Meeting	Public Trust Board
Date of Meeting	6th October 2020
Item Number	Item 6.1
Title	First Quarterly Review following temporary conversion of Grantham Hospital to a Covid-19 Green Site Model
Accountable Director	Simon Evans – Chief Operating Officer
Presented by	Simon Evans – Chief Operating Officer
Author	Simon Evans – Chief Operating Officer
Report previously considered at	N/A

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	
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	4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic The paper is in direct response to mitigating this risk.
Financial Impact Assessment	The temporary establishment of a Covid-19 Green site at Grantham Hospital was as a direct response to a Level 4 National Incident, not requiring a detailed FIA to be considered; however clear processes to authorise financial expenditure in line with the agreed business case have been established to support a detailed evaluation to take place. De-escalation to a Level 3 National Incident on 1st August has not changed the protocols under which a detailed FIA is not required.
Quality Impact Assessment	*Completed June 2020*
Equality Impact Assessment	*Completed June 2020*
Assurance Level Assessment	*Significant*
Decision Required	The Trust Board are asked to consider the findings of the first quarterly review of Grantham Green site model and approve the primary recommendation for the continuation of the temporary changes in operation at Grantham. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021 Subject to such approval the Trust Board are asked to approve a further 9 recommendations to strengthen existing arrangements operationally and corporately.

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Appendix 1 – Green Site Clinical Model approved in June 20

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1. Executive Summary

The establishment of a Green Site at Grantham District Hospital within 18 days following the Board decision to do so in June was a significant undertaking. The subsequent implementation of these plans within 2 weeks was only achieved through the significant efforts and commitment of many colleagues across corporate and operational divisions.

The overarching objective of these proposals being to seek to address the requirements for urgent care in response to Covid-19 in addition to also addressing the need to re-establish and maintain access to elective care for the benefit of all patients across Lincolnshire.

The activity modelling presented in the original proposals in June were predicated upon the circumstances and assumptions known at that point. Some of these assumptions have changed due to the dynamic nature of the pandemic, making it difficult to evaluate actual delivery against plan. Notwithstanding this point it is clear that the changes made have delivered most of the expected benefits.

The establishment of a Green Site at Grantham being one important element of the Trust's overall Covid-19 Strategy and Recovery plan, however the evaluation and impact of which should be considered alongside the measured contribution that all 4 trust sites are making to the overall performance of the Trust.

There is also a clear opportunity for reflection on the findings from this review to ensure that the translation into wider organisational learning is not lost.

This detail within this review provides significant evidence of the achievement in full of the Trust's 3 strategic aims required to be met to support the implementation of the Green site model as RAG rated below.

Strategic Aims	RAG	Evidence
IPC excellence		No instances of Covid-19 Perioperative infection
Capacity to deliver at scale		There has been a 69% increase in overall activity
Future service resilience		All services have remained open in spite of ongoing and escalating Covid-19 status.

Strengthening existing arrangements for refining patient flow projections, revisiting specialty activity targets and developing the coordination and consistency by which performance is measured and reported upon with regard to the effectiveness of the Grantham Green site model with particular focus upon the impact for patients and staff will significantly improve the Trust's ability to continue to respond to the ongoing complexities presented by the evident second wave of the Covid-19 epidemic being experienced now across the UK.

A RAG rated summary of the degree to which the primary priorities and objectives of the Green site model have been achieved are presented below:

Priorities	RAG
To enable planned surgery to resume to a level which maintained the current waiting list level, ensuring no further deterioration.	
To bring the trusts overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery	
To continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	
To contribute to an increase in the trusts overall capacity to undertake urgent endoscopy work.	
To increase the number of patients receiving outpatient care by an indicative 9000 patients per annum.	

To provide UTC services 24/7 to the majority of patients who attended A&E – 20,014 attendances	

NB Amber RAG ratings reflecting incomplete information and the requirement for further data collection, validation and analysis.

Whilst there is no doubt that the services approved within the Green site model have been implemented as intended, the full effect of these changes upon other sites and services provided by the Trust remain to be fully quantified and understood. Whilst these interdependencies may be complex, strengthening the approach to evaluation going forward as suggested in this paper will develop a clearer understanding that will inform both organisational and system wide decision making as the NHS continues to respond to the Covid-19 pandemic.

The trust's original criteria to determine the return of Grantham Hospital to pre Covid-19 model are represented below:

- Regional or National Incident Override – where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model.
- Covid-19 alert level reduces to L2.
- Impact to other organisations - resulting in a request for mutual aid.
- Identified risks of threat to life or limb are identified with existing models of care.
- Overall waiting lists for Cancer patients reaches standards for 31 & 62 day, with all other treatments/surgeries reduced to pre Covid-19 levels.
- Winter pressures lead to activation of the surge plan – where emergency bed base, critical care demand and/or staffing requirements for critical care is not satisfied with Grantham model.

These 6 criteria have been designed to consider all known scenarios that should lead initially to a consideration of amendment of the model. They may in turn lead to reverting back to the original pre-Covid-19 model. They are sufficiently broad to consider the full range of risks to stakeholders. The criteria are highly visible and easy to communicate, so as to easily alert the Trust to a need to consider its response differently. An assessment of these criteria is detailed within this report, which confirm at this point that no criteria have been met that would suggest the need to substantially change the temporary model in place, or to drive a reversion back to pre-Covid configurations.

On the basis of information within this paper, the Trust Board is asked to approve the continuation of the temporary service changes enacted in June as a consequence of establishing the Grantham Green site model. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021. This timescale to be subject to a system wide review of next quarters activity data, which is available in early January 21 for the Trust Board's consideration in February 21. The Board is also asked to approve a further 9 recommendations relating to operational and strategic aspects of the Green Site model.

2 Purpose

This paper seeks to present the findings from a targeted desktop review undertaken regarding the delivery and performance of the Green site model established at Grantham Hospital from 29th June. Included is clarification of the circumstances leading up to the decision to establish a Green site model, the rationale and criteria used to evaluate options and a summary of the operating model and the impact assessments upon which implementation plans were predicated.

The review findings focus on an assessment of service delivery, primarily from an operational, safety and quality perspective as well as the experience of patients and staff. This assessment has been undertaken cognisant of opportunities to strengthen the temporary model and testing ongoing appropriateness with a view to identifying potential alternative considerations.

Specifically, the aim of this paper is to:

- Evaluate the extent to which the aims and intentions of the approved green site model at Grantham were achieved
- Identify and learning and subsequent opportunities for further improvement in any aspect of site specific and or trust wide performance
- Review the ongoing need and potential timescales for a green site model
- Recommend intentions and options for ongoing evaluation and the next quarterly review scheduled for December
- To state criteria for closing the Green site and reverting to pre Covid-19 service configuration

3 Context

On 30 January the first phase of the NHS's preparation and response to Covid-19 was triggered with the declaration of a Level 4 National Incident. The definition of this being that a Covid-19 epidemic is in general circulation, with transmission high or rising exponentially. 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. This triggered a national preparation and response to Covid-19 in the following four phases, beginning with the first Manage phase.

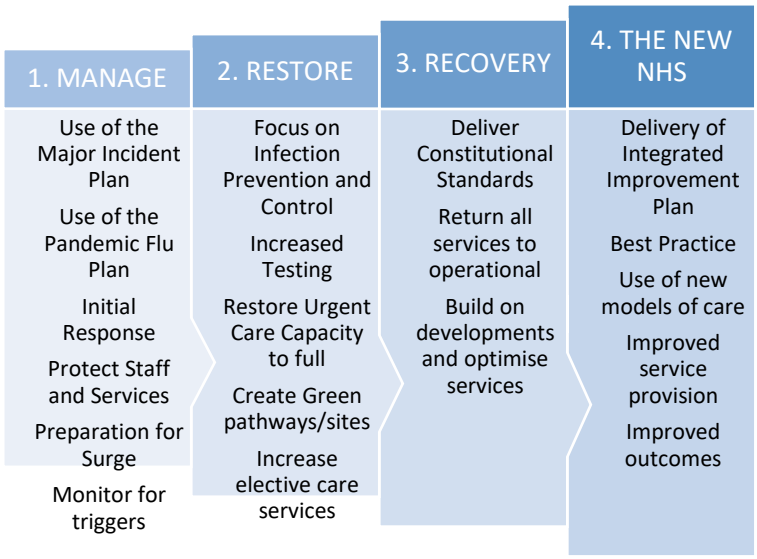
1. Manage – to 29 April
2. Restore – to 31 July 2020
3. Recovery – to 31 March 2021
4. The new NHS – 1 April 2021 onwards

It is important to recognise that at the time of developing proposals for a Green site model and the Board's subsequent consideration and decision to approve implementation the Trust was in the 'Restore Phase', requiring it to plan to restore urgent care capacity and increase elective care services through the creation of green pathways/sites.

Nationally, objectives of the response to the Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

A high-level summary of each phase of the Covid-19 response is provided below:



Consequently, United Lincolnshire Hospitals NHS Trust ('ULHT') as part of the first Manage phase, quickly repurposed services, staffing and capacity to treat and care for patients with confirmed Covid-19 infection. Hospital services were reduced very quickly in order to free up capacity to manage Covid-19 cases and to reduce the risk to elective patients of going into hospitals where Covid-19 patients were being cared for. At the time clinical reports suggested the risk of death for patients contracting Covid-19 during the operative period was as high as 40%.

Large numbers of clinical staff were redeployed in response to these patients, with stringent IPC procedures established to mitigate risks. This has resulted in many appointments for cancer surgery, clinically urgent cases and urgent diagnostic testing being deferred. As a result, many more patients are now waiting for their care. Without re-establishing these services, waiting lists will continue to grow and those patients whose procedures and investigations have been delayed could suffer harm as a result. During the initial phase of the pandemic, the demand for urgent care also significantly declined, although this is now rising again, and we need to be able to continue to safely care for these patients too.

On 11 May the Trust confirmed it's Restore Phase plan (up to 31st July) as an important component of its overall Covid- 19 campaign strategy, which was presented at Trust Board in June. A further report presenting a summary review of this Restore Phase plan and progress made to date against required and intended actions was presented to, and considered by the Trust Board in July. Multiple service changes have been made at pace through this restore phase, following rigorous assessment for risk, quality and equality impact through the trust's agreed authorisation processes. The pace of this approach being focused upon providing the safest environment to deliver services to improve the health outcomes of the population served by the trust.

As national case numbers began to decline, national guidance was issued requiring all NHS organisations to develop plans to restore some essential non-Covid-19 services. 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 with the 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. The identification and zoning of areas to support Green and Blue pathways was considered fundamental to deliver these measures and integral component of the Trust's Restore phase plan identified as the creation of a Green site. Putting in place measures to minimise hospital transmission of Covid-19 to protect patients and staff was prioritised in this stage to increase public confidence in accessing our services again.

On 5 May the Trust Board supported the establishment of Green site at Grantham for cancer and elective surgery and non-surgical procedures, supporting the setting up of 'Task and Finish' group with support from KPMG to explore proposals to restore surgical services.

On June 11th, 2020, an extraordinary public meeting of the Trust Board was held, to consider a single paper presenting detailed proposals for the temporary reconfiguration of services at Grantham as a Green site with a Blue (Covid status positive or unknown) isolated Urgent Treatment Centre. 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.

This change would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire onto the Grantham site.

Considerable public interest in these proposals generated a volume of questions unable to each be responded to within the time available in the meeting. Written responses were subsequently provided to each individual and every question posed.

The Trust Board approved the proposal to proceed with the temporary changes in response to the Level 4 incident response to the Covid-19 pandemic following full support and approval being received from all voting members. The timescale of the Green Site was agreed for the duration of Covid-19 up to at least 31 March 2021; recognised as a key element of the trust's Restore and Recovery phases. It was additionally agreed that the wider solution would be subject to quarterly review.

With direction and oversight provided by Gold Command, detailed plans for clinical leadership, governance arrangements, workforce and IPC protocols and procedures were established, enabling the Grantham green site to go live from 29 June. Lincolnshire County Council health scrutiny committee have voiced its concern about the changes with reference to the impact to Grantham residents requiring to access services on alternative sites.

On 19th June the UK was de-escalated to Level 3, (the definition of which being that a Covid-19 epidemic remains in general circulation). As a consequence, (in the absence of national vaccination programme) the ongoing circulation and posed threat to life should be expected for some time to come and at least the next 12 months.

On 31st July the Trust received confirmation of the beginning of Phase 3 *Recovery*. From the 1st 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 (ICCs) and Single Point of Contact systems (SPoC). A paper detailing the progress made within this Recovery Phase was considered by the trust board in September. The main objectives within this phase being to:

A. Accelerate 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. Prepare 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; locking in beneficial changes; and explicitly tackling fundamental challenges including: support for our staff, and action on inequalities and prevention.

On 21st September, the NHS Covid Alert level was raised again to Level 4, reflecting the National picture of increasing numbers of Covid-19. The Trust currently remains in Phase 3 *Recovery,* with the CEO for NHS England confirming that whilst escalation plans are being prepared for a potential 'second wave' of Covid-19, there will be an expectation that local intentions to restore elective services will be expected to continue for as long as possible. This approach further reinforced following a letter received this week from the National Strategic Incident Director advising trusts of the importance to continue to separate Covid and non Covid pathways in order to strengthen local efforts to re-establish elective services whilst reviewing local escalation plans in anticipation of increasing hospital admissions.

4 Summary of Operating Model

The Operating Model was predicated upon 3 conditions being met, these being:

1. **Infection Prevention Control (IPC) excellence** – this to minimise hospital transmission of Covid-19 to protect patients and staff.
2. **Capacity to deliver at scale** – this to reduce risks associated with delay in treatments.
3. **Future service resilience** – this to maintain capability over an extended timescale.

A summary of the option assessment provided in the table below informed the decision to introduce a Green site for cancer surgery, urgent elective services and diagnostics, in addition to the conversion of the A&E to a UTC to maintain urgent care for the Grantham population.

Conditions	Option A – Do nothing	Option B – Green pathway	Option C – Green site
IPC excellence	*Condition not fully met*	*Condition fully met*	*Condition fully met*
Capacity to deliver at scale – theatres, staffing and estate	*Condition not met*	*Condition not fully met*	*Condition fully met*
Future service resilience	*Condition not fully met*	*Condition not fully met*	*Condition fully met*

Additionally, these three conditions required adherence to the following design principles:

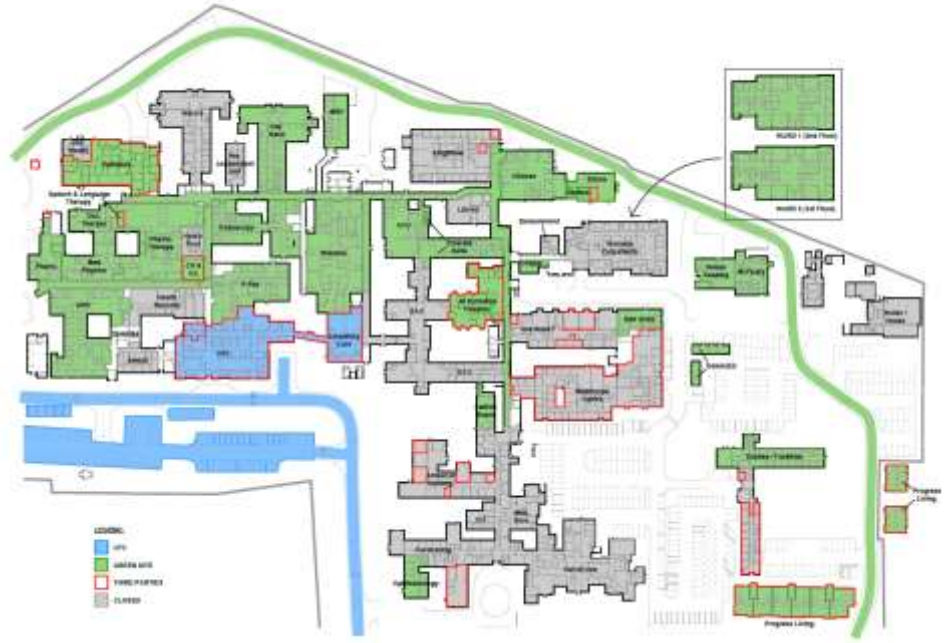
- Eliminate the risk of nosocomial infection reducing chance of contracting Covid-19 in our hospitals
- Access controlled by exemplary IPC and Personal Protective Equipment (PPE) compliance
- Conform to all guidance and standards provided within the NHS IPC Board Assurance Framework with strict adherence to the NHSE Hygiene Code.
- Adhere to a strict and rigorous regime of monitoring and surveillance for Covid-19 of our patients and staff along with reinforcing social distancing and hand hygiene guidance. This will include the use of any new testing (antibody testing is unclear at present time)
- Clinical care provided during the Restore phase will be prioritised to treat cancer patients or those requiring care that is deemed to be clinically urgent, ensuring support is in place to enable patients to comply with requirements - mental capacity, social and other factors
- Maintain consistency in staff and equipment allocation and restrict movement of staff and equipment between different sites and areas which will support minimising the risk surface contact transmission accompanied by a rigorous cleaning regime.

The model of converting a hospital site into a Green site, aimed to deliver elective and planned care in a setting that minimised the risk of cross contamination of Covid-19, with no Blue activity (unplanned or otherwise) cohabiting with Green activity i.e. Blue activity and Green activity physically separated with staff working in separate Green and Blue areas.

A summary of the detailed evaluation undertaken for the potential for each existing hospital to become a dedicated Green site is also provided below; this evidencing Grantham as the only viable option with the ability to create a large-scale surgical service, whilst having the greatest level of IPC protection to patients and staff and in such a way that provides future service resilience. Additionally, Grantham was recognised as the only site with urgent care services that could separate patients with confirmed Covid-19 status from those that are undifferentiated.

Conditions	Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence – protecting patients and staff	Condition fully met	Condition fully met	**Condition fully met**	Condition not fully met	Condition fully met
Capacity to deliver at scale	Condition not fully met	Condition not fully met	**Condition fully met**	Condition not fully met	Condition not fully met
Future service resilience	Condition not fully met	Condition not fully met	**Condition fully met**	Condition fully met	Condition not fully met

Translation of this evaluation into an approved site plan to implement the agreed Operating Model at Grantham is shown below:



To reduce the footfall on the site and maintain IPC principles a review was undertaken to identify the staff that could be relocated elsewhere. In total, c.600 ULHT staff and an additional 50-75 staff members from third party tenants were identified for relocation. At this time, many of these staff were already working from home or had been redeployed as part of the Manage phase of Covid-19 response. The remaining affected staff were supported in transition to work from home, from a different ULHT site or in the community as required.

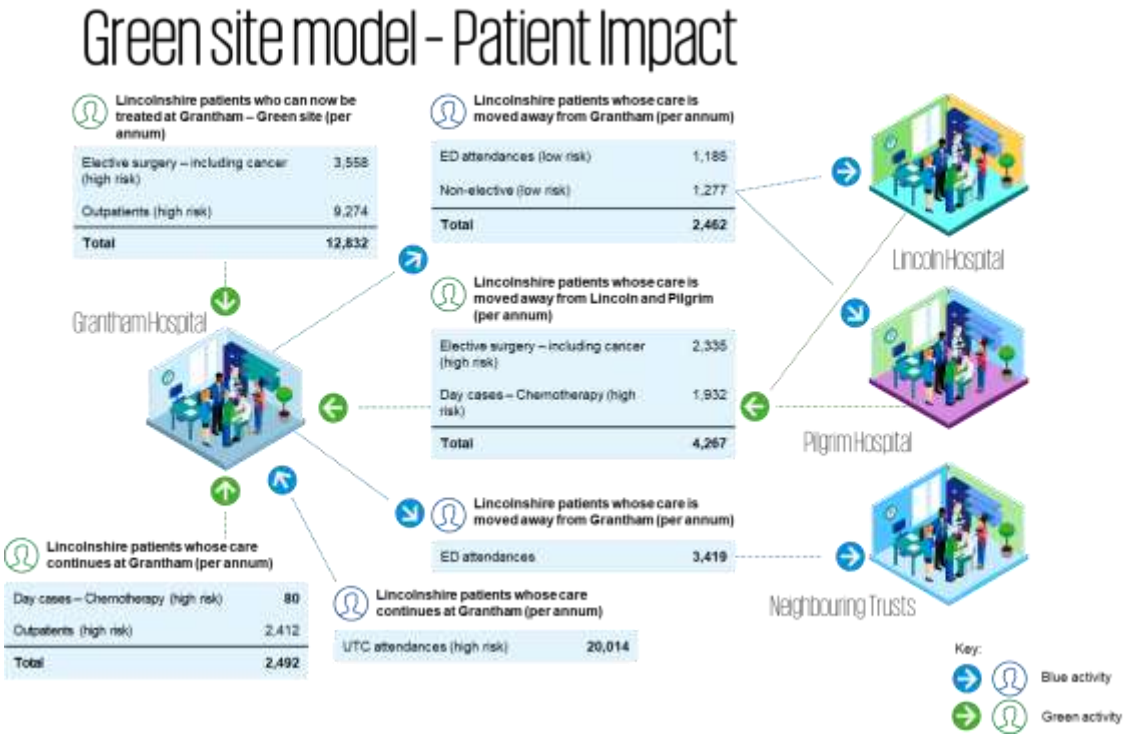
In total, the initial configuration of the Green site and Blue UTC was identified as requiring c.200 staff, with an additional c1200 badges authorising access to the site. This represented a significant reduction from the previous c3000 access passes that had been issued prior to implementation of the green site model.

A range of addition steps to be taken with the aim of protecting staff from contracting or conveying Covid-19 were agreed upon and put into place, these including:

- A defined protocol for the migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on the same day
- Screening by wellbeing assessment including temperature check at the start and end of each shift
- A programme of random staff swabbing to screen for asymptomatic carriers – work is being undertaken to refine this approach
- Risk assessments for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site
- Swabbing if symptomatic or for contact tracing - adhere to the new National Test and Trace system

- Maintain the consistency in staff and equipment allocation and restrict the movement of staff and equipment between sites, accompanied by a rigorous cleaning regime that minimises the risk of contact transmission
- Maintain the advice and guidance in respect of hand washing and social distancing

The detail of the clinical model agreed can be found in **appendix 1**. This model necessitated the removal of medical admissions (and transfer to blue sites), recommissioning of 4 theatres, an increase in elective care beds and conversion of A&E to a UTC. The indicative modelling of anticipated patient flows to reflect this clinical model was presented as below:



It should be recognised that the activity levels provided in the above infographic were modelled upon assumptions known in June. Throughout the Covid-19 pandemic both emergency and planned demand for services have continued to change which effects the accuracy of the forecast and indicative activity proposed.

The clinical benefits following implementation of this clinical model were identified as:

1. Rapidly treating patients requiring cancer surgery, eradicating waiting lists within 2-3 weeks following full implementation.
2. Enabling planned elective surgery to resume and prevent further deterioration of waiting times whilst permitting the treatment of clinically urgent cases.
3. Increase urgent diagnostics to prevent further deterioration of waiting times and reduce the risk of delay in diagnosis
4. Increasing access to UTC services 24/7. Through converting 8am – 6.30pm A&E to an Urgent Treatment Centre whilst increase operating hours to become a 24/7 walk-in function.

Implementation of the agreed operational and clinical model was swiftly achieved and within 2-3 weeks of going live (29th June) all members of the recognised 'project group' responsible for development and implementation had returned full time to their primary roles, with ongoing responsibility for maintenance of the green site model being shared across the Trust's four divisions.

5 Implementation of the Clinical Model

The indicative patient flows presented in the formal proposals were based upon the initial priority to quantify and provide treatment to the most clinically urgent patients to optimise outcomes. The expectation that the acuity of these patients would likely necessitate a level of critical care support that was not currently available at Grantham further reduced the quantification of potential patients appropriate to consider transferring to the Grantham site. In this regard the indicative patient flows originally presented are a relatively small cohort of the full potential of patients whose elective care could be undertaken at Grantham.

That being the starting position, it is noted that the potential for Ophthalmology to feature within the green site model, was not realised due to the eventual prioritisation of other specialties. This decision would have further affected the indicative patient flow of activity within the original model, with the need now recognised for revision of this to take place to reflect the more complex specialty mix. Correspondingly, the decision for complex colorectal surgery to be undertaken at Grantham was taken; this in recognition of the numbers of patients with extended waiting times in this specialty. This decision similarly necessitates a revision of indicative activity to reflect the implementation of a more complex case mix of elective surgical patients.

The model's intention to move from an initial 5 day a week operating theatre to 7-day working was 75% achieved from the end of July, with the additional lists being dedicated to Orthopaedics in recognition of the long waits in this specialty and availability of clinical expertise at weekends. Operational utilisation targets for theatres should be revisited to reflect the actual and intended case mix going forward so that the opportunity for further increasing activity at Grantham within existing resources may be quantified. At this point the opportunity to further increase theatre capacity on the site should be considered as part of the trust's plans for the winter.

The model's intention for chemotherapy patients to transfer from other sites to receive treatment at Grantham has also been achieved. Standardising the measure of performance used to evaluate chemotherapy performance to agree consistent measures to develop a consistent interpretation of the impact of the change upon patients will be helpful in evaluating trust wide performance going forward.

The refurbishment of the endoscopy suite currently providing 6 day working, has also enabled the model's intention to increase diagnostic interventions for the most urgent of patients has also been significantly achieved, with the site on track to provide 7-day services from the end of October.

Standards for medical cover were planned to be reviewed in recognition of the rotation of trainees in August, with the recognition that a reduced level of clinical exposure has affected the training of medical staff within all specialties. Considerable priority is being given Nationally to mitigating these effects as a direct result of responding to Covid-19.

In reviewing the potential for returning any displaced services and teams to the Grantham site, a focus on analysing health outcomes of the wider population could assist to identify and develop services best placed at Grantham going forward. Some questions posed by Clinicians from the outset regarding the limitations of the original clinical model clearly remain, specifically regarding the decision not to include a green rehabilitation ward within the operational model from the outset. The model did commit to the establishment of in-patient rehabilitation services recognising the essential need for such services during the winter. A location for these facilities at Grantham has been identified with plans on track for these rehabilitation services to go live from 1st November. Given current challenges regarding patient flow, the number of medical beds presently closed across the sites (60 – 90) and the planning for winter underway, it is important that rehabilitation services will be provided as part of the Green site model going forward.

Despite a clear rationale developed at the time to identify which staff skills and experience were required to care for patients on the Green Site, questions continue to be raised by staff regarding the perceived inequality with which staff were identified to transfer away from the Grantham site. This has undoubtedly contributed to significant logistical and daily challenges for individuals which is viewed as having unfairly impacted upon them. Given the escalating National concerns regarding the rising transmission of Covid-19 and the expectation of the need for ongoing review and revision of services to prioritise the safety of staff and patients within the trust, the importance of developing an explicit framework for engaging authentically with all staff cannot be

underestimated. Such an approach should significantly assist in preparing staff for the way services at Grantham may continue to develop to meet the needs of the Grantham and wider Lincolnshire populations.

6 Assessment of Service Delivery

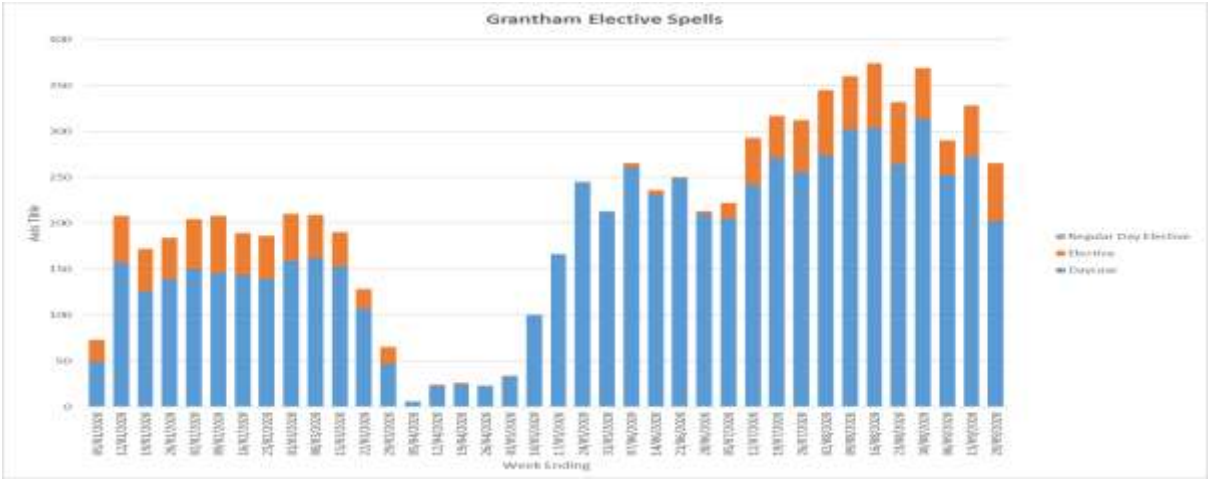
The achievement of developing the proposal for the Trust Board on 11th June and going live from 29th June, must be recognised as a significant achievement for the Trust. The pace with which aspects of this complex proposal required to be taken forward was only achieved through the significant efforts and commitment of many colleagues across corporate and operational divisions.

Most importantly the 3 strategic aims have been met to provide services that deliver:

- Infection Prevention Control (IPC) excellence
- Capacity to deliver at scale
- Future service resilience

The position that no surgical patient has contracted Covid-19 whilst in Grantham Hospital representing a kite mark for the IPC standards in place across the trust.

The graph below provides a site-wide indication of the extent to which all in patient spells (which include all activity relating to elective surgery, endoscopy and chemotherapy) have increased at Grantham. The comparison and increase from pre Covid-19 activity levels are clearly presented; with pre Covid-19 average of 196 spells/weekly and green site average of 331 spells/weekly representing a 69% increase in overall activity following implementation of the green site model.



This significant increase in elective activity has contributed to the Trust's current overall performance of recovering back to 73% of elective activity compared with pre Covid-19 performance.

Suggestions made in subsequent sections of this report anticipate ongoing routine data collection and triangulation of locally available information as well as the potential benefits for the ownership of elective performance information being focused within the responsibility of a nominated individual. Such an approach will:

- significantly strengthen both the Trust's ability to evaluate local performance going forward and
- assist in understand how the green site model continues to contribute to the Trust's operational priority to re-establish services suspended due to the pandemic.

It is to be expected within the ongoing context of a pandemic effecting service delivery that assessment of any intervention or action to extend or improve the delivery of services will continue to present considerable challenges in accurately reflecting performance within a fast-changing national context.

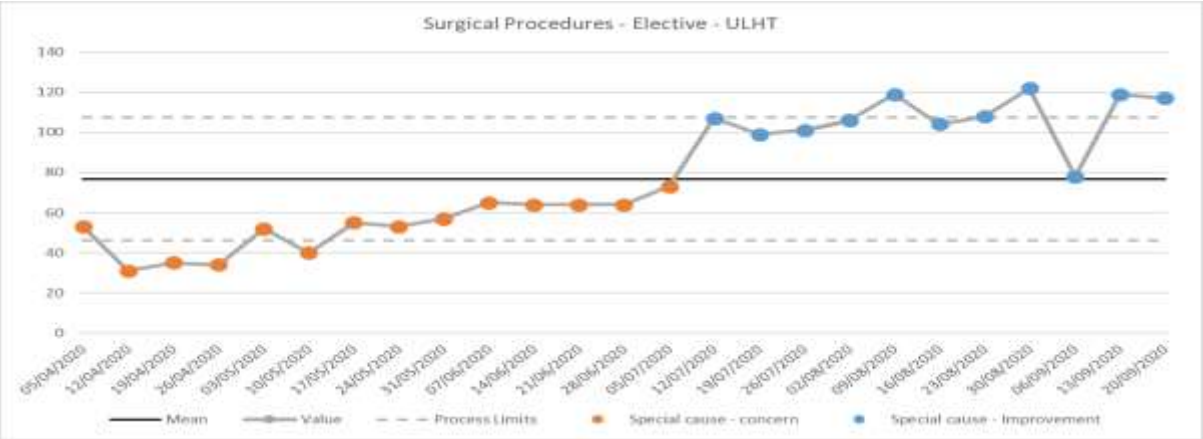
There is no doubt that establishment of a green site has resulted in several new specialties now operating from Grantham, with some indications that there may be potential for this surgical activity to increase further. Strengthening the multi-professional approach to exploring these opportunities with the benefit of improved activity information could significantly develop the trust's internal capabilities to address ongoing Covid-19 challenges as they will undoubtedly be presented in coming months.

6.1 Operational Delivery

6.11 Planned Surgical activity:

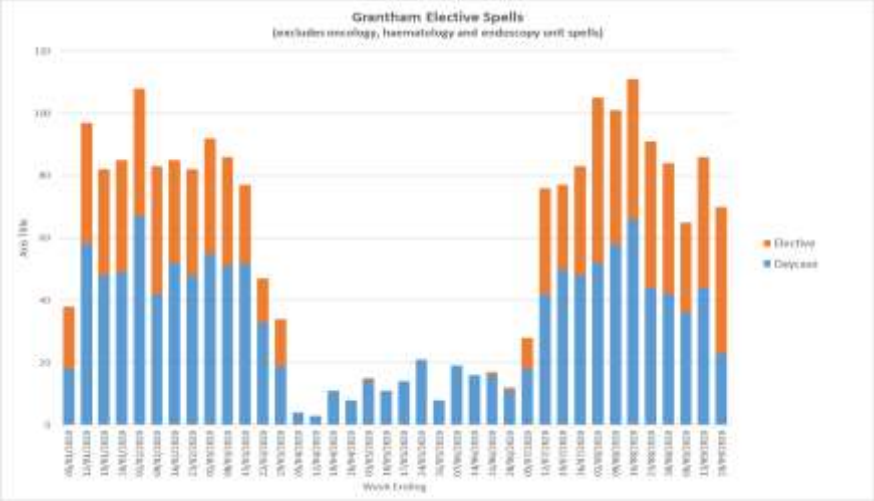
The aim of the Grantham Green Site model was primarily to enable planned surgery to resume to a level which maintained the current waiting list level, ensuring no further deterioration, (this identified as requiring 7902 cases per annum).	RAG

Total numbers of elective surgical procedures undertaken in the Trust has risen week on week (as represented in the graph below), since the end of June following implementation of the Green site model at Grantham and Green Pathways across other sites.



Specifically, the establishment of two surgical wards at Grantham with fully functioning theatres (75% of which work 7 days a week) has helped restore elective surgery for a range of specialties at Grantham. The Trust-wide run rate of elective and day case spells (the definition of the original ambition) are currently on track to hit 7061 cases, representing 90% achievement of the intended aim at this point.

Within the context of significant activity change and increase at Grantham over a short period of time, the graph below seeks to remove chemotherapy and endoscopy activity to present this data for 2020 to date, focusing purely on elective and day-case spells. This analysis represents a current average of 88 surgical cases being undertaken each week at Grantham. Whilst this is 0.2% higher than per Covid-19 levels, is explained by an 11.8% increase in inpatient elective cases offset by a 7.7% decrease in day cases. This analysis therefore suggests that the actual surgical activity undertaken at Grantham is currently operating 29% below the original indicated activity levels within the June paper, reasons for which are provided below.



The detail of surgical specialty activity undertaken at Grantham pre Covid-19 compared with current levels is presented below:

Change in Elective and Day case Spells by Discharging Specialty (excludes Endoscopy Unit)

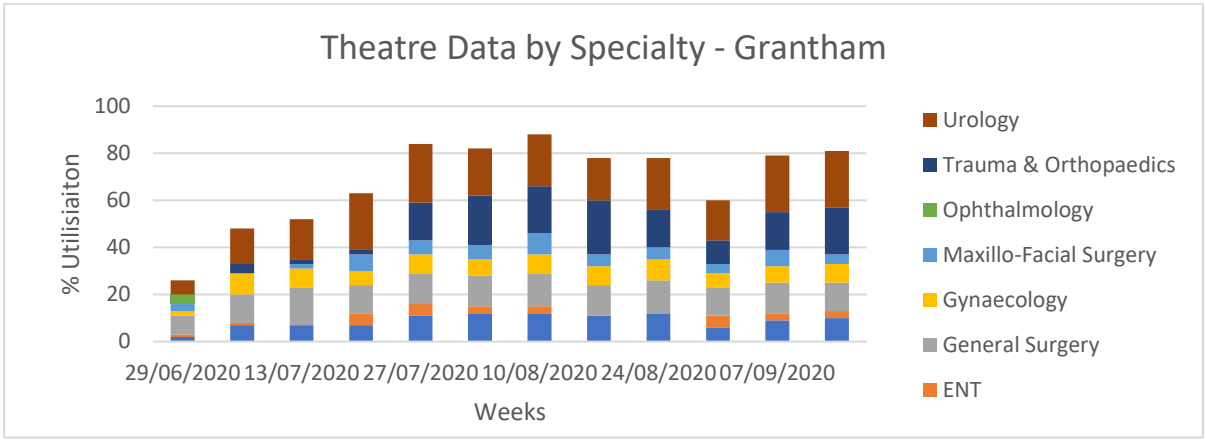
Specialty	Pre-Covid Cases (w/e 12th Jan - w/e 15th Mar)	Recent Cases (w/e 12th Jul - w/e 13th Sept)	% Change
100 - General Surgery	396	192	-52%
101 - Urology	121	259	114%
103 - Breast Surgery	31	125	303%
104 - Colorectal Surgery	8	0	-100%
110 - Orthopaedic	764	150	-80%
120 - Ear Nose & Throat	7	27	286%
130 - Ophthalmology	318	0	-100%
144 - Max Facial Surgery	40	195	388%
145 - OMF Surgery	0	1	
192 - Critical Care Med *	50	13	-74%
300 - General Medicine	24	45	88%
301 - Gastroenterology	135	2	-99%
302 - Endocrinology	1	0	-100%
303 - Haematology (Clin)	297	582	96%
320 - Cardiology	0	2	
330 - Dermatology	3	0	-100%
340 - Chest	6	0	-100%
370 - Medical Oncology	20	272	1260%
410 - Rheumatology	0	7	
430 - Care of the Elderly	6	0	-100%
502 - Gynaecology	35	99	183%
800 - Clinical Oncology	50	1190	2280%
811 – Int. Radiology	33	0	-100%
999 - Unknown	0	3	

*reflects Level 1 critical care – coding validation required

The activity levels above reflect the expected increases in specialties moved to the green site with three notable exceptions; Orthopaedics which has reduced by 80%, General Surgery by 52% and Colorectal Surgery by 100%.

For these three specialties within Orthopaedics the case mix of patients has changed significantly to protect the green site status. Operational teams are exploring the rational for other changes.

Considering the potential for theatre utilisation to be a constraint that could be impacting upon activity levels, the graph below evidences a trending increase in theatre utilisation since establishment of the green site model to date. The stepped increase in cases from the end of July marks the move to 75% 7 day working, with Orthopaedics using these sessions. The original indicative level of 25 cases per day was identified, on the premise that Ophthalmology would be undertaken on site. Currently there is an average of 10 cases per day being undertaken with the trend of increasing activity for most weeks. It would be appropriate to quantify the extent to which current activity levels may continue to improve within existing theatre resources and consider the potential options and impact of increasing local theatre capacity further. Increasing theatre capacity further so that all theatres are open 7 days a week at Grantham being the intended next step to be taken by the division.



Examination of September performance dashboard for theatres shows more sessions being used against a backdrop of a decline in cases per session. The current performance being 1.6 cases per session. The reasons for the decline in cases/list may be explained by changes to case-mix but needs to be better understood. Further exploration to identify the current constraints and opportunities to increase existing theatre utilisation will provide a sound foundation for informing alternative options currently being considered strategically and operationally by the Trust with the aim of further reducing the overall surgical waiting list to pre Covid-19 levels.

An initial review of surgical bed capacity at Grantham confirms 54 open beds for use on the site which after removing chemotherapy and oncology surgery activity from the numbers, would indicate an average of 8 additional surgery patients are being admitted overnight to the 2 wards available. This would indicate a detailed review of theatre and surgical bed utilisation is required, upon which revised targets can be based.

The graph below presents the numbers of patients waiting on the admitted patient waiting list. It shows that the increase reported from April to July would seem to have been mitigated and begun to reduce in August. This represents fewer patients now waiting for elective procedures across the Trust.

6.12 Cancer Surgical activity:

The aim of the Grantham Green Site model was to undertake in excess of 13 cancer surgery per week, to bring the trusts overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery.	RAG

This aim has been significantly achieved with some aspects still requiring further clarification.

Very positively referrals to the Trust have continued to increase and have now returned to pre Covid-19 levels, as represented in the graph below. The significant drop in referrals was clearly a concern since it represented patients deciding not to attend their GP, with a corresponding potential for longer term harm.

The impact of this increasing referral rate on the Trust's overall 2 week waiting list has effectively increased this by c 500 patients since Jan 20. The most recent Cancer waiting list position regarding urgently categorised patients presented are included in the table below. This confirms that all L1 patients (those with the highest clinical urgency) have dates for surgery to be undertaken and only 7.8% of L2 patients remain awaiting confirmation of a date to be provided.

Level of urgency	Number of patients on the waiting List	Number of patients on the waiting list with TCI date	Number of patients on the waiting list requiring TCI date
Level 1 (highest)	3	3	0
Level 2	750	691	59
Level 3 (lowest)	79	66	13
Awaiting Priority Level from CBU	32	21	11
Total	864	781	83

**Please note that the above excludes those patients who have been requested for a TCI through the cell that are non-cancer, and those who have had surgery at another Trust. The information held on the MWL is only as up to date as that provided to the cell by either Cancer Services or the CBU Teams.*

Changes over recent months in data capture systems relating to cancer surgery activity have highlighted some opportunities for strengthening arrangements going forward to improve interpretation of all aspects of performance data relating to cancer services going forward.

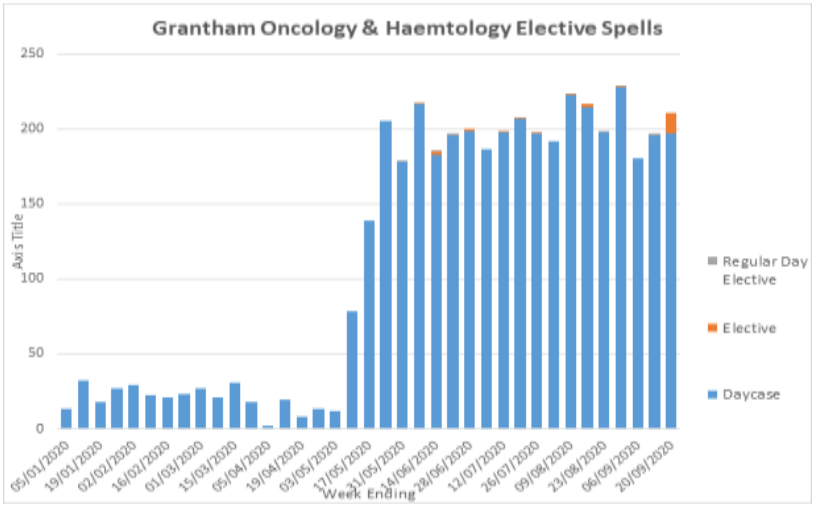
6.13 Chemotherapy activity:

The aim of the Grantham Green Site model was to continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	RAG

The aim of the Grantham Green Site model was to restart Covid-19 Green site Chemotherapy in much larger volumes accommodating the circa 80 patients in Grantham and transferring other Chemotherapy patients from across Lincolnshire to the low risk site. 1932 patients were anticipated to receive treatment at the remodelled unit in Grantham.

This aim has been achieved in terms of the effective transfer of all patients previously receiving outpatient chemotherapy at Lincoln & Pilgrim being to Grantham. The exception to this is where patients require specialist acute inpatient care with Oncology teams that are part of an emergency spell, or where patients require multiple treatment regimes, such as Radiotherapy and the use of the Trusts Linear Accelerator (LINAC) treatments.

The graph below evidences the significant increase in chemotherapy (in episodes of care) activity undertaken at Grantham since mid-May. The timing of this increase in activity reflecting the Trust Board's endorsement of the Recovery plan for the trust and the immediate opportunities taken within Oncology to implement this plan. Some very positive feedback has been received from both patients and staff regarding this change.



6.14 Outpatient performance:

The aim of the Grantham Green Site was to increase the number of patients having a first outpatient appointment on site by 9000 per annum. This largely reflecting the potential from historical data on 1st OP appointments.	RAG

For the four weeks (17th August to 14th September) data shows a total of 2500 outpatients were seen at Grantham including 726 first appointments. Extrapolated for a year this suggests that the Trust is on-track to achieve this objective.

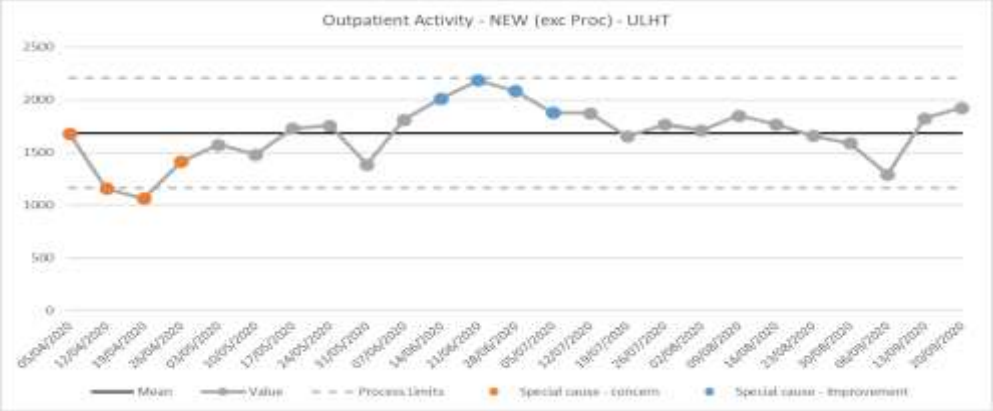
In addition to outpatient activity being run at Grantham hospital itself the introduction of the HealthCentre and Gonerby Road Health clinics have increased the number of services being offered locally in Grantham. The introduction of these new sites increases the number of face to face outpatient appointments delivered locally by a further 4500 per year. This is expected to increase with the completion of renovation works at Gonerby

Road facility, however provides a much greater spectrum of services above just those that are cancer or Green pathway; including
General Surgery,
Vascular Surgery,
Trauma and Orthopaedic,
Ophthalmology,
Dermatology and Paediatric Dermatology (some of which are provided from GP Surgeries locally)
Gastroenterology,
Clinical Physiology Tests,
Cardiology,
Neurology
As well as antenatal outpatient services.

During August 2020, 589 appointments were booked for these services although some of these were non-face to face clinics.

Recognising the impact that Covid-19 has had in accelerating the shift towards non-face to face appointments and the additional changes made to in-person services locally the Trust should reconsider how to evaluate the success, or otherwise, of the services locally. This should include inter alia agreement on a new set of KPI to evaluate success against.

The graph below shows overall 1st outpatient appointments Trust wide. The upward trend provides some assurance that activity displaced from Grantham as a consequence of the move to a different model is being delivered elsewhere.



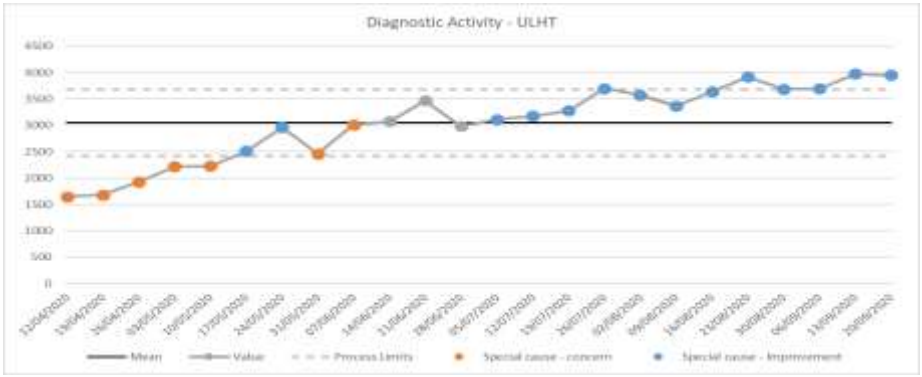
Similarly, the graph below representing the Trust's overall PBWL which quantifies the effect of Covid-19 on the increase in patients, clearly evidences the start of an improving position following approval of the Trust's Recovery plan, evidencing a c1000 patient reduction in the overall list to date. This reinforcing the importance of the Green site and Green pathways in operation across the Trust.

Harm reviews continue to be undertaken for time critical overdue patients to ensure patient safety is maintained with long waiting patients.

6.15 Urgent Diagnostic Endoscopy performance:

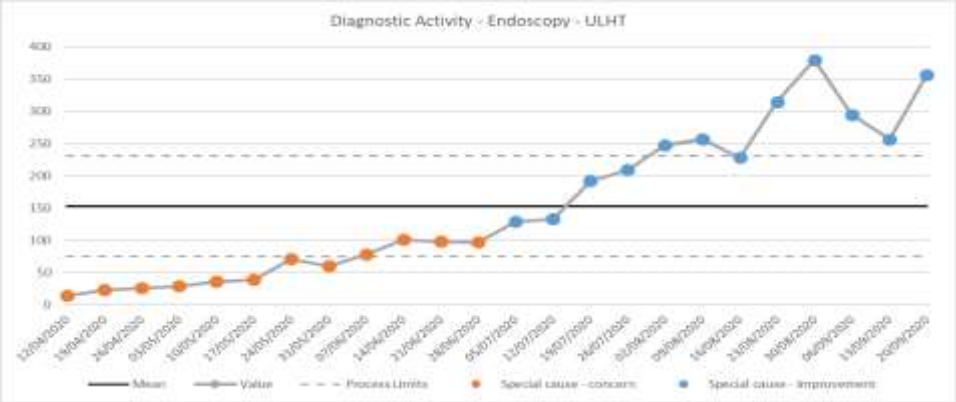
The aim of the Grantham Green Site model was to contribute to an increase in the trusts overall capacity to undertake urgent endoscopy work (June activity being 70% of normal levels). This to be achieved through the establishment of 12 hr sessions (x3 lists) 7 days a week.	

The trust wide performance regarding all diagnostic activity levels presents a context of significant increases in excess of 100% being delivered against previous years. This is the largest recovery of any trust in the Midlands and is demonstrated in the graph below.



Notwithstanding the tremendous increases in endoscopy activity since the beginning of the pandemic, the Trust's validated waiting list (as represented above) evidences a steady increase in patients referred over the last 8 weeks. This is anticipated to be a consequence of patients not presenting through the peak of Covid-19 now seeking GP assessment. For the most recent week reported a decline in waiting list numbers is reported indicating that the increased activity may be beginning to positively impact upon patient access and diagnosis.

Furthermore the graph below evidences the increase in endoscopy activity across the trust as prioritised within the Trust's Recovery plan of which Grantham increased activity is a key component. It is not possible however to definitively attribute this to the delivery of the Green site model.



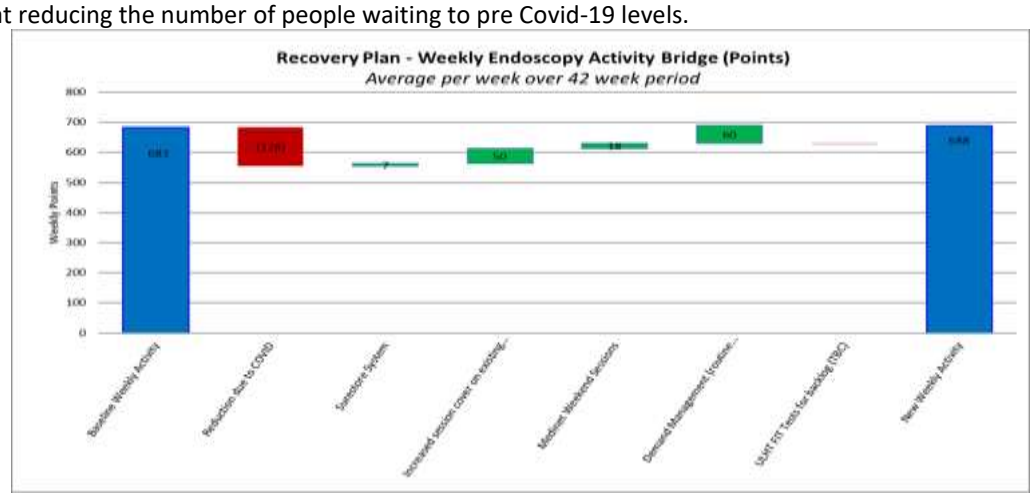
The indicative Grantham activity was predicated upon IPC standards in place at the time. It presented the potential for a maximum of 79% of available capacity to be utilised. Subsequent notification through national guidance regarding the recommended increase in IPC standards had the effect of significantly reducing the activity levels able to be achieved within given circumstances to a maximum of 48% utilisation.

Despite this the outcome being sought regarding the trust's ability to achieve urgent 2 week waits for diagnosis when cancer is suspected is now being achieved, which demonstrates that the trust's approach to increasing access to endoscopy has undoubtedly been effective through running additional lists (7 day working on alternate weeks) to off-set the in session throughput impact of augmented IPC standards. This model of working will be fully rolled out from end October 2020.

Since the reopening of the endoscopy suite, challenges with booking have also been recognised. These relate to availability of workforce to schedule bookings and some remaining safety concerns from patients resulting in cancellations. Delays experienced in receiving patient swab results have also resulted in patients being rescheduled for investigation at other sites on a 'blue pathway'. Operational teams have been focused upon resolving these issues, with no delays reported most recently due to swabbing issues.

It has been expected that the trust may receive in due course approval to implement nationally revised IPC standards which will increase potential capacity to 79%. At this point it would seem appropriate to remodel the target endoscopy activity for Grantham as part of the trust plans to further increase outcomes for cancer patients.

The graph below summarises the measures which currently form the Trust's overall endoscopy recovery plan aimed at reducing the number of people waiting to pre Covid-19 levels.



6.16 UTC performance:

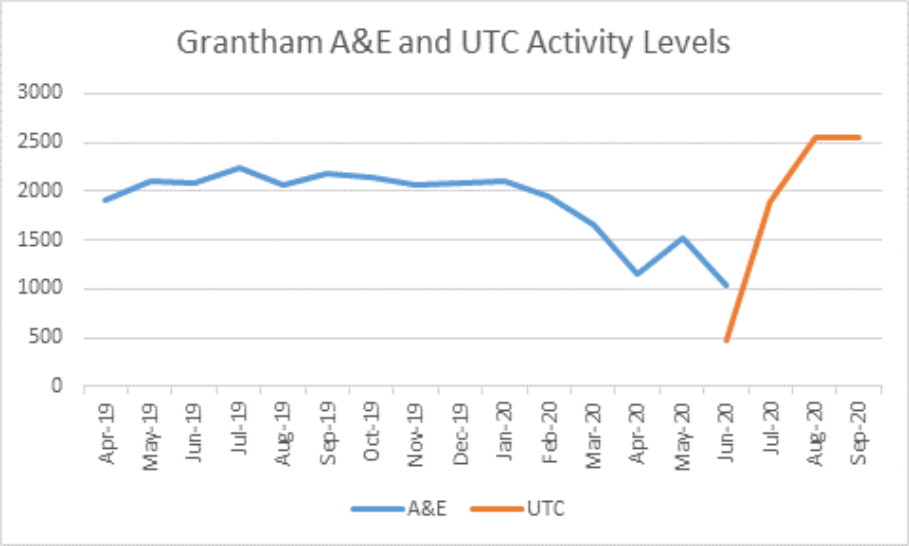
The aim of the Grantham Green Site model was to provide UTC services 24/7 to most patients who attended A&E – 20,014 attendances.	RAG

The original operational model estimated 81% of baseline levels of attendances (averaging 385 weekly) would be accommodated within the UTC. Up to mid-August, this performance was exceeded, with an average of 406 weekly attendances being recorded, representing an increase to 86% of the baseline utilising these new facilities. It is possible that the increase in hours the service was available may have impacted upon this increased performance.

Similarly, the original model anticipated that the admission rate from Grantham UTC would be 6.9% with the actual rate being recorded as 5.6%. We have been unable to quantify the proportion of patients going to other Trusts rather than an A&E within the Trust, although given the increased attendance and reduced admission rate from that projected, one might reasonably conclude that these numbers will be minimal.

Activity Levels

UTC attendance data has been overlaid against A&E activity during 2020 and is represented in the graph below. This clearly shows that attendance at UTC has continued to increase since opening, with an approximate 8% increase in patients now attending the UTC above the levels of these patients previously attending A&E on the site. This suggests that the perceived increased access to UTC services has been well received by local residents.



The Impact to Patients

In recognising the importance of fully understanding the impact of these changes for all patients an initial quantitative analysis has been undertaken on the impact to patients who may now be required to attend either Lincoln or Boston A&E. Data focusing on understanding the experience of patients who have been impacted by these changes needs to now be sought to enable further strengthening of this temporary model.

The table and graph below shows those patients with a Grantham postcode who have historically attended Lincoln A&E against current attendance. Interestingly, whilst attendance was generally below that experienced in 2019 there was a sharp increase in the month immediately following the temporary closure of the Grantham A&E and reclassification to a UTC, with numbers reducing for August. Close monitoring of these changes will be maintained.

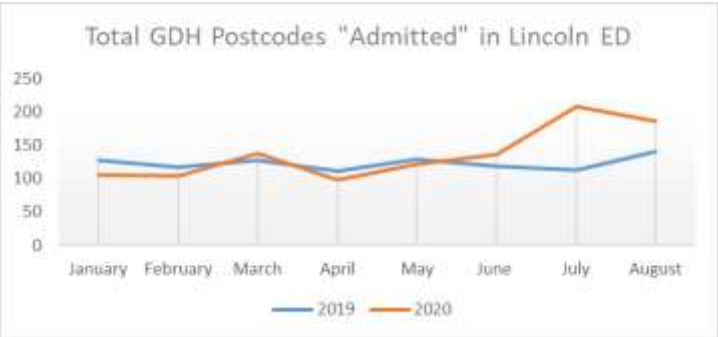
Total GDH Postcodes "Seen" in Lincoln ED

	2019	2020	Difference
January	278	259	**-19**
February	307	253	**-54**
March	291	298	**+7**
April	268	192	**-76**
May	303	251	**-52**
June	271	288	**+17**
July	292	451	**+159**
August	295	368	**+73**

Similarly, the table and graph below quantify those patients with a Grantham postcode who have historically been admitted via Lincoln A&E against current admissions. Again, whilst admissions were generally below that experienced in 2019 there was a sharp increase in the month immediately following temporary closure of the Grantham A&E and reclassification to a UTC, with numbers reducing for August. This may reflect the change to the 'stroke pathway' made in response to Covid-19 and the planned intention for Grantham patients with a suspected stroke to be assessed and treated at Lincoln, but close monitoring of these changes will be maintained.

Total GDH Postcodes "Admitted" in Lincolr

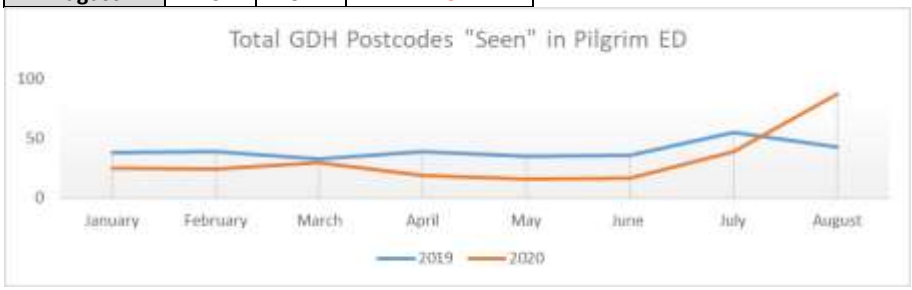
	2019	2020	Difference
January	128	105	**-23**
February	117	104	**-13**
March	128	137	**+9**
April	111	98	**-13**
May	129	121	**-8**
June	118	136	**+18**
July	113	208	**+95**
August	140	186	**+46**
Monthly Average	**123**	**137**	**+14**



A similar analysis of the impact of these changes for all patients who may now be required to attend Boston A&E is also presented below. The table and graph below quantify those patients with a Grantham postcode who have historically attended Boston A&E against current attendance. Interestingly whilst attendance was generally below that experienced in 2019 there have been increasing attendances since June with a sharp increase in August. Close monitoring of these changes will be maintained.

Total GDH Postcodes "Seen" in Pilgrim ED

	2019	2020	Difference
January	38	25	-13
February	39	24	-15
March	33	30	-3
April	39	19	-20
May	35	16	-19
June	36	17	-19
July	55	39	-16
August	43	87	+43



Similarly, the table and graph below quantify those patients with a Grantham postcode who have historically been admitted via Boston A&E against current admission. Again, whilst admissions have been generally below that experienced in 2019 there has been a trend of increasing admissions since May with a significant increase recorded for August which will be closely monitored.

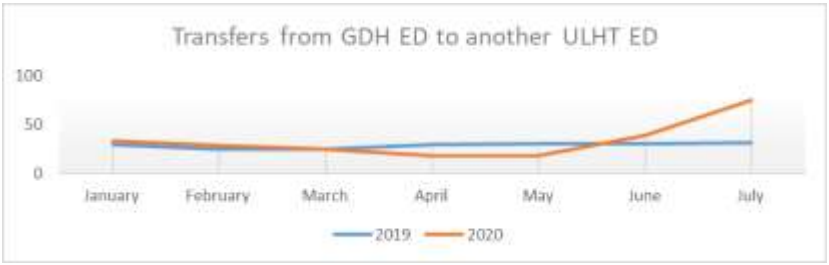
Total GDH Postcodes "Admitted" in Pilgrim ED

	2019	2020	Difference
January	15	15	**0**
February	19	16	-3
March	20	20	**0**
April	20	10	-10
May	19	9	-10
June	19	12	-7
July	27	20	-7
August	29	37	+8
Monthly Average	21	17	-4

The importance is recognised of the need to maintain the necessary data capture to continue to track and analyse the impact for all patients to inform ongoing review regarding these temporary changes.

Finally, the table and graph below quantify the number of ambulance transfers by ambulance from Grantham A&E to either Lincoln or Boston A&E. Whilst this activity has been similar for the last 2 years a significant increase in transfers required in the month following the closure of the A&E at Grantham is again noted and will require ongoing monitoring. It is noteworthy though that the combined total of all patients now going to other Trust A&E departments represents an overall increase of between only 1 – 2 patients each day.

Total Transfers from GDH ED to another ULHT ED		
	2019	2020
January	30	33
February	25	29
March	25	25
April	30	18
May	31	18
June	31	39
July	32	75



Whilst the review can confirm that the indicative activity proposed for the extended 24/7 UTC has been achieved, the initial indication of the impact upon local patients is something that the Trust will wish to monitor closely to understand fully the clinical quality, safety and experiential impact of this change. Close working with the Community Trust to ensure a comprehensive evaluation continues to inform opportunities for strengthening this temporary model and the timing and nature of any further improvements.

6.2 Quality & Safety

Systems and processes pertaining to maintaining a safe environment for all patients at Grantham are predicated upon robust IPC arrangements to maintain the site Covid-19 free. A commitment was given within the proposals for a Green site for all aspects of the IPC Board Assessment Framework (BAF) to be met. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users. In the absence of any reported concerns regarding the safety of patients at Grantham, assurance will now be sought to evidence the consistency of systems and processes in place across Grantham to escalate and report any concerns, incidents or near misses. Currently the Trust has assessed the following aspects in detail relating to all services at Grantham:

1. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
2. Appropriate antimicrobial in use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
3. Provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
4. Prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
5. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

6. Provision of secure adequate isolation facilities
7. Adequate access to secure laboratory support as appropriate
8. Implementation of policies designed for the individual's care and provider organisations that will help to prevent and control infections
9. Systems in place to manage the occupational health needs and obligations of staff in relation to infection

Detailed evidence has been presented to the CQC regarding the establishment and effectiveness of these standards, with confirmed regulatory satisfaction if they are assured all appropriate IPC standards are in place.

A further strategic review of IPC standards across the Trust has been undertaken as part of this review the details of which can be found in **Appendix 2**. A focused review of IPC standards at Grantham should now be undertaken as part of the developing performance management framework recommended to be developed.

6.3 Patient & Staff Experience

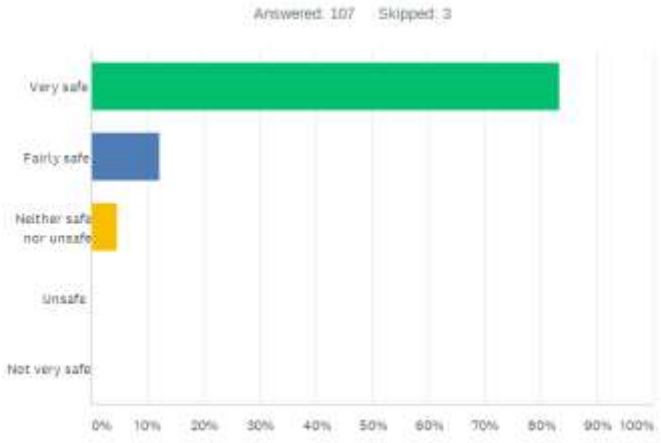
Patient Survey:

To understand the impact of the temporary service change on patients, an initial patient survey has been undertaken with 110 responses received, representing an extremely small sample of the patients treated at Grantham since June.

The findings show that most patients found it easy to access the hospital by car, primarily to receive chemotherapy. Patients reported that they had confidence in the medical, nursing and therapy care and treatments they received, and no patients indicated that they felt unsafe regarding the steps taken to manage Covid-19. Indeed, many examples were offered regarding good IPC practices observed as being in place.

Pleasingly the key question that asked patients to rate how safe the changes to IPC and pathways made them feel received excellent scores with 95% reporting feeling very or fairly safe.

Q. We have taken a number of steps to manage the risk of COVID-19 including cleaning and hygiene, social distancing, personal protective equipment and testing' How safe have these measures made you feel?



Many individual members of staff were individually recognised and praised for the positive impact they made to the individual's experience at Grantham.

> *"All staff made my visits to chemo wonderful and felt very safe all the time"*
>
> *"All staff were very kind and understanding"*

However, some specific practical suggestions were offered regarding how facilities for relatives accompanying patients could easily be improved upon, which the operational team are seeking to immediately address.

> *"A lack of access to toilet facilities for my relative whilst waiting for me to complete treatments"*
>
> *"My husband has to wait in our car for six/seven hours whilst I receive my treatment. This is not good and especially with the winter coming it is very difficult and uncomfortable for him"*

More broadly the Trust may wish to consider a more routine approach to seeking feedback from patients attending Grantham, ensuring all specialties are included, to provide a more comprehensive view of services and how any changes/improvements have been received to inform further developments.

Staff Survey:

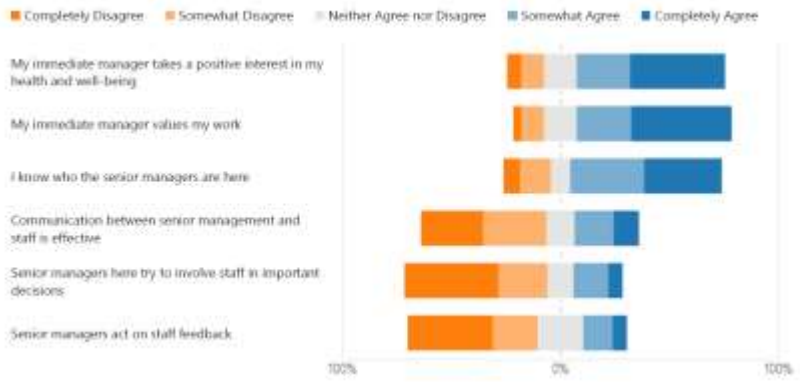
A survey of staff working on the Grantham site (not including UTC or ACU staff) has also been undertaken, with 157 responses received. This represents a 75% response rate from the staff identified within the model as being retained on site although it has been suggested that the overall number of staff currently working on the site might be nearer 600. It is noted that the number of passes issued to staff to access the site has been significantly reduced from c3000 to c1200, with the possibility that the views of staff visiting the site might also be helpful going forward to further strengthen the temporary model.

Understanding the views and differing perceptions of all staff involved in delivering services at Grantham could be very helpful in both evaluating the impact of service changes and inform options going forward. Similarly, the trust might wish to consider how one seeks to understand the experience and perspectives of those staff relocated from the Grantham site to ensure a balanced picture be developed regarding the experiences of staff to inform ongoing development and provision of services.

Notably the responses received included significant additional detailed suggestions and examples that would suggest a commendable level of commitment from local staff to further improve services at Grantham. The development of a more effective and sustainable approach to engaging with staff that have moved from or remain working on the Grantham site, would establish a more dynamic way of evaluating and developing services to be provided from Grantham going forward.

Analysis of responses received present mixed levels of confidence in the steps taken to manage risks of Covid-19 at Grantham Hospital. Specific concerns relating to the consistent application of IPC standards potentially impacting upon the safety of the environment for patients are taken seriously by the divisions with issues regarding systemic reasons for concerns appropriately escalated to the corporate team. As expected, most staff have reported as being directly affected by the changes; with workload, levels of support available, communication and effect upon mental /emotional health being identified as most significantly impacted.

Staff feedback positively recognised the extent to which immediate managers both valued and were interested in individuals' health and well-being with a clear area for improvement identified for senior managers to strengthen existing levels of engagement and communication with staff, specifically in terms of actions taken in response to feedback received. This is shown in the chart below.



The Executive team are currently actively exploring these finding with a view to determining what action is required to address these themes and the specific additional concerns and suggestions provided by staff. This including liaison with LCHS to ensure the views of UTC staff are sought and fed into the process of wider consideration. Whilst it is anticipated that many of the specific issues raised by staff can be clarified or addressed swiftly, some of the issues pertaining to the clinical model in place will necessitate wider engagement and discussion to understand fully the nature of concerns to identify the most appropriate actions to be taken. Given the consistency of themes within this local survey and wider trust surveys, it will be important to ensure that any actions taken in response to specific feedback from staff regarding Grantham are cognisant of those being developed and taken as a direct consequence of the finding from the National survey considered by the trust board in September. Oversight from the trust's Governance committee would be helpful in this regard.

Engagement with Trade Unions

Following engagement and consultation with TU s in advance of formal presentation of the Green site proposals in June, Executive representatives have continued to meet weekly with Staff Side Representatives to ensure their ongoing involvement in evaluating the implementation of the model. TU s have been asked to present the detail of their members views so that these may be considered alongside the views available from staff and patients. Specifically, the Chief Operating Officer will be meeting personally with Staff Side Representatives to discuss the final draft of the review paper intended for presentation to the Trust Board. This level of engagement will continue to ensure the full impact on staff of any changes are fully understood to inform ongoing evaluation.

Quality & Equality Impact Assessments:

Following both strategic QIA & EIA being undertaken and presented to the trust board in June to support decision making, 3 further QIAs and EIAs were additionally undertaken pertaining to services at St Barnabas, Medical services and the UTC. All assessments have a range of mitigating actions documented. A review to confirm that mitigating actions have been completed is scheduled in the next two weeks

Whilst it was recognised that considerable detailed work was undertaken at pace to support the development and subsequent approval of proposals, it was noted that all impact assessments were undertaken by the same individuals all of whom represented a corporate perspective. It is suggested that the trust now can develop its approach to reviewing decisions taken at pace, to ensure that these assessments undertaken are revisited with the benefit of divisional and clinical perspectives to strengthen both the evaluation and the identification of mitigations for identified risks. The reestablishment of a project group as an effective vehicle for achieving this would seem appropriate.

6.4 Recognition and Response to Public Concerns

Specific Concerns raised by the Public:

All individual concerns raised by parties to date to the trust board at its extraordinary meeting in June 20 have been responded to directly and in full either in the meeting at that time or in writing by the CEO. Confirmation

of these responses and a description of those answers given on the day were published on 7th July at its Board meeting held in public. These have subsequently been shared with the wider leadership team, with consideration being given to enable learning from these to influence future actions.

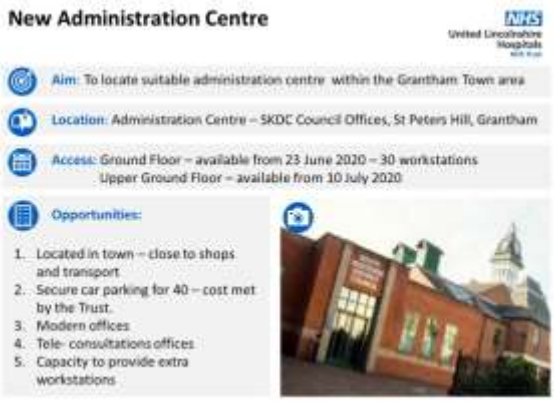
A number of these concerns raised have led to additional measures being put in place such as;

- The implementation of dedicated transport services for patients to and from Grantham Hospital via a new Patient Transport Service contract with Ambicorp Ltd. a CQC licensed independent patient transport provider.
- Maternity and Paediatric services have been restored at the Grantham Family Health Centre and additional services for the Grantham Green site itself for most vulnerable patients.
- Additional outpatient services have been restored at Clinical Assessment and Treatment Centre at Gonerby Road in Grantham reducing the need to travel to services at PHB and LCH hospitals.
- In addition to Grantham Green Site Surgical services the Independent Sector are supporting the Trust at the BMI facility in Lincoln and Ramsey in Boston.

Specific Concerns raised by Elected Representatives

Concerns have been expressed by local elected representatives that have focused upon the impact to residents requiring to travel to services to be moved from the Grantham site. The importance of these concerns has been recognised by the Trust and as previously mentioned the intended strategic development of several new sites away from the Grantham site, but within the Grantham locality have been completed and are in operation. These strategic developments reflecting the increasing choice of Lincolnshire patients to access services at Grantham in addition to operationally offering significant opportunities for increasing local access to services for Grantham residents than were originally committed to within the proposals approved in June. These developments serve to maintain the highest level of protection and IPC standards on the Green site, continue to restore services suspended during the manage phase of the epidemic and reduce both patients and staff need to transfer to other hospital sites across Lincolnshire.

These 4 new sites described below describe the main function location and timescales of when services occupied them:



6.5 Financial

A process of rapid senior decision making with analysis of risk, benefit and signed off by executive and clinical directors has been in place since the Emergency Level 4 Response nationally was confirmed on 30th January. The business case developed for the Grantham Green site model and all associated expenditure has been approved as per existing SFIs and the summary of expenditure to date is provided below:

Additional Investment Approved to Strengthen the Grantham Green Site Model 20/21

Costs	One Off	July to March	Total
Grantham Health clinic	29,080	50,862	**79,942**
SKDC Council Offices	64,280	127,155	**191,435**
Units 4,5 &6 Hill Court Estate	51,237	82,822	**134,059**
Conversion of Gonerby Health Clinic	877,060	68,801	**945,861**
Purchase of three mobile clinical trailers	25,040	18,043	**43,083**
Vine Street	2,000	56,682	**58,682**
Mobile X ray	0	0	**0**
COVID Pods	8,391	211,649	**220,040**
Total	**1,057,088**	**616,013**	**1,673,101**

Description	20/21	21/22	22/23	23/24	24/25
Total Capital	127,550	0	0	0	0
Capital Charges	6,631	13,296	13,166	12,839	12,512
Total direct Pay costs	0	0	0	0	0
Total direct Non Pay costs	1,666,470	20,332	0	0	0
Cost reductions	0	0	0	0	0
Income	0	0	0	0	0
Total Revenue	**1,673,102**	**33,627**	**13,166**	**12,839**	**12,512**

Current expenditure levels are reported as totalling £1,673,102 for 20/21, A detailed review of these costs and projections ahead is scheduled to be undertaken for next week.

7.0 Assessment of Original Decision within Current Conditions

Design Principles:

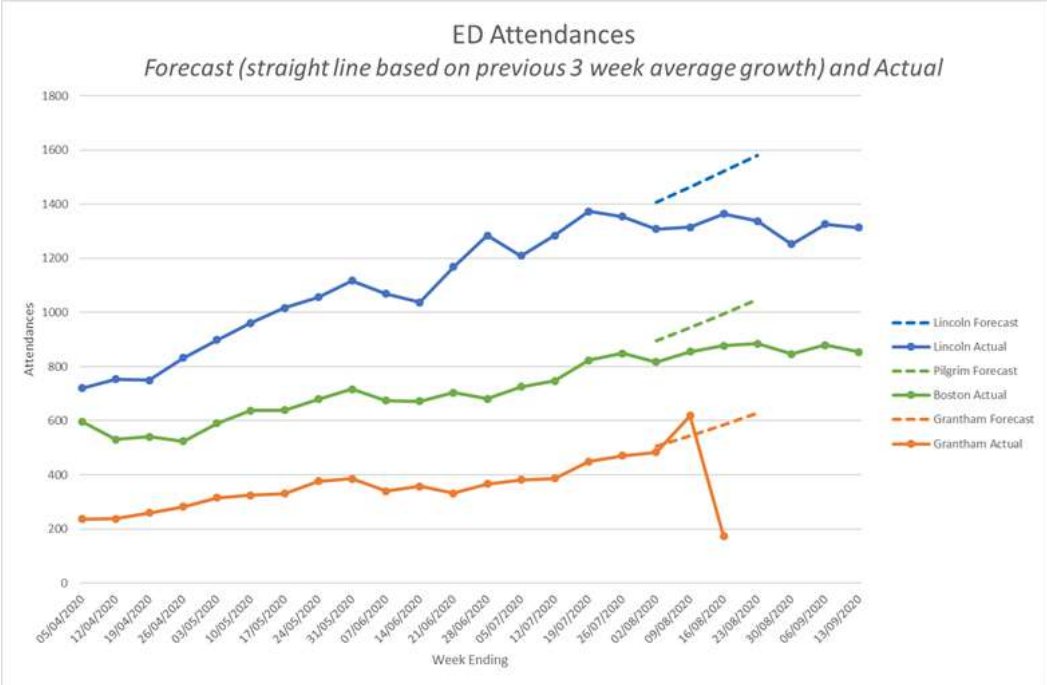
Given that the NHS Covid Alert level has recently been raised again to Level 4, reflecting the National picture of increasing numbers of Covid-19 and the trust remains in Phase 3 *Recovery* it is suggested that the 3 conditions upon which the Operating Model was predicated and indeed the design principles upon which options were evaluated remain as relevant and given the current conditions Nationally, are as important now as the time the original decision was taken.

Current transmission of Covid-19:

Currently the daily cases of Covid- 19 are rising steeply across the UK, projected as doubling every 7 days; current hospital admissions and deaths remain low. In response to this the government has introduced more stringent measures to reduce transmission with the government's chief scientific adviser and medical adviser forecasting a significant number of deaths – 200 per day by the end of October without further interventions. Given this emerging prevalence and if the National Covd-19 response phase remains at L3 – Recovery Phase, the necessity of a Green site will potentially become increasingly important to maintain and strengthen to optimise the undertaking of routine surgical and potentially medical services.

Temporary Reclassification of A&E to UTC:

The relevance of A&E attendances remains important context regarding the temporary reclassification of A&E to a UTC on the Grantham site, with ongoing monitoring of increasing activity key to assessing the ongoing appropriateness of the UTC. The graph below presents the growth in A&E attendances because of the Covid-19 epidemic. This shows that the growth rate has slowed in recent weeks to around 90% of seasonal pre-Covid levels. Please note that the Grantham UTC attendances drop then disappears due to data recording being moved to an external LCHS system. It will be important to ensure UTC activity data is available to the trust going forward to fully evaluate the impact of this temporary change and enable effective response to future A&E demand.



Existing Criteria for the Return of GDH to Pre-Covid-19 Model:

The trust has documented explicit criteria against which the original proposals in June were assessed and any question regarding the continuation of the temporary changes implemented at Grantham would be evaluated. The detail of these criteria and subsequently developed measures and trigger points to instigate formal reassessment are detailed in the next section.

8.0 Criteria, Measures and Triggers to Assess the Continuation of The Grantham Green Site Model or the Return of GDH to Pre-Covid-19 Model:

At the June 11th Extraordinary Board meeting the proposed model of care was agreed should run temporarily until 31st March 2021. Within that same proposal was a confirmation that there would be a quarterly review (this document) where the model would be evaluated against a set of criteria designed to indicate either a change to the model is required or a complete revert back to previous model should commence.
The below criteria was developed that reflects when circumstances either within the Trusts control or outside of their control would require the model to change or revert back to previous model.

The trust's original criteria to determine the return of Grantham Hospital to pre Covid-19 model are represented below:

- Regional or National Incident Override – where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model.
- Covid-19 alert level reduces to L2.
- Impact to other organisations - resulting in a request for mutual aid directly relating to the temporary model.
- Identified risks of threat to life or limb are identified with existing models of care.
- Overall waiting lists for Cancer patients reaches standards for 31 & 62 day, with all other treatments/surgeries reduced to pre Covid-19 levels.
- Winter pressures lead to activation of the surge plan – where emergency bed base, critical care demand and/or staffing requirements for critical care is not satisfied with Grantham model.

The fast changing national position regarding prevalence of Covid-19 and the introduction of tighter restrictions to reduce transmission, presents an extremely challenging and complex environment within which the trust must seek to both continue to deliver against existing priorities to restore service delivery whilst revisiting contingency plans in the event of guidance changing. Under these circumstances the criteria above remain wholly appropriate, with the importance being to strengthen current methods and mechanisms for evaluating specific aspects of performance within the context of the Trust's overall performance such that the most informed decisions may be taken by the Executive team and Trust Board in due course.

The list of criteria below has been designed in such a way that any one single would trigger the need for a change or complete revert back to previous model.

Trigger	Rationale	Measure or Indicator
○ Where Regional or National Incident Directives state this model is either incompatible with a model of care or where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	Whilst working within emergency measures either at national Emergency planning level 3 or 4 the Trust must respond to regional or national directives.	Directive from NHSE/I either via MIDSEAST or national Command Centres/Incident Directors.
○ Where Impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	Where consequences of the model have unintentional impact on other organisations to a level requiring formal mutual aid for cessation or change of the current model.	Formal Aid Request via the Local Resilience Forum.
○ Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	Where new risks are identified that indicate a substantial threat to loss of life or limb that had not been identified there is a need to urgently review and potentially change/cease the current model.	Completed Risk Assessment that indicates an inability to mitigate risk through countermeasures.
○ Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, and incomplete waiting lists reduced to pre Covid-19 standard.	Where the Trust has responded completely to the pandemic incident and restored services to levels of care within safe constitutional standards the current model should be reviewed and consideration be made to reverting back to pre-covid models.	62 day Backlog Patients <40 patients 104 day backlog <10 patients Incomplete waiting list < 37,762
○ Covid-19 alert level reduces to L2 or below	L2 Covid-19 Alert level reducing would indicate a substantial decrease in the risk of Covid-19 being acquired in the community and subsequently in hospital. This would reduce the need for such high IPC measures and would trigger a consideration of change of model or revert back to previous state.	Covid-19 Alert Level <=2
○ Activation of the Trusts Full Covid-19 Surge Plan	The impact of a subsequent wave of Covid-19 or other winter extreme demand events (including a Major Incident) could trigger the need to convert all Inpatient Capacity and re-task supporting services to Covid-19 or Urgent and Emergency Care facilities.	OPEL L4 Indicators for the system.

These 6 criteria have been designed to consider all known scenarios that should lead at first to a consideration of amendment of the model which in turn may lead to reverting back to the original pre-Covid-19 model. They are sufficiently broad to consider the full range of risks to stakeholders internally (patients) and externally (other organisations in our and out of NHS Midlands). The measures or indicators used as evidence to trigger are not greatly sophisticated in nature, but are considered to be highly visible and easy to communicate so as to easily alert the Trust to a need to consider its response differently.

The fast changing national position regarding prevalence of Covid-19 and the introduction of tighter restrictions to reduce transmission, presents an extremely challenging and complex environment within which the trust must seek to both continue to deliver against existing priorities to restore service delivery whilst revisiting contingency plans in the event of guidance changing. Under these circumstances the criteria are wholly appropriate. The National *expectation that local intentions to restore elective services will continue for as long as possible, reflects a 'window of opportunity' for the trust to continue providing services for the benefits of all patients across Lincolnshire. This approach further reinforced following a letter received this week from the National Strategic Incident Director advising trusts to continue to strengthen local efforts to re-establish elective services whilst reviewing local escalation plans in anticipation of increasing hospital admissions.*

8.1 Evaluation of Current Circumstances:

Previous sections of this report have described outcomes delivered as a result of the model of care put in place at the beginning of July 2020. In order to ascertain whether the triggers for change in model/revert back to pre Covid-19 model have been met the below table evaluates data available and provides statements of fact against each criteria.

Trigger	Current State	Has the Indicator been Triggered?
1. Where Regional or National Incident Directives state this model is either incompatible with a model of care– where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	No directives have been received by the Trust to date suggesting incompatibility with the current temporary model. Subsequent guidance sent through MIDSEAST and from national teams support the use of Green Sites.	No
2. Where Impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	No requests for mutual aid have been received. Regular reviews of patients accessing other organisations urgent care services as a result of the temporary model indicate a lesser impact than that described in the June 11th proposal.	No
3. Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	No new substantial risks have been identified.	No
4. Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, with all other waiting lists reduced to pre Covid-19 levels.	Reductions in waiting lists for cancer have occurred and all initial surgical waits have been treated or seen in alternative services. On the 24th September 2020	No

	62 day Treatment Standard backlog was at 280 against a trigger of 40 or less 104 day Treatment Standard backlog was at 42 against a trigger of 10 or less Overall waiting list levels reported 44,393 against a trigger of 37,762 or less	
5. Covid-19 alert level reduces to L2	National Covid-19 alert increased to L4 on the 22nd September 2020	No
6. Activation of the Trusts Full Surge Plan	Although the Trust has frequently increased escalation levels to OPEL 3 at LCH and PHB sites in recent weeks there have been no occasions where OPEL4 levels have been reached on a system wide basis.	No

Noting that these statements have been made about a specific position at a specific time, it is apparent that no criteria have been met that would suggest the need to substantially change the temporary model put in place or revert back to pre-Covid configurations.

9.0 Findings & Recommendations

The complex implementation of the Grantham Green site model within 2 weeks of approval was as a direct consequence of the significant efforts and commitment of many corporate and divisional colleagues which given the environmental challenges presented by Covid-19, were nothing less than outstanding.

Whilst the aims and intentions of the Green site model remain sound, the opportunity to revisit and strengthen existing arrangements for refining patient flow projections, revisiting specialty activity targets and developing the coordination and consistency by which performance is measured and reported upon is one that the Trust is recommended to take now.

Whilst there is no doubt that the services approved within the Green site model have been implemented as intended, the full effect of these changes upon staff, Grantham residents, patients, other sites and services provided by the Trust remain to be fully quantified and understood. Whilst these interdependencies may be complex, strengthening the approach to evaluation going forward as is outlined within the recommendations below will help to developing a clearer understanding that will inform both organisational and system wide decision making as the NHS continues to respond to the Covid-19 pandemic.

There is a clear opportunity for reflection on the findings from this review to benefit from the translation of the learning from the planning and implementation of the Grantham Green model by informing the approach to other developments and changes being considered by the Trust to ensure that the translation into wider organisational learning is not lost.

Decision Required:

The Trust Board is invited to approve the primary recommendation to continue with the Green site model at Grantham, recognising the review of the specialty findings presented within this paper and the prevailing context regarding Covid-19 which have been assessed against the criteria, measures and triggers detailed within the report.

In the event that approval is given to the primary recommendation, the Trust Board is additionally invited to approve 6 further recommendations pertaining specifically to the operation and implementation of the Grantham Green Site Model and 3 further Corporate recommendations that directly relate to the Green site model.

Primary Recommendation regarding the Grantham Green site model:

1. Given the Trust Board is invited to approve the continuation of the temporary service changes enacted in June as a consequence of establishing the Grantham Green site model. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021. This timescale to be subject to a system wide review of the full next quarters activity available in early January 21 for the Trust Board's consideration in February 21.

Subsequent Recommendations regarding the Continuation of the Grantham Green site model:

Site Specific

2. Consider strengthening the **Operational Management Capacity** to provide oversight to the delivery of the Green site model at Grantham, to last for the duration of Covid-19. This capacity to ensure the establishment of a comprehensive performance management framework so that ongoing evaluation and routine reporting of the impact of these arrangements may be made. This to include
    - routine triangulation of Grantham **surgical activity** data pertaining to patient activity, theatre and bed utilisation to identify opportunities for further improvement of operational performance and update original modelled activity projections within the context of overall Trust activity.
    - revised **OP attendance** targets for Grantham
    - an audit of IPC standards on the Grantham site, against the IPC BAF

3. Consider establishing a **Grantham Green site working group** with clear terms of reference to undertake a review the existing Clinical Model with a view to further optimising capacity at Grantham and formally refresh the activity modelling, activity targets and QIAs & EIAs previously undertaken. This to include modelling of intended rehabilitation services to be present on the Grantham site from 1st November identifies clear activity and performance targets, the monitoring of which may be included in the ongoing Grantham wide evaluation and next formal review and as part of the Trusts overall performance reporting.
4. Invite the endoscopy working group to remodel **endoscopy activity** trust wide in anticipation of easing of IPC requirements, translating this to explicit targets for Grantham going forward, including the potential for establishing 12hr sessions. This information to enable a routine monthly evaluation of performance to be reported on as part of the Trusts overall performance reporting.
5. Invite the chemotherapy management team to remodel **chemotherapy activity** based upon the transfer of all patients onto the Grantham site. This information to enable a routine monthly evaluation of performance to be accurately and consistently reported on as part of the Trusts overall performance reporting.
6. Consider the identification of a single individual taking responsibility for standardising, coordinating and reporting on **surgical performance** of the Trust as a whole, this to include overall surgical performance at Grantham.
7. Formally establish with LCHS a collaborative framework for comprehensively evaluating the **impact to patients** and staff following the closure of Grantham A&E, findings to shared monthly with all stakeholders and as part of the next formal quarterly review of the Grantham Green model.

Corporate

8. Consider ways of establishing a **dialogue with all staff** currently working at Grantham, those visiting Grantham and those transferred from the Grantham site, to ensure all experiences and suggestions inform learning and ongoing strengthening of the temporary model.
9. Ensure any future need to redeploy staff is based upon clear corporate criteria relating to skills and need, to promote **fairness and equality**.
10. Consider inviting STP colleagues to support the trust develop an explicit framework for establishing and sustaining **effective engagement with staff** to strengthen communication across the trust.

Clinical Model

IPC Excellence facility supporting a range of surgical activity including

- General Surgery
- Urology
- Breast Surgery
- Gynaecology

With smaller numbers of

- ENT
- OMF

Vascular Surgery and Paediatrics not supported in Restore at GDGH.

Casemix will vary weekly according to clinical prioritisation and be scheduled centrally in Restore.

Cohorting of specialty activity to provide speciality presence over several days to facilitate speciality cover for ward areas and support IPC excellence

A combination of day case and inpatient activity covering 2 28 bed areas, namely Ward 2 and Ward 1.

Green workforce supported by careful adherence to IPC principles and embedded culture of IPC excellence. Screening by wellbeing assessment including temperature check at start and end of each shift. Swabbing if symptomatic or for contact tracing. Programme of random staff swabbing to screen for asymptomatic carriers. Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on same day. Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site.

Medical cover provided by foundation grade doctors drawn from existing Grantham team. Existing Hospital at Night team to provide out of hours ALS cover with middle tier perioperative medical practitioner cover on call drawn from existing GS/Anaesthetic middle tier doctors. Speciality on call cover and arrangements for postoperative review of inpatients defined by individual specialities. Inpatients will require daily specialty review.

ACU functioning as 6 bed Level 1 postoperative care unit PACU (with outreach facility to support inpatient areas) Medical cover from on site anaesthetic staff (in hours) and middle tier perioperative medical practitioner cover on call drawn from existing General Surgery/Anaesthetic middle tier doctors. Defined SOP for escalation of ward patients into ACU and utilise existing SOP for transfer to L2 / L3 facility if required.

4 theatres operating 5 days a week initially with a view to 7 day working. Lists initially running from 09:00 – 18:00 (soft cap, intention to complete listed activity). Medical staffing of operating lists 8 – 18.00 to accommodate preop visits, consent etc. On call team for out-of-hours returns supported by on call non resident consultant anaesthetist and on call consultant surgeons as per agreed specialty models. Review of planned activity to ensure appropriate facilities (eg laser point), equipment (clinical engineering stream) and staffing skill mix.

Support in theatres from radiography for Urology, and occasional other use. Overnight on call radiographer required for ward / ACU (portable chest xray)
Radiology Support for breast surgery – wire guided and Sentimag machine

Histopathology function to support specimen processing from theatres

Chemical pathology function to support ward requests (including urgent out of hours), outpatient bloods and preassessment including phlebotomy

Haematology function to support ward requests, outpatient bloods and preassessment; blood bank to support elective surgery (including urgent out of hours)

Microbiology function to support ward, theatre and preassessment samples, including arrangements for urgent processing/transport of samples.

Clinical measurement function to support ward, outpatient and preassessment function with ECG.

Pharmacy function to support day case, inpatient and ACU areas and 4 theatres 5 days a week. Additional support for day case chemotherapy unit.

Preassessment function to support elective surgery including telephone assessment where possible. Includes arrangements for self isolation and swabbing (including home swabbing/CCG led swabbing).

Additional services in Green areas

Hospice	Utilises existing staffing arrangements
Day Case Chemotherapy	CSS managed; existing staffing arrangements; SOP needed for deteriorating patients
Endoscopy	CSS led; existing staffing arrangements; SOP needed for screening and for deteriorating patients
Outpatients including Emerald Suite	CSS led remote consultations and defined SOP for screening face to face attendances
Rehab Unit	Ward 6 area (following redevelopment) – therapy led facility for IPC green patients; level of nursing support to be defined. SOP to be defined for medical emergencies/deteriorating patient. Implementation later in Restore

Medical staff movement

Existing foundation tier to be reallocated to surgery (12 doctors) supporting ward work and overnight ward cover. Exception is 3 A&E F1s who will support UTC.
Model to be revisited for August rotation and numbers likely to reduce significantly
Existing Anaesthetic consultant and middle tier (14 doctors) supporting theatre activity. Anaesthetic consultant non resident on call supporting returns to theatre / PACU deterioration/transfer

Existing surgical middle tier (7 doctors) supporting theatre activity.
Anaesthetic and surgical middle tier supporting out of hours ward cover including PACU – this does not include the ST5's who support the Lincoln acute work. Workforce of 11 doctors (3 vacant posts at present)
Surgical consultants support theatre work along with visiting specialty teams. Post operative specialist cover defined by specialty.
Orthopaedic CONS and SAS reallocated to other sites / support OP activity at GKGH. Specialty to define.
Medical and speciality medical CONS, SAS, IMT and CT reallocated to other sites / support OP and endoscopy activity at GKGH. Specialties to define in conjunction with CSS.
A&E CONS and SAS support UTC model – any extra resource reallocated

Infection prevention and control board assurance framework

27th September 2020 Version 2

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance	All patients are screened on admission to the organisation. Those who are suspected COVID-19 are cared for in dedicated wards Patients with suspected or confirmed COVID-19 are placed on dedicated wards or placed in isolation room on other wards if deemed clinically necessary The Trust has been consistent in following national guidance on discharges and has supported social care discharges with a supply of PPE for 72 hours The Trust has followed PHE national guidance throughout the pandemic	Swabbing not a perfect method of screening Asymptomatic cases have been detected Some initial gaps in notifying discharged patients with swab results There have been occasions where supplies have been running low.	The Trust allows for other diagnostic evidence such as CT or X-ray and clinical picture to be considered pending re-testing If an asymptomatic case is detected, close monitoring of contacts is undertaken System now in place with Local Authority Public Health to notify post discharge patients of results The Trust has sufficient supplies of all types of PPE and is building alternative and compliant PPE for future demand

• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	The Trust has subscribed to automated updates and has notified incident commanders at daily briefings with relevant updates cascaded through SBAR communication tool and live webinars Changes to PHE guidance are discussed with strategic commanders and any necessary adjustments or communications are agreed through daily meetings. The Trust BAF and risk register have been updated to reflect the current issues and signed off at subcommittee and board External additional support for non-COVID-19 IPC activity has been sourced by the DIPC.	This work is part of an ongoing refresh piece of all IPC functions & compliance with the hygiene code, currently assurance is limited	IPCT continue to monitor and manage HCAI cases including RCA investigations for alert organisms. Refreshed IPC group in place. Terms of reference approved and will be ratified by Quality & Governance Committee on 19 May 2020. Strengthened reporting arrangements in place
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Designated cohorting and isolation areas with specifically allocated teams to reduce the risk of transmission These teams are further supported by IPCNs QM Clin Ed		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All relevant housekeeping staff are trained to work in these areas. training sessions are recorded		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	In conjunction with IPC areas when identified, are cleaned in line with PHE guidance. Chlor Clean and HPV fogging	Historically there was no deep clean process in use Rolling programme in situ across all sites to undertake deep cleaning as wards become empty	New process for deep clean currently being implemented with a defined deep clean schedule and accompanying SOP
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Increased cleaning is in place across all sites/areas during this pandemic in line with the Deep cleaning protocol		New deep clean process now includes hydrogen peroxide vaporisation (HPV) and staff have been trained to use it appropriately
	All Linen is treated as infectious and is managed using soluble laundry bags double bagged in a clear outer sack to be transported to the laundry. It is then		To increase collection from designated areas and

• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	laundered as infectious laundry by the 3rd party laundry service	Infectious linen builds up in COVID-19 ward areas Currently No decontamination lead appointed within the Trust	remove to areas to await collection by 3rd party IP Team have written and updated cleaning and decontamination of medical equipment at ward level and have produced guidance at a glance to assist staff to clean and decontaminate equipment at ward level
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to	Ongoing and strengthened accessibility to Antimicrobial Pharmacists for advice on antibiotics and infection management for all staff including junior doctors 7 day working PGME and pharmacy reminders, newsletters, tweets, very good uptake of this availability.	ASSG meeting cancelled in April as rooms bookings were over-ruled for COVID cells and other organisational purposes without options. ASSG held virtually in May. Productive but not quorate. Nothing to sign off but have progressed some actions	Direct contact from persons requiring ASSG input for antimicrobial stewardship, encouraged by request for virtual returns as enquired if anyone in group

and boards continue to maintain oversight		and had opportunity for updates.	
	C.Diff walk arounds halted, but have been taken over by phone calls to discuss patient where required with the lead consultant.		
	RCAs being held at Lincoln for all C.diff cases have antimicrobial input	Not got same assurance for PHB and GDH New RCA documentation and process launched across all sites including DDIPC /DIPC and Multi-disciplinary Rapid Review Group	New Antimicrobial Pharmacist at PHB will be assigned to pick these sites up for RCA input virtually with support of existing antimicrobial pharmacists if needed Specific training to be launched for new RCA process for senior management teams to enhance knowledge and understanding of process
	Antimicrobial stewardship and requests for advice. Virtual platforms used more frequently by pharmacists seeking advice on the wards – mobile, office line, skype, teams, whatsapp groups. Includes frequent requests for advice from Rowlands Outpatient Pharmacists. Comms sent out re availability over mon-sun have had good response and uptake.		
	PII audit(s) still prioritised and completed. Virtual communications with clinical teams and very good response. Confident no gaps in this assurance		
	Repeat PII audit planned and will be prioritised despite pressures, with ward pharmacist involvement	Unable to complete PII investigation with Ribotyping, would be very helpful in drawing further conclusion	

	Non-essential (or non-mandatory) Antimicrobial Stewardship audits halted to avoid risk to patient safety due to inaccessibility to patient medical notes and to reduce unnecessary footfall on wards. Junior doctor projects registered with Clin Governance largely concluded, some have actions of final report remaining, which will be completed once pressures are manageable.	and assurance for antibiotic prescribing assessment	
	Ongoing contribution in virtual DTC, working to sign off guidelines related to antimicrobials, providing input in developing safe and effective documents, with feedback mechanisms.		
	Rapid updates sent out around COVID and antimicrobial stewardship – evidences PGME emails, newsletter and pharmacy advice		Provided updates by email instead. Working on further means of communicating these to increase awareness
		Usually would be captured in team brief and educational update sessions	Sent updates to PGME and all pharmacy staff for sharing with all relevant staff
	Commenced work on an antimicrobial app procured by pharmacy, and being led by Antimicrobial Pharmacy team using STP funds. Collaborative effort captured in the 'long term plan' to improve AMS and support organisations across the patch. Will help with C.diff and ESBL bacteraemia rates related to correct antimicrobial use – governance process to be finalised via DTC before release/launch	COVID priorities have slowed antimicrobial team on antimicrobial guideline work	Specific resource funded via SPT has been ring-fenced for populating the microguide app, pending governance sign-off, using existing Trustwide guidelines
		COVID interruption of DTC and PACEF access pathways may impact on governance sign off, but will	New antimicrobial pharmacist started Mid May will be part of effort to

	Review of paediatric antibiotic guidelines out of date by 5 years. Commenced work on this but halted by COVID	be pursued as virtual set up is formalised for these committees	prioritise this work on guideline review
	Review of adult antibiotic guidelines due this year and requires some updates to bring in line with NICE	Will need to secure microbiologist review and Pathlinks sign off	Antibiotic guideline review will also address some of the feedback from end-users where clarity was requested
	Surveillance continues	Extrapolation against occupied bed days and admissions may be skewed on system used for surveillance	Using various means and parameters for extrapolation to ensure good level of confidence in surveillance and trends identified
	RECOVERY trial input including screening patients and advising on antimicrobial choices that have been made, next steps etc. Commas sent out via Trust, pharmacy, and STP		
	Follow up of patients with support of ward pharmacists, including complex patients on microbiology radar	Educational sessions for pharmacy teams halted, and will need to be re-developed depending on means of delivering them amid social distancing	All antimicrobial advice requests include educational aspect on rationale behind this advice and is acknowledged as being very helpful. Evidence of pharmacy colleagues applying this rational in their daily work, as notable difference in those who request advice frequently

	OPAT of patients where feasible	Some issues with premature and error in handover of patients amidst COVID rotas which could have impacted patient outcomes, and have required safety mechanisms to be used.	Tightened OPAT criteria to reduce risk of recurrence, at expense of delays to OPAT but important for patient safety

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	In line with national recommendations, the Trust suspended visiting with controlled exceptions i.e. end of life visiting	Some issues remain on rules for visitors bringing in patient possessions	The Trust has developed a protocol for acceptance of patient possessions
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Dedicated wards have been in use for both suspected and confirmed COVID-19 patients. The Trust has a place based approach to PPE precautions so all clinical areas take the same precautions regardless of the COVID-19 status of any patient		A series of laminated door cards are in use for identification of isolation and staff considerations when entering and leaving the rooms alongside PHE COVID-19 relevant Posters distributed through the Communication team
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	There is a link on the Trust website front page taking the user to the national NHS COVID-19 page.		
		Initial gaps in communication were identified both for	

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The status (known at time of transfer) of each patient is communicated to the receiving organisation. This includes when swab results are pending.	discharge home and to social care	Local Authority Public Health now communicate results to discharged patients. Discharge protocol in place
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	Each ED has a designated streaming process for patients with suspected COVID-19.		
• patients with suspected COVID-19 are tested promptly	All patients admitted to ULHT are swabbed on admission.	Some patients have tested positive but have been asymptomatic	Swab turnaround times are less than 24hrs meaning patients can be quickly isolated
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	The Trust follows national guidance in relation to the management of patients who may have either a diagnostic or clinical presentation consistent with COVID-19. In	Atypical presentations can cause delays in diagnosis	This has now been largely mitigated by the inclusive testing of all admitted patients

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	these cases, patients are isolated and re-swabbed Patients attending for planned care appointments are requested to shield for 7 days prior to appointment. The patient is then swabbed 48hrs prior to the planned intervention. If the patient is positive or has symptoms consistent with COVID-19, they will be deferred and a new appointment made.	Some anecdotal evidence from a nearby Trust identified that some patients became symptomatic shortly after their procedure meaning they were likely positive during their appointment	All reasonable precautions are in place and are in line with national guidance
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	The Trust uses the published videos and posters provided by PHE to ensure that PPE is correctly used. There is a continuous programme of fit testing in all Divisions to ensure that staff can use all FFP3 mask types issued.	There is no control over the type of PPE received by the Trust from NHS Supply Chain including FFP3 masks. This means some risks exist of having sufficiently fit tested staff on a given mask type	The Trust is procuring reusable respirator masks that can be issued to individuals (400 + 23 Hoods). This will negate the need for high volume repeated fit testing
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff who require fit testing attend training. The Trust uses the PHE videos and posters to assist with training relating to selection, donning and doffing of PPE	High FFP3 fit test failure rate in some areas. Lack of choice with masks further restricting fit tested staff available for a given shift	The Trust has purchased 2 quantitative fit testing kits. These kits can confirm a fit test pass or fail without the reliance on the human factor to smell/taste the fit test solutions

• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken	Staff fit testing records are held by Divisions and recorded on Health Roster While arrangements are in place (the published PHE guidance), the Trust has not yet introduced the reusing of PPE The Trust is currently not reusing PPE however if needed, it would follow PHE published guidelines	Health Roster does not include medical staff.	Evidence of fit trained staff held by clinical areas
• adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions	The Trust has consistently abided by the national PHE PPE guidelines and daily reports on PPE usage are supplied to the COVID-19 Tactical Cell The Trust has employed Personal Safety Champions (PSC) to visit all areas to ensure staff are adhering to hand hygiene, PPE, cleanliness and social distancing. Reports are provided daily	There is still evidence of inappropriate PPE use however this has significantly reduced The PSC team work across all sites however out of hours is not fully covered.	Personal Safety Champions provide reports on challenges around inappropriate PPE usage and provide immediate training in the work place. Infection Prevention has a dedicated hand hygiene audit system in place completed and submitted by each ward/department across the Trust relating to the WHO 5 moments of hand Hygiene
• staff understand the requirements for uniform laundering where this is not provided for on site	The Trust has provided soluble red laundry bags to all staff who take uniform home to support safe laundering practices.		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national	Staff self-isolate and contact Occupational Health if they experience any symptoms consistent with COVID-19. The Occupational Health team also support national guidance in relation to	Outbreak management of staff following on from contact both at work and socially requiring screening and isolation	IPTeam have been undertaking regular weekly support visits to ward areas reviewing social distancing, PPE, Hand hygiene, staff social areas

guidance if they or a member of their household display any of the symptoms.	symptomatic household contacts and support staff isolation.		Outbreak management plan and working and supporting teams including occupational health in a more collaborative manner sharing information and communicating on a wider level
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Dedicated suspected or confirmed pathways have been established. This starts at ED and is facilitated throughout the Patient stay.		
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Designated suspected and confirmed COVID-19 wards have been identified. If a Patient needs care on their base ward, suitable isolation facilities are required.	Many clinical areas are in need of refurbishment	Processes have been agreed (awaiting business case) for the complete refurbishment of 3 wards and environmental upgrades of a further 12 wards across the Trust
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients identified with an alert organism or resistant organism are managed as per Trust policy.	Review of alert organism and Gram –ve BSI plans are in progress but not complete	External support for review of IPC function has been sourced by DIPC
8. Secure adequate access to laboratory support as appropriate			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Molecular testing is undertaken within the microbiology section of Path Links laboratories which have UKAS accreditation and which are applying for an extension to scope for COVID-19 testing as part of the regional network. HCPC registered BMS staff are undertaking and overseeing the testing. Full validation and verification has been undertaken, and V&V documents, SOPs, training records and manufacturers' information documents are available on request**.**		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	PHE guidance is used as the framework for testing, although some locally arranged additional testing has been taking place. NHSE is co-ordinating across the MidE2 network. Current turnaround time is 13-18 hours from receipt of samples.		
• screening for other potential infections takes place	Demand management has been implemented according to national guidance, and according to the attached letter. Samples of limited clinical value are not being processed, but CPE screening and MRSA screening from high risk contexts is ongoing. We are reviewing the situation in light of "business as usual"		

	guidance, balanced with the additional workforce pressures and demand upon the laboratory.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in	The Trust provides daily updates (SBAR) and the Exec team host Facebook Live events to provide advice and information to staff. The Trust has also deployed Personal Safety Champions who visit all areas on all sites to ensure there is good practice on hand hygiene, PPE use, cleanliness and social distancing. The IPC team continue to support wards and departments with regular visits to ensure that non-COVID-19 infections are properly managed. The Trust has subscribed to the automated PHE update system and once notifications are received they are reviewed and escalated to the DIPC and COVID-19 Gold command. Any necessary actions or adjustments are communicated as soon as practicably possible From the outset, the Trust has followed national PHE guidance on waste segregation. This is also in line with the national specification HTM 07-01 (Management of Healthcare Waste)	IPC policies need review to support staff. The Trust annual IPC plan and structure is in need of a review.	The DIPC has sourced an external support to review and refresh the Trust IPC policies. Systems and processes New Policies are being uploaded to the IPC intranet pages along with new innovation of Guidance at a glance to support salient bullet points as a reference for staff with more in depth advice contained in the policy The IPC and Procurement teams have worked to source alternative types of PPE (masks and gowns) that meet the same or better PHE standards. This has meant that stocks are more manageable.

accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	PPE is stored centrally and controlled by the Trust procurement teams. There is a PPE 'hotline' so staff can access PPE stocks at short notice. A daily PPE stock report is produced which includes a tracker for each line item stating the number of days stock available.		

		There have been occasions when stocks of PPE have	

		decreased to dangerous levels	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	As a Trust we are proactive in recognizing the risk to our staff of Covid19 and provide an action plan that is supportive of their physiological and mental health needs at this time. Individual managers are aware of the risk to our staff and provide time for conversation surrounding the anxieties this may cause for some staff signposting for additional support as required, seeking the advice from Occupational Health, where appropriate the counselling service and wellbeing service offered by the Trust. This includes BAME staff. All staff absence is recoded and on two data bases. All staff who are self-isolating will be contacted by their line manager OH and HR also Maintain contact with individuals considered at greater risk. All staff are offered a swab test. Priority is given to staff and Household members isolating for 10 and 14 days.	Staff testing through national testing centres is difficult and appts and timeliness of results is poor	Staff are tested through in house NHS testing Labs commissioned for patient services managed by Occ/Health

	All staff are called personally by a Nurse from Occupational Health to support them on having a confirmed positive test. They are offered support through wellbeing and counselling		

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