Public Document Pack

Lincolnshire COUNTY COUNCIL *Working for a better future*		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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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, 18 May 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), 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), Mrs A White (West Lindsey District Council) and 1 Vacancy (City of Lincoln Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 13 April 2022**	3 - 16
4	**Chairman's Announcements**	17 - 26

Item	Title	Pages
5	**United Lincolnshire Hospitals NHS Trust - Elective Recovery Plan and Response to the Care Quality Commission Inspection** *(To receive a report from United Lincolnshire Hospitals NHS Trust (ULHT), which invites the Committee to consider the Lincolnshire Elective Recovery Plan 2022/23 and the response of ULHT to the inspection report by the Care Quality Commission. Simon Evans, Chief Operating Officer ULHT and Sarah Brinkworth, Planned Programme Lead, Lincolnshire Clinical Commissioning Group will be in attendance for this item)*	27 - 146
6	**United Lincolnshire Hospitals NHS Trust - Reconfiguration of Urology Services Update** *(To receive a report from United Lincolnshire Hospitals NHS Trust (ULHT), which provides the Committee with an update of the implementation of the new model for urology in Lincolnshire's Hospitals. Andrew Simpson, Consultant Urologist ULHT will be in attendance for this item)*	147 - 176
7	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forth coming work programme)*	177 - 180

Debbie Barnes OBE
Chief Executive
10 May 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, 18th May, 2022, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
13 APRIL 2022

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough 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), Mrs A White (West Lindsey District Council) and C Watt (City of Lincoln Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Sarah-Jane Mills (Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group) and Kevin Gibson (Senior Communications & Engagement Manager NHS Lincolnshire Clinical Commissioning Group).

The following representatives joined the meeting remotely, via Teams:

Sarah Connery (Acting Chief Executive, Lincolnshire Partnership NHS Foundation Trust), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Christopher Higgins (Interim Director of Operations, Lincolnshire Partnership NHS Foundation Trust), Sarah-Jane Mills (Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group), Dr Kieran Sharrock (Medical Director, Lincolnshire Local Medical Committee) and Kevin Gibson (Senior Communications & Engagement Manager NHS Lincolnshire Clinical Commissioning Group).

County Councillors C Matthews (Executive Support Councillor NHS Liaison, Community Engagement, Registration and Coroner’s Services and Mrs S Woolley (Executive Councillor NHS Liaison, Community Engagement, Registration and Coroner’s Services) attended the meeting as observers, via Teams.

86 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors B Bilton (City of Lincoln Council) and S R Parkin.

It was noted that Councillor Calum Watt (City of Lincoln Council) had replaced B Bilton (City of Lincoln Council) for this meeting only.

87 DECLARATION OF MEMBERS' INTERESTS

No declarations of members' interest were received at this stage of the proceedings.

88 MINUTES OF HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 16 MARCH 2022

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 16 March 2022 be agreed and signed by the Chairman as a correct record.

89 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 12 April 2022. The supplementary announcements referred to:

- Covid-19 Update, Appendix A to the supplementary announcements provided weekly briefing information prepared by Lincolnshire County Council Public Health;
- Further information on the Lincoln County Hospital major incident, with reference being made to the collaborative working of all staff and system partners involved in the incident; and
- Further to paragraph 4 of the announcements circulated with the agenda, further information was provided regarding the progress of the Health and Care Bill.

Some reference was made to the report on NHS Backlogs and Waiting Times in England, and the need for this to be raised with local MPs.

RESOLVED

That the Supplementary Chairman's announcements circulated on 12 April 2022 and the Chairman's announcements as detailed on pages 13 to 19 of the report pack be noted.

90 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST - UPDATE

Consideration was given to a report from Lincolnshire Partnership NHS Foundation Trust, (LPFT) which provided the Committee with an update on the activities of LPFT.

The Chairman invited the following representatives from LPFT: Sarah Connery, Chief Executive and Chris Higgins, Chief Operating Officer, to remotely, present the item to the Committee.

In guiding the Committee through the report, mention was made to:

- The challenges during the last 12 months for the NHS and the local community, with the continued impact of the Covid-19 pandemic, rising demand for mental health services and the increasing cost of living;

(Councillor M A Whittington joined the meeting at 10:12)

- The Trust's Covid-19 response, it was noted that there had been temporary changes to ward-based services in response to unprecedented staffing pressures, these changes were listed on page 22 of the report. Reference was made to the temporary closure of Ashley House, Grantham. The Committee noted that prior to its temporary closure, the service had been operating below its 100% occupancy since 2018; and that an alternative open rehabilitation provision remained available at Maple Lodge in Boston, with other rehabilitation care also being available at Discovery House in Lincoln. It was noted further that for the three-years prior to the temporary closure, Ashley House had 52 admissions, of which 14 had been from Grantham and the surrounding area. The closure had therefore not had a direct adverse effect on any one geographic population. It was also highlighted that the Trust, had on occasion, had to make use of out of area bed placements. It was highlighted further that this was being closely monitored and was only used when absolutely necessary;
- Changes to services, it was noted that the Trust continued to utilise the learning from delivering services in a different way during the pandemic, details of which were shown on pages 23 to 25 of the report;
- The Mental Health and Wellbeing Transformation Programme;
- The new Acute Mental Health Wards;
- Increased crisis support;
- The increasing demand on services. It was highlighted that nationally there had been an increase in the number of people needing to access mental health services. The Committee noted that during the last two years, there had been notable increases in the following services: children and young people services, in particular young people experiencing an eating disorder; adult autism diagnostic assessments; early intervention in psychosis; chronic fatigue; and talking therapies. It was reported that despite the increased demand the Trust continued to perform well against nationally

set waiting times for most services, with only the children and young people services currently being an outlier compared to national expectations;

- Suicides. It was reported that the Trust had a local suicide prevention strategy, which strived to achieve zero suicides for those people known to the service. It was highlighted that on average only 20 percent of suicide deaths in the county were known to mental health services. It was reported further that the Trust worked closely with public health colleagues at Lincolnshire County Council and other local partners such as Lincolnshire Police and district councils on a county wide strategy for suicide prevention;
- Staff recruitment and retention. The Committee was advised that the Trust had received substantial additional investment to expand teams, to meet increasing demand, and to transform ways of working in the local community. It was highlighted that recruitment remained one of the Trust's main risks. The report highlighted that currently there was 333 vacancies, largely in two professional areas of nursing and additional professional, scientific and technical which included roles such as psychology and social workers. Page 32 of the report provided the Committee with a summary of the main workforce projects and initiatives for 2022/23, to help the Trust meet its recruitment and retention challenges;
- Awards and Accreditations achieved despite the challenges and pressures of the pandemic. These were listed on page 34 of the report; and
- The future ambitions for mental health, learning disabilities and autism services.

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

- Concern was expressed on the pressures for services, and the lengthy waiting times. It was highlighted that the mental health and wellbeing transformation programme would help alleviate some of the pressures, details of what had been completed so far in this major transformation project were shown in Appendix A to the report. Reassurance was given that emergency cases were prioritised. The Committee noted that there was also commitment to increase children and young people capacity, however, recruitment as previously mentioned had been a limiting factor. The Committee was also advised that the Trust continued to lobby NHS England, and that the Trust was also working as an East Midlands Alliance to try to attract people to come and work in Lincolnshire. It was highlighted that the Trust was also growing its own staff through training and apprenticeship programmes. The Committee noted that the Trust was also in contact with local schools and colleges, to try and attract young people to have a career within the Trust;
- What help was being provided to Ukrainian and Russian expatriates living in Lincolnshire. The Committee was advised that the Trust was working as a system to recruit refugee members of staff, with a focus initially on medical training and staffing. It was noted that it was believed that two refugee nurses would be joining the Trust. It was highlighted that there was more that could be done, but it was necessary to ensure that there was a proper role for them and that they were properly trained. It was noted that international qualifications did not directly

match. Reassurance was given that the Trust was committed to making international recruitment a success, and that every time there had been an international crisis of this nature, the Trust was always there to respond on how services were provided to actively support those in need. It was highlighted that the Trust had developed care packages over the years to reach out to people wherever they were. The Committee was advised that if families needed mental health support because of the impact of the Ukrainian crisis, the Trust would actively work with them;

- General mental health provision in the Boston area. The Committee noted that the Trust was committed to making sure that there was appropriate provision on the east coast. The Committee noted further that there were inpatient wards in Boston, as well as a thriving community service offer. It was reported that Boston was one of the first pilot sites out of twelve in the county to get investment into the community health transformation programme. This was investment in community resources and community assets and prescribing. The Committee noted that this programme was still in development, but already, the impact was being seen in the Boston area. It was highlighted that one of the challenges on the east coast was expanding the provision of crisis night light cafes. It was highlighted that the Trust was working with the community and voluntary sector to rebuild capacity and capability, and the desire to provide mental health services. Reassurance was given that the Trust was committed and had an active programme to stimulate that market to get people coming forward to provide the services. The committee noted that the Trust wanted to upgrade the inpatient unit at Pilgrim Hospital, so that it was modern fit for purpose, and provided an outstanding environment to treat patients, and for staff who worked there. Further reassurance was given that the Trust was committed to Boston. Representatives agreed to respond directly to provide a written response to these questions;
- The need to ensure that nationally more effort was placed on training more mental health staff;
- Some concern was expressed that residents in Lincolnshire did not receive help until they were at a critical level and in some cases, when it was too late. The Committee was advised that the transformation programme investment would ensure that community assets were integrated with secondary services. The Committee was reminded that only 20% of those who had taken their lives were known to mental health services. It was highlighted that work was ongoing to make sure that those in need of support got the support they needed, to prevent the need for escalation; and that more was being done with the third sector to build up more resilience. The Committee was advised that further development on the east coast was due in the next year regarding mental health support teams. Trust representatives agreed to make a copy of the implementation plan available to members of the Committee outside of the meeting;
- Whether the mental health liaison scheme at Lincoln County Hospital was a hospital wide scheme or just in A & E, and whether there were any plans to expand it further. The Committee noted that the liaison service was available at Lincoln, Boston and Grantham and that it was planned that the service would be extended to Louth and Skegness. Confirmation was given that the assessment centre at Lincoln was in addition to and would not replace the mental health liaison scheme;

- The need for the expansion of the new urgent assessment across the county. There was recognition that services were Lincoln centric and that steps were being taken as part of the transformation programme to expand them across the county;
- Recognition of the challenges faced regarding the expansion of services;
- Chronic fatigue. The Committee noted that the Trust's specialist chronic fatigue syndrome service had been working closely as part of the system's Long Covid clinics. It was noted that demand was currently greater than current capacity and that waiting lists were increasing as a result. The Committee was advised that discussions were being held with local commissioners for additional investment to expand the team to meet the current demand;
- The need to concentrate the increase in provision of services in the east and south east parts of the county;
- That better communication was required to advise members of the public of what services were available across the county, as there appeared to be some inconsistencies. There was recognition that there were gaps in provision across the county, and that more that needed to be done;
- What help was being provided to service personnel. The Committee was advised that the trust had a veteran service, which was highly regarded across the East Midlands area;
- Some concern was expressed that support was not being provided quickly enough, which had resulted in some suicide cases. The Committee was advised that there were numerous reasons why someone would take their own life. Reassurance was given that each incident of suicide was investigated to ensure that lessons were learnt. It was noted that the introduction of a 24/7 helpline for support and crisis cafes were part of the transformation programme for individuals to be able to make contact; and for young people to have access to healthy minds in schools. The Committee was advised that where people were waiting to access services, these people were regularly contacted and when appropriate, would be prioritised, if their needs were to change;
- The provision of in-patient beds. It was reported that at the moment, it was not known what the demand for in-patient beds would be. It was highlighted what was available was intensive home treatment support, which would avoid someone having to go into hospital. It was recognised that there was a balance to be reached to ensure that beds were available if required. Reference was also made to the reduction in bed availability because of social distancing, leading to out of county placements. The Committee was advised that in the last couple of months there had been approximately five out of county placements, and that these had been because of a number of Covid-19 outbreaks. The Committee was advised that the latest figure was four out of county placements, some of whom were satisfied with their placement; and every effort was made to establish relationships during the care period, so that the patient's journey was not disrupted. It was noted that the out of county placements were in Nottinghamshire. Reassurance was given that secure transport arrangements were available, and that digital arrangements were also in place; so that family and friends could stay in contact;

- The increase in the number of adults diagnosed with autism. There was recognition that the number was on the increase and that there was a gap in provision, and that work was on going to have an all-age diagnosis. It was also noted that there had also been an increase in the number of adults with eating disorders needing support;
- Manthorpe Ward, Grantham. The Committee was advised that the proposal was to re-open Manthorpe Ward on a pilot basis in a new clinic format, utilising the space as an eight-bed short stay step-up/down service. The pilot would also enable the Trust to continue with the pilot dementia home treatment and provide additional care pathways in the older adult/dementia services, parallel to the stepped options available to working age adults;
- Whether the data sharing agreement was county wide and how that fitted into the data sharing care portal. The Committee was advised that data sharing agreements were already in place with various partners, it was however noted, that data sharing had not been completely rolled out across the county yet. The Committee noted that the care portal was the mechanism that would make data sharing a reality. It was highlighted that the Committee was due to consider a further report on the care portal at its 14 September 2022 meeting;
- 24/7 crisis freephone helpline. One member enquired how long after initial contact on average was it before people received follow up support, or potential treatment began. The Committee noted that the time period varied as this was dependent on the nature of the call; some callers were repeat callers just needing someone to talk to; others were signposted to groups such as a walking group; and some would be seen by professionals the same day if the need was required;
- The eradication of dormitory accommodation in Boston, due to increasing costs, and what options were now being considered. The Committee was advised that the Trust was still committed to eliminating dormitory accommodation, and that the Pilgrim Site (or the Norton Lea site) was still being considered, either as a new build option, or a refurbishment scheme and that work was continuing with United Lincolnshire Hospitals NHS Trust regarding this matter; and
- When the Trust foresaw when it would be returning to its pre-pandemic waiting times and what additional support would be received to help achieve this. The Committee was advised that this information would be available in the performance report, and that additional investment was available for this to happen.

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

RESOLVED

1. That the update report from Lincolnshire Partnership NHS Foundation Trust be noted.

2. That the consultation on the mental health rehabilitation service be considered at the 15 June 2022 meeting.

3. That mental health provision and suicide prevention be reviewed in more detail by a working group and that membership of the said working group be agreed under item 9 on the agenda - Health Scrutiny Committee for Lincolnshire – Work Programme.

91 GENERAL PRACTICE ACCESS

The Committee considered a report from the Lincolnshire Local Medical Committee (LMC), which provided a report on access to general practice services.

The Chairman invited Dr Kieran Sharrock, former Medical Director of Lincolnshire Local Medical Committee and Deputy Chair of the British Medical Association (BMA) Practitioner Committee for England, to remotely, present the item to the Committee.

The Committee was advised that nationally the demand for general practice appointments was higher than it had ever been, but the workforce in general practice was declining. It was reported that this mismatch had led to practices not having the capacity to provide the access which patients that the system would like.

It was reported that general practices had a backlog of care caused by the pandemic, and that hospital trusts also had long waiting lists due to the pandemic, which was impacting on general practice, as patients were seeking further support with their increased health needs which were unable to be managed by secondary care.

The report advised that as of January 2022, in England there were 1,608 fewer fully qualified full-time GPs compared to 2015. It was highlighted that to compensate for the reduced number of GPs and nurses, practices, and Primary Care Networks (PCNs) now employed other health professionals to manage patients' conditions. These professionals were qualified to manage conditions in their sphere of practice but did not have the holistic skills of a GP.

The Committee was advised of the Lincolnshire position, with reference being made to Lincolnshire having a deficit of available professionals; practices in rural and coastal communities being less able to recruit; and that the additional roles funding was limited by national pay scales, which was a disadvantage to PCNs. Details on page 46 of the report provided the Committee with the number of total appointments and face to face appointments conducted by Lincolnshire's general practices for December 2019 and December 2021. The figures highlighted that despite a reduced workforce, Lincolnshire's general practices had increased their appointments by 6% since pre-pandemic.

The Committee was advised that increasing workload was causing GPs and other clinical staff to leave the profession early, and that from a recent poll, one third of GPs had reported they were suffering from depression, burn out or mental distress. Further details relating to a recent poll of GPs was shown on page 47 of the report for the Committees consideration. It was also highlighted that a lack of workforce planning, and other factors had resulted in GPs feeling that the health service was now unsafe for patients and practitioners.

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

- The frustrations and problems encountered by patients not being able to get an appointment with a GP. The Committee noted that receptionists were designated as care navigators trained to identify a patients need and direct them to the most appropriate person. It was highlighted that unfortunately there were not enough professional people to deal with the demand, and that patients tended to prefer the holistic care provided by a GP. The Committee was advised that since the pandemic appointments had increased, some of which were face to face, some were telephone conversations, and some were conducted via video link. The Committee was advised that 60% of consultations across the trust were conducted face to face. Some members highlighted that some patients were still unable to get through to a receptionist due to the high volume of calls. It was highlighted that practices were doing three times the amount of work, and did not having the right number of staff to meet the demand;
- Concern was expressed at the lack of national planning by the government with regard to recruitment;
- Some clarity was sought regarding digital data and whether the figures included Covid-19 vaccinations. Confirmation was given that it excluded Covid-19 vaccinations;
- The usefulness of on-line consultations for GP practices. The Committee was advised that modelling information was available from the BMA and that the Lincolnshire Clinical Commissioning Group would have data concerning workforce investment;
- Average working time for a GP was 38.3 hours per week. The Committee was advised that a recently published report by the Policy Exchange into general practice had advised that GPs should do no more that 25-30 clinical contacts a day to maintain safety, but NHS figures were showing that GPs were doing on average 47 contacts a day, and as a result several GPs and other clinical staff were leaving the profession;
- That more resources and funding was needed along the east coast to support the practices to provide services;
- Whether a workforce plan existed for Lincolnshire. The Committee was advised that there was a Lincolnshire People Board, and that the PCN represented GPs on the said Board. The Committee was advised that this was something the Lincolnshire CCG would be able to help with; and
- The changes to GP service as a result of GP contracts;

On behalf of the Committee the Chairman extended his thanks to Dr Sharrock for his presentation.

RESOLVED

1. That Lincolnshire GP practices be recognised for increasing the number of appointments by six per cent since before the pandemic.

2. That an update on GP provision be considered by the Committee in six months' time.

92 GENERAL PRACTICE PROVISION

Consideration was given to a report from the Lincolnshire Clinical Commissioning Group, which provided the Committee with an update on the current service provision by general practice across the county.

The Chairman invited Sarah Jane Mills, Chief Operating Officer, (West Locality) Lincolnshire Clinical Commissioning Group, to present the item to the Committee.

An acknowledgement was given to the outstanding contributions of GP colleagues across the county who had continued to provide local primary care services throughout the pandemic, in addition, to working with Primary Care Networks (PCNs) in delivering the Covid-19 vaccination programme to people living in their local communities. It was however recognised that there were continued challenges associated with increased demand and workforce availability, which meant that the model of primary care service provision would need to change and evolve in the coming years to meet the required need.

There was recognition that there were problems accessing GP services, and that data had shown when compared to the same period pre-Covid in 2019/20, GP colleagues were providing on average 20% more appointments. It was highlighted that the 'Ask my GP' App had seen an increase of 5% in same day appointments and a 4% increase in appointments being provided between 1 – 6 days.

It was reported that practices were mindful that new ways of accessing primary care services had been welcomed by some patients, whilst others felt the new arrangements did not meet their personal needs. As a result, practices were working hard to understand these issues, to be able to refine their processes and enable the continued development of local access arrangements. It was noted that in the coming year, the CCG along with GP colleagues and other partner organisations would be continuing to develop arrangements to improve access to primary care services, which would include developing services for a timelier access for people with minor illnesses, which would then enable the GP to develop local arrangements to create time to support more vulnerable people and those with more complex health needs.

(Councillor Mrs L Hagues left the meeting at 12:37)

It was reported that although the CCG continued to work closely with practices to ensure and help facilitate continuous improvement, the assessment of the Care Quality Commission (CQC) was relied on to provide an independent assurance of the quality of GP service provision. Current CQC rating details were provided within the report which indicated that Lincolnshire practices were in a good position, with 80 practices being rated good or outstanding.

The Committee noted that the makeup of GP teams had changed and developed in recent years; and those practices independently of Primary Care Networks (PCNs) had introduced new roles to provide additional capacity and professional support to help treat each patient's individual needs.

Although Lincolnshire had a slightly lower than the national average number of GPs, the number of clinical staff working in primary care compared favourably. Details of the current position relating to GPs compared to the national average were shown on page 52 of the report for the Committee to consider. The Committee noted that there had been a reduction in the number of GP partners and an increase in salaried GPs, which was consistent with the national picture. It was noted further that this had prompted a national discussion with regards to the need to reform general practice.

The Committee was advised that PCNs enabled GP practices to come together to share staff and collaborate to deliver extended primary care services to the local community. It was highlighted that PCNs had become an established part of the NHS structure across Lincolnshire.

A copy of the Lincolnshire Primary Care Network Alliance Annual Report for 2020/21 was attached as Appendix A to the report for consideration by the Committee.

In conclusion, the Committee was advised that the establishment of PCNs, increased availability of digital services and that the opportunity to work in partnership with other agencies/services would influence and enable how people access primary care in the future.

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

- The problems patients had encountered in getting an appointment to see a GP or being able to obtain access to their surgery physically. The Committee was advised that practices had multi-disciplinary teams, with professionals being able to deal with the issues on a daily basis, which then enabled GPs to be able to have more time to see patients with more complex needs. There was recognition that some patients were still unclear as to how to access their GP, and how the service model had changed. The Committee noted that telephone systems were continuing to be upgraded, and that a programme of modernisation was planned, to ensure services were better connected to the wider health system;
- Digital technology. It was reported that digital technology was being used and from patient feedback 90% of patients using it preferred it as a way of contacting their surgery. It was recognised that digital contact was not the preferred option for all patients. Some concern was expressed that the statistics were incorrect, as they were not asking the right questions of patient users. Some disappointment was also expressed that there was very little patient feedback. The Committee was advised that the CQC report would be able to provide further information. Reassurance was given that the CCG quality team worked with practices that were rated as requiring

improvement or inadequate. With regard to patient feedback the Committee was advised that the CCG worked very closely with Healthwatch Lincolnshire;

(Dr B Wookey left the meeting at 13:10)

- Personal experiences of using 'Ask my GP' App, and to the fact that some surgeries were turning the app off. The Committee was advised that post pandemic, to mitigate risks, some practices had turned the app off, due the increased volume of demand and staff absences. It was reported that at the end of 2021 GP practices were received up to 6,000 calls in a day, and with the introduction of digital technology, this had been reduced to 600 a day. It was highlighted that the introduction of Ask my GP and e-consultations provided patient choice. Reassurance was given that GP services were safe and where there were concerns, the CCG were proactively working with practices, and where necessary providing support. The Committee was advised that the GP model, as independent businesses had its challenges and that there was more to be done to understand local delivery; and

(Cllr R J Cleaver left the meeting at 13:17)

- The need for GP provision to be improved on the east coast to address their needs, as services provided were inconsistent to other areas in the county. There was recognition that recruitment was a challenge, and work was on going to make Lincolnshire more attractive for people to want to come to for work. Concern was also expressed at the increased population along the east coast during the holiday season, which resulted in an increased demand on services, which were already over stretched. A question was asked as to whether a plan was in place to deal with the challenges faced. The Committee was advised that there was a People Board in Lincolnshire, which looked at workforce needs across a whole range of services with regional and national teams. The board also informed training and development needs in the county and additional training for extended roles. It was also noted that a board had been established specifically for primary care, and that the coastal issues were known and were being considered.

RESOLVED

1. That thanks be extended to the Lincolnshire NHS Clinical Commissioning Group for presenting information on general practice provision.

2. That a further update on GP provision be considered in six months' time.

93 UNITED LINCOLNSHIRE HOSPITALS CONSULTATION ON NUCLEAR MEDICINE - FINALISATION OF THE COMMITTEE'S RESPONSE

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the item, which invited the Committee to finalise its response to the consultation by United Lincolnshire Hospitals NHS Trust on its nuclear medicine.

A further copy of the draft response document had been circulated to Member of the Committee for their consideration in advance of the meeting.

Some concern was expressed that the proposals were again seeing services being eroded from Grantham and District Hospital and Pilgrim Hospital, Boston and services being centralised at Lincoln County Hospital.

The Committee extended their support to the draft response document circulated.

The Chairman extended thanks on behalf of the Committee to the Health Scrutiny Officer for preparing the response document.

RESOLVED

> That the Committee's final response to the consultation by United Lincolnshire Hospitals NHS Trust on its nuclear medicine service be approved.

94 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 94 to 96 of the report pack.

The Committee was advised that the Lincolnshire Acute Services Review – Decision by Lincolnshire Clinical Commissioning Group scheduled for the 18 May 2022 meeting was to be re-scheduled to the 15 June 2022 meeting.

During discussion of this item, the following suggestions/comments were put forward:

- Future commissioning arrangements for dental services, ophthalmology and pharmaceutical services – whether this item currently in the list of items to be programmed could be brought forward to the 15 June 2022 meeting; and
- Membership of the working group to look at mental health provision and suicide prevention. The following members put their names forward: Councillors C S Macey, S R Parkin, T J N Smith, Mrs A White and M A Whittington.

RESOLVED

1. That the Committee's work programme as detailed on pages 94 – 96 of the report pack be received, subject to the comments/suggestions made above and the items agreed at minute numbers 90(2), 91(2) and 92(2).

2. That the working group to look at mental health provision and suicide prevention be comprised of the following Committee members: Councillors C S Macey, S R Parkin, T J N Smith, Mrs A White and M A Whittington.

The meeting closed at 1.52 pm.

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 May 2022**
Subject:	**Chairman's Announcements**

1. Information Requested at Previous Meetings

National Funding for Increasing NHS Dentist Appointments in 2021/22 (16 February 2022)

On 16 February 2022, it was reported to the Committee that the government had announced funding of £50 million to secure 350,000 more dental appointments by 31 March 2022 with NHS dentists. The Midlands NHS region was allocated £8.9 million from this sum and the Committee requested more information on how this would translate to funding and appointments in Lincolnshire. NHS England and NHS Improvement has replied as follows:

"The additional funding was made available to be used within the 2021/22 contractual year and a value of this investment has been dispersed to all regions across NHS England and Improvement (NHSE/I) to address urgent dental care such as oral pain, disease and infection.

"NHS dental practices were encouraged to submit expressions of interest; and it had been anticipated that there would be a good uptake of the investment in Lincolnshire. Locally, 35 additional sessions were commissioned in which NHS teams used the funds to secure increased care capacity amongst local dentists. In comparison to other ICS areas in the East Midlands, the interest from Lincolnshire dentists to deliver additional sessions was considerably lower than in other ICS areas."

The Committee is due to receive an update from NHS England and NHS Improvement on dental services in Lincolnshire on 15 June 2022. It is expected that this report will explore some of the reasons why the take up of the national scheme by Lincolnshire dental practices was so low.

Mental Health Services in Boston Area (13 April 2022)

On 13 April 2022, as part of the item presented by Lincolnshire Partnership NHS Foundation Trust, written answers were requested in response to three questions on mental health services in the Boston area. These responses are attached at Appendix A.

2. Covid-19 Update

Vaccination Programme

The vaccination programme is continuing with the emphasis on calling forward the remaining cohorts of children in the five to twelve age group.

The mass vaccination centre at the Lincolnshire Showground closed on 28 April 2022, as the venue is needed for other activities. The NHS in Lincolnshire is exploring options for an alternative site in the Lincoln area. The Boston mass vaccination centre remains open.

Visiting at United Lincolnshire Hospitals NHS Trust

On 28 April 2022, United Lincolnshire Hospitals NHS Trust announced the reintroduction of patient visiting. All inpatient areas have been given a classification of low, medium, and high risk, reflecting patient conditions and infection prevention and control measures. For each level, different visiting arrangements would be in place. This will be determined at individual patient level, depending upon the risk rating.

All visitors will need to call the relevant ward to book a visit in advance and are asked to come to the main hospital entrance no more than ten minutes before the start of their visiting session. All visitors are asked to wear a hospital-provided face mask throughout their visit, but visitors are no longer required to show proof of a negative lateral flow test.

Latest Data

The latest Lincolnshire data on infection, vaccination and mortality rates will be circulated at the meeting.

3. Acute Inpatient Mental Health Wards in Boston

Currently in Boston acute mental inpatient services are provided at Ward 12 (a traditional dormitory ward) at Pilgrim Hospital. On 13 April 2022, Lincolnshire Partnership NHS Foundation Trust (LPFT) reported to the Committee that it remained committed to eradicating dormitory accommodation in Boston, as work was continuing on clearing the Norton Lea site, which had been identified by LPFT for a new development for its mental health inpatient services in the area.

LPFT has confirmed that demolition work at Norton Lea has been completed. However, LPFT has paused plans for developing Norton Lea, as costs have escalated to over £30 million, which makes it no longer affordable. LPFT has stated that it is developing options for future provision.

4. Grantham Community Diagnostic Centre

On 25 April 2022, the Grantham Community Diagnostic Centre at Gonerby Road was opened to patients. This followed the announcement in October 2021 by the government of funding of £350 million for 40 community diagnostic centres in England, including one in Grantham. The government stated that the community diagnostic centres would achieve:

- earlier diagnoses for patients through a full range of diagnostic tests needed to understand patients' symptoms including breathlessness, cancer, ophthalmology;
- a reduction in waits by diverting patients from hospitals, with a focus on tackling the backlog; and
- reducing the number of patient journeys by providing multiple tests at one visit.

5. Second Community Diagnostic Centre for Lincolnshire

The NHS in Lincolnshire is engaging with the public on a second community diagnostic centre, with the following three options at this stage being put forward (with the text from the engagement exercise listed):

<u>Option 1: Lincoln</u>

- Largest catchment area for both patient demand and workforce
- Would support training facilities and urgent care pathways
- Does not address areas of highest health inequalities (East Coast) or challenges in access

<u>Option 2: Louth Hospital as the main hub, with spoke sites at Skegness and Mablethorpe</u>

- Would help to address health inequalities and some of the access challenge
- Capacity is currently difficult to use at Louth due to patients being unwilling to travel
- North Lincs may be looking at locations in Cleethorpes and Grimsby

<u>Option 3: Boston as the main hub, with spoke sites at Skegness, Mablethorpe and possibly Spalding</u>

- Would help to address health inequalities and some of the access challenges
- Has better transport links to/from the East of county than other two sites

The engagement survey will be open for a period of eight weeks and is due to be considered at the Committee's next meeting on 15 June 2022. This will provide more detail on the proposed options, including the hub and spoke arrangements in options 2 and 3.

6. Stackyard Surgery – Transfer from the Lincolnshire Clinical Commissioning Group

In October 2020, this Committee considered two proposals from the Vale Medical Group, which is based in Croxton Kerrial in Leicestershire. Firstly, Vale Medical Group proposed the closure of the Woolsthorpe Branch Surgery in Lincolnshire. Following consultation and the relevant approval process, this was closed with effect from 1 April 2021. Secondly, Vale Medical Group consulted on an application to transfer from the Lincolnshire Clinical Commissioning Group (CCG) to the East Leicestershire and Rutland CCG.

In April 2022, it was confirmed that NHS England and NHS Improvement had confirmed the transfer application with effect from 1 July 2022. However, also from this date all CCGs will be dissolved, and the East Leicestershire and Rutland CCG, together with two other CCGs will form the Leicester, Leicestershire, and Rutland Integrated Care System.

The Vale Medical Group has advised that the transfer will mean patients can access primary care services in Leicestershire, which were not previously available. Previous impact assessments have indicated that the health and wellbeing of patients would not be affected. However, some patients may see their care transferring from an existing provider in Lincolnshire to an equivalent provider in Leicestershire, for example, community district nursing and mental health services. All patients of existing services will complete their programme of treatment with their current provider, so the transfer arrangements will be over a period of time and the principle of patient choice continues.

7. United Lincolnshire Hospitals NHS Trust – Critical Incident

A critical incident was declared at by United Lincolnshire Hospitals NHS Trust on Thursday 14 April 2022, just prior to the four-day Easter weekend, owing to increased system pressures and disruption to normal services.

8. Appointments to the NHS Lincolnshire Integrated Care Board

Chair

As previously reported to this Committee, Sir Andrew Cash was appointed in January 2022 as the interim chair of the NHS Lincolnshire Integrated Care Board (ICB), which will be formally established on 1 July 2022.

Non-Executive Directors

On 12 April 2022, four non-executive director appointments were confirmed:

- Dawn Kenson, who as a non-executive will lead on service delivery and performance;
- Dr Gerry McSorley, who as a non-executive will lead on the Remuneration Committee, primary care, and East Midlands partnerships;
- Pete Moore, who as a non-executive will lead on audit and risk; and
- Sir Jonathan Van-Tam, who as a non-executive will lead on quality, health inequalities, population health and prevention, and research, education and innovation.

Arrangements for the appointment of the remaining non-executive director are in hand.

Executive Directors

Appointments have already been made to the posts of Chief Executive (John Turner), Director of Finance (Matt Gaunt), and Director of Nursing (Martin Fahy). The process of appointing to the final executive director role, the Medical Director, is in hand.

Partner Members of the ICB

In addition to non-executive and executive director roles, each ICB is required to have at least three partner members, as specified in legislation:

- at least one member nominated jointly by NHS trusts and NHS foundation trusts;
- at least one member nominated jointly by providers of primary medical services; and
- at least one member nominated jointly by local authorities (in this case, one representative from Lincolnshire County Council).

The partner members are appointed to bring the perspective of their sector to the discussions and decisions made by the ICB. They are not appointed as representatives of the interests of any particular organisation or sector. The appointment process for the partner members will be set out in each ICB's constitution.

The Health and Care Act 2022 also requires at least one of the ordinary members (that is members other than the Chair and Chief Executive) to have "knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness". In Lincolnshire this will be achieved through appointment to an additional post on the board to meet this legal requirement.

9. Health and Care Act 2022

The Health and Care Act 2022, which as a Bill began its passage through Parliament on 6 July 2021, received Royal Assent on 28 April 2022. The main provisions of the Act include:

- the establishment of integrated care boards (1 July 2022);
- the discontinuation of clinical commissioning groups (1 July 2022);
- the merger of previous statutory entities, such as the NHS Commissioning Board, the Trust Development Authority and Monitor, into a new legal entity of NHS England

Powers of the Secretary of State on NHS Reconfigurations

As reported to the Committee on 16 December 2021, the Health and Care Bill, as introduced to the House of Lords in November 2022, contained provisions requiring local health systems to notify the Secretary of State of reconfigurations of NHS services; and enabling the Secretary of State to make decisions on the proposed reconfigurations. As a result, the current referral power of health overview and scrutiny committees, which is set out in secondary legislation, would be amended. Amendments were made to these provisions in House of Lords and accepted by the House of Commons. I will update the Committee on any further developments arising from the implementation of the Health and Care Act 2022.

10. Joint Humber and North Yorkshire Health Overview and Scrutiny Committee

The Humber and North Yorkshire Health and Care Partnership is an integrated care system (ICS), which covers six upper tier local authority areas, including North Lincolnshire and North East Lincolnshire.[1] These six upper tier areas are making arrangements to establish a joint health overview and scrutiny committee to review any proposed NHS reconfigurations.

The business of the new joint committee will include consideration of proposed service changes arising from the Humber Acute Services programme, which as previously reported to this Committee, are likely to affect the Diana Princess of Wales Hospital in Grimsby and Scunthorpe General Hospital. These two hospitals, which are operated by Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), receive a significant number of Lincolnshire patients, and in addition NLaG provides some outpatient services at Louth County Hospital. For this reason, it is expected that there will be a facility in the terms of reference to co-opt one representative from the Health Scrutiny Committee for Lincolnshire.

The Health Scrutiny Committee for Lincolnshire would continue to be able to consider and make responses to the consultation on service changes arising from the Humber Acute Programme, which are expected in late summer 2022, or any subsequent consultations affecting Lincolnshire residents.

[1] In addition to North Lincolnshire and North East Lincolnshire, the Humber and North Yorkshire Health and Care Partnership covers (in whole or in part) the local authority areas of the East Riding of Yorkshire Council, Hull City Council, North Yorkshire County Council and the City of York Council.

APPENDIX A

WRITTEN RESPONSES TO QUESTIONS ON MENTAL HEALTH SUPPORT IN BOSTON AREA

(1) *What are you doing to reach out to the foreign national community, because Boston has a significant proportion of people from foreign national areas, particularly eastern Europe?*

From an employment opportunities perspective, the Trust is progressing a number of actions to engage with the eastern European community specifically. We have created a list of local community groups / contacts through which we can promote our job adverts and we are actively researching eastern European groups as part of this work to promote Trust vacancies within them. We are aware of Facebook groups for specific ethnic groups and have planned promotion of adverts through these sites, to reach this audience more effectively.

Rather than making assumptions about the most effective way to engage with the community, we are also communicating with colleagues within the Trust who are from this ethnicity background/community to gain their views/comments on how to effectively highlight our vacancies. We are also considering options around some of our colleagues acting as ambassadors within their communities to promote opportunities.

The Trust is also currently trialling a new method of rolling recruitment for roles where we have a high number of posts across the Trust (for example Health Care Support Workers). In future the recruitment events will be held in various venues across the county and adverts will be adapted to engage with the community groups within the areas where recruitment is taking place. Future events to be held in the Boston area would therefore be designed to engage with local community groups such as eastern European.

(2) *Considering the issue in Ukraine, have you considered the Ukrainian and Russian families in Lincolnshire, but particularly, the Boston area, with relatives in say, Mariupol? If I had family in Mariupol, I would be under stress and if you had children, they would also be feeling that stress, so what are you doing to reach to the Ukrainian and Russian expatriates, who live in this part of the world?*

Most of the foreign national communities are closed communities and most of them do not see government in the same way. They in many cases come from repressive regimes. For them it is more a question what you are doing to reach out to them and to make your services known.

From a workforce perspective, we are working as a system to recruit refugee members of staff, with a focus initially on medical staff and nursing. We have two refugee nurses joining the trust this month from Lebanon.

International qualifications do not always directly match our own, and so we have developed a challenging training programme with clinical examinations to make sure they are qualified to work in England. As they work through that training, we support them to make sure they have got a house and a bank account; and they understand our tax system. This has some resource implications, but we are committed to making this a success. We are being heralded nationally as an organisation that has really pushed forward on international recruitment and there is potential that we could provide the clinical examination training on a regional footprint to support refugees and other international recruits to take up employment in other areas of the country.

With regard to supporting people and their families who might be affected by an international Crises, such as the war in Ukraine. The Trust is well experienced in this area and works proactively with local commissioners and other health and care providers to identify individuals and families that might be in need of support. Our teams provide mental health treatment where that is required, and signpost to partner services for other forms of wellbeing support.

(3) What is your relationship with Boston College, Haven High School or Boston Grammar School, where staff may be picking up on issues? What are you doing to support these schools?

Boston College, Haven High School and Boston Grammar School are all supported by Mental Health Support Teams. The staff within these teams work closely within the schools to offer direct support to pupils who may be experiencing mild to moderate mental health issues by using CBT based therapy as well as offering guidance on whole school approaches to mental health and wellbeing. All 3 schools are also able to access services from Healthy Minds Lincolnshire (HML). HML provides emotional wellbeing support to children and young people aged 0-19 and up to 25 for those who have special educational needs or are considered a Looked After Child. The service provides training in emotional wellbeing to all education staff, student teachers and parents; consultation to education staff and parents; groups of various emotional wellbeing topics to children and young people; and 1-1 interventions using evidence-based practice for children and young people.

(4) There does not seem much provision for Boston generally. It seems like Boston and the east coast is the last area to be considered. I accept, of course, there is a shortage of professionals, but there is a shortage of professionals in all areas of our life. It's not just the health service, every area suffers from a shortage of professionals. It requires a certain level of intellect to do most professional jobs and there is always a shortage of those people.

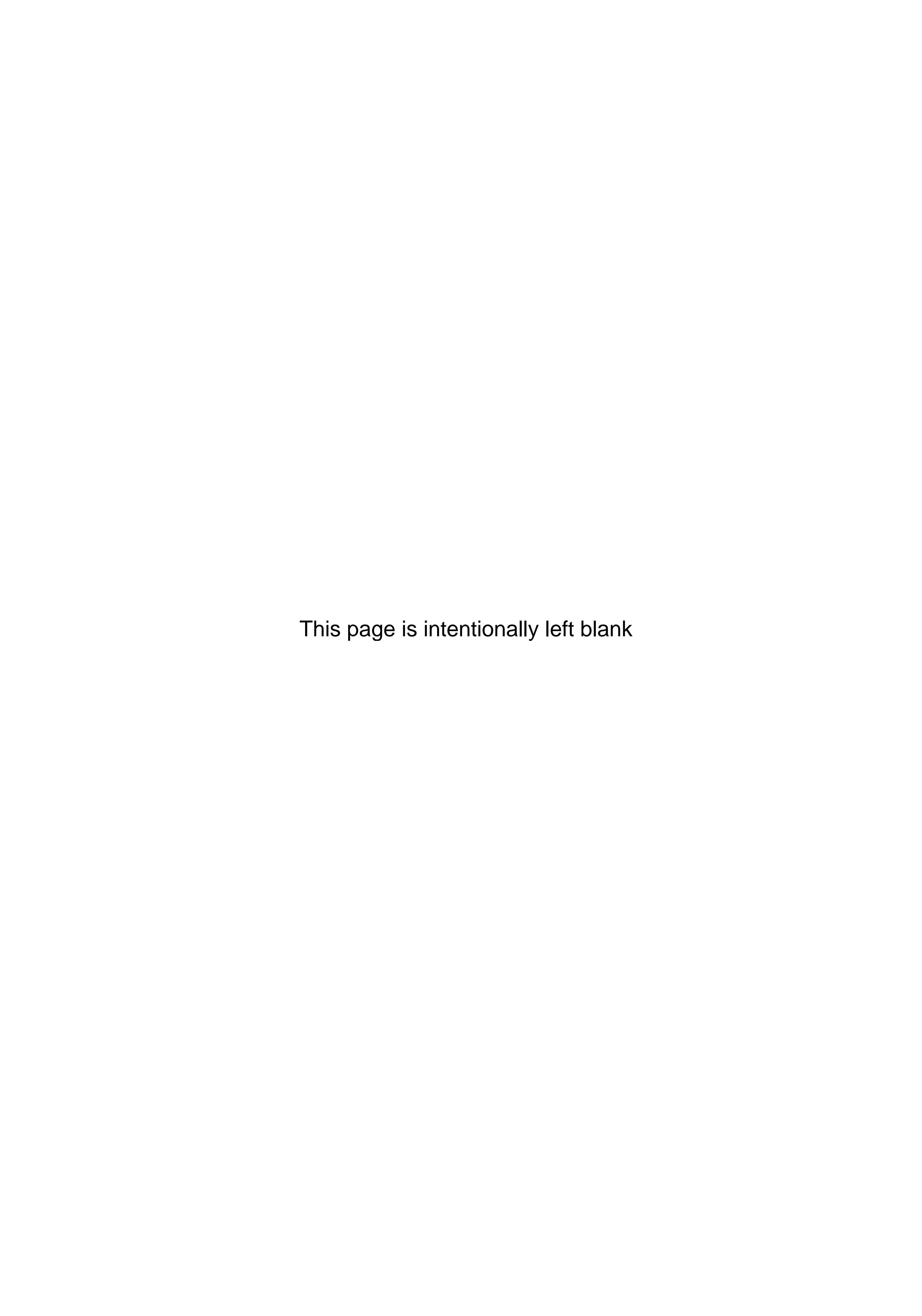
We have a wide range of services in Boston and the east coast, including inpatient wards and a comprehensive community offer. Boston was one of the first pilot sites out of twelve in the country to get investment into a new community mental health transformation programme. This has seen extra investment in community mental health teams, new workers in primary care, new social prescribing workers, and community connector roles for mental health, as well as more community and

voluntary services. This programme of work is developing all the time, and so there is still more to do, but we are now starting to see the positive impact of that work.

You can find out more about that programme through this link: https://www.itsallaboutpeople.info/programmes/mental-health-transformation

One of our newest initiatives is the introduction of new crisis 'Night Light' cafes to support people when they are feeling unable to cope with their mental health alone. We are trying to expand these cafés across the county, ideally having one in every town, but we are reliant upon the charity and voluntary sector to run them and there is currently a lack of capacity on the east coast to get them off the ground. We are therefore actively working with a range of voluntary groups to make sure the capacity is put in place to get these set up in Boston and the east coast.

We are also currently looking at options to upgrade our mental health inpatient unit at Pilgrim Hospital, so it is modern and fit for purpose, and an outstanding environment to treat patients in and for staff work in. We are still working on the details, but this is likely to be a multi-million-pound scheme to improve services for the people of Boston and the surrounding area.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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:	**18 May 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust – Elective Recovery Plan and Response to the Care Quality Commission Inspection**

Summary:

On 16 March 2022, the Committee considered the report of the Care Quality Commission (CQC) on United Lincolnshire Hospitals NHS Trust (ULHT), which was published on 8 February 2022. It was agreed that ULHT would report to this meeting on its actions and further improvements in response to the CQC report and also report on the elective recovery programme for Lincolnshire.

Actions Requested:

To consider the information presented by United Lincolnshire Hospitals NHS Trust on:

(a) The Lincolnshire Elective Recovery Plan 2022/2023

(b) The Response of United Lincolnshire Hospitals NHS Trust to the inspection report by the Care Quality Commission

1. Lincolnshire Elective Recovery Plan 2022/2023

On 8 February 2022, the NHS and the Government published the *Delivery Plan for Tackling the Covid-19 Backlog of Elective Care*. This plan and the NHS's *2022/23 Priorities and Operational Planning Guidance* required each integrated care system to submit its planning priorities for 2022/23 by 30 April 2022. The Committee agreed that the recovery plan would be considered at this meeting.

As required, by the NHS these plans were submitted to NHS England and NHS Improvement in the form of presentations. The relevant extract from this submission relating to Lincolnshire Elective Recovery Plan is set out in Appendix A.

2. Response to the Care Quality Commission Inspection Report

Introduction

As reported to this Committee on 16 March 2022, on 8 February 2022, the Care Quality Commission (CQC) published its inspection report on ULHT and recognised the widespread improvements which ULHT had made in the quality and safety of services since the previous inspection in 2019. The CQC had commented that this was particularly impressive against the Covid-19 backdrop. As a result of the inspection, the overall Trust CQC rating remained 'Requires Improvement', as the overall rating of ULHT could not change as the CQC had not inspected all services on all sites.

The Committee recorded its support for the efforts of United Lincolnshire Hospitals NHS Trust, in making a range of improvements across a number of services, as reported by the Care Quality Care Commission. It was agreed that a further update on improvements in line with the action plan in response to the CQC would be received by the Committee at this meeting.

Background

Following the unannounced Care Quality Commission (CQC) core-service inspection and the announced Well-Led inspection during the months of October and November 2021, the CQC published its findings on 8 February 2022. The Trust responded to the CQC on the 10 March 2022 with a copy of its improvement plan.

Also approved at this time was a revised approach for the Trust to obtain assurance in relation to CQC. One of the approved recommendations was to ensure that board sub-committees receive a 'cut' of the Trust's CQC Improvement Action Plan relevant to their area of focus. Sub-committees began to receive this during March and April. As part of this, the Trust's Quality Governance Committee (QGC) is receiving the full improvement plan on a quarterly basis to undertake a stock take on progress being made. Trust Board will receive the full CQC improvement action plan in response to the 2022 inspection report. A summary presentation is set out in Appendix A.

A full list of CQC required actions following the recent inspection is set out in Appendix C. There were five 'must-do' actions that the Trust had to take in order to comply with its legal obligations. These are detailed below.

Set out in Appendix C is the Trust's improvement action plan in response to the 2022 inspection report, broken down by service/corresponding CBU/Division.

Detailed Review of ULHT ‘Must-do’ Improvement Actions

There were five ‘must-do’ actions that the Trust had to take in order to comply with its legal obligations, to demonstrate compliance with Regulation 12 and 13 of the Health and Social Care Act 2008. These are detailed as follows:

Regulation 12: Safe Care & Treatment
Urgent & Emergency Care

CQC2021-02: Lincoln: *“The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.”*

CQC2021-05: Pilgrim: *“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.”*

ULHT Improvement Action Plan:

- Review and update the ‘Management of Reducing Ambulance Delays in the Emergency Departments’ SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).
- Complete by **31-Mar-22**, referencing the NHS England and NHS Improvement Document (October 2021) ‘Managing ambulance conveyances to hospital’.
- Add the SOP into the Clinical Operational Flow Policy by **31-Mar-22**
- Track effectiveness of SOP with audit of key metrics. Commence audit by **31-Mar-22 and undertake monthly**. This will be a manual snapshot audit.
- Additional milestones will likely be added on completion of the SOP.

Regulation 12: Safe Care & Treatment **Maternity**
CQC2021-03: Lincoln: *"The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment."*
ULHT Improvement Action Plan: • Map out locations across maternity (at both sites) where medicines are stored. **Due on 15-Mar-22.** ***[NB: This action has now been completed]*** • Undertake gap analysis, against medicines management policy key standards for security and storage. **Due on 15-Mar-22.** ***[NB: This action has now been completed]*** • Identify gaps across maternity and ensure mitigating actions in response planned. **Due on 31-Mar-22.** • Understand risks related to routine ambient storage temperatures exceeding 25 degrees and develop risk based mitigation plan with Pharmacy team. **Due on 31-Mar-22.** • Escalation of estate related challenges to storage of medications into estate/division plans for building works. **Due on 30-Apr-22.** • Ensure escalation reporting relating to medicines storage/estate issues feature within PRM content. **Due on 31-Mar-22.**

Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment: **Urgent and Emergency Care**
CQC2021-01: Lincoln: *"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."*
CQC2021-04: Pilgrim: *"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."*
▪ Ensure ED staff have received training in accessing and acting on information from the national system. **Due on 31-Mar-22.** ▪ Ensure ED staff can access the Care Portal system to access the national system. **Due on 31-Mar-22.** ▪ Build training into ED nursing competencies to ensure new staff are trained. **Due on 31-Mar-22.** ▪ Undertake monthly audits of compliance. The first audit has been completed, and repeat monthly assurance audits are commencing **during March 2022**.

3. Mapping of the CQC Improvement Action Plan to Existing Work Streams to Avoid Duplication

A number of the CQC 'Should-do' actions reference areas with existing mechanisms to oversee, escalate and take improvement action. In these instances, to avoid duplication, the CQC Improvement Action Plan cross-references these as separate work streams.

In many instances, these areas are long-term pieces of work to overcome particularly difficult challenges and obstacles (i.e. provide 'sufficient staffing'; staff complete mandatory training in line with Trust targets; estates challenges and continued improvement of medicines management within the Trust).

It is planned in these instances to keep CQC updated with the progress being made towards completion throughout the year, with regular progress updates being written up by accountable owners, approved internally via the appropriate groups and sub- committees. A schedule to plan these throughout the year is being developed to support this aim.

The following areas are mapped within the CQC Improvement Action Plan (Appendix C) to existing internal mechanisms to oversee and take improvement action:

- ***2021-06: 'Should-do'*** *"…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. [**Trust wide**]*
- ***2021-08: 'Should-do'*** *"…providing all staff at every level with the development they need through the appraisal process."[**Trust wide**]*
- Given operational pressures, performance has been impacted, divisions need a recovery plan for performance during 2022/23 towards the Trust aim of 95% and 90% compliance respectively.
- ***2021-07: 'Should-do'*** *"…provide sufficient numbers of nursing and medical staff…[**Trust wide**]*
- ***2021-09: 'Should-do'*** *"…ensure the requirements of duty of candour are met." [Trust wide]*
- ***2021-10: 'Should-do'*** *"…review and manage the work required to improve medicines management across the organisation."[**Trust wide**]*
  The response to the CQC 'should-do' has been linked to medicines management Integrated Improvement Plan (IIP) improvement work being led on by the refreshed task and finish group to prevent duplication. The Medical Director is chairing a medicines management task & finish group.
- ***2021-14: 'Should-do'*** *"…ensure the design, maintenance and use of facilities, premises and equipment keep patients safe."[**Trust wide**]*
  This action is linked to the Business as Usual work to develop the Trust's estate and mitigate gaps identified. This reports through to Finance, Performance and Estates Committee (FPEC). Divisional specific actions in relation to the estate are also captured in service level action plan. Going forward, issues relating to the Trusts estate that hamper progress with CQC actions or that risk patient safety will be flagged and reported on (escalation: Performance Review Meetings & Trust Leadership Team; assurance: Finance, Performance and Estates Committee) in line with revised CQC

Assurance Process. This is a significant risk area given the size and age of the Trust's estate. The Trust needs to be able to demonstrate mitigation when resolution by capital works is not immediately possible.

4. Next Steps

The Trust Board will receive regular updates and any risks to delivery and how these are being mitigated. Progress will be tracked using the Trust's established BRAG ratings. Identified risks to delivery of actions, including those that have elapsed planned timescales, will be escalated into the Trust's Performance Review Meetings and reporting through Executive and Trust Leadership Team meetings.

A revised approach to obtaining assurance linked to CQC has recently been approved. This will now be implemented for all elements of the Trust's monitoring and management of action in response to the 2022 inspection report, as well as other improvement actions identified from the wider context of the inspection report (that did not result in 'must/should-do' actions and also elements of the 2019 inspection report where further embedding is required.

The approved process includes the following elements:

- Investment in time across all Divisions to develop / strengthen process for the delivery of clinically led improvement actions, with regular update meetings with the compliance team and integration of escalation/assurance reporting into established governance arrangements;
- Establishment of a divisionally led 'assurance' process to sign off action(s)/milestone(s) as complete, based on robust collation of evidence. Additionally, through regular engagement with and supported by the Compliance team, Divisions to retain oversight and seek ongoing assurance that improvement work remains embedded; or take appropriate remedial action to recover improvement plans;
- Development of effective and regular communications to teams, within Divisions and the wider Trust, to share and celebrate improvements and achievements;
- Establishment of a formal Executive 'assurance' process (Director of Nursing and Medical Director) to strengthen internal assurance of completion and closure of improvement actions and form a gateway to enable regular and robust updates to external regulators on progress with improvement actions and sharing of progress updates for improvement activities against difficult/challenging issues;
- Review and strengthen escalation and assurance reporting linked to CQC/external regulators through existing channels:
  - Trust's Performance framework;
  - Executive Leadership Team / Trust Leadership Team;
  - Sub-committees/Trust Board;
  - Quality Governance Committee (QGC) oversight and taking a periodic 'stock-take' of progress.
- Linked to the CQC external updates, will be a regular internal update for ULHT staff to ensure a 'CQC said, we did' communications feed.

5. Consultation

This is not a direct consultation item.

6. Conclusion

The Committee is invited to consider the information presented on the Lincolnshire Elective Recovery Plan 2022/23 and the action plan in response to the Care Quality Commission inspection report of February 2022.

7. Appendices These are listed below and attached to the report.

Appendix A	Lincolnshire Elective Recovery Plan 2022/23
Appendix B	Care Quality Commission Summary Response
Appendix C	Full List of 'Must Do' and 'Should Do' Actions
Appendix D	CQC Improvement Action Plan

8. 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 United Lincolnshire Hospitals NHS Trust.

APPENDIX A

LINCOLNSHIRE ELECTIVE RECOVERY PLAN 2022/2023

Lincolnshire NHS

Lincolnshire Elective Recovery Priorities

Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

Deliver more elective care

- Our ambition is to deliver more elective care than pre-pandemic i.e. 104% of the elective activity delivered in 2019/20 and 120% of the diagnostic activity delivered in 2019/20. This will be done at system level which includes our Independent Sector Providers.
- In terms of reducing long waits, 104-week waits will be eliminated by June 2022 and 78-week waits will be at zero by 01/04/23
- The recovery of non-admitted outpatient activity recovery will be supported through: strengthened advice & guidance; growth in patient initiated follow-up and virtual consultation; efficient clinic utilisation; referral optimisation via the Elective Activity Coordination Hub
- The recovery of admitted patient activity will be supported through: the High Volume, Low Complexity programme; theatre utilisation; clinical prioritisation; use of independent sector providers which has been developed with the support of the 'Getting It Right First Time' Team and Grant Thornton
- Continue with the development of Community Diagnostic Centres including expanding the services at Gonerby Road, Grantham Community Diagnostic Centre and drafting a business case for a further Community Diagnostic Centre in the County

Improve performance against all cancer standards

- There will be a strong system focus on improving cancer waits and outcomes for patients during 2022/23 with a key focus on reducing the backlogs and improving waiting times.
- We will return the number of people waiting for longer than 62 days, from 424 in April 2022 to 149 in March 2023
- Improve delivery of the 62-day urgent referral to first treatment standard: move from 57% in February 2022 to 85% in March 2023
- Increase diagnostic throughput and achievement of the 28-day faster diagnosis standard: move from 53% in February 2022 to 75% in March 2023
- Refine delivery of the 31-day decision-to-treat to first treatment standard: move from 89% in February 2022 to 96% in March 2023
- There will also be a focus on the non-specific site (NSS) pathway: ensure that 100% of GP practices have access to a Rapid Diagnostic Concept NSS pathway

Lincolnshire Elective Recovery Priorities

Using our collective resources more effectively and equitably

In delivering the priorities outlined above it will require a shift in approach to focus on population health outcomes, improving the stability of our workforce including developing new roles and reducing the usage of agency staff, along with accelerating our adoption of digital technologies.

Workforce

- Total workforce establishment increasing by 420 WTE, with substantive staff in post increasing by 531 WTE.
- Initially, agency reducing by 174 WTE and bank usage reducing by 55 WTE. Further significant reductions are currently being planned.

Population health management, prevention and health equity

- Using data and analytics in service planning and delivery, with a focus on targeting the most relevant patient cohorts and improving access and health equity for underserved communities. Specific 22/23 priorities: progressing the development of the ICS intelligence function and a Population Health Management implementation roadmap; creating the supporting digital infrastructure
- Prevention: implementing tobacco dependency services in NHS services; establishing a CVD & respiratory prevention programme; Targeting weight management, alcohol, TB and diabetes

Digital

- Exploiting digital technologies to transform the delivery of care and patient outcomes: initiating the Lincolnshire electronic patient record; expanding the care portal and patient portal; using the National Electronic Referral System; introducing care home remote clinical observation kits and new monitoring at home services; supporting virtual wards; establishing system-level sharing and governance of health and care data

Finance:

- The system has a trajectory to deliver financial balance over the next 3 years.
- The 22/23 financial plan: strips out COVID-related costs; minimises inflationary pressures as far as possible; includes only those investments that respond to nationally-mandated priorities and/or system transformation that will deliver savings and quality improvement

Activity & Performance | Achievement of Key Targets

Planned Care	
104% of Activity Levels for Electives against 2019/20	104% (System) 107.5% (ULHT)
104% of Activity Levels for Daycase against 2019/20	104% (System) 104% (ULHT)
104% of Activity Levels for Outpatient Firsts 2019/20	104% (System) 104% (ULHT)
75% of 19/20 Outpatient Follow Ups by March	*With further development of patient initiated follow ups and virtual consultations the plan for 75% is still under review.*
120% of 19/20 Diagnostics	c120.7% (ULHT)
130% of 19/20 Activity Levels for Independent Sector Providers	c132% (Elective and Daycase)
Eliminate 78 week waits by March 2023	ULHT - 0 In March 2023
16% specialist advice	18.7% - in March 2023
5% Patient Initiated Follow Up Appointments	** As per above* ULHT Plan c4.1% in March 23
25% non face to face appointments	28% ULHT

Key Risks

- Non-elective pressures/capacity: Continued occurrence of critical and major incidents that impact on availability of workforce; Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds;

- COVID: continued COVID pressures on staff sickness and isolation as well as patients cancelling appointments and surgery at short notice

- Workforce: Significant workforce issues (sickness & absence; Reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; Inability to ring-fence cancer capacity - complexities across planned and urgent care programmes; Reluctance to undertake additional sessions due to exhaustion; Heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual)

- System financial position: System financial situation is challenging before adding additional cost to recover waiting lists

- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time

- Additional diagnostic demand: is expected when starting to clear the outpatient waiting lists, this whilst recovering from the fire at Lincoln County will be challenging

APPENDIX B

RESPONSE TO CARE QUALITY COMMISSION REPORT – SUMMARY PRESENTATION

Key Milestones:

Date:	Event:
5-8 October 2021	Unannounced CQC Core Service Inspection Focused inspection on Children & Young People, Urgent and Emergency Medicine (UEC) and Medical care (including older people's care)
9-11 November 2021	Announced CQC Well-Led Inspection
8 February 2022	CQC Inspection Report Published
03 March 2022	Divisions and Corporate Action Leads approve the ULHT CQC Improvement Action Plan
10 March 2022	Trust submitted to CQC the ULHT Improvement Action Plan and Strengthened CQC Assurance Process approved by Executive and Trust Leadership Tea
05 April 2022	Public Board receive first quarterly update report on progress (Attached)
w/c 12 April 2022	ULHT Sub-committees of the Board commence receipt of their 'cut' of the action plan f assurance
22 April 2022	Executive Leadership Team receive copy of the action plan for escalation and assurance
w/c 25 April 2022	For escalation purposes, action plan reported, by exception, at Divisional Level Perfor Review Meetings (PRM)
Future:	
13 May 2022	First Executive Led CQC Assurance Meeting
05 July 2022	Public Board: Update on progress (Quarterly update)

OUTSTANDING CARE personally DELIVERED 2

Strengthened approach to CQC Assurance:

- The Trust has reviewed and strengthened its approach to assurance with CQC, this was approved on the 10 March 2022 and is in the process of being implemented.
- This includes the following key features:
  - Development of clinically owned improvement actions by Divisions;
  - Strengthened confirm/challenge of actions thought to have been completed, using evidence. First stage for divisional confirmation with second stage executive-led review and confirmation;
  - Regular communications internally and with CQC;
  - Strengthened escalation and assurance reporting via:
    - Divisional Performance Review Meetings (PRM)– Escalation
    - Executive & Trust Leadership Team Meetings – Escalation and assurance
    - Sub-committees of the Board and Trust Board – Assurance
  - Proactive review of CQC standards to identify gaps or risks

Key points to note:

- The Trust Board receive updates on progress with the ULHT CQC Improvement Action Plan on a quarterly basis
- A copy of the update report provided to Public Board on the 5 April 2022 has been attached for HOSC information
- There are no significant issues to escalate at this stage from the CQC Assurance Process
- Trust Board will next receive an update on the 5 July 2022

Public Trust Board Update:

- Copies of the Public Trust Board update received on the 5 April and the associated appendix has been issued separately for Health Overview and Scrutiny Committee information

APPENDIX C

Full List of CQC 'Must' & 'Should-dos':

URN	Core Service	Trust/ Site	'Must-Do'	CQC Requirement
CQC2021-01	Urgent and emergency care	Lincoln County Hospital	Must Do	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.
CQC2021-02	Urgent and emergency care	Lincoln County Hospital	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.
CQC2021-03	Maternity	Lincoln County Hospital	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.
CQC2021-04	Urgent and emergency care	Pilgrim Hospital	Must Do	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.
CQC2021-05	Urgent and emergency care	Pilgrim Hospital	Must Do	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.

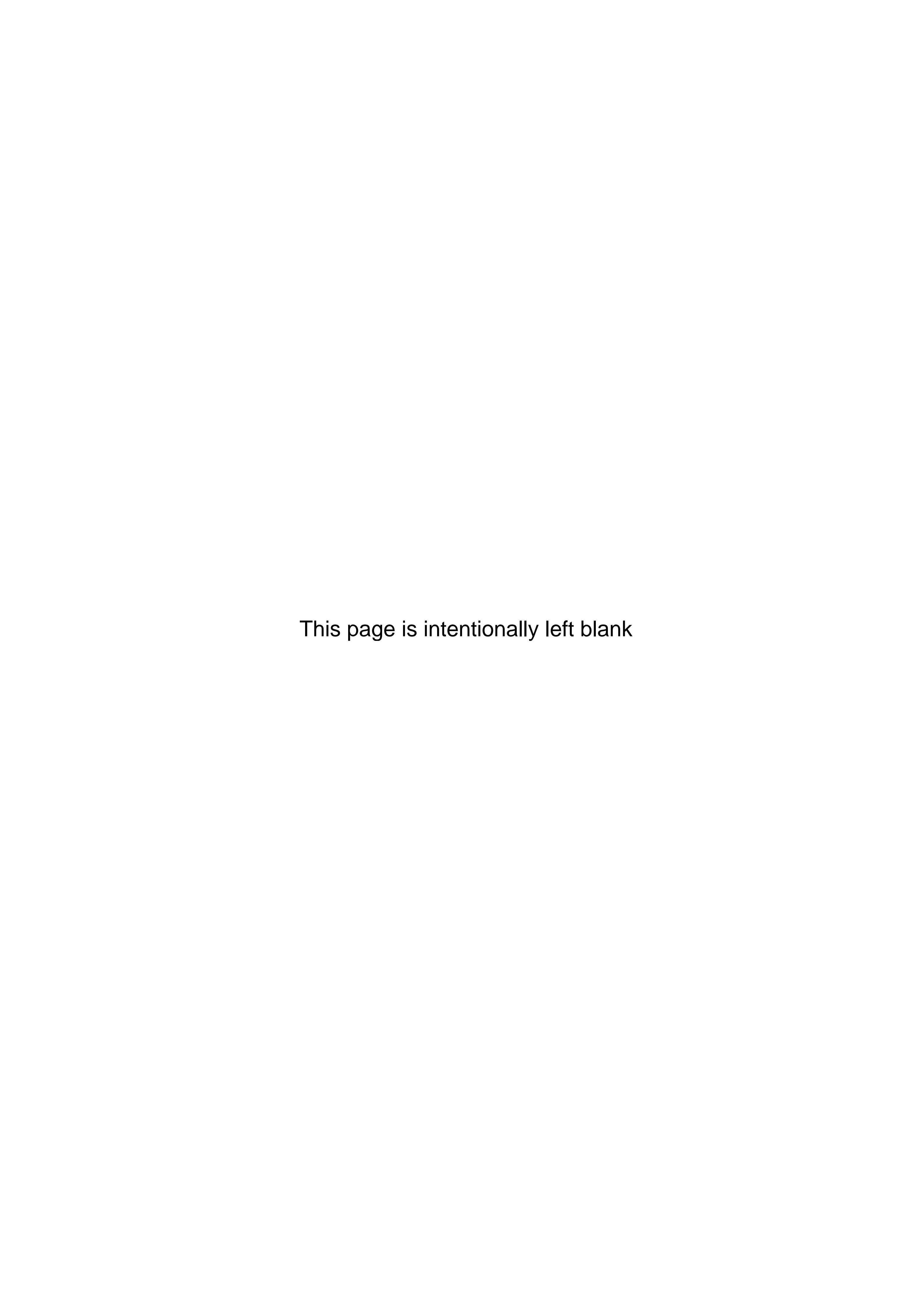
URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-06	Trust wide	Trust	Should Do	The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.

URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-07	Trust wide	Trust	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
CQC2021-08	Trust wide	Trust	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.
CQC2021-09	Trust wide	Trust	Should Do	The trust should ensure the requirements of duty of candour are met.
CQC2021-10	Trust wide	Trust	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.
CQC2021-11	Trust wide	Trust	Should Do	The trust should ensure they are using timely data to gain assurance at board.
CQC2021-12	Trust wide	Trust	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.
CQC2021-13	Trust wide	Trust	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.
CQC2021-14	Trust wide	Trust	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.
CQC2021-15	Urgent and emergency care	Lincoln County Hospital	Should Do	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.
CQC2021-16	Urgent and emergency care	Lincoln County Hospital	Should Do	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).

URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-17	Urgent and emergency care	Lincoln County Hospital	Should Do	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.
CQC2021-18	Urgent and emergency care	Lincoln County Hospital	Should Do	The trust should ensure effective systems are in place to review the service risk register.
CQC2021-19	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.
CQC2021-20	Children and young people	Lincoln County Hospital	Should Do	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.
CQC2021-21	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure cleaning records are completed as per trust policy.
CQC2021-22	Children and young people	Lincoln County Hospital	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.
CQC2021-23	Children and young people	Lincoln County Hospital	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.
CQC2021-24	Children and young people	Lincoln County Hospital	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.
CQC2021-25	Children and young people	Lincoln County Hospital	Should Do	The trust should consider adding specific action plans to the service risk register.
CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.

URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.
CQC2021-28	Maternity	Lincoln County Hospital	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.
CQC2021-29	Maternity	Lincoln County Hospital	Should Do	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.
CQC2021-30	Maternity	Lincoln County Hospital	Should Do	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.
CQC2021-31	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.
CQC2021-32	Urgent and emergency care	Pilgrim Hospital	Should Do	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.
CQC2021-33	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.
CQC2021-34	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.
CQC2021-35	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
CQC2021-36	Urgent and emergency care	Pilgrim Hospital	Should Do	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).

URN	Core Service	Trust/ Site	'Should-Do'	CQC Requirement
CQC2021-37	Urgent and emergency care	Pilgrim Hospital	Should Do	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.
CQC2021-38	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.
CQC2021-39	Urgent and emergency care	Pilgrim Hospital	Should Do	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.
CQC2021-40	Urgent and emergency care	Pilgrim Hospital	Should Do	The trust should ensure effective systems are in place to review the service risk register.
CQC2021-41	Children and young people	Pilgrim Hospital	Should Do	The trust should consider all key services being available seven days a week.
CQC2021-42	Children and young people	Pilgrim Hospital	Should Do	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).
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Should Do	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.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CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 10/03/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	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.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 95% to have completed mandatory training. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Amber		Mandatory training reporting at Divisional PRMs; Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

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CQC2021-07	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.	All	The Trust has already established work streams focussed on ensuring sufficient nursing and medical staff. The Nursing work stream includes the process for twice daily oversight arrangements, annual nurse staffing reviews for all ward areas led by the Director of Nursing and reporting through to Trust Board. This is supported by the Trust's 5-year workforce plan which includes new and emerging roles. Key performance indicators to be included to summarise progress along with highlight reporting.	Helen Clark (Assistant Director of Nursing for Workforce & Education) Claire Low (Deputy Director of People) Lisa Geraghty (HR)	31-Mar-23	Amber		Reporting to PODC committee on progress with workforce plans; Progress with key workforce indicators.	(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

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CQC2021-08	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 90% to have an appraisal. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Amber		Mandatory training reporting at Divisional PRMs; Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (3) Assurance reporting through to People and OD committee.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well- established governance oversight.]	Divisional/CBU Leads (see Divisional / CBU CQC Improvement Action Plans)	31-Dec-2022	Amber		DoC performance data demonstrates timescales are routinely met; Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met; (2) Oversight through PRM process.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	All	The Trust have an established improvement programme of work in place to review and manage the work required to improve medicines management. Medicines management related themes and findings from the CQC inspection have been included within this programme of work. The Medical Director chairs the Medicines management T&F group to oversee delivery of this work. Key performance indicators will be scoped and included to summarise progress along with highlight reporting.	IIP Improvement Project focussing on Medicines Management	Various	Amber		Assurance reporting from IIP programme of work; Assurance reporting into QGC sub-committee.	(1) Assurance reporting from IIP programme of work; (3) Assurance reporting into QGC sub- committee.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well- established governance oversight.]	Divisional/CBU Leads (see Divisional / CBU CQC Improvement Action Plans)	31-Dec-2022	Amber		DoC performance data demonstrates timescales are routinely met; Performance with timescales for SI investigations are met.	(3) DoC performance data demonstrates timescales are routinely met; (4) Performance with timescales for SI investigations are met; (2) Oversight through PRM process.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	All	The Trust have an established improvement programme of work in place to review and manage the work required to improve medicines management. Medicines management related themes and findings from the CQC inspection have been included within this programme of work. The Medical Director chairs the Medicines management T&F group to oversee delivery of this work. Key performance indicators will be scoped and included to summarise progress along with highlight reporting.	IIP Improvement Project focussing on Medicines Management	Various	Amber		Assurance reporting from IIP programme of work; Assurance reporting into QGC sub-committee.	(3) Assurance reporting from IIP programme of work; (4) Assurance reporting into QGC sub- committee.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	All	Provide a paper to FPEC considering options available in response to CQC Should-do action. Establish additional milestones in response to actions agreed at FPEC.	Shaun Caig (Associate Director of Performance & Information)	30-Apr-2022	Amber		Paper to FPEC summarising options; Actions agreed in response.	(5) (1) Board reporting of performance.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Update Trust provision of information to patients policy (ULHT-NUR-PPI-PDWPI) to include process for escalation to PEG should 'information owners' not update existing information resources in line with periodic, 2 yearly review dates.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Amber		Revised policy in draft.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Approve new policy at PEG.	Sharon Kidd (Patient Experience Manager)	10-May-22	Amber		Minutes of PEG demonstrating approval of policy.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refine quarterly PEG update report regarding patient information to include escalation of specific areas/owners of overdue patient information.	Sharon Kidd (Patient Experience Manager)	30-Apr-22	Amber		Revised PEG update; Minutes from PEG when update received.	Evidence from information resource register showing ongoing work to update information with escalation to PEG for those overdue review; Evidence that overdue information is being risk stratified and escalated accordingly to PEG; Outcome evidence: reducing numbers of overdue patient information.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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						All	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	plan owners (with support from FAB	Set with divisions.	Amber		Evidence of listening opportunities from divisions to identify information resources required by local population.	Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to assign 'information owners' to provide information resources in response to feedback from local patients.	Who: Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of listening events with patients.	Amber		Evidence of information resources completed in response to listening events with patients; Evidence of these resources being entered onto the information resource register (held by Patient Experience team).	Metrics for ongoing assurance: Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	Divisional CQC action plan owners to nominate	Set with divisions.	Amber		Register of locally held patient information resources being provided to patients.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
						All	Patient Experience team to update the Trust central register with findings from the walk-around/audit and compare and contrast with Trust standards for patient information and determine if further action is required to update the information being provided (i.e. update/refresh the information - Divisional lead required; or update the format - Patient Experience team).	Scope out action needed on completion of audit and scope of work better understood.	Set on completion of audit and scope of work better understood.	Amber		Updated central register of patient information available and work required as a result of audit/updated register.	Evidence from Patient Experience team that patient information in use is in keeping with Trust approved standards and formatting through ongoing reporting to PEG/links to electronic information available in multiple languages via MS Edge.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Refresh Patient Experience strategy and determine KPIs relating to the provision of patient information.	Jennie Negus	30-Apr-22	Amber		Refreshed patient experience strategy with KPIs to support delivery.	Update reporting on progress with strategy to PEG and measurement against agreed KPIs.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd (Patient Experience Manager)	31-Mar-22	Amber		Copies of resource available; Scope out further milestones required/timescales/ leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-14		Trust	Core services inspection	Should Do		All	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Amber		Scoped out detail of what resources would support improved communication with patients presenting in UEC; Scope out further milestones required/timescales /leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14		Trust	Core services inspection	Should Do		All	Patient Experience team to liaise with specialist teams (i.e. Learning Disability CNS) and review patient/service user feedback to determine if further information in easy read is required, and scope additional milestones/timescales accordingly.	Sharon Kidd (Patient Experience Manager)	30-Mar-22	Amber		Scoped out detail of what resources are required and a plan to deliver; Scope out further milestones required/ timescales/ leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14		Trust	Core services inspection	Should Do		All	Scope out plan for translation of internal information resources into different languages.	Jennie Negus (Head of Patient Experience); Sharon Kidd (Patient Experience Manager)	30-Apr-22	Amber		Plan for translation of patient information resources.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities,	All	Service specific actions relating to the estate (i.e. the £37m development of a new Emergency Department at Pilgrim) are outlined within the service level improvement action plans.	For further detail see the service level improvement action plans.	For further detail see the service level improvement	Amber			For further detail see the service level improvement action plans.	the service level improvement action	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

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					premises and equipment keep patients safe.	All	Undertake a 6-facet survey to refresh the Trust's understanding of current estate conditions to further support the Trust to take a risk based approach.	Michael Parkhill (Director of Estates & Facilities)	31-Dec-22	Amber		Evidence of findings from 6- facet survey; Evidence of inclusion of key areas from the 6-facet survey into the Trust's estate plans.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						All	The Trust is continuing to focus on strengthening its Planned Preventative Maintenance (PPM) regime with ongoing assurance reporting through the Trust's Finance, Performance and Estates Committee. This is supported by the appointed Authorising Engineers (AEs) across the Trust focussed on all aspects. The Premises Assurance Model (PAM) provides a key assurance function as part of this process. This is a business as usual action.	Michael Parkhill (Director of Estates & Facilities)	31-Mar-23	Amber		FPEC assurance reporting of progress with planned preventative maintenance regime; FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; PAM assurance reporting into FPEC; FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; AE reporting from key subgroups (i.e. water, fire,	(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; AE reporting from key subgroups (i.e. water, fire, electrical).		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 10/03/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

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CQC2021-01	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	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.	UEC	The flowchart describing the correct process has been reinforced within ED. This will be supported by the Safeguarding team who have commenced education work with key staff as part of team huddles and supervision sessions. This education work will be completed by 30 November 2021. A record of staff trained will be maintained for assurance.	Elaine Todd (Named Nurse for Safeguarding Children and Young People); Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie Peet and Sharon Laverton / Vikki Hoadley (ED Clinical Educators)	31-Mar-2022	Amber		(1) Training records for ED staff; (2) Evidence of this being added to UEC risk register.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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CQC2021-04	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	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.	UEC	A compliance audit was already planned by the Safeguarding team, this will be undertaken as planned on this process retrospectively and will be completed by 5 November 2021. A re-audit will be undertaken following delivery of educational sessions. This will be completed by 31 January 2022.	Elaine Todd (Named Nurse for Safeguarding Children and Young People)	31-Jan-2022	Green		(1) Audit findings / report; (2) Action plan in response.	(1) Monthly audit to be undertaken to test compliance.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	A list of those who cannot access care-portal within ED is needed and then access needs to be requested from IT.	Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Amber		(1) Evidence of access arrangements to Care Portal being in place for existing staff.	undertaken to test compliance; (2) Evidence this has been added to Nursing induction as		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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						UEC	Include within ED nursing competencies Safeguarding and access to the National Child Protection Register spine to ensure this training/education is provided on a routine and regular basis.	Maxine Skinner (Lead Nurse Urgent & Emergency Care) Ellie and Sharon (ED Clinical Educators)	31-Mar-2022	Amber		(1) Inclusion of Safeguarding training as part of induction programme for new starters; (2) Inclusion of access to the Care Portal system as part of the induction programme for new starters.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	Implement monthly audit process to monitor compliance and to provide assurance that process is fully embedded.	Tracey Wall (Divisional Nurse); Craig Ferris (Head of Safeguarding)	31-Mar-2022	Green		(1) Monthly audit data; (2) Action plan in response; (3) Findings from audit demonstrate compliance.	compliance; (2) Reporting to appropriate UEC governance arrangements;		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-02	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	UEC	Assurance data that patients waiting in ambulances are seen by a doctor.	Cheryl Thomson (General Manager)	01-Nov-2021	Green		(1) 30-Sept-21 Information report which shows first location and time seen; (2) Ambulance handover SOP: Section 2.5; (3) S.31 CQC full assurance report; tab 1 'triage times'; tab 9 '60 mins'.	and location first seen; (2) CQC full assurance documentation – tab 1 focus on triage;	The evidence supplied provides assurance that patients waiting in ambulances, due to capacity bottlenecks with the Emergency Department, are seen and assessed by a doctor whilst in the ambulance. This mitigates the risk of harm to patients waiting outside of the Emergency	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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CQC2021-05	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Must Do	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	UEC	Inclusion of additional field into the Harm template to ensure this is more clearly evidenced from harm reviews.	Cheryl Thomson (General Manager)	01-Nov-2021	Blue		(1) Email request for the UEC harm reviews to include a specific field to capture the time patients receive their first assessment; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews	This additional field makes it easier, at the time of undertaking a harm review, for harm to be accurately assessed related to waiting times/locations.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						UEC	within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.	PHP log not felt to be best solution, amendments to CAS card instead have been made that include location of the patient when handed over.	Blanche Lentz (Clinical Services Manager UEC)	Amber	31-Mar-2022			(1) Amended casualty card.	(1) Audit evidence of the new CAS card being used in practice and recording where patient has been seen – including ambulance.	

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						UEC	Develop clinically led standardised admission pathways guidance to support ED teams identify: . The primary specialty to take ownership for the ongoing care from the ED . If necessary, and additional MDT input required, this will be undertaken by the primary speciality. These have been agreed by the group, this was ratified during May and June 2021.	Urgent Emergency Care Clinical Standards Group		Blue		(1) Copy of the standardised admission pathway guidance; Minutes from the Urgent Emergency Care Clinical Standards Group evidencing approval of guidance.	(1) Copy of the standardised admission pathway guidance.	Clinically agreed guidance exists to support the Emergency Department consult and seek assistance from specialties for patients waiting in the department. The guidance includes a commitment for specialties to pull patients out of the Emergency Department. Evidence of impact from these standardised admission pathways is now needed.	Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Review and update the 'Management of Reducing Ambulance Delays in the Emergency Departments' SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).	Cheryl Thomson (General Manager)	31-Mar-2022	Amber		(2) (1) Revised SOP completed and approved.	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them; Evidence that SOP has a timely review date to ensure guidance remains updated and fit for purpose.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Add the SOP into the Clinical Operational Flow Policy.	Michelle Harris (Deputy Chief Operating Officer)	31-Mar-2022	Amber		(3) (1) Revised SOP included within the Clinical Operational Flow Policy.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						UEC	Revised SOP to include effectiveness measures to track progress with key metrics: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking to provide ongoing assurance against SOP.	Cheryl Thomson (General Manager)	31-Mar-2022	Amber		(4) (1) Evidence of effectiveness measures for ongoing monitoring of performance against key metrics.	(1) Evidence that performance with key metrics, as part of revised SOP, are being used for ongoing monitoring of performance against key metrics; Evidence of audit data being used for improvement purposes.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	In the interim, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment ≤ 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(5) (1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit; (2) Evidence of audit data being used for improvement purposes.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Scope out the inclusion of performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking as part of the Trust's Clinical Audit Programme to provide further external assurance.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	30-Apr-2022	Amber		(6) (1) Development of Clinical Audit Project plan.	(2) None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Develop an audit tool to obtain this assurance with key milestones. Feed into monthly CBU governance reporting process (escalations to divisions and PRM).	Jeremy Daws (Head of Compliance)	31-Mar-2022	Amber		(1) Completed audit tool; (2) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	(1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						UEC	Add into Harm Review proforma - Has patient been seen within 1 hour. Review in 3 months to see if this is giving assurance needed.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-Mar-2022	Amber		(1) Email request for the UEC harm reviews to include a specific field to capture this; (2) Copy of amended harm template.	(1) Random, snapshot sample of UEC Clinical Harm reviews		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Provide a monthly overview of performance against these key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking. In addition to other related metrics (i.e. time to first assessment etc.) to Governance meeting process.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Apr-2022	Amber		[2] (1) Ongoing monthly assurance reporting.	[5] (1) Ongoing monthly assurance reporting.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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						UEC	Build monthly assurance reporting of key milestones into one of the standard ED assurance processes so this becomes a standard feature of the ED assurance process.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	31-May-2022	Amber		(3) (1) Ongoing monthly assurance reporting.	(6) (1) Ongoing monthly assurance reporting.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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CQC2021-35	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (4) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (7) Completed harm reviews.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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CQC2021-33	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

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CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Understand performance with DoC at CBU Level and ensure reliable data is available to feed into monthly Clinical Governance processes.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements; (3) Inclusion within the Divisional PRM process.	(1) Ongoing regular reporting of DoC into CBU Governance; (4) Ongoing inclusion within the Divisional PRM process.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						All	Review DoC performance data and, through CBU Governance, scope additional improvement actions to be taken.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(2) (1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.	(2) (1) Use of data to inform improvement action plans.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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CQC2021-12		Trust wide Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits in place currently that monitor this, but this is a recurrent problem. Senior Sisters and Lead Nurse to meet to refine the contents of the B7 daily assurance process which will support proactive action to address performance issues.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Amber		(3) (1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (3) Improvements in the security of records observed.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)
						All	Review availability of CAS card trolleys availability at Pilgrim.	Holly Carter (Senior Sister, ED)	30-Apr-2022	Amber		(4) (1) Evidence of a review of note storage controls and identification of any gaps.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in the security of (2) records observed.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

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CQC2021-13	Trust wide		Trust	Core services inspection	Should Do	UEC		do not currently exist (including UEC and advice cards).	Cheryl Thomson (General Manager)	Amber		(5)	(3) (1) Inclusion of patient information within the UEC Governance meeting process/schedule.	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.		Karen Dunderdale, Director of Nursing
						UEC	Undertake a review of the patient information and identify any gaps where additional information is required.	Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Amber		(1) Evidence of undertaking review of information resources currently available; (2) Review at Governance of review and any gaps identified where further (6) resources are required.	(4) None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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						UEC	Collate a register of information resources in use within UEC and submit this to the Patient Experience Team to support the strengthening of internal document control processes in relation to patient information.	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	30-Jun-22	Amber		(1) Register of information resources currently available.	(1) Ongoing review of information resources available and at UEC Governance as evidenced by document control register.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.	Sharon Kidd	31-Mar-22	Amber		Copies of resource available; Scope out further milestones required/timescales/leads at this time.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

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						UEC	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	UEC leads with support from Patient Experience Team.	30-Apr-22	Amber		(1) Scoped out detail of what resources would support improved communication with patients presenting in UEC; (2) Scope out further milestones required/timescales/leads at this time.	(7) None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	Scope out employment for a play specialist for ED area.	Bowler (Senior	30-Sep-2022	Amber		(1) Scoped out plan for recruitment of a play specialist.		None.	Evans, Chief Operating	nce and Estates
						UEC	Review arrangements for 1:1 supervision of patients with mental health needs at Lincoln ED.	Jemma Bowler (Senior Sister, ED)	30-Sep-2022	Amber		TBC		TBC	Simon Evans, Chief Operating Officer	Performance and Estates Committee

					UEC	Consider addition of the mental health room (location and staffing oversight) to the departmental risk register.	Jemma Bowler (Senior Sister, ED)	30-Apr-2022	Amber		(1) Evidence of risk scoping and mitigation actions considered.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
					UEC	New ED at Pilgrim which is valued at £37m and is at the full business planning stage. This is scheduled for Trust Board approval in April, and then for final approval by NHSE/I. Enabling works (included decant of staff) have begun. Build to progress over the next 2 years. Determine if dementia friendly aspects have been included in the plans.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Amber		TBC	TBC		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CQC2021-15	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	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.	UEC	Process for assessing falls risk has been changed to being assessed on entry to ED by the PHP. Once identified as at risk of falling, yellow socks, yellow wristband and falls risk assessment document completed. Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate this into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Amber		(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with falls risk assessments.			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-34	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.	UEC	A review of the transfer document has been held with UEC and Quality Matrons. The UEC transfer documentation has been merged with the Trust's transfer documentation and SOP. Transfer documentation has been replaced with a sticker, in SBAR format, to be applied to the CAS card and completed in ED before the patient is transferred. Limited supplies of the sticker are available, to launch pilot when there is a greater stock of stickers.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Amber		(1) Launch of pilot utilising the newly fashioned transfer stickers; (2) Copy of revised sticker; (3) Evidence of communications to staff regarding pilot.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						UEC	Review effectiveness of pilot to determine if supportive of improved documentation.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	Amber		(1) Evidence of performance with completion of transfer sticker documentation; (2) Additional actions if needed to support improvements.	(1) Ongoing evidence of audit outcomes demonstrating improved recording and documentation of transfer information via the sticker.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						UEC	Meeting with Senior Sisters, Matron and Lead Nurse to be held to incorporate mental health risk assessment completion into the B7 daily assurance review process.	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	31-Mar-2022	Amber		(1) Amended B7 Daily assurance proforma.	(1) Action in response to the review and inclusion as part of the B7 daily assurance process; (2) Improvements in performance with mental health risk assessments.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-16	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	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).	UEC	Provide written clarification with evidence to CQC on the following points: .The Paediatric area within the ED, whilst moved to a distinct part of the department, is retained within the UEC management and governance structure. .There is a 24/7 nominated lead doctor, detailed within the rota. .Close links with the CYP team with cross divisional learning and	Denise Dodd, (UEC Matron) Rebecca Thurlow (CYP Matron)	01-Dec-2021	Blue	-Nov-2021	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	(1) 24/7 Paediatric named lead clinician rota; (2) Nursing rota demonstrating nurses on duty 24/7 with paediatric competencies.	A written narrative has been provided to CQC that outlines the functionality of the Emergency Department and how it operates, how systems and controls have been established to care for children within the department. The Trust were concerned that CQC inspectors	Paul Matthew, Director of Finance and OD	People & Organisational Development Committee (PODC)

CQC2021-36	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	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	UEC	Review and confirm RCPCH standards for ED departments in ULHT and staffing requirements from the guidance.	UEC CBU Leads	30-Jun-2022	Amber		(1) Completed assessment of the impact on ULHT through a review and gap analysis; (2) Highlight reporting to the Children's and Young People Board.	(1) Highlight reporting to the Children's and Young People Board (and inclusion on the UEC risk register if required).		Simon Evans, Chief Operating Officer	People & Organisational Development Committee (PODC)

					(RCPCH).	UEC	Complete workforce review for nursing and medical staff on the back of the gap analysis and draft a business case for additional recruitment to close the gaps (if any).	Cheryl Thomson (General Manager)	30-Jun-2022	Amber		(1) Draft business case; (2) Submission for approval.	(1) Evidence of a plan to close gaps identified; (2) Clarity on mitigations in place if gaps identified; (3) Highlight reporting to Children's and Young People Board		Simon Evans, Chief Operating Officer	People & Organisational Development Committee (PODC)

CQC2021-17	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	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.	UEC	Refresh CBU Governance process and arrangements for 2022/23 with renewed TOR for UEC Governance and Cabinet meetings.	Cheryl Thomson (General Manager)	31-Mar-2022	Amber		(1) Approved TOR; (2) Minutes evidencing approval of TOR.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

CQC2021-39	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	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.	UEC	Strengthen the UEC Governance processes in line with the revised and approved TOR.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	31-Dec-2022	Amber		(1) 80% of CBU governance meetings achieved; (2) 75% attendance at meetings; (3) Recognising implications of operational pressures - escalate if more than 2 meetings are cancelled to divisional governance; (4) Addition to CBU risk register if operational pressures lead to	(1) Evidence that Governance meetings are being held; (2) Regular highlight reporting from UEC to Children's and Young People (CYP) Board.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

CQC2021-18	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	CBU Risk Register has been refreshed. Embed regular review of risk register at strengthened Governance meeting process.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Apr-2022	Amber		(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise; (3) Risks should be reviewed in line with timescales within Trust (new) policy: Very high (20-25): Monthly review; High risk (15-16): review quarterly; Moderate risk (8-12): review quarterly; Low/very low (4-6; 1- 3) review 6-monthly; (4) Datix version of risk register to be updated after every review.	(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-40	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	UEC	Include within the UEC risk register the risk around the control of policies and SOPs.	Thompson (General	30-Mar-2022	Amber		(1) Addition of risk to risk register.	None.			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-31	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.	UEC	Revised cleaning checklist has been developed. To implement this on a shift by shift basis. To review how this roll-out to be communicated and completion of revised checklist to be completed.	Jemma Bowler & Holly Carter (Senior Sister ED)	31-Mar-2022	Amber		(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.	(1) Flo-audit completion data; (2) Mattress audits; (3) Matrons audit contains IPC checks.			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	Review completion of domestic cleaning checklist with domestic supervisor and identify any gaps that require further action.	Jemma Bowler & Holly Carter (Senior Sister ED)	30-Apr-2022	Amber		TBC	TBC			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-32	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	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	UEC	Room 15 has been identified as a suitable room that can be used to assess mental health patients with some modifications. The room has 2 doors meaning suitable access / egress and is situated away from the 'plaster room'.	Blanche Lentz (Clinical Services Manager UEC)	TBC	Amber		(1) Quote for modifications; (2) Photographic evidence of modifications made to Room 15.	(1) Audit evidence of appropriate access/use by MH patients; (2) Ligature risk assessment completed for refurbished MH room.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

					Accreditation network (PLAN) and mental health risk assessments and care plans are completed for all patients at risk.	UEC	In the interim, until the modifications to room 15 are complete, any patient with mental health conditions requiring use of the room will have 1:1 supervision from a sitter. The staffing template for the unit will enable this in most circumstances, and in situations where this is more challenged, escalation will be made to Site Management Team to support backfill arrangements. This arrangement has been communicated to all the team.	Denise Dodd (UEC Matron)	01-Nov-2021	Blue	01-Nov-2021	(1) Evidence of communication cascade.	(1) Audit to be undertaken in Nov-21.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						UEC	The Trust's Estates team have been contacted to fit locks to cupboard doors in the clean procedures room to ensure that there is not easy access to sharps.	Estates	01-Dec-2021	Blue	01-Dec-2021	(1) Photographic evidence of pin locks fitted and in use.	(1) Audit/walk-around visits.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

					UEC	An audit will be undertaken during November 2021 to test this arrangement and the quality of record keeping. Evidence from this audit will made available for sharing with CQC.	Denise Dodd (UEC Matron)	29-Nov-2021	Green	20-Jan-2022	(1) Audit findings / report	(1) Inclusion in the CQC monthly assurance document on most relevant tab.	An audit has been completed which demonstrates that all patients with mental health needs who have been cared for in Room 15 within Pilgrim ED have had a 1:1 sitter with them to mitigate the fact that the room has not yet had the required alterations to make this ligature free.	Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
					UEC	Agree a schedule of audits to provide ongoing assurance that enhanced care is provided where needed, including for patients with identified mental health needs.	Holly Carter (Senior Sister, ED)	31-Mar-2022	Amber		(1) Evidence of scheduled audits being undertaken; (2) Appropriate action in response to the audit findings.	(1) Ongoing assurance that audits are continuing.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CQC2021-37	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	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.	UEC	Backlog of incidents has re-occurred linked to extreme operational pressures. Strengthened governance meetings will include regular ongoing oversight of this area. Theme and trend all backlog of incidents to enable sharing of lessons learnt.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	30-Jun-2022	Amber		(1) Resolution of the backlog; (2) Evidence of learning from the analysis of themes and trends being shared with staff.; (3) Sustained compliance with timescales for Serious Incident Reporting and investigation.	(1) Ongoing oversight of incident reporting metrics to measure effectiveness of the process and assurance that a backlog position does not again appear; (2) Ongoing oversight of Serious Incident Reporting and investigation timescales.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						UEC	Review the effectiveness of current learning lessons processes in UEC and strengthen if needed.	Dr David Flynn (Clinical Lead - A&E); Cheryl	30-Jun-2022	Amber		(1) Completed review and evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						UEC	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	TBC	Amber		(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-38	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	UEC	Undertake service by service review to identify and catalogue all SOPs and Policies currently being used or referred to within UEC.	Cheryl Thompson (General Manager)	31-Jul-2022	Amber		(1) List of SOPs and Policies in use; (2) Clear local policy for approval of SOPs and Policies within UEC that includes process to review documents at a scheduled and timetabled point to ensure they remain up-to date and evidence based.	(1) Addition of all SOPs and Policies in use to central register for tracking and control process.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

						UEC	Review, update and approve all UEC SOPs and Policies and ensure registered as controlled documents, in approved Trust format and stored in the CBU U drive and accessible via the intranet.	Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)	31-Dec-2022	Amber		(1) Evidence that all SOPs and Policies have been reviewed and approved.	(1) Ongoing process to track compliance with the control of SOPs and Policies in use with reference to Trust document control processes.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 10/03/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Must Do/ Should Do / Immediate/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	BRAG Readiness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Maternity	Action taken at the time of the inspection. Trolleys with medications were moved to a secure area.	Dr Suganthi Joachim (Division Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Divisional Managing Director)	31-Oct-2021	Green	31-Oct-2021	(1) Evidence submitted as part of core service evidence request; (2) Evidence of communications to team; (3) Evidence of more security for trolleys (locker type trolley).	(1) B7 Assurance process (weekly) includes an assessment of security of medications.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Maternity	Wall thermometer ordered. Daily check added to the daily check list. Staff aware of escalation process if needed.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Oct-2021	Green	31-Oct-2021	(1) Wall thermometer in place; (2) Daily check added to the daily check list; (3) Audit of the process.	(1) Review of daily checks; (2) Survey of staff regarding action needed if temperature too high; (3) B7 Assurance process (weekly) includes an assessment of this point; (4) Pharmacy pro-forma outlines process of what to do with out of range temperatures in relation to medicines storage.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do /	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
						Maternity	Map out across Maternity at both sites locations where medicines (drugs rooms (inc. fluids), medication fridges, mobile trolleys) are stored	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue		(1) Map of locations within Maternity at both sites outlining where medicines are being stored.	(1) 6-monthly review to determine if any changes in process/location for storing medicines.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Maternity	Undertake gap analysis audit against Trust's Medicines Management Policy that relates to storage and security (i.e. have locations that store medicines got digital thermometers?)	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	15-Mar-2022	Blue		(1) Completed audit, by location, outlining controls in place/gaps.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks; (2) 6-monthly review to determine if any changes in process for storing medicines to determine compliance against policy.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Maternity	Develop audit tool for use by Maternity Matrons to undertake gap analysis against medicines storage section of medicines management policy.	Jeremy Daws (Head of Compliance)	03-Mar-2022	Blue		(1) Completed audit proforma.	None.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Maternity	Plan out action in response to audit to close any gaps identified (i.e. order digital thermometers).	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Amber		(1) Action plan collating all actions in response to gap analysis audit.	(1) Evidence that all gaps have been closed and that actions have been completed; (2) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	ness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
						Maternity	Identify any risks from audit undertaken (i.e. rooms where ambient temperature is routinely 25 degrees or above and take advice from pharmacy around mitigations.	Libby Grooby (Divisional Head of Nursing and Midwifery) c/o Matrons in Maternity	31-Mar-2022	Amber		(1) Action plan outlining mitigations to identified risks, in line with policy with Pharmacy advice (inventory of medicines; any with specific sensitivities; stock rotation - how long kept? Insulin length of time stored?) (2) Evidence of mitigations being in place.	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do /	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	ness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
						Maternity	Understand mitigations to environmental challenges in storage of medicines (i.e. age of estate at Lincoln maternity with a lack of air-conditioning/ventilation).	Simon Hallion (Divisional Managing Director)	30-Apr-2022	Amber		(1) Mitigating actions scoped out in relation to environmental issues (i.e. ventilation and temperature management).	(1) Ongoing assurance on medicines management as gathered through daily assurance checks; B7 Spot checks.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Maternity	Ensure regular escalation reporting into PRM regarding estate issues that impact on medicines storage arrangements.	Simon Hallion (Divisional Managing Director)	31-Mar-2022	Amber		(1) Evidence of PRM escalation; (2) Addition to divisional risk registers of medicines storage matters.	(1) Ongoing escalation reporting to PRM.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Suganthi Joachim (Divisional Clinical Director); Simon Hallion (Divisional Managing Director); Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Amber		(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Matrons audits assess security and storage of records, but main focus will be in relation to nursing documents. The Doctor's office is currently a shared room that doubles as a staff room. The doctor's office is moving to opposite the nurses station. As part of this move incorporate a door closure mechanism to ensure the door is not left open.	Carol Hogg (Ward Manager)	30-Apr-2022	Amber		(1) Evidence of door closure device being added to the Doctors Office door.	(1) Ongoing monitoring as part of the Matron's audit process.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

						All	Scope out with Dr Amol Chingale additional actions in relation to medical staff raised awareness regarding information governance matters and other key messages (i.e. IPC).	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Amber		(1) Evidence of raising awareness with medical staff.	(1) Programme of work to raise awareness for medical staff.		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)
CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	CYP / Maternity	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Rennison, Karen O'Connor, Kay Probert (Sisters/Clinical Educators/Play Specialists) C/O Rebecca Thurlow (Lead Nurse, CYP)Matrons within Maternity, C/O Emma	30-Apr-2022	Amber		(1) Evidence of divisions identification of currently available information resources and any additional resources that are felt to be needed.	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						CYP / Maternity	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.	(Sisters/Clinical Educators/Play Specialists) C/O Rebecca Thurlow (Lead Nurse, CYP) Matrons within Maternity, C/O Emma Upjohn	30-Apr-2022	Amber		(1) Register of locally held patient information resources being provided to patients.	(1) Maternity: Maternity Voices Partnership (MVP) have done a review of information provision within maternity. Track outcomes from future iterations for assurance.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

						CYP / Maternity	Divisions to assign 'information owners' to provide information resources in response to feedback of information for patient needs.	Divisional CQC action plan owners to nominate lead 'information owners'.	To confirm on completion of information availability scoping.	Amber		(1) Evidence of information resources completed in response to listening events with patients; (2) Evidence of these resources being entered onto the information resource register (held by Patient Experience team).	(1) Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						CYP	Scope out additional communication aids for use in CYP in British Sign Language and Makaton with Charitable funds.	Rebecca Thurwell (Lead Nurse, CYP)	01-Aug-22	Amber		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-14	Trust wide	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Family Health Specific]	CYP	Understand from Rainforest Ward if the following issues have been reported to Estates: · Entrance flooring; · Some surfaces in poor repair in bathrooms/toilets; · Worn flooring; · Broken equipment (only 1 item - Immediately repaired); · Equipment needing repair	Carol Hogg (Ward Manager)	30-Apr-2022	Amber		(1) Evidence that environmental issues have been reported to Estates; (2) Evidence of Estates action in response; (3) Escalation if no action yet taken.	(1) Environmental audits evidencing that issues requiring escalation are identified and appropriately reported.			Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						CYP	Charity funds are being secured through a major fundraising for a total refurbishment of the Rainforest Ward. Potential to incorporate Safari into ward footprint. Scope out timescales and more detailed plans.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Refurbishment plans; (2) Evidence of completed works.	None.			Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						CYP	Replacement of 'Z' beds with new reclining chairs/beds to support decluttering of Rainforest ward with replacement of tables and lockers to support improved environment for patients and parents.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Evidence of replacement of old equipment with new; (2) Review of the effectiveness of decluttering of ward environment.	(1) Environmental audits to identify any estates issues; (2) Evidence that environmental issues have been escalated appropriately for remedial action.			Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CYP	Scope out the development of an internal Family Health 15-steps process to provide 'fresh eyes' on the environment.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Amber		(1) Evidence of plan being scoped out.	(1) Roll-out of internal 15-steps challenge methodology.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
CYP	Understand the ULHT Trust process for undertaking, recording and frequency for undertaking ligature risk assessments.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Amber		(1) Clarification Trust processes.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
CYP	Continue to scope out additional steps for CYP in relation to risk mitigation for children with mental health concerns linking in with LPFT and ULHT Safeguarding team.	Rebecca Thurlow (Lead Nurse, CYP)	30-Apr-2022	Amber		TBC	TBC		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
CYP	Review and seek assurance that routine weekly fire checks are being undertaken on Safari ward.	Carol Hogg (Ward Manager)	30-Apr-2022	Amber		(1) Evidence of weekly fire checks being undertaken.	(1) Assurance of processes in place to maintain this going forward; (2) Evidence of weekly fire checks (spot checks).		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CQC2021-25	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	CYP	Revised risk register format now being used. Continue to embed the use of this in strengthened governance structures.	Dr Suganthi Joachim (Divisional Clinical Director); Libby Grooby (Divisional Head of Nursing and Midwifery); Simon Hallion (Managing Director).	31-Mar-2022	Amber		(1) Maternity risk register in new style format and updated; (2) Evidence of the risk register being reviewed within Maternity meeting structure; (3) Evidence risk register is maintained in line with Trust (new) policy: Each risk has a named owner; Risk register entries are clear and concise; Risks should be reviewed in line with timescales: Very high (20-25): Monthly review; High risk (15-16): review quarterly; Moderate risk (8-12): review quarterly; Low/very low (4-6; 1- 3) review 6-monthly; Datix risk register to be updated after every review.	(1) Evidence of the risk register being reviewed within Maternity meeting structure and updated as per Trust policy.			Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Surgery	Theatre safety bulletin to be devised and disseminated to all theatre staff outlining roles and responsibilities in monitoring of ambient temperatures alongside why this is a requirement.	Divisional Nurse	04-Mar-2022	Amber		(1) Completed Safety bulletin; (2) E-mail evidence of dissemination	None.			Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

						Surgery	Thermometers to be ordered for all Anaesthetic Rooms	Theatre Matrons	02-Mar-2022	Amber		(1) Written confirmation by Theatre Matrons that Thermometers are in place; (2) Temperature check sheets; (3) Practice has been commenced.	(1) Quality Accreditation Process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Daily Temperature Checks Sheets to be installed in all Anaesthetic rooms	Theatre Matrons	02-Mar-2022	Amber					Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Daily Temperature Checks to be instituted by Theatre Teams	Theatre Matrons	02-Mar-2022	Amber					Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	SOP to be devised outlining procedure to be undertaken and actions to be undertaken in the case of a temperature breach.	Lead Nurse/Matron for Health Safety	02-Mar-2022	Amber		(1) Written SOP document	(1) Audit of SOP compliance at 6 month		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Band 7 Weekly Quality and Safety Audit	Matrons/Band 7 Practitioner for Theatre	02-Mar-2022	Amber		(1) Audit document with additional checks	(1) Ward accreditation process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
						Surgery	Ambient temperature monitoring in Anaesthetic Rooms to be added to Monthly Matrons Audit	Matrons for Theatre	02-Mar-2022	Amber		(1) Audit document with additional checks	(1) Ward accreditation process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

						Surgery	As this is a new process - compliance will be reported at monthly CBU PRM	Lead Nurse TACC	01-Apr-2022	Amber		(1) Monthly PRM Slide Deck	(1) CBU PRM Quality Process		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)
CQC2021-20	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	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.	CYP	Reminders provided to staff around the availability of interpreting services.	Rebecca Thurlow (Lead Nurse, CYP)	01-Nov-2021	Blue	01-Nov-2021	(1) Communication messages shared with the team; (2) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Message of the month schedule; (2) Monthly Matron Audit data.	Work undertaken to proactively remind staff of the availability of the translation services for patients/families whose first language is not English.	Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)
						CYP	To include within the message of the month schedule reminders to act as an aide memoir to support staff continue to make good use of the interpreting services.	Carol Hogg (Ward Manager)	31-Dec-2021	Green		(1) Addition to the message of the month schedule.	(1) Message of the month schedule; (2) Monthly Matron Audit data.		Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)
						CYP	Nursing admission document being revised, currently in development by Shared Decision Group, with a prompt and space documentation relating to interpreting services booked	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		(1) Completed nursing admission document.	(1) Message of the month schedule; (2) Monthly Matron Audit data.		Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)

						CYP	Section to be added in Matrons monthly assurance audit. To ensure this practise is embedded and monitored – evidence received	Rebecca Thurlow (Lead Nurse, CYP)	01-Dec-2021		01-Dec-2021	(1) Addition (during Nov 21) of this to the monthly matrons audit.	(1) Monthly Matron Audit data.	Matrons assurance audit has been updated to include assessment of interpreting service being used. This will support ongoing compliance and continual reminders being provided to staff.	Paul Matthew, Director of Finance and OD	Quality Governance Committee (QGC)
CQC2021-21	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	CYP	Embed use of new cleaning schedules that have been introduced through Nurse In Charge taking a lead role in ensuring this is completed at the end of each day.	Rebecca Thurlow (Lead Nurse, CYP)	TBC			(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						CYP	Scope out action needed in relation to Neonatal cleaning records.	Rebecca Thurlow (Lead Nurse, CYP)	31-Aug-2022	Amber		(1) Evidence from cleaning schedules assurance metrics.	(1) Ongoing process to oversee completion of cleaning schedules and confidence this is embedded.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

CQC2021-22	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.	CYP	Scope out further actions in response to inclusion of patients/parents in service provision whose first language is not English. Set up meeting with Lead Nurse CYP; Equality & Diversity Trust Lead and Patient Experience Lead. [Include within this availability of information for patients whose first language is not English, communication aids and proactive communication relating to cultural issues that impact on mixed sex accommodation]	Jeremy Daws (Head of Compliance)	30-Apr-2022	Blue		(1) Meeting held and further actions needed scoped and included within CQC Improvement Action Plan.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
							To include this and wider cultural issues to the Shared Decision Making group within CYP to scope out tangible improvement actions to support this action.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber					Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-23	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.	CYP	Work is underway in participating in the Trust trial of 'This is me' document. To be included in the next wave. Aiming to link in with CAMHS and work on this in partnership with LPFT to ensure an integrated approach. To scope out additional details and timescales. D/W Becky - action plan	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		TBC	TBC		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
CQC2021-24	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.	CYP	New tool/risk assessment has been drafted specifically for CYP in collaboration with Dietetics and Clinical Education team. Awaiting ratification and approval of the document to then roll-out. Scope out additional detail and timescales and include further milestones to test implementation and embedding of documentation.	Rebecca Thurlow (Lead Nurse, CYP)	TBC	Amber		TBC	TBC		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff’s compliance with the systems in place to enable learning from incidents.	Maternity	The incident 'Trigger List' has been provided to all staff and discussed at team meetings. On the back of this link in with the Trust piece of work looking at mapping of the various processes that share learning across both sites.	Paula Izod (Risk Midwife)	31-Mar-2022	Green		(1) Survey of staff using Survey Monkey to ascertain further staff understanding of incidents;	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						Maternity	A review of the mechanisms for sharing learning will be undertaken during 2022/23. As part of this work, the views of Trust staff will be sought to determine what works best for the different areas and staff groups.	Helen Shelton (Assistant Director of Clinical Governance / Patient Safety Specialist)	TBC	Amber		(1) Trust level understanding of mechanisms in use to share learning; (2) Evidence of action in response.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
						Maternity	Review the corporate assurance tools to understand what questions are regularly asked of staff and determine if further assurance relating to incidents could be included within these (i.e. ward accreditation review process).	Jeremy Daws (Head of Compliance)	30-Jun-2022	Amber		(1) Review of corporate assurance tools.	None.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

CQC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	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.	Maternity	Midwives whose training / sign off of competence is outstanding to have obtained competencies. In the interim, where there is a case and a midwife who has not received the training for GA recovery, the theatre recovery nurses will remain in attendance. *NB: Original action planned to have fully completed competence for those midwives outstanding by Dec-21. However, to attain competence requires a full-day in Theatres and there is insufficient capacity in Theatre rotas for these staff to be attain competence until end of the financial year 21/22 (an average of 1-2 midwives a week can attend).* *16-Mar-22: Timescale reset from 31-Mar-22 to 30-Apr- 22 (PHB) and 31-Oct-22 (LCH).*	Libby Grooby (Divisional Head of Nursing and Midwifery)	30-Apr-2022 (PBH); 31-Oct-2022 (LCH).	Amber		(1) Assurance provided to CQC directly; (2) Clinical Education team have all the records – reviewed each year during Mandatory training.	(1) Progress against trajectory for outstanding midwives whose training / sign off of competence is outstanding, who work on labour ward; (2) Database of competences is maintained by Education team and consultant midwife; (3) Strengthened reporting to Maternity Neonatal and Oversight Group.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)

						Maternity	Look at further strengthening, reduce the likelihood still further, by including this competency as part of roster planning. Scope out during October 2021. *Action amended subsequently to being provided to CQC:* *The majority of midwives on the labour ward are B6 and therefore have, for the most part, obtained necessary competencies as part of their training at B5 level*	Libby Groby (Divisional Head of Nursing and Midwifery)	01-Dec-2021	Green	01-Dec-2021	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.	(1) Rotas that evidence staffing on the unit and higher ratio of B6 nurses to B5.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)
						Maternity	Monitoring of compliance and assurance through the Maternity and Neonatal Assurance Group.	Yvonne McGrath (Consultant Midwife)/ Emma Upjohn (Interim Deputy Head of Midwifery)/Lead Nurse Breast/Gynae	31-Mar-2022	Blue		(1) Update provided in the Maternity and Neonatal Assurance Report to the Maternity & Neonatal Oversight Group in November 2021.	(1) Formal reporting on compliance against the agreed trajectories to be included within the Maternity and Neonatal Assurance Report; (2) Include within next MNOG report.		Simon Evans, Chief Operating Officer	People and Organisational Development Committee (PODC)

Ref	Core service	Site	Inspection	Must/Should Do	Recommendation	Service	Action	Lead	Date	RAG		Measure of success	Evidence		Executive lead	Committee
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	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.	Maternity	BAU: Ongoing review and assurance that environmental audits do assess the estate and escalate appropriately into MNOG.	Libby Grooby (Divisional Head of Nursing and Midwifery)	31-Dec-2022	Green		(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues.	(1) MiCad audits focus on cleanliness; (2) Matrons audits pick up estate issues; (3) Evidence of onward escalation reporting into MNOG.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
CQC2021-41	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	CYP	Scope out and define key clinical support services needed by CYP over a 7 day period by urgency (i.e. routine management vs. seriously unwell).	Dr Suganthi Joachim (Divisional Clinical Director)	31-Mar-2022	Blue		(1) Defined list of key services and when needed in terms of urgency.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						CYP	Identify availability of key clinical support services over a 7 day period, by urgency and identify any gaps.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	30-Apr-2022	Amber		(1) Key services availability and identification of any gaps.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

						CYP	Outline a plan for mitigating any gaps in available clinical support services and define risks.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	31-May-2022	Amber		(1) Risk stratification of gaps; (2) Plan in place to mitigate gaps.	None.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
						CYP	Add any risks to divisional risk register.	Nick Edwards (Deputy General Manager); Anita Cooper (Interim Lead Clinician)	30-Jun-2022	Amber		(1) Evidence that risk has been considered and added to the risk register as necessary.	(1) Evidence of ongoing risk mitigation as part of risk register process.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)
CQC2021-42	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	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).	CYP	Review RCPCH guidance to determine specific requirement as to what waiting times need auditing and then discuss further with Lead Nurse and Clinical Lead for CYP.	Jeremy Daws (Head of Compliance)	30-Apr-2022			(1) Evidence of detail for the audit being scoped out.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						CYP	Plan a prospective audit to log and record the details, a set number of times a year (to scope). Co-ordinators to collect data. Scope of wards included would be 4a/Safari/Rainforest. To be led by Dr Chingale and Becky.	Dr Chingale (Clinical Lead); Rebecca Thurlow (Lead Nurse CYP)	30-May-2022	Amber		(1) Plan for the audit.	(1) Schedule for the audit to be undertaken throughout the year.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

CQC Improvement Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 10/03/2022

BRAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet fully embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agreed timescales

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	All	Continue to monitor and track performance with support from the Trust's Risk & Governance team. Aim is 100% of incidents that require DoC to have evidence of written DoC. [This is a business as usual action/oversight with well-established governance oversight.]	Anita Parmar (Deputy General Manager); Claire Spendlove (Lead Nurse); Michael Bland (General Manager); Donna Gibbins (Deputy Divisional Nurse)	31-Dec-2022	Amber		(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.	(1) DoC performance data demonstrates timescales are routinely met; (2) Performance with timescales for SI investigations are met.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	All	Review assurance evidence available from existing metrics to determine if additional action is required, other than the ongoing education work resulting from ongoing assurance work.	Clare Spendlove (Lead Nurse); Donna Gibbis (Deputy Divisional Nurse)	30-Apr-2022	Amber		(1) Matrons audit data in relation to security of patient records/information (systems etc.).	(1) Matrons audit data in relation to security of patient records/information (systems etc.).		Paul Matthew, Director of Finance and OD	Finance, Performance and Estates Committee (FPEC)

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CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	All	Medicine Cabinet to scope out how to determine what information resources are required that do not currently exist (including UEC and advice cards) and catalogue information currently available and in use.	Katy Mooney (Divisional Lead Nurse)	31-Mar-2022	Amber		(1) Inclusion of patient information within the specialty Governance meeting process/schedule.	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe. [Medicine specific]	Medical	Review evidence that estates issues are being identified as part of the Ward/department environmental audits and FLO audits and determine mitigations in place to safeguard quality of service provision.	Clare Spendlove (Lead Nurse); Donna Gibbins (Deputy Divisional Nurse); Maxine Skinner (UEC).	30-Apr-2022	Amber		(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related	(1) Environmental audits / FLO audits demonstrating that estates issues are being identified; (2) Evidence of escalation / mitigation of estates related issues by risk.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)
						Medical	Scope out opportunities to better plan routine replacement programme for equipment with Trust's procurement team.	Clare Spendlove (Lead Nurse).	30-Apr-2022	Amber		(1) Understand options available.	None.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

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CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.	Medical	Standardise and merge out-of-hours checklist with Divisional checklist and ensure this is accessible and version controlled as part of the Trust's documentation control processes and procedures. Katy to chair a meeting of matrons and lead nurses across divisions and with OPs team.	Katy Mooney (Divisional Lead Nurse)	31-May-2022	Amber		(1) Revised checklist for opening a ward; (2) Assurance evidence the checklist is in use when opening a ward; (3) Inclusion within the Trust's document control processes.	(1) Assurance evidence the checklist is in use when opening a ward.		Simon Evans, Chief Operating Officer	Finance, Performance and Estates Committee (FPEC)

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CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.	Medical	With support from the Trust's audit department, embed the process that all national audits are participated in, presented at the respective audit meetings, discussed at Governance and an action plan agreed.	National Audit leads (with support from Trust Audit Team)	31-Mar-2023	Amber			(1) CEG Quarterly Report; (2) CQC Insights data.		Colin Farquharson, Medical Director	Quality Governance Committee (QGC)

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CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspection	Should Do	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.	Medical	Scope out with HR/ESR level of access Ward managers have already to ESR which provides oversight in relation to training compliance levels within their teams.	Jeremy Daws (Head of Compliance)	30-Apr-2022	Amber					Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

CQC Action Plan
Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-01	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Must Do	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.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. We were not assured there was a system in place to check an approved national child protection information sharing system for children attending the department. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided assurance this process had been in place previously and would be reinstated. Systems were in place to add an alert to emergency department electronic patient record should there be a safeguarding concern. For example, to identify children and young people who attend frequently. (Page 188; Safe)
CQC2021-04	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Must Do	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.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. Whilst there was a process in place to check an approved national child protection information sharing system for children attending the department, staff were not following this. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided us with a plan for this to be reinstated fully by 30 November 2021. A flowchart describing the process had been shared within staff. The safeguarding team had commenced education sessions with key staff as part of team huddles and supervision sessions. (Page 29; Safe)
CQC2021-02	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	The number of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover at County Hospital has mostly been worse than the Midlands and England averages. Between March and September 2021 there were 1,322 patients waiting over an hour. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced. (Page 206: Responsive)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-05	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Must Do	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.	Processes were in place for medical staff to complete face to face reviews of patients waiting over 60 minutes on an ambulance, however, this was not fully implemented. The trust standard operating procedure (SOP) for management of reducing ambulance delays states patients who experience ambulance offload delays should be reviewed by a member of the ED medical team within one hour of arrival. During our inspection we did not observe this was routinely completed and ambulance staff commented this did not always take place. Following the inspection, the service sent us harm reviews of 17 patients who waited more than two hours on an ambulance. Only three of the reviews showed evidence the patients were reviewed on the ambulance by the emergency physician in charge (EPIC). In two cases, this was over an hour after arrival. Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. (Page 32-33: Safe)
CQC2021-03	Maternity	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.	Medicines, including controlled drugs were not always stored securely. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. On two occasions during our inspection on the maternity ward, we were able to access medicines in unlocked drawers in an unlocked room. This room was accessible from two separate corridors meaning patients and their visitors could enter the room potentially accessing the medicines. We escalated this twice during our inspection to managers which resulted in the medicines being moved each time. Women could not be assured that their medicines were effective as staff were not ensuring medicines were being stored in line with manufacturers guidance. Temperature monitoring of medicines stored at room temperature were not being monitored despite staff telling us the rooms were consistently warm. We escalated this to managers on the labour and maternity wards. Temperature monitoring was immediately put in place on the labour ward. However, when we returned to the maternity ward on the second day of the inspection temperature monitoring was still not being completed. (Page 126-127; Safe)

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CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	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.	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. (Page 3) **UEC-Pilgrim (Page 27-28; Safe):** Registered nurses were compliant with the trust target in seven out of 11 modules. For those modules where compliance levels were not achieved, the service was close to achieving the target. Medical staff received but did not always keep up to date with mandatory training. Compliance levels had improved since our last comprehensive inspection in 2019. However, medical staff were not compliant with seven out of 11 modules. For example, major incident awareness (69%), information governance (79%), infection control and prevention (79%) and fire safety (86%). Compliance to the highest level of life support training was not achieved for medical or nursing staff. Data provided to us following the inspection showed all 10 consultants and 78% of middle grade doctors working in urgent and emergency care had completed advanced life support adults (ALS) training. Furthermore, advanced trauma life support (ATLS) training had been completed by 80% of consultants and 56% of middle grade doctors. Training compliance data for basic life support (66%) was poor for registered nursing staff. Data showed 80% of consultants, 72% of middle grade doctors and three out of five locum middle grades working at the trust had completed European advanced paediatric life support (EPALS) training. Training compliance data for paediatric basic life support (75%) was below expected standards for registered nursing staff. Only 38.6% of registered nurses had completed paediatric intermediate life support (PILS) and 65% EPALS. However, a plan was in place to improve compliance. For example, it was expected 58% of nurses would have completed PILS and 71% completed EPALS by December 2021. Staff received training on sepsis recognition and treatment. Training compliance levels had improved significantly. Data provided by the service following our inspection demonstrated 91% of staff in urgent and emergency care had completed sepsis training. Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. On average 94% of registered nursing, medical and non-clinical staff had completed mental health training and 95% dementia training. Training in learning disability and autism was not provided, however, the service was in the process of developing an online training programme expected to be available to staff in December 2021. **Safeguarding Page 28:** Nursing staff received training specific for their role on how to recognise and report abuse. The 90% compliance target was met for safeguarding adults and children level two and safeguarding adults' level three. However, was not met for safeguarding children level three (87%). A plan was in place to achieve compliance. Medical staff were provided with training specific for their role on how to recognise and report abuse, however, compliance was poor. For example, data provided by the trust following our inspection showed 68% of medical staff had completed safeguarding adults and children level two, 67% had completed safeguarding adults level three and just over half (54%) had completed level three safeguarding children. However, medical staff understood how to identify a safeguarding concern and how to act on it. **Medical Care - Pilgrim (Page 69; Safe):**

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CQC2021-07	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.	**UEC - Pilgrim (Page 36-38; Safe):** The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure therewere enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service did not have enough nursing and support staff; however, action was taken to ensure patients were safe. Planned emergency department (ED) staffing was 12 registered nurses (RN) and eight healthcare assistants (HCA) day and night. This included the nurse in charge and pre-hospital practitioner (PHP). Managers told us the current staffing template did not meet the demand of the service. For example, the blue majors' stream was particularly challenged during our inspection. One RN and one HCA was allocated to cover the cubicles and walk-ins which staff told us was challenging for them due to the variety of the role as well as number of patients they were looking after. Furthermore,the triage nurse role was challenged at time of peak demand. The number of nurses and healthcare assistants did not always match the planned numbers. On the day of our inspection the number of registered nurses met the planned level, but the service was down one healthcare assistant. The senior sister and band seven nurses were included in the numbers and working clinically to support the gaps in staffing levels to ensure all areas were covered. From June to September 2021, of the 2692 shifts unable to be filled by substantive registered nurses, 14.6% of these were unfilled. This meant 392 shifts were not covered by a nurse over this three-month period. Furthermore, over the same period 1776 shifts were unable to be filled by substantive healthcare support workers and 38% of these were unfilled. This meant 679 shifts were not covered by a healthcare assistant over this period. The service had some staffing vacancies. However, shifts were covered with bank and locum staff to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service did not always have enough medical staff. The medical staff did not always match the planned number. There were gaps in the medical rota the service was unable to fill. For example, during September 2021 there were 28 unfilled medical shifts. On day one of our inspection there was a middle grade doctor unfilled shift and on day two a junior doctor unfilled shift. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads said they reviewed staffing to ensure it was 'adequate', and as safe as possible. The service had consistently high vacancy rates for medical staff. Data provided to us following the inspection demonstrated from April to September 2021 the average vacancy rate for medical staff was 22.2%. The consultant vacancy rate remained at 16.67% throughout this period and for middle grade Doctors was particularly high with an average rate of 34%. Junior doctors showed an increasing vacancy rate with 10.4% vacancy rate in August and September 2021. **Maternity - Pilgrim (Page 63; Safe):** The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. The service had enough staff to keep women and babies safe. Staffing data for September 2021 showed the service had -5% medical and -2.47% midwifery and support staff vacancies.

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CQC2021-08	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure there are mechanisms for providing all staff at every level with the development they need through the appraisal process.	**UEC - Pilgrim (Page 46; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff had an appraisal within the 12 months prior to our inspection. For example, 97% medical staff had received an appraisal, however, only 46.7% of registered and non-registered nursing staff had received an appraisal. **Maternity - Pilgrim (Page 65; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 92% of medical staff, 72% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process. **Medical Care - Pilgrim (Page 80; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 60%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic. A new job management software package had recently (May 2021) been introduced to support and improve the quality of appraisals, including clear objective setting, career and development conversations, wellbeing conversations, and aligning performance and behaviour to the trust values. The system was still very new to the trust and had not been fully embedded. However, we observed an action plan which contained six actions the division were working towards, documented at the August 2021 'medicine performance management framework meeting'. **CYP - Pilgrim (Page 107; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff said their appraisals were really beneficial and helped them to plan their development and career pathway. All staff we spoke with told us they had received an appraisal or were due one soon. Some had been rescheduled during the Covid-19 pandemic. Data provided by the trust showed that 68% of staff had received an appraisal within the last 12 months. **Maternity - Pilgrim (Page 129; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. This ensured that staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of our inspection, 91% of medical staff, 67% of registered nursing staff and 81% of support staff had received an appraisal. Nursing and support staff appraisal rates were below the trust target of 90%, however plans were in place to increase appraisal rates and staff and managers had been contacted to remind them to engage in the appraisal process. **Medical Care - Lincoln (Page 142; Effective):** Managers supported staff to develop through yearly, constructive appraisals of their work. Across the medical division there was an average appraisal completion rate of 93%. Across the medical division for non medical staff the average appraisal rate was 55%. The trust had a plan and targets they wanted to achieve to increase appraisal rates after they were paused due to the pandemic.

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CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	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. (Page 13) **UEC - Pilgrim (Page 41; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not applied in line with trust policy. **Maternity - Pilgrim (Page 64; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Pilgrim (Page 76; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. **CYP - Pilgrim (Page 103; Safe):** They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed governance meeting minutes and found that duty of candour had been used for each of the incidents discussed. **Maternity - Lincoln (Page 127; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Lincoln (Page 139; Safe):** Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. **CYP - Lincoln (Page 164; Safe):** Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

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CQC2021-10	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.	**UEC - Pilgrim (Page 39; Safe):** Staff did not always follow systems and processes when storing medicines, however, did when prescribing, administering, and recording medicines. Medicines were not always locked away. **Medical Care - Pilgrim (Page 75; Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. **CYP - Pilgrim (Page 101; Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. **Maternity - Lincoln (Page 126; Safe):** The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely or in line with manufacturers guidance **Medical Care - Lincoln (Page 138; Safe):** The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely. **CYP - Lincoln (Page 162-163, Safe):** The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always follow these. **UEC - Lincoln (Page 195; Safe):** Staff did not always follow systems and processes when storing medicines, however, they did when prescribing, administering, and recording medicines. The medicine room door was regularly left open.

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CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	**Governance Lincoln (Page 16)** 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.

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CQC2021-12	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	Patient records were not always stored securely. (Page 3) **UEC - Pilgrim (Page 40, Safe):** Records were not stored securely. Throughout our inspection we observed patient records being left out and unattended on trolleys in walkways. For example, we saw patient record on a trolley in a corridor outside of room 15. We raised this with managers who removed the records, however we continued to see records being placed there throughout out inspection. **Medical Care - Pilgrim (Page 75, Safe):** Records were stored securely. On the wards we visited notes were stored in lockable trolleys which were locked when not in use by staff. On all the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. There was also space for staff to sit in the bays to maintain observation of patients when required. **CYP - Pilgrim (Page 102, Safe):** Records were easily accessed by relevant staff, legible and comprehensively completed, stored securely and locked in cabinets **Medical Care - Lincoln (Page 139, Safe):** Records were generally stored securely. On the wards we visisted notes were stored in lockable trolleys which were locked when not in use by staff. On some of the wards we visited these had been moved so they now were stored in the patient bays to ensure staff members were more visible when completing their notes. On one ward we visited there was a notes trolley that was left unlocked and was near to the entrance to the ward meaning anyone could walk in from the main hospital corridor and have access to the notes. This was raised with the ward manager who reminded staff the importance of ensuring the trolley was kept locked when not in use. **CYP - Lincoln (Page 163, Safe):** Records were stored securely when not in use. Staff kept records for patients in the hospital in lockable cabinets near to nurse stations. However, we did see two occasions where patient records were accessible to unauthorised people. See well led ‘information management’ for more details. Patient records were left unsecured on two occasions which could have led to a data breach. On Rainforest ward, staff had left the door to the doctors’ office open allowing inspectors to enter and review a large quantity of patients’ notes unchallenged. One member of staff had also not logged out of a computer which would have allowed other people to use their account and access confidential patient information. We also saw unsecured patient

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CQC2021-13	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure it has access to communication aids and leaflets available in other languages.	**UEC - Pilgrim (Page 52; Responsive):** Staff did not always understand or apply the policy on meeting the information and communication needs of patients with a disability or sensory loss and did not have access to communication aids to help patients become partners in their care and treatment. Staff were not aware of communication aids that could be used for patients who had communication difficulties. Staff told us they could access sign language. **Medical Care - Pilgrim (Page 86; Responsive):** The service had information leaflets available in languages spoken by the patients and local community. **CYP - Pilgrim (Page 113; Responsive):** The service had information leaflets available in languages spoken by the children, young people, their families and local community. However, these had been removed during the Covid-19 pandemic. **Medical Care - Lincoln (Page 147; Responsive):** The service had information leaflets available in languages spoken by the patients and local community. **CYP - Lincoln (Page 177; Responsive):** The service had information leaflets available; however, these were in English only. Patients and parents/ carers told us staff provided helpful leaflets, particularly in outpatients. Data from the trust reported there are limited leaflets available in other languages. However, there were a large number in other languages for breast feeding. The trust told us they were reviewing this in line with local networks and were in the process of launching a translation tool on the neonatal website specifically. We observed that the peer review audit conducted recently by the local mental health trust also recommended information leaflets be made available in a variety of commonly used languages. **UEC - Lincoln (Page 206; Responsive):** The service did not have information leaflets available in languages spoken by the patients and local community. We did not see any information available in different languages.

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CQC2021-14	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the design, maintenance and use of facilities, premises and equipment keep patients safe.	The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance. (Page 4 and 7) **UEC - Pilgrim (Page 30-31; Safe):** The design of the environment did not always follow national guidance. However, following our focused inspection in 2020 action was taken to improve the department. Reconfiguration works at Pilgrim hospital included a new x-ray room, an additional triage room, a modular waiting room, a fit to sit area and paediatric emergency department (ED). Patients were no longer cared for in the central area of majors. All majors' patients were streamed to a cubicle if they required a trolley. Furthermore, a fit to sit area had been created within majors and in the main waiting room. Patients attending by ambulance were held on ambulances when the department was at capacity. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by ambulance staff whilst waiting f the department. In order to improve safety, patients were reviewed on arrival by the pre-hospital practitioner (PHP). Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of selfharm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. **UEC - Pilgrim (Page 51 ; Safe):** The department was not designed to meet the needs of patients living with dementia. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided. **Medical Care - Pilgrim (Page 71; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. Time scales were sometimes changeable according to ward risks. However, senior ward staff and matrons were aware of changes and involved in ensuring the wards they were being decanted into were suitable for the patients within their care. For example; the cardiac monitored patients would all be moved into an area that would always be able to provide the same monitoring facilities to ensure safety of the patient. The discharge lounge was an old mental health secure unit. There was identified space in each bay for six patients. However, there were only effective curtained areas for four patients. This meant if the area did reach capacity some patients may not be afforded privacy. (Health Building Note 04-01 – Adult in-patient facilities 4.21 Privacy). **Medical Care - Lincoln (Page 135; Safe):** The design of the environment did not always follow national guidance. Some of the wards we visited were old and required refurbishment. The trust had plans in place regarding refurbishments and were working through the wards. The trust had recently carried out some refurbishment works on Coleby ward, Clayton ward, Lancaster ward and Medical Emergency Assessment Unit (MEAUB). However, staff did report that

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CQC2021-15	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Should Do	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.	Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern of following self-harm or attempted suicide. During our inspection, we reviewed a patient care who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This was escalated and the risk assessment was subsequently completed. (Page 191) Staff did not always complete, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record of a patient. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance. (Page 192) Patient notes were not always comprehensive, Nursing and medical staff had access to patients' paper and electronic records and all staff could access them easily. Most sections of the casualty assessment were completed. Risk assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them, and transfer documentation was not regularly completed. Records were regularly updated to record two hourly care rounding. This was escalated whilst on site and the risk assessments were completed by staff. (Page 194-195) **Page 7 U&E Lincoln** 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. **Page 35 U&E Lincoln (Good)** Staff shared key information to keep patients safe when handing over their care to others. We reviewed the handovers of six patient who transferred to another ward. The handover records were fully completed with key risk information to enable the incoming ward to implement measures to manage the patient safely. **Page 192 U&E Lincoln** Staff could not always evidence that they shared key information to keep patients safe when handing over their care to others. The service had developed a handover document which was supposed to be used when patients were moving into other inpatient areas of the hospital. This was developed in line with SBAR (situation, background, assessment and recommendations). Patients' notes were also photocopied and sent over when they were transferred. In five records we reviewed of patients who had been transferred out of the emergency department, only two had complete transfer form. **Page 195 U&E Lincoln** - For example, we found falls and mental health risk assessments were not consistently used for patients who required them, and transfer documentation was not regularly completed. Records were regularly updated to record two hourly care rounding. This was escalated whilst on site and the risk assessments were completed by staff. When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within the hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff. However, patients transfer documentation was not always completed.

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CQC2021-16	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Should Do	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 service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased. The department had been refurbished since our previous inspection with a waiting area observable at all times by staff. (Page 192-193) The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, 'Facing the Future: Standards for children in emergency care settings'. However, there was a lead consultant for paediatrics and medical staff working in paediatrics. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement. (Page 194)
CQC2021-36	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	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 service continued not to meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children nurses on each shift. The service had one registered nurse with level four paediatric competencies on duty 24 hours with support from a healthcare support worker. Improvements had been noted since our previous inspection. Paediatric skill mix was included on the main ED roster and the service ensured there were more than one staff member with paediatric competencies available so they could offer support if demand increased. (Page 36) The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings. However, there was a lead consultant for paediatrics and medical staff working in paediatrics had special interests. The model was supported by paediatricians working in the trust and systems were in place to ensure there was a paediatrician available in the event of deterioration. The senor leadership team recognised this was an area for improvement. (Page 38)

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CQC2021-17	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Should Do	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.	However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular updates in governance meeting minutes we reviewed. (Page 58)
CQC2021-39	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	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.	However, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. We did not see evidence of regular paediatric updates in governance meeting minutes we reviewed, this included at both local and divisional levels within the governance structure. (Page 212)
CQC2021-18	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. (Page 213)

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CQC2021-40	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure effective systems are in place to review the service risk register.	Divisional risk register review and oversight processes were not always effective. It was not always clear what the risk was, when the risk was added, and it was unclear who had oversight of the risk registers. Local leaders did not have ownership of the risk register therefore there was the potential for departmental risks to be missed. Whilst most managers could describe risks, they could not always tell us what the risks were on the risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. For example, we reviewed the Pilgrim site ED speciality governance meeting minutes for 11 August 2021. There was reference to the risk register in terms of a discussion about the best way to present to the CQC, however, there was no discussion about risks and actions. Furthermore, there was no evidence the risk register was discussed at the 15 July 2021 UEC clinical business unit governance meeting despite this being an agenda item. (Page 59)
CQC2021-19	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.	Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We checked medicine storage and prescriptions on both patient wards, the neonatal unit and within theatres. All medicines were stored correctly and securely. Temperature checks were undertaken as per the trust policy except for theatres where the ambient room temperature was not recorded. Paediatric services were included in an annual fridge temperature monitoring audit dated 2020/2021. This demonstrated that room temperature checks were not consistently completed including in paediatric theatre areas. (Page 163)
CQC2021-20	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	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.	During the inspection, we were told by family members that interpreters had not been provided to enable parents who did not speak English to give informed consent. We reviewed two relevant patient records and found that on three occasions, there was no evidence of an interpreter being used out of a total of seven opportunities reviewed. These opportunities included medical reviews, outpatient consultations and ward admissions during which parents would be required to provide relevant patient information and give consent to various care and treatment plans. (Page 172)
CQC2021-21	Children and young people	County	Core services inspection	Should Do	The trust should ensure cleaning records are completed as per trust policy.	Cleaning records did not always demonstrate that all areas were cleaned regularly. For example, on Safari ward we found that the parents room cleaning checklist had not been completed the week of our inspection, 4 October to 7 October 2021. On the neonatal unit, we saw the cleaning log for high and low clinical areas was not completed for the 6 and 7 October 2021. (Page 156)

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-22	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.	Staff knew about and understood the standards for mixed sex accommodation. The trust policy 'eliminating mixed sex accommodation' (updated 2021) outlined that children and young people, should ideally not share sleeping areas with patients of the opposite sex; however clinical conditions, age and other factors would take precedence over this. Staff on the wards for children and young people described working within this policy. Staff told us if a patient/ parent or carer raised this as a concern they would try to accommodate them, however this was by exception basis. Therefore, some young people may have felt uncomfortable but due to not directly raising this with staff; this was not considered. (Page 174-175)
CQC2021-23	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider the use of a communication tool to support staff working with children who have additional needs.	Staff supported children and young people living with complex health care needs however did not use 'this is me' type documents. Managers and staff told us they did not use 'this is me' or similar documents to provide a quick and concise overview of individual children's needs, particularly children with additional needs which may have impaired communication. The trust had an 'all about me' booklet specific to adult patients with dementia. (Page 177)
CQC2021-24	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that a patient's food and fluid intake is accurately recorded.	Staff did not always fully and accurately complete children and young people's fluid and nutrition charts where needed. Managers audited nutrition and hydration. Managers monitored staff use of the Paediatric Yorkhill Malnutrition Score (PYMS) and care plans where appropriate, patients' weight being taken upon admission, children with alternate feeds having care plans, nil by mouth care plans being in place and fluid and feed charts being competed accurately. Data from the trust for Rainforest ward showed mixed results. For measures relating to PYMS; the audit score was 0% from April to July 2021 from a review of 10 patient records. This indicates staff were not using this method in this timeframe. However, 100% of records reviewed showed children had been weighed and measured on admission to a ward. In addition, where children had alternate feed plans in place; 100% had a care plan to support this. For July 2021, the audit showed 100% of fluid/ food charts were completed correctly. However, for April, May and June 2021 a score of 0% was recorded. This indicated that either there was not enough data to review, or that staff were non-compliant with this measure. (Page 166)
CQC2021-25	Children and young people	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider adding specific action plans to the service risk register.	The service had a corporate risk register for the children and young people service as a whole. This included one risk specific to Pilgrim Hospital; the remainder were more generalised potential risks rather than specific to the current status of the service at Lincoln County Hospital. Mitigating actions were listed to reduce risks however these were not specifically allocated or dated therefore it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the directorate leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated. (Page 182)

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CQC2021-26	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.	Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys containing medicines and equipment required in an emergency were accessible on all wards we visited. They were safely secured with tamper proof seals. Most of resuscitation trolleys we looked at during our inspection were checked daily and weekly to ensure they were stocked, equipment was in working order and medicines were up to date. However, one ward which we visited, which had just been opened to receive patients, had a resuscitation trolley which had not been checked. This wasn't in line with the trust policy of checking wards before they were opened. (Page 135)
CQC2021-27	Medical care (including older people's care)	Lincoln County Hospital	Core services inspection	Should Do	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.	As a result of the Covid-19 pandemic and the resulting ward reconfigurations, performance had declined on a number of national clinical audits including; the National Lung Cancer Audit 2020 and the Sentinel Stroke National Audit Programme 2019/21. The Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit Benchmarking (NCAB) report for the data period 2018/19 was published in July 2020 and showed the trust to be performing generally 'as expected'. (Page 141)
CQC2021-28	Maternity	Lincoln County Hospital	Core services inspection	Should Do	The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	Most staff knew what incidents to report and how to report them and we saw evidence that incidents were being reported however, two of the 14 midwifery staff we spoke with told us they did not always report incidents relating to safe staffing. One staff member told us their manager had told them not to report safe staffing incidents and the other staff member had not recognised that the incident they described to us was potentially a reportable incident. The systems in place to ensure there was shared learning from incidents were not consistently followed. These systems included emailing all staff with this learning and reading out lessons learned and safety information in every handover. This safety update was referred to as a 'newsflash'. Staff did not read the newsflash out during the handovers we observed during our inspection which was not in line with the trust's agreed processes. This meant there was a risk that staff may not access learning from incidents in a timely manner if they were unable to access their emails. Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. Staff told us that managers provided debriefs and support after any serious incident. (Page 128)

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QC2021-29	Maternity	Lincoln County Hospital	Core services inspection	Should Do	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.	Specialist training for staff specific to their roles was provided. However, effective systems were not in place to ensure staff consistently completed all the required additional training for their roles. We found that an effective system was not in place to ensure midwives responsible for recovering women post anaesthesia were competent to carry out this role. At the time of our inspection, only 24 of the 42 midwives eligible for recovery training had completed this training and a list of competent midwives in recovery was not readily accessible to enable midwives in charge to allocate competent staff to the recovery role. This meant there was a risk that women would be recovered by staff who were not trained to do so. We escalated this during our inspection and the trust told us how they would address this to mitigate this risk. We found no evidence that harm had been caused as a result of this competency gap. (Page 128)
CQC2021-30	Maternity	Lincoln County Hospital	Core services inspection	Should Do	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.	The maternity dashboard audit scores from July to September 2021, had not been effective in addressing risks associated with the environment; the general environment for the maternity ward was consistently scored as 78% and RAG rated as red. This meant the equipment and facilities concerns we identified such as; unsafe door frames, broken bath panels and non-functioning blinds, whilst identified, had not been addressed in a timely manner. The lack of action from the estates team to address reported issues had also not been effectively escalated to ensure reported issues were rectified in a timely manner. This included the broken toilet seat that had been reported in May 2021 that had not been fixed at the time of our inspection. (Page 131)

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CQC2021-31	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.	The service did not always perform well for cleanliness. Monthly audits demonstrated the service did not always meet the expected infection, prevention and control (IPC) standards. From July to August 2021 monthly IPC audit compliance averaged from 79% to 87%. An action plan was in place to improve compliance and was monitored monthly by the IPC group. Regular IPC briefings were communicated to staff to demonstrate expected standards. For example, in August 2021 a COVID-19 pandemic briefing was sent out following a rise in outbreaks with guidance for staff to protect themselves and patients. Cleaning records were generally up to date to demonstrate areas were cleaned regularly. Cleaning records over the three-month period prior to our inspection showed all areas had been cleaned as per the cleaning schedule. However, the 'decontamination of bed space' following discharge record in cubicles was not completed to demonstrate the area had been appropriately de-contaminated. Staff could not confirm a room had been decontaminated before moving a new patient in. (Page 29) Staff cleaned equipment after patient contact. We observed equipment was generally clean including blood pressure monitors, electrocardiogram machines and trolleys. A health care assistant was allocated each shift to maintain a clean and tidy environment. Equipment was not always labelled to show when it was last cleaned. 'I am clean' stickers were not always used to indicate equipment had been cleaned to the correct standard. For example, we saw a commode and ultrasound machine did not have a sticker to let staff know if it had been cleaned since last use. However, we saw urinals did have 'I am clean' stickers. Monthly matron audits from April to September 2021 demonstrated on average 86% compliance with 'I am clean' stickers on commodes. In May 2021 this was 56% and June 2021 70%. Whilst stickers were not present, we observed equipment appeared to have been cleaned. (Page 30)

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CQC2021-32	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	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.	Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. Staff told us a patient requiring additional supervision would be placed in an observable majors' bay. However, due to the layout of the department patients who were at risk of selfharm could have access to rooms and equipment which had the potential to cause harm. For example, the clean procedures room was easily accessible and we saw contained hazardous equipment. Toilets and bathrooms were accessible and contained ligature points. Following our inspection, the trust provided us with a plan to reinstate a mental health room (room 15) which was intended to be modified to meet appropriate standards. As an interim, the trust advised us any patient with mental health conditions requiring use of the room will receive one to one supervision. The trust confirmed they had also removed ligature risks identified in this room. (Page 31) Mental health risk assessments were not routinely completed. However, staff told us they would be completed if a patient attended with a mental health related concern or following self-harm or attempted suicide. During our inspection we reviewed the care of a patient who attended following self-harm. Despite the notes indicating the patient was at 'medium' risk, there was no mental health risk assessment in place. This meant the service did not identify actions to be taken to reduce the risk of harm to the patient whilst in the department. This was escalated and the risk assessment was subsequently completed. (Page 34) Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed one record where a patient was deemed to be medium risk of self-harm. However, there was no mental health risk assessment completed to ensure the patients' needs were being met and mitigations in place to reduce risk of self-harm. This was escalated and the risk assessment was implemented. Managers told us risk assessments were normally in place, however, did not audit compliance. (Page 35) We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines. (Page 42) Processes were in place to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we did not see evidence these processes were fully implemented. Documentation was in place which directed staff on managing patients presenting with a mental health condition. We reviewed one set of notes for a patient presenting with mental health concerns and self-harm. However, there was no mental health risk assessment in place to determine the patients background, individual needs, risks and actions to prevent the patient coming to harm. Audits were not completed to assess staff compliance with mental health risks assessments to provide assurance they were consistently implemented. (Page 43)

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CQC2021-33	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	However, during our inspection we found ambulance conveyed patients did not always undergo a face to face triage by the pre-hospital practitioner (PHP) at the point of arrival. The triage was taken from clinical information provided by ambulance staff who were mostly ambulance technicians as opposed to paramedics. This included an overview of the patient's complaints, condition and any clinical observations taken to enable the PHP to complete the triage tool. Ambulance crews continued to monitor patients and perform observations on the ambulance where patients could not be admitted to the department straight away. (Page 32) Processes were in place for medical staff to complete face to face reviews of patients waiting over 60 minutes on an ambulance, however, this was not fully implemented. The trust standard operating procedure (SOP) for management of reducing ambulance delays states patients who experience ambulance offload delays should be reviewed by a member of the ED medical team within one hour of arrival. During our inspection we did not observe this was routinely completed and ambulance staff commented this did not always take place. Following the inspection, the service sent us harm reviews of 17 patients who waited more than two hours on an ambulance. Only three of the reviews showed evidence the patients were reviewed on the ambulance by the emergency physician in charge (EPIC). In two cases, this was over an hour after arrival. Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. (Page 32-33) Whilst there were some concerns with patients not being physically reviewed by the PHP and medical staff whilst on ambulances, the service had improved its oversight and management of patients waiting on ambulances. Systems were in place to monitor patients. Patients were handed over in time order unless the clinical condition of the patient indicated otherwise. There was good communication between ambulance staff and PHP. We observed patients showing signs of deterioration being escalated and arrangements being made to re-prioritise for admission. For example, a patient who arrived and developed chest pain was immediately prioritised. (Page 33)

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CQC2021-34	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.	Falls risk assessments were not completed routinely within the emergency department. However, staff told us they would be completed for patients at risk of falling. We identified five patients at risk of falling. Three had been in the department more than four hours yet did not have a falls risk assessment completed. This was escalated at the time and they were subsequently completed. Matrons monthly audits from April to September 2021 demonstrated variable compliance with falls risk assessments. In May 2021 75% falls risk assessments were completed and in June 2021 83%. Compliance had improved to 100% from July to September 2021. (Page 35 now Page 34) Patient notes were easily accessible but not always comprehensive. Nursing and medical staff had access to patients' paper and electronic records. Most sections of the casualty assessment were completed; however, the content was minimal and lacked detail of patients individualised needs. Risk assessments were not always completed for patients with specific needs. For example, we found falls and mental health risk assessments were not consistently used for patients who required them. Record were regularly updated to record two hourly care rounding, however, the content varied with lack of standardised approach to information recorded. (Page 40 now Page 39) Evidence that changes had been made as a result of feedback was variable. For example, managers told us they had introduced a ward handover document for staff to complete and document key information when handing patients over to wards. We reviewed six records of patients who had been transferred and these were completed. However, we were not assured learning from falls related incidents had been fully implemented as we observed three patients who were high risk of falling without a falls risk assessment and falls prevention practices in place. (Page 42 now Page 41)

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CQC2021-35	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.	Furthermore, the SOP stated patients with a NEWS score of five or above or any clinical condition which required prioritisation should be reviewed by medical staff on the ambulance within 30 minutes. During our inspection we saw a consultant review a patient on the ambulance where the NEWS score had increased and another where pain levels had worsened. However, we were not assured this process was fully implemented. For example, harm reviews showed one patient arrived at 19.53 with a National Early Warning Score (NEWS) score of five which deteriorated to a score of eight at 21.43. There was no evidence the patient had been reviewed by the consultant according to the harm review. The patient was seen by a doctor at 22.45 once offloaded from the ambulance. Whilst there were some concerns with patients not being physically reviewed by the PHP and medical staff whilst on ambulances, the service had improved its oversight and management of patients waiting on ambulances. Systems were in place to monitor patients. Patients were handed over in time order unless the clinical condition of the patient indicated otherwise. There was good communication between ambulance staff and PHP. We observed patients showing signs of deterioration being escalated and arrangements being made to re-prioritise for admission. For example, a patient who arrived and developed chest pain was immediately prioritised. The PHP undertook hourly ambulance checks to review clinical observations taken by ambulance crew. This included reviewing signs of deterioration, pain assessments and comfort rounds. This was recorded in the patient casualty card. The PHP liaised with the nurse in charge (NIC) and EPIC to update on patients waiting, clinical condition and overview of NEWS. Two hourly safety huddles took place between the NIC and EPIC to review all patients in the department with input from the PHP. Harm reviews were completed where patients waited longer than two hours and rapid reviews for those waiting over four hours. Of the 17 patients waiting more than two hours on an ambulance on the days of our inspection, none had come to harm. Staff used a nationally recognised tool to identify deteriorating patients and generally escalated them appropriately. Patients were seen by a triage nurse for an initial assessment in time order, unless they presented with a red flag condition, such as suspected stroke or chest pain. A nationally recognised tool was used to triage patients which provided a risk rating of one to five. An emergency button was in the triage room used by the triage nurse if there was a clinical need for urgent prioritisation. If the patient required prioritisation but was stable a process was in place to escalate to doctors for immediate review. A consultant was located in the waiting room to ensure patients were streamed to the correct area and assisted the triage nurse in assessing patients. Clinically unwell patients were identified by a red/purple card system. We observed triage nurses escalating to the NIC and EPIC for medical review where there were concerns. The department used NEWS2 to identify acutely ill patients, which supported staff with the early recognition of deteriorating patients. NEWS we looked at during our inspection were generally completed on time and escalated and monitored in line with frequency rules. We saw where required they were escalated to the NIC and EPIC. For children and young people, the paediatric early warning score (PEWS) was used in conjunction with the paediatric observation priority score (POPS). All paediatric patient records we reviewed had observations recorded and monitored. (Page 34-35 now Page 33)

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CQC2021-37	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	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.	The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses however, this was not always done in a timely manner. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, learning was not always fully implemented. When things went wrong, staff apologised and gave patients honest information and suitable support but not always in a timely manner. Managers ensured that actions from patient safety alerts were implemented and monitored. (Page 40) Staff raised concerns and reported incidents and near misses, but this was not always done within timescales outlined in trust policy. For example, we reviewed three serious incident reports and noted a delay in reporting. One was not reported for 31days following the incident, another for 18 days and another for six days. Staff told us they escalated incidents to the nurse or consultant in charge at the time. (Page 41) Incidents were not always investigated in a timely manner and there was a backlog of incidents requiring investigation. However, significant improvements had been made investigating the back log since our previous inspection in 2019 where there was a back log of over 1000 incidents. Managers told us this had reduced to approximately 140 at the time of the inspection and a plan was in place to continue to address the back log. (Page 41) However, we were not assured learning from falls related incidents had been fully implemented as we observed three patients who were high risk of falling without a falls risk assessment and falls prevention practices in place. (Page 41)
CQC2021-38	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure clinical pathways and policies are updated in line with national guidance.	Staff followed the most up to date policies to plan and deliver high quality care according to best practice and national guidance. However, policies were not always up to date. For example, the guideline for the assessment of acute chest pain was last reviewed in 2018 and was due to be reviewed in August 2021. We also identified the mental health risk assessment had not been updated to reflect changes with the footprint of the department and removal of the mental health room. This had a significant impact on the safe management of patients at risk of self harm. Whilst staff appeared to be aware of pathways, they could not always sign post us to where to find local guidelines. (Page 42)
CQC2021-41	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	The trust should consider all key services being available seven days a week.	Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week. However, there were some tests such as ultrasound which were not always available at weekends. A business case was being formulated to move to seven-day service provision. (Page 108)

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CQC2021-42	Children and young people	Pilgrim Hospital	Core services inspection	Should Do	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).	The trust did not routinely monitor or audit waiting times for children to have a medical review as per the Royal College of Paediatrics and Child Health (RCPCH). This meant the trust did not have full oversight or assurance against this measure. (Page 120)
CQC2021-43	Medical care (including older people's care)	Pilgrim Hospital	Core services inspe	Should Do	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.	The trusts target for mandatory training was 90%, the average completion across all the courses for medical wards was 82%. Nursing staff received and kept up to date with their mandatory training. Face to face modules of mandatory training had been reduced during the pandemic. The division had a plan in place to increase this training as the pressure of the pandemic decreased. The trust aimed to be back to 90% by the end of November 2021. During the inspection, bank staff across the trust reported that they did not always feel supported with their mandatory training and having time to complete it. This was raised with the trust and they provided us with assurance that they were looking into mandatory training for bank staff and putting processes in place to support this. Medical staff received and kept up to date with their mandatory training. At the time of our inspection the completion rate for medical staff mandatory training across the medical wards was 85%. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support. Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed this training once every three years, the compliance rate for Mental Health awareness training at the time of our inspection was 90% and dementia awareness was 91%. At the time of our inspection the trust were in the process of starting training on learning disabilities and autism and hoped to have this started by December 2021. Managers monitored mandatory training and alerted staff when they needed to update their training. The trust had reports that could be collated to show compliance with mandatory training at different levels and this was monitored through the trust's governance structures. However, ward managers we spoke with would like 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. (Page 69)

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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:	**18 May 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust – Reconfiguration of Urology Services Update**

Summary:

A reconfiguration of urology services at United Lincolnshire Hospitals NHS Trust (ULHT) became effective on 9 August 2021, following a twelve week consultation period and a decision by the ULHT Board on 3 August 2021.

On 16 February, a report was submitted to this Committee on the progress with the intended aims of the reconfiguration, and it was agreed that a further report would be committee to this Committee in three months.

This report set outs improvements in performance, including a sustained and significant reduction in expenditure on agency staff. These improvements have been impacted by the significant urgent and emergency care pressures and progress will continue to be monitored.

Actions Requested:

The Health Scrutiny Committee for Lincolnshire is requested to consider this paper as an update of the implementation of the new model for urology in Lincolnshire's hospitals.

1. Background

In early 2021, United Lincolnshire Hospitals NHS Trust (ULHT) highlighted challenges facing the urology service across Lincolnshire's hospitals and proposed a public engagement exercise to consult upon proposed changes to these services.

The twelve week consultation began on 17 May 2021 and included a discussion at Health Scrutiny Committee for Lincolnshire on 23 June 2021 and at ULHT's Trust Board on 6 July 2021. On 3 August 2021, the findings of the consultation were presented to the ULHT Trust Board, and the proposed changes to the urology service approved, to start on 9 August 2021.

An update was provided to the Health Scrutiny Committee on 16 February 2022 regarding the operation of the reconfigured service model, who requested a further update be provided in May 2022.

2. The Model

Whilst previously the urology service within ULHT involved emergency urology patients being admitted to both Lincoln County Hospital and Pilgrim Hospital, Boston, the approved reconfigured model enabled Lincoln County Hospital to receive all emergency urology admissions seven days per week. The aim was to ensure that the other sites were better organised to manage the majority of elective urology procedures, thereby reducing elective cancellations, increasing capacity and supporting the recovery of services post-Covid-19.

Essentially, this approach planned to level the demand across the sites, creating enhanced patient choice and reducing patient wait times, while better meeting the needs of our emergency cases.

Under the current reconfigured model, Pilgrim Hospital continues to see emergency urology patients, but if the patient needs admission or surgery, they are transferred to Lincoln County Hospital, if they are medically stable to do so. Where patients are too unstable for transfer, they are admitted to Pilgrim Hospital Intensive Care Unit and the on-call urology consultant will travel to Pilgrim hospital site as required to assess and support with the management of the patient.

3. Case for Change

Historically ULHT had struggled with delivering the optimal mix of capability, capacity, and resources for urology across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked ways of working. Over recent years ULHT has experienced pressure on elective beds due to a high volume of unplanned admissions.

Alongside this, prior to the service reconfiguration, high medical vacancies existed across ULHT in the urology (elective and non-elective) service (c.28% of medical posts vacant). Data analysed between 2017 - 2020 inclusive showed that, on average, five urology procedures were cancelled every day (c.1,900 annually). For the procedures that were cancelled by the hospital (i.e., not by the patient), around 25% were cancelled on the day and 10% due to lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, and additional pressure on the waiting list. Being cancelled on the day of surgery is extremely distressing for patients and their families.

The NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate dedicated site allows improved emergency assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

Getting It Right First Time

On the basis of recommendations arising from the Urology Getting It Right First Time (GIRFT) visit, Urology was selected for a major reconfiguration supported by the Integrated Improvement Directorate (IID) Delivery Team and KPMG, with strong executive sponsorship.

The GIRFT programme's national report into urology services, published in 2018, made a number of important recommendations around the delivery of emergency urological care. These include providing consultant delivered emergency care by reducing elective commitments when on call, reviewing workloads to ensure on-call arrangements are sustainable, and focusing available resources to ensure high-quality emergency care is available seven days a week. Most NHS organisations ensure that consultants are not on-call when delivering elective commitments to ensure prompt response to emergency care.

The current reconfigured model for urology services at ULHT was developed following an options appraisal with GIRFT clinical lead, Mr Simon Harrison, who supports the delivery of these recommendations. Support has been provided by the regional GIRFT implementation team throughout the project, through weekly meetings with the project team, and the current reconfigured model was presented to the GIRFT clinical leads on 23 July 2021. The team offered uniform support for the model. The successful embedding and operation of the model was noted at the GIRFT re-visit on 5 April 2022.

The key features of the reconfiguration include:

- focus for acute urology at a single site emphasising increased same day care, acute lists and clinics;
- maintenance of diagnostic and outpatient activity across sites;
- increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures;
- retaining some complex major procedures at Lincoln County Hospital; and
- a single urology team with expanded consultant and SAS (middle tier) colleagues and a new tier of acute care practitioners.

Additionally, the project outcomes link directly to the Trust's 5 year Integrated Improvement Plan. At high level, the alignment to each of the strategy themes is as follows:

Patients	• Complaints, SI's and DATIX • Average length of stay (emergency) • Cancelled procedures • Cancer Performance (28d) • Variation in cost per patient (PLICS) • Procurement costs
People	• Staff engagement and medical vacancy rates
Service	• Financial performance • Agency costs • Service stability
Partners	• Collaboration with GIRFT – best practice alignment and delivery of GIRFT recommendations.

4. Evaluation of Performance

In the original evaluation of the new reconfigured model, it was recommended that the trust adopts a reporting dashboard to track delivery of the key expected benefits, monitor desirable/undesirable impacts and drive performance improvements in terms of quality, safety, patient experience and use of resources.

These criteria were fully defined in the original Project Charter for the reconfiguration. This dashboard has now been created, therefore, performance against the KPI's is regularly monitored and performance against these are highlighted below in 'Benefits Matrix'. The dashboard aligns with the 'scorecard principle' adopted by the wider Outstanding Care Improvement System (OCIS).

	Expected Benefit Areas
	Medical agency spend reduction Procurement cost opportunities Reduction in service deficit against budget Sustainable financial service Urology assessment unit Improved flow from the Emergency Department
	Improved engagement Training opportunity for SAS & ACP tier Reduced admin burden to manage rota and resource

Complaints, SIs and DATIX reductions
Average length of stay reduction
Direct access model for cancer pathway
Continuity and consistency of care
Increase in proportion of patients discharged from assessment unit
Improved flow from ED
Reduced waiting list and pathway times for cancer and RTT
Reduced cancellations on the day
Reduction in non-elective admissions and overall bed usage

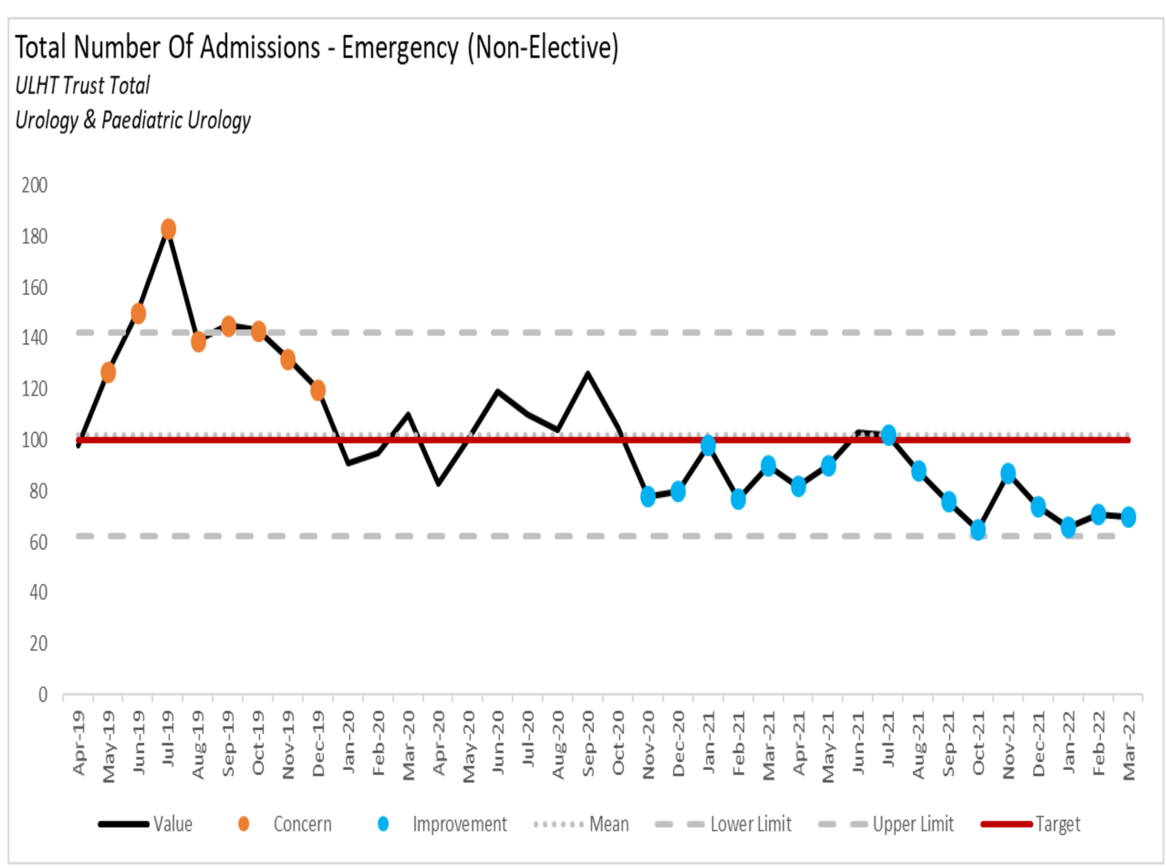
Alignment of solution with GIRFT recommendations and best practice guidance
Increased support of Primary Care
Work with system to provide best care for Lincolnshire patients

Performance Review

The following figures are taken from the Performance Dashboard with figures updated to March 2022

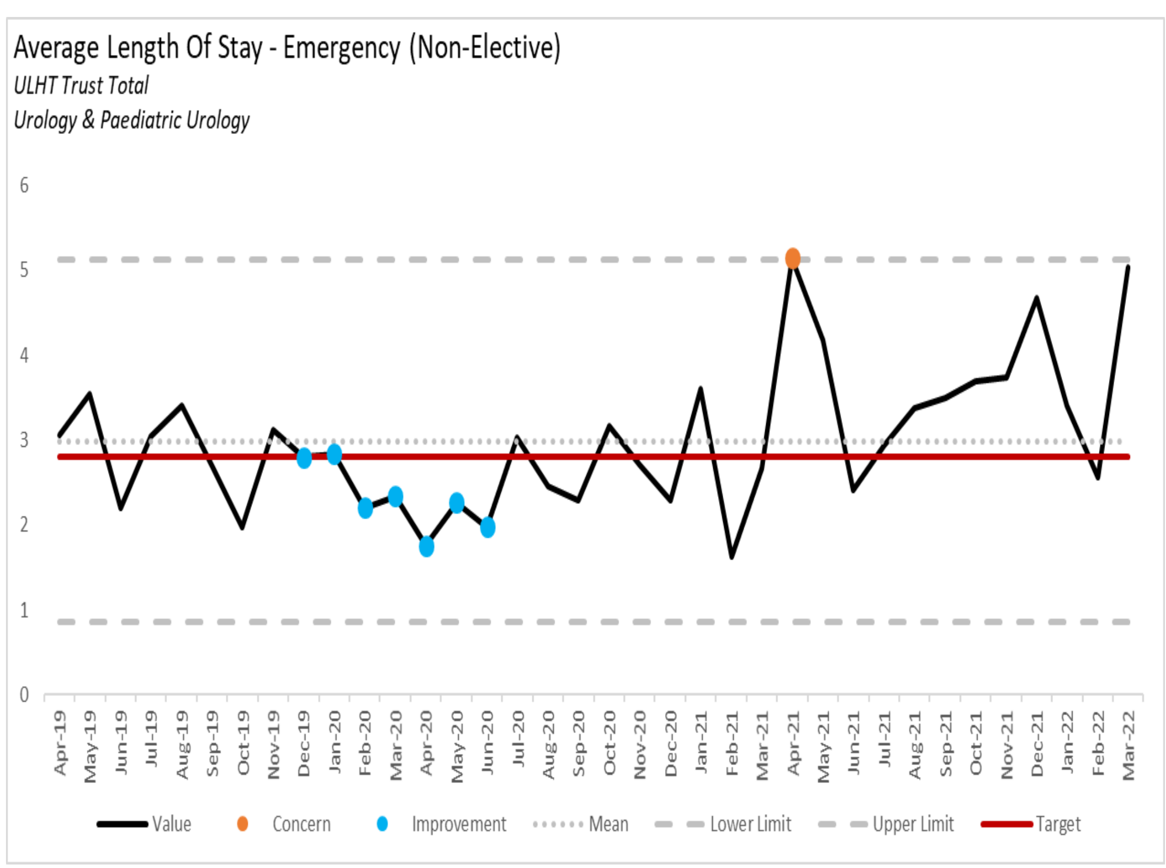
Non-Elective Performance

There was concern prior to the re-configuration that non-elective admissions would increase. The reconfigured service went live on the 9 August 2021. As you will see from the graphs below, admissions increased at Lincoln County Hospital once the reconfiguration commenced but are now significantly lower than what they were Trust-wide pre re-configuration. This improvement has been sustained through to March 2022.



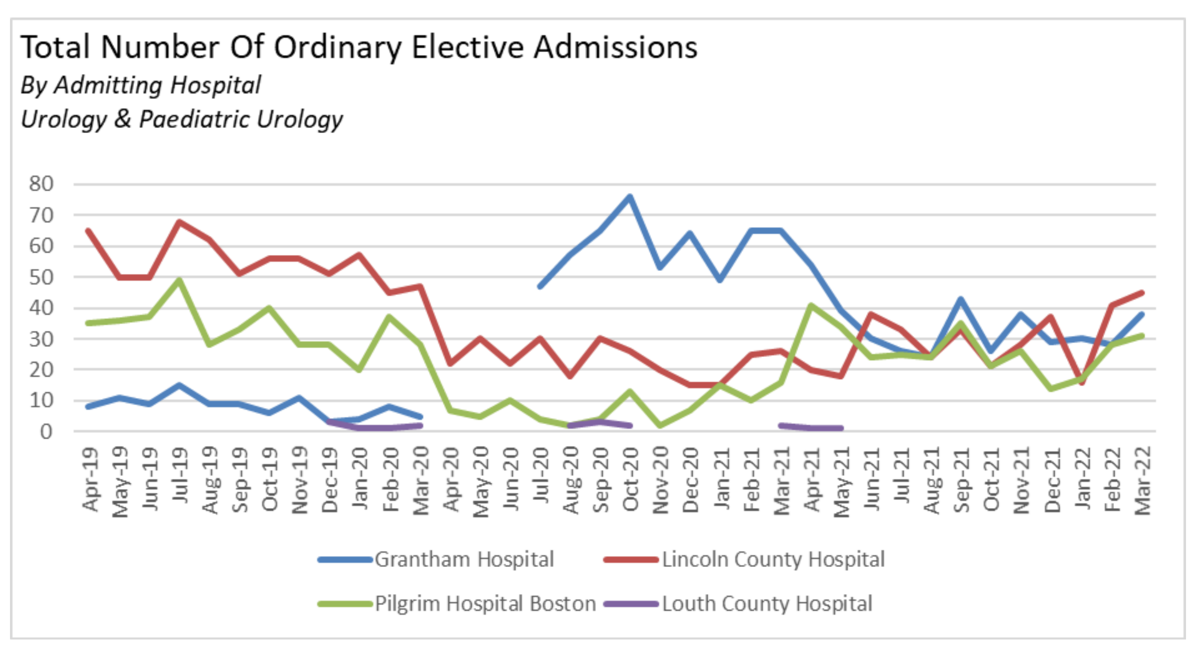
<u>Average Length of Stay Non-Elective</u>

Average length of stay on the urology non-elective pathway has increased, as have all other specialties within ULHT. In part the related to increased complexity with less complex patients being seen and discharged rather than admitted. It is anticipated that further improvement will occur following development of the Urology Assessment Hub



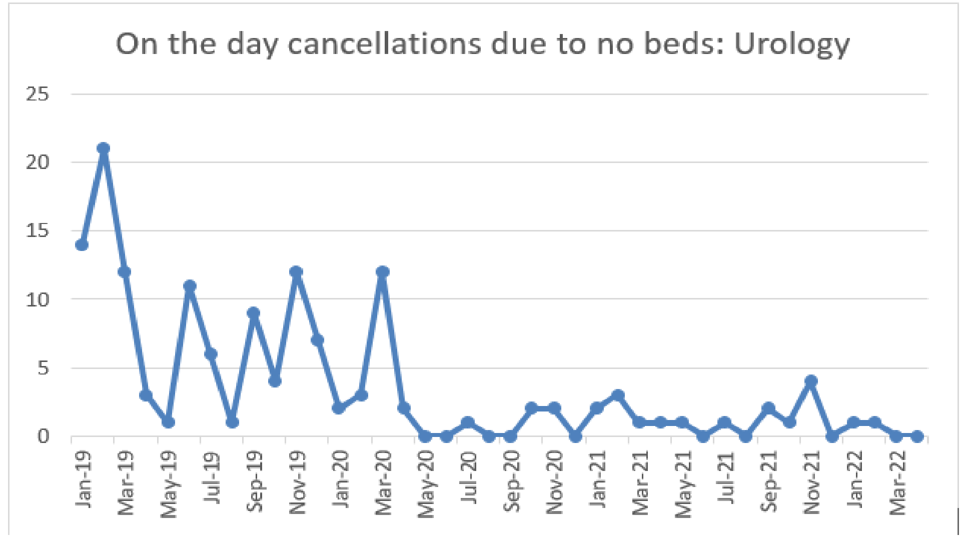
Elective Admissions

The elective admission profile has now reached a steady state following reconfiguration, with a balance of elective admissions across the three main sites: Lincoln is the focus for more complex and robotic work; Grantham provides lower complexity high volume work and Pilgrim delivers intermediate level activity including specialist stone surgery.



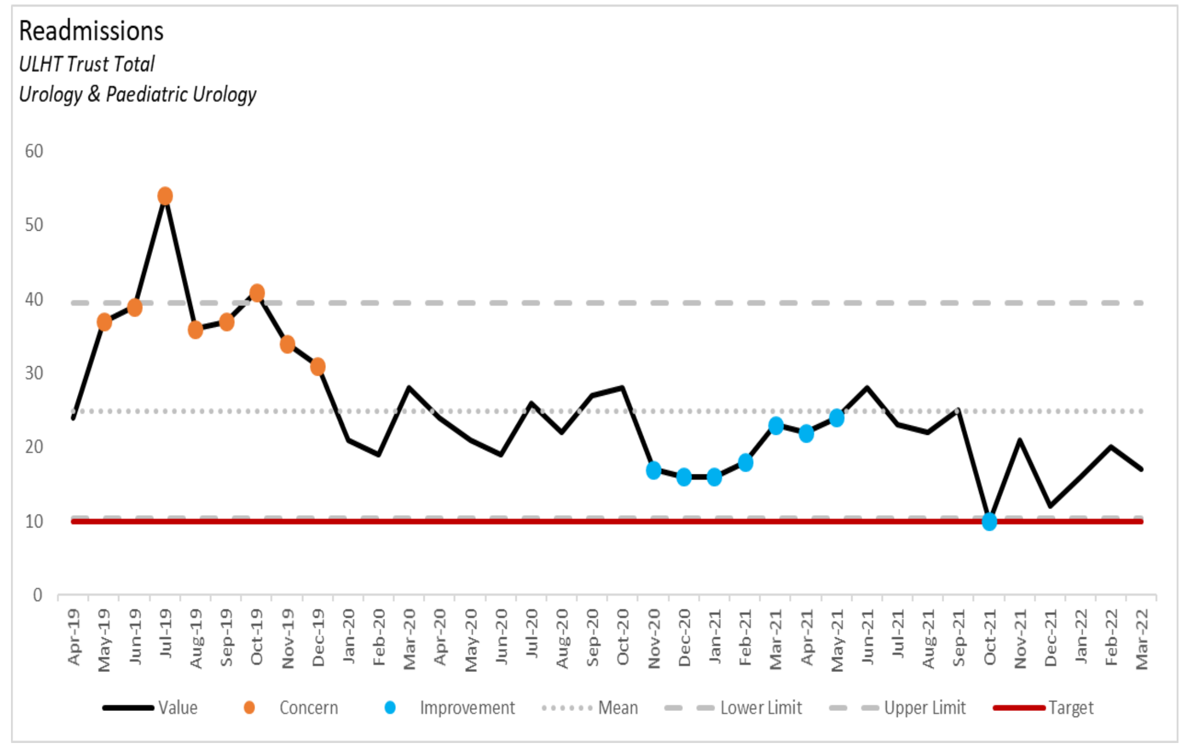
Cancellations on the Day – Non Clinical

The previous high levels of on the day cancellations have now been virtually eliminated; this has been achieved by a combination of increased activity through the Grantham site and protected capacity within the admission areas on the Pilgrim and Lincoln sites.



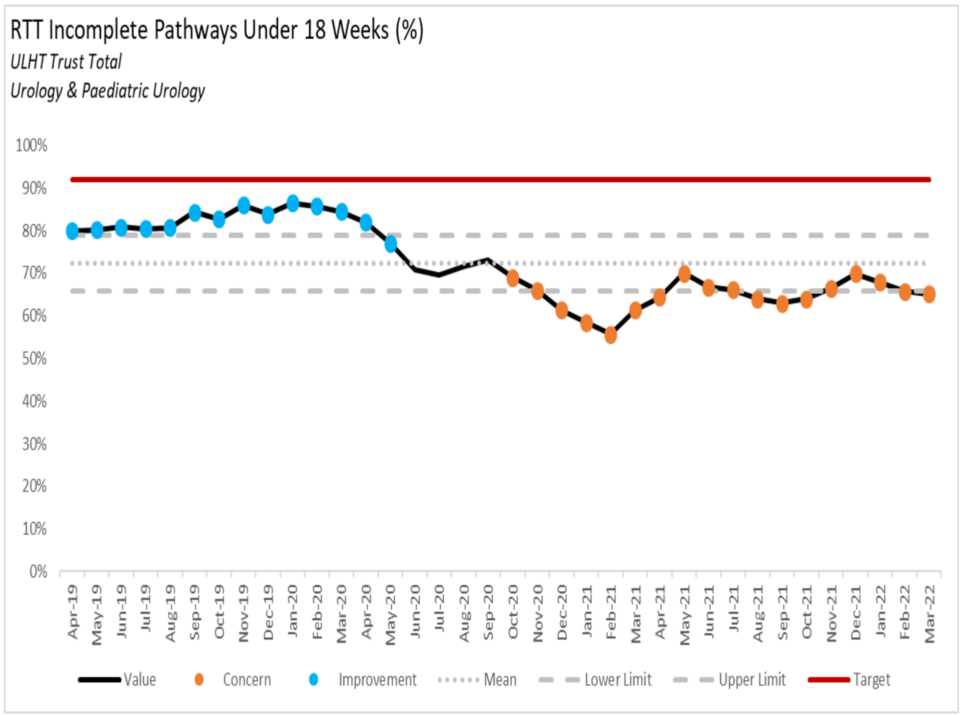
Readmissions

Readmission rates are an important quality indicator and have shown continued improvement through and following reconfiguration.



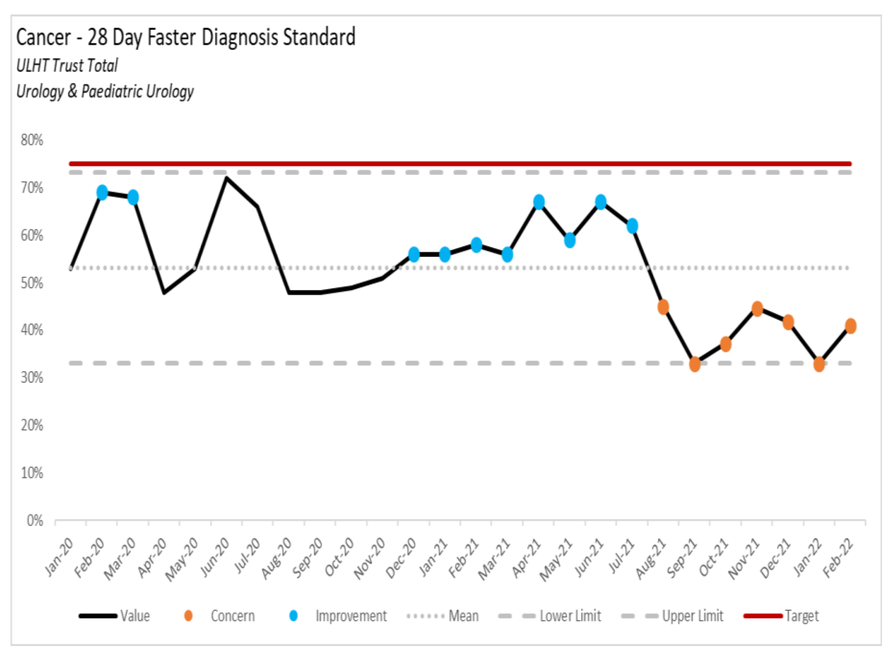
Referral to Treatment (RTT) Performance

In common with other specialties and other providers, urology continues to struggle with RTT performance, although the position remains static. However, the number of patients overdue on the partial booking waiting list has fallen significantly and the specialty has no patients waiting over 65 weeks for admission.



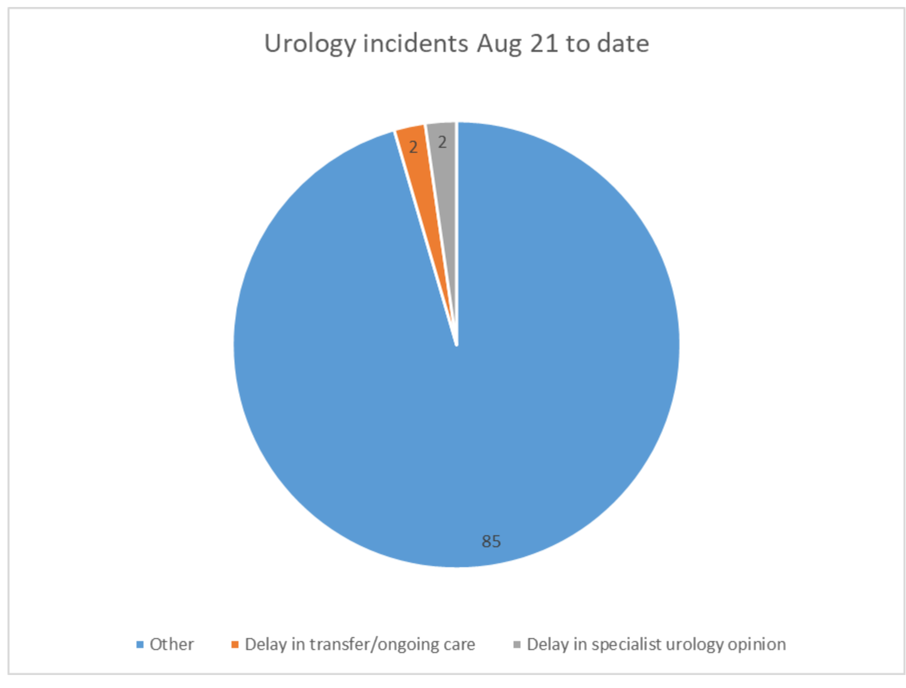
Cancer Faster Diagnosis Standard

The speciality has not achieved the faster diagnosis standard since reconfiguration. However expedited pathways have now been implemented for testicular and prostate cancer. Additionally the urology Acute Care Practitioners are now undertaking cancer diagnostic activity (cystoscopies and prostate biopsies) as part of their extended role which will see this position improve significantly through increased diagnostic capacity.



Urology Incidents

The speciality actively monitors adverse incidents relating to the specialty. 89 incidents were reported during the period from August 2021 to April 2022. Of these, two related to delay in transfer/ongoing care for emergency urology patients and two related to delay in receiving specialist urology opinion for inpatients at Pilgrim Hospital. Of these four, all were categorised as no or low harm on investigation.

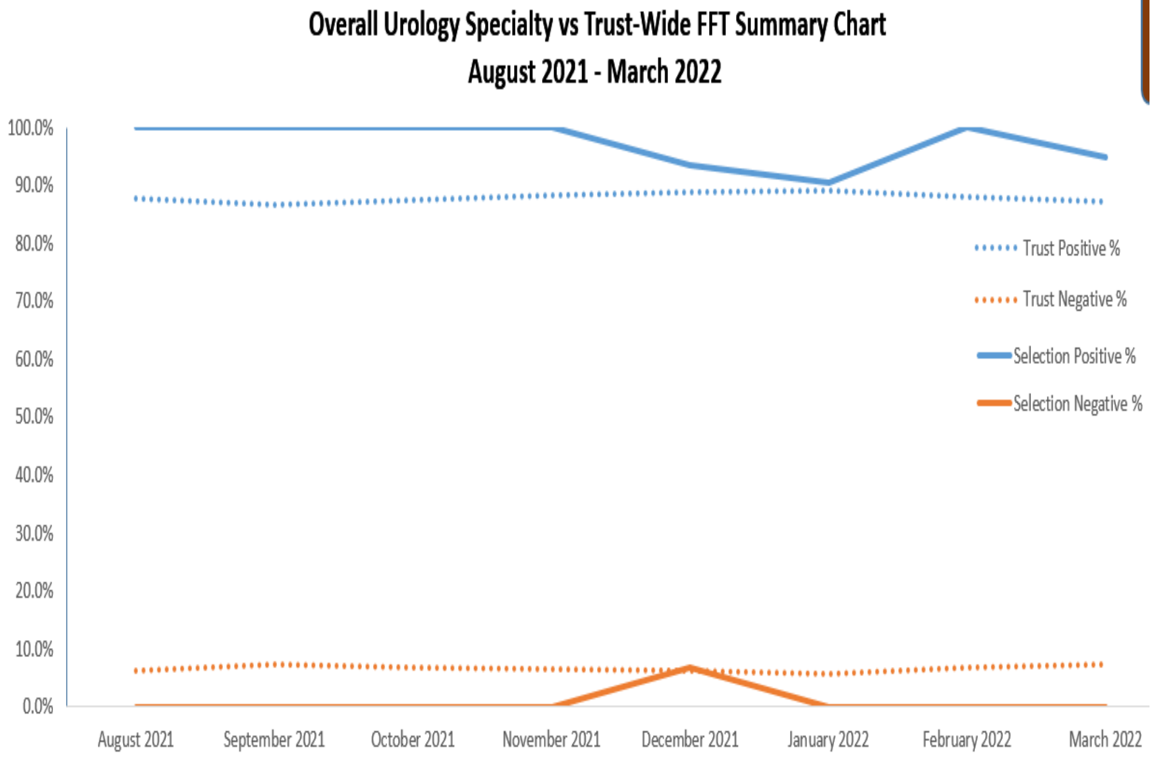


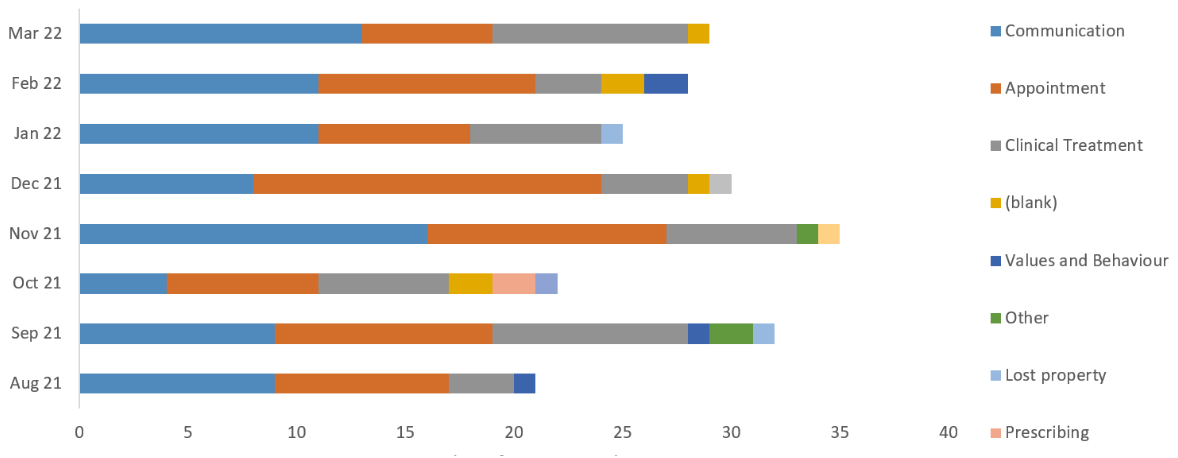
Quality Impact Assessment

The clinical risk analysis has directly fed into the Quality Impact Assessment (QIA). The QIA was signed off by the Trust's QIA Panel on 12 July 2021. A further update QIA and scorecard was presented on 17 November 2021, which received full support and final sign off. The QIA received high praise from the panel and commented that the level of detail and due diligence that has gone into the document is outstanding. The QIA is set out in Appendix A to this report.

Patient Feedback

The specialty continues to monitor patient feedback, including Friends and Family Test (FFT), compliments, PALS and complaints. The positive feedback on FFT sits above the Trust average, at 97% with only 1% adverse feedback. Analysis of complaints and PALS concerns shows the main areas of concern relate to communication and access to appointments, with no concerns relating to the service reconfiguration itself.





5. Public / Patient Engagement

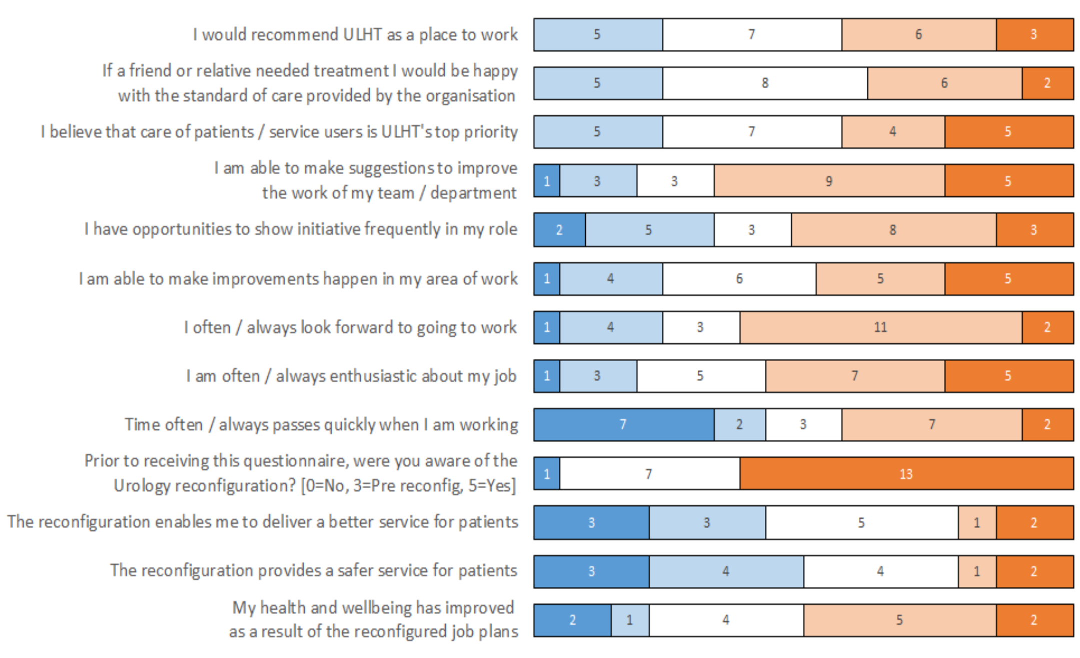
Prior to implementing the reconfiguration, we consulted with Lincolnshire patients over a twelve week period. This involved formal communications about the changes, focus group meetings with patients, clinicians and service leadership for patients to share their views about the proposed changes and to directly influence the reconfiguration model.

Positive Feedback	Concerns	Mitigation
Staff: complementary about current staff, see the change as a vehicle to improved recruitment and specialists. Resource usage: general feeling that reconfiguration will positively improve access to resources / service.	Travel & transport: concern about delays in treatment due to emergency transport to another hospital site. concerns about how Boston-area patients would get back home after discharge from Lincoln hospital.	Hospital transport on discharge will be provided for qualifying patients; for other patients, solutions including taxi provision will be explored on an ad hoc basis.
Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in cancellations of elective activity. Support a reduction in elective waiting	Impact on other providers: EMAS ability to cope with demand.	EMAS are in full support of the proposal; modelling suggests the impact will be one additional transfer for admission per day

Positive Feedback	Concerns	Mitigation
times. Patients happy to travel for expert care. Activity: welcome increased elective activity at Pilgrim, Grantham and Louth hospitals	Patient safety: concern about risks connected with not receiving emergency care as quickly. Concerns about services being moved away from Pilgrim- disadvantaging population of Boston and the East Coast	The additional tier of on call provides enhanced access to specialist opinion through the SPOC and duty urologist at PHB. The provision of elective, diagnostic and specialist services at PHB will increase.

Staff Engagement

Although the next cycle of staff engagement is still underway, the specialty recognised the concerns previously expressed concerning the reconfigured model with particular reference to access to specialist urology opinion at sites other than Lincoln, especially Pilgrim Hospital. This was evident through the staff survey (below) and through concerns voiced at the Medical Advisory Committees. As a result, enhanced support, in addition to that offered by the urology single point of contact and on call consultant, is now provided on a daily basis at Pilgrim site through a "duty urologist" offering on site patient reviews and liaison where required with the on call team for ongoing management.



6. Finance

Prior to implementation there was a high reliance on agency medics. The investment into this service and improvements to the model of working was expected to improve recruitment and retention of staff. This included:

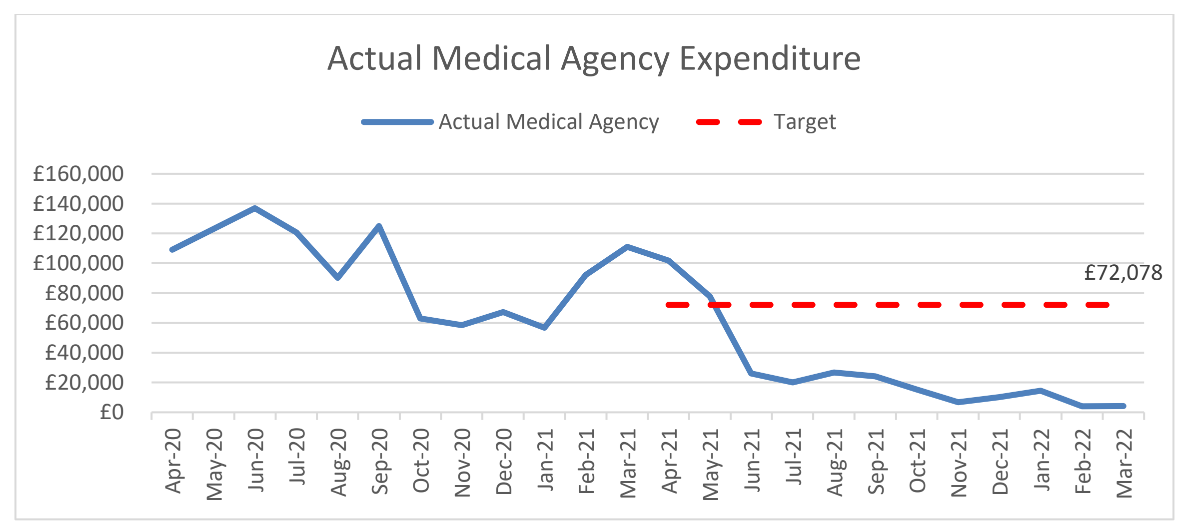
- Investment of 7.00 WTE Advanced Clinical Practitioners (ACP), who form part of the first on-call and reduce reliance on agency locums.
- Drive on substantive recruitment of medical staff, including an investment of budget from within the CBU to fund a 10th consultant post.
- Introduction of Core Trainees working across Urology and Orthopaedics at Grantham site, funded from within the CBU.

The total investment into the service is £700k pa. Spend on medical agency was £780k in 19/20 and £1,153k in 20/21.

	Current Establishment			Future Establishment	
Cost Category	WTE	Cost 19/20 £k	Cost 20/21 £k	WTE	Cost £k
Consultants	8.00	2,143	2,313	10.00	1,682
SAS	8.80	948	992	8.00	878
Specialist Trainee	1.00	119	99	1.00	81
Junior Drs	7.00	325	358	8.00	373
ACPs	-	-	-	6.00	470
Total	24.80	3,535	3,762	33.00	3,484

Table showing current vs future costs of the medical workforce plus the ACPs. The future cost represents the model fully established with post-holders at 'top of scale' and without any premium costs from agency or extra duties.

Medical agency spend has been virtually eliminated through substantive recruitment.



As a result of these investments and the subsequent elimination of agency the specialty is was projected to achieve a cost improvement of £300,000 (full year equivalent): the actual realisation is closer to £160,000 as a result of extra duty costs incurred as part of the elective recovery programme.

7. Key Risks / Issues

There are a number of potential issues to the continued success of the programme identified. These are listed below: –

Issues *(An Issue has already occurred)*							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Reviewed**
Retention of Middle Grade Doctors	21/10/2021	Open	Sara Anscombe	Working ongoing with HR to develop an individual development and training structure for each Middle Grade Doctor. Ongoing regular meetings with SAS doctors Ongoing recruitment cycle	2 (Low)	We may not be able to fulfil the obligations of the rota in its entirety and may have to utilise agency staff De-stabilisation of service.	01/04/2022
Compliance with the new service model by clinical staff – **all** urology patients being directed to LCH, without prior USPOC contact and agreement	19/08/21	Open	Sara Anscombe	Completion of SOP to incorporate roles and responsibilities model – this will then become and official Trust document and communicated accordingly and will ensure absolute clarity in terms of all aspects of the service model for non-elective walk-ins at non-receiving sites (SOP in final draft for CBU to verify and sign off) .	2 (Low)	The impact is: The flow of the patient pathway, and therefore the patient experience, may be compromised if the correct process is not followed, causing potential delay and inconvenience to our patients. Additional pressure on LCH to accommodate non-urgent urology patients, sent in by Pilgrim, that should be seen and treated as usual within A&E.	01/04/2022
Establishment of Urology/Trauma Assessment Hub (UTAH) – delayed partly owing to the stand down of CRIG halting progression	16/09/21	Open	Sara Anscombe	Although approved in principle and an area identified, funding to permit staff recruitment not yet agreed. Continued pressure on the surgical assessment area as a result.	3 (Moderate)	The establishment of the UTAH is essential to ensuring improved patient flow and timely treatment in the right location. The status quo of using SAU will need to be maintained.	01/04/2022

8. Conclusion and Next Steps

The model has now become embedded and accepted within the Trust as a safe and effective means of delivering urology services at United Lincolnshire Hospitals NHS Trust.

Metrics have shown performance improvements, although these have been impacted by the significant urgent and emergency care pressures that the Trust continues to experience. The team intends to continue to monitor the data to determine any trends over a longer time period.

To ensure performance recovers and remains on track the urology department, along with Information Services, monitor the dedicated dashboard (contained within the QIA) tracking key expected benefits. This dashboard is reviewed in real time to assess performance and give the CBU triumvirate team the ability to identify issues and rectify.

Additionally, a thorough lesson learned exercise has been carried out by the project team to ensure knowledge transfer is shared across the Trust.

The outstanding actions for the project team are:

- Implementation of Urology and Trauma & Orthopaedics Hub
- Recovery of Urology elective RTT and cancer KPI's in order to achieve target performance. Using C2-AI to ensure patients are treated in clinical priority order to optimise patient outcomes
- Ensure improved efforts to gain regular patient and staff feedback

The ULHT Board considered a paper which reviewed the service change to date on 7 December 2021, and agreed the continuation of the current model, based on the expected benefits of this model.

9. Appendices – These are listed below and attached to the report.

Appendix A	Quality Impact Assessment for the Reconfiguration of Urology Services at United Lincolnshire Hospitals NHS Trust

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 United Lincolnshire Hospitals NHS Trust.

APPENDIX A

QUALITY IMPACT ASSESSMENT – UROLOGY SERVICES RECONFIGURATION

Programme/Project	**Urology Surgery Reconfiguration**
Scheme Overview	On the basis of recommendations arising from the Urology GIRFT visit, Urology was selected for a major reconfiguration supported by the Improvement Team and KPMG, with strong executive backing. The key features of the new configuration include: Focus for acute urology at a single site emphasising increased same day care, acute lists and clinics. Maintenance of diagnostic and outpatient activity across sites. Increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures. Retaining some complex major procedures at LCH. Single urology team with expanded consultant and SAS numbers and a new tier of acute care practitioners. The current model of parallel working at the Lincoln and Pilgrim sites has caused some difficulties with onerous on call rota with frequent gaps which impact on our ability to provide a consistent and stable service for our patients. Alternating on call system at weekends has led to confusion in acute pathways, with many patients being redirected from one site to another. Financial impact through duplicate rotas, agency use and extra duties. Recruitment and retention problems, silo working and lack of whole team identity.
Quality Impact Overview	The new model will ensure the safety and well-being of clinical staff and will increase development and training opportunities for ACP's and middle grade doctors. This will stabilise our workforce, reducing reliance on agency staffing, ensuring consistency and safety for our patients. We will improve patient experience by ensuring efficient patient flow through the service, reducing unnecessary admissions, reducing same day cancellations of elective surgery, responsive ACP team (Urology Single Point of Contact USPOC) to ensure urology patients accessing the service through the ED route are seen and treated quickly and safely, without disruption to elective activity.
Quality Indicators	SI's (DATIX), Friends & Family Test, Complaints, Compliments, PAL's

Project Lead	Chloe Scruton, General Manager	Division	Surgery, Urology
Clinical Lead	Mr Andrew Simpson, Consultant Urologist and Deputy Medical Director – Clinical Effectiveness	Stakeholder Engagement	Neil Scott, Service Delivery Manager, EMAS; Patient Engagement Panel; internal meeting forums; project team membership and key contacts (including, CCG, Finance, GIRFT); public engagement exercise; HOSC
Senior Responsible Officer	Mark Brassington, Director of Improvement & Integration	QIA Completed By	Dawn Malloney, Project Manager, Delivery Team, IID
Financial Value	Projected year 1 service cost reduction of ~£300k	Overall Risk Score	12

Approved by Director of Nursing	Karen Dunderdale (remotely)	Date	12/07/2021
Approved by Medical Director	Andrew Simpson, Deputy Medical Director as Medical Director on annual leave	Date	12/07/2021

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Where a patient presents at A&E at a non-receiving site, consideration given to potential risk that a urology specialist will not be not available on site to provide immediate support	Negative	5	4	20	In the reconfiguration, 24 hour Single Point of Contact (USPOC) to ACP support based at LCH will be in place. The ACP's will have direct access to an on-call Consultant 24 hours. The USPOC will be able to provide immediate assessment and agree pathway for the patient remotely with the on-call Consultant. A Middle Grade doctor will available at Pilgrim and Grantham (during the day only) can attend to the patient if required.	1	4	4	We are measuring the number of patients admitted as a non-elective emergency (unplanned emergency), this measure supports the volume of emergency patients being treated and enables an understanding of capacity and demand for the urology service. We expect this number to decrease over a period of time as a sign of success	Assumption on benefits is a movement of demand into planned care. 08/21 figures show an overall Trust reduction in non-elective admissions, with an increase in LCH admissions and a reduction in Pilgrim admissions, which is what we would expect to see. We would expect to see a continued decrease in 09/21 figures when they become available. There have been no issues reported from Clinicians in relation to accessing the USPOC service. The Urology staff survey, due to be launched imminently, will provide further opportunity to gain insight to any issues.
Patient Safety	Delay to patient care - unable to contact USPOC in a timely manner	Negative	3	4	12	There is a dedicated mobile phone to USPOC and there have been no issues to date with contact. Backup is that the on-call consultant can also be contacted through switchboard	1	4	4	No issues reported by Clinical staff in relation to timely contact and support with USPOC. No impact on patient pathway/experience reported as a result of inability to access USPOC support/input.	There have been no issues reported in relation to contacting USPOC. The Urology staff survey, and patient experience survey, due to be launched imminently, will provide further opportunity to gain insight to any issues.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Delay to patient care - EMAS unable to perform timely inter-facility transfer to LCH	Negative	2	3	6	EMAS protocol to prioritise based on condition. Consultant led decision to transfer based on severity of patient. Refer to existing Policy and Procedures for Patient Transfer CESC/2011/040. Engage with secondary patient transfer service (as a backup) TESL. Ongoing monitoring of the patient and clear engagement with ACPs to manage care of the patient in collaboration with the on-call consultant. EMAS document 'National Framework for Inter-Facility Transfers v0.8' provided by EMAS provides guidance on Inter Facility Transfers and timescales, including escalations.	2	3	6	Delay to patient care avoided owing to delay in patient transfer.	EMAS are not able to stratify transfers based on clinical condition to a suitable level for analysis of operational metrics impact. However, EMAS have reported that, on a combination of untoward incident reviews and staff feedback groups (alternate pathways in and out of hospital) there has not been any negative commentary or feedback raised. There have been no complaints in relation to delays in patient care and no SI's reported. The Patient Experience questionnaire, now launched for LCH 'fit to sit' patients, will provide more intelligence on this measure
Patient Safety	Insufficient bed capacity at receiving site - delays in patient care owing to patient flow at receiving site. Demand constraints at the receiving site.	Negative	3	3	9	Mitigated by ensuring 'protected' bed capacity at Digby Ward	1	3	3	ALoS by ward - measures demand. Excess bed days - beyond planned discharge. Expect to see decrease in ALoS. - success criteria - reduction in ALoS and no excess bed days being reported. Delays in admission avoided owing to sufficient bed capacity.	The protected bed status for Urology patients within Digby ward has not being able to be enforced owing the incident level 4 owing to the Covid pandemic. A move is now being made to revert back to normal protected bed capacity arrangements. Q3 & Q4 data will hopefully provide a more steady state picture in relation to the impact of reconfiguration. The ACP tier should facilitate timely discharge and improve ALoS, to facilitate bed availability.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Any site - Delay in patient care - patient deteriorates post operatively and needs urgent urology attention.	Negative	4	4	16	24 hour Single Point of Contact (USPOC) to ACP support based at LCH (Resident), with direct access to an SAS doctor 24 hours and on-call Consultant 24 hours. SAS doctor available at Pilgrim (during the day only) and can attend if required. CT doctor based at Grantham 24 hours (Resident). Current state - Consultant non Resident overnight. No SAS or ACP presence.	1	4	4	Delays reduced and patient clinically optimised post operation in a timely manner	There have been no issues reported in relation to post op support
Patient Safety	Patient undergoing surgery within another speciality develops urological complication requiring urgent attention (non-receiving sites). Urology specialist not available for support	Negative	4	1	4	Access to 24 hour ACP via USPOC support. If urgent surgery required, on-call consultant would attend. Middle Grade doctor available at Pilgrim and Grantham (during the day only).	1	1	2	Patient receives timely intervention an no issues experienced by surgeon in accessing urology specialist support	There have been no issues reported in relation to post op support
Patient Safety	Patient not stable enough to transfer. Delay in consultant attending	Negative	4	2	8	Seek intensive care unit admission if at Pilgrim and on-call consultant to attend at site. If patient presents at another hospital site within ULHT, on-call consultant will attend	2	2	4	Proactive clinical decision making, rather than waiting for patient optimisation. Pre-emptive intervention on access of consultant to monitor patient conditions	No issues have been reported in relation to delays in oncall consultant attending to a patient at a site other than LCH. Frequency of occurrence for non-LCH attendance to be looked at - included in ACP reporting.
Patient Safety	Transfer of patients in a timely manner for time critical conditions (EMAS). Risk of patient dying during transfer. Based on past data, anticipated transfer requirement of 1 patient per day	Negative	1	5	5	Suitability for transfer is part of the pathway and will have been pre-assessed. If risk is deemed too high, patient will not be transferred as per existing Policy and Procedures for Patient Transfer CESC/2011/040.	1	5	5	No SI's reported in relation to a patient dying as a result of inappropriate transfer	No SI's have been reported

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Efficient access to urology specialist support	Positive	3	4	12	Implementation of 3 tier system and reconfigured on-call consultant rota will ensure direct access 24/7 to urology specialist	1	4	4	No incidents/issues/delays occurring that impact on patient safety, as a result of urology specialist support not being available	There have been no issues reported or concerns raised to date with regard to access to timely urologist specialist intervention. General feedback from staff on an ad-hoc basis is the reconfiguration is much better and works well. This will be verified further upon completion of the Urology staff survey
Patient Safety	Delays in accessing non-elective treatment/surgery	Positive	5	4	20	Dedicated on-call consultant will be available to attend to non-elective patients 24/7, as opposed to reliance on consultants performing elective duties to also respond to non-elective requests	1	4	4	Indicators that demonstrate improvement of patient flow through the service. No incidents/issues/delays occurring that impact on patient safety, as a result of urology consultant not being available to perform emergency surgical procedures	The level 4 critical incident status has had an impact on cancelled procedures. It is expected that once steady state is achieved the success of the reconfiguration will be reflected in the data that maps patient flow through the service.
Patient Safety	Same day cancellations of elective surgery	Positive	3	4	12	Same day cancellations will reduce as consultant with scheduled elective surgeries will not be required to cover on call	1	4	4	Demonstrate a reduction in number the of same day cancelled operations which will improve the safety and well-being of patients, acknowledging the distress this can cause patients and the potential associated safety risks	Awaiting recent figure for same day cancellations. Expected to see a drop post 9/8 go live, particularly for cancellation reason being no consultant available. (September increase - October coming back down again)

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Unnecessary admissions for urological conditions	Positive	4	3	12	Access to 24 hour ACP SPOC support will enable a treatment plan to be put in place and the patient is more likely to be discharged back home as opposed to admitted as a precaution	1	3	3	Reduce the number of unnecessary admissions occurring, which is in the best interests of patients.	The scorecard captures all types of admissions of which monitoring of emegency admissions is expected to reduce over time and more planned admission to take place as part of patient treatment plans. 08/21 figures already show a slight Trustwide decrease in non-elective admissions. It is expected that 09/21 data will show further reduction.
Public Image	Adverse publicity - making LCH main receiving site for non-elective	Negative	4	3	12	Members of the public can still present to any ED site with urgent urological condition and they will be seen and treated in accordance with the ACP/Consultant remote support. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	2	3	6		No issues have been reported.
Public Image	Public concern about being transported from another hospital site to LCH if in need of urgent potential urological surgery	Negative	4	4	16	Patients will only be transferred under consultant guidance and if deemed suitable for transfer. They will not be transferred if any risk. On-call consultant will attend at site of patient. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	1	4	4	Potential track through consultant decision - Proactive monitoring of patient experience through surveys. Success Criteria: positive patient survey results with regard to our pathways. Reduction of SI's and Complaints	To be evaluated on an ongoing basis following current launch of Patient Experience survey for LCH fit to sit patients

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Public Image	Public concern about reducing services at their local hospital	Negative	4	4	16	Elective capacity is remaining at all sites, decreasing slightly at LCH, but still retaining a large proportion. Capacity increasing at Grantham and Pilgrim. Change in non-elective is that EMAS will take patient straight to LCH from point of pick-up and walk-in's at other hospital sites will be transferred to LCH by EMAS, to be determined case by case by consultant. Benefits of this model are clear. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	3	4	12		No issues have been reported.
Public Image	Risk of same day cancellations and faster access to non-elective support/treatment and surgery	Positive	4	4	16	Anticipated that access to care will be a priority for patients and that avoiding disruption to any planned surgery is positive. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	2	4	8	Narrative & public consultation feedback	
Clinical Outcomes	Reduced length of stay for non-elective patients	Positive	4	4	16	Greater availability of staffing and will there be an assessment area that will increase the numbers of patients that are seen and discharged on the same day. Continuity of care due to single on call team, following up the patients and chasing up the discharge plan. Access to hot lists to deal with emergency surgery in a more expeditious way	1	4	4	Reduction of unplanned admissions which in turn should reduce overall ALoS due to reduction in the number of patients being admitted as an emergency	
Clinical Outcomes	Reductions in same day cancellation will improve outcomes for elective patients in terms of undisrupted care and impact on their wellbeing	Positive	3	4	12	Consultant performing elective duties will not be required to be on call. Therefore will not disrupt non-elective scheduled surgeries	1	4	4	Same day cancellation measures and number of planned admissions - we should see a reduction in same day cancellations and an increase on the number of planned admissions	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Clinical Outcomes	Efficient and accurate diagnosis and treatment of patients attending ED with an urgent/non-urgent urological condition	Positive	3	4	12	Access to 24/7 USPOC ACP support will ensure the care diagnosis and treatment and plan for the care of the patient are performed efficiently and with accuracy, with a direct link to middle grade doctor and on call consultant support	1	4	4	Positive patient outcomes maximised as a result of early invention from specialist support	No issues reported. Patient survey results will provide further intelligence
Clinical Outcomes	Reduced elective and non-elective re-admissions following initial emergency admission	Positive	3	4	12	Hot list allowing for definitive treatment during first admission rather than requiring subsequent admissions	1	4	4	Manageable, reduced number of readmissions occurring and a general reduction month on month	
Clinical Outcomes	Avoidable admissions	Positive	4	4	16	Patients will not be admitted to hospital unnecessarily, as a precaution whilst obtaining urological clinical support. Better for the patient to be seen and treated without admission, avoiding unnecessary stress. Access to 24/7 USPOC support will avoid unnecessary delays in seeing and treating patients and will enable avoidance of unnecessary admissions that may be made as a precaution	1	4	4	Reduction in the number of emergency admissions, increased in planned admissions, understanding nature of internal transfer of patients from one consultant to another	Decrease Aug to October
Clinical Outcomes	Cancer surgical procedures	Positive	4	4	16	At present we operate a rota for LCH and a rota for Pilgrim. There is no cross-cover in place in the current model. Moving into the reconfiguration there will be cross-cover that has been reviewed within consultant job plans, therefore capacity will not be lost, creating better utilisation of theatre lists and clinics. Therefore cancer waiting times will be reduced and outcomes will improve.	1	4	4	Theatre utilisation available slots and slot management for theatres. Cancer waiting times RTT will support this as an evidence based outcome. Cancer 28 days measure and cancer 62 day measure. Measure of success: Better efficiency of theatre utilisation and a raising to the national target for RTT	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Clinical Effectiveness	NICE Guidance	Positive	3	4	12	Reconfigured non-elective pathway to single acute site with hot list enables us to meet NICE guidance for the management of stones and ureteric obstruction, 48 hour standard	1	4	4	Operational internal monitoring against the principles of NICE Guidance	
Clinical Effectiveness	GIRFT Recommendations	Positive	2	3	6	The reconfiguration is based on GIRFT best practice pathways for urology	1	1	2	Operational GIRFT checkpoints and reviews. Measure of Success: GIRFT support for reconfiguration	Full GIRFT support provided. To be reviewed in January
Patient Experience	Complaints - same day cancellations	Positive	4	4	16	Reduction in complaints in relation to same day cancellation of elective surgery owing to reconfigured rota which avoids disruption of elective surgery.	1	4	4	Reduction of complaints and an improvement overall of patient experience as a result of a reduction in same day cancellations	
Patient Experience	Complaints about distance of travel, if mode is EMAS, from patients further south of the County, being transported up to Lincoln, for example, bypassing Pilgrim/Grantham	Negative	1	3	3	We may see this increase - patient consultation responses will enable us to review this and the number of complaints, post go-live, will be monitored as part of the performance dashboard	3	3	9	No complaints from patients in relation to access to service and distance of travel	The patient experience survey will provide us with more intelligence in relation to impact on patients as a result of travel/transfer requirements
Patient Experience	Lack of access to urology clinical advice, treatment and support, through the ED department.	Positive	4	4	12	Patients will experience improved access to urology clinical advice, treatment and support, through the ED department, avoiding longer wait times, through access to USPOC and on-call consultant availability	1	4	4	Patients do not feel agreived about excessive length of waits and are satisfied with the quality of service and care they receive	Patient experience questionnaire for LCH fit to sit patients - to be collated end October for initial feedback

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Pathways	Unrefined Patient Pathway for non-elective surgical need	Positive	4	5	20	Non-elective clear patient pathways defined for non-elective patients presenting at ED (non LCH sites) and inpatient access to urology services. Supported by an operational roles and responsibilities document, providing clarity of process and ownership for the patient at each stage of the pathway. Inter-dependencies with EMAS are mapped in. EMAS have been fully engaged and consulted with in order to inform the clinical risk analysis and interdependencies with the pathway map.	1	5	5	No SI's occurring as a result of lack of clarity and ownership of the patient within the non-elective urology pathway	SI's. Case mix audit (now and then in 6 months or sample every 3-6 months)? (see what ACP's are collecting?). Clinicians point of view with regard to success. Patient experience questionnaire for LCH fit to sit patients - to be collated end October for initial feedback. Staff survey feedback.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Accessibility	Access to transport post discharge	Neutral	2	3	6	Patients transported for urgent urological intervention, to LCH, from further points of the County, particularly south westerly and north easterly areas, may have concerns about getting home following discharge. Current position... PTS Contract, currently with TASL, specifies eligibility criteria in line with the DH Eligibility Criteria for Patient Transport Services published August 2007 which is detailed below:- • Where the medical condition of the patient is such that they require the skills or support of NEPTS service staff on/after the Journey and/or where it would be detrimental to the patients' condition or recovery if they were to travel by other means; • Where the patients' medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patients' condition or recovery to travel by other means; or • Recognised as a parent or guardian where children are being conveyed. No additional mitigation to current position.	2	3	6	Patients are not subjected to distress or concern in relation to how they will return home post attendance at LCH from further parts of the County.	No concerns raised to date - further analysis to take place once complaints information is available and following patient and staff surveys.
Accessibility	Access for friends and relatives to visit inpatients post admission for urgent urological condition	Negative	2	3	6	Inpatients at LCH who have been transported for LCH for urgent urological intervention, from further parts of the County, may have concern about accessibility for friends and family to visit owing to distance of travel. No mitigation	2	3	6	Patients are not subjected to distress in relation to isolation from friends and family owing to distance of travel	No concerns raised to date - further analysis to take place once complaints information is available and following patient and staff surveys. However, the visitors policy across the Trust currently governs this aspect.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Inequalities of Care	Access to same level of care services across the County	Positive	4	3	12	All patients in Lincolnshire will be able to access a better quality service - all sites working to the same standards as opposed to working in silos. Variation in care will improve.	1	3	3	Patients are satisfied with the care and treatment received regardless of location of provision	
Staff Impact	Inability to recruit and retain substantive consultants and ACP's	Positive	4	4	12	The recruitment and retention of substantive consultants and ACP's is enabled and more attractive with the implementation of the new rota. This will provide a more stable working environment, allowing the development of working relationships, as opposed to reliance on agency staff	2	4	8	Workforce rotation and agency spend. Contribution to strategic outcome in reduction of agency spend. Sustainable resource and service.	Successful recruitment of Consultants, Middle Grade and ACP's - we now have a full compliment of clinical staff. 09/21 10/21 figures to follow - reduction in agency expenditure to be reported.
Staff Impact	Issues in relation to staff wellbeing, health and safety	Positive	4	4	12	The wellbeing of consultants, particularly in terms of fatigue and distances of travel, will be improved owing to the separation of duty between being on call and performing elective surgery.	2	4	8	Improved wellbeing of clinical workforce	Re-run of staff survey with regard to satisfaction - to be launched w/c 10 October
Staff Experience	Lack of training and development opportunities	Positive	3	4	12	The reconfiguration of rotas and rotation between hot and cold sites will enable ACPs and middle grade doctors to experience a broader range of conditions, treatments and surgeries, which will provide development and training opportunities, thus improving recruitment and retention	1	4	4	Clinical staff feel that they have development and training opportunities	
Staff Experience	Staff at Boston and Lincoln have a rotation 1 in 6 (weeks) on-call. Consultants and middle grades. Morale - affect on team having to come (travel)					1 in 6 is the mitigation to minimise travel for consultants to LCH (1 week is the designated on-call)				Reduction in issues being raise by consultants owing to excessive travel requirements in order to undertake on call duties	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Staff Experience	Lack of clarity around roles and responsibilities in relation to the non-elective patient pathway	Positive	3	5	15	Clinical staff will benefit from a defined patient pathway for non-elective patients, which will also define processes, roles and responsibilities. This will provide surety around individual responsibilities and improve confidence in the effectiveness of the pathway model. This will also aide standardisation of procedures across sites.	1	5	5	Staff are clear about their roles and responsibilities and have confidence in the service they are providing, thus providing them with assurance and greater job satisfaction	SOP in the process of completion to formalise the pathway. This will be issued to staff to ensure full understanding and compliance with the requirements of the pathway, clarifying roles and responsibilities.
Targets/Performance	Finance - high spend on agency costs	Positive	5	3	10	The successful recruitment of Consultants and ACP's creates a reduction in medical agency spend across the urology service, with an estimated saving of £300k pa	2	3	6	Reduction in dependency on agency and temp cover thus reducing costs for the Trust and stabilising the service. Sustainable cost effective staffing/service model	09/21 10/21 figures to follow - reduction in agency expenditure to be reported.
Targets/Performance	Cancelled Procedures	Positive	2	4	16	Reduction expected. Reduces administrative burden, reduces wait times, reduce complaints, improved theatre utilisation	1	4	4	Reduction in same day cancellations with more emphasis on planned care	The level 4 critical incident status has had an impact on cancelled procedures. It is expected that once steady state is achieved the success of the reconfiguration will be reflected in the data. Reduction specifically in relation to 'no consultant available' and 'no beds available' to significantly reduce
Targets/Performance	Avoidable Admissions	Positive	3	4	12	Reduction expected. Improved utilisation of ward resources	1	4	4	Reduction in unplanned admissions which will ultimately reflect as a increase in planned care capacity	Trustwide non-elective admissions showing a slight reduction, with an increase at LCH and a decrease at Pilgrim, as expected. Further reductions expected to be realised when latest data becomes available

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Targets/Performance	Excessive length of stay & discharge rates	Positive	4	4	16	Reduction expected. Access to USPOC and better facilitated discharge/ward rounds	1	4	4	Gradual reduction of ALoS and to have the ambition to have 0 excess bed days being reported	To be evaluated when latest data becomes available to assess impact post 9/8/21.
Targets/Performance	Waiting Times/RTT	Positive	4	4	16	Reduction expected. Rota reconfiguration and USPOC covering both sites will ensure a reduction in disruption to elective activity, improved discharge rates, reduction in admissions, reduction in LoS, improved theatre utilisation, will allow an improved flow of activity and an increase in capacity.	1	4	4	Gradual reduction resulting in higher reporting reaching towards the 92% target. Main factors are the handling of referral ASI's and PBWL management	Incomplete pathways under 18 weeks RTT. Overall 92% target. Current 64/66%.
Equality & Diversity	Distance of travel for patients	Neutral	2	1	3	Elective capacity is remaining at all sites, decreasing slightly at LCH, but still retaining a large proportion. Capacity increasing at Grantham and Pilgrim. Therefore this reconfiguration is not increasing travel and patients can could still have the opportunity to choose location based on capacity (as happens now). The change in non-elective means that EMAS will take patient straight to LCH from point of pick-up. EMAS will also transport patients from non LCH sites as required. Patients can still walk in to any A&E. No mitigation - current PTS protocols apply.	2	1	3	No patients disadvantaged in terms of access to services as a result of the reconfiguration and increase in travel	An impact assessment study was undertaken scoping out the impact on local resident population and access to specific sites of treatment. Ask CCG to do a re-run 3 months post Go-Live

	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:	**18 May 2022**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

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.

Actions Requested

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

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. Work Programme for Today's Meeting

18 May 2022		
	Item	*Contributor*
1	United Lincolnshire Hospitals NHS Trust – Recovery Programme and Action Plan in Response to Care Quality Commission Report	• Simon Evans, Chief Operating Officer, United Lincolnshire Hospitals NHS Trust • Sarah Brinkworth, Planned Care Programme Lead, Lincolnshire Clinical Commissioning Group
2	United Lincolnshire Hospitals NHS Trust: Update on Urology Services	Representatives from United Lincolnshire Hospitals NHS Trust: • Andrew Simpson, Consultant Urologist

3. Future Work Programme

15 June 2022		
	Item	*Contributor*
1	Lincolnshire Acute Services Review – Decision by Lincolnshire Clinical Commissioning Group	Representatives from Lincolnshire Clinical Commissioning Group
2	Dental Services Update	Representatives from NHS England
3	Lincolnshire Partnership NHS Foundation Trust – Consultation on Mental Health Rehabilitation Services	Representatives from Lincolnshire Partnership NHS Foundation Trust
4	Second Community Diagnostic Centre for Lincolnshire	Sarah Brinkworth, Planned Care Programme Lead, Lincolnshire Clinical Commissioning Group
5	Humber Acute Services Programme Update (or 13 July 2022)	Representatives from the Humber Acute Services Programme
6	Finalising Committee's Response to the Lincolnshire Pharmaceutical Needs Assessment	Simon Evans, Health Scrutiny Officer

13 July 2022		
	Item	*Contributor*
1	Cancer Care Update	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
2	Staffing Challenges in Hospitals and NHS Lincolnshire People Plan	Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust. Ceri Lennon, Senior Responsible Officer for the Lincolnshire People Board (to be confirmed)

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

12 October 2022		
	Item	*Contributor*
1	East Midlands Ambulance Service Update	Representatives from the East Midlands Ambulance Service: • Ben Holdaway, Director of Operations • Sue Cousland Divisional Director, Lincolnshire Division

12 October 2022		
	Item	*Contributor*
2		

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.

- **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. Working Group Activity

Pharmaceutical Needs Assessment

This working group comprising Councillors Carl Macey, Linda Wootten, Ray Wootten and Angela White, is due to meet on 23 May 2022 to consider the draft Pharmaceutical Needs Assessment. The working group's draft response will be submitted to the next meeting of this Committee on 15 June for approval.

Quality Accounts

This working group, comprising Councillors Carl Macey, Linda Wootten, Richard Cleaver, Sarah Parkin, Angela White, Mark Whittington and Ray Wootten, is due to meet on 12 May 2022. The working group's statement on the North West Anglia NHS Foundation Trust's quality account. A further meeting will be arranged to consider the draft quality account of United Lincolnshire Hospitals NHS Trust.

Suicide and Mental Health

This working group, comprising Councillors Carl Macey, Sarah Parkin, Tom Smith, Angela White and Mark Whittington was established on 13 April, following consideration of items on Suicide the Prevention Strategy (16 February 2022); and an update from Lincolnshire Partnership NHS Foundation Trust (13 April 2022).

5. 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