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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**15 December 2021**
Subject:	**Chairman's Announcements**

1. Membership of the Committee

Councillor Tom Smith has permanently replaced Councillor Robert Reid as one of the county councillor representatives on this Committee.

2. Information Requested at Previous Meetings

There are four outstanding requests for additional information from the previous two meetings:

(a) Grantham Urgent Treatment Centre – Usage Numbers as part of the 'green' site operation – This information is contained in paragraph 5 below.
(b) List of All NHS Services provided at Louth County Hospital – A full list of the services provided by three NHS trusts at the hospital will be circulated when it is available.
(c) Orthopaedic Patients from the East Lindsey Area – The question of the availability of follow-up appointments at Louth County Hospital for patients who have been treated at the proposed centre of excellence at Grantham, can be covered as part of item 5 on this agenda.
(d) Primary Care Networks in Lincolnshire - As an initial response to this the Lincolnshire Primary Care Network Alliance annual report for 2019/20 was circulated. The 2020/21 annual report is now available at the following link: Annual_Report_2020-21.pdf (lpcna.nhs.uk)
(e) Urgent Community Response Service – It has been confirmed that this service, provided by Lincolnshire Community Health Services NHS Trust since 4 October 2021, is a county-wide service.
(f) Lincolnshire Acute Services Review – Financial Details – Financial details of the Lincolnshire Acute Services review may be found in chapter 13 of the Pre-Consultation Business Case, available at: Pre-Consultation Business Case :: Lincolnshire STP

(g) Capital Expenditure for Proposed Grantham Urgent Treatment Centre – The Lincolnshire Acute Services Review Pre-Consultation Business Case (PCBC) refers to a moderate amount of capital investment to address backlog maintenance and the functional suitability of the environment, including expansion of the proposed UTC into underused adjoining departments. The figure is not quantified, but the PCBC states that the Lincolnshire system has sufficient reserves to meet all the anticipated capital needs. Furthermore, PCBC states that capital works are not required prior to the implementation of the proposal.

3. Covid-19

An update on Covid-19, based on information available on 29 November 2021 is attached at Appendix A. A further update, which will include information up to and 13 December 2021, will be circulated just prior to the Committee's meeting.

4. Intermediate Minor Oral Surgery

On 23 November 2021 NHS England (Midlands) launched a consultation on the contracts for intermediate minor oral surgery, which are due for renewal in 2023. Details of the consultation, which is due to close on 21 December 2021, are attached at Appendix B to these announcements.

Intermediate minor oral surgery is a specialist dental service for patients over the age of 16 years which provides complex extractions and treatment in a community setting. The service is provided by clinicians with enhanced specialist qualifications and experience, following a referral from a general dental practitioner. Existing locations in Lincolnshire for intermediate minor oral surgery are available in Lincoln, Boston, Grantham Gainsborough and Skegness. Across the East Midlands in 2019/20 the service accepted 37,000 referrals and treated 33,000 patients.

I intend to propose to the Committee that, in consultation with the Vice Chairman, I am authorised to respond on behalf of the Committee to the consultation, advising NHS England that intermediate minor oral surgery should at least continue in the existing five locations in Lincolnshire (Lincoln, Boston, Grantham, Gainsborough and Skegness) and consideration should be given by NHS England to extending the provision to other towns in the county.

5. Grantham and District Hospital: Temporary Urgent Treatment Centre Usage Data

On 13 October 2021, the Committee requested information on the patient attendances at temporary urgent treatment, which had operated at Grantham Hospital as part of its 'green' site activity between June 2020 and June 2021. The following figures have been provided for the eight months from October 2020 to May 2021.

Month	Attendances	Percentage Treated within Four Hours	Number Referred to A&E	Percentage Referred to A&E
October 2020	2,250	97.8	97	4.3
November 2020	2,084	98.0	88	4.2
December 2020	2,013	98.4	81	4.0
January 2021	1,945	98.4	69	3.5
February 2021	1,815	98.8	72	4.0
March 2021	2,386	97.9	112	4.7
April 2021	2,675	98.6	90	3.4
May 2021	1,641	98.2	66	4.0

The Lincolnshire Acute Services Review Pre-Consultation Business Case includes the following paragraphs on the temporary arrangements.

10.2.16 *Although caution should be exercised when comparing the proposed 24/7 UTC at Grantham Hospital identified through the ASR programme with the temporary UTC provided as part of the Covid-free 'Green' site at Grantham Hospital in response to the pandemic, the temporary changes do provide useful insights.*

10.2.17 Key considerations to consider in the context of these insights is the proposed UTC model set out within this PCBC would be able to see patients with a higher level of acuity and additional pathways of attendances such as 111 appointments (much more in line with what was provided 'pre-covid', compared to the temporary UTC that was implemented. The temporary UTC was also operating in a 'constrained' COVID-19 environment which will have shaped patient behaviour.

6. Revenue and Capital Funding Announcement – Winter 2021-22

On 3 December 2021, the Government confirmed funding of £700 million to help tackle waiting lists and improve care. This sum includes £330 million for upgrading NHS facilities; £250 million for new technology; and £120 million for supporting revenue costs.

United Lincolnshire Hospitals NHS Trust (ULHT) received a share of this funding totalling £11.6 million, which includes £8.2 million of capital for upgrading facilities; £3.1 million for new technology; and £0.3 million of revenue funding. The Lincolnshire Integrated Care System Partnership was allocated £1 million, bringing the total allocation for Lincolnshire to £12.6 million.

ULHT has confirmed that it will be spending:

- £5 million for two new laminar flow theatres at Grantham and District Hospital;
- £3.3m for the refurbishment and expansion of its critical surgical wards at Pilgrim Hospital, Boston, and Grantham and District Hospital;
- £1.1 million for the replacement of its digital cardiology system, including the replacement of some of the existing paper systems;
- £2.5 million for an artificial intelligence solution to support triage and management of its patient waiting list; and
- £0.6 million for digital support for the musculo-skeletal service.

North West Anglia NHS Foundation Trust's share of this funding totals £4.5 million, which includes £0.9 million of capital for upgrading facilities; £3.5 million for new technology; and £0.1 million of revenue funding. As a result of this funding, the Trust's initiatives will include:

- providing more space for outpatient orthopaedic appointments at Peterborough City Hospital;
- enhancing diagnostic facilities at several sites, including Stamford and Rutland Hospital, by converting x-ray facilities to digital radiography; and
- extending the hours of the emergency gynaecological assessment unit at Peterborough City Hospital.

Northern Lincolnshire and Goole NHS Foundation Trust's allocation was £0.6 million, which includes £0.5 million of capital for upgrading facilities; and £0.1 million for new technology.

7. United Lincolnshire Hospitals NHs Trust – Care Quality Commission Inspection

Between 5 and 8 October 2021, the Care Quality Commission (CQC) undertook an unannounced and focused inspection on four core services provided by United Lincolnshire Hospitals NHS Trust (ULHT). These services were:

- urgent and emergency care;
- medicine;
- children and young people; and
- maternity services.

In addition to this, between 9 and 11 November the CQC undertook an announced 'well-led' inspection of ULHT. The publication of a full report on the CQC's findings is expected in January 2022. In advance of this, the ULHT Board on 7 December 2021 considered the informal feedback from the CQC, which was given immediately following the inspections, and then summarised in two letters, dated 11 October and 12 November 2021, which are attached as Appendices C and D respectively.

8. Health and Care Bill 2021-22

The Health and Care Bill is currently at its second reading stage in the House of Lords, after its completion of its House of Commons stages. A summary of the main provisions is set out in Appendix E to these announcements.

9. Proposed Merger of Newark Road Surgery and Portland Medical Practice, Lincoln

On 3 December 2021m, a six-week engagement exercise was launched on the plans to merge Newark Road Surgery and Portland Medical Practice. The engagement period closes at noon on 15 January 2022.

Newark Road has over 7,000 registered patients at the surgery, while Portland has nearly 22,000 patients registered across its three sites: Portland Street, Newland Health Centre, and the University of Lincoln Health Service. The two practices are encouraging patients to share their views, which can be done via an online questionnaire:
https://nhslincolnshire.qualtrics.com/jfe/form/SV_bkpkNB5Pay5bnFk

Alternatively patients may request a paper copy of the questionnaire. In addition, a series of events for patients to attend have been planned, where patients can hear more about the proposals, and ask questions or share their views. Patients wishing to attend will need to book in advance (except for event one). The times, dates and locations are as follows:

- Event 1: 13 December 2021, 9am -2pm CCG Stand at Lincoln University in the Minerva Building Atrium, Brayford Pool Campus, Brayford Pool, Brayford Wharf N, Lincoln LN6 7TS. No booking required.
- Event 2: 15 December 2021, 6-8pm at Ruston Sports & Social Club, Newark Rd, Lincoln LN6 8RN. To book online: https://www.eventbrite.co.uk/e/proposed-merger-event-6-8pm-at-ruston-sports-social-club-tickets-221514414577 or call 07890 047 409.
- Event 3: 16 December 2021, 6-8pm at Bridge Central, Portland Street, Lincoln, LN5 7NN. To book online: https://www.eventbrite.co.uk/e/proposed-merger-event6-8pmbridge-central-portland-streetlincolnln5-7nn-tickets-221019403987 or call 07890 047 409.
- Event 4: 13 January 2022, 6-8pm at at Ruston Sports & Social Club, Newark Rd, Lincoln LN6 8RN. To book online: https://www.eventbrite.co.uk/e/221894922687 or call 07890 047 409.

10. Appointment of Chief Executive for NHS Lincolnshire Integrated Care Board

On 15 November 2021, it was announced that John Turner had been appointed as Chief Executive designate for the NHS Lincolnshire Integrated Care Board, which is due to be established on 1 April 2022. John, who is currently the Chief Executive of NHS Lincolnshire Clinical Commissioning Group, was appointed following a recruitment process, led by NHS England and NHS Improvement. John will be accountable for the development of the long-term plan for the new Integrated Care Board and, through this, for delivering improvements in the quality of patient care, patient safety, health inequality, workforce productivity and financial health for the population of Lincolnshire.

The next steps will be to recruit a Designate Chair, as well as Non-Executive Members and Executive Directors to the ICB.

APPENDIX A

COVID-19 UPDATE

This update has been compiled using data provided by Lincolnshire County Council's Public Health Service.

1. LATEST DATA

A. Tests (updated: 29 November 2021)

	Total Tests Carried Out	Total Positive Tests	% Positive Tests	Positive Cases	Rate of Positive Cases per 100,000 Population
Lincolnshire	**85,721**	**3,930**	**4.6%**	**3,049**	**397.9**
Boston	6,540	338	5.2%	273	385.4
East Lindsey	14,698	499	3.4%	376	264.7
Lincoln	9,506	547	5.8%	412	411.8
North Kesteven	15,091	670	4.4%	521	441.0
South Holland	10,648	455	4.3%	345	359.9
South Kesteven	18,350	971	5.3%	767	535.5
West Lindsey	10,888	450	4.1%	355	369.1

The data in the table above are a rolling seven-day summary of Pillar 1 and Pillar 2 Tests. Data have been extracted from Public Health England (PHE) daily line lists, which provide data on laboratory confirmed cases and tests captured through their Second Generation Surveillance System. The rates shown are crude rates per 100,000 resident population.

B. Cases (updated: 29 November 2021)

	Cases in the Last Seven Days	Cases to Date
Lincolnshire	**3,049**	**104,729**
Boston	273	10,209
East Lindsey	376	17,812
Lincoln	412	15,940
North Kesteven	521	15,432
South Holland	345	12,406
South Kesteven	767	19,820
West Lindsey	355	13,110

Data on cases are sourced from Second Generation Surveillance System. This is PHE's surveillance system for laboratory confirmed cases. Lab confirmed positive cases of Covid-19 confirmed in the last 24 hours are reported daily by NHS and PHE diagnostic laboratories. This is the most accurate and up to date version of data and as such it will not align with the data that is published nationally due to delays in reporting.

C. Deaths (updated: 28 November 2021)

Area	Total deaths	Total Deaths in the last Seven days
Lincolnshire	**1,824**	**12**
Boston	192	0
East Lindsey	438	5
Lincoln	212	1
North Kesteven	245	1
South Holland	225	3
South Kesteven	298	2
West Lindsey	214	0

Total number of deaths since the start of the pandemic of people who have had a positive test result for Covid-19 and died within 28 days of the first positive test. The actual cause of death may not be Covid-19 in all cases. People who died from Covid-19 but had not tested positive are not included and people who died from Covid-19 more than 28 days after their first positive test are not included. Data on Covid-19 associated deaths in England are produced by Public Health England from multiple sources linked to confirmed case data. Deaths newly reported each day cover the 24 hours up to 5pm on the previous day. As of 31 August 2020, the methodology for counting Covid-19 deaths was amended and, as such, the total number of Covid-19 related deaths was reduced.

D. Vaccinations in Lincolnshire – Period Covered 8 December 2020 – 21 November 2021 (Published: 25 November 2021)

Total number of vaccines given in Lincolnshire up to 21 November was 1,346,318

Age Group	First Dose	Second Dose	Booster or Third Dose	% who have had at least one dose	% who have had both doses	% who have had a booster or third dose
12 - 15	17,170	2,470		51.9%		
16 -17	11,372			73.6%		
18 - 24	48,073	43,166	20,847	80.5%	72.2%	
25 - 29	34,139	31,194		81.9%	74.8%	
30 - 34	37,053	34,353		85.5%	79.2%	
35 – 39	36,990	35,109		86.8%	82.4%	

Age Group	First Dose	Second Dose	Booster or Third Dose	% who have had at least one dose	% who have had both doses	% who have had a booster or third dose
40 – 44	37,258	35,847		92.1%	88.6%	
45 – 49	41,581	40,439		87.8%	85.4%	
50 – 54	51,909	50,822	10,572	96.4%	94.4%	19.6%
55 – 59	55,167	54,215	13,352	96.9%	95.2%	23.5%
60 – 64	50,242	49,280	16,599	99.0%	97.1%	32.7%
65 – 69	45,247	44,822	26,377	94.9%	94.1%	55.3%
70 – 74	48,180	47,899	37,515	94.8%	94.2%	73.8%
75 – 79	37,694	37,499	31,646	100%*	100%*	86.5%
Over 80	45,801	45,533	38,317	97.0%	96.5%	81.2%

The number of people who have been vaccinated for Covid-19 split by age group published by NHSEI. All figures are presented by date of vaccination as recorded on the National Immunisation Management Service (NIMS) database. *100% signifies that the number who have received their first dose exceeds the latest official estimates of the population from the ONS for this group.

2. RECENT DEVELOPMENTS

- In the seven days prior to 29 November, 92.4% of cases in Lincolnshire that were genome sequenced were the Delta variant. The remaining 7.6% were the Delta Plus (AY 4.2) variant.

- The Omicron variant is under investigation by the UK Health Security Agency and has been classified as a variant “of concern” by the World Health Organization. This variant includes several mutations which could potentially change the way the virus reacts to vaccines, treatments and transmissibility.

- All individuals who have been in contact with a suspected Omicron case must self-isolate immediately, regardless of vaccination status. NHS Test and Trace will contact these individuals to advise on next steps.

- On or before 29 November 2021, ten countries had been added to the UK travel red list: South Africa, Namibia, Zimbabwe, Botswana, Lesotho, Eswatini, Angola, Malawi, Mozambique and Zambia. Nigeria was added to the list with effect from 6 December 2021. Travellers from these countries will be unable to enter the UK unless they are UK or Irish nationals or UK residents. Upon returning to the UK, travellers from these countries must self-isolate in a government-approved hotel for ten days.

- Data published by the UKHSA on 25 November show no consistent differences between birth outcomes in vaccinated pregnant women and all pregnant women. Approximately 20% of pregnant women hospitalised with Covid-19 require preterm delivery to aid recovery and around 20% of their babies require care in neonatal units. As only 22% of women who gave birth in August were vaccinated, health officials are urging pregnant women to get the Covid-19 vaccine.

- The UK Health Security Agency has updated the infection prevention and control guidance for health and care settings. The aim of this update is to help prevent transmission of seasonal respiratory viral infections, such as Covid-19, Influenza and Respiratory Syncytial Virus in health and care settings. Updated guidance can be found at Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 - GOV.UK (www.gov.uk).

- As 30 November 2021, face coverings became compulsory in shops, supermarkets, indoor shopping centres, post offices, banks, building societies, estate and letting agents, pharmacies, takeaways without space for the consumptions of food and drink, and on public transport.

- On 4 December 2021 the Government announced that from 7 December anyone aged 12 and above wishing to travel to the UK would need to show a negative pre-departure test (LFD or PCR) as close as possible to departure and not more than 48 hours before to slow the importation of the new variant.

APPENDIX B

Intermediate Minor Oral Surgery East Midlands Stakeholder Briefing

1 Introduction

The purpose of this briefing paper is to provide an update to Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on the engagement outcomes of the Intermediate Minor Oral Surgery services across the East Midlands and plans for recommissioning of services.

2 Background Information

NHS England and NHS Improvement is responsible for commissioning NHS Dental Services
e.g. primary, community and secondary care to meet the local population needs.

Intermediate Minor Oral Surgery (IMOS) is a referral service for over 16 years and is provided within a community setting. The service provides specialist treatment e.g. complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment may be provided under local anaesthetic and the clinician may use quality behavioural management techniques or provide treatment under conscious sedation where appropriate for minor oral surgery procedures. Once the one-off treatment has been completed, the patient is then returned to the referring General Dental Practitioner.

The IMOS contracts are commissioned using a Personal Dental Services (PDS) Agreement, the earliest of which commenced in 2008/09 and are due to expire. The existing contractual agreements have no Units of Dental Activity (UDA) contracted activity nor financial value, financial payments are made in arrears based on claims submitted for cost per case for either assessment, assessment and treatment or assessment, treatment and sedation.

There are 36 IMOS providers across the East Midlands area, which cover Northamptonshire, Leicester, Leicestershire & Rutland, Lincolnshire, Derbyshire and Nottinghamshire. Please see Appendix 1 for existing locations. Due to historic contracting arrangements, the service arrangements are on different contracting terms and payments rates. Within the existing contracting arrangements treatment may be provided under conscious sedation in Derbyshire and Nottinghamshire, however, there is limited access in Lincolnshire/Northamptonshire and no access in Leicester, Leicestershire and Rutland. In 2019/20, the service accepted approximately 37,000 referrals and treated 33,000 patients.

A Midlands IMOS service specification has been developed in line with the Oral Surgery Commissioning Guide to standardised the service model, payments and reduce inequalities in access/treatment under conscious sedation, where appropriate.

3 Engagement Outcomes

As part of the pre procurement planning, it has been agreed to undertake a two-stage engagement and consultation process to seek views and feedback from patients, public and the dental profession.

A four week patient, public and dental profession engagement process was undertaken in May/June 21. Approximately 5,000 patients who had received treatment under the IMOS pathway were contacted to complete the online engagement survey. Communications was sent to Healthwatch, Local Authorities and other voluntary organisations requesting their support to promote the public engagement and all East Midlands dental providers, Oral Surgery Managed Clinical Network, IMOS providers received communications regarding the engagement survey. We received the following responses:

Engagement Group	Number of Responses Received
Patients and/or carers/guardians of patients who have had treatment	167
Public	12
Dental Profession	45
Total	**224**

Outcomes and themes are as follows:

Patients:

- Responses received across all ICS areas with Leicestershire having the largest response rate (58.68%)
- Just over half of patients were not offered choice of IMOS provider
- 78.44% were involved with their treatment decision
- Approximately 50% of patients travelled between 0-5 miles vs 8.98% who travelled more than 21 miles, which increases to 12.5% for Lincolnshire
- Majority of patients felt the distance travelled was acceptable
- 85.63% travelled by car vs 4.19% using public transport; in Leicestershire 57.14% walked to the practice
- 73.65% were satisfied with the waiting time
- 55% waited 3 months; 42.30% waited over 6 months in Lincolnshire vs 15.5% for East Midlands and 29.26% felt they had waited longer for treatment due to impact of COVID
- Majority of patients felt their personal and physical needs were met; however, concerns were raised regarding anxiety due to waiting times; lack of care for those with physical needs due to disability and management of records
- 79.64% did not have any complications, however, there were some poor experiences regarding aftercare and complications following treatment
- 90.41% received one form of aftercare advice vs 7.19% who did not receive any aftercare advice
- 55.69% were extremely satisfied with the service vs 8.38% who were not at all satisfied
- Patients felt: Quality of care; appointment availability; waiting time for treatment and location of services were important when accessing the services

Public:

- Responses received from all ICS areas except Leicester, Leicestershire and Rutland
- Majority of the public were happy to have IMOS treatment within primary care, however, some would prefer treatment in secondary care due to lack of confidence in staff having skills and knowledge to provide treatment
- Over half would feel extremely or very anxious if they had to go for complex extraction
- 100% are happy for a Specialist to be support by a Specialist trainee
- Over half felt it is important services are accessible by public transport (particularly in Nottinghamshire, Derbyshire and Lincolnshire)
- 50% are willing to travel between 16-20 miles to access treatment; 16.67% wiling to travel between 0-5 and 6-10 miles
- The majority would prefer to be seen between 12noon to 5pm, followed by 9 am to 12 noon or after 5pm
- Would like services to be accessible between 9am to 5pm Monday to Saturday and some would like to be seen on a Sunday
- Public felt Quality of care; waiting time for treatment and location of services and car parking availability were important.

Dental Professional:

- Response from all ICSs and health care professionals.
- Majority of dentists have access to digital radiography with 2 respondents advising they use plain film or radiograph facility not computerised.
- Majority of respondents do not provide conscious sedation currently vs 28.89% that do in Nottinghamshire and Derbyshire
- Majority felt clinical triage in the current referral management system pathway is beneficial
- Waiting times; fees/funding and clinic access were identified as the top three improvements
- Confirmed they would be happy to approach a colleague for advice and guidance
- Over half stated they could always or most of time take on an emergency referral within 24 hours for treatment for failed extraction or patient in acute pain
- Identified potential gap in provision of 3a cases being provided and not covered in the draft Midlands Service Specification and potential to impact on secondary care.

The engagement feedback has been considered along with other public health data factors to develop proposed locations for the new services for formal consultation and service specification feedback received from the dental profession has been reviewed.

4 Next Steps

A consultation document for each ICS area will be developed with support from the Communications and Public Health teams. A stakeholder and ICS webinars will be arranged to promote the formal consultation process. The consultation is planned for be undertaken in November/December 21. Feedback will be considered to support finalising the commissioning intentions for tender.

We will continue to update Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on the outcome of the IMOS consultation processes and plans for recommissioning.

Appendix 1 – Existing IMOS Service Locations

Area	Locations
Derbyshire	Derby City Chesterfield Kirk Hallam Alferton Matlock Belper
Nottinghamshire	Nottingham West Bridgford Wollaton Hyson Green Mansfield Keyworth Carlton
Leicester, Leicestershire and Rutland	Leicester Coalville Hinckley Loughborough Market Harborough
Lincolnshire	Lincoln Boston Grantham Gainsborough Skegness

APPENDIX C

Care Quality Commission
Citygate
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www.cqc.org.uk

By email

Mr. Andrew Morgan Chief Executive Officer
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire LN2 5QY

Date: 11 October 2021

CQC Reference Number: INS2-11012116741 Dear

Mr Morgan

Re: CQC Core Service inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Michelle Dunna and Anna Kerrigan on 6 and 8 October 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meetings.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 6 and 8 October 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you was:

Pilgrim Hospital

<u>Children and young persons</u>

- Children and young people were cared for in a safe way.
- Medical staff felt well supported and described a good experience.
- All staff described good educational opportunities

- Staff told us they were proud of the improvements made within the service.

However:

- There was no dedicated pharmacy service which meant staff were often taken away from clinical duties to sort discharge medicines.
- Staff were anxious about being moved to work in adult areas.
- Staff described a poor experience when working in the emergency department but did acknowledge work had been done to address this.
- Staff described delays in in moving children from the emergency department to the ward.

Maternity

- Good MDT working.
- Strong leadership of the service.
- A positive culture.
- No concerns with staffing.
- Good governance processes in relation to management and learning from incidents and risk management.

Medical

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the service specifically, diabetes management, MCA and DoLS, falls and non-invasive ventilation.
- Generally, staff morale was good especially on Ward 6B and Bostonion and staff were happy to work at the Trust.
- Patient feedback was mostly positive.

However:

- There appeared to be no oversight, in terms of leadership, of the discharge lounge which impacted on a good patient experience.
- Staff morale on Ward 6A was poor however, this was not seen to impact on patient care.

Urgent and emergency care

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the care of the deteriorating patient including the recognition and treatment of sepsis.
- Improvements had been made in areas of the department dedicated to the care of children and young people including resus.
- The inspection team saw a good pathway for children and young people.
- All staff were described as caring and doing their best for patients despite an extremely busy environment and patient feedback was positive.
- Where concerns were identified for example, an unlocked medicine cupboard staff responded quickly and appropriately.

However:

- Oversight of flow out of the emergency department did not appear to be given sufficient priority. Some staff felt ‘left to get on with it’ when the department was full.
- Specialties did not appear proactive in ‘pulling’ patients from the department.

- The inspection team expressed concern that where a patient had to remain on an ambulance due to capacity in the department, ED staff would not physically have sight of the patient for a minimum of 60 minutes when the first comfort round was due. They did, however, acknowledge that observations would be carried out and escalated appropriately.

Pharmacy

- The pharmacy team recognised significant improvement in medicines management since our last inspection.
- The MOCH pilot in elderly care was seen as a particular area of good practice.

However:

- The prescription chart within the emergency department lacked scope to add medicines administered outside of the department. I.e. during conveyance or whilst waiting on the ambulance. This meant there was a risk patients could receive more medicines than required.
- Prescribing within the emergency department tended to be for 'immediate' medicines with no mechanism in place to prompt staff to prescribe a patient's regular medicine.

Lincoln County Hospital

Children and young persons

- We saw good MDT working.
- Staff were caring and we observed some good examples of care delivery in the neonatal Unit.
- Staff described good executive oversight of Children and young persons and said it felt better than previously.

However:

- At times, there was no evidence to suggest interpreting service were used when required and we saw two occasions where a relative was used.
- There was no dedicated breast feeding/milk kitchen available.

Maternity

- Comprehensive risk assessments were carried throughout a lady's pregnancy.
- We saw good MDT working.
- We saw areas of good practice. For example, mechanical induction of labour.
- We saw evidence of learning from incidents.
- At the time of our inspection, mums and babies were safe.

However:

- We were concerned midwifery staff were not appropriately trained to recover women post C-Section. However, we have since received information giving assurance that staff are appropriately trained.
- We were not assured staff reported all incidents appropriately.
- The physical environment was in poor condition although we appreciate estates have been on site addressing our issues.
- On two separate occasions we found medicines which were not secure.
- Not all staff appeared engaged, morale was mixed, and we found an inconsistent safety culture with not all staff happy to challenge.

- The temperature of the treatment room was not monitored despite feeling warm. We were concerned that medicines may not be stored at the correct temperature. In addition, there was not restricted access to this room.

Medical

- Staff were patient focused.
- We saw good MDT working with staff describing how supportive they were of each other.
- Patients were safe and appeared well cared for.
- Patient information boards in the ward areas enabled staff to clearly identify where the sickest patient was.
- We saw good record keeping.
- We were told about projects in place to reduce falls and saw positive outcomes on the wards.

However:

- On MEAU there was only one shower for 26 patients (previously 50 patients). This shower was not working. Whilst MEAU was a 'short stay' area, one patient had been on the ward for 14 days. In addition, the area was mixed sex.
- We saw three patients across two wards who were self-medicating with no documented risk assessment in place.
- We saw loose tablets in the clinical area on two wards. On one occasion there were approximately 25 sleeves of unsecure tablets.

Urgent and emergency care

- Local leadership was strong.
- Staff demonstrated a willingness to embrace change and improve.
- Patients were well cared for and patient feedback was overwhelmingly positive.
- We saw good learning from incidents. For example, diabetes.

However:

- We felt there was a lack of ownership of the paediatric area and did not feel there was one individual taking the lead.
- We saw some inconsistencies with record keeping especially in relation to risk assessments for falls and mental health.
- The medicines room door was open for the entirety of the inspection.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair

Dale Bywater, Midlands Regional Director NHSEI

Jonathon Davies, CQC regional communications manager

APPENDIX D

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon
Tyne NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Mr. Andrew Morgan Chief Executive Officer United
Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire LN2 5QY

Date: 12 November 2021

CQC Reference Number: INS2-11012116741

Dear Mr Morgan

Re: CQC Well Led inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Sarah Dunnett, Michelle Dunna, Caroline Bell and Garry Marsh on 11 November 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 11 November 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

W1. There is the leadership capacity and capability to deliver high quality, sustainable care.

- There is a strong, cohesive leadership team.
- There is a strong board development programme.

W2. There is a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.

- There was bold decision making of the board that underpinned a well-planned and understood strategy.

W3. There is a culture of high-quality, sustainable care.

- Without exception the patient is now at the heart of this organisation.
- The organisation's approach to changing the culture is supported by credible plans and a palpable energy within the board.
- The work that has already started needs to continue at pace to ensure the requirements of duty of candour are met.

W4. There are clear responsibilities, roles and systems of accountability to support good governance and management at board level.

- However, there are inconsistencies in its application at some levels of leadership across the organisation of which, the trust has plans in place to address.

W5. There are clear and effective processes for managing risks, issues and performance.

- The trust should continue to ensure they are using timely data to gain assurance and continue their described work on the integrated performance report.
- The trust should continue to review and manage the work required to improve medicines management across the organisation.

W6. Appropriate and accurate information is being effectively processed challenged and acted on.

W7. People who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services.

- There are positive and collaborative relationships with stakeholders and providers across the Lincolnshire system.
- There is executive presence across all sites, engaging with staff at all levels.

W8. There are robust systems and processes for learning, continuous improvement and innovation.

- Quality improvement is embedded across the organisation and we have heard of some good examples where the quality and safety of patient care has improved.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

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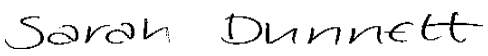
Yours sincerely



Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair
Dale Bywater, Midlands Regional Director NHSEI Jonathon
Davies, CQC regional communications manager

APPENDIX E

HEALTH AND CARE BILL 2021-22

Introduction

The Health and Care Bill was introduced in Parliament in July 2021. The Government has stated that the purpose of the Bill is to give effect to the policies that were set out as part of the NHS's recommendations for legislative reform following the Long Term Plan and in the White Paper *Integration and Innovation: Working together to Improve Health and Social Care for All,* published in February 2021.

The Government's stated aim is that the Bill will :

- promote local collaboration;
- reform the NHS Provider selection regime;
- improve accountability and enhance public confidence in the health and care system; and
- deliver a range of targeted measures to support people at all stages of life.

The Health and Care Bill has completed its House of Commons stages and is currently due for its second reading in the House of Lords on 7 December 2021. On arriving in the House of Lords, the Bill comprised 154 clauses and 17 schedules. The main provisions in the Bill are as follows:

Establishment of NHS England

The term 'NHS England' has been widely used for several years to describe the NHS Commissioning Board, which was established by the Health and Social Care Act 2012. Two other legislative entities 'Monitor' and the 'Trust Development Authority' had in effect previously merged to form NHS Improvement from 1 April 2016. In turn, NHS England and NHS Improvement have been working as a single organisation since 1 April 2019, referred to as NHS England and NHS Improvement. The Bill seeks to abolish Monitor and the Trust Development Authority, and transfer their functions to NHS England, as a new statutory entity.

Establishment of NHS Integrated Care Boards and Abolition of Clinical Commissioning Groups

The Health and Social Care 2012 led to the establishment of 211 clinical commissioning groups across England, with responsibilities for the planning and commissioning of health care services in local areas. Clinical commissioning groups assumed many, but not all the functions, of primary care trusts which were abolished by the 2012 Act. Following a series of mergers, there are currently 106 clinical commissioning groups in England.

Since 2016, health and care organisations have increasingly been working together to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups. Non-statutory integrated care systems (ICSs) have been formed to bring together commissioners and providers.

The Bill proposes the establishment of NHS integrated care boards (ICBs), which will assume the commissioning functions of the CCGs, as well as some of NHS England's commissioning functions. However, the Government states that an ICB will not simply be a larger clinical commissioning group and it will be expected to work differently in practice. Its governance model will reflect the need for integration and collaboration across the system and it will also be directly accountable for NHS expenditure and performance within the system.

In anticipation of the new legislation, NHS England and NHS Improvement has been publishing detailed guidance on ICS and ICB development. The Lincolnshire ICS is co-terminous with the boundary of the county council and will be formally named: *Better Lives Lincolnshire*; and the name of the ICB will be: *NHS Lincolnshire Integrated Care Board*.

Establishment of Integrated Care Partnerships

Each NHS integrated care board and its partner local authorities will be required to establish an integrated care partnership (ICP), which will bring together health, social care and public health. Each ICP will be tasked with developing a strategy to address the health, social care and public health needs of its system. The NHS ICB and local authorities will have to have regard to that plan when making decisions. In Lincolnshire, the Health and Wellbeing Board has been undertaking the role of ICS Partnership board in shadow form.

Reconfiguration of NHS Services

The Bill provides several powers to the Secretary of State in relation to health service reconfigurations, which are summarised as follows:

- If an NHS commissioning body proposes a reconfiguration of its NHS services it must notify the Secretary of State.
- If an NHS commissioning body, NHS trust or NHS foundation trust is aware of circumstances that it thinks are likely to result in a need for the reconfiguration of NHS services, it must notify the Secretary of State.
- The Secretary of State may give an NHS commissioning body a direction calling in any proposal by the body for the reconfiguration of NHS services.
- Where a direction is given as above, the Secretary of State may take any decision in relation to the proposal that could have been taken by the NHS commissioning body.

The Secretary of State must publish guidance on the above provisions and a reconfiguration of NHS services is defined as a change in the arrangements made by an NHS commissioning body for the provision of NHS services where that change has an impact on: (a) the manner in which a service is delivered to individuals (at the point when the service is received by users), or (b) the range of health services available to individuals.

Guidance on the Bill issued to the House of Lords on 24 November 2021 states that these new powers are intended to be used in cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action. Cases such as these can lead to difficult debate and lengthy processes. To support this intervention power, the current referral power of health overview and scrutiny committees will be amended, but there is no intention to remove the requirement to involve these committees in reconfigurations.

Powers to Direct NHS England

The Bill provides further powers to the Secretary of State to direct NHS England, for example to ensure that NHS England continues to work effectively with other parts of the system for which the Secretary of State has responsibility including social care and public health, to support integration and tackle broader priorities such as health inequalities. There are also powers to direct NHS England to take on certain public health functions.

Other Provisions

The Bill also includes provisions relating to:

- hospital discharge arrangements;
- the regulation of professional bodies;
- medical examiners within the NHS to investigate deaths;
- reimbursements to pharmacies;
- hospital food standards;
- reducing exposure to advertising of less health food and drink;
- water fluoridation; and
- powers to amend retained EU law.

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