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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 16 March 2022 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T J N Smith, Dr M E Thompson and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), M A Whittington (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
	(To receive a report from United Lincolnshire Hospitals NHS Trust, which invites the Committee to consider the information presented on the inspection report by the Care Quality Commission on United Lincolnshire Hospitals NHS Trust, and the Trust's actions in response to the inspection report. Andrew Morgan, Chief Executive and Karen Dunderdale, Deputy Chief Executive and Director of Nursing, at United Lincolnshire Hospitals NHS Trust will be in attendance for this item)	
6	**Public Consultation on the Nuclear Medicine Service at United Lincolnshire Hospitals NHS Trust** *(To receive a report from United Lincolnshire Hospitals NHS Trust, which invites the Committee to consider and comment on the service proposals and to formulate a formal response to the consultation. Laura White, Head of Nuclear Medicine at United Lincolnshire Hospitals NHS Trust will be in attendance for this item)*	61 - 82
7	**Community Pain Management Service - Update** *(To receive a report from the NHS Lincolnshire Clinical Commissioning Group, which provides the Committee with an update on the Community Pain Management Service (CPMS). A senior representative from Lincolnshire Clinical Commissioning Group will be in attendance for this item)*	83 - 88
8	**Arrangements for the Quality Accounts 2021-2022** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider its approach to the Quality Accounts for 2021-22 and to identify its preferred option for responding to the draft Quality Accounts for 2022)*	89 - 96
9	**Health Scrutiny Committee for Lincolnshire - Work Programme and Working Groups** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forthcoming work programme and to consider two proposals for working groups)*	97 - 102

Debbie Barnes OBE
Chief Executive
8 March 2022

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing

Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 16th March, 2022, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
16 FEBRUARY 2022

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T J N Smith, Dr M E Thompson and N Sear.

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), M A Whittington (South Kesteven District Council) and Mrs A White (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer) and Simon Evans (Health Scrutiny Officer).

The following representatives joined the meeting remotely, via Teams:

Sue Cousland (Lincolnshire Divisional Director, East Midlands Ambulance Service), Lucy Gavens (Consultant - Public Health), Ben Holdaway (Director of Operations, East Midlands Ambulance Service NHS Trust), Wendy Martin (Associate Director of Nursing & Quality, Lincolnshire Clinical Commissioning Group), Andrew Simpson (Consultant Urologist), Christie (Programme Manager, Strategy and Development), Dr Colin Farquharson (Medical Director United Lincolnshire Hospitals NHS Trust) and Helen Sands (Continuing Healthcare Clinical Lead, Lincolnshire Clinical Commissioning Group).

County Councillor C Matthews (Executive Support Councillor MHS Liaison, Community Engagement, Registration and Coroners) attended the meeting as an observer.

68 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors G Scalese (South Holland District Council) and R Wootten.

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

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

69 DECLARATIONS OF MEMBERS' INTEREST

Councillor Mrs S Harrison (East Lindsey District Council) wished it to be noted that she was a member of the Lincolnshire Patient Group for the East Midlands Ambulance Service (EMAS).

70 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 19 JANUARY 2022

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 19 January 2022 be agreed and signed by the Chairman as a correct record.

71 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committees attention the supplementary announcements circulated on 15 February 2022. The supplementary announcements referred to:

- Care Quality Commission Report on United Lincolnshire Hospitals NHS Trust;
- Covid-19 Update;
- The Government's Proposals for Health and Care Integration: *Joining up Care for People, Places and Populations*;
- Intermediate Minor Oral Surgery – Response from NHS England (Midlands); and
- NHS Support for Victims of Sexual Assault.

During a short discussion, some clarity was sought regarding the following:

- How much money had been allocated from the East Midlands to Lincolnshire for Dental Services; and the time scale for spending the allocation. The Committee noted that the amount would have to be spent within the existing financial year; and that confirmation would be sought regarding this, and the allocated amount for Lincolnshire;
- Some questions were raised regarding mental health support. The Committee was advised that an update would be received from Lincolnshire Partnership NHS Foundation Trust at the 13 April 2022 meeting; and

- Findings of Care Quality Commission report for United Lincolnshire NHS Hospitals Trust. It was highlighted that this item would be picked up later in the agenda when the Committee considered its work programme.

RESOLVED

That the Supplementary Chairman's announcements circulated on 15 February 2022 and the Chairman announcements as detailed on pages 13 to 17 of the report pack be noted.

72 EAST MIDLANDS AMBULANCE SERVICE UPDATE

The Chairman advised the Committee that this item had been circulated as part of the supplement issued on the 10 February 2022.

The Chairman invited the following presenters from East Midlands Ambulance Service (EMAS): Sue Cousland, Lincolnshire Divisional Director and Ben Holdaway, Director of Operations, to remotely present the report.

Note: Councillor S R Parkin joined the meeting at 10.20.am.

The presentation provided the Committee with an update on the EMAS, which made reference to:

- The strategic vision, the strategy and supporting strategies; and the objectives of EMAS respond, develop and collaborate;
- EMAS Performance 2021/22 – Quarter 1 to Quarter 3.
- Lincolnshire Performance 2021/22 – Quarter 1 to Quarter 3. It was noted that the number of Lincolnshire incidents had continued to increase, and details of activity rates, conveyances, operational resources and pre-handovers were shared with the Committee. It was noted that there had been a downward trend in conveyances;
- Details relating to the reshaping of operations, service improvements were shared;
- The importance of system relationships and that the positive benefits from the pandemic had been enhanced system working with all stakeholders;
- In relation to system relationships strategically and with providers, particular reference was made to the relationship with United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust;
- Lincolnshire Initiatives; and
- Priorities for 2022/23. It was highlighted that the top priority for EMAS was to provide safe and effective care delivery. There was recognition that some responses to patients were delayed, but when crews arrived the service delivered was a quality service. Reference was also made to empowering staff to reach their full potential; and improving efficiency and effectiveness of all resources.

During discussion, the Committee raised the following comments:-

- Whether the times for Lincolnshire pre-handovers were averages. Confirmation was given that the figures provided were mean averages and that the service recorded data on 90th percentile and 95th percentiles. There was recognition that some people were waiting longer and, similarly some people were waiting less time. Confirmation was also given that in circumstances where patients required care immediately, these were prioritised. Reassurance was also given that processes were in place to ensure patients received the care they required as soon as possible;
- Some concern was expressed, from personal experience to the questions asked by 999-call handlers regarding the condition of patients. The Committee noted that the 999-call handlers used a script based on a series of algorithms to assess the information provided and initiate the most appropriate response. There was recognition that it was sometimes difficult for a caller to communicate the exact nature of the problem, but call handlers were trained to get the best information they could to help identify the problem. The Committee noted that all calls were prioritised and allocated to one of five categories, with category one being the top priority, and that EMAS aimed to get to these patients within seven minutes; with 99% of them being within 15 minutes. Confirmation was also given that Covid-19 tests were not performed on ambulances. It was also highlighted that any patient waiting in an ambulance would be assessed in greater detail so that more informed advice could be provided to clinicians, to ensure that the patient went to the right place; and that anyone waiting in an ambulance would be regularly checked by ambulance staff and emergency department staff;
- Hear and Treat for Lincolnshire. One member enquired whether there was any clinical breakdown in the categories for those treated; and how ongoing clinical care was provided or communicated in these instances. The Committee noted that 10% of the transport provided was for cardiac related incidents, and around 10% to 15% was for patients with breathing difficulties, and then between 5% and 10% was for patients who had fallen, and that stroke patients represented under 5% of the total responses. It was highlighted that a better breakdown of clinical cases could be provided for in the next update to the Committee. In relation to see and treat incidents, the Committee was advised that normally EMAS staff would see, treat and refer the patient to primary care, or back to their GP, or to out of hours care. In relation to stroke and heart attack patients, it was highlighted that staff had a direct line in to the hospital and that nearly always, stroke patients were taken directly for a CT scan, which was the initial part of the diagnosis;
- Timing of calls – The Committee was advised that prior to Covid-19, early hours of the morning demand would decline and then increase at lunchtime; then fall and increase again in the evening. However, since Covid-19, there had been a change in the pattern of demand, there was now more demand in the early hours of the morning and between nine and ten in the morning, with people accessing their healthcare through 999. As a result of this change, resources had been changed to meet the demand;

- Whether handovers were still being made at Grantham hospital, as there had been no mentioned of this in the presentation. The Committee noted that only a small number of patients were taken to Grantham & District Hospital;
- Whether there were ambulances dedicated to Lincolnshire. Confirmation was given that Lincolnshire ambulances were predominantly available to respond to emergencies in Lincolnshire. If, however, there was a serious emergency in a neighbouring county, Lincolnshire would send whatever was available to help, as there were clear protocols in place to deal with serious emergency situations. Likewise, if a serious emergency were to happen in Lincolnshire, mutual aid would be received from other counties. Further reassurance was given that Lincolnshire received a large proportion of aid, whether that was additional ambulances or additional clinicians working with colleagues on the front-line to support see and treat elements. The Committee noted that a system approach was taken, based on demand and the right amount of resource. It was highlighted what would help the resource and demand situation, would be better flow through a hospital, enabling the service to hand over patients quicker, freeing up ambulance staff to be able to attend the next incident to treat further patients. It was highlighted that two summits had been held by the County Council working with partners to try and address the issues, and that a system was already in place to start to move things forward in the right direction. The Committee was also advised that if a major incident occurred in Lincolnshire local crews would deal with the incident and support would be provided from neighbouring counties to keep the day-to-day services running and that processes were in place to deal with differing scenarios;
- Outcomes of patients, via hear and treat and see and treat. The Committee noted that re-contact rates were monitored, and that re-contact rates were below 5%. It was also highlighted that call incident response forms were looked at and issues were logged if it was felt that the response made was incorrect. The Committee was advised that different mechanisms were in place to ensure that the service was making the right decision for the patient;
- Military support provided to EMAS. It was reported that the trust had received assistance from sixty general duty staff who had gone out with clinical staff. Twelve of those staff had been in Lincolnshire. The Committee was advised that that the military personnel had provided great support and had been fantastic to work with;
- Relationships with providers, Particular reference was made to Lincolnshire Integrated Volunteer Emergency Services (LIVES), neighborhood teams and Community Emergency Medicine Services (CEMs). The Committee noted that the CEMs, which was provided by LIVES had three vehicles which were active most days; and that advice could be sought from them regarding clinical input, pre-hospital, and that their focus was mainly on the more complex cases. It was highlighted that they had a range of diagnostic equipment on board to help them determine the best route for a patient to take. Ambulance staff liaised with them, and they were linked to the day-to-day service. With regard to primary care networks, it was reported that a pilot had been working in the south of the county, which was focused on the role of an advanced paramedic or a first contact paramedic working side by side in primary care. It was noted that work continued with the more engaged networks to demonstrate the value of the role, both for primary care and for EMAS. With regard

to the role of CEMs staff, it was noted that staff were available to attend emergencies, working with ambulance crews as they arrived, ascertaining the acuity of patients. It was noted further that CEM staff aimed to keep the flow through any hospital; and

- The effect the acute services review could have on existing services pressures. Confirmation was given that EMAS had put together a business case based on the impact of the review on services. EMAS had also been involved in the consultation and had attended public meeting to address any concerns. Overall, it was felt that there would be minimal impact on the proposed changes from both EMAS and the patient perspective.

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

RESOLVED

1. That the Committee's thanks be recorded to all staff of the East Midlands Ambulance Service NHS Trust for their efforts since the beginning of the pandemic.

2. That a further presentation be requested in six months' time, to include the additional statistical information requested by the Committee.

73 NHS CONTINUING HEALTHCARE

Consideration was given to a report from the NHS Lincolnshire Clinical Commissioning Group, which provided the Committee with an update on NHS Continuing Healthcare, a defined package of ongoing care arranged and funded solely by the NHS, where an individual had been assessed and found to have a 'primary health need'

The Chairman invited the following representatives from the NHS Lincolnshire Clinical Commissioning Group: Wendy Martin, Associate Director of Nursing and Quality and Helen Sands, Continuing Healthcare Clinical Lead, to remotely, present the item to the Committee.

The Committee noted that this item and been circulated as part of the supplement on 10 February 2022.

The Committee was advised of the background to NHS Continuing Healthcare, primary health need, NHS-Funded Nursing Care and the roles of the NHS and Local Authorities.

It was reported that Lincolnshire Clinical Commissioning Group (CCG) had an in-house Continuing Healthcare team and that the team comprised of five main areas, details of which were shown within the report presented.

Details of the expenditure on Continuing Healthcare for 2020/21 was shown on the bottom of page 17 of the supplementary report pack for consideration by the Committee.

During consideration of the item, the Committee raised the following comments:

- If a patient's circumstances changed to the point that they were no longer eligible for continuing healthcare, but they still needed support, what measures were in place to ensure a smooth transition to another service. It was reported that a package of care was not handed over until it was known that there was a subsequent package of care in place. It was reported further that a 14 day notice period would be given to end continuing healthcare packages and that during that time an assessment would always be done with social care colleagues, and that ongoing discussion would continue with workers to see if any funding needed to be carried on until the package of care was in place;
- What measures were in place to ensure that accessing the service was not too complicated, and how long, if a patient was not fast tracked, did the process take. The Committee was informed that there was 28-day process, informed through a checklist of need via the health care worker or social care worker. The Committee was advised that the process was a national process which could not be changed, and the starting point was receiving the checklist. It was noted that so far, the 28-day process time had been met;
- Whether there was an appeals process and what percentage were accepted for continuing healthcare. The Committee noted that there was an appeals process for the checklist stage. Unfortunately, the percentage accepted was not a figure available at the meeting;
- Whether the access to NHS continuing healthcare was fair and equitable. The Committee was advised that the CCG had reviewed their process over the last three years to ensure that the process was fair and equitable;
- Whether the demand for NHS continuing healthcare was expected to increase over the next few years. The Committee was advised as the elderly population was increasing, yes, there was an expected increased in demand for NHS continuing healthcare;
- Clarification was given that the funding shown at the bottom of page 17 of the report pack was just NHS funding, and that Section 75 figures was what continuing health care paid to the County Council for the section 75 agreement. In terms of cost increases, these would be expected year on year. It was noted that there had been additional Covid-19 funding for the current year, which had supported hospital discharges. It was noted further that funding in the coming year was likely to reduce, as there would not be as much hospital funding expended;
- If the move to an integrated care system would have an impact. The Committee noted that close working arrangements were already in place with County Council colleagues and other health colleagues. It was however highlighted that there would be opportunities to look at the way services were contracted; and what more could be done to aid working as an integrated system; and
- Discharge arrangements. The Committee was advised that there was an assessment on discharge regarding care needs, and where those care needs were met, a full assessment would take place within 28 days. It was noted that the assessment would determine the funding route and that the hospital discharge fund had been

put in place to make the process more effective. The Committee noted that the 28-day period would not start until the person was discharged, if required a checklist would be put in place and that would then start the 28 days. It was highlighted that most packages of care from hospital to home went through the local authority, and it was only the most complex cases which were funded by the NHS.

The Chairman on behalf of the Committee extended his thank to the presenters.

RESOLVED

1. That the report on NHS Continuing Healthcare be noted.

2. That Lincolnshire Clinical Commissioning Group's obligation to follow national guidance, as set out in *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care,* (revised October 2018) in its implementation of NHS Continuing Healthcare arrangements be noted.

3. That no changes are currently proposed to the eligibility arrangements for NHS Continuing Healthcare be noted.

74 SUICIDE PREVENTION IN LINCOLNSHIRE

Consideration was given to a report from the Director of Public Health, which provided the Committee with information on recent suicides in Lincolnshire and the action being taken locally to reduce future suicide deaths.

The Chairman invited Lucy Gavens, Consultant in Public Health, Public Health Division, to remotely, present the item to the Committee.

In guiding the Committee through the report, reference was made to the number of suicide deaths (5,224) registered in England and Wales in 2020; the number of suicide deaths (90) in Lincolnshire in 2020. It was noted that between 2018 and 2020 the male suicide rate in Lincolnshire was 20.3 per 100,000, which was significantly higher that the England average (15.0 per 100,000). Figure 2, on page 21 of the report provided details of directly standardised mortality rates due to suicide in Lincolnshire, by gender. Figure 3, on page 23 of the report provided details of suicide rates by district. It was highlighted that Lincoln had the highest suicide rates in the county since 2010/12, except for 2015/17 when rates were highest in East Lindsey.

The Committee was advised of the key factors that increased the risk of death by suicide; details relating to preventing suicide in Lincolnshire. Appendix A to the report provided the Committee with a copy of the Authority's suicide audit, and Appendix B provided a copy of the Lincolnshire Suicide Prevention Strategy for the Committee to consider. The Committee noted the Lincolnshire Suicide Prevention Strategy five 'Priorities for Action'; the key actions in 2020/21; and the key priorities for 2022.

During consideration of this item, the Committee raised the following comments:

- Why people were waiting so long for treatment. The Committee noted that work was ongoing with Lincolnshire Partnership NHS Foundation Trust (LPFT) around how to make sure that children and young people and adults could be identified before the point of crisis. It was noted further that a group of senior stakeholders across the system were looking at this, to make sure that the support pathways were joined up, as it was anticipated that the impact of Covid-19 on mental health and wellbeing had been significant. It was also reported that more needed to be done to support individuals, their families and communities to be able to have conversations and to be able to access the support needed for anyone at risk of suicide;
- Concern was expressed to the Covid-19 and economic pressures and the impact this was having on families and communities, and that vulnerable people needed to know who to contact for help and support. There was recognition that it was hard to reach individuals who were not already in contact with mental health services. It was recognised that more need to be done to obtain more information about the impact of Covid-19 on suicide deaths and to gain an understanding on what the key risks were. With regard to financial struggles, it was highlighted that officers were working with the Financial Inclusion Partnership to better understand the key factors where extra support would be put in place where necessary. It was also highlighted that there needed to be closer working with GPs both nationally and locally to understand the position. It was highlighted further that closer working would also be taking place with Primary Care Networks (PCNs) to help identify the more vulnerable people presenting themselves to primary care rather than mental health services; using primary care as an early door to such cases;
- Concern was expressed as to why Lincoln had the highest number of suicides cases. It was noted that some local projects had been set up across Lincolnshire to support suicide prevention, and these had also been targeted at Lincoln to obtain the necessary data to see what might be happening. The Committee noted that over the last few months East Lindsey was also a concern and as a result work was ongoing with colleagues from the districts and communities involved. One member also expressed concern regarding suicide rates in the younger population aged between 14 and 21. The Committee noted that during the last year there had been six suicide deaths in this age group. It was noted that there had been a review of the six cases to identify whether there were specific services they had been in contact with, and whether anything could have been done differently, and where possible mechanisms would be put in place to prevent future suicide deaths. It was highlighted that it was important to understand the challenges of children and to be able to create an environment where young people felt able to talk about how they were feeling. This included the impact of the pandemic and other social changes were having on children and young people in some of the county's most deprived areas, this is would then help to prevent any child or young person getting to the point where they felt hopeless;
- Some concern was also expressed regarding links between LPFT and voluntary groups involved in care. Reassurance was given that there was a multi-agency stakeholder group which had representation from colleagues at LPFT. There was recognition that

there was always more that could be done regarding suicide prevention work, particularly working with bereaved families and friends, and learning more from suicide cases;

- Inclusion of forces families in the Suicide Strategy. One member expressed from personal experience the risks attributed to this group of society. There was recognition that the strategy did not cover all risks groups. The Committee was advised inclusion of this group would be taken away as an action from the meeting;
- What was being done to reduce suicide rates in Lincolnshire. The Committee was advised that the strategy would help, as there was a range of actions that would be delivered during the year, these were as detailed in the action plan. Work was also being undertaken with neighboring areas with lower suicide rates to try and understand what they are doing different to Lincolnshire. Also, as part of that work, following national guidance, officers were trying to understand local needs and using the local data to guide any future actions;
- Key actions for 2020/21, reference was made to supporting the establishment of a range of local projects to prevent suicide through the Community Suicide Prevention Innovation Fund. One member requested further information regarding the projects and their location. Officers agreed to circulate the information to members of the Committee after the meeting;
- Reference was made to page 45, which referred to the fact that the Coroner's office was unable to provide enhanced data, and whether this situation was going to improve. Reassurance was given that the issue had been resolved and that data was expected before 1 April 2022; and
- How many of the key objectives had been achieved. The Committee was advised that the action plan was updated each year and that the most recent version could be shared with members of the Committee. It was highlighted that everything had been achieved in the action plan for 2020/21, but some of the priorities within the strategy were still outstanding.

The Chairman on behalf of the Committee extended his thanks to the Consultant in Public Health for the presentation.

RESOLVED

1. That the report on suicide prevention in Lincolnshire be received and noted.

2. That a more detailed action plan be received to highlight the actions being taken to reduce suicide deaths.

3. That consideration be given to establishing a working group, which could explore some of the issues related to suicide prevention in Lincolnshire.

75 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST- RECONFIGURATION OF UROLOGY SERVICES UPDATE

Consideration was given to a report from United Lincolnshire Hospitals NHS Trust (ULHT), which provided the Committee with an update of the implementation of the new model for urology in Lincolnshire's hospitals.

The Chairman invited the following representatives from ULHT: Dr Colin Farquharson, Medical Director and Mr Andrew Simpson, Consultant Urologist, to remotely present the item to the Committee.

The Committee was reminded of the challenges facing urology services across Lincolnshire's hospitals, the public engagement exercise to consult upon the proposed changes, and the subsequent approval by the ULHT Board on 2 August 2021 to the proposed changes.

The Committee were advised of the model of service; the case for change; the benefits of the reconfigured service to date; non-elective performance, it was noted that non-elective admissions were now significantly lower than they were Trust-wide before the re-configuration, and that this trend would be monitored; average length of stay on the urology non-elective pathway; the quality impact assessment; patient feedback, it was noted that to date although patient survey responses had been low, no negative feedback or formal complaints had been received; public/patient engagement in the process; staff engagement; finance; and key risks and issues.

In conclusion, the Committee was advised that the expected benefits of the model and its wider impact were continuing to be being monitored.

During discussion, the Committee raised the following points:

- The reluctance of some patients to engage with services due to Covid-19. Confirmation was given that Covid-19 had clearly affected the willingness and ability of some people to engage with services. Confirmation was given that so far in February there had been no cancellations due to elective bed pressures, despite considerable emergency activity at hospital sites;
- Level of response received from the consultation and the themes of concern had been highlighted. It was reported that the level of response from patient feedback had been limited (3 responses). Confirmation was given that there had not been any concerns raised apart from one isolated complaint. There was recognition that further feedback from patients and staff was necessary. It was highlighted that from 50 staff, 20 responses had been received. The Committee was advised that the feedback exercise would be repeated;
- When would there be evidence of reduced cancellations of elective appointments and improvements to cancer care. The Committee was advised that there was an expectation to see reduced cancellations due to the split between emergency and elective care, which at present was not supported by the present data, and as a result this information would be reported to a future meeting of the Committee. Regarding cancer care, the Committee was advised that there had been a reduction in the most urgent cases, but the service was still struggling with its cancer

performance figures. It was highlighted that the introduction of robotic surgery would reduce reliance from other providers to deliver the most complex cases; and

- Whether the urology/trauma assessment hub had progressed any further and if not, when was it likely to be put in place. A suggestion was made that a further report be considered by the Committee in three to four months' time, when further information was available.

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

RESOLVED

1. That the report and presentation on the urology service, provided by United Lincolnshire Hospitals Trust be noted, and that the Committee welcomes
   a. The reduced expenditure on agency expenditure for medical staff;
   b. The plans to recruit a tenth consultant; and
   c. The use of robotic surgery.

2. That further progress be made in other areas such as reduction in the number of cancelled appointments, and improvements to the 28-day cancer performance.

3. That a further update on urology services be received in four months' time.

76 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the report, which invited the Committee to consider and comment on its work programme as detailed on pages 73 to 76 of the report pack.

The Committee noted that the item on Nuclear Medicine would be included on the work programme for the March meeting, and that the Lincolnshire Pharmaceutical Needs Assessment item would not be a substantive item, but a working group would need to be considered to respond to the draft document.

From the items considered earlier in the agenda, it was highlighted that a urology update would be received in either May/June; and that a report would be received concerning United Lincolnshire NHS Hospital Trusts progress on the response from the Care Quality Commission report; and that a working group would be set up to look into the issues relating to suicides in Lincolnshire.

During consideration of this item, the Committee raised the following suggestions:

- North West Anglian NHS Foundation Trust (NWAFT) – Revised Estate Strategy; and
- Recovery planning of the NHS;

RESOLVED

That the work programme presented be agreed subject to the inclusion of the items/suggestions highlighted.

The meeting closed at 12.54 pm

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Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**Chairman's Announcements**

1. Information Requested at the Last Meeting (16 February 2022)

More detail was requested at the last meeting on the following items:

Community Emergency Medicine Services
(*Minute 72 – East Midlands Ambulance Service Update*)

Community Emergency Medicine Services (CEMs) are provided by LIVES [Lincolnshire Integrated Volunteer Emergency Services]. CEMs have three highly equipped response vehicles, and is supported solely by qualified medical specialists and experienced clinicians, including doctors, paramedics, and nurses, who volunteer their time to provide this service. CEMs are able to provide enhanced care at the scene of the emergency, such as testing and ultrasound, which can reduce the need for a patient to enter the healthcare system as an emergency, thus reducing pressure on A&E. This service is unique to Lincolnshire.

The specialist skills provide by CEMs mean that they can carry out many procedures, that often an ambulance crew cannot, for example, stitching and treating a serious wound to diagnosing and treating complex diabetic emergencies in a patient's own home. The LIVES annual report for 2020/21 refers to CEMs attending 753 jobs during the year, following which they escorted patients to hospital on 103 occasions; conducted 51 surgical procedures and provided sedations to 76 patients.

Dental Services
(*Minute 71 – Chairman's Announcements*)

At the last meeting it was reported that NHS England and NHS Improvement (Midlands) had received £8.9 million as its share of a national funding allocation of £50 million (announced on 25 January 2022) to secure more dental appointments by the end of the year. Information on the allocation of funding for dental services in Lincolnshire has been requested and will be circulated when provided by NHS England and NHs Improvement.

Suicide Prevention Action Plan
(*Minute 74 – Suicide Prevention in Lincolnshire*)

The Lincolnshire Suicide Prevention Action Plan is available on the County Council's website: Suicide prevention action plan – Lincolnshire County Council

Information on the Community Suicide Prevention Innovation Fund may be found on the gov.uk website: Suicide Prevention Fund 2021 to 2022 - GOV.UK (www.gov.uk)

2. Covid-19 Update

Covid-19 Response: Living with Covid-19

Since the Committee's last meeting on 16 February 2022, the main development has been the publication of the government's its plan for living with Covid-19 (*Covid-19 Response: Living with Covid-19*) on 21 February 2022. The government plans to enable the country to manage Covid-19 like other respiratory illnesses, while minimising mortality and retaining the ability to respond if a new variant emerges with more dangerous properties than the omicron variant, or during periods of waning immunity, that could again threaten to place the NHS under unsustainable pressure. The following key dates were included:

- **From 21 February**
  - The guidance for staff and students in most education settings to undertake twice weekly asymptomatic testing was withdrawn.

- **From 24 February**
  - The legal requirement to self-isolate following a positive test was removed, but adults and children who test positive continue to be advised to stay at home and avoid contact with other people.
  - Self-isolation support payments and funding for practical support ceased.
  - Routine contact tracing ceased.
  - The Health Protection (Coronavirus Restrictions) (England) (No 3) Regulations were revoked.

- **From 24 March**
  - The Covid-19 provisions in the statutory sick pay regulations will cease.

- **From 1 April**
  - Guidance will be updated on the steps that people with Covid-19 should take to minimise contact with other people.
  - Free universal symptomatic and asymptomatic testing for the general public will cease, but will remain available for social care staff and fore a small number of at-risk groups.
  - The health and safety requirement for every employer to explicitly consider Covid-19 in their risk assessments will cease.
  - Guidance to the public and businesses will be consolidated, in line with public health advice

Testing

The PCR testing network across England will be decommissioned in a phased approach over the next nine months. This will include all regional and local testing sites across Lincolnshire, as well as the mobile testing units. This aligns with the new strategy to remove free population wide PCR testing by the end of March.

Simultaneously all national and local components for asymptomatic testing will also be removed by the end of March. This includes the current Later Flow Test universal offer (covering home delivery and pharmacy collect) as well as the local targeted community testing programme.

Vaccination Programme

The government has stated that the vaccination programme will continue, with the current focus on all 12-15 year olds, and on at-risk 5-11 year olds. Subject to the advice of the Joint Committee on Vaccinations and Immunisation (JCVI), further vaccinations (boosters) may be recommended for people who are most vulnerable to serious outcomes from Covid-19 in the autumn of 2022 this autumn and, ahead of that, a spring booster for groups which the JCVI consider to be at particularly high risk.

3. Mental Health Rehabilitation in Lincolnshire

Lincolnshire Partnership NHS Foundation Trust (LPFT) has announced that it would like to hear the views of service users, carers, partners and the general on mental health rehabilitation services in Lincolnshire. LPFT states that feedback will help the Trust develop the best mental health rehabilitation support for people now and in the future.

LPFT will host three face-to-face events as follows:

- 22 March 2022, 10am – Midday at the Alive Church, Newland, Lincoln, LN1 1XG
- 23 March 2022, 10am – Midday at Boston United FC, Jakemans Community Stadium, Pilgrim Way, Wyberton, Boston, PE21 7NE
- 24 March 2022, 10am – Midday at Jubilee Church Life Centre, 5 London Road, Grantham, NG31 6EY

The events will invite the views and feedback of anyone who is connected to mental health rehabilitation services; whether they have cared for someone in rehabilitation, have an interest in NHS mental health community care, or have personal lived experience. Further information and bookings can be made via LPFT's Participation Coordinator, Sarah Cox, via email at: lpft.involvement@nhs.net.

The engagement events will also provide attendees with an update on current services and opportunity to help shape new developments within mental health rehabilitation services in Lincolnshire. Two of the areas where feedback is going to be sought are:

Ashley House, Grantham

In February 2021, to support the pandemic response and to ensure services were staffed safely, LPFT made a decision to temporarily close Ashley House, a 15-bed mixed gender open rehabilitation inpatient unit in Grantham. As well as supporting staffing on the LPFT's other rehabilitation and acute mental health wards, this enabled LPFT to put additional resource into its Community Rehabilitation Service, which was launched in 2020.

Community Rehabilitation Service

The Community Rehabilitation Service, launched in 2020, initially provided support to people living in Lincoln and Gainsborough but has now expanded to the Grantham and South Holland areas of the county. LPFT states that the community teams are able to support a larger number of people than inpatient units, with people being cared for closer to their home. The teams work to support those with long-term mental health difficulties who have been in hospital for a length of time. Service users receive increased on-going support with their day-to-day lives, enabling the building of skills and confidence, helping to improve relationships and support networks.

4. Lincoln Medical School Placements at United Lincolnshire Hospitals NHS Trust

On 21 February 2022, United Lincolnshire Hospitals NHS Trust (ULHT) announced that it would be welcoming into its hospitals the first ever cohort of 80 third year medical students from the Lincoln Medical School at the University of Lincoln. The students will receive training at Lincoln County Hospital and Pilgrim Hospital, Boston, whilst also caring for patients.

ULHT will be providing clinical placements for these medical students, in a collaboration between the Universities of Lincoln and Nottingham. This Lincoln Medical School students will be training alongside the existing cohort of students from Nottingham., who will conclude their training in 2023, after which all student intakes will be from Lincoln Medical School.

It is hoped the new Medical School in Lincoln will address future projected shortages of doctors by encouraging graduates to complete their junior doctor training and applying for jobs locally. The numbers of students coming to Lincolnshire's hospitals will increase over the next two years as part of the increase to the government cap on medical school places.

5. Healthwatch Lincolnshire Live Panel Event: Dental Services in Lincolnshire

This is a further reminder that the Healthwatch Lincolnshire Live Panel Event on dental; services in Lincolnshire is taking place on 30 March, from 10 am until 11 am. It will provide patients the opportunity to ask the questions that about their dental care in Lincolnshire. Further details are available at the following link: -

YourVoice@Healthwatch: Dental Services in Lincolnshire March 2022 | Healthwatch Lincolnshire

6. North West Anglia NHS Foundation Trust – Three Year Strategy

On 15 September 2021, the Committee considered an item on North West Anglia NHS Foundation Trust (NWAFT) and requested a copy of their overall strategy once it had been revised and approved. On 8 February 2022, the NWAFT Board of Directors approved its three year strategy for the period 2022/23 – 2024/25, entitled *Local Care for Local People*. This document is available in full on the Trust's website: Trust Strategy - North West Anglia NHS Foundation Trust (nwangliaft.nhs.uk)

On 16 February 2022, a request was made for the inclusion of an item in the Committee's work programme on the Trust's estate strategy, with particular reference to the Stamford and Rutland Hospital site following reports in December 2021 that a planned sale of the western end of the site had fallen through. The Trust remains committed to the sale, as indicated on page 23 of its approved three year strategy which includes a commitment "to finalise a land sale and development of the west end of the Stamford and Rutland Hospital site".

7. Delivery Plan for Tackling the Covid-19 Backlog of Elective Care

On 8 February 2022, NHS England and NHS Improvement published its *Delivery Plan for Tackling the Covid-19 Backlog of Elective Care*. This plan includes several ambitions, including the following four:

(1) Waits of longer than a year for elective care will be eliminated by March 2025. Within this, by July 2022, no one will wait longer than two years, the NHS will aim to eliminate waits of over 18 months by April 2023, and of over 65 weeks by March 2024. Long-waiting patients will be offered further choice about their care, and over time, as the NHS brings down the longest waits from over two years to under one year, this will be offered sooner.

(2) Diagnostic tests are a key part of many elective care pathways. The NHS's ambition is that 95% of patients needing a diagnostic test receive it within six weeks by March 2025.

(3) The NHS has continued to prioritise cancer treatment throughout the Covid-19 pandemic and has consistently seen record levels of urgent suspected cancer referrals since March 2021. To maintain this focus, the NHS's ambition is that, by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. Local systems have also been asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.

(4) For patients who need an outpatient appointment, the time they wait can be reduced by transforming the model of care and making greater use of technology. The NHS will work with patient groups to monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

The full plan, including supporting documents, may be found at:
Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)

The NHS's *2022/23 Priorities and Operational Planning Guidance*, which is issued to local health systems, was updated on 22 February 2022 to reflect the delivery plan for dealing with the backlog of elective care.

8. The Health and Care Bill

The Health and Care Bill, which was introduced in the House of Commons on 6 July 2021, is now completing its final stages in the House of Lords. Two elements of the Bill are considered below:

Integrated Care Systems

The government's intention remains that integrated care systems (ICSs) will be established as statutory entities, each comprising:

- an integrated care partnership – a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS; and
- an integrated care board bringing the NHS together locally to improve population health and care.

As previously reported the original implementation date of 1 April 2022 for the ICSs has been deferred to 1 July 2022, as the statutory instruments and statutory guidance cannot be made until the Bill has been enacted. However, interim guidance has been issued by NHS England and NHS Improvement, which has enabled local health systems to plan for the new arrangements. Lincolnshire's ICS will be called the *Better Lives Lincolnshire Alliance*. In addition to ICSs, the Committee will need to become familiar with new abbreviations:

- ICB – Integrated Care Board
- ICP – Integrated Care Partnership

As previously reported, Lincolnshire has appointed Sir Andrew Cash as the ICB's Interim Chair, and Andrew Turner as its Chief Executive.

NHS England is also requiring local systems to establish a provider collaborative, with the aim of driving the provision of high quality, cost-effective health and care services. The Lincolnshire Health and Care Collaborative (LHCC) has been established. As reported to the Committee previously, Peter Noble has been appointed as its Managing Director.

Health Overview and Scrutiny Powers

When the Bill is enacted, there will be particular focus on the planned provisions enabling the Secretary of State for Health and Care to intervene in local NHS reconfigurations, which has been subject to particular consideration by the House of Lords. These provisions would affect the existing powers of health overview and scrutiny committees to make referrals to the Secretary of State in cases of substantial variations of local health services. The Centre for Governance and Scrutiny is reporting that it expects the powers of referral for health overview and scrutiny committees to remain in their current form until April 2023, when the new intervention powers of the Secretary of State would be introduced.

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

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust - Care Quality Commission Inspection Report - February 2022**

Summary:

On 8 February 2022, the Care Quality Commission (CQC) published its inspection report on United Lincolnshire Hospitals NHS Trust (ULHT), following inspections during October and November 2021. The CQC's overall rating for ULHT has remained as 'Requires Improvement'. The overall rating of ULHT could not change as the CQC did not inspect all services on all sites. However, the CQC has welcomed the widespread improvements at ULHT, which are set out in the report.

The inspection report was considered by the ULHT Board of Directors on 1 March, who noted the report and the requirement for the Trust to submit its action to the CQC by 10 March 2022.

The Trust's Chief Executive, Andrew Morgan, and its Deputy Chief Executive and Director of Nursing, Dr Karen Dunderdale, are due to attend the meeting of the Committee for this item.

Actions Requested:

To consider the information presented on the inspection report by the Care Quality Commission on United Lincolnshire Hospitals NHS Trust, published on 8 February 2022; and the Trust's actions in response to the inspection report.

1. Background

The Care Quality Commission (CQC) undertook an unannounced core-service inspection and an announced 'well-led' inspection during the months of October and November 2021 at United Lincolnshire Hospitals NHS Trust.

The CQC published its findings on 8 February 2022, together with a media release, which is attached at Appendix A. The CQC has recognised the widespread improvements the Trust have made in the quality and safety of services since the last inspection in 2019. The CQC commented that this was particularly impressive against the Covid-19 backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level. As a result of the inspection, the overall Trust CQC rating remains 'Requires Improvement'. The overall rating of ULHT could not change as the CQC did not inspect all services on all sites.

Attached as Appendix B are the key findings of the report (pages 1 - 25). The full report is available on the CQC's website: United Lincolnshire Hospitals NHS Trust (cqc.org.uk)

For reference the contents of the full inspection report are set out below: -

2. Comparisons with 2019

Comparisons with the previous ratings in 2019 are set out below:

Overall Trust Ratings 2019					
Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019

Overall Trust Ratings 2022					
Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

Ratings by Hospital Site 2019						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019
Pilgrim Hospital	Inadequate ↓ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↑ Oct 2019	Requires Improvement ↑ Oct 2019	Requires Improvement ↑ Oct 2019
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Trust Overall	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019	Requires Improvement ➔➔ Oct 2019

Ratings by Hospital Site 2022						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement ➔➔ Feb 2022	Good ↑ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022

Ratings by Hospital Site 2022						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Pilgrim Hospital	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Trust Overall	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

Ratings for Lincoln County Hospital Site 2019						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Medical Care (including older people's care)	Requires Improvement →← Oct 2019	Requires Improvement ↓ Oct 2019	Good →← Oct 2019	Requires Improvement →← Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement →← Oct 2019
Services for Children and Young People	Requires Improvement →← Oct 2019	Requires Improvement ↓ Oct 2019	Good →← Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↓ Oct 2019
Critical Care	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Outstanding →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019
End of Life Care	Requires Improvement Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and Emergency Services	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019	Requires Improvement ↓ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019
Outpatients	Requires Improvement Jul 2018	N/A	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Maternity	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Overall	Requires Improvement →← Oct 2019	Requires Improvement →← Oct 2019	Good →← Oct 2019	Requires Improvement →← Oct 2019	Requires Improvement →← Oct 2019	Requires Improvement →← Oct 2019

Ratings for Lincoln County Hospital Site 2022						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Medical Care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for Children and Young People	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Critical Care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019
End of Life Care	Requires Improvement Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and Emergency Services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022
Outpatients	Requires Improvement Jul 2018	Not Rated	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Maternity	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good Oct 2019	Good Oct 2019	Good →← Feb 2022	Good →← Feb 2022
Overall	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022

Ratings for Pilgrim Hospital Boston 2019						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Medical Care (including older people's care)	Requires Improvement →← Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement →← Oct 2019	Requires Improvement →← Oct 2019
Services for Children and Young People	Inadequate ↓ Oct 2019	Requires Improvement →← Oct 2019	Good →← Oct 2019	Requires Improvement ↑ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019
Critical Care	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019
End of Life Care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and Emergency Services	Inadequate →← Oct 2019	Inadequate →← Oct 2019	Requires Improvement ↑ Oct 2019	Inadequate →← Oct 2019	Requires Improvement ↑ Oct 2019	Inadequate →← Oct 2019

Ratings for Pilgrim Hospital Boston 2019						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Outpatients	Requires Improvement Jul 2018	N/A	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Maternity	Good Oct 2019	Requires Improvement Oct 2019	Good Oct 2019	Requires Improvement Oct 2019	Requires Improvement Oct 2019	Requires Improvement Oct 2019
Overall	Inadequate ↓ Oct 2019	Requires Improvement →← Oct 2019	Requires Improvement ↓ Oct 2019	Requires Improvement ↑ Oct 2019	Requires Improvement ↑ Oct 2019	Requires Improvement ↑ Oct 2019

Ratings for Pilgrim Hospital Boston 2022						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Medical Care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for Children and Young People	Good ↑↑ Feb 2022	Good ↑ Feb 2022	Good →← Oct 2019	Good ↑ Feb 2022	Good ↑↑ Feb 2022	Good ↑↑ Feb 2022
Critical Care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
End of Life Care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and Emergency Services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Oct 2019	Requires Improvement ↑ Feb 2022
Outpatients	Requires Improvement Jul 2018	N/A	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Maternity	Good Oct 2019	Requires Improvement Oct 2019	Good Oct 2019	Requires Improvement Oct 2019	Requires Improvement Oct 2019	Requires Improvement Oct 2019
Overall	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022

3. Trust Board Consideration

On 1 March 2022 the CQC's report was submitted to the ULHT Board of Directors, who acknowledged the widespread improvements made and recognised that further improvements would be required; and endorsed the preparation of an action plan to be submitted to the CQC, as required, by 10 March 2022.

4. Consultation

This is not a direct consultation item.

5. Conclusion

The Committee is requested to consider the information in this report on the CQC's inspection report of ULHT, and ULHT's actions planned in response to the findings in the report.

6. Appendices – These are listed below and attached to this report

Appendix A	Care Quality Commission Media Release – Published on 8 February 2022
Appendix B	Care Quality Commission Inspection Report on United Lincolnshire Hospitals NHS Trust (Pages 1-25)

7. Background Papers

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

APPENDIX A

CARE QUALITY COMMISSION MEDIA RELEASE
ISSUED: 8 FEBRUARY 2022

CQC Finds Widespread Improvement at United Lincolnshire Hospitals NHS Trust

The Care Quality Commission (CQC) has welcomed widespread improvements at United Lincolnshire Hospitals NHS Trust following an inspection of its medical, maternity, urgent and emergency services and services for children and young people. The CQC carried out the inspection in October at Pilgrim Hospital and Lincoln County Hospital, as part of continual checks on the safety and quality of healthcare services.

As a result of the inspection, the overall trust rating remained requires improvement. The trust ratings for being effective and well-led went up from requires improvement to good. Safe and responsive remained as requires improvement and caring remained as good.

The ratings for medical care and children's and young people's services at Lincoln County Hospital moves from requires improvement to good. Children's and young people's services at Pilgrim Hospital went up from inadequate to good. Urgent and emergency services went up from inadequate to requires improvement and maternity services at Pilgrim Hospital went up from requires improvement to good.

Ted Baker, Chief Inspector of Hospitals said: "Our inspection of United Lincolnshire Hospitals NHS Trust found many areas that had improved since we last inspected which is good news for people receiving care. I would like to congratulate the trust and all its staff for the progress they have made. It is particularly impressive set against the backdrop of the Covid-19 pandemic. The trust has had historic issues, particularly regarding concerns with Pilgrim Hospital's urgent and emergency department and maternity services and was in special measures for several years.

"Staff and their leaders must be commended for the steps they've taken towards improving patient care in these previously troubled areas. We rated well-led as good. Leaders across the trust understood the challenges that staff were facing and worked hard to support colleagues in a compassionate way.

"We saw a marked improvement across maternity, medical care and services for children and young people. Staff morale had improved with initiatives in place to promote wellbeing. For example, staff on the maternity ward could share positive messages and feedback to their colleagues by leaving messages in a 'Ta jar'. These messages were then shared directly with individuals which made them feel respected and valued.

“While widespread improvements had been made, there are still concerns regarding access and flow in the urgent and emergency department at Lincoln County Hospital. People continued to experience delays in accessing the service and receiving care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were still below national standards.

“I recognise the enormous pressure NHS services are under across the country, especially in the urgent and emergency department, but it is important they do all they can to mitigate risks to patient safety while facing these pressures. We continue to monitor the trust closely and leaders know where we expect to see improvements and where to sustain areas where good patient care is already being delivered.”

At Lincoln County Hospital, inspectors found:

- The children and young people’s service had 24-hour access to mental health liaison support if staff were concerned about a child or young person’s mental health. Staff could access the internal mental health team who could attend to patients at any time, day or night
- On medical wards, staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required
- The trust had worked hard over the last year to recruit staff onto medical wards and had recruited several overseas nurses which resulted in reduced vacancy rates
- When patients transferred to a new area, there were no delays in staff accessing their records. The trust had an electronic system on which staff recorded observations, key information and treatment plans. This was accessible on all wards and enabled staff to quickly identify areas of risk and treatment plans
- In the maternity department, facilities and equipment concerns were not always responded to in a timely manner to ensure the environment met the needs of women. For example, one woman told us the toilet in their room was out of order and another room had blinds that didn’t work
- Whilst improvements had been made in A&E, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets.

At Pilgrim Hospital, inspectors found:

- Maternity leaders displayed enthusiasm to improve services for women, babies and staff. Staff spoke positively about the culture and were supported to carry out their roles effectively
- Staff knew how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with agencies to protect them
- Staff gave patients emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state. We observed staff reassuring patients and taking time to interact with them despite being extremely busy

- The design of the A&E department did not always follow national guidance. However, action had been taken to improve the department, including; a new x-ray room, an additional triage room, a waiting room, and a paediatric emergency department.

Inspectors also found the following outstanding practice:

- The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Significant work had taken place to implement a 'one team' approach to establishing a community-based stroke rehabilitation service that was able to support stroke survivors seven days a week
- In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy
- The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their premature baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities
- The trust was the first in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions who acted as local leads for patient experience. This work aimed to engage with patients, families and their carers to improve care.

United Lincolnshire Hospitals NHS Trust

Inspection report

Greetwell Road
Lincoln
LN2 5QY
Tel: 01522512512
www.ulh.nhs.uk

Date of inspection visit: 5 6, 7, 8 October 2021 and November 9,10,11 2021
Date of publication: 08/02/2022

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs nearly 8,000 people.

In the last year the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and also delivers services from community hospitals and centres in Louth, Gainsborough, Spalding and Skegness.

Between 5 October 2021 and 11 November 2021, we inspected four core services provided by the trust across two locations. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity at Pilgrim Hospital and Lincoln County Hospital. We also inspected the well-led key question for the trust overall.

We carried out this unannounced inspection of services provided by this trust because the trust was placed in financial and quality special measures in 2017/18 and is currently placed into System Oversight Framework (SOF) segment 4 of NHS England & NHS Improvement (NHSEI) Recovery Support Programme (RSP). At our last inspection we rated the trust overall as requires improvement.

Our findings

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

On 5, 6, 7, 8 October 2021 we inspected four core services provided by the trust across two locations. We inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity at Pilgrim Hospital. At our last inspection, Urgent and Emergency Services and Services for children and young people were rated as inadequate overall. Medical care (including older people's care) and Maternity were rated as requires improvement overall.

At Lincoln County Hospital we inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity. At our last inspection, Urgent and Emergency Services was rated as inadequate overall. Services for children and young people and Medical care (including older people's care) were rated as requires improvement overall. Although Maternity at the Lincoln County Hospital was rated good overall at our last inspection, we inspected this service because we had concerns.

We did not inspect Outpatients previously rated requires improvement because we are monitoring the progress of improvements to outpatients and had no concerns. We will re-inspect them as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed ‘is this organisation well-led’. We inspected the well-led key question between 9 and 11 November 2021. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSEI). There was not a separate ‘Use of Resources’ assessment in advance of this inspection.

Our rating of the trust stayed the same. We rated them as requires improvement because:

- We rated safe and responsive as requires improvement and effective, caring and well-led as good.
- We rated six of the trust’s services as good and two as requires improvement. In rating the trust, we took into account the current ratings of services not inspected this time.
- We inspected maternity using our focused maternity framework and guidance. Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.
- In maternity services at Lincoln County Hospital we rated safe as requires improvement, the key questions of effective and well led remained the same. In maternity services at Pilgrim Hospital we reviewed actions the trust had taken to address areas for improvement identified in Maternity services following our 2019 inspection. We found the trust had taken sufficient action and improved Maternity services at Pilgrim Hospital and have therefore updated our ratings for this service. We rated the key questions of safe, effective and well led as good, the key questions of caring and responsive remained the same.
- Not all services had enough staff to care for patients and keep them safe and not all staff were up to date with mandatory training or additional safeguarding training.
- Medicines were not always stored safely and patient records were not always stored securely.

Our findings

- Outcomes from national audits were not always positive and some services did not always use systems to manage performance effectively.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance.
- Services in urgent and emergency care were not designed in a way that always met the needs of local people, were inclusive and took account of patients' individual needs and preferences.
- People could not always access services when they needed to, and they did not always receive the right care promptly.
- Risks on the risk register, in some services, were not always effectively managed and not all risks were identified and escalated to reduce their impact.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Most services controlled infection risk well. Staff assessed risks to patients, acted on them and mostly kept good care records. Most services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were mostly available seven days a week.
- Without exception, staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders had the skills and abilities to run services. They understood and managed the priorities and issues services faced. Improvements were observed in clinical leadership.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Services engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

Outstanding practice

We found the following outstanding practice:

Our findings

Trust wide

- Significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.
- The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week.

Lincoln County Hospital

Medical care (including older people's care)

- The clinical engineering department had used innovation to support a patient to receive their care and treatment in a comfortable way.
- The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.
- In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

Pilgrim Hospital

Services for children and young people

- In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy.
- Parents received training, guidance and support to carry out care such as tube feeding and utilised a set of parent competencies in a booklet to enable parents to carry out as much or as little as they felt comfortable with.
- The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their very tiny baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities. There was room for siblings to visit. Parents still had access to nursing and medical staff on the neonatal unit whilst staying in the transitional rooms.

Our findings

- Leaders had implemented a project with a community team where they worked closely with specialist community nurses to enable neonates who required ongoing specialist care such as continuous oxygen, could be discharged early with the support of a specialist community nurse.
- The service funded nursery nurses to complete their nurse training as part of a recruitment initiative.

Medical care (including older people's care)

- The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.
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Areas for improvement

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to three services.

Lincoln County Hospital

Urgent and emergency care

- The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.
- The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.

Maternity

- The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.

Our findings

Pilgrim Hospital

Urgent and emergency Care

- The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.
- The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.
- The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
- The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.
- The trust should ensure the requirements of duty of candour are met.
- The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.
- The trust should ensure they are using timely data to gain assurance at board.
- The trust should ensure all patient records and other person identifiable information is kept secured at all times.
- The trust should ensure it has access to communication aids and leaflets available in other languages.
- The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.

Lincoln County Hospital

Urgent and emergency care

- The trust should ensure that falls and mental health risk assessments and transfer documentation are in place for patients when they are required and that completion risk assessments and transfer documentation are audited.
- The trust should ensure, the paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).
- The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.
- The trust should ensure effective systems are in place to review the service risk register.

Services for children and young people

Our findings

- The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.
- The trust should ensure an interpreter is used as per trust policy to ensure all young people, parents or guardians are able to consent to care and treatment and fully understand clinical conversations.
- The trust should ensure cleaning records are completed as per trust policy.
- The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.
- The trust should consider the use of a communication tool to support staff working with children who have additional needs.
- The trust should ensure that a patient's food and fluid intake is accurately recorded .
- The trust should consider adding specific action plans to the service risk register.

Medical care (including older people's care)

- The trust should ensure that safety checks of new ward environments are fully completed before moving patients.
- The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.

Maternity

- The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.
- The trust should continue to work towards increasing the number of midwives who are competent in theatre recovery to ensure women are recovered by appropriately skilled staff.
- The trust should improve the completion of safety, quality and performance audits to ensure these are consistently completed effectively, to enable safety and quality concerns to be identified and acted upon.

Pilgrim Hospital

Urgent and emergency care

- The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.
- The trust should ensure patients at risk of self harm or suicide are cared for in a safe environment meeting standards recommended by the Psychiatric Liaison Accreditation network (PLAN) and mental health risk assessments and care plans are completed for all patients at risk.
- The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.
- The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.
- The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
- The trust should ensure the, paediatric area within the Emergency Department, nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health (RCPCH).
- The trust should ensure effective systems are in place to investigate incidents in a timely manner and identify and share learning from incidents to prevent further incidents from occurring.

Our findings

- The trust should ensure clinical pathways and policies are updated in line with national guidance.
- The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.
- The trust should ensure effective systems are in place to review the service risk register.

Services for children and young people

- The trust should consider all key services being available seven days a week.
- The trust should consider routine monitoring or auditing of waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH).

Medical care (including older people's care)

- The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good because:

- There was the leadership capacity and capability to deliver high quality, sustainable care.
- There was a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.
- There was a culture of high-quality, sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.
- Appropriate and accurate information was effectively processed, challenged and acted on.
- People who use services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.
- There were robust systems and processes for learning, continuous improvement and innovation.

However:

- The culture of the organisation did not always encourage openness and honesty at all levels within the organisation. Compliance with the duty of candour regulation had been variable however, the trust were taking appropriate action to address this.
- There were inconsistencies at some levels of leadership across the organisation in relation to governance awareness.
- Medicines management across the trust remained a significant challenge. However, the board were cognisant of these risks and were taking steps to address them.

Leadership

Our findings

There was the leadership capacity and capability to deliver high quality, sustainable care.

The trust board included five voting executive directors, one of whom was the trust chief executive, two non-voting executive directors and six non-executive directors (NEDs), one of whom was the trust chair. At the time of this inspection, the director of people and organisational development position was vacant and was being covered by the director of finance. There were effective systems in place to ensure that their portfolio was manageable. The vacancy was being recruited to. Two of the non-executives were in the process of retiring from the board and recruitment was in train.

The trust board was accountable for setting the strategic direction of the trust. The board was working effectively together to achieve its full potential. Leaders had the skills, knowledge and experience that they needed. We observed a strong, cohesive team with collective leadership at board level. All executive directors and NEDs were collectively and corporately accountable for the trust's performance. Our observation of trust board meetings and review of board papers evidenced that opportunities were regularly provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

NEDs gave a clear and consistent account of their role within the unitary board. NEDs had a range of experience and backgrounds including leadership within the NHS; three, including the chair, had close knowledge of services in Lincolnshire through membership of the board of another trust in Lincolnshire.

The director of finance had joined the trust as deputy director of finance in 2018 and had been appointed as director in 2019. They were supported by an experienced deputy director of finance who was also an experienced and valued financial leader; and by an energetic and well-motivated finance team. The director's portfolio also included digital and HR; and from interviews it was apparent that there was a well-developed and empowered infrastructure in each department that mitigated the risk of such a broad leadership portfolio in a financially challenged trust.

The board recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. There was a strong board development programme in place designed to improve the effectiveness and efficiency of the board.

Chair and NED development programmes were available to NEDs both internally and through NHS England and Improvement (NHSE/I). NEDs we spoke with told us they were aware of these and some had and/or were accessing programmes depending on their development needs.

The trust was committed to succession planning in order to identify and develop potential future leaders and senior managers, as well as individuals, to fill senior roles that could become vacant and avoid a department or service becoming vulnerable if the post was not filled quickly. Succession planning and talent management linked directly to the trust's Integrated Improvement Plan (IIP) under the "People" strategic objective. In August 2021 the trust successfully submitted a bid to become a pilot trust for the NHSE/I approach to talent management. This would align the trust to NHSE/I and would serve as a Lincolnshire systems approach. The pilot was expected to commence in Jan 2022.

Leadership and management development within the trust was supported through the Lincolnshire Talent Academy. The Talent Academy was formed in April 2015 within the trust, as an initial pilot to support the engagement of young people with the organisation and to influence future career choice. The Talent Academy supported staff at all levels, from entry level apprentices taking their first employed position upon leaving education, through to senior staff looking for further development.

Our findings

Executive directors and NEDs were visible and approachable. Ward and department visits by board members continued throughout the COVID-19 pandemic albeit, on a much smaller scale. In addition, some executive directors had been, on occasion, working clinically in ward and department areas. Reverse mentoring and 15-steps challenge were also used as tools for engagement with front line staff. The 15 steps challenge focuses on seeing care through a patient or carer's eyes and exploring their first impressions.

There was a leadership structure within the pharmacy team to support the delivery of care. A recent appointment of deputy chief pharmacists had improved this leadership capacity.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of four executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

Vision and Strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The trust vision 'Outstanding Care personally Delivered 'was underpinned by five key values: Patient-centred; Safety; Excellence; Compassion and Respect. These values supported the trust's integrated improvement plan, a five year plan (2020-2025) that identified the key priorities for the trust.

It was clear during our core service inspection that significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.

There was a robust, realistic strategy for achieving the trust's priorities and delivering good quality sustainable care. The trust was in year two of their strategy realised through the integrated improvement plan and supported through the trust's Outstanding Care Together Programme (OCTP). Four workstreams worked to deliver the trust's four strategic objectives: Patients, People, Services and Partners. Each strategic objective had an executive senior responsible officer (SRO), identified leads for each workstream and delivery lead for each project.

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust was working with the whole Lincolnshire health and care system on proposals for improvements to services, improvements that aligned to the partners workstream.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Staff at all levels 'walked' the trust values during the course of their work and were empowered to contribute to the strategic direction of

the trust. Throughout the core service and well led inspections we heard of many examples of service improvements made not only at board level but at ward and department level where staff were motivated and committed to improve the safety and quality of care patients received. This included for example, a reduction in falls and pressure ulcers and significant improvements within respiratory medicine.

The pharmacy operational plan 2019-21 detailed the activity of the pharmacy team and we were told the team were still working to this model. The trust single integrated improvement plan included the review of the pharmacy model and service within the improving clinical outcomes section.

Culture

There was a culture of high-quality, sustainable care.

Staff felt positive and proud to work in the organisation. There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Throughout our core service and well led inspections, staff were enthusiastic, motivated and were keen to share with us their pride at working for this trust. From every conversation the inspection teams had with trust staff it was clear that the patient was at the heart of their work.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and we saw where appropriate learning and action had been taken as a result of concerns raised. Executive leaders told us they adopted an 'open door' policy and we heard of many examples from staff outside the executive team who felt comfortable raising their concerns with the executive team. However, a small number of staff told us they were fearful of raising concerns with their immediate line managers and that this was having a significant effect on their mental health.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. On 12 May 2021 the trust launched an electronic performance and appraisal management system for staff. This was implemented in response to the NHS people plan and the trust's integrated improvement plan, and to support staff in having meaningful conversations about their performance. The system was designed to facilitate quality, values based discussions and encouraged staff to have ownership for their own personal performance and development. The discussions also factored in wellbeing and behaviours.

Current appraisal compliance was 56.8% against a target of 90%. Compliance was 74.9% at the time of launch. The fall in compliance was attributed to staff not being accustomed to the new system, staffing and operational pressures. The board were sighted on appraisal compliance and were taking a number of actions to address this.

There was a strong emphasis on the safety and wellbeing of staff. The trust provided an all-round package of support for staff, helping them to look after their own health and to support those around them. On top of the core occupational health services, the trust had a number of innovative ways to support staff, including; in-house counselling, mental health first aid and mindfulness courses, training for staff and managers in emotional and wellbeing resilience, health check MoTs, an overall health and wellbeing assessment, physiotherapy, counselling training for managers and cognitive behavioural therapy training for managers.

Despite the extensive well-being offer from the trust, staff within pharmacy told us they did not feel valued by the organisation and that lip service was paid to support for their well-being. Examples were given of working long hours without breaks and staffing such that only one Band 3 post was allowed to take annual leave at a time. This had led to low morale.

Our findings

Equality and diversity was promoted within and beyond the organisation. A number of staff networks were in place to provide a safe space for discussion of issues and help to raise awareness of issues within the wider trust. Equality impact assessments (EIA) were shared across the wider Lincolnshire healthcare system and ensured policies, practices and decisions were fair, met the needs of staff and that they were not inadvertently discriminating against any protected group. The trust had a 'Our Inclusion Strategy' which set out the trust's strategic vision for all the work around the equality, diversity, inclusion and human rights agenda.

Without exception, staff told us they felt supported, respected and valued by the executive team and felt there had been a positive shift in the culture at the trust since our last inspection. However, a small number of staff felt there was work to do to develop those staff in middle management posts. Whistleblowing information received following the well led inspection suggested a small number of staff did not feel supported, respected and valued by their immediate line managers and that they had or were experiencing bullying and harassment. The 2020 National Staff Survey results placed the trust 58th out of 58 acute trusts nationally.

The executive team were committed to addressing behaviour and performance that was inconsistent with the vision and values, regardless of seniority. The organisation's approach to changing the culture was supported by credible plans and a palpable energy within the board. Throughout our interviews with executive directors and NEDs we heard the same message; trust staff and how they were feeling was integral to providing safe and quality care. The trust had signed up to the NHS England and Improvement (NHSE/I) Culture and Leadership Programme and within nursing and midwifery, a nursing and midwifery framework was in place to develop a culture that placed quality at the heart of everything staff did and was centred on the needs and experience of people who use services.

The Freedom To Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The FTSU index score for this trust was 73.6% and below the national average of 79%. Despite this, the trust had made improvements since our last inspection. The trust had appointed a FTSU Guardian, to work exclusively in this role, in September 2021. Staff had a much greater awareness of the role and staff were supported to raise concerns. The number of contacts since September 2021 had increased significantly with 41 contacts made compared to seven for the previous three months and 63 for the whole of 2020/21.

The culture of the organisation did not always encourage openness and honesty at all levels within the organisation, including with people who used services, in response to incidents. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.

For the reporting period October 2020 to September 2021, compliance with the duty of candour regulation had been variable (verbal compliance 84%, written compliance 68%). The board were sighted on duty of candour performance and had taken a number of actions to address this. Further planned actions included; commissioning a piece of investigative work to review the way in which the trust record duty of candour compliance to try and understand the variability in the data, refresher training for staff covering duty of candour requirements and a review of the trust's duty of candour policy and related documentation to ensure it was fit for purpose.

In addition to the planned actions, there was a process in place whereby the incident reporting system was reviewed daily by the clinical governance team. If an incident had been reported as meeting the duty of candour criteria, the team contacted the clinical team as a prompt.

Our findings

Governance

There were clear responsibilities, roles and systems of accountability to support good governance and management.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Progress against delivery of the strategy and local plans were monitored and reviewed. Monitoring of the integrated improvement plan was coordinated through the project lead where monthly support and challenge sessions took place with the relevant executive lead. Following the support and challenge sessions, an upward report was completed and fed into the finance, performance and estates committee on a monthly basis. In addition, the integrated improvement plan status report fed monthly into the people and organisational development and quality governance assurance committees. Board and committee papers we reviewed and interviews with executive directors and NEDs demonstrated there was bold decision making of the board that underpinned a well-planned and understood strategy. The consistent message we heard was the board were not afraid of change and felt it necessary to improve the safety and quality of services at the trust.

Since our last inspection the trust had reviewed its governance processes and structure and developed a business partner model approach to risk and governance, clinical audit and complaints. This allowed for triangulation of information to determine an accurate picture of performance across the trust. In addition to this, the trust had introduced an integrated clinical governance report for clinical divisions and a complaints, litigation, incident and Patient Advice and Liaison Service (PALS) (CLIP) report. Both provided a summary of key data at divisional and board level.

All levels of governance and management functioned effectively and interacted with each other appropriately. There were four board sub-committees; quality governance committee, people and organisational development committee, finance, estates and performance committee and audit and risk committee. The role of each board committee was to consider evidence provided by members of the executive team in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that could be provided to the trust board.

There were medicines governance processes in place, and we could see that these had been strengthened following our last inspection. However, senior pharmacy staff told us they did not have clear lines of communication to escalate concerns and were unable to articulate concerns to people who were in a position to address them. We heard from senior trust leaders that there were escalation mechanisms in place and these were effective.

Executive directors and NEDs were clear about their roles and understood what they were accountable for, and to whom. However, there were inconsistencies at some levels of leadership across the organisation. Further work was underway with divisions to develop their understanding of what governance meant for them.

There was complaint sign posting and a complaint policy available on the trust's website for patients and services users to access. During our inspection of well led we reviewed six complaint responses. All responses were clear and transparent throughout and followed the Ombudsman's 'principles of good complaint handling' and 'principles for remedy'. At the time of this inspection the trust had a low number of outstanding complaints (29).

Management of risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Our findings

There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved.

The trust board was responsible for setting the strategic direction of the trust. This included defining the risk appetite, which was the tendency of the board to accept risk in particular situations and in pursuit of its goals. The trust's risk appetite was defined using the following scale:

- Open – prepared to tolerate a high level of risk
- Cautious – prepared to tolerate a moderate level of risk
- Minimal – prepared to tolerate only a low level of risk

A risk management strategy described the approach that the trust would take in managing risks to the achievement of its objectives through a formalised structure that included both corporate and operational risks. The trust had adopted an Enterprise Risk Management (ERM) approach, this approach enabled the trust board, its committees and senior management to consider the potential impact of all types of risk on its objectives and in doing so supported well-informed, risk-aware corporate and operational decision-making.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The audit committee chair described how the committee and board gained assurance not only from auditors' reports but also from audit regulators. The programme of internal audit had been adapted during the period of the pandemic; but the head of internal audit had only been able to provide partial assurance on the operation of internal controls for 2020-21. They had greater confidence in levels of awareness and training on counter fraud and evidenced a reduction in the numbers of referrals.

We saw evidence of clinical audit relating to medicines reconciliation activity and audit activity presented to clinical groups relating to medicines errors. Both of these demonstrated poor levels of care and this was a recurrent problem. Trust senior teams were cognisant of these risks and were taking steps to address them.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions and we saw there was alignment between the recorded risks and what board members said was 'on their worry list'. As part of this inspection we reviewed the trust's board assurance framework (BAF) and current corporate and service level risk registers. Through our review we were confident the trust board had sight of the most significant risks through the BAF and corporate risk register.

We were assured executive directors and NEDs had a robust oversight of all risks across the trust. During our interviews we were told a piece of work was currently underway to reconfigure the trust's risk registers and in turn strengthen the management and oversight of risk across the organisation. This work was supported by training and the implementation of an executive led risk register 'Confirm & Challenge' group. In September 2021, the trust introduced a risk register confirm and challenge meeting. This was chaired by the director of nursing who was the executive lead for risk and patient safety. At these meetings, over time, each division / directorate would have a deep dive of their risk register. This meeting would provide an additional level of challenge and oversight of risk issues and assurance that appropriate mitigations were in place.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had a winter plan that brought together the culmination of key improvement schemes in planning for recovery and urgent care. The recent NHS Confederation (H2) guidance had been considered in order to produce the plan. The process for authorisation included internal and

external confirm and challenge and resulted in a trust and system plan that worked seamlessly together and one that would ensure safe services. The system coordination of the plan was to run through the Urgent and Emergency Care System Partnership Board. Internal monitoring of both planned and urgent care continued to run through divisional performance review meetings focussing on those elements aligned to the trust's integrated improvement plan.

The trust had been under particular scrutiny from regulators because of its financial and service quality challenges. The trust described itself as improving and starting to embed governance including financial governance; this assessment was confirmed by evidence provided from committee and board papers.

The trust had identified the ability to attract staff as being a very high risk with both service and financial impacts. It told us that it saw the development of a medical school at the University of Lincoln as a development key to improving recruitment and retention of staff.

The trust estate was recognised as requiring significant investment to make premises fit for purpose. The trust told us that the backlog maintenance requirement was c £250m on an asset base valued at £1.1bn. The trust told us about the processes that it had implemented to provide assurance about fire safety; and the improvements that it had made to the safety of infrastructure including electrical; ventilation and medical gas provision. The trust had used the findings of commissioned reporting engineers to build business cases for essential improvements and told us it was able to respond quickly to national ad hoc requests for capital bids.

Information management

Appropriate and accurate information was effectively processed, challenged and acted on.

Through the use of key performance indicators (KPIs) and divisional and trust wide integrated performance reports, the board had a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Board papers we reviewed evidenced where information was used to measure for improvement, not just assurance.

Through interviews with board members and our review of board papers, including agendas we were assured quality and sustainability both received sufficient coverage in relevant meetings at all levels.

Information provided to the sub-committees and ultimately the board was of a good quality and enabled the NEDs to have an independent oversight and to provide constructive challenge to the executive directors.

There were clear and robust service performance measures, which were reported and monitored. The trust's integrated performance report (IPR) was presented to public board monthly and provided an overview of performance over time. However, from our review of board papers we were not assured the board was using timely data to gain assurance. For example, November's IPR referenced performance data from August/September 2021. Board members told us up to date data for example, emergency department waits, was discussed through the finance, performance and estates committee meeting.

Effective arrangements were in place to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Triangulation of evidence to provide assurance was important to the board. Internal audits, matron walkabouts and safety huddles were amongst a number of measures the board used to validate information that was upwardly reported to the board. Where issues were identified, executive directors would hold divisions to account, in turn, NEDs would hold directors to account.

Our findings

Information technology systems used to monitor and improve the quality of care had yet to be realised. There was a significant reliance on paper to deliver clinical services which created challenges for clinical and other staff to perform their duties. With approximately 200 different clinical systems in use and no single information source containing all patient health information, clinicians needing to log into multiple systems separately.

The trust was one of 32 NHS organisations to receive support in the second wave of the Digital Aspirants programme. The money was to be used to develop the trust's digital strategy and business case to deliver an electronic health record. Plans and funding were also in place around introducing electronic medicines management systems across the trust. The business case for digital transformation was due to be approved in December 2021. Oversight of this was through the digital hospital group with upward reporting to the finance, estates and performance committee.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but not limited to, the care quality commission, commissioners and the local authority.

There were robust arrangements (including appropriate internal and external validation) in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The trust had four information governance data breaches which were reportable in line with the Information Commissioners Office (ICO) guidance in 2020/21. In all cases the ICO were satisfied with action taken by the trust and had closed the incident. No financial penalties were issued.

The Data Security and Protection Toolkit (DSPT), developed by NHS Digital (NHSD), sets out the standards and requirements in respect of receipts, storage and processing of information. The DSPT is structured into a series of numbered criteria. The DSPT is completed on a self -assessment basis each year. NHSD had extended the submission date for the 2020/21 DSPT from 31 March 2021 to 30 June 2021 whereby the trust had met all standards.

Engagement

People who use services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. The patient experience group (PEG) were committed to ensuring patients had the best possible experience in the trust. During our interview with the PEG team we heard and saw evidence to demonstrate a clear mantra being to understand what the process of receiving care felt like for the patient, their family and carers. The team gave many examples of where the public had been involved in shaping safe, quality services.

People in a range of equality groups were actively engaged and involved in decision-making to shape services and culture. A 'sensory loss group' had been set up as a sub-group of the PEG and included patients who were visually or hearing impaired in addition to, representation from charity organisations and Healthwatch. Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

People's views and experiences, including people in a range of equality groups had been gathered and acted on to shape and improve the services and culture. The team gave us many examples where changes had taken place as a result of patient stories at board, in the matron's forum and as part of quality improvement training. In addition, views and experiences had been sought from the travelling community and a number of community groups.

Our findings

The trust proactively engaged and involved staff (including those with protected equality characteristics) and ensured that the voices of all staff were heard and acted on to shape services and culture. The chief executive chaired the 'council of staff networks', an umbrella group in place to be the collective voice of four active equality staff networks; Women's Network and allies, Lesbian, Gay, Bi and Transgender (LGBT+) and allies, Black Asian and Minority Ethnic people (BAME) and allies and Mental And Physical Lived Experience (MAPLE) and allies. Furthermore, there was a collection of staff who were connected by the Armed Forces Network.

The trust's research and innovation (R&I) strategy (2021- 2024) and vision had been developed through targeted, informal consultation with internal and external stakeholders including:

- Patients and service users through the Lincolnshire Research Patient & Public Forum
- research management leaders from other local healthcare providers
- Local Authority / Local Universities
- trust staff
- R&I managers from other similar trusts
- The National Institute for Health Research (NIHR) Network East Midlands.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust was actively engaged with the development of the Integrated Care System (ICS) and described how it was developing closer links with system colleagues to develop financial strategies and plans to reduce the structural deficit that presently sat within the trust.

Relations between the four finance directors were described as highly collaborative and examples were given of task-and-finish groups to scope the service and financial impact of changes in prescribing; care closer to home; and musculo-skeletal care on the health system deficit. The levels of system ownership of the financial deficit were described as high with quantified financial and service benefits arising from the substitution of agency staff with a more clinically appropriate staff mix based in primary, community and social care organisations.

There was transparency and openness with all stakeholders about performance. The trust was an active participant in the Lincolnshire monthly system review meeting whereby there was attendance from multiple stakeholders including the care quality commission. At the November 2021 meeting the trust raised concerns around their cancer performance which showed the number of patients waiting longer than 62 days had increased and the 14-day standard was not being delivered, particularly in breast cancer where increased demand had outstripped extended capacity. This transparency and openness enabled a discussion amongst external colleagues whereby possible solutions were proposed.

Learning, continuous improvement and innovation

There were robust systems and processes for learning, continuous improvement and innovation.

Trust leaders and staff were committed to continuous learning, improvement and innovation which included participating in appropriate research projects and recognised accreditation schemes.

Our findings

The trust had an active improvement academy that supported innovation. Through working with NHS England and Improvement (NHSE/I) and external advisors, the trust had championed quality improvement at all levels of the organisation. By training staff in standardised quality improvement tools and methods, staff were empowered to continuously improve the quality of care and outcomes for patients.

Improvement pieces of work that had been completed by individuals who had completed the trust's quality improvement programmes included for example; improving compliance with heart failure management through accurate fluid balance monitoring and daily weights, introducing three dimensional imaging within the trust to ensure consistency with the National Institute for Health and Care Excellence (NICE) and national nuclear medicine guidelines, supporting staff to continue breastfeeding on return to work and creating a plus size equipment availability information sheet for physiotherapy staff.

The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week. Improvements included for example, a reduction in length of stay (LoS) on the stroke unit in Lincoln County Hospital from 11 to seven days, launching a patient handbook that travelled with the patient from acute to community and beyond and initiating a dedicated stroke orthoptic clinic.

As a provider of NHS clinical research services, the trust were required to publish performance metrics relating to recruitment and delivery to clinical trials for the previous 12 months through the National Institute for Health Research. Areas of research included oncology, haematology, stroke, cardiology, paediatrics, dermatology, diabetes, midwifery, ophthalmology, respiratory, anaesthesia, general surgery gastroenterology and orthopaedics.

The trust research and innovation department was undertaking an ambitious three-year improvement journey. This was vital for the trust, its' staff, patients and service users as research and innovation was a thread through the core of trust business as described through the integrated improvement plan.

Research within the trust had delivered growth over 10 years, with active pockets across three of the sites (Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital). However, a change of leadership within the department and the subsequent unprecedented changes as a result of the Covid-19 pandemic provided a unique opportunity for the trust to review the department, consider their ambitions for research and innovation (R&I) and plan how they were going to get there. The purpose of the trust's research and innovation (R&I) strategy was to set out the vision and objectives of the trust in relation to R&I from 2021-2024, demonstrating how the trust would meaningfully embed R&I plans into the core business of the trust. It identified the key priorities for the R&I department over the next three years, ensuring that the trust focussed on the right things that would allow staff, patients and service users access to high quality research and innovation opportunities.

We saw evidence of members of the pharmacy team involved in discreet, externally funded roles that supported patient care. This included a project to facilitate safe discharge of people resident in care homes.

The trust was in the early stages of a '90 Minute Standard project' which was aligned to the integrated improvement plan and the surgery transformation programme plan for 2021/22. The aim of the project was to formalise the 90 minute standard process currently utilised in colorectal surgery and by applying a phased approach, roll-out the 90 minute standard to the other tumour sites within the other surgical specialities. Throughout the project, the main objective was to be to build a strong communication strategy to promote this best practice and the huge benefit it has on patient

experience at a time when cancer care is of key national importance. Strategically, this project was aligned to the "Patients" strategic objective and once completed, 100% of suitable patients that had been placed on the two week wait (2WW) list that did not have a suspicion of cancer would be informed within 90 minutes of that confirmation in those specialities.

As part of the transformation of emergency care at Lincoln County Hospital, patients needing urgent care were, from early summer 2021, now being treated in a new purpose built centre. The new state-of-the-art urgent treatment centre (UTC) provided a bright and welcoming entrance for the whole of the emergency department (ED), including a new reception and waiting area that followed the latest social distancing guidance, as well as 10 treatment rooms, a new X-ray and dedicated triage areas. The centre had been built next to the ED, allowing patients to be booked in at reception, assessed and treated in the right place for their needs. The final design had taken into account contributions by clinical and nursing staff from across the trust and partner organisations, as well as from patient experience and sensory impairment groups.

The completion of the UTC was the first phase in a programme of works that was to transform the hospital's ED. Other phases were to see the expansion of the existing ED to include: a bigger resus area with twice as many bays for the sickest emergency patients, a new paediatrics area with its own dedicated waiting room, treatment cubicles and a sensory area for the youngest patients and their families, additional treatment rooms for mental health patients, a new ambulance drop-off and bays created outside the front of the department with entrances directly into the resus and majors areas and additional clinical space, meaning that the emergency department would be able to accept patients from ambulance crews with improved speed and safety.

The trust had a Joint Advisory Group on Gastrointestinal Endoscopy (JAG) re-accreditation assessment visit in July 2021. At the time of our inspection, the draft report, for factual accuracy checking, was awaited. The JAG website showed this as being in the 'QA Process – for approval'. The verbal feedback provided at the time of the visit was positive.

Participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service was effective and learning shared effectively and used to make improvements.

As part of this inspection we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed six cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Respiratory medicine had been an area of concern identified by the trust in relation to the management of patients requiring non-invasive ventilation and other specialist respiratory treatments. The trust had undertaken significant improvement work to improve respiratory services. During late summer 2021 the trust opened a state-of-the-art respiratory unit at Lincoln County Hospital. The unit had been designed with 10 side rooms, all equipped with video technology and monitoring equipment. The unit was available to treat both inpatients and outpatients from across the county who had diseases of the lining of the lung.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement ➔➔ Feb 2022	Good ↑ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022
Pilgrim Hospital	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for County Hospital Louth

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Mar 2015	Not rated	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Rating for Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for children and young people	Good ↑ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Critical care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019
End of life care	Requires improvement Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Maternity	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good Oct 2019	Good Oct 2019	Good →← Feb 2022	Good →← Feb 2022
Overall	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022

Rating for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Services for children and young people	Good ↑↑ Feb 2022	Good ↑ Feb 2022	Good → ← Feb 2022	Good ↑ Feb 2022	Good ↑↑ Feb 2022	Good ↑↑ Feb 2022
Critical care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Good ↑↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022	Requires Improvement ↑ Feb 2022
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Maternity	Good → ← Feb 2022	Good ↑ Feb 2022	Good Oct 2019	Requires improvement Oct 2019	Good ↑ Feb 2022	Good ↑ Feb 2022
Overall	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement → ← Feb 2022	Requires Improvement → ← Feb 2022	Requires Improvement → ← Feb 2022

Rating for Grantham and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients and diagnostic imaging	Good Mar 2015	Not rated	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Urgent and emergency services	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Overall	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

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

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**Public Consultation on the Nuclear Medicine Service at United Lincolnshire Hospitals NHS Trust**

Summary:

United Lincolnshire Hospitals NHS Trust is currently running a twelve week public consultation into the future of nuclear medicine services across Lincolnshire hospitals. This will run until Monday 23 May 2022.

This report brings this public consultation to the Committee for consideration and response. This follows a previous paper brought to the Committee describing the fragility of the nuclear medicine service in September 2021. The consultation document is set out at Appendix A to this report.

Actions Requested:

The Committee is asked to note the ongoing public consultation, is encouraged to ask questions about the service proposals and to formulate a formal response to the consultation.

1. Consultation

The Committee is invited to formulate a formal response to the consultation.

2. Conclusion

The Committee is to note the ongoing public consultation and to comment on the service proposals, prior to formulating a response to the consultation.

3. Appendices

Appendix A	United Lincolnshire Hospitals NHS Trust – The Future of Nuclear Medicine in Lincolnshire's Hospitals – Public Consultation Document

4. Background Papers

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

This report was written by ULHT Head of Nuclear Medicine, Laura White, who can be contacted via Laura.White@ulh.nhs.uk

United Lincolnshire Hospitals NHS Trust

The future of nuclear medicine in Lincolnshire's hospitals

Public consultation document

OUTSTANDING CARE *personally* DELIVERED

Contents

What is nuclear medicine?

Nuclear medicine is a specialist imaging technique involving the administration of radioactive substances (called radiopharmaceuticals) in the diagnosis and treatment of disease. The technique enables assessment of the function of organs, whereas most conventional imaging modalities (e.g. X-ray) look at anatomy.

The majority of radiopharmaceuticals used for these tests are made daily in an aseptic facility known as a radiopharmacy.

There are over 20 different tests that nuclear medicine can perform and they look at conditions as diverse as Parkinson's disease to delayed gastric emptying. In United Lincolnshire Hospitals NHS Trust (ULHT) hospitals, the most common tests performed are bone scans and heart scans.

After administration of the radiopharmaceutical, patients must wait for a time for the radiopharmaceutical to distribute in their bodies before the images are then taken on a specialist camera called a gamma camera. This camera detects the radiation emitted from the patient to enable the organ of interest to be investigated. A gamma camera is similar in size to a CT scanner.

Due to the fact nuclear medicine involves radiation, the technique is highly regulated and all staff have to undergo extensive specialist training. This is to ensure the risk to the patient from the radiation is outweighed by the benefits of having the procedure.

In addition, a clinician is required to oversee the service and hold an ARSAC (Administration of radioactive substances advisory committee) licence (Practitioner Licence). This licence lists the different diagnostic tests that can be performed under the Practitioner. Only tests that the clinician has proven training and experience in are listed on this licence to ensure the test is diagnostic and the impact on the patient management is optimised. Each site also has an ARSAC licence which requires a Medical Physics Expert (MPE) to oversee the service at that site (site licence), this also lists the tests that can be performed at that site.

Background to the nuclear medicine service at ULHT

Nuclear medicine services are provided at Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston. The imaging is performed at all three sites, using five gamma cameras.

There is also a relatively new £1 million radiopharmacy that produces the radiopharmaceuticals, based at Lincoln County Hospital. This radiopharmacy also provides radiopharmaceuticals for Grantham and Pilgrim hospitals, which are transported there on a daily basis.

The tables below show the current configuration of the nuclear medicine service in ULHT and the number of studies that are performed:

Current configuration of the service			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Number of gamma cameras	2	1	2
Age of cameras (years)	10,12	16	11,11
Annual Number of patients (2019-2020)*	1771	680	792
Annual number of studies*	2114	886	955
Radiopharmacy on site (needed daily to produce drugs for the scan)	Yes (installed 2019)	No (from LCH)	No (from LCH)

* N.B. Patient numbers are different to number of studies as some tests require two visits

The below tables show staffing and the geographical demand on the service:

Base of current staffing (Whole time equivalents WTE)			
Sites	**Lincoln**	**Grantham**	**Boston**
Technologists	5.65	1.6	2.8
Clinical Scientists Provide support for the 3 sites.	2.8 (1.0 WTE Medical Physics expert)	0	0
Clinical imaging assistants	1.8 (also helps admin)+ 1 apprentice	1 currently vacant	0
Nurses	2.0	0	1.0
Admin	0.8	0	1.06
Total	**14.05**	**2.6**	**4.86**

This table shows the postcodes of patients who use the nuclear medicine service.

Geographical patient demand for nuclear medicine				
Postcode	**LN**	**NG**	**PH**	**Other**
Patients	1540	685	894	124
Percentage	47%	21%	28%	4%

Challenges faced by nuclear medicine nationally

Due to the fact, that nuclear medicine is a very specialist service, there are a number of challenges it faces nationally, in particular with workforce. The following table shows some of these challenges.

Challenge	**Mitigations**
Shortage of trained Clinical Technologists since the end of the national training program (on Governmental Migration Advisor list).	Apprenticeship scheme, but this requires individual departments finding the wage for the trainee. Each apprenticeship course is three years long.
Shortage of ARSAC Practitioners, in addition to a national shortage of radiologists.	None, in fact it is getting harder to get these licences.
Shortage of trained Medical Physics Experts. (takes approximately 10 years to become a consultant Clinical Scientist).*	None.
Aged equipment with a requirement to replace 211 gamma cameras nationally in the next five years.**	None.
Problems with supply of radiopharmaceuticals and isotopes.	Companies supplying the material have altered their process of delivery with additional cost to the company.

(*British Nuclear Medicine Society (BNMS) Scientific Support for Nuclear Medicine guidance 2016)

(** Diagnostics: Recovery and Renewal paper Oct 2020 NHSE)

Challenges faced by the nuclear medicine service in Lincolnshire

When we look at the service in ULHT the challenges mirror those seen nationally:

Shortage of technologists: Lincolnshire has struggled to recruit and retain clinical technologists over the last five years, as can be seen in the table below. This has been impacted further by the national training scheme for nuclear medicine clinical technologists ceasing, meaning there is now a national shortage of trained specialists in the country. Attempts to recruit abroad have been protracted and unsuccessful in a couple of instances.

Sites	**LCH**	**GDH**	**PHB**
Technologists in post (WTE).	5.65*	2.6**	2.8
Number of staff that have left in the last 5 years.	3	4	3
Long standing staff >10 years	3	1.53	1
<5 years of retirement (60 years)	1	1	1

**runs the radiopharmacy (2 tech staff daily) and the imaging of the service.*

*** 1 of these posts converted to an apprentice to try to "grow our own" technologists.*

Shortage of ARSAC Practitioners: We have two part time radiologists in Lincolnshire who hold an ARSAC licence (full list of all tests performed in ULHT) and one full time radiologist with a licence (limited list of tests permitted). Due to the fact that one of the radiologists doesn't have a full licence, to access some tests patients must currently travel to a different site to their local hospital.

Shortage of trained Medical Physics Experts (MPE): Lincolnshire nuclear medicine service has 1.0 WTE Clinical Scientists who can act as MPEs (two staff members who also have other duties). There is a legal requirement to have a specific number of MPEs in every service where radiation is utilised. The ideal number is based on a number of factors including the number of investigations and cameras. Using European and national guidance of how many MPEs the department

should ideally have, we should have 2.44 WTE to be a well-led, progressive department.

Workload of service: Lincolnshire workload demand has been static in the last five years, but the mix of tests performed have altered. The workload demand is only enough for three cameras within the county, however there are currently five.

Aged gamma cameras: The five gamma cameras in Lincolnshire are all over 10 years old, which is the age where consideration of replacement is needed (Diagnostics: Recovery and Renewal paper Oct 2020 NHSE). The oldest camera is 16 years old (currently at Grantham).

Impact of other services: The development of the new Emergency Department at Pilgrim hospital will require the redevelopment of the building that currently houses the nuclear medicine department, and a new area will need to be identified and developed for the nuclear medicine service.

Case for change

Given the challenges faced by the Lincolnshire nuclear medicine service, it is important that we consider changing how we deliver the service to secure it for the patients of Lincolnshire for the future.

At present, the staff and services are spread thinly, meaning that even low levels of staff absence impacts on the amount of work the service can perform.

Delivering the service across three sites means that some staff do not get experience of the variety of studies/techniques performed (as not all the sites have a licence to perform all the tests/treatments). In addition, the junior staff at the smaller sites currently do not have much peer support, which means there is less opportunity for them to be involved in development and to raise suggestions for improvements of the service.

The lack of Medical Physics Experts (MPE) within the county means that optimisation of the service and the ability to introduce new services into the county is limited, as they must repeat work on three sites. This also affects the amount of audit and governance that can be performed.

The fact that all the gamma cameras in Lincolnshire are over 10 years old means they are prone to be unreliable and require repair, causing cancellation of patient studies and a potential waste of radiopharmaceuticals. Due to the fact all these

pieces of equipment are old the replacement parts and expert engineers are getting harder to obtain, and two of the five systems have been served/due to be served end of life notices, meaning if they break repairs may not be possible. This means the services provided become vulnerable with potential long downtimes for some of the cameras.

At present, the utilisation of the equipment is not optimised. The British Nuclear Medicine Society (BNMS) guidance is that it would be appropriate to perform approximately 1500 scans on each gamma camera. This means that, according to our level of demand, Lincolnshire should have three gamma cameras, whereas there are currently five.

Patient experience

The nuclear medicine service carries out a patient experience survey every two years, to help understand patient opinions for the service and where improvements can be made.

Results of these surveys from 2020 and 2018 show that, at present, patients are overwhelmingly complimentary about the service that they receive.

In the most recent survey (2020) the service performed exceptionally well in terms of patients being seen quickly (the majority within a month of referral), staff being polite, helpful and reassuring and cleanliness and the quality of the waiting areas.

Overall, all patients surveyed would recommend the service to their friends or family. It showed that patients are satisfied with the service that they receive in the nuclear medicine department at present in all aspects.

Options appraisal

We believe that the safest way to provide a sustainable, long-term service to the patients of Lincolnshire is to reduce the number of sites that the nuclear medicine service is provided from. This will reduce the redundancy of equipment and create a greater capacity to replace aged equipment.

As mentioned before, the patient demand and the centralised radiopharmacy at Lincoln means there would be no real option to close the service from this site. We recommend that Lincoln remains as either the single site providing nuclear medicine, or operating alongside a second site in the county.

A full options appraisal has been performed to determine the preferred site(s) for the centralisation of the nuclear medicine service in Lincolnshire, taking into account a range of factors including input from the ULHT Patient Panel, as described below.

Below you can see the options that were reviewed. Closing Lincoln was not considered as an option, as the radiopharmacy has recently been built there and this cannot be moved.

	Option
1	Centralise to Lincoln and Pilgrim
2	Centralise to Lincoln and Grantham
3	Centralise to just Lincoln
4	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Pilgrim, and close Grantham
5	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Grantham, and close Pilgrim
6	“Hub and spoke” with staff based at Lincoln and running a 2 day a week service at Grantham and 3 days a week at Pilgrim

A round table discussion was performed which included staff from nuclear medicine, the diagnostics lead and the Managing Director of the Clinical Support Services division. The weighting score that was used can be seen in the table below.

Factor	Weighting (%)
Patient Experience	25
Quality of Service	25
Robustness of Service	20
Cost/Efficiency	20
Long term Sustainability	10

The hub and spoke options scored highly on patient experience but were low scoring for all other factors. The option that gave the most robust (staff, equipment), efficient, service and ensure responsiveness for urgent patient requests was option three (centralise service at Lincoln).

Patient Panel involvement in developing proposed options for future service model

The ULHT Patient Panel met on Tuesday 19 October 2021 to discuss the challenges facing the nuclear medicine service, and were asked to consider a range of factors to help in determining the proposed options for the future of the service. These were:

- Best use of staff/ ability to develop staff
- Ease of access for patients
- Proximity to facilities and co-dependent services
- Most efficient use of equipment
- Risk of test cancellation
- Cost effectiveness
- Robustness of service

Overall, the panel accepted the need to change the service and consolidate it to fewer sites. There was largely an acceptance that Lincoln should be the main site for centralisation. Some had the view that there should be a second 'hub', with opinion split between whether this should be at Pilgrim or Grantham hospitals.

The overwhelming message from the Patient Panel was a request that the Trust take seriously the concern that patients may struggle to reach their appointments if the service was centralised, and an ask for mitigating actions to be put in place to improve access if the service were to be centralised.

Considering the second site

Below is a comprehensive appraisal of the options for a second site that would provide a service alongside Lincoln hospital, based on a range of factors. **Green** is defined as the optimum, or least disruptive option, with **red** being the least beneficial option.

Patient Experience:

- **Patient travel:** Having **Grantham** as the second site would mean 28% of patients would have to travel further for their tests, based on the postcodes of current referrals. If **Pilgrim** was the second site, 21% would need to travel further. However, both options would mean inconvenience for some patients and concern has been raised about difficulty with access to transport.

- **Test cancellation risk:** The radiopharmaceuticals are made in Lincoln daily. Having the second site at **Pilgrim** would have the highest risk of cancellation due to the poor transport infrastructure in Lincolnshire which can introduce delays. There is a risk that the service at **Grantham** would be affected, but this is smaller than at Pilgrim due to closer proximity to Lincoln.

- **Patient referral to report turnaround:** The radiopharmaceuticals have to be transported to the other sites after being made in Lincoln, meaning studies cannot start at **Pilgrim** or **Grantham** until typically 10.30am-11am. This means fewer tests can be carried out at the other sites per day. In addition, the radiopharmaceuticals decay by approximately 15% during the time it takes to

transport them. They typically expire eight hours post-production and can no longer be used. This impacts on Pilgrim more than Grantham as the travel time to Pilgrim is greater than to Grantham.

- **Patient test availability:** The number of tests available at **Grantham** is more than Pilgrim. The number of tests available at **Pilgrim** is reduced due to their limited licence, and a lot of work would need to be done to get the other tests added to the licence.

- **Therapies:** No therapies are performed at **Grantham,** but **Pilgrim** have a therapy service. If Grantham was the second site then all the therapy patients from Pilgrim would need to travel to Lincoln.

- **Clinical interdependency:** The majority of breast surgeries (59%) are carried out in Lincoln. The number of patients impacted would be lower if the second site was **Pilgrim** (33% of surgeries) compared to **Grantham** (8% of surgeries).

- **Inpatients:** The vast majority of nuclear medicine tests are performed as outpatient procedures. However, if performed as inpatients the most responsive site would be Lincoln as the radiopharmacy orders are more flexible and can be added later in the day, and if possible a second manufacture session can be undertaken to ensure patients have their test as soon as possible which would help with discharge. At the moment, **Grantham** and **Pilgrim** have to order preps the day before, so cannot always do same-day request to scan studies. However, the number of inpatients/urgent patients Pilgrim do see is much higher than Grantham, so there is a preference to having a service at Pilgrim over Grantham.

Staffing:

Staff base: As Grantham has 1.6WTE in post and Pilgrim has 4.86WTE in post, making **Pilgrim** the second site would cause fewer staff members to relocate/be displaced than making **Grantham** the second site.

Support from radiologist/ARSAC: **Pilgrim** have a full time ARSAC holder on site. **Grantham's** on site ARSAC holder is part time and is due to retire in 2023.

Medical Physics Experts: There is a legal requirement to have a certain number of these in all nuclear medicine departments to advise on quality control of equipment and images. The recommendations are based on different factors including the number of cameras and equipment the department has. If we reduced the service to three gamma cameras, the number of MPEs would be closer to that recommended by legislation. This would be the same if either **Pilgrim** or **Grantham** were picked as the second site.

Efficiency of the service:

Efficiency would be improved by closing either of the sites. There might be some improved efficiency if the second site was **Pilgrim** compared to **Grantham,** as there is a larger number of referrals so it would be easier to batch patients. This is because each specific test has a set radiopharmacy kit that needs to be made for it. For a number of reason departments will wait until there is a certain number of a set test ready to book. This always has to be balanced between ensuring the patient does not wait too long for the test. Therefore, if there are less referrals there is less chance to batch patients into a session.

Quality of building and compliance with current legislation:

If **Pilgrim** is chosen as the second site the department will be a new purpose-built building and will comply with all the relevant legislation, whereas this will be less easy to accommodate at **Grantham** where the department is already in a crowded area within the hospital with little scope for further expansion.

Robustness of the service:

This would be improved irrespective of the second site and would allow training of new staff more effectively at **Grantham** or **Pilgrim**.

Quality and governance:

This would be improved by reducing to two sites, as there would be more time to perform audits, as currently work is duplicated at different sites. The Lincoln site is already IS09000:2015 accredited and is it recommended that all radiation services should have such a governance accreditation. As regards a second site there is no difference between **Pilgrim** or **Grantham** as it is simply about reducing the sites rather than which one.

Summary

Consideration	**Preferred second site (if two site model)**
Patient experience	Pilgrim
Staffing	Pilgrim
Efficiency of service	Pilgrim
Building compliance with legislation	Pilgrim
Robustness of service	No preference
Quality and governance	No preference

The options

Running the nuclear medicine service at three sites is not sustainable, and centralising the service to either one or two sites would ensure a robust service for the people of Lincolnshire.

As a result of the above described options appraisal work, we are consulting with our staff, stakeholders and public on two possible options:

- Option 1: Centralisation of the service at Lincoln
- Option 2: Centralisation of the service at two sites - Lincoln and Pilgrim

The following risks and benefits have been identified for each option.

Option 1 - benefits
Most efficient use of batching kits and studies.
Most efficient use of the cameras and staff.
Robustness for continuity of service if poor weather/traffic problems.
Greater mix of scans and tasks for technologists, so should be more likely to keep staff interested and improve staff retention.
Improve monitoring of Governance (as on one site). LCH is already ISO9000:2015 accredited.
More capacity to introduce new techniques as Clinical Scientists and senior staff will have more time to do this.
Ensure that the service is only using the equipment it needs, negating the need to equip three sites at a cost of £650k per camera (plus approximately £50k per annum servicing) as well as the other equipment and consumables needed.
Ensuring a more responsive service to patients, as the radiopharmacy is on site so can help with discharge. Currently, Grantham and Pilgrim have to order preps the day before, so cannot always do same day request to scan studies.

New camera at Lincoln, meaning a reliable service and access to up to date technology that will aid diagnosis and turnaround of studies. In addition this should increase staff retention.	
Risks of this option	**Notes/ mitigations**
Requirement for patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test.	Patients already travel for a variety of nuclear medicine tests due to equipment, lack of staffing at Pilgrim and legal requirements for performing the tests. There is also support with transport if required.
Need to transfer inpatients from Pilgrim to Lincoln.	Most nuclear medicine scans do not require the patient to be kept in for their test; those who require a test not performed at Pilgrim already are transferred between sites.
Possible impact on other services that rely on our service before breast surgery.	Will need working through with the teams.

Option 2 - benefits
Somewhat improved efficiency of batching kits and studies.
More efficient use of the cameras.
More capacity to introduce new techniques as Clinical Scientists and senior staff will have more time to do this.
Robustness of service if problem in Lincoln hospital (power outage, flood).
Ensure that the service is only using the equipment it needs, negating the need to equip three sites at a cost of £650k per camera (plus approximately £50k per annum servicing) as well as the other equipment and consumables needed.

Reduced impact on patients - fewer patients will need to travel further for their nuclear medicine tests.	
Reduced impact on staff - fewer members of staff will need to be relocated/displaced.	
Risks of this option	**Notes/ mitigations**
Requirement for some patients to travel for their scans leading to inconvenience to patients and could lead to some patients going out of county for the tests or not having the test.	Patients already travel for a variety of nuclear medicine tests due to equipment. There is also support with transport if required.
Need to transfer inpatients from Grantham to Lincoln or Pilgrim.	Most nuclear medicine scans do not require the patient to be kept in for their test and the number of Grantham inpatients is low.
Retention of some existing issues around effective use of resources and staffing.	Still an improvement on three site model.
Risk that cannot effectively staff 2 sites	Little to mitigate this.
Harder to ensure good governance as management not day to day on site.	Regular visits from Clinical scientists and teams meetings.

Have your say

We are carrying out a 12 week public consultation on the future on the nuclear medicine service, focussing in on the two options for the future of the service as outlined in this consultation paper.

We are seeking views from staff, patients and the public of Lincolnshire on the service and how it should be configured for the future.

This consultation will run from Monday 28 February 2022 to Monday 23 May 2022.

These are a number of ways to participate in this consultation, which include:

- Fill in our survey
- Come along to one of our virtual consultation events on Microsoft Teams, details below:
    - Tuesday 8 March- 6.30pm-7.30pm
    - Monday 28 March- 3pm-4pm
    - Wednesday 13 April- 6.30pm-7.30pm
    - Tuesday 3 May- 3pm-4pm
- Invite us to one of your meetings to discuss the service, by emailing communications@ulh.nhs.uk

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

Open Report on behalf of NHS Lincolnshire Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**Community Pain Management Service – Update**

Summary:

This report provides an update from NHS Lincolnshire Clinical Commissioning Group (LCCG) on the Community Pain Management Service (CPMS). A report on the CPMS was previously considered by the Committee in September 2021.

The CPMS has continued to make progress over the last six months, with specific improvement in reducing time from referral to assessment and referral to treatment whilst continuing with the operational challenges and impact of Covid-19 safe working systems for patients and staff. The CPMS has re-instated activity at all pre-Covid-19 clinic locations to enable access to face-to-face appointments. A blend of virtual and face-to-face care continues to be in place and this blended approach will continue as the usual way of working in the service.

Actions Required:

The Health Scrutiny Committee is asked to consider and note the content of this report.

1. Background

Lincolnshire Clinical Commissioning Group (LCCG) commissions a Community Pain Management Service (CPMS) for the patients of Lincolnshire from Connect Health. This service is for the assessment, treatment, and support of patients with chronic pain. The contract was awarded in November 2018, following a robust competitive procurement process. The service started on 1 April 2019. The service is an end-to-end service contract with the CPMS being responsible for the full pain pathway from GP referral through assessment and treatment to discharge including treatments undertaken at a number of hospital sites under sub-contract arrangements.

In line with guidance from the National Institute of Health and Care Excellence (NICE) and the British Pain Society, the service has been commissioned to support a holistic biopsychosocial model of care that includes supporting patients to better manage the psychological, social and physical aspects of their chronic pain and which moves away from treatment focussed on injections and medications which were not in line with current evidence and did not meet patient needs of the population to enable effective pain management.

In May 2021, the CQC undertook an inspection on Connect Health. The report of the inspection was published on 24 June 2021. Due to Covid-19 restrictions, the inspection team did not visit the CPMS locations in Lincolnshire but did collect views from patients and other stakeholders, reviewed records and visited Connect Health's head office. The CQC assessed the services provided by Connect Health which includes the CPMS at an overall rating of good. The CQC rated Connect Health as good for safety, effectiveness, caring and responsiveness, and as outstanding for Well Led.

2. Lincolnshire CCG Commentary

Covid-19 Update

The CPMS has continued to employ safe systems of working for patients and staff in accordance with guidance to minimise the risk of infection from Covid-19. CPMS staff have full access to appropriate PPE and lateral flow testing and patient facing staff have all had Covid-19 vaccinations.

In keeping with national NHS policy, the use of remote virtual and telephone appointments has continued, alongside the restoration of face-to-face activity in 15 clinic locations across Lincolnshire. Virtual Pain Management Programmes developed during Covid-19 continue and have over the last six months been supplemented by face-to-face pain management programmes.

Quality

The latest CPMS Quarterly Quality Report for the period October to December 2021 was reviewed by the CCG at the January Contract Management Meeting with the CPMS service. The report highlights ongoing service improvement, and no concerns were highlighted from this review.

The report shows improvement in positive feedback received by those patients completing and returning a patient satisfaction survey and a reduction in negative feedback in comparison to the previous quarter as follows:

July - September 2021	**October – December 2021**
386 surveys – 33% response rate	277 surveys – 29% response rate
77% positive feedback	79% positive feedback
9% negative feedback	8% negative feedback

There were 144 positive comments from friends and family test feedback over the last six months. Positive themes from these comments include that Connect Health have a friendly, knowledgeable, professional and understanding clinical team who take time to listen to patients' issues and concerns. Advice and treatment was frequently described as informative, helpful and effective. Negative comments over this six-month period were limited to 13 patients and related to telephone appointments not being received on time, the service not being able to resolve some patients pain and not offering repeat injections. These issues have been raised with CPMS by the CCG.

The reduction in complaints and concerns received as reported at the last Health Scrutiny Committee has continued in this review period. There were three formal complaints received in the quarter from October 2021 to December 2021 with four concerns raised. Complaints and concerns are investigated by the CPMS in a timely manner with lessons continuing to be learned and action taken with the service using this to support ongoing quality improvement.

Key Performance Indicators

A summary of the performance of the CPMS against contracted Key Performance Indicators for the period April 2021 to January 2022 is included at Appendix A to this report.

As previously reported to the Committee, actions had been agreed with the CPMS to improve the performance for the time from referral to initial assessment of 40 days (LQR4) and this has shown significant sustained improvement with year-to-date achievement of this performance target. Patients staring treatment within 18 weeks (LQR5) and waiting no longer than 26 weeks (LQR6) have also undergone sustained improvement. LQR5 has been achieved consistently since October 2021. LQR6 is not yet being achieved, however, this is in large part due to a number of patients accessing treatment within the Connect health Pain Management Service as a waiting list initiative. These patients have accessed assessment and treatment but data within the reports will not be updated until care is returned to CPMS or the patient is discharged

The CPMS has moved to a blended approach of face-to-face and virtual pain management programs. The LQR9 measure does not reflect the current service provision and as such this performance measure is not reflective of pain management program attendance / completion. Since face-to-face pain management programmes have recommenced, three programmes have been completed with 14 out of 16 participants completing the full programme.

3. Conclusion

The CPMS has made improvements in access and performance over the last six months. It is expected that these improvements will be sustained for future months. Services continue to be commissioned and delivered in accordance with NICE and British Pain Society guidance.

No quality assurance concerns have been identified, and reported patient experience and outcomes are good.

4. Consultation

This is not a consultation item.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	KPI Performance Summary – April 2021 to January 2022

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 Tim Fowler, NHS Lincolnshire CCG, who can be contacted as follows:
Telephone 07810 770476 or email: t.fowler1@nhs.net

Appendix A

KPI Performance Summary – April 2021 to January 2022

Lincolnshire YTD KPI Report
for the period 01 Apr 2021 to 31 Jan 2022

Target			Apr-21	May-21	Jun-21	Q1	Jul-21	Aug-21	Sep-21	Q2	Oct-21	Nov-21	Dec-21	Q3	Jan-22	Q4	Total
90%	Numerator	Triaged within 2 Working Days	343	354	329	1,026	324	337	382	1,043	365	320	309	994	326	326	3,389
	Denominator	Total Referrals	358	364	343	1,065	354	346	388	1,088	382	334	324	1,040	344	344	3,537
	LQR2 Performance		95.81%	97.25%	95.92%	96.34%	91.53%	97.40%	98.45%	95.86%	95.55%	95.81%	95.37%	95.58%	94.77%	94.77%	95.82%
90%	Numerator	Rejected within 2 Working Days	91	89	93	273	118	106	93	317	102	75	78	255	69	69	914
	Denominator	Total Inappropriate Referrals rejected at triage or registration	100	100	100	300	120	108	97	325	105	91	79	275	71	71	971
	LQR3 Performance		91.00%	89.00%	93.00%	91.00%	98.33%	98.15%	95.88%	97.54%	97.14%	82.42%	98.73%	92.73%	97.18%	97.18%	94.13%
90%	Numerator	Accepted referrals with first appointment date offered within 8 weeks	51	52	177	280	202	277	287	766	262	254	233	749	222	222	2,017
	Denominator	Total Accepted referrals with first appointment offered	205	167	226	598	229	396	358	983	283	279	234	796	222	222	2,599
	LQR4 Performance		24.88%	31.14%	78.32%	46.82%	88.21%	69.95%	80.17%	77.92%	92.58%	91.04%	99.57%	94.10%	100.00%	100.00%	77.61%
95%	Numerator	Patients starting treatment within 18 weeks	209	238	219	666	391	501	497	1,389	347	325	345	1,017	230	230	3,302
	Denominator	Total patients starting treatment	311	331	368	1,010	592	536	589	1,717	388	409	629	1,426	265	265	4,418
	LQR5 Performance		67.20%	71.90%	59.51%	65.94%	66.05%	93.47%	84.38%	80.90%	89.43%	79.46%	54.85%	71.32%	86.79%	86.79%	74.74%
0	Numerator	Patients who have exceeded 26+ weeks waiting time from Decision Made to Treatment	0	0	0	0	0	0	274	274	305	338	255	299	49	49	244
	LQR6 Performance		-	-	-	-	-	-	274	274	305	338	255	299	49	49	244
100%	Numerator	Care Management Plans	166	187	239	592	449	406	447	1,302	255	231	220	706	170	170	2,770
	Denominator	Total New Patients	168	189	239	596	453	410	458	1,321	260	233	224	717	176	176	2,810
	LQR7 Performance		98.81%	98.94%	100.00%	99.33%	99.12%	99.02%	97.60%	98.56%	98.08%	99.14%	98.21%	98.47%	96.59%	96.59%	98.58%
100%	Numerator	Letter sent within 5 Working Days	96	88	93	277	126	94	99	319	90	82	70	242	99	99	937
	Denominator	Total Discharges from appointment	98	89	94	281	126	96	100	322	92	82	71	245	99	99	947
	LQR8 Performance		97.96%	98.88%	98.94%	98.58%	100.00%	97.92%	99.00%	99.07%	97.83%	100.00%	98.59%	98.78%	100.00%	100.00%	98.94%
75%	Numerator	Patients completing 6 out of 8 PMP sessions	0	0	0	0	0	0	0	0	0	0	0	0	4	4	4
	Denominator	Total completed PMP Programmes	21	38	23	82	0	0	0	0	0	0	0	0	4	4	86
	LQR9 Performance		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	4.65%

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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 Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**Arrangements for the Quality Accounts 2021-2022**

Summary

The Health Scrutiny Committee for Lincolnshire is invited to consider its approach to the *Quality Accounts* for 2021-22 and to identify its preferred option for responding to the draft *Quality Accounts*, which will be shared with the Committee, by local providers of NHS-funded services.

Actions Required:

(1) To determine which draft *Quality Accounts for 2021-22* from the local providers of NHS-funded services where the Committee would wish to make a statement.

(2) To consider the arrangements for drafting statements in response to *Quality Accounts* for 2022.

1. Legal Framework for Quality Accounts

The legal framework for *Quality Accounts* requires each significant provider of NHS-funded services is required to submit their draft *Quality Account* to*:*

- their local health overview and scrutiny committee;
- their local healthwatch organisation; and
- their relevant clinical commissioning group.

The regulations define 'local' as the local authority area, in which the provider has their principal or registered office. Whilst there is a requirement for local providers to submit their draft *Quality Accoun*t to their local health overview and scrutiny committee, there is no obligation on such a committee to make a statement in response.

Role of the Health and Wellbeing Board

The regulations do not include a formal role for health and wellbeing boards. However, providers may share their draft *Quality Account* with their local health and wellbeing board for comments, if they wish. Any involvement of health and wellbeing boards would be discretionary.

2. What is a *Quality Account*?

The content of a *Quality Account* is prescribed by regulations, with additional requirements for NHS bodies. The *Quality Account* must include:

- three or more **priorities for improvement** for the coming year;
- an account of the progress with the **priorities for improvement** in the previous year; and
- details of:

  - the types of NHS funded services provided;
  - any Care Quality Commission inspections;
  - any national clinical audits;
  - any Commissioning for Quality and Innovation (CQUIN) activities;
  - general performance and the number of complaints; and
  - mortality-indicator information.

It should be noted that statements prepared need not be limited to a response to the content of the draft *Quality Account*, but could in addition reflect the views of the Committee on the quality of services provided during the course of the year by the provider.

No Financial Content

The term *Quality Account* has been used by the Department of Health and Social Care since 2010 and has caused some confusion. For the purposes of clarity, a *Quality Account* does not focus on finances, but represents an account of the quality (as opposed to an account of the finances) of a particular organisation. Overall financial information on a particular trust is found in their annual report.

3. What Should a Statement on a *Quality Account* Cover?

The Department of Health and Social Care has previously issued guidance to those making statements to focus on the following questions: -

- Do the priorities in the *Quality Account* reflect the priorities of local people?

- Have any major issues been omitted from the *Quality Account?*
- Has the provider demonstrated involvement of patients and the public in the production of the *Quality Account*?
- Is the *Quality Account* clearly presented for patients and the public?
- Are there any comments on specific issues, where the Committee has been involved?

The Health Scrutiny Committee is entitled to make a statement (up to 1,000 words) on the draft *Quality Account*, which has to be included in the final published version of the *Quality Account.*

4. *Quality Account* Arrangements in 2021

In 2021, the Committee agreed to provide statements on the draft *quality accounts* for the following two providers:

- East Midlands Ambulance Service NHS Trust
- United Lincolnshire Hospitals NHS Trust

As the requirement to share the draft quality account is stated in the regulations, other local providers have continued to share them and their receipt is acknowledged by the Chairman on behalf of the Committee.

Each provider's final *Quality Account* has to be published by 30 June each year.

5. Handling *Quality Accounts* in 2022

In the table below is a list of providers of NHS-funded services, on which the Committee has previously made a statement. In recent years the Committee has concentrated on those providers, with identified quality issues, by principally focusing on the overall Care Quality Commission (CQC) rating of the provider. The table below includes the latest CQC rating and the date of the most recent CQC report. As the CQC has changed its approach to inspections as a result of the pandemic, it should be noted that several of the latest ratings are from 2019 or earlier.

Provider	Current CQC Rating	Date of Latest CQC Report
East Midlands Ambulance Service NHS Trust	**Good**	17 July 2019
Lincolnshire Community Health Services NHS Trust	**Outstanding**	27 Sept 2018
Lincolnshire Partnership NHS Foundation Trust	**Good**	22 June 2020
Northern Lincolnshire and Goole NHS Foundation Trust	**Requires Improvement**	7 Feb 2020

Provider	Current CQC Rating	Date of Latest CQC Report
North West Anglia NHS Foundation Trust	**Requires Improvement**	20 Dec 2019
St Barnabas Hospice	**Outstanding**	7 Nov 2019
United Lincolnshire Hospitals NHS Trust	**Requires Improvement**	8 Feb 2022

Other Health Overview and Scrutiny Committees

Three of the providers have their principal office located outside the administrative county of Lincolnshire. Two of the acute hospital providers, Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust, have been and continue to be willing to share their draft quality accounts with this Committee. Norther Lincolnshire and Goole NHS Foundation Trust would also expect statements on their draft quality account to be provided by the health overview and scrutiny committees from North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. Similarly North West Anglia NHS Foundation Trust would expect statements on their draft quality accounts to be provided by the health overview and scrutiny committees from Cambridgeshire and Peterborough.

Although the principal office of the East Midlands Ambulance Service (EMAS) is located in the City of Nottingham, EMAS shares it draft quality accounts with all twelve health overview and scrutiny committees in the area where it operates.

6. Arrangements for Making Statements in Response to Draft Quality Accounts

If the Committee were to choose to make statements on draft *Quality Accounts,* it could use one or both of the following options:

- working group arrangements (held virtually, potentially with representatives of the provider in attendance); or
- the circulation of draft *Quality Accounts* on email, with a request for comments to be sent by email.

7. Conclusion

The Committee is invited to consider the arrangements for the *Quality Account* process for 2021-22. This includes the Committee making a decision on which quality accounts it would wish to review, via a working group arrangement.

8. Consultation

This is not a consultation item. However, as part of the annual *Quality Account* process, the Health Scrutiny Committee for Lincolnshire is entitled to make a statement up to 1,000 words on the content of each local provider's draft *Quality Account*.

9. Appendices

These are listed below and attached to this report.

Appendix A	Quality Accounts 2020-21 – Summary of the Priorities of the Main Providers of NHS-Funded Services for Lincolnshire Residents

10. 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, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

APPENDIX A

QUALITY ACCOUNTS 2020-21 – SUMMARY OF THE PRIORITIES FOR IMPROVEMENT OF THE MAIN PROVIDERS OF NHS-FUNDED SERVICES FOR LINCOLNSHIRE RESIDENTS

East Midlands Ambulance Service NHS Trust

Priorities for Improvement

(1) We will improve the way in which we listen to and use feedback from our patients, carers and families to continually improve our services.

(2) We will continue to promote the safe and appropriate use of alternatives to ED by ensuring that our staff have the necessary knowledge, skills, experience and confidence to do so. This will include ensuring that staff have digital access to shared records and to senior clinical support where required.

(3) We will improve our performance against the nationally reported Ambulance System Indicators and Clinical Outcomes, with a particular focus on cardiac arrest.

(4) We will continue to learn from when things go well as well as when they go wrong, ensuring that learning is shared both internally and externally to improve the quality of care we provide to our patients.

(5) We will improve the timeliness of managing safeguarding referrals raised by our staff by fully automating the referrals process ensuring that relevant third parties are alerted in real-time.

The quality account for 2020/21 is available at the following link:
https://www.emas.nhs.uk/about-us/trust-documents/

Lincolnshire Community Health Services NHS Trust

Priorities for Improvement

(1) Patient involvement and patient partners:

- Patient panel members will share their views via surveys with the Trust.
- Service specific interest groups will be established around specific service lines and work on specific projects, sharing views via surveys or consultation.
- There will be patient partners, a core group of trained patient panel members, who participate in visits, appropriate Trust committees and recruitment panels.

(2) Embed the principles of the safety culture (National Patient Safety Strategy):

- During quarter 1, the 'Just Culture Guide' will be embedded into Trust policy.
- During quarter 2, a gap analysis will be completed on stakeholder engagement.
- During quarters 3 and 4, the new Patient Safety Incidences Response Framework will be implemented.

(3) Personalised Care and Support Planning (PCSP)

- There will be a baseline check of the number of personalised care plans in place.
- Evidence will be gathered on patient involvement in the planning of their care.
- Information will be shared with the personalisation board.

The quality account for 2020/21 is available at the following link:
https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-publications/quality-accounts

Lincolnshire Partnership NHS Foundation Trust

Priorities for Improvement

(1) To improve the involvement of carers and families in patient/service user care. This builds on previous work to improve carer and family involvement in relation to the adult inpatient care pathways and particularly leave and discharge arrangements.

(2) To develop and implement robust dual diagnosis (alcohol/substance use and mental ill health) pathway. This will address the challenges faced by patients and service users who have a dual diagnosis, as Lincolnshire's dual diagnosis pathway has been found to fall short of the standard required to deliver safe and effective care.

(3) To make it easier for people who use our services to share their experiences of care by providing a range of methods to provide feedback across the services. This feedback will inform service development and improvement. There will be opportunities for people to give real time feedback, to ensure they are listened to.

(4) To deliver a home treatment service in Lincoln and Boston Hubs for people living with dementia. These would prevent admission and support discharge by delivering care as close to home as possible for people, require intensive support to maintain as much independence as possible.

The quality account for 2020/21 is available at the following link:
https://www.lpft.nhs.uk/about-us/accessing-our-information/annual-reports-and-accounts

Northern Lincolnshire and Goole NHS Foundation Trust

Priorities for Improvement

(1) Improve end of life care and reduce mortality rates
(2) Improve care for deteriorating patients and improve the treatment of sepsis
(3) Increase medication safety
(4) Improve safety of discharge
(5) Improve the management of diabetes

The quality priorities for 2021/22 were aligned with the Trust's quality strategy longer term objectives. Some of the above quality priorities and the underpinning measures link to Trust performance indicators.

The quality account for 2020/21 is available at the following link:
https://www.nlg.nhs.uk/resources/quality-accounts/

North West Anglia NHS Foundation Trust

Priorities for Improvement

(1) To continue to improve position to regain top quartile status for HSMR and Standardised Hospital Mortality Indicator (SHMI)
(2) To implement the principles of the NHS Patient Safety Strategy Framework.
(3) To reduce pressure ulcers arising from hospital acquired infections.
(4) To improve sepsis recognition and management.
(5) To maximise safety through the implementation of the Ockenden Recommendations for maternity services and to enhance women's birth experience.
(6) To implement the new legislation on liberty protection safeguards.
(7) Health Inequalities: to enhance patient experience through the engagement of minority patient groups; to improve targeted health promotion that focus on minority ethnic groups; to support improvement of health inequalities in women and children; and to improve outcomes for women and babies who are from either a minority ethnic group or are vulnerable.
(8) To enhance patient experience through the use of volunteers within the chaplaincy.
(9) To improve patient experience, safety and quality by streamlining patient flow in Peterborough City Hospital's A&E.
(10) To reduce hospital acquired Clostridium difficile infections
(11) To embed new CQC strategy following publication in May 2021; to Improve internal governance processes, the accuracy and use of data from CQC insight reports and to complete outstanding actions on CQC action plan.

The quality account for 2020/21 is available at the following link:
file:///C:/Users/Simon.Evans/Downloads/Quality%20Account%202020-21%20v16%2029.06.21%20FINAL%20(1).pdf

United Lincolnshire Hospitals NHS Trust

Priorities for Improvement

(1) Improving Respiratory Services, where success measures include:
- total elapsed time from suspicion of type 2 respiratory failure to non-invasive ventilation less than 120 minutes;
- start for non-invasive ventilation less than 60 minutes from arterial blood gas;
- non-invasive ventilation progress for all patients to be reviewed every four hours;
- 90% of patients to have continuous observations for the first 15 minutes after having received a chest drain

(2) Developing a Safety Culture, where success measures include:
- developing dedicated intranet for safety culture, including monthly newsletters;
- developing a faculty of 'train the trainers' to deliver training on *Human Factors*.
- recruitment of all vacant posts in the safety Culture team by September 2021; and
- a programme of visits to theatres to consider systems and processes.

(3) Improving Patient Experience, where success measures include:
- communication using *Objective Structured Clinical Examination* methodology;
- a reduction in poor communication and lack of dignity and respect being cited in the Friends and Family Test; and
- a reduction in complaints and concerns raised by patients, where poor communication and a lack of involvement in decisions are cited.

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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2022**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme and Working Groups**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is required to consider whether any further items should be considered for addition to or removal from the work programme.

The Committee is also asked to consider two proposals for working groups.

Actions Requested

(1) To consider and comment on the Committee's work programme.

(2) To consider establishing a working group to respond to the consultation draft of the Lincolnshire Pharmaceutical Needs Assessment (as detailed in section 4 of this report).

(3) To consider establishing a working group to explore in more detail the issues raised at the Committee's last meeting in relation to access to mental health services in Lincolnshire (as set out in section 5 of this report and Minutes 74 and 76).

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Today's Work Programme

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

16 March 2022		
	Item	*Contributor*
1	United Lincolnshire Hospitals NHS Trust - Care Quality Commission Inspection Report - February 2022	Representatives from United Lincolnshire Hospitals NHS Trust: • Andrew Morgan, Chief Executive • Karen Dunderdale, Deputy Chief Executive and Director of Nursing
2	Public Consultation on the Nuclear Medicine Service at United Lincolnshire Hospitals NHS Trust	Laura White, Head of Nuclear Medicine United Lincolnshire Hospitals NHS Trust. Clair Raybould, Director of Operations, Lincolnshire Clinical Commissioning Group
3	Community Pain Management Service Update	Representative from Lincolnshire Clinical Commissioning Group
4	Quality Accounts 2021-22 – Arrangements for Making Responses	Simon Evans, Health Scrutiny Officer

3. Future Work Programme

13 April 2022		
	Item	*Contributor*
1	GP Services Access Update	Dr Kieran Sharrock, Medical Director Lincolnshire Local Medical Committee
2	Mental Health Update from Lincolnshire Partnership NHS Foundation Trust	Sarah Connery, Chief Executive, or Jane Marshall, Director of Strategy, People and Partnership, Lincolnshire Partnership NHS Foundation Trust

18 May 2022		
	Item	*Contributor*
1	Dental Services Update	Representatives from NHS England
2	Cancer Care Update (or 15 June)	Lincolnshire Clinical Commissioning Group: • Clair Raybould, Director of Operations, Lincolnshire Clinical Commissioning Group • Louise Jeanes, Programme Lead Cancer Care United Lincolnshire Hospitals NHS Trust: • Colin Farquharson, Medical Director
3	Staffing Challenges in Hospitals and NHS Lincolnshire People Plan (to be confirmed)	Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust. Ceri Lennon, Senior Responsible Officer for the Lincolnshire People Board

15 June 2022		
	Item	*Contributor*
1	United Lincolnshire Hospitals NHS Trust: Update on Urology Services	United Lincolnshire Hospitals NHS Trust: • Colin Farquharson, Medical Director • Andrew Simpson, Consultant Urologist
2	Finalising Committee's Response to the Lincolnshire Pharmaceutical Needs Assessment	Simon Evans, Health Scrutiny Officer

13 July 2022		
	Item	*Contributor*
1		

14 September 2022		
	Item	*Contributor*
1	Sustainability Transformation Partnership Clinical Care Portal Data Sharing - Update	Lincolnshire County Council (Adult Care and Community Wellbeing) Representatives: • Theo Jarratt, Head of Quality and Information • Samantha Francis, Information and Systems Manager Representative from United Lincolnshire Hospitals NHS Trust
2	Lincolnshire Pharmaceutical Needs Assessment – Consideration of Final Draft	Shabana Edinboro, Senior Public Health Officer, Lincolnshire County Council

Items to be Programmed

The following items are due to be programmed at forthcoming meetings:

- **Future Commissioning Arrangements for Dental Services, Ophthalmology and Pharmaceutical Services** – The commissioning of these services is due to transfer to the Lincolnshire Integrated Care Board from July 2022.

- **Recovery of Secondary Care –** This item would cover the plans to reduce waiting lists for services at acute hospitals.

- **Humber Acute Services Programme** – Following the Committee's consideration on 19 January 2022, it is expected that there will be an update in the programme between April and June 2022.

- **Care Quality Commission Report: Protect, Respect, Connect – Decisions about Living and Dying Well During the Covid-19 Pandemic** – On 18 March 2021, the Care Quality Commission published its report, with eleven recommendations, three of which were directed at NHS providers.

- **Lakeside Medical Practice Stamford** – A further inspection report is due to be published, and depending on its content may merit further consideration by the Committee.

4. Pharmaceutical Needs Assessment

In 21 July 2021, the Committee considered an introductory item on the Lincolnshire Pharmaceutical Needs Assessment (PNA). The PNA, which is a statutory document prepared by the Health and Wellbeing Board, details the present and future needs for pharmaceutical services. The PNA is used to identify any gaps in current service

provision or improvements that could be made in future pharmaceutical service provision. To prepare the PNA, data are gathered from pharmacy contractors, dispensing GP practices, pharmacy users and residents, and from a range of other sources (commissioners, planners and others). The document also includes evidence and a range of maps that are produced from data collected as part of the PNA process.

Owing to the Covid-19 pandemic, the statutory date of renewal of the existing PNA has been delayed on two occasions. The confirmed date for the approval of the PNA is 30 September 2022.

In advance of this, there is a period of consultation on the draft PNA, which is due to begin on 19 April and conclude on 20 June 2022. On previous occasions, the Committee has formed a working group, which would meet once, to work through the detail of the document.

5. Access to Mental Health Services

At the last meeting the Committee considered a report on Suicide Prevention in Lincolnshire. Following its consideration, it was suggested that a working group be established to consider some of the issues arising from the report. Subsequent discussions have indicated that one of the key issues is access to mental health services, and the impact of waiting times on patients, including a decline in their health and wellbeing during the waiting period.

The Committee is due to receive a general update report from Lincolnshire Partnership NHS Foundation Trust (LPFT) on 13 April 2022. LPFT has been requested to include information on access, including waiting list numbers and average waiting times in the report. Therefore, in the first instance it is proposed that their report is considered by the Committee, and then a decision made on whether issues need to be explored via a working group.

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 Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

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