Executive Thames Ambulance Service Ltd (TASL) and Mike Casey, General Manager, TASL.

The Committee were reminded that a report had been issued to them prior to the meeting. Figures relating to the March performance were circulated at the meeting for the Committee's consideration. Apologies were given for the lateness of the performance information for March. It was noted that the figures provided were only interim at this stage, and when finalised, a copy would be made available to members of the Committee.

The Chief Executive of TASL introduced himself; and provided the Committee with some background information relating to his knowledge and expertise.

The Committee was advised that since the last meeting, TASL had made further improvements: better management sustainability, the implementation of a performance improvement plan in February 2018; that work was ongoing with the CQC and Commissioners; and that the Quality Directorate had set up a High Impact Quality Team who were going into bases and working with local management teams to address issues and concerns. Details of the improvements were contained on pages 2 and 3 of the report presented.

Particular reference was made to the work that had been undertaken with voluntary car service drivers. The Committee was advised that since the revised offer had been sent to the voluntary car service, 16 of the existing drivers had returned. As there was now a realisation of the importance of the voluntary car service, the Committee was advised that TASL would continue working with them to improve relations. It was highlighted that a further revised offer would be going out to the drivers to encourage them to come back into the organisation. It was highlighted that the first 10 mile payment exclusion had been removed, and drivers would now get paid from when they left home.

The Committee was advised that a new call process had been implemented; which had led to some significant improvements in call answering times. The Committee was advised further that recruitment of staff continued; however a fleet expert was now overseeing the areas of Louth and Horncastle; and that an advertisement was to be placed for a Manager of the Contact Centre.

It was reported that journey planning was now part of daily routine; with the introduction of daily and weekly reporting to improve the KPI reporting, and the overall efficiency of TASL.

It was highlighted that there was still work to be done, but with the appointment of the new management structure, the current recovery action plan, and support from the parent company, HTG, TASL was expecting the current improvements to service delivery to continue.

During discussion, the Committee raised the following issues:-

- Some members were encouraged by the improvements made. Some concern was made as to whether the progress made was static. Reassurance was given that now some voluntary car drivers were offering their services again, it was felt that performance would improve further;

- The Committee was advised that TASL felt that it would be May 2018 before the progress trajectory was where it needed to be;
- One member asked whether TASL was still as stretched as it was when they first took over the contract. The Committee was advised that although North and North East Lincolnshire had given notice to terminate their contract, TASL would still be providing services during the 12 month notice period, and no further resources had become available;
- One member extended congratulations to TASL for their reconsideration of their position relating to voluntary car drivers; and
- Manual handling training. The Committee was advised that manual handling training was mandatory, and would be renewed each year. The Committee also noted that there had been agreement to introduce work base training, to ensure that jobs were being conducted correctly.

The Chairman extended thanks to TASL for their openness and to the fact there had been improvements to the service being provided.

RESOLVED

1. That the report on Non-Emergency Patient Transport Service for NHS Lincolnshire CCGs from Thames Ambulance Service Ltd be received.

2. That the next report on the Thames Ambulance Services Ltd be received in June 2018, with any urgent information highlighted to the Committee on 16 May 2018; then from June 2018 onwards, quarterly update reports be received from the Thames Ambulance Service Ltd.

## 90 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which enabled the Committee to consider and comment on the content of its work programme to ensure scrutiny activity was focussed where it would be of greatest benefit.

Detailed within the report were populated work programmes up to 11 July 2018, and on pages 65 and 66 was a list of items to be programmed.

The Committee was invited to put forward items for consideration, these included:-

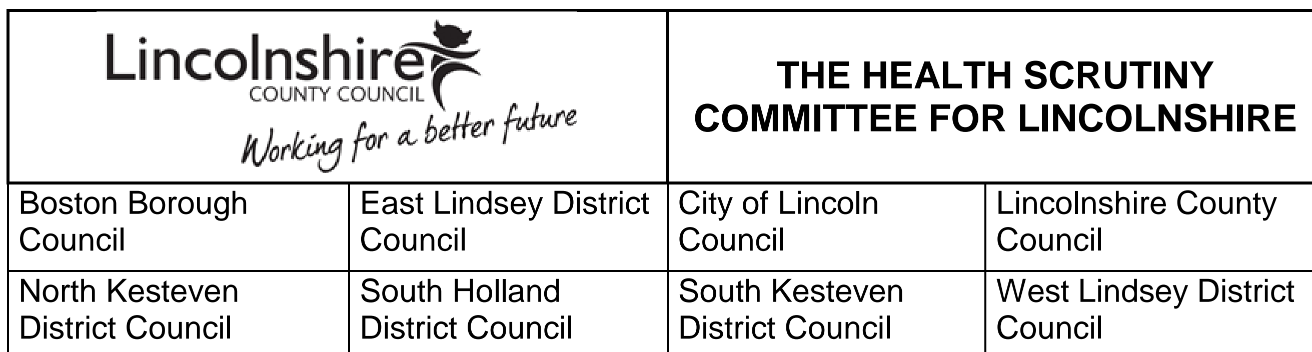
- Update from the ULHT Board on 27 April 2018;
- Paediatric Service Update;
- STP Quarterly update;
- Integrated Neighbourhood Working; and
- Orthopaedic Services at Grantham.

RESOLVED

That the work programme as presented be agreed subject to the inclusion of the items mentioned above.

The meeting closed at 2.55 pm

Agenda Item 6



| Lincolnshire County Council — Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
|---|---|---|---|
| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 May 2017** |
| Subject: | **Chairman's Announcements** |

**1. Lincolnshire Sustainability and Transformation Partnership - Quarterly Update, including Acute Services Review – Item Withdrawn**

The work programme for this meeting had included a quarterly update on the Lincolnshire Sustainability and Transformation Partnership (STP), including the Acute Services Review. However, when it became clear to me that there would be no information presented at this meeting on the content of the Acute Services Review, I withdrew the item. The draft paper submitted to me contained information on the national guidance and processes, rather than the content of the Lincolnshire Acute Services Review.

I have written to John Turner, the Senior Responsible Officer for the Lincolnshire STP, to express my disappointment with the draft paper, which compounds the Committee's frustration that it is not able to engage directly with the content of the Lincolnshire Acute Services Review.

In my letter I have referred to NHS England's guidance (*Planning, Assuring and Delivering Service Change for Patients – 1 March 2018*), in particular section 5.4 which states: *"It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service change. Early involvement will give early warning of issues likely to raise concerns in local communities and gives commissioners' time to work on the best solutions to meet those needs."*

My announcements on 18 April 2018 included a link to a website for the Humber Acute Services Review. This web-link provides access to a 19 page 'issues paper', published on 19 March 2018, on the various activities and timescales of the Humber Acute Services Review. In my letter I have urged the Lincolnshire STP to produce and make available a similar amount of information on the activities and timescales of the Lincolnshire Acute Services Review.

I will continue to seek meaningful information on the Lincolnshire Acute Services Review for consideration by this Committee, and my intention is that an item will be included on the agenda for 13 June.

## 2. Lincolnshire Sustainability and Transformation Partnership - Decision by Lincolnshire County Council Executive - 1 May 2018

On 1 May 2018, the County Council's Executive considered a report on the Lincolnshire Sustainability and Transformation Partnership. The intention of the report was to clarify the relationship between the County Council and the NHS in Lincolnshire.

The Executive expressed its concern that despite considerable effort being expended into producing a Lincolnshire plan for health and care over several years, nothing substantive has yet emerged.

The Executive decided to advise the NHS in Lincolnshire that it is the County Council's strong view that an external review should be undertaken of the governance arrangements for the Lincolnshire Sustainability and Transformation Partnership to provide:

(1) clarity of decision making and accountability;
(2) a clear definition of the roles of the partners;
(3) effective engagement with democratic processes; and
(4) robust oversight of the delivery of the STP plan and associated financial savings and changes in NHS expenditure.

## 3. Healthwatch Lincolnshire Report: *'When Will I be Seen?' - Patients Experience of Accessing GP Appointments*

On 16 April 2018, Healthwatch Lincolnshire published *'When Will I be Seen?' Patients Experience of Accessing GP Appointments*. This report is based on the analysis of the views of patients in October and November 2017, at twelve GP practices, three in each of the four clinical commissioning group areas. The report is available at the following link:

http://www.healthwatchlincolnshire.co.uk/wp-content/uploads/GPappointmentreportfinal-2.pdf

The report highlighted eight key messages:

(1) Patients need to understand the impact of waiting to see a preferred GP.
(2) Patients may need to be more flexible about the days and times of their appointments.
(3) Patients welcome online booking and suggest this should be extended to advanced booking.
(4) GPs often ask patient to see them 'next week', but are not always aware of appointment availability. This impacts on the patient's ability to self monitor.
(5) Recognition that some groups of people need more flexibility e.g. working parents and carers.

(6) Sit-and-wait and GP telephone triage are well received – patients really like this system.
(7) Patients would benefit from understanding the role of reception. For example, initial telephone triage is an important step for patients, signposting to the correct support to meet their needs.
(8) Healthwatch Lincolnshire are told that, for many patients, booking a 'routine' appointment to see their GP is taking longer than a few years ago.

Healthwatch Lincolnshire has indicated that it would welcome any observations and comments about this report from Health Scrutiny Committee members.

**4. East Midlands Ambulance Service NHS Trust – Request for Additional Recurrent Funding of £20 million**

On 25 April, the East Midlands Ambulance Services NHS Trust (EMAS) issued a stakeholder briefing, in which it made reference to a case for increased funding of £20 million per annum. An increase of £20 million would represent a 12% increase in EMAS's annual budget.

EMAS states that benchmarking, undertaken by the National Audit Office, shows that EMAS is one of the most efficient ambulance trusts in the country, based on service performance versus the level of funding received. This supports the belief that EMAS has held for some time that EMAS is presently delivering the best possible service that it can to its patients with current funding levels. Although EMAS continues to strive for improvements, EMAS do not believe that it is possible to achieve national standards in full without essential additional resources.

EMAS has concluded that there is therefore a fundamental gap between the resources that it has and the resources it needs to meet the present requirements of the East Midlands population, as well as remain responsive to the continuing growth in demand. This gap has been confirmed by a formal demand and capacity review undertaken jointly with commissioners (the 22 clinical commissioning groups in the EMAS region).

EMAS has formally discussed the resourcing gap with its commissioners on a number of occasions. The capacity and demand review has provided appropriate evidence to suggest that EMAS needs an additional £20 million of recurrent funding if it is to meet demand. As a result of this evidence, EMAS has requested this amount from its commissioners on a phased basis, starting with £10 million for the 2018/19 financial year.

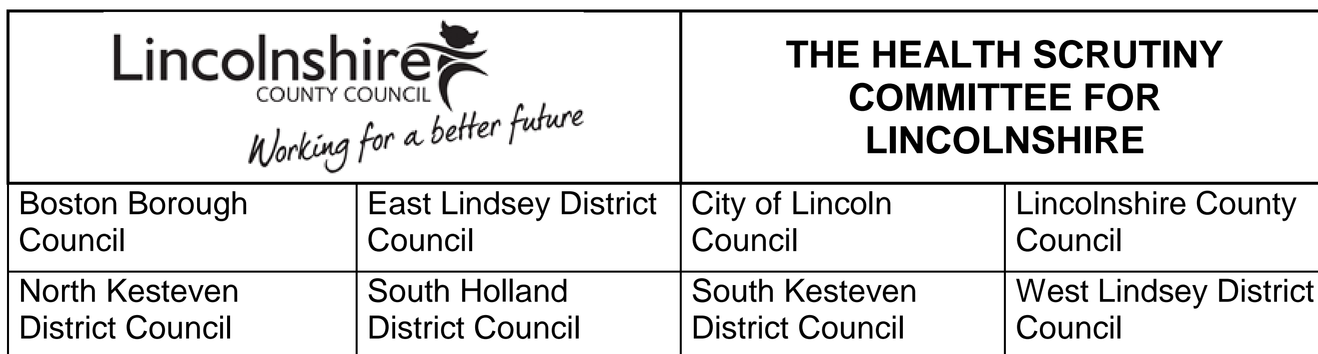
EMAS also states that over the next two years this funding would enable it to increase the number of frontline staff and ambulances on the road. In turn, it would enable improvement in ambulance response times and minimise the risk of prolonged waits.

As EMAS would need to recruit and train staff and secure additional staff and ambulances these improvements would not happen immediately, however, EMAS states it is ready to move forward with these plans with urgency if commissioners approve the funding requested.

EMAS states that it continues to focus on delivering the best possible care to its patients whilst awaiting the commissioners' decision.

It should be noted that the level of funding requested by EMAS is based on the successful reduction of hospital handover times by healthcare partners. Presently, these are significantly above acceptable levels and take vital ambulance resources off the road.

# Agenda Item 7




**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**

| | | | |
|---|---|---|---|
| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 May 2018** |
| Subject: | **Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Risk to the Safety of the Service** |

**Summary:**

This paper has been developed as a response to the difficulties and challenges faced by the children's and young person's services at Pilgrim Hospital, Boston caused by a severe shortage of doctors and nurses. This service also has clinical interdependencies with neonatal and maternity services at United Lincolnshire Hospitals NHS Trust.

The Children's and Young Persons Directorate has reviewed temporary options for children's services at the hospital due to concerns raised by paediatricians and senior nurses, who have said that although current services are safe, they may struggle to provide safe care in the future if things remain as they are due to severe staffing shortages.

A paper was presented to ULHT Board on 27 April 2018. The paper presented five options on temporary measures that may need to be taken to maintain safe paediatric services at Pilgrim Hospital, Boston. ULHT Board has supported further working up of four out of five options

Before ULHT can make a decision, ULHT will carry out the risk assessments and carry out public, staff and stakeholder engagement to get a full picture of the quality and equality impacts on the options. We will also continue to recruit to maintain safe services.

The Board asked for more detailed work to be completed and a report brought back to the next meeting on 25 May before a decision will be made.

This paper to health scrutiny committee provides the background of how this has

happened and why the position has deteriorated. It clearly identifies and analyses the issues that are faced in our current service.

**Actions Required:** To provide feedback to United Lincolnshire Hospitals NHS Trust on the content of this report.

## 1. Background

- The children's services provided at Pilgrim Hospital cannot be sustained in their current form beyond 4 June 2018 unless additional middle grade doctors can be found to fill gaps in the rota.
- With effect from 1 July, it is expected that there will be only 1 substantive middle grade doctor on the rota at Pilgrim out of an establishment of 8 wte (whole time equivalent).
- The issues with the middle grade rota at Pilgrim for children's services will also impact on the obstetric (maternity) and neonatal services at Pilgrim, which will no longer be sustainable from 1 July unless additional medical cover can be found to cover the middle grade rota.
- National and international recruitment extensively pursued by the clinical directorate has failed to produce significant numbers to support the rota.
- The clinical directorate are working relentlessly with medical agencies, irrespective of financial cost, to find agency and locum medical staff to support the rota at Pilgrim in order to keep the children's services running safely.
- There is a concern raised by the medical team of the safety relating to a potential medical rota, if recruitment of locums was possible, where 7 wte out of an establishment of 8 wte are locum/agency doctors. Therefore, the clinical directorate are attempting to recruit senior medical staff to cover the middle grade rota at Pilgrim, and are also seeking to recruit locum consultants to cover the middle grade rota.
- This paper identifies four options that the Trust Board considered as possible temporary options to mitigate against potential safety risks caused by immediate staffing crisis until a longer term strategic solution can be implemented.
- The paper includes an initial quality impact assessment of the options being proposed, and also includes an initial equality impact assessment that the Trust Board considered.
- A task and finish group that has been established to develop the work required to mitigate the current risks and ensure the safe and sustainable running of children's, obstetrics and neonatal services at ULHT.
- We continue to work hard to recruit to the vacant posts with the intention of sustaining as many services as safely possible at Pilgrim Hospital.

The report submitted to the Trust Board is set out in Appendix A to this report. Also included are Appendices 1, 2 and 3 of the Trust Board's report. Appendices 4 and 5 are not included, but are available at the following link:

https://www.ulh.nhs.uk/about/board-meetings/friday-27-april-2018/

## 2. Conclusion

The Health Scrutiny Committee is asked to provide feedback to United Lincolnshire Hospitals Trust on the content of this report.

## 3. Consultation

Where a decision has to be made without allowing time for consultation because of the risk to safety or welfare of patients or staff, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 allows for the decision to be made without consultation. However, at this stage no decision has been made by United Lincolnshire Hospitals NHS Trust and the Committee may wish to provide feedback to the Trust Board for its consideration on 25 May.

## 4. Appendices

<table>
<tr><td colspan="2">These are listed below and attached at the back of the report</td></tr>
<tr><td>Appendix A</td><td>ULHT Trust Board Paper – 27 April 2018: Children and Young Persons Services at ULHT - Risk to the Sustainability of the Service, including:<br>• Appendix 1 – Staffing Escalation Timeline<br>• Appendix 2 – United Lincolnshire Hospitals NHS Trust: Quality Impact Assessment Tool<br>• Appendix 3 – Full Equality Analysis – Consolidation of In-patient Paediatrics to Lincoln County Hospital and Subsequent Impact on Neonatal and Maternity Services<br><br>Note: Appendix 4 (Terms of Reference of the Children and Young Persons Programme Board) and Appendix 5 (Terms of Reference of the Children and Young Persons Task and Finish Group) are not included in these papers.</td></tr>
</table>

## 5. Background Papers

No background papers within Section 100D of the Local Governance Act 1972 were used in the preparation of this report.

The report was written by Dr Neill Hepburn, who can be contacted on 01522 573978 or via email neill.hepburn@ulh.nhs.uk

This page is intentionally left blank

# Children & Young Persons Services at ULHT
# Risk to the sustainability of the service

## April 2018

**Contents**


Executive Summary ........ 6

1. Introduction ........ 9

1.1 An overview of United Lincolnshire Hospitals NHS Trust ........ 9

2. Children's activity and performance ........ 12

2.1 Children's activity details ........ 12

2.2 Length of stay for Children's inpatient activity ........ 13

2.3 Children's critical care ........ 14

2.4 Children's A&E activity ........ 14

2.4.1 Children presenting to A&E by the hour at Lincoln Hospital ........ 14

2.4.2 Children presenting to A&E by the hour at Grantham & District Hospital ........ 15

2.4.3 Children presenting to A&E by the hour at Pilgrim Hospital ........ 15

2.4.4 Children's presentations to A&E by day of the week at Pilgrim Hospital 16

2.5 Current performance against national waiting time standards ........ 17

2.6 Current performance against national quality standards for Children's & Young Persons ........ 18

3 Current Service Provision & the Children's Staffing Position ........ 18

3.1 What levels of staff are needed to run Children's services across ULHT? ........ 19

3.1.1 Medical staff ........ 19

3.1.2 Registered Nursing staff ........ 21

3.2 What levels of staff do we currently have in our Children's Departments ........ 23

4 Our Response to the Deteriorating Position ........ 27

4.1 What mitigation actions have we already taken? ........ 27

4.1.1 Utilising our current workforce ........ 27

4.1.2 Recruitment activities ........ 27

4.1.3 Other Agency Recruitment ........ 30

4.1.4 Agency Recruitment ........ 30

4.1.5 Use of Agency staff ........ 30

4.1.6 Use of Community Paediatric Doctors ........ 30

4.2 Escalation meetings (internal and external) ........ 31

4.3 Actions agreed as a result of the escalation meetings detailed in section 4.2 ........ 32

4.4 Summary ........ 32

4.5 Immediate Risk Mitigation Proposal ........ 33

5 Options beyond July 1st 2018 for consideration ........ 34

5.1 Option One ........ 35

5.2 Option Two ........ 36

5.3 Option Three ........ 37

5.4 Option Four ... 39
6. Quality Impact Assessment of the options ... 40
7. Equality Impact Assessment ... 41
8. Next Steps ... 41
8.1 Governance Process ... 41
9 Recommendations to the Trust Board ... 41

## Executive Summary

This paper is the culmination of a series of circumstances that have led to the challenging position within our children's and young Persons Departments, specifically at Pilgrim Hospital. This is not a situation that any health economy wants to find itself in. However, patient safety is, and must always be our first and foremost concern and that is why this paper is being presented to Trust Board by the Women's & Children's Clinical Directorate detailing the risks and options for discussion and recommendations.

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

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

The objectives of the report are;

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

**We have consultant medical staffing commitment to keep Paediatric inpatient services running at Pilgrim Hospital until 4th June 2018. At the time of writing this paper, there is no mitigation in place to continue this commitment beyond June 4th 2018.**

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

**Background context**

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

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

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

**Current staffing position**

| | | |
|---|---|---|
| • Tier 3 (Consultant Grades): | PHB and LCH site | Continuing risk |
| • Tier 2 (Middle Grades) | PHB Site | Continuing & deteriorating risk |
| • Registered Children's Nurses | PHB Site | Continuing & deteriorating risk |

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

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

**CQC (Care Quality Commission) inspection Feb 2018**

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

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

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

**Current Workforce Establishment**
**Consultants – No change**

| Site | Current Establishment | March 2018 | July 1st 2018 |
|---|---|---|---|
| PHB | 6 | 5.5 (1.5 Locums) | 5.5 (0.5 Locum) |
| LCH | 8 | 8.0 (2 Locums) | 8.0 (2 Locums) |
| TOTAL | 14 | 13.5 (3.5 Locums) | 13.5 (2.5 locums |

- New Substantive consultant at Pilgrim June 2018
- Consultant establishments of 14 is 9wte below facing the future requirements as recommend by the Royal College of Paediatrics & Child Health (RCPCH). The consultant establishment should be 23 wte.

**Middle Grades – Deteriorating position at PHB**

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

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

- 20.4 wte [out of 28.65 wte ] in post
- 16.25 wte RN (Child) in post
- Available to work
  i) 12.95 wte RN(Child)
  ii) 4.23 WTE RN (Adult)

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

**Summary**

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

- Inability to provide assurance that nursing and medical rotas can be prospectively filled
- Mitigations have been exhausted
- Further deterioration of staffing numbers expected at Middle grade level without a known pipeline of replacements in the next 6 months.

# 1. Introduction

## 1.1 An overview of United Lincolnshire Hospitals NHS Trust

- **Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.**
- **Transport networks are underdeveloped resulting in transport times of around 1 hour between the respective hospital sites.**
- **Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.**
- **We provide acute hospital care, to around 757,000 residents of Lincolnshire.**
- **Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037.**
- **These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.**
- **In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.**

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

We deliver services across the following specialities:

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

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

**An overview of the services provided at our hospitals**

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

- Neurosurgery
- Cardiothoracic surgery
- Spinal surgery

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

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

Our hospitals have the following number of beds:

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

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

.

### Lincoln County Hospital

Consultant led Obstetrics & Gynaecology, Neonatology and Children's services at Lincoln Hospital.
Circa 3,200 births per annum. A 19 bed inpatient children's ward, separate children's 8 bed day surgery/assessment unit and outpatient department supported by a Community Children's nursing team. The Emergency Department at Lincoln provides unrestricted access to A&E services 24/7 for children's emergencies. Children's High Dependency Care services is currently not a commissioned service, however a significant number of children on the ward receive PHDU level 1 care.

**Pilgrim Hospital, Boston**

.
Consultant led Obstetrics & Gynaecology, Neonatology and Children's services at Pilgrim Hospital. Circa 2,000 births per annum. A 19 bed inpatient children's ward, currently reduced to 10 with 2 assessment beds due to registered sick children's nurse staffing gaps. Children's Outpatient Department and Community Children's Nursing Team.
The Emergency Department at Pilgrim provides unrestricted access to A&E services 24/7 for children's emergencies. Children's High Dependency Care services is currently not a commissioned service, however a significant number of children on the ward receive PHDU level 1 care

**Grantham & District Hospital**

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

## 2. Children's activity and performance

### 2.1 Children's activity details

The tables below show the number of patients attending per day and per annum for each point of delivery, e.g. Outpatients, Day Case, Elective admission, Non-elective admission and ward attenders.

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

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

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

| Non Elective | Pilgrim Hospital | | Lincoln Hospital | | Total Activity | |
|---|---|---|---|---|---|---|
| Speciality | Year | Day | Year | Day | Year | Day |
| Children's & Young | 2388 | 6.5 | 4303 | 11.8 | 6691 | 18.3 |
| Orthopaedics | 153 | 0.4 | 292 | 0.8 | 445 | 1.2 |
| General Surgery | 103 | 0.3 | 196 | 0.5 | 299 | 0.8 |
| ENT | 1 | 0.0 | 66 | 0.2 | 67 | 0.2 |
| Oral Max Fax | | 0.0 | 53 | 0.1 | 53 | 0.1 |
| Urology | 15 | 0.0 | 19 | 0.1 | 34 | 0.1 |
| Gynaecology | 1 | 0.0 | 6 | 0.0 | 7 | 0.0 |
| Total | 2661 | 7.3 | 4935 | 13.5 | 7596 | 20.8 |

* Elective activity is based on 250 days per annum

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

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

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

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

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

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

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

## 2.2 Length of stay for Children's inpatient activity

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

| | PHB | LCH |
|---|---|---|
| Elective | 1.0 | 1.0 |
| Non-elective | 1.4 | 1.4 |

## 2.3 Children's critical care

ULHT is not commissioned to provide Children's critical care level 1 (basic HDU), however, on regular occasions, both Pilgrim and Lincoln Children's services regularly deliver critical care level 1. Patients requiring level 2 or 3 critical care are transferred to a tertiary centre. The table below shows the number of children that required level 1 critical care from September 2017 to current date.

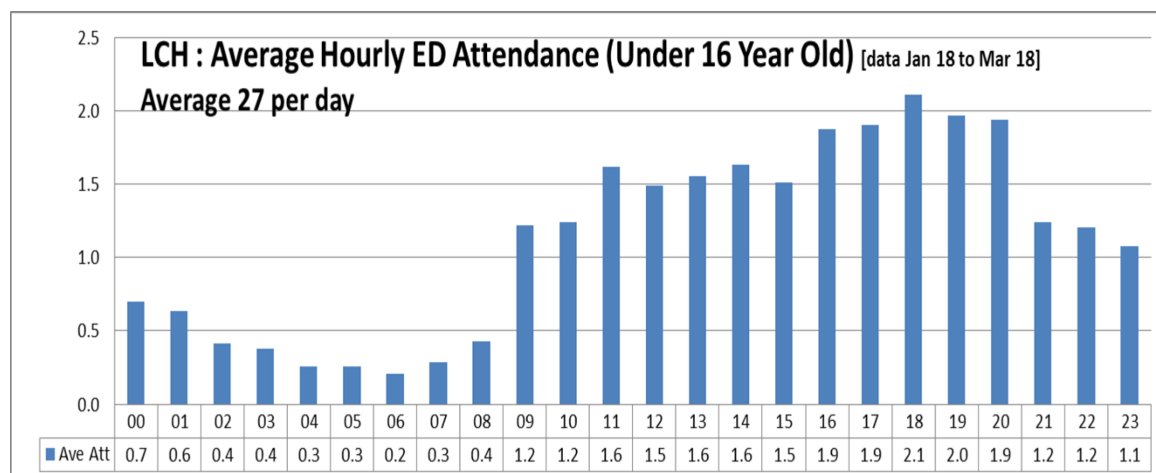
| | | LCH | | | PHB | | | Trust | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Years** | **start** | Patients | Beds Days | LoS | Patients | Beds Days | LoS | Patients | Beds Days | LoS |
| **2017** | Sep | 44 | 129 | 2.9 | 10 | 40 | 4.0 | 54 | 169 | 3.1 |
| | Oct | 28 | 109 | 3.9 | 22 | 52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

## 2.4 Children's A&E activity

### 2.4.1 Children presenting to A&E by the hour at Lincoln Hospital

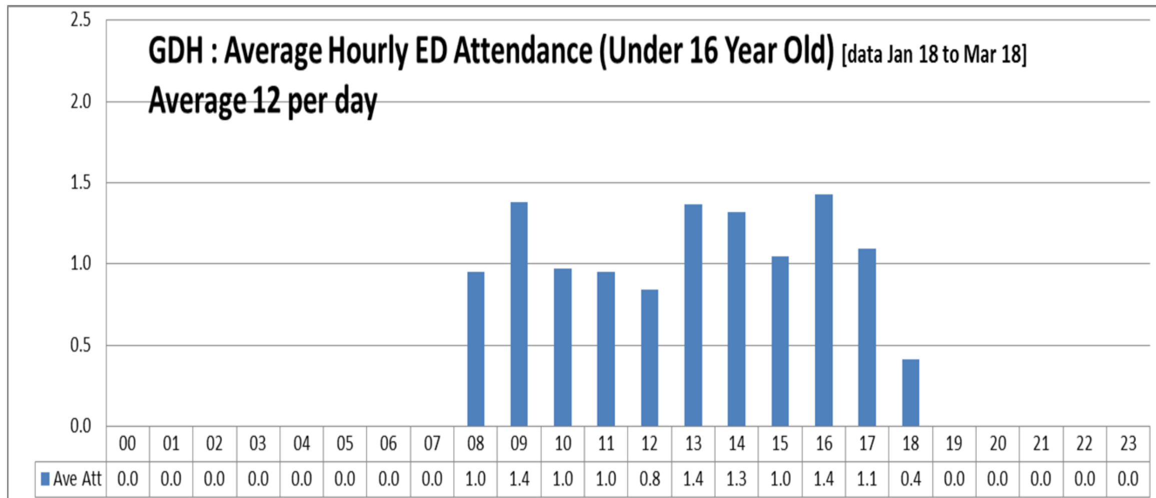
The bar charts below demonstrate the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 at the Lincoln Hospital.

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



**2.4.2 Children presenting to A&E by the hour at Grantham & District Hospital**

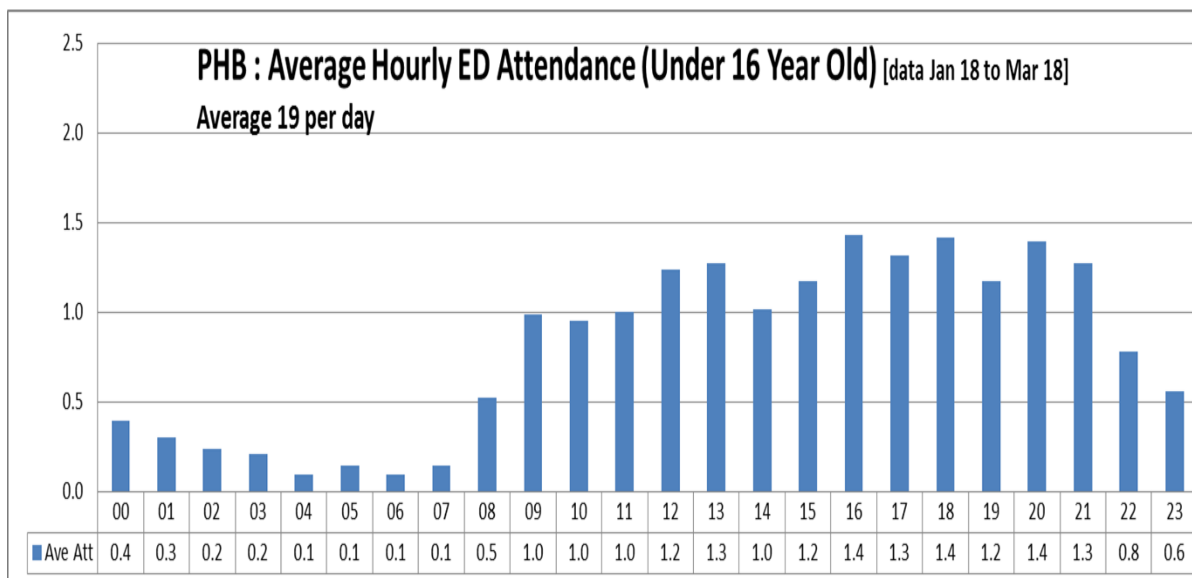
The bar chart below shows the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 at the Grantham Hospital.




| | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ave Att | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 1.4 | 1.0 | 1.0 | 0.8 | 1.4 | 1.3 | 1.0 | 1.4 | 1.1 | 0.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**2.4.3 Children presenting to A&E by the hour at Pilgrim Hospital**

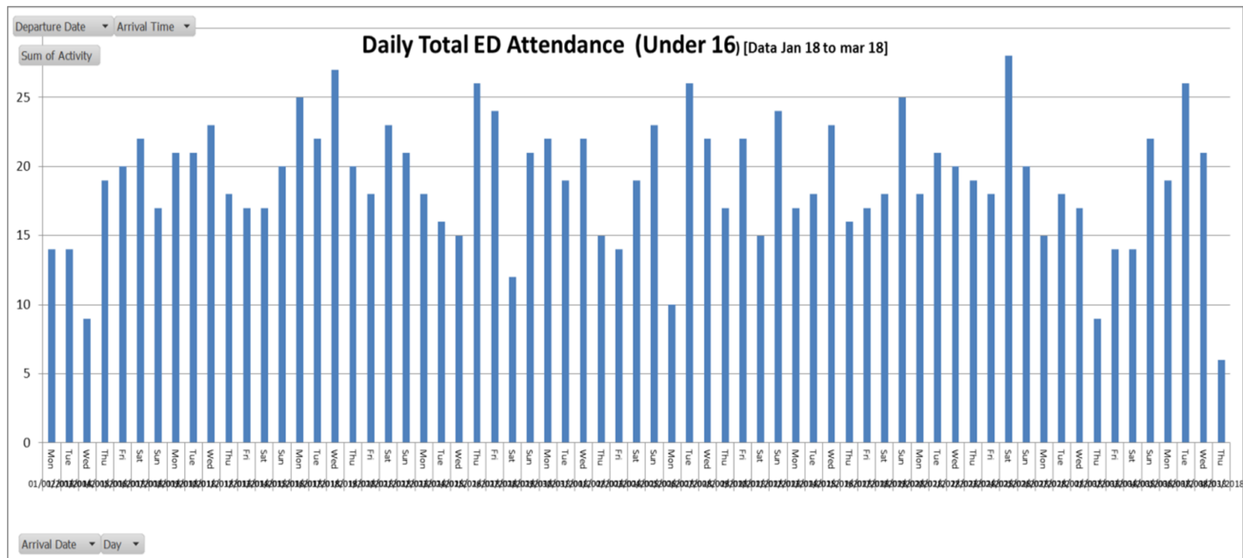
The bar chart below shows the total number of children attending by hour of the day for the three month period; January 2018 to March 2018 for the Pilgrim Hospital. The chart demonstrates that the peak time for attendance at the A&E department is between the hours of 16:00 hrs and 21:00 hrs. Peak time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




| | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ave Att | 0.4 | 0.3 | 0.2 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.5 | 1.0 | 1.0 | 1.0 | 1.2 | 1.3 | 1.0 | 1.2 | 1.4 | 1.3 | 1.4 | 1.2 | 1.4 | 1.3 | 0.8 | 0.6 |

### 2.4.4 Children's presentations to A&E by day of the week at Pilgrim Hospital

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




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

| | Grantham Hospital | Lincoln County Hospital | Pilgrim Hospital Boston | Grand Total |
|---|---|---|---|---|
| Car | **11.00** | **22.93** | **16.42** | **50.34** |
| 999 | 0.03 | **3.72** | **2.28** | **6.03** |
| Walked in | 0.30 | 0.28 | 0.07 | 0.66 |
| Other | 0.31 | 0.09 | 0.06 | 0.46 |
| Bus | 0.03 | 0.07 | 0.06 | 0.16 |
| Police | 0.00 | 0.04 | 0.03 | 0.07 |
| Bicycle | 0.01 | 0.01 | 0.00 | 0.03 |
| Work Transport | 0.03 | 0.00 | 0.00 | 0.03 |
| Helicopter | 0.00 | 0.03 | 0.00 | 0.03 |
| Ambulance (not 999) | 0.00 | 0.00 | 0.01 | 0.01 |
| **Grand Total** | 11.72 | 27.18 | 18.94 | 57.84 |

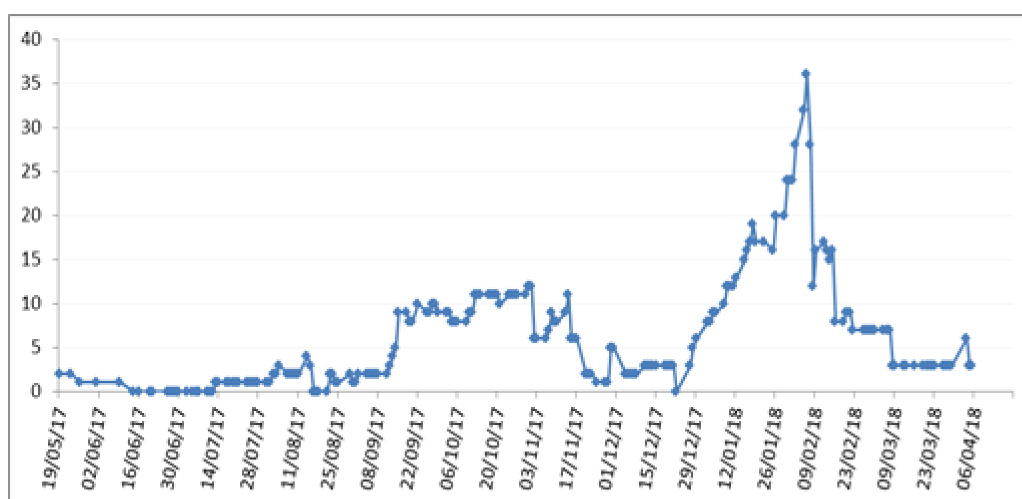
| ED Outcome: Arrival by 999 Ambulance | Grantham Hospital | Lincoln County Hospital | Pilgrim Hospital Boston | Grand Total |
|---|---|---|---|---|
| Home | 0.0 | **1.9** | **1.0** | **2.9** |
| I/P (This hospital) | 0.0 | **1.4** | **1.2** | **2.7** |
| Out-Patient Clinic | 0.0 | 0.1 | 0.0 | 0.1 |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

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

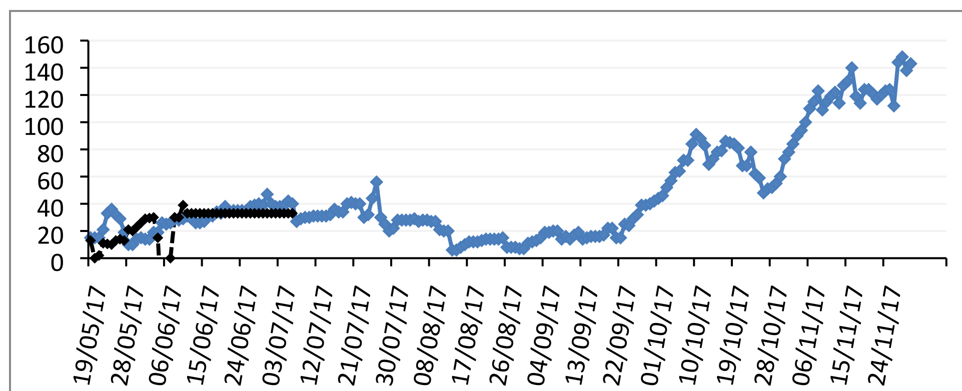
## 2.5 Current performance against national waiting time standards

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

The chart below shows children's new outpatient appointments waiting over 12 weeks. The high number for the period from the end January & beginning of February reflected the leaving of two Paediatric Consultants.



The service is not achieving the standard for follow up appointments. The chart below demonstrates the number of overdue follow up appointments (Waiting for more than six weeks)




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

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

| Acute Children and Young Person's Standards (Medical) | | Standard Met? | |
|---|---|---|---|
| Ref | Summary of Standard | PHB | LCH |
| AP1 | New admission reviewed by senior paediatrician within 4 hours | -YES- | -YES- |
| AP2 | New admission assessed by consultant within 14 hours of admission | - NO - | - NO - |
| AP3 | Consultant Paediatrician (On site) available during times of peak activity (up to 10pm 7/7) | - NO - | - NO - |
| AP4 | Admitting consultant for emergency admissions free from other clinical duties | -YES- | -YES- |

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

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

## 3 Current Service Provision & the Children's Staffing Position

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

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

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

Utilising the standards as set out by the RCPCH (Royal College Paediatric & Child Health) in the document called *"2011 Facing the future"* it would suggest that in order to provide adequate clinical medical cover, supervision and training, we would require a minimum of 23.0 wte Children's consultants, 18.0 wte middle grades, and 24.0 wte Junior Doctors across the Children's services within ULHT. The staffing numbers include cover for Obstetric, Neonatal and Emergency Department for a District General Hospital.

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

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

**3.1.1 Medical staff**

**Lincoln Hospital – Medical Staff**

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

#1: 2 X Agency Locum

**Pilgrim Hospital – Medical Staff**

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

#2: 1 X Agency Locum & 1 x Bank covering OP clinics only
#3: 1 x Agency Locum Consultant working @ MG plus internal bank and ad hoc agency
#4: 1 x Agency Junior Dr
#5: x0.5 Agency Locum
#6: x1 Deanery position high risk

**Grantham Hospital – Medical Staff: No Paediatric Medical staff**
Only children's outpatient clinics delivered at Grantham Hospital by clinical staff from both Pilgrim and Lincoln Hospitals.

### 3.1.2 Registered Nursing staff

**Lincoln Hospital**

| Band | Registered Nursing Establishment | RN In post | Block Agency | RN In Post But Unavailable to work on ward (includes sickness / absence) | WTE Long-Term Sickness / Absence | Current WTE Available to Work minus sickness/ Absence | Current Vacancies |
|---|---|---|---|---|---|---|---|
| 6 | 3.73wte **(uplift to 5.48wte )** | 4.48wte | 0 | 0 | 0 | 4.48wte | 1.0wte |
| 5 | 21.06wte | 14.42wte | 0.96wte | 0.64wte (Maternity leave) | 0.64wte (Maternity leave) | 13.78wte | 6.64wte |
| **Total** | **24.79wte (26.54wte)** | **18.9wte** | **0.96wte** | **0.64wte** | **0.64wte** | **18.26wte (19.22wte with agency)** | **7.64wte** |

1.0wte Band 6 now advertised (temp uplift from band 5 budget)
1.0wte Band 6 to return to post from Band 7 secondment.

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

In addition a further:

- 2.0wte were interviewed in March 2018, these will be newly qualified and will commence in September 2017. Both are from Sheffield University.

- 1.0wte band 2 currently seconded to do Children's Nursing at Nottingham. Due to qualify and commence in post as a band 5 in September 2018

- 0.43wte interviewed in February Cohort and was the offered post. Currently awaiting DBS, Occupational Health Clearance and references. This is a Registered Children's Nurse

**Expected availability End April = 18.26wte**
**Expected availability End May = 19.26wte**

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

| | Registered Nursing Establishment | RN In post | Block Agency | RN In Post But Unavailable to work on ward (includes sickness / absence) | WTE Long-Term Sickness / Absence | Current WTE Available to Work minus sickness/ Absence | Current Vacancies |
|---|---|---|---|---|---|---|---|
| 6 | 3.13wte **5.2wte (Includes Uplift)** | 4.3wte (0.2wte temp cover = 4.5wte) | 0 | 0.7wte | 0.7wte | 3.8wte | 0.9wte |
| 5 | 23.45wte | RN(C) 11.75wte | 1.88wte (included in RNC figures) | 2.6wte | 0.6wte | RNC 9.15wte | 8.35wte |
| | | RN(A) 5.23wte | 0 | 1.0wte (On Nursing course) | 0 | RN 4.23wte (1.0wte Induction) | |
| **Total** | **26.58wte (28.65wte uplift not funded)** | **20.48wte** | **1.88wte** | **4.3wte** | **1.3wte** | **17.18wte** | **9.25wte** |

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

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

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

**CHILDRENS NURSES IN POST = 16.25wte**
**CHILDRENS NURSES AVAILABLE TO WORK = 12.95wte**

Changes to figures since 6th April = increase by 1.08wte (Block agency included in *'In post'* figures)
0.2wte Band 6 temporary uplift in hours
0.88wte Band 5 RNC block agency

Block Agency – included in the current numbers
1.0wte RNC since September 2017.
0.88wte RNC commenced Monday 16th April

In post but Unavailable to work
Band 5 RNC
1.0wte Maternity leave
1.0wte redeployed to clinic
0.6wte long term sickness

**=2.6wte**

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

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

**CURRENT RECRUITMENT**
Shortlisted x3 RNC for Interviews 5th April 2018:
x1 invited for Interview but no response.
x1 requested alternative date – 18th April but now withdrawn
x1 already recruited through cohort recruitment (starting in June – as above)

x1 potential newly qualified RNC with possible start September – reliant on relocation.
Ward Manager Recruitment – x2 shortlisted – Interview date to be arranged (3rd attempt to recruit).

RAD completed for 1.0wte Band 6 vacancy

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

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

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

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

**Consultants – No change**

| Site | Current Establishment | March 2018 |
|---|---|---|
| PHB | 6 | 5.5 (0.5 Locums) |
| LCH | 8 | 6 (2 Locums) |
| TOTAL | 14 | 11.5 (of which 2.5 are locums) |

- New substantive Consultant expected to start at Pilgrim June 2018
- Establishments 8.0 wte below facing the future requirements

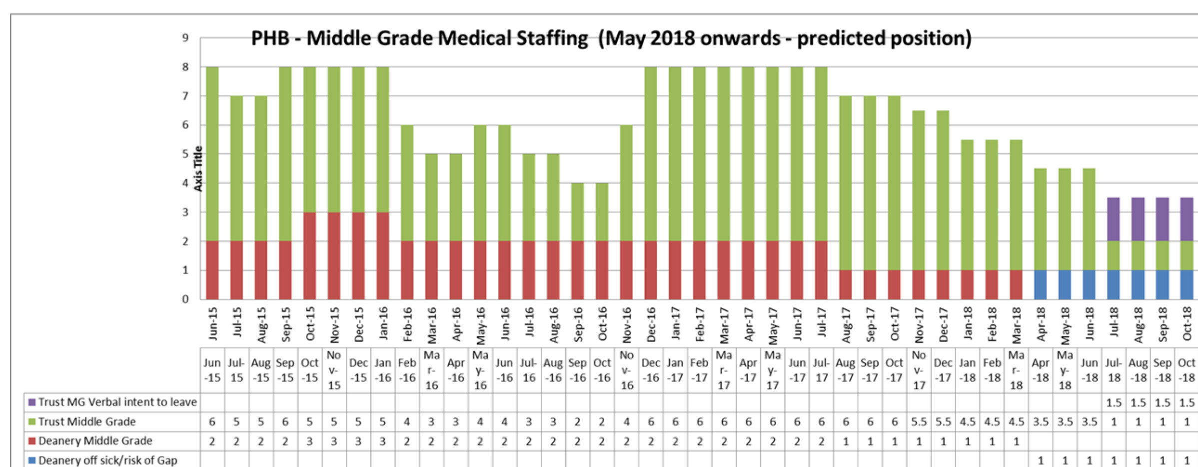
**Middle Grade Staff (PHB site)**

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

- Deanery trainee on Long term sickness
- Short term agency secured 16.04.18 to 06.05.16 temporarily increasing to 4.5 wte out of 8
- Reduction of 1 wte MG from May 2018, and by 1.5 wte MG July 2018
- Only 1 wte MG will be available in July if the deanery MG remains on sick leave (or is not replaced as currently thought)
- From August 2018, the Deanery has advised they are unlikely to sustain their Middle Grade rota post if the ward does not remain open
- 1 international recruit will be ready for Tier 2 rota Sept-Dec 2018 (visa dependent)
- Inability to recruit following multiple recruitment events / long term Agency locum staff

| Role | Comment | Comment 2 |
|---|---|---|
| Speciality doctor | Full time | |
| Speciality doctor | Full time | Leaves July 18 |
| Speciality doctor | Full time | Leaves 1st July |
| Speciality doctor | Full time | Leaves 31st March 2018 |
| Speciality doctor | 50% Community<br>50% Paeds | Leaves 1st July 18 |
| Speciality Trainee (Deanery) | Full time | Off sick (LT)<br>High risk of not replacing this post from August onwards if the ward is the closed |
| Middle Grade | Full time | Start date 16/4/18 Agency Consultant to cover Middle Grade gap (for 5 weeks only) |
| Middle Grade | Vacant | Unable to secure long term cover<br>Ad hoc agency cover as able<br>Consultants step down to cover |

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



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

**April Rota**

| Date | Day | 09:00 to 17:00 | 17:00 to 21:00 | Clinic | SCBU (9-5.pm) | Night |
|---|---|---|---|---|---|---|
| 01.04.18 | Sunday | (Trust) AL | | | | (SPR) Locum Shift |
| 02/04/2018 | Monday | Trust Trust Dr 1 | (Trust) Trust Dr 1 | | | (SPR) Locum Shift |
| 03/04/2018 | Tuesday | | (SPR) Trust Dr 3 | | Trust Trust Dr 3 | (Trust) Trust Dr 2 L |
| 04/04/2018 | Wednesday | | (Trust) Trust Dr 1 | | Trust Trust Dr 1 | (Trust) Trust Dr 2 L |
| 05/04/2018 | Thursday | | (SPR) Trust Dr 3 | | Trust Trust Dr 3 | (Trust) Trust Dr 2 L |
| 06/04/2018 | Friday | | (SPR) Trust Dr 1 | | Trust Trust Dr 3 | Agency (Dr M) |
| 07/04/2018 | Saturday | Agency Dr F | | | | (SPR) Trust Dr 1 L |
| 08/04/2018 | Sunday | Agency Dr F | | | | (SPR) Trust Dr 2 L |
| 09/04/2018 | Monday | Trust Trust Dr 1 | Trust Trust Dr 1 | | Trust Trust Dr 3 | Agency (Dr F) |
| 10/04/2018 | Tuesday | Trust Trust Dr 1 | Trust Trust Dr 1 | | Trust Trust Dr 2 | Agency (Dr F) |
| 11/04/2018 | Wednesday | Trust Trust Dr 1 | Trust Trust Dr 1 | | Trust Trust Dr 3 | Agency (Dr F) |
| 12/04/2018 | Thursday | (Trust) Trust Dr 2 | Vacant | | Trust Trust Dr 2 | Vacant |
| 13/04/2018 | Friday | Trust Trust Dr 1 | | | Trust Trust Dr 2 | Agency Dr M |
| 14/04/2018 | Saturday | (Trust) Trust Dr 1 | | | | (Trust) Trust Dr 2 |
| 15/04/2018 | Sunday | (Trust) Trust Dr 1 | | | | (Trust) Trust Dr 2 |
| 16/04/2018 | Monday | Trust Trust Dr 3 | | | vacancy | Vacancy |
| 17/04/2018 | Tuesday | vacant | Vacant | | Trust Trust Dr 2 | Trust Trust Dr 1 |
| 18/04/2018 | Wednesday | Trust Trust Dr 3 | | | vacancy | Trust Trust Dr 1 |
| 19/04/2018 | Thursday | Trust Trust Dr 3 | | | Trust Trust Dr 2 | Trust Trust Dr 1 |
| 20/04/2018 | Friday | Trust Trust Dr 3 | | | Trust Trust Dr 2 | Vacant |
| 21/04/2018 | Saturday | Trust Trust Dr 3 | | | | Vacant |
| 22/04/2018 | Sunday | Trust Trust Dr 3 | | | | Vacant |
| 23/04/2018 | Monday | Trust Trust Dr 1 | Trust Trust Dr 2 | | Trust Trust Dr 2 | Vacant |
| 24/04/2018 | Tuesday | Trust Trust Dr 1 | Trust Trust Dr 2 | | Trust Trust Dr 2 | Trust Trust Dr 3 |
| 25/04/2018 | Wednesday | Trust Trust Dr 1 | Trust Trust Dr 2 | | Trust Trust Dr 2 | Trust Trust Dr 3 |
| 26/04/2018 | Thursday | Agency Ghias | Tust Trust Dr 2 L | | Vacant | Trust Trust Dr 3 |
| 27/04/2018 | Friday | vacant | Vacant | | Vacant | Trust Trust Dr 1 |
| 28/04/2018 | Saturday | Agency Dr Z | | | | Trust Trust Dr 1 |
| 29/04/2018 | Sunday | Agency Dr Z | | | | Trust Trust Dr 1 |
| 30/04/2018 | Monday | Trust Trust Dr 3 | Vacant | | Vacant | Trust Trust Dr 1 |

**May Rota**

| Date | Day | 09:00 to 17:00 | 17:00 to 21:00 | Clinic | SCBU (9-5.pm) | Night |
|---|---|---|---|---|---|---|
| 01.05.18 | Tuesday | Agency 1 | | | Trust Trust 2 | SPR Trust 1 L |
| 02.05.18 | Wednesday | Agency 1 | Agency 1 | | Trust Trust 2 | SPR Trust 1 L |
| 03.05.18 | Thursday | | Agency 1 | | Trust Trust 4 | (Trust) Trust 1 L |
| 04.05.18 | Friday | | Agency 1 | | Trust Trust 4 | SPR Trust 2 |
| 05.05.18 | Saturday | Trust Trust 1 | | | | SPR Trust 2 |
| 06.05.18 | Sunday | Trust Trust 1 | | | | SPR Trust 2 |
| 07.05.18 | Monday | Agency2 | | | Agency 3 | SPR Trust 2 |
| 08.05.18 | Tuesday | Agency 2 | | | Agency 3 | SPR Trust 1 |
| 09.05.18 | Wednesday | Agency2 | | | Agency 3 | SPR Trust 1 |
| 10.05.18 | Thursday | Agency2 | | | Agency 3 | SPR Trust 1 |
| 11.05.18/ | Friday | Agency2 | | | Vacant | Agency 3 |
| 12.05.18 | Saturday | Trust Trust 3 | | | | Agency 3 |
| 13.05.18 | Sunday | Trust Trust 3 | | | | SPR Trust 1 L |
| 14.05.18 | Monday | Agency 3 | | | Trust Trust 2 | SPR Trust 1 L |
| 15.05.18 | Tuesday | Agency 3 | | | Trust Trust 2 | SPR Trust 3 |
| 16.05.18 | Wednesday | Agency 3 | | | Trust Trust 2 | SPR Trust 3 |
| 17.05.18 | Thursday | Agency 3 | | | Trust Trust 2 | SPR Trust 3 |
| 18.05.18 | Friday | Agency 3 | | | Trust Trust 2 | SPR Trust 1 |
| 19.05.18 | Saturday | Agency1 | | | | SPR Trust 1 |
| 20.05.18 | Sunday | Agency1 | | | | SPR Trust 1 |
| 21.05.18 | Monday | Trust Trust 4 | Vacant | | Trust Trust 2 | SPR Trust 1 |
| 22.05.18 | Tuesday | Trust Trust 4 | | | Trust Trust 2 | Agency 3 |
| 23.05.18 | Wednesday | Trust Trust 2 | Vacant | | Trust Trust 4 | Agency 3 |
| 24.05.18 | Thursday | Trust Trust 4 | | | Trust Trust 2 | Agency 3 |
| 25.05.18 | Friday | Trust Trust 4 | Vacant | | Trust Trust 2 | SPR Trust 3 |
| 26.05.18 | Saturday | Trust Trust 1 | | | | SPR Trust 3 |
| 27.05.18 | Sunday | Trust Trust 1 | | | | SPR Trust 3 |
| 28.05.18 | Monday | Trust Trust 4 | | | Trust Trust 2 | SPR Trust 3 |
| 29.05.18 | Tuesday | Trust Trust 2 | | | SPR Trust 1 | Agency 3 |
| 30.05.18 | Wednesday | Trust Trust 4 | | | Trust Trust 2 | Agency 3 |
| 31.05.18 | Thursday | Trust Trust 1 | | | trust Trust 2 | Agency 3 |

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

**Nurse staffing (PHB site)**

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

Each Paediatric inpatient ward must have two RNC's on duty at all times to provide a safe service and in line with the national standards. The service is finding it increasingly difficult to fill the rota with the substantive staff and uses significant amounts of additional, bank and overtime hours to

maintain the rota. The service is often in the position where there are only two RNC's on a night shift. There is significant risk that when last minute sickness occurs and there are not two RNC's available on duty. The service has managed these occasions with current staff agreeing at short notice to the changing of their shifts to make the service safe. There has now been the necessity for the Lincoln County Hospital RNC staff at short notice (12 hrs) to provide emergency cover for the children's ward at PHB. This is not a medium or long term solution and it is having an impact on the health and well- being of the staff.

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

# 4 Our Response to the Deteriorating Position

The deteriorating staffing position within the children's services at ULHT has been carefully monitored over the last few years with a risk assessment on the risk register since 2008, and there have been times for concern on a number of occasions and these have been escalated, with both internal and external risk summits taking place to address the concerns. A timeline of the escalation history can be evidenced in ***Appendix 1***

## 4.1 What mitigation actions have we already taken?

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

### 4.1.1 Utilising our current workforce

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

### 4.1.2 Recruitment activities

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

- 8 mid-grade doctors were on the rota in March 2018.
- The rota consists of 6 Speciality Doctors and 2 Registrars (1 of which is long term sick).

- From the 1st July 2018 the rota will consist of 1 Speciality Doctor and 1 Registrar (long term sick).

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

- Roles advertised through NHS Jobs
- Direct approach to agencies via trusts recruitment specialist
- ULHT independently assessing the English Language skills and supporting candidates through the GMC registration via a two week attachment to the service and a formal assessment of the candidates English language skills via the process; SELF (Structured English Language Reference Forms. X6 candidates have been assessed
- Business Unit approach to the International Medical recruitment agency known as BDI Resourcing direct, (6 CVs acquired)
- Non PSL (Preferred Supplier list) agencies (quoting 25k rate per appointment)
- MTI (Medical training Initiative) scheme.
- HOLT for a short/medium term solution (requested by the Clinical Directorate until end of October 2018).

There are a number of evident recruitment difficulties, one being around the lead time for the COS (Certificate of Sponsorship)/Visa process. The Trust is currently only obtaining visas for approximately 30% of those Dr's whom the Trust has provided a COS.

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

There are significant delays and difficulties in international recruitment in terms of obtaining GMC registration for the international recruits who have been assessed and signed off as competent in English language. Once signed off there are further delays in obtaining immigration visas. ULHT experience only a 30% success rate in candidates obtaining an immigration visa.

There are currently two adverts for Middle Grade Doctors, one for each site, on a rolling basis on the NHS Jobs website.

**ULHT process for International Recruitment & Language Assessment**

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

1) 2 week clinical attachment to the Children's Speciality (with 2 year offer letter if successful)
2) Language / Clinical competency assessment
3) Sponsorship by the Trusts Executive Medical Director (to GMC re: Language competence)
4) Support and evidence facilitated by the speciality to enable the relevant medical staff to apply to register with the GMC
5) With successful registration on the GMC register achieved the member of staff initially commences in post at tier 1 level to ensure that a robust orientation and induction into the English Health Care System is facilitated and achieved

6) When assessed as compliant the medical staff move from the Tier 1 to the Tier 2 rota (middle grade), previous experience of this process has seen that the individual achieves the necessary competencies within 3-6 months.

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

**Via the SELF Route**

- 14 Candidates interviewed via skype (2 were rejected)
- 12 conditional offers sent (Conditional upon attending ULHT for a two week attachment, completing the SELR assessment and subsequent registration with the GMC.
- 6 attended for the two-week attachment/SELR assessment (From Nov 12 to Jan 18)
- The next 6 were not progressed by the Trust following delays and issues with the process as described earlier.
- 6 were assessed as competent in the SELR process and supported in their application with the GMC of these 6 candidates:
    - One candidate decided not to proceed with the process/job offer
    - Two candidates have not had the SELR evidence accepted by the GMC
    - Three candidates have now been accepted onto the GMC register and have now had a CoS for their necessary work visa for the UK/ULHT. The Trusts anticipates that the visa's will be applied for at the next round on the 5th May
        - One candidate has experience to work at Tier 1
        - Two candidates have experience to work at Tier 2 following a 3 -6 month orientation period at Tier 1.

**Via Other international Recruitment of GMC registered Dr's**

- 17 Dr's CV's submitted
- The directorate interviewed all suitable Dr's , usually interviewing within 48 hours on the following dates:
    - 29.10.17
    - 14.12.17
    - 18.12.17
    - 21.12.18
    - 12.01.18
    - 21.01.18
    - 23.02.18
    - 16.03.18

- 7 Dr's have been offered employment, to date none have accepted

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

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

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

#### 4.1.3 Other Agency Recruitment

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

Resulting from these interviews there are 7 offers in progress with the recruitment team. None have been accepted to date. If any do accept there would be a 4-6 month process for them to start due to Visa requirements, followed by a period of induction and orientation to the NHS / ULHT whilst on the Tier 1 rota for 3-6 months. Therefore if any accept our offers it is likely to be 7-12 months before any additional staff would join the Tier 2 rota.

#### 4.1.4 Agency Recruitment

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

#### 4.1.5 Use of Agency staff

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

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

#### 4.1.6 Use of Community Paediatric Doctors

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

Working as a Community Paediatrician is very different to working in an acute hospital Children's department, where often the essence is on emergency care, higher acuity of the patient, and children deteriorating quickly. We have asked the Community Paediatric Doctors if they would consider taking a refresher course to enable them to support the acute hospital rota at Pilgrim

Hospital, but they do not feel confident about doing this after being away from the acute hospital service, they do not feel it would be safe for the children in the hospital.

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

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

## 4.2 Escalation meetings (internal and external)

There have been a number of engagement and risk summits addressing the same issues identified in this paper. The details of these are contained within ***Appendix 1.*** Most recently, the following escalation meetings have taken place, with the outcome shown against each as follows;

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

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

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

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

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

- To explore different service models with particular reference to Shrewsbury

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

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

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

**For April 2018**

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

**Actions: Surgery Service in conjunction with W&C CD**

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

**Actions: ED Service**

- Review compliance against section 31 notice

## 4.4 Summary

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

19 inpatient children's beds at Lincoln Hospital and the Safari assessment unit
10 inpatient children's beds, plus 2 assessment beds at Pilgrim Hospital

However, from a medical staffing perspective, we have struggled to cover the rota for April at Pilgrim Hospital, and after June 4th 2018, the medical rota at Pilgrim Hospital will only be able to provide a 2 tier rota which will enable cover only to the Emergency department, Maternity and Neonatology.

The Clinical Directorate and the Children's multi-disciplinary team at Pilgrim believe that a comprehensive Children's service at Pilgrim can no longer be supported in its entirety. The reasons for this are;

- Inability to provide assurance that nursing and medical rotas can be prospectively filled
- Mitigations have been exhausted
- Further deterioration of staffing numbers expected at Middle grade level without a known pipeline of replacements in the next 6 months
- Inability to recruit to the Royal College of Nursing and Medical posts currently vacant at Pilgrim Hospital

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

- Inability to provide compliant medical and nursing rotas at Pilgrim Hospital
- Poor patient satisfaction and experience
- The ability to meet national standards of care
- Difficulty retaining and recruiting Paediatric staff
- Cancellation of elective paediatric surgery
- Longer waiting times in the A&E departments for Paediatric patients while beds are located at out of county providers or at Lincoln
- Deterioration in the health and well-being of staff
- Poor experience for doctors and other clinicians in training
- Risk of trainees being removed from the department, thereby exacerbating the risks
- Cost arising from high staff turnover, locums, and performance failure
- Inability to innovate, develop practice, or invest time in basic departmental management and quality improvement

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

## 4.5 Immediate Risk Mitigation Proposal

Following advice we are currently unable to identify nationally that a middle grade tier run solely by locums is safe and whether it could carry a bigger risk and therefore need to seek assurance as to whether it is safe to do so.

**Proposed Children's services short term plan (April 2018 to 4th June 2018)**

- Maintain current service to
  - Maternity
  - Neonatology
  - Paediatric ward (10 Beds + 2 Assessment beds)
  - Paediatrician support to ED
  - Establishment of multi-professional project team

**Proposed Children's services short term plan (4th June 2018 to 1st July)**

- Continue service to:
    - Maternity (with progressive increase in gestational age to 34 weeks, Neonatology)
- Temporary closure of children's In patient service
- Temporary closure of the GP referral pathway
- Commencement of Children's Hot Clinics
- Commissioning private ambulance for transfer of children requiring admission to another site
- Children's Middle Grade and Consultants to be based in PHB ED but providing cover to maternity & Neonatology (Children's Middle grade doctors and consultants to support ED, maternity and Neonatology).
- Transfer of children's Nurse workforce to PHB ED and to the LCH site facilitating an increase in elective & non-elective beds on LCH site (increase to 24 Beds on Rainforest)

# 5 Options beyond July 1st 2018 for consideration

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

| | |
|---|---|
| **Option One** | • Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover children's, maternity & neonatal services<br><br>Following advice we are currently unable to identify nationally that a middle grade tier run solely by locums is safe and whether it could carry a bigger risk and therefore need to seek assurance as to whether it is safe to do so. |
| **Option Two** | • Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 4th June 2018<br>• Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC<br>• Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations<br>• Paediatric support with emergencies in Emergency Department at Pilgrim Hospital<br>• Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks |
| **Option Three** | • Temporary closure of Paediatric inpatient services at Pilgrim with effect from 4th June 2018<br>• Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC<br>• Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations<br>• Paediatric support with emergencies in the ED department at Pilgrim Hospital up until July 1st |

| | |
|---|---|
| | • Retaining Consultant led Obstetrics and Neonatology at Pilgrim until July 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<br>• Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks<br>• Establish midwifery led birthing unit at Pilgrim Hospital and a co-located midwifery led birthing unit at the Lincoln Hospital to facilitate increased activity on the consultant led unit. |
| **Option Four** | • Maintain Current Paediatric inpatient services, Consultant led Obstetrics and Neonatology services at Pilgrim & Lincoln Hospital Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital.<br>• Stop all paediatric inpatient and day case elective (planned) activity for all paediatric specialities at both Lincoln and Pilgrim Hospital sites (This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln)<br>• Stop all general Paediatric outpatient appointments |
| **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. |

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

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

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

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

## 5.1 Option One

*Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover children's, maternity & neonatal services (NHSI do not support a rota of middle grade doctors populated with 1.0 substantive recruit and 7.0 Locum middle grade doctors)*

**Disruption to patient activity**
There would be no disruption to patients however there is a risk of running a rota with a 1.0 wte substantive middle grade doctor, and 7.0 locum doctors, and this risk is high from a patient safety perspective.

Following advice we are currently unable to identify nationally that a middle grade tier run solely by locums is safe and whether it could carry a bigger risk and therefore need to seek assurance as to whether it is safe to do so.

**The financial impact is as follows;**

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

**Impact on Staff**

There is a risk on the Consultants in post at Pilgrim to assure safety of medical care from a team of doctors that they do not know and are not familiar working with and addition supervision and support is needed from the Consultant body to the agency locum workforce. This risk is magnified by the higher number of agency locums in place so therefore in this instance with 7 locums and 1 middle grade, the risk would be deemed as very high.

## 5.2 Option Two

- *Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 4th June 2018*
- *Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC*
- *Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations*
- *Paediatric support with emergencies in Emergency Department at Pilgrim Hospital*
- *Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks*

**Disruption to patient activity**

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

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

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

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

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

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

**The financial impact**
The financial impact for option 2 is as follows:
Loss of income

- ED activity for children: May to July = £42,724, Full year effect = £170,896
- Admitted care: May to July = £558,712, Full year affect = £2,234,848
- Neonatal care: May to July = £15,474, Full year affect = £185,693

Additional expenditure

- Middle Grade locum doctors =May to July £115,287, Full year affect = £498,740
- Dedicated ambulances for transfers = May to July £60,000, Full year affect = £240,000
- Reduction in non-pay costs due to temporary closure of the inpatient children's ward at Pilgrim
    - May to July = £80,890, Full year affect = £323,561

Net financial impact of option 2 = Negative impact of:

- May to July £714,162
- Full year affect £2,298,077

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

**Impact on Staff**

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

## 5.3 Option Three

- *Temporary closure of Paediatric inpatient services at Pilgrim with effect from 4th June 2018*
- *Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim; redirected to nearest ED or UCC*

- *Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations*
- *Paediatric support with emergencies in the ED department at Pilgrim Hospital up until July 1st*
- *Retaining Consultant led Obstetrics and Neonatology at Pilgrim until July 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 midwifery led birthing unit at Pilgrim Hospital and a co-located midwifery led birthing unit at the Lincoln Hospital to facilitate increased activity on the consultant led unit.*

**Disruption to patient activity**

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

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

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

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

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

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

**Impact on Maternity and Neonatal activity**
In option 3 the impact on Maternity and Neonatal activity at Pilgrim is such that:
- Approximately 1,000 ladies would go out of county to give birth at a hospital closer than Lincoln County

- 28.75% (650 per annum) of births currently taking place at Pilgrim Hospital would transfer to Lincoln Hospital, and
- 11.25% (73 per annum) of these births would result in the baby being admitted to the Neonatal service at Lincoln Hospital.
- Around 300 ladies would deliver their baby in a midwifery led unit at Pilgrim Hospital

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

**The financial impact**
The financial impact for option 3 is as follows:
Loss of income

- ED activity for children: May to July = £42,724, Full year effect = £170,896
- Admitted care: May to July = £558,712, Full year affect = £2,234,848
- Neonatal care: May to July = £94,301, Full year affect = £1,131,615
- Obstetric Care: May to July = 168,271, Full year affect = £2,019,249

Additional expenditure

- Middle Grade locum doctors =May to July £115,287, Full year affect = £498,740
- Impact/Reduction on Junior rotation = Full year affect (from August rotation) = £92,520-
- Dedicated ambulances for transfers = May to July £60,000, Full year affect = £240,000
- Cost relating to staff travel = May to July £2,855, Full year affect = £37,111
- Reduction in non-pay costs due to temporary closure of the inpatient children's ward at Pilgrim
    - May to July = £80,890-, Full year affect = £323,561-

Net financial impact of option 3 = Negative impact of:

- May to July £961,260
- Full year affect £5,916,378

**Impact on staff**

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

## 5.4 Option Four

- *Maintain Current Paediatric inpatient services, Consultant led Obstetrics and Neonatology services at Pilgrim & Lincoln Hospital Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital.*
- *Stop all paediatric inpatient and day case elective (planned) activity for all paediatric specialities at both Lincoln and Pilgrim Hospital sites*
  *(This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln)*
- *Stop all general Paediatric outpatient appointments*

**Disruption to patient activity**

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

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

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

**The financial impact**
The financial impact for option 4 is as follows:

Loss of income
- Admitted children's care: May to July = £183,709, Full year affect = £734,837
- Outpatient: May to July = £244,895, Full year affect = £2,938,737

Additional expenditure
- Middle Grade locum doctors =May to July £115,287, Full year affect = £498,740
- Cost relating to staff travel = May to July £1,427 Full year affect = £18,555

Net financial impact of option 4 = Negative impact of:
- May to July £545,318
- Full year affect £4,190,869

**Impact on Staff**

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

## 6. Quality Impact Assessment of the options

A quality impact assessment has been undertaken to understand the impact of the option. The quality impact assessment is attached as ***Appendix 2.***

# 7. Equality Impact Assessment

An equality impact assessment has been started and this can be found in ***Appendix 3.*** This assessment will require more work over the coming weeks, and will require an action plan to mitigate the risks that are currently being identified.

# 8. Next Steps

## 8.1 Governance Process

The next steps in this process are to establish a formal governance structure for the further work to be undertaken to ensure that our children's and young person's services are delivered in a safe and sustainable manner. A children's and young People's Programme Board, and Task and Finish Group have been established to continue the work.

The Programme Board and the Task and Finish Group have a membership representation from ULHT and major external stakeholders including the local clinical commissioning groups, Lincolnshire Community Health Services, NHSE and NHSI.
The terms of reference for the programme board and the task and finish group can be seen in ***Appendix 4*** and in ***Appendix 5***

The Task and Finish Group will be working immediately on detailed development of each option that has been identified as possible mitigation for the risks that have been identified, if sufficient staffing levels cannot be attained. In addition, the Task and Finish Group will be developing a programme of actions to implement the recommended option, should it be necessary, once this has been identified and has been through the appropriate approval route and governance assurance process.

A full review of the children and young person's service provision at ULHT is being undertaken by the East of England Clinical Senate on 21st May 2018.

The Royal college of Paediatric Child Health is also undertaking a review of the children and young person's services; the date for this review is to be confirmed.

# 9 Recommendations to the Trust Board

The Trust Board is asked to consider carefully the risks raised in this paper relating to the medical and nursing challenges that will be heightened further over the coming months. The Task and Finish Group would like to assure the Trust Board that they will be working hard to recruit to the vacant posts to mitigate the risks to the service from June 4th 2018.

The Trust Board is asked to consider each option that has been discussed in this paper for mitigating the immediate risks relating to the staffing crisis, and to offer their recommendations for which option(s) they consider would mitigate the risk to the service on a temporary basis if necessary until a longer term strategic solution can be agreed and delivered.
These will then be developed further by the task and finish group and presented to the May 2018 Trust Board meeting.

This page is intentionally left blank

# STAFFING ESCALATION TIMELINE

| Date | Communication | |
|---|---|---|
| 2008 | Staffing levels were first placed on the directorate risk register in 2008 and have been reviewed at subsequent directorate governance forums. | |
| 08.02.11 | CQC visit at Lincoln identified that the current establishment did not meet the RCN recommendations. | |
| Jan 2013 | Staffing levels at Lincoln were raised urgently with the Deputy Director of Operations at Lincoln. There had been some specific challenging issues around vacancies, maternity leave and sickness levels. The service was able to increase temporarily the hours of some part time staff to help fill some of the maternity leave. | |
| Dec 2013 | A paper was requested by the Director of Nursing and presented to the Children and Young Person's Board. It was requested that some further work was done around monitoring acuity and activity which was completed. | |
| April 2014 | The Director of Operations requested a paper to take to the Trust Development Authority (TDA) identifying the key risks within Paediatric services and the nurse to patient ratios where included.<br>As a result of this paper, the Senior Business Manager was asked to write a further paper on the key risks to be presented to the Trust Executive. An acuity and activity monitoring tool was put in place. | |
| July 2014 | The CQC visited the service and identified that the service did not meet the RCN standards in regards to registered nurse staffing. | |
| Aug 2014 | As part of the Chief Nurse's safer staffing review, evidence was submitted relating to the non-compliance against agreed nurse ratios within the Registered Children's nurse workforce. | |
| Oct 2014 | Agreement to close 10 beds (5 at Lincoln and 5 at Boston) in order to improve staff to patient ratios. | |
| Dec 2014 | An increase of 10 WTE B5 staff was agreed by the Trust Board | |
| 04.09.15 | Meeting with DON re using staffing vacancies to recruit unregistered staff to enable RNs to focus on nursing duties. | |
| Nov 2015 | Confirm and challenge with Deputy Director of Nursing. Agreed new staffing template. Situation with vacancies remain the same but further issues caused by maternity leave and sickness. This has led to an implementation at Lincoln of a winter plan which advocated reducing elective activity, partial closure of Safari Ward in the mornings (losing 4 beds for this period each day), staffing Clinic 5 with HCSW staff only, moving staff from Grantham and utilizing community services more effectively and to help with cover (ULHT employed).<br><br>Recruitment has also taken place for additional band 4 nursery nurse staff (5 WTE). | |

<table>
<tr><th>Date</th><th>Communication</th><th></th></tr>
<tr><td></td><td>RISK SUMMIT HELD.</td><td></td></tr>
<tr><td>Dec 2015</td><td>Review of staffing with vacancies plus long term sickness and maternity leave shows 41% RN staff unavailable for rota. This was escalated to Head of Nursing and then to the Director of Nursing</td><td></td></tr>
<tr><td>04.01.16</td><td>Matron & Head of Nursing sent paper to Director of Nursing & Chief Operating Officer - Risk Summit re: Maintaining Registered Nurse Staffing Levels on Acute Paediatric Wards.<br>• Currently 41% (23.5 WTE) of the funded registered workforce is not available for rostered shifts due to vacancy factor, long term sickness and maternity leave.<br>• Current ward template does not take into account the Royal College of Nursing's standards on Paediatric nurse ratios. Thus many shifts do not reflect accepted nurse to patient safety standards when assessed against acuity.<br>• Benchmarking against local district general hospitals indicates that staffing levels are significantly lower than our local comparators.<br>• Papers have previously been presented raising concerns in December 2013 and April 2014. A briefing paper recommending uplift in RN staffing was then presented in August 2014.<br>• In October 2014 10 beds were close across the service and further investment of an uplift of 10 WTE Band 5 posts was agreed in December 2014.<br>• Recruitment during 2015 has been immensely challenging and we have been unable to recruit into the vacancies within the registered workforce.<br>• Current RN vacancies combined with long term sickness and maternity leave means that the position in January 2016 is that there are 23.5 WTE RN staff unavailable for roster. This means that on a daily basis, it is not possible to staff all areas at the current agreed template. This agreed template does not allow us to meet the RCN Standards on most shifts.<br>• A winter plan was put in place to help manage this position and has made some minimal impact.</td><td></td></tr>
<tr><td>04.04.16</td><td>Medical Director & Chief Operating Officer sent report written by Senior Business Manager & Clinical Director on PHB Paediatric Middle Grade Rota and associated actions / risks to Trust Board.<br>The purpose of this report is to provide the Trust Board with an update regarding the risks associated with the staffing of the PHB middle grade rota, current risk mitigation and options for the future acute paediatric service on the PHB site</td><td></td></tr>
<tr><td>April 2016</td><td>PHB Paediatric Service contacted W&C Clinical Director to inform that they may have over-recruited to the middle grade rota. No further escalation of medical staff risks from PHB site.</td><td></td></tr>
<tr><td>May 2016</td><td>Nurse Staffing Risk reviewed. In same position until RN vacancies are filled.</td><td></td></tr>
<tr><td>13.07.16</td><td>The Acute Paediatric Service at PHB escalated a severe medical middle grade staffing risk on 13 July 16 to the W&C Clinical Director. The service could not provide assurance to the triumvirate that all medical clinical shifts could be covered for August 16.</td><td></td></tr>
</table>

| Date | Communication | |
|---|---|---|
| | **INTERNAL RISK SUMMIT** with PHB Consultants, W&CCD & HOM/N | |
| 14.07.16 | W&C Triumvirate meeting; Request to M Brassington for Exec Risk Summit | |
| 20.07.16 | **RISK SUMMIT** | |
| 20.07.16 | Meeting with PHB consultants, CD & Senior Business Manager | |
| 25.07.16 | **RISK SUMMIT** | |
| 29.07.16 | Ward Sister & Head of Nursing sent paper to DoN reporting an inability to maintain safe RNC staffing levels on the Children's Ward, PHB.<br>Issue: RN staffing vacancies on Ward 4A are currently running at 8.97 wte but when added to maternity leave and long term sick, 14.85 wte are unavailable for roster - this equates to **51%.**<br>This makes the rota exceedingly challenging to populate with the safe and appropriate skill mix of clinical staff.<br>Report Recommendations:<br>• To secure approval to uplift the non-registered establishments in order to release registered nurse staffing to carry out the RN role over the next six to twelve months.<br>• Flex the bed capacity so as to ensure a safe staffing ratio within the Paediatric ward at PHB.<br>• Enhanced support from Site Duty Managers.<br>• Communication strategy so as to ensure all staff fully aware. | |
| 02.08.16 | Significant issues at Pilgrim that were taken to **Risk Summit in July 2016** and followed up by a paper to **Executive Team** on 2 August 2016. Therefore risk remains the same. | |
| 01.11.16 | Briefing paper presented at **Trust Board.** This report provided an update to the **Trust Board**, following the recent papers which discussed imminent risks to staffing within Paediatric middle grades and the risk to maintaining a safe registered sick children nurse (RSCN) staffing levels on the Children's wards at Pilgrim Hospital, Boston. There has been significant short term recruitment to the middle grade posts but minimal RSCN recruitment; however the service is far from stable with additional staff turnover and shortages in general.<br><br>The paper included current risk mitigation and options for future planning. | |
| 05.12.16 | **RISK SUMMIT** | |
| 12.07.17 | Matron sent email escalating concerns re: expected staffing levels on Children's wards from September 2017.<br>Rainforest Ward Current vacancy **= 5.29wte**<br>September Vacancy **= 8.92wte**<br>Requesting agreed plan as matter of urgency.<br><br>Children's Ward 4A Current vacancy **= 7.13wte** | HoN, CD,HoS, GM Risk Manager, Business Manager |

| Date | Communication | |
|---|---|---|
| | September vacancy **= 9.41wte** | |
| 14.07.17 | Email escalating concerns re: staffing levels on Children's wards<br>Briefing paper sent | HoN, CD,HoS, GM Risk Manager, Business Manager |
| 18.07.17 | July 2017 Staffing Report Update sent | HoN |
| 20.07.17 | Amended July 2017 Staffing Report Update sent | HoN |
| 14.08.17 | Emailed Staffing Shortage briefing paper & draft Quality Impact Assessment to Deputy Director of Nursing Penny Snowden & Julie Pipes Assistant Director of Strategy at request of Head of Nursing | Deputy Director of Nursing. Assistant Director Strategy. |
| 15.08.17 | Emailed draft QIA: Temporary closure of the generic community children's nursing service at Boston to support safe staffing levels on children's ward 4A. | HoN |
| 15.08.17 | July 2017 Staffing report update sent. Reformatted and narrative added by DDN to take comments from ET on 17.08.2017 so ready for TB. DDN requested final QIA to go to NHSI by end of 17.08.2017. | HoN |
| 15.08.17 | E-mail trail – MD e-mailed CD and HOM/N stating need a risk summit with CCGs to go through issues. | |
| 17.08.17 | **RISK SUMMIT** | |
| 22.08.17 | Emailed draft QIA Reduction in Beds | HoN, CD, HoS, Deputy Director of Nursing, Business Manager |
| 23.08.17 | Emailed QIA Reduction in beds Children's wards | HoN, CD, HoS, Deputy Director of Nursing, Business Manager |
| 24.08.17 | E-mail from CD to Paediatricians and subsequent responses. | |
| 29.08.17 | Response from NHSI forwarded by DON (from 21.08.2017) | |
| 30.08.17 | Email to DoN answering queries on QIA closure CCN Teams & QIA Reduction in beds Children's wards | DoN |
| 05.09.17 | CD went to TB when nursing issues were discussed along with the paper written that went to TB week before. Board has unanimously agreed to support short term measures and to seek systems views in | |

| Date | Communication | |
|---|---|---|
| | the escalation meeting tomorrow for medium and long term approach. | |
| 06.09.17 | **PAEDIATRIC RISK SUMMIT** | |
| 18.09.17 | E-mail Paediatric Continuity – SB stated that she thought an external nursing review would be very beneficial with ref to STP work and in relation to options and workforce requisition | |
| 09.10.17 | September Staffing Report Update sent | HoN |
| 12.10.17 | Establishment reviews with DCN & e-Rostering | |
| 06.11.17 | October 2017 Staffing report update sent | HoN, GM, CD |
| 07.11.17 | October 2017 Staffing report update sent | DoN in absence of HoN |
| 04.12.17 | **RISK SUMMIT 04.12.2017**<br>Email received from Penny Snowden Deputy Director of Nursing following her attendance at Risk Summit on behalf of Michelle Rhodes | |
| 05.12.17 | Email from Matron to Bank Business Manager, HOM/N, Deputy DON & DON Re: Paediatric Agency Staffing – requesting to put back into Rainforest staffing due to difficulties covering sickness & x3 nurses on a shift is not enough.<br><br>Advised staff reporting poor experience due to turnaround & volume rather than acuity. Ie) 15 admissions and 12 discharges simultaneously – pressure on staff. Concerns reported re: winter & potential increase in babies admitted which requires higher staff ratio. Reported challenging shifts for staff. Reports concerns recently have not been able to always get cover when needed and we now have a number of new staff. | |
| 12.12.17 | November 2017 Staffing report update | HoN |
| 15.12.17 | 12.12.2017 – E-mail re prep for Risk Summit on 15.12.2017 + e-mail from 14.12.2017 | |
| 29.12.17 | E-mail from GM for Risk Meeting | |
| 12.01.18 | HOM/N e-mailed DON to discuss/update her re discussion with DCN re templates and the review of establishments above. | |
| 18.01.18 | Paediatric Discussion Based Exercise – Exercise PITSTOP 1000hrs-1400hrs<br>*Women & Children's Paediatric speciality is experiencing staffing shortages at all levels. In order to mitigate a critical staffing shortage within the Paediatric inpatient setting at Pilgrim Hospital, a contingency plan has been proposed. This will re-locate Pilgrim Paediatric inpatient services to Lincoln Hospital Rainforest and Lancaster Wards and will provide sufficient beds and resources for inpatients, day case and Paediatric Assessment Activity.* | Led by Business Manager |
| 18.01.18 | December 2017 Staffing report update sent | HoN |

| Date | Communication | |
|---|---|---|
| | | |
| 06.02. 18 | January 2018 Staffing update report sent | HoN |
| 06.02.18 | Meeting held to discuss fill rates and staffing template with Deputy Director of Nursing Workforce: HOM/N & Matron. Nettleham Ward Annexe | HoN & Deputy Director Nursing - Workforce |
| 19.02.18 | E-mail from GM re regular risk summits | |
| 20.02.18 | E-mail from HOM/N to escalate concerns regarding nurse staffing on 4a and advising of a reduction to 12 beds, and acknowledged by DON (12.45h).<br><br>Daily Paediatric shift fill rates reviewed by HoN, Matron and Ward Sister for 4A.<br>Concerns raised as to compliance against fill rates - This concern has been escalated via the risk summits and staffing papers.<br>Proposal with immediate effect due safety & quality concerns to reduce bed capacity to 12 for the next 6 months, this will give us a ratio of 1RN to 4 children / bed which is the national staffing recommendations for a child of 2 and above. Within this proposal it does not facilitate the coordinator being able to be supervisory as recommended. The interim ward manager is continually covering the gaps within the rota.<br><br>Further urgent risk summit request where this can be further discussed but an agreement is required now by us all. | COO, GM, DON, HOS |
| 20.02.18 | E-mail from DON with letter from CQC re PHB A&E (17.06h) | |
| 21.02.18 | E-mail from DON with letter from CQC re possible Section 31 action | |
| 21.02.18 | E-mail from GM to PHB Surgery advising to decrease in beds to 8 and inability to take elective surgery. | |
| 22.02.18 | E-mail from HOM/N supporting the e-mail from Deputy Matron outlining the requirements for children in ED. | |
| 23.02.18 | E-mail from HOM/N outlining the requirement for Children's Nursing to support ED. Acknowledged by DON with thanks to all.<br><br>Decrease of Children's Bed Capacity on Ward 4A from 19 to 8 beds / cots with immediate effect on Ward 4a at Pilgrim Hospital.<br><br>Request to support the A&E department by facilitating 3 of our registered children's nurses to work in the A&E at PHB.<br><br>W&C Clinical Directorate supported these required actions so that our children can continue to be assessed in our A&E at PHB. There is no plan to implement the same measures at LCH currently. The Executive Directors and Trust Board support these actions. | |

| Date | Communication | |
|---|---|---|
| | The Trust is aware of the affect this will have on activity and this is being addressed. | |
| 23.02.18 | E-mail from GM to Contracting re elective surgery and response indicated that CCG aware. | |
| 23.02.18 | Draft briefing paper to Execs from GM to HOM/N & HOS | |
| 23.02.18 | E-mail from Pharmacy re TTOs and acknowledgement from HOM/N | |
| 23.02.18 | E-mail from Head Of Service to Pediatricians and Senior Nursing re pathway and a response from Pediatrician | |
| 25.02.18 | E-mail thanks re support to ED | |
| 26.02.18 | E-mail from Matron to Acute Paediatric Matron and ED Matron re core competency doc and HOM/N acknowledgement that this would be ratified by her, as Chair, at W&CCD Meeting on 27.02.2018 with a short review date. | |
| 26.02.18 | E-mail from GM to advise that at Operational Meeting escalated re impact on Rainforest and a follow up response from HOS. | |
| 26.02.18 | HOM/N response to DCN request for evidence for CQC response | |
| 26.02.18 | E-mail from Matron to University re support for training | |
| 27.02.18 | E-mail re rota provided to ED | |
| 27.02.18 | E-mail to DON with info for media | |
| 27.02.18 | E-mail trail re SOP for escalation when RN (Paediatrics ) not available | |
| 27.02.18 | E-mail from HOS with attachments for discussion at W&CCD Governance Meeting | |
| 27.02.18 | E-mail trail – Consultant Pediatrician/junior staff re issues in A&E & response from HOM/N to Pediatrician. | |
| 28.02.18 | E-mail trail re liaison with Surgical colleagues re elective waiting list | |
| 02.03.18 | ULHT SOP e-mailed to DON & DCN | |
| 06.03.18 | E-mail correspondence re surgical waiting list children | |
| 07.03.18 | E-mail from HOM/N to Exec Team re Surgery | |
| 11.03.18 | Escalation by HOM/N to DON re 4a cover and response re risk summit + further correspondence with HOS. | |
| 12.03.18 | ED SOP sent by Matron to Site Duty Managers PHB&LCH, plus | |

| Date | Communication | |
|---|---|---|
| | subsequent e-mails re staffing. | |
| 12.03.18 | E-mail of rota for rest of March to Director of Nursing/Head Of Midwifery/Nursing | |
| 13.03.18 | E-mail from Exec Team PA re risk summit – subsequently arranged for 26.03.2018 | |
| 14.03.18 | E-mail summary to Exec re CQC inspection | |
| 17.03.18 | E-mail trail from DON re Paediatric College Tutor escalating to EM School of Paediatrics reduction of beds to 8 and response from GM. | |
| 21.03.18 | Meeting with Senior Nursing Team & Consultants to discuss current situation. | |
| 21.03.18 | E-mail from DON to HOS Surgery & Anaesthetics, HOM/N & GMs | |
| 23.03.18 | Paediatric Improvement Committee (dial in) | |
| 26.03.18 | **Pilgrim ED Escalation Risk Summit** | |
| 26.03.18 | **PAEDIATRIC RISK SUMMIT** | |
| 09.04.18 | Preparation for Paediatric Multi-Agency Risk Summit | |
| 10.04.18 | **MULTI-AGENCY PAEDIATRIC RISK SUMMIT** | |
| 13.04.18 | Task & Finish Group (Paediatric Staffing PHB) – Skype meeting – Chief Operating Officer, Chief Executive Officer, General Manager, Head Of Service, Matron | |
| 17.04.18 | Pre-meet Task & Finish Group (Paediatric Staffing PHB) | |

# United Lincolnshire Hospitals NHS Trust: Quality Impact Assessment Tool

## Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive, neutral or adverse) on quality from any proposal to change the way services are delivered. Where potential adverse impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially adverse risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

## Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

| LIKELIHOOD | | IMPACT | |
|---|---|---|---|
| 1 | RARE | 1 | MINOR |
| 2 | UNLIKELY | 2 | MODERATE / LOW |
| 3 | MODERATE / POSSIBLE | 3 | SERIOUS |
| 4 | LIKELY | 4 | MAJOR |
| 5 | ALMOST CERTAIN | 5 | FATAL / CATASTROPHIC |

| Risk score | Category |
|---|---|
| 1 - 3 | Low risk (green) |
| 4 - 6 | Moderate risk (yellow) |
| 8 - 12 | High risk (orange) |
| 15 - 25 | Extreme risk (red) |

A fuller description of impact scores can be found at appendix 1.

| | | IMPACT | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| LIKELIHOOD | 1 | 1 | 2 | 3 | 4 | 5 |
| | 2 | 2 | 4 | 6 | 8 | 10 |
| | 3 | 3 | 6 | 9 | 12 | 15 |
| | 4 | 4 | 8 | 12 | 16 | 20 |
| | 5 | 5 | 10 | 15 | 20 | 25 |

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

**Stage 1**

The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact positively, adversely or have a neutral impact on patients / staff / organisations. Where adverse impacts score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality team. **Where there are more than 3 negative impacts and all total scores are less than 8 the Chief Nurse following review will request a full assessment to be completed.**

**Title of the scheme/project being assessed:**
Temporary reconfiguration of the Children & Young Persons services at the Pilgrim Hospital site Boston, on the grounds of patient safety

**Executive Director Leads:** Dr Neill Hepburn, Medical Director and Mark Brassington, Chief Operating Officer

**Brief overview of the scheme:**

The proposal is to reconfigure Children's & Young Peoples services on the Pilgrim Hospital site on a temporary basis to address the imminent risk to children & young people brought about by the medical staffing crisis within the services. In summary, there will be from July 1st 2018, 1.0 wte substantive middle grade doctor within a rota of 8.0 wte, the Paediatric consultant body have advised that this will not be safe and will be untenable, as they do not have capacity to cover the significant middle grade rota gaps. The Paediatric Consultants have been consistently acting down as middle grades to cover the rota in addition to their own consultant substantive role. (Refer to section3 in the Trust Board paper).

Based on the proposed four options for consideration by the Trust Board, each of the options lead to a similar reconfiguration scenario but on a phased implementation. Therefore, this QIA is based on the temporary relocation of inpatient children's services with potential effect from June 4th 2018, and is based on the temporary relocation of consultant led obstetrics and neonatology services with effect from July 1st 2018.

The Medical Director has approved this QIA, and it will now go to the Quality Assurance Committee on xxx in line internal governance processes

***Answer positive, neutral or adverse (P/N/A) against each area. If A score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment***

| Area of Quality | Impact question | P/N/A | Impact | Likeli-hood | Score | Full Assessment required |
|---|---|---|---|---|---|---|
| **Duty of Quality** | Could the proposal impact on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality? | A | 3 | 4 | 12 | Yes |
| **Patient/Staff Experience** | Could the proposal impact on any of the following - positive survey results from patients and staff, patient choice, personalised & | A | 3 | 5 | 15 | Yes |

| | compassionate care? | | | | | |
|---|---|---|---|---|---|---|
| **Patient Safety** | Could the proposal impact on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections? | N | | | | |
| **Clinical Effectiveness** | Could the proposal impact on evidence based practice, clinical leadership, clinical engagement and high quality standards? | N | | | | |
| **Prevention** | Could the proposal impact on promotion of self-care and improving health equality? | N | | | | |
| **Productivity and Innovation** | Could the proposal impact on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway? | A | 2 | 3 | 6 | No |

| Please describe your rationale for any positive impacts here: |
|---|

**PMO Trust wide Projects**

| Signature: | Designation: | Date: |
|---|---|---|
| | Director of Nursing: Michelle Rhodes | |
| | Medical Director: Dr. Neill Hepburn | |
| | Director of Finance: Karen Brown | |

**Stage 2**

| Area of quality | Indicators | Description of impact (Positive, Neutral or Adverse) | Risk (5 x5 risk matrix) | | | Mitigation strategy and monitoring arrangements |
|---|---|---|---|---|---|---|
| | | | **Impact** | **Likelihood** | **Overall Score** | |
| **DUTY OF QUALITY** | What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides; in accordance with "Everyone Counts: Planning for Patients 2013-14" | **N** | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution? | **N** | | | | |
| | Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution? | **A** | 3 | 5 | 15 | This will impact on staff working in the Children's department at Pilgrim hospital who will be asked to work on a temporary basis at Lincoln County Hospital, and in the ED at Pilgrim Hospital<br>**Mitigation:**<br>Support will be offered to facilitate temporary movement of the staff. Robust recruitment processes will be maintained as a high priority for the organisation to try and mitigate the need to move staff. |
| | What is the impact on strategic partnerships and shared risk? | **A** | 4 | 5 | 20 | All partner organisations attended the risk summit held on 10th April with exception of Peterborough & Stamford NHS Trust who sent their apologies. The consensus agreed at the summit was that the status quo was not an option due to the risk posed to patient safety, which has been identified and evidenced.<br>**Mitigation:**<br>Work closely with all external partner organisations to support the solutions proposed within the four options |
| | What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual access to services and experience of using the NHS (Refer to ULHT Equality Impact Assessment Tool)? | **A** | 3 | 4 | 12 | The options proposed will impact on the maternity and neonatal services at Pilgrim as both women & babies will have to travel further for full services. This will have implications for the neonatal transport team in addition to EMAS<br>**Mitigation:**<br>Establish a service level agreement with a private provider to transfer patients to Lincoln County Hospital. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Are core clinical quality indicators and metrics in place to review impact on quality improvements? | **N** | | | | |
| | Will this impact on the organisation’s duty to protect children, young people and adults? | **N** | | | | |
| **PATIENT EXPERIENCE** | What impact is it likely to have on self-reported experience of patients and service users? (Response to local surveys/complaints/PALS/incidents) | **A** | 3 | 4 | 12 | It is likely there will be a surge of patient complaints, together with complaints from the Local Councillors protesting against the temporary closure of the children’s, and potentially the temporary closure of maternity & neonatal services<br>**Mitigation**<br>A robust communications plan that includes highlighting to residents the clinical pathways to alternative places for care where appropriate for urgent care. |
| | How will it impact on patient choice? For example choice being influenced by wait times, access to services and clinical outcomes. | **A** | 3 | 4 | 12 | Due to children being taken by ambulance to alternative A&E departments and patients seeking out self-referral to alternative sources of care e.g. Urgent Care Centres in Sleaford and Newark. Some families may not be able to access their local hospital for care of their child. This will lead to a potential increase in waiting times for inpatient medical & nursing reviews, ward attenders and ambulances, resulting in a delay for transfer to other hospitals. There may be associated increased costs for families resulting in their inability to visit their sick child.<br>**Mitigation** – Keep patients, CCG’s and GP’s and the public fully informed of future developments, and the key reason for the temporary change, which is to sustain safe and sustainable care for children, women and their babies. Consider funding of transport for families to visit their sick child or baby. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Does it support the compassionate and personalised care agenda? | **N** | | | | |
| PATIENT/STAFF SAFETY | How will it impact on patient safety? | **P** | 3 | 3 | 9 | The unstable middle grade rota on the PHB site from June 4th does not facilitate the appropriate medical workforce required for patient ratios in order to support a safe Children's service, thus the temporary co-location of inpatient children's services will keep the service sustainable and safe.<br><br>. |
| | How will it impact on preventable harm? | **N** | | | | |
| | Will it maximise reliability of safety systems? | **P** | 2 | 3 | 6 | Reasons: It will maximise the use of the Medical resources to provide a safe children's service in Lincolnshire |
| | How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced? | **N** | | | | |
| | What is the impact on clinical workforce capability care and skills? | **N** | | | | |
| | How will it impact staff safety incidents? | **N** | | | | |
| | How will it impact staff satisfaction? | **A** | 4 | 4 | 16 | Children's Medical and Nursing staff at Pilgrim will feel vulnerable for their future employment position. Medical and Nursing staff at Lincoln and Pilgrim Hospitals may also feel unsettled in relation to the future service delivery. **Mitigation** – keep all staff informed of future service development; include them in discussions about any future changes. Ensure that all HR and employee relations systems and processes are enacted as per policy and guidelines |

| | | | | | | |
|---|---|---|---|---|---|---|
| **CLINICAL EFFECTIVENESS** | How does it impact on implementation of evidence based practice? | **N** | | | | |
| | How will it impact on clinical leadership? | **P** | 2 | 2 | 4 | Reasons: It will reduce the current pressures on Paediatric Consultants who have been covering the middle grade rota in addition to their own job plan. It will allow more time to be given to clinical leadership rather than covering gaps in the middle grade rota. |
| | Does it reduce/impact on variations in care? | **N** | | | | |
| | Are systems for monitoring clinical quality supported by good information? | **N** | | | | |
| | Does it impact on clinical engagement? | **N** | | | | Reasons- Children's Medical and Nursing staff at Pilgrim Hospital will feel vulnerable, but this will be counteracted by the increase of engagement at the Lincoln Hospital site. Overall the Children's Medical and Nursing staff understand the current constraints and that we can no longer sustain the middle grade medical rota at the Pilgrim Hospital site. |
| **PREVENTION** | Does it support people to stay well? | **N** | | | | |
| | Does it promote self-care for people with long term conditions? | **N** | | | | |
| | Does it tackle health inequalities, focusing resources where they are needed most? | **N** | | | | |
| **PRODUCTIVITY AND INNOVATION** | Does it ensure care is delivered in the most clinically and cost effective way? | **P** | 2 | 3 | 6 | Reason: Through maximising children's medical and nursing resources it ensures that patient safety is not compromised |
| | Does it eliminate inefficiency and waste? | **P** | 2 | 3 | 6 | Reason: It supports the utilisation of limited medical staff available most efficiently. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Does it support low carbon pathways? | **A** | 2 | 3 | 6 | Reason: Patients will need to travel further.<br>**Mitigation** Try to get the children to the right place first time. EMAS conveying to nearest site other than Pilgrim first time, GP's referring to alternative hospitals, Public advised to use UCC for non-life threatening conditions |
| | Does it lead to improvements in care pathway(s)? | **N** | | | | |

Appendix 1.

| Impact / Consequence score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| **Negligible** | **Minor (Green)** | **Moderate (Yellow)** | **Major (Orange)** | **Catastrophic (Red)** |
| Informal complaint/inquiry | Formal complaint (stage 1) | Formal complaint (stage 2) complaint | Multiple complaints/ independent review | Gross failure of patient safety if findings not acted on |
| | Local resolution | Local resolution (with potential to go to independent review) | Low performance rating | Inquest/ombudsman inquiry |
| | Single failure to meet internal standards | Repeated failure to meet internal standards | Critical report | Gross failure to meet national standards |
| | Minor implications for patient safety if unresolved | Major patient safety implications if findings are not acted on | | |
| | Reduced performance rating if unresolved | | | |
| Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff | Uncertain delivery of key objective/service due to lack of staff | Non-delivery of key objective/service due to lack of staff |
| | | Unsafe staffing level or competence (>1 day) | Unsafe staffing level or competence (>5 days) | Ongoing unsafe staffing levels or competence |
| | | Low staff morale | Loss of key staff | Loss of several key staff |
| | | Poor staff attendance for mandatory/key training | Very low staff morale | No staff attending mandatory training /key training on an ongoing basis |
| | | | No staff attending mandatory/ key training | |
| No or minimal impact on breech of guidance/ statutory duty | Breech of statutory legislation | Single breech in statutory duty | Enforcement action | Multiple breeches in statutory duty |
| | Reduced performance rating if unresolved | Challenging external recommendations/ improvement notice | Multiple breeches in statutory duty | Prosecution |
| | | | Improvement notices | Complete systems change required |
| | | | Low performance rating | Zero performance rating |
| | | | Critical report | Severely critical report |
| Rumours | Local media coverage – | Local media coverage – | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) |
| | short-term reduction in public confidence | long-term reduction in public confidence | | |
| Potential for public | Elements of public expectation | | | Total loss of public confidence |

| | | | | |
|---|---|---|---|---|
| concern | not being met | | | |
| Insignificant cost increase/ schedule slippage | <5 per cent over project budget | 5–10 per cent over project budget | Non-compliance with national 10–25 per cent over project budget | Incident leading >25 per cent over project budget |
| | Schedule slippage | Schedule slippage | Schedule slippage | Schedule slippage |
| | | | Key objectives not met | Key objectives not met |
| Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget | Loss of 0.25–0.5 per cent of budget | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget | Non-delivery of key objective/ Loss of >1 per cent of budget |
| | Claim less than £10,000 | Claim(s) between £10,000 and £100,000 | Claim(s) between £100,000 and £1 million | Failure to meet specification/ slippage |
| | | | Purchasers failing to pay on time | Loss of contract / payment by results |
| | | | | Claim(s) >£1 million |
| Loss/interruption of >1 hour | Loss/interruption of >8 hours | Loss/interruption of >1 day | Loss/interruption of >1 week | Permanent loss of service or facility |
| Minimal or no impact on the environment | Minor impact on environment | Moderate impact on environment | Major impact on environment | Catastrophic impact on environment |

| **Likelihood score** | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |

# Full Equality Analysis Template

## Consolidation of In-patient Paediatrics to Lincoln County Hospital and subsequent impact on Neonatal and Maternity Services

Currently, United Lincolnshire Hospital NHS Trust (ULHT) provide a range of acute and community paediatric services.

With regards to hospital-based services, ULHT provides children's services for children ranging from 0 to 18 years of age, including: an emergency service with links to inpatient beds, elective and day-case services, day assessment unit, a broad range of outpatient service with visiting specialist consultants and Intermittent respite care for specific diseases

At Lincoln County Hospital, a 24 hour paediatric service is provided, which includes: day case, inpatient and outpatient services. Paediatric consultants are available for general paediatric referrals. Current bed configuration is a general paediatric ward which is 19 bedded and an assessment unit which is 8 bedded.

At Pilgrim Hospital, Boston, a 24 hour paediatric service is provided, which includes: day case, emergency and outpatient services . Paediatric consultants are available for general paediatric referrals. Current bed configuration is an 8 bed paediatric in- patient ward, which currently will also undertake assessment activity with 2 assessment beds

At Grantham and District Hospital, The Kingfisher unit is open between 10am and 5pm Monday to Friday and provides an outpatient service only. Children in the Grantham area who have presented at Accident and Emergency that require emergency care and review by a consultant paediatrician are transferred to Lincoln or Boston. Transfer will only take place after review by an accident and emergency doctor or GP (based in the department) and a registered adult nurse. Very few children require this on a daily basis.

Both in-patient services need to comply with the RCPCH's *Facing the Future: Standards for Acute General Paediatric Services – revised 2015.* Standard 5 states:

> "Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner".

ULHT advise that from July 2018 there will only be 1.0 wte substantive middle grade doctor available to work. ULHT have been continually attempting to recruit middle grades and paediatric consultants (to work as middle grades) since May 2017 with limited success.

Concerns have been raised internally to the ULHT Trust Board by the Women's and Children's Clinical Directorate regarding the fragility of Children's Services particularly at Pilgrim Hospital, Boston resulting in an internal risk summit called by ULHT.
An external, system wide risk summit was held and chaired by the Executive Medical Director on the 10th April 2017 where five potential options moving forward were presented:

- **Option 1:** No change to current model
- **Option 2:** Temporary closure of Paediatric inpatients at Pilgrim Hospital, a Paediatric assessment model in place & retain Consultant led Obstetrics, Gynaecology and Neonatology at Pilgrim Hospital
- **Option 3**: Temporary closure of Paediatric inpatient service, Neonatology and Consultant Led Maternity services at Pilgrim Hospital. Facilitate a midwifery led unit at Pilgrim Hospital as a temporary mitigation and a Paediatric assessment model
- **Option 4**: Maintain two site working for paediatric inpatients, Consultant led Obstetrics & Neonatology, but reduce paediatric bed numbers on each site to align with staff availability
- **Option 5:** With effect from July 1, 2018, providers across the region to support Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology

The general consensus at the system wide risk summit was that the status quo was not an option, and option 2 was considered a safe option. Subsequent to that meeting further refinement to the options have been proposed by ULHT as follows, but should be noted that Option 5 was discounted at the risk summit on April 10th by the external providers who attended the summit. The updated options are shown in the table below.

| | |
|---|---|
| **Option One** | • Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover children's, maternity & neonatal services<br><br>Following advice we are currently unable to identify nationally that a middle grade tier run solely by locums is safe and whether it could carry a bigger risk and therefore need to seek assurance as to whether it is safe to do so. |
| **Option Two** | • Temporary Closure of the Children's inpatient ward at Pilgrim with effect from 4th June 2018<br>• Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC<br>• Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations<br>• Paediatric support with emergencies in Emergency Department at Pilgrim Hospital<br>• Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks |
| **Option Three** | • Temporary closure of Paediatric inpatient services at Pilgrim with effect from 4th June 2018<br>• Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest ED or UCC<br>• Temporary re-direction of urgent GP paediatric referrals to neighbouring organisations<br>• Paediatric support with emergencies in the ED department at Pilgrim Hospital up until July 1st<br>• 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<br>• Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks<br>• Establish midwifery led birthing unit at Pilgrim Hospital and a co-located midwifery led birthing unit at the Lincoln Hospital to facilitate increased activity on the consultant led unit. |
| **Option Four** | • Maintain Current Paediatric inpatient services, Consultant led Obstetrics and Neonatology services at Pilgrim & Lincoln Hospital Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital.<br>• Stop all paediatric inpatient and day case elective (planned) activity for all paediatric specialities at both Lincoln and Pilgrim Hospital sites (This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln)<br>• Stop all general Paediatric outpatient appointments |
| **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. |

| |
|---|
| |
| Who will be affected?<br><br>Staff:<br>ULHT Clinical staff working in Accident and Emergency, Paediatric Wards, Maternity, Neonatal,<br>East Midlands Ambulance Team<br>General Practitioners and Practice Nurses<br>Urgent Care Staff<br>Health Visitors and School Nurses<br>Community Paediatric Consultants and Community Paediatric Nurses<br>Children Centre Staff and neighbourhood teams<br>Clinical and non-clinical staff at Nottingham University Hospitals NHS Trust, North Lincolnshire and Goole NHS Hospitals Trust, Queen Elizabeth NHS Trust (Kings Lynne), Peterborough and Stamford Hospitals NHS Trust<br><br>Patients<br>Pregnant Women<br>Children under 16 and under 25 their SEND (Special Education and High Needs)<br>Neonates and Well babies<br><br>Users<br><br>Young Carers and Carers<br>Parents<br>Families |

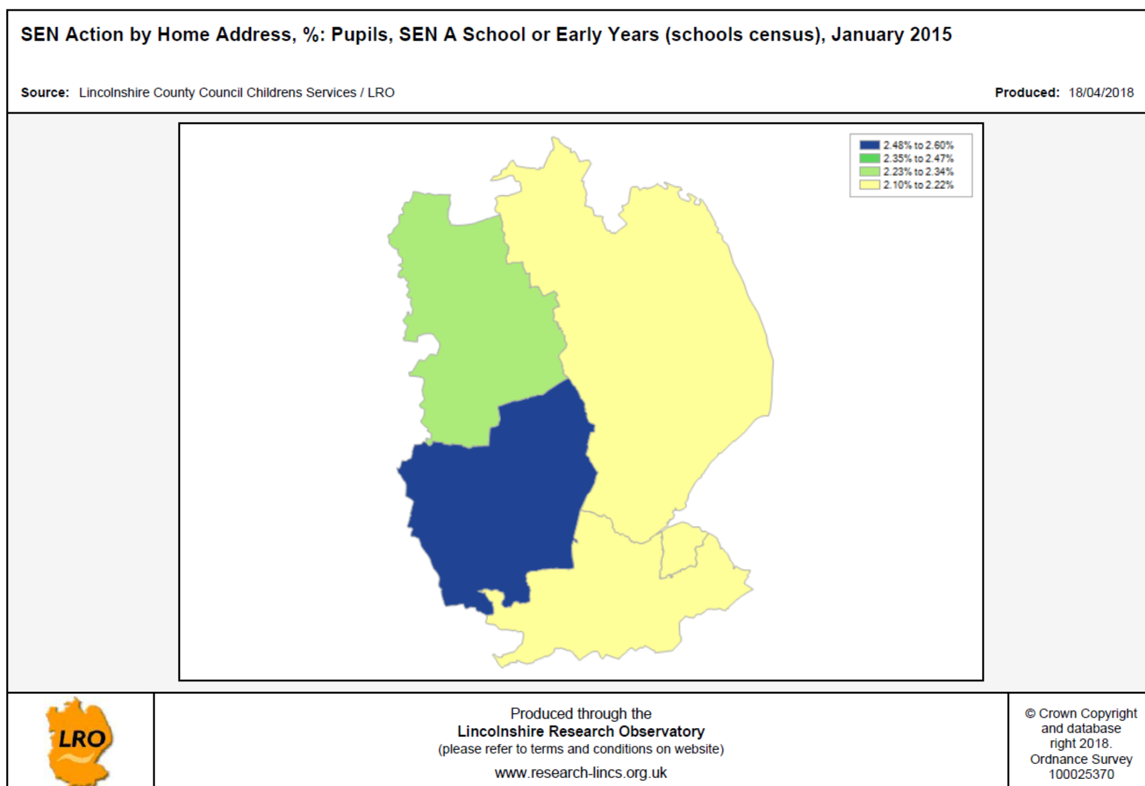
| Evidence |
|---|
| • Public Health – Finger Tips Reports<br>• Public Health – Child Health Outcome Report – March 2017<br>• ONS 2013 Census<br>• ONS Religion in England and Wales 2011<br>• Joint Strategic Needs Assessment (JSNA)<br>• Lincolnshire Research Observatory 2011 Census Country of Birth, Ethnicity and Nationality of Lincolnshire Residents<br>• LRO Schools Population Characteristics (SQL Latest Census) English as an additional Language, 2013<br>• EMMBRACE Saving Lives, Improving Mothers' Care**.** Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. December 2017<br>• SuS Activity Data for 2016/2017<br>• Emergency Planning Services, Draft Final Report: Lincolnshire STP Obstetric and Paediatric Modelling. April 2018<br>• Lincolnshire Research Observatory<br>• Better Births Engagement Results<br>• ULHT Women's and Children's Engagement Results<br>• Intercollegiate Guidelines for Safer Childbirth: Minimum Standards for the organisation and delivery of care in labour, 2007 |

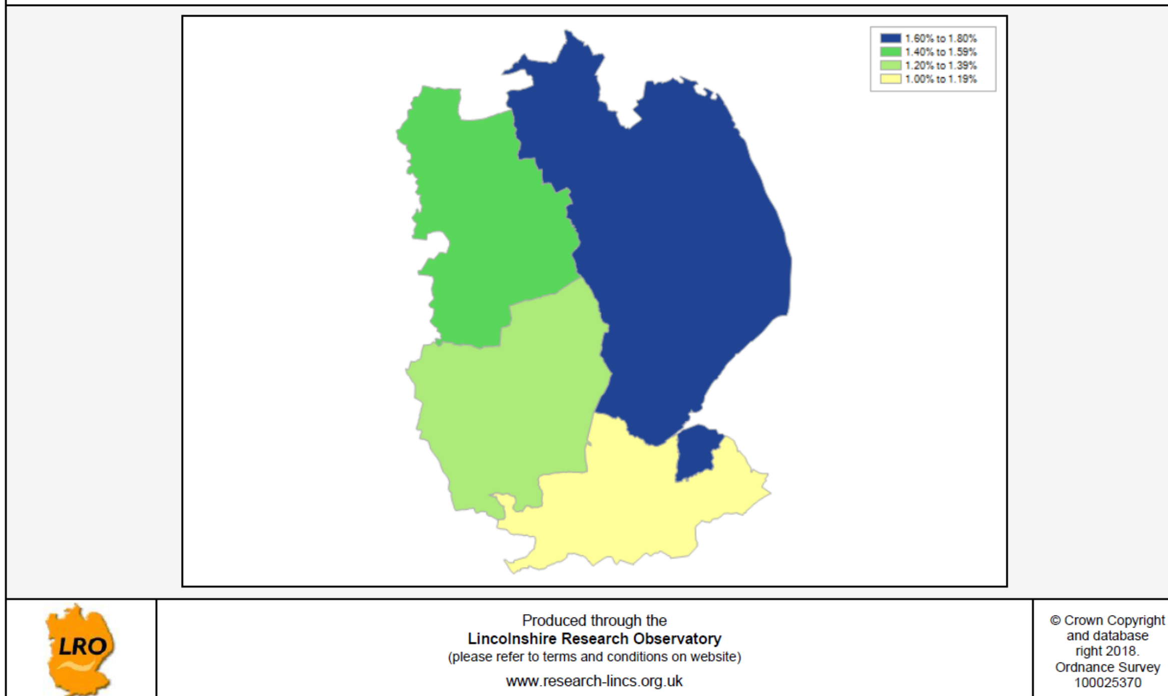
- RCPCH's *Facing the Future: Standards for Acute General Paediatric Services – revised 2015.*
- Defining staffing levels for children and young people's services. *RCN standards for clinical professionals and service managers. 2013*
- Department of Health (2009) *Toolkit for high quality neonatal services*, London: DH.
- RCPH Guidance of Short Stay Paediatric Assessment Units
- Section 11, Children's Act, 2004
- Working together to safeguard children, 2015
- Children's and Families Act, 2014
- Special Educational Needs and Disability Code of Practice: 0 to 25 Years (January 2015)
- Equality Act, 2010
- Public engagement findings from 2021 strategy engagement and targeted engagement carried out by ULHT

**Disability**

In Lincolnshire in 2014/15, 10.3% of Children in Need had a disability (England average is 12.8%). There are around 250 children and young people open to the Children with Disabilities Social Care team with approximately 40% aged 14-18. All of these children and young people have severe or profound disabilities (Source: LCC MOSAIC case management system). In January 2017 there were 105,806 pupils on the roll in Lincolnshire maintained and academy schools, of these 15.9% (approx. 16,820 pupils) are in receipt of some form of provision for their SEND

The graph below reports this data by home address of the child and shows higher incidence rates in South West CCG; however the more complex cases are in Lincolnshire East CCG






Under the Children's and Families Act 2014, NHS providers and Commissioners have a responsibility that health provision promotes the well-being of children or young people in its area who have special educational needs or a disability. Well-being to include physical, mental and emotional health. Given that Children with physical disability may require on-going support from their local paediatric unit, consolidation to Lincoln reduces access for this group and has the potential to adversely impact on their clinical outcomes. Greater travelling times will also lead to more time away from education so also impacting on their educational attainment. So consideration regarding assistance with travelling is required.

Children with very complex needs i.e.) with a tracheostomy & with / or without long term ventilation who become acutely unwell should go to PHB A/E, (if nearest), be treated & stabilised (as required) and then be transferred to tertiary hospital – not Lincoln, as they are considered to be HDU patients.

The Equality Act, 2010 outlines the requirement to offer reasonable adjustment and the Trust needs to consider how Children with disabilities receive an equitable service throughout the county as well as ensuring that the decision to consolidate services does not disadvantage this group of children.

Engagement sessions undertaken by the Trust, with parents, report that proper consideration is given to children with speciality 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.

Further engagement sessions are required where voices of children with disabilities are gathered. Several forums facilitated by the Lincolnshire County Council as well as a Commissioner led SEND user group are in place and the Trust should give consideration to eliciting views through these groups to satisfy their responsibilities under Working together to

safeguard children, 2015, Children’s and Families Act, 2014 and Special Educational Needs and Disability Code of Practice: 0 to 25 Years (January 2015) when redesigning services.

Other considerations that required greater exploration are:

1. Number of disabled parents/ family members required to travel greater journey times to visit or accompany their children to in-patient care at Lincoln rather than Pilgrim
2. What is the impact of consolidation on Young Carer’s of disabled parents not only their own access to health but also assisting the access to health for their parents.
3. Impact on disabled mothers and fathers receiving maternity care

**Sex**

Consideration to the following issues is required:

1. Gender of parent who has the main childcare responsibilities
2. Impact of centralised services and increased travelling times on other family and caring responsibilities
3. Impact of increased time away from work for different genders

**Race**

In 2011, 7.1% of Lincolnshire residents were born outside the UK; 4.5% hold only a non-British passport. This figure had doubled since 2001 largely due to the new EU accession states. Lincoln, Boston and South Holland have the greatest proportion of foreign-born residents. Boston is the only district in Lincolnshire where proportion of non-UK born (15.1%) is higher than England's rate.

| Ethnic Group | Boston | | East Lindsey | | Lincoln | | North Kesteven | | South Kesteven | | West Lindsey | | Lincolnshire | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | number | % | number | % | number | % | number | % | number | % | number | % | number | % |
| White | 62,592 | 96.8 | 134,314 | 98.5 | 89,379 | 95.6 | 105,835 | 98.2 | 130,394 | 97.5 | 87,600 | 98.2 | 610,114 | 94.9715 |
| White: English/Welsh/Scottish/Northern Irish/British | 54,221 | 83.9 | 131,717 | 96.6 | 83,653 | 89.4 | 103,343 | 95.9 | 125,261 | 93.6 | 85,977 | 96.3 | 584,172 | 90.9 |
| White: Irish | 208 | 0.3 | 490 | 0.4 | 719 | 0.8 | 512 | 0.5 | 656 | 0.5 | 411 | 0.5 | 2,996 | 0.5 |
| White: Gypsy or Irish Traveller | 63 | 0.1 | 61 | 0.0 | 80 | 0.1 | 74 | 0.1 | 78 | 0.1 | 161 | 0.2 | 517 | 0.1 |
| White: Other White | 8,100 | 12.5 | 2,046 | 1.5 | 4,927 | 5.3 | 1,906 | 1.8 | 4,399 | 3.3 | 1,051 | 1.2 | 22,429 | 3.5 |
| Mixed/multiple ethnic groups | 664 | 1.0 | 937 | 0.7 | 1,230 | 1.3 | 791 | 0.7 | 1,142 | 0.9 | 630 | 0.7 | 5,394 | 0.8 |
| Mixed/multiple ethnic groups: White and Black Caribbean | 171 | 0.3 | 414 | 0.3 | 367 | 0.4 | 242 | 0.2 | 410 | 0.3 | 222 | 0.2 | 1,826 | 0.3 |
| Mixed/multiple ethnic groups: White and Black African | 114 | 0.2 | 87 | 0.1 | 189 | 0.2 | 91 | 0.1 | 138 | 0.1 | 58 | 0.1 | 677 | 0.1 |
| Mixed/multiple ethnic groups: White and Asian | 167 | 0.3 | 261 | 0.2 | 372 | 0.4 | 256 | 0.2 | 304 | 0.2 | 205 | 0.2 | 1,565 | 0.2 |
| Mixed/multiple ethnic groups: Other Mixed | 212 | 0.3 | 175 | 0.1 | 302 | 0.3 | 202 | 0.2 | 290 | 0.2 | 145 | 0.2 | 1,326 | 0.2 |
| Asian/Asian British | 928 | 1.4 | 789 | 0.6 | 1,794 | 1.9 | 750 | 0.7 | 1,580 | 1.2 | 728 | 0.8 | 6,569 | 1.0 |
| Asian/Asian British: Indian | 374 | 0.6 | 231 | 0.2 | 522 | 0.6 | 217 | 0.2 | 509 | 0.4 | 370 | 0.4 | 2,223 | 0.3 |
| Asian/Asian British: Pakistani | 148 | 0.2 | 63 | 0.0 | 139 | 0.1 | 29 | 0.0 | 93 | 0.1 | 64 | 0.1 | 536 | 0.1 |
| Asian/Asian British: Bangladeshi | 72 | 0.1 | 100 | 0.1 | 139 | 0.1 | 68 | 0.1 | 63 | 0.0 | 0 | 0.0 | 442 | 0.1 |
| Asian/Asian British: Chinese | 130 | 0.2 | 198 | 0.1 | 452 | 0.5 | 215 | 0.2 | 436 | 0.3 | 130 | 0.1 | 1,561 | 0.2 |
| Asian/Asian British: Other Asian | 204 | 0.3 | 197 | 0.1 | 542 | 0.6 | 221 | 0.2 | 479 | 0.4 | 164 | 0.2 | 1,807 | 0.3 |
| Black/African/Caribbean/Black British | 278 | 0.4 | 264 | 0.2 | 778 | 0.8 | 251 | 0.2 | 509 | 0.4 | 224 | 0.3 | 2,304 | 0.4 |
| Black/African/Caribbean/Black British: African | 174 | 0.3 | 160 | 0.1 | 504 | 0.5 | 108 | 0.1 | 330 | 0.2 | 127 | 0.1 | 1,403 | 0.2 |
| Black/African/Caribbean/Black British: Caribbean | 57 | 0.1 | 75 | 0.1 | 165 | 0.2 | 101 | 0.1 | 117 | 0.1 | 74 | 0.1 | 589 | 0.1 |
| Black/African/Caribbean/Black British: Other Black | 47 | 0.1 | 29 | 0.0 | 109 | 0.1 | 42 | 0.0 | 62 | 0.0 | 23 | 0.0 | 312 | 0.0 |
| Other ethnic group | 175 | 0.3 | 97 | 0.1 | 360 | 0.4 | 139 | 0.1 | 163 | 0.1 | 68 | 0.1 | 1,002 | 0.2 |
| Other ethnic group: Arab | 63 | 0.1 | 40 | 0.0 | 175 | 0.2 | 43 | 0.0 | 48 | 0.0 | 38 | 0.0 | 407 | 0.1 |
| Other ethnic group: Any other ethnic group | 112 | 0.2 | 57 | 0.0 | 185 | 0.2 | 96 | 0.1 | 115 | 0.1 | 30 | 0.0 | 595 | 0.1 |

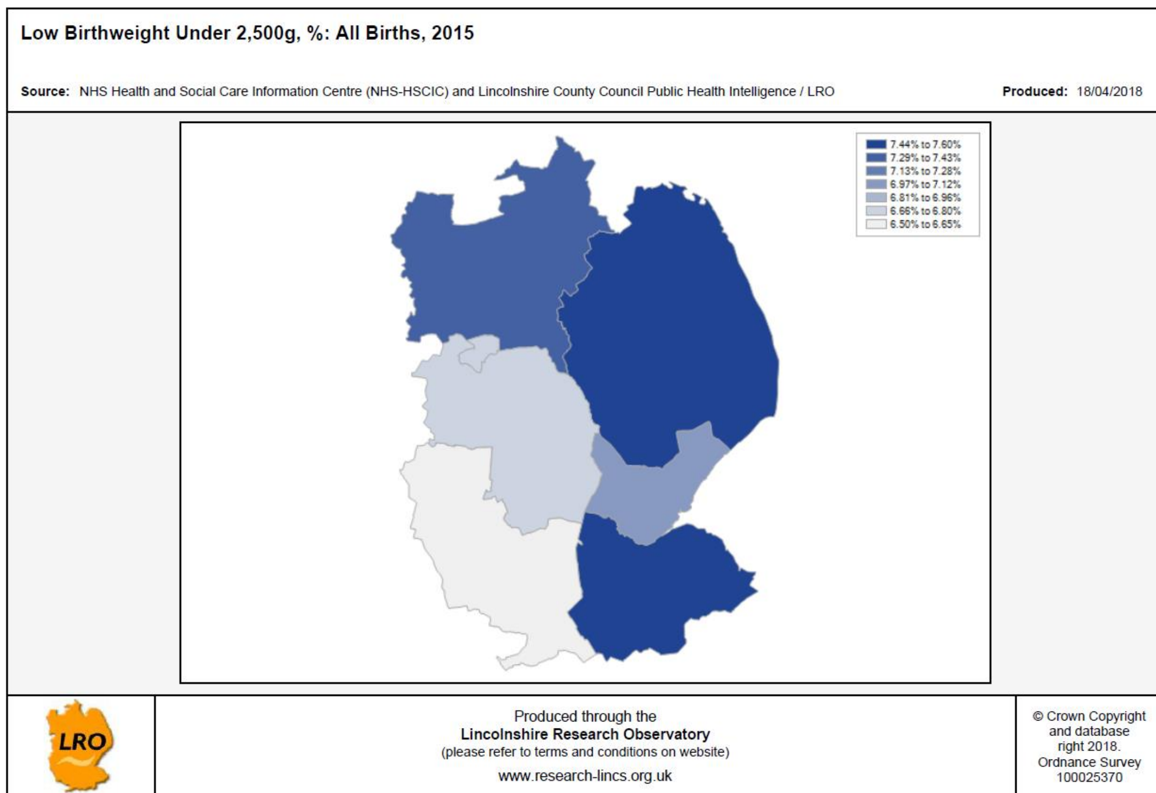
The non-white population make up 2.4% of the total population in 2011 compared to 1.4% in 2001. The proportion of people born in the Middle East and Asia is significantly lower in Lincolnshire (1.1%) than in England (4.8%) or in the East Midlands (3.4%). The proportion of people born in African countries is also much lower in Lincolnshire (0.6%) than in England (2.4%). Over 28,500 people speak a foreign language as their main language with 69.3% of those speaking English well; which is below the national average

People born outside the UK tend to be younger than the general population of Lincolnshire. Over a quarter of people born outside the UK were aged 25-34 in April 2011. The same age group makes up 10.7% of the general population in Lincolnshire. Differences in age structure are even greater in Boston and South Holland districts, where nearly a third of the non-UK born population was aged between 25 and 34 so likely to be parents. This population data suggests higher demand for women’s and children services and so will be significantly impacted by the consolidation of paediatric and subsequent neonatal and maternity services to Lincoln

Given the higher concentration of adults being of childbearing age it is not surprising that 12% of school children are from a minority ethnic group. Reviewing the Lincolnshire School data that reports on English as an additional language; the average percentage of children across Lincolnshire is 6% though reviewing this data by economic area and CCG level, there are higher concentration of children speaking English as an additional language in Boston (21%), Lincoln (10%) and Spalding/ Holbeach (10%). This data reinforces that a considerable ethnic group will be adversely impacted through the consolidation of services.

Unsurprisingly, there is a link with deprived wards and higher levels of residents born abroad. The consideration for children's & young people's services temporary reconfiguration from the PHB site when considering infant mortality rate for England and Wales, though low, mother's county of birth and parent's socioeconomic status are risk factors and services should be designed so health inequalities are minimised. Currently, the Lincolnshire infant mortality is similar to that reported regionally and nationally (2.4-3.6 per 1000 compared to 3.7-3.9). However, low birth rate is a leading contributory factor to infant mortality rates and this is shown geographically across Lincolnshire below.

Additionally 24% of those mothers that died nationally between 2013-15 were born abroad of which 13% were from East Europe particularly Poland – access to maternity care is therefore of paramount importance for the population of Boston which has a high concentration of young East Europeans.




South Holland and East Lindsey report the highest number of low birth with babies so reinforcing the link between ethnicity and poorer health outcomes. The temporary consolidation of children's & young peoples , neonatal and maternity services will adversely impact on access for this venerable group. . Consideration needs to be given with regarding to continuity of carer maternity models that are known to improve clinical outcomes such as birth weight in these areas as a preventative measure moving forward.

Consideration is also then required regarding travelling for parents to enable access to maternity & neonatal care and if the baby is expected to be born with low birth weight and required to birth at Lincoln or a neighbouring unit with appropriate neonatal support this will potentially negatively impacts on the significant ethnic population in the Boston area.

Engagement sessions with East European mothers reported that they expect to be admitted to hospital earlier to give birth, more availability of c-sections and less focus on natural birth. They also want a doctor present for all births s which is not within current UK maternity standards.

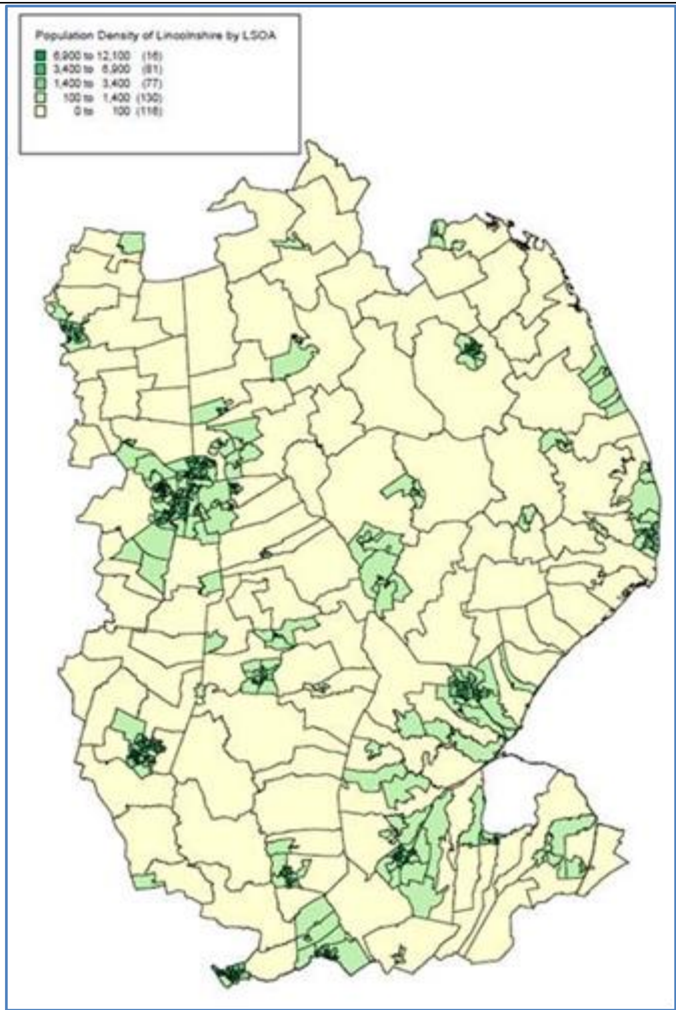
**Age**

Children and young people under the age of 20 years make up 21.7% of the population of Lincolnshire. 15.8% of the population are aged 0-14, compared with a national average in England of 17.3%.

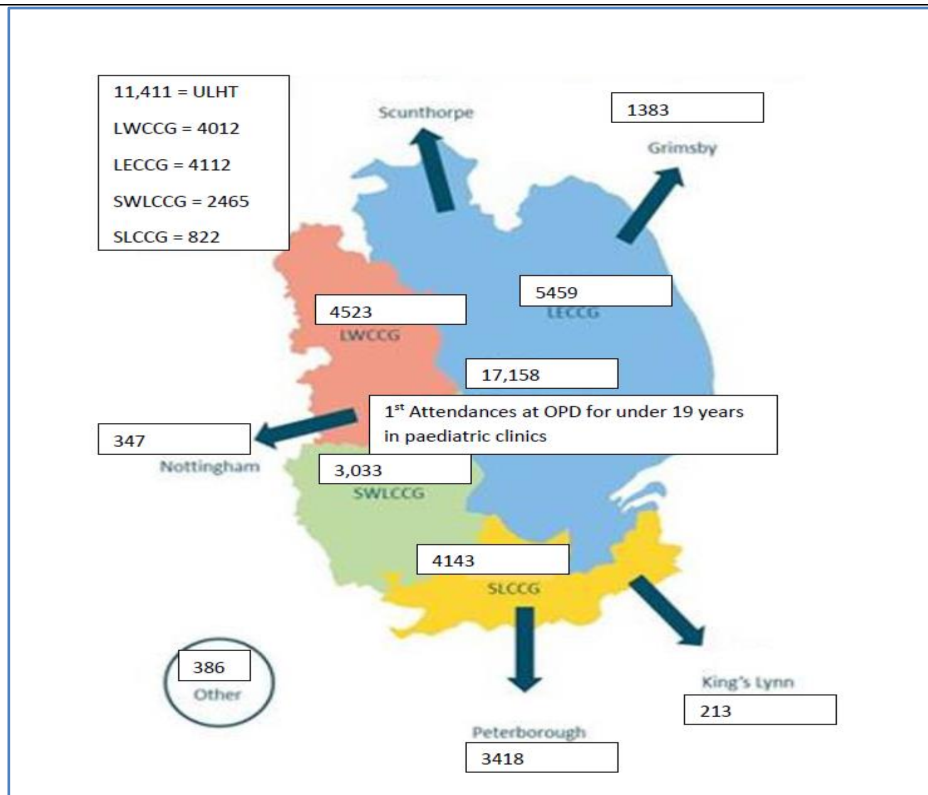
The number and proportion of children across the four CCGs is illustrated in the table below (based on mid 2014 population figures from ONS for 0-15 year olds):

| CCG Area | Total Number of Children | Proportion of Children |
|---|---|---|
| **East Lincolnshire** | 37,616 | 16.4% |
| **West Lincolnshire** | 39,025 | 16.8% |
| **South West Lincolnshire** | 21,070 | 17.3% |
| **South Lincolnshire** | 26,601 | 17.9% |
| **Lincolnshire** | 124,300 | 17% |
| | | |

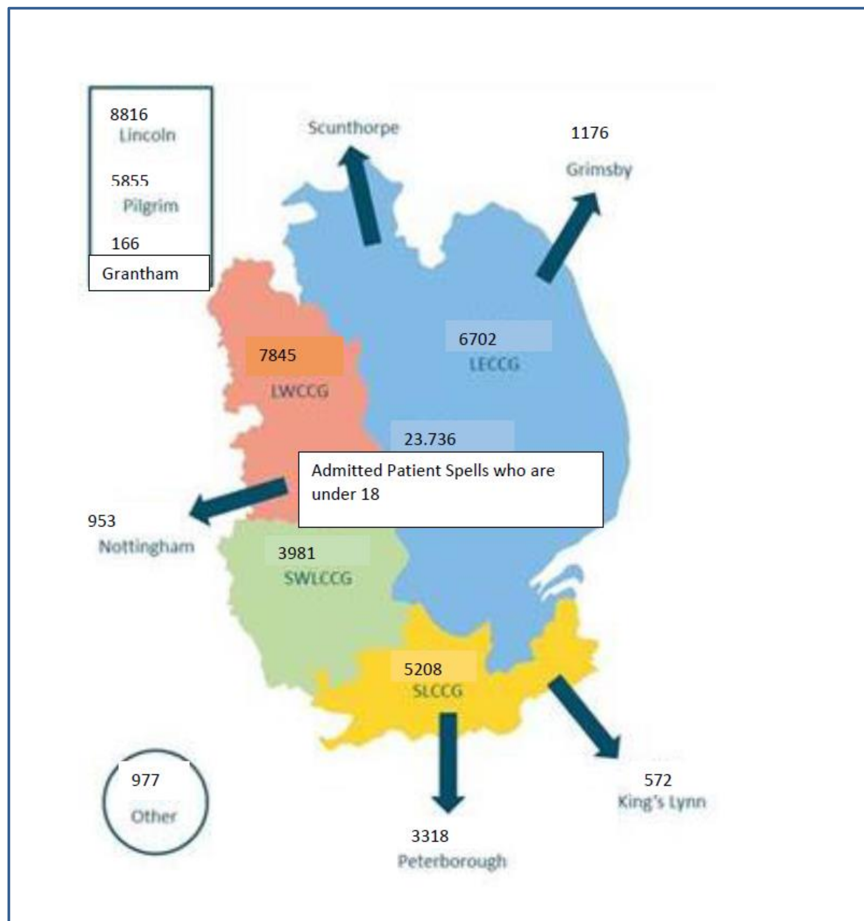
Across Lincolnshire there are several areas that have a higher density of children. The highest densities of children are concentrated predominantly in the urban areas of Gainsborough, Lincoln and surrounding neighbourhoods. There are pockets of high-density areas of children in Bourne, Stamford and Boston with the east coast having a much lower density areas.




This population data is aligned with the referral activity data by CCG regarding Children under 19. The following graphs illustrate the referrals activity data by CCG and by provider.

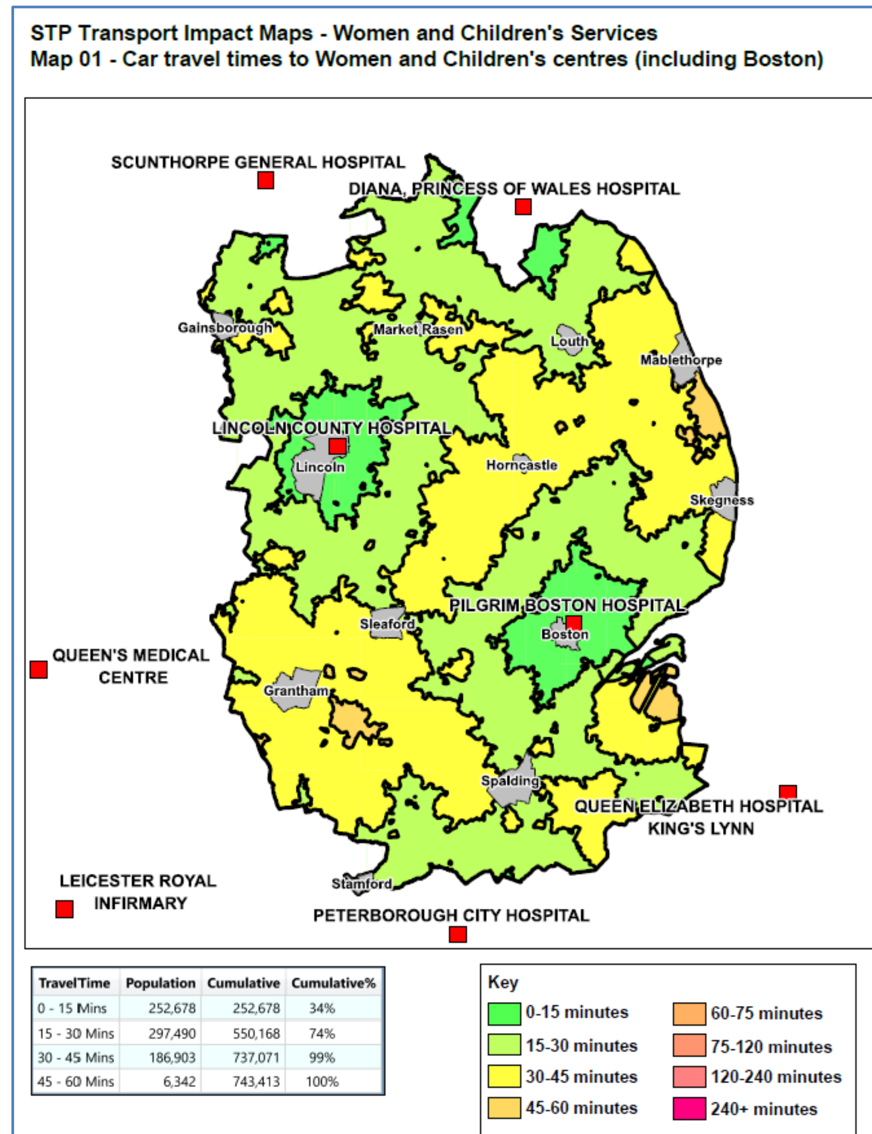



The next graph reports admitted patients spells for children 18



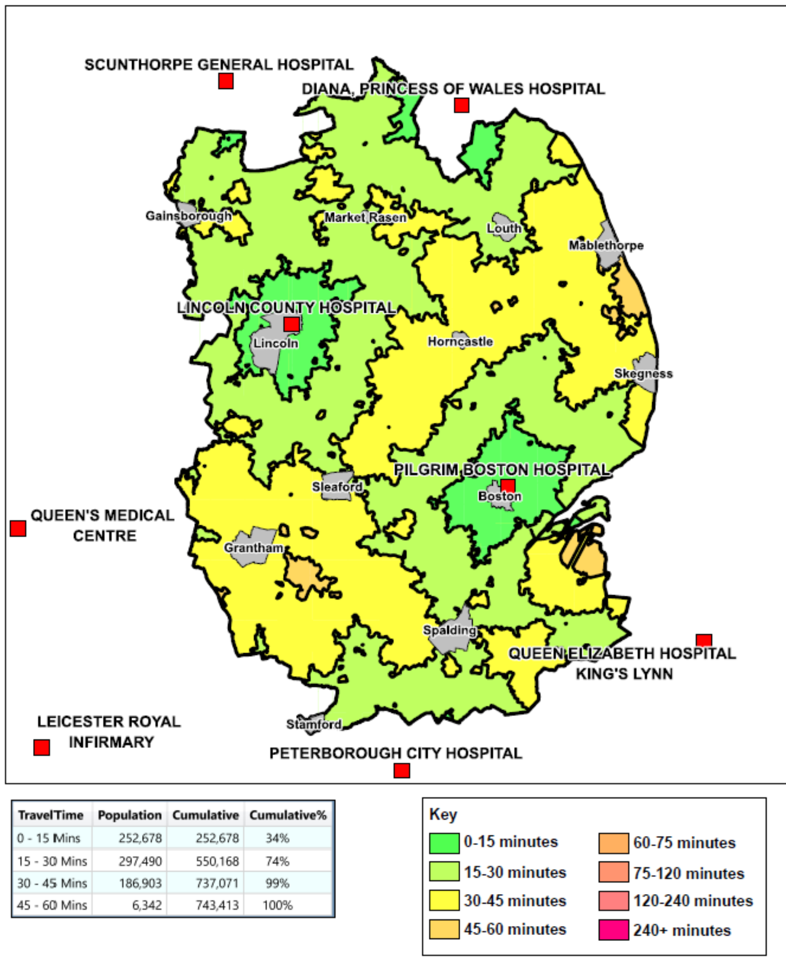
Both graphs highlight the significant number of children being referred to ULHT from Lincolnshire West and East CCG. Consolidation of in-patient services to Lincoln will significant impact on the population in Lincolnshire East. Access is then compounded by the lack of public transport infrastructure.

Transport modelling has been completed by the Lincolnshire STP team and the current transport times by car as follows




| TravelTime | Population | Cumulative | Cumulative% |
|---|---|---|---|
| 0 - 15 Mins | 252,678 | 252,678 | 34% |
| 15 - 30 Mins | 297,490 | 550,168 | 74% |
| 30 - 45 Mins | 186,903 | 737,071 | 99% |
| 45 - 60 Mins | 6,342 | 743,413 | 100% |

Transport by car has also been modelled if services are to be consolidated onto the Lincoln site and the following map reports the significant impact of this in reducing access to the population on the east coast. This has the potential to increase clinical risk and disadvantage children on the east coast; so consideration to how this risk is mitigated needs to be considered by ULHT




| TravelTime | Population | Cumulative | Cumulative% |
|---|---|---|---|
| 0 - 15 Mins | 252,678 | 252,678 | 34% |
| 15 - 30 Mins | 297,490 | 550,168 | 74% |
| 30 - 45 Mins | 186,903 | 737,071 | 99% |
| 45 - 60 Mins | 6,342 | 743,413 | 100% |

The graphs show that in the current configuration of services, a population of 6,342 would be required to travel 30-45 minutes to access a maternity or paediatric site. The consolidation of services to Lincoln County Hospital, leads to a population size of 186,903 travelling 30-45 minutes and 6,342 45-60 minutes to their nearest maternity or paediatric site.

Further modelling by public transport is required for consolidation of paediatrics, neonatal and maternity; however work done to date on access to emergency care report that during the week a population of 42,784 do not have access to public transport to an accident and emergency which rises to 318,216 on a Sunday. This will impact on families visiting children in hospital and accessing emergency paediatric care.

Additionally, if there is no paediatric support at Boston Accident and Emergency, the lack of public transport infrastructure has the potential to place greater demand on East Midland Ambulance Services and neighbouring services. These concerns were raised by parents in the engagement sessions undertaken by the Trust where the following trends emerged:

- Issues with travelling for care if family has no car- public transport can be difficult
- Patient transport needs to keep pace if services are centralised.
-

Maternity

- High Reliance on taxis to get to hospital, not affordable for those on low incomes
- Low social-economic backgrounds rely on ambulances alone, so will be disadvantaged

compared to those with transport.

- Number of parents do not own a car therefore they have to reply on public transport.

**Deprivation**: overall deprivation, measured by the Index of Multiple Deprivation (IMD) in 2015, shows that Lincolnshire ranked 92nd overall (where 1st is the most deprived). However, Districts are varied, with Lincoln ranking 62nd for overall deprivation, and 34th for Income Deprivation Affecting Children Index (IDACI).

The countywide level of child poverty is better overall than the England average of 20.1%, with 18.1% of children aged under 16 year's old living in poverty in 2014. However, this rises to 23.3% in Lincoln and 23.9% in East Lindsey.

Given the higher levels of deprivation in East Lindsey and the higher density of children living in Skegness with poor access to Lincoln by public ransport; consolidation of inpatient paediatric unit to Lincoln significantly reduces access thus having the potential to widen health inequalities further; so consideration how this risk will be mitigated is required.

Child Health Outcomes vary across the county with both Lincolnshire West and East having significantly more children compared to the regional and national average attending accident and emergency. The impact of removing paediatric medical cover from Pilgrim hospital requires further thought given that in 2016/2017 approximately 3000 IS THIS CORRECT? children presented at Pilgrim Hospital, Boston Accident and Emergency department. Parents expressed that they tended to access A&E directly rather than going through NHS 111, so these cultural norms of accessing services needs to be considered to ensure that there is adequate paediatric expertise in the Accident and Emergency Department in Boston

Lincolnshire East also have higher rates of obesity in children aged 4-5 and 10-11years which has the potential to increase their risk of developing diabetes. This will place additional demand for hospital services and through consolidation has the potential to delay initiation of treatment in the case of diabetic ketoacidosis or other acute diabetic issues. Lincolnshire South report having more children with one or more missing, decayed or filled teeth than the national and regional average though the number of admissions to hospital for dental procedures is currently in line with the national average.

All NHS provider organisations are required to consider their obligation under Section 11 of the Children's Act 2004 and Working Together to Safeguard Children, 2015; which places duties on NHS Trusts to ensure their functions, and any services that they provide safeguard and promote the welfare of children. This statutory responsibility includes the requirement to listen to children and take account of their wishes and feelings in both individual decisions, and development of services. To date, ULHT have engaged with a range of groups and parents regarding views of paediatric services. Themes emerging from that engagement are:

- Some parents were concerned about safety if they needed to travel in an emergency/ feel that centralising services will cost lives
- No consensus on travelling times for emergency care was gained through the engagement sessions
- In case of emergency, the majority of parents take their children to A&E in Pilgrim
- Majority of parents would expect their child to be admitted to the local (Pilgrim) hospital. Some families had to travel to Leicester or Nottingham. They would expect paediatrician to care for their child at all times.
- Most agreed that emergency paediatric care needs to stay in Boston.
- A handful suggested that if you centralise maternity and paediatric service, there needs to be a way for partners and other children to stay overnight

- There was a concern around lack of paediatric provision for holidaymakers on the East Coast at peak times
- It is very difficult to get a GP appointment so people end up going to Pilgrim A&E.
- Worry that if we centralise, more children will be sent out of county for care as Lincoln won't be able to cope with the increased capacity. Some expressed concern about poor reputation of Lincoln children's & young people's service

However, the Trust needs to consider how they will engage directly with children in eliciting the views to satisfy this responsibility as Children have a right to receive and impart information, to express an opinion and to have that opinion taken into account in any matters affecting them from the early years. Their views should be given due weight according to their age, maturity and capability (Articles 12 and 13 of the United Nations Convention on the Rights of the Child). Additionally, how children's welfare is protected and safeguarding through consolidation of paediatric services and the subsequent impact on Neonates and Maternity requires careful consideration and mitigated action to be developed.

Lincolnshire east CCG have also undertaken a survey where 141 people responded to a question on access to emergency of which 29% expected to be seen the same day and 33% to be reviewed by someone with specialist paediatric training which has impact of the staffing model in Accident and Emergency at Pilgrim. There was support for GP's to extend their services for children (63%).

Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.
Consideration is required regarding

- Children with indeterminate gender
- Parents

Sexual orientation Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.

Consideration is required regarding

- Children who are aware of their sexual orientation
- Same Sex Parents

**Religion or belief** Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.

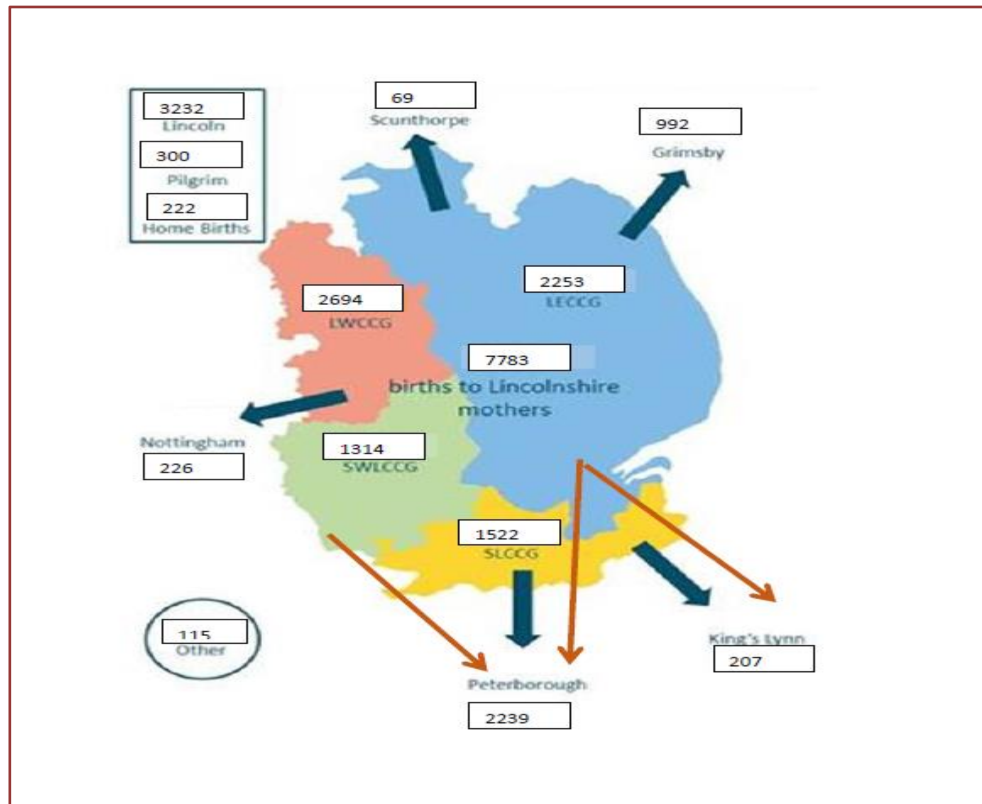
National statistics report that for the county of Lincolnshire over 60% of the population report their religion to be Christian – ONS 2011

**Pregnancy and maternity**
Any consolidation of medical staffing in paediatrics that leads to the deficit in the above standards then affects the viability of both the neonatal and obstetric service.

In view of this, the decision to consolidate paediatric services impacts on the wider pregnant population in Lincolnshire. Across the 4 Lincolnshire CCGs there were 7783 women who gave birth in 2016/2017, with 5448 of these births taking place at United Lincolnshire Hospitals NHS Trust, 3278 at Lincoln County Hospital and 1948 at Pilgrim Hospital in Boston. 222 women chose to give birth at home. Boston has the lowest birth rate in the county and Lincoln has the highest .

Population predictions of women aged 15-44 years show a stable or a slight fall in the number of women considered to be of child birthing age within all four CCG areas in Lincolnshire (projected up to 2037). This is against an increasing population projection in general.

Exploratory work regarding anticipated displaced activity as a result of consolidating obstetric units at Lincoln is shown in the diagram below




This would appear to result in ULHT's birth rate reducing from 5448 to 3752 if women then access their nearest maternity unit which will incur longer travelling times.

The latest maternity dashboard reported in January 2108 12 BBA's (Born before Arrival); it is likely that as families have longer to travel to birth in an obstetric unit, this figure could potentially rise.

Family and Friends recommend rate is 94.7% as an average for the past year for feedback on Birth which is rag rated as "red"' which is likely to deteriorate further for ULHT if maternity services are consolidated. .

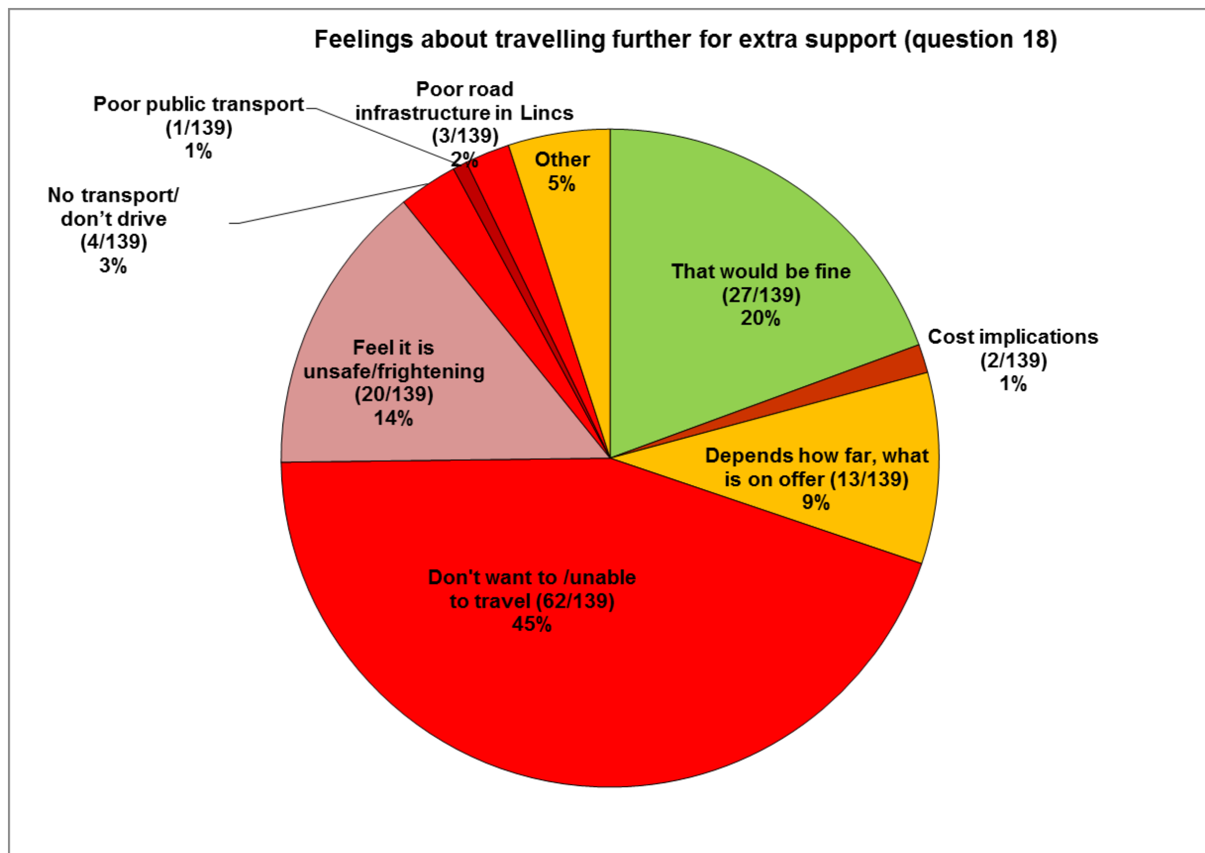
Some women will have to travel further if they choose to have either an epidural or be in an obstetric unit rather than a midwifery led unit as per their choice. This was confirmed in the ULHT engagement sessions undertaken where the following themes were articulated:

- Anxiety from mothers in the Boston area about having to travel for maternity care more often- cost, stress, appointment times (difficult to get to early appointments if they are far away)
- Overall feeling was that Lincoln maternity would not be able to cope if everything was centralised there.

- A large number of women said they would not use a midwifery-led unit at Pilgrim. They reported it would be “too scary and something might go wrong”. Expect pain relief and consultant care close to home.

Additionally, engagement work has been undertaken by Lincolnshire East CCG as part of the STP Women’s and children’s services review. A survey was undertaken with 349 people responded of which 219 were from Lincolnshire East. The following outlines the main findings from the Lincolnshire East area as they are mostly affected by the proposals

- 50% of respondents wanted obstetric services on both sites
- 84% wanted to give birth in an obstetric unit and 10% would birth in a midwifery led unit
- See graph below regarding comments on travelling to a central site




Additionally, the teenage pregnancy rate throughout the whole of Lincolnshire is similar to the England average. In 2015/16, 1.1% of women giving birth were teenage which, whilst higher than the national average, represents a decrease from the previous year. The greatest fall in conceptions has been seen in Lincoln, although this is still the district of the county with the highest rates of conception in under 18s.

Only Lincoln and Boston are significantly above the national average for teenage pregnancy rates, with Lincoln being the highest at 36 per 1,000. The percentage of births to mothers over the age of 35 years is lower than England at 15.7% compared to 21.1%. Delayed booking, poor antenatal attendance are familiar patterns often presenting in labour. Consideration regarding continuity of carer for teenage pregnant young children will be essential to maximise clinical outcomes for young mums.

| Marriage and Civil Partnership Consider and detail (including the source of any evidence) on same sex people who are in a civil partnership, and heterosexual people and same sex people who are married.<br><br>See above |
|---|
| Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.<br><br>Potential for children to feel more isolated whilst in hospital if families live further away either due to the journey times, the lack of public transport and caring conflicts with other members of the family whether this is school runs or working.<br><br>Increased requirement for carers to stay in services are further away which again impacts on the other caring responsibilities and work commitments |
| Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access. |

| Engagement and involvement<br><br>Risk summits raising and escalating the risks to patient safety have been held internally at ULHT on the following dates:<br>• November 2015<br>• 4th January 2016<br>• 13th July 2016<br>• 20th July 2016<br>• 25th July 2016<br>• 5th December 2016<br>• 17th August 2017<br>• 4th December 2017<br>• 26th March 2018<br><br>Multi Agency / external stakeholder risk summits have been held on the following dates:<br><br>• August 2016<br>• 6th September 2017<br>• 10th April 2018 |
|---|
| How have you engaged stakeholders in gathering evidence or testing the evidence available? |

How have you engaged stakeholders in testing the function proposals?

The proposals have not been fully developed – this appraisal has been completed with the assumption that the temporary re-location of the in-patient children's ward and paediatric medical workforce.

Over the last two years, ULHT and STP partners have engaged the population of Lincolnshire on the future of women and children's services and support for and impact any potential change may have on them. This included a mix of qualitative and quantitative techniques to reach harder to reach people and a wider representation of the population. it is recognised that engagement with children is required

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

In total, we've engaged almost 2,000 people on childen's & young peoples and maternity services. We have spoken to nearly 120 parents in face-to-face meetings specifically about children's & young peoples and maternity services over the past 18 months, as well as a further 1,000 people about the ULHT 2021 strategy, which has included discussions on maternity, children's and young people's services.

The targeted community groups engaged include:

- Maternity groups, Skegness
- Toddlers play groups in Skegness and Boston
- Little SNAPPS (neonates group), Boston
- Children's Centres in Boston and surrounding area
- NCT groups - Aschoughfee Hall and Black Sluice
- International parents group, Lincoln
- Polish group, Boston

In addition, more than 800 people responded to our 2021 strategy survey in 2017, and comments around paediatrics and maternity in particular were collated.

The main themes from all of this engagement were:

Children's & Young People's Services

- Parents generally have no issue with their child being transferred away from their local hospital for specialist non-emergency treatment.
- In an emergency, some would expect child to be stabilised locally first
- No consensus on travelling for emergency care – some expected this to be provided locally, yet others would travel an hour to receive care for their child
- Some are concerned about safety if they needed to travel in an emergency/ feel that centralising services will cost lives
- Generally parents praise the staff, nurses and doctors at Pilgrim. They feel the medical staff are helpful and caring.
- In case of emergency, the majority of parents take their children to A&E in Pilgrim. Few said they called 111 and followed the process. Very few tried to get an appointment at GP surgery, which seemed to have been a challenge.
- In case of emergency, most parents say they wouldn't mind their child being seen by a nurse or GP instead of consultant as long as they were trained appropriately.

- Outpatients appointments – preferably local hospital however prepared to travel for specialist appointments; to be seen by a specialist with paediatric background.
- Inpatient stay – majority of parents would expect to be admitted to local (Pilgrim) hospital. Some families had to travel to Leicester or Nottingham. They would expect paediatrician to care for their child at all times.
- Most agreed that emergency paediatric care needs to stay in Boston.
- A handful suggested that if you centralise maternity and paediatric service, there needs to be a way for partners and other children to stay overnight.
- There was a concern around lack of paediatric provision for holidaymakers on the East Coast at peak times
- Need proper consideration for children with special needs who need stability and familiarity, as well as those with heart conditions, epilepsy, chronic asthma and bleeding disorders who need immediate attention.
- Worry that if we centralise, more children will be sent out of county for care as Lincoln won't be able to cope with the numbers. Some expressed concern about poor reputation of Lincoln children's services.
- Issues with travelling for care if family has no car- public transport can be difficult
- Patient transport needs to keep pace if services are centralised.
- It is very difficult to get a GP appointment so people end up going to Pilgrim A&E.

Maternity

- Most women said they accept going out of county for very specialist care if baby is born early/ needs a certain level of care.
- Boston mothers said they worry about having to travel for maternity care more often- cost, stress, appointment times (difficult to get to early appointments if they are far away)
- The overall feeling was that Lincoln maternity could not cope if everything was centralised there.
- Many people in the Boston area said they are worried that babies will die if there isn't a consultant presence at Boston.
- A large number of women said they would not use a midwifery-led unit at Pilgrim. "Too scary and something might go wrong". Expect pain relief and consultant care close to home.

Every woman spoken to said they would like maternity scans, antenatal appointments and check-ups locally.

Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
No protected group will suffer discrimination, harassment or victimisation as a result of the changes

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

*We will work with community groups representing protected groups who will be adversely affected to develop an action plan to promote equality.*

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
As above. Plus ULHT engagement team will continue engage ULHT members who represent all protected groups, patient experience will continue to engage with carers' groups.

What is the overall impact?

Disability – negative impact
Age- negative impact
Sex – neutral impact
Gender reassignment – neutral impact
Sexual orientation – neutral impact
Race – negative impact
Pregnancy and maternity – negative impact
Religion – neutral impact
Marriage and civil partnership – neutral impact
Carers – negative impact

Overall – negative impact

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.
We will work with community groups representing protected groups who will be adversely affected. ULHT engagement team will continue engage ULHT members who represent all protected groups.

Action planning for improvement

This will be developed following Trust board meeting on 27 April 2018.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

There is a requirement to:

- During April, May and June:
    - Undertake engagement with children and young people regarding proposed temporary service changes and future options for the services
    - To undertake specific engagement with children with disabilities, parents and carers and user groups regarding the proposed service changes and future options
- To scope an option that mitigates the significant clinical risk of possible displaced obstetric activity
- Further activity has been included in the action plan

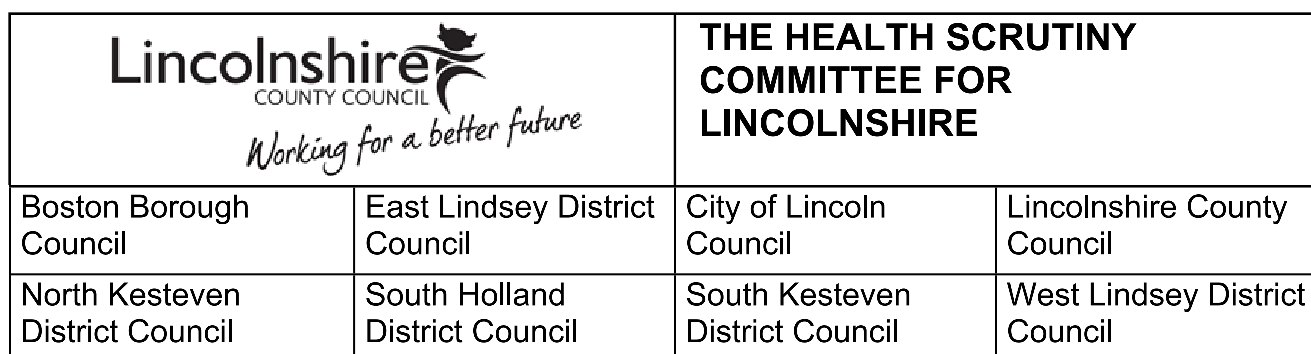
Name of persons who carried out this assessment:

Paul Hinchliffe, General Manager of Women's and Children's, ULHT
Dr R Kolliparo, Consultant Paediatrician, ULHT
Julie Pipes, Associate Director of Strategy, ULHT
Lucy Ettridge, Associate Director of Communications and Engagement, ULHT
Penny Snowden, Deputy Chief Nurse – Lincolnshire East CCG
Mandy L Clarkson: Consultant in Public Health, Department of Public Health, Lincolnshire Council

Date assessment commenced:
18th April 2018

| |
|---|
| **Name of responsible Director/ General Manager:**<br><br>**Neill Hepburn, Medical Director** |
| **Date assessment was signed:** |

Agenda Item 8



| Lincolnshire County Council – Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
|---|---|---|---|
| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |

Open Report on behalf of Lincolnshire West Clinical Commissioning Group

| | |
|---|---|
| Report to: | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 May 2018** |
| Subject: | **Patient Access to Primary Care – Lincoln Area** |


**Summary:**

This report is provided by Lincolnshire West Clinical Commissioning Group (LWCCG) to update the Health Scrutiny Committee on development of primary care services to meet patient need following the closure of the Lincoln Walk-in Centre in Monks Road.


**Actions Required:**

Members of the Health Scrutiny Committee are asked to consider the updated information provided in response to specific questions raised at the Health Scrutiny Committee in February 2018.

## 1. Background

Following a full consultation programme, plus promotion and development of the alternative services, the Lincoln Walk-in Centre was closed on the last weekend in February 2018. Information on the consultation and decision has previously been provided to this Committee. At the February 2018 Health Scrutiny Committee, an update on the following was requested from Lincolnshire West CCG (LWCCG) following the closure of the Walk-in Centre on Monks Road:

- Abbey Medical Practice – Further assurance was required on capacity in view of the fact that this practice is located on Monks Road and therefore likely to be impacted the most by the closure.
- GP Practices List Sizes – Is there capacity to manage their presenting demand?

- GP Appointments/ Primary Care Access:
  - Any increase in the number of pre-bookable GP appointments
  - Any increase in the number of same day GP appointments
  - Increase in the number of 111 calls
- Reception Staff Training

## 2. Updated Information

Abbey Medical Practice

The Abbey Medical Practice was identified as challenged in matching local demand and service capacity. This practice has now recruited an additional GP, an additional practice nurse and an additional clinical pharmacist to manage presenting demand following the closure of the Arboretum surgery and the Walk-in Centre. The practice is currently using additional space at the Arboretum surgery and there is a plan being developed with a business case, to be approved by Primary Care Commissioning Committee (PCCC), to enable them to consolidate their services onto one site. We are confident that the additional staffing provides the capacity to meet the increased demand associated to changes to service provision on Monks Road. We continue to work with the practice to secure the development of their facilities so that they will be able to deliver all services from a single site.

GP List Sizes

The majority of patients (81%) attending the Walk-in Centre over the last two years were registered with GP practices located in the Lincolnshire West CCG with 86% registered with GP Practices located in Lincolnshire. On average 3.3% of patients who attended the Walk-in Centre were unregistered.

Provision of additional resources and better use of existing resources at GP Practices, particularly city centre practices, has enabled GP practices to manage presenting demand. This is demonstrated in Appendix 1 and 1a which provides the full details of the alternative services. Appendix 2 shows responses from eight GP practices, identified as likely to be the most effected by the Walk-in Centre closure, which outlines the impact and management of the additional demand.

The Lincoln University GP practice has actively promoted registration to increase their list size to manage their demand. This has resulted in additional registrations and increased daily appointment availability.

No GP practice in the Lincolnshire West locality is closed to new patients. Every opportunity is taken to encourage people who are not registered with a GP to register. We have specifically worked with colleagues in the third sector, the University and Out of Hours/A&E who have contact with people who are unregistered to encourage these individuals to register with a local practice. In addition all GP practices have confirmed that arrangements are in place to support temporary registration.

Access for Pre-bookable and Same Day

We asked GP practices who potentially were the most affected by the closure of the Walk-in Centre, informed by the Walk-in Centre attendance information, what impact the Walk-in Centre closure had on the practice and the availability of same day and pre-booked appointments. Appendix 2 shows the responses by these eight practices.

In summary any impact has been managed through extended triage, clinics and additional resources or better use of existing resources. It was noted anecdotally through this survey (Appendix 2), that there is a perceived increase in patient expectations of same day appointments regardless of clinical need. This supports the need for ongoing communication and engagement plans around alternative provisions which are outlined below.

Reception Training

Making Every Contact Count (MECC) training is currently being delivered across the LWCCG with 112 reception and administration staff of 120 having completed this training. The final training will be completed by the end of May 2018. MECC training will give staff the local healthy lifestyle information to assist them with signposting/supporting patients.

Pharmacy / NHS 111 / Lincolnshire Clinical Assessment Service

Utilisation of NHS 111 and by default the Lincolnshire Clinical Assessment Service has also increased across Lincolnshire over the winter and spring period. This is reported in Appendix 4 which shows the number of calls to NHS111 for Lincolnshire.

There is evidence of greater use of local pharmacies and consulting rooms in pharmacies, which is being validated through further survey. Local pharmacists report an increase in providing advice and guidance, treatment or signposting to NHS111 and the dispensing of emergency medication in the last 10 weeks. No particular challenges for the pharmacists were identified through our survey to date.

Utilisation of both of the above has been promoted through both local and national communication campaigns, so it would be difficult to attribute directly to the Walk-in Centre closure. Certainly NHS 111 is the preferred NHSE National Emergency and Urgent Care Team promoted route into urgent care services, as this enables appropriate triage to the right service for the patient, avoiding unnecessary patient journeys, ambulance conveyances and face to face consultations/visits in both primary and secondary care.

A&E Effect

We have continued to monitor A&E data and performance and worked with the Lincolnshire A&E Delivery Board to ensure that any potential impact from the Walk-in Centre closure is quickly identified and plans to mitigate are implemented.

The Attendance Impact Review (Appendix 3) show a comparison between a period when the Walk-in Centre was open to the period from the start of the phased closure and compared attendance in these periods to the prior year.

This preliminary data suggests (See Appendix 3) that there has been an increase in A&E attendance of on average 10 patients per day since the phased closure of the Walk-in centre, accounting for the seasonal profile of attendances over this period. Analysis of these attendees suggests only 5 of this total are likely to be previous Walk-in Centre users and these attendances can be accommodated through available Urgent Care Streaming capacity. It is not possible to provide definitive data regarding whether these patients would have previously attended the Walk-in Centre as we do not ask this question as we focus on educating patients to contact their GP or Out of Hours provision.

This will be kept under review to ensure this situation does not deteriorate as public awareness increases of the changed provision at A&E.

Communication and Engagement

The CCG's extensive communication and engagement work has continued - and will continue to do so moving forward.

Key messages centre around the following:

- Educating patients on how they can better look after themselves when they are suffering from minor ailments - with an emphasis on parents and their young children.
- The huge benefits of using your local and highly trained walk-in pharmacy who can treat and give advice on common illnesses and medicines. This includes raising awareness of private consultation rooms within pharmacies.
- When and how to access a GP or nurse practitioner appointment. This is for when an injury or illness won't go away. This includes raising awareness of same-day GP appointment for urgent cases and same-day triage systems within practices.
- The benefits of NHS 111 and, more locally, Lincolnshire's successful Clinical Assessment Service - which can book patients appointments when required. 111 is for when a patient needs medical help but it is not an emergency. This includes raising awareness the service is 24 hours a day and seven days a week.
- The Out of Hours GP service. This includes raising awareness there is 24/7 access to a GP.

The LWCCG has spread, and will continue to spread, the message far and wide by utilising the local media (TV, radio, newspapers and websites), distributing leaflets through every door in Lincoln, making maximum use of social media channels and NHS websites, printing in magazines and on informative Z-Cards and displaying information on GP waiting room TV screens.

The CCG continues to go out and engage, every week, with different public groups to talk about the above messages. Crucially these involve really important face-to-face discussions with our patients.

As a result, the CCG is receiving positive feedback about the alternative provisions through its social media channels - most notably on Facebook.

It should be noted, this work is not complete. Under Lincolnshire's wider Sustainability and Transformation Partnership, the educational messages and engagement must continue with our patients.

**3. Consultation**

This is not a consultation item.

**4. Conclusion**

The alternative services in place continue to be strengthened and developed as planned to accommodate this change in service provision. The current provisions and plans have managed any increase in presenting demand.

There will be ongoing monitoring to ensure access to services that are meeting the primary care needs of patients, particularly in the city centre for the specific groups of the population previously identified

**5. Appendices**

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix 1: | Alternative Provisions Plan |
| Appendix 1A: | Alternative Provisions Description |
| Appendix 1B: | Alternative Provision Engagement Plan |
| Appendix 1C: | Alternative Provision Comms Review - **TO FOLLOW** |
| Appendix 2: | GP Practice Impact Review |
| Appendix 3: | A&E Attendance Impact Review |
| Appendix 4: | NHS 111 Lincolnshire Calls |

**6. Background Papers**

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah-Jane Mills, Chief Operating Officer, who can be contacted on 01522 513355 or Sarah-Jane.Mills@LincolnshireWestCCG.nhs.uk

This page is intentionally left blank

**APPENDIX 1**

**ALTERNATIVE PROVISIONS PLAN 2017/2018**

**Lincoln Walk-In Centre**

NHS Lincolnshire West Clinical Commissioning Group

| | Provision | Description | KPI's to Evidence | Milestones | STATUS | Additional Capacity per day in LWCCG |
|---|---|---|---|---|---|---|
| **1. GP Appointments and Access** | | **Responsible Person : Sarah Button** | | | | **@ 24.01.2018** |
| 1.1 | GP Optimisation | Reduce GP admin time; create up to 6 GP appointment per day | Training to provide up to 6 Extra Appointments Per Day per GP | Completed. All GP's and Practices. | GREEN | 99 |
| 1.2 | Same Day Access for Urgent Need | Arrangements to ensure patients are seen appropriately to meet their clinical need. Develop by sharing best practice. | 100% confirm arrangements for review of patients requiring urgent same day treatments when appointments are limited. | In Place | GREEN | |
| 1.3 | Extending clinical skills in the Primary Care team | Includes Utilising community pharmacists for medical issues | 4 Additional Pharmacists with 1 further appointment being progressed (planned Qtr 1 18/19). Additional bid for January 2018 submission for NHSE funding - awaiting response from NHSE | In Place | GREEN | 50 |
| 1.4 | Making Every Contact Count training | Ensure practices are signposting patients to the most appropriate help and support. Will free up appointments by avoiding unecessary ones. | 120 receptionists trained across CCG practices | Commenced Feb 18. (112 receptionist completed training) Full coverage by the end of May 18 | AMBER | |
| 1.5 | City Centre Practices Provision | Identified 1 GP practice (Abbey)had been identified as challenged in matching local demand and service capacity. This practice have now recruited an additional GP, an additional practice nurse and an additional clinical pharmacist to manage the additional demand following the closure of the Arboretum surgery and the Walk-in Centre. The practice is currently using additional space at the Arboretum surgery and there is a plan being developed with a business case, to be approved by Primary Care Co-commissioning committee (PCCC) to enable them to consolidate their services onto one site. | Increase in FTE GP; premises space according to population. | Planned | AMBER | |
| 1.6 | 8-8 - (Additional Capacity) 7 days a week planned care | 83.5 extended hours are available across 21 practices each week. Some practices already offer additional Saturday morning sessions, evening sessions or sessions earlier in the morning to help GP's see patients sooner. A national directive requires an additional 123 extended GP hours.There are 4 GP led localities in our CCG. The intention is to provide further GP extended hours and services via these localities. This will result in 100% of registered patients having access to pre-bookable appointments 7 days per week. Plans for this service are on track. | 120 Additional Hours across 31 Practices | 123 Hours from 1st October 2018 | AMBER | |
| 1.7 | Continued action on reducing DNA rates | Practices utilising proven methods to prevent high DNA rates eg. Use of social media to promote the message to cancel appointments when not needed; pre-appointment reminder text and comms to let your GP practice know if you can't make your appointment etc | DNA rate reduction per practice | All Practices confirm best practice actions taken | GREEN | |
| 1.8 | Implementation of Neighbourhood Teams | NT at each (4) localities including community nurses, mental health professionals and clinical pharmacy; Enable "homeless patients" and those supported by local third sector to better access primary care. Neighbourhood Team leads for Gainsborough; North of Lincoln and South of Lincoln have all been appointed. Recruitment of team lead for City South in progress. | A&E attendance avoidance and reduce ambulance conveyance | Gainsborough established; North and South Lincoln Federation's in place; City dates TBC | GREEN/ AMBER | |
| **2. Urgent Primary Care / GP Out of Hours / WIC Transition / CAS** | | **Responsible Person : Wendy Martin** | | | | |
| 2.1 | GP Out of Hours Service | Provides Urgent medical care outside normal GP hours (evenings, weekends and bank holiday) | NQRS standards maintenance | In Place | GREEN | |
| 2.2 | 111& CAS | Provision of 111 and CAS capacity | A&E attendance avoidance, reduce ambulance conveyance, OOH appointment reduction, reduction of unnessary face to face | In Place | GREEN | 20 |
| 2.3 | A&E Attendance Avoidance | Including Home First; EMAS Pathfinder & See and Treat capability; CAS (Care Home Support - Advanced Care Planning; Star 6 and Pharmacist and Consultant Geriatician support) | A&E attendance avoidance and reduce ambulance conveyance | Programmes in progress | AMBER | |
| 2.4 | Emergency Medication (Prescriptions & Advice) | Community pharmacy supports 111 and CAS (via 111) | 80 participating pharmacies across Lincolnshire; Hours coverage incl. bank holiday cover | In place | GREEN | 20 |
| **3. University of Lincoln Practice Plans** | | **Responsible Person : Sarah Button** | | | | |
| 3.1 | Additional clinical rooms | Plans to develop the GP practice premises. Funding bids being developed using section 106. | 3 Additional Consulting Rooms | In development from 1 Apr 18 | AMBER | |
| 3.2 | Access to Routine Appointments | Review of clinic times and access. (Increase in student registration from last year is 3,150) | Additional appointments | From Dec 17 | GREEN | 5 |
| 3.3 | Access Choice | Skype Utilisation | Skype Utilisation | Pilots Complete; Other pathways to use skpe | GREEN | 5 |
| 3.4 | Bishop Grosseteste University | Deliver services at BGU campus. All students have access to local GP services. | Encourage registration of students at local practice. This project includes evaluating whether provision of an on-site clinic for students is required. | In development | AMBER | |
| **4. Clinical Advice and GP Access for Children** | | **Responsible Person : Wendy Martin** | | | | |
| 4.1 | Same Day Access for Children | Ensure arrangement are in place for Same day access for Children (and Urgent) | 100% confirm arrangements for review of patients requiring urgent same day treatments when appointments are limited. | In place | GREEN | |
| 4.2 | Children's Centres | Local hubs for family support; health visitors appointments | 4 pilot Children's Centres across Lincolnshire went LIVE from 4th December 2017 | Birchwood, Grantham, Skegness and Boston live | GREEN | |
| 4.3 | Telephone Line for Children | The CCG did consider introducing a telephone line specifically for children, but thought this would cause further confusion with the nationally supported lines of 999 for emergency need and 111 for urgent health care need and advice. | 111 urgent care line in place; communication plan implemented to promote 111 for urgent care need | In place | GREEN | |
| **5. Homeless and Vulnerable Patients** | | **Responsible Person : Sarah Button** | | | | |
| 5.1 | Primary Care Provision for Homeless / Violent Patients (<0.5% of attendance) | Opportunity to link the services provided at Nomad Trust with Primary Care by engaging their ANP's to give them access to routine GP appointments, signposting and support services access including NHT | Increased Provision | Planned | AMBER | |
| **6. Comms and Engagement** | | **Responsible Person : Wendy Martin** | | | | |
| 6.1 | Comms Plans | using media, GP practices; social media channels; | Full plan underway. Detail to follow. | Ongoing | GREEN | |
| 6.2 | Engagement Plans | Including Alternative Provision Plans | Full plan underway. Appendix 1b | Ongoing | GREEN | |
| | | | | | | **199** |

This page is intentionally left blank

NHS Lincolnshire West Clinical Commissioning Group

# ALTERNATIVE PROVISIONS DESCRIPTION

| 1. GP Appointments and Access | Responsible Person : Sarah Button |
|---|---|
| 1.1 | GP Optimisation |

GP Workflow Optimisation has been implemented across the CCG's GP Practices. The training was delivered by AT Medics. The aim of this initiative is to make the most effective use of primary care resources by transforming the way administrative tasks are undertaken within general practice. This is an innovative way of improving capacity within general practice – ultimately it release GPs to focus on clinical care for their patients.

Members of the GP practice clerical team are trained to read, code and action incoming clinical correspondence according to a framework based on practice protocols. Each Practice has an identified GP champion for this initiative and they are supported in the key responsibilities of their role – the role is pivotal in ensuring the practice achieves a safe, sustainable and full implementation of Workflow Optimisation.

This training has been proven to free up to 6 appointments per GP per day and has now been completed for all Practices.

| 1.2 | Same Day Access for Urgent Need |
|---|---|

Same day access for Urgent need is currently available at all practices. This means that if a patient cannot get an appointment that day but considers it is urgent, either a nurse or GP will call back. If, following this phone conversation, it is deemed urgent, the nurse or GP will book the patient an appointment that day. This applies for both children and adults.

If it is not urgent that person may be given a routine appointment or advice on how to self-care a condition such as a cold or hay fever or signposted to the nearest pharmacy for over-the-counter medicines.

If patients have difficulty in getting through to their practice early in the morning and they have an urgent issue, they can ring NHS 111, where they will be diverted to the Lincolnshire Clinical Assessment Service (CAS) for an urgent clinical issue. This service has been fully established

NHS Lincolnshire West Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS DESCRIPTION

| | |
|---|---|
| since April 2017 and sees a Lincolnshire clinician pick up calls, where necessary, to give clinical input. They are able to discuss medical needs, recommend and arrange treatment.<br><br>There is 24/7 access to a GP or an advanced nurse practitioner via the GP Practice or the GP Out of Hours Service (OOH). The latter is accessed by calling 111. There is a GP OOH's base located at Lincoln County Hospital, meaning patients who don't need to attend A&E can still be seen locally if an out of hours appointment is indicated for their clinical condition when their GP practice is closed.<br><br>The GP OOH's service runs between 6.30pm and 8.00am every weekday and 24 hours a day over weekends and Bank Holidays. This service can also offer home visits to those patients who would genuinely find it difficult to get to Lincoln County Hospital. There are also other out of hours units across the county which means patients who genuinely need to see a nurse or GP out of hours, can do so. | |
| 1.3 | Extending clinical skills in the Primary Care team |
| Many GP practices are employing community pharmacists which will see patients and free up GP's appointments accordingly. 4 additional Pharmacist have been employed (one more planned in Qtr 1 2018/19) whose roles will develop to see patients where it's more appropriate than to see their GP. The Pharmacist can complete medical reviews and treat minor ailments as appropriate. | |
| 1.4 | Making Every Contact Count (MECC) Training |
| Making Every Contact Count (MECC) Training is underway with our CCG's 120 GP Practice reception and administration staff, to ensure patients are signposted to the most appropriate help and support. Sometimes the GP isn't really the best person to see a patient. Patients could be seen or treated quicker by a pharmacist, nurse or a physiotherapist for example and in some cases, the GP practice might not be the right place at all for the query. Receptionists and admin staff, through specialist training are able to signpost patients to the right place which could free up appointments by avoiding unnecessary ones. We will have trained 112 staff across our practices in LWCCG and this will be completed by the end of May 2018. | |

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS DESCRIPTION

| 1.5 | City Centre Practices Provision |
|---|---|
| We have identified 1 GP practice – Abbey Medical Practice on Monks Road, as challenged in matching local demand and service capacity. This practice have now recruited an additional GP, an additional practice nurse and an additional clinical pharmacist to manage the additional demand following the closure of the Arboretum surgery and the Walk-in Centre. The practice is currently using additional space at the Arboretum surgery and there is a plan being developed with a business case, to be approved by the Primary Care Co-commissioning Committee (PCCC) to enable them to consolidate their services onto one site. | |
| 1.6 | 8-8 - 7 days a week planned care |
| LWCCG is following a national direction and from 1st October 2018, national funding will be made available to provide 123 hours extended access to GP practices across the area.<br>83.5 extended hours are currently available across 21 practices each week. Some practices already offer additional Saturday morning sessions, evening sessions or sessions earlier in the morning to help GP's see patients sooner.<br>There are 4 GP led localities in our CCG. The intention is to provide further GP extended hours and services via these localities. This will result in 100% of registered patients having access to pre-bookable appointments 7 days per week. Plans for this service are on track.<br>Local practices publish their current extended hours on their website or at the surgery. | |
| 1.7 | Continued action on reducing DNA rates |
| LWCCG communications plan has included communication aimed at reducing DNA ( do not attend) rates. Patients are being reminded to remember to let the GP Practice know if they can't attend their appointment as soon as possible and to consider signing up to the text message reminder service. | |

ALTERNATIVE PROVISIONS DESCRIPTION



| 1.8 | Implementation of Neighbourhood Teams |
|---|---|
| GP's are working together as Federations to work within Neighbourhood Teams. These teams promote care closer to home and continuity of care from a Neighbourhood Integrated Team. The aim is only specialist services will need to be provided to patients outside this community health and social care support structure.<br>These Neighbourhood Teams will see GP's working alongside a dedicated team of highly skilled Advanced Nurse Practitioners, Nurse Practitioners, Community Nurses, Occupational Therapists, Clinical Pharmacists, Mental Health Professionals, plus social care and voluntary sector partners. Team members will also have direct links to mental health services, physiotherapy, palliative care, chronic disease specialist nurses, social care and the third sector as well as inpatient and outpatient secondary care services and diagnostics.<br>These services will increase services and capacity in the community and avoid urgent care & A&E attendance and reduce ambulance conveyance.<br>The Gainsborough Neighbourhood Team is established and progressing; the South Lincoln Federation NHT and the IMP Federation (North Lincoln) NHTs have commenced, with the City date of commencement to be confirmed. | |
| **2. Urgent Primary Care / GP Out of Hours / WIC Transition / CAS** | **Responsible Person : Wendy Martin** |
| 2.1 | GP Out of Hours Service |
| **GP Out of Hours Service (OOH)** This service is provided by Lincolnshire Community Health Services. It provides urgent medical care outside normal GP hours, which is during evenings, weekends and bank holidays. The Out of Hours Service is accessed by calling 111, which is the national recommended route for accessing urgent medical care. 111 is the number to call when medical help is required urgently, but it is not an emergency. This is sensible because it ensures the appropriate telephone triage of calls to the right service and reduces unnecessary NHS demand. In Lincolnshire the Out of Hours Service is provided from bases in Lincoln, Gainsborough, Grantham, Boston, Louth, Skegness and Spalding. The Out of Hours Service also provides for home visiting where this is indicated by the clinical need. Since the phased closure of the | |

ALTERNATIVE PROVISIONS DESCRIPTION

Walk-in Centre, the capacity of OOH provision at weekends and the Clinical Assessment Service are meeting current demands and are under constant review as the Urgent Care provision across Lincolnshire is developed, as it anticipated that as patients become more familiar with these services there will be increased demand.

The GP Out of Hours Service provided by LCHS was inspected in October 2017 by the CQC with a good outcome from the inspection visit.

| 2.2 | 111 & CAS |
|---|---|

NHS 111

NHS 111 was launched in Lincolnshire in 2010 and has been in operation since that time. It is a free local single non-emergency number medical helpline operating in England and Scotland. The service is part of each country's National Health Service. The service is available 24 hours a day, every day of the year and is intended for 'urgent but not life-threatening' health issues and complements the long-established 999 emergency telephone number for more serious matters.

There is a continued national drive to have NHS 111 as the route into urgent care provision. This is sensible because it ensures the appropriate telephone triage of calls to the right service and reduces unnecessary NHS demand. 111 was actually introduced in order to prevent public confusion about which healthcare service to access and when 111 is the number to call if a patient needs urgent medical advice or treatment in and out of hours but the health issue is not serious enough to attend accident and emergency. General Health advice can also be accessed through 111 and advice on which health service is needed and how to access that service. So the national 111 service is very important for helping people access the right care and treatment for their needs at times when the traditional routes such as GP surgeries are closed. We have had a new provider for the NHS 111 Service in Lincolnshire since October 2016: Derbyshire Health United (DHU). DHU provides NHS 111 services across the East Midlands region. The calls picked up through this service are subject to regular clinical audit, demonstrating a consistently good quality of response to calls answered.

When a patient rings 111, the call is picked up by a trained health advisor, who is often not a clinician but is supported by a team of clinicians. The health advisor will take the caller through a series of questions to determine what the best service is for that patient's needs. The algorithm of questions has been carefully designed by expert clinicians and is called NHS Pathways. This ensures navigation to the most appropriate level of care, supported by a comprehensive Directory of Services. (For non-English speaking patients there is also a translation

ALTERNATIVE PROVISIONS DESCRIPTION



service that supports 111).

From this initial call, if a patient needs to speak to a clinician the health advisor will arrange for this by either transferring the call (warm transfer) directly over to a clinician or will arrange for a clinician to call the patient back in a time frame suitable to the clinical urgency. In Lincolnshire the clinical response is provided by the Lincolnshire Clinical Assessment Service (CAS).

In addition to telephoning 111 the public will also have access to an online 111 service in 2018. Using an established national website, patients will be able to type in their concern, answer relevant questions and then receive advice on which service to access and when. There will also be the ability for the patient to access a clinician for advice if the response to the questions (a public version of NHS pathways) indicates this to be necessary.

The Clinical Assessment Service (CAS)

The Lincolnshire Clinical Assessment Service (CAS) has been fully operational since April 2017. It is an Alliance arrangement between Lincolnshire Community Health Services and East Midlands Ambulance which provides clinical assessment into 111 calls. When someone calls 111 and the health advisor picking up the initial call concludes the caller needs clinical advice and/or treatment, the call is re-directed to this service. The CAS is staffed by Lincolnshire Clinicians who will give health advice, arrange treatment if needed or refer the patient on to another required service. CAS calls are also subject to regular clinical audit and also demonstrate good quality clinical care provision. Both NHS 111 and the supporting CAS are able to arrange ambulance dispatches through EMAS when this is indicated.

| 2.3 | A&E Attendance Avoidance |
|---|---|

There are various initiatives in place across the county to reduce demand on urgent and emergency care provision. Just a few examples are provided below:

Home First and Neighbourhood Teams – the driver is to ensure patients can remain or return quickly to their own homes for care. Work to enable this includes consistent care needs assessment (eg. Edmonton tool), good care planning and review with the patient in conjunction with the multi-disciplinary Neighbourhood Team.

ALTERNATIVE PROVISIONS DESCRIPTION



EMAS Pathfinder, Hear & Treat & See & Treat - EMAS have done significant work in the last couple of years to increase both hear and treat and see and treat capabilities in order to reduce ambulance attendances and conveyances respectively. The EMAS Pathfinder initiative ensures that where a patient conveyance is necessary, the conveyance is to the most appropriate place, avoiding A&E units where possible.

CAS Care Home & Health Professional Support – the Lincolnshire Clinical Assessment Service is also accessible by healthcare professionals eg. care home staff members, Ambulance staff or community nurses for advice on urgent care if they are with a patient and require additional advice on ongoing management. This often enables patients to remain in their home rather than needing to be conveyed to hospital.

Frequent attenders/Care Planning: Where patients frequently (>10 times in a year) attend A&E, a managed care plan will be put in place by the GP and where appropriate the Neighbourhood Teams with the patient. The health and social care plan is a personalised care and support plan. It will help all involved in the patients care to understand what's important to the patient and how best to support them.

| 2.4 | Emergency Medication (Prescriptions & Advice) |
|---|---|

Urgent Repeat Prescriptions are now available through contacting 111. This service integrates with the NHS 111 service and CAS to manage requests from patients for urgent medications. At least 80 pharmacies are now signed up to provide this service in Lincolnshire whose opening hours include bank holidays.

| **3. University of Lincoln Practice Plans** | **Responsible Person : Sarah Button** |
|---|---|
| 3.1 | Additional clinical rooms |

Architect plans are being drawn to develop the University of Lincoln Practice premises to provide additional consulting rooms. Funding is

ALTERNATIVE PROVISIONS DESCRIPTION

being identified for this and funding bids are being developed using section 106. The Practice is providing additional appointments to correlate with the increased numbers of patient registrations it has received since September 2017. Communication and engagement initiatives have been successful in encouraging students to register with the University Practice for their Primary Care needs.

| 3.2 | Access to Routine Appointments |
|---|---|
| Additional appointments per week are being provided at the University of Lincoln Practice. Appointment availability has been reviewed and re-modelled to the most appropriate clinic times to best suit the patient's needs. E.g. Wednesday evening or Thursday morning after Wednesday afternoon sports. | |
| 3.3 | Access Choice |
| A pilot to use Skype appointments has been completed and other opportunities are being explored to further utilise Skype in this way, E.g Advice and Guidance. There has also been extensive communication and engagement initiatives, particularly with students to encourage GP registration and to ensure aware of access routes to self-care, routine and urgent healthcare. See Communication & Engagement Plan details. | |
| 3.4 | Bishop Grosseteste University (BGU) |
| We continue to work with the University Practice and Bishop Grosseteste with the aim to increase the number of students attending BGU to register at the University practice. This project includes evaluating whether provision of an on-site clinic for students is required. | |

ALTERNATIVE PROVISIONS DESCRIPTION



| **4. Clinical Advice and GP Access for Children** | **Responsible Person : Wendy Martin** |
|---|---|
| 4.1 | Same Day Access for Children |

Same day access for Urgent need is currently available at all practices. This means that if a patient cannot get an appointment that day but considers it is urgent, either a nurse or GP will call back. If, following this phone conversation, it is deemed urgent, the nurse or GP will book the patient an appointment that day. This applies for both children and adults.

If you are worried your child is ill, there are several options to consider:

1: If there is an urgent need then a GP will see your child that day after a nurse or GP calls you back under the system described above. Practices will not refuse an appointment to a child who needs urgent medical attention.

2: Many practices actually run their own walk-in facilities – so check with your local practice about this option.

3: If you can't get through to your GP practice in the morning and it doesn't run a walk-in facility, you can ring 111. NHS 111 will put your call through to a clinician, if needed, in the Lincolnshire Clinical Assessment Service (CAS) (see 6.3 details of CAS) or direct you to the most suitable treatment option.

4: Is it a condition you can treat yourself? Colds, hay fever, and sore throats (for example) can be treated with over the counter medicine.

5: Call in at a pharmacy where trained members of staff can give you advice on health and treatment.

6: If it is a medical emergency, call 999 or visit the nearest A&E.

| | |
|---|---|
| 4.2 | Children's Centres |

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS DESCRIPTION

To enhance care for new parents and children four Community Children's hubs have opened across Lincolnshire. The first was in Birchwood in the Lincoln City area. The Community hubs are another source of advice and guidance for parents with children under 5 particularly and

| | |
|---|---|
| include health visitor advice and appointments, wellbeing services, feeding support groups etc. A further four Community Children's hubs are planned for 2019 but firm dates to be confirmed. | |
| 4.3 | Telephone Line for Children |
| The CCG did consider introducing a telephone line specifically for children, but thought this would cause further confusion with the nationally supported lines of 999 for emergency need and 111 for urgent health care need and advice. | |
| **5. Homeless and Vulnerable Patients** | **Responsible Person : Sarah Button** |
| 5.1 | Primary Care Provision for Homeless / Violent Patients (<0.5% of attendance) |
| There is an opportunity to link the services provided at Nomad Trust with Primary Care by engaging and providing practice learning time for their Advanced Nurse Practitioners with the aim to give them access to routine GP appointments, signposting and support services access including to the Neighbourhood Teams. These plans are currently being developed between our Primary Care Team, Engagement Team, City Council and third sector organisations and will be incorporated in initiatives to improve support for homeless and vulnerable people in Lincoln City. | |
| **6. Communications and Engagement** | **Responsible Person : Wendy Martin** |
| 6.1 | Comms Review |
| Full details and description of the communications review is to follow | |
| 6.2 | Engagement Plans |
| Full details and description of the engagement plan is attached – Appendix 1B | |

NHS
Lincolnshire West
Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Introduction

Following the decision by the LWCGG Governing Body to close the Lincoln NHS Walk in Centre (WIC) after the winter period, the CCG will continue to engage with high user groups of the WIC, i.e. students, parents with children under 12, etc. to prepare them for the closure. One of the requests from the governing body was that the CCG encouraged people to take more responsibility over their own health, give them the confidence to treat minor illness and conditions themselves, and give them a better understanding of which services they should access for support. A series of engagement activities have been planned with high user groups to talk to them about these topics.



Following the closure of the WIC at the end of February 2018, the CCG carried out further engagement activities, specifically with pharmacies and homeless organisations to understand what positive or negative impact, if any, the closure had on these organisations and how they managed this.

## Engagement aims and objectives

- Raise awareness of the importance of self-care and using NHS services appropriately.
- Increase people's understanding of what services they should be accessing if they require healthcare advice, guidance, treatment, and support.
- Build people's confidence in treating minor conditions and illness themselves and knowing what over the counter medicines to stock up on.
- Encourage people to register with a local GP or call NHS 111 if they have urgent medical need and their surgery isn't open.
- Promote some of the changes to services that have already happened since the decision to close the WIC was made and what further changes can be expected in primary and urgent care as part of the GP Five Year Forward View and Sustainability and Transformation Plan.
- Understand what positive or negative impact, if any, the WIC closure had and how this was managed.

## Stakeholders

- **Students:** University of Lincoln, Lincoln College and Bishop Grosseteste University.
- **Parents with children under 12:** Children's Centres in Lincoln city centre and surrounding areas.
- **Workers:** Lincoln city centre.
- **Pharmacies:** Lincoln city centre.

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

- **Homeless organisations:** Rough sleepers, homeless, and vulnerable adults.
- Patients from top 10 GP practices who frequently use the WIC.
- Lincoln NHS Walk in Centre attendees.

## Resources

- **Z-cards and scratch cards:** Patient information on which services to access based on symptoms.
- **Staffing:** Engagement Manager, Engagement officer, LWCCG.
- **Posters:** Promoting engagement activities to be displayed at various locations.
- **Communications:** Social media posts promoting engagement activities.

## Engagement activities

Engagement activities will be held in a variety of locations and will be informal discussions between the CCG and stakeholders identified. Scratch cards (see Appendix 1) will be used as a conversation starter, followed by some questions (see samples below) and will end with stakeholders receiving the z-cards (see Appendix 2). With consent, stakeholders contact details will also be taken so we can update them with further information and health advice.

### Sample questions:

- How much do you know already about treating minor conditions yourself and what services to access if you need support?
- What would help you to make better decisions about living a healthier life and taking more responsibility over your own health?
- What is the best way for us to inform you of what services are available?
- What positive or negative impact, if any, has the closure of the WIC had on your organisation and how this was managed?

### Action planner:

| All Stakeholders | | | | |
|---|---|---|---|---|
| **Date** | **Activity/Channel** | **Comments** | **Lead** | **Status** |
| Phase 1 – Alternative provision awareness raising | | | | |
| 20-Nov | Design and print z-cards and scratch cards. | Quote for printing and sign off from senior CCG | KG | Completed |

**APPENDIX 1b**

NHS
Lincolnshire West
Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

| | | | | |
|---|---|---|---|---|
| 20-Nov | Confirm time/date for engagement activities | Liaise with contacts at each location. Check availability of Sam M | KG | Completed |
| 20-Nov | Design, print and display posters promoting engagement activities at various locations | Email posters to contacts at each location | KG | Completed |
| 20-Nov | Promote engagement activities across social media | Liaise with Sam M to confirm content | KG | Completed |
| 23-Nov | Brayford PPG Meeting | Group discussion with members. Z-card given to staff and handed out to members | KG | Completed |
| 28-Nov | Voluntary Centre Services Forum | Group discussion with members. Z-card given out to handed out to members for them to pass onto their clients and service users | KG | Completed |
| 30-Nov | Boultham PPG Meeting | Group discussion with members. Z-card given to staff and handed out to members | KG | Completed |
| 03-Jan | Framework Housing Association | Z-card given to staff to hand out to service users | KG | Completed |
| 03-Jan | P3 | Z-card given to staff to hand out to service users | KG | Completed |
| 04-Jan | Abbey Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Brayford Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Portland Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | University Health Service | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Richmond Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Newark Road Surgery | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Minster Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Lindum Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Glebe Park Medical Practice | Z-card given to staff to hand out to patients | KG | Completed |
| 04-Jan | Brant Road Surgery | Z-card given to staff to hand out to patients | KG | Completed |
| 05-Jan | St Giles Neighbourhood Board Meeting | Group discussion with members. Z-card given out to handed out to members for them to pass onto their clients and service users | KG | Completed |
| 05-Jan | Community Chaplain | Z-card given to Community Chaplain to hand out to service users | KG | Completed |
| 05-Jan | YMCA/Nomad Trust | Z-card given to staff to hand out to service users | KG | Completed |
| 09-Jan | Birchwood Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |

NHS Lincolnshire West Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

## ALTERNATIVE PROVISIONS ENGAGEMENT PLAN



| | | | | |
|---|---|---|---|---|
| 09-Jan | Lincoln Central Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 09-Jan | Double Impact | Z-card given to staff to hand out to service users | KG | Completed |
| 09-Jan | ACTS Trust | Z-card given to staff to hand out to service users | KG | Completed |
| 10-Jan | Witham Family Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 10-Jan | Branston PPG Meeting | Group discussion with members. Z-card given to staff and handed out to members | KG | Completed |
| 11-Jan | Lincoln North Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 12-Jan | Washingborough PPG Meeting | Group discussion with members. Z-card given to staff and handed out to members | KG | Completed |
| 15-Jan | Gainsborough Market Arcade Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 15-Jan | Sturton by Stow Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 16-Jan | Gainsborough North Marsh Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 17-Jan | Welton Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 17-Jan | Willingham by Stow PPG Meeting | Group discussion with members. Z-card given to staff and handed out to members | KG | Completed |
| 18-Jan | Bracebridge Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 20-Jan | Lincoln Walk in Centre & Lincoln High Street | Discussions with patients at WIC and general public on near Lincoln Stonebow and Waterside Centre. Z-cards handed out to patients and public | KG | Completed |
| 22-Jan | Carholme Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 22-Jan | University of Lincoln | Stand at Refreshers Fayre. Z-card handed out to staff and students | KG | Completed |
| 23-Jan | Washingborough Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 30-Jan | North Hykeham Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 31-Jan | Lincoln College | Group discussion with students. Z-card given to staff and handed out to students | KG | Completed |
| 31-Jan | Abbey Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 01-Feb | Waddington Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 02-Feb | Lincoln Toy Library | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |

NHS Lincolnshire West Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

| | | | | |
|---|---|---|---|---|
| 06-Feb | Cherry Willingham Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 13-Feb | St Giles Children's Centre | Group discussion with parents. Z-card given to staff and handed out to parents | KG | Completed |
| 15-Feb | Bishop Grosseteste University | Group discussion with students. Z-card given to staff and handed out to students | KG | Completed |
| PHASE 2 – Engagement with pharmacies and homeless | | | | |
| 25-Apr | YMCA/Nomad Trust | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 26-Apr | Lincolnshire Co-op Pharmacy, Monks Road | Discussions with pharmacists and pharmacy staff to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 26-Apr | Framework Housing Association | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 26-Apr | Boots Pharmacy, Carlton Centre | Discussions with pharmacists and pharmacy staff to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 27-Apr | Tesco Pharmacy, Wragby Road | Discussions with pharmacists and pharmacy staff to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 3-May | Addaction | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Completed |
| 9-May | P3 | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Planned |
| May | Community Chaplain | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | Planned |
| May | Homeless organisations in Lincoln City Centre | Discussions with homeless organisation staff and service users to understand what positive or negative impact, if any, the closure had and how this was managed | KG | In progress |
| May | Pharmacies in Lincoln City Centre | Discussions with pharmacists and pharmacy staff to understand what positive or negative impact, if any, the closure had and how this was managed | KG | In progress |

NHS Lincolnshire West Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Engagement feedback

During the first phase of engagement activities, the CCG spoke to over 300 people, the majority of who were parents with children under 12 and students, two groups identified as high users of the Walk in Centre.

On the whole people spoken to were less anxious about the closure of the WIC than expected given the views expressed during the consultation, and they felt reassured once the alternative services available had been explained to them in detail. The role of pharmacies was a particular topic of conversation as many people didn't appreciate what services they offered. A number of people were also not aware of the Out of Hours GP service.

Many people's experiences of the alternatives were positive, particularly parents who were happy that their children could access urgent appointments when needed, and students who had seen an improvement in access to the University Health Centre in recent months. NHS 111 was also praised for reassuring people and offering advice that saved them a trip to their GP or A&E.

On the whole people said they were making a conscious effort to use NHS services appropriately however a number of people still expressed concern about the variation that these services offered, particularly advice and treatment given by pharmacies and access to appointments at their GP practice. People also felt frustrated with NHS 111, as often they would be asked what was perceived as inappropriate questions, or people were told someone would call them back within two hours when in fact this often would be four to six hours later.

Whilst people felt they were seeing more information about the NHS, particularly how to treat certain conditions, they felt more needed to be done, and information could be even more specific and tailored to certain groups of people, for example, common illnesses for children during winter months and what medicines can treat them.

Although people were less anxious than expected, and reported positive experiences of the alternative services, people were concerned what impact the closure would have on these services and whether they would be able to cope with the extra demand.

The variation in people's experience of the alternative services was also something that people felt needed to be addressed quickly, particularly pharmacies and NHS 111, otherwise people would become frustrated and revert to only choosing to access their GP or A&E.

A second phase of engagement is currently taking place specifically with pharmacies and homeless organisations to understand what positive or negative impact, if any, the closure had on these organisations and how they managed this.

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

A full breakdown of feedback from engagement activities can be viewed below.

## Students

- Some students still not registered with a local GP practice;
- Overall people were impressed with how access to University Health Centre has improved over recent months;
- People felt reassured by the different NHS services available locally and felt less anxious about the WIC closing because of this;
- Very few people spoken to had used NHS 111 or considered speaking to a pharmacy but would do so now that they are more aware of what services are available;
- People would like more health information displayed across campus and on social media;
- People did feel annoyed that the WIC was closing as they think it is a valuable service that provides a safety net for students.



## Parents with children under 12

- Most people felt reassured that alternatives to the WIC were already in place and felt less anxious about the closure;
- Mainly positive experiences of children being able to access urgent appointments when needed, however often the parents would struggle to get urgent appointments with their GP practice;
- Many people felt that they found it difficult to see a health visitor and didn't really know what was happening with this service;
- Although people said they had positive experiences of using NHS 111, people felt frustrated that often they were told someone would call them back within two hours, but they did not receive a call back until four to six hours later, by which point their poorly child was asleep so they had to wake the child up and carry out various checks;
- People would like more health information displayed across children's centres, nurseries, and schools, and on social media;
- People did feel annoyed that the WIC was closing as they think it is a valuable service that provides a safety net for young parents, particularly those that do not have family or friends to ask for advice.

## Homeless organisations

Prior to WIC closing:

- Mainly clients and service users still struggle to attend appointments both with the hospital and their GP practice, often because of the time of day in which appointments are offered don't fit in with their lifestyles, or because their lives are so chaotic and lack structure;

NHS
Lincolnshire West
Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

## ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

- Organisations often have to act on "good will" and go beyond their own remits to make sure clients attend appointments, something they are not properly resourced to do. Homeless people are unlikely to access pharmacies or call NHS 111 which is why the WIC is seen as such a valuable service;
- General public will often call 999 if they see homeless person who appears to need medical attention, but often when the ambulance arrives the person does not require any treatment.
- Homelessness in Lincoln is spiralling out of control and NHS would benefit from a dedicated homeless health service that ran clinics from various locations within the city familiar to the homeless community. This service could ensure people have regular health checks and medication reviews to prevent them from reaching crisis point and being admitted to either mental health services or frequently presenting at A&E;
- There were general concerns about the WIC closing and how the cohort of people they support would access treatment, often when it is urgently needed.



Impact of WIC closing:

- Many of the challenges faced by homeless people accessing GP services listed above still exist;
- Many people associate the WIC as somewhere you go to see a nurse for minor things, whereas a GP practice is where you go to see a doctor for complex health issues. More awareness still needed that people can also see a nurse at GP practice for minor things or use NHS 111 or pharmacies for advice and guidance;
- Unlikely to buy over the counter medicines from a pharmacy as cannot afford them;
- Trust issues – important to see same health professional(s) so they can build up relationship with them and feel comfortable talking about their health needs. Dr Caruana was a popular GP but he has retired;
- A lot of the challenges could be overcome if people could be seen by a GP or nurse in a location that is familiar to them or is somewhere they are already attending for other health needs, i.e. YMCA or Addaction;
- Addaction in Lincoln currently commissioned by Public Health to provide a part time GP and full time nurse to prescribe Opiate Substitute Therapy (OST) only. Also commissioned by PH to provide full time nurse to carry out health assessments, blood tests, HEP-C, triage, etc. They are not commissioned to treat wounds but are doing so voluntarily.
- Public Health also commission P3's Lincolnshire Street Outreach Service which includes helping people to access drug and alcohol services, stable and safe accommodation and physical and mental health services.

Lincoln Walk-In Centre Consultation 2017

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Walk in Centre attendees

- Visited WIC during a Saturday morning session. 44 people had been seen or were waiting to be seen. Checked with WIC staff and during the same time period 31 people were also being treated at OOH;
- Majority of people seen received treatment or prescribed medication;
- A large number of people spoken to had been advised to attend the WIC, either by NHS 111, pharmacies or A&E;
- Many people spoken to didn't think about ringing 111 or going to see a pharmacist;
- General concern about the WIC closing, especially how the alternative services would cope outside of GP and pharmacy opening times.

## Pharmacies

- Have reported an increase in people coming to see them for advice, guidance and treatment since the WIC closed, especially weekends and bank holidays. On average 10 people per day;
- No particularly challenges with dealing with additional people;
- Any people they have been unable to assist have been signposted to alternative services. One pharmacy has started to keep a log, confirmed they are signposting 10 people a week to NHS 111;
- Some pharmacies reporting they have seen small increase in dispensing emergency medications, something the WIC would have done previously;
- One pharmacy in Monk Road area (close to WIC) many people who come to them are exception from paying prescriptions so don't but over counter medicines;
- Some people still reporting long wait to see GPs or attending A&E for minor things as they feel they have nowhere else to go for help.

NHS
Lincolnshire West
Clinical Commissioning Group

**APPENDIX 1b**

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Appendix 1 – Scratch card



**What do I choose?**

| | | | |
|---|---|---|---|
| Day 1 or 2 with upset tummy | GP | Pharmacist | Call 111 |
| In pain after a bad fall | Call 111 | Self Care | Pharmacist |
| Severe earache | Self Care | GP | Pharmacist |

1.1 Scratch card front answers concealed

**What do I choose?**

| | | | |
|---|---|---|---|
| Day 1 or 2 with upset tummy | GP<br>**Wrong!** This can be treated by a Local pharmacist | Pharmacist<br>**Correct!** Get professional advice and medication without an appointment | Call 111<br>**Wrong!** This can be treated by a local pharmacist |
| In pain after a bad fall | Call 111<br>**Correct!** Specialist advisors can help 24/7 | Self Care<br>**Wrong!** Call 111 for specialist advice | Pharmacist<br>**Wrong!** Call 111 for specialist advice |
| Severe earache | Self Care<br>**Wrong!** Your GP can provide specialist advice | GP<br>**Correct!** Your GP provides a range of health services | Pharmacist<br>**Wrong!** Your GP can provide specialist advice |

1.2 Scratch card front answers revealed

**APPENDIX 1b**

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Which NHS service is best for me?

| | |
|---|---|
| Sore throat, cough, grazed knee, hangover? | Self Care: A lot of illnesses or symptoms can be treated by stocking up on over the counter medicines, getting plenty of rest, and drinking lots of fluids. |
| Diarrhoea, runny nose, painful cough, headache? | Pharmacist: Your local pharmacist is a highly trained professional and can give you advice on common illnesses and the medicines you need to treat them. |
| Vomiting, ear pain, sore belly, backache? | GP: If you have an illness or injury that won't go away, make an appointment with your GP surgery. If you are not registered with a local GP you should do so asap. |
| Unwell, unsure, confused, need help? | NHS 111: Call 111 when you need to access medical help fast but it is not an emergency. It is free to call and available 24 hours a day, 7 days a week, 365 days a year. |
| Need to see a GP urgently when your surgery is closed? | Out of Hours GP: If you have an urgent medical need that can't wait until your GP surgery re-opens, call 111 who, if required, will direct you to the out of hours GP. |
| Heavy bleeding, broken bones, burns, heart attack, stroke? | A&E or 999: Accident and emergency departments and the 999 ambulance service should only be used in a serious or life threatening situation. |

1.3 Scratch card back

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

## Appendix 2 – Z-card

2.1 Z-card front folded

**Useful Information**

My GP's name and telephone number:

_______________________________________

_______________________________________

My NHS number:

_______________________________________

2.2 Z-card back folded

**APPENDIX 1b**

NHS
Lincolnshire West
Clinical Commissioning Group

**Lincoln Walk-In Centre Consultation 2017**

# ALTERNATIVE PROVISIONS ENGAGEMENT PLAN

A guide to choosing the right NHS services if you live in Lincoln and are injured, feeling unwell or in need of healthcare advice.

Keep it in your wallet or purse.

Some helpful contacts

For information on all local NHS services visit the NHS Choices website or call 111.

If you require this leaflet in another format please call 01522 515380 or email communications@lincolnshirewestccg.nhs.uk

Useful information

My GP's name and telephone number:

My NHS number:

**Self-Care**

**Symptoms: Sore throat, cough, blocked nose, cold, upset stomach, grazed knee, hangover.**

Stock up on: paracetamol, aspirin, ibuprofen, anti-diarrhoea medicine, re-hydration mixtures, indigestion remedies, plasters and a thermometer.

**Pharmacist**

**Symptoms: Diarrhoea, minor infections, headache, toothache, general aches and pains.**

Pharmacists are a great source of professional advice and treatment for a range of common illnesses and complaints. Many pharmacies are open in the evenings, weekends, and bank holidays.

**GP**

**Symptoms: Feeling unwell, child with fever, vomiting, ear pain, backache, persistent cough, general concerns, concerns about child health.**

GPs can provide a wide range of family health services. Nurses and healthcare assistants often work alongside the GPs to support patients' everyday health.

**NHS 111**

**Symptoms: Unwell, unsure, confused, need help, minor injury or illness, not sure where to go.**

NHS 111 makes it easier for people to find the right local service. You can talk to a fully trained advisor supported by a team of local healthcare professionals.

Call 111 24 hours a day, 7 days a week, free of charge from both mobiles and landlines.

**Out of Hours GP**

**Symptoms: You have an urgent medical need that can't wait until your GP surgery re-opens.**

Call 111 for assistance. If required they will direct you to the out of hours GP.

The service is located at Lincoln County Hospital, Greetwell Road, Lincoln LN2 5QY and offers telephone advice, face-to-face consultations, or home visits for patients who are housebound.

It is available 6.30pm to 8am weekdays, and 24 hours a day at weekends and Bank Holidays.

**A&E or 999**

**Symptoms: This is for life-threatening accidents and emergencies only such as: Suspected heart attack or stroke, loss of consciousness, heavy bleeding, severe breathing difficulties, severe burns or fits that are not stopping.**

The A&E is located at Lincoln County Hospital, Greetwell Road, Lincoln LN2 5QY.

READY FOR A NEW YOU?

Making small changes to your lifestyle can improve your health and increase your chances of staying healthy as you get older. Take the free One You health quiz and see how you score. www.lincolnshire.gov.uk/oneyou

NHS

Which NHS service is best for me?

2.3 Z-card front folded out

| Sore throat cough grazed knee hangover? | Diarrhoea Runny nose Painful cough Headache? | Vomiting Ear pain Sore belly Back ache? | Unwell Unsure Confused Need help? | Need to see a GP urgently when your surgery is closed? | Heavy bleeding Broken bones Burns Heart attack Stroke? |
| --- | --- | --- | --- | --- | --- |
| **Self-care**<br>Self care at home is the best choice for most minor illnesses, ailments and injuries.<br>Normally with things like coughs, colds, stomach upsets, sore throats and headaches, the right medicine, plenty of fluids and proper rest are enough to help you feel better within a day or two.<br>Make sure you have a well stocked medicine cabinet and first aid kit including pain killers, cold and flu remedies, plasters, cleansing wipes, thermometer, etc.<br>If you're a family with young children, make sure you've got the right medicines according to their age. | **Pharmacist (Chemist)**<br>Pharmacists can:<br>• Give advice on treating minor illnesses, ailments and injuries and sell you the right treatments<br>• Provide advice on whether you should see a GP<br>• Dispense prescriptions and provide advice on how to take them<br>• Help you manage long term conditions<br>• Give advice on sexual health and contraception<br>• Give advice on staying healthy, including stopping smoking and getting active | **GP (Doctor)**<br>GP surgeries are normally the first point of call for non-urgent, on-going illnesses when self care has not relieved the symptoms.<br>The types of healthcare services provided by GP surgeries include:<br>• Examinations<br>• Treatment of minor injuries<br>• Prescriptions and repeat prescriptions for medicines<br>• Vaccinations<br>• Mental health and emotional wellbeing<br>• Advice on any health problems or concerns<br>• Advice on, and referrals to, other health and social care services | **NHS 111**<br>Call 111 when you need to access medical and dental help fast but it is not an emergency.<br>When should I call 111?<br>• If you, or someone with you, is unwell and you are unsure what to do or where to go<br>• If you need medical help and advice or urgent dental care but your GP/dental surgery is closed<br>• If you think you might need to go to A&E or call 999 for an ambulance but you are not sure<br>• If you need any information or advice about a health issue | **Out of Hours GP service**<br>If you need urgent medical advice or treatment out of hours (when your own GP surgery is closed) call 111.<br>If your condition requires the need for out of hours care you will be transferred to the clinical assessment service, where you will either be given advice or asked to attend an appointment at the Out of Hours GP service.<br>If it is thought appropriate, a visit from a doctor will be organised based on clinical need. | **A&E or 999**<br>Accident and emergency departments and the 999 ambulance service should only be used in a serious or life threatening situation.<br>A&E provides immediate emergency care for people who show the symptoms of serious illness or are badly injured. If you telephone 999 the telephone advisor may send a response vehicle to your location.<br>**Please remember:** Emergency services are very busy. They should only be used in very serious or life-threatening situations. |

2.4 Z-card back folded out

This page is intentionally left blank

**APPENDIX 2: GP Survey: Impact of Walk-in Centre Closure**

16th April 2018

| | ***1.Have you seen an impact of the Walk-In Centre closing in your practice? If so, what has the impact been and how have you managed it?*** | ***2.If a patient phones your practice and asks for a clinically relevant same day appointment when will they be seen?*** | ***3.When is your next pre bookable appointment for a HCA, Nurse, GP and/or Nurse Practitioner/ Minor Illness Nurse?*** | ***4.Other Information*** |
|---|---|---|---|---|
| **1.University Health Centre** | No real impact on the practice. Demand has been managed within existing capacity. | Continuing with same day access as always done. | Next pre-bookable – HCA tomorrow (20/04/18)<br>Nurse practitioner 25/04/18<br>Nurse 01/05/18 (due to annual leave), GP 26/04/18<br><br>As @ 19/4/18 | 5 Additional appointment available per day |
| **2.Abbey Medical Practice** | 3 personnel start earlier at 8.00am to manage additional morning phone calls.<br><br>Extended triage list to manage same day demand. | If a patient contacts and asks for an appointment for that day and there are no appointments available and it is clinically relevant it is put on triage and GP will then either call patient to offer appointment or message reception to contact patient advising of appointment time. | Next pre-bookable appointment with HCA - 25/4/18,<br>Nurse - 20/04/18<br>GP/Minor illness Nurse - 23/4/18.<br><br>As @ 19/4/18 | 1 additional GP recruited.<br><br>1 additional practice nurse<br><br>Additional Clinical Pharmacist time<br><br>List size has increased by 30 (net) since 5 Feb 2018. |

16th April 2018

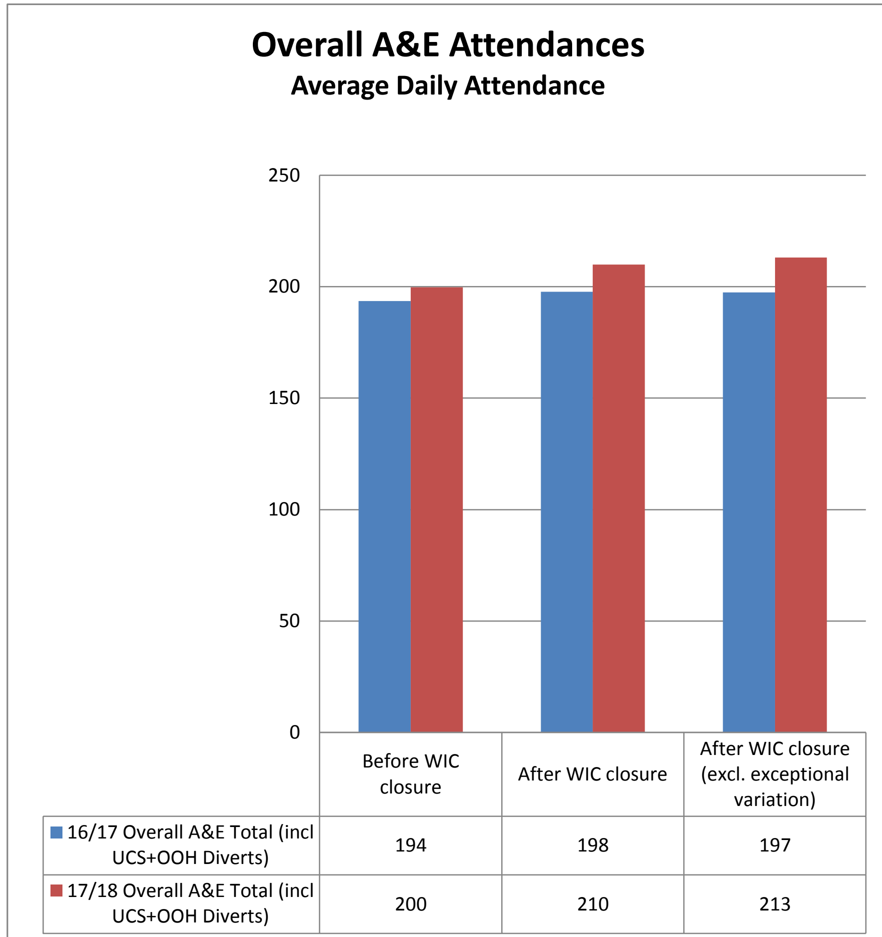
| | | | | |
|---|---|---|---|---|
| **3.Portland Medical Practice** | Notable increase in requests for same day appointments There is a perception that they are entitled to be seen the same day regardless of clinical need,<br><br>We have put in place additional appointments at the end of the clinician's sessions. The request is passed on to the duty doctor who has access to book the slot if required and/or appropriate. | We have same day appointments available. Staff are training in the management of these. If a child and there are no appts, the parents are told to bring the child down and we will see. Patients may have to call back the next day. | Advanced Nurse practitioner – 30/4/18<br>Doctor – 3/05/18<br>Nurse – some immediate and necessary available 18/4/18<br><br>As @ 18/4/18 | Additional appointments per day. Numbers dependant on Clinicians on duty. |
| **4.Lindum Medical Practice** | We have seen an increase in our minor illness/open access clinic in the mornings. Approximately by 20%. We have managed this by putting more clinicians on the open access clinic. This does result in less routine bookable slots. | Minor illness clinic in the morning. If patients contact us in the afternoon and want to be seen same day (I.e unable to wait until following day open access) passed to GP for telephone triage who then has slots available to use same day if required. | HCA – 24/4/18<br>Nurse – 23/4/18<br>GP – 24/4/18<br>Nurse Practitioner – 23/4/18 (Minor illness clinic)<br><br>As @ 20/4/18 | Additional clinicians at the minor illness/open access clinics. |
| **5.Cliff House Medical Practice** | Yes, there has been an impact, we have dealt with this by increasing our clinic times for on-the-day appointments. The staff have had to reduce their admin time to do this. | All patients needing same day appointments will be seen same day. | HCA – 04/5/18<br>Nurse - 8/5/18<br>GP – 22/5/18<br><br>As @ 30/4/18 | The practice has a clinical pharmacist to support GP workload at the practice. |
| **6.Brayford Medical Practice** | We have seen a few extra patients with same day needs. All have been seen on the day at the end of clinic. | As before, all patient with a same day need are seen on the same day at the end of each clinic. | HCA:- 25/4/18 unless urgent for the day.<br>Nurse minor illness - 23/4/18<br>Next prebook unless urgent for the day – 30/4/18<br>GP Online – 23/04/18<br>Prebook through reception - 01/05/18<br><br>As @ 20/4/18 | |

| | | | | |
|---|---|---|---|---|
| **7.Newark Road Surgery** | Continue to manage any additional demand. | They will be seen that day if we have an appointment available or put on the emergency call back list if it falls within specific criteria as detailed by the partners or else told to phone back the next day | HCA is 25/4/18<br>Nurse - 27/4/18<br>GP/Nurse Practitioner is 18/4/18 for on the day and 25/4/18 for pre booked<br><br>As @ 17/4/18 | |
| **8.Minster Medical Practice** | No impact whatsoever | If appointment available then this is offered. If same day appointments already fully booked and calling before 11.30am and say urgent for that day emergency slot at end of morning surgery offered. Calling after 11.30am and saying urgent for that day patient is added to telephone triage and duty doctors calls them and sees if appropriate. | HCA – 16/4/18 pm<br>Nurse - 17/4/18<br>ANP – 17/4/18<br>GP – 17/4/18<br><br>As @ 16/4/18 | 5 additional extended hours of appointments per week |

This page is intentionally left blank

**Average Daily A&E Attendance at Lincoln ULHT Comparing Pre Walk-in Centre Closure (4/12/17 - 04/02/18) to Post-Walk-in Centre Closure (05/02/18 to 29/4/18)**

*Note: This Analysis of A&E Attendances is from 4th December 2017 to 29th April 2018. The Phased Closure of Walk-in Centre (WIC)Commenced Week 45; Walk-in Centre closure from Week 48. For the purposes of providing this data we have also provided a comparison excluding the week where there was exceptional variation caused by bad weather. (Week 48)*




| | Before WIC closure | After WIC closure | After WIC closure (excl. exceptional variation) |
|---|---|---|---|
| 16/17 Overall A&E Total (incl UCS+OOH Diverts) | 194 | 198 | 197 |
| 17/18 Overall A&E Total (incl UCS+OOH Diverts) | 200 | 210 | 213 |

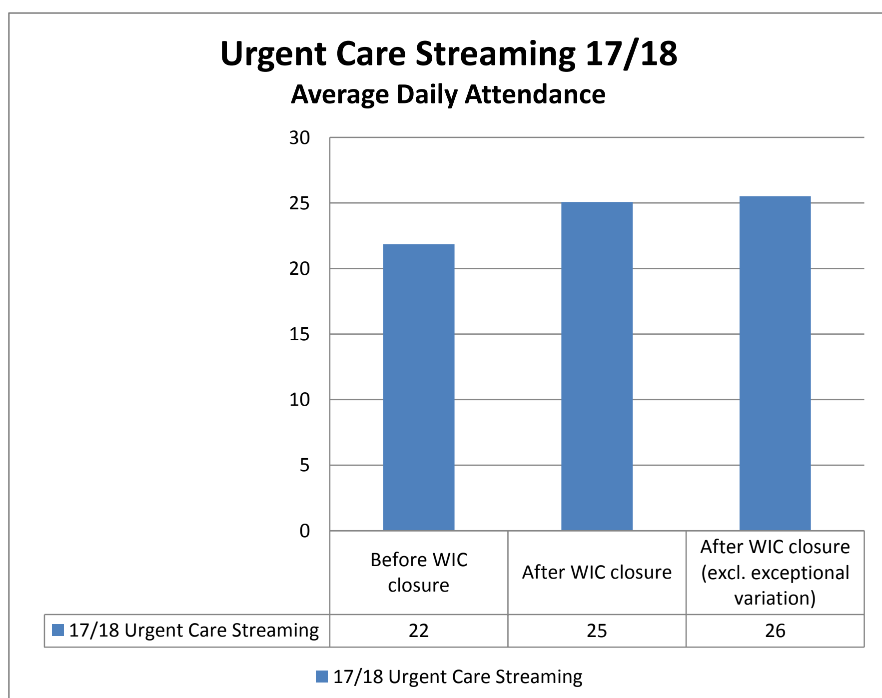
**Notes:**

*On average an additional 10 patients attended A&E per day since the closure of the Walk-in Centre. Excluding the week where there was exceptional variation caused by bad weather, there has been an additional 13 patients on average per day attending compared with the period when the Walk-in Centre was open.

*Last year (16/17) when comparing the same periods, there was on average an increase of 4 patients attending A&E per day. Comparing the "After Walk-in Centre" closure period (excluded exceptional variation) average in 16/17 to the "before WIC closure" 16/17 period shows there was an average increase of 3 patients per day attending A&E.

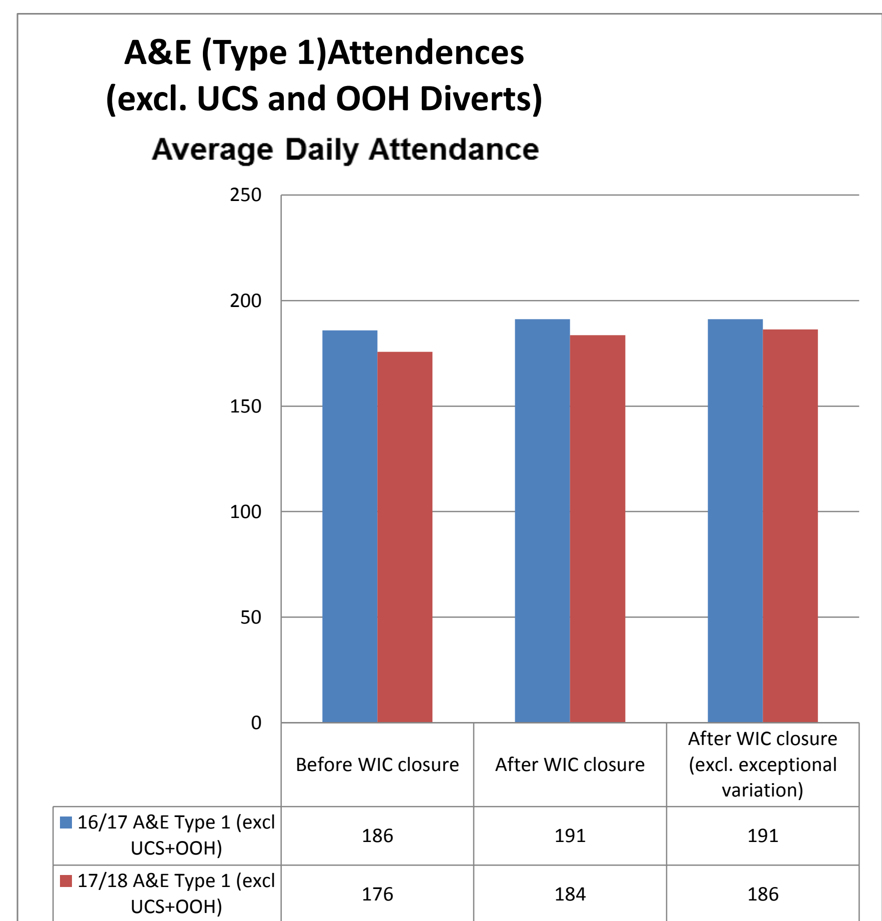
***Accounting for this 16/17 increase in attendance as a seasonal profile the nett number of patients attending A&E has increased on average by 6 patients per day in 17/18. If comparing the 17/18 (excluding exceptional variation) in the same way, this would equate to an additional 10 patients on average nett per day in 17/18 following closure of the WIC.**

*Comparing attendance year on year (16/17 to 17/18), the number of patients attending A&E has increased on average by 12 patients per day since 5th February (see detailed data). This equates to an average of 16 patients per day using the After WIC closure (excl. exceptional variation).




| | Before WIC closure | After WIC closure | After WIC closure (excl. exceptional variation) |
|---|---|---|---|
| 17/18 Urgent Care Streaming | 22 | 25 | 26 |

**Notes:**
*On average an additional 3 patients attended Urgent Care Streaming per day since the closure of the Walk-in Centre
*There was no Urgent Care Streaming Last year (16/17) so no comparison to last year is shown. Urgent Care Streaming began in October 2017.
***On average an additional 5 patients attended Urgent Care Streaming per day when comparing the After WIC Closure (excl. variation) period attendance to the period prior to the closure of the Walk-in Centre.**




| | Before WIC closure | After WIC closure | After WIC closure (excl. exceptional variation) |
|---|---|---|---|
| 16/17 A&E Type 1 (excl UCS+OOH) | 186 | 191 | 191 |
| 17/18 A&E Type 1 (excl UCS+OOH) | 176 | 184 | 186 |

**Notes:**
*On average an additional 8 patients attended A&E (type 1) per day since the closure of the Walk-in Centre. Excluding the week of exceptional variation, there has been an additional 10 patients per day attending compared with the period when the Walk-in Centre was open.

*Last year (16/17) when comparing the same periods, there was on average an increase of 5 patients attending A&E (Type 1) per day. Comparing After Walk-in Centre (excluding variation) in 16/17 to the "before WIC closure" 16/17 period shows there was an average increase of 5 patients per day attending A&E (Type 1).

***Accounting for this 16/17 increase in attendance as a seasonal profile the nett number of patients attending A&E (type 1) has increased on average by 3 patients per day in 17/18. If comparing the 17/18 (excluding exceptional variation) in the same way, this would equate to an additional 5 patients on average nett per day in 17/18 following closure of the WIC.**

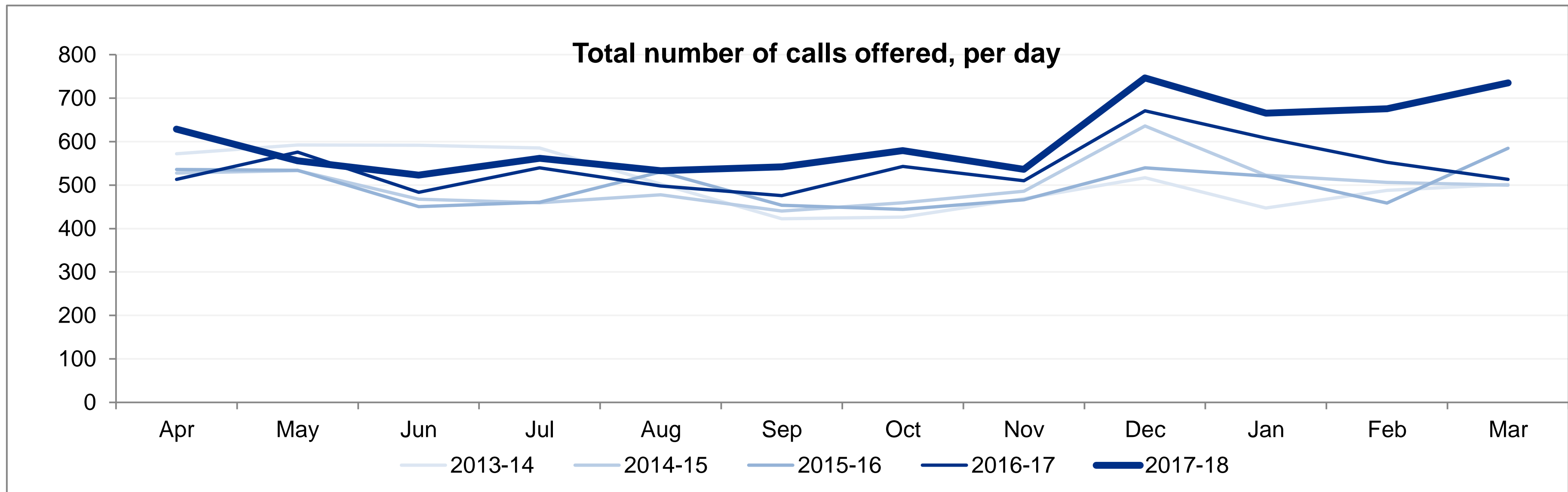
*Comparing attendance year on year (16/17 to 17/18), the number of patients attending A&E (Type 1) has reduced on average by 7 patients per day since 5th February (see detailed data). This equates to an average of 5 patients per day reduction using the After WIC closure (excluding exceptional variation).

Please see the Data Tables Appendix for further detail. This data is taken from the weekly SITREP (ULHT)

This page is intentionally left blank

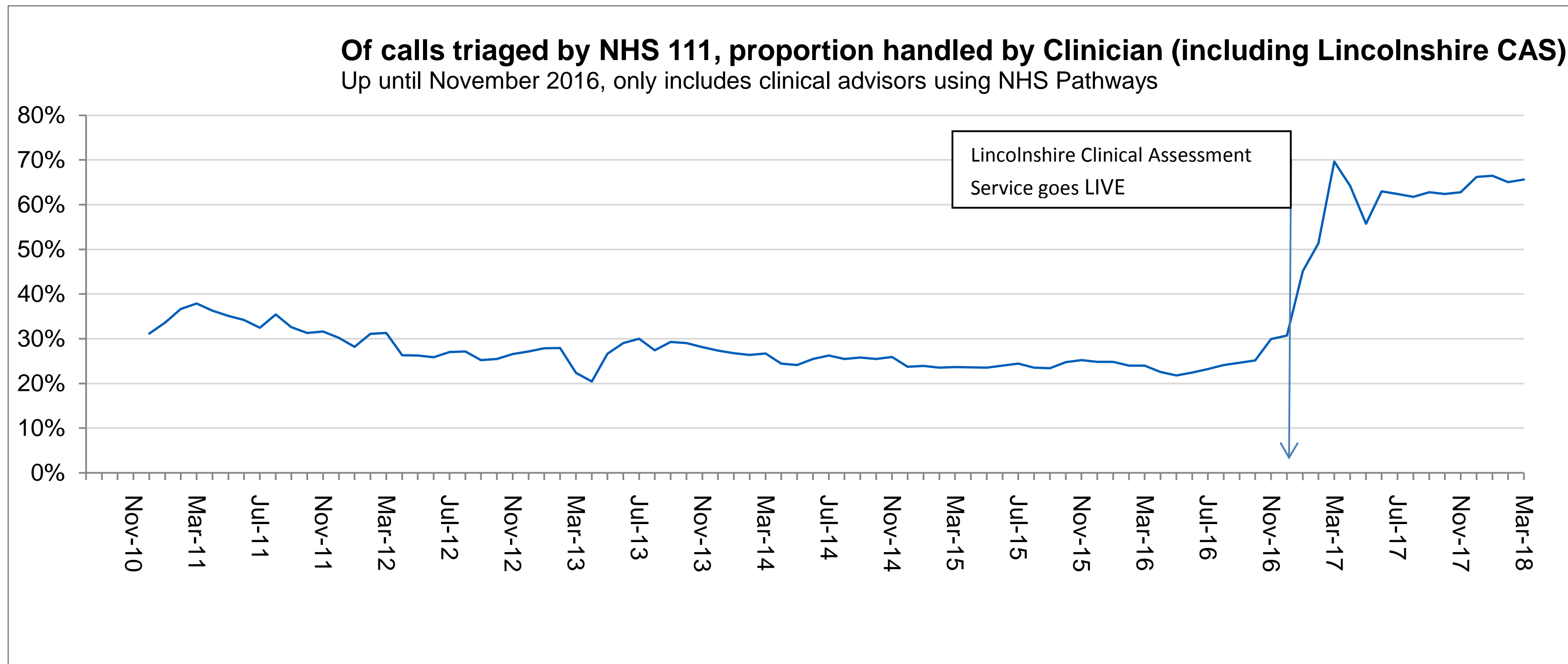
**APPENDIX 4: NHS111 LINCOLNSHIRE**

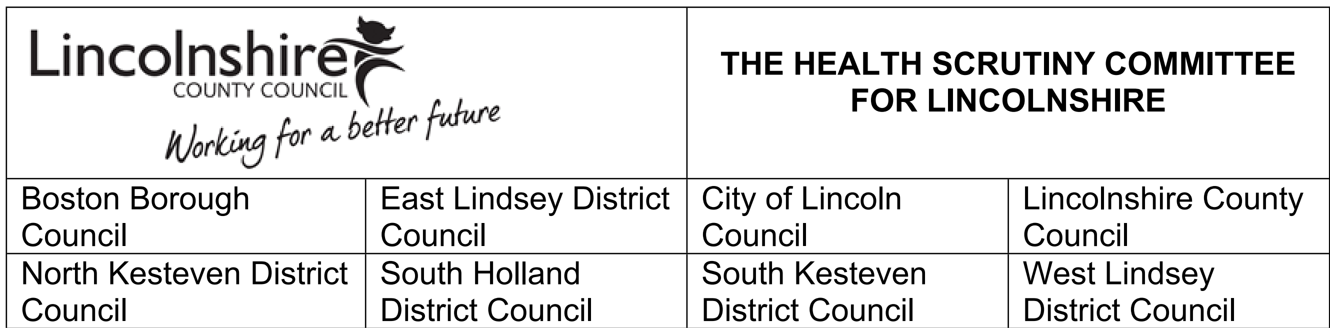
Lincolnshire



**Appendix 4: NHS111 LINCOLNSHIRE**

**Proportion of call handled by Clinician (including Lincolnshire Clinical Assessment Service)**





**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**

| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
|---|---|---|---|
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

| Report to: | **Health Scrutiny Committee for Lincolnshire** |
|---|---|
| Date: | **16 May 2018** |
| Subject: | **Winter Resilience Review 2017/18** |

**Summary:**

The purpose of this item is to update the Health Scrutiny Committee on system resilience during Winter 2017/18.

**Actions Required:**

Members of the Health Overview and Scrutiny Committee are asked to consider the approach taken to prepare for Winter pressures as set out in the report and to offer their comments.

## 1. Background

The NHS frontline is always under considerable pressure over the winter period as demand for services tends to increase significantly with the onset of cold weather and flu. In response, our urgent and emergency care system places a particular focus on winter to ensure there is enough bed and staff capacity to meet patients' needs. Patients are usually more unwell over winter, for example, because of flu and respiratory conditions, and because of slips and falls in the cold weather. This adds to the complexity of the task, as does establishing additional capacity when the service is already running at full stretch.

Throughout the year and in particular during winter, contingency plans were in place to manage these risks and protect patient safety. At a national level and locally, the NHS was better prepared this year than in previous years, nevertheless, it is unavoidable that resilience in one organisation very much depends on the resilience of the rest of the local health and social care system.

## 1.1 National Context

Nationally this winter, pressures increased week by week, with a noticeable surge in demand for NHS care at the start of January 2018. NHS trusts reported particular challenges with regard to bed occupancy levels, A&E performance, demand for ambulance services and handover, pressures on bed and out of hospital capacity, together with increasing levels of flu, respiratory conditions and norovirus. The challenges were system-wide, with mental health and community trusts also experiencing severe pressures. This is in spite of careful planning undertaken by the NHS to prepare for winter, with higher than expected demand combined with an underlying lack of bed and staff capacity, as well as on-going pressures in primary and social care.

## 1.2 Local Context

The Lincolnshire Urgent and Emergency Care (UEC) system took a proportionate and realistic approach in response to the level of winter pressures both predicted and real.

It was clear before winter that the health and care system was already under pressure, with performance against the 4-hour A&E standard having been 75.54% in quarter 3 of 2017 (lower than the expected 90% target for November), and delayed transfers of care (DTOC) performance for December rose to 5.4% well above the government target of 3.5%. At the start of winter reporting, it was an immediate concern that general and acute bed occupancy was already at 98.58% (31 October). The level peaked at 104.67% on 13 December. To put this in context, half of acute trusts nationally were reporting occupancy of over 95%, despite an additional 800 beds being opened. The data on ambulance arrivals and delays indicates a particular surge in pressures. The acute trust received 21,084 ambulance arrivals between November and March, the equivalent being an ambulance arriving every 10.31 minutes, 24 hours a day. The A&E departments have been overwhelmed by this level of demand and the number of ambulance handover delays (the wait between an ambulance arriving and the patient being transferred to the A&E department), high admissions, increased length of stay, high bed occupancy and additional delays increased during the winter.

## 1.3 What is Behind the Pressures

The first week of January 2018 saw extensive reports of growing NHS pressures. We understand locally the severity of the pressure was due to a combination of long and short term factors. Over the long term, there is the known trend of increasing demand and acuity (i.e. sicker and frailer patients), as well as limited capacity (across the ambulance, mental health, community and acute sectors, all of which contribute to urgent and emergency care performance), workforce shortages (particularly in the emergency department), and on-going capacity challenges in primary and social care.

In Lincolnshire we have seen a trend similar to the national picture of higher levels of respiratory illness than expected; higher levels of flu than expected, with more people hospitalised and admitted above the respective baselines from last year and loss of bed capacity due to norovirus.

## 1.4 Local and National Responses to Increased Pressure

By mid-September 2017 the Winter Plan for Lincolnshire's health and care system had been signed off. Partners across the system worked hard to prepare for extra winter pressures and minimise the risks for patients.

Actions included:

- Creating extra capacity through opening temporary (escalation) beds; providing additional staffing to respond to increased demand
- Steps to ensure the seamless flow of patients through to discharge
- Increased trusted assessor capacity to expedite discharges
- Developing local resilience plans with partner organisations such as social care
- Improved communications
- Support to ensure people with mental health needs were treated in the right place
- Increased availability of community beds
- Discharge surge events
- Urgent care streaming in emergency departments to ensure patients are treated in the right setting

Significant steps were also taken at a national level to improve NHS resilience, which included:

- A more joined-up approach, including a National Director responsible for winter planning and establishing the National Emergency Pressures Panel (NEPP)
- Contingency plans to support trusts at greatest risk of having difficulties this winter
- An extra £335 million in the 2017 Budget to help the NHS cope with winter

While preparations for winter have never been more meticulous and thorough, there remained a number of continuing difficulties and pressures jeopardising the system's ability to cope:

- Flu – this year's strain has already placed health systems in Australia and New Zealand under severe pressure.
- Funding pressures – the additional NHS funding for winter in the Budget was welcome but has come very late to be used to maximum effect. To make the most of every pound, the system needed to see this in the summer, so that additional beds, services and staff could have been put in place.
- Lack of beds – in late autumn ULHT was already over the recommended safe bed occupancy level of 92%. This means there was very little give in the system. Too many patients still faced delays in being discharged after they were ready to move on.
- Workforce pressures –shortages of key staff groups including paramedics, GPs and A&E consultants and nurses.
- Underlying performance pressures – capacity was already stretched, as evidenced by all four key NHS performance targets being missed last year, for the first time ever, even though productivity gains have been much greater than the whole economy average.

### 1.5 Patient Impact

With the acute trust seeing more people, in both worse and more frail conditions, it is right that the system focuses first on those patients who need help. With this in mind, the National Emergency Planning Panel recommended to all acute trusts that non urgent operations be cancelled during January. Whilst this was enacted in Lincolnshire it was regularly reviewed and not all operations were cancelled. Along with risking patient safety and quality when cancelling operations and outpatient appointments, cancelling operations results in less income for NHS trusts, which is an additional challenge for our system which is already under significant pressure to deliver savings; recover financial targets and assure their sustainability.

### 1.6 The Wider Context

The NHS is in the middle of the longest and deepest financial squeeze in NHS history. Costs and demand are growing by 5% a year, but we are in the midst of a twelve year period where funding increases have not matched this. Three independent health think tanks estimate, based on projections from the Office for Budget Responsibility (OBR), that health spending would need to rise to approximately £153 billion (from £123.8 billion in 2017/18) by 2022/23 to maintain standards of care and meet rising demand.

There are severe workforce shortages, with recruitment and retention problems. Many staff say they cannot provide the safe, high quality care that patients deserve, even though they are routinely working longer than recommended or paid hours. The pressure on NHS performance can be seen throughout the year. Despite best efforts, in 2016 all four key NHS hospital performance targets were missed; and waiting lists for routine surgeries are the longest they have been for a decade.

## 2. Lincolnshire Performance

### 2.1 System Performance

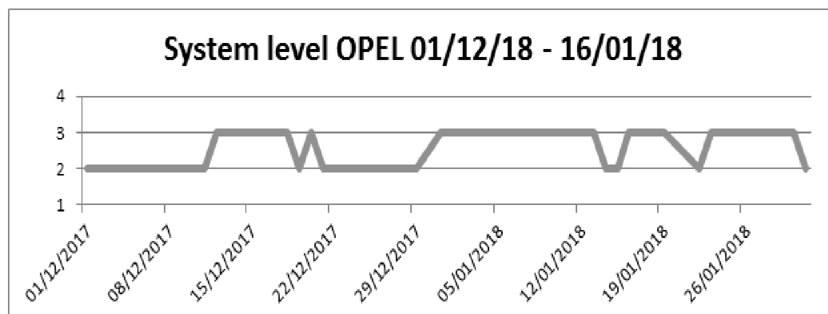
The Operational Pressures Escalation Level (OPEL) is utilised throughout winter to identify daily system performance, capacity and risk. Daily reporting takes place via the CCG Urgent Care Team to NHS England to provide a system perspective to regional and national directors.

The OPEL reports are comprised of organisation OPEL levels which are reviewed and fed into a system wide level. The levels vary from level 1 to 4, one being the lowest level of pressure to OPEL 4 being critical. The report is generated following a 9am teleconference where system partners discuss current OPEL levels and provide feedback on high priority issues and signed off by the Urgent Care Programme Director.

The organisations that provide an individual sitrep and OPEL level who contribute to this report are:

- ULHT – Daily updates
- LCHS – Daily updates
- LPFT – Daily updates

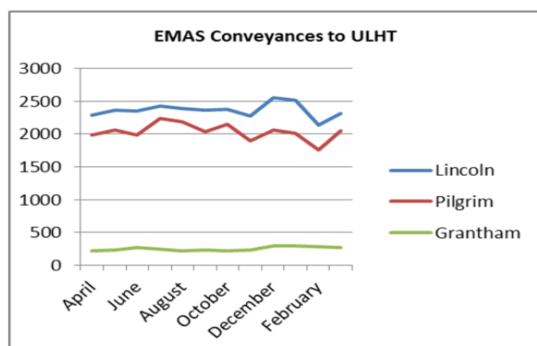
- EMAS – Daily updates
- ASC – Weekly updates (adhoc as requested)
- NHS 111 – Daily Updates

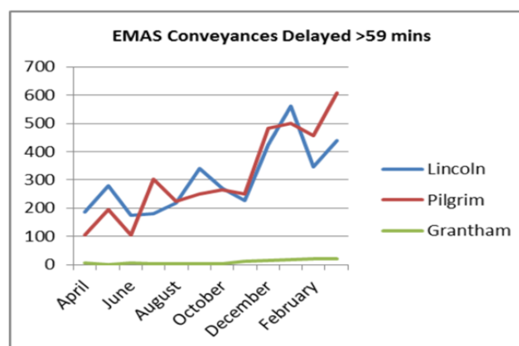



Normal operating for the Lincolnshire system is OPEL level 2; this reflects a system that is able to de-escalate quickly from surges in demand. The chart above shows Lincolnshire was above average and operating at OPEL 3 for the duration of December and January. In contrast, we have reported OPEL level 2 for 20 of the past 21 days during April. Level 4 was reported on only 2 occasions (days) this winter during severe weather.

OPEL levels are built from current performance and pressures. These are therefore a good indication of how well a system and organisation is able to deal with the demand on its services.

## 2.2 Ambulance Handover




Ambulances conveyances on all sites remained consistent during winter. The new RAT area at Lincoln has had a positive impact, whilst at Pilgrim hospital there have been issues with process and staffing. This was picked up by the CQC and is a key focus area for improvement with external help from NHSI and the trust has brought in SSG to assist with an improvement programme across the trust "ADPRAC" to help in ACP training at PHB. Early indications for April are positive.

United Lincolnshire Hospitals NHS Trust was among the top five poorest performers nationally for % of ambulances delayed over the 30-minute arrival to clear target, in December 2017. The impact of this is far reaching by stretching already thin resources. EMAS and ULHT are being supported in improve process and system improvement by NHS Improvement and SSG Health. To date, additional changes have been made to the patient cohorting process – including plans for the pre-handover practitioner to be able to take a cohort of up to 3 patients and speed up handovers. SSG facilitators are coaching

staff with a focus on internally-led immediate and practical interventions and to ensure new working habits stick; and medium term change interventions remain on track. Since the work commenced, the system is tracking a 35% improvement in handover delays.

### 2.3 Urgent Care Streaming

The Urgent Care Streaming Service (UCS) is in place at the front door of the Accident and Emergency Departments at Lincoln and Pilgrim Hospitals, enabling patients presenting with a perceived A&E need (which is actually on assessment a Primary Care need) to be streamed in to a Primary Care Service within the hospital.

UCS has been in place at Lincoln and Pilgrim since mid-October 2017. The impact of UCS can vary per day; ranging from approximately 8% to 20% of patients treated in the emergency department. The table below shows UCS performance by month from October 2017 – April 2018.

| Month | ULHT A&E Attendances (All Types) | Streaming Activity | Streaming as % of A&E |
|---|---|---|---|
| Oct-17 | 13,351 | 1,286 | 9.6% |
| Nov-17 | 12,746 | 1,609 | 12.6% |
| Dec-17 | 13,023 | 1,332 | 10.2% |
| Jan-18 | 12,849 | 1,298 | 10.1% |
| Feb-18 | 11,635 | 1,126 | 9.7% |
| Mar-18 | 13,551 | 1,358 | 10.0% |
| Apr-18 | - | 1,332 | - |

A CCG led monthly Clinical Governance Group monitors quality of the service and performance is managed via an Operational Group with system wide representation to ensure the development of an integrated and effective service. There are basically two elements to the Urgent Care Streaming Service; these are the initial streaming process and then behind this the supporting Primary Care Service.

The Urgent Care Streaming Service has already been building referral capability straight to specialties or other services such as social care and mental health liaison.

The existing pathways through UCS are for patients amenable to traditional Primary Care provision, was extended with enhanced diagnostic and treatment capabilities e.g. Near Patient Blood Testing, X-ray accessibility, staff training from 01 May. This will enable more patients to be seen and treated within the Urgent Care Streaming Service e.g. some Minor Injuries such as: small wounds needing suturing, patients with suspected DVT, Frail Elderly etc.

This extended capability will enable more patients to be streamed away from the main A&E footfall. With Near Patient Testing and X-ray capability more patients will be able to be discharged without need for day case/short stay < 1day admission/observation. Further training in Minor Injuries care, so all UCS clinical staff have these competencies will also

reduce footfall on the main Emergency Department by enabling treatment within UCS of some of what were previously Minors patients.

Currently there is marked variation between the numbers through UCS at Pilgrim compared to Lincoln, with Lincoln having a higher rate as a percentage of total A&E attendees. LCHS Urgent Care Medical Lead is currently reviewing the reasons for this and spending time at both sites to establish whether there is a difference in presentations to the A&E Departments or ways of working of UCS that would account for this difference.

Within Lincolnshire we have the Lincolnshire Clinical Assessment Service that has been established fully since April 2017. This service, an alliance between, LCHS & EMAS provides Clinical Triage to 111 calls both in and out of hours, this service already prevents significant footfall to our GPs in and out of hours, to A&E and to Urgent Care Centres.

This and other admission/attendance avoidance initiatives may be the reasons why we are not hitting the initially predicted targets (25 -30%) for patients presenting to A&E amenable to a Primary Care Service via UCS.

However the number of patients being seen by UCS at Pilgrim has been at low levels on some days which given high overall attendances to the A&E Department at Pilgrim, would not have been expected, so it is clear there is a need to fully understand this variation and take action to improve the service if this is indicated from the review.

## 2.4 Four Hour Standard

The figures for A&E attendances and emergency admissions up to March 2018 demonstrate a system under significant pressure; although there is no simple correlation between A&E performance data and risk to patient safety, A&E pressures are closely tracked and can give a broad indication of the health of the wider system. The four-hour standard is a proxy for safe patient care, and every breach of the standard can therefore be regarded as a potentially elevated risk.

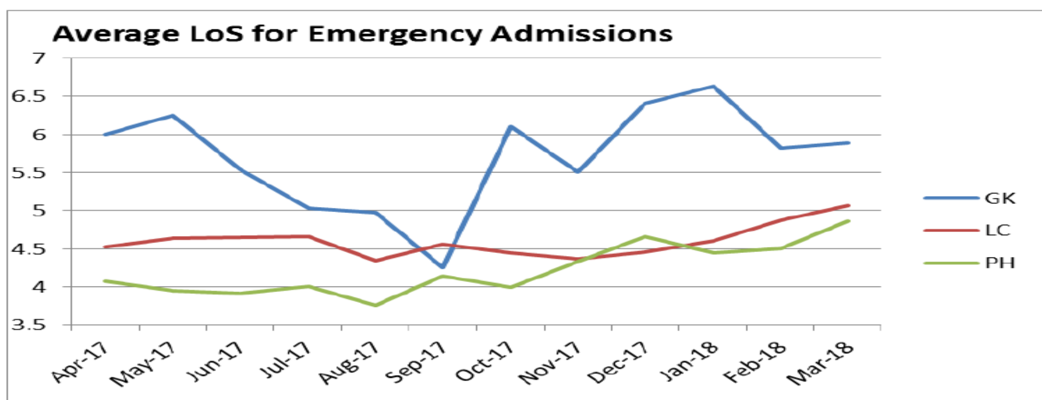
Acute Trust performance for Type 1 attendances plus streaming was 65.21% in March against a target of 95%. Month on month the trust falls short of the target, with the addition of community based Type 3 performance (97.33%) the system achieved 76.33% in March.

A realistic improvement trajectory for 18/19 has been developed and agreed across the urgent and emergency care system. The plan is dependent on a number of system wide actions to improve hospital flow and reduce DTOC, enabling the emergency department to move patients through the system quickly.

| Lincolnshire 4 Hour Standard Trajectory 2018/19 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
| ULHT Type I | 69.69% | 72.03% | 74.38% | 76.72% | 79.07% | 81.41% | 82.22% | 83.02% | 79.07% | 76.72% | 77.53% | 86.24% |
| ULHT + Streaming | 72.04% | 74.33% | 76.63% | 78.92% | 81.22% | 83.51% | 84.39% | 85.26% | 81.22% | 78.92% | 79.79% | 88.74% |
| ULHT + Streaming & Type 3 | 82.07% | 83.68% | 85.30% | 86.91% | 88.52% | 90.13% | 90.94% | 91.75% | 88.52% | 86.91% | 87.72% | 95.00% |

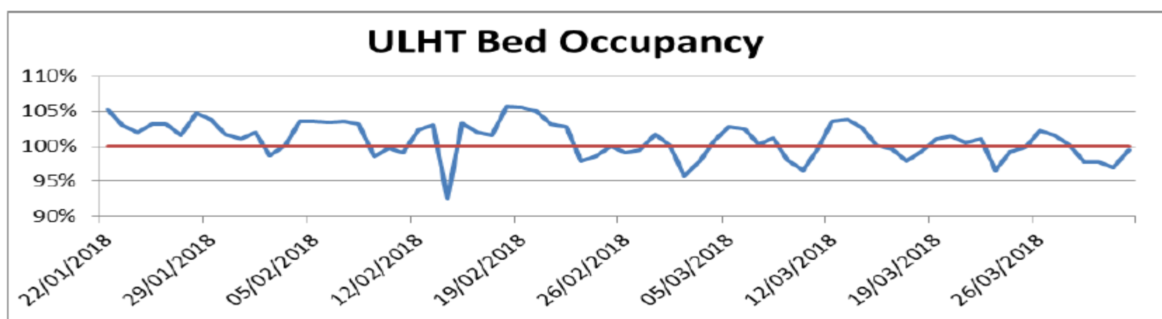
## 2.5 Admissions

Length of stay (LoS) for emergency admissions has been increasing steadily since October 2017. Grantham continues to have the highest non elective LoS but Lincoln and Pilgrim Hospitals have seen their highest average for the year in March. With an increasing LoS, bed occupancy has remained high and “exit block” persists as one of the key breach reasons during March. Occupancy across the acute trust has been consistently at or in excess of 100% throughout winter with highest occupancy on Mondays, slowly reducing through the week as a regular pattern.




## 2.6 Bed Capacity

In assessing bed capacity, it is important to look at the number of available beds and demand. In terms of demand for beds, there are year-on-year increases in demand itself and the acuity of that demand. For example, in total, A&E departments in 2016/17 saw attendances increase by 3% with 3% more patients admitted to hospital. While the data for this winter is not yet available, it is clear from the sitreps that local bed occupancy levels are higher in 2017/18 than in 2016/17, suggesting that demand and/or acuity has risen, creating real pressure on bed stock and capacity.




Within the community, bed occupancy for February is 85.1% remained within tolerance levels.

## 2.7 Delayed Transfers of Care

Like the four hour standard, Delayed Transfers of Care (DTOC) are a crude measure of the health of the urgent care system. Most importantly, delayed transfers of care have negative impacts on the people who become delayed, with significant implications for their independence. In addition, delays have an impact on wider service delivery and performance across the whole health and care system but the immediate effects manifest themselves within hospitals.

The DTOC standard is less than 3.5% of available bed days will be lost due to delays. The table below gives the local performance during the past 7 months.

| Provider perspectives (NHS acute only) | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 |
|---|---|---|---|---|---|---|---|
| United Lincolnshire Hospitals | 3.6% | 3.4% | 4.1% | 4.9% | 5.4% | 5.0% | 4.5% |

Within the community, Lincolnshire Community Health Trust has continued to the work around the tight management and escalation of all DTOC, which has enabled the Trust to successfully manage a high number of very complex cases seen across Community Hospitals and Transitional Care. Like the ULHT, LCHS engaged with two recent Discharge Surges which resulted in a huge increase of patients discharged from the acute hospital into community beds, home or to alternate care settings. This led to an increase in the number of beds spot purchased by LCHS and Adult Social Care and a decrease in beds occupied within the acute hospital by patients medically stable to transfer.

## 3. Conclusion

The focus right now needs to be on what can be done to help frontline services respond to patient need. For example, we continue to be guided by national directions through the NEPP to support our system to take action and reallocate resources to emergency care as appropriate during periods of high demand. All local partners are working to create additional care capacity to respond to surge, particularly along the east coast during the summer period when demand mirrors winter.

Urgent and Emergency Care is a complex adaptive system that is dynamic in terms of its interactions and relationships between professionals, services and organisations.

In a system working with limited resources to meet the demand, interactions can be compromised. The system works through the relationships and tolerances of each organisation. Future planning will consider the impact on performance and building positive relations between professionals and organisations to reduce the opportunities for process led organisational conflicts.

In Lincolnshire, there is now a shared understanding that these interactions are detrimental to flow through the acute hospitals, by a reduced number of beds and high occupancy, and high numbers of delayed transfers of care, In response, the Recovery Plan is focused on improving these interactions and the Winter Plan has focused on the wider system actions that will impact on system resilience.

## 4. Consultation

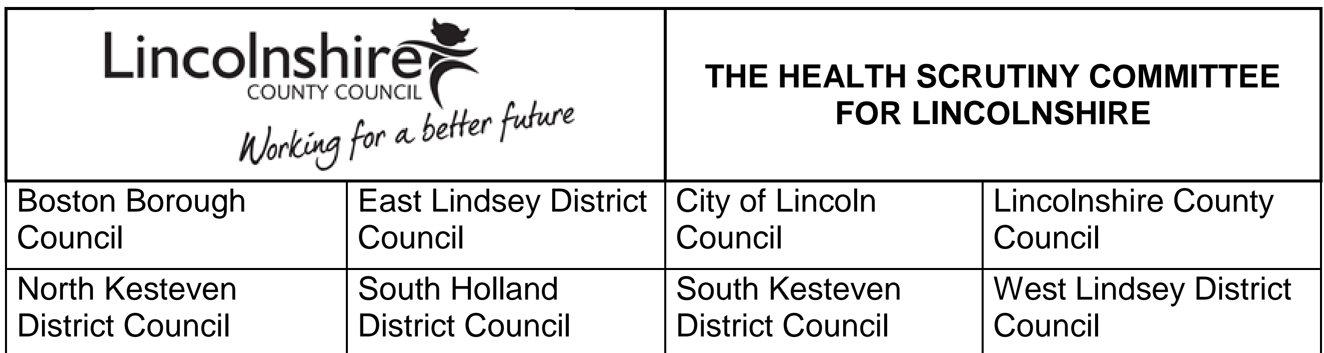
This is not a direct consultation item.

## 5. Background Papers

No background papers were used within the meaning of Section 100D of the Local Government Act 1972

This report was written by Ruth Cumbers, Urgent Care Programme Director, who can be contacted on 01522 513355 or ruth.cumbers@lincolnshireeastccg.nhs.uk

# Agenda Item 10



| Boston Borough Council | East Lindsey District Council | City of Lincoln Council | Lincolnshire County Council |
|---|---|---|---|
| North Kesteven District Council | South Holland District Council | South Kesteven District Council | West Lindsey District Council |

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

| Report to | **Health Scrutiny Committee for Lincolnshire** |
|---|---|
| Date: | **16 May 2018** |
| Subject: | **Health Scrutiny Committee for Lincolnshire - Work Programme** |

**Summary:**

This item enables the Committee to consider and comment on the content of its work programme, which is reviewed at each meeting of the Committee so that its content is relevant and will add value to the work of the Council and its partners in the NHS. Members are encouraged to highlight items that could be included for consideration in the work programme.

**Actions Required:**

(1) To review, consider and comment on the work programme set out in the report and to highlight for discussion any additional scrutiny activity, which could be included for consideration in the work programme;

(2) To note the activity of the Committee's Quality Accounts Working Group; and

(3) To consider a proposal for the merger of the Committee's STP Operational Efficiency Working Group and the United Lincolnshire Hospitals Financial Special Measures Working Group, with the following terms of reference:

*"(1) To consider the financial impacts of the Lincolnshire STP, with particular emphasis on the operational efficiency priority.*

*(2) To consider financial special measures of United Lincolnshire Hospitals NHS Trust, and any impacts of these financial special measures on the quality of care provided by the Trust.*

*(3) To submit reports to the Committee as required on its findings, including any recommendations for further activity by the Committee."*

**1. Work Programme**

The items listed for today's meeting are set out below: -

| ***16 May 2018 – 10 am*** | |
|---|---|
| *Item* | *Contributor* |
| Children's and Young People Services at United Lincolnshire Hospitals NHS Trust | Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust |
| Access to Primary Care – Lincoln Area | Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG<br>Wendy Martin, Chief Nurse, Lincolnshire West CCG |
| Winter Planning: Review of 2017-18 and Initial Plans for 2018-19 | Sam Milbank, Accountable Officer, Lincolnshire East CCG<br>Ruth Cumbers<br>Urgent Care Programme Director, and Senior Responsible Officer, STP Urgent Care Programme<br><br>Simon Evans, Director of Operations, United Lincolnshire Hospitals NHS Trust |

Planned items for the Health Scrutiny Committee for Lincolnshire are set out below:

| ***13 June 2018 – 10 am*** | |
|---|---|
| *Item* | *Contributor* |
| United Lincolnshire Hospitals NHS Trust – Care Quality Update | Michelle Rhodes, Director of Nursing, United Lincolnshire Hospitals NHS Trust |
| Lincolnshire Sustainability and Transformation Partnership – Update (including Acute Services Review) | John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership<br>Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership |
| Annual Report of the Director of Public Health | Derek Ward, Director of Public Health, Lincolnshire County Council |
| Non-Emergency Patient Transport | Mike Casey, Interim Manager, Thames Ambulance Service |

| *11 July 2018 – 10 am* | |
|---|---|
| *Item* | *Contributor* |
| Learning Disability Services – Outcomes of Targeted Engagement | Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust |
| Specialised Commissioning | Contributors to be confirmed. |

| *12 September 2018 – 10 am* | |
|---|---|
| *Item* | *Contributor* |
| Lincolnshire Sustainability and Transformation Partnership – Update | John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership<br>Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership |
| Lincolnshire Sustainability and Transformation Partnership – Mental Health Update | To be confirmed. |
| East Midlands Ambulance Service Update | To be confirmed. |
| Non-Emergency Patient Transport | Mike Casey, Interim Manager, Thames Ambulance Service |

Items to be Programmed

- Cancer Care (including prostate cancer services)
- Lincolnshire East Clinical Commissioning Group Update
- Lincolnshire West Clinical Commissioning Group Update
- South Lincolnshire Clinical Commissioning Group Update
- South West Lincolnshire Clinical Commissioning Group Update
- Commissioning of Continuing Health Care
- Adult Immunisations
- Developer and Planning Contributions for NHS Provision (This could be included as part of each CCG Update)
- Dental Services
- NHS Staff Survey 2017

Other Items to be Programmed – No earlier than September 2018

- Lincolnshire Sustainability and Transformation Partnership Consultation Elements:
  - ➢ Women's and Children's Services
  - ➢ Emergency and Urgent Care
  - ➢ Stroke Services
- North West Anglia NHS Foundation Trust Update
- Joint Health and Wellbeing Strategy Update

## 2. Working Group Activity

Quality Accounts Working Group

In accordance with the Committee's decision of 21 March 2018, the draft quality accounts of four NHS providers are being considered by the Quality Accounts Working Group. On 1 May, the Working Group met and made arrangements for statements to be prepared on the draft quality accounts of Lincolnshire Partnership NHS Foundation Trust and the East Midlands Ambulance Service NHS Trust.

The Working Group is due to meet on 22 May to consider the draft Quality Accounts of United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust.

Finance-Related Working Groups

On 21 March 2018, the Committee established the STP Operational Efficiency Working Group, comprising Councillors Carl Macey, Chris Brewis, Jackie Kirk and Mark Whittington.

On 18 April the Committee established the ULHT Financial Special Measures Working Group, comprising Councillors Carl Macey, Chris Brewis, Paul Gleeson, Rosemary Kaberry-Brown and Mark Whittington.

In view of the potential overlap of the scope of these two working groups, the Committee is invited to consider merging the two groups, which could work to the following terms of reference:

*"(1) To consider the financial impacts of the Lincolnshire STP, with particular emphasis on the operational efficiency priority.*
*(2) To consider financial special measures of United Lincolnshire Hospitals NHS Trust, and any impacts of these financial special measures on the quality of care provided by the Trust.*
*(3) To submit reports to the Committee as required on its findings, including any recommendations for further activity by the Committee."*

## 3. Conclusion

The Committee's work programme for the coming year is set out above. The Committee is invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

**4. Background Papers -** No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk