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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 September 2020**
Subject:	**United Lincolnshire Hospitals NHS Trust – Covid-19 Update**

Summary

This item enables the Health Scrutiny Committee for Lincolnshire to consider the progress of United Lincolnshire Hospitals NHS Trust (ULHT) in its restoration and recovery following the acute phase of the Covid-19 pandemic. The information submitted to the Committee comprises two reports, which have been submitted to the ULHT Board in July and September 2020.

Management representatives from ULHT are due to attend the meeting to present the information and respond to questions.

Actions Required

(1) To consider the information presented by United Lincolnshire Hospitals NHS Trust on their restoration and recovery, following the acute phase of the Covid-19 pandemic.

(2) To note that a full review of the Grantham Hospital 'green' site is due to be considered by United Lincolnshire Hospitals NHS Trust Board on 6 October 2020.

(3) To consider the timing of the Committee's next update from the United Lincolnshire Hospitals NHS Trust on its recovery from Covid-19.

1. Previous Committee Consideration

On 17 June 2020, the Health Scrutiny Committee considered an item on the arrangements of United Lincolnshire Hospitals NHS Trust to restore NHS services, following the acute phase of the Covid-19 pandemic. The Committee requested a further update within three months.

2. Latest Information

This item comprises two reports, which have been submitted to the Board of Directors of United Lincolnshire Hospitals NHS Trust (ULHT). The most recent report, submitted to the ULHT Board on 1 September 2020, is attached at Appendix A. This followed an earlier report, considered by the ULHT board on 7 July 2020 (Appendix B).

3. Consultation

This is not a direct consultation item.

4. Conclusion

The Committee is invited to consider the information presented by on its restoration and recovery, following the acute phase of the Covid-19 pandemic. A full review of the Grantham Hospital 'green' site is due to be considered by United Lincolnshire Hospitals NHS Trust Board on 6 October 2020.

5. Appendices

These are listed below and attached to this report: -

Appendix A	Report to United Lincolnshire Hospitals NHS Trust Board of Directors (1 September 2020) - ULHT Covid-19 Recovery Phase Update – Progress Summary
Appendix B	Report to United Lincolnshire Hospitals NHS Trust Board of Directors (7 July 2020) - ULHT Covid-19 Restore Phase Update – Progress Summary

6. Background Papers

No background papers, as defined by Part VA of the Local Government Act 1972, were used to a material extent in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, Lincolnshire County Council, who can be contacted via 07717 868930 or Simon.Evans@lincolnshire.gov.uk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Public Board*
Date of Meeting	*1st September 2020*
Item Number	*Item 7.1*
ULHT Covid-19 Recovery Phase Update – Progress Summary	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*ELT*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Strategic Risk Register Covid-19 Pandemic Entry*
Financial Impact Assessment	*Both Significant Capital & Revenue- Further Described in Financial Reports*
Quality Impact Assessment	*QIAs are completed for service changes in line with Covid-19 Governance As previous reported*
Equality Impact Assessment	*EIAs are completed for major service changes in line with Covid-19 Governance As previous reported*
Assurance Level Assessment	• *Moderate*
Recommendations/ Decision Required	• *The Board are asked to accept this progress update, noting the nature of the current emergency response, the nature of frequent new guidance and requirement for all plans to be flexible and responsive.*
	• *The Board are asked to accept a future report on Grantham Green Site at October Trust Board*
	• *The Board are asked to consider future Covid Reports beyond the October report being reviewed at FPEC, with upward reporting from that Committee only.*

Executive Summary

On the 31 July the Trust received confirmation of the move to Phase 3 of the Covid-19 Pandemic Response. This notification described in more detail the requirements for Recovery phase operating until 31 March 2020.

This report does not describe the response to this plan in full as this extensive exercise similar to an annual planning round is being conducted with submissions due in early September. As such September's report provides an update in between Restoration and Recovery articulating the progress made on Restoring capacity in key service areas.
Phase 3 planning has been split into 3 high level objectives:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first

Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The Trust's response to date in diagnostic capacity recovery has been positive, with particular progress in Endoscopy and Radiology. Both areas having put in place capacity to support Cancer services and reduce backlogs swiftly. Other areas of diagnostic waiting lists are still large recovery trajectories will be set as part of the Phase 3 plan.

Planned care waiting lists have continued to plateau after a period of decrease in the Restore Phase. In addition to this patients waiting more than 46 weeks for treatment have continued to increase, however increased surgery and progress on treatment capacity in particular at Grantham Hospital is expected to start to impact on these non-urgent waiting lists now cancer waiting lists have reduced.

Cancer recovery has been positive and the Trust has met the objective of reducing patients waiting more than 62 days for treatment by 20% by the 21 August 2020. Patients waiting more than 103 days objective was not met, however significant progress was made reducing the waiting list by more than 60%.

Urgent care demands have continued to increase and waiting time standards have continued to decline. Comparisons with previous years' performance are still positive, however continuing to show improvements.

1. Background

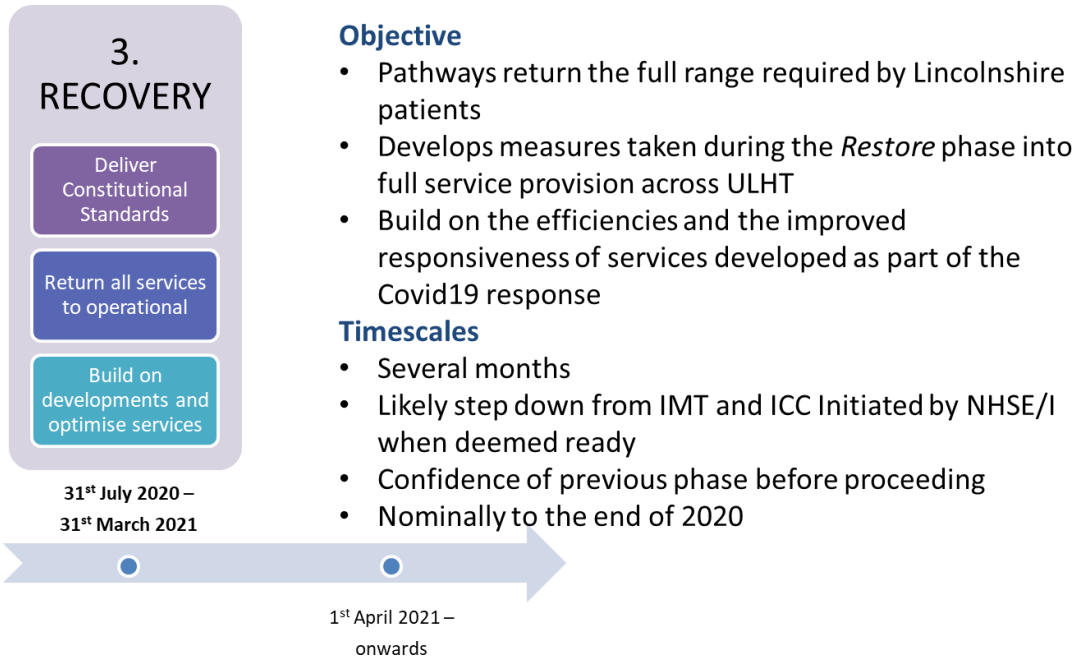
On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid-19 was confirmed as a High Consequence Infectious Disease and the UK risk level was raised from moderate to high. On 3 March the Department of Health and Social Care issued the Coronavirus action plan; a guide to what you can expect across the UK. This reflected the strengthened legal powers announced by Secretary of State for Health and Social Care.

On 31 July the Trust received confirmation of the beginning of Phase 3 *Recovery* in a letter to all Trusts from Sir Simon Stevens NHS Chief Executive and Amanda Prichard, NHS Chief Operating Officer. From 1 August the NHS would officially begin its medium-term recovery planning with submission of detailed planning assumptions, activity levels and impact on waiting times due by 8 September 2020.

From 1 August 2020 the NHS National Emergency level was lowered to Level 3 describing the response moving from National to regional direction. During this time Trusts have been reminded that this does not negate the rapid response required should circumstances change and the level of preparedness which must continue to be at its highest, maintaining such key functions as Incident Command Centres and Single Point of Contact systems.

2. Recovery Phase Planning and National

The Trust's campaign plan approved in May 2020 described the main objectives of Phase 3 as per below:



Detailed Phase 3 guidance was issued on the 31 July and describes the following key elements that must be planned for in the remainder of 2020/2021. These three main principles A, B and C are sub-divided into more detailed explanations of what is

required, some of which have targets set for Recovery of capacity levels.

The main objectives are as follows:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

With more detailed explanation of the 'ask' described as:

A1 Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:
    - Ensuring that sufficient diagnostic capacity is in place in Covid-19secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
- Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
- Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
- Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
- Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.
- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre- pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2 Recover the maximum elective activity possible between now and winter.

- Trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

    - In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);
    - This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
    - 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
- Elective waiting lists and performance should be managed at system as well as trust level to ensure equal patient access and effective use of facilities.
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.
- To further support the recovery and restoration of elective services, a modified national contract will be in place giving access to most independent hospital capacity until March 2021.

Both A3 and A4 Recovery objectives make reference to services in Primary, Community and Mental Health Services.

B1 Continue to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes: Trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- Continuing to follow Public Health England's guidance on defining and managing communicable disease outbreaks.
- Continue to follow Public Health England /DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS.
- Ongoing application of Public Health England's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising nosocomial infections across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.
- Ensuring NHS staff and patients have access to and use PPE in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2 Prepare for winter including by:

- Sustaining current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.
- Deliver a very significantly expanded seasonal flu vaccination programme
- Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly.
- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.
- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.
- Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/ Public Health England policies.

C1 Workforce

All systems should develop a local People Plan in response to these actions. It includes specific commitments on:

- Actions all NHS employers should take to **keep staff safe, healthy and well** – both physically and psychologically.
- Specific requirements to **offer staff flexible working**.
- Urgent action to **address systemic inequality** that is experienced by some of our staff, including BAME staff.
- **New ways of working and delivering care**, making full and flexible use of the full range of our people's skills and experience.
- **Growing our workforce**, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- **Workforce planning and transformation** that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

C2 Health inequalities and prevention

Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant

protected characteristics and social and economic conditions; and better engage those communities who need most support.

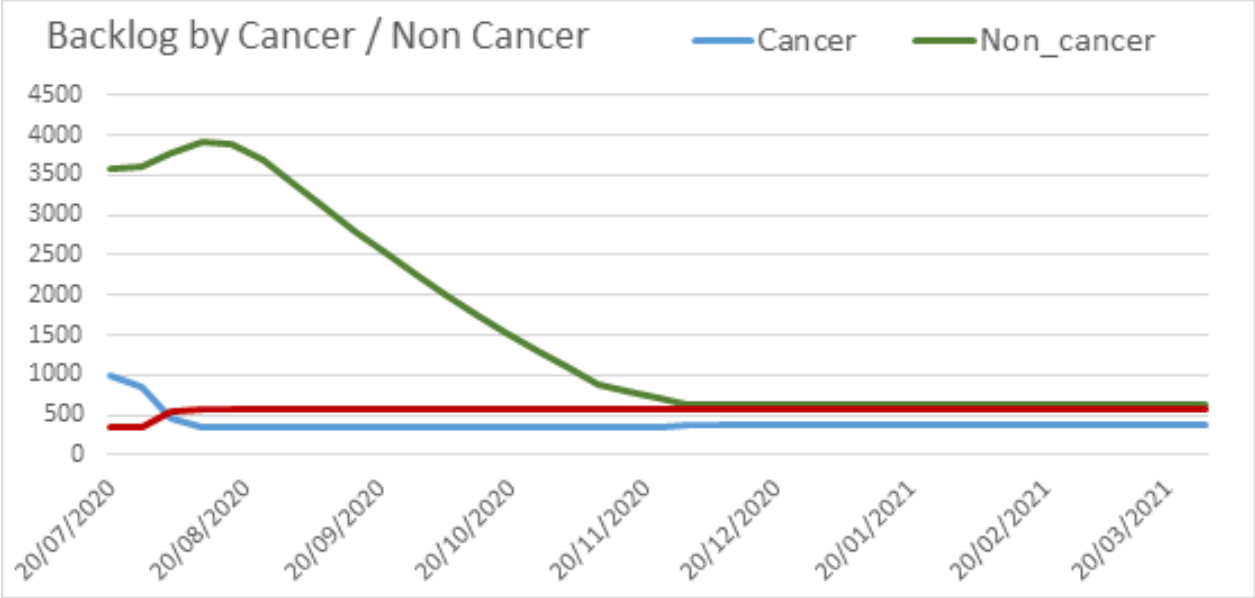
- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.
- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities.

3. Progress on Recovery of Planned Care Services including Cancer Care A1 and A2

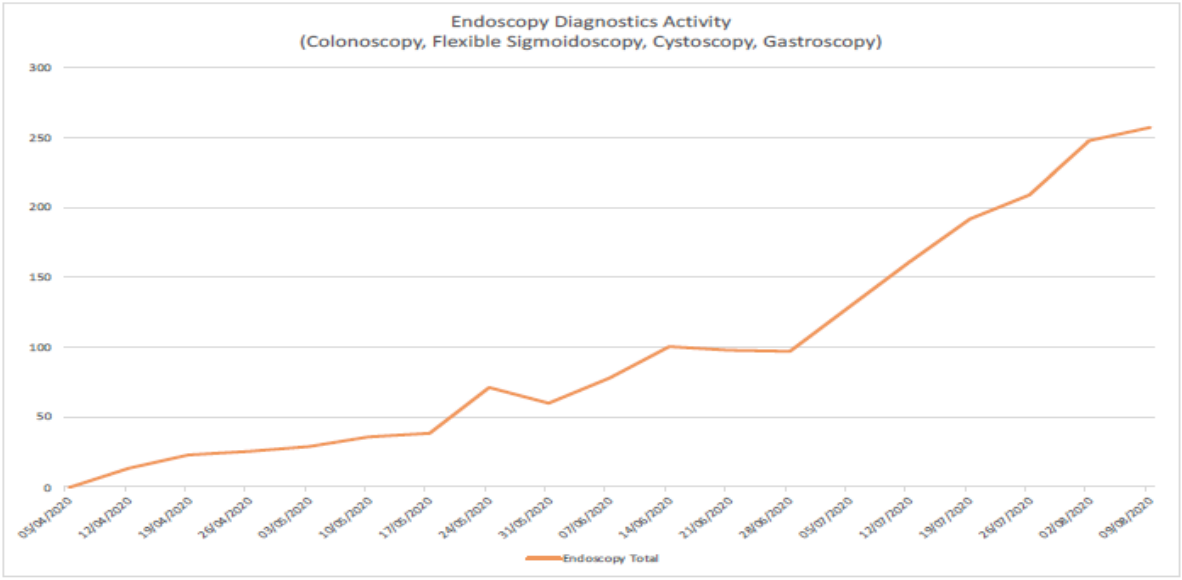
Phase 3 planning is still in progress at the time of production of this report. Submission of the initial draft of the planning assumptions is due on the 1 September with subsequent iterations combined with a confirm and challenge due in the weeks following. This planning process includes many aspects of a traditional planning round with commissioners and regulators, detailing all types of activity in all specialties with a comprehensive financial and workforce plan that sits alongside. Clearly this is a very intensive piece of planning work from divisions and has condensed what is normally in 3 month process into less than 1 with added complexity of planning for scenarios that include resurgence of Covid-19 waves as well as Influenza and other increased urgent care pressures.

3.1. Endoscopy Recovery

Endoscopy recovery plans have continued to show improvements in capacity and reduced waiting times. Initial focus has been to improve access to suspected cancer services, and from the trajectory shown overleaf this reduction has been achieved rapidly. A deliberate prioritisation of clinical time for all staff capable of carrying out endoscopy procedures has led to mitigation in the reduction in productivity through increased IPC measures. In addition to this, restoration of Louth Endoscopy unit as well as all three other hospital sites, together with the use of insourcing has now more than compensated for the original loss because of Covid-19 measures.

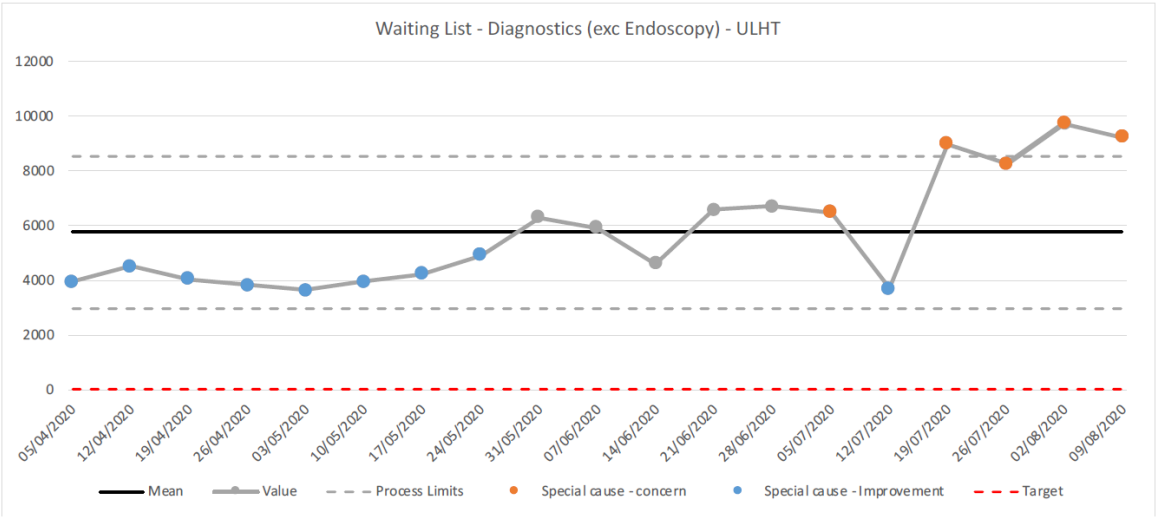


By the 1 September bookings for suspected cancer in Endoscopy will be made within the 14 day window required as part of the cancer 2ww standard.

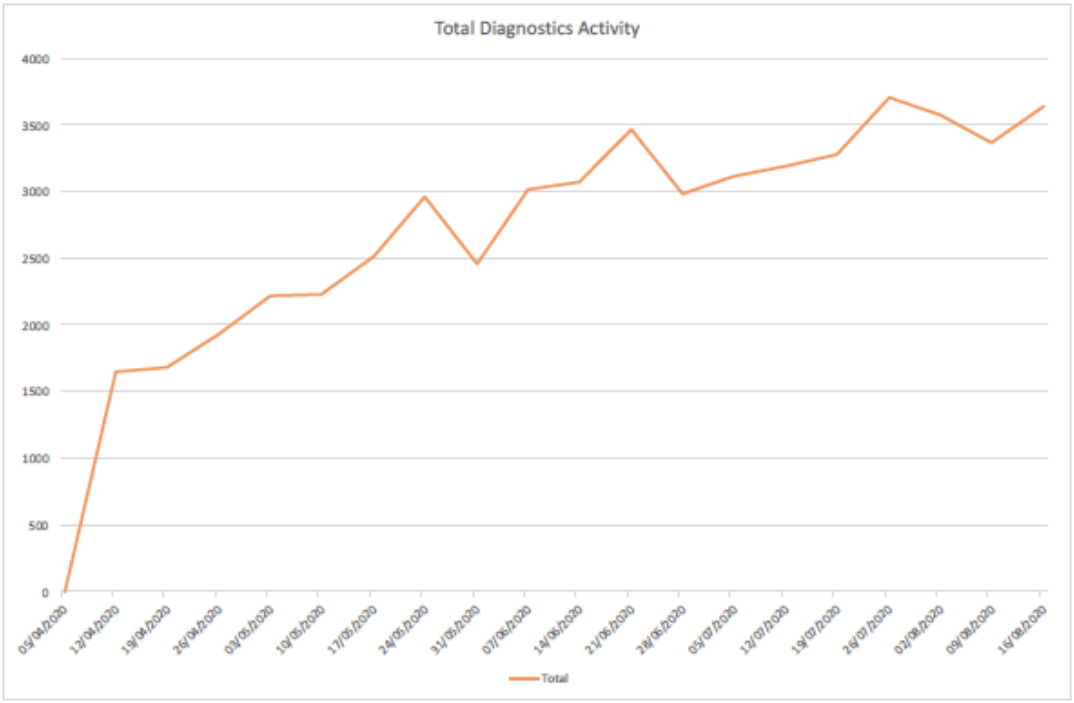


Although the full recovery plan is still being compiled full recovery of all cancer and non cancer endoscopy waiting lists are expected by November/December. Subject to resurgence of Covid-19 and other winter impact.

3.2 Radiology and Other Diagnostic Recovery

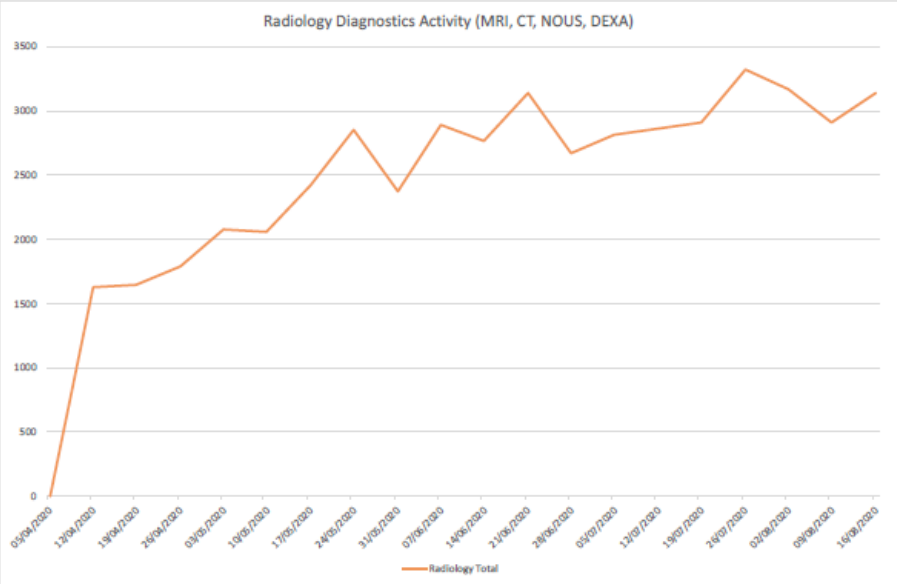


Although diagnostic services have restarted and in most cases steadily increased capacity as part of restore phase, those services that are non-cancer have not had the same priority as services such as Endoscopy. As a result waiting lists have started to slow and now in recent weeks have been maintained without significant increases.



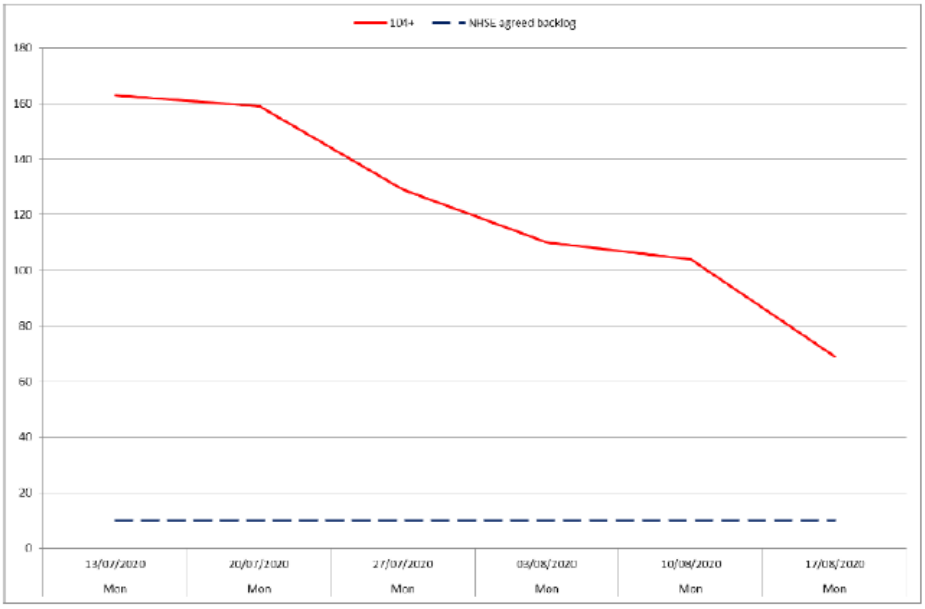
Despite priority having been given to those cancer and clinically urgent services, it is clear to see that the overall increase in capacity that has been achieved since the near complete shutdown of diagnostic service capacity is tangible. This is expected to continue and Phase 3 plans will look to forecast what impact this will have on waiting lists across the remainder of the year.

Of particular note in diagnostic services is the Recovery of diagnostic imaging capacity. Increases in the availability of diagnostic imaging equipment (ultrasound, CT and MRI) as well as developments in the way that the equipment is used in conjunction with Covid-19 precautions has led to the now near full Recovery of pre Covid-19 capacity ahead of the deadline stipulated in the mandate in Phase 3.



Continued work with system partners and the wider regional Diagnostics board is supporting the adoption of best practice in Radiology, and developments continue particularly at the Gonerby Road Health Clinic in Grantham, where possibilities for the Lincolnshire Community Diagnostic Hub are being developed.

3.3 Cancer 62 and 104 Trajectories and Reductions



Cancer services have remained a focus throughout the Restore phase and expectations are clearly stipulated in A1 of the phase 3 directives. Prior to Phase 3 notification all Midlands region acute Trusts were given directives from the regional Medical Directors office stipulating the need for urgent response to patients waiting more than 62 days and 104 days for Cancer treatment.

These objectives were as follows:

All patients waiting 104 days and over including endoscopy, to be seen within 6 weeks by the 21 August 2020.

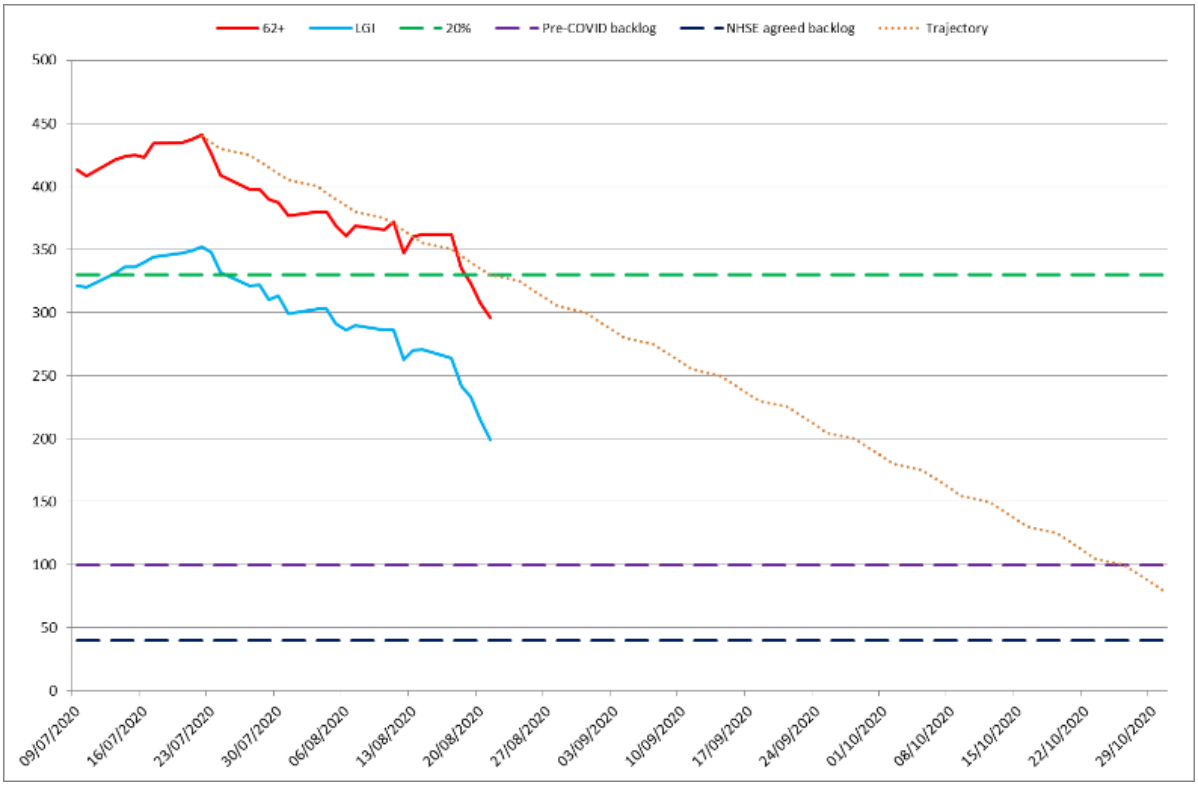
The Trust response to this was to fully maximise the capacity available in diagnostic services described in section 3.1 and 3.2 of this report together with priority access to treatments (particularly at the Grantham Green Site). The result was of the 163 patients who were over 103 days on 9 July, only 27 remain on the pathway on the 21 August.

Of these remaining 27 patients, every patient was seen in an outpatient setting, had a diagnostic investigation or had a telephone consultation with the clinical team. (Telephone consultations were made available to patients who did not want to come to hospital to be seen or treated.)

By 21 August 2020 only 44 total patients were waiting over 104 days. (This number included the 27 from 9 July 2020, plus 17 more patients whose waiting times increased to over 103 days during that time. (These figures exclude where patients chose not to receive treatment or attend the hospital and tertiary patients waiting for services at other hospitals). Recovery of the 104 day cancer standard to pre-Covid levels will be part of phase 3 plan developed for September sign-off.

The second objective for Cancer restoration was :

The number of patients waiting over 62 days should be reduced by 20% within 6 weeks with a trajectory in place for full recovery, high risk non cancer surveillance patients must also be included.



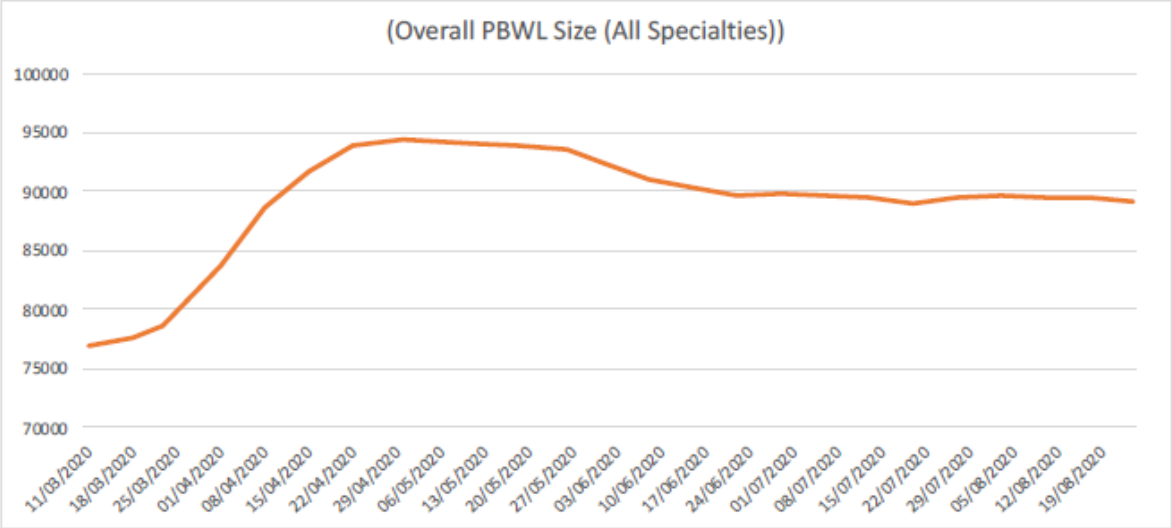
413 patients were waiting over 62 days for cancer treatment on 9 July. A 20% reduction would need to reduce this to below 330 patients by 21 August. As of 21 August 296 patients remained waiting over 62 days representing an achievement of this objective and exceeding the original ask by reducing waiting list further.

Colorectal patients continue to account for c.70% of patients waiting for cancer treatment and remain the greatest concern of patients waiting for cancer treatment. The Colorectal pathway is a complex pathway that has been severely affected by Covid-19, with reduced access to surgery and diagnostics through reduced productivity. Capacity was further impacted on with the loss of surgical capacity as a result of illness and quarantine impacts in the early stages of the Covid-19 response.

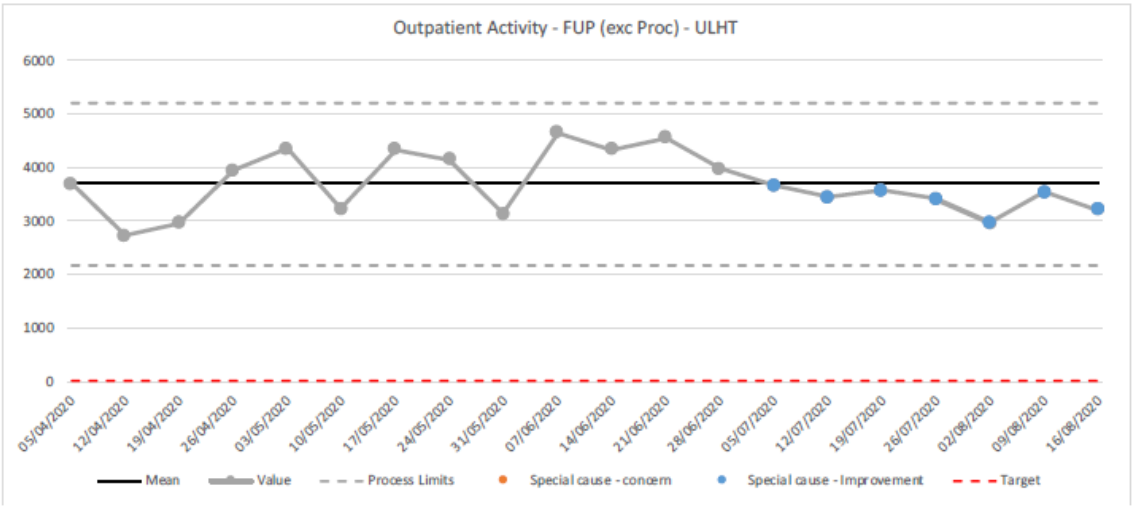
A specific recovery plan for Colorectal will feed into the Trust level plan, using a mixture of internal services as well as Independent Sector capacity, building on the best practice work that has taken place thus far.

Overall trajectory for recovery of the 62day standard to pre-Covid levels by October 2020, with ambition to reduce to a sustainable achievement of constitutional standards in November 2020. Full details of this will be described in future updates that will articulate the Phase 3 plan.

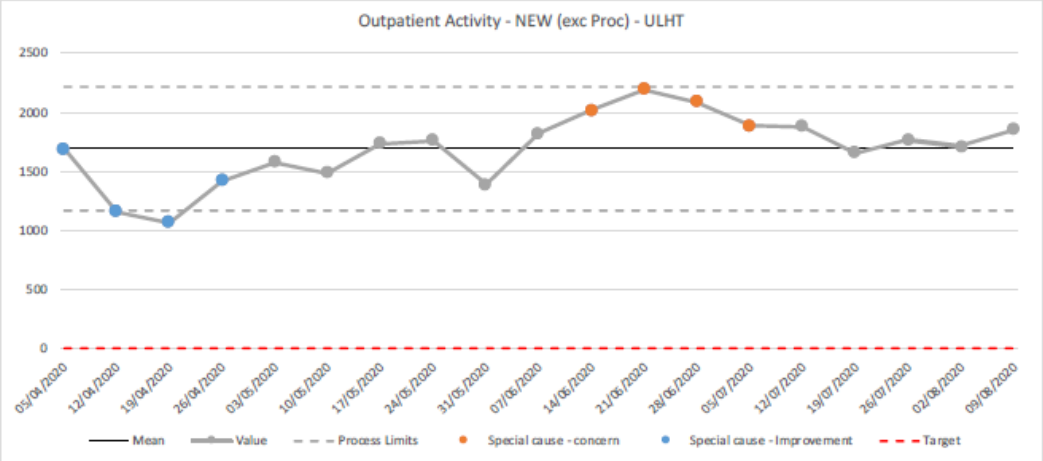
3.4 Planned Care Waiting List



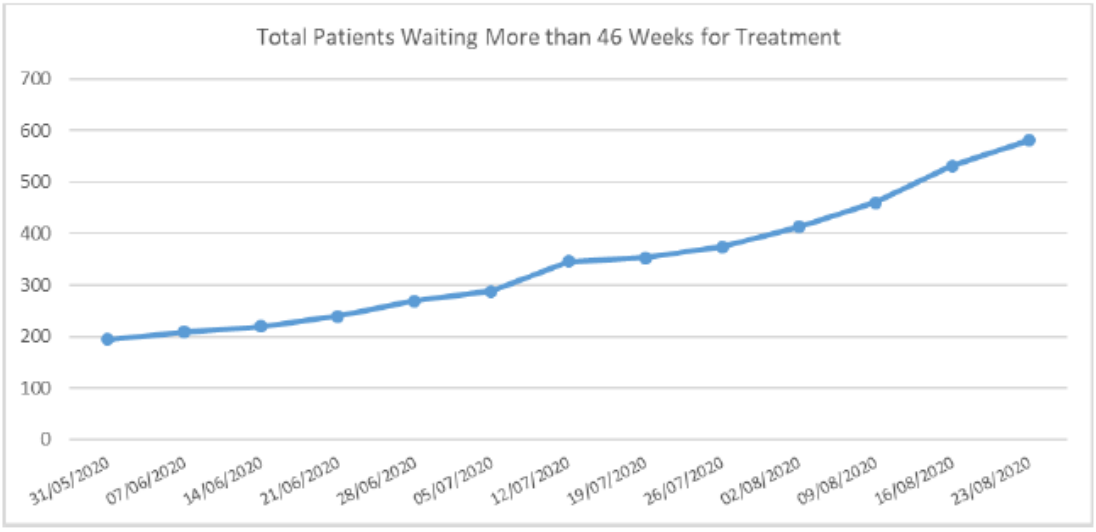
Planned care waiting lists both for people waiting for a follow-up subsequent outpatient appointment (know as the partial booking waiting list) or for treatment and surgery have expectedly increased throughout the early stages of the response to Covid-19. This position echoes the national and regional increase and reflects the prioritisation of services on urgent care and on cancer as Trusts Restore services and start their Recovery.



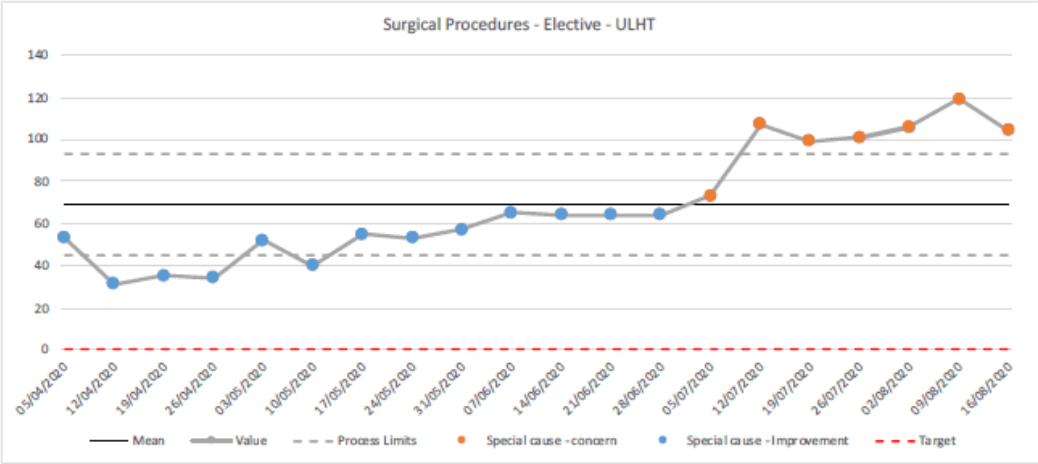
Despite the early growth in PBWL the use of technology and non-face to face appointments meant that the overall waiting list size did start to reduce. However, in recent weeks as other services start and increase in capacity, teams who were working predominantly on outpatients, some of which may have been shielding themselves, are splitting their time more equally across outpatients, surgical and treatment areas. This is in addition to staff needing to take overdue leave, and being released to rest and recuperate, from what has been for many very intense 6 months of Covid-19 response.



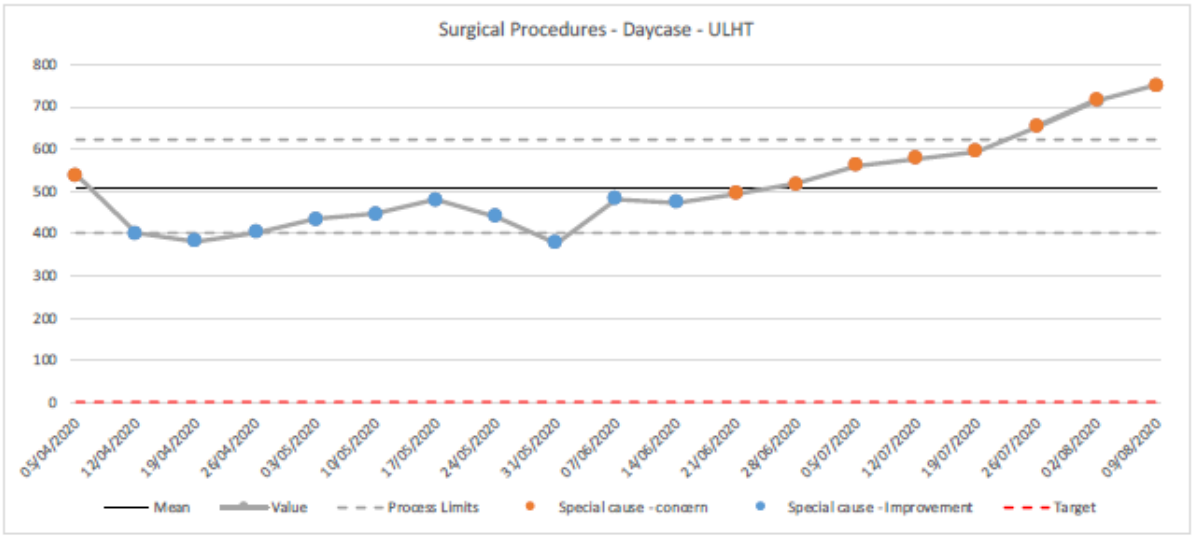
Access to first outpatient appointments has also to date been focussed on suspect cancer 2ww and clinically urgent appointments. In June as services began to restore this saw a substantial increase in new appointments for patients who have been delayed in the first phase. In recent weeks, in a similar way to follow-up clinic capacity, the number of patients seen has reduced as other treatments and services come on line, and staff take overdue annual leave.



Throughout the Covid-19 response the Trust has largely prevented patients from waiting beyond 52 weeks. In July and August this increased, but still to comparably low levels in relation to other Trusts across the region. Patients waiting more than 46 weeks has continued to increase and represents the challenge for Recovery Phase 3 with nearly 600 more patients requiring treatment.

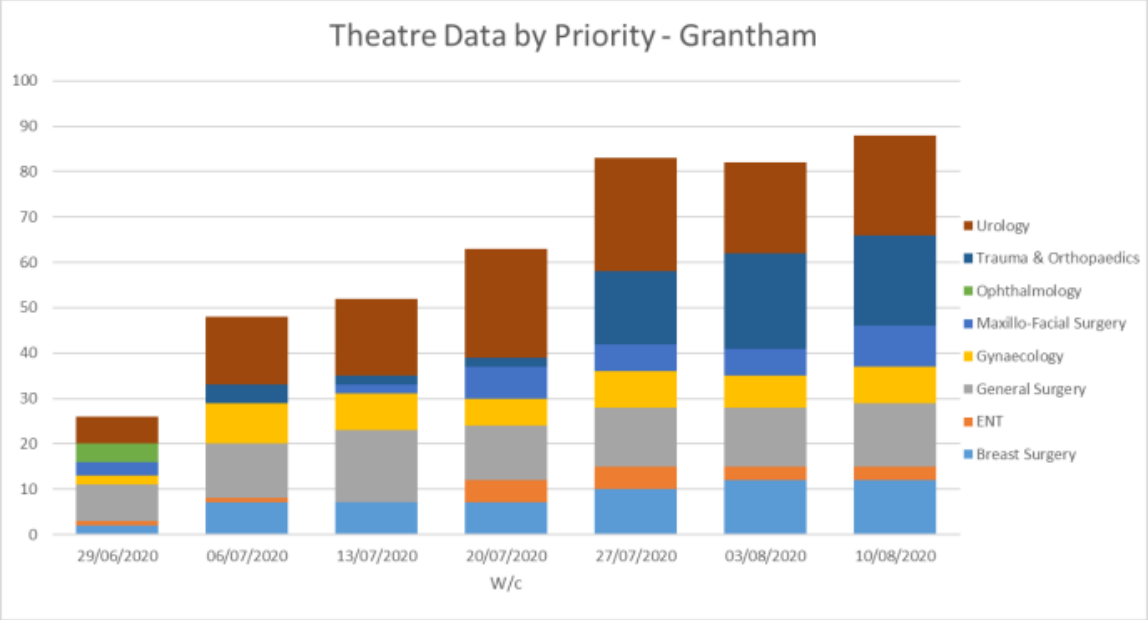


As forecasted the number of Surgical treatments has continued to increase with the introduction of the Grantham Green site model.



Planned Surgery requiring an overnight stay and Day Case procedures have both made excellent progress and will continue to improve as part of recovery.

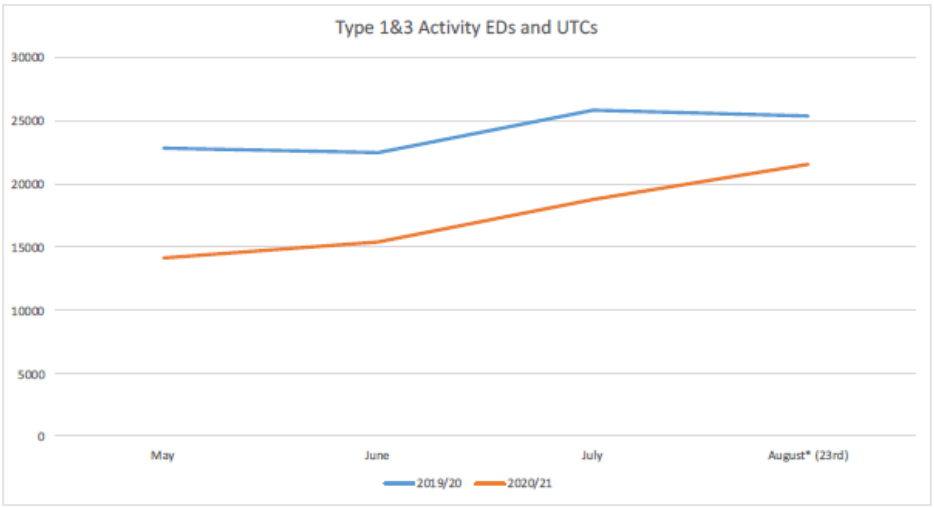
The Grantham Green site continues to deliver an important part of the Restoration of services as both Cancer and Planned care waiting lists are reduced. At this stage there is still much more to be done as can be seen from the waiting list information above, however the protection of patient pathways in this way provides a critical response to Covid-19 and will be an important feature of the Phase 3 plan.



Theatre throughput has increased up to 19 cases per/day, and whilst not achieving the 25 case per day target the number of patients accessing surgery who would otherwise not be able to continues to climb. Recent introduction of urgent Trauma & Orthopaedic operations at weekends has moved operating into a 7 day format maximising the opportunity of the Green site model.

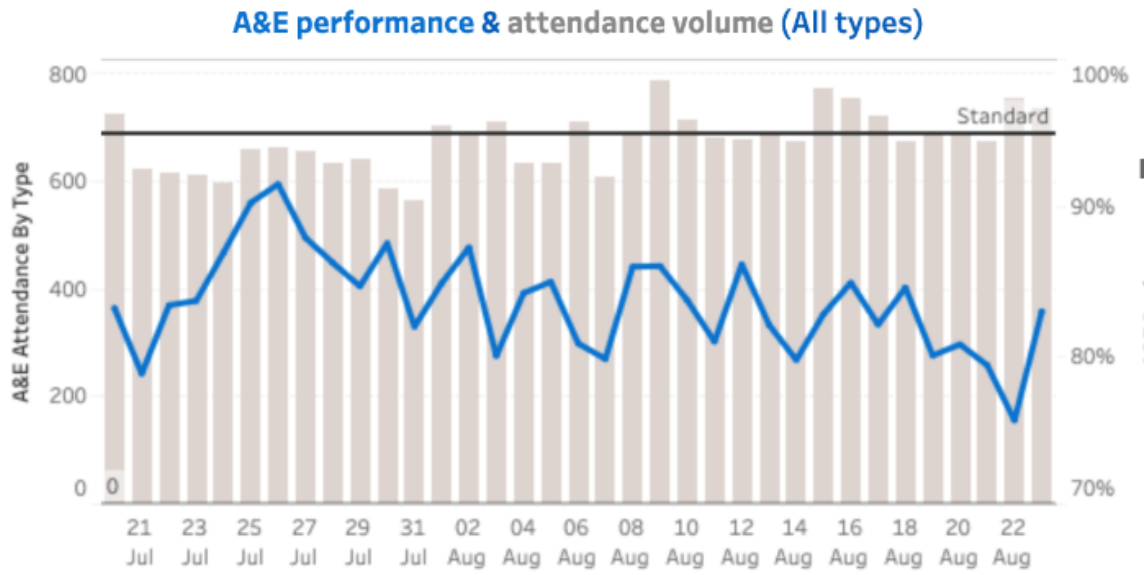
Full quarterly review of the Grantham Green site model is due in October 2020 and will contain a deeper analysis of the impacts of Grantham Green site model, however at the point of publishing this report 0 serious incidents have been recorded at or as a result of the Green Site Model. 0 patients have contract Covid-19 post operatively.

4. Progress on Recovery of Urgent Care Services including Resurgence of Covid and the preparation for Winter B1 and B2

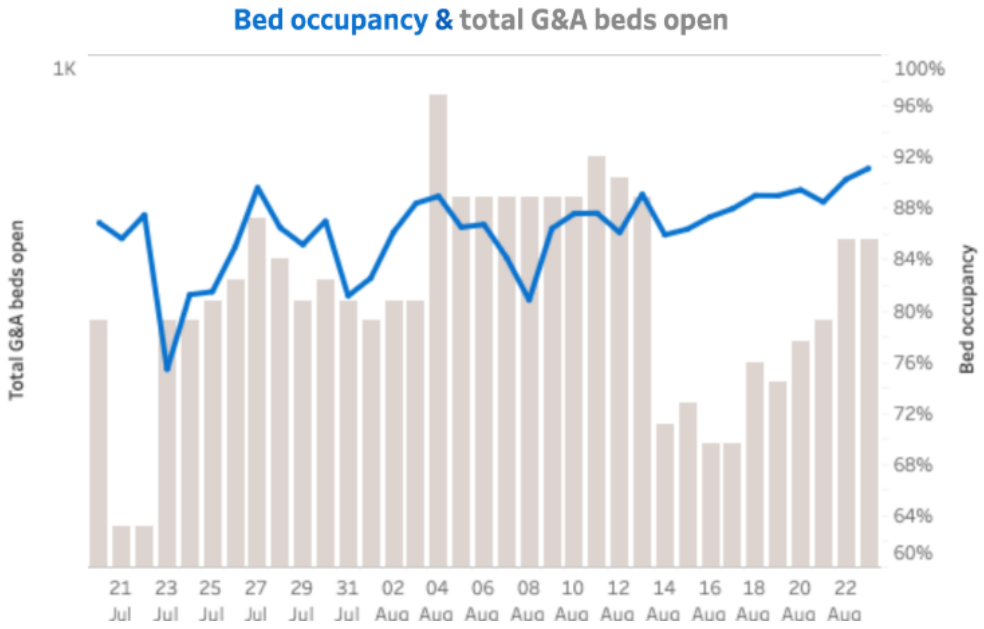


The increase in emergency activity and attendances at the Trusts Emergency Departments and co-located Urgent Treatment Centres demonstrates the relative

increase in confidence in patients accessing hospital services. At the beginning of Covid-19 pandemic demand dropped by more than 66% of previous years' levels. In August to date this has now risen back to pre-covid levels. The increase in demand seen in each year as part of summer season demand (most notably in the east of the region) has not been replicated in July and August weeks, however the steady increase in demand has started to place pressure on urgent care services.

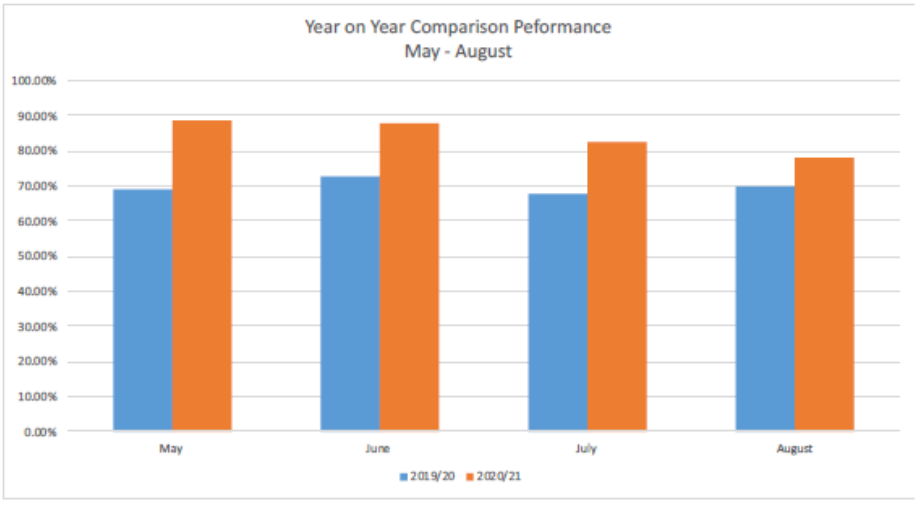


As demand has increased, alongside the increased in bed occupancy access standards have deteriorated. Despite increases in staffing in Emergency Departments agreed prior to Covid-19 response, delays have occurred as a result of overcrowding in departments. Partly as a result of maintaining Covid-19 suspect and non-physical separation and maintaining social distancing where possible, but also as a result of the extra precautions PPE and other safety measures introduced. Combined with reduced flow as be occupancy increases, and reduced discharge rates this has highlighted the need for substantial changes to the Urgent Care physical environment.



*(Please note the scale on the chart for beds is a range from 920-930 beds)

The Trust has been successful in its application for capital to support the increase in Emergency Department capacity at Pilgrim Hospital with a £2M allocation being awarded in August. Other bids have been put forward for Lincoln Emergency Department as well as ward environment improvements to deliver the necessary measures required for IPC in future waves of Covid-19 or other infectious diseases such as Influenza and Norovirus.



Examining the comparison from 2019 to 2020 urgent care performance against the 4 hours standard, it is clear to see that improvements have still been maintained throughout the Covid-19 response although that margin is reducing as bed occupancy and A&E attendances increase. Phase 3 section B planning will be factoring in the necessary measures to reduce occupancy, and to compensate for bed reductions through necessary IPC measures. These schemes although not complete yet, are likely to include the improvement in discharge of patients pending results for Covid-19, as well other length of stay improvements.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th July 2020*
Item Number	*Item 7*
ULHT Covid-19 Restore Phase Update – Progress Summary	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*Executive Leadership Team*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	Covid-19 Strategic Risk
Financial Impact Assessment	Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.
Quality Impact Assessment	
Equality Impact Assessment	Equality Impact Assessments are conducted on significant changes within the authorisation/governance system in place from the outset of the Covid-19 Level 4 Pandemic
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	The Board are asked to accept this progress update, noting the nature of the current national level 4 incident, the nature of frequent new guidance and requirement for all plans to be flexible and responsive. In addition, the board is asked to offer thanks and gratitude to system partners who have supported the Trust in enacting this complex and challenging phase of the Covid-19 *Restore* plan.

Executive Summary

On 11 May the Trust confirmed it's *Restore* Phase plan as an important component of its overall Covid 19 campaign strategy. This report presents a high-level review of this *Restore* Phase plan and the progress made to date against required and intended actions.

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. This report describes the approach being taken and progress to date to restore, revert or embed these changes during the *Restore* Phase.

The Trust's *Restore* phase response has been heavily focused on Infection Prevention and Control (IPC) to create optimum levels of protection for patients and staff. An important vehicle to deliver this and an integral component of the Trust's *Restore* phase plan is the creation of a Green site at Grantham, which was approved by Trust Board on 11th June 2020.

The Grantham green site went live on 29 June, an achievement in delivering a large-scale change in a very short time frame. On 1st July cancer surgery commenced and it is anticipated that as efficiency of the surgical model develops over the next month there will be up to 25 cases operated on each day.

At the time of this report, there were no cancer Priority Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August). These timescales could be shortened depending on weekend working and productivity increases as teams become acclimatised to the new model of working.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change. It also recognises the disruption and additional effort required to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The report describes the progress made in enacting *Restore* phase plans and impact on quality and access performance in urgent and emergency care, planned care, cancer, maternity services and screening programmes.

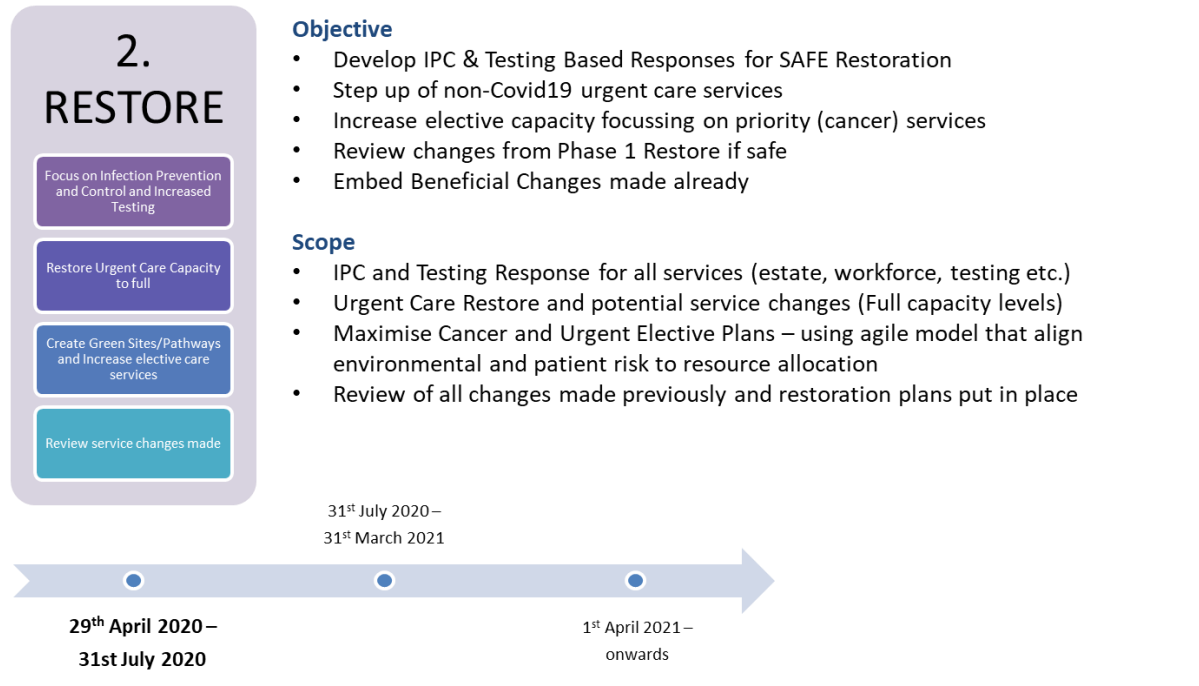
Finally, the Trust's approach to prioritisation, risk stratification and harm review is described and assurance provided regarding monitoring processes in place

1 Background

On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. On 3 March the Department of Health and Social Care issued the Coronavirus action plan; a guide to what you can expect across the UK. This reflected the strengthened legal powers announced by Secretary of State for Health and Social Care.

On 11 May the Trust confirmed it's Restore Phase plan as an important component of it's overall Covid 19 campaign strategy, which was presented at Trust Board in June. This report presents a summary review of this Restore Phase plan and progress made to date against required and intended actions.

2 Restore Phase



With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally continues to be that the initial wave of Covid19 demand is subsiding. All modelling suggests that whilst subsiding, Covid19 will be a disease that will be in general population for many more months. During this phase focus will be heavily on infection prevention and control measures as well as use of testing services to create optimum levels of protection for patients and staff. Emphasis will be placed on the safe restoration of services and not to create additional risks.

3 Review of service changes

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. Sections 6 onwards in this report describes at a high level the approach being taken and progress to date to restore, revert or embed these changes during the Restore Phase.

The following table identifies the service changes made and whether planning sits within the Restore Phase (by 31 July) or Recovery Phase (August 2020 – March 2021). These plans form part of the system restoration activities that are regularly reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Table 1: ULHT service changes deployed during Covid 19

Anaesthetics	Pre-Op assessment change	Moved to virtual pre-operative assessments during Covid, and there is a plan to sustain this change, and only bring patients in when absolutely necessary.	Restore
Audiology	Stop service	Audiology service was paused during covid, but is planned to be reinstated.	Recovery
Audiology	Pathway change	Newborn hearing screening programme was continued during covid, but with no call-backs, there is a plan to restore this.	Restore
Cancer	2ww pathway change	Redesign of 2ww pathway for suspected lung and Upper GI cancer patients. More work is to be undertaken through restore and recovery phase to complete pathway redesign. This will depend on reinstatement of endoscopy services, green site development and pathway specific work.	Restore
Cancer	Pathway change	Lung cancer pathway was changed during covid, some of the adjustments such as clinical triage have worked well, and will be maintained. Some of the changes are not sustainable, such as reduced access to diagnostics and will be developed in the remaining Restore and early recovery phase.	Restore
Cancer	Pathway change	Cancer referral pathways and management of cancer cases was altered to support covid-manage (no endoscopy, risk stratification for treatment, triage of referrals) and while the wider plan is to reinstate cancer diagnosis and treatment clinical pathways, the learning from these pathway changes will be taken and developed for the future to benefit patients of Lincolnshire during restore, recovery and Future NHS.	Restore
Cancer	Pathway Change	Chemotherapy delivered on GDH site during covid-*manage*, with the exception of: chemo-radiotherapy (Lincoln) oral-chemotherapy (patient home) It is likely that this arrangement will continue into Covid-restore and be reviewed for covid-recovery.	Restore
Cardiology	Guidance	Cardiology Primary Care Guidelines - introduced during Covid, have had positive feedback for helping primary care management of patients.	Recovery
Covid pathways	Clinical pathways & hospital sites	Creation of Green and Blue pathways and sites (Green covid free, Blue covid)	Restore
Dermatology	Pathway change	Skin Cancer Pathways - some aspects of the dermatology service have been paused or moved during covid, while retaining as much of the cancer service as possible. In reinstating the service, Green Pathways, social distancing and PPE will be contributing factors to where the service is delivered.	Restore
Dermatology	Pathway change	Dermatology during covid has managed urgent and time sensitive cases, in order to reinstate the routine service, Green pathways, social distancing and PPE will be factored into plans.	Restore
Diabetes and Endocrinology	Pause service	Diabetes and Endocrinology - during covid ULHT Medics have been on a 24/7 medicine rota, and only managed emergency diabetes and endocrine cases. It is possible that at this point, we could develop the community diabetes services to take on the acute backlog at the end of Restore and into Recovery Stage.	Restore
Diagnostics	Pause service	Clinical Neurophysiology service was paused during covid but is planned for restoration with social distancing in place.	Restore
Diagnostics	Pause service	Dexa scanning is planned for restoration	Restore

Diagnostics	Pause service	Endoscopy procedures were halted during Covid-manage, and restoration will require BSG and JAG guidance. There will be a significant impact on capacity due to PPE and Social distancing requirements for AGP. (See later section)	Restore
Diagnostics	Reduced service	MRI service is planned to be reinstated during covid-restore, with social distancing in place.	Restore
Diagnostics	Reduced service	Peripheral site X-ray cover was ceased during covid-manage and staff were redeployed onto other sites. The plan is to restore this service only once demand increases for the peripheral sites again.	Recovery
Diagnostics	Pause Service	Respiratory physiology is planned to be reinstated with PPE and social distancing in place	Restore
Diagnostics	Pathway change	Patients suspected of Upper GI cancer have been offered barium swallows instead of endoscopy during covid-manage. See later section for Restore plans in Endoscopy.	Restore
Diagnostics	Diagnostics	The Urodynamics service paused during Covid-manage and is planned to be reinstated	Recovery
Family Health	Paediatrics	Suspension of Paediatric Surgery - the plan is to reinstate paediatric surgery but this will need to be considered with the Green Pathways.	Restore
Head and Neck	Pathway change	Reduced provision of outpatient services for Otolaryngology at Peripheral sites was introduced during covid and it is proposed that this will continue.	Restore
Head and Neck	Pause service	Orthodontics were managed with as little f2f as possible during manage phase, this service could be restarted outside of the acute setting post-covid.	Recovery
Head and Neck	Pathway change	OMF services have been scaled back during covid, but for the future a large amount of the referrals could be seen by dentists, keeping acute for those who need it.	Recovery
Medicine	Pause service	Medical Day Unit - all non-urgent work paused during Covid, if services retain their left-shift post covid, there is a potential to repurpose Medical Day Unit in the future.	Recovery
Neurology	Pathway change	Neurology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute neurology assessment.	Recovery
Rheumatology	Pathway change	Rheumatology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute rheumatological assessment.	Recovery
Obstetrics	New pathway	Revised maternity pathways (hospital and community) to optimise the safe use of Video Consultation as part of the pathway. This has been assessed as successful, particularly in regard to the community midwifery clinical pathway – in excess of 500 video consultations.	Restore
Orthopaedics	New pathway	Trauma Assessment Unit Established at Pilgrim Hospital (same as in place for Lincoln) to align the process across sites. It is planned for this to continue.	Recovery
Paediatrics	PAU at Lincoln	Use of Safari Unit as a Paediatric Assessment Unit at the Lincoln Hospital site	Restore
Pharmacy	New pathway	Pharmacy provided deliveries of prescriptions during Covid, and these changes are planned to be reviewed and develop in order to support a permanently increased level of remote outpatient activity	Restore
Pharmacy	Pathway change	Rowlands Pharmacy Supply of Methotrexate - this was a pathway developed during Covid to support patients without requiring clinic attendance.	Recovery
Pharmacy	Pathway change	Pathway for Respiratory - Omalizumab & Mepolizumab. Patients receiving these drugs following referrals from NUH have been receiving their care via Homecare under existing contracts during Covid-Manage. Prior to this patient would have attended clinic for injections.	Recovery
Pharmacy	Pause service	Closure of Louth Hospital Pharmacy Department during Covid Manage phase. Reinstating the service will be in line with the recovery phase. Restarting with other services.	Recovery
Respiratory	Guidance	The guidance given to primary care for management of respiratory conditions during Covid-manage, could be developed and kept with clinical input from primary and acute services.	Recovery
Screening	Pause service	AAA screening service was stopped during Covid-Manage, there is a plan to restore the service but social distancing and PPE measures will reduce capacity from 115 appointments per week to 80.	Restore

Screening	Pause service	Bowel Cancer Screening Programme was paused during Covid, and will be reinstated when guidance is given by BSG and JAG. There will be a significant impact on capacity due to social distancing and PPE necessary in AGP.	Restore
Screening	Pause service	Breast screening will be reinstated, and will have capacity impacts due to social distancing.	Restore
Screening	Pause service	Diabetic eye screening programme was paused during covid but is planned for restoration with social distancing and PPE measures in place, which will impact on capacity.	Restore
Therapies	Pause service	The Hydrotherapy service closed during Covid-manage, and is planned to be restored with social distancing and risk assessments in place.	Recovery
Therapies	Pause service	Spasticity clinics were paused during Covid, and are planned to be reinstated with risk assessments, PPE and social distancing	Restore
Stroke medicine	**Patient flow/discharge**	Due to significant COVID related sickness, consultants shielding and the withdrawal of agency locums, it became urgently necessary to move from 2 x single site on Stroke On Call Rotas (1:4) to one trust wide on call rota to maintain safety and sustainability of access to thrombolysis.	Recovery
Elective Care	**Green Site**	A Green site (Covid-19 free) at Grantham and District Hospital for this next phase of the pandemic. This would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire.	Restore
A&E	**Urgent Care**	Convert A&E to Urgent Treatment Centre ('UTC') and make physical estate changes to isolate from the rest of site. UTC isolation can be done in a way that removes staff/patient movement between Blue and Green areas. The preferred model converts the A&E, currently open from 8am to 6:30pm, into a 24/7 walk-in UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities dedicated to the UTC. The UTC will be equipped to diagnose and treat many of the most common ailments people go to A&E for - 81% of patients who attended the A&E will still be able to attend the UTC. Patients may be referred to an urgent treatment centre by NHS 111 or by a GP, and patients can also turn up and walk-in. The Ambulatory Care Unit will be retained to provide day care for patients.	Restore
Medicine	**Inpatient beds**	Withdrawal of medical beds at Grantham - As medical beds will be withdrawn at Grantham a proportion of patients will be treated in the Ambulatory Care Unit (largely GP referrals) at Grantham and a number of patients will be re-routed and admitted at Lincoln.	Recovery

4 Grantham Green site

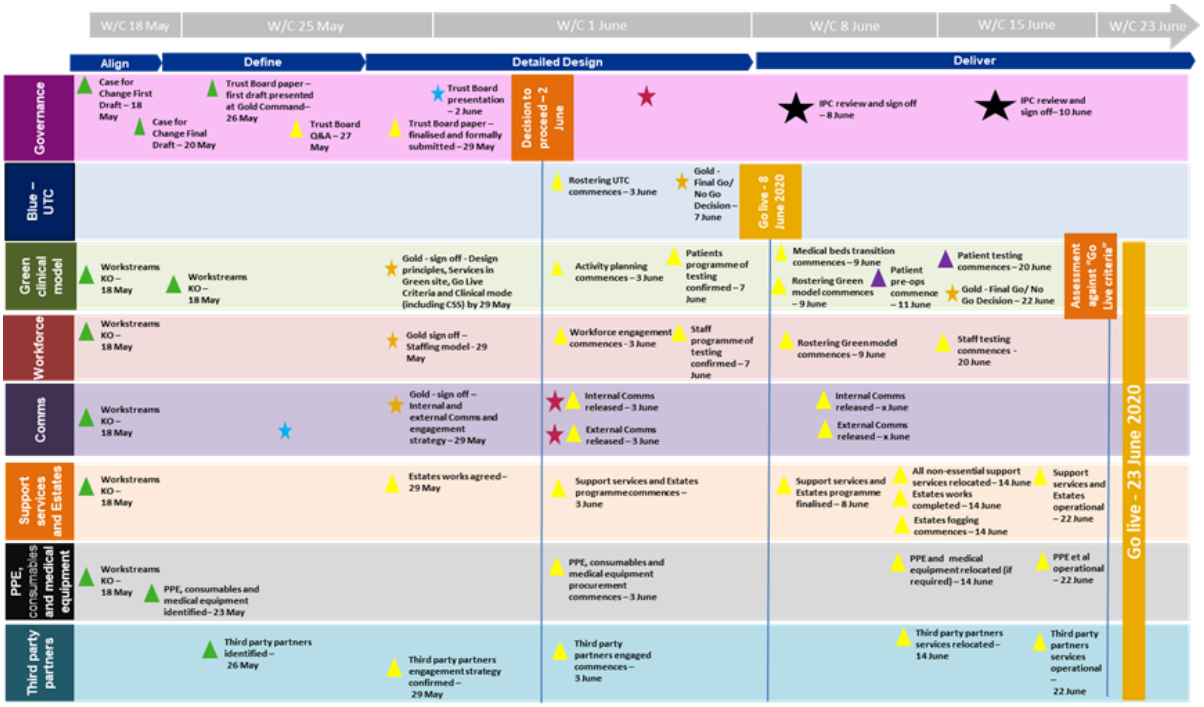
The Trust's Restore phase response has been heavily focused on reducing the risk of hospital acquired Covid-19 and associated Infection Prevention and Control measures. This is with an aim to create optimum levels of protection for patients and staff, drawing on a bundle of measures including social distancing, environmental enhancements, cleaning programmes, hygiene and hand washing, and test and trace. Additional measures are required to ensure that environments can support improvements in IPC including controlling access through hospital areas, reducing footfall wherever possible, and zoning of areas to support Green and Blue designation of areas. An important vehicle to deliver these measures and integral component of the Trust's Restore phase plan is the creation of a Green site.

On June 11th 2020, the Trust Board approved the proposal for temporary reconfiguration of services at Grantham as a Green site with a Blue isolated Urgent Treatment Centre. This decision was made following presentation of a case for the temporary reconfiguration of services as part of the Trust's response to the level 4 incident declared on 30 January 2020. This case for change included the

options considered and the preferred option, the legal basis for the change, clinical leadership and governance established to oversee and enact the proposed changes.

Approval was given to proceed with the changes proposed and approval for the necessary work to deliver this change to commence, whilst recognising that these are temporary and that any proposal to make them permanent will be subject to public consultation. The timescale for the Green site is the duration of the Covid-19 Restore and Recovery phases up to at least 31 March 2021.

The critical path below describes the workstreams within the project task and finish group and at a very high level the activities required to achieve go live of the Grantham green site by the target 23 June. Behind this sat detailed plans for clinical leadership and governance models, workforce, IPC protocols and procedures, and a go live checklist. Subsequently the Grantham green site went live on 29 June, 6 days overdue owing to uncontrollable factors, and a very credible achievement in delivering a large-scale change in a very short time frame.



The Trust, in collaboration with LCHS, has converted the (currently open from 8am to 8pm) ED into a 24/7 UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities linked to the centre, maintaining urgent treatment and care to the population of Grantham. This isolated Blue area within the Green site has been achieved in a way that removes staff crossing between Blue UTC and Green site and does not compromise IPC excellence, while affording the option of having completely Green diagnostics and inpatient services.

In order to maintain the highest level of protection and IPC standards on the Green site it has been necessary to relocate a number of services internally as well as with system partners. In order to reduce the number of services on site overall and remove all services that cannot sustain a Green pathway (Covid-negative patients only) a number of new/alternative locations have been identified

and implemented. This approach has reduced both patients and staff need to transfer to other hospital sites across Lincolnshire.

Table 2: Services requiring relocation or new working practices to limit site presence to essential only

System partners	ULHT clinical services	ULHT non-clinical services
LCC – Social workers	**Community midwifery**	**Medical secretaries and**
LPFT - Neuropsychology	**Orthodontics**	**bookings –** Hybrid solution
LCHS – GU Medicine services	**ENT**	**CNN team**
LCHS – SALT	**Audiology**	**Estates/Facilities**
LCHS – AIR in reach into UTC	**Respiratory**	**Procurement**
LCHS- Out of hours	**AAA screening**	**Divisional support**
Macmillan – remain on site	**Plain film x-ray**	**Corporate Nursing**
Uni of Lincoln –student	**Physiotherapy/OT**	**Library**
nursing support	**Paediatrics**	**Finance**
Respiratory physiology	**Dietetics**	**HR**
OT/Physiotherapy	**Surgical and Medicine**	**PALS** – tbc
System Partners (including	**specialist outpatients**	**Operations Centre**
Marie curie)	**Clinical coding**	
	Research office	

In order to maintain local access to these services within Grantham a number of alternative accommodation solutions have been identified in the town area including South Kesteven District Council offices, Grantham Health Centre and commercial office units, as well as mobile diagnostics facilities.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change and the disruption and additional effort required in order to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The potential for medical inpatient and diagnostic services to share Blue and Green services is significantly short of the IPC principles set and the design principles of a Green site. Therefore, medical inpatient admissions have been removed from the Grantham model temporarily for the duration of the Covid 19 Restore and Recovery phases. The displacement of urgent care activity and medical admissions to other Trust sites and neighbouring providers has been modelled and will be closely monitored.

A formal Quarterly Review of the Green Site Proposal will be presented in October (i.e. presenting the first 3 months of operation.) However, in the interim each month will present important information on attends, ambulances, cancer treatments and incidents specific to Grantham

On 1 July elective surgery commenced within the Grantham Green site and it is anticipated that as efficiency of the surgical model develops over the next month that throughput will see 25 cases through four extended theatres each day.

Additional diagnostic services are planned for one of the offsite Grantham locations further reducing any unnecessary transfers to other hospital sites, and reducing the demand on services in the UTC. Although the Trust is in a priority list for these diagnostic units with many other trusts across the UK. It is likely that x-ray services will be in place off site from August 2020 until the Grantham Green Site model is reverted and services return to previous configuration.

5 Patient and staff testing and screening

All patients undergoing cancer or elective inpatient procedures on a green pathway are being advised to self-isolate for 14 days prior to procedure and tested 48-72 hours prior to admission. Patients attending for an outpatient appointment or day case procedure are advised to self isolate for 7 days.

Our approach to staff testing is aimed at reducing healthcare associated Covid 19 infections in the Trust. Testing our staff is essential to ensure patient safety, maintain confidence in the Trust and protect the health and wellbeing of our staff. Trust protocol is to test all staff with symptoms or the index case if a household member. We do not test non-symptomatic staff.

In the event of an untoward incident or outbreak the Trust has an outbreak plan and staff and patients from the outbreak department will be tested. If a healthcare worker tests positive this will be risk assessed and colleagues who they've been in contact with may subsequently be identified and tested.

We are currently offering staff the opportunity for antibody test, which tests for the presence of antibodies that will demonstrate whether an individual has had the disease.

All staff attending the Grantham green site to work on the green pathway are now required to have a daily health screen, which includes a health and wellbeing assessment and temperature check.

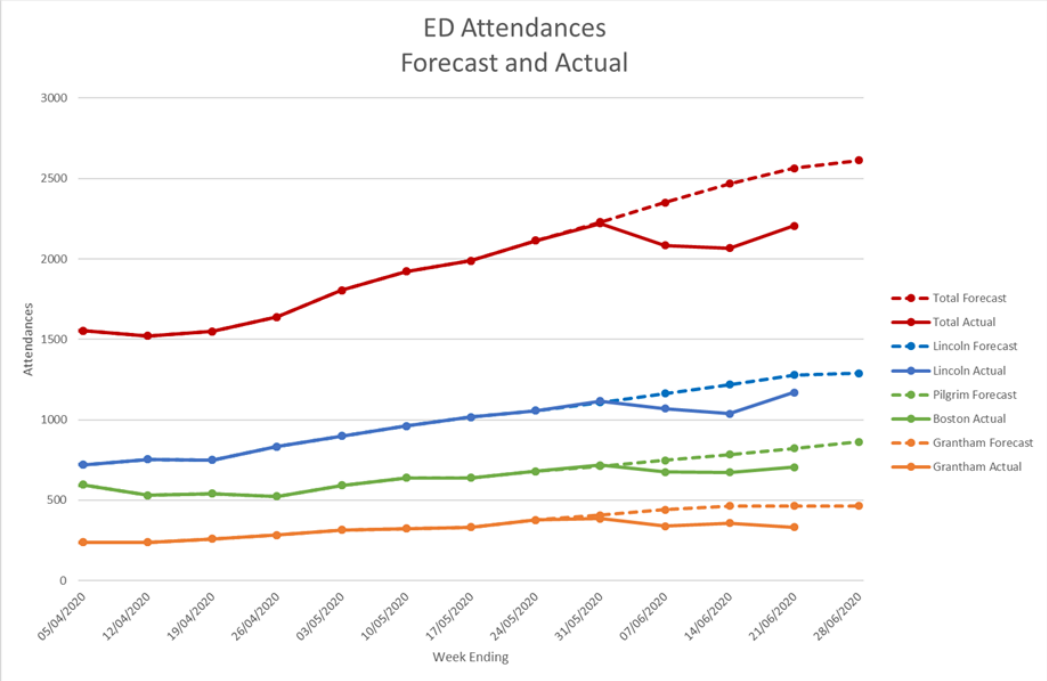
6 Urgent and Emergency Care, Urgent and Routine Surgery

6.1 Urgent and emergency care:

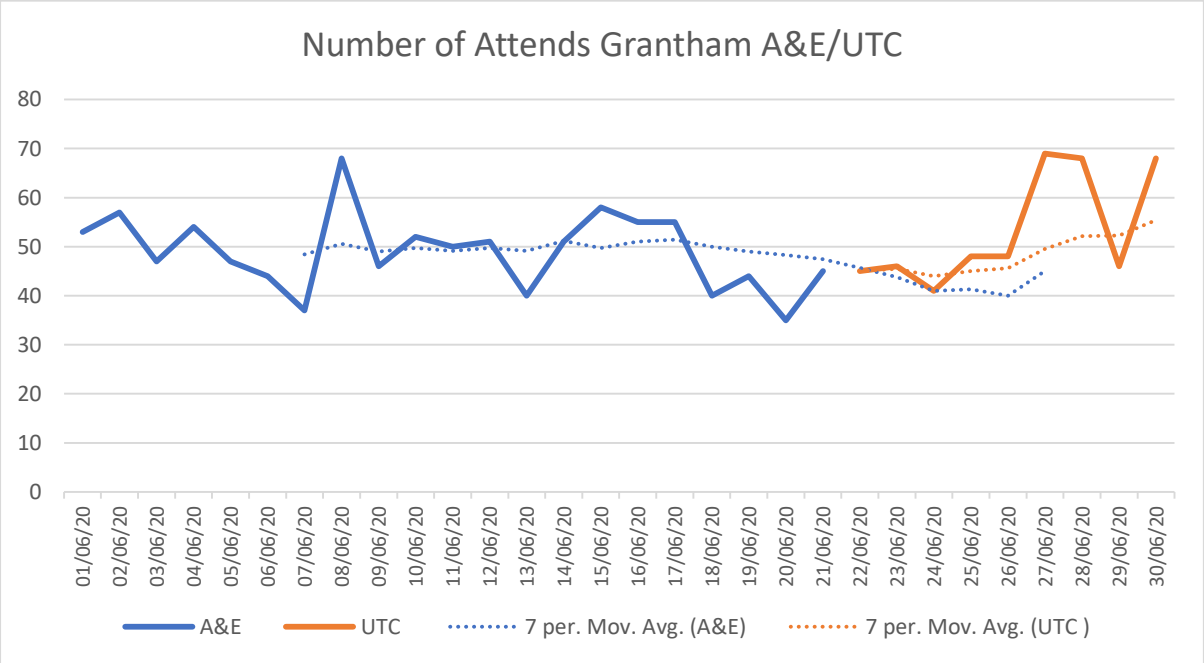
The Trust's urgent and emergency care (UEC) activity reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. Local UEC demand modelling forecasted non-elective admissions to increase by 13.6% per week up to a normal level by the end of May resulting in potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.

High rates of increase in ED attendances during May drove activity back towards pre-Covid 19 levels; however, in late May and early June the growth rate has plateaued. Currently ED attendance activity compared to pre-Covid 19 levels is

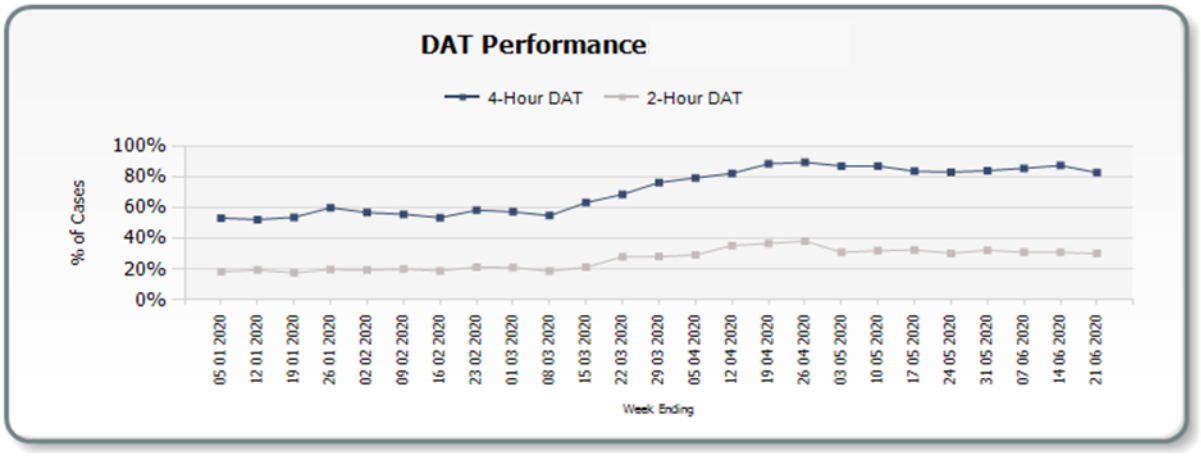
- Lincoln 88%
- Boston 73%
- Grantham 75%



Since transition to an Urgent Treatment Centre (UTC) model Grantham attendances have continued to increase.

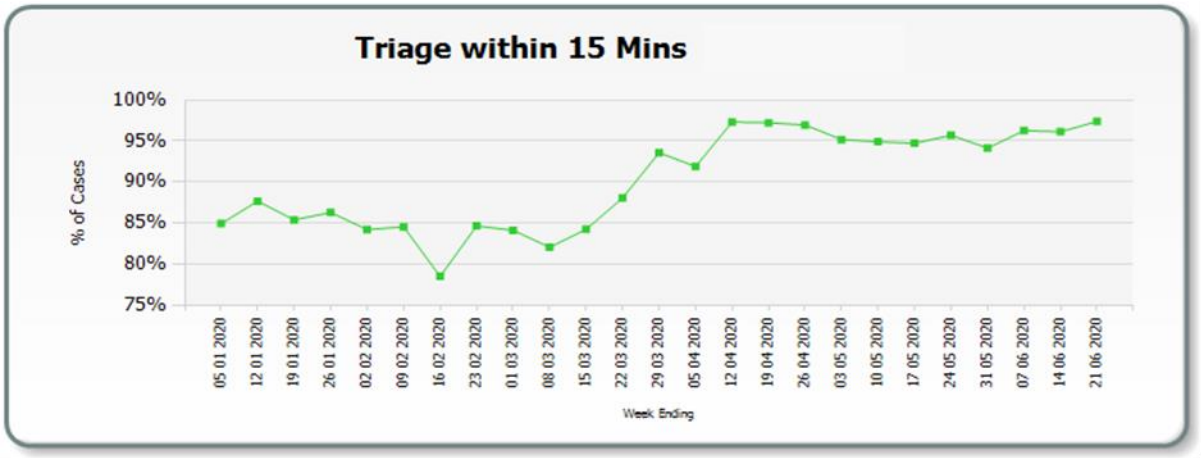


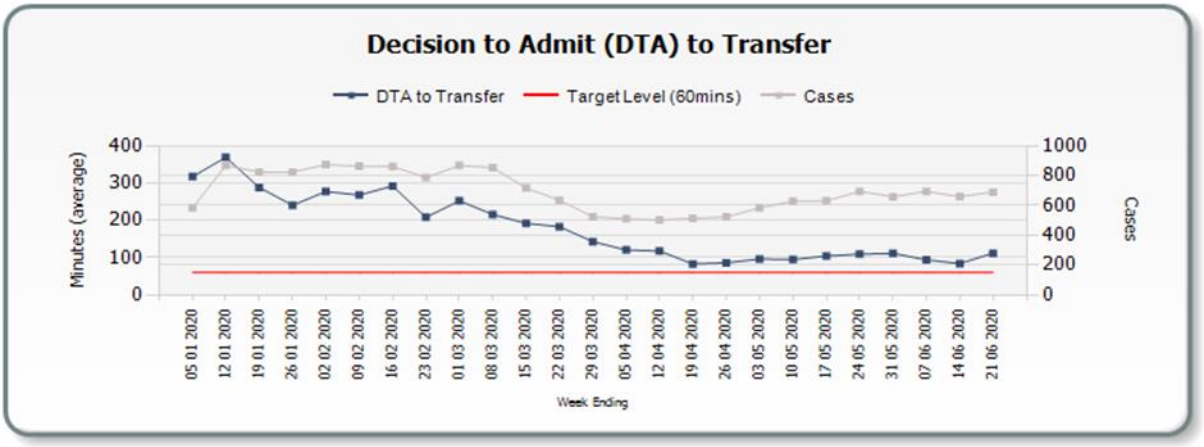
Despite attendances returning to over 80% of pre-Covid 19 levels, the Trust's significantly improved 4-hour performance is being maintained at over 80%. For May, the most recent reporting period, 88.70% was achieved despite a 26% increase in ED attendances compared to the previous month.



Drivers for this have been the reduction in delays due to triage, being seen by a doctor and time to transfer to a base ward. Ambulance handover delays have also significantly reduced across the Trust.

This success has resulted from coordinated work to restore our UEC capability at the required pace and scheduling immediate changes to our front door model, ED pathways, same day emergency care (SDEC) provision and discharge efficiency.

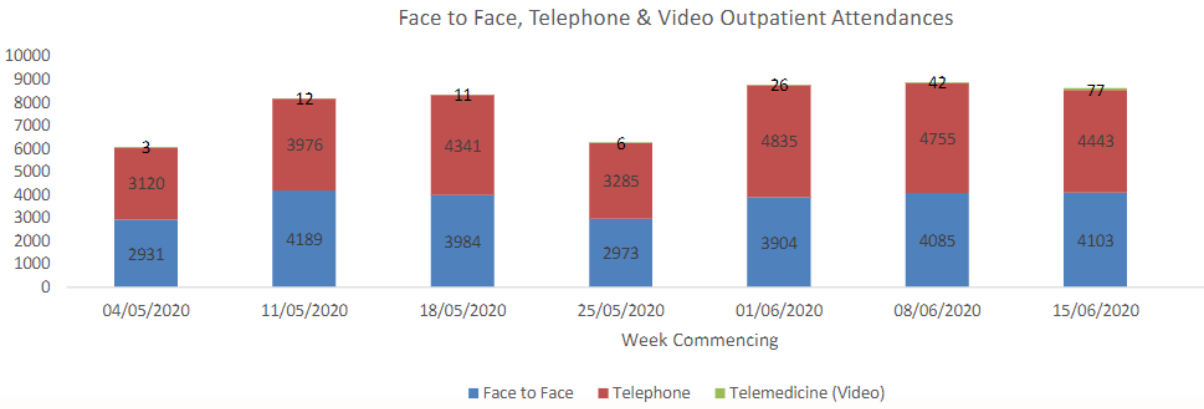




6.2 Outpatients:

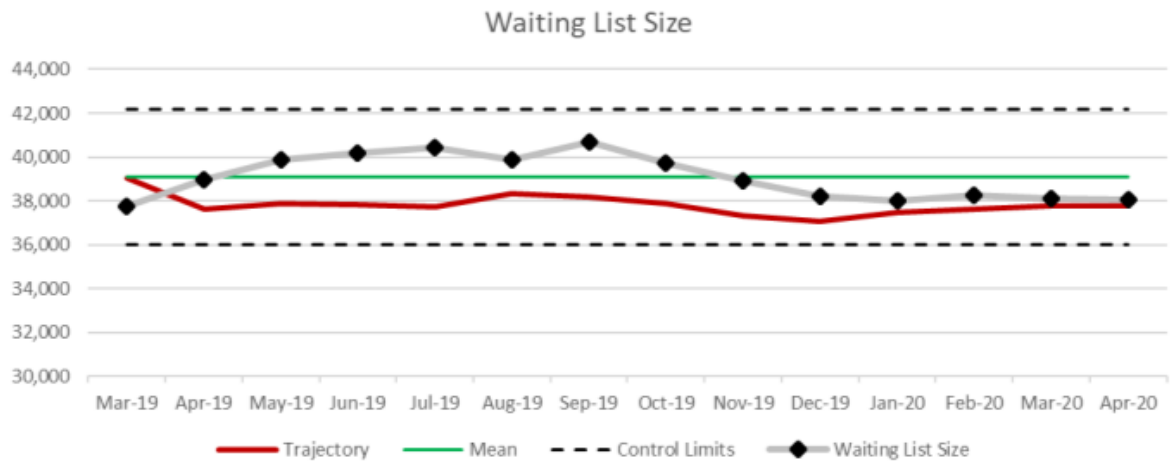
The Trust has continued to provide outpatient consultations for cancer and urgent patients throughout the pandemic, while scaling up routine appointments during June, utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. The scaling up of our use of technology-enabled care has been very successful, benefiting both patients and clinicians, and our focus is on embedding this new way of working as future business as usual.

During June total outpatient's weekly activity has been approximately 60% of pre-pandemic volume. Currently circa. 55% of the Trusts maintained outpatient activity is being conducted by technology enabled care; over the telephone or by video consultation.

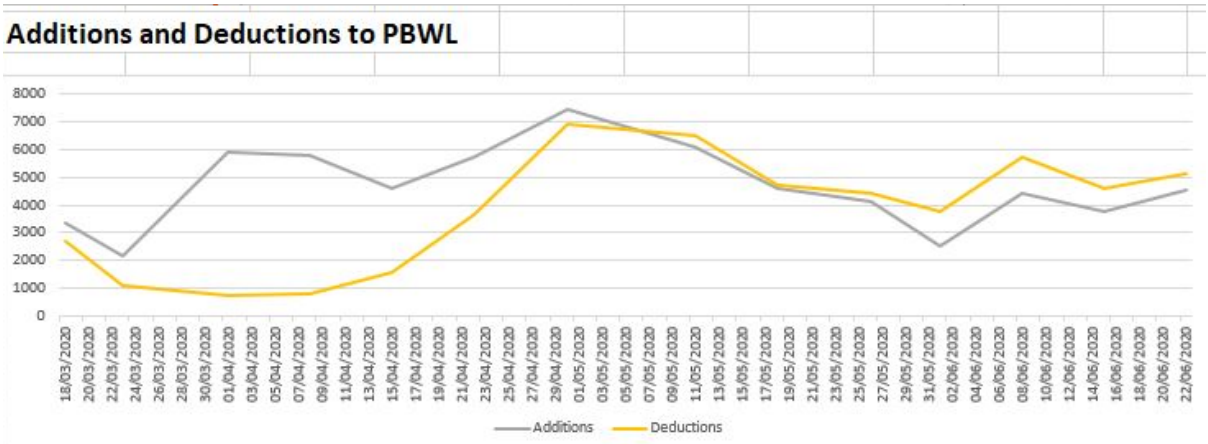


Specialty level waiting list recovery plans are being monitored and current performance is exceeding national and regional peer performance. The Trust reported three RTT incompletes 52-week breaches for April (latest reporting period). However, it should be noted that the volume of 52-week breaches will increase over the next few months, until elective surgery capacity is increased and the admitted backlog has been cleared.

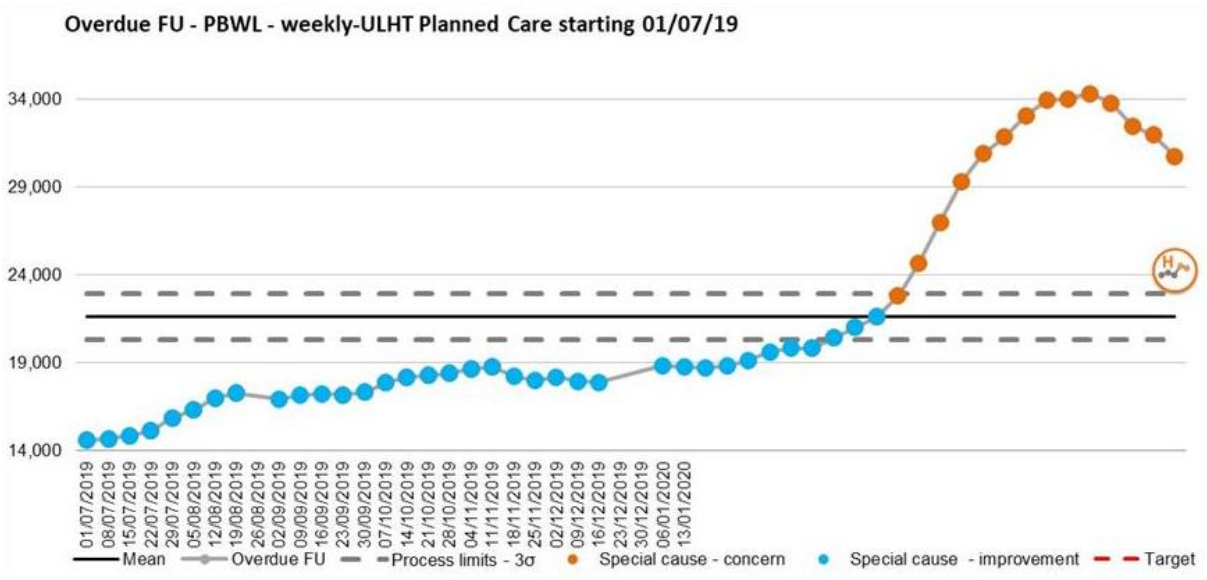
The overall waiting list size has improved from March and remains better than the 2020 target volume.



Following a period of significant growth due to a reduction in routine outpatient activity, the partial booking (follow up) waiting list size has been identified as a key risk. Successful management of this risk so far has been achieved through a programme of recovery actions include clinical triage and validation together with the scaling up of technology enabled care, such as telephone clinics. As a result of these actions waiting list deductions have consistently overtaken additions since mid-May.



Monitoring now illustrates a clear improvement trend and continued reduction of the PBWL by circa. 900 per week.



Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm due to delayed follow up. Prospective clinical reviews are in place across specialties as part of our Covid 19 response in addition to normal operational practices. Our follow up waiting lists are regularly reviewed and prioritised by senior clinicians, with the use of a patient initiated follow up (PIFU) approach wherever suitable to provide patients with the means of self-accessing services if required. We are utilising those health professionals who are shielding during this time to review waiting lists and continue with appointments by telephone or video conferencing from home. If face to face is required we are following all PHE guidelines on IPC.

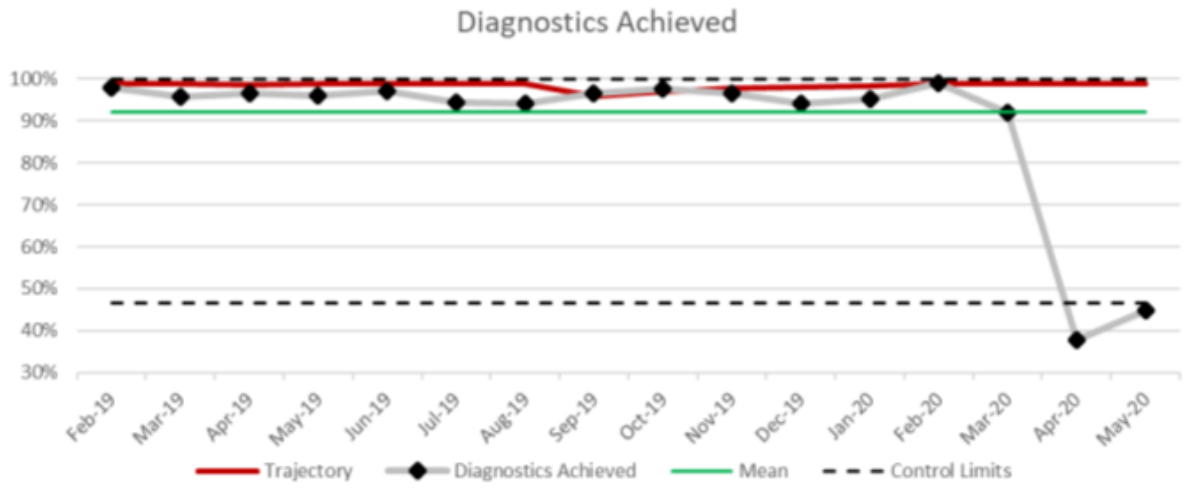
Therapy outpatient services have ensured urgent patients have access to appointments through new referral triage and prioritisation, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place. Restoration of services to date has involved limited implementation of the reintroduction of outpatients and community provision in order to retain seven day staffing of in-patient settings and support discharge planning.

6.3 Diagnostics

Diagnostics access remains protected for emergency and cancer activity and this will continue. There is in place, the capacity to scan all current and forecast cancer and emergency patients and throughout the pandemic period the Trust has consistently delivered 90-95% access to cancer diagnostics within 7 days.

As a direct result of Covid 19 impact 55% of patients waiting for a DM01 diagnostic test at the end of May were waiting over 6 weeks. This is in line with the average performance of Trust's nationally. Most patients waiting over 6 weeks continue to be within echocardiography and endoscopy diagnostic procedures. We continue to be guided by national and regional body recommendations for the safe restoration of these diagnostics procedures and are proactively planning additional capacity to be implemented at the point when this is possible. In the meantime, demand

management pathways are proving successful and we have implemented robust monitoring procedures for patients awaiting diagnostics.

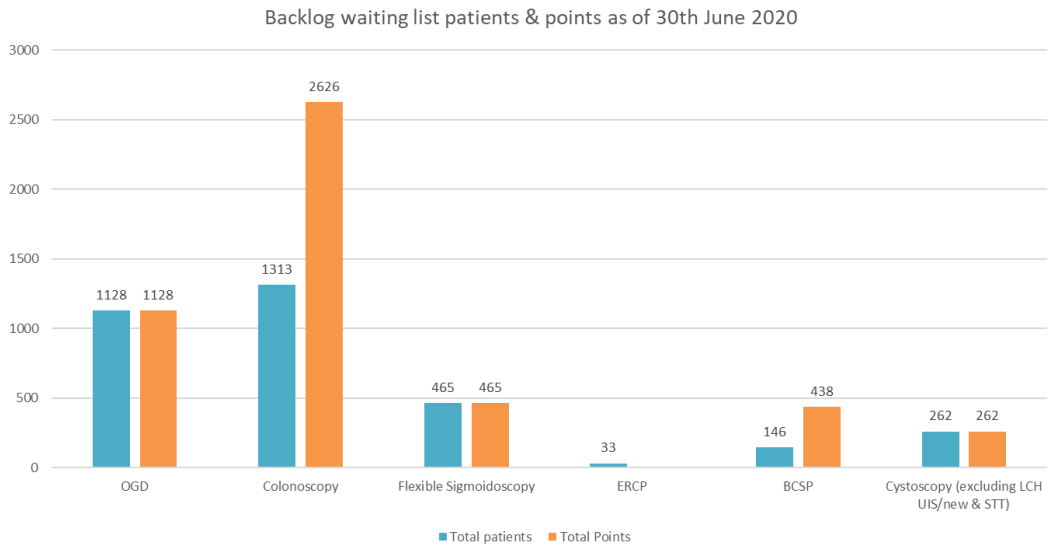


From the end of March only urgent cardiac echo activity continued to support cancer pathways with all routine activity temporarily stopped. This routine activity re-commenced from 8 June as planned at reduced capacity due to social distancing constraints. Estates reconfiguration work has been approved to proceed with investment which will support green pathways for TOE procedures through Lincoln and Pilgrim sites, in addition to Grantham site.

6.4 Endoscopy

6.4.1 Current position

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and their recommendations remain unchanged. Endoscopy procedures are considered Aerosol Generating Procedures and current guidance requires significant change in practice that in turn impacts on capacity of the service. Specifically, the additional IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity. Demand management pathways for upper GI and lower GI introduced during the *Manage* phase are proving successful. The Trust continues to monitor and report weekly referrals, performance against DM01 standards and 7 & 10 day cancer standards.



6.4.2 IPC and ventilation constraints

Under the current PHE guidance, a minimum of 10-12 air exchanges per hour in each procedure room is required. This air exchange requires the room to remain closed for 20 minutes post procedure to allow for airborne droplets to settle. A more efficient ventilation system could potentially reduce this time down to 5 minutes per procedure which would equate to one additional patient per list.

The rooms require cleaning between patients, 10 minutes cleaning time followed by 15 minutes drying time before the next patient and team can enter.

6.4.3 Demand

Demand average based on the last 4 weeks referrals received is 338 points (points are units of endoscopy procedure time measurement) per week. Future demand is difficult to predict due to unknowns in outpatient clinic recovery, screening programme/bowel scope, increased demand of non-GI specialties and any impact on new interventions such as FIT and capsule endoscopy.

If demand returns to pre COVID levels demand would average 700 points per week. Current maximum capacity is 415 points per week. The Endoscopy Recovery Cell is leading development of a strategy to meet this shortfall in capacity of circa. 300 points per week.

6.4.4 Demand management

This recovery strategy will include demand management and alternative capacity plans including:

- Primary Care pathways
- Secondary Care pathways
- Vetting of referrals received
- FIT (faecal immunochemical testing)

- Capsule endoscopy
- Maximisation of capacity through 7 day working and extended session days

6.4.5 Key next actions

To support this recovery strategy the Endoscopy Recovery Cell has identified the following supporting enablers which will be completed within the next few weeks:

- Completion of estates and workforce audits
- Production of a detailed capacity and demand model
- Review of job planning to support additional endoscopy sessions
- Work with estates to review improved ventilation systems in procedure rooms
- Put in place maximum workforce clinical time after reviewing available teams
- Engagement with the independent sector to secure arrangements with all potential IS providers

6.5 Urgent surgery and non-surgical procedures:

The Trust has continued to ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Level 2 and 3 (critical care level) surgical activity continues through green pathways on Lincoln and Pilgrim sites, with the earlier described Grantham green site model being the vehicle for all other cancer and elective surgical activity delivery.

Elective surgery commenced at Grantham from 1 July with four theatres running initially Monday to Friday extended days, eventually enabling throughput of a planned 25 surgery cases per day. Once efficiency and capacity are tested and fully understood elective backlog recovery trajectories will be modelled, but initial forecasting is for elective recovery by December 2020.

6.6 Prioritisation, risk stratification and harm review:

The approach taken to prioritising services is based on clinical risk with the highest priorities being cancer treatment, urgent and emergency care, and time critical non-cancer treatment. Only once the appropriate levels of capacity for these priorities is in place the process of restarting routine electives will commence, prioritising long waits.

Although co-dependent, risk stratification (prospective analysis) and harm review (retrospective analysis) should be considered distinctly. Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm as a result of the response to Covid 19. Prospective clinical reviews are in place across urgent and planned care, inpatients and outpatients, cancer and maternity services, as well as other areas, as part of our Covid 19 response in addition to normal operational practices.

The increased UEC demand described earlier in this report raises the potential for delays in ambulance handover times, time patients spend in the ED and delayed discharge, and subsequent risk of harm. To mitigate these risks we have made immediate changes to our front door model, ED pathways, SDEC provision and discharge efficiency. All such incidents are reported using the Datix

incident reporting system, using the Trust's Clinical Harm Review template and Rapid Review Report if applicable. The purpose of a Rapid Review Report is to enable a timely decision to be made as to the level of investigation required following the report of an incident which appears to meet the Serious Incident criteria.

National Guidance issued in March proposed a system of prioritisation for cancer patients requiring surgery. Simultaneously, Royal Colleges issued advice on which treatments should go ahead and which are considered a greater risk due to coronavirus.

Our approach to minimising potential harm has been in line with the three key principles set out in the letter received in June from the National Cancer Director, these being:

1. Capacity: there needs to be sufficient capacity to ensure anyone referred with suspected cancer can be diagnosed and treated promptly
2. Fairness: access to cancer diagnostics and treatment services should be equitable and based on clinical priority
3. Confidence: patients need to have confidence their diagnostics and treatment will take place in an environment and manner that is safe

No moderate or severe harms have been reported in relation to the harm reviews undertaken by the Trust during the response to Covid-19 (93% reported no harm, 7% low harm).

The harm review processes used have been in place within the Trust following co-design and development with the CQC and CCG(s) in 2017.

Learning from harm reviews has fed back into the way that patients on RTT pathways are being tracked, managed and where necessary escalated. As an example, root cause analysis and harm review completed following a gastroenterology 52-week breach in March has led to review and improvements of the standard operating procedure for open referral monitoring and reporting, and hepatology sub-specialty referral mapping, minimising the risk of this happening again in the future.

6.7 Independent Sector Support:

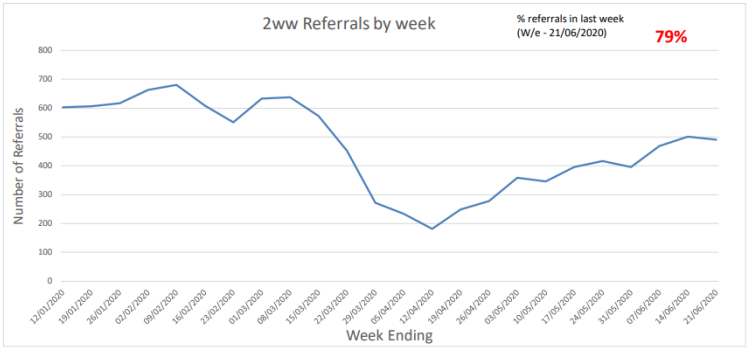
The Trust has been and continues to work with system colleagues to make use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer, urgent and elective long waits.

At the time of writing BMI Lincoln had undertaken 56 operations on behalf of the Trust; 32 orthopaedics and 24 ophthalmology procedures; this support will continue with plans to maximise available capacity. An agreement has also been reached with Ramsey Boston for 200 endoscopy procedures initially and further opportunity being scoped.

7 Cancer

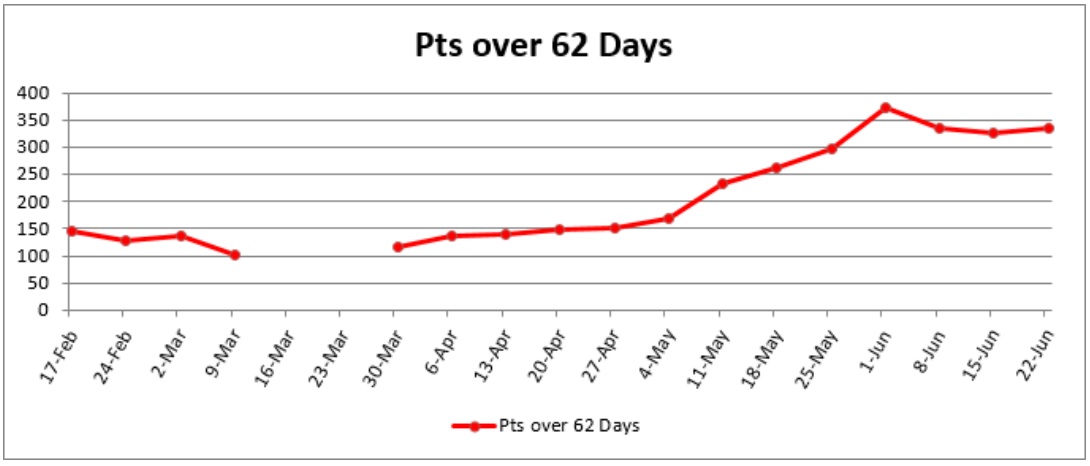
The Trust has maintained urgent access to essential cancer surgery and other treatment, and the provision of 2WW appointments, throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners.

2WW referrals significantly reduced during the *Manage* phase and, as anticipated, have increased during the *Restore* phase with some tumour sites now returned to near pre-pandemic activity volume.



	Average referrals on baseline	% referred latest week against base line
Exhibited (non-cancer) Breast Symptoms	38	87%
Suspected brain/central nervous system	5	40%
Suspected breast cancer	70	84%
Suspected gynaecological cancers	49	108%
Suspected haematological malignancies	6	50%
Suspected head and neck cancers	62	97%
Suspected lower gastrointestinal cancers	135	73%
Suspected lung cancer	16	44%
Suspected Sarcomas	4	25%
Suspected skin cancers	102	89%
Suspected upper gastrointestinal cancers	52	79%
Suspected urological cancers (excluding t	82	50%
Total	622	79%

The Trust's 62 day cancer standard performance for June is forecast to be circa. 70% against an agreed recovery trajectory of 70.8%. During the course of the pandemic the over 62 day backlog has increased significantly and as of 19 June was 322 patients. This is similar to other Trust's regionally as is the predominance of colorectal pathways within this backlog cohort (73% of the total) due to the suspension of endoscopy procedures.



Cancer surgery commenced on the Grantham Green site from 1 July. At this time, there were no Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August).

Table 3: Outstanding ULHT cancer surgery with no TCI by specialty and priority level as at 1 July 2020

Specialty and Priority Level	No Planned TCI
Breast Surgery	**31**
Level 2	21
Level 3	2
No Priority Level	8
ENT	**5**
Level 2	2
Level 3	0
No Priority Level	3
General Surgery	**30**
Level 1	0
Level 2	7
Level 3	22
Gynaecology	**3**
Level 2	1
Level 3	1
Non-cancer	0
No Priority Level	1
Maxillo-Facial Surgery	**3**
Level 2	0
Level 3	1
No Priority Level	2
Urology	**33**
Level 1	0
Level 2	2
Level 3	31
Grand Total	**104**

8 CVD, heart attacks and stroke

Capacity has been prioritised for acute cardiac interventions and cardiology services, urgent arrhythmia services, severe heart failure and valve disease. Stroke service capacity remains unchanged offering 24/7 access to thrombolysis and 7-day access to TIA Services.

The majority of elective cardiology operating ceased at the end of March with only PPCI and urgent elective device procedures continuing, alongside urgent echo diagnostics to support the cancer pathway. Routine catheter lab activity, including angiograms and complex devices, resumed in June as planned. However, restoration of cardioversions and TOE procedures has been delayed as a result of work on the Grantham green site model. Scaling up of these procedures will be prioritised in July and August.

On 31 March, in order to maintain capacity, the Trust's stroke pathway was temporarily revised to a hub and spoke model, supporting a single consultant on call rota. All Hyper-acute strokes are currently conveyed to and received by our Lincoln site. Patients who self-present to our Pilgrim Hospital site showing symptoms of stroke are transferred to Lincoln. Robust monitoring and weekly reporting to Gold Command of stroke ambulance conveyance and admission activity is in place. This pathway will continue temporarily while being under continual review.

9 Maternity services

The Trust's maternity services are currently delivering all antenatal, intrapartum and postnatal care in line with NICE guidance CG62, CG37 and Fetal Anomaly Screening Standards. The services Covid 19 Standard Operating Procedure remains in place to support management of pregnant women who are symptomatic or positive to Covid 19. Whilst all care is in line with national guidance and supports face to face contacts as required, some care continues to be delivered via telephone and video conference, where this is deemed appropriate. This has been a very successful initiative during the pandemic and is something that will be embedded and continue to be used.

Of note, the Trust has seen an increase in domestic abuse disclosure, as has been seen nationally, and safeguarding referrals to MARAC have increased. This is being managed well by the midwifery teams supported by the safeguarding team and in conjunction with other agencies.

10 Screening programmes

During the Restore Phase we have prioritised making screening services available for the recognised highest risk groups as identified in individual screening programmes. Planning to restore screening programmes has been approved by the Trust's ICC, is on track and outlined below. Recovery Phase activity trajectories are under development and will be presented in the August progress update.

10.1 AAA screening:

The AAA screening programme stopped screening on 16 March 2020 in line with PHE and Vascular Society guidance due to the assessed high risk to a vulnerable patient group. This has resulted in the Trust cancelling circa. 1000 screening appointments. All patients cancelled and all affected surveillance patients have been kept informed to enable full disclosure and ease stress surrounding their diagnoses.

National guidance has advised that activity should be reinstated during the Restore and Recovery Phases prioritising those patients at greatest risk of rupture, with plans agreed at local level.

The Trust currently has 572 patients on follow up with identified known small/medium AAA. Our current AAA screening backlog is circa. 900.

AAA screening will recommence in July with follow up of small/medium AAA patients prioritised.

10.2 Bowel screening:

The bowel cancer screening programme remains suspended nationally and the Trust continues to follow guidance set out by JAG and BSG. The Trust has a robust risk stratification process in place, patients are being contacted regularly to check on wellbeing and, where intervention is required, patients are being referred accordingly.

Screening centres have been advised to manage their own capacity and recommence FIT screening colonoscopies when able. Test kits should recommence following backlog clearance and future capacity has been identified. There is no recommendation from national bodies to recommence bowel scope currently.

The Trust is making use of available independent sector capacity from 6 July. Future capacity is being planned ahead of further national guidance on the reintroduction of bowel scope.

10.3 Breast screening:

The breast screening service is currently suspended in line with national guidance. The high risk service is provided by Nottingham University Hospitals through a service agreement and this service has resumed. Cancer 2WW services have been maintained throughout the pandemic.

National guidance describes programme recovery in two phases. Phase one is risk stratified backlog clearance and our plan to commence phase one from August is on track. Phase two will consist of women aged 53+ and not previously invited and 71+ in the screening slippage auto batch, with phase two start date anticipated March 2021.

10.4 Diabetic eye screening:

The DES programme stopped the majority of screening on 20 March due to the assessed high risk to this vulnerable group. Patients identified as at clinical risk have continued to be screened, approximately 2% of total normal screening activity.

National guidance describes recovery in two phases. Phase one is risk stratified backlog clearance of digital surveillance, newly diagnosed, pregnant, and previous low level pathology and DNA patients. The Trust will commence this phase in July. Phase two will consist of all other patients with no pathology noted on last screen, with follow up deference protocol guidance enabling a March 2021 start for this phase.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme has been maintained throughout the pandemic. Outreach clinics were suspended from 1 April due to insufficient staffing availability and following PHE guidance. Since, parents have been offered screening for their babies at the bedside while still an inpatient. Outreach clinics will be resumed from July.

11. Corporate Governance – Review of Covid 19 Business Continuity Arrangements

At the April meeting the Trust Board agreed the measures it would put in place to maintain effective corporate governance arrangements, whilst adhering to national guidance and recognising the operational pressures being experienced by the Trust's executive, clinical and operational teams. The Board agreed the temporary suspension of the current governance structure and creation of Covid-19 specific governance arrangements.

Since April 2020 the position has been reviewed by the Chief Executive and Chair on a rolling weekly basis.

The Trust applied the following principles to meetings:

- Follow national advice and guidance relating to avoiding unnecessary social contact and travel
- Protect patients and staff from harm and avoid the spread of coronavirus
- Release staff time to focus on COVID19 and the delivery of front-line care
- Retain appropriate levels of leadership, governance and assurance

All but the most essential meetings were stood down.

At a corporate level the following principles were agreed:

- Decisions made during the period would continue to be in line with standing orders. The Board adopted a streamlined approach to governance and standing financial instructions.
- The Board acknowledged that its risk appetite and tolerance of risks needed to rise. The BAF was updated to reflect risks relating to Covid-19 and continued to be reviewed by the Board and the Quality Governance Committee monthly.

In order to free up Executive and Senior Staff time from the preparation of papers, attending meetings the following changes were agreed:

- Trust Board moved to being held virtually on a monthly basis, lasting no more than two hours. The agenda agreed by the Chair and Chief Executive. Board papers continued to be published on the website and members of the public will be able to submit questions in the normal way. The public will not be able to attend the meeting due to national social distancing requirements. Microsoft Teams has allowed the public to observe Board meetings online with over 140 people watching the June Board meeting in this way.
- Board Development sessions will be stood down
- The Audit Committee to meet (virtually) only as necessary to enable the completion of the final accounts process
- The Quality Committee to meet virtually on a monthly basis to focus on assuring the board on patient safety
- The People & OD Committee and Finance, Performance and Estates Committee were stood down. This position would be kept under review.

All Board and Committee papers would be kept brief, with only critical issues brought to the Board/ Committees attention.

Matters for approval were either:

- Deferred if not urgent
- Circulated vie email, allowing time for response and decision recorded by Trust Secretary/ Deputy Trust Secretary
- Discussed between Chief Executive or nominated Executive with appropriate Board/ Committee Chair for Chairs action

As the Trust moves to restore some services the Board are asked to consider re-instating some additional governance arrangements. It is proposed that monthly meetings for both the Finance, Performance and Estates Committee and the Workforce and OD Committee are re-introduced but with a lean agenda.

The focus for the meetings will be as follows:

- Finance, Performance and Estates Committee
    - Assurance on financial position and governance arrangements
    - Assurance on statutory responsibilities in respect of the estate
    - Assurance against performance standards
- Workforce and OD Committee
    - Assurance on workforce planning
    - Assurance on values and behaviours

The Trust Board and Quality Governance meetings will continue in line with current arrangements. These arrangements will continue to be kept under review, including providing the opportunity for the public to attend Board meetings when social distancing guidelines and access to appropriate venues allow.