NHS
United Lincolnshire Hospitals
NHS Trust

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

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-06	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure that staff complete mandatory training in line with trust targets. Including but not limited to the highest level of life support, safeguarding and mental capacity training.	All	The Trust's established process for overseeing and targeting improvement around mandatory training and appraisal rates will be strengthened as a result of an increased focus through the Performance Review Meetings (PRM) with increased assurance reporting to the People and Organisational Development Sub-Committee of the Board. Improvement trajectories will be set via the PRM process with divisions. Target to achieve is 95% to have completed mandatory training. Key performance indicators to be included to summarise progress along with highlight reporting.	Claire Low (Deputy Director of People)	31-Mar-23	Amber		Mandatory training reporting at Divisional PRMs; Assurance reporting through to People and OD committee.	(1) Mandatory training reporting at Divisional PRMs; (2) Assurance reporting through to People and OD committee.		Paul Matthew, Director of Finance and OD	People and Organisational Development Committee (PODC)

Reporting to sub-committee for assurance	People and Organisational Development Committee (PODC)
Accountable Executive Lead	Paul Matthew, Director of Finance and OD
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	(1) Reporting to PODC committee on progress with workforce plans; (2) Progress with key workforce indicators.
Evidence available to demonstrate completion	Reporting to PODC committee on progress with workforce plans; Progress with key workforce indicators.
Date action completed	
Completeness rating	Amber
Deadline	31-Mar-23
Action Lead	Helen Clark (Assistant Director of Nursing for Workforce & Education) Claire Low (Deputy Director of People) Lisa Geraghty (HR)
Local action agreed to resolve the issue	The Trust has already established work streams focussed on ensuring sufficient nursing and medical staff. The Nursing work stream includes the process for twice daily oversight arrangements, annual nurse staffing reviews for all ward areas led by the Director of Nursing and reporting through to Trust Board. This is supported by the Trust's 5-year workforce plan which includes new and emerging roles. Key performance indicators to be included to summarise progress along with highlight reporting.
Core Service	All
CQC Must Do / Should Do / Issue	The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
Immediate/ Must Do/Should Do/	Should Do
Recommendation Source	Core services inspection
Trust/ Site	Trust
Core Service	Trust wide
URN	CQC2021-07

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

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

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

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

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Karen Dunderdale, Director of Nursing	Karen Dunderdale, Director of Nursing	Karen Dunderdale, Director of Nursing
On completion: Outcome - How has the action been met?			
Evidence available to track that action remains completed and embedded	Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).	Metrics for ongoing assurance: Established schedule for reflection in future on information needs for local patients (obtained from Patient Experience Team).	None.
Evidence available to demonstrate completion	Evidence of listening opportunities from divisions to identify information resources required by local population.	Evidence of information resources completed in response to listening events with patients; Evidence of these resources being entered onto the information resource register (held by Patient Experience team).	Register of locally held patient information resources being provided to patients.
Date action completed			
Completeness rating	Amber	Amber	Amber
Deadline	Set with divisions.	To confirm on completion of listening events with patients.	Set with divisions.
Action Lead	plan owners (with support from FAB	Who: Divisional CQC action plan owners to nominate lead 'information owners'.	Divisional CQC action plan owners to nominate
Local action agreed to resolve the issue	Divisions to reach out to patients in their areas to determine what information resources are required that do not currently exist (including UEC and advice cards).	Divisions to assign 'information owners' to provide information resources in response to feedback from local patients.	Divisions to undertake a walk-around/audit of current patient information resource available and being provided to patients within the division and compile a register, to include what languages the information is available in.
Core Service	All	All	All
CQC Must Do / Should Do / Issue			
Immediate/ Must Do/Should Do/			
Recommendation Source			
Trust/ Site			
Core Service			
URN			

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

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

Reporting to sub-committee for assurance	Accountable Executive Lead	On completion: Outcome - How has the action been met?	Evidence available to track that action remains completed and embedded	Evidence available to demonstrate completion	Date action completed	Completeness rating	Deadline	Action Lead	Local action agreed to resolve the issue	Core Service	CQC Must Do / Should Do / Issue	Immediate/ Must Do/Should Do/	Recommendation Source	Trust/ Site	Core Service	URN
Finance, Performance and Estates Committee (FPEC)	Simon Evans, Chief Operating Officer		None.	Evidence of findings from 6- facet survey; Evidence of inclusion of key areas from the 6-facet survey into the Trust's estate plans.		Amber	31-Dec-22	Michael Parkhill (Director of Estates & Facilities)	Undertake a 6-facet survey to refresh the Trust's understanding of current estate conditions to further support the Trust to take a risk based approach.	All	premises and equipment keep patients safe.					
Finance, Performance and Estates Committee (FPEC)	Simon Evans, Chief Operating Officer		(1) FPEC assurance reporting of progress with planned preventative maintenance regime; (2) FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; (3) PAM assurance reporting into FPEC; (4) FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; AE reporting from key subgroups (i.e. water, fire, electrical).	FPEC assurance reporting of progress with planned preventative maintenance regime; FPEC assurance reporting of findings following Authorised Engineer (AEs) reviews; PAM assurance reporting into FPEC; FPEC assurance reporting of progress with reducing the estates backlog and controls in place to prevent backlog from developing; AE reporting from key subgroups (i.e. water, fire,		Amber	31-Mar-23	Michael Parkhill (Director of Estates & Facilities)	The Trust is continuing to focus on strengthening its Planned Preventative Maintenance (PPM) regime with ongoing assurance reporting through the Trust's Finance, Performance and Estates Committee. This is supported by the appointed Authorising Engineers (AEs) across the Trust focussed on all aspects. The Premises Assurance Model (PAM) provides a key assurance function as part of this process. This is a business as usual action.	All						

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BRAG Rating Matrix	
Blue	Completed and embedded.
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URN	Core Service	Trust/ Site	Recommend ation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-01	Urgent & Emergency Care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	UEC	The flowchart describing the correct process has been reinforced within ED. This will be supported by the Safeguarding team who have commenced education work with key staff as part of team huddles and supervision sessions. This education work will be completed by 30 November 2021. A record of staff trained will be maintained for assurance.	Elaine Todd (Named Nurse for Safeguarding Children and Young People); Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie Peet and Sharon Laverton / Vikki Hoadley (ED Clinical Educators)	31-Mar-2022	Amber		(1) Training records for ED staff; (2) Evidence of this being added to UEC risk register.	(1) Monthly audit to be undertaken to test compliance; (2) Evidence this has been added to Nursing induction as a core competency.		Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Karen Dunderdale, Director of Nursing	Karen Dunderdale, Director of Nursing
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	(1) Monthly audit to be undertaken to test compliance.	undertaken to test compliance; (2) Evidence this has been added to Nursing induction as
Evidence available to demonstrate completion	(1) Audit findings / report; (2) Action plan in response.	(1) Evidence of access arrangements to Care Portal being in place for existing staff.
Date action completed		
Completeness rating BRAG	Green	Amber
Deadline	31-Jan-2022	31-Mar-2022
Action Lead	Elaine Todd (Named Nurse for Safeguarding Children and Young People)	Holly Carter / Jemma Bowler (Senior Sister, ED); Ellie and Sharon (ED Clinical Educators)
Local action agreed to resolve the issue	A compliance audit was already planned by the Safeguarding team, this will be undertaken as planned on this process retrospectively and will be completed by 5 November 2021. A re-audit will be undertaken following delivery of educational sessions. This will be completed by 31 January 2022.	A list of those who cannot access care-portal within ED is needed and then access needs to be requested from IT.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue	The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	
Immediate/ Must Do/ Should Do/	Must Do	
Recommend ation Source	Core services inspection	
Trust/ Site	Pilgrim Hospital	
Core Service	Urgent & Emergency Care	
URN	CQC2021-04	

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

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	
Accountable Executive Lead	Simon Evans, Chief Operating Officer	(1) Audit evidence of the new CAS card being used in practice and recording where patient has been seen – including ambulance.
On completion: Outcome - How has the action been met?	This additional field makes it easier, at the time of undertaking a harm review, for harm to be accurately assessed related to waiting times/locations.	(1) Amended casualty card.
Evidence available to track that action remains completed and embedded	(1) Random, snapshot sample of UEC Clinical Harm reviews	
Evidence available to demonstrate completion	(1) Email request for the UEC harm reviews to include a specific field to capture the time patients receive their first assessment; (2) Completed amended harm review template.	
Date action completed		31-Mar-2022
Completeness rating BRAG	Blue	Amber
Deadline	01-Nov-2021	Blanche Lentz (Clinical Services Manager UEC)
Action Lead	Cheryl Thomson (General Manager)	PHP log not felt to be best solution, amendments to CAS card instead have been made that include location of the patient when handed over.
Local action agreed to resolve the issue	Inclusion of additional field into the Harm template to ensure this is more clearly evidenced from harm reviews.	within 30 minutes where the national early warning score is five or more or requiring prioritisation. Regulation 12 Safe care and treatment.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue	The service must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Patients waiting on ambulances should be reviewed by medical staff within an hour and	
Immediate/ Must Do/ Should Do/	Must Do	
Recommend ation Source	Core services inspection	
Trust/ Site	Pilgrim Hospital	
Core Service	Urgent & Emergency Care	
URN	CQC2021-05	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	Clinically agreed guidance exists to support the Emergency Department consult and seek assistance from specialties for patients waiting in the department. The guidance includes a commitment for specialties to pull patients out of the Emergency Department. Evidence of impact from these standardised admission pathways is now needed.
Evidence available to track that action remains completed and embedded	(1) Copy of the standardised admission pathway guidance.
Evidence available to demonstrate completion	(1) Copy of the standardised admission pathway guidance; Minutes from the Urgent Emergency Care Clinical Standards Group evidencing approval of guidance.
Date action completed	
Completeness rating BRAG	Blue
Deadline	
Action Lead	Urgent Emergency Care Clinical Standards Group
Local action agreed to resolve the issue	Develop clinically led standardised admission pathways guidance to support ED teams identify: .The primary specialty to take ownership for the ongoing care from the ED .If necessary, and additional MDT input required, this will be undertaken by the primary speciality. These have been agreed by the group, this was ratified during May and June 2021.
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	(1) Evidence that SOP has been added to the Trust's controlled documents procedures and is available for staff to access easily to guide them; Evidence that SOP has a timely review date to ensure guidance remains updated and fit for purpose.
Evidence available to demonstrate completion	(1) Revised SOP completed and approved. (2)
Date action completed	
Completeness rating BRAG	Amber
Deadline	31-Mar-2022
Action Lead	Cheryl Thomson (General Manager)
Local action agreed to resolve the issue	Review and update the 'Management of Reducing Ambulance Delays in the Emergency Departments' SOP. Ensure this includes links to wider corporate policies and SOPs (i.e. Full Capacity Protocol and the Ambulance Turnaround Protocol) and includes all relevant roles (i.e. Pre-Hospital Practitioners (PHP) and Hospital Liaison Officers (HALO)) and makes it clear that patients are being seen regardless of location (i.e. on ambulances during extreme pressures).
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	None.	[1] Evidence that performance with key metrics, as part of revised SOP, are being used for ongoing monitoring of performance against key metrics; Evidence of audit data being used for improvement purposes.
Evidence available to demonstrate completion	[3] (1) Revised SOP included within the Clinical Operational Flow Policy.	[4] (1) Evidence of effectiveness measures for ongoing monitoring of performance against key metrics.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	31-Mar-2022	31-Mar-2022
Action Lead	Michelle Harris (Deputy Chief Operating Officer)	Cheryl Thomson (General Manager)
Local action agreed to resolve the issue	Add the SOP into the Clinical Operational Flow Policy.	Revised SOP to include effectiveness measures to track progress with key metrics: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking to provide ongoing assurance against SOP.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue		
Immediate/ Must Do/ Should Do/		
Recommend ation Source		
Trust/ Site		
Core Service		
URN		

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	[1] Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit; [2] Evidence of audit data being used for improvement purposes.
Evidence available to demonstrate completion	[5] (1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.
Date action completed	
Completeness rating BRAG	Amber
Deadline	31-Mar-2022
Action Lead	Maxine Skinner (Lead Nurse Urgent & Emergency Care)
Local action agreed to resolve the issue	In the interim, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment ≤ 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	(2) None.
Evidence available to demonstrate completion	(6) (1) Development of Clinical Audit Project plan.
Date action completed	
Completeness rating BRAG	Amber
Deadline	30-Apr-2022
Action Lead	Maxine Skinner (Lead Nurse Urgent & Emergency Care)
Local action agreed to resolve the issue	Scope out the inclusion of performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking as part of the Trust's Clinical Audit Programme to provide further external assurance.
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	[3](1) Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	[4](1) Random, snapshot sample of UEC Clinical Harm reviews
Evidence available to demonstrate completion	[1]Completed audit tool; [7]Evidence of audit tool being used to collect data against key metrics as part of monthly matrons audit.	[1]Email request for the UEC harm reviews to include a specific field to capture this; [2]Copy of amended harm template.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	31-Mar-2022	31-Mar-2022
Action Lead	Jeremy Daws (Head of Compliance)	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)
Local action agreed to resolve the issue	Develop an audit tool to obtain this assurance with key milestones. Feed into monthly CBU governance reporting process (escalations to divisions and PRM).	Add into Harm Review proforma - Has patient been seen within 1 hour. Review in 3 months to see if this is giving assurance needed.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue		
Immediate/ Must Do/ Should Do/		
Recommend ation Source		
Trust/ Site		
Core Service		
URN		

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	[5] (1) Ongoing monthly assurance reporting.
Evidence available to demonstrate completion	[2] (1) Ongoing monthly assurance reporting.
Date action completed	
Completeness rating BRAG	Amber
Deadline	30-Apr-2022
Action Lead	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)
Local action agreed to resolve the issue	Provide a monthly overview of performance against these key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking. In addition to other related metrics (i.e. time to first assessment etc.) to Governance meeting process.
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	[6] (1) Ongoing monthly assurance reporting.
Evidence available to demonstrate completion	[3] (1) Ongoing monthly assurance reporting.
Date action completed	
Completeness rating BRAG	Amber
Deadline	31-May-2022
Action Lead	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)
Local action agreed to resolve the issue	Build monthly assurance reporting of key milestones into one of the standard ED assurance processes so this becomes a standard feature of the ED assurance process.
Core Service	UEC
CQC Must Do / Should Do / Issue	
Immediate/ Must Do/ Should Do/	
Recommend ation Source	
Trust/ Site	
Core Service	
URN	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	[1] Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; [2] Performance against deteriorating patient audits (sepsis); [3] Ongoing monthly assurance reporting as part of S.31 response process; [7] Completed harm reviews.
Evidence available to demonstrate completion	[1] Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; [2] Performance against deteriorating patient audits (sepsis); [4] ED Daily Assurance Tool.
Date action completed	
Completeness rating BRAG	Amber
Deadline	31-Mar-2022
Action Lead	Maxine Skinner (Lead Nurse Urgent & Emergency Care)
Local action agreed to resolve the issue	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.
Core Service	UEC
CQC Must Do / Should Do / Issue	The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
Immediate/ Must Do/ Should Do/	Should Do
Recommend ation Source	Core services inspection
Trust/ Site	Pilgrim Hospital
Core Service	Urgent & Emergency Care
URN	CQC2021-35

URN	Core Service	Trust/ Site	Recommend ation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Core Service	Local action agreed to resolve the issue	Action Lead	Deadline	Completeness rating BRAG	Date action completed	Evidence available to demonstrate completion	Evidence available to track that action remains completed and embedded	On completion: Outcome - How has the action been met?	Accountable Executive Lead	Reporting to sub-committee for assurance
CQC2021-33	Urgent & Emergency Care	Pilgrim Hospital	Core services inspection	Should Do	The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.	UEC	*(Same action above in reference to 'Must-do' action)* In the interim, whilst SOP being revised, undertake monthly, matron led, snapshot assessments of patients waiting longer on ambulances to track performance with key milestones: (a) PHP assessment (face to face) < 15 minutes; (b) Doctor assessment < 1 hour; (c) Doctor assessment < 30 minutes if NEWS > 5; (d) Assurance that NEWS observations in the ambulance by PHP are recorded on WebV for ongoing monitoring and tracking.	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	31-Mar-2022	Amber		(1) Monthly matrons audits of patients waiting on ambulances demonstrating performance against key metrics; (2) Performance against deteriorating patient audits (sepsis); (3) ED Daily Assurance Tool.	(1) Assurance evidence available following revision of SOP/monthly matrons audits for patients waiting on ambulances; (2) Performance against deteriorating patient audits (sepsis); (3) Ongoing monthly assurance reporting as part of S.31 response process; (4) Completed harm reviews.		Simon Evans, Chief Operating Officer	Quality Governance Committee (QGC)

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Karen Dunderdale, Director of Nursing	Karen Dunderdale, Director of Nursing
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	[1] Ongoing regular reporting of DoC into CBU Governance; [4] Ongoing inclusion within the Divisional PRM process.	[2] (1) Use of data to inform improvement action plans.
Evidence available to demonstrate completion	[1] Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements; [3] Inclusion within the Divisional PRM process.	[2] (1) Performance reporting of DoC for CBU (verbal and written) into monthly CBU governance arrangements.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	31-Mar-2022	31-Mar-2022
Action Lead	Maxine Skinner (Lead Nurse Urgent & Emergency Care)	Maxine Skinner (Lead Nurse Urgent & Emergency Care)
Local action agreed to resolve the issue	Understand performance with DoC at CBU Level and ensure reliable data is available to feed into monthly Clinical Governance processes.	Review DoC performance data and, through CBU Governance, scope additional improvement actions to be taken.
Core Service	All	All
CQC Must Do / Should Do / Issue	The trust should ensure the requirements of duty of candour are met.	
Immediate/ Must Do/ Should Do/	Should Do	
Recommend ation Source	Core services inspection	
Trust/ Site	Trust	
Core Service	Trust wide	
URN	CQC2021-09	

Reporting to sub-committee for assurance	Finance, Performance and Estates Committee (FPEC)	Finance, Performance and Estates Committee (FPEC)
Accountable Executive Lead	Paul Matthew, Director of Finance and OD	Paul Matthew, Director of Finance and OD
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	[1]Action in response to the review and inclusion as part of the B7 daily assurance process; [3]Improvements in the security of records observed.	[1]Action in response to the review and inclusion as part of the B7 daily assurance process; [2]Improvements in the security of records observed.
Evidence available to demonstrate completion	[3](1) Amended B7 Daily assurance proforma.	[4](1) Evidence of a review of note storage controls and identification of any gaps.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	31-Mar-2022	30-Apr-2022
Action Lead	Maxine Skinner (Lead Nurse); Denise Dodd (Matron, Urgent & Emergency Care); Jemma Bowler & Holly Carter (Senior Sister, ED)	Holly Carter (Senior Sister, ED)
Local action agreed to resolve the issue	Matrons audits in place currently that monitor this, but this is a recurrent problem. Senior Sisters and Lead Nurse to meet to refine the contents of the B7 daily assurance process which will support proactive action to address performance issues.	Review availability of CAS card trolleys availability at Pilgrim.
Core Service	All	All
CQC Must Do / Should Do / Issue	The trust should ensure all patient records and other person identifiable information is kept secured at all times.	
Immediate/ Must Do/ Should Do/	Should Do	
Recommend ation Source	Core services inspection	
Trust/ Site	Trust wide Trust	
Core Service		
URN	CQC2021-12	

Reporting to sub-committee for assurance	Karen Dunderdale, Director of Nursing	Quality Governance Committee (QGC)
Accountable Executive Lead		Karen Dunderdale, Director of Nursing
On completion: Outcome - How has the action been met?	(1) Inclusion of patient information within the UEC Governance meeting process/schedule.	
Evidence available to track that action remains completed and embedded	(3) (1) Inclusion of patient information within the UEC Governance meeting process/schedule.	(4) None.
Evidence available to demonstrate completion	(5)	(1) Evidence of undertaking review of information resources currently available; (2) Review at Governance of review and any gaps identified where further (6) resources are required.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	Cheryl Thomson (General Manager)	30-Jun-22
Action Lead	do not currently exist (including UEC and advice cards).	Manager), Maxine Skinner (Lead Nurse,
Local action agreed to resolve the issue		Undertake a review of the patient information and identify any gaps where additional information is required.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue	Should Do	
Immediate/ Must Do/ Should Do/	Core services inspection	
Recommend ation Source	Trust	
Trust/ Site	Trust wide	
Core Service		
URN	CQC2021-13	

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	Quality Governance Committee (QGC)
Accountable Executive Lead	Karen Dunderdale, Director of Nursing	Karen Dunderdale, Director of Nursing
On completion: Outcome - How has the action been met?		
Evidence available to track that action remains completed and embedded	[5](1) Ongoing review of information resources available and at UEC Governance as evidenced by document control register.	[6]None.
Evidence available to demonstrate completion	[7](1) Register of information resources currently available.	[21]Copies of resource available; [8]Scope out further milestones required/timescales/leads at this time.
Date action completed		
Completeness rating BRAG	Amber	Amber
Deadline	30-Jun-22	31-Mar-22
Action Lead	Cheryl Thomson (General Manager), Maxine Skinner (Lead Nurse, UEC)	Sharon Kidd
Local action agreed to resolve the issue	Collate a register of information resources in use within UEC and submit this to the Patient Experience Team to support the strengthening of internal document control processes in relation to patient information.	Patient Experience team to work with Maxine Skinner and Denise to ensure communication aids and resource folders are available in the department and agree further actions to ensure these resources are communicated with the wider team and made use of.
Core Service	UEC	UEC
CQC Must Do / Should Do / Issue		
Immediate/ Must Do/ Should Do/		
Recommend ation Source		
Trust/ Site		
Core Service		
URN		

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)	nce and Estates	Performance and Estates Committee
Accountable Executive Lead	Karen Dunderdale, Director of Nursing	Evans, Chief Operating	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?		None.	TBC
Evidence available to track that action remains completed and embedded	None.		
Evidence available to demonstrate completion	(1) Scoped out detail of what resources would support improved communication with patients presenting in UEC; (2) Scope out further milestones required/timescales/leads at this time.	(1) Scoped out plan for recruitment of a play specialist.	TBC
Date action completed			
Completeness rating BRAG	Amber	Amber	Amber
Deadline	30-Apr-22	30-Sep-2022	30-Sep-2022
Action Lead	UEC leads with support from Patient Experience Team.	Bowler (Senior	Jemma Bowler (Senior Sister, ED)
Local action agreed to resolve the issue	Patient Experience team to determine with UEC leads how communication with patients/carers whose first language is not English is currently facilitated and determine what resources would support this to be more effective.	Scope out employment for a play specialist for ED area.	Review arrangements for 1:1 supervision of patients with mental health needs at Lincoln ED.
Core Service	UEC	UEC	UEC
CQC Must Do / Should Do / Issue			
Immediate/ Must Do/ Should Do/			
Recommend ation Source			
Trust/ Site			
Core Service			
URN			

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

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

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

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

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

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

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

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

Quality Governance Committee (QGC)	Simon Evans, Chief Operating Officer		None.	(1) Approved TOR; (2) Minutes evidencing approval of TOR.		Amber	31-Mar-2022	Cheryl Thomson (General Manager)	Refresh CBU Governance process and arrangements for 2022/23 with renewed TOR for UEC Governance and Cabinet meetings.	UEC	The trust should ensure, the paediatric area within the Emergency Department, governance processes are fully implemented and aligned to the Royal College of Paediatrics and Child Health (RCPCH) standards for children in the emergency department.	Should Do	Core services inspection	Lincoln County Hospital	Urgent & Emergency Care	CQC2021-17

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

Quality Governance Committee (QGC)
Karen Dunderdale, Director of Nursing
(1) Ongoing evidence of Risk Register review; (2) Evidence from meeting documentation that risk register is being reviewed and is effectively capturing risks.
(1) Evidence that risks on the register have a named owner; (2) Risks should be clear and concise; (3) Risks should be reviewed in line with timescales within Trust (new) policy: Very high (20-25): Monthly review; High risk (15-16): review quarterly; Moderate risk (8-12): review quarterly; Low/very low (4-6; 1- 3) review 6-monthly; (4) Datix version of risk register to be updated after every review.
Amber
30-Apr-2022

Dr David Flynn (Clinical Lead - A&E); Cheryl Thompson (General Manager); Maxine Skinner (Lead Nurse)

CBU Risk Register has been refreshed. Embed regular review of risk register at strengthened Governance meeting process.
UEC
The trust should ensure effective systems are in place to review the service risk register.
Should Do
Core services inspection
Lincoln County Hospital
Urgent & Emergency Care
CQC2021-18

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

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

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

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

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

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

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

NHS United Lincolnshire Hospitals NHS Trust

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.	
Should Do	
Core services inspection	
Lincoln County Hospital	
Maternity	
CQC2021-28	

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

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

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

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

NHS
United Lincolnshire Hospitals
NHS Trust

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

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

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

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

Reporting to sub-committee for assurance	Finance, Performance and Estates Committee (FPEC)
Accountable Executive Lead	Simon Evans, Chief Operating Officer
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	(1) Assurance evidence the checklist is in use when opening a ward.
Evidence available to demonstrate completion	(1) Revised checklist for opening a ward; (2) Assurance evidence the checklist is in use when opening a ward; (3) Inclusion within the Trust's document control processes.
Date action completed	
Complete ness rating	Amber
Deadline	31-May-2022
Action Lead	Katy Mooney (Divisional Lead Nurse)
Local action agreed to resolve the issue	Standardise and merge out-of-hours checklist with Divisional checklist and ensure this is accessible and version controlled as part of the Trust's documentation control processes and procedures. Katy to chair a meeting of matrons and lead nurses across divisions and with OPs team.
Core Service	Medical
CQC Must Do / Should Do / Issue	The trust should ensure that safety checks of new ward environments are fully completed before moving patients.
Immediate/ Must Do/ Should Do/	Should Do
Recommendation Source	Core services inspection
Trust/ Site	Lincoln County Hospital
Core Service	Medical care (including older people's care)
URN	CQC2021-26

Reporting to sub-committee for assurance	Quality Governance Committee (QGC)
Accountable Executive Lead	Colin Farquharson, Medical Director
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	(1) CEG Quarterly Report; (2) CQC Insights data.
Evidence available to demonstrate completion	
Date action completed	
Completeness rating	Amber
Deadline	31-Mar-2023
Action Lead	National Audit leads (with support from Trust Audit Team)
Local action agreed to resolve the issue	With support from the Trust's audit department, embed the process that all national audits are participated in, presented at the respective audit meetings, discussed at Governance and an action plan agreed.
Core Service	Medical
CQC Must Do / Should Do / Issue	The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.
Immediate/ Must Do/ Should Do/	Should Do
Recommendation Source	Core services inspection
Trust/ Site	Lincoln County Hospital
Core Service	Medical care (including older people's care)
URN	CQC2021-27

Reporting to sub-committee for assurance	People and Organisational Development Committee (PODC)
Accountable Executive Lead	Paul Matthew, Director of Finance and OD
On completion: Outcome - How has the action been met?	
Evidence available to track that action remains completed and embedded	
Evidence available to demonstrate completion	
Date action completed	
Complete ness rating	Amber
Deadline	30-Apr-2022
Action Lead	Jeremy Daws (Head of Compliance)
Local action agreed to resolve the issue	Scope out with HR/ESR level of access Ward managers have already to ESR which provides oversight in relation to training compliance levels within their teams.
Core Service	Medical
CQC Must Do / Should Do / Issue	The trust should consider giving ward managers direct access to training systems for their areas in order to monitor and action mandatory training needs of their teams on a more regular basis.
Immediate/ Must Do/ Should Do/	Should Do
Recommendation Source	Core services inspection
Trust/ Site	Pilgrim Hospital
Core Service	Medical care (including older people's care)
URN	CQC2021-43

United Lincolnshire Hospitals NHS Trust

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-01	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. We were not assured there was a system in place to check an approved national child protection information sharing system for children attending the department. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided assurance this process had been in place previously and would be reinstated. Systems were in place to add an alert to emergency department electronic patient record should there be a safeguarding concern. For example, to identify children and young people who attend frequently. (Page 188; Safe)
CQC2021-04	Urgent and emergency care	Pilgrim Hospital	Core services inspection	Must Do	The service must ensure systems and processes to check nationally approved child protection information sharing systems are fully embedded and compliance is monitored. Regulation 13 Safeguarding service users from abuse and improper treatment.	Systems and processes to check nationally approved child protection information sharing systems were not embedded. Whilst there was a process in place to check an approved national child protection information sharing system for children attending the department, staff were not following this. This meant opportunities to review any current safeguarding risks associated with the child were potentially missed. Following the inspection, the service provided us with a plan for this to be reinstated fully by 30 November 2021. A flowchart describing the process had been shared within staff. The safeguarding team had commenced education sessions with key staff as part of team huddles and supervision sessions. (Page 29; Safe)
CQC2021-02	Urgent and emergency care	Lincoln County Hospital	Core services inspection	Must Do	The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.	The number of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover at County Hospital has mostly been worse than the Midlands and England averages. Between March and September 2021 there were 1,322 patients waiting over an hour. Whilst processes were in place to improve the safe care of patients waiting on ambulances, patients had to wait until there was space in the department to be assessed and treatment commenced. (Page 206: Responsive)

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

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

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

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

URN	Core Service	Trust/ Site	Recommendation Source	Immediate/ Must Do/ Should Do/	CQC Must Do / Should Do / Issue	Context - Taken from the report (why was this identified as an issue)
CQC2021-09	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure the requirements of duty of candour are met.	The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. For the reporting period October 2020 to September 2021, compliance with the duty of candour regulation had been variable (verbal compliance 84%, written compliance 68%). The board were sighted on duty of candour performance and had taken a number of actions to address this. Further planned actions included; commissioning a piece of investigative work to review the way in which the trust record duty of candour compliance to try and understand the variability in the data, refresher training for staff covering duty of candour requirements and a review of the trust's duty of candour policy and related documentation to ensure it was fit for purpose. (Page 13) **UEC - Pilgrim (Page 41; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, three serious incidents we reviewed showed duty of candour was not applied in line with trust policy. **Maternity - Pilgrim (Page 64; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Pilgrim (Page 76; Safe):** Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. **CYP - Pilgrim (Page 103; Safe):** They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed governance meeting minutes and found that duty of candour had been used for each of the incidents discussed. **Maternity - Lincoln (Page 127; Safe):** Serious incident reports showed that incidents were investigated thoroughly and women and their families were invited to be involved in these investigations. Staff understood the duty of candour. Serious incident reports evidenced that staff were open and honest when things went wrong. **Medical Care - Lincoln (Page 139; Safe):** Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. **CYP - Lincoln (Page 164; Safe):** Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a legal requirement; every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

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

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CQC2021-11	Trust wide	Trust	Core services inspection	Should Do	The trust should ensure they are using timely data to gain assurance at board.	**Governance Lincoln (Page 16)** Through the use of key performance indicators (KPIs) and divisional and trust wide integrated performance reports, the board had a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Board papers we reviewed evidenced where information was used to measure for improvement, not just assurance. Through interviews with board members and our review of board papers, including agendas we were assured quality and sustainability both received sufficient coverage in relevant meetings at all levels. Information provided to the sub-committees and ultimately the board was of a good quality and enabled the NEDs to have an independent oversight and to provide constructive challenge to the executive directors. There were clear and robust service performance measures, which were reported and monitored. The trust's integrated performance report (IPR) was presented to public board monthly and provided an overview of performance over time. However, from our review of board papers we were not assured the board was using timely data to gain assurance. For example, November's IPR referenced performance data from August/September 2021. Board members told us up to date data for example, emergency department waits, was discussed through the finance, performance and estates committee meeting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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