

Public Document Pack

 Lincolnshire COUNTY COUNCIL <i>Working for a better future</i>		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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 23 January 2019 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, C Matthews, R A Renshaw, R H Trollope-Bellew and R Wootten

District Councillors: P Gleeson (Boston Borough Council), C L Burke (City of Lincoln 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) and P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

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4	Chairman's Announcements	15 - 20
5	United Lincolnshire Hospitals NHS Trust - Update on Care Quality Commission Inspection <i>(To receive a report from United Lincolnshire Hospitals NHS Trust (ULHT), which provides the Committee with an update on the progress ULHT has made in response to the Care Quality Commission inspection. Senior representatives from ULHT, will be in attendance for this item)</i>	21 - 104

Item	Title	Pages
6	<p>Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update <i>(To receive a report from United Lincolnshire Hospitals NHS Trust (ULHT), which provides the Committee with an update on Children and Young Persons Services. Senior representatives from ULHT, will be in attendance for this item)</i></p>	105 - 180
7	<p>Non-Emergency Patient Transport Service - Update <i>(To receive a report from Lincolnshire West Clinical Commissioning Group (CCG), which updates the Committee on the Non-Emergency Patient Transport Service. Tim Fowler, Director of Commissioning and Contracting, Lincolnshire West CCG and Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG, will be in attendance for this item)</i></p>	To Follow
8	<p>Grantham Accident and Emergency Department - Referral to the Secretary of State for Health and Social Care <i>(To receive a report from Simon Evans, Health Scrutiny Officer, which provides an update with regard to the Health Scrutiny Committee for Lincolnshire's referral of the Grantham and District Hospital's overnight closure of the Accident and Emergency Department to the Secretary of State for Health and Social Care)</i></p>	181 - 192
9	<p>NHS Long Term Plan <i>(To receive a report from Simon Evans, Health Scrutiny Officer, which provides the Committee with an overview of the NHS Long Term Plan)</i></p>	193 - 202
10	<p>Health Scrutiny Committee for Lincolnshire - Work Programme <i>(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its work programme)</i></p>	203 - 208

Debbie Barnes OBE
Head of Paid Service
15 January 2019



**HEALTH SCRUTINY COMMITTEE FOR
LINCOLNSHIRE
12 DECEMBER 2018**

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors C L Burke (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and P Howitt-Cowan (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Dr Dave Baker (GP Chair, South West Lincolnshire Clinical Commissioning Group), Liz Ball (Executive Nurse, South Lincolnshire CCG), Mike Casey (General Manager, TASL), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Partnership), Andy Hill (Contract Manager Lincolnshire, TASL), Dr Kevin Hill (Chair, South Lincolnshire CCG) and John Turner (Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership).

County Councillor Dr M E Thompson (Executive Support Councillor for NHS Liaison and Community Engagement) attended the meeting as an observer.

60 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors P Gleeson (Boston Borough Council), T Boston (North Kesteven District Council) and Mrs R Kaberry-Brown (South Kesteven District Council).

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

61 DECLARATIONS OF MEMBERS' INTEREST

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

**62 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR
LINCOLNSHIRE MEETING HELD ON 14 NOVEMBER 2018**

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 14 November 2018 be agreed and signed by the Chairman as a correct record subject to the final sentence of the fifth bullet point on page 9 being amended to read "*Confirmation was give that GP Access Hubs would be open for a minimum of twelve hours and that it was not known at this stage whether any Urgent Treatment Centres would be open 24 hours.*"

63 CHAIRMAN'S ANNOUNCEMENT

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the Supplementary Chairman's announcements circulated at the meeting.

The Supplementary Chairman's announcements made reference to:

- Dental Services in Mablethorpe;
- United Lincolnshire Hospitals NHS Trust (ULHT) – Children and Young Persons Services – Royal College of Paediatrics and Child Health Report; and
- Lincoln Medical School – Capital Funding.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 17 to 20; and the supplementary announcements circulated at the meeting be noted.

**64 THE NHS LONG TERM PLAN - IMPACT ON THE LINCOLNSHIRE
SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP**

The Chairman welcomed to the meeting John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership (LSTP) and Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership.

In guiding the Committee through the report the Senior Responsible Officer (LSTP) made reference to the NHS Long Term Plan (LTP). The Committee was advised that the Prime Minister had set out a funding settlement for the NHS in England for the next five years. In return for this the NHS had been asked to set out a Long Term Plan for the future of the NHS service. It was highlighted that work on the LTP was being co-ordinated nationally by NHS England and NHS Improvement (NHSI). As part of the process NHS England and NHSI had been engaging with stakeholders and groups to develop policy proposals for inclusion in the plan. The Committee was

advised that the Secretary of State for Health and Social Care had stated that his three priorities were Workforce, IMT, and Prevention; and it was expected that these would feature strongly in the LTP, along with greater emphasis on integration and system working. Details of the considered themes were shown on page 31 of the report. Particular reference was made to the clinical priorities, which were Cancer; Cardiovascular and Respiratory Diseases; Mental Health including Learning Disability and Autism.

It was highlighted that publication of the LTP was the start of the next phase; as local systems would be required to engage with patients, the public, stakeholders and health and overview scrutiny committees in developing local strategic plans in line with the LTP.

A copy of a letter sent to Council Leaders, Health and Wellbeing Boards and Health Scrutiny Committees from NHS England and NHSI was attached to the report at Appendix A. Appendix B provided the Committee with a copy of a letter from the NHS England Chief Executive and the NHSI Chief Executive which advised of their approach to planning.

It was highlighted that nationally steps were being put in place to streamline working procedures between the NHS England and NHSI, to have one team of National and Regional Directors working together. It was highlighted further that the new region had just been announced. It was reported that there would now be seven regions across the country and that Lincolnshire would be part of the Midlands Region.

The Committee was advised that planning for the content of the LTP as a system approach was already on-going. Previously, there had been individual plans; but now for 2019/20 there would be a one system approach, with Clinical Commissioning Groups and NHS Trust working together as one team. It was noted that the priorities that would be addressed were care in the local community where appropriate, diabetes and frailty. There was an emphasis on supporting more care in the community.

The Committee noted that there would be one Accountable Officer for all the four CCG's; and a single leadership team. The Committee noted further that there was a requirement for a 20% reduction in CCG running costs; and as a result there would need to be a different approach to how business was conducted going forward and a different approach to transforming services. The Committee was advised that there would be a CCG joint committee making commissioning decisions on behalf of the four CCGs.

The Committee noted that the Acute Services Review was currently going through the assurance process and that once concluded in 4 - 6 months' time, NHS England would then support the CCGs in going out for a full and public consultation. It was highlighted that the consultation would be a full and open event to gather the thoughts of the public; and that it would involve a range of activities across the County.

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The Committee noted further that once the LTP was published, there would be conversations with staff and the public concerning the plans for Lincolnshire. It was noted that these conversations could not happen until all information was in the public domain and that this would be in advance of any formal consultation. The publication of the NHS LTP had been expected in early December, but now there was some uncertainty over the publication date.

During discussion, the Committee raised the following issues:-

- Page 54 - One member referred to the 3,000 comments received in response to the questionnaire and the need for the formal consultation to attract a higher number of responses;
- The continued overnight closure of Grantham A & E remained a concern;
- Some concern was expressed that the whole system could be slowed down by small consultations, as the STP could not be viewed as a variation of the LTP. The Committee was advised that the new LTP would build on the old plans and address new issues. Clarification was given that engagement was on-going with patients and stakeholders when there were minor changes to services. However, where there was a significant material change proposed, a consultation exercise would take place;
- One member expressed concern regarding the newly formed NHS England and NHS Improvement regions, with some hospitals continuing to be in a different region; and whether this would have implications for patients. The Committee was advised that there were already good relationships with neighbouring health providers; and there was already joined up thinking. It was highlighted that a quarter of the Lincolnshire population attended hospitals outside of Lincolnshire;
- Some concern was expressed to the 20% reduction in CCG administration costs and how that would be achieved, particularly as there appeared to be some resistance to change in the NHS. The Committee noted that this time it was different; as colleagues across the country had expressed views that the current system was not working; and that the changes proposed had come from the CCGs themselves rather than from central NHS management. At the heart of any changes was the drive to ensure that a good service was provided for the residents of Lincolnshire. The 20% reduction in administration costs was a hurdle and would be a shift in working practices, which would have to be maintained by the four CCGs. It was noted that the system was up for the challenge;
- The need to ensure that the work force issues were addressed, to ensure that improvements were achieved;
- That prevention was a priority and as such needed to have adequate resources. It was felt that it needed to be a priority for national and local government;
- The impact of rurality and transport links in Lincolnshire had on service provision and the need to ensure that the County received adequate funding to compensate for these issues. The Committee was advised that rurality and transport were a shared concern across all organisations in Lincolnshire, especially on the east coast where access was an issue. It was highlighted

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that integrated community care provision across the County would help with this issue;

- One member highlighted that Ophthalmology appeared to be struggling and confirmation was sought as to whether this was the case? The Committee was advised that there had been some challenges for the 100 day programme for Ophthalmology due to the loss of staff, and that services changes were being planned to make ophthalmology more sustainable;
- A question was asked relating to the proposed integrated community care model, did that mean that staff would be integrating into primary care and GPs. Confirmation was given that staffing remained fragile; but getting the right staff was fundamental for the system to move forward. The Committee noted that with regard to rurality, Lincolnshire was a member of the Rural Health and Care Centre; and that a report was due to be published concerning workforce in the early part of 2019;
- Some Members welcomed the single CCG Joint Committee. The Committee was advised that the Joint Committee would ensure that the right issues were highlighted and managed across the County. Other members welcomed the working together of NHS England and NHS Improvement. It was highlighted that the public perception was that the NHS was one single organisation, whereas in practice the NHS was still working in silo's; and the whole principle was to get one NHS working within its constraints;
- One member enquired as to the newly appointed Regional Director for the Midlands; and also where the new single Accountable Officer would be recruited from. The Committee was advised that the newly appointed Regional Director, Dale Bywater, had been appointed following a vigorous recruitment process and had expertise in the new roles he would be undertaking; he was also familiar with Lincolnshire and its challenges. The Committee was advised further that the Accountable Officer position would be advertised nationally;
- One member extended thanks to the officers for their optimistic report; and made reference to the fact that the budget for health services would need to increase year on year to address the needs of the older population; that a career in the health service needed to be promoted better in schools; and that more needed to be done to fund the 'hidden' Lincolnshire population. The Committee was advised that the NHS offered a brilliant service; and that it needed to have ambition and hope; as there was a clear understanding of what needed to be done to address the issues in Lincolnshire. Confirmation was given that work was on going with Lincolnshire schools; and that health colleagues were always learning what other areas were doing; seeing what was working and whether these could be replicated in Lincolnshire; and
- Clarification was sought as to when engagement would commence for the LTP or the Acute Services Review. The Committee was advised that once the LTP was published, things would move quickly; and at a best guess it was felt that the LTP would be published early in 2019. As the Urgent Treatment Centres would be dealt with as a system, the consultation on them would be part of the overall consultation.

The Chairman extended thanks to the representatives.

RESOLVED

1. That the NHS Long Term Plan – Impact on the Lincolnshire Sustainability and Transformation Partnership report presented be noted.
2. That a further update report be received at the 23 January 2019 meeting to update the Committee with regard to the local planning, engagement and progress, alongside the response with regard to the future consultation plans for Grantham and District Hospital A & E Services, as requested by the Minister of State for Health.

65 ANNUAL REPORTS OF SOUTH LINCOLNSHIRE CLINICAL COMMISSIONING GROUP AND SOUTH WEST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

The Chairman welcomed to the meeting John Turner, Chief Officer, South Lincolnshire CCG and South West Lincolnshire CCG, Dr Kevin Hill, Chair, South Lincolnshire CCG; and Dr Dave Baker, Chair, South West Lincolnshire CCG.

The Chief Officer introduced the report and brought to the Committee's attention the Appendices attached to the report. Appendix A provided a copy of the Annual Report and Accounts 2017/18 for South Lincolnshire CCG; and Appendix B provided a copy of the Annual Report and Accounts 2017/18 for South West Lincolnshire CCG.

The Committee noted that John Turner was the Chief Officer for both South Lincolnshire CCG and South West Lincolnshire CCG. The report highlighted that each clinical commissioning group had a statutory duty to produce an annual report and accounts.

The Committee noted further that South Lincolnshire CCG had a population 162,000; and a budget of £229 million; and South West had a population of 133,000; and a budget of £182 million. It was highlighted that each of the CCGs had differing leadership responsibilities; details of which were contained within Appendix A and B attached to the report. It was highlighted further that the Appendices contained historical data up to 31 March 2018.

During discussion, the Committee raised the following issues:-

- One member enquired whether GP extended hours had made a difference to the number of people turning up at A & E. The Committee was advised that surprisingly more patients had turned up at A & E; as the focus had been changed to pre-booked appointments, with same day access;
- One member enquired whether there was any control through the 'Choose and Book' system to keep patients in Lincolnshire, rather than attending hospitals in bordering counties. The Committee was advised that many people in Lincolnshire lived close to borders and chose to use health facilities out of Lincolnshire, as that was their closest hospital, and likely to be their preferred hospital. It was highlighted that there was no intention on the part of the NHS to change this. The emphasis of the work was to provide more care

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in local communities, so that fewer people actually needed to go in to hospital. It was also highlighted that it was in the CCGs interest to ensure that the population of Lincolnshire received the best care possible; where the care was received was not an issue. It was highlighted that the Patient Charter ensured that patients had choice; and to the fact that Lincolnshire never had sufficient health funding; in relation to using hospitals in neighbouring counties, it was emphasised that health funding was not for Lincolnshire NHS organisations, but for the care of Lincolnshire people, wherever that might be;

- Page 128 – Some concern was expressed that the Bar Chart on page 128 appeared inaccurate. It was also highlighted that there was a lack of information for members of the public to compare GP services in their area with other GP areas. The Committee was advised that there was more information available for the public to view on GP services than there had been previously. The Committee was reminded that the information presented in the annual reports was for 2017/18 and was therefore historical. The Committee was advised that there was a primary care dashboard, from which comparison information could be made available from; and that this was an area that was being looked at, as to what information could be placed in the public domain. The Chief Officer advised that he was delighted with the quality of GP Practices in the South Lincolnshire and South West Lincolnshire CCGs;
- Page 75 – One member expressed concern that mental health patients in the more rural areas did not have the same services available to them as in the more urban areas. The Committee was advised that lots of work was going on with dementia care; and as part of that work Neighbourhood Teams initiative staff were actively searching and visiting those with dementia to make sure that the necessary care plans were in place. The Committee was also advised that work was being undertaken with a cohort of patients under the Transforming Care Project for Learning Disabilities. Work was also being done to offer facilities in Lincolnshire, so as to prevent patients going out of County;
- One member enquired as to what could be done to reduce the number of missed appointments. Confirmation was given that the issue of missed appointments was a national issue; and that some measures were already in place to try and reduce the number, for instance a text message reminding the patient of their appointment;
- What the most significant challenge was for South Lincolnshire CCG. The Committee was advised that workforce was the biggest challenge, having staff available in the right place at the right time;
- What the most significant challenge was for South West Lincolnshire CCG. The most significant challenge highlighted from the SWLCCG was finance, as there were no reserves left; and that there were significant challenges ahead to make savings;
- As the report presented related to historical data, a question was asked whether so far for 18/19, had there been any improvements in the RAG rating. Then Committee was advised that there had not been any significant improvements in the RAG rating; and
- Reference was made to commissioning under sustainable development, where it had mentioned the stopping of services. A question was asked as to

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what services these might be; and whether some had already been stopped. The Committee was advised that no services had been stopped the services were just being re-shaped.

The Chairman on behalf of the Committee extended thanks to the representatives.

RESOLVED

1. That the Annual Report for 2017/18 for the South Lincolnshire and South West Lincolnshire CCG's be noted.
2. That an update on the RAG Rating be presented to a future meeting of the Committee; along with a copy of the improvement plan.

66 NON-EMERGENCY PATIENT TRANSPORT - THAMES AMBULANCE SERVICE LTD

The Chairman welcomed to the Committee Mike Casey, Director of Operations, Thames Ambulance Service Ltd and Andy Hill, Contract Manager, Thames Ambulance Service Ltd.

A copy of the "To Follow" report had been emailed to members of the Committee prior to the meeting and a hard copy of the aforementioned report was circulated at the meeting.

The Director of Operations guided the Committee through the journey of Thames Ambulance Service Limited (TASL) had made since taking over as provider of the non-emergency patient transport services in Lincolnshire on 1 July 2017. Details of which were shown within the report represented.

The Committee noted that originally there had been 900 complaints outstanding of which 369 had related to Lincolnshire. It was noted that to date there was two outstanding complaints, one of which had been upheld; and one that was still on going.

The Committee was advised that TASL had been inspected by the Quality Care Commission (CQC) in November 2018, and that TASL was working with NHS England and the CQC prior to publication of the final report. The Committee was advised further that TASL continued to work with the CQC and the Commissioners.

It was reported that the performance KPIs had not achieved the expected trajectory since the 12 September 2018 Health Scrutiny Committee for Lincolnshire meeting. The Committee was advised that the two main factors for this were data collection and staff attrition, as the service was carrying a number of vacancies. The Committee noted that TASL had lost a number of staff as a result of the recent NHS ambulance recruitment drive; TASL had found it hard to keep up with the staff turnover. The Committee was advised further that TASL had brought in additional third party support and taxis to support the service, but these had not been always as efficient. It was reported that TASL was trying alternative ways to increase its

recruitment drive. It was noted that TASL had appointed seven apprentices working in partnership with Lincoln College, in addition to this, agreement had been reached for TASL to utilise the NHS jobs website; and that there was a rolling recruitment drive for front line staffing in Lincolnshire.

The Committee was advised that the Operations Team remained focussed on delivering the action plan which underpinned attainment of improvement in KPI performance.

It was highlighted that in October 2018, performance had dropped against all contract performance indicators; and that the reason for this had been the current contract reporting process. The Committee noted that a new reporting process had commenced in early October 2018, which had led to some issues relating to data capture. The Committee noted further that contractual requirements had meant that TASL had to continue to report performance and where there was no recorded time the contract dictated that this was a failed journey.

The Committee was advised by TASL that by April 2019, 8 of 18 of the KPIs would be on target; and by June 2019, 15 out of the 18 KPIs would be on target.

Reassurance was given that a lot had been achieved during the course of the journey and that there was recognition that more could be done, one of which was using resources more efficiently.

During discussion, the Committee raised the following points:-

- One member highlighted that the performance data provided was very difficult to understand. The Committee was advised that the purpose of the red/green was that the KPI was either achieved or not achieved. It was highlighted that the amber indicator was for internal use only;
- One member extended thanks to the Director of Operations for his openness; and questioned how TASL were going to address the issue of EMAS recruiting ambulance personnel. The Committee was advised that certain things had already been achieved, for example a fixed number of staff for contracts; and the implementation of a rolling recruitment programme. It was highlighted there had also been links with EMAS; and linking with Lincoln College with regard to apprenticeships;
- Clarification was given that there were currently only two outstanding complaints for Lincolnshire patients. It was highlighted that so far for November only three complaints had been received;
- Accuracy of Data – The Committee was advised that for renal services there had been data issues, and the system had not captured time; these had been entered in manually. It was highlighted that the move forward to the on-line platform would be more accurate on point of delivery. Clarification was given that for November TASL could not confirm if the recording system had worked satisfactorily. There was recognition that moving forward performance needed to be recorded accurately;
- One member enquired whether there were any cultural issues. The Committee was advised that there were variants as there were five different contracts. The

Committee was advised that the workforce's opinions had changed and that now there was a feeling of being part of a team, which was evident in Lincolnshire; and that staff wanted to stay with TASL;

- Improvement – The Committee was advised that the CQC had recognised that there had been some improvement, however, they did have concerns; and as a result a lot of work had been put into the action plan. It was stated that if there was to be another CQC inspection, it would highlight that things had improved; and
- Recruitment – A question was asked as to whether volunteers would be considered for paid work. The Committee was advised that the opportunities were there and anyone was free to apply. Most volunteers liked doing what they were doing, as they liked the flexibility; which also helped TASL with extra capacity.

In conclusion, the Chairman in summing up expressed concern at the continued low performance levels. Whilst there was an understanding of why performance had dropped as a result of the new reporting system, there were frustrations that the system had not been tested enough prior to going live. Further concern was expressed that again no papers had been received to send out with the agenda for the Committee to consider; and to the on-going problems since TASL had taken over the contract; and to the fact that there was still not an agreed performance recovery action trajectory agreed by commissioners.

As a result of the concerns raised the Chairman advised he had no confidence in TASL being able to deliver a good enough service for the residents of Lincolnshire and the Committee agreed that a letter should be written to Lincolnshire West CCG (the lead CCG commissioner) advising them that the performance of TASL was unacceptable and requesting that the CCGs should seriously consider a managed strategic exit from the contract as soon as possible; and that representatives from Lincolnshire West CCG should be invited to attend the next Health Scrutiny Committee for Lincolnshire meeting to respond to the issues raised.

RESOLVED

1. That the Health Scrutiny Committee for Lincolnshire record that it had no confidence in TASL being able to deliver a good enough non-emergency patient transport service for the residents of Lincolnshire.
2. That a letter be written to Lincolnshire West CCG advising them that the performance of TASL was unacceptable and that the Lincolnshire CCGs should seriously consider a managed and strategic exit from the contract as soon as possible.
3. That representatives from Lincolnshire West CCG be invited to attend the next Health Scrutiny Committee for Lincolnshire meeting due to be held on 23 January 2019 to respond to the issues raised.

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 could be of greatest benefit.

The Committee gave consideration to the work programme as detailed on pages 138/139 of the report presented.

During discussion one member requested that Dental Services (including an update on dental services in Mablethorpe) should be included as an agenda item on the 23 January 2019 meeting. The Chairman advised that it had been included on the March agenda as no response had been received. In response to an enquiry as to whether a response would be received from the Secretary of State for Health and Social Care regarding Grantham Accident and Emergency Department in readiness for the January meeting, it was stated that at the moment it was unknown whether a response would be received or not.

A further item suggested for consideration was the Pain Management Service. It was felt that an update could be given as part of the Chairman's Announcements.

The issue of NHS Workforce was also raised; and when it was likely to be scheduled as an item as Healthwatch was also doing some work on this matter. The Committee was advised that the intention was that this item would be considered as part of the United Lincolnshire Hospitals NHS Trust report at the 23 January 2019 meeting.

RESOLVED

That the work programme presented be agreed subject to the changes as detailed above.

The meeting closed at 1.05 pm

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Agenda Item 4

		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:	23 January 2019
Subject:	Chairman's Announcements

1. United Lincolnshire Hospitals NHS Trust – Stroke Services

United Lincolnshire Hospitals NHS Trust has advised that its stroke services are fragile due to a national shortage of stroke doctors. This means the Trust struggles to provide a sustainable service across two sites, with two separate on-call rotas, while trying to meet national standards. Following a review into possible interim solutions, it has been proposed to change the on-call arrangements at weekends and public holidays from February 2019. The Trust has advised that this proposal would see one team alternating between the Lincoln and Boston sites, creating a safer and better experience for stroke patients, a viable on-call rota for stroke consultants and will also help to recruit new stroke consultants to current vacancies at the Trust.

2. NHS Dental Services in Lincolnshire

On 21 December 2018, the Locality Director (North) from NHS England, Midlands & East (Central Midlands), issued an update on dental services across Lincolnshire following the recent procurement processes. The update stated:

"As you will be aware, the Central Midlands Local Office developed commissioning intentions based on the Oral Health Needs Assessment and Commissioning Strategy recommendations to improve access to NHS dental services in identified priority areas. You will be aware from the stakeholder briefing that was distributed in July that the procurement process resulted in the following contract awards:

8 to 8 Service:

Lincoln
Sleaford
Spalding
Preferred Provider – JDSP Dental Ltd

Extended Access:

Spalding (Johnson Community Hospital)
Preferred Provider – Community Dental Services CiC
Boston - Preferred Provider – JDSP Dental Ltd

"Following notification of the procurement outcome to the preferred providers and the required standstill period, JDSP Dental Ltd and Community Dental Services CiC moved forward with mobilising the new services in readiness for the agreed start date of 7 January 2019.

"I am pleased to advise that JDSP Dental Limited (known as Treeline Dental) will open two new NHS dental practices to commence delivering services between 8am to 8pm, 365 days a year from 7 January 2019 at two new dental practices, and these are currently being advertised via local media. The two practices are located at: -

- 361/362 High Street, Lincoln, LN5 7RL
- 86A Southgate, Sleaford, NG34 7SW

"Regrettably, owing to the difficulties experienced by both JDSP Dental Ltd and Community Dental Services CiC in recruiting qualified dentists, the new services identified for Boston, Spalding and Johnson Community Hospital, Spalding, will not start on 7 January 2019 as originally planned.

"NHS England is disappointed not to have these new services mobilised in January so that patients can access NHS dental services in these areas. We have had frequent meetings with both preferred providers during the mobilisation period and supported them where appropriate. However, despite the preferred providers exploring a number of options, they have not been able to find the workforce required to operate these services safely from 7 January.

"Discussions are now taking place as a priority with the preferred providers, internal colleagues and other stakeholders to consider alternative models of service delivery and workforce solutions. This will enable us to understand the local context and the impact of any alternative approaches before we consider next steps.

"I am pleased to advise that Community Dental Services CiC and other local providers in Spalding have confirmed they are able to continue with the interim urgent dental service that is currently in place. This means patients will be able to access urgent dental care if needed, although we do acknowledge the importance of ensuring patients are also able to access routine dental care.

"You will also be aware that unfortunately Bupa Dental Care has decided to withdraw from provision of NHS dental services in Mablethorpe and have given us the required three-month notice period to end their contract on 8 February 2019. NHS England is disappointed with Bupa Dental Care's

decision, which they have attributed to their difficulty in recruiting and retaining qualified dentists.

"We are currently reviewing our options for patients to access urgent dental care as a minimum in Mablethorpe and will be looking at an interim solution similar to that which we have put in place in Spalding whilst we consider our longer-term plans in the light of the discussions mentioned above. Further updates will be provided in the New Year as discussions progress."

3. NHS England and NHS Improvement - Joint Management Arrangements

On 12 December 2018, as part of the item on the *NHS Long Term Plan – Impact on Lincolnshire Sustainability and Transformation Partnership*, the Committee was advised that NHS England and NHS Improvement had announced a new joint leadership team. Further information on the announcement, made on 11 December 2018, is set out below:

NHS England and NHS Improvement will share a combined management group, referred to as the *NHS Executive Group*, which will jointly chaired by the two chief executives: Simon Stevens, Chief Executive of NHS England and Ian Dalton, Chief Executive of NHS Improvement. The Executive Group will also comprise: -

- Chief Financial Officer
- National NHS Medical Director
- Chief Nursing Officer
- Deputy Chief Executive, NHS England
- National Director for Emergency and Elective Care
- National Director for Transformation and Corporate Development
- Chief Commercial Officer
- Chief Improvement Officer
- Chief People Officer
- Chief Provider Strategy Officer
- Seven Regional Directors: -
 - East of England
 - London
 - Midlands
 - North East and Yorkshire
 - North West
 - South East
 - South West

Lincolnshire lies within the Midlands Region and Dale Bywater has been appointed as the Midlands Regional Director.

Under the new structure, the seven integrated regional teams will make decisions on how best to assure and support performance in their region, as well as supporting local system transformation.

The corporate teams will provide specialist support and expertise to the regional teams, as well as taking a national lead on their areas. As part of this, NHS England and NHS Improvement have announced they are cutting their running costs by a further 20%.

The *NHS Executive Group* is due to hold its first meeting in January 2019, with the new national and regional directors expected to formally lead their integrated directorates by April 2019.

As indicated to the Committee on 12 December, previously NHS England had overseen CCGs as commissioners, and NHS Improvement had overseen NHS providers and at times these separate roles led to some inconsistency. One of the benefits of the new integrated approach should be a consistent approach in each local area.

4. A Review of the Role and Costs of Clinical Commissioning Groups - National Audit Office Report

On 18 December 2018, the National Audit Office published a report entitled: *A Review of the Role and Costs of Clinical Commissioning Groups*. The full report is available on the National Audit Office website:

<https://www.nao.org.uk/report/a-review-of-the-role-and-costs-of-clinical-commissioning-groups/>

The National Audit Office report includes the following conclusions:

"CCGs were created from the reorganisation in how healthcare services are commissioned in the NHS. They were designed to give more responsibility to clinicians to commission healthcare services for their communities and were given resources to do this. NHS England's assessment of CCGs' performance shows a mixed picture. Over half of CCGs were rated either 'outstanding' or 'good', but 42% (87 of 207) are rated either 'requires improvement' or 'inadequate', with 24 deemed to be failing, or at risk of failing. Many CCGs are struggling to operate within their planned expenditure limits despite remaining within their separate running cost allowance. Attracting and retaining high-quality leadership is an ongoing issue.

"There has been a phase of CCG restructuring with increased joint working and some CCGs merging. If current trends continue, this seems likely to result in fewer CCGs covering larger populations based around STP footprints. This larger scale is intended to help with planning, integrating services and consolidating CCGs' leadership capability. However, there is a risk that commissioning across a larger population will make it more difficult for CCGs to design local health services that are responsive to patients' needs, one of the original objectives of CCGs.

"CCGs have the opportunity to take the lead in determining their new structures. NHS England is expected to set out its vision for NHS commissioning in its long-term plan for the NHS to be published in

December 2018. NHS England has said it will step in where CCGs diverge from its vision of effective commissioning. However, it has not set out fully the criteria it will use to determine when to step in.

"Our previous work on the NHS reforms brought in under the Health and Social Care Act 2012 highlighted the significant upheaval caused by major organisational restructuring. It is therefore important that the current restructuring of CCGs creates stable and effective organisations that support the long-term aims of the NHS. Following almost three decades of change, NHS commissioning needs a prolonged period of organisational stability. This would allow organisations to focus on transforming and integrating health and care services rather than on reorganising themselves. It would be a huge waste of resources and opportunity if, in five years' time, NHS commissioning is going full circle and undergoing yet another cycle of restructuring."

5. Humber Acute Services Review

On 31 December 2018, the Humber Acute Services Review issued an update on their review, which is currently focusing on six service areas:

- Cardiology
- Critical Care
- Stroke
- Neurology
- Complex Rehabilitation
- Haematology/Oncology

The Humber Acute Services Review is part of the Humber, Coast and Vale Sustainability and Transformation Partnership (STP) and includes a review of services at Diana Princess of Wales Hospital Grimsby, and Scunthorpe General Hospital, both of which are widely used by Lincolnshire residents. More information can be found at: www.humbercoastandvale.org.uk/humberacutereview

The Humber, Coast and Vale STP is holding a number of patient workshops and would like to involve as many current and former patients, their families, friends and carers, so future services are designed in a way that meets the needs of local patients.

Two patient involvement workshops on cardiac and critical care are taking place at the end of January. One of these workshops will be held at the Pelham Suite, Cambridge Road, Grimsby, DN34 5SZ on 28 January, 9.30 to 11.30 am. The other workshop will be held near Hull.

Further workshops will take place in February on stroke, neurology and complex rehabilitation. These will be advertised on the Humber, Coast and Vale STP website when dates have been confirmed.

If a member of the Committee wishes to attend the first workshop on 28 January, please contact the Health Scrutiny Officer (Simon.Evans@lincolnshire.gov.uk) for details.

6. United Lincolnshire Hospitals NHS Trust – Appointment of Chair

On 9 January 2019, NHS Improvement announced the appointment of Elaine Baylis as the permanent Chair of United Lincolnshire Hospitals NHS Trust (ULHT) until 31 December 2021. Elaine Baylis had been interim Chair of the Trust since January 2018, and will also continue in her role as Chair of Lincolnshire Community Health Services NHS Trust, running alongside her role at ULHT. Elaine is currently chair of the Lincolnshire Co-ordinating Board, which includes chief executives and chairs of NHS organisations in the county and provides oversight of the local health and care system, as well as the implementation of Lincolnshire's Sustainability and Transformation Partnership (STP).

Agenda Item 5

		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:	23 January 2019
Subject:	United Lincolnshire Hospitals NHS Trust – Update on Care Quality Commission Inspection

Summary:

This paper provides an update on United Lincolnshire Hospitals NHS Trust (ULHT) progress with the response to the Care Quality Commission inspection.

Actions Required:

The Health Scrutiny Committee is asked to: -

- 1) Note the Care Quality Commission's findings.
- 2) Note the progress from United Lincolnshire Hospitals NHS Trust has made in improving quality and safety since the inspection in February and April 2018 and the update to the committee in September 2018.

1. Background

1.1 Introduction

The Care Quality Commission (CQC) inspected the United Lincolnshire Hospitals NHS Trust (ULHT) between Thursday 15 February and Thursday 8 March 2018. A further separate 'well-led' assessment took place between Tuesday 10 April and Thursday 12 April 2018. Subsequent visits to Pilgrim Hospital Emergency Department occurred on 30 November 2018 and 18 December 2018.

The Trust developed and submitted an improvement plan to the CQC at the end of July 2018 containing ten work programmes. The Trust's process for delivering and monitoring progress against the Quality and Safety Improvement Plan (QSIP) remains the same as 2017/18. Individual Executive Directors hold responsibility for each of the work programmes. The QSIP plan is scrutinised on a weekly basis and presented to the Quality Safety Improvement Board bi-weekly and to the Quality Governance Committee (QGC) monthly. Upward escalation of issues to Trust Board happens via QGC.

1.2 Trust Progress

The detail for each work programme can be seen at Appendix A. As a result of further considerations of patient safety, in December 2018 the Trust added a further two work programmes to the QSIP: QS11Hospital at Night and QS12 Medical Devices.

The Trust is making positive progress against the work programmes with some areas achieving significant improvements. The Trust's milestone plan is at Appendix B. Specific areas of improvement include:

- **Safety Culture:** Peer support through a buddying arrangement is being provided from Northumbria Healthcare NHS Foundation Trust. Reciprocal visits, conversations and reviews of working practices and procedures between groups of the two trusts' staff have been undertaken. This has included a reciprocal extended three day visit by six ward sisters from both trusts. The buddying arrangements have been well received with improvement opportunities and learning identified and by both organisations. Further Board to Board conversations and visits are being planned.
- **Governance:** Greater transparency has been developed across ULHT's governance structure and teams. This has resulted in improved compliance against legislative requirement of Duty of Candour and resolution of the backlog of all outstanding Serious Incidents.
- **The Deteriorating Patient:** ULHT alongside partners across Lincolnshire is making significant progress to implement the national ReSPECT programme in 2019.

The CQC inspection report identified a number of 'must do's' and 'should do's'. All these requirements are mapped to individual work programmes and good progress is being made against all. A detailed review of the evidence supporting completion of each requirement is being undertaken in January 2019. Additional supportive action will be agreed for those areas where confidence of attaining the requirement is limited.

The next unannounced CQC inspection is expected early spring 2019. The process to ensure all ULHT staff have an understanding of the format of the inspection is being finalised.

1.3 Identified Challenges

QS04. Delivering urgent and emergency care on the Pilgrim site specifically the Emergency Department was identified as one of the 3 areas requiring significant focus to improve. The challenges identified within the inspection report were all challenges that were known to the trust and improvement work focussed on these concerns with support from partners and regulators. Internal work included the development of an emergency department quality assurance tool which mapped to the trusts accreditation process. Quality assurance accreditation visits commenced at the end of October 2018 and confirmed significant challenges remained with the culture, leadership and in the delivery of patient care. These concerns were discussed extensively by the Trust's Board and additional leadership, financial and staffing resources were put in place. Internal quality assurance accreditation visits are being undertaken monthly with areas of concerns and improvement discussed with the team and escalated.

In November 2018 the CQC revisited Pilgrim Hospital Emergency Department and raised significant concerns. The report pertaining to this visit is in the public domain. As a result of requests by the Trust and the concerns within the CQC inspection report Pilgrim Hospital Emergency Department has been subject to a formal risk summit chaired by NHS Improvement. Whilst the care of patients remains the responsibility of ULHT and the Trust recognises it must improve the quality and safety of patient care within the emergency department, the risk summit was called as system partners have the ability to directly influence and impact on the improvement of the performance of the department.

In December 2018, the CQC revisited Pilgrim Hospital Emergency Department whilst they noted some improvements including nursing and medical staffing levels which matched patient acuity, they remained concerned about the areas raised in the November 2018 inspection.

1.4 Next steps

The performance of Pilgrim Hospital Emergency Department will continue to be monitored daily by ULHT's Executive Directors and Senior Leadership Team. Greater assurance of patient safety and improvement of quality is being sought of the Divisional team by the Trusts Board and through the Risk Summit process and System Improvement Board.

2. Consultation

This is not a direct consultation item although the Committee is asked to consider how it wishes to monitor progress.

3. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Improve the quality and safety of care provided to patients in ULHT.

4. Conclusion

Since the inspection in February 2018 measurable progress has already been made to respond to the CQC's immediate concerns. Details of the individual work programmes within the plan are included at Appendix A and the plan is included at Appendix B.

Peer support will be provided from Northumbria Healthcare NHS Foundation Trust.

Trust Board and System oversight from NHSI is in place following further internal and external inspections of the Pilgrim Hospital Emergency Department.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Quality and Safety Improvement Plan – Work Programmes
Appendix B	Detail of the Quality and Safety Improvement Plan

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 Victoria Bagshaw, who can be contacted on 01522 307320 or victoria.bagshaw@ulh.nhs.uk

QUALITY AND SAFETY IMPROVEMENT PLAN – WORK PROGRAMMES

QS01 - Developing the Safety Culture

Building a consistent safety culture through the delivery of the range of projects within the overall Quality and Safety Improvement Programme.

To ensure that learning from events and SIs is embedded in our governance systems

To ensure that a consistent Quality Improvement Methodology is embedded across all parts of the Trust

To maximise the learning opportunities from the buddying arrangements with Northumbria

QS02 - Governance

Trust-wide review and update to the governance and well led structure, processes, monitoring and assurance. Ensuring that the trust and its staff are able to meet local, statutory and contractual requirements; independently identifying areas of concern and outstanding practice.

Delivery of improvements to governance processes across clinical specialties.

Greater transparency and openness with patients following identification of harm through improvements to duty of candour

Improvements to the well led capabilities of senior leaders across the Trust

Improvements to the trusts meeting and assurance structure and processes

Better recognition, monitoring and mitigation of risk at all levels

QS03 - The Deteriorating Patient

Trust wide review and update to policy, education, practice and performance management to better recognise and rescue the deteriorating patient.

Further improvements in sepsis early recognition and treatment

Identification of patient with AKI and the care required

Maintaining fluid balance

Lessons learned from failure to escalate

Effective communications using SBAR

Recognising failure to escalate deteriorating patients

Implementation of national ReSPECT programme

QS04 - Pilgrim ED

Delivery of an Emergency Department wide improvement plan to ensure that the department delivers consistent high quality care and meets key national performance indicators.

Patient care is delivered within Royal College of Emergency Medicine 'Initial Assessment of Emergency Patients' guidelines.

The department consistently achieves 95% plus 4 hr target.

Patients are cared for by appropriately trained and caring staff.

Quality and experience of patient is consistently positive and measured against agreed parameters.

QS05 - Paediatric Services - Developing and Improving care of the Hidden Child

The programme looks to identify the 'hidden child' across all services within the Trust and then ensure that we are delivering safe, care that identifies and measures the quality of the experience for both the child and their parent or next of kin and how we can further improve

Identify those pathways, services and departments beyond children services, that provide care for children and young people

Identify markers of safe care within these environments

Identify mechanisms within these environments to measure the experiences of children, young people and their families or carers

QS06 - Safe Care

Trust-wide implementation and embedding of Safe Care with 5 individual projects to enable the Trust to robustly demonstrate a consistent approach to SI's and Never Events ensuring learning and quality improvement.

Reduction in SI's and Never events and ability to demonstrate learning

Consistent approach across all sites, all departments in the delivery of evidenced based processes

- positive patient ID

- intentional rounding

- safety Huddles

- handover

- Nasogastric tubes

- responding to never events

QS07 - Safeguarding

Delivery of the safeguarding improvement plan to ensure that the Trust is fulfilling its duties and statutory responsibilities to safeguard and promote the welfare of children, young people and adults who come into contact with our services

Conscious sedation is used appropriately and safely when required.

Patient care is delivered in line with the following policies: Chemical Restraint in the Management of Agitated Patients on General Adult Wards & in A&E Policy; and Clinical Holding & Restraint Policy.

All adults are offered a chaperone for all intimate examinations and children and young people are provided with chaperones.

The Trust is fully compliance with Savile and Bradbury report recommendations.

Pathway is seamless for patients with LD who require access to ULHT services, including those without a ULHT Consultant

Trust is compliant with Child Protection Information Sharing (CP-IS) requirements.

QS08 - Medicines Management

Pharmacy, nursing and medical staff to improve Medicines Management; in order to improve patient safety and reduce harm from medication. Maintain and develop education and training resources relating to Medicines Management for all those undertaking medication related tasks.

Improved culture of medicines safety and learning from incidents

Pharmacy providing a sustainable clinical service

Readily accessible pharmaceutical support for clinical services

Staff knowledge and competence in Medicines Management increased through access to education and training – pharmacy staff, nursing staff and junior doctors

Safer medication supply and administration processes from admission through to discharge

Improved medicines security and safer storage of medicines

QS09 - Mortality Outliers

Focused improvements actions in those areas where the trust is identified as a mortality outlier

Initial work focuses on trust wide review of Perinatal Mortality to identify

- reasons why perinatal mortality is alerting
- What actions are required
- Systematic improvement and embedding changes

QS10 - Data Quality

Delivery of improvements and standardisation to the sources, triangulation, validity and timeliness of data used to support the Trust governance processes

Clarity regarding sources of data used for trust wide information ensuring reliability

Improved validity process including appropriate triangulation

Ward to Board processes uses the same information to analyses and provide improved governance

Improvements to the trusts analytics capabilities

QS11 - Hospital at Night

To review the delivery of ULHT's Hospital at Night structure to ensure that it provides an effective and safe structure to manage patient safety in the out of hours period.

To ensure there is an appropriate governance structure in place

To ensure robust rota management and oversight for nursing and medical staff.

Ensure that the

To seek areas of good practice and adopt them. Learning from external organisations and national recommendations.

To explore the development of a single service, including the ways of working and supporting informatics systems, delivered across multiple sites with clear lines of communication, leadership and management thereby reducing unwarranted variation.

QS12 - Medical Devices

To provide assurance regarding the safety of medical equipment and devices and their use throughout the Trust.

Ensuring that there is a comprehensive up to date register of medical equipment in use across the Trust, which is clear about the equipment owner; the Trust's 'standard' risk rating for each device; and the maintenance status of each device.

Reviewing, annually, the standard risk rating assigned to each Medical device.

Reviewing medical equipment risks on the risk register, providing assurance about how risks are monitored and mitigated.

Giving assurance about actions taken in response to:

- Incidents involving the use of Medical equipment
- Medical device safety alerts
- Patient safety alerts as relevant.

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QUALITY AND SAFETY IMPROVEMENT PLAN (Version 3.0)

Introduction

The purpose of this plan is to define, at a high level, the Quality and Safety Programme and the continuing quality and safety improvement journey ULHT is making, including improvement goals that ULHT will work towards over the next 12 months. The plan includes all of the Compliance Notice requirements and MUST DO recommendations in the CQC Quality Reports. The plan is broader than the specific CQC requirements/recommendations and includes longer-term pieces of work that the trust is pursuing to improve overall quality and safety across the organisation.

The plan outlines the Trust’s overall ambition to improve quality and safety. The plan includes a number of key milestones and these will be reported on at the weekly Quality and Safety Implementation Group, fortnightly Quality and Safety Improvement Board and monthly at the 2021 Programme Board, Quality Governance Assurance Committee and Trust Board. The milestone dates are all the end of the month unless a specific date is recorded. A separate monthly overview report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan below will not change unless specifically agreed by the Quality and Safety Improvement Programme Board.

QS01 - Developing The Safety Culture

SRO: Neill Hepburn

Project Leads: Karen Sleight, Helen Nicholson, Sally Seeley

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS1.1	Staff across the organisation proactively learn and share lessons from incidents and complaints (System 2)	Mar-19	Evidence of newsletters, bulletins, changes in practice, discussions at sharing forums	QS1.1.1	There is regular communication as part of the trusts communication plan	Sep-18	
				QS1.1.2	There is an active feedback loop and discussion with staff following incidents/complaints being reported on Datix	Jan-19	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS1.1.3	There is a network in place where staff can share lessons and experience with each other in a safe environment	Dec-18	
				QS1.1.4	Learning and experience from NHCT is included in ongoing engagement/cascade mechanisms as part of the peer support work	Nov-18	
				QS1.1.5	There is an agreed mechanism to recognise staff who demonstrate good practice in learning and sharing lessons	Sep-18	
QS1.2	An in-house Quality Improvement (QI) Programme is developed and delivered	Dec-18	Full programme prepared for delivery	QS1.2.1	The In-house QI programme is delivered across ULHT sites.	Dec-18	Final sharing event to celebrate the projects / improvement initiatives to be delivered
QS1.3	Quality, Service Improvement and Redesign (QSIR) methodology is adopted by the organisation.	Apr-19	Achievement of Practitioner status - accreditation with NHS Improvement	QS1.3.1	Staff identified and registered on the QSIR Programme at practitioner level.	Apr-18	NHSI has confirmed accredited practitioner level for the named individuals
				QS1.3.2	Staff identified and registered on the QSIR Programme at faculty level.	Aug-18	
QS1.4	There is an exchange programme in place with NHCT to enable staff to gain knowledge, experience and best practice and to share that across the organisation	Mar-18	The individuals from the three cohorts are undertaking pieces of improvement work in their areas	QS1.4.1	The exchange programme is developed	Aug-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS1.4.2	The first exchange cohort have completed the programme	Sep-18	
				QS1.4.3	The first exchange cohort experience is evaluated and changes to the programme made as necessary	Oct-18	
				QS1.4.4	The second exchange cohort have completed the programme	Nov-18	
				QS1.4.5	The third exchange cohort have completed the programme	Feb-18	

QUALITY AND SAFETY IMPROVEMENT PLAN (Version 3.0)

Introduction

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The plan outlines the Trust’s overall ambition to improve quality and safety. The plan includes a number of key milestones and these will be reported on at the weekly Quality and Safety Implementation Group, fortnightly Quality and Safety Improvement Board and monthly at the 2021 Programme Board, Quality Governance Assurance Committee and Trust Board. The milestone dates are all the end of the month unless a specific date is recorded. A separate monthly overview report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan below will not change unless specifically agreed by the Quality and Safety Improvement Programme Board.

QS02 - Governance

SRO: Kevin Turner (Overarching) / Karen Brown (Corporate) / Neill Hepburn (Clinical)

Project Leads: Jayne Warner (Corporate) / Sally Seeley & Paul White (Clinical)

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS02a - Corporate Governance SRO: Karen Brown Project Lead: Jayne Warner							
QS2.1	The organisation has a Board Assurance Framework which is aligned to the organisations objectives and allows Board Committees to discharge their responsibilities	Nov-18	Board Assurance Framework report presented at Trust Board	QS2.1.1	The format of the Board Assurance Framework is fit for purpose and associated action plans are in place	Oct-18	Interim Head of Internal Audit Opinion stage 2 work gives positive assurance on Board Assurance Framework

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.1.2	Robust governance, reporting, challenge and scrutiny processes are established surrounding the Board Assurance Framework	Oct-18	Interim Head of Internal Audit Opinion work stage 2 gives positive assurance on Board Assurance Framework
				QS2.1.3	The Board Assurance Framework is aligned with the organisations corporate risk register and wider risk management arrangements.	Nov-18	Interim Head of Interim Audit Opinion work stage 2 gives positive assurance on Board Assurance Framework
				QS2.1.4	The Board has an agreed risk appetite which is described in the Risk Strategy.	Nov-18	Description of risk appetite in approved Trust risk strategy.
				QS2.1.5	Roles and responsibilities for the Board Assurance Framework and wider risk ownership are clearly described in the Board Assurance Framework and Escalation Policy document	Nov-18	Published Board Assurance Framework and Escalation Policy and Risk Strategy and Policy
QS2.2	Board Committees and Sub Committees have clearly defined roles and responsibilities which have eliminated overlap or omission.	Jan-19	Full set of revised TOR that have all been approved at Trust Board	QS2.2.1	Objectives are agreed and formally recorded for all Board Committees	Oct-18	Board Committees are operating to published objectives.
				QS2.2.2	Roles and responsibilities for each Board Committee based on objectives are defined and described in their ToR.	Sep-18	Revised ToR published and in use.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.2.3	Board Committee agenda and work plans have been structured to align with the Committee objectives and the Board Assurance Framework	Oct-18	Revised agenda and work plans in use at Board Committees.
				QS2.2.4	The Board and Committees have agreed the required sub committees/groups to support the assurance arrangements	Oct-18	Structure chart showing Board Committees and reporting committees/groups published on intranet.
				QS2.2.5	Board Committees have reviewed ToR relating to all of their reporting sub committees/groups	Nov-18	Minutes from Board Committees demonstrating sign off of ToR for reporting committees/groups
QS2.3	Corporate Governance Cornerstone documents and policies are all current, available to staff and in use.	Nov-18	Published, up-to-date documents available	QS2.3.1	Standing Orders, Standing Financial Instructions and Scheme of Delegation reviewed to align with interim management arrangements and best practice	Oct-18	Draft documents to present to Audit Committee
				QS2.3.2	Standing Orders, Standing Financial Instructions and Scheme of Delegation approved by Audit Committee	Oct-18	Audit Committee minutes from Oct 18 meeting
				QS2.3.3	Standing Orders, Standing Financial Instructions and Scheme of Delegation approved by Trust Board	Nov-18	Trust Board minutes

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.4	Agreed framework in place for Trust corporate and clinical policy management	Mar-19	Up-to-date policies are available	QS2.4.1	Stock take of existing corporate and clinical policies complete and cleansing exercise concluded	Feb-19	Refreshed list of all remaining policies
				QS2.4.2	Governance arrangements for the development, approval, review and dissemination of policies are in place.	Feb-19	Approved, published Policy on policies document.
				QS2.4.3	Document classification terms agreed and published	Feb-19	Approved, published Policy on policies document.
				QS2.4.4	Policy group re-established	Feb-19	Minutes of policy group meetings
				QS2.4.5	Agreed Trust approach for managing and maintaining policies and keeping them fit for purpose.	Mar-19	Policy owners and Exec Directors advised of responsibilities in respect of management of policies.
				QS2.4.6	Minimum quality standards for policy compliance and monitoring arrangements are in place.	Jan-19	Quality standards for policy compliance and monitoring documented in approved policy on policies document.
				QS2.4.7	Agreed process of escalation for non compliance documented	Jan-19	Quality standards for policy compliance and monitoring documented in approved policy on policies document.

QS02b - Clinical Governance

SRO: Neill Hepburn

Project Lead: Sally Seeley and Paul White

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.5	Incident management systems and processes that are lean, practical, widely understood and consistently applied.	End of January 2019	Incident Management Policy with supporting guidance and documentation.	QS2.5.1	Clear guidance on incident reporting using Datix that is made available to all staff.	End of August 2018	Copy of guidance document; intranet screenshot showing publication.
				QS2.5.2	Revised policy and processes for incident reporting and investigation.	End of December 2018	Policy & guidance documents; minutes of meeting where approved.
				QS2.5.3	Integration of revised policy requirements for incident management within directorate and specialty governance arrangements.	End of January 2019	Directorate & specialty governance reports.
QS2.6	Serious Incident (SI) management systems and processes that are consistent with the national framework and support effective learning.	End of January 2019	Serious Incident section of Incident Management Policy; supporting documentation for SIs.	QS2.6.1	Backlog of overdue SI investigations is cleared.	End of June 2018	Data extract from Datix showing number of overdue SI investigations is below 20 (agreed with NHSI).
				QS2.6.2	Pilot revised SI management process at LCH.	End of July 2018	SI process flow chart.
				QS2.6.3	SI management processes are reviewed against updated national frameworks for SIs & Never Events and requirements are incorporated within Trust policy.	End of December 2018	SI & Never Events sections of Incident Management Policy clearly reference national framework.
				QS2.6.4	Introduction of dedicated, centralised SI support team.	End of January 2019	SI support team established & recruited to within Clinical Governance.

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Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.7	Risk management systems and processes that are widely understood, supporting and informing good governance and decision making.	End of December 2018	Risk management reports to Trust Board & Committees; Internal audit review of risk management (Substantial level of assurance).	QS2.7.1	Up to date and approved risk management policy & strategy.	End of August 2018	Strategy & policy documents & minutes of Trust Board.
				QS2.7.2	Establishment of comprehensive corporate and operational risk registers aligned to core objectives and the Board Assurance Framework (BAF).	Nov-18	Corporate and operational risk registers; BAF.
				QS2.7.3	Establishment of clear, regular reporting on risk through the Trust's governance arrangements to ensure the Board is appropriately informed as to the extent of its risk exposure and assured that risk management processes are effective.	End of November 2018	Copies of reports to Trust Board, assurance committees & executive-led groups.
				QS2.7.4	QS2.7.4 Provision of direct support and guidance to all clinical and corporate directorates to facilitate routine use of their new risk registers and risk reporting.	End of December 2018	Record of attendance at directorate governance / management meetings.
QS2.8	A Datix system that supports revised policy and process requirements for incident, risk, complaints and claims management.	End of January 2019	Screenshots from Datix modules & 'recent changes' page of intranet.	QS2.8.1	Up to date Datix intranet page providing practical guidance, system development updates and contact details.	End of July 2018	Intranet screenshots & 'recent changes' section.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.8.2	Expansion of DatixWeb to include 'Dashboards', 'Claims' & 'Complaints' modules.	End of July 2018	Datix invoices, screenshots & 'recent changes' section.
				QS2.8.3	Implementation of management 'Dashboards' module for DatixWeb.	End of September 2018	Datix screenshots & 'recent changes' section.
				QS2.8.4	Datix system is consistent with approved changes to risk management policy & documents are linked.	End of September 2018	Datix screenshots & 'recent changes' intranet updates.
				QS2.8.5	Implementation of 'Claims' module for DatixWeb.	End of October 2018	Datix screenshots & 'recent changes' intranet updates.
				QS2.8.6	Implementation of 'Complaints' module for DatixWeb.	End of November 2018	Datix screenshots & 'recent changes' intranet updates.
				QS2.8.7	Datix system is consistent with approved changes to incident management policy & documents are linked.	End of January 2019	Datix screenshots & 'recent changes' intranet updates.
QS2.9	Risk & incident management training that meets organisational and individual needs is routinely made available to all relevant staff.	End of March 2019	Training availability / advertisements, training needs analysis & attendance / completion records.	QS2.9.1	Introduce regular provision of introductory risk & incident management training for junior doctors Foundation Programme.	End of June 2018	Training advertisement, attendance records & feedback forms.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.9.2	Delivery of 'Hearts & Minds' training in incident management & Duty of Candour.	End of July 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.3	Introduce regular provision of introductory risk & incident management training for the nursing Preceptorship Programme.	End of September 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.4	Delivery of a 2-day Serious Incident investigator training course.	End of October 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.5	Development & introduction of regular (quarterly) risk management training as part of Core Management Skills (M3 - Improving services).	End of November 2018	Training advertisement, attendance records & feedback forms.
				QS2.9.6	Datix system and user training tailored to specific role profiles.	End of December 2018	Training attendance / completion records.
				QS2.9.7	Development & introduction of regular provision of incident management & SI investigation training.	End of March 2019	Training advertisement, attendance records & feedback forms.
QS2.10	Establishment of a dedicated Duty of Candour resource hub on the Trust intranet	End of September 2018	Screen shot of intranet page.	QS2.10.1	Review and update of current Duty of Candour intranet page content.	End of July 2018	Screen shot of intranet page.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.10.2	Develop a 'case studies' section of the intranet page to enable Trust good practice stories and advice to be shared.	End of September 2018	Screen shot of intranet page.
QS2.11	Up to date and published policy and guidance on Duty of Candour.	Oct-18	Policy and guidance documents published on trust intranet	QS2.11.1	Review and update the existing Duty of Candour / Being Open Policy. Ensure consistency with Regulation 20 & that responsibilities are made clear.	End of October 2018	Approved policy & guidance documents.
QS2.12	Up to date training on Duty of Candour available to all relevant staff.	Dec-18	Screenshots from intranet & copies of training materials (e-learning and classroom).	QS2.12.1	Develop bespoke Trust e-learning on Duty of Candour & include as either Core or Core Plus (tbc) mandatory training	End of October 2018	Screenshot of Core / Core Plus training on intranet. Copy of e-learning materials.
				QS02.12.2	Incorporate up to date Duty of Candour training in classroom-based incident management training courses.	Dec-18	Incident management training materials.
QS2.13	A Datix system that supports the Duty of Candour requirements.	Jan-19	Datix screenshots.	QS2.13.1	Review and update Datix system fields to correspond with Regulation 20 and NHS Standard Contract requirements.	End Aug 18	Datix screenshots.
				QS2.13.2	Link to up to date Trust policy and guidance on DoC through Datix.	Nov-18	Datix screenshots.
				QS2.13.3	Review processes for gaining staff access to Datix and introduce role-based access controls for all users.	Jan-18	Copy of protocol for role based access to Datix.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS2.14	Effective performance management of Duty of Candour compliance is firmly established as part of directorate performance reviews.	End of January 2019	Compliance rates; performance improvement action plans for directorates.	QS2.14.1	Establish that the Trust is recording and reporting on the correct DoC compliance requirements through Datix.	End of July 2018	Copy of regular compliance data provided from Datix.
				QS2.14.2	Identify a Duty of Candour Champion for each Directorate (responsible for driving local compliance).	Aug-18	Details of named Champions for each directorate.
				QS2.14.3	Review effectiveness of DoC performance management.	Jan-18	Action plans and minutes from performance review meetings
QS2.15	There is an agreed governance team structure with leadership posts appointed	Dec-18	Agreed structure with named leaders / team members in post or appointed	QS2.15.1	The proposed structure is reviewed, revised and finalised by the newly appointed Associate Director of Clinical Governance (commenced in post 03/09/18)	Oct-18	Finalised version of structure for consultation
				QS2.15.2	Following the steps outlined within the Trusts Change Management Policy (2014), consult with staff about the proposed structure for Governance	Nov-18	New governance structure consulted upon and ready for implementation
				QS2.15.3	Following the steps outlined within the Trusts Change Management Policy (2014), implement the new structure for Governance	Dec-18	New governance structure implemented and posts filled

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Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.15.4	There is clarity on the functions / roles / responsibilities of the Clinical Governance Team which is understood across the organisation	Dec-18	Document showing functions
QS2.16	ULHT Governance, Assurance and Performance Framework is in place across the Trust	Dec-18	Framework document	QS2.16.1	ULHT Governance, Assurance and Performance Framework is formally agreed	Sep-18	Framework document
				QS2.16.2	Existing meeting infrastructure is identified	Sep-18	
				QS2.16.3	New meeting structure agreed	Oct-18	
				QS2.16.4	The framework narrative and communications materials are prepared (including SOPs)	Nov-18	
				QS2.16.5	The ULHT Governance, Assurance and Performance Framework is launched across the organisation	Nov-18	
				QS2.16.6	The Quality and Safety Oversight Group (QSOG) is established and meeting regularly	Nov-18	1. QSOG Terms of Reference, agenda, minutes and action logs. 2. Assurance and Escalation reports to Quality Governance Committee and Clinical Management Board

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.16.7	Structures and processes for Governance Meetings to be standardised, established and embedded across all levels of the new Trust Operating Model (Speciality, Clinical Business Unit and Division)	Dec-18	Minutes of governance meetings at Speciality, Clinical Business Unit and Division Evidence of escalation of concerns from speciality upwards (to appropriate level group / Committee) which can be tracked and traced Evidence of flow of information downwards which can be tracked and traced
				QS2.16.8	Assessment of current compliance with the Clinical Governance Toolkit (for specialities) undertaken	Oct-18	Report of performance / compliance at speciality level
				QS2.16.9	Assessment of current compliance against the revised, standardised process for governance meetings within the Trust Operating Model(Specialty, Clinical Business Unit or Divison)	Jan-19	Report of performance / compliance

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS2.16.10	Improvement and sustainability plans are in place for any governance meetings within the Trust Operating Model (Speciality, Clinical Business Unit or Division) deemed to be not compliant with the revised process	Feb-19	Improvement and sustainability plans
				QS2.16.11	Governance processes are established and functioning on a Trust wide basis	31/03/2019	Formal, documented assessment of compliance against process.
QS2.17	To refresh the Trust's current Quality Impact Assessment (QIA) Process to ensure it is effective, embedded and offers assurance to the organisation that all improvement works have a QIA.	Apr-19	Completed and approved QIA for each improvement work.	QS2.17.1	To review and update the Trust's Quality Impact Assessment Policy.	Jan-19	Completed QIA Policy.
				QS2.17.2	Bi-Monthly highlight report to be submitted to Quality Governance Committee (QGC) to assure that the QIA Process is effective and embedded.	Jan-19	Submission of highlight report to QGC.
				QS2.17.3	Communications exercise to be undertaken Trust Wide to embed the updated Quality Impact Assessment Process.	Jan-19	Newsletter, intranet, Twitter, Facebook.
				QS2.17.4	The revised QIA Process to be monitored for a period of 3 months from Feb to Apr 2019 to ensure process is embedded within the organisation.	Apr-19	QIA submissions to QIA Panel.

QUALITY AND SAFETY IMPROVEMENT PLAN (Version 3.0)

Introduction
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The plan outlines the Trust’s overall ambition to improve quality and safety. The plan includes a number of key milestones and these will be reported on at the weekly Quality and Safety Implementation Group, fortnightly Quality and Safety Improvement Board and monthly at the 2021 Programme Board, Quality Governance Assurance Committee and Trust Board. The milestone dates are all the end of the month unless a specific date is recorded. A separate monthly overview report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan below will not change unless specifically agreed by the Quality and Safety Improvement Programme Board.

QS03 - Deteriorating Patient (including Sepsis)
 SRO: Michelle Rhodes
 Project Leads: Laura Strong, Jane Dulake, Chelsea Tomlin

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.1	Medical engagement with sepsis is increased	Dec-18	Medical engagement with process	QS3.1.1	Medical lead for each work stream identified	Sep-18	Identified leads in place
QS3.2	An up-to-date sepsis policy that is embedded across the Trust	Nov-18	Sepsis policy being updated	QS3.2.1	Updated adult section of the sepsis policy	Jul-18	Sepsis policy in place

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.2.2	Updated children's section of the sepsis policy	Aug-18	Children's section within the sepsis policy is in place
				QS3.2.3	Updated neutropenic section of the sepsis policy	Oct-18	Section in place within the sepsis policy
				QS3.2.4	Updated neonates section of the sepsis policy	Sep-18	Neonates section within the sepsis policy is in place
				QS3.2.5	Updated maternity section of the sepsis policy	Sep-18	Maternity section is in place within the sepsis policy
				QS3.3	E-learning modules are up-to-date and available for all staff	Sep-18	Updated e-learning modules available on the intranet
				QS3.3.2	Maternity e-learning module is available	Jul-18	E-learning module is in place and accessible to staff
				QS3.3.3	Patients on anti-cancer treatment e-learning module is available to all staff	Aug-18	E-learning module is in place and accessible to staff
				QS3.3.4	Evaluation and review of e-learning modules	Aug-18	Evaluation tool in place for review of e-learning modules

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.4	Accountability is reinforced	Nov-18	Staff receive regular updates on compliance with accountability	QS3.4.1	Sending of accountability letters for sepsis screens missed or completed outside of 60 minutes or 6 in 60 actions not completed appropriately has commenced.	Oct-18	Evidence of accountability available in patient records
QS3.5	All departments recognise and respond to missed/late sepsis screens or incomplete 6 in 60 actions	Nov-18	Ongoing audit of patient records and reported incidents	QS3.5.1	All areas have an allocation on web v	Oct-18	
				QS3.5.2	All areas returning their monthly reviews every month has commenced	Aug-18	Compliance with submission of reviews is measured each month
QS3.6	Information is provided to patients, relatives and carers in line with NICE guidance	Nov-18	Access to most up to date information in compliance with nationally recognised guidance	QS3.6.1	Information is provided at discharge for people assessed for suspected sepsis, but not diagnosed with sepsis	Oct-18	Patients have information provided to them before discharge
				QS3.6.2	Information is provided at discharge for people at increased risk of sepsis	Oct-18	Patients have information provided to them before discharge
				QS3.6.3	Information is provided at discharge for people who have had sepsis	Nov-18	Patients have information provided to them before discharge

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.6.4	Patients with sepsis and their families and carers are given details of national charities and support groups who provide information about sepsis and the causes of sepsis.	Dec-18	Patients, familiars and carers have information provided to them before discharge
QS3.7	90% Sepsis Screening achieved	Dec-18	Ongoing audit of patient records	QS3.7.1	90% Sepsis Screening for adult inpatients achieved	Nov-18	Audit of patient records
				QS3.7.2	90% Sepsis Screening for adult A&E patients achieved	Nov-18	Audit of patient records
				QS3.7.3	90% Sepsis Screening for Paediatrics achieved	Nov-18	Audit of patient records
				QS3.7.4	90% Sepsis Screening for maternity achieved	Nov-18	Audit of patient records
QS3.8	90% administration of IV antibiotics on diagnosis of sepsis achieved	Dec-18	On-going audit of patient records	QS3.8.1	90% administration of IV antibiotics on diagnosis of sepsis for adult inpatients achieved	Nov-18	Audit of patient records
				QS3.8.2	90% administration of IV antibiotics on diagnosis of sepsis for adult A&E patients achieved	Nov-18	Audit of patient records

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.8.3	90% administration of IV antibiotics on diagnosis of sepsis for Paediatrics achieved	Nov-18	Audit of patient records
				QS3.8.4	90% administration of IV antibiotics on diagnosis of sepsis for maternity achieved	Nov-18	Audit of patient records
QS3.9	Neonates to be incorporated into sepsis work	Jan-19	Work undertaken to include neonates screening	QS3.9.1	Neonatal screening tool developed	Dec-18	Screening tool in place
				QS3.9.2	Audit sepsis screening within neonates	Dec-18	Audit of patient records
				QS3.9.3	Audit antibiotic administration within neonates	Dec-18	Audit of patient records
QS3.10	There is a clear rescreening protocol for sepsis	Jan-19	Work undertaken for rescreening protocol	QS3.10.1	Adult rescreening protocol embedded within practice	Dec-18	Audit of patient records
				QS3.10.2	Paediatric sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place
				QS3.10.3	Maternity sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place
				QS3.10.4	Neonates sepsis rescreening protocol produced	Dec-18	Rescreening protocol in place

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS3.11	Quick and efficient screening process available for staff	Jan-19	Work undertaken for screening process to be in place	QS3.11.1	iPod are in use to enable staff to complete the first two questions of all the sepsis screens	Dec-18	Screening process in place
				QS3.11.2	Adult Sepsis trust bundle implemented	Dec-18	Audit of patient records
QS3.12	Deteriorating patient/Sepsis link nurses on identified areas	Dec-18	Nominated staff in key areas	QS3.12.1	There is an identified link nurse for relevant areas and link nurses for deteriorating patients incl.sepsis	Nov-18	Link nurses identified in all relevant areas
				QS3.12.2	Link nurses role profile is developed	Aug-18	Link nurses role agreed and in place
				QS3.12.3	Competencies and expectations identified in the role profile	Aug-18	Review of link nurse role agreed
QS3.13	Deteriorating patient incl. AKI/Fluid balance, NEWS2, SBAR, Failure to escalate	Dec-18	Staff and patients aware of fluid balance and AKI	QS3.13.1	Fluid balance inpatients policy developed and launched across the organisation	Nov-18	Policy agreed and followed
				QS3.13.2	e-learning package available for fluid balance charts and AKI including AKI Bomb with signposting in place	Sep-18	Staff able to access e-learning package for their development

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.13.3	There is a poster providing guidance to patients to record all fluid intake daily in place across the organisation	Nov-18	Posters in place in patient areas for their information
				QS3.13.4	Housekeepers record fluid intake from cups and jugs before removing from patient area	Nov-18	Documentation audit reflects evidence of patient fluid intake
				QS3.13.5	There is an e-learning package for HCSW and Housekeepers to adequately record fluid intake	Oct-18	E-learning package available for staff to access
				QS3.13.6	There is an AKI/FBC micro-teaching session developed	Nov-18	
				QS3.13.7	30 minute micro-teaching sessions are delivered four days a week at AKI/FBC at LCH every 3 weeks.	Aug-18	Staff have accessed a micro-teaching session on all sites for their development
				QS3.13.8	30 minute micro-teaching sessions are delivered four days a week at AKI/FBC at PHB every 3 weeks.	Sep-18	Staff have accessed a micro-teaching session on all sites for their development
				QS3.13.9	30 minute micro-teaching sessions are delivered two days a week AKI/FBC at GDH every 3 weeks.	Sep-18	Staff have accessed a micro-teaching session on all sites for their development

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.13.10	NEWS2 is used to record observations and escalation in a timely manner	Nov-18	Compliance with NEWS2 evidenced through audit of patient records
				QS3.13.11	SBAR - communication tool is in use across the trust	Dec-18	Evidence of tool through audit of patient records
				QS3.13.12	Notable reduction in failure to escalate deteriorating patients	Dec-18	Increased evidence noted in escalation rates
QS3.14	ReSPECT is in place across the organisation	Jan-19	Promotion of appropriate management and use of relevant forms in patient records	QS3.14.1	DNACPR forms are accurately completed	Nov-18	Increased evidence demonstrated in audit of patient records
				QS3.14.2	The plan for every review is documented accurately	Nov-18	
QS3.15	Learning from DKA serious incidents is implemented within ULHT.	Mar-19		QS3.15.1	Near patient testing for hyperglycaemia.	Dec-18	
QS3.16	Delivery of action plan in line with the external review by the University Hospitals of Leicester NHS Trust			QS3.16.1	The Trust to ensure the re-designed Diabetes Service Model delivers care in accordance with the recently published NHS Right Care Diabetes Pathway.		

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Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.16.2	Implement a system to identify inpatients with diabetes to help prioritise In-Reach more effectively.		
				QS3.16.3	Implement the availability of Ketonaemia testing on all wards.		
				QS3.16.4	The Trust to explore the feasibility of merging LCH and PBH Specialist Services with regard to cover out of hours.		
				QS3.16.5	Examine the role of consultant diabetologists at ULHT and within the community taking into account STP plans for diabetes.		
				QS3.16.6	Examine the current DISN staff to patient ration, compare it to national recommendations and take a strategic view regarding the role of diabetes inpatient care.		
				QS3.16.7	BSPED guidelines to be readily available within A&E and Medical Assessment Units for the age group 16-19 year olds.		

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.16.8	Write guidance on how to manage an emergency situation when insulin pump users can become ketoacidotic in the event of pump failure or disconnection.		
				QS3.16.9	Within POCT Guidelines include blood glucose testing in line with NaDIA standards.		
				QS3.16.10	The Trust to introduce a Self-Administration of Insulin Policy.		
				QS3.16.11	The Trust to communicate a clear statement to staff who prescribe, dispense or administer insulin or manage patients with diabetes, that they must be trained in the safe use of insulin and diabetes safety.		
				QS3.16.12	Training for safe use of insulin and diabetes safety must include locum and agency staff and staff who work permanent night shifts.		
				QS3.16.13	The Trust to ensure training is in place for Pregnancy and Diabetes.		
QS3.17	Delivery of action plan is line with DKA Serious Incident.			QS3.17.1	Duty of Candour.		

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.17.2	A Standard Operating Procedure for difficult cannulation requires formulation.		
				QS3.17.3	The Trust's DKA pathway is reviewed.		
				QS3.17.4	The revised DKA pathway to be re-launched.		
				QS3.17.5	A clinical audit of compliance with the revised DKA pathway should be undertaken.		
				QS3.17.6	The A&E Department should review the process for caring for patients in majors if they are unable to care for them in resus.		
				QS3.17.7	Review the process which should be followed when a non-formulary drug is requested for prescription.		
				QS3.17.8	The A&E barcode machines should be checked.		

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.17.9	The Trust's procedure for Point of Care use of blood glucose and blood ketones meters to be disseminated across the Trust and training provided.		
				QS3.17.10	The Trust should investigate how agency staff can have access to their own barcode access for blood glucose and ketone meters once competency has been assessed.		
				QS3.17.11	Skills and competencies of the Navenby Ward nursing staff should be reviewed.		
				QS3.17.12	The management of diabetic emergencies and high strength insulin should be reviewed to ensure staff have access to training and core skills are in place.		
				QS3.17.13	Multi-disciplinary reflective learning session should be held to review the actions and learning from this case.		
				QS3.17.14	All patients with medical emergencies are to be admitted in accordance with the Trust's usual admissions pathway.		

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS3.17.15	All fluids in A&E should be administered through an infusion pump unless there are specific clinical reasons not to do so.		

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QS04 - Emergency Department at Pilgrim

SRO: Chris Garner

Project Leads : Dr Meg Ryan/ Dr Dan Boden/Tracy Bell/Maxine Skinner/ Dr Hesham Turki /Mandy Charles/Tracy Wall

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS4.1	Increase the level of assurance and monitoring of this plan to support successful delivery and sustainability	Nov-18		QS4.1.1	A senior leadership assurance group (to include partners and CCG) oversee the delivery of the whole patient pathway and provide increased level of support for the delivery of this shared plan	Complete Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS4.1.2	There is a weekly Trust Clinical Leadership Emergency Care Board to ensure monitoring of plan and oversight of task and finish groups	Nov-18	
				QS4.1.3	There is monthly reporting of delivery of key milestones and actions from this patient flow programme to the local system A&E delivery board	Complete Sep-18	
QS4.2	Reduced Ambulance handover Delays in ED	Feb-19		QS4.2.1	Achieved the upper quartile of national performance with no 2 hour or longer delays at PBH	Feb-19	
QS4.3	Improve time for RAIT for all patients, contributing to the achievement of the four hour standard trajectory	Jan-19		QS4.3.1	100% of patients go through RAIT within 30 minutes of arrival in the ED at PH	Jan-19	
QS4.4	Deliver an effective GP streaming service	Jan-19		QS4.4.1	Appropriate patients have been effectively directed to the GP streaming service	Jan-19	
QS4.5	Deliver a safe and effective service to meet the needs of ambulatory patients arriving in the department requiring Immediate Emergency Treatment	Jan-19		QS4.5.1	Identification of all ambulatory patients arriving in the department with Emergency treatment needs	Jan-19	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS4.6	Patients are streamed to the most appropriate service to meet their health care needs.	Jan-19		QS4.6.1	Review & development of Standard operating procedures for RAIT, Streaming and Triage	Jan-19	
QS4.7	Provision of a comprehensive and effective triage service	Feb-19		QS4.7.1	100% of eligible nurses are trained to deliver triage at.	Jan-19	
				QS4.7.2	Patients are triaged within 15 minutes of arrival	Feb-19	
				QS4.7.3	Patients receive the appropriate triage to meet their presenting clinical condition, in accordance to Local and National Guidance. Including Analgesia and Early warning scores	Feb-19	
QS4.8	To increase the number of urgent, emergency and ambulatory care pathways to avoid unnecessary attendance at ED and improve the patients outcome and experience - Deliver an effective Fractured Neck of Femur pathway	Dec-18		QS4.8.1	Deliver the direct to care fractured neck of femur patient pathway	Dec-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS4.9	To increase the number of urgent, emergency and ambulatory care pathways to avoid unnecessary attendance at ED and improve the patients outcome and experience - Deliver an effective direct access stroke care pathway	Dec-18		QS4.9.1	Zero four hour transit time breaches for FAST positive / stroke patients	Dec-18	
QS4.10	Improve the patients and staff experience of the ED and achieve the four hour transit time trajectory - Deliver an effective minor injury and minor illness pathway	Jan-18		QS4.10.1	There is an effective minor injury and minor illness pathway which is staffed and led by experienced clinicians and delivers the non-admitted four hour transit time standard	Jan-18	
QS4.11	Improve the patients and staff experience of the ED and achieve the four hour transit time trajectory - model and infrastructure	Mar-18		QS4.11.1	There is a reduction of the conversion rate to admission (for further development with ECIST)	Mar-18	
				QS4.11.2	The environment is conducive to delivering safe, effective care and there are no outstanding estates work that impedes care.	Dec-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS4.11.3	100% of patients requiring a speciality review are seen within 30 minutes of the request	Dec-18	
QS4.12	The Urgent and Emergency Care Department meets the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings'	Dec-18		QS4.12.1	1 EPALS trained member of staff per shift	Dec-18	
				QS4.12.2	The Emergency Department must ensure medical staff, looking after children in the emergency department, are appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS). (90%)	Jan-19	
QS4.13	The Emergency Department meets the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day. (100%)	Dec-18		QS4.13.1	Review of medical rota and development of escalation process.	Dec-18	
QS4.14	Vulnerable Patients in the Emergency Department are identified, appropriately assessed.	Jan-18		QS4.14.1	All staff in the department have received the appropriate safe guarding training	Jan-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS4.14.2	Ensure that vulnerable patients are identified and appropriately assessed	Jan-18	
QS4.15	All patients attending the Emergency Department receive Safe Care, in accordance with Trust Policies.	Feb-18		QS4.15.1	Staff working in the Urgent and Emergency Care Department have adequate training to perform their role	Feb-18	
				QS4.15.2	Staff in the Urgent & Emergency care Department provide safe care in accordance with trust policies and meeting the ward accreditation standards.	Feb-18	
				QS4.15.3	Patients who are at risk of falls receive appropriate assessments and care	Dec-18	
				QS4.15.4	Patients in the Urgent & Emergency care Department receive a Tissue viability assessment and the appropriate care		
				QS4.15.5	Staff are compliant with the medicine management policy		

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS4.15.6	patients are safely discharged/transferred with the appropriate handover/safety advice.	Dec-18	

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QS05 Children and Young People Services
SRO: Michelle Rhodes
Project Leads: Jo Wilson

Key milestone				Milestone			
No.	Description	Baseline finish date	Evidence key milestone has been achieved		Description	Baseline finish date	Evidence milestone has been achieved
QS5.1	Expert Children's Improvement Lead identified and recruited into post.	Sep-18	Expert Children's Improvement Lead in post	QS5.1.1	Draft Children's and Young People's quality and safety improvement plan is reviewed and refined by Children's Improvement Lead	Sep-18	Plan re-written, reviewed, agreed and in operation.
				QS5.1.2	A defined, in -depth review of the quality and safety of care within Children's and Young People's Services is undertaken Pan Trust (Inclusive of all Non Specific Children and Young peoples areas).	Nov-18	Written report of the review against national / regional quality markers

Key milestone				Milestone			
							<p>Localised improvement plan is developed for each service area reviewed.</p> <hr/> <p>A weekly action plan monitoring group will be established to ensure all actions are understood, timely delivered and are embedded into practice.</p> <hr/> <p>Localised improvement plans are monitored (long term), locally through robust directorate governance systems. progress reports are provided to the directorates quality and safety meetings for confirm and challenge on progress</p>
				QS5.1.3	Where current compliance cannot be met against national standards / Guidance - this is reflected locally within the service lines risk register with clear plans to mitigate / action the risk.	Dec-18	Risk registers reflect where national standards / guidance are currently not met with clear plans for mitigation / managing the risk
				QS5.1.4	A "Child and Young People Safe and Friendly Service" symbol is created and awarded for display for those areas across the trust where positive improvements have been undertaken to meet the needs of Children and Young People.	Dec-18	Symbol is created and in use across to the trust in "Child and Young People Friendly Services"

Key milestone				Milestone			
QS5.2	Children and Young people requiring care in 'Non-children and Young People specific' services are identified across the trust	Nov-18	Comprehensive list which identifies areas in which services are delivered to children across the trust	QS5.2.1	Emergency and Urgent Care Pathways which Children and Young People may access are identified	Sep-18	Emergency and Urgent Care Pathways have been identified, developed and implemented.
				QS5.2.2	Emergency and Urgent Care pathways which Children and Young People may access are developed	Oct-18	
				QS5.2.3	Emergency and Urgent Care pathways which Children and Young People may access are implemented	Nov-18	
				QS5.2.4	Elective Care pathways which Children's and Young People may access are identified	Oct-18	Elective pathways have been identified, developed and implemented.
				QS5.2.5	Elective care pathways which Children and Young People may access are developed	Nov-18	
				QS5.2.6	Elective care pathways which Children and Young People may access are implemented	Dec-18	
				QS5.2.7	Outpatient pathways which Children and Young People may access are identified	Nov-18	Outpatient care pathways have been identified, developed and implemented.
				QS5.2.8	Outpatient care pathways which Children and Young People may access are developed	Dec-18	
				QS5.2.9	Outpatient care pathways which Children and Young People may access are implemented	Jan-19	

Key milestone				Milestone			
QS5.3	Children and Young People receive patient centred care and treatment	Feb-19	A review of current processes which captures, evaluates and responds in a timely manner to information from Children, Young People, Families / Carers regarding their experiences of care in both Non / Children and Young People specific areas.	QS5.3.1	Relevant process and metrics are in place to capture the experience of care of children, Young People and their Families and Carers in Non / Children and Young people specific environments	Feb-19	There is a clear process across the trust both in Non / Children's and Young People Specific areas to collect patient experience from Children and Young People in a variety of methods
				QS5.3.2	Appropriate process and metrics are in place to regularly evaluate the experience of care of children, young people and their families Children specific environments	Feb-19	
				QS5.3.3	Appropriate and timely action where possible is taken in response to feedback from Children and Young People	Feb-19	
				QS5.3.4	Appropriate and accessible information leaflets are in place to support the imparting of information (written information, pictures, symbols, large print, Braille and different languages). Staff must be available to explain what is happening and the plans for care in a variety of communication methods	Apr-19	
QS5.4	There is a defined governance structure in place to assure the board of the quality and delivery of safe care to children	Sep-18	Trust wide meetings in place providing oversight and governance for Children and Young People's pathways	QS5.4.1	Multidisciplinary Children and Young People's board in place, meetings occur and report to Trust Board on a quarterly basis.	Jul-18	Minutes of meetings from both C&YP Board and Trust Board.

Key milestone				Milestone			
							Meetings have commenced
							Evidence in Trust Board minutes of regular discussion at board level of C&YP agenda.
							The C&YP agenda is demonstrated in published plans, reports and within the leadership and management structure to support the service.
							Evidence that the role of chair is identified in the job plan of exec and non exec lead with evidence of review at appraisal
							Evidence of overarching governance of audit and compliance against acute care standards for CYP and action plan (Monitoring and Scrutiny of the C&YP Audit plan) - Minutes
				QS5.4.2	There is an effective process for clinically prioritising C&YP (patients) for admission	Sep-18	Children and Young people are RAG rated for admission in order of priority, there is a clear process for contacting the family should there be any delay to ensure safety.
				QS5.4.3	Multidisciplinary C&YP surgical committee in place and meetings occur and report to Trust Board	Sep-18	Minutes of meetings and attendance list

Key milestone				Milestone			
				QS5.4.4	Evidence based care and treatment tools are consistently used across C&YP pathways.	Jan-19	Evidence based treatment tools are up to date and are embedded in every day practice in all relevant areas.
				QS5.4.5	Paediatric morbidity and mortality review meetings are held on a monthly basis and report to the patient safety committee quarterly regarding outcomes, lesson learnt and actions.	Jan-19	Paediatric morbidity and mortality minutes are available, which identify areas for action / escalation. Evidence of quarterly reporting to the patient safety committee.
				QS5.4.6	All deaths of children and young people are reported to the trusts risk team for inclusion within the trusts serious incident process	Sep-18	Completed serious Incident reports and investigation following a notification of a child or young persons death
				QS5.4.7	There is a robust audit plan which is carried out to ensure evidence-based care is applied to Children and Young People.	Feb-19	There is a clear Children's and Young peoples audit schedule which is reflected within the trust wide audit plan Audit schedules are followed and governed by appropriate divisional governance structures Implementation of changes post audit are undertaken using quality improvement cycle methodologies

Key milestone				Milestone			
				QS5.4.8	Children and Young people are seen as our regulators as well as our customers - Children and Young people should therefore be involved in the trusts audit / assessment process where appropriate	Feb-19	
QS5.5	Environments in which Children and Young People are cared for are assessed and improved to meet their needs.	Feb-19	Each specific service area has an individualised improvement plan where required pertaining to environmental standards for children and young people which is driven locally	QS5.5.1	Environmental standards for children and young people are assessed within the internal "Quality of Care Review" and environmental action plans are developed. This includes audio-visual separation from adults as well as consideration of: <input checked="" type="checkbox"/> Security issues <input checked="" type="checkbox"/> Availability of food and drink <input checked="" type="checkbox"/> Breastfeeding areas <input checked="" type="checkbox"/> Hygienic, Safe play facilities <input checked="" type="checkbox"/> Access to quieter waiting and treatment areas, and age-appropriate games, music or films <input checked="" type="checkbox"/> Parental overnight stay, if required	Dec-18	Each service area has an environmental improvement plan in place which is actively being addressed.
				QS5.5.2	Areas where Children and Young People access for treatment / care have access to play specialist provision	Feb-19	
				QS5.5.3	Ensure all sites / Children and Young peoples areas have access to a play specialist	Feb-19	

Key milestone				Milestone			
				QS5.5.4	Children and Young People accessing Radiology / Theatres and Anaesthetics have alternative modes of transport to / from / in such departments as an alternatives to patient trolleys	Feb-19	
				QS5.5.5	There is suitable provision of activities for Children and young people within the environments they are cared for	Feb-19	
				QS5.5.6	All areas accessed by Children and Young people / families / carers for care and treatment display health promotion information	Feb-19	
Page 72	QS5.6	There is a rolling programme of training and education across the trust to areas of non specific children's and young peoples services which specifically focuses on safeguarding	TBC	Rolling programme of education in place and operationalised within the non specific children's and young peoples services	QS5.6.1	There is a robust rolling programme of education in practical safeguarding topics.	
					QS5.6.2	Confidentiality and consent policies are made explicit to young people and parents and carers.	
	QS5.7	There is a robust model of Mental Health provision in Children's and Young Peoples Physical health care settings	TBC		QS5.7.1	The Mental health of the child, young person and their family is an integral part of all children's services, and not overlooked when a physical health disorder takes priority.	

Key milestone				Milestone			
				QS5.7.2	<p>Emergency departments have a single point of access for child and adolescent mental health (CAMHS), or adult mental health services with paediatric competencies for children over 12 years old. Referrals are available 24 hours a day, seven days a week, with a maximum response time of 30 minutes (this can be remotely).</p> <p>Mental health assessment takes place within 4 hours of call to assess physical, psychological and emotional needs.</p> <p>Appropriate staff receive training and appraisal to ensure they are: able to talk to young people about mental health issues; knowledgeable about a range of support and treatment options; clear about who they are able to help; able to recognise and facilitate informed consent; and able to recognise and respond to different therapeutic needs such as those relating to gender, sexual orientation and age.</p>		
QS5.8	Transition to adult services should be as seamless as possible for the young person.	TBC		QS5.8.1	There is a clear lead clinician responsible for transition leading work on policies and pathways of care to prepare young people for the transition to adult services across the trust.		

Key milestone				Milestone			
				QS5.8.2	There are appropriate policies and pathways in place which identify how young people should be prepared for the transition to adult services.		
QS5.9	Staff working with Children and Young People will have the appropriate qualifications and competencies to deliver safe and effective care	TBC		QS5.9.1	All Nurses / AHP's / Medics (Clinical staff) looking after Children and Young People are trained in the assessment of the unwell child, inclusive of sepsis awareness. Pain management and effective communication where appropriate.		
				QS5.9.2	All staff looking after children and young people are trained in Paediatric / Adult basic life support. **This relates to non specific children's area (Exclusive of A&E and Children's Wards)		
				QS5.9.3	All staff looking after children and young people are trained in level 3 safeguarding		
				QS5.9.4	(A&E Specific Children's Nurses / Day Care Services) Trust networks encourage rotation of staff and encourage learning opportunities to maintain skills and competencies across the pathway.		
				QS5.9.4	Compliance against emergency standards for staffing and competencies in Children's A&E are adhered too.		

Key milestone				Milestone			
QS5.10	Development of a Children's and Young Peoples Strategy for UHLT	TBC		QS5.10.1	The strategy articulates a clear vision of what is to be achieved for the Children and Young people of Lincolnshire with a clear plan on how this will be delivered.		

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QS06 - Safe Care

SRO: Michelle Rhodes

Project Lead: Victoria Bagshaw

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS6.1	Positive Patient ID is used consistently across the trust	Dec-18	All ULHT sites utilising consistent approach to patient identification	QS6.1.1	Positive Patient ID policy reviewed and amended as required	Sep-18	Complete policy
			No incidents reported concerning incorrect patient identification	QS6.1.2	methodology, interventions and timeline for rollout identified	Aug-18	Project plan

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
			Patient ID policy approved	QS6.1.3	Implementation sites agreed	Aug-18	Ward managers / matron agreement to take part
				QS6.1.4	Implementation commenced across All 3 sites at the same time	Aug-18	Implementation progress, feedback from staff, datix.
				QS6.1.5	Regular reporting on compliance commenced	Dec-18	Audit / report results, ward accreditation, ward assurance
QS6.2	Intentional Rounding used consistently across the trust	Dec-18	All adult inpatient areas trust wide effectively using intentional rounding Reduction in hospital acquired pressure damage, falls Increased quality of care & documentation to evidence this	QS6.2.1	Implementation methodology agreed	Aug-18	Implementation Plan
				QS6.2.2	Initial implementation sites agreed	Aug-18	Identification of 3 sites
				QS6.2.3	Intentional Rounding launched across the trust	Nov-18	Implementation progress, feedback from staff, datix.
				QS6.2.4	Regular reporting on compliance commenced	Dec-18	Audit / report results, ward accreditation, ward assurance
				QS6.3	Safety Huddles are used consistently across the trust	Mar-19	All adult inpatient areas effectively integrated the safety huddle process

Key milestone				Milestone				
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved	
			Patients at risk and daily factors which could impact on patient safety are identified and managed appropriately	QS6.3.2	Initial implementation sites agreed	Aug-18	Identification of 3 sites	
			Potential lapses in care or documentation are identified early	QS6.3.3	Implementation commenced (All 3 sites at the same time)	Oct-18	Implementation progress, feedback from staff, datix.	
				QS6.3.4	Regular reporting on compliance commenced	Feb-19	Audit / report results, ward accreditation, ward assurance	
				QS6.4	There is a consistent accountability handover process across the trust	Mar-19	Handover is consistent across all sites.	QS6.4.1
			Consistently effective communication between incoming and outgoing teams, highlighting areas of importance for the upcoming shift.	QS6.4.2	Initial implementation sites agreed	Aug-18	Ward managers / matron agreement to take part	
			Improved documentation / individualised care planning.	QS6.4.3	Initial implementation commenced all sites	Dec-18	Evidence of data	
				QS6.4.4	Accountability handover launched across the trust	Mar-19	Ward compliance with accountability handover	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.4.5	Regular reporting on compliance commenced	Mar-19	Audit / report results, ward accreditation, ward assurance
QS6.5	NG tubes are inserted and managed safely and effectively across the trust	Mar-19	All patients with NG tube have decision discussion prior to inserting the tube and this is documented	QS6.5.1	NG tube policy reviewed and amended as required	Aug-18	Ward managers / matron agreement to take part
			Insertion fully documented in all cases	QS6.5.2	Safety improvement methodology agreed	Aug-18	Education plan
			Patients aren't delayed with feeding	QS6.5.3	Improvement implementation sites agreed	Aug-18	Ward managers / matron agreement to take part
			Patient aren't exposed to unnecessary x-rays				
			Staff aware of policy revision and their responsibilities.				
			Training and competencies in place and staff uptake >75% in key areas				
				QS6.5.4	Policy evaluated and changes to policy agreed	Sep-18	No incidents, SI's or never events associated with NG tubes.
				QS6.5.5	Revised NG Tube policy launched across the trust	Sep-18	All staff are fully aware of NG policy, competencies, documentation and processes

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.5.6	Compliance monitoring method agreed and commenced	Sep-18	Ongoing evaluation continues, audit, SQD, Datix
				QS6.5.7	Regular reporting on compliance commenced	Oct-18	Ongoing evaluation continues, audit, SQD, Datix
				QS6.5.8	Staff competencies have been reviewed across the trust	Oct-18	Policy agreed by stakeholders
				QS6.5.9	There is an engagement programme in place across the trust	Nov-18	Intranet, written evidence of comms Launch new policy
				QS6.5.10	There is an agreed NG Tube audit and timetable across the trust	Sep-18	NT Tube audit timetable
				QS6.5.11	There is an agreed Never Event Template for NG Tubes in place across the trust	Oct-18	Template
QS6.6	Registered nurses are being recognised for their compassion through the Daisy Awards scheme	Nov-18	Number of RNs recommended for Daisy award	QS6.6.1	Agreements is in place with the DAISY Foundation to be a recognised member	Aug-18	MOU in place
				QS6.6.2	Daisy Awards launched Trust wide	Sep-18	launch event

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS6.6.3	RN receiving Daisy awards	Nov-18	names of RN's recognised for compassion in care through the Daisy award scheme

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QS07 - Safeguarding
SRO: Michelle Rhodes
Project Lead: Elaine Todd, Lisa Newbould

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS7.1	Conscious sedation is used appropriately and safely when required.	Dec-18	Conscious sedation policy & local guidance in place. Compliance and effectiveness audited.	QS7.1.1	Conscious Sedation Policy developed by Task & Finish Group.	Oct-18	Conscious sedation policy approved by CESC and published.
				QS7.1.2	Speciality guidelines reviewed/ developed for departments where conscious sedation used.	Oct-18	Speciality guidelines in place.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.1.3	Specialities to audit practice against Trust policy and guidelines to ensure effective monitoring after sedation & intervention.	Dec-18	Audit results shared at speciality governance meetings and SGC.
QS7.2	Adherence to Use of Appropriate Chemical Restraint in the Management of Agitated Patients on General Adult Wards & in A&E Policy and Clinical Holding & Restraint Policy.	Mar-19	Capacity assessed and evidence least restrictive options considered in 100% of cases audited where restraint or chemical sedation used.	QS7.2.1	Clinical Holding and restraint training completed for all identified staff.	Dec-18	Training compliance.
				QS7.2.2	Audit of chemical sedation logs and pharmacy data show compliance with policy.	Mar-19	Audit results.
QS7.3	All adults are offered a chaperone for all intimate examinations and children and young people are provided with chaperones.	Jan-19	Audit of compliance with chaperone policy.	QS7.3.1	Chaperone policy updated by task & finish group.	Sep-18	Updated Chaperone policy approved and published.
				QS7.3.2	Risks of full compliance in all clinical areas assessed to inform ongoing priorities and training needs.	Nov-18	Updated risk assessment.
				QS7.3.3	Audit of compliance with Chaperone Policy undertaken by clinical leads.	Dec-18	Audit results.
QS7.4	Trust is fully compliance with Savile and Bradbury report recommendations.	Dec-18	Evidence reviewed by SGC.	QS7.4.1	Management of Allegations Policy updated and ratified.	Dec-18	Policy approved and published.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.4.2	Managerial lead to ensure that the chaperone policy is embedded on each site.	Dec-18	See QS7.3
				QS7.4.3	DBS checks (including, where applicable, enhanced DBS and barring list checks) are undertaken on all staff and volunteers	Oct-18	Risk assessment in place and decision reached re DBS checks.
				QS7.4.4	The Trust has a social media policy which is widely communicated to staff. It is used to ensure all members of staff understand their rights and responsibilities in relation to the correct use of social media.	Dec-18	Updated Social Media Policy published.
				QS7.4.5	Arrangements and processes for the recruitment, checking, general employment and training of <u>contract and agency staff</u> are in place	Dec-18	Policy in place to support requirements.
				QS7.4.6	A review to ensure that the support, advice and care provided to victims of sexual assault and statutory rape are consistent with current best practice has been undertaken	Dec-18	Audit results demonstrate compliance.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS7.4.7	All Trust policies have been extended in their scope to the broader community, including volunteers, non-executive directors and, where appropriate, contractors; and in time, to governors	Dec-18	Policy in place to support requirements.
				QS7.4.8	Assurance that charitable funds are channelled appropriately are gathered on a systematic and ongoing basis and reported to both the Charitable Trustees and the Trust Board Audit Committee to ensure that the mechanisms in place to do this continue to be effective.	Sep-18	Reports to Committee showing evidence of compliance.
QS7.5	Pathway is seamless for young adults with LD who transition between children and adult services.	Mar-19	Pathway in place. Compliance audited.	QS7.5.1	LD pathway developed.	Oct-18	Pathway approved and published.
				QS7.5.2	Compliance audited against pathway.	Dec-18	Audit results shared at speciality governance meetings and SGC.

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS7.6	Trust is compliant with CP-IS	Mar-19	CP-IS in place.	QS7.6.1	Care portal approved to support CP-IS.	Sep-18	Notification received.
				QS7.6.2	Requirements mapped and understood.	Sep-18	Process map developed and training planned.
				QS7.6.3	Test site to test CP-IS system and training scheduled	Sep-18	Test completed.
				QS7.6.4	Rollout of CP-IS.	Mar-19	CP-IS in use in all relevant areas.

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QS08 - Medicines Management
SRO: Michelle Rhodes
Project Leads: Colin Costello, Nabil Fahimi & Dana Sheanon

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KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS8.1	Reducing harm through the culture of safety and learning from medication related adverse events.	Mar-19	Increase reporting rate of medication related incidents and near misses.	QS8.1.1	There is a baseline of external benchmarking and audit to enable monitoring of performance and support to Directorate Service Improvement Plans.	Sep-18	Monthly data report
				QS8.1.2	Datix reporting system for medication incidents is approved.	Mar-19	
				QS8.1.3	Ensuring learning from medication incidents and near misses informs future practice.	Dec-18	Trends and themes collated, learning shared and training needs identified.

KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS8.1.4	There is a local ward accreditation medication action plan with measurable outcomes for all areas.	Jul-18	Ward accreditation action plans to reflect learning from visits, incidents and near misses.
				QS8.1.5	Guidance for reducing risk of omitted and delay doses reviewed.	Oct-18	
				QS8.1.6	Safer medication administration process reviewed.	Mar-19	Reduction/zero medication related Datix incidents.
				QS8.1.7	Ward handover process reviewed.	Sep-18	Critical information communicated and chart reviewed as part of handover process.
				QS8.1.8	The management of patients with allergies and adverse reactions to medications is improved.	Sep-18	Reduced number of incidents related to allergies and adverse reactions.
				QS8.1.9	Use of the Summary Care Record (SCR) for medicines reconciliation.	Oct-18	
				QS8.1.10	Reduce risk of errors with use of multiple prescription charts.	Mar-19	Prescription charts and processes reviewed. SOP/Policy in place.
				QS8.1.11	The opportunity for near patient dispensing explored.	Sep-18	
				QS8.1.12	Self administration of medicines practice reviewed and use increased as appropriate.	Mar-19	Policy and procedures updated and published on intranet.
QS8.2	Pharmacy are integrated into clinical areas MDT and Specialty Governance Meetings.	Mar-19	Minutes of Specialty Governance Meetings.	QS8.2.1	Clinical pharmacy ward cover is improved.	Mar-19	

KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS8.2.2	Pharmacist rota based on risk assessments.	Mar-19	
				QS8.2.3	Urgent care/Emergency Department Pharmacist in post.	Dec-18	
				QS8.2.4	Full time pharmacy cover for Acute Admissions Units.	Sep-18	
				QS8.2.5	Clinical Pharmacy Technician role integrated into nursing team.	Mar-19	
				QS8.2.6	Pharmacy open hours are extended.	Mar-19	
				QS8.2.7	Pharmacy Team leaders are integrated into Divisional Governance Meetings.	Mar-19	
				QS8.2.8	Ensuring a safe process is in place to support supply of discharge medication.	Mar-19	
				QS8.2.9	Chief Pharmacist and Medication Safety Officer has a formal governance reporting line.	Mar-19	
QS8.3	An education and training process for pharmacy, medical staff and nurses on medicines optimisation is robust and effective.	Mar-19	Training compliance numbers.	QS8.3.1	Core learning reviewed and updated as required.	Dec-18	Core learning and competency assessments in place.
				QS8.3.2	Policies reviewed to ensure they support the Nursing Associate role regarding administration of medicines.	Dec-18	Policies updated and published on intranet.
				QS8.3.3	Prescribing Skills Induction for junior doctors in place.	Mar-19	

KEY MILESTONES				MILESTONES			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS8.3.4	Distribution of Pharmacy newsletter commenced.	Sep-18	
				QS8.3.5	Pharmacy intranet pages are developed as resource for MDT.	Mar-19	
QS8.4	Improve Medicines security, storage and safe handling.	Mar-19		QS8.4.1	Medicines stored according to policy.	Dec-18	Audits demonstrate medicines and controlled drugs stored safely and securely.
				QS8.4.2	Medicines are transferred safely with the patient when patients are moved between wards.	Dec-18	Audit demonstrated medicines are transferred with patient and process safe.
				QS8.4.3	Introduction of green bins to ensure medicines no longer in use are safely returned to Pharmacy.	Dec-18	Audit demonstrates compliance

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QS09 - Mortality Outliers

SRO: Neill Hepburn

Project Leads: Bernadine Gallen

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS9.1	Clinicians are engaged with mortality	Mar-19	% increase in clerking proforma completion for Main Condition Treated, Comorbidities and significant History	QS9.1.1	Consultants to improve their knowledge and understanding of clinical coding.	Mar-19	Clinicians are fully appraised of the importance of documentation

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.1.2	Information and clinical coding training is in place for middle grade and junior doctors to improve knowledge and understanding	Mar-19	To be in line with national average for elective and non elective depth of coding. Elective: National Average is 3.9. Non elective: National Average is 4.4
				QS9.1.3	Each speciality reviews their mortality and discusses mortality briefings at their monthly specialty governance meetings	Mar-19	100% compliance with reviews
				QS9.1.4	Review compliance with Senior review	Mar-19	Senior Review is occurring by 9am Mon - Fri
QS9.2	Medical Examiner Role is in place	Mar-19	Implementation of the Medical Examiner role at Lincoln and Pilgrim	QS9.2.1	Appoint Medical Examiner	Mar-19	Medical Examiners are in post at Lincoln and Pilgrim
				QS9.2.2	MCCD are completed accurately	Mar-19	All MCCD are discussed with the Medical Examiner prior to being completed
				QS9.2.3	There is a process in place for the Medical Examiner to engage with bereaved families	Mar-19	All bereaved families to be contacted by the Medical Examiner

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.2.4	Initial screening of deaths is undertaken within 7 days.	Mar-19	All deaths have an initial screen by the Medical Examiner within 7 days of a patients death
				QS9.2.5	All reviews that have been graded 1 or above are escalated for a Speciality review	Mar-19	All reviews who have been graded 1 or above have been reviewed by the Speciality
QS9.3	Trust not to be an outlier for Perinatal mortality	Mar-19	HSMR for perinatal mortality to be 100 or less	QS9.3.1	Review coding of perinatal deaths	Mar-19	% increase in Comorbidities and significant History coded
				QS9.3.2	Implement the full Gap & Grow Programme to increase detection of foetal growth restriction	Mar-19	All standards of the Gap & Grow programme are implemented
				QS9.3.3	Implement the Perinatal Mortality Review Tool (PMRT) fully	Feb-19	Perinatal Mortality Review Tool (PMRT) is used for all perinatal mortality
				QS9.3.4	Implement the Saving Babies Lives Care Bundle	Mar-19	Reduction of women smoking at time of delivery (SATOD)
				QS9.3.5	2. Risk assessment and surveillance for foetal growth restriction	Mar-19	Algorithm is in use for high and low risk women
				QS9.3.6	Raising awareness of reduced foetal movement	Mar-19	Information leaflets are given to women and checklist is in use

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.3.7	Effective foetal monitoring during labour	Sep-18	All staff have had an annual assessment on CTG and escalation protocol available
				QS9.3.8	Women are aware of the importance of accessing maternity care within 24 hrs of reduced foetal movements	Mar-19	Communication strategies are deployed to increase awareness of accessing maternity care within 24 hrs of reduced foetal movements
				QS9.3.9	Women are accessing the maternity care within 24 hours of reduced foetal movements	Mar-19	Reduction in still birth rate (7%) to national rate (4%)
				QS9.3.10	Reduction of hypothermia in the new born	Mar-19	A reduction in babies admitted to the neonatal units with a temperature below 36.5c
QS9.4	Coding and documentation are accurately recorded	Mar-19	Achieve the national rate of spells coded for age 65+ 2.08% Achieve national rate of 43.45% for deaths coded	QS9.4.1	Medical clerking proforma's are completed accurately	Mar-19	To be in line with national average for elective and non elective depth of coding. Elective: National Average is 3.9. Non elective: National Average is 4.4
				QS9.4.2	Main condition treated is accurately coded	Mar-19	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
				QS9.4.3	Co-morbidity and significant history is accurately coded	Aug-18	To be in line with national average for elective and non elective depth of coding. Elective: National Average is 3.9. Non elective: National Average is 4.4
				QS9.4.4	Palliative care patients seen are coded and are present in Dr Foster data	Mar-19	Achieve the national benchmark of 1.19% for palliative care coding of spells Achieve the national rate of 43.45% for palliative care coding for deaths
QS9.5	The Trust not to be an outlier for sepsis mortality which attributes to 20% of all in-hospital deaths.	Mar-19	Sepsis HSMR not alerting on Dr Foster	QS9.5.1	Review coding of sepsis deaths	Oct-18	Report to be completed on sepsis notes review
QS9.6	The Trust not to be an outlier for pneumonia /COPD in SHMI which attributes to 16% of all in- hospital deaths. (SHMI includes deaths within the community).	Dec-19	Pneumonia / COPD not to be alerting on SHMI	QS9.6.1	Evidence based guidance is followed to deliver care in hospital.	Dec-19	Compliance with the COPD and Community Acquired Pneumonia (CAP) care bundles.
				QS9.6.2	Evidence based guidance for non invasive ventilation (NIV) is followed to deliver care out of hospital.	Dec-19	Compliance with the NIV criteria for discharged patients
				QS9.6.3	Business case to support the appointment of Pneumonia Specialist Nurses	Mar-19	Business Case developed

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS9.7	Review Learning from Deaths policy to ensure policy marries with current processes	Jan-19	Learning from Deaths policy signed off at Patient Safety Committee (PSC) & Quality Governance Committee (QGC).	QS9.7.1	Update Learning from Deaths policy	Jan-19	Learning from Deaths policy updated
QS9.8	Review function of MoRAG to align to the introduction of ME's and Learning from deaths.	Mar-19	Group implemented	QS9.8.1	Implement a meeting to deliver improvements in mortality and are meeting the requirements of Learning from Deaths policy	Mar-19	Group established

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(Version 3.0)

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QS10 Data Quality
SRO: Kevin Turner
Project Leads: Antony Jackson

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS10.1	Core data quality improvement	Mar-19		QS10.1.1	Agree Information requirements of Trust	Nov-18	
				QS10.1.2	Agreed KPI data specs, and Information SOPs	Nov-18	

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS10.2	Single repository for Information (Inphase)	Nov-18	Inphase becomes the single source for Board and Governance information	QS10.2.1	Establish Inphase build capacity to commence build of SSOT	Sep-18	
				QS10.2.2	Build Inphase capability	Oct-18	
				QS10.2.3	Use Inphase to feed IPR and Governance reporting	30/11/2018 (for December reports)	
QS10.3	Implement Data Quality (Kite Marking) approach	Dec-18	20% of Board data on IPR quality assessed in January 19 Board reports)	QS10.3.1	Review best practice in NHS	Dec-18	
		Mar-19	All Board data on IPR quality assessed in January 19 Board reports)				

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QS11 Hospital @ Night

PRO: Mark Brassington

Project Leads: Simon Evans / Victoria Bagshaw

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the current H@N service and any issues	Sep-18	Names of ED and Trust Wide service lead	QS11.1.1	An Executive Director has oversight and leadership responsibility for the H@N framework.	Sep-18	Named ED with responsibility

Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the current H@N service and any issues	Sep-18	Names of ED and Trust Wide service lead	QS11.1.1	An Executive Director has oversight and leadership responsibility for the H@N framework.	Sep-18	Named ED with responsibility
				QS11.1.2	A trust wide lead position for the service is identified and in place who will work within a well described H@N framework.	Sep-18	Named Trust Wide lead with responsibility
QS11.2	Clear defined corporate and clinical governance arrangements for the current H@N service and the care and safety of patients is in place.	Nov-18	Updated H@N service framework in place	QS11.2.1	A system is in place to ensure the H@N workforce model is in place and monitored	Nov-18	Clear workforce model incorporated into the H@N service Framework
				QS.11.2.2	A suite of management reports are in place which provide oversight of patient safety, compliance and operational performance.	Nov-18	A system is in place to ensure incidents, issues and feedback related to the H@N model are monitored, and actions taken and escalated in line with operating model
				QS.11.2.3	A system is in place to ensure all SOPs associated to the H@N operating model are in place and monitored	Nov-18	A refreshed SOPs incorporated into H@N service Framework
				QS.11.2.4	Sharing Learning from incidents and practice from internal improvements occurs widely across the trust	Dec-18	Process in place

Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS11.1	There is a oversight and management of the current H@N service and any issues	Sep-18	Names of ED and Trust Wide service lead	QS11.1.1	An Executive Director has oversight and leadership responsibility for the H@N framework.	Sep-18	Named ED with responsibility
QS11.3	There is a revised H@N model in place	Apr-19	Revised H@N model	QS11.3.1	Best practice in NHS is reviewed	Jan-19	Examples of national best practice identified
				QS11.3.2	A single service delivered across multiple sites with clear lines of communication, leadership and management	Apr-19	Revised model rolled out
				QS11.3.3	Sharing Learning and best practice from internal improvements, external organisations and national recommendations widely across the trust	May-19	

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QS12 Medical Devices

SRO: Neill Hepburn

Project Leads: Gurdip Samra

Key milestone				Milestone			
Number	Description	Baseline finish date	Evidence key milestone has been achieved	Number	Description	Baseline finish date	Evidence milestone has been achieved
QS12.1	Medical devices policy in place and used effectively	Mar-19	Policy in place	QS12.1.1	Policy agreed and uploaded to Trust intranet.	Jan-19	Policy in place
				QS12.1.2	There is an up to date inventory of all medical devices.	Nov-19	Inventory in place
				QS12.1.3	SOPs are agreed	Jan-19	SOPs available

				QS12.1.4	Audits against policy are developed, implemented and monitored	Mar-19	Audit Calendar
QS12.2	Trust Wide medical devices group has been reconstituted and is delivering against the Terms of Reference	Feb-19	ToR available	QS12.2.1	ToR for medical devices group ratified	Jan-19	ToR available
				QS12.2.2	First meeting of medical Devices group has taken place	Feb-19	Minutes from first meeting
QS12.3	Wards , A&E's and outpatient departments have process in place to demonstrate adherence to trust policy and Health and Safety legislation	Apr-19	Ward accreditation demonstrates compliance	QS12.3.1	Wards , A&E's and outpatient departments have a process and documentation in place to check all medical equipment is checked and tested in line with requirements	Jan-19	Sample of documentation
				QS12.3.2	Wards have a process in place to ensure all staff have initial and update training on all medical devices in use in their area.	Apr-19	Training log
				QS12.3.3	Ward accreditation captures medical device equipment compliance	Jan-19	Ward Accreditation documentation

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Agenda Item 6

		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:	23 January 2019
Subject:	Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update

Summary:

This paper is an update on previous the papers presented to the Health Scrutiny Committee.

It describes the current position regarding the interim paediatric service model in place at Pilgrim Hospital, Boston and also the continuing work to address the significant challenges faced by the children and young people's services (C&YP), which also has clinical interdependencies with neonatal and maternity services at United Lincolnshire Hospitals NHS Trust (ULHT).

The interim service model described in previous papers is in place and remains operational. The medical Trust-wide rota continues to develop to further integrate the site based teams.

In addition, the paper informs the Health Scrutiny Committee for Lincolnshire on the status of the review report by the Royal College of Paediatrics and Child Health and its relevance to the interim model.

Actions Required:

To note the information presented by United Lincolnshire Hospitals NHS Trust on children and young people's services.

1. Interim Model

Background

To address the severe difficulties and challenges caused by a severe shortage of doctors and nurses faced by the paediatric service at Pilgrim Hospital, Boston, ULHT set up a task and finish group, including representatives from the wider NHS system, as described in the papers presented previously to the Health Scrutiny Committee.

The temporary service model described at the June meeting of the Health Scrutiny Committee is in place and became operational on 6 August 2018. This consists of an enhanced paediatric presence in the Pilgrim hospital emergency department and an acute paediatric assessment unit with a twelve-hour length of stay standard. Outpatient clinics and paediatric surgery continue at Pilgrim hospital.

This matter has been considered at each monthly Board of Directors meeting of United Lincolnshire Hospitals NHS Trust (ULHT) since April 2018.

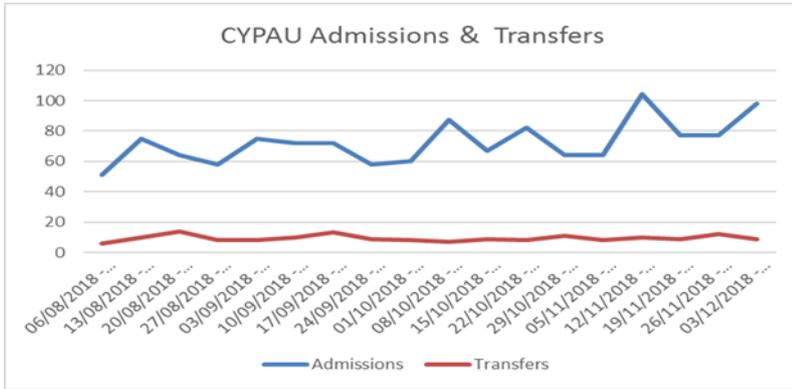
Dedicated Transport Arrangements

Dedicated ambulances were brought in by the Trust to ensure safe transfer of all women and children who require transfer away from Pilgrim hospital under the interim model. A further contract for the dedicated transport provision has been awarded to the existing provider with an option to extend for a further six months. The new contract includes arrangements for transfer of level 1 patients not covered by the existing arrangements with EMAS and Comet, for example the transfer of patients requiring high flow oxygen therapy support.

Patient Activity

Since the interim arrangements were implemented, the paediatric assessment unit (CYP AU) at Pilgrim hospital has seen, assessed and treated over 1,300 children, of which 161 have been transferred to other hospitals using one of our dedicated ambulances, far less than was originally estimated. Whilst these transfers were mainly to Rainforest Ward at Lincoln Hospital, 37 were transferred to other hospitals, 15 being transferred for further specialist care.

In addition, there have been seven in-utero transfers of pregnant ladies with a gestational age of below 34 weeks. Other transfers occurred but they did not cover the gestation age of 30-34 weeks. The total number of transfers out of Pilgrim hospital, as a result of the interim arrangements, is 168 overall.



Impact on Patients

Since the introduction of the interim model, no patient safety incidents have been experienced or reported as a result of the change. One patient complaint is currently under investigation. It is acknowledged that the transfers of patients have caused disruption to those patients involved and their families.

During the first few months of the interim model, there have been a number of occasions when children have stayed longer on the unit than the agreed twelve hours maximum stay. Decisions are made to allow children to exceed the specified time limit on an individual basis only when it is safe to do so and in the best interests of the child. The twelve hour standard is also used flexibly when the transfer would be for a short time period required to complete observations or tests.

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

The system of open access for some children with ongoing health needs has continued at Pilgrim Hospital under the interim service model. Whilst it may be necessary for some patients to be transferred to Lincoln County Hospital if they require a prolonged length of stay, access to the staff and support remains freely available through the pre-existing channels. The Trust has sent a second letter to all registered open access families to remove any doubt, and a meeting will soon take place with a group of parents with children with ongoing health needs. An invitation has also been extended to anyone interested in attending this meeting to contact the Trust and details will be forwarded when they are finalised.

Children on Adult Wards

The Trust can also report that no children have been cared for on adult wards against the child or parent/carer's wishes. No children have been transferred to an adult ward from the assessment unit, although one patient chose to exercise their choice to be admitted to an adult ward during October.

Staffing

As in previous months, the recruitment activity continues at pace. The requirement for a full complement of consultants at Pilgrim Hospital for paediatrics has not changed and remains at 8 x whole time equivalents. The service currently has four full time consultants and two agency locums, making a complement of six whole time equivalents.

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

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

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

The Tier 2 rotation of doctors to Lincoln managed by Health Education England will reduce in February, putting additional pressure on recruitment and meaning we will require additional agency staff. Whilst an active plan is in place, the consultants remain very concerned over the impact on the service.

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

Risk Management

Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group. Incidents are being tracked through the Trust's incident reporting system Datix. No incidents of patient harm have been reported although we are very aware that patient transfers can be inconvenient and a cause for concern.

Feedback from Engagement Events and Communications Plan

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

The Programme Director met with members of SoS Pilgrim and interested parents on Monday 19 November 2018 and will be holding similar meetings at Skegness and Spalding in the New Year. The Programme Director has responded to all outstanding questions from the communications events including concerns about advice given by NHS 111 about the availability of services at Pilgrim, the current low levels of activity, a wish to return to a 24/7 full ward at Pilgrim and the difficulties of attracting doctors to work at Pilgrim.

He will also be meeting with parents of children with ongoing medical needs in January.

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

The findings of all engagement activity are fed directly into the Directorate team, for consideration as part of continuing monitoring and development of the interim model. Full feedback notes from the event have been shared with our women's and children's managers, to be used in development of the service and to ensure current and future service models meets the needs of our patients. Details of a patient survey, carried out earlier in the year and attracting over 700 responses, have also been shared with the service.

The communications plan remains with regular newsletters, public engagement and staff engagement sessions.

The next engagement session is planned for Thursday 17 January 2019.

2. Royal College of Paediatrics and Child Health (RCPCH) Independent Review Report

The report of the Royal College of Paediatrics and Child Health (RCPCH) [*Appendix A to this report*] provided affirmation that change was necessary and that the interim arrangements were in accordance with their professional considerations. It also acknowledged that the Trust has made extensive efforts to mitigate the situation, since the scale of the problem became apparent during Care Quality Commission inspections at the start of 2018 and the hard work being done by all stakeholders to ameliorate the current situation and the absolute focus on safety and quality over cost.

The RCPCH was invited to review the paediatric services at the Pilgrim and Lincoln County Hospitals during a period of extreme challenge to the staffing of the service at Pilgrim. A culmination of factors over several years had led to a high number of medical vacancies at Tier 2 (middle grade) level, combined with difficulties in recruiting consultants, changes to Tier 1 (junior) doctor deployment and children's nursing vacancies.

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

stakeholder organisations. In parallel, a survey of patients, parents, staff and the public was carried out which generated over 820 responses.

The report proposes a model of low-acuity overnight paediatrics for the Pilgrim, supported by a guideline-led short stay paediatric assessment unit, matching demand and minimising the need for transfer of patients whilst providing on-site skilled cover and access to a consultant on call from home. To achieve this will require an increase in substantive medical staff from the current situation and depends upon maintenance of a daytime Tier 1 junior doctor or equivalent rota. The overnight Tier 2 cover could be supplemented through development of the Advanced Nurse Practitioner role with a mixture of Medical Training Initiative, Trust grade and specialty doctors, Clinical Fellows and consultants working resident shifts.

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

The report suggests that the changes will take three to four years to complete but once established should be sustainable if the vision is clear. Strong leadership across all three sites (including Grantham) and a commitment to and by clinical and managerial staff to work differently with a focus on outcomes, quality improvement, swift clinical decision making and strong teamwork with colleagues across the Trust will be required.

It recommends a single plan with shared protocols, guidelines and investment in Quality Improvement to stimulate recruitment and ensure efficient working across both nursing and medical staff.

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

The Trust accepts the RCPCH report in full and has developed an outline action plan to deliver the required improvements and is discussing with staff how it can be most effectively achieved. The Trust is consolidating a number of initiatives into one plan and will consult with stakeholders throughout the process. [*The Action Plan is set out in Appendix B.*]

3. Consultation

This is not a consultation item.

4. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

N/A

5. Conclusion

To address the significant difficulties and challenges caused by a severe shortage of doctors and nurses in the children's and young peoples' services at Pilgrim hospital, an interim service model became operational on 6 August 2018.

The paper describes the performance of the interim model over the first four months of operation, the number of transfers completed, activity on each site, the issues encountered, and actions undertaken to resolve those issues and the importance of the RCPCH Independent Review.

5. **Appendices** – These are listed below and set out at the end of the report.

Appendix A	United Lincolnshire Hospitals NHS Trust – Paediatrics (<i>Service Design Review by the Royal College of Paediatrics and Child Health – 9 October 2018</i>)
Appendix B	United Lincolnshire Hospitals NHS Trust – RCPCH Action Plan

6. Background Papers

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

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Service/design review

United Lincolnshire Hospitals NHS Trust - Paediatrics

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Executive Summary

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

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

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

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

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

The remit of the RCPCH review was to examine the current arrangements for paediatrics across both sites and propose an interim solution and longer term viable vision which would be workable, attract new staff and provide the population with the assurance of safety and sustainability, although not necessarily the same provision as they had traditionally received.

The review involved a multi-disciplinary team examining documentary evidence and interviewing a range of staff across the Trust and from other stakeholder organisations. In parallel, a survey of patients, parents staff and the public was carried out which generated over 820 responses.

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

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

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

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

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

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

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

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

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

Recommendations

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

Immediate

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

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

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

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

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

Enabling actions

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

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

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

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

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

Nursing

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

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

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

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

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

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

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

Medical Staffing

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

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

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

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

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

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

Other recommendations

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

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

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

1. Introduction

- 1.1. In April 2018 the RCPCH was approached by Dr Neill Hepburn, Medical Director of United Lincolnshire Hospitals NHSFT, to conduct a review of the paediatric services across the two sites. This report sets out the process and findings of the review.
- 1.2. An RCPCH Invited Review is an independent critique against agreed Terms of Reference, based on information provided to the reviewers, interviews with staff and stakeholders and published regulations, policy and standards from RCPCH and other professional bodies.
- 1.3. The report belongs to the Trust and remains confidential unless the Trust decides to publish it. The RCPCH does encourage wider dissemination of this report amongst those involved in the service but will not itself publish or comment on review reports without the express permission and agreement of the Trust..

2. Terms of Reference

- 2.1. The RCPCH Invited Reviews team will conduct a review of the ULHT neonatal emergency and paediatric service provision, focussing particularly on the Pilgrim Hospital, to develop an achievable long-term model of care, examining
 - a) The current provision of neonatal, emergency and paediatric services within the Trust in terms of
 - Staffing and workforce arrangements—medical and nursing teams
 - Emergency, urgent and neonatal care pathways for infants and children
 - Activity and workload
 - Clinical governance, risk, QI and compliance with professional standards
 - Operational and strategic liaison with neonatal, emergency and other networks
 - b) Options for future workforce provision, taking into account
 - Progress with the STP and the region's policy drivers and impact of proposals
 - The national picture for workforce and new ways of working
 - Experience /benchmarking from other equivalent units in the UK
 - Any areas that require further exploration that may not have been considered.

3. Background and context

- 3.1. United Lincolnshire Hospitals NHS Trust is one of the most challenged trusts in the Midlands with three acute hospitals serving a largely rural population including around 160,000 children. A Care Quality Commission (CQC) inspection in October 2016 published in April 2017 rated the Trust as Inadequate and in special measures. This was primarily due to a poor rating on safety, although the children's services were rated 'good'. A follow up inspection in February 2018 raised concerns about the paediatric provision.
- 3.2. Lincoln County Hospital has a fully staffed ED seeing 71,000 patients a year, with a 19-bed children's ward, 8 bed assessment unit and Level 2 Local Neonatal Unit serving 3700 births a year, caring for infants over 27 weeks' gestation. There are around 3500 acute and 96 elective paediatric admissions, 2700 ward attenders, with 1900 new and 2900 follow up outpatient attendances per year
- 3.3. Grantham and District Hospital has no paediatric inpatients and a limited emergency service which sees 29,000 patients a year and has been closed overnight since July 2016. Two long term locum consultants provide a weekday presence between 9am and 5pm and a limited service at weekends and the extensive list of exclusions is well understood by the local health community. Following a Clinical Senate review in November 2017 there are no plans to reopen the overnight service.
- 3.4. Children's services at the Pilgrim Hospital in Boston include an ED seeing around 55,000 patients a year. a children's ward designed for 19 beds, plus an 8-cot special care neonatal unit supporting around 2000 births a year taking infants from 30 weeks gestation¹. This sometimes includes transfers from Lincoln County when that unit is full. There are around 2700 acute and 90 elective admissions, 2600 ward attenders, with 1500 new and 3000 follow up outpatients annually. The site is 39 miles from Lincoln County Hospital but the roads are not fast, taking around 80 minutes by car to travel between the sites. Public transport is extremely limited between the sites and in the catchment area of the Pilgrim, which extends up to 43 miles to some coastal towns. We heard that sometimes families cannot get home following out of hours' discharge.

¹ this was changed to 34+ weeks in August

- 3.5. Although the joint Strategic Needs Analysis produced by the local authority² did not highlight significant need beyond a raised neonatal mortality³ it is based on 2016 data for the whole county. The review team was told that the population specifically using maternity and child health services is characterised as high risk. Lifestyle behaviours lead to obesity with high BMIs and a smoking rate of around 21% overall, increasing to 40-50% of the childbearing community from eastern Europe. In addition, many people are not fluent in English, live in multiple occupancy rented accommodation, are in low-paid employment and have a poor understanding of how the NHS works. In their home countries many would not use a GP but go direct to an acute paediatrician and the review team was told that many women choose to have their babies in their home country.
- 3.6. For the population of Lincolnshire in 2016, 67% of live births took place in Lincolnshire hospitals (42.2% Lincoln County and 24.8% Pilgrim and Grantham⁴). However, in the same period, a high proportion of local women gave birth outside the county; 28% of live births took place at hospitals in counties that border Lincolnshire (13.5% Peterborough, 8.5% Grimsby, 2.9% Nottingham, 2.4% at Kings Lynn and 0.9% Scunthorpe) and 1.5% babies are born in other hospitals. The number of Lincolnshire mothers giving birth at home is increasing with 2.85% being born at home in 2016. However, 0.3% of babies are 'born before arrival' – i.e. neither born at home nor at a hospital, usually en route⁴.
- 3.7. A CQC visit in February 2018 required the Trust to ensure that the Pilgrim ED was appropriately staffed with suitably trained nurses to meet the needs of children and young people. To enable this, three registered children's nurses were transferred there from the 4th floor children's ward. The reallocation of nurses added to the CQC requirement to reduce bed numbers from 19 to 8. However, this added to the risks to children requiring emergency care, placing pressure on decision-making due to the lack of capacity on the ward.
- 3.8. CQC served a notice of intent of enforcement action on the Trust about Pilgrim in March 2018 under Section 31 of the Health and Social Care Act 2008, requiring the Trust to demonstrate a safe model of care and risk assessment. They cited two previous emergency care incidents and concerns about delays in implementing improvements.

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

³ most deprived decile, PHE 2014-6)

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

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

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

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

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

Option One	<ul style="list-style-type: none"> Maintain Current Services at Pilgrim Hospital, this is reliant on finding additional multi-professional staff from agency to cover paediatric, maternity & neonatal services
Option Two	<ul style="list-style-type: none"> Temporary Closure of the Paediatric inpatient ward at Pilgrim with effect from 1st May Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest A&E or UCC Temporary re-direction of GP paediatric referrals to neighbouring organisations Paediatric assessment model adopted for Children self-presenting at A&E Retain running of Consultant led Obstetric and Neonatology services on the Pilgrim site (& the Lincoln site) for the foreseeable future, this is reliant on finding additional medical staff from Agencies with effect from July Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks
Option Three	<ul style="list-style-type: none"> Temporary closure of Paediatric inpatient services at Pilgrim from May 1st Temporary redirection of paediatric emergencies transported by ambulance to Pilgrim – redirected to nearest A&E or UCC Temporary re-direction of GP paediatric referrals to neighbouring organisations Paediatric assessment model adopted for Children self-presenting at A&E Retaining Consultant led Obstetrics and Neonatology at Pilgrim until July 1st when medical staffing reduces beyond the ability to support Neonatology. From July 1st Temporary closure of Consultant led Obstetrics and Neonatology at Pilgrim until the staffing gaps could be addressed

	<ul style="list-style-type: none"> • Increase gestational age for delivery within the high risk birthing unit from 30 weeks to 34 weeks • Establish a midwifery led birthing unit at Pilgrim Hospital and a co-located midwifery led birthing unit at the Lincoln Hospital to facilitate increased activity on the consultant led unit.
Option Four	<ul style="list-style-type: none"> • Maintain Current Paediatric inpatient services, Consultant led Obstetrics and Neonatology services at Pilgrim & Lincoln Hospital but reducing paediatric bed numbers on each site to align with available staffing. Achieving this by: Temporary Transfer of staff (medical and nursing) from Lincoln Hospital to Pilgrim Hospital. (This will require adjustment to bed numbers at Lincoln and cancellation of some elective activity at Lincoln)
Option Five	With effect from July 1, 2018, providers across the region to provide Neonatal Medical cover (Consultants and/or Middle Grade doctor) for Pilgrim Maternity and Neonatology.

NB the dates quoted were correct as at April 2018

- 3.13. The Board agreed to pursue Options 1 and 3 as 2 was temporary, 4 did not release sufficient medical time to cover the out of hours rota and 5 was not supported by neighbouring units. A temporary model based on Option 2 was the objective from 1st August 2018 with twice weekly task and finish group meetings and regular reports to the Board and public.
- 3.14. Current provision from 1st August is twelve assessment and observation beds running 24/7 with any child needing more than 12 hours care being transferred to Lincoln using one of two private ambulances retained on standby. EMAS ambulances are directed past the site and neonates under 34 weeks are transferred (ideally in utero). There is a Neonatal Life Support (NLS) trained midwife or neonatal nurse on every shift.
- 3.15. The Trust needs to move to a sustainable model that will map to the developing strategic plans for the region and provide a safe, equitable service across the rural communities of Lincolnshire, supported by the Clinical Senate and NHS Improvement. This model needs to address patient flow and demand but can consider new ways of working to tackle recruitment problems with the engagement of the staff involved.

4. The Review Process

- 4.1. The Trust commissioned an RCPCH Invited Review alongside various other parties (including NHS England/NHS Improvement and other stakeholders) offering immediate planning and interventions to provide a fresh, independent opinion on what is currently being delivered, what works well and what could be done differently. The recommendations should propose how to deliver sustainable, effective services that meet the current and anticipated future demands of the population and makes the greatest use of resources and paediatric and other expertise.
- 4.2. The RCPCH review team comprised two consultant paediatricians, an experienced children's nurse and a lay reviewer, all supported by a manager from the RCPCH.
- 4.3. The review team was provided with pre-reading in order to prepare for the review. A pre-visit took place on 14 May and the full team visited both sites to interview staff on 13-14 June 2018. Some additional documentation was requested and received during and after the visits and some telephone calls were conducted after the visits due to people being unavailable to meet the team in person. Contact details for the review team were provided to all interviewees and the review was conducted in a climate of 'confidential openness' to enable staff to share their views freely. Notes were taken at the meetings; these have not been transcribed but have been used alongside the documentation, to inform this report.
- 4.4. The review team would particularly like to pass on their thanks to all participants for their hospitality, engagement with the process, their openness, and their time.

5. Findings

5.1 Nursing staffing – Pilgrim

- 5.1. The problem highlighted by the CQC visit in terms of children's nursing presence in the Emergency Department (ED), and consequent reorganisation of children's nurse staffing had been at the time of the visit mitigated temporarily by reducing inpatient bed numbers, alongside training of adult nurses and increasing availability of non-registered staff to provide support. Ensuring at least two RN(C) staff are on shift at all times has been a challenge and at times staff from Lincoln County have supported shifts at Pilgrim and assistance and advice from NHS Improvement has supported development of the service.
- 5.1.2 As of May 2018 nurse staffing at Pilgrim showed 8.25 wte vacancies against an establishment of 26.65 wte and 17.18 wte available to work, restricting the number of beds available for use. Senior staff explained several measures that have been initiated to build the service through a focus on recruitment and retention alongside dealing with the day-to-day challenges of filling shifts.
- 5.1.3 Adult nurses have been recruited and trained in paediatric competencies. Funded Band 6 posts have been increased to enable one Band 6 nurse on each shift for supervision and safety. This has mitigated the position but numbers are still insufficient with 0.9 WTE Band 6 vacancy.
- 5.1.4 The nursing team leader from the children's community nursing service had been temporarily assigned as Matron at Pilgrim pending the appointment of a permanent ward manager. This secondment was initially for six months but has lasted 15 months. The Review Team was told that Matron had transformed the nursing service, with improved morale and opportunities for training and development.
- 5.1.5 Bed numbers had been reduced to 8 whilst three nurses were temporarily reassigned to ED but these have returned to the ward. At the time of the visit there were 12 beds open, with occupancy ranging from five to 13 patients over the course of a week although acuity can be very high. Detailed analysis had shown a need for 16 beds during winter months. Nurses reported that managing the full complement of 19 beds (and also bed capacity as children backed up in ED) had been particularly difficult but 12 was manageable and they felt they could provide good, safe care. There was general enthusiasm for the

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

- 5.1.6 There is no HDU and sick children are transferred if they need ongoing level 2 care. Skills to provide Level 1 high dependency care or short-term Level 2 care whilst awaiting transfer should be available on all children's in-patient services⁵. It was reported that funding had been allocated for an additional 5.5 WTE Band 5 nurses to fully staff one level 2 bed. Whilst initially it was thought this would attract nurses it is not practical in the future model to provide this level of care within a PAU at Pilgrim. However, a PAU can be a busy area and a stabilisation bed, ideally in a slightly separate area, should be provided.
- 5.1.7 In recent months there has been a significant emphasis on training, from developing a robust induction, and strengthening preceptorship to maintaining and improving clinical competencies such as tracheostomy care and ensuring nursing staff are up to date with required training. Essential skills are being reviewed, refreshed and developed including as a priority resuscitation training, with plans to develop paediatric skills in surgical and orthopaedic nursing and provide basic CAMHS sessions to all nurses. Resuscitation training compliance has increased from 45% to 95% in recent months. Staff are valuing this investment in their development, coming in to be trained and appraised in their own time as they cannot be spared from the ward; they are paid for the time and are happy to support the service in this way, with indications that morale is increasing.
- 5.1.8 Children's nurses are required to cover on the special care unit (SCU) as well as in the ED at the Pilgrim which requires them to have skills in both paediatric and neonatal resuscitation. Although all contracts include a clause requiring cross site working between Boston and Lincoln, discussions about this have not resulted in a formal trial as there is some reluctance on the part of existing nurses to routinely add an additional hour journey to each end of their shifts.
- 5.1.9 Staff reported good access to allied health professionals, including physiotherapists to reduce lengths of stay and speed discharge although Speech and Language Therapy is more difficult to access. There is a pharmacy technician and an agreement for "TTO" medicine packs on the ward, with paediatric pharmacy support from Lincoln, which can speed discharge.

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

5.2. Nursing Staffing – Lincoln County

- 5.2.1. Nurse staffing on Rainforest Ward in March 2018 comprised 26.54 wte, made up of 5.48 x Band 6s and 21.06 Band 5s. There are 17.26 wte children's nursing staff in post and available to work and 7.64 wte vacancies. It was not confirmed whether there are any adult-trained nurses supporting the service. Recruitment activity was reported to have been successful with all vacancies planned to be filled by September 2018.
- 5.2.2. Nurse staffing on Safari (Daycase ward) was stable with 5.13 wte in post and 0.6 wte vacancy. The team are discussing establishing nurse-led clinics for ward attenders and are keen to make these work, to improve the efficiency of the unit.

5.3. Nursing Staffing – General and Community

- 5.3.1. Nursing problems were raised back in November 2015 when a risk summit was held as 41% of nursing staff were unavailable for their shifts due to sickness, maternity and vacancies. Following the appointment of a new Director of Nursing in 2016 and the more recent involvement of NHS Improvement's Head of Children, Young People and Transition, two senior nurses have been moved on a temporary basis from community nursing to lead the acute children's nursing service at each site. They had been in these 'temporary' roles for around 15 months and were making a noticeable difference to morale, competences and development of the nursing staff at each site. However, these are operational roles and are unable to make a significant contribution at senior management level, to influence the development of children's nursing within the trust.
- 5.3.2. A Head of Nursing or Associate Director of Nursing for children's services would provide the strategic vision and leadership for children's nursing, wherever children are seen. Working with a children's services matron on each site and the Children's Practice Development Nurse, the leadership capacity would enable development at both operational and organisational levels to ensure the proposed model has the nursing resource required to provide high standards of care to children.

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

Nurse training

- 5.3.3. Several interviewees explained that some of the problems with nurse recruitment lay with the absence of locally commissioned nurse training – this needs to be embedded in the service strategy to ensure a continuing supply of nurses and support backfill and development of those able to work at more senior levels. The degree-level courses in Peterborough and Nottingham place nurses locally to the faculty so they did not get experience of working in Lincoln and Boston. There is a tendency for many nurses to stay where they were placed after training was complete – although two nurses had just come from Peterborough to join the team which was an exception.
- 5.3.4. There is a new degree-level course being reintroduced at Lincoln University from September 2019 (awaiting NMC Accreditation) which has potential for supplying the Trust with a steady stream of new recruits from 2022, although numbers will initially be small. This will improve the unit's reputation amongst nurses and, it is hoped, improve retention. There are good relationships with the university including occasional 'exchange' between a lecturer and the acting matron swapping lectures and shifts on the ward.
- 5.3.5. The induction programme and preceptorship for nurses was reported to require development to help reduce the drain of skilled children's nurses from the Trust. There is a national problem that newly qualified nurses do not stay long unless there is a career structure and development – which is not always the tertiary centres. To provide a focus on education, a Children's Practice Development Nurse is required to build on the university links and focus on staff development in children's and neonatal services at all levels including supporting student placements (in future), induction and preceptorship, the development of competencies in adult nurses and the development of specialist and advanced nursing practice roles. This role would provide effective communication across all children's areas and with the university, supporting the creation of a career framework for nurses within the trust.

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

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

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

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

Provision of community nursing

- 5.3.7. It is important strategically to ensure that the positive investment in development of nurses on the wards does not deplete community nursing leadership. The future of hospital services relies on strengthening community provision to support services aimed at keeping children and young people out of hospital.
- 5.3.8. Community children's nurses work in three localities, broadly centred around the hospital sites. Each team comprises a Band 7, 3 band 6, a healthcare assistant and administrative support. They work between 9 am and 5 pm, Monday to Friday, covering long term conditions, including long term ventilation. They also aim to provide a 24-hour palliative care service, providing cover for the palliative care rota across the county. They have been able to provide some intravenous antibiotics for children following acute admission. Currently, however their staff numbers are suffering from secondments to the hospital, maternity leave and vacancies: of 11.7 WTE, 6.6 are unavailable. Pending further recruitment, the teams had been merged to two, focusing on long term conditions, complex care, long term ventilation, tracheostomies and home oxygen; they are unable to accommodate acute care including intravenous antibiotics and there is no community neonatal nursing service.
- 5.3.9. District nurses do not see children and attendance by a CCN has to be authorised by the consultant paediatrician, making it difficult for the GPs to refer directly to the service. As the service is not currently able to cover the whole catchment it would be too thinly stretched to provide a service to GPs to reduce attendance at the acute site. However, this would be possible in the future, if a seven-day service was provided with night-time on call for palliative care and staff told us that this would enable reduction in length of hospital stay for children and young people. Locally, the team have discussed using advanced children's nurse practitioners in both assessment unit and community teams, to establish a rapid response service to provide interventions, education and support to families at home.

- 5.3.10. In order for the service to minimise emergency attendance and/or the needs for overnight transfers, investment is required in GP liaison and a rapid response acute children's nursing service, which should include palliative care and enable some children to be sent home from the PAU overnight. This should be as described in the RCPCH intercollegiate Publication "Facing the Future: Together for Child Health"⁶ which sets out eleven standards for reducing attendance and admission to acute services, including strengthening of community nursing services and better liaison between teams.
- 5.3.11. Community children's nurses need to be able to communicate with the non-English speaking population where required and work closely with GPs, pharmacists and the CCGs on public education about emergency services. These are longer term actions to build a strong framework of care in community settings in line with the NHS Five Year Forward View. The current community children's nursing service was reported to be difficult to access by families and is not yet working efficiently as it could with the paediatric and emergency teams to speed discharge and reduce attendance.
- 5.3.12. There are a number of schemes in the UK which have placed children's nurses in GP practices, reducing pressure on GPs and EDs, with clear governance and SoPs. Given the geography of the region this could be a helpful model for the population and a further opportunity to develop nurses if sufficient supply of appropriately trained children's nurses can be secured. The RCPCH can provide contact details

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

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

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

⁶ Facing the Future: Together for Child Health RCPCH 2015

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

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

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

5.4. Medical Staffing – Pilgrim

- 5.4.1. There have been reported problems with medical staffing at the Tier 2 grade since April 2016 with a number of Risk Summits and short-term fixes since then.
- 5.4.2. At the time of the visit there was a consultant establishment of 14 across the two sites, (8 Lincoln, 6 Pilgrim) of which 13.5 were recruited including 2.5 locum staff, on an average of 11.5PA contracts. The website however shows 16 consultants but states nine are in post. Compliance with Facing the Future standards⁷ requires 19 consultants across the two sites (21 if on 10 PA contracts) to include the neonatal cover. Nationally, the average number of consultants on a general/neonatal tier 3 rota is 8.3⁸ .
- 5.4.3. At Pilgrim funding was agreed in June to take establishment to 7.6 wte consultants, with 5 substantive in post, most on 12PA contracts. None of the consultants had been in post for more than 2 years so they were objective about the comparisons with other units and expressed concerns about morale, workload and the expectations on them from management. This had escalated since April 2018 when they felt that decisions were being made without involving them. They reported feeling undervalued despite providing what they considered to be a good standard of care and they were concerned that colleagues are leaving. Morale was reported to be 'flat'.

⁷ Facing the Future: RCPCH 2015

⁸ Workforce census 2015 <https://www.rcpch.ac.uk/resources/workforce-census-2015> RCPCH March 2017

- 5.4.4. At the time of the visit the consultants were aiming to work to a traditional 3-tier model on both sites with 24/7 tier 2 cover and consultant on call from home overnight. They were not prepared to work resident on call routinely, but since the introduction of the new model of care in August they have been working until 10pm to ensure that patients are appropriately reviewed, transferred or discharged.
- 5.4.5. At tier 2 there have been long term problems recruiting to posts with just 3.5 wte available at Pilgrim in April out of an establishment of eight.
- 5.4.6. Until recently the consultants have been providing cover and acting down when required when long term locums were not available. Their goodwill had been exhausted by the time of the review visit as problems with tier 2 recruitment had been long standing and have not improved despite attempts to recruit.
- 5.4.7. Uncertainty about the future was compounded in June when the Health Education England/Deanery announced that from 1st August tier 1 doctors should no longer work out of hours at Pilgrim suggesting that individual slots are rostered from Lincoln County and cover daytime work only, to ensure quality training and avoid burn-out.
- 5.4.8. As a result, from October 1st there was predicted to be one whole time equivalent Trust grade doctor and one tier 2 doctor out of an establishment of eight with the rest of the shifts covered by locums when they can be recruited, which is proving increasingly difficult.
- 5.4.9. The consultants are anxious about the service risks of this arrangement for three reasons:
- locum doctors can cancel with two hours' notice or demand inflated fees and leave the unit without cover,
 - although the cost is not a driver in this situation, resources spent on locum staff could be used more constructively elsewhere if permanent staff can be recruited,
 - in an emergency having a locum first and second on call leaves a significant amount of accountability with the consultant, and they feel that the level of risk is unacceptably high.
- 5.4.10. There were significant concerns expressed about the quality of some of the short-term locum cover experienced at Pilgrim, requiring the consultants to cover extra shifts in order to provide supervision. There were reports that some of the locum doctors do not keep

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

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

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

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

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

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

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

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

Trainee Experience

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

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

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

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

- 5.4.18. Trainees need 12 weeks’ notice of their assignment which can be before their exam results are known, and a large proportion apply for London Trusts leaving fill rates lower in more rural communities like Lincolnshire. There is some longstanding resentment within the Trust about inconsistency and perceived lack of transparency over allocations. It is of note that the Deanery does not include Lincoln on its website⁹, citing only Nottingham, Leicester and Derby and the reason for this is unclear.
- 5.4.19. Trainees spoken to by the review team reported that they did not feel valued or supported by the Trust; they were expected to fill service gaps including unsocial hours and did not receive recognition for this contribution in comparison to how they were treated in other rotations. Their training time was often not protected. There was little surprise that rota gaps were hard to fill as trainees’ communications systems are good and consequently there were fewer applications for these posts.
- 5.4.20. An example was that no trainees attended the slot allocated for them to meet the review team; it had been arranged for a time when they were all on service, courses or leave but nobody had found this out ahead of the visit and the trainees were disappointed to hear that they had missed their chance to participate. We did arrange for telephone input after the visit however.
- 5.4.21. Since the review visit there has been considerable work with the Deanery and trainees are now working well under the new arrangement (Since 1st August). There is more time for teaching and learning and they are not working overnight. This is a potentially sustainable situation and provides support to the rotas and a positive experience by the doctors of the opportunities available at the Pilgrim site. See also .para 6.4.6

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

⁹ <https://www.eastmidlandsdeanery.nhs.uk/paediatrics>

5.5. Medical Staffing – Lincoln County

- 5.5.1. Medical staffing at Lincoln comprises eight consultants including 2 locums. At the Tier two level there are currently eight posts comprising five trainees, one Associate Specialist, one Teaching Fellow and one Speciality Doctor. Two further Specialty Doctor /Senior Clinical Fellow posts (ST4+) in neonates and general paediatrics are being advertised to a total of ten posts to enable a 1:10 rota and support out of hours for the emergency department. At Tier 1 there are eleven doctors¹⁰ covering the ward, ED and neonatal unit, including 4 GPVTS trainees, 4 whole time ST1-3s, 1 junior clinical fellow on the neonatal unit and 2 F1 Junior Doctors, all based in Lincoln. There are four Advanced Neonatal Nurse Practitioners rostered to cover the neonatal unit.
- 5.5.2. The consultants at Lincoln are feeling under pressure and consequently unable to assist their colleagues in Boston; although some conduct outpatient clinics there at least one had never visited the Pilgrim. The concept of ‘one team two sites’ has not yet become embedded and the Lincoln consultants are concerned that the proposed requirement to cover both sites is hampering their own recruitment process as applicants have pulled out, potentially putting both sites at risk. The review team did however hear of Pilgrim consultants covering rota gaps on Lincoln night shifts and the neonatal unit but this was an ad hoc arrangement.

5.6. Emergency Care

- 5.6.1. The Emergency Department at Pilgrim has been facing its own staffing pressures with just one substantive consultant and two long term locums, and is reliant upon the paediatric service to support attendances.
- 5.6.2. There is a triaging/streaming service provided by Primary Care Lincoln Community Health service through either a GP or an Advanced Clinical Practitioner (ACP), who can prescribe and order x-rays, located in the new ED front entrance. This arrangement was reported to deal with 20% of attendances but it was not confirmed whether the nurses have children’s nursing competencies. All ACPs must complete a range of paediatric competencies for which they are assessed. Each ACP has access to the Royal College

¹⁰ From a current Job description

of Emergency Medicine competencies document¹¹, which includes paediatric competencies. Two of the four ACPs were reported to have completed these.

- 5.6.3. The ED consultants reported that the paediatricians arrive swiftly in ED when called and they had not noticed any increased risk despite the current staffing pressures at Tiers 2 and 3. There were two RN(C) on duty when the review team visited with a total of three employed but at least six wte are required to provide one per shift at all times. All anaesthetic staff were reported to have basic competencies to level 4. There is no 24/7 anaesthetist on site but three anaesthetists are paediatric trained and will usually attend if required and available even if they are not rostered on-call. Whilst resuscitation is possible without a paediatrician there would be no diagnosis or long-term planning for attending children if they were not present. All staff in ED have EPLS and 88% of nurses have Level 3a safeguarding training.
- 5.6.4. The level of support from CAMHS for children with mental health problems has improved and referrals are collected directly from ED where appropriate with no need for the inpatient ward to be used as a place of safety. There is good telephone access to the crisis team who will attend if required. Training for ED staff in managing patients with mental health problems was planned when we visited.
- 5.6.5. The East Midlands Ambulance Service (EMAS) is currently under significant pressure. Midwives told us that emergency ambulances can take up to four hours to arrive as the unit is considered to be a 'place of safety' and the paediatricians quoted six hours for one retrieval with limited facilities for waiting for transport. EMAS does not have specialist transport for neonates, and the CenTre Neonatal Transport Service will only pick up from neonatal units so would not attend a midwife led unit. The Lincolnshire and Nottinghamshire Air Ambulance based at RAF Waddington can provide some cover but cannot be relied upon in bad weather or at night and sometimes only road access is possible.
- 5.6.6. Since 1 August two privately-run staffed ambulances have been stationed at Pilgrim to transport women in labour, newborns and children to other units if they no longer meet the new criteria for staying at Pilgrim. Monitoring of their use is essential to map demand and

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

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

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

5.7. Activity Governance and Quality Improvement

- 5.7.1. Whilst the published Board papers and various summits have provided extensive analysis of the current activity and the staffing required to deliver it, they do not explore the approach to provision of care, whether services are using the latest techniques to maximise efficiency and effectiveness and the overall satisfaction and outcomes experienced by patients and their families. Staff reported in June that they felt the service at Pilgrim was 'unsafe' but were reluctant to say so for fear of it being closed, indeed one member of staff felt the service was 'broken at every point' and there was 'lots of interference from people from outside'. This is explored in 5.9.2..
- 5.7.2. The review team has not seen the divisional quality report but noticed that the audit data and patient feedback information displayed on boards on the ward was out of date, with some 'monkey' feedback going back to 2016.
- 5.7.3. There was little evidence of active Quality Improvement within the service. Staff were weary of the pressure and had little time, 'headspace' or senior encouragement to develop innovative techniques or new ways of working. Trainees were limited in their capacity to do audit or QI projects due to the intensity of their roles, but investment in this kind of work is just as important as filling the rota gaps in motivating staff to provide more effective care.
- 5.7.4. Modern ways of working, use of technology and telemedicine and harnessing the enthusiasm, expertise and innovation often brought by newer members of staff within a robust governance framework are key ingredients to a successful service. This can lead to a climate and culture that attracts high calibre staff and maintains morale whilst enabling significant improvement and efficiency if supported at every level. All doctors are required to demonstrate Quality Improvement activity as part of revalidation and there

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

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

- 5.7.5. Whilst there is a high level of confidence and trust in Pilgrim by parents and carers it is essential that there is active monitoring of incidents and outcomes and a climate of continuous exploration as to what could have been 'even better'.
- 5.7.6. The paediatricians at Pilgrim are all relatively new appointments (less than 2 years) and 25% of medical staff are locums, mainly because they are not yet fully trained to take on a substantive role, but this proportion risks impeding development and growth of the service as substantive doctors are too busy supervising colleagues.
- 5.7.7. The RCPCH has published a series of standards under the 'Facing the Future' heading with practice examples and metrics that enable a service to assure itself that it is offering safe and effective care. Many units in the UK are now benchmarking against these standards and the audit findings from 2017. Although the RCPCH has not been furnished with the latest governance and quality reports by the Trust there are a number of initiatives which are becoming the norm in other units and which should be actively developed at Pilgrim such as:
- Consultant presence at peak activity – usually 5 - 9pm – seven days a week to speed diagnosis and decisions. 38% of units achieved this in 2017.
 - Rapid Response next day clinics for urgent GP referrals to reduce ED attendance
 - GP access to immediate telephone advice, (86% of units offer this) plus some units offer an email advice service – responding to queries swiftly to reduce referrals and share learning
 - Link consultant paediatricians to GP practices to seek feedback and share information about the service. 7.4% of units had this in 2017
 - Community children's nursing service seven days a week– supporting families whose children have complex care needs or are recently discharged from hospital or ED. 14.8% had a 24/7 service in 2017
 - Clear care pathways agreed with primary care for common acute conditions. 16.9% had these in 2017

- 5.7.8. Development of a formal governance structure to accommodate the changes to the service provision at Pilgrim and provide a visible record of progress and priorities will also help to change ways of working and stimulate improvement. This would usually include a dashboard on PALS, Datix, Complaints, Incidents alongside the formal Trust-level targets.
- 5.7.9. For patients, parents and carers, there is little information on the Trust website about the service, how to access help and the current arrangements for paediatric care at Pilgrim. This makes it harder for parents to self-care and make choices about where to seek advice.

5.8. Leadership and Vision

Perceptions of management intent

- 5.8.1. Medical and Nurse staffing problems in the paediatric service have been a serious concern at the Trust for almost four years with short-term fixes and summits providing only temporary solutions. In 2014 work by the previous medical director on a Trust wide clinical strategy recognised the continuing failure of both sites to meet RCPCH workforce and other standards and proposed consolidation of all paediatric activity on one site, presumed (but not stated) to be Lincoln. The review team was told that there was little consultation or engagement in development of the strategy, a lack of clarity about the emergency care implications and little or no assessment of population-based risk. However, recruitment activity and subliminal management communications promoted the perception that Pilgrim was set for closure which continues to increase the difficulty of recruiting permanent staff. Despite assurances from senior management and politicians that Pilgrim will not close a previous strategy suggesting it might was at the time of the visit still available on the Trust intranet
- 5.8.2. More recently an Acute Service Review conducted internally by the Trust aimed to save some £80m and recommended diverting some services, but the review team was told they did not explore where these patients would go nor if there was capacity and the emergency department staff were not involved.
- 5.8.3. The consultants at Pilgrim are feeling increasingly undervalued which has resulted in their ceasing to cover the tier 2 rotas. They clearly stated that they will not consider resident on call, although there were reports of better staff engagement since April. Many staff

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

- 5.8.4. The leadership of the Trust have stated their current vision of 'Two sites, one team' and strive to explain their commitment to Pilgrim but although the phrase was used many times during our visit it was only by management and we did not see evidence that the clinicians were working this way. Those at Lincoln are reluctant to support their Boston colleagues and the distances make routine shift cover an ineffective use of consultant time except in exceptional circumstances. It was pointed out that almost all the meetings and Risk Summits about the problems at Pilgrim had been held at Lincoln and that words were not underpinned with actions from senior staff; discussions often did not include staff from Pilgrim.
- 5.8.5. The Trust Board papers of 29 June recognised Trust-wide concern about turnover and vacancy rates which were driving up agency spend, and the recent announcements regarding relaxation of visa rules for doctors and nurses would not resolve the issues. A review of the approach to recruitment was under way to determine what more the Trust can do to improve recruitment rates and change the workforce model and establishment to a lower cost model. Many of the solutions are included in this and the previous section and there must be a focus on why staff should and would choose to work in Lincolnshire over another unit. Indeed even the basic advertisements for the roles lack lustre and energy when compared with other similar jobs advertised elsewhere.

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

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

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

Going forward

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

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

5.9. Liaison with other units and Networks

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

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

- 5.9.2. There has, as previously mentioned been extensive engagement from NHS Improvement, NHS England, CQC, Health Education East Midlands and other stakeholders towards helping to shape a safe and effective model. The Clinical Senate in East Midlands has also been engaged to assist in identifying options for the service. Comprising clinicians and managers from neighbouring Trusts alongside lay representatives, the Senate is meeting on 12th September 2018 to consider the current model and review a longer term plan to further support the Trust.
- 5.9.3. The neonatal ODN and specialist commissioners have been involved with the neonatal provision and support the unit at Pilgrim as a Level 1 unit from 34 weeks, but would not support provision if the threshold was raised to 37 weeks, as originally proposed.
- 5.9.4. The STP Expert reference groups established during 2016 covered the major pathways. but this did not result in a clear strategy for maternity, children and young people and this will be discussed at the Clinical Senate on 12th September 2018. Since the STP covered only Lincolnshire, rather than neighbouring counties, large scale cross-county redesign of acute services was outside the scope and there is no strategic agency which is in a position to do that.

5.10. Maternity Services

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

- 5.10.2. The Lincoln better births strategy and implementation plan for Lincolnshire 2017, are founded on engagement with Women and their families through the Maternity Voices Partnership. The strategy sets an ambitious vision over five years to increase the homebirth rate to 10% and midwife led care to 40% and plans for movement to 60%. A range of models for provision have been explored and are being rolled out including ‘pop-up’ birth centres, four maternity ‘hubs’ and better links between midwives and health visitors. The review team was told that only 37% of women are currently assessed as having a low risk pregnancy and therefore suitable for consideration for non-obstetric midwifery only care so this is an ambitious target.
- 5.10.3. Maternity staff were concerned that they had not been consulted or involved in discussions about the paediatric changes which could significantly affect delivery of the better births strategy, and the Trust’s maternity webpage does not give details about the changes to service. Midwives are the main point of contact between the Trust and expectant parents who were concerned about the newspaper reports of closure. None of the obstetricians from either site reported having been involved in development of the options; although the Head of Midwifery is involved but the midwives and doctors told us that they felt that the plans were something that was “being done to them”.
- 5.10.4. From April 2018 staff engagement in the decision making had apparently improved and we understand that following the RCPCH visit a more comprehensive communications plan was established which included maternity staff.

5.11. Staff and Public Engagement

- 5.11.1. In line with the NHSE assurance process for service change are the four tests from the Government’s Mandate to NHS England which apply in all cases of major service change.
- strong public and patient engagement
 - consistency with current and prospective need for patient choice
 - a clear clinical evidence base
 - support for proposals from clinical commissioners

- 5.11.2. Appendix 5 sets out in more detail the range of engagement activity being undertaken by the Trust and the wider health community, and Appendix 6 summarises the RCPCH survey responses from over 800 people. During the visit the review team attended a public meeting to discuss the forthcoming changes to the service, visited the Paediatric Wards at both sites and looked at facilities for play and enriching the environment and experience of children and young people. Whilst the play worker works with children going to theatre, they also support children to feedback on their experiences and there was evidence of patient comments on walls in the ward together with 'feedback clouds'. A lot of the feedback however seemed to have been there for some time. There was not a great deal of evidence from the visit regarding significant engagement with children and young people but this may be available in the engagement strategy, quality report and discussion with Patient Experience and Engagement Manager.
- 5.11.3. Since April there have been greater efforts to engage with the public and politicians around the potential service changes, initially through the efforts of the 'Save our Hospitals' group who arranged and funded two large public meetings (one of which the review team attended) providing a platform for local politicians and the Trust management to address concerned patients, carers staff and public. Separately, engagement with staff has gradually improved since April and with the appointment of an interim manager further engagement work has taken place with three public meetings planned and regular update newsletters from the Chief Executive.
- 5.11.4. There have been staffing changes within the communications team which has hampered development of a co-ordinated communications plan, and more could still be done through social media – for example the ULHT Young people Twitter account is cited on the Trust's paediatric webpage but has no mention of the changes.
- 5.11.5. Our recommendations in this report reflect the emerging themes from the engagement and support the first two tests set out in 5.11.1 as follows:
- Links between maternity and paediatrics are not understood by many women and families at the moment. However, as they are now realising that there will be an impact on Boston based maternity care many women express fears about what will happen
 - There is a need for a safe, good quality locally based paediatric service as there are challenges of travel and access for families living in Boston
 - Mixed community voices and needs of East European women and families should be understood and addressed; there is high demand for women's and children's services

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

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

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

5.11.7. The Trust website has information on Care Opinion¹² feedback and the Trust launched a children's feedback project at Lincoln County Hospital as a partnership between Patient Opinion and Monkey wellbeing and aims to get more children and young people to give feedback about their health care experiences.

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

5.11.9. The Trust reports in its engagement strategy in its Quality Account for 2016-17¹³ that it has a robust Patient Experience Committee which oversees the wide range of patient feedback data received within the Trust. However, the information displayed on Pilgrim ward notice board did not suggest engagement with CYP & the feedback was old.

¹² <https://www.careopinion.org.uk/blogposts/565/meeting-the-needs-of-our-youngest-patients>

¹³ <https://www.ulh.nhs.uk/content/uploads/2015/06/FINAL-Quality-Account-2016-17.pdf>

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

- 5.11.10. The Trust should review the level and quality of information and communication to ensure it is open and honest so that that women and families have accurate information regarding the services available. Key to the concerns of families in Boston are travel and transport as there are significant challenges for members of the community in the Boston area where car ownership may be low and there are pockets of deprivation. Their view is that some paediatric and emergency services appropriate for children need to be on site so the community will need reassurances about the safety of travelling in an emergency.
- 5.11.11. In terms of staff engagement, there was mixed feedback from staff about morale and feeling that they could raise concerns and were listened to. Some staff reported morale as good in their area, whereas others were less engaged with the hospital and did not feel as comfortable to raise concerns.

6. Options for Future Provision

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

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

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

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

- 6.1.3 The concerns of the population are not unfounded and it has been difficult for the management at the Trust to respond to all their questions. This is partly as they have truthfully explained the uncertainty of the position, because they did not yet have answers, which has unsettled the public. The impact of the changes on the provision of maternity services is clear on paper but has not been fully addressed by the proposals in terms of the psychological and emotional impact of indecision and uncertainty on local expectant parents and their midwives.
- 6.1.4 Whilst the longer-term aim of the STP was consolidation, the review team had not seen the latest draft and details of how it will be achieved safely and the palatability of this option are still uncertain, with a number of enabling projects that must be completed before this can be realistically considered.
- 6.1.5 The review team considered the two 'viable' options proposed by the Board. Under option 2/3 (closure at night) there were serious concerns about the availability and time taken to transport sick children, expectant women and neonates to an alternative site, although the dedicated ambulance vehicle has alleviated these concerns albeit at a high cost. There remain strong memories of the closure of Grantham hospital and the anxieties that provoked relatively recently and the phrase 'temporary solution' is widely seen as a shot cut to a permanent arrangement.
- 6.1.6 There remain concerns about the capacity at Lincoln County in terms of staffing and estates to manage additional patients. This would be a transfer of services to an 'already oversubscribed service at Lincoln' and no guarantee that all the staff would willingly transfer too. Capacity in other units which are also stretched must also be considered.

6.2 The national picture for workforce and new ways of working

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

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

- 6.2.2 Standards – For acute paediatrics the RCPCH's Facing the Future standards, RCN-defined nurse staffing levels, BAPM neonatal standards and the Intercollegiate Emergency Care Standards¹⁴ provide a template for design of safe paediatric services (see Appendix 3. They include integrated provision across primary and community-based care to manage acute admissions and reduce emergency presentations through investment in care closer to home and alternative models of urgent care.
- 6.2.3 Workforce - As predicted in the first Facing the Future in 2011, nationally the paediatric workforce is diminishing as demand increases, and new ways of working are essential to ensure long term provision of safe services nationally¹⁵. There are an estimated 241 WTE career grade vacancies (133.4 consultant, 57.5 SAS, and 50.5 WTE other non-training grades) and applications for paediatric training have fallen 27% in 2 years. Reconfiguration to cope with the changes is happening in many units and nationally 45% of consultants have resident shifts in their job plan which might include late evenings as well as overnight.
- 6.2.4 Difficulties recruiting to medical posts and filling rotas has resulted in a range of innovative practice across the UK. Roles such as physician's associates¹⁶ (B7) (or assistants) and Doctors Assistants (B3) to support tier 1 have been introduced to support medical practitioners. The Advanced Nurse Practitioner is the role most commonly introduced to support tier 2 medical roles. Where this role has been introduced successfully, it has brought stability to service provision and aided training of both medical and nursing staff. The role has been used since the early 1990s in neonatal units and is now seen in critical care and emergency departments throughout the country. More recently, it has been introduced into primary care and assessment units, having benefits on both waiting times

¹⁴ Due for relaunch June 2018

¹⁵ [RCPCH State of Child Health – the paediatric workforce](#)

¹⁶ <https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions/roles-medical-associate-professions/physician-associate>

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

- 6.2.5 Some units are finding opportunities recruiting from overseas either directly or through the [RCPC's Medical Training Initiative](#) scheme. Whilst this can take a period of time to recruit suitable qualified doctors, and ensure their training is sufficient to work in the UK, these two-year placements can provide a steady stream of Tier 2 support so long as the working environment enables time for training and development of skills. See para 5.4.11 for the Trust's progress with this initiative and recommendations for the future.
- 6.2.6 Although the implications are still being discussed, the recent GMC case of Dr Bawa-Garba has raised anxiety amongst doctors about working in environments which are significantly understaffed. Although the current model (from 6th August) at Pilgrim is reported to be working well so far, the implications of consistently running a service with insufficient staffing and poor governance processes could potentially result in staff refusing to work at all.

6.3 The proposed way forward

Pilgrim site

- 6.3.1 The relatively deprived nature of the population, lack of personal transport, high proportion of families without English as a first language and significant comorbidities amongst the childbearing population make it imperative that there are emergency medical and maternity facilities available for mothers and children at the Pilgrim site. Whilst it is clear that Option 1 – continuing as at present - is not sustainable, a 39 mile drive (on top of that to reach the Pilgrim) in an emergency is too far and there is no indication that there will be sufficient ambulance cover to provide transfers for a PAU that closes overnight. A model is therefore required that matches essential demand with a minimum level of competent staffing to ensure safety for patients and adequate support for those staff when they need it.
- 6.3.2 The review team proposes in the medium and longer-term development of a hybrid medical staffing model for PAU with a low acuity overnight service. This is a model being developed in other areas but is not yet formally working in the UK. The ward would not actually admit overnight as numbers requiring this are low, so the service can manage

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

- 6.3.3 Consultants should be present 15 hours a day, 8am until 11 pm, with more flexibility at weekends, to ensure that the Facing the Future 14-hour standard is met and a consultant is present at peak times. The model would include a late ward round by the consultant and overnight resident to agree an escalation and treatment plan for each child. This would reduce the need to call the consultant overnight; the service would not be admitting patients so the consultant would be non-resident at home. All paediatricians should work this model unless there are exceptional reasons not to. The consultants should not routinely cover the Tier 2 rota although they could be rostered to work overnight by agreement, and there may be nights when they need to be resident when the minimum competencies could not be achieved with more junior resident staff.
- 6.3.4 Development of a stronger Tier 2 rota to ensure the resident doctor was confident with sufficient competencies to cover ED, neonates and any urgent resuscitation is key, so a hybrid model of combined competencies would be needed based around those basic principles and the availability of skilled support from midwives and ED staff.
- 6.3.5 The rota could include some consultant resident sessions as above, (but this should not be compulsory), together with trust grade doctors, a continuing turnover of 2-year MTI trainees, ST4+ paediatricians (in the longer term if the Deanery supports the model) and Advanced Nurse Practitioners. It will take 2-3 years, depending on previous experience, to develop these staff from the commencement of training to ensure that they have the competencies needed to run this arrangement safely.

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

- 6.3.6 The model requires the maintenance of a daytime/evening Tier 1 rota, and the current loss of trainees at the Pilgrim site must be addressed, alongside development of other roles such as Advanced Nurse Practitioners to supplement the rotas.
- 6.3.7 An APNP can cover the neonatal unit as well as the paediatric ward for infants from 37 weeks, but with NLS and assessed competencies could cover from 34 weeks. In children's wards nurses are managing care of ex-premature infants who have been

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

- 6.3.9 The whole unit needs to move to have the psychology and philosophy of a PAU whilst supporting those children staying overnight and their families. Whilst some progress has been made to date in redesigning pathways of care to focus on early decision making, there is a considerable shift in attitude and risk assessment required to challenge assumptions and use networks and telemedicine for advice rather than 'wait and see'. It is particularly important to develop assessment criteria and thresholds for admission and early plans for discharge.
- 6.3.10 Moving to this model will require a clear plan and robust oversight, as it will include development of ANPs, continued recruitment of MTI doctors, and regular review of impact, alongside development of innovative approaches to workforce planning and clinical care.

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

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

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

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

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

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

Lincoln Site

- 6.3.13 It was clear that the paediatricians at the Lincoln site are struggling to maintain their own service and do not have capacity or enthusiasm to provide additional support for colleagues at the Pilgrim beyond existing liaison over transfers and cross cover of specialist clinics and occasional shifts. The distance is just a little too far for comfortable cross site working and the benefits do not currently justify the travel time, although Pilgrim consultants will readily cover Lincoln County rota gaps. The management ethos of 'one service two sites' was a long way from reality in Lincoln but a plan should be put in place towards greater joint working, shared protocols and fluency in transfer and cross referrals for specialised review.
- 6.3.14 For trainees, the experience at Pilgrim provides an important opportunity to work in a rural setting and the challenges that it provides and some cover of twilight shifts should be encouraged along with protected time for training and learning. See section 5.4.15 on.

6.4 Enabling Actions

- 6.4.1 It is imperative, for the model outlined in the previous section to succeed, that there is strong and committed leadership to take forward what must be a shared and clearly articulated vision that the unit is viable with a long-term purpose, given the population served, which will inspire staff to want to work there. The development of a long term strategy for paediatrics and by association maternity services should be a priority, to prevent the continued lurching from one staffing crisis to the next and enable planned developments to mitigate unmanageable demand for acute service. There are standards and frameworks from the RCPCH and others to provide confident support for such a strategy and a published document will provide potential job applicants with a positive and attractive. message that is more likely to secure their interest.
- 6.4.2 Key to efficient working, swift discharge and reduction of repeat attendances are the working guidelines for referral and management of patients. Given the high numbers of locum doctors (who tend to make more conservative decisions) it is important that decision algorithms are clear and monitored and that the Assessment Unit operates in a

new way with a focus on discharge. The recently published RCPCH guidance¹⁷ can help with this and should be used in the design of the units at both sites.

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

General practice referrals

6.4.3 There is support from the GP community for a paediatric presence at Boston but there is scope to extend the liaison with GPs once the future is secure to reduce referrals. Facing the Future Together for Child Health¹⁸ recommends the following measures:

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

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

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

¹⁷ 2017 <https://www.rcpch.ac.uk/resources/standards-short-stay-paediatric-assessment-units-sspau>

¹⁸ <https://www.rcpch.ac.uk/resources/facing-future-together-child-health>

Trainees

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

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

Nursing

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

Neonatal services

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

Elective surgical activity

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

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

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

Pure PAU model – making option 3 permanent

- 6.4.14 It should be part of the plan that if recruitment and mentoring fails to secure sufficient staff or applicants for the new Tier 2 roles within one year then it will not be possible to maintain safe trained overnight paediatric cover. The paediatric service will need to work daytimes only, say from 8am, closing at 11pm with the department emptied through transfer or discharge in the evening.
- 6.4.15 In such a situation ED and the neonatal unit would lose on site paediatric medical support overnight and the neonatal unit would close, requiring the obstetric unit at Pilgrim to become a low-risk Midwife Led Unit with all births under 37 weeks being transferred to other units. The implications on capacity at other units is being evaluated but in itself would pose considerable risk not least as staff may be unwilling to transfer and a shortage of midwives could compound capacity issues.

7. Conclusion

- 7.1 This review has been carried out alongside involvement of several other parties focusing on the significant staffing problems at the Pilgrim and challenges to the ULH paediatric service as a whole. During the course of the review an interim model was developed to maintain paediatric services for over 90% of patient activity whilst supporting the staffing problems through locum cover.
- 7.2 Our proposed solution supports the current model but suggests actions towards greater sustainability, with a step-change in approach and strategy for the Pilgrim. This will need strong leadership and investment in Advanced Nurse training alongside alternative and innovative ways to manage care safely and attract and retain staff within available resources. We will continue to work with the team wherever possible to help with achievement of this objective.

Appendix 1: The Review Team

Lead reviewer:

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

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

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

Paediatric reviewer:

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

Nursing Reviewer:

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

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

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

Lay Reviewer:

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

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

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

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

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

Management Support:

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

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

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

Appendix 2: Abbreviations

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

Appendix 3: Reference documents

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

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

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

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

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

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

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

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

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

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

Appendix 4: Sources of information

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

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

The following individuals participated in the review)

Ward Manager Children's ward 4a

Matron Maternity

Consultant paediatricians at Pilgrim

General Manager Women's and Children's clinical directorate

Head of Service Obstetrics and Gynaecology, Pilgrim

Clinical Director, Theatres, Anaesthesia, Critical Care and Pan-Trust chronic Pain

Consultant in Anaesthesia and intensive care

Consultant paediatrician, Lincoln site

Chair and Accountable Officer, Lincolnshire East CCG

Chief Nurse Lincolnshire East CCG, SRO Local Maternity System, Lincolnshire

Consultant paediatrician, Lincoln and College Tutor paediatrics

Medical Director

Matron children's community services and interim Matron Children's Acute Inpatient Services

Consultant paediatrician and Head of Service

Interim Project Manager Women and Children

ED Nurse Band 7

ED nurse

ED Consultant lead (anaesthetics)

Appendix 5: Patients' and Families' perspectives and issues

A 5.1 Initiatives in place across the Trust

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

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

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

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

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

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

A5.1.5 For Maternity services the CQC Patient Survey was conducted in February 2017 with 121 respondents. Results were broadly similar with other Trusts¹⁹. For children and young people it was conducted between February and June 2017 and overall the service was given a rating of 'about the same' for all categories in comparison with Trust departments across the country. Exceptions were 'Play' which was not applicable (presumably as there were too few responding) and 'Privacy' which was rated 'better'.

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

A5.2 STP & CCG engagement and feedback

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

¹⁹ <https://www.cqc.org.uk/provider/RWD/survey/5>

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

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

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

A5.3 Better Births

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

A5.4 SOS Pilgrim Public Meeting

A5.4.1 The review team attended a public meeting of the SOS Pilgrim group on 14th June. SOS Pilgrim was formed as a 'Focus Group' Autumn 2015 comprising 'concerned Boston Residents who joined a surgery Patient Liaison Group (PLG)' However the group has developed into one with a specific interest in maintaining quality locally based services for children and young people at Pilgrim Hospital. They have undertaken significant research and made many approaches to ULHT to stress the importance of access to services.

The well attended meeting provided an opportunity for health providers, commissioners and the local MP to hear views of families and answer questions on the strategy and approach for the delivery of children and young people's services. Members of the Review Panel also took the opportunity to outline the purpose of the Review and answer questions.

Questions and issues raised

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

A5.5 Discussion with midwives and obstetricians, Pilgrim

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

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

A5.6 RCPCH Survey

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

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Appendix 2

**UNITED LINCOLNSHIRE NHS TRUST
RCPCH REPORT ACTION PLAN**

No.	Recommendation	Action	Date	By Whom
1	Identify an experienced Project Manager/Clinical Director to continue to work with the Clinical Leaders to lead and shape the vision and drive implementation and innovation for the maternity and paediatric teams going forward (5.8.7)	Experienced Project Director appointed with extensive programme management and paediatric experience.	22/10/18	CM
2	Develop a model and plan for a 'low acuity' overnight service at Pilgrim through development of hybrid Tier 2 working and explore with the medical and nursing teams a migration towards this arrangement (6.3.5)	The introduction of this model is being considered as we move from the interim model put in place on the 6th August. The model will be co-designed with staff, parents and children. Outline plan and timeframe to be agreed at Children and Young Persons Task & Finish Oversight Group (T&F).	29.11.18	CB
3	Appoint a 'Project Board' from stakeholders or use the Clinical Services Transformation Board to monitor progress with the vision and plan and provide external scrutiny (6.3.11)	Membership of Project Board to be discussed at T&F	29.11.18	CB
4	Actively promote a positive vision backed with a robust communications plan that drives forward change and develops confidence and commitment to a whole-county solution that embeds a sustainable service at Pilgrim (6.3.11)	Communication Strategy to be reviewed at T&F. Programme Director to meet with SOS Pilgrim 19.11.18	Ongoing co-ordinated with STP	CB/T&F
5	Introduce a monitoring and outcome analysis process to review admissions	Daily monitoring Included in Balanced Score Card reviewed at	In place 1/12/18	CB T&F

	transfers and outcomes to demonstrate the model is working safely at the current time and through transition to new ways of working (6.3.10)	fortnightly T&F		
6	Adopt the RCPCH standards for PAUs at both sites as an approach to managing ambulatory patients not requiring long term stays, with pathways of care and SoPs that focus on discharge and decision making in the ED and PAU and monitor length of stay and outcomes. (6.4.2)	Structure for stock take to be agreed at T&F Included in Balanced Score Card	15/11/18 1/12/18	CB/ALL T&F
7	Continue to support and audit use of the dedicated ambulance vehicle for safe transport of sick children and maternity patients who require transfer from Pilgrim (5.6.6)	Contract in place Included in Balanced Score Card	In place 1/12/18	BB T&F
8	Actively involve local user groups as well as children young people, parents and those from minority communities to “change the narrative” and improve engagement with the public, including development of written, web based and social media resources. (5.11.9)	Communication Strategy to be reviewed at T&F Obtain views of SOS Pilgrim Redraft Communication Strategy	15/11/18 19/11/18 30/11/18	T&F CB CB
9	Expedite changes to the approach to recruitment including a refreshed and dynamic marketing approach (5.8.5).	Manpower and Recruitment strategies to be reviewed at T&F	ongoing	T&F
10	Focus on retention and development of existing staff through genuine involvement and listening	Linked to action 9	ongoing	T&F

	and acting on their concerns (5.8.6)			
11	Recruit a Head of Nursing/ADN with experience of developing and modernising nursing services, to develop the children's nursing service at ULHT to meet the needs of children across Lincolnshire (5.3.2)	Appointment timescale to be agreed	30/11/18	DF
12	Strengthen paediatric nursing competencies in ED and neonatal life support through advanced nursing roles to improve patient care and reduce the demand for medical intervention (5.3.6)	Linked to 9	Ongoing	DF
13	Develop a strategy for children's community nursing to reduce hospital attendance and increase engagement with the NHS through (5.3.12): <ul style="list-style-type: none"> •Expanding the CCN Team •Enabling a seven-day service across the county •Enable early discharge from the Emergency Department and PAUs. •Review referral process to enable direct GP access to community nursing 	Linked to 9	31.12.18	DF
14	Consider recruiting specialist nurses for long term health disorders such as asthma and epilepsy to support the medical team and promote self-management of conditions from an early age. (5.3.13)	Linked to 9 Business cases to be drafted	31.1.19	T&F
15	Ensure the practice development nurse role is clear to promote an effective impact on recruitment and retention of nurses and good	Linked to 9	31.12.18	DF

	working relationships between the clinical areas and the university. (5.3.6)			
16	Develop nurse led clinics to manage children attending the ward following discharge and to support medical colleagues in managing children with long term conditions (5.3.13)	Linked to 2	29.11.18	CB T&F
17	Continue to support MTI recruitment for a steady supply of Tier 2 paediatricians. (5.4.12)	Linked to 9	On going	T&F
18	Expedite changes to the approach to recruitment including a refreshed and dynamic marketing approach. (5.8.5)	Linked to 9	On going	T&F
19	Explore the benefits of developing advanced practice children's nurses and review how these operate in other services, with a view to establishing the role at both sites to support the medical rotas. (5.4.14)	Linked to 9	On going	T&F
20	Conduct an audit review of the quality and implications of the locum provision including incident analysis and risk assessment. (5.4.10)	Methodology to be agreed at T&F	31.12.18	T&F
21	Work closely with HEEM to Increase the profile for training and compliance with requirements to enable continuing rotation of Tier 1 doctors through Pilgrim (5.4.21)	On-going dialogue established with HEEM	On-going	All Consultants
22	Rethink the 'offer' for trainees, increase the profile of training through websites and promotional materials to attract more	Plan to be agreed at T&F	29.11.18	T&F

	trainees to Lincolnshire's hospitals (6.4.6)			
23	A focus on Quality Improvement, including working differently, learning from findings and shared whole-team goals should be implemented as soon as possible (5.7.4)	Focus on Continuous Improvement Programme agreed	On-going	T&F
24	Work with the CCGs to reconsider the future of Pilgrim and opportunities to expand rather than contract the service within the STP. (6.1.1)	Preferred model for Pilgrim Hospital is being developed through the T&F	31.12.18	T&F
25	Retain and develop a day surgery service at the Pilgrim site with a catchment across the Trust's footprint. (6.4.14)	Day Surgery service and plan to be reviewed	31.1.19	T&F

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Agenda Item 8

		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 David Coleman, Chief Legal Officer

Report to	Health Scrutiny Committee for Lincolnshire
Date:	23 January 2019
Subject:	Grantham Accident and Emergency Department – Referral to the Secretary of State for Health and Social Care

Summary:

On 17 January 2018, the Health Scrutiny Committee for Lincolnshire decided to refer the continued overnight closure of Grantham and District Hospital Accident and Emergency Department to the Secretary of State for Health and Social Care. This referral was based on the grounds of inadequate consultation on the continued overnight closure. On 10 September 2018, the Minister of State for Health advised that South West Lincolnshire Clinical Commissioning Group and United Lincolnshire Hospitals NHS Trust had been asked by 31 December 2018 to provide the Minister of State a report, including a timetable, on how they planned to carry out engagement and consultation envisaged in the report of the Independent Reconfiguration Panel of March 2017.

As of 15 January 2019, the report had not been received, but will be circulated if it becomes available prior to the Committee's meeting date. If the report is received from the Minister of State, this item will enable the Committee to consider the latest position.

Actions Required:

To note the current position with regard to the Health Scrutiny Committee for Lincolnshire's referral of the Grantham and District Hospital's overnight closure of Accident and Emergency Department to the Secretary of State for Health and Social Care.

1. Background

Current Referral to the Secretary of State for Health and Social Care

On 17 January 2018, the Health Scrutiny Committee for Lincolnshire decided to refer the continued overnight closure of Grantham and District Hospital Accident and Emergency Department to the Secretary of State for Health and Social Care. This referral was based on the grounds of inadequate consultation on the continued overnight closure. The referral statement and supporting documents were submitted to the Secretary of State for Health and Social Care on 31 January 2018.

Following the referral, an official in the Department of Health and Social Care advised by letter on two occasions that the Committee's referral had not met the requirements of the regulations and the Secretary of State's guidance. In response to each letter the Chairman provided a clear argument that the referral had satisfied these requirements.

On 10 September 2018, the Minister of State for Health advised that South West Lincolnshire Clinical Commissioning Group and United Lincolnshire Hospitals NHS Trust had been asked by 31 December 2018 to provide the Minister of State a report, including a timetable, of how they planned to carry out engagement and consultation envisaged in the report of the Independent Reconfiguration Panel of March 2017.

Further clarification was sought on the status of the January 2018 referral, and it was confirmed in November 2018 that it was still live.

Chronology and Relationship with Previous Referral

A previous referral of the overnight closure of Grantham A&E was made by the Committee in December 2016, which led to a determination by the Secretary of State for Health in August 2017, in which he endorsed the findings of the Independent Reconfiguration Panel, who had concluded in March 2017:

"The time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham and more widely across Lincolnshire. Recognising that the staffing threshold currently required to restore the service at Grantham is unlikely to be achieved in a sustainable way CCGs, as commissioners of these services, must as a matter of urgency work with the local providers (including mental health care and community providers as well as ULHT) and the HSC to engage and consult the public across Lincolnshire on current services and what might be achievable and sustainable in the future."

The IRP's conclusion was thus wider than Grantham A&E. The Committee's January 2018 referral was made on the grounds of inadequate consultation, and included the above conclusion of the IRP in its submission.

A full chronology is set out in Appendix A to this report, which also includes other developments such as the Lincolnshire Sustainability and Transformation Partnership.

2. Consultation

This item relates to a referral by the Committee to the Secretary of State for Health and Social Care on the continued overnight closure of Grantham A&E, which was made in January 2018.

3. Conclusion

The Committee is invited to note current position with regard to the Health Scrutiny Committee for Lincolnshire's referral of the Grantham and District Hospital's overnight closure of Accident and Emergency Department to the Secretary of State for Health and Social Care.

4. Appendices

These are listed below and attached at the end of the report

Appendix A	Health Scrutiny Committee for Lincolnshire and Grantham and District Hospital A&E - A Chronology (Since August 2016)
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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

APPENDIX A

Health Scrutiny Committee for Lincolnshire and Grantham and District Hospital A&E

A Chronology (Since August 2016)

	Date	Event
(1)	2 Aug 16	United Lincolnshire Hospitals NHS Trust (ULHT) Board decided that with effect from 17 August 2016 A&E at Grantham and District Hospital (GDH) would be closed between 6.30 pm and 9.00 am for a period of three months, on the grounds of patient safety. This was because the number of substantive ULHT middle grade A&E doctors stood at 12.6 against an establishment of 28.
(2)	21 Sep 16	The Health Scrutiny Committee for Lincolnshire (HSC) considered the ULHT decision of 2 August and recorded its support for the permanent reinstatement of overnight A&E at GDH. HSC was not reassured that overnight A&E would be reinstated at GDH by 17 November 2016, owing to the difficulty of recruiting A&E staff, and anticipated a further extension to the temporary closure. HSC agreed to reconsider the matter on 23 November 2016.
(3)	1 Nov 16	ULHT Board decided to extend the period of the closure to 17 Feb 2017. ULHT Board was also advised that the middle grade A&E doctor threshold to re-open GDH A&E overnight had been set at 21 substantives and long term locums, against an establishment of 28 middle grade doctors.
(4)	23 Nov 16	HSC decided to make a report (also known as a referral) to the Secretary of State on the grounds that the overnight closure of GDH A&E was not in the interests of the health service in the Grantham and surrounding area. <i>This referral was made in accordance with Regulation 23(9)(c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.</i>

	Date	Event
(5)	6 Dec 16	The Lincolnshire Sustainability and Transformation Plan was published, which included reference to a public consultation on a long term solution to GDH A&E. It was stated that public consultation on the significant changes to hospital services in the Plan was expected in May 2017.
(6)	15 Dec 16	A report was submitted to the Secretary of State for Health in accordance with HSC's decision 23 November 2016.
(7)	16 Dec 16	The Lincolnshire County Council Meeting unanimously resolved that it could not support the Lincolnshire Sustainability and Transformation Plan in its current form and confirmed that the Council was prepared to work with all local NHS organisations to encourage them to adhere to and act upon the views which emerge from the public consultation. The Council also mandated the HSC to scrutinise the likely impact of the proposals in the STP on different medical services in all parts of the county.
(8)	12 Jan 17	HSC considered the Lincolnshire Sustainability and Transformation Plan at a special meeting and agreed a draft initial statement would be considered for approval on 18 January 2018.
(9)	18 Jan 17	HSC approved its initial statement on the Lincolnshire Sustainability and Transformation Plan, which indicated that it would like to see A&E services restored at GDH to the way they had operated prior to 17 August 2016, when the 'temporary' overnight closure began.
(10)	7 Feb 17	The ULHT Board made a decision to reduce the period of overnight closure of GDH A&E, so that it would be closed from 6.30 pm to 8.00 am (instead of 9.00 am), and extended the overnight closure for a further three months.
(11)	22 Feb 17	The Secretary of State advised the Chairman of the HSC that the Independent Reconfiguration Panel (IRP) would complete an initial assessment of the referral by 22 March 2017, to see if it merited a full review by the IRP.
(12)	7 Mar 17	The ULHT Board confirmed the February 2017 decision to reduce the period of the overnight closure of GDH A&E, with the new closure hours of 6.30 pm to 8.00 am becoming effective from 27 March 2017.

	Date	Event
(13)	22 Mar 17	The IRP completed its initial assessment and submitted it to the Secretary of State for Health.
(14)	9 May 17	The ULHT Board decided to extend the temporary closure of GDH A&E for a further three months.
(15)	1 Aug 17	<p>The ULHT Board decided: -</p> <ul style="list-style-type: none"> • to continue with the opening hours of GDH A&E of 8.00 am - 6.30 pm, implemented on 27 March 2017; • to review the overnight closure in three months; and • to work with CCGs to explore an interim service model for a 24 hour emergency / out of hours service.
(16)	2 Aug 17	<p>The Secretary of State published the March 2017 IRP report and advised the Chairman of HSC that he accepted the IRP's report and recommendations in full. The letter from the Secretary of State included the following:</p> <p><i>"After careful consideration the IRP is of the view that your referral does not warrant a full review and I accept the IRP's advice in full."</i></p> <p><i>"They [IRP] recommend that as the staffing threshold currently required to restore the service at Grantham is unlikely to be achieved in a sustainable way, CCGs and local commissioners must work with local providers and the HSC to engage and consult the public on future services."</i></p> <p>The IRP report included:</p> <p><i>"The Panel considers that the time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham and more widely across Lincolnshire. Recognising that the staffing threshold currently required to restore the service at Grantham is unlikely to be achieved in a sustainable way CCGs, as commissioners of these services, must as a matter of urgency work with the local providers (including mental health care and community providers as well as ULHT) and the HSC to engage and consult the public across Lincolnshire on current services and what might be achievable and sustainable in the future. "</i></p>

	Date	Event
(17)	13 Sep 17	HSC considered the Secretary of State's letter of 2 August 2017 and the IRP report and put on record, pursuant to the advice of the IRP, its position that full, meaningful and transparent public consultation be undertaken on the future of A&E services across Lincolnshire by all appropriate sections of the NHS, to address the issues raised in the report of the IRP.
(18)	11 Oct 17	<p>HSC considered a report from the Lincolnshire Sustainability and Transformation Partnership (STP), which included the following statement:</p> <p><i>"Following the Secretary of State's letter to the Committee in August, work continues with local stakeholders to identify a short term solution to extend access to Grantham A&E during this winter and also to agree a sustainable model for the town in the future."</i></p> <p>HSC recorded its serious concern at the lack of full, extensive and meaningful consultation on the proposals in the Lincolnshire Sustainability and Transformation Plan, and its concern that no consultation would be taking place before April 2018.</p>
(19)	7 Nov 17	<p>ULHT Board decided that:</p> <ul style="list-style-type: none"> • subject to a safety review by NHS Improvement, ULHT would move to a decision to re-open GDH A&E at the December meeting of the ULHT Board; and • ULHT would continue to work with CCGs and partners to find a more sustainable model. <p>The report to the Board on 7 November 2017 made reference to the overall increase in establishment for A&E middle grade doctors:</p> <p><i>"It is also important to highlight that the funding for establishment has been increased since the previous papers submitted to the Trust Board. The funded establishment for middle grade posts has been increased to 38.0 whole time equivalent, an increase of 10.0 whole time equivalent since the last paper that was submitted to the Trust Board."</i></p> <p><i>"Funding for middle grade establishment will further increase from 1/1/2018 to a total of 42.0, and again from 1/4/2018 to a total of 44.0."</i></p>

	Date	Event
(20)	12 Dec 17	<p>The ULHT Board papers for 15 December 2017 were published, including:</p> <p>(a) the report of the East of England Clinical Senate, in which the Senate stated it did not support the reopening of the 24/7 A&E department at GDH on the grounds of potential adverse impact on patient safety at A&E Departments at all three ULHT hospitals; and in which the Senate had recommended:</p> <ul style="list-style-type: none"> • on the grounds of patient safety, that ULHT Trust Board reconsider the proposal to extend the current A&E service opening hours at GDH; and • ULHT continue to provide a GDH A&E service on the current opening hours. <p>(b) a letter from NHS Improvement, dated 5 December 2017, which strongly advised the ULHT Board to follow the recommendations in the Clinical Senate's report.</p>
(21)	13 Dec 17	<p>The HSC recorded its opposition to the conclusions of the East of England Clinical Senate on the basis that it would prejudice any future consultation on A&E services at GDH and the current restricted opening hours would in effect be made permanent; and the consultation exercise would be based on these opening hours as the status quo, rather than the previous 24/7 service.</p> <p>HSC requested that ULHT Board defer its planned decision on 15 December 2017 in relation to the East of England Clinical Senate report to its next meeting on 26 January 2018, as this would enable the Health Scrutiny Committee to give detailed consideration to the Clinical Senate's report and recommendations at its next Committee meeting on 17 January 2018.</p>

	Date	Event
(22)	15 Dec 17	<p>HSC's request to defer its decision was put before the ULHT Board, which was advised that ULHT had 'received direction in the form of a letter from NHS Improvement and had no option but to comply with that direction.'</p> <p>ULHT Board resolved that:</p> <ul style="list-style-type: none"> • on the basis of the Clinical Senate review, supported by the advice of the regulator, to endorse the recommendation that there would be no change to the current opening hours of the Grantham A&E department; • ULHT should accept advice to move to single A&E team; and • ULHT should urge the CCGs to move at pace to review urgent care across Lincolnshire.
(23)	17 Jan 18	<p>HSC decided to make a report to the Secretary of State on the grounds that the consultation on the continued overnight closure of Grantham A&E had not been adequate.</p> <p><i>This referral was made in accordance with Regulation 23(9)(a) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.</i></p>
(24)	17 Jan 18	<p>HSC considered an update from the Lincolnshire STP, which stated that the previous work on acute services was being refreshed, in effect the <i>Acute Services Review</i>. HSC was also advised that it was not expected that there would any consultation on significant changes to services until the spring of 2018.</p>
(25)	31 Jan 18	<p>A report submitted to the Secretary of State in accordance with HSC's decision of 17 Jan 18.</p>
(26)	12 Feb 18	<p>An official in the Department of Health and Social Care (DHSC) advised the Chairman of HSC that the report submitted on 31 January did not meet the requirements of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Furthermore, the letter stated that HSC had not provided evidence that conditions at GDH A&E had changed since the previous referral.</p>

	Date	Event
(27)	20 Feb 18	The Chairman of HSC replied to the DHSC letter of 12 February 2018, setting out in detail how HSC's referral complied with Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Chairman also refuted the DHSC's assertion of the need for evidence of change in the conditions at GDH A&E, as this was not a requirement of the regulations.
(28)	27 Feb 18	An official in the DHSC wrote to the Chairman of HSC advising that HSC's referral had not met a particular provision in the Secretary of State's guidance.
(29)	15 Mar 18	The Chairman of HSC replied to the DHSC letter of 27 February 2018, stating that the particular provision cited in the guidance did not apply to HSC's referral. The Chairman of HSC also requested that the urgent and emergency care elements of the Lincolnshire <i>Acute Services Review</i> be accelerated to enable early consultation. The Chairman of HSC urged the Secretary of State for Health and Social Care to make a determination on HSC's referral.
(30)	21 Mar 18	<p>HSC considered a report from the Lincolnshire STP on Urgent and Emergency Care, which included the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, which stated the following:</p> <p><i>"Following the overnight closure of GDH A&E in August 2016, significant work is being undertaken to design the substantive urgent and emergency care services that will be offered on the site. This work is mindful of the East of England Clinical Senate report (December 2017) and is being managed in line with the Pre-Consultation Business Case being produced by the STP operational delivery unit. Whilst out of scope for this strategy, any service redesign work will be closely linked and incorporated in the Lincolnshire Urgent and Emergency Care delivery plan."</i></p> <p>HSC was also advised that the outcome of the <i>Acute Services Review</i> would not be completed until May 2018.</p>
(31)	13 Jun 18	HSC received a report from the Lincolnshire STP, which stated it was not possible to say when public consultation on the <i>Acute Services Review</i> proposals would commence, although it would not be during 2018.

	Date	Event
(32)	10 Sept 18	On 10 September, 2018, the Minister of State for Health advised the Chairman by letter that he had asked South West Lincolnshire CCG and ULHT to send to him by the end of December a report setting out, including a timetable, how they have carried out, or plan to carry out engagement and consultation envisaged in the IRP report of March 2017. This would then be shared with the Health Scrutiny Committee.
(33)	14 Sept 18	Chairman of HSC wrote to the Minister of State for Health seeking clarification of the status of the Committee's referral.
(34)	6 Nov 18	In response to the letters from the Chairman of HSC on, an official in the DHSC confirmed that the Secretary of State had asked the relevant NHS bodies to report on the implementation of the actions identified by the IRP by December 2018; and the January 2018 referral was ongoing.
(35)	26 Nov 18	A letter from NHS England to health scrutiny committees advised of the timetable for the national NHS Long Term Plan. The letter advised that between January and the summer of 2019, NHS organisations, local councils and the voluntary sector would work together to develop a local strategy, tailored for their particular circumstances, that will help to deliver on the aims of the national long-term plan.
(36)	7 Jan 19	The NHS Long Term Plan was published, in which local health systems <i>"will be expected to engage with their local communities and delivery partners in developing plans, which will be based on a comprehensive assessment of population need. We expect that they will build on their existing plans and set out proposals for how they will deliver the outcomes set out in the Long Term Plan. They will also take account of the different starting points and phasing of progress in different parts of the country. ... Local implementation plans will then be brought together in a detailed national implementation programme in the autumn."</i>

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Agenda Item 9

		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 David Coleman, Chief Legal Officer

Report to	Health Scrutiny Committee for Lincolnshire
Date:	23 January 2019
Subject:	NHS Long Term Plan

Summary:

On 7 January 2019, the NHS published the NHS Long Term Plan, which covers a ten year period. This report provides an overview of the Plan, and will enable the Committee to consider the next steps.

Actions Required:

- (1) To note the publication of the NHS Long Term Plan.
- (2) To consider the next steps.

1. Background

Introduction

On 7 January 2019, the NHS published the NHS Long Term Plan, which covers a ten year period. This report provides an overview of the Plan, and will enable the Committee to consider the next steps.

The NHS Long Term plan is available at the following link:

<https://www.longtermplan.nhs.uk/>

A summary is attached at Appendix A. In addition to the summary the Plan includes a chapter-by-chapter overview which is reproduced in the table below:

Chapter	Overview
One	<p>Chapter One sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. GP practices and hospital outpatients currently provide around 400 million face-to-face appointments each year. Over the next five years, every patient will have the right to online ‘digital’ GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments - saving patients 30 million trips to hospital, and saving the NHS over £1 billion a year in new expenditure averted. GP practices - typically covering 30-50,000 people - will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff. Now expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. Within five years over 2.5 million more people will benefit from ‘social prescribing’, a personal health budget, and new support for managing their own health in partnership with patients’ groups and the voluntary sector.</p> <p>These reforms will be backed by a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment – an NHS ‘first’ - creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24.</p> <p>We have an emergency care system under real pressure, but also one in the midst of profound change. The Long Term Plan sets out action to ensure patients get the care they need, fast, and to relieve pressure on A&Es. New service channels such as urgent treatment centres are now growing far faster than hospital A&E attendances, and UTCs are being designated across England. For those that do need hospital care, emergency ‘admissions’ are increasingly being treated through ‘same day emergency care’ without need for an overnight stay. This model will be rolled out across all acute hospitals, increasing the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on hospitals’ success in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. And building on recent gains, in partnership with local councils further action to cut delayed hospital discharges will help free up pressure on hospital beds.</p>

Chapter	Overview
Two	<p>Chapter Two sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities. Wider action on prevention will help people stay healthy and also moderate demand on the NHS. Action by the NHS is a complement to - not a substitute for - the important role of individuals, communities, government, and businesses in shaping the health of the nation. Nevertheless, every 24 hours the NHS comes into contact with more than a million people at moments in their lives that bring home the personal impact of ill health. The Long Term Plan therefore funds specific new evidence-based NHS prevention programmes, including to cut smoking; to reduce obesity, partly by doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme; to limit alcohol-related A&E admissions; and to lower air pollution.</p> <p>To help tackle health inequalities, NHS England will base its five year funding allocations to local areas on more accurate assessment of health inequalities and unmet need. As a condition of receiving Long Term Plan funding, all major national programmes and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years. The Plan also sets out specific action, for example to: cut smoking in pregnancy, and by people with long term mental health problems; ensure people with learning disability and/or autism get better support; provide outreach services to people experiencing homelessness; help people with severe mental illness find and keep a job; and improve uptake of screening and early cancer diagnosis for people who currently miss out.</p>
Three	<p>Chapter Three sets the NHS's priorities for care quality and outcomes improvement for the decade ahead. For all major conditions, results for patients are now measurably better than a decade ago. Childbirth is the safest it has ever been, cancer survival is at an all-time high, deaths from cardiovascular disease have halved since 1990, and male suicide is at a 31-year low. But for the biggest killers and disablers of our population, we still have unmet need, unexplained local variation, and undoubted opportunities for further medical advance. These facts, together with patients' and the public's views on priorities, mean that the Plan goes further on the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multimorbidity and healthy ageing including dementia. But it also extends its focus to children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.</p> <p>Some improvements in these areas are necessarily framed as 10 year goals, given the timelines needed to expand capacity and grow the workforce. So by 2028 the Plan commits to dramatically improving cancer survival, partly by increasing the proportion of cancers diagnosed early, from a half to three quarters. Other gains can happen</p>

Chapter	Overview
	<p>sooner, such as halving maternity-related deaths by 2025. The Plan also allocates sufficient funds on a phased basis over the next five years to increase the number of planned operations and cut long waits. It makes a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people. The Plan also recognises the critical importance of research and innovation to drive future medical advance, with the NHS committing to play its full part in the benefits these bring both to patients and the UK economy.</p> <p>To enable these changes to the service model, to prevention, and to major clinical improvements, the Long Term Plan sets out how they will be backed by action on workforce, technology, innovation and efficiency, as well as the NHS' overall 'system architecture'.</p>
Four	<p>Chapter Four sets out how current workforce pressures will be tackled, and staff supported. The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. But our staff are feeling the strain. That's partly because over the past decade workforce growth has not kept up with the increasing demands on the NHS. And it's partly because the NHS hasn't been a sufficiently flexible and responsive employer, especially in the light of changing staff expectations for their working lives and careers. However there are practical opportunities to put this right. University places for entry into nursing and medicine are oversubscribed, education and training places are being expanded, and many of those leaving the NHS would remain if employers can reduce workload pressures and offer improved flexibility and professional development. This Long Term Plan therefore sets out a number of specific workforce actions which will be overseen by NHS Improvement that can have a positive impact now. It also sets out wider reforms which will be finalised in 2019 when the workforce education and training budget for HEE is set by government. These will be included in the comprehensive NHS workforce implementation plan published later this year, overseen by the new cross-sector national workforce group, and underpinned by a new compact between frontline NHS leaders and the national NHS leadership bodies.</p> <p>In the meantime the Long Term Plan sets out action to expand the number of nursing and other undergraduate places, ensuring that well-qualified candidates are not turned away as happens now. Funding is being guaranteed for an expansion of clinical placements of up to 25% from 2019/20 and up to 50% from 2020/21. New routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support, are all being backed, together with a new post-qualification employment guarantee.</p>

Chapter	Overview
	<p>International recruitment will be significantly expanded over the next three years, and the workforce implementation plan will also set out new incentives for shortage specialties and hard-to-recruit to geographies</p> <p>To support current staff, more flexible rostering will become mandatory across all trusts, funding for continuing professional development will increase each year, and action will be taken to support diversity and a culture of respect and fair treatment. New roles and inter-disciplinary credentialing programmes will enable more workforce flexibility across an individual's NHS career and between individual staff groups. The new primary care networks will provide flexible options for GPs and wider primary care teams. Staff and patients alike will benefit from a doubling of the number of volunteers also helping across the NHS.</p>
Five	<p>Chapter Five sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS. These investments enable many of the wider service changes set out in this Long Term Plan. Over the next ten years they will result in an NHS where digital access to services is widespread. Where patients and their carers can better manage their health and condition. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today. Where predictive techniques support local Integrated Care Systems to plan and optimise care for their populations. And where secure linked clinical, genomic and other data support new medical breakthroughs and consistent quality of care. Chapter Five identifies costed building blocks and milestones for these developments.</p>
Six	<p>Chapter Six sets out how the 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path. In ensuring the affordability of the phased commitments in this Long Term Plan we have taken account of the current financial pressures across the NHS, which are a first call on extra funds. We have also been realistic about inevitable continuing demand growth from our growing and aging population, increasing concern about areas of longstanding unmet need, and the expanding frontiers of medical science and innovation. In the modelling underpinning this Long Term Plan we have therefore not locked-in an assumption that its increased investment in community and primary care will necessarily reduce the need for hospital beds. Instead, taking a prudent approach, we have provided for hospital funding as if trends over the past three years continue. But in practice we expect that if local areas implement the Long Term Plan effectively, they will benefit from a financial and hospital capacity 'dividend'.</p> <p>In order to deliver for taxpayers, the NHS will continue to drive efficiencies - all of which are then available to local areas to reinvest in</p>

Chapter	Overview
	<p>frontline care. The Plan lays out major reforms to the NHS' financial architecture, payment systems and incentives. It establishes a new Financial Recovery Fund and 'turnaround' process, so that on a phased basis over the next five years not only the NHS as a whole, but also the trust sector, local systems and individual organisations progressively return to financial balance. And it shows how we will save taxpayers a further £700 million in reduced administrative costs across providers and commissioners both nationally and locally.</p>
Seven	<p>Chapter Seven explains next steps in implementing the Long Term Plan. We will build on the open and consultative process used to develop this Plan and strengthen the ability of patients, professionals and the public to contribute by establishing the new NHS Assembly in early 2019. 2019/20 will be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation for their populations, taking account of the Clinical Standards Review and the national implementation framework being published in the spring, as well as their differential local starting points in securing the major national improvements set out in this Long Term Plan. These will be brought together in a detailed national implementation programme by the autumn so that we can also properly take account of Government Spending Review decisions on workforce education and training budgets, social care, councils' public health services and NHS capital investment.</p> <p>Parliament and the Government have both asked the NHS to make consensus proposals for how primary legislation might be adjusted to better support delivery of the agreed changes set out in this LTP. This Plan does not require changes to the law in order to be implemented. But our view is that amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to: create publicly-accountable integrated care locally; to streamline the national administrative structures of the NHS; and remove the overly rigid competition and procurement regime applied to the NHS.</p> <p>In the meantime, within the current legal framework, the NHS and our partners will be moving to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.</p>

2. Health Scrutiny Committee Topics Covered in NHS Long Term Plan

In this section of the report, extracts from the NHS Long Term Plan are set out where they relate to the main topics considered by the Health Scrutiny Committee in the last year.

Topic	Extract from NHS Long Term Plan
A&E	<p>Under this Long Term Plan, every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third. At the same time we should not see the proportion of non-SDEC zero length of stay admissions rise. Hospitals will also reduce avoidable admissions through the establishment of acute frailty services, so that such patients can be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units. The SDEC model should be embedded in every hospital, in both medical and surgical specialties during 2019/20.</p>
Adult Mental Health Services	<p>The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. The NHS in England is already meeting the goal set in the recently launched Lancet Commission on Global Mental Health that high income countries should be spending at least 10% of their health services budget on mental health¹⁴⁴, and NHS England will be the only major Western health service to have made and sustained such a funding pledge for what will have been eight years by 2023/24. NHS England’s renewed pledge means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24. As a result mental health investment will be growing faster over the next five years than over the past five years. It is also the ‘floor’ level of uplift now being set nationally, and we expect it will be further increased by local investment decisions. We will ensure this translates into additional funding for frontline services, including locally agreed spending and delivery plans signed-off by commissioners and providers.</p>

Topic	Extract from NHS Long Term Plan
Ambulance Services	<p>Ambulance services are at the heart of the urgent and emergency care system. We will work with commissioners to put in place timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter’s recent report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response. We will continue to work with ambulance services to eliminate hospital handover delays. We will also increase specialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.</p>
Cancer: Early Diagnosis	<p>This Long Term Plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis. We will build on work to raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, accelerate access to diagnosis and treatment and maximise the number of cancers that we identify through screening. This includes the use of personalised and risk stratified screening and beginning to test the family members of cancer patients where they are at increased risk of cancer.</p>
Cancer: Diagnosis Standard	<p>We will begin introducing a new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening. For people diagnosed with cancer, it will mean they can begin their treatment earlier. For those who aren’t, this will put their minds at rest more quickly at a very stressful time. To support the delivery of the new standard, we will align our Cancer Alliances with STP and ICS footprints and NHS England and NHS Improvement regions. They will implement a new timed diagnostic pathway for specific cancers, building on the timed pathways already being introduced in lung, colorectal and prostate cancer. Data collection for all patients will start in 2019, with full monitoring against the standard beginning in April 2020, and performance ramping up as additional diagnostic capacity comes online.</p>

Topic	Extract from NHS Long Term Plan
Cancer: Treatment	<p>Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates. We will complete the £130 million upgrade of radiotherapy machines across England and commission the NHS new state-of-the-art Proton Beam facilities in London and Manchester. Reforms to the specialised commissioning payments for radiotherapy hypofractionation¹ will be introduced to support further equipment upgrades. Faster, smarter and effective radiotherapy, supported by greater networking of specialised expertise, will mean more patients are offered curative treatment, with fewer side effects and shorter treatment times. Starting with ovarian cancer, we will ensure greater access to specialist expertise and knowledge in the treatment of cancers where there are fewer or more risky treatment options.</p>
Cancer: Care Planning	<p>By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. This will be delivered in line with the NHS Comprehensive Model for Personalised Care. This will empower people to manage their care and the impact of their cancer, and maximise the potential of digital and community-based support. Over the next three years every patient with cancer will get a full assessment of their needs, an individual care plan and information and support for their wider health and wellbeing. All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.</p>
Cancer: After Care	<p>After treatment, patients will move to a follow-up pathway that suits their needs, and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred. This stratified follow-up approach will be established in all trusts for breast cancer in 2019, for prostate and colorectal cancers in 2020 and for other cancers where clinically appropriate by 2023. From 2019, we will begin to introduce an innovative quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer.</p>

¹ **Hypofractionated** radiotherapy is increasingly being used to treat cancer. For this radiation treatment, the total dose of radiation is divided into large doses and treatments are given once a day or less often. **Hypofractionated** radiotherapy is given over a shorter period of time than standard radiation therapy. (Source – British Institute of Radiology)

Topic	Extract from NHS Long Term Plan
Rurality	We will develop a standard model of delivery in smaller acute hospitals who serve rural populations . Smaller hospitals have significant challenges around a number of areas including workforce and many of the national standards and policies were not appropriately tailored to meet their needs. We will work with trusts to develop a new operating model for these sorts of organisations, and how they work more effectively with other parts of the local healthcare system.
Urgent Treatment Centres	We will fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. UTCs will work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to A&E for patients who do not need to attend hospital.
Workforce	<p>This Long Term Plan sets out a number of specific workforce actions developed by NHS Improvement and others that can have a positive impact now. The Plan also sets out our wider reforms for the NHS workforce which will be finalised by NHS Improvement and the Department of Health and Social Care when the education and training budget for HEE is set in 2019.</p> <p>As a service, we will now take sustained and concerted action to:</p> <ul style="list-style-type: none"> • ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well; • ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare; • strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.

3. Consultation and Conclusion

Local health systems will be expected to consult on their own versions of the NHS Long Term Plan during 2019. The Health Scrutiny Committee is requested to note the publication of the NHS Long Term Plan and consider the next steps in terms of its own work programme.

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

Agenda Item 10

		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 David Coleman, Chief Legal Officer

Report to	Health Scrutiny Committee for Lincolnshire
Date:	23 January 2019
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:

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.

1. Work Programme

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

23 January 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>
United Lincolnshire Hospitals NHS Trust – Update on Care Quality Commission Inspection	Senior Management Representatives, United Lincolnshire Hospitals NHS Trust
Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update	Senior Management Representatives, United Lincolnshire Hospitals NHS Trust

23 January 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>
Non-Emergency Patient Transport Service – Update	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG Tim Fowler, Director of Commissioning and Contracting, Lincolnshire West CCG
Grantham Accident and Emergency Department – Referral to the Secretary of State for Health and Social Care	Simon Evans, Health Scrutiny Officer
NHs Long Term Plan	Simon Evans, Health Scrutiny Officer

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

20 February 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>
Non-Emergency Patient Transport	Mike Casey, Director of Operations, Thames Ambulance Service
North West Anglia NHS Foundation Trust Update (to be confirmed)	Management representatives from North West Anglia NHS Foundation Trust Update
Lincolnshire Sustainability and Transformation Partnership Update	To be confirmed.

20 March 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>
Dental Services in Lincolnshire	Carole Pitcher, Contracts Manager Dental and Optometry, NHS England – Midlands & East (Central Midlands)
Older Adult Mental Health Services	Chris Higgins, Deputy Director of Operations, Lincolnshire Partnership NHS Foundation Trust
Quality Accounts - Arrangements for 2019	Simon Evans, Health Scrutiny Officer

17 April 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>
East Midlands Ambulance Service Update	Sue Cousland, East Midlands Ambulance Service Divisional Manager, Lincolnshire

16 May 2019 – 10 am	
<i>Item</i>	<i>Contributor</i>

Items to be Programmed

- Adult Immunisations
- Developer and Planning Contributions for NHS Provision
- Joint Health and Wellbeing Strategy Update
- CCG Role in Prevention
- Cancer Strategy Update
- Lincolnshire Sustainability and Transformation Plan – Formal Consultation Elements:
 - Women's and Children's Services
 - Emergency and Urgent Care

Appendix A to the report contains the work programme in a table format.

23. 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.

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

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE AT-A-GLANCE WORK PROGRAMME

	2017					2018							2019							
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar
KEY																				
✓ = Substantive Item Considered																				
ca = Chairman's Announcement																				
■ = Planned Substantive Item																				
<i>Meeting Length - Minutes</i>	170	225	185	170	205	230	276	280	270	230	244	233	188	280	160	275				
Cancer Care																				
General Provision																✓				
Head and Neck Cancers														ca						
Clinical Commissioning Groups																				
Annual Assessment														ca						
Lincolnshire East																✓				
Lincolnshire West															✓					
South Lincolnshire																		✓		
South West Lincolnshire																		✓		
Community Maternity Hubs								ca												
Community Pain Management												ca								
Dental Services							✓		ca									ca		
GPs and Primary Care:																				
Extended GP Opening Hours								ca			ca					ca				
GP Recruitment			ca		ca															
Lincoln GP Surgeries		ca		ca																
Lincoln Walk-in Centre		✓	ca	✓		✓		✓			✓									
Louth GP Surgeries		ca	ca																	
Out of Hours Service																	ca			
Sleaford Medical Group									ca											
Spalding GP Provision																	ca			
Grantham Minor Injuries Service												ca	✓	ca						
Health and Wellbeing Board:																				
Annual Report												ca								
Joint Health and Wellbeing Strategy		✓							✓											
Pharmaceutical Needs Assessment					✓		✓													
Health Scrutiny Committee Role	✓																			
Healthwatch Lincolnshire											ca		ca		ca					
Lincolnshire Community Health Services NHS Trust																				
Care Quality Commission														ca		ca				
Learning Disability Specialist Care				✓									✓							
Lincolnshire Sustainability and Transformation Partnership																				
General / Acute Services Review				✓			✓				ca	✓	ca	✓					✓	
GP Forward View										✓										
Integrated Community Care																			✓	
Integrated Neighbourhood Working										✓										
Mental Health										✓					✓	ca				
NHS Long Term Plan																ca			✓	
Operational Efficiency																				
Urgent and Emergency Care																			✓	
Lincolnshire Partnership NHS Foundation Trust:																				
General Update / CQC		✓																		
Psychiatric Clinical Decisions Unit							ca													
Lincolnshire Reablement & Assessment Service																			ca	
Louth County Hospital														ca	✓		ca			

KEY	2017					2018										2019				
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar
<p>✓ = Substantive Item Considered</p> <p>ca = Chairman's Announcement</p> <p>■ = Planned Substantive Item</p>			ca												ca					
Northern Lincolnshire and Goole NHS Foundation Trust			ca												ca					
North West Anglia NHS Foundation Trust						✓										ca				
Organisational Developments:																				
CCG Joint Working Arrangements												✓	ca							
Integrated Care Provider Contract													ca	✓						
National Centre for Rural Care												ca								
NHSE and NHSI Joint Working											ca									
Lincoln Medical School			ca														ca			
Patient Transport:																				
Ambulance Commissioning			✓																	
East Midlands Ambulance Service			✓		ca					✓	ca	ca	ca	✓		ca	ca			
Non-Emergency Patient Transport						✓	ca	✓	✓	✓		✓	ca	✓	ca	ca	✓			
Sleaford Joint Ambulance & Fire Station											ca	ca								
Public Health:																				
Child Obesity													ca							
Director of Public Health Report												✓								
Immunisation					✓															
Influenza Vaccination Programme																	ca			
Pharmacy			ca																	
Renal Dialysis Services														✓						
Quality Accounts	✓								✓											
United Lincolnshire Hospitals NHS Trust:																				
A&E Funding			ca																	
Introduction	✓																			
Care Quality Commission		✓										ca	ca	✓						
Children/Young People Services											✓	✓	✓	✓		✓	ca			
Financial Special Measures										✓										
Grantham A&E			✓				✓	ca						ca	ca	ca				
Orthopaedics and Trauma												ca		ca						
Winter Resilience					ca	✓	ca	ca			✓				✓					

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