# Bundle Trust Board Meeting in Public Session 1 March 2022

PLEASE NOTE THAT ALL OF THE AGENDA TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1 Introduction, Welcome and Chair's Opening Remarks

*Chair*

2 Public Questions

*Chair*

3 Apologies for Absence

*Chair*

4 Declarations of Interest

*Chair*

5.1 Minutes of the meeting held on 1 February 2022

*Chair*

Item 5.1 Public Board Minutes February 2022v1.docx

5.2 Matters arising from the previous meeting/action log

*Chair*

Item 5.2 Public Action log February 2022.docx

6 Chief Executive Horizon Scan

*Chief Executive*

Item 6 Chief Executive's Report, 010322.docx

6.2 Publication of CQC Inspection Report

*Director of Nursing*

Item 6.2 CQC Report.docx

Item 6.2 INS2-11012116741 - RWD United Lincolnshire Hospitals NHS Trust - 2022-01-31 FINAL FOR PUBLICATION.pdf

7 Patient/Staff Story

*Director of Human Resources and Organisational Development*
*Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*

7.1 BREAK

8 Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities

8.1 Assurance and Risk Report from the Quality Governance Committee

Item 8.1 QGC Upward report February 2022v1.1.doc

Item 8.1 QGC Appendix 1 ULHT NHSEI followupVisit letter Final.docx

Item 8.1 QGC Appendix 2 Ockenden and Kirkup Update for QGC.docx

Item 8.1 QGC Appendix 2.1 Lincolnshire Ockenden Kirkup Return February 2022.pdf

Item 8.1 QGC Appendix 2.2 RESIDUAL OCKENDEN AND KIRKUP ACTIONS AND PROGRESS.docx

8.2 Patient Safety Strategy

*Director of Nursing*

Item 8.2 Board Briefing Paper on National Patient Safety Strategy February 2022.docx

Item 8.2 Patient Safety Specialist Board Briefing Presentation.pdf

Item 8.2 Patient Safety Strategy Position v4.pdf

9 Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT

9.1 Assurance and Risk Report from the People and Organisational Development Committee

Item 9.1 POD - Upward Report - February 2022.docx

10 Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report February 2022v1.docx

11 Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing

12 Integrated Performance Report

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board February 2022.pdf

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 Trust Board - Strategic Risk Report - March 2022 v3.docx

Item 13.1 Appendix A - Details of all active Very high and High risks (15-25).pdf

13.2 Board Assurance Framework

Item 13.2 BAF 2021-22 Front Cover March 2022.docx

Item 13.2 BAF 2021-2022 v23.02.2022.xlsx

13.3 Board Committee Arrangements

*Trust Secretary*

Item 13.3 Committee Arrangements February 2022.docx

16 Any Other Notified Items of Urgent Business

17 The next meeting will be held on Tuesday 5th April 2022

*EXCLUSION OF THE PUBLIC*
*In accordance with Standing Order 3:1 and Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 1 February 2022

Via MS Teams Live Stream

**Present**

**Voting Members:**
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Mrs Sarah Dunnett, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Dr Colin Farquharson, Medical Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer
Dr Chris Gibson, Non-Executive Director
Mrs Gail Shadlock, Interim Non-Executive Director

**Non-Voting Members:**
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration

**In attendance:**
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Dr Maria Prior, Healthwatch Representative
Ms Cathy Geddes, Improvement Director, NHSE/I
Mrs Zoe Chapman, Specialist Nurse Safeguarding Adults (Item 7)

**Apologies**

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| 001/22 | **Item 1 Introduction**<br><br>The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.<br><br>In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions. |

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| | The Chair highlighted that although national Covid-19 restrictions were lifted on the 19 July 2021 the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic. |
| 002/22<br><br><br>003/22 | The Chair moved to questions from members of the public.<br><br>**Item 2 Public Questions**<br><br>**Q1 Vi King**<br><br>**First please can I thank all the staff that worked over the Festive period.**<br><br>**Please can I ask what Equality Impact Assessments have been carried out regarding the vaccinations for staff that have not had any vaccinations. As I am sure this is going to be a very complex situation and each one will be dealt with, on an individual basis.**<br><br>**Also, what have the Trust got in place for any contractors etc, that will be coming into the hospitals, but not have any indirect care with patients etc, in relation to not be vaccinated.**<br><br>The Director of People and Organisational Development responded:<br><br>Since the question was received there had been a change to vaccination requirements however in order to offer assurance it was noted that there were circa 450 staff who had not been vaccinated and as such had been subject to a sensitively managed Trust process. This process was individual and included one to one meetings to complete appropriate documentation in order for the Trust to understand each individuals position. This led to some staff deciding to take up the vaccine and others requiring further work to be done to understand their position. This came to a standstill on 31 January following the receipt of a national letter pausing the process. A communication had since been shared with all staff across the Trust advising of this.<br><br>The Director of People and Organisational Development noted that work was ongoing with the Trust contractors in terms of progress and what was required. Whilst this was not indirect patient care it was working in where a regulated activity took place, as such a process was built in so that as of 1 April the relevant compliance check could be in place. |
| 004/22 | **Q2 Sue McQuinn**<br><br>**I understand that ULHT will be leading the Community Diagnostic Centre when it opens at the Gonerby Road Clinic. I understand the aim of the CDC is to give additional capacity for diagnostic services, easily & quickly, and to reduce outpatient referrals & attendances.** |

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| | **Could you clarify where the staff will be coming from to provide this service? Are you recruiting additional staff or will they be moved from other sites, for example, Grantham hospital?**<br><br>**Can you also explain the rationale behind setting up the CDC at this location? Are there no areas on the Grantham Hospital site that could have been adapted or repurposed for this facility? In terms of public access, Gonerby Road doesn't appear significantly more convenient than Manthorpe Road.**<br><br>The Chief Operating Officer responded:<br><br>This was a great opportunity for Lincolnshire to have additional centres which was, as stated, about additional capacity rather than capacity being moved. This would deal with some of the backlog in terms of people waiting for diagnostics and initially staff were being asked for additional hours within the Trust to add the extra services at the Community Diagnostic Centre venues. There was however recruitment activity underway to add additional capacity.<br><br>The rationale for the location at Gonerby Road again went back to the same principle of capacity and not repurpose. The Trust was looking at all sites and services in order to reintroduce as much capacity as possible. Having the additional facility offered additional capacity, clinical space and diagnostic capacity for patients. |
| 005/22 | **Q3 Jody Clark**<br><br>**Can you let us know how many patients the 3 A&E's have seen over December 2021 and Jan 2022.**<br><br>**I will add a big thank you to all staff working over these challenging months.**<br><br>**And can we please have an update on the new theatres being built at Grantham Hospital please.**<br><br>The Chief Operating Officer responded:<br><br>The thanks that were offered were gratefully received and would be passed to the teams with the Chief Operating Officer echoing the thanks, from himself and Board colleagues, and noting how difficult and pressured the past couple of months had been for staff with huge demands on services.<br><br>Regarding data, this was published following a publication system meaning that validation of numbers was required at certain timescales and as such January data was not yet available and could not be shared.<br><br>Within the Integrated Performance Report included within the papers of the meeting, information could be found about the changes in Accident and Emergency attendances between November and December 2021. |

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| | It was important to note however that December was not a standard month with a significant reduction in the number of attendances see on Christmas Day, Boxing Day and New Year's Day. It was difficult to make a comparison from the report however changes in attendances should be seen. It was noted that whilst there was an increase in numbers this was not yet at pre-Covid-19 levels.<br><br>The Chief Operating Officer noted that the development of the theatres at Grantham were progressing well however there had been a delay in the installation. These were now anticipated to be completed by June 2022 however it was hoped that access to some areas would be possible prior to this date in order to increase the number of treatments taking place. |
| 006/22 | **Item 3 Apologies for Absence**<br><br>There were no apologies for absence.<br><br>The Chair welcomed new members of the Board including Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration, Dani Cecchini, Non-Executive Director and chair of the Finance, Performance and Estates Committee and Gail Shadlock, Interim Non-Executive Director. |
| 007/22 | **Item 4 Declarations of Interest**<br><br>The Chair requested that new members of the Board ensured all interests had been declared to the Trust Secretary as soon as practicable. |
| 008/22 | **Item 5.1 Minutes of the meeting held on 7 December 2021 for accuracy**<br><br>The minutes of the meeting held on 7 December 2021 were agreed as a true and accurate record. |
| 009/22 | **Item 5.2 Matters arising from the previous meeting/action log**<br><br>The Chair advised that all actions were noted with the updates provided within the action log closing those indicated within the log. |
| 010/22<br><br>011/22<br><br><br><br>012/22<br><br><br><br><br>013/22 | **Item 6 Chief Executive Horizon Scan**<br><br>The Chief Executive presented the report to the Board noting that the System had been operating under significant pressure over Christmas and New Year which had continued into January and saw the Trust in a critical incident for 13 days and a major incident for 19 hours during the month.<br><br>The Board was advised that there had been input from national colleagues who were impressed with the way in which colleagues were dealing with the very difficult set of circumstances and stating that the right actions were being taken. Comments were also received in respect of the great leadership that had been seen.<br><br>Echoing the thanks of the Chief Operating Officer the Chief Executive thanked all colleagues, regardless of role for the fantastic work being done in difficult |

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| | circumstances. These circumstances were shown in the long waits in the emergency departments and issues with flow and highlighted why there was a continued focus, both in the Trust and across the system, on key issues regarding ambulance handovers to minimise delays. |
| 014/22 | There was a strong focus on discharges from the Trust's hospitals including those patients who were medically optimised and no longer needed to remain in acute care. Collectively as a system there was a need to improve discharge which would in turn increase flow within the hospitals to impact on the pressures on the front door where people were waiting for a bed. |
| 015/22 | The Chief Executive noted that, following national visits from the National Emergency Planning Team and Ministry of Defence (MOD), the Trust was delighted to have 30 military personnel working in the Trust. There were 20 personnel with healthcare training and 10 general duty colleagues who were already having a positive impact. |
| 016/22 | The Chief Executive advised the Board that, since writing the report, mandatory vaccination of staff to be implemented by 1 April 2022, had been stopped following the announcement by the Secretary of State for Health late on 31 January 2022. |
| 017/22 | A consultation was now being launched on the regulations that had been put in place, subject to the response to this and the parliamentary process, the government was looking to revoke the regulations of Vaccination as a Condition of Deployment (VCOD) whereby the requirement would no longer apply. |
| 018/22 | An immediate letter was received from NHS England on 31 January pausing the process that was in place with the Chief Executive stating that the Trust would not be serving notice on staff or pursuing the VCOD regulations. More information would be received in due course however this was the immediate position with a communication to staff having been signed off to advise of the situation. |
| 019/22 | The Board was advised that the Integrated Care Board (ICB) would now come in to effect in July 2022 and not April 2022 as previously advised. It was also noted that, a recent announcement, had been that of Sir Andrew Cash being the interim Chair of the ICB. |
| 020/22 | The public consultation on the four NHS services had now closed and it was expected that the Clinical Commissioning Group (CCG) would meeting in March with the outcome of the consultation. |
| 021/22 | The Chief Executive noted that the Lincolnshire Health and Care Collaborative continued to be formed and would, as with the ICB, come in to place in July 2022. It was noted that Mr Peter Noble would be joining at the Managing Director from 1 April 2022. |
| 022/22 | The National Priorities were now available with a key issue for the system and Trust would be to ensure that plans in place were simple, consistent and had a golden thread with a need to be clear about what success looked like. |

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| 023/22 | The financial position was reported at a breakeven position in month with a year-to-date surplus of £1.8m in line with plan. |
| 024/22 | The Chief Executive advised of the publication of the Trust's recent Care Quality Commission report, due to be published on 8 February, following the core services and well led inspections in October and November 2021. |
| 025/22 | The first undergraduate medical students would be starting with the Trust during February from the University of Lincoln and the Chief Executive was pleased to note and welcomed Dr Sameedha Rich-Mahadkar, who had now commenced with the Trust as the Director of Improvement and Integration. |
| 026/22 | The Chair noted the update reflecting that this had set out the context of the operating environment of the Trust which is extensive and had been challenging over the course of last few months. |
| 027/22 | The Chair, on behalf of the Board, thanked everyone in the organisation who had continued to support patient care and delivery of services during the difficult time. |
| 028/22 | Dr Prior noted that the military personnel were due to be with the Trust until approximately the end of January and asked if there was a time limit and what the criteria would be for them leaving the Trust. |
| 029/22 | The Chief Operating Officer noted that 11 February was the current point at which the military personnel were due to leave the Trust and a meeting had been held with military leadership colleagues in relation to the circumstance in which they would leave. |
| 030/22 | Discussion had been held regarding the possibility for this period to extend however the Trust recognised the demands on their time in the forces. It was noted that, as previously, the personnel had been hugely beneficial to the Trust not only practically but also for morale. The Trust was grateful for the input that they had given. |
| 031/22 | The Chair noted that the opportunity had been taken to welcome the military personnel on behalf of the Board and organisation noting that the staff were keen to be in the Trust and were excited by the opportunity presented. |
| 032/22 | Mrs Dunnett was excited to hear about the 80 medical students joining the Trust and asked if feedback was being received regarding the experience of the medical students, Trust induction programme and facilities provided as this could support the future medical workforce of the Trust. If this feedback was being sought Mrs Dunnett was keen to understand how this was being done and if it would be captured on a timely basis. |
| 033/22 | The Medical Director noted that this could support recruitment and retention within the Trust once the medical students were qualified and noted that discussion was underway with the University about how feedback would be captured. It was noted that any key performance indicators would need to support both the Trust and the University to include the perception of the medical curriculum being delivered. Time was being taken to define this to ensure there was a good experience for all involved. |

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| 034/22 | Dr Gibson noted the release of the NHS National Priorities and Planning Guidance which placed a strong emphasis on health inequalities particularly drawing attention to the requirement of Trust Board performance packs to be disaggregated by deprivation and ethnicity. This was viewed as quite a challenge and asked if the Trust was beginning to prepare for this. |
| 035/22 | The Chief Executive noted that part of the purpose of the Integrated Care System was about health inequalities and was a golden thread running through all policies. Health inequalities was one of 10 national priorities with an expectation of an initial focus on waiting lists and times and was also a role of the Provider Collaborative Networks. |
| 036/22 | The Director of Finance and Digital noted that there was a significant piece of work to be undertaken by the Trust and other organisations noting that this would need to develop over time but that core areas would be the initial focus, such as waiting lists. This would improve as the quality of data in the organisation improved however it was recognised that the use of paper records would make this more difficult. |
| 037/22 | The Chair looked forward to the outcome from the CCG in respect of the service changes noting that this would help the strategic planning for the future of the Trust. It was also noted that there were multiple planning elements that would be challenging to algin however these needed to be understood in order for the Trust to produce something properly structured around the Integrated Improvement Plan. The output of this would need to be clear to staff so that they had an awareness of what was required and the expectations to progress priorities. This would be a critical piece of work. |
| 038/22 | The Chair noted that the Trust Board would need to be clear about engagement with the Provider Collaborative to ensure oversight and further information would be welcomed. |
| 039/22 | The Chair looked forward to the publication of the Care Quality Commission inspection report the following week.<br><br>Finally, the Chair was pleased to note the feedback received, particularly the Executive Leaders, from national colleagues in response to the critical incident at what had been a challenging time. It was pleasing to note that this feedback had been offered to NHS England and Improvement.<br><br>The Trust Board:<br>• **Noted the report and significant assurance provided** |
| 040/22 | **Item 7 Patient Story**<br><br>The Director of Nursing presented the patient story to the Board advising that the story detailed falls prevention work taking place within the Trust and was pleased that Zoe Chapman, Specialist Nurse Safeguarding Adults was able to join for the item. |
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| | The Director of Nursing noted that the Specialist Nurse Safeguarding Adults had done a huge amount of work supporting falls prevention and had now moved into her current role as Dementia Lead as part of the safeguarding team. |
| 042/22 | The Board watched the video presentation that detailed the Trust's commitment to reducing falls within the Trust and changes that were being developed and implemented to support this, known as the Think Yellow initiative. |
| 043/22 | The Board noted the reduction that had been seen in falls following the initial implementation of the yellow non-slip socks and wrist bands however over recent months there had been a steady increase in the number of falls and heard from a staff member about their involvement in the prevention of falls. |
| 044/22 | Mrs Dunnett was struck with the change in the risk assessment process during the pilot and sought to understand what change had taken place to see the reduction in falls. Mrs Dunnett went on to ask if there was sufficient equipment across the Trust to support patients and asked if it was possible to triangulate call bells and responses times to these. |
| 045/22 | The Specialist Nurse Safeguarding Adults advised that she had been involved in falls prevention for some time and had been involved in redevelopment of the risk assessment. It was noted that the previous risk assessment did not clearly identify those patients at significant risk or ways to reduce the risk. The risk assessment had been taken back to basics with hourly to two hourly checklists to ensure patients had medication reviews, call bells were to hand, there was appropriate foot ware and day to day changes that may have occurred were considered. |
| 046/22 | It was hoped that the new risk assessment would place more emphasis on regular update and review of patients, meaning that staff should be able to adapt care to be patient centred and limit risks. |
| 047/22 | In respect of sufficient equipment, it was noted that there was the ability to order suitable beds for patients and there were a number of pieces of equipment available to support patients. All beds had a call bell system however it was noted that there was a need to ensure staff were aware of the equipment, where this was available and how to correctly use. The training package would focus on where to find equipment and how to use this with appropriate moving and handling. |
| 048/22 | The Specialist Nurse Safeguarding Adults advised that the call bell system in place was dated and it was not believed to have the technology to support the monitoring of call times. |
| 049/22 | The Director of Nursing noted that the benefit of having an experienced person in the role and now being in the safeguarding team, undertaking the lead dementia role would provide an understanding of cognitive impairment. Whilst it was possible to help and support patients to use facilities, if they suffered from cognitive impairment, they would struggle to use things such as a call bell. |
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| 051/22 | The Specialist Nurse Safeguarding Adults would work in the dementia role and pull work together that would drive forward the initiative for vulnerable patients and be a step forward for the organisation. |
| 052/22 | Dr Prior noted that this seemed like a positive initiative but sought to understand feedback from patients given the visibility of yellow wristbands and socks. |
| 053/22 | The Specialist Nurse Safeguarding Adults noted that from the point of view of those patients who could communicate about this they were grateful for the staff awareness. It was generally the group of patients able to articulate how they felt that were the ones less likely to ask for support. The identification through the initiative meant they were more relaxed and felt staff were looking after their best interests without the need to seek help. |
| 054/22 | The Chief Executive noted the great work that was being done and reflected that this was not just about inpatients or clinical staff but that, as identified in the presentation, a responsibility for all. There was a need for staff to consider this a personal role. |
| 055/22 | Ms Cecchini sought an understanding of the deterioration following the positive improvement and asking if this was correlated to staffing levels. |
| 056/22 | The Director of Nursing advised that on a daily basis nursing red flags, including falls and harm as a result, were considered alongside Datix incidents and complaints. On a monthly basis, this was aggregated into the quality dashboard and reviewed with the Divisions and Ward and Nurse Leads. The quality report was then provided to the Quality Governance Committee and safer staffing reports offered to the People and Organisational Development Committee. These reports triangulated quality and workforce metrics. |
| 057/22 | The Director of Nursing noted that currently there was a degree of assurance being offered that, up to December, there was not an impact being seen as a result of the reduction in nurse staffing numbers, skill mix and the number of falls. Although there had been an increase in the number of falls this was not corresponding with an increase in levels of harm. |
| 058/22 | The Board was advised that falls prevention work was a key piece of work from the nursing and midwifery framework which had been launched in the past year. |
| 059/22 | The Director of Nursing noted that the January data was now starting to be reviewed and whilst this did not currently show a correlation it was possible that a deterioration may, as a result of the critical incident at the beginning of January, demonstrate deterioration in the level of assurance offered. |
| 060/22 | Ms Cecchini noted that this was such a good initiative and explored further if the reason for the increase in the number of falls, whilst not related to the workforce, was known. |
| | The Director of Nursing advised that it was thought to be related to the nature of the temporary workforce that had been in place for that period of time noting that the training package, linked to the induction for all staff including bank and agency, would |

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| 061/22 | resolve the issue seen. The issue was thought to be related to a lack of knowledge and understanding of the individuals working and hence why this was being linked to the improvement project of ward inductions. |
| 062/22 | The Chair offered thanks to the Specialist Nurse Safeguarding Adults for presenting the story to the Board and offered the opportunity to alert the Board to anything else that may be of interest. |
| 063/22 | The Specialist Nurse Safeguarding Adults thanked the Board for listening to the presentation and confirmed, as raised by the Chief Executive that this was a responsibility for all requesting that Board members offer support or direct support to patients in need when out and about on Trust sites. |
| 064/22 | The Director of Nursing also offered thanks to the Specialist Nurse Safeguarding Adults for the work undertaken noting that wider discussions would be held regarding the dementia work.<br><br>The Chair congratulated the Specialist Nurse Safeguarding Adults on her new role and looked forward to seeing the impact that would be had in the new role and these being reported through to the Board.<br><br>The Trust Board:<br>• **Received the staff story** |
| | **Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities** |
| 065/22 | **Item 8.1 Assurance and Risk Report Quality Governance Committee**<br><br>The Chair of the Quality Governance Committee, Dr Gibson provided the assurances received by the Committee at the 21 December 2021 and 18 January 2022 Meetings. |
| 066/22 | Dr Gibson noted that at the December Committee a report was received from the Clinical Harm Oversight Group noting that this had demonstrated work to assess potential harms utilising the Artificial Intelligence system. It was recognised that there was an external review process alongside the internal gold commend structure. |
| 067/22 | The Committee noted the pressure on the Integrated Improvement Plan workstreams and achievement of these with Dr Gibson raising with the Board a possible review of prioritisation to ensure deliverable timescales. |
| 068/22 | Dr Gibson highlighted from the January 2022 report the reduction in the number of overdue actions relating to serious incidents despite operational pressures. It was noted that a significant increase in serious incidents was not being seen noting that a further update would be received through the regular detailed quarterly analysis. |
| 069/22 | Dr Gibson noted that many of the subgroups of the Committee had stood down during the period and as such there was a reduced level of assurance however the Committee had received Chair's reports from some of the groups. |

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| 070/22 | A detailed summary had been received from the Patient Safety Group noting that an issue had been raised regarding redeployment of staff in to more clinical facing areas noting that there would be an impact of improvement projects and training and development. The Committee felt that the action was appropriate as a temporary measure. |
| 071/22 | Dr Gibson noted that in due course the Board would receive the Patient Safety Strategy which had been received by the Committee and noted the need for the Trust to have in place a named Patient Safety Specialist Lead. |
| 072/22 | The Committee noted the daily Infection, Prevention and Control Cells that were taking place and were advised of an increase in Covid-19 outbreaks during December and January. This had been due to the greater transmissibility of the Omicron variant however due to actions in place no further outbreaks had occurred following the peak. |
| 073/22 | Dr Gibson alerted the Board to the imminent Infection, Prevention and Control visit from NHS England and Improvement. This would be a follow up visit to that which had taken place the previous year. |
| 074/22 | The Committee were concerned regarding Duty of Candour due to operational pressures and the adverse underlying trend. The Committee noted that actions being taken, specifically a review process to look back at case notes to identify if this has been completed. The Committee were pleased to note that the regulatory body was being kept informed and monthly updates would be received by the Committee over the next 3 months to monitor the recovery trajectory. |
| 075/22 | Dr Gibson advised that the Urgent Care parameters were suffering due to performance, and it was noted that there had been a deterioration in quality and nursing indications. The Committee would refer to the People and Organisational Development Committee a request for workforce red flags to be reported in a clear manner for better triangulation. |
| 076/22 | The Committee noted an improvement in the performance indicator in respect of mortality with the Summary Hospital-Level Mortality Indicator (SHMI) reporting within the expected range across all three sites. |
| 077/22 | The Committee noted the revision of the risk register and looked forward to more detailed reviews now that this was being presented in the new format. |
| 078/22 | The Chair noted the thorough report despite the reduced meeting held and was pleased to see the level of detail offering a view on assurance. |
| 079/22 | The Chair advised that, in relation to the Integrated Improvement Plan escalation, this would naturally fall under review as part of the 2022/23 planning. A revision would be required to take stock of the position and ensure alignment into the next year.<br>The Chair was pleased to see the stronger leadership in place in respect of medicines management thanking the Medical Director for this. |

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| 080/22 | The Patient Safety Strategy would need to be received by the Board with a desire to implement as soon as possible. |
| 081/22 | The Board noted the performance of Duty of Candour and recognised that this was being monitored by the Committee.<br><br>The Trust Board:<br>• **Received the assurance report** |
| | **Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT** |
| 082/22 | **Item 9.1 Assurance and Risk Report People and Organisational Development Committee**<br><br>The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 14 December 2021 and 11 January 2022 Meetings with a reduced agenda in January due to clinical priorities. |
| 083/22 | Professor Baker noted that whilst development of the Committee remained a work in progress there had been some progress seen as a result of work by the Director of People and Organisational Development and the team that was being established. |
| 084/22 | Progress has been made in particular regard to having functioning and effective subgroups to report to the Committee including Equality, Diversity and Inclusion and Workforce. It was noted that the view of the Committee was that workforce was one of the greatest issues being faced by the Trust and the wider NHS and was one of the issues being picked up in the shorter term by the Committee including the winter staffing analysis. |
| 085/22 | The Committee were trying to garner similar assurances around staffing and safer staffing in addition to nursing and midwifery staff requesting that this to be extended to Allied Health Professionals, medical and non-clinical elements of the workforce. The Committee were looking for real progress to be made over the coming year in order to achieve this. |
| 086/22 | Professor Baker noted that other subgroup of the Committee included culture and leadership, academic issues such as the medical school and teaching school status and research advising that the subgroups were generating real endeavour. |
| 087/22 | The Committee welcomed the start of the dashboard noting that this would provider a clearer snapshot of issues across the Trust with Professor Baker noting the improvements in the iterations received. |
| 088/22 | At the January Committee the priorities for the People and Organisational Development Teams had been presented and whilst these were welcomed by the Committee concern was noted on the ambitious timescales. Reassurance was offered that these were realistic as well as ambitious. |

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| 089/22 | The Committee had requested that a discussion regarding mandatory vaccines be held by the Board however events had been preceded and noted by the Board. |
| 090/22 | Professor Baker noted the red assurance ratings within the Board Assurance Framework advising that progress was expected in order to gain the necessary and appropriate assurances. Whilst this was a work in progress there was cause for optimism due to the genuine progression being seen. |
| 091/22 | The Chair noted the sense of optimism being seen through the upward reports noting that there was some grip and control in respect of what needed to be done. It was pleasing to note that the reporting groups would be properly structured and aligned in order to provide assurance to the Board. Thanks were offered to Professor Baker and the Executives for moving the position forward in a short space of time. |
| 092/22 | Mrs Dunnett sought confirmation that the Trust were engaged in the development of the System One People Plan and asked when the plan would be received by the Trust for discussion. |
| 093/22 | The Director of People and Organisational Development noted involvement in the development of the plan that was currently in draft noting that the Deputy Director of People was also involved in the forming of the plan. The Trust was the largest employer in the county, and it was appropriate for there to be input from leads. |
| 094/22 | The plan was expected to be received by the People and Organisational Development Committee in March for discussion and subsequently received by the Board in April. |
| 095/22 | The Chair noted the need for the plan to be received to ensure that this would fit with planning and the Integrated Improvement Plan refresh to ensure alignment.<br><br>The Trust Board:<br>• **Received the assurance report** |
| 096/22 | **Item 9.2 Vaccination programme**<br><br>The Director of People and Organisational Development presented the report to the Board advising that as of 1 February, 96% staff had received at least one vaccine. |
| 097/22 | 82% of staff had received two doses and the booster with just under 400 colleagues not having had any vaccination. It was noted however that around half had received the vaccination somewhere in the UK or overseas with a lag in data to confirm. |
| 098/22 | The Director of People and Organisational Development noted that work that had been undertaken to achieve the position thanking the teams involved and colleagues who had received the vaccination. Those who had not, had been required to have sensitive conversations however this had now come to a standstill with a communication having been sent to colleagues to pause the position. |
| 099/22 | The Chair noted the position statement and thanked those colleagues who how taken up the vaccines and those encouraging others to receive it. There had been some |

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| | good work undertaken given the challenging circumstances and the Board note and expressed appreciation to both staff and those providing clinical support. Both in terms of vaccine hesitancy and the vaccine programme. |
| 100/22 | The Chief Executive drew the attention of the Board to the flu vaccination programme noting that whilst this was reported at 64% currently, and some way from the previous year position, the Trust had in fact vaccinated 500 more staff than the previous year. It was noted that this was due to the denominator being refreshed however noted the need to continue to encourage take up of the vaccine. There was some way to go to achieve the 90% target.<br><br>The Trust Board:<br>• **Received the report noting the significant assurance** |
| | **Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate** |
| 101/22 | **Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**<br><br>The Deputy Chair of the Finance, Performance and Estates Committee, Dr Gibson provided the assurances received by the Committee at the 23 December 2021. |
| 102/22 | The Committee received the second draft of the new Estates Strategy noting that this was a comprehensive strategy that reflected the transformation within the estate function over the past year. The Committee looked forward to this being further refined and presented to the Board. |
| 103/22 | Dr Gibson noted the discussion that had taken place regarding the risk and gain share option which would be part of the system recovery programme. The Committee noted some concerns about how this would work in practice but were mined to support the paper subject to further clarification, in particular, the distinction between the recovery programme and the core business of the Trust. |
| 104/22 | Dr Gibson noted that the Committee had received a report in respect of cyber security risks noting the positive work that was taking place within the Trust and the high standard of cyber security that was being achieved. |
| 105/22 | The Committee had received an update in relation to Information Governance noting that this now sat within the Trust Secretary's portfolio. Work was taking place to strengthen the department and the Committee were advised of an Information Commissioners Officer Audit conducted in December. A report would be offered to the Trust in early 2022. |
| 106/22 | The Chair looked forward to the Board reviewing the estates strategy and noted that the Board would need to consider risk and gain share and how this worked in practice in due course. |

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| 107/22 | The Director of Finance and Digital noted that the draft Information Commissioners Office audit report had been received in early January with a formal response from the Trust offered by the deadline of 21 January. |
| 108/22 | The Information Commissioner Office were due to imminently publish the report on their public website with the Director of Finance and Digital pleased to report that the Trust had received a rating of Reasonable Assurance. This was the second-best level of assurance with a clear action plan now in place. An update would be offered to the Finance, Performance and Estates Committee however the verbal update was offered due to the report being published. |
| 109/22 | The Chair noted recent correspondence that had been received in respect of cyber security noting that this would be considered in further detail by the Committee in due course. |
| 110/22 | The Chair of the Finance, Performance and Estates Committee, Ms Cecchini provided the assurances received by the Committee at the 20 January 2022. |
| 111/22 | Ms Cecchini was pleased to advise the Board that the fire enforcement notice at Grantham Hospital has been lifted at the end of December noting the good news this offered following on from the works undertaken. |
| 112/22 | The Estates Team continued to improve reporting and assurances to the Committee and would use the Premises Assurance Model to inform the Trust of the position. This would start to see positive assurance being received by the Committee. |
| 113/22 | Ms Cecchini noted that the Green Plan, a condition of the next year's planning, was underway and would be received by the Board for sign off in due course. |
| 114/22 | The Committee noted the financial position and the continued reporting of delivery against plan. Whilst the reports offered did not contain the usual detail, due to the implementation of the new financial ledger, the Committee were assured of the continued achievement to meet the plan of £1.8m surplus. |
| 115/22 | Ms Cecchini noted the capital reports that had been received noting that the Committee was assured that the Team had an understanding of the position on all capital schemes. It was however noted that the position at the end of December was circa £5m below plan. In order to deliver the capital plan for the remainder of the year there would need to be spend of circa £11m each month by year end. The Committee would continue to monitor the position. |
| 116/22 | As mentioned by the Chief Executive, information regarding planning for the coming year had been received with the Committee being advised of the planning, a brief outline of the planning timeline and the work required through March and April 2022 to finalise the plans. |
| 117/22 | Ms Cecchini noted that there had been no items received in respect of digital capability of evidence-based models of care due to the meeting being held to a reduced time. |

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| 118/22 | The Committee considered operational performance and the challenges that had adversely impacted on many targets. It was noted however that the Trust was holding firm on 104 day waits compared to others however deterioration had been seen in other areas with some green shoots noted, particularly on sickness levels. |
| 119/22 | The Committee noted the turnaround time of patients in the P2 category which was also an area of improvement. The Committee noted concern regarding 12-hour trolley waits noting that these, along with potential harm were reported to the Quality Governance Committee. Given the number of 12-hour trolley waits in recent months the Committee were concerned that harm reviews should be reviewed for these. |
| 120/22 | A further area of concern noted was the speed at which the Trust would be able to restore against the original restoration trajectory. Planning would commence to support this however was an area where the Committee had received less assurance. |
| 121/22 | The Chair noted the position of the capital programme however reflected that the Committee were clear on the position. The lifting of the fire enforcement notice was a huge achievement in terms of the efforts put into the site and an example of the improvements at the Grantham Hospital site that the Board were keen to support.<br><br>The Trust Board:<br>• **Received the assurance report** |
| | **Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing** |
| 122/22 | No items |
| 123/22 | **Item 12 Integrated Performance Report**<br><br>The Director of Finance and Digital presented the report to the Board noting the impact of the Omicron variant of Covid-19 on the workforce and sickness levels. |
| 124/22 | The Board was advised that the Trust had been running at 5.2% sickness through the year with a peak in the early part of January 2022 at just under 11%. As of 1 February, this had reduced to 9% with staffing being a contributory factor of the major incident and critical incidents. |
| 125/22 | It was noted that mandatory training and appraisal were seeing an impact due to the position however actions were in place for recovery. |
| 126/22 | The Director of Finance and Digital confirmed that the Trust remained on track to deliver a breakeven position in H2 and would deliver a full year surplus of £1.8m. There was a significant amount of work to be undertaken in respect of capital for the remaining 2 months of the year. Both Finance and Estates were working closely and carefully to achieve plan. Action was taken in September 2021 to put in place overcommitment that would enable achievement of the position. |

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| 127/22 | The Chair noted the operational performance noted within the report stating that if this was viewed by someone not immersed in the position this would indicate a fundamental issue with patient flow. Whilst it was appreciated that there was work ongoing the Chair stated that it would be helpful to understand what was happening in the Trust, system issues and what action was required by the Trust and system partners to support. |
| 128/22 | The Chief Operating Officer noted that this was a question for Boards across the country noting there was similar issues in most Trusts however special factors were making it more challenging such as the natural vacancy rate and ability to staff. |
| 129/22 | Actions to be taken were split in to internal and external. Internal actions being taken were largely building on the planning in place for winter with the Trust having received 2 national reviews from the NHS England National Incident Directors team and the National Emergency Planning Team. |
| 130/22 | The visits had been undertaken to review the response in place by the Trust to respond to challenges. The outcome of the visits had been to confirm that the actions being taken were right and mainly focused on the ability to reduce the number of people admitted who did not require overnight care. These patients were referred to Same Day Emergency Care (SDEC) with assessment areas in medicine and surgery and were on each of the three Trust sites that had emergency pathway presentations. |
| 131/22 | The Chief Operating Officer noted that progress was strong in these areas with the strategies maturing well with volumes, at times, 3 or 4 times more patients being seen in SDEC than pre-Christmas or going into the winter period. |
| 132/22 | The Chief Operating Officer reflected why issues continued to be seen despite actions going well noting that this was due to the second element of work, discharge. At times there were 20% or more of all patients in hospital who were medically optimised, those not requiring acute hospital care, but required care outside of hospital. The Trust was working with system partners to provide the necessary care outside of hospital. |
| 133/22 | The Board was advised that the Trust was not unique in the system with being impacted by Omicron with sickness, vacancy and capacity issues outside of the Trust impacting on the ability to discharge patients. As a system, strategies were in place to look at what more could be done to better use capacity outside of hospital and to extend capacity to recruit more people in to reablement type services. Increased provision of this type would support patient discharges in a timely manner. |
| 134/22 | Whilst this had worked well and extended capacity the strategy had not managed to keep pace with demand on those services. The term exit block was largely used to describe the situation where emergency pathways were not able to discharge patients in the way desired as capacity was not there, this then resulted in blockages of inpatients. |
| 135/22 | The Chief Operating Officer noted that a focus remained on care at home and care closer to home as a strategy taken on by the system. Together with colleagues in |

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| | community services and local authorities there was continued activity to discharge more patients. |
| 136/22 | The Finance, Performance and Estates Committee continued to be appraised of the situation with key points noted within the Integrated Performance Report. |
| 137/22 | The Chair noted the reassurance however stated that as these actions were being taken there was a need to see the desired impact on patient flow, which was yet to be seen. |
| 138/22 | The Chief Operating Officer noted that there had been some improvements seen in breast service capacity noting there was an issue at the beginning of the suspected cancer pathway with patients needing to be seen in the 2 week window. |
| 139/22 | Previous actions put in place had increased capacity and seen a reduction in the backlog substantially from a peak of more than 700 down to less than 100 at the best point. However, breast, like other services was susceptible to sickness and the impact of sickness was seen in those more fragile services due to demand and capacity issues. A further deterioration had been seen, as predicted, due to fragility combined with sickness. It was anticipated that performance would continue to decrease. |
| 140/22 | The Chief Operating Officer noted that as a resulted dialogue had commenced with the East Midlands Cancer Alliance to seek support. It was noted however that this was a difficult service for other providers who were also having difficulties although support was being sought from neighbouring Trusts and regions. |
| 141/22 | Changes in pathways were expected for patients who did not or were extremely unlikely to have cancer. This was known as the nostalgia pathway with patients being at a much lower risk. Work had been completed by the Trust which had been seen as exemplar in this regard however it had not progressed at the desired pace. The Trust was looking to increase the pace and impact to move out of the current position. |
| 142/22 | The Chief Operating Officer noted that full assurance could not be offered however key actions were in place with the hope that there would be progress in the level of assurance.<br><br>The Trust Board:<br>• **Received the report noting the limited assurance** |
| | **Item 13 Risk, Governance and Assurance** |
| 143/22 | **Item 13.1 Risk Management Report**<br><br>The Director of Nursing presented the report to the Board noting that this was presented in the new format following the work to strengthen risk management arrangements in the Trust. |

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| 144/22 | The Board was aware of the comprehensive review of the risk register that was now complete and allowed a better understanding, identification and reflection of risks currently being managed. |
| 145/22 | The Director of Nursing noted that the risks were now better aligned to the Board Assurance Framework to better demonstrate how these impacted on the ability to deliver the corporate objectives. |
| 146/22 | The previous report had offered 4 very high risks which remained within the report being the impact of Covid-19. This risk was described and articulated more fully in terms of how this manifested within the Trust, for example staff sickness due to Covid-19 and impact of vaccination. It was understood however that the world had shifted in this regard. |
| 147/22 | The second risk related to Non-Invasive Ventilation that remained on the risk register and would be subject to a deep dive at the next confirm and challenge meeting later in the month. These meetings were chaired by the Director of Nursing and attended by the responsible officer for risk and other Executives. These meetings took place on a monthly basis to confirm and challenge all strategic risks throughout the year. |
| 148/22 | The urgent and emergency demand risk was undergoing further review along with risk regarding planned care to ensure the detail of the specific issue of the risk was offered to the Board. As an example the Divisions were working through the specialties most at risk with regard to planned care and recovery. |
| 149/22 | The fourth risk related to workforce engagement, morale and productivity with the risk articulated under objective 2b, making ULHT the best place to work, which linked back to objective 2a regarding the workforce. |
| 150/22 | The report also included 2 new risks these being the risk of not learning lessons and risk to the Joint Advisory Group (JAG) accreditation if the Trust are unable to implement actions identified in the previous year's JAG accreditation visit. |
| 151/22 | The risks regarding medical records and medicines management had been reviewed and taken through the last confirm and challenge meeting. These would be included in the report from next month however reassurance was offered on the medical records risk that would be overseen by the Medical Records Group. |
| 152/22 | It was noted that the Medical Director would be chairing the new Medicines Management Task and Finish Group to give oversight of the medicines risk and report through the subgroup to Quality Governance Committee and on to the Board. |
| 153/22 | The Director of Nursing advised that appendix 1 of the report offered the high level risks being managed across the Trust that was usually seen within the report. |
| 154/22 | The Board noted the work to review the risk management process that was underpinned by a training programme. This had been completed for staff in the central clinical governance team and staff within divisions and corporate function, who had authority, leadership and support to manage their own risks. This was |

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| | developing into a programme of ongoing training as part of the overall governance training offer from the central team. |
| 155/22 | The risk register confirm and challenge meetings that had been implemented were already demonstrating benefit in terms of discussion across divisions and directorates regarding risk and was increasing the overall understanding. The Director of Nursing noted that a wider understanding of risk was now being seen whereas there had been isolated silos of reviews previously, which had been identified by the Quality Governance Committee. |
| 156/22 | The Director of Nursing noted that a full review of the risk policy had been undertaken and was out to consultation. This would be taken through the risk register confirm and challenge meetings and through the Audit and Risk Committee for approval in due course. |
| 157/22 | The Chair offered thanks for the update and information presented including the methodology used to put forward the report. |
| 158/22 | Mrs Dunnett noted that it was felt that there was stronger governance that sat behind the risk register as a result of the work. |
| 159/22 | The Chief Executive noted the work that had been undertaken noting the difference in the approach to risk that moved on from reporting to active management to reduce risk. It was noted that there was a need to have in mind a reduction in the likelihood was being sought of the impact or both. The Chief Executive reflected that the difference between likelihood and impact in the managing of the reduction of risk was mistaken and looked forward to this being embedded and risks reducing. |
| 160/22 | The Director of Nursing noted that the report was trying to articulate risk as something that may happen and there was a need to mitigate against this as opposed to reporting issues. Whilst conducting the work there was an attempt to distinguish between risk and issue and it was recognised that previously the register had been an issues register and not a risk register. |
| 161/22 | Mrs Shadlock reflected that, as a new member to the Board, the report was clear. |
| 162/22 | The Chair invited Board members to confirm the top risks as reported seeking to ensure that the Board was satisfied that the risk reduction plans were relevant and appropriate.<br><br>The Trust Board:<br>• **Accepted the top risks within the risk register**<br>• **Received the report and noted the moderate assurance** |
| 163/22 | **Item 13.2 Board Assurance Framework**<br><br>The Trust Secretary presented the report to the Board noting that this had been considered by all Board Committees during December 2021 and January 2022. |

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| 164/22 | The Board Assurance Framework had also been received by the Audit Committee in January 2022 undertaking a review and update of Objective 2c. The Audit Committee also undertook an appropriate review to ensure the adequacy of the framework. |
| 165/22 | The Trust Secretary noted that work was now underway to develop the 2022/23 framework in line with the Integrated Improvement Plan.<br><br>The Trust Board:<br>• **Received the report and noted the moderate assurance** |
| 166/22 | **Item 13.3 Audit and Risk Committee Upward Report**<br><br>The Chair of the Audit and Risk Committee, Mrs Dunnett presented the report to the Board from the meeting held on 14 January 2022. |
| 167/22 | As noted with other Committees the meeting was held with a reduced agenda reflecting operational pressures. |
| 168/22 | The Committee reviewed and agreed the External Audit strategy for the completion of the 2021/22 Accounts noting this was a high level report with detailed plans to be received at the next meeting. Mrs Dunnett advised the Board that there was no requirement to have the Quality Account audited this year. |
| 169/22 | The Committee noted the work of the internal and external auditors that would be undertaken on the new financial ledger and received an update from the Trust's Internal Auditors. |
| 170/22 | It was noted that Internal Audit were on track to deliver all required audits in order to offer a Head of Internal Audit Opinion by year end. |
| 171/22 | As part of the report received the Committee received four internal audit reports, 3 offering partial assurance and 1 substantial assurance. It was noted that due to the the reports would be received by the relevant Committees for further consideration. |
| 172/22 | Mrs Dunnett noted that the Trust Operating Model internal audit had been received offering partial assurance and comments were positive on the direction. The report reflected the impact of Covid-19 and operational pressures meaning that delivery across the Trust had been challenged. |
| 173/22 | The Audit Committee recognised that the Executive Team had not had time to review the report and as such discussion would be held with the relevant Directors at the next meeting to receive an operational response. |
| 174/22 | The Committee received a progress report from Counter Fraud with the Committee seeing good progress being made to meet the required standards by March 2023. 5 areas remained outstanding however progress was being made. |
| 175/22 | The overarching compliance report demonstrated areas within the Trust that remained a work in progress including the position with policies. There was a lot of |

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| | work to be completed however the quantum of which was now known and there had been progress made over the past 12 months with a need to ensure this remained on track. |
| 176/22 | Work had been conducted in respect of gifts and hospitality and the standards of business conduct which now required rolling out to the Trust with communications planned to take place in the coming months. |
| 177/22 | The Committee noted the ongoing work in relation to the risk register with a strengthened position and proactive approach. As previously discussed, there was not active management of risk. As highlighted by the Director of Nursing the Committee would receive to the next meeting the Risk Policy for review. |
| 178/22 | The Chair was pleased to note that the Trust Operating Model audit report had been received noting that a view would be taken from the Audit Committee on whether this would need to be received by the Board through a development session in the future.<br><br>The Trust Board:<br>• **Received the report noting the moderate assurance** |
| 179/22 | **Item 14 Any Other Notified Items of Urgent Business**<br><br>The Chair, following the Chief Executive's report, formally welcomed Sir Andrew Cash as interim Chair of the Integrated Care Board on behalf of the Trust Board. |
| 179/22 | The Chair noted that Sir Andrew would bring a significant level of expertise and would, at the earliest opportunity, invite for him to meet with the Board. |
| 180/22 | The next scheduled meeting will be held on Tuesday 1 March 2022, arrangements to be confirmed taking account of national guidance |

| **Voting Members** | **2 Feb 2021** | **2 Mar 2021** | **16 Mar 2021** | **6 Apr 2021** | **4 May 2021** | **1 June 2021** | **6 July 2021** | **3 Aug 2021** | **7 Sept 2021** | **5 Oct 2021** | **2 Nov 2021** | **7 Dec 2021** | **1 Feb 2022** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elaine Baylis | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Chris Gibson | X | A | X | X | X | X | A | X | X | A | X | A | X |
| Geoff Hayward | X | X | X | X | A | A | X | | | | | | |
| Gill Ponder | X | X | X | X | A | | | | | | | | |
| Neill Hepburn | X | X | X | X | X | X | A | | | | | | |
| Sarah Dunnett | X | X | X | A | X | X | X | X | X | X | X | X | X |
| Elizabeth Libiszewski | X | X | X | X | X | X | X | X | X | X | X | X | |
| Paul Matthew | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Andrew Morgan | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Mark Brassington | X | X | X | X | X | X | X | X | | | | | |

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| Karen Dunderdale | X | X | X | A | X | X | X | X | X | X | X | X | X |
| David Woodward | | | | | | X | A | A | X | X | X | X | |
| Philip Baker | | | | | | | | X | X | X | X | X | X |
| Colin Farquharson | | | | | | | | X | X | X | X | X | X |
| Gail Shadlock | | | | | | | | | | | | | X |
| Dani Cecchini | | | | | | | | | | | | | X |

**PUBLIC TRUST BOARD ACTION LOG**

Agenda item: 5.2

| Trust Board date | Minute ref | Subject | Explanation | Assigned to | Action due at Board | Completed |
|---|---|---|---|---|---|---|
| 4 February 2020 | 077/20 | Assurance and Risk Report Quality Governance Committee | Action: Review of TOM and governance to be presented to the Board | Chief Operating Officer | ~~02/11/2021~~ 01/02/2022 | Report received at Jan Audit Committee. Upward report agenda item. Closed |
| 6 April 2021 | 579/21 | Staff survey | Action: Consideration to be given to triangulation of data between staff survey results and quality measures | Int Dir of P&OD | ~~01/06/2021~~ 01/02/2022 | To build in to actions from 2021 Staff Survey and action be transferred to PODC. Closed |
| 6 April 2021 | 596/21 | Smoke Free Policy | Action: Post implementation review following relaunch to be presented to the Board | Int Dir of P&OD | ~~02/11/2021~~ 01/02/2022 | Build in to actions for PODC in line with prioritised work plan for Committee. Closed |
| 7 December 2021 | 1914/21 | Action Log | Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022 | Director of Nursing | 01/03/2022 | Reviews pushed back to March as result of operational pressures. |
| 7 December 2021 | 2021/21 | Integrated Performance Report | Action: Director of Finance and Digital to meet with Dr Prior to explain the position of the watch metrics within the report | Director of Finance and Digital | 01/02/2022 | Ass Dir of Perf and Inf met with Dr Prior to discuss. Complete |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | *Public Trust Board* |
| Date of Meeting | *1 March 2022* |
| Item Number | *Item number 6* |
| **Chief Executive's Report** | |
| Accountable Director | *Andrew Morgan, Chief Executive* |
| Presented by | *Andrew Morgan, Chief Executive* |
| Author(s) | *Andrew Morgan, Chief Executive* |
| Report previously considered at | *N/A* |

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

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| Risk Assessment | *N/A* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | • *Significant* |

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| Recommendations/ Decision Required | • *To note* |
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## Executive Summary

**System Overview**

a) The NHS in the county continues to operate under significant operational pressure, acknowledging that these are the winter months. Key areas of focus continue to be around reducing ambulance handover delays at hospitals and in the community and on the timely and safe discharges of patients who no longer require hospital care.

b) The Government is reviewing the legislation around compulsory vaccinations for front line health staff. Subject to further consultation and the passing of amended legislation in Parliament, the Government has indicated that it intends to revoke the legislation. All of the employment action related to Vaccination as a Condition of Deployment (VCOD) has been stopped. This includes action that would have led to the dismissal of unvaccinated staff.

c) The Government has issued a new White Paper relating to proposals for health and care integration. This is entitled 'Joining up care for people, places and populations'. The White Paper contains a number of questions that the Government intends engaging stakeholders on over the coming months. The proposals in the White Paper should be read alongside the Health and Social Care Bill, the Adult Social Care White paper, and the Levelling- Up White Paper.

d) The All-Party Parliamentary Group for Rural Health and Care and the National Centre for Rural Health and Care have published a national Inquiry into rural health and care. The National Centre is based in Lincolnshire. The Inquiry calls for an overarching place-based rural strategy to address rural health inequalities. This Inquiry will inform the work of the Lincolnshire ICS.

e) Sir Andrew Cash has been appointed as the Interim Chair of the Lincolnshire Integrated Care Board. Subject to legislation, the ICB will be fully established on 1st July 2022 to oversee the commissioning, performance, financial management and transformation of the local NHS. It will subsume the responsibilities of the NHS Lincolnshire CCG, which will cease to exist on 30th June. The ICB is currently appointing its Board members. Sir Andrew Cash was until 2018 the CEO of Sheffield Teaching Hospitals NHS Foundation Trust.

f) The provider collaborative in Lincolnshire, Lincolnshire Health and Care Collaborative (LHCC), is continuing to develop its plans and working arrangements. This includes formalising the Alliance Agreement between its members and agreeing the governance and decision making arrangements.

g) The Government has recently announced changes to the COVID legislation, including those relating to testing and isolation. NHS organisations across the county are working together on the implications for the provision of local services. This includes measures relating to visiting, mask wearing and social distancing.

h) The next Quarterly System Review Meeting (QSRM) with NHS Midlands takes place on Wednesday 2nd March 2022.

**Trust Overview**

a) At Month 10, the Trust reported an in-month surplus of £123k, with a year to date position of a surplus of £1.923m. Both of these figures are £123k better than plan. The forecast year-end position remains a surplus of £1.8m.
b) The CQC published their latest inspection report on ULHT on the 8th February. This followed their inspection in October and November 2021. The overall rating remained at Requires Improvement. This overall rating could not change this time because not all sites and all services were inspected. The ratings for both the Effective and Well Led domains improved from Requires Improvement to Good. The rating for the Caring domain remained at Good. The ratings for Safety and Responsive remained at Requires Improvement. The CQC highlighted the significant and widespread improvements in the safety and quality of the services in the Trust. The CQC commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level. Whilst widespread improvements have been made there was an acknowledgement that the Trust needs to improve access and flow in the A&E department at Lincoln County Hospital and also improve waiting times and the arrangements to admit, treat and discharge patients.
c) Work is continuing to produce year 3 of the Trust's Integrated Improvement Plan. This needs to align with the System's Strategic delivery Plan, Operational Plan and the national planning guidelines.
d) The appointment process is underway for the leadership positions in each of the Trust's five Staff Networks.
e) The first patient at ULHT has undergone an operation using a state of the art robotic surgery system. This follows an investment of more than £3.2m by the Trust to bring this technology to the county for the benefit of urology and colorectal cancer patients.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | *Trust Board* |
| Date of Meeting | *1 March 2022* |
| Item Number | *Item number allocated by admin* |
| **Publication of CQC Inspection Report** | |
| Accountable Director | *Karen Dunderdale, Director of Nursing / Deputy Chief Executive* |
| Presented by | *Karen Dunderdale, Director of Nursing / Deputy Chief Executive* |
| Author(s) | *Kathryn Helley, Deputy Director of Clinical Governance* |
| Report previously considered at | *Not Applicable* |

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

| | |
|---|---|
| Risk Assessment | *Link to strategic risks:- 4405; 4083; 4175; 3688; 3951; 4156; 3503; 4041; 4081; 4145; 4300; 4476* |
| Financial Impact Assessment | *Not Applicable* |
| Quality Impact Assessment | *Through governance process of IIP.* |
| Equality Impact Assessment | *Through governance process of IIP.* |
| Assurance Level Assessment | *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | *The Trust Board is asked to:-*<br>• *Acknowledge the publication of the CQC inspection report and the submission date for the plan to address any actions identified.* |

## 1. Background

Following the unannounced CQC core-service inspection and the announced Well-Led inspection during the months of October and November 2021, CQC published their findings on the 8 February 2022. This is attached as Appendix 1.

The report indicated that the CQC recognised the widespread improvements the Trust have made in the quality and safety of services since the last inspection in 2019. The CQC commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level.

As a result of the inspection, the overall Trust CQC rating remains 'Requires Improvement', however, within the individual service and domain scores huge improvements since the last inspection in 2019 can be seen below:-

Trustwide Position

**2019 Inspection Ratings:**

Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| County Hospital, Louth | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Lincoln County Hospital | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| Pilgrim Hospital | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| Grantham and District Hospital | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| **Overall trust** | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

**2022 *Final* CQC Inspection Report Ratings:**

Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| County Hospital Louth | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Lincoln County Hospital | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |
| Pilgrim Hospital | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |
| Grantham and District Hospital | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Overall trust | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Site Scores - Lincoln Hospital

**2019 Inspection Ratings:**

Ratings for Lincoln County Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| Services for children and young people | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Outstanding Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Requires Improvement Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Inadequate Oct 2019 | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Inadequate Oct 2019 | Inadequate Oct 2019 | Inadequate Oct 2019 |
| Outpatients | Requires Improvement Jul 2018 | N/A | Good Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 |
| Maternity | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| **Overall*** | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |

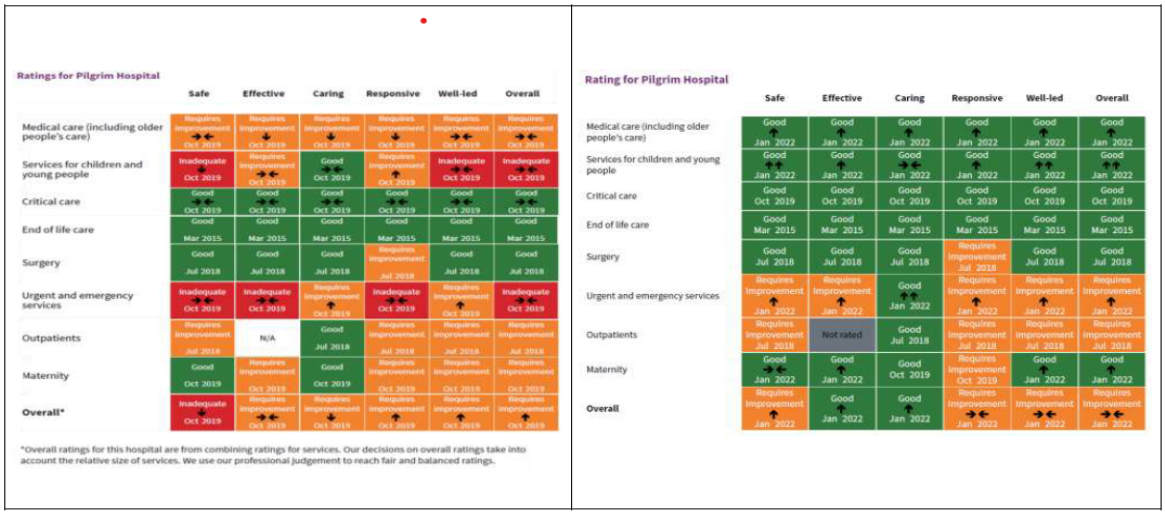
*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

**2022 *Final* CQC Inspection Report Ratings:**

Rating for Lincoln County Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 |
| Services for children and young people | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Outstanding Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Requires Improvement Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |
| Outpatients | Requires Improvement Jul 2018 | Not rated | Good Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 |
| Maternity | Requires Improvement Jan 2022 | Good Jan 2022 | Good Oct 2019 | Good Oct 2019 | Good Jan 2022 | Good Jan 2022 |
| **Overall** | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |

## Site Scores – Pilgrim Hospital, Boston



Ratings for Pilgrim Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| Services for children and young people | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Inadequate Oct 2019 | Inadequate Oct 2019 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Requires Improvement Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Inadequate Oct 2019 | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Inadequate Oct 2019 |
| Outpatients | Requires Improvement Jul 2018 | N/A | Good Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 |
| Maternity | Good Oct 2019 | Requires Improvement Oct 2019 | Good Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |
| **Overall*** | Inadequate Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 | Requires Improvement Oct 2019 |

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Pilgrim Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 |
| Services for children and young people | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 | Good Jan 2022 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Requires Improvement Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |
| Outpatients | Requires Improvement Jul 2018 | Not rated | Good Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 | Requires Improvement Jul 2018 |
| Maternity | Good Jan 2022 | Good Jan 2022 | Good Oct 2019 | Requires Improvement Oct 2019 | Good Jan 2022 | Good Jan 2022 |
| Overall | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 | Requires Improvement Jan 2022 |

## 2. Next Steps

While widespread improvements had been made, the report identified where further improvement is required. The Trust had already established an interim action plan following the feedback provided immediately after the visit and are now in the process of developing the final action plan which must be submitted to the CQC by 10 March 2022

## 3. Recommendation / Decision Required

The Trust Board is asked to:-

- Acknowledge the publication of the CQC inspection report and the submission date for the plan to address any actions identified.

# United Lincolnshire Hospitals NHS Trust

## Inspection report

Greetwell Road
Lincoln
LN2 5QY
Tel: 01522512512
www.ulh.nhs.uk

Date of inspection visit: 5 6, 7, 8 October 2021 and November 9,10,11 2021
Date of publication: N/A (DRAFT)

## Ratings

| Overall trust quality rating | Requires Improvement |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires Improvement** |
| Are services well-led? | **Good** |

# Our findings

## Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

## Overall summary

**What we found**

### Overall trust

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs nearly 8,000 people.

In the last year the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and also delivers services from community hospitals and centres in Louth, Gainsborough, Spalding and Skegness.

Between 5 October 2021 and 11 November 2021, we inspected four core services provided by the trust across two locations. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity at Pilgrim Hospital and Lincoln County Hospital. We also inspected the well-led key question for the trust overall.

We carried out this unannounced inspection of services provided by this trust because the trust was placed in financial and quality special measures in 2017/18 and is currently placed into System Oversight Framework (SOF) segment 4 of NHS England & NHS Improvement (NHSEI) Recovery Support Programme (RSP). At our last inspection we rated the trust overall as requires improvement.

# Our findings

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

On 5, 6, 7, 8 October 2021 we inspected four core services provided by the trust across two locations. We inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity at Pilgrim Hospital. At our last inspection, Urgent and Emergency Services and Services for children and young people were rated as inadequate overall. Medical care (including older people's care) and Maternity were rated as requires improvement overall.

At Lincoln County Hospital we inspected urgent and emergency care, Services for children and young people, Medical care (including older people's care) and Maternity. At our last inspection, Urgent and Emergency Services was rated as inadequate overall. Services for children and young people and Medical care (including older people's care) were rated as requires improvement overall. Although Maternity at the Lincoln County Hospital was rated good overall at our last inspection, we inspected this service because we had concerns.

We did not inspect Outpatients previously rated requires improvement because we are monitoring the progress of improvements to outpatients and had no concerns. We will re-inspect them as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed ‘is this organisation well-led’. We inspected the well-led key question between 9 and 11 November 2021. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSEI). There was not a separate ‘Use of Resources’ assessment in advance of this inspection.

Our rating of the trust stayed the same. We rated them as requires improvement because:

- We rated safe and responsive as requires improvement and effective, caring and well-led as good.
- We rated six of the trust’s services as good and two as requires improvement. In rating the trust, we took into account the current ratings of services not inspected this time.
- We inspected maternity using our focused maternity framework and guidance. Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.
- In maternity services at Lincoln County Hospital we rated safe as requires improvement, the key questions of effective and well led remained the same. In maternity services at Pilgrim Hospital we reviewed actions the trust had taken to address areas for improvement identified in Maternity services following our 2019 inspection. We found the trust had taken sufficient action and improved Maternity services at Pilgrim Hospital and have therefore updated our ratings for this service. We rated the key questions of safe, effective and well led as good, the key questions of caring and responsive remained the same.
- 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.
- Medicines were not always stored safely and patient records were not always stored securely.

# Our findings

- Outcomes from national audits were not always positive and some services did not always use systems to manage performance effectively.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe or follow national guidance.
- Services in urgent and emergency care were not designed in a way that always met the needs of local people, were inclusive and took account of patients' individual needs and preferences.
- People could not always access services when they needed to, and they did not always receive the right care promptly.
- Risks on the risk register, in some services, were not always effectively managed and not all risks were identified and escalated to reduce their impact.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Most services controlled infection risk well. Staff assessed risks to patients, acted on them and mostly kept good care records. Most services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were mostly available seven days a week.
- Without exception, staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders had the skills and abilities to run services. They understood and managed the priorities and issues services faced. Improvements were observed in clinical leadership.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Services engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

**How we carried out the inspection**

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Outstanding practice

**Outstanding practice**

We found the following outstanding practice:

# Our findings

**Trust wide**

- Significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.
- The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week.

**Lincoln County Hospital**

**Medical care (including older people's care)**

- The clinical engineering department had used innovation to support a patient to receive their care and treatment in a comfortable way.
- The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.
- In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

**Pilgrim Hospital**

**Services for children and young people**

- In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy.
- Parents received training, guidance and support to carry out care such as tube feeding and utilised a set of parent competencies in a booklet to enable parents to carry out as much or as little as they felt comfortable with.
- The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their very tiny baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities. There was room for siblings to visit. Parents still had access to nursing and medical staff on the neonatal unit whilst staying in the transitional rooms.

# Our findings

- Leaders had implemented a project with a community team where they worked closely with specialist community nurses to enable neonates who required ongoing specialist care such as continuous oxygen, could be discharged early with the support of a specialist community nurse.
- The service funded nursery nurses to complete their nurse training as part of a recruitment initiative.

**Medical care (including older people's care)**

- The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.
- In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

## Areas for improvement

**Areas for improvement**

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust MUST take to improve**:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to three services.

**Lincoln County Hospital**

**Urgent and emergency care**

- 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.
- The trust must ensure the trust standard operating procedure for management of reducing ambulance delays is fully implemented. Regulation 12 Safe care and treatment.

**Maternity**

- The trust must ensure that all medicines are stored safely and securely. Regulation 12 Safe care and treatment.

# Our findings

**Pilgrim Hospital**

**Urgent and emergency Care**

- 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.
- 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.

**Action the trust SHOULD take to improve:**

**Trust wide**

- 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.
- The trust should ensure they provide sufficient numbers of nursing and medical staff to safely support patients.
- 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.
- The trust should ensure it continues to review and manage the work required to improve medicines management across the organisation.
- The trust should ensure they are using timely data to gain assurance at board.
- The trust should ensure all patient records and other person identifiable information is kept secured at all times.
- 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.

**Lincoln County Hospital**

**Urgent and emergency care**

- 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.
- 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 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.
- The trust should ensure effective systems are in place to review the service risk register.

**Services for children and young people**

# Our findings

- The trust should ensure ambient temperature checks are undertaken in theatres for medicine storage as per trust policy.
- 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.
- The trust should ensure cleaning records are completed as per trust policy.
- The trust should consider discussing mixed sex accommodation with young people proactively rather than reactively.
- 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 .
- The trust should consider adding specific action plans to the service risk register.

**Medical care (including older people's care)**

- The trust should ensure that safety checks of new ward environments are fully completed before moving patients.
- The trust should ensure national audit outcomes are continued to be monitored and any areas for improvement acted upon.

**Maternity**

- The trust should consider monitoring staff's compliance with the systems in place to enable learning from incidents.
- 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.
- 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.

**Pilgrim Hospital**

**Urgent and emergency care**

- The trust should ensure that policies and procedures in place to prevent the spread of infection are adhered to.
- 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.
- The trust should ensure triage is a face to face encounter with a patient for ambulance conveyances.
- The trust should ensure patients at risk of falling undergo a falls risk assessment and falls preventative actions are in place.
- The trust should ensure deteriorating patients are identified and escalated in line with trust policy.
- 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 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.

# Our findings

- The trust should ensure clinical pathways and policies are updated in line with national guidance.
- 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.
- The trust should ensure effective systems are in place to review the service risk register.

**Services for children and young people**

- The trust should consider all key services being available seven days a week.
- 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).

**Medical care (including older people's care)**

- 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.

## Is this organisation well-led?

Our rating of well-led improved. We rated it as good because:

- There was the leadership capacity and capability to deliver high quality, sustainable care.
- There was a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.
- There was a culture of high-quality, sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.
- Appropriate and accurate information was effectively processed, challenged and acted on.
- People who use services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.
- There were robust systems and processes for learning, continuous improvement and innovation.

However:

- The culture of the organisation did not always encourage openness and honesty at all levels within the organisation. Compliance with the duty of candour regulation had been variable however, the trust were taking appropriate action to address this.
- There were inconsistencies at some levels of leadership across the organisation in relation to governance awareness.
- Medicines management across the trust remained a significant challenge. However, the board were cognisant of these risks and were taking steps to address them.

**Leadership**

# Our findings

**There was the leadership capacity and capability to deliver high quality, sustainable care.**

The trust board included five voting executive directors, one of whom was the trust chief executive, two non-voting executive directors and six non-executive directors (NEDs), one of whom was the trust chair. At the time of this inspection, the director of people and organisational development position was vacant and was being covered by the director of finance. There were effective systems in place to ensure that their portfolio was manageable. The vacancy was being recruited to. Two of the non-executives were in the process of retiring from the board and recruitment was in train.

The trust board was accountable for setting the strategic direction of the trust. The board was working effectively together to achieve its full potential. Leaders had the skills, knowledge and experience that they needed. We observed a strong, cohesive team with collective leadership at board level. All executive directors and NEDs were collectively and corporately accountable for the trust's performance. Our observation of trust board meetings and review of board papers evidenced that opportunities were regularly provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

NEDs gave a clear and consistent account of their role within the unitary board. NEDs had a range of experience and backgrounds including leadership within the NHS; three, including the chair, had close knowledge of services in Lincolnshire through membership of the board of another trust in Lincolnshire.

The director of finance had joined the trust as deputy director of finance in 2018 and had been appointed as director in 2019. They were supported by an experienced deputy director of finance who was also an experienced and valued financial leader; and by an energetic and well-motivated finance team. The director's portfolio also included digital and HR; and from interviews it was apparent that there was a well-developed and empowered infrastructure in each department that mitigated the risk of such a broad leadership portfolio in a financially challenged trust.

The board recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. There was a strong board development programme in place designed to improve the effectiveness and efficiency of the board.

Chair and NED development programmes were available to NEDs both internally and through NHS England and Improvement (NHSE/I). NEDs we spoke with told us they were aware of these and some had and/or were accessing programmes depending on their development needs.

The trust was committed to succession planning in order to identify and develop potential future leaders and senior managers, as well as individuals, to fill senior roles that could become vacant and avoid a department or service becoming vulnerable if the post was not filled quickly. Succession planning and talent management linked directly to the trust's Integrated Improvement Plan (IIP) under the "People" strategic objective. In August 2021 the trust successfully submitted a bid to become a pilot trust for the NHSE/I approach to talent management. This would align the trust to NHSE/I and would serve as a Lincolnshire systems approach. The pilot was expected to commence in Jan 2022.

Leadership and management development within the trust was supported through the Lincolnshire Talent Academy. The Talent Academy was formed in April 2015 within the trust, as an initial pilot to support the engagement of young people with the organisation and to influence future career choice. The Talent Academy supported staff at all levels, from entry level apprentices taking their first employed position upon leaving education, through to senior staff looking for further development.

# Our findings

Executive directors and NEDs were visible and approachable. Ward and department visits by board members continued throughout the COVID-19 pandemic albeit, on a much smaller scale. In addition, some executive directors had been, on occasion, working clinically in ward and department areas. Reverse mentoring and 15-steps challenge were also used as tools for engagement with front line staff. The 15 steps challenge focuses on seeing care through a patient or carer's eyes and exploring their first impressions.

There was a leadership structure within the pharmacy team to support the delivery of care. A recent appointment of deputy chief pharmacists had improved this leadership capacity.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of four executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

**Vision and Strategy**

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

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The trust vision 'Outstanding Care personally Delivered 'was underpinned by five key values: Patient-centred; Safety; Excellence; Compassion and Respect. These values supported the trust's integrated improvement plan, a five year plan (2020-2025) that identified the key priorities for the trust.

It was clear during our core service inspection that significant improvements had been made to the safety and quality of care at the trust since our last inspection. The integrated improvement plan provided a framework for the trust to continue to deliver further improvements. Executive directors and NEDs consistently gave us the same message, that this was a proactive rather than reactive trust that was focused on doing the right thing for its patients and staff.

There was a robust, realistic strategy for achieving the trust's priorities and delivering good quality sustainable care. The trust was in year two of their strategy realised through the integrated improvement plan and supported through the trust's Outstanding Care Together Programme (OCTP). Four workstreams worked to deliver the trust's four strategic objectives: Patients, People, Services and Partners. Each strategic objective had an executive senior responsible officer (SRO), identified leads for each workstream and delivery lead for each project.

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust was working with the whole Lincolnshire health and care system on proposals for improvements to services, improvements that aligned to the partners workstream.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Staff at all levels 'walked' the trust values during the course of their work and were empowered to contribute to the strategic direction of

the trust. Throughout the core service and well led inspections we heard of many examples of service improvements made not only at board level but at ward and department level where staff were motivated and committed to improve the safety and quality of care patients received. This included for example, a reduction in falls and pressure ulcers and significant improvements within respiratory medicine.

The pharmacy operational plan 2019-21 detailed the activity of the pharmacy team and we were told the team were still working to this model. The trust single integrated improvement plan included the review of the pharmacy model and service within the improving clinical outcomes section.

**Culture**

**There was a culture of high-quality, sustainable care.**

Staff felt positive and proud to work in the organisation. There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Throughout our core service and well led inspections, staff were enthusiastic, motivated and were keen to share with us their pride at working for this trust. From every conversation the inspection teams had with trust staff it was clear that the patient was at the heart of their work.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and we saw where appropriate learning and action had been taken as a result of concerns raised. Executive leaders told us they adopted an 'open door' policy and we heard of many examples from staff outside the executive team who felt comfortable raising their concerns with the executive team. However, a small number of staff told us they were fearful of raising concerns with their immediate line managers and that this was having a significant effect on their mental health.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. On 12 May 2021 the trust launched an electronic performance and appraisal management system for staff. This was implemented in response to the NHS people plan and the trust's integrated improvement plan, and to support staff in having meaningful conversations about their performance. The system was designed to facilitate quality, values based discussions and encouraged staff to have ownership for their own personal performance and development. The discussions also factored in wellbeing and behaviours.

Current appraisal compliance was 56.8% against a target of 90%. Compliance was 74.9% at the time of launch. The fall in compliance was attributed to staff not being accustomed to the new system, staffing and operational pressures. The board were sighted on appraisal compliance and were taking a number of actions to address this.

There was a strong emphasis on the safety and wellbeing of staff. The trust provided an all-round package of support for staff, helping them to look after their own health and to support those around them. On top of the core occupational health services, the trust had a number of innovative ways to support staff, including; in-house counselling, mental health first aid and mindfulness courses, training for staff and managers in emotional and wellbeing resilience, health check MoTs, an overall health and wellbeing assessment, physiotherapy, counselling training for managers and cognitive behavioural therapy training for managers.

Despite the extensive well-being offer from the trust, staff within pharmacy told us they did not feel valued by the organisation and that lip service was paid to support for their well-being. Examples were given of working long hours without breaks and staffing such that only one Band 3 post was allowed to take annual leave at a time. This had led to low morale.

# Our findings

Equality and diversity was promoted within and beyond the organisation. A number of staff networks were in place to provide a safe space for discussion of issues and help to raise awareness of issues within the wider trust. Equality impact assessments (EIA) were shared across the wider Lincolnshire healthcare system and ensured policies, practices and decisions were fair, met the needs of staff and that they were not inadvertently discriminating against any protected group. The trust had a 'Our Inclusion Strategy' which set out the trust's strategic vision for all the work around the equality, diversity, inclusion and human rights agenda.

Without exception, staff told us they felt supported, respected and valued by the executive team and felt there had been a positive shift in the culture at the trust since our last inspection. However, a small number of staff felt there was work to do to develop those staff in middle management posts. Whistleblowing information received following the well led inspection suggested a small number of staff did not feel supported, respected and valued by their immediate line managers and that they had or were experiencing bullying and harassment. The 2020 National Staff Survey results placed the trust 58th out of 58 acute trusts nationally.

The executive team were committed to addressing behaviour and performance that was inconsistent with the vision and values, regardless of seniority. The organisation's approach to changing the culture was supported by credible plans and a palpable energy within the board. Throughout our interviews with executive directors and NEDs we heard the same message; trust staff and how they were feeling was integral to providing safe and quality care. The trust had signed up to the NHS England and Improvement (NHSE/I) Culture and Leadership Programme and within nursing and midwifery, a nursing and midwifery framework was in place to develop a culture that placed quality at the heart of everything staff did and was centred on the needs and experience of people who use services.

The Freedom To Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The FTSU index score for this trust was 73.6% and below the national average of 79%. Despite this, the trust had made improvements since our last inspection. The trust had appointed a FTSU Guardian, to work exclusively in this role, in September 2021. Staff had a much greater awareness of the role and staff were supported to raise concerns. The number of contacts since September 2021 had increased significantly with 41 contacts made compared to seven for the previous three months and 63 for the whole of 2020/21.

The culture of the organisation did not always encourage openness and honesty at all levels within the organisation, including with people who used services, in response to incidents. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. 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.

In addition to the planned actions, there was a process in place whereby the incident reporting system was reviewed daily by the clinical governance team. If an incident had been reported as meeting the duty of candour criteria, the team contacted the clinical team as a prompt.

# Our findings

**Governance**

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Progress against delivery of the strategy and local plans were monitored and reviewed. Monitoring of the integrated improvement plan was coordinated through the project lead where monthly support and challenge sessions took place with the relevant executive lead. Following the support and challenge sessions, an upward report was completed and fed into the finance, performance and estates committee on a monthly basis. In addition, the integrated improvement plan status report fed monthly into the people and organisational development and quality governance assurance committees. Board and committee papers we reviewed and interviews with executive directors and NEDs demonstrated there was bold decision making of the board that underpinned a well-planned and understood strategy. The consistent message we heard was the board were not afraid of change and felt it necessary to improve the safety and quality of services at the trust.

Since our last inspection the trust had reviewed its governance processes and structure and developed a business partner model approach to risk and governance, clinical audit and complaints. This allowed for triangulation of information to determine an accurate picture of performance across the trust. In addition to this, the trust had introduced an integrated clinical governance report for clinical divisions and a complaints, litigation, incident and Patient Advice and Liaison Service (PALS) (CLIP) report. Both provided a summary of key data at divisional and board level.

All levels of governance and management functioned effectively and interacted with each other appropriately. There were four board sub-committees; quality governance committee, people and organisational development committee, finance, estates and performance committee and audit and risk committee. The role of each board committee was to consider evidence provided by members of the executive team in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that could be provided to the trust board.

There were medicines governance processes in place, and we could see that these had been strengthened following our last inspection. However, senior pharmacy staff told us they did not have clear lines of communication to escalate concerns and were unable to articulate concerns to people who were in a position to address them. We heard from senior trust leaders that there were escalation mechanisms in place and these were effective.

Executive directors and NEDs were clear about their roles and understood what they were accountable for, and to whom. However, there were inconsistencies at some levels of leadership across the organisation. Further work was underway with divisions to develop their understanding of what governance meant for them.

There was complaint sign posting and a complaint policy available on the trust's website for patients and services users to access. During our inspection of well led we reviewed six complaint responses. All responses were clear and transparent throughout and followed the Ombudsman's 'principles of good complaint handling' and 'principles for remedy'. At the time of this inspection the trust had a low number of outstanding complaints (29).

**Management of risks, issues and performance**

**There were clear and effective processes for managing risks, issues and performance.**

# Our findings

There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved.

The trust board was responsible for setting the strategic direction of the trust. This included defining the risk appetite, which was the tendency of the board to accept risk in particular situations and in pursuit of its goals. The trust's risk appetite was defined using the following scale:

- Open – prepared to tolerate a high level of risk
- Cautious – prepared to tolerate a moderate level of risk
- Minimal – prepared to tolerate only a low level of risk

A risk management strategy described the approach that the trust would take in managing risks to the achievement of its objectives through a formalised structure that included both corporate and operational risks. The trust had adopted an Enterprise Risk Management (ERM) approach, this approach enabled the trust board, its committees and senior management to consider the potential impact of all types of risk on its objectives and in doing so supported well-informed, risk-aware corporate and operational decision-making.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The audit committee chair described how the committee and board gained assurance not only from auditors' reports but also from audit regulators. The programme of internal audit had been adapted during the period of the pandemic; but the head of internal audit had only been able to provide partial assurance on the operation of internal controls for 2020-21. They had greater confidence in levels of awareness and training on counter fraud and evidenced a reduction in the numbers of referrals.

We saw evidence of clinical audit relating to medicines reconciliation activity and audit activity presented to clinical groups relating to medicines errors. Both of these demonstrated poor levels of care and this was a recurrent problem. Trust senior teams were cognisant of these risks and were taking steps to address them.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions and we saw there was alignment between the recorded risks and what board members said was 'on their worry list'. As part of this inspection we reviewed the trust's board assurance framework (BAF) and current corporate and service level risk registers. Through our review we were confident the trust board had sight of the most significant risks through the BAF and corporate risk register.

We were assured executive directors and NEDs had a robust oversight of all risks across the trust. During our interviews we were told a piece of work was currently underway to reconfigure the trust's risk registers and in turn strengthen the management and oversight of risk across the organisation. This work was supported by training and the implementation of an executive led risk register 'Confirm & Challenge' group. In September 2021, the trust introduced a risk register confirm and challenge meeting. This was chaired by the director of nursing who was the executive lead for risk and patient safety. At these meetings, over time, each division / directorate would have a deep dive of their risk register. This meeting would provide an additional level of challenge and oversight of risk issues and assurance that appropriate mitigations were in place.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had a winter plan that brought together the culmination of key improvement schemes in planning for recovery and urgent care. The recent NHS Confederation (H2) guidance had been considered in order to produce the plan. The process for authorisation included internal and

external confirm and challenge and resulted in a trust and system plan that worked seamlessly together and one that would ensure safe services. The system coordination of the plan was to run through the Urgent and Emergency Care System Partnership Board. Internal monitoring of both planned and urgent care continued to run through divisional performance review meetings focussing on those elements aligned to the trust's integrated improvement plan.

The trust had been under particular scrutiny from regulators because of its financial and service quality challenges. The trust described itself as improving and starting to embed governance including financial governance; this assessment was confirmed by evidence provided from committee and board papers.

The trust had identified the ability to attract staff as being a very high risk with both service and financial impacts. It told us that it saw the development of a medical school at the University of Lincoln as a development key to improving recruitment and retention of staff.

The trust estate was recognised as requiring significant investment to make premises fit for purpose. The trust told us that the backlog maintenance requirement was c £250m on an asset base valued at £1.1bn. The trust told us about the processes that it had implemented to provide assurance about fire safety; and the improvements that it had made to the safety of infrastructure including electrical; ventilation and medical gas provision. The trust had used the findings of commissioned reporting engineers to build business cases for essential improvements and told us it was able to respond quickly to national ad hoc requests for capital bids.

**Information management**

**Appropriate and accurate information was effectively processed, challenged and acted on.**

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.

Effective arrangements were in place to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Triangulation of evidence to provide assurance was important to the board. Internal audits, matron walkabouts and safety huddles were amongst a number of measures the board used to validate information that was upwardly reported to the board. Where issues were identified, executive directors would hold divisions to account, in turn, NEDs would hold directors to account.

# Our findings

Information technology systems used to monitor and improve the quality of care had yet to be realised. There was a significant reliance on paper to deliver clinical services which created challenges for clinical and other staff to perform their duties. With approximately 200 different clinical systems in use and no single information source containing all patient health information, clinicians needing to log into multiple systems separately.

The trust was one of 32 NHS organisations to receive support in the second wave of the Digital Aspirants programme. The money was to be used to develop the trust's digital strategy and business case to deliver an electronic health record. Plans and funding were also in place around introducing electronic medicines management systems across the trust. The business case for digital transformation was due to be approved in December 2021. Oversight of this was through the digital hospital group with upward reporting to the finance, estates and performance committee.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but not limited to, the care quality commission, commissioners and the local authority.

There were robust arrangements (including appropriate internal and external validation) in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The trust had four information governance data breaches which were reportable in line with the Information Commissioners Office (ICO) guidance in 2020/21. In all cases the ICO were satisfied with action taken by the trust and had closed the incident. No financial penalties were issued.

The Data Security and Protection Toolkit (DSPT), developed by NHS Digital (NHSD), sets out the standards and requirements in respect of receipts, storage and processing of information. The DSPT is structured into a series of numbered criteria. The DSPT is completed on a self -assessment basis each year. NHSD had extended the submission date for the 2020/21 DSPT from 31 March 2021 to 30 June 2021 whereby the trust had met all standards.

**Engagement**

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

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. The patient experience group (PEG) were committed to ensuring patients had the best possible experience in the trust. During our interview with the PEG team we heard and saw evidence to demonstrate a clear mantra being to understand what the process of receiving care felt like for the patient, their family and carers. The team gave many examples of where the public had been involved in shaping safe, quality services.

People in a range of equality groups were actively engaged and involved in decision-making to shape services and culture. A 'sensory loss group' had been set up as a sub-group of the PEG and included patients who were visually or hearing impaired in addition to, representation from charity organisations and Healthwatch. Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

People's views and experiences, including people in a range of equality groups had been gathered and acted on to shape and improve the services and culture. The team gave us many examples where changes had taken place as a result of patient stories at board, in the matron's forum and as part of quality improvement training. In addition, views and experiences had been sought from the travelling community and a number of community groups.

# Our findings

The trust proactively engaged and involved staff (including those with protected equality characteristics) and ensured that the voices of all staff were heard and acted on to shape services and culture. The chief executive chaired the 'council of staff networks', an umbrella group in place to be the collective voice of four active equality staff networks; Women's Network and allies, Lesbian, Gay, Bi and Transgender (LGBT+) and allies, Black Asian and Minority Ethnic people (BAME) and allies and Mental And Physical Lived Experience (MAPLE) and allies. Furthermore, there was a collection of staff who were connected by the Armed Forces Network.

The trust's research and innovation (R&I) strategy (2021- 2024) and vision had been developed through targeted, informal consultation with internal and external stakeholders including:

- Patients and service users through the Lincolnshire Research Patient & Public Forum
- research management leaders from other local healthcare providers
- Local Authority / Local Universities
- trust staff
- R&I managers from other similar trusts
- The National Institute for Health Research (NIHR) Network East Midlands.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust was actively engaged with the development of the Integrated Care System (ICS) and described how it was developing closer links with system colleagues to develop financial strategies and plans to reduce the structural deficit that presently sat within the trust.

Relations between the four finance directors were described as highly collaborative and examples were given of task-and-finish groups to scope the service and financial impact of changes in prescribing; care closer to home; and musculo-skeletal care on the health system deficit. The levels of system ownership of the financial deficit were described as high with quantified financial and service benefits arising from the substitution of agency staff with a more clinically appropriate staff mix based in primary, community and social care organisations.

There was transparency and openness with all stakeholders about performance. The trust was an active participant in the Lincolnshire monthly system review meeting whereby there was attendance from multiple stakeholders including the care quality commission. At the November 2021 meeting the trust raised concerns around their cancer performance which showed the number of patients waiting longer than 62 days had increased and the 14-day standard was not being delivered, particularly in breast cancer where increased demand had outstripped extended capacity. This transparency and openness enabled a discussion amongst external colleagues whereby possible solutions were proposed.

**Learning, continuous improvement and innovation**

**There were robust systems and processes for learning, continuous improvement and innovation.**

Trust leaders and staff were committed to continuous learning, improvement and innovation which included participating in appropriate research projects and recognised accreditation schemes.

# Our findings

The trust had an active improvement academy that supported innovation. Through working with NHS England and Improvement (NHSE/I) and external advisors, the trust had championed quality improvement at all levels of the organisation. By training staff in standardised quality improvement tools and methods, staff were empowered to continuously improve the quality of care and outcomes for patients.

Improvement pieces of work that had been completed by individuals who had completed the trust's quality improvement programmes included for example; improving compliance with heart failure management through accurate fluid balance monitoring and daily weights, introducing three dimensional imaging within the trust to ensure consistency with the National Institute for Health and Care Excellence (NICE) and national nuclear medicine guidelines, supporting staff to continue breastfeeding on return to work and creating a plus size equipment availability information sheet for physiotherapy staff.

The trust had been part of the 'Lincolnshire Stroke Transformation: 100 Day Challenge'. Stroke services had been identified as a system priority during 2019/20. Using both dedicated organisational development support and the 100 Day Rapid Improvement methodology significant work had taken place to implement a 'one team' approach to establishing an integrated, seamless pathway and a community based stroke rehabilitation service that was able to support stroke survivors, operating seven days a week. Improvements included for example, a reduction in length of stay (LoS) on the stroke unit in Lincoln County Hospital from 11 to seven days, launching a patient handbook that travelled with the patient from acute to community and beyond and initiating a dedicated stroke orthoptic clinic.

As a provider of NHS clinical research services, the trust were required to publish performance metrics relating to recruitment and delivery to clinical trials for the previous 12 months through the National Institute for Health Research. Areas of research included oncology, haematology, stroke, cardiology, paediatrics, dermatology, diabetes, midwifery, ophthalmology, respiratory, anaesthesia, general surgery gastroenterology and orthopaedics.

The trust research and innovation department was undertaking an ambitious three-year improvement journey. This was vital for the trust, its' staff, patients and service users as research and innovation was a thread through the core of trust business as described through the integrated improvement plan.

Research within the trust had delivered growth over 10 years, with active pockets across three of the sites (Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital). However, a change of leadership within the department and the subsequent unprecedented changes as a result of the Covid-19 pandemic provided a unique opportunity for the trust to review the department, consider their ambitions for research and innovation (R&I) and plan how they were going to get there. The purpose of the trust's research and innovation (R&I) strategy was to set out the vision and objectives of the trust in relation to R&I from 2021-2024, demonstrating how the trust would meaningfully embed R&I plans into the core business of the trust. It identified the key priorities for the R&I department over the next three years, ensuring that the trust focussed on the right things that would allow staff, patients and service users access to high quality research and innovation opportunities.

We saw evidence of members of the pharmacy team involved in discreet, externally funded roles that supported patient care. This included a project to facilitate safe discharge of people resident in care homes.

The trust was in the early stages of a '90 Minute Standard project' which was aligned to the integrated improvement plan and the surgery transformation programme plan for 2021/22. The aim of the project was to formalise the 90 minute standard process currently utilised in colorectal surgery and by applying a phased approach, roll-out the 90 minute standard to the other tumour sites within the other surgical specialities. Throughout the project, the main objective was to be to build a strong communication strategy to promote this best practice and the huge benefit it has on patient

experience at a time when cancer care is of key national importance. Strategically, this project was aligned to the "Patients" strategic objective and once completed, 100% of suitable patients that had been placed on the two week wait (2WW) list that did not have a suspicion of cancer would be informed within 90 minutes of that confirmation in those specialities.

As part of the transformation of emergency care at Lincoln County Hospital, patients needing urgent care were, from early summer 2021, now being treated in a new purpose built centre. The new state-of-the-art urgent treatment centre (UTC) provided a bright and welcoming entrance for the whole of the emergency department (ED), including a new reception and waiting area that followed the latest social distancing guidance, as well as 10 treatment rooms, a new X-ray and dedicated triage areas. The centre had been built next to the ED, allowing patients to be booked in at reception, assessed and treated in the right place for their needs. The final design had taken into account contributions by clinical and nursing staff from across the trust and partner organisations, as well as from patient experience and sensory impairment groups.

The completion of the UTC was the first phase in a programme of works that was to transform the hospital's ED. Other phases were to see the expansion of the existing ED to include: a bigger resus area with twice as many bays for the sickest emergency patients, a new paediatrics area with its own dedicated waiting room, treatment cubicles and a sensory area for the youngest patients and their families, additional treatment rooms for mental health patients, a new ambulance drop-off and bays created outside the front of the department with entrances directly into the resus and majors areas and additional clinical space, meaning that the emergency department would be able to accept patients from ambulance crews with improved speed and safety.

The trust had a Joint Advisory Group on Gastrointestinal Endoscopy (JAG) re-accreditation assessment visit in July 2021. At the time of our inspection, the draft report, for factual accuracy checking, was awaited. The JAG website showed this as being in the 'QA Process – for approval'. The verbal feedback provided at the time of the visit was positive.

Participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service was effective and learning shared effectively and used to make improvements.

As part of this inspection we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed six cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Respiratory medicine had been an area of concern identified by the trust in relation to the management of patients requiring non-invasive ventilation and other specialist respiratory treatments. The trust had undertaken significant improvement work to improve respiratory services. During late summer 2021 the trust opened a state-of-the-art respiratory unit at Lincoln County Hospital. The unit had been designed with 10 side rooms, all equipped with video technology and monitoring equipment. The unit was available to treat both inpatients and outpatients from across the county who had diseases of the lining of the lung.

## Key to tables

| Ratings | Not rated | Inadequate | Requires improvement | Good | Outstanding |
|---|---|---|---|---|---|
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| **Symbol *** | ➔➔ | ↑ | ↑↑ | ↓ | ↓↓ |

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| County Hospital Louth | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Lincoln County Hospital | Requires Improvement ➔➔ Jan 2022 | Good ↑ Jan 2022 | Good ➔➔ Jan 2022 | Requires Improvement ➔➔ Jan 2022 | Requires Improvement ➔➔ Jan 2022 | Requires Improvement ➔➔ Jan 2022 |
| Pilgrim Hospital | Requires Improvement ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Requires Improvement ➔➔ Jan 2022 | Requires Improvement ➔➔ Jan 2022 | Requires Improvement ➔➔ Jan 2022 |
| Grantham and District Hospital | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Overall trust | Requires Improvement Jan 2022 | Good Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 | Good Jan 2022 | Requires Improvement Jan 2022 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Rating for County Hospital Louth

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Outpatients and diagnostic imaging | Good Mar 2015 | Not rated | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| **Overall** | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |

## Rating for Lincoln County Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good →← Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 |
| Services for children and young people | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good →← Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Outstanding Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Requires improvement Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Good ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 |
| Outpatients | Requires improvement Jul 2018 | Not rated | Good Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 |
| Maternity | Requires Improvement ↓ Jan 2022 | Good →← Jan 2022 | Good Oct 2019 | Good Oct 2019 | Good →← Jan 2022 | Good →← Jan 2022 |
| **Overall** | Requires Improvement →← Jan 2022 | Good ↑ Jan 2022 | Good →← Jan 2022 | Requires Improvement →← Jan 2022 | Requires Improvement →← Jan 2022 | Requires Improvement →← Jan 2022 |

## Rating for Pilgrim Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 |
| Services for children and young people | Good ↑↑ Jan 2022 | Good ↑ Jan 2022 | Good → ← Jan 2022 | Good ↑ Jan 2022 | Good ↑↑ Jan 2022 | Good ↑↑ Jan 2022 |
| Critical care | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| End of life care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Requires improvement Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Good ↑↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 | Requires Improvement ↑ Jan 2022 |
| Outpatients | Requires improvement Jul 2018 | Not rated | Good Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 |
| Maternity | Good → ← Jan 2022 | Good ↑ Jan 2022 | Good Oct 2019 | Requires improvement Oct 2019 | Good ↑ Jan 2022 | Good ↑ Jan 2022 |
| **Overall** | Requires Improvement ↑ Jan 2022 | Good ↑ Jan 2022 | Good ↑ Jan 2022 | Requires Improvement → ← Jan 2022 | Requires Improvement → ← Jan 2022 | Requires Improvement → ← Jan 2022 |

## Rating for Grantham and District Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Critical care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| End of life care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Outpatients and diagnostic imaging | Good Mar 2015 | Not rated | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Urgent and emergency services | Requires improvement Apr 2017 | Good Apr 2017 | Good Apr 2017 | Good Apr 2017 | Good Apr 2017 | Good Apr 2017 |
| **Overall** | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |

# Pilgrim Hospital

Sibsey Road
Boston
PE21 9QS
Tel: 01522573982
www.ulh.nhs.uk

## Description of this hospital

Pilgrim Hospital, Boston serves the communities of South and South East Lincolnshire. It provides all major specialties and a 24-hour major accident and emergency service.

Between 5 and 8 October 2021, we inspected four core services provided by the trust at this location. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate. we did not identify a breach of regulation in Maternity services at Pilgrim Hospital.

However, following our inspection of Maternity services we reviewed actions the trust had taken to address areas for improvement identified in Maternity services following our 2019 inspection. We found the trust had taken sufficient action and improved Maternity services at Pilgrim Hospital and have therefore updated our ratings for this service.

Following our 2019 inspection we issued a Section 29A Warning Notice to the trust as we found significant improvement was required to the governance in children and young people services at Pilgrim Hospital. Following a review of all the evidence from this inspection and a review of additional information provided by the trust before and following our inspection, we are satisfied that significant improvements have been made and the requirements of the Section 29A Warning Notice have been met.

# Urgent and emergency services

**Requires Improvement** 

## Is the service safe?

**Requires Improvement** 

### Mandatory training

**The service provided mandatory training in key skills including the highest level of life support training, however not all staff had completed it.**

Most registered nurses kept up to date with mandatory training. Following our inspection, the service provided us with a breakdown of registered nurse mandatory training compliance data. 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%). A plan for improving training compliance for both nursing and medical staff was in place.

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. However, 19 nurses had completed immediate life support training along with a further 20 nurses being trained in ALS. 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% or registered nurses had completed paediatric intermediate life support (PILS) and 65% EPALS.

Managers told us life support training compliance was impacted by the COVID-19 pandemic resulting in limited availability of external and internal training courses. 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. Further training dates were booked for ALS and EPALS where staff had not completed it or due an update. We saw all medical staff who had not completed this training had a date booked. To mitigate risks, the rota was planned to ensure adequate numbers of medical and nursing staff were on duty with the relevant level of life support skills. On the day of the inspection, we saw nursing and medical staff working within the paediatric area within the Emergency Department had completed EPALS.

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.

# Urgent and emergency services

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. 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.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept a log of staff training requirements which they used to remind staff when they were due to complete training. Compliance was reported to matrons through confirm and challenge meetings monthly.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. Systems and processes to check nationally approved child protection information sharing systems were in place but not embedded or monitored by managers.**

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.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided us with examples of where they have made safeguarding referrals for both children and adults. Details of local safeguarding arrangements were displayed in the department for staff to reference.

Staff generally followed safe procedures for children visiting the department. The paediatric area within the Emergency Department had significantly improved since our previous inspection. It was co-located within the adult emergency department with its own waiting area, separated from the adults waiting area. The department was accessible in and out by a keypad to ensure no unauthorised access. Staff told us children and young people at high risk of potential safeguarding concerns were reviewed by a senior paediatrician.

Systems were in place to review cases where children and young people left the department without being seen. Staff told us this did not occur often but demonstrated an understanding of how to deal with this. The trust safeguarding team were notified when a child or young person left, and a medical staff member attempted to make contact. General practitioners were notified through a discharge letter. The process was reviewed by the safeguarding team through quarterly audits.

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.

Systems were in place to add an alert to emergency department electronic patient records should there be a safeguarding concern. For example, to identify children and young people who attend frequently.

### Cleanliness, infection control and hygiene

**The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

All areas were clean and had suitable furnishings which were clean and well-maintained. Most areas we visited appeared clean. Chairs were wipe clean and most equipment appeared to be clean.

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.

Staff generally followed IPC principles including the use of personal protective equipment (PPE). We observed all staff were bare below the elbow and wore surgical face masks. Monthly matron IPC audits showed from April to September 2021 an average 90% compliance with hand hygiene practices and 98% compliance with adherence to PPE standards appropriate to the patients need.

Patients were routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. A rapid assessment intervention treatment (RAIT) consultant was located in the reception area from 8am to midnight daily to stream patients into the most appropriate areas based on COVID-19 risk.

Staff wore surgical face masks, aprons and gloves when caring for patients with or suspected of COVID-19. Staff told us they only wore FFP3 masks and eye protection for aerosol generating procedures (AGP).

Green and blue pathways were implemented to separate patients with suspected or confirmed COVID-19. Perspex screens were erected to physically separate pathways to reduce the risk of cross contamination in the department.

Staff had access to appropriate hand hygiene facilities. Hand sanitising gel was readily available. We observed staff washing their hands with soap and water after patient care, including after removing gloves following contact with bodily fluids. Staff used alcohol gel following patient contact.

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.

Single use equipment was used to avoid cross contamination between patients such as blood pressure cuffs.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.**

Most patients had a call bell to hand and staff responded quickly when called. However, a patient who was high risk of falling did not have an accessible call bell. Once made aware staff ensured it was in reach of the patient. Call bells were answered quickly by staff during our inspection.

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 area within the Emergency Department. 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 for transfer into the department. In order to improve safety, patients were reviewed on arrival by the pre-hospital practitioner (PHP).

During our previous inspection we found the resuscitation area operated at full capacity for the duration of the inspection. In response the service created a fully equipped second resuscitation room with two bays as part of the 'green' pathway. This meant there were six resuscitation spaces available to accommodate surges in demand. The bay was intended to be stepped down to a majors bay when resuscitation capacity was not required. During our inspection, the department was under considerable pressure and the additional beds were used as majors.

# Urgent and emergency services

The walk-in waiting room had undergone refurbishment and increased capacity to 16 chairs. Chairs were a mixture of sizes to accommodate people with different needs. They were wipe clean and were separated with perspex screens to ensure patients were separated to prevent the spread of COVID-19. Four chairs were dedicated to fit to sit streams and were monitored by staff.

The paediatric area within the Emergency Department had undergone significant refurbishment since our last inspection. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings were being followed. The resuscitation bay was in the adult area, however, was at the end and decorated in child friendly colour and pictures. This was used by adults at times of peak demand, however, was prioritised for children and young people. In an emergency the nurse assigned to paediatrics would accompany the child with support from the paediatric emergency team.

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 self-harm 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.

Storage space was limited across the department. For example, we saw unused trolleys stored in front of cubicle nine and ten blocking a walkway. Wheelchairs and linen trolleys were stored in corridors. Limited storage space meant a cubicle was used to store equipment. Areas containing equipment which could cause harm to a patient were not always secure to prevent unauthorised access. For example, we found the clean procedure room contained a cupboard with a 'slim body skin staple' and surgical scissors were on a trolley. The door to this room was always wide open throughout the inspection, we were therefore not assured staff took steps to ensure the environment was always secure. Following the inspection, the trust advised us locks would be fitted on cupboard doors in the clean procedures room to ensure there was no access to sharps.

Whilst the department was cluttered due to the demand exceeding the size of the area, staff made efforts to keep the patient cubicles as clutter free as possible.

Staff carried out daily safety checks of most specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis kits. All were checked as per the trust policy and included all relevant equipment. However, a difficult airway trolley in the blue resuscitation area had three items which had expired including two laryngeal mask airways and one tracheotomy tube. This was escalated to the nurse in charge who agreed to update the equipment and ensure checks were completed.

The service did not have suitable facilities to meet the needs of patients' families. The service had made considerable changes to the department since our previous inspection to ensure they could separate patients with COVID-19 and improve safety of patients in the department. This impacted the family room which was turned into a COVID-19 testing room at the time of the inspection. Staff told us when having sensitive conversations or delivering bad news, they would find a private space for families. Managers recognised this was not ideal but were restricted due to the limited space in the department.

The service had enough suitable equipment to help them to safely care for patients. Equipment was accessible and processes were in place to report when not working. Pressure relieving mattress toppers were readily available and were used for patients at risk of pressure tissue damage. Beds could be ordered for patients where a trolley was unsuitable, although there was limited room for beds in the department.

Staff generally disposed of clinical waste safely. Waste segregation was in place. Personal protective equipment (PPE) such as aprons and gloved were disposed of in clinical waste bins. However, we identified a blood bottle disposed of in a clinical waste bin rather than a sharps bin. This was escalated to the senior sister. Needle sharp bins in the department were not over full and the bins were dated and signed by a member of staff.

### Assessing and responding to patient risk

**Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not complete all relevant risk assessments on patients admitted to the department and tried to remove or minimise risks.**

Following our previous inspection, we found improvements had been made in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021 an average of 92% of adults and paediatrics were triaged within 15 minutes of arrival. During our inspection we reviewed 30 patient triage records and found 24 (80%) patients had been triaged within 15 minutes of arrival. Of the six that were not triaged within 15 minutes, the times ranged from 18 to 30 minutes.

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.

Ambulance handover delays had got worse as the number of conveyances increased. The proportion of patients attending by emergency ambulance who waited between 30 and 60 minutes from arrival to handover at Pilgrim Hospital was consistently higher than the Midlands and England averages from 23 May 2021 to 12 September 2021. As of 12 September 2021, 29.6% of patients waited between 30 and 60 minutes, compared to 18% for the Midlands and 13.1% for the England average. Furthermore, over the same period the proportion of patients attending by emergency ambulance who waited over 60 minutes from arrival to handover had been getting worse. As of 12 September, the proportions were 30.9% for Pilgrim Hospital, 14.5% for the Midlands average and 9.6% for the England average.

From April to September 2021 there was an increase in the number of ambulance handovers delayed over 60 minutes from arrival. For example, in April 2021 the service reported 87 patients waiting longer than 60 minutes and by September 2021 it had risen to 446 patients. The service had experienced a significant increase in attendances. During our inspection, the emergency department was under high pressure and demand. Patients had long waits on ambulances. For example, on 5 October 2021 at 2pm we noted 49 patients were in the department with six ambulances waiting. The longest wait at the time we checked was 152 minutes. Furthermore, on 6 October, we noted a patient had been waiting on an ambulance for more than 4 hours. We were assured these patients were being appropriately monitored and escalated where required in line with trust policy.

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.

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.

# Urgent and emergency services

During our inspection we randomly checked patients who were flagging as having a high NEWS score. We found in all cases action had been taken to escalate and review the patient. Following the inspection, the service provided us with outcomes of monthly high NEWS care audits. This demonstrated from May to September 2021 all patients attending with a high NEWS score by ambulance were triaged within 15 minutes and the average ambulance handover time was 5.5 minutes. The critical care outreach team had a presence within ED; to support staff in managing patients who had deteriorated.

Staff did not always complete risk assessments for each patient on arrival, using a recognised tool. Risk assessment tools such as skin integrity and pressure care body maps were generally included in the casualty assessment document completed by nursing staff. Additional documents were used including mental health and falls risk assessments.

We found variable compliance with completion of risk assessments. Fifteen out of 17 records we checked had an initial assessment of a patient's skin and where required a body map of any skin damage documented. Monthly matron audits generally reflected our findings during the inspection. From April 2021 to September 2021, an average of 82% of skin assessments checked had been completed within an hour of arrival and 100% patients had a pressure relieving mattress if required.

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.

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.

Staff knew about and dealt with some but not all specific risk issues. There were protocols in place to ensure patients requiring emergency interventions were placed on a pathway or received a package of care. Staff knew about conditions requiring prioritisation such as stroke and chest pain and we observed staff following escalation processes.

During our inspection we found improvement had been made in the identification and management of patients with sepsis or suspected sepsis. We reviewed seven patients who were identified at risk of sepsis. We found all had undergone a sepsis screen and the sepsis six bundle had been implemented and all actions completed within the hour including the administration of intravenous antibiotics. An audit completed from 4 to 17 August 2021 showed 90.6% of adults had a sepsis screen completed within 60 minutes and 93.4% of children and young people. Where required, treatment had commenced within 60 minutes in 90.6% of cases for adults and 100% for children.

Effective systems were in place to identify non-compliance with sepsis assessment and treatment protocols. The NIC and EPIC checked the electronic patient at a glance boards for patients with high NEWS to ensure they had been escalated and the sepsis bundle had been started. Where non-compliance was identified, rapid harm reviews were undertaken to identify whether the patient had come to harm or there were any care delivery issues. The trust section 31 urgent care report dated 20 August 2021, showed 14 harm reviews had been completed where staff had not completed a

sepsis screen and five where the full sepsis bundle had not been implemented within an hour. Furthermore, there had been three missed sepsis screens in the paediatric area within the Emergency Department. No harm to patients had occurred in any of these cases. We saw individual staffing issues were addressed and learning was shared during staff huddles. The service had a sepsis workbook and competency sign off process in place to improve practice.

Venous thromboembolism (VTE) risk assessments were completed in the medical assessment and doctors told us these were normally completed prior to prescribing preventative medicines to patients. VTE assessments had been completed in the records we checked, and patients had been prescribed preventative medicines where appropriate.

Where a patient was at risk of developing pressure tissue damage, we saw air flow mattress toppers were in place. Intentional rounding was in place and documented in the nurse led safety checklist. We found this was generally completed and included a repositioning record for patients at risk of developing a pressure ulcer. Monthly matron audits from April to September 2021 showed 100% of patients who needed one had a pressure relieving mattress in place.

Preventative actions to reduce the risk of a patient falling were not fully implemented or personalised. None of the patient records we reviewed documented personalised actions to be taken to reduce the risk of a patient falling. During our inspection we found preventative actions were not implemented in three out of five patients we observed who were at risk of falling. For example, none of the patients had a yellow wrist band, suitable footwear, bed rail assessment or lying and standing blood pressure. One patient had a one to one overnight, but this was not in place during the day. There was no reason documented why this had stopped. Staff told us their risk had reduced yet there was no evidence the risk had been reassessed. One out of the five patients did not have a call bell to hand and was not in a visible cubicle. Staff did however have an awareness of which patients were at risk of falling. Risks were discussed at shift handover and safety huddles. Matron monthly audits from April to September 2021 demonstrated poor (76%) compliance with lying and standing/sitting blood pressures. Patients at risk of falling were discussed at shift handover and safety huddles.

Patient trolleys were high and bedrails were in place which meant patients who were confused were at increased risk of harm from falling or harm through bed rail use. During the inspection we observed the trolleys were high and bed rails were in place for all patients and those at risk of falling. Most trolleys were at their lowest height but there was still a potential risk of harm, particularly with other preventative methods not being consistently implemented.

The service had 24-hour access to mental health liaison and specialist mental health support. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours which placed them or others at risk.

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.

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.

Shift changes and handovers included all necessary key information to keep patients safe. We observed both the nurse handover and medical handover. We found the medical handover lacked structure in comparison to the nursing handover. All patents were discussed at medical handover but did not see evidence of overview of departmental risks,

staffing levels, plan to mitigate information technology failure. The nursing handover covered key areas including patients with high NEWS, at risk of pressure ulcers and falling, patients who lacked capacity. Nursing handovers provided an overview of capacity, staffing and escalation processes. We also saw managers or lead nurses go through current topics such as sepsis screening.

### Nurse staffing

**The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure there were 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.

Skill mix was a challenge for managers due to the volume of new and junior RN's. For example, new nurses could not do triage training until they had been in post six months and some international nurses were still undertaking key competencies or were still supernumerary.

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 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 took action to regularly assess and improve staffing levels. A staffing review was undertaken in September 2021 using a nationally recognised tool which recommended an adjustment to the staffing template. The recommendation, for an additional three registered nurses, had been submitted to the director of nursing for consideration. Managers told us it was expected the additional nurses would be allocated to the blue majors' stream, one to flex into the paediatric area within the Emergency Department and an additional staff member between 12-12 to support peak activity.

# Urgent and emergency services

Staff told us staffing levels had improved. Processes were in place to escalate staffing concerns. The service worked with the other ED departments and where appropriate could swap staff to mitigate skill mix challenges. For example, moving staff with paediatric competencies. Healthcare support workers with extended roles had been introduced to support more challenging areas in the department such as triage.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Managers uploaded all required skills on the roster which was not approved until all skills were covered. Staffing gaps or increased pressures were added onto the ED risk tool which was updated twice per shift by the nurse in charge. Staff would be pulled from other areas in the trust if required as well as managers working clinically.

The roster was completed in advance and daily assurance calls took place with the nurse in charge to review staffing for the following day to confirm numbers and skill mix was correct.

The department manager could adjust staffing levels daily according to the needs of patients. Managers escalated department pressures through the matrons and the daily bed meeting. Additional staff could be requested to support the service to manage capacity and demand.

Staff were assigned to specific areas at the beginning of the shift depending on their experience and competencies.

The service had reducing vacancy rates. Data provided to us by the service following the inspection demonstrated a significant improvement with registered nurse vacancy rate. In April 2021 the vacancy rate was 25% which had steadily reduced to 4.3% in August 2021. The service had undergone a successful recruitment campaign, including an international nurse recruitment campaign. As of September 2021, there was a 1% vacancy rate for non-registered nursing staff.

The service had low and reducing turnover rates. Data provided by the trust demonstrated in April 2021 the turnover rate was 9.3% and had reduced to 4.5% by September 2021. The turnover rate for non-registered nursing staff was higher with an average 12.1% from April to September 2021.

The service had reducing sickness rates for registered nurses. From April to September 2021 the average vacancy rate was 6.4%. The rate was higher for non-registered nursing staff which averaged 10.1% over the same time period.

The service had high but reducing rates of bank and agency nurses. During our inspection we observed bank and agency nurses used to fill shifts. However, the rate of usage had reduced since new nurses had started. Managers limited their use of bank and agency staff and requested staff familiar with the service. Enhanced rates for bank staff started in November 2020 which increased uptake of shifts by substantive staff.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers told us bank and agency staff were included in any topical training such as sepsis and pressure care to ensure practice was in line with trust standards.

### Medical staffing

**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.**

# Urgent and emergency services

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.

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.

The service took action to regularly assess and mitigate and medical staffing risks. The service reviewed its skill mix of medical staff on each shift. Staffing levels were discussed at handovers and medical staff were assigned areas to work based on skill mix. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had high rates of bank and locum staff. The service was committed to ensure locum cover was available when required. The locums used were regular doctors who had worked in the service for some time. Managers could access locums when they needed additional medical staff. The service utilised bank and agency medical staff to ensure the service had adequate cover due to the high vacancy rate. However, it was expected the reliance on agency would reduce once all posts recruited into had commenced employment.

Significant improvements in medical staffing and recruitment had been made. The service agreed an uplift in medical staffing resulting in increased numbers of consultants and middle grade doctors being recruited. There was reliance on agency and locum staff. For example, on the first day of our inspection there were five locums covering middle grade and junior doctor shifts. Recruitment of middle grade doctors had been a challenge; however, most positions had been recruited to at the time of the inspection and awaiting start dates. Where there were shortages and demand was high consultants acted down into more junior positions. The service always had a consultant on call during evenings and weekends.

At our last focused inspection, we reported there were eight whole time equivalent consultants on duty with only one being substantive. Significant improvements were seen during our inspection. All consultants on the rota the week of the inspection were substantive. The service was able to meet recommendations from the Royal College of Emergency Medicine (RCEM), that consultant staffing in the ED to be present in the ED for a minimum of 16 hours a day. Consultants cover was provided Monday to Friday 8am to midnight. On call cover was provided at all other times. At times of peak demand, consultants would work extended hours. The service had recruited to all 12 consultant posts with two awaiting a start date.

The service had made significant progress with recruitment, however, start dates for successful candidates had been impacted by the COVID-19 pandemic. It was expected all prospective candidates would be in post early 2022.

The service had consistently low turnover rates for medical staff. The turnover rate for both consultants and middle grade doctors from April to September 2021 was 0%.

Sickness rates for medical staff were low. The average sickness rate from April to September 2021 for all grades was 1.35%.

Managers made sure locums had a full induction to the service before they started work. Locums working in the service had an induction including an orientation and were included in departmental meetings and safety huddles. New doctors were given the opportunity to shadow before starting and we saw this was included on the medical rota.

### Records

**Records were not always stored securely. Staff did not always keep detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.**

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. Records were regularly updated to record two hourly care rounding, however, the content varied with lack of standardised approach to information recorded.

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.

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.

### Medicines

**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.**

Staff did not always follow systems and processes when storing medicines. During our inspection we found the medicine cupboard in the green resuscitation room which was being used as a majors cubicle unlocked and containing intravenous (IV) antibiotics. The cupboard had a keypad lock; however, it did not work therefore could be accessed by unauthorised persons. We also found a store cupboard in the same room contained several IV paracetamol infusions. This was not intended for a medicines cabinet and was not lockable. The door to the room was always open and used by patients. Staff told us the lock had not worked for some time, yet ward storage audits undertaken from April to September 2021 indicated 100% drug cupboards were always locked which suggested the cupboard had not been effectively checked. Once escalated to the senior sister these were moved immediately and the lock quickly fixed.

Not all liquid medication bottles had open dates recorded that were stored in the medicines room. For example, we found oral morphine, peptic and nurofen for children had been opened with no date recorded to indicate when it was opened.

We reviewed fridge temperature checks from August to September 2021 and found there were four occasions the temperature went out of range. On two occasions there was no evidence of any action taken to escalate this to pharmacy, therefore we were not assured the correct steps for escalation were followed to ensure the medicines were safe to be used. This is something we identified at our previous inspection and were not assured it had improved.

The service routinely monitored medicine room temperatures.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records were maintained to show medicines that had been prescribed had administered. We reviewed five medicine charts and found allergies were recorded in all records. Medicines were administered on times indicated and antibiotics were administered in a timely fashion when indicated.

Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. We saw pharmacy team audits of controlled drug logs were regularly recorded.

Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine

We saw information about medicines administered went with the patient to ward when they were admitted from ED.

Staff reviewed patients' medicines regularly. Medical staff recorded medicines already prescribed and when last taken on the casualty card. Any medicines administered by ambulance crew were also recorded and time administered.

Staff followed current national practice to check patients had the correct medicines. We observed staff checking patients details before administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a chemical restraint policy and procedure in place. Decision making procedures were in place to aid staff to use least restrictive measures first. A rapid tranquilisation and chemical restraint checklist was in place. Medical staff we spoke to understood the procedures. Matron audits from April 2021 to August 2021 demonstrated 100% compliance with policy where patients were administered chemical sedation.

### Incidents

**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.**

Staff knew what incidents to report and how to report them. Staff could provide examples of incidents they had reported and whether improvements had been made as a result.

# Urgent and emergency services

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.

Serious incidents were reported. From September 2020 to August 2021, ten Serious Incidents (SI's) relating to urgent and emergency care were reported at Pilgrim Hospital.

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. For example:

- Incident one – occurred on 4 June 2021, reported on 23 June 2021 and duty of candour applied verbally and in writing on 17 August 2021.
- Incident two – occurred on 30 March 2021, reported on 30 April 2021 and duty of candour applied 7 July 2021.
- Incident three – occurred 9 April 2021, reported 15 April 2021. Whilst duty of candour was applied on the day of reporting, this was verbal, and no written duty of candour applied.

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.

Managers investigated incidents thoroughly. We reviewed SI reports and saw a thorough investigation took place with key learning identified to improve. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff notice boards contained information and earning relating to serious incidents which had occurred within the department and elsewhere. Staff told us they received feedback from incidents they reported. Staff could describe learning from historical and recent incidents which occurred at the service and other areas within the trust. For example, we observed learning was shared across sites following an incident resulting in a missed diagnosis of aortic dissection. Managers debriefed and supported staff after any serious incident.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at monthly governance meetings and shared with staff at medical and nursing handovers. A newsletter was produced monthly where learning from incidents including serious incidents were shared with staff. Managers and staff told us they used social media platforms to communicate learning with staff to ensure learning was widely disseminated and consistently shared. Mortality and morbidity meetings took place bi-monthly where reviews of patient's care and treatment were undertaken, reviewed and learning shared. Feedback following medical examiner reviews was shared with staff at local governance meetings.

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.

# Urgent and emergency services

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere.

## Is the service effective?

**Requires Improvement** 

### Evidence-based care and treatment

**Clinical pathways and policies were not always updated in line with national guidance. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.**

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.

The standard operating procedure and flowchart for identification of patients presenting with potential sepsis for adults had been revised following our previous inspection.

The service had a programme of monthly quality audits to assess compliance against best practice. For example, sepsis, pain management and diabetes care. Matrons completed monthly quality audits which included reviewing records, speaking to patients and observations. This was put into a report and triangulated with daily department assurance reports to discuss with local managers to set actions to improve through monthly confirm and challenge meetings. Two hourly nurses in charge checks were completed to assess compliance with documentation throughout the shift. Issues were addressed at the time with staff and where required, support from practice facilitators was put in place to support learning.

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.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

### Nutrition and hydration

**Staff did not assess all patients using a nationally recognised screening tool. Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs**.

Staff did not use a nationally recognised screening tool to monitor patients at risk of malnutrition. Screening for malnutrition was completed on admission to a ward. However, many patients were in the department a long time and could arrive with a poor nutritional status.

Staff generally made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Two hourly comfort rounds were in place where food and drinks were offered. The service had recently introduced hot food for patients with extended stays in the department. Support was provided to patients who needed assistance with food and fluid intake. Matron audits from April to September 2021 demonstrated all patients received nutrition and hydration in line with their individual needs. The service did not have any staff trained to complete swallow assessment for patient with dysphagia, but managers told us arrangements would be made for patients to be assessed on the acute medical short stay ward (AMSS). There were 17 patients referred and seen in AMSS in Pilgrim in the three months prior to our inspection.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded on the comfort round log in the casualty documentation where patients had been offered and accepted food. Where required fluid balance charts were in place and generally up to date. Matrons monthly audits demonstrated improvements with fluid balance monitoring across nine measures which in August and September 2021 was 100% compliant.

Specialist support from staff such as dietitians was available for patients who needed it, however there was not speech and language therapy service provided in accident and emergency.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and generally gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Improvements had been made since our comprehensive inspection in 2019. Pain scores were documented at the point of triage in 16 out of 19 records we reviewed. This included two paediatric patients. One of the patients where a pain score was not documented was given timely analgesia. All patients we spoke to told us they had been asked about their level of pain and offered analgesia if in pain. Matron quality audits from April 2021 to September 2021 demonstrated 100% compliance with pain assessment measures.

Staff told us they used specific pain assessment tools for patients with dementia or a learning disability. Service leads felt this was an area for improvement. Work was being undertaken to implement a visual scale to use for patients with communication difficulties which would feature in regular pain audits.

Patients generally received pain relief soon after it was identified they needed it, or they requested it. Patients told us they received pain relief quickly after they were assessed in most cases. We found analgesia was generally administered in a timely manner. However, in two records we found a delay of more than two hours. In one case this was a result of staff having difficulty cannulating and the other impacted by ambulance delays. Monthly matron audits demonstrated improvements in action being taken and documented in response to pain. From April to August 2021 the average compliance was 80%, however in July and August the expected standards were met.

Staff prescribed, administered and recorded pain relief accurately. For patients brought in by ambulance where medicines were prescribed, staff recorded this on this on the casualty card along with medicines prescribed at point of triage. We did not see any prescribing or recording errors on prescriptions.

# Urgent and emergency services

## Patient outcomes

**Staff monitored the effectiveness and quality of care and treatment. Outcomes from national audits were not always positive.**

The service participated in several national clinical audits. This included the Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Vital signs in adults 2018/2019
- RCEM Audit: Feverish child 2018/2019
- RCEM Audit: VTE in lower limb immobilisation 2018/2019
- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Some of the data submitted to national audits was incomplete.

Outcomes for patients were not always positive and did not always meet expectations or national standards. The service participated in the Trauma Audit and Research Network (TARN) audit. Data was collected from April 2016 to March 2018. Outcomes were not always positive as follows:

- 0% of eligible patients received tranexamic acid within three hours of injury. This was lower than the TARN aggregate.
- Crude proportion of patients with severe open lower limb fracture receiving appropriately timed surgery was 10% which was much lower than the TARN aggregate (32%) against a target of 100%.

More recent data published for three TARN audit measures found:

- For the reporting period 1 January 2020 to 31 December 2020, all eligible patients received tranexamic acid within three hours of injury.
- The crude median time from arrival to CT scan of the head for patients with traumatic brain injury from January 2018 – May 2021 was one hour 28 minutes. This takes much longer than the TARN aggregate which is 33 minutes and against an audit standard of 60 minutes.
- The risk-adjusted in-hospital survival rate following injury out of every 100 patients, from January to May 2021 was as expected with 3.2 additional survivors.

Managers and staff did not use results from national clinical audits to improve patients' outcomes. Not all managers knew what national audits the service participated in. We did not see evidence there was regular review of national audit outcomes or actions to improve.

Managers and staff carried out a programme of local audits to check improvement over time. Regular local quality audits were undertaken, and the results were fed back into the trust's internal quality assurance systems. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Systems were in place to check and monitor performance against standards daily through nurse in charge audits and monthly assurance audits.

Managers shared and made sure staff understood information from quality audits but not national patient outcome audits. Audit results were shared with managers who provided feedback to staff in newsletters and daily huddles. However, we did not see evidence outcomes from national audits was shared with staff.

The service had a lower than expected risk of re-attendance than the England average. The reattendance (within seven days of previous attendance rate) was mostly lower than the Midland average and consistently lower than the England average from August 2019 to July 2021.
In July 2021 the reattendance rate was 7% compared to the Midland average of 9.7% and England average of 8.9%. This increased to 8.3% in August 2021 against a national average of 8.6%.

### Competent staff

**The service had a plan in place to make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Not all staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept an up to date record of staff competencies they had received training and sign off in. A plan was in place to train and assess staff skills in all areas. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses were junior, new to the service or were international nurses who had recently joined the services training programme. This group of staff did not have all the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, 63% of registered nursing staff had completed Manchester triage training. The service was unable to book junior nurses on until they had undergone six months in post. There was a plan for this to be completed and two staff were booked on to training in December 2021.

All eligible registered nurses with skills to work in the paediatric area within the Emergency Department had completed level four paediatric competencies. All staff had to undergo a two-day training before being signed off as competent to work with children and young people. Managers told us staff had been trained and assessed as competent to triage and assess children and young people using POPS (Paediatric Observation Priority Score) and PEWS (Paediatric Early Warning Score) and undertake an initial assessment within 15 minutes of arrival to ED.

Junior doctors were provided with opportunities for skill development. For example, ultrasound training sessions were provided.

Managers gave all new staff a full induction tailored to their role before they started work. The induction period was flexible to accommodate individual learning requirements and new nurses told us they were happy with the training and support they were receiving. All substantive staff completed new pressure care e-learning. New starters received additional training on ED standards.

All new doctors attended an induction and were provided with opportunities to shadow.

The clinical educators supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. A clinical educator worked in the department to support junior staff to develop competencies and facilitate any localised training for experienced staff.

Sepsis practitioners offered coaching and one to one support for staff in identification and management of sepsis. They supported the sign off of staff competencies and attended huddles to support staff knowledge.

Junior staff spoke highly of the support they had received from practice facilitators in supporting them to develop skills and undergo competency sign off.

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.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, newly appointed band seven nurses had been booked on to leadership training to support them in the management aspect of their role.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular training which covered their learning needs. Weekly junior and middle grade doctors training sessions took place. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or through a monthly newsletter. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, band two healthcare assistants were given opportunities to provide extended skills such as completing electrocardiograms.

Managers identified poor staff performance promptly and supported staff to improve. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Four times daily huddles took place between medical and nursing staff to review each patient. Staff told us relationships between staff in the department had significantly improved and disciplines respected each other's roles. We observed medical and nursing staff working well together with appropriate challenge when necessary.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, frailty pathways were in place. A frailty team visited the department daily Monday to Friday to assess and support safe discharge of patients. This was a nurse led model at Pilgrim site who were supported by consultants on other sites.

Staff could call upon the children and young people services for advice and support and to review patients where required.

# Urgent and emergency services

The service had developed good working relationships with the local ambulance service. We saw effective communication take place during our inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Mental health liaison nurses attended the department to review patients.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. There was suitable support from diagnostic services elsewhere in the hospital such as pathology, and radiology including Computerised Tomography (CT) to support the provision of care in the emergency department. Some imaging was available in the department including plain film x-ray and ultrasound. COVID-19 testing was undertaken in the department to improve the diagnosis and segregation of patients.

### Health Promotion

**Staff gave patients limited practical support and advice to lead healthier lives.**

The service did not have relevant information promoting healthy lifestyles and support. The waiting room did not contain information leaflets for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patient's physical, psychological and social needs formed part of the admissions booklet. Patients were referred to their general practitioner for continuing support if required. Staff knew how to refer to local drug and alcohol support services.

### Consent, Mental Capacity Act and Deprivation of Liberty safeguards

**Staff did not keep up to date with Mental Capacity Act training. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**

Not all staff kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance data provided to us following the inspection showed less than half of medical staff had completed this training (45%). For medical staff this was worse than at our previous comprehensive inspection in 2019. Compliance was below the trust target for non-registered clinical staff (81%) and above the target for registered nursing staff (94%). However, most staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some staff had clearly recorded they had sought consent from a patient before carrying out an intervention. Patients provided examples where staff had sought consent. For example, when undertaking observations. Monthly matron audits demonstrated from August to September 2021 100% of records checked showed consent was gain for a procedure undertaken.

# Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. A capacity flow chart was included in the casualty card. We saw this was completed where there were concerns about a patients capacity, however, this was not routinely completed for all patients. Monthly matron audits demonstrated from August to September 2021 100% of records checked showed patients requiring a mental capacity assessment and best interests had one.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could tell us what their responsibility was in relation to decision making requirements. Staff made referrals to mental health liaison services where required.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff and managers working in the paediatric area within the Emergency Department demonstrated a good understanding of consent processes for children and young people.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

## Is the service caring?

**Good** ↑↑

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were generally discreet and responsive when caring for patients. Most staff took patients into cubicles to complete assessments, undertake procedures or have private discussions. Curtains were used to protect patients privacy and dignity.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. In general, we observed staff interactions being kind and empathic. All patients spoke highly of the care they had received from staff.

Staff followed policy to keep patient care and treatment confidential. Whilst the environment was challenged in space, we observed staff making effort to maintain confidentiality when talking to patients. However, we did observe a medical staff member having a conversation about blood results with a patient in the fit to sit area of the waiting room.

# Urgent and emergency services

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

### Emotional support

**The department lay out did not support staff to maintain privacy and dignity of patients at all times. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff gave patients emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state. We observed staff reassuring patients and taking time to interact with them despite being extremely busy.

The dedicated relative's room was unavailable during our inspection as it had been used for other purposes. We observed on one occasion a family of a patient sat in the fit to sit area of the department whilst their relative was in the resuscitation area.

Members of the chaplaincy team also visited patients in departments, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment, but there were limited facilities to help them maintain their privacy and dignity. There was no dedicated mental health room or family room to take patients into when they became distressed. Staff made effort to maintain privacy and dignity, but the department did not support this. Following the inspection, the trust told us they intended to refurbish a room suitable for patients with mental health concerns or in distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

### Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported they felt involved in their care and decisions. They also told us that most staff were approachable, and they generally felt able to ask any questions they had.

Staff talked to patients in a way they could understand. We observed nursing staff communicating in a way which put patients at ease and could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how patients and their families could give feedback on their care was displayed in the department.

Staff supported patients to make advanced decisions about their care. We saw staff made effort to contact and include family where advanced decisions had to be made. Staff told us they would discuss with patients were able.

# Urgent and emergency services

Staff supported patients to make informed decisions about their care. Staff told us they provided patients with relevant information to make a decision.

The feedback from the Emergency department 2020 survey test was positive. The trust's emergency departments scored about the same as other trusts in 25 out of 38 questions and lower than others in 13 questions.

## Is the service responsive?

**Requires Improvement** 

### Service delivery to meet the needs of local people

**The service was managed in a way that met the needs of local people and the communities it served. Managers and staff worked with others in the wider system and local organisations to plan care.**

Managers tried to plan and organise services, so they met the needs of the local population. However, they were restricted due to an unsuitable environment, lack of inpatient hospital beds and system challenges. System challenges included poor engagement from local general practitioners, lack of intermediate care beds to discharge patients medically fit and inconsistent information technology systems not allowing joined up working. Leaders worked closely with the commissioners and community providers to find system responses to the capacity issues both in the emergency department (ED) and the wider trust. Trust representatives were active members in regional urgent and emergency care boards. They met regularly with the ambulance service to improve services.

The service had introduced strategies to ensure the patient went to the right place at the right time and to avoid unnecessary admissions. For example, a consultant was placed in the waiting area to support walk in flow, assess suitability for same day emergency care, ensure patients were directed to the most suitable area and oversee the rapid assessment and treatment (RAT) stream.

The percentage of attendances resulting in an admission was consistently higher for Pilgrim Hospital than the Midlands average and the England average from 23 of May to 12 of September 2021. On the 12 of September 2021 the percentage for Pilgrim Hospital was 36.6% compared to the Midlands average of 25.6% and England average of 23.9%. Service leaders recognised further system wide work was required to build on progress in ensuring patients were seen in the right place.

Facilities and premises had significantly improved, however were not always appropriate for the services being delivered. The building and capacity had outgrown the demand. The service had a capital build plan and had made significant efforts to improve since our last inspection. The service had implemented the following improvements:

- COVID pathways had been implemented to enable effective separation of COVID-19, suspected, confirmed and negative.
- A separate and fully functioning paediatric area within the Emergency Department. It was secure access in and out. There was a waiting room, triage room and decorated to a suitable standard.
- A modular waiting area to increase waiting room capacity was implemented with 16 chairs.
- A fit to sit stream implemented in the waiting area with four dedication chairs and in the ambulance stream area.
- An additional triage room meant there could be two triage streams during busy periods.

- Additional resuscitation capacity created in the 'green' COVID-19 stream which could be stepped down. This was used as additional majors' bays at the time of the inspection as the resuscitation facility was not required.
- X-ray room to improve timeliness of x-ray.

Furthermore, the service no-longer cared for patients in the central corridor space. At the time of the inspection the corridor was not in use. Managers told us an escalation procedure was in place which had to be signed off at executive level. Corridor care had only been used once since our last inspection due to having four trauma patients at one time impacting capacity.

There were three cubicles dedicated to a Rapid Assessment and Treatment (RAT) process and additional fit to sit capacity in the waiting room (four chairs) and ambulance streaming corridor.

During our inspection, the waiting rooms were over capacity due to the volume of patients attending the department. There were periods where ambulances could not be offloaded due to the department being full. Exit blockages prevented admissions. Access to specialities to review patients within ED sometimes impacted exit block as did capacity issues with the integrated assessment unit (IAU).

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was applicable to the integrated assessment unit.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, there was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required, and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead. The service utilised fit to sit areas where appropriate to take the pressure off majors' cubicles. Pathways were in place to ambulatory care.

### Meeting people's individual needs

**The service was not always inclusive and took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. For example, a patient with a learning disability waited on an ambulance for a prolong period (152 minutes) and then moved to the clean procedure room for assessment. The patient had become increasingly distressed and the clean procedure room was not considered to be a suitable environment for a patient in distress or with a learning disability. We found staff lacked situational awareness in managing the patients' individual needs. Staff used the room to ensure the patient was assessed as they had been on the ambulance for a prolonged period but failed to recognise the impact of the environment.

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.

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.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Hot foods had been introduced for patients waiting for long periods in the department. Staff said they had access to other food types and were able to meet patient's individual preferences.

### Access and flow

**People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients fell below national standards.**

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. Systems had been implemented to increase triage capacity in terms of additional rooms and flexibility to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival. From April to September 2021 an average of 91.7% of adults and 91.5% of paediatrics were triaged within 15 minutes of arrival.

However, there were delays in patients being transferred from the ambulance to the emergency department. On day one of our inspection we observed six ambulances waiting at 2.41pm with the longest wait approximately three hours. The department was above capacity with 51 patients in the department. 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. For example, at 9am on day one of our inspection, there were 38 patients in the department with 20 waiting to be admitted. There were no beds identified for the patients which impacted on the ability to bring new patients into the department in a timely manner. We were advised at 11am three patients had been transferred to a ward area, leaving 17 patients still waiting for a bed.

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard. However, the service had consistently met its internal target of 50% to be seen within 60 minutes based on its medical staffing model. From March 2021 to September 2021 the average percentage of patients seen within 60 minutes was 56.4%. Performance has worsened slightly over this time as demand for the service has increased. The average time from arrival to first seen by a doctor was 93.29 minutes in July, 90.27 in August and 103.30 in September. The service had implemented systems to mitigate risks such as a consultant being placed in the waiting areas to reassess patients waiting more than 60 minutes.

Compliance with the RCEM guidance to see, treat, admit or discharge within a four-hour target was not always met. From February to August 2021 the trust's percentage of patients waiting over four hours from decision to admit to admission was among the top three in the Midlands. In August 2021, 55% of patients waited between 4-12 hours to be admitted to a ward from the point of decision to admit. This was against a national average of 26%. Furthermore, in September 2021, 71 patients waited more than 12 hours in the emergency department from the decision to admit time.

# Urgent and emergency services

During our inspection two patients were identified as waiting more than 12 hours. Rapid reviews were completed and no harm was identified. One patient was delayed for medical reasons and the second due to a delay in facilitating a transfer. On the second day of our inspection the performance against the access target was reported to be 52% with 56 breaches.

Managers monitored waiting times to ensure people with the most urgent needs had their care and treatment prioritised. The emergency physician in charge (EPIC) and NIC undertook two hourly huddles where they reviewed all patients waiting and undertook assessments to ensure patients were offloaded from ambulances and moved to a safe area in the department according to acuity.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. The nurse in charge (NIC) completed an emergency department risk tool hourly which used information such as number of patients waiting at different part of the system, staffing levels and acuity to assign a risk level. There were clear escalation processes as a result of the risk rating which were reported into capacity meetings.

Patients details were added to electronic system which provided managers with oversight of the department. This was used when reviewing patients. A local ambulance service electronic board was visible in the department to show times crews arrived, inbound ambulances and expected arrival times so staff are aware.

The PHP was in place 24 hours to ensure rapid and safe handover of ambulance patients. Any ambulances that were not immediately offloaded were escalated to the department site manager.

A full capacity protocol was in place which was sensitive to departmental pressures as identified through the ED risk score. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status. We observed staff escalate appropriately. For example, we observed the triage nurse escalate concerns about waiting room capacity to the NIC who updated the risk tool and clinical site manager.

During our inspection the department had declared a level three OPEL, with level four evoking the maximum system supports possible. Managers told us whilst at level three they were implementing level four actions.

Managers and staff worked to make sure patients did not stay longer than they needed to, however they were impacted by wider hospital and system issues. A fit to sit area was implemented so patients who were likely to be discharged the same day could be then either discharged or transferred to ambulatory emergency care of SDEC.

Managers told us they had improved working relationships with specialities to increase timeliness of speciality reviews. However, managers told us this was a challenge due to the medical workforce pressures and lack of engagement with surgical speciality caused delays. When under considerable pressure the ED department implemented its STRAP (short term rescue accident and emergency protocol) which meant a decision could be made to request speciality s to in reach into the department get assess, review and transfer patients to their wards.

Medical patients requiring admission went from the ED to the integrated assessment centre (IAC) which was a 12 hour stay ward to decide whether they would require admission. If further diagnostics or treatment was required, they would then go to the short stay ward for up to 72 hours. On the morning of day one of our inspection there were 20 patients with a decision to admit and waiting for a bed, yet the IAC was at capacity. Therefore, patients had to wait for beds to become available which created a bottle neck. For example, we spoke to consultants who identified there were two

patients who required a surgical bed. They were aware there were two surgical bed available, however, the process was for patients to go to IAC first where they would receive a speciality review. This meant patients had to wait for long periods on trolleys in a busy department before a bed became available. Consultants were unable to admit straight to base wards. Senior leaders told us this was because the staffing template did not support direct referrals from ED.

The number of patients leaving the service before being seen for treatments was in line with the midland and England average. The percentage of patients who left before being seen was close to the Midland regional average and England average for most of the two-year period from August 2019 to July 2021. July 2021 saw an increase in patients who left before being seen to 5% but this is now below the Midland average of 5.8% and England average of 5.6%.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed the frailty team attended the ED to assist with discharges. We observed consultants reviewing patients on ambulances with a plan to discharge where safe. There was a trust wide initiative to free up hospital beds earlier in the day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it. Daily bed meetings occurred three times a day to set actions for identifying and reviewing patients ready for discharge. Any blockages were addressed and where required senior management intervention.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff sought advice and support in discharging from the mental health liaison team. We observed a patient waiting for a mental health assessment prior to being discharged to ensure the discharge was planned appropriately to the patient's needs.

Staff supported patients when they were referred or transferred between services. The service implemented a transfer checklist which we saw was in place for six records we reviewed. This ensures all relevant information about the patient was shared with the incoming ward.

Managers monitored patient transfers and followed national standards. Children and young people were transferred to other hospitals using recognised safety standards which staff understood.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff could describe the complaints process. Staff tried to resolve any issues at the time in the first instance and report it to the nurse in charge. Staff knew how to signpost to the trust complaints process. From April 2021 to September 2021 the serviced received a total of 65 complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. At the time of the inspection, the service had eight open complaints, one of which was 17 days overdue. On average responses were sent to complainants within 44 days of receipt. This included a review by the complaints manager, divisional and executive sign off. This is in line with the trust complaints policy which states complaints will be responded to within 25 to 50 working days dependent on the complexity.

# Urgent and emergency services

Managers shared feedback from complaints with staff and learning was used to improve the service. An action log was in place to keep track of learning actions and implementation dates. Learning and themes were shared through divisional governance meetings. Staff received feedback in daily huddles and in the departmental newsletters.

Staff could give examples of how they used patient feedback to improve daily practice. For example, communication with patients and relatives was a common theme. The service had introduced regular patient comfort rounding which provided staff with an opportunity to update patients. The service had also recently introduced regular hot food service on the back of feedback for patients who experience long waits in the department.

## Is the service well-led?

**Requires Improvement** 

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Improvements were observed in clinical leadership. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Leaders had the skills and abilities to run the service. The urgent and emergency care (UEC) service sat in the medicine division and was led by a divisional clinical director, a divisional managing director and divisional nurse. However, at the time of the inspection the divisional nurse position was vacant, and recruitment was underway. Urgent and emergency care leadership consisted of a clinical lead, a general manager and deputy divisional nurse who covered all three sites across the trust. At Pilgrim hospital the nursing team was led by a matron and a band 8a senior sister. Both had completed leadership training.

At our last focused inspection, we found leaders did not have the skills and abilities and gaps in clinical leadership had not been addressed. We found improvements had been made following our last inspection. For example, we found:

- A divisional director had been recruited to oversee and lead the medicine and urgent care division.
- A clinical lead was in post with overall responsibility for UEC across the trust and there was a clinical director in post.
- The emergency physician in charge (EPIC) role had improved since our last inspection. Training in leadership had been provided to consultants undertaking the EPIC role which covered leadership, development of situational awareness, escalation processes, rapid handover protocol, full capacity protocol and short-term rescue protocol (STRAP). EPIC training sessions were held monthly.
- The service had recruited into band seven pre-hospital practitioner (PHP) posts. This improved management of flow in the department and oversight of safety of patients.
- The service had improved its joint working between the EPIC and Nurse in Charge (NIC) role. We observed greater team work along with operations teams and the PHP to improve flow and quality of care.

The service had strengthened local leadership by recruiting into band seven sister posts. Each band seven was assigned a lead role. For example, safeguarding, IPC, flow, sepsis and clinical education. Whilst the posts were recruited into, the post holders had not yet been able to complete the leadership elements of their role due to increased demand in the department, a junior workforce and requirement to work clinically. This meant leaders including the matron and senior sister were working down to ensure the service was safe.

Staff in senior leadership positions had completed leadership training. For example, the matron and senior sister had completed Royal College of Nursing (RCN) leadership courses. New band seven nurses in post were intended to complete the RCN course and had completed leadership sessions internally.

The Royal College of Paediatrics and Child Health recommends every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. This was not in place at Pilgrim hospital. Leaders told us there was a consultant who took a lead with paediatrics and there was always a consultant on duty with paediatric competencies. However, this did not meet the standards and we were not assured there was robust leadership of the paediatric area within the Emergency Department at Pilgrim hospital.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address it. During our inspection we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, medical staffing was a challenge. Leaders had a recruitment plan which meant all vacant post would be filled the beginning of 2022. Junior doctor training had opportunities for career escalation within the department. The service had a plan to sustain medical staffing by developing the certificate of eligibility for specialist registration (CESR) programme within the service. Furthermore, there were plans to apply for teaching status.

Leaders were visible and approachable. Staff told us the senior leadership team were visible. Senior managers including divisional directors and the deputy divisional nurse undertook regular walk rounds in the department. Managers told us they would support the day to day operation at times of peak demand.

The senior sister was visible and had a good relationship with staff.

Engagement workshops took place following our previous inspection with the aim of improving the working relationship between clinical, nursing and operational leads.

### Vision and Strategy

**The service vision was integrated into the trust wide vision which outlined what it wanted to achieve and a strategy to turn it into action. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The service did not have a specific urgent and emergency care vision and set of values. However, leaders told us they were aligned to the trust strategy. The trust vision was to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon services. The trust had five key values underpinning its strategy including: patient-centred care, compassion, respect, excellence and safety. During our inspection we saw examples of staff enacting these values.

The trust implemented a five-year integrated improvement plan started in 2020 aimed at delivering the trust strategic objectives. This included actions in relation to the emergency departments (ED) such as medical recruitment plans which had proved successful. Furthermore, there were workstreams that would impact ED such as becoming a university hospital, enhancing data and physical capacity, improving the environment, developing the workforce and well-led services. During our inspection we saw the impact of some of these including improving the environment and improved workforce planning.

# Urgent and emergency services

The trust had a five-year clinical strategy and delivery plan started in 2019. It contained a brief strategy for urgent and emergency care services to:

- ‘Maintain A&E /Emergency Department services at both Lincoln and Pilgrim Hospitals, and to add an Urgent Treatment Centre at both sites’.

Other key deliverables identified were to establish a separate paediatric department at Pilgrim, extend the resuscitation capacity and development of urgent treatment centres. During our inspection we saw these deliverables had been completed and work continued to embed the processes. However, we were unclear what the key objectives were and actions to develop were moving forward. Managers could however describe the plans in the form of a new build and workforce development

The trust worked alongside health and care partners in Lincolnshire to ensure the clinical strategy was aligned with their strategic direction for the county wide health and care services. The system delivery lead chaired an urgent and emergency care delivery board that ULHT attends.

Staff could describe the trust vision and values.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff felt generally supported, respected and valued. Most clinical staff we spoke to spoke highly of the support they received from line managers and other leaders. Staff told us morale was low following the previous inspection, but this had significantly improved. Junior doctors spoke highly of the support and guidance they had received from consultants. However, some clerical staff felt their role was not as valued as they were not included in a salary uplift as were clinical staff. Despite this they were positive about the improvements made to the service.

Staff generally felt positive and proud to work in the organisation. The culture encouraged openness and honesty at all levels. Most staff described how much the service had improved and one commented it was the best it had ever been for them as a place to work. Improved staffing levels and reintroduction of students was cited as reasons staff felt more positive.

The culture was centred on the needs and experience of people who use the service. Leaders completed regular walk rounds in the department to speak to patients about their experience. Matrons spoke to 10 patients as part of their assurance audits. Staff were supportive of service changes as they knew they benefited the patient. For example, the introduction of two hourly rounding was effectively implemented as staff knew this would make the service safer for patients.

Managers took action to address behaviour and performance consistent with the vision and values. During our inspection, managers acted swiftly to address feedback provided to them. For example, feedback was given to a staff member who had not completed an assessment. This was done at time and with a learning approach to positively support improvement. Managers told us they sought support from human resources for more formal management.

There was an emphasis on the safety and well-being off staff. Matrons included staff wellbeing checks in monthly assurance audits. Senior leaders provided staff with opportunities to feedback about how they are feeling. We saw staff breaks were encouraged and managers told us they monitored the number of additional shifts staff booked. The trust wellbeing team had attended the department to support wellbeing of staff. The matron had introduced coffee, cake and chat sessions for staff.

There were co-operative, supportive and appreciative relationships amongst staff. Staff and teams worked collaboratively. Staff described improvements in the collaborative working between different roles. For example, there was a mutual appreciation of roles between medical and nursing staff and we observed good team working. Staff told us managers helped when the service was under pressure.

### Governance

**Leaders operated effective governance processes; however, we were not assured there were clear lines of governance in relation to the paediatric area within the Emergency Department. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were generally clear. Local departmental speciality governance meetings were held as well as divisional business and clinical meetings. Clinical and business governance meetings were regular, well attended and covered a wide range of issues. For example, operational performance, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

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.

All levels of governance and management function effectively and interact with each other appropriately. Local governance meetings fed into a divisional cabinet meeting which had oversight of safety and quality of the service. A divisional score card with several metrics including finance, HR, people, quality, performance was in place. This was reported by divisional leaders to executives and trust board through performance review meetings and the quality and safety oversight group.

Staff at all levels were mostly clear about their roles and understood what they were accountable for, and to whom. Although it was recognised the service had introduced a new tier of band seven sisters who had not fully embedded at the time of the inspection due to pressures to work clinically.

Processes were in place to ensure relationships with partners were managed effectively. Standards operating procedures (SOPs) were in place with the local ambulance service and urgent treatment centre. These were reviewed regularly. For example, there were routine and regular meetings with the local ambulance service as well as extraordinary meetings to address concerns of long ambulance waits. The service attended a monthly Lincolnshire providers UEC governance meeting. This was an opportunity to assess practice against the SOPs and raised and concerns to improve joint working. Minutes contained case discussions to explore the most appropriate place for patients to be treated.

The mental health liaison nurse attended departmental governance meetings.

# Urgent and emergency services

## Management of risk, issues and performance

**Risks on the risk register were not always effectively managed to reduce their impact. Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.**

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.

Day to day identification and management of risk was done using the emergency department risk tool. Processes were in place to escalate with clear actions to be taken dependent on the level of risk. Safety issues were reviewed throughout the shift by a nurse in charge who completed an assurance checklist on each shift which covered staffing, communication of safety messages, an audit of patients, controlled drug checks, infection prevention and control checks, equipment checks and key performance indicator updates. This was regularly updated and used to address an issue with performance in real-time.

Monthly matron assurance audits were completed which provided an overview of quality, performance, staffing, patient experience and staff wellbeing. This along with departmental performance indicators was discussed with the deputy divisional nurse during confirm and challenge meetings and pulled together into a score card.

Performance in national audit outcomes were not effectively integrated into the governance structures to ensure management oversight. There was a lack of interface between national patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we saw limited evidence of consideration of national patient outcomes and monitoring of improvements plans in governance meetings.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. For example, during the inspection the electronic systems went down, and staff quickly implemented actions in their business continuity plan to manage the risk and maintain oversight of the department.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but not always integrated.**

The service had an integrated score card which demonstrated performance across all areas of the service. Data was collected from various systems including electronic, audits, feedback from staff and patients. The information was analysed to form an assessment of risk and used to monitor performance overtime which was reported to the board. Local managers met with more senior managers regularly to set actions in response to these.

Clear and robust performance measures were used to assess quality and safety. Managers and staff knew what these were in relation to emergency department standards and patient care and safety. We saw the service used data to monitor performance against standards in real-time.

Electronic systems were used effectively to provide local leaders with oversight of the department. Large screens in the department provided staff with an electronic queue meant they could see where all patients were. This included vital information about numbers in the department and at which point of their journey. It also allowed nurses and consultants in charge to identify deteriorating patients and ensure they have been appropriately escalated.

The information systems were secure. The systems were integrated with the wider hospital but not always with partner organisations. For example, where the ambulance service was holding patients and monitoring observations, this was not on the service electronic system. This meant consultants and nurses in charge were reliant on being verbally updated by ambulance staff and pre-hospital practitioner of any signs of deterioration.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service used people's views and experiences to shape and improve the service. For example, feedback was sought from patients' relatives and staff to formulate the integrated improvement plan. The feedback helped leaders develop key priorities and decide which to prioritise. The Emergency Department (ED) gathered patient feedback through the Friends and Family Test (FFT). The service participated in the annual emergency department survey and used feedback to improve. For example, the service used feedback to introduce hot food rounds for patients waiting in the department for long periods. We saw messages to staff in monthly departmental newsletters requiring staff to act in response to views of people using services.

Staff were actively engaged, and their views were reflected in the planning and delivery of services. For example, feedback was sought from staff to help shape the future new build of the emergency department due to start in 2022. During our inspection, staff were asked to complete an on-line survey to provide feedback and suggestions about improving the paediatric area within the Emergency Department. General feedback from staff was they felt senior management were more interested in their views providing them with more opportunities to feedback than previous.

The service worked collaboratively with external partners to build a shared understanding of challenges within the system. Regular meetings were held with key partners including the local ambulance service and urgent treatment centre providers.

The service also worked collaboratively with other departments. For example, feedback had been sought from children and young people services when designing and decorating the new paediatric department. Leaders were passionate about making it a child friendly environment. Staff were very proud of the improvements made.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

# Urgent and emergency services

Systems and processes were in place to monitor performance. Outcomes and learning were shared with staff to improve understanding and set actions for improvement. The service had improved oversight of their performance, took action resulting in improvements in performance. For example:

- The triage process and performance had improved.
- Identification and management of deteriorating patients had improved.
- Two hourly intentional rounding had resulted in improvements in patients being provided with adequate nutrition, hydration and repositioning where required.
- Improvements were noted in the timeliness of pain assessments and administering analgesia.
- Twelve-hour trolley waits had generally reduced.

The service had made significant service improvements since our previous inspection. For example:

- The service acted following our previous inspection to stop central corridor care of patients being normal practice.
- Training had been provided to staff to improve clinical leadership. Oversight of the department and collaborative working between nursing and medical leaders was observed as a significant improvement.
- Action had been taken to improve staff recruitment and retention resulting in reducing vacancy rates. The service commenced the certificate of eligibility for specialist registration (CESR) to recruit doctors which enables doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.
- Improvements were observed in the oversight of skill mix for both medical and nursing staff by creating rotas with skills required filling.
- Departmental refurbishments had improved the environment in terms of safety and patient experience. For example, the implementation of a paediatric area within the Emergency Department, expanding resuscitation space, improving the waiting area and fit to sit areas.
- Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

Managers were able to tell us areas for further improvement such as development of governance and risk register oversight, continued focus on ambulance waits, continued review of medical staffing levels to improve the number of patients seen and treated within 60 minutes of arrival. The paediatric area within the Emergency Department was also seen as a further area for development in terms of governance and staffing levels.

# Maternity

Good ↑

## Is the service safe?

Good →←

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women and babies at risk of deterioration.**

Staff used the Modified Early Obstetric Warning Score (MEOWS) and Paediatric Early Warning Score (PEWS) which are nationally recognised tools to identify women and babies at risk of deterioration and escalated them appropriately. Records showed and we observed timely and appropriate responses to rising early warning scores, ensuring women and babies were escalated appropriately in the event of clinical deterioration.

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk factors included; blood clot risk, carbon monoxide risks and a general risk assessment relating to whether the pregnancy was high or low risk. These risk assessments were recorded in both electronic and paper records, and were used by community and acute staff. This ensured that staff always had access to this information in the event of an emergency. We saw this was effective as staff used these paper records when the electronic records system was unavailable during part of our inspection.

Staff knew about and dealt with any specific risk issues. For example, we saw when women were identified as having a risk of developing blood clots, appropriate action was taken to reduce this risk.

In line with national recommendations, a 'fresh eyes' approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. A CTG measures a baby's heart rate and monitors the contractions in the womb (uterus). Fresh eyes checks were performed every hour by a second staff member during continuous fetal monitoring. This provided a safety net to reduce the risk of misinterpreting a CTG reading. Records we reviewed showed appropriate monitoring, interpretation and escalation of CTG readings.

Staff completed a mental health screen on all women and arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Every woman's' risk of domestic violence was also assessed during every appointment when this was appropriate. Risks associated with mental health and domestic violence were clearly recorded in the patient records and flagged on the electronic patient record system. Referrals for specialist support were made for women who were at risk of or experiencing domestic violence.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health.

Records showed that staff consistently performed swab counts in theatre and completed the World Health Organisation (WHO) checklist in line with National Patient Safety Agency (NPSA) guidelines. The WHO checklist is a global initiative that was designed and implemented to improve surgical safety. Regular WHO checklist audits were undertaken and recorded electronically which showed 100% compliance with the WHO surgical safety checklist.

# Maternity

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery handover and the multi-disciplinary team (MDT) handover meetings. This ensured midwives and medical staff had access to key information to keep women and babies safe when handing over their care to others.

## Staffing

**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. This meant the service had no vacancies.

Staffing rotas for August and September 2021 evidenced that actual staffing numbers did not always meet planned numbers. Staff told us this was due to sickness. However, staff also told us that if patient acuity meant any staffing gaps needed to be filled to ensure the safety of women, those shifts were always covered. Cover was provided by staff picking up additional shifts, managers and specialist midwives. Trust data showed that one to one care during labour was provided to women 100% of the time between November 2020 and October 2021.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The birth rate plus tool was used to measure and review acuity and in workforce planning. At the time of our inspection, the service (which included Pilgrim Hospital and Lincoln County Hospital) was staffed based on the trust's Birth rate Plus recommendations of 2017. Managers had since completed a birth rate plus review which recognised an increase in acuity of women admitted to the service. This report was received by the trust in March 2021. This review identified a shortfall of 3.51 whole time equivalent (WTE) midwives. A bid for the funding for the posts was in progress.

A continuity of carer (CoC) review had also been completed. CoC is an approach that aims to provide consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey. The trust had submitted a bid to fund an additional 8.69 WTE staff to support the rollout of CoC to 35% of women.

The ward manager could adjust staffing levels daily according to the needs of women. Staff reviewed acuity every four hours which meant adjustments to staffing could be made in response to an increase in acuity. Staff told us that when acuity increased, additional staffing was provided to keep women and babies safe.

Consultants and anaesthetists were always available. This included the provision of out of hours on call cover which staff told us was always provided in a timely and responsive manner.

Managers made sure all staff had a full induction and understood the service.

## Incidents

**The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. They reported serious incidents and near misses in line with trust policy.

# Maternity

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.

Managers shared learning with their staff about serious incidents that happened at the service and elsewhere within the trust. Learning from incidents was emailed out to all staff and read out in every staff handover which the staff referred to as a 'newsflash'. We observed the newsflash being read out at the handovers we observed.

Staff met to discuss incident feedback and look at how they could improve patient care. For example, maternity staff reviewed CTGs with consultants and learned from incidents where CTG interpretation was incorrect. This learning took place during weekly CTG meetings. This showed the service had learned from previous serious maternity incidents where CTGs had been incorrectly interpreted to prevent recurrence.

The service had no maternity never events in the 12 months leading up to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff also worked with external agencies to ensure learning from incidents was shared. The service referred relevant incidents to the maternity Healthcare Safety Investigation Branch (HSIB). Staff used recommendations from HSIB reports to improve patient safety.

## Is the service effective?

**Good** 

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 11 clinical policies relating to the maternity department. This included; diabetes in pregnancy, hypertensive disorders in pregnancy and sepsis guidance. These were all up-to-date and reflected best practice guidance and national standards.

Managers used audits to check that staff followed agreed clinical guidance. Audits appropriately identified areas of compliance and areas for improvement. Audit areas included; assessment and management of sepsis, fetal monitoring and catheter care.

In accordance with national guidance, staff routinely referred to the psychological and emotional needs of women. We observed nursing and multidisciplinary handover meetings which evidenced this.

# Maternity

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers gave all new staff a full induction tailored to their role before they started work and staff were supernumerary in their areas until they became familiar with the service's environment and processes.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor.

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.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us team meetings had become more accessible as they had moved to virtual meetings.

Specialist training for staff specific to their roles was provided. For example, training in fetal monitoring was provided, this included CTG training. The trust's CTG training target was 90%. Training data for September 2021 showed that 84% of midwives and 88% of consultants had completed this training. Training data for trainee doctors was much lower at 10% but this was because trainee doctors had recently rotated and their training was in progress. All staff had received a reminder to complete this training in order to improve compliance rates. Support staff also told us they were able to access specialist training for their role. This included attending breastfeeding workshops to enable them to offer practical and emotional support to women.

Staff participated in multidisciplinary training and utilised external resources including those produced by the Practical Obstetric Multi-Professional Training (PROMPT) charity. PROMPT is an evidence-based multi-professional obstetric emergencies training package that has been developed for use in local maternity units. Staff we spoke to confirmed they participated in MDT training and that the service had adapted during the pandemic and moved to virtual PROMPT training. PROMPT compliance data from November 2021 showed that 86% of midwives and 59% of medical staff had completed this training. The trust had plans to achieve their 90% target compliance rate by March 2022.

Private social media platforms were also utilised to make training more accessible to staff. For example, a social media live video showing staff how to don and doff personal protective equipment had been shared that staff could replay at a time convenient to them.

Managers identified poor staff performance promptly and supported staff to improve. Examples were shared that demonstrated this.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.**

# Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed these meetings and saw that risks were appropriately discussed and information was shared in a manner that promoted continuity of care.

All the staff we spoke with spoke positively about the multidisciplinary working on the wards, within the wider hospital and in the community. We saw maternity staff worked effectively with other teams within the hospital. This included working with surgical teams and paediatricians.

Staff worked across health care disciplines and with other agencies when required to care for patients. Records showed that staff referred women to other agencies such as; safeguarding, social care and mental health services.

## Is the service well-led?

**Good** 

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The senior leadership team within maternity were mostly new to post since our last inspection. Staff described this as refreshing and positive. The managers and leaders we spoke with displayed enthusiasm and drive to improve maternity services for the women, babies and staff.

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved.

Managers and senior staff understood the priorities and issues the service faced. This included the poor estates and facilities within maternity which they escalated appropriately. Managers and senior staff escalated any safety issues with the estates and facilities promptly to promote the safety of women and babies.

Managers and senior leaders displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that managers and senior leaders were visible in all the areas we visited. All the staff we spoke with told us they felt supported and valued by their managers.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

We saw there was a positive open culture as staff spoke with the inspection team openly and honestly. Staff told us there was a no blame culture and they felt able to raise concerns with their managers and freedom to speak up guardians were accessible if required.

Staff morale in the areas we visited was particularly positive and local initiatives were in place to promote wellbeing and morale. For example, staff on the maternity ward could share positive messages and feedback to their colleagues by leaving messages in a 'Ta jar'. These messages were then shared directly with individuals which made them feel respected and valued.

Joint meetings and training sessions were facilitated within this service and the service at Lincoln County Hospital site. This promoted joint working and learning between the two maternity units at the trust.

Staff promoted equality and diversity within the service. Staff told us and we saw that many of the women cared for within maternity services were from minority groups. Staff understood and used the trust's systems to ensure these women and their families were able to access appropriate care.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Senior leaders from maternity services attended monthly cross site Maternity and Neonatal Oversight Group (MNOG) meetings. The purpose of the MNOG was to have oversight of maternity and neonate services to monitor if these services were safe and in line with national safety and quality standards. The group discussed key topics such as; the maternity and neonatal monthly safety assurance report and monitored the progress and effectiveness of the local maternity improvement plan. The maternity and neonatal quality dashboard which included incidents and other safety data was also scrutinised by senior leaders and external stakeholders in the MNOG meetings. Minutes of these meetings showed that the agreed terms of reference were followed, safety and quality concerns bought to the groups were appropriately acted upon and any improvement actions were appropriately followed up.

Stakeholder feedback was discussed at MNOG. This included stakeholders such as; NHS England and Improvement and patient groups.

The MNOG fed into the trust's Quality Governance Committee (QGC). Minutes of MNOG showed that areas of concern were escalated to the Quality Governance Committee and to ensure any identified risks were appropriately captured. The QCG then fed into the board to ensure they had a regular overview of quality, safety and performance relating to all services at the trust, including maternity. Minutes from trust board meetings evidenced this.

The maternity service had a non-executive director sponsor who was the services named maternity and neonatal safety champion. This sponsor attended the MNOG meetings on a regular basis.

Staff told us that mortality and morbidity reviews were regularly completed to review and learn from deaths, incidents of sepsis and other adverse incidents. However, records did not always evidence the discussion and outcomes of these meetings. The trust were aware of this and had a plan in place to address this. These reviews were not cross site meetings, therefore this was a missed opportunity to have cross site discussions and learning from deaths and other adverse events.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

# Maternity

A monthly maternity and neonatal quality dashboard was produced. Items covered included national safety standard performance data, such as; 10 Steps to Safety performance data (a national maternity incentive scheme used to improve safety) and saving babies lives performance data (a nationally recognised care bundle aimed at reducing perinatal mortality). Other performance data was also included in this report, including; incidents, patient feedback, complaints and staffing training compliance. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

The service was working from a joint maternity and neonatal improvement plan. This plan set out how the service planned to improve safety, leadership and patient experience. Each recommendation and action within the plan had been risk assessed and rated to enable leaders to establish if improvements were embedded, on track or behind in terms of performance.

We found that risks were appropriately identified and managed. Identified organisational and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. For example, staff had identified that paper CTG readings faded over time which meant there was a risk of accurate records not being maintained. This had been recorded on the risk register and appropriate mitigation plans were in place while a long-term solution was agreed. Minutes of governance meetings evidenced that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

Each area's top three risks were also shared to staff through the use of governance boards which meant staff were aware of the risks and the mitigation plans in place to address these risks.

Plans and procedures were in place to enable staff to manage emergency situations such as baby abduction and sudden increases in acuity. Staff confidently explained how they would react to these situations in line with agreed plans and procedures.

Managers told us that staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures.

Minutes of these reviews clearly stated learning actions, including who was responsible for sharing this learning.

# Medical care (including older people's care)

Good

## Is the service safe?

Good

### Mandatory Training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

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.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

All staff received training specific for their role on how to recognise and report abuse. Staff completed different levels of safeguarding mandatory training according to their roles. The trust target was 90 %. Whilst the trust target had not been achieved across all levels, the trust aimed to be back to 90% by the end of November 2021. All staff we spoke with could explain how to recognise and report concerns related to adult and children's safeguarding.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff could describe caring for patients with protected characteristics and how to keep them safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could describe how they had worked with other organisations to ensure patients were protected from harm. Staff told us how they had put measures in place to ensure patients were protected from harm and had their individual wishes listened to. Processes for safeguarding had been strengthened and simplified in order to ensure consistency in referral pathways.

The safeguarding team completed monthly safeguarding audits to assess the quality of safeguarding and DOLS referrals. These were reviewed at a safeguarding operational group. Any areas in need of extra training or specific support were identified in order that targeted support can be provided within an immediate time frame. Good practice was also discussed and disseminated for ongoing learning and development. Monthly audits of safeguarding and deprivation of liberty safeguards (DoLS), identified between January and September 2021 79% of Safeguarding referrals and 98% of DoLS referrals were appropriate.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew who to raise concerns with if they had any questions relating to safeguarding. The trust safeguarding team were described as extremely visible and supportive. The safeguarding lead would identify and support safeguarding investigations from the local authority. The ward manager and matron would be involved as it related to their area and gave them ownership and offered a learning opportunity to prevent recurrence of the same or similar incidents. This is done in conjunction with the ward manager and matron, so they own it.

Staff followed safe procedures for children visiting the ward. At the time of the inspection visitors to ward areas were restricted in line with the trust's Covid-19 pandemic response plans.

### Cleanliness, infection control and hygiene

**The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust had monthly infection prevention control audits, these were divisional wide and compared scores cross site and for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created. We observed high intensity cleaning in progress on several wards within the directorate with specialist teams identified to increase cleaning of frequent touch points.

We observed wards had also introduced "ring the bell for clinell" all staff were to pause and clean high touchpoint areas when the bell rang. The trust had introduced a standard operating procedure to ensure this was carried out consistently.

Specialist cleaning teams were also allocated to clean rooms after a patient discharge in order to allow usual ward staff to continue with the usual daily cleaning. This ensured patient flow throughout the hospital.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection we observed staff using PPE appropriately and wearing masks throughout our visit. There was also clear signage on the wards to show Covid-19 risk levels for different areas and where patients were being isolated due to infectious diseases or illnesses. PPE provision on wards was monitored daily to ensure there were no problems with supply.

The trust also had daily bulletins which could be used to share key messages such as about Covid-19 and steps required to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff mostly responded when called. However, we observed a patient on one ward decide to mobilise without the aid of a nurse despite being asked to call for help. As she was “fed up of waiting”.

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).

Staff carried out daily safety checks of specialist equipment. However, we observed out of date or missing items in three resuscitation trolleys. We raised this whilst we were on the wards and items were renewed and replaced immediately. This was then raised with ward teams across the division to ensure all staff were aware of the importance of checking this equipment.

The service had suitable facilities to meet the needs of patients’ families. Wards we visited had day rooms equipped with items of furniture and memorabilia designed to enhance care and support of patients living with dementia. Unfortunately, due to the Covid -19 pandemic these had not been fully utilised in recent months. However, ward staff were now starting to use these facilities again with patients and families in accordance with Covid-19 safety policies.

The service had enough suitable equipment to help them to safely care for patients. New cardiac monitoring equipment had been purchased in order to fully refit cardiac short stay after refurbishment.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

# Medical care (including older people's care)

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review. All patient records we reviewed identified when escalation was required and a plan of care for the patient.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues. We were shown information on one ward that identified a 70% reduction in pressure ulcers over the year.

Staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required. If patients scored more than five on their NEWS, then they would be seen by the critical care outreach team and if they had a score of more than seven then they would receive an immediate response by the critical care outreach team. We observed this within patient care records.

Staff completed monthly VTE audits, in September 2021 the audit score was 95% for medical wards. This indicated staff were following the trusts policies correctly and reducing risk for patients.

Patients identified at risk of falls were provided with non-slip socks an identifying wristband and a flag on the patient management system. Senior nurses on all wards reported improvements in falls and pressure ulcer management. Ward information boards also displayed this information on safety crosses to highlight to patients and visitors about what was being done about patient safety.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. If patient risk levels were high nursing staff from the ward would accompany the patient to move to the new ward area.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information. We observed a multi-disciplinary safety huddle on one of the wards which enabled staff of several disciplines to discuss safety concerns regarding a patient discharge in order that problems could be rectified in a timely way. Information was also shared on the electronic patient boards in terms of which patient referrals had been made and accepted.

### Staffing

### Nurse staffing

**The service had enough nursing and support 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.**

# Medical care (including older people's care)

The service had enough nursing and support staff to keep patients safe. Each ward staffing establishment was reviewed at least twice yearly in order to ensure meeting safe staffing standards. During our inspection the wards we visited were staffed in line with these guidelines. The trust had recruited a large cohort of overseas nurses in order to increase substantive staffing numbers. The trust also had a bank of nurses in order to ensure staff familiar with trust policies and procedures were employed where possible. Ward staff were also offered overtime where possible. However, to maintain these establishments most wards were still required to use bank and agency staff. The trust was working towards a reduction in agency spend with increased recruitment and talent management in order to ensure skills were used for the benefit of the local population.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift. Managers populated a staffing software which determined the level of acuity and dependency for patients. This calculation informed the nurse to patient ratio and skill mix as well as quantity of registrants on duty.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing was managed across the trust by daily staffing meetings and staff could be moved to help support areas with lower staffing/higher acuity.

During our inspection the number of nurses and healthcare assistants matched the planned numbers.

The service had reducing vacancy rates. At September 2021 the hospital had a vacancy rate of 15% for registered nursing staff, nurse associates and unregistered staff. Staff we spoke with identified a total of 132 vacancies (registered and non-registered staff) across both sites. However, there were 47 new starters waiting to join the trust.

The service had increasing turnover rates. At September 2021 the hospital had a turnover rate of 20% for registered nursing staff, nurse associates and unregistered staff. Staff told us that this was due to the impact of Covid-19 on staff. However, several staff we spoke with told us they were not leaving the trust but moving areas or promotions within the trust. Senior staff we spoke with identified an increase due to staff fatigue in order to recognise this they told us the trust had done extra work around resilience and supporting staff with their mental health.

The service had reducing sickness rates. At September 2021 the hospital had a sickness rate of 6% for registered nursing staff, nurse associates and unregistered staff.

For the medical wards the Allied Health Professional vacancy rate was 5%, turnover rate was 24% and sickness 5% (September 2021).

The service had reducing rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe. We observed signed documentation identifying each bank nurse's orientation to the wards.

### Medical staffing

**The service mostly had 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 locum staff a full induction.**

# Medical care (including older people's care)

The service had enough medical staff to keep patients safe. However, it was necessary to rely on the use of locum staff to do this. During August and September, the total number of shifts unable to be covered was 1,336. Of these 48.5% were covered by agency, 3.6% were covered by care1 bank (a collaborative regional bank arrangement with other trusts); and 45.4% were covered by internal bank.

The medical staff almost matched the planned number there were 2.4% of shifts unfilled during August/September 2021 (33/1336).

The service were working towards reducing rates of bank and locum staff. The Trust's internal controls in managing gaps was to go through internal bank arrangements to cover gaps first, and then if unable to find cover, to go out to agency. This was supported and controlled by a central team. As part of the central teams' controls, core shifts within medicine were not left unfilled, only those shifts deemed to be low risk to patient safety would be left unfilled. If a core shift was unable to be covered through the bank, or agency, alternative mitigations were applied to ensure the shift was covered including the use of acting down arrangements.

The service had reducing vacancy rates for medical staff. Pilgrim Hospital had a vacancy rate of 22% for medical staff across the wards in September 2021. This showed a slight decrease on the August vacancy rate of 24%.

The service had low and/or reducing turnover rates for medical staff. Pilgrim Hospital had a turnover rate of 0% for medical staff across the wards in September 2021.

Sickness rates for medical staff were low and/or reducing. Pilgrim Hospital had a sickness rate of 1% for medical staff across the wards in September 2021.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staffing was a key area of focus with a range of reviews and controls in place.

The service always had a consultant on call during evenings and weekends. During the pandemic some wards had also utilised virtual consultant ward rounds to ensure effective patient care decisions were made.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. Notes we looked at were easy to follow and consistently completed. The trust had standard booklets and forms to fill out for patients notes which helped staff to ensure comprehensive records were kept. The matrons completed records audits and monitored standards throughout the ward areas to ensure consistency.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had an electronic system on which staff recorded observations, key information and treatment plans. This was accessible on all wards and enabled staff to quickly identify areas of risk and treatment plans for patients on the ward.

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.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Charts demonstrated medicines were prescribed and recorded appropriately. Medicines were stored in patient lockers and there was a process to ensure these were replenished as needed. Where medicines had not been recorded as administered, we saw this was identified and we were told that critical medicines that were omitted without reason would be reported through the trust's electronic reporting system. This was also audited and actioned as part of the matron reviews.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Ward and medical staff spoke to patients about their medicines, occasionally a pharmacist would also speak to patients e.g. regarding use of inhalers.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We did not identify any concerns with the storage of medicines. Staff on one ward were not aware of the use of the trust paperwork to support risk assessing self-administration of medicines, staff on other wards were using this documentation to support patients in managing their medicines.

Staff followed current national practice to check patients had the correct medicines. We saw evidence of timely medicines reconciliation. (within 24-48hrs of admission). When patients were admitted over a weekend their charts were prioritised for reconciliation when pharmacy team members arrived on the ward on Monday. We heard that, due to time constraints, not all charts were reviewed by pharmacy staff daily, but patients were prioritised for review based on complexity of treatment regime, discharge and admission dates.

The service had systems in place to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff advised that where necessary the pharmacy team handled medicines alerts.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw no evidence of peoples' behaviour being controlled by excessive or inappropriate use of medicines. During the inspection we spoke with staff who were aware of the sedation policy and any previous incidents. All wards now had sedation logs and staff were aware of where these were stored.

The trust had taken part in the Medicines Optimisation in Care Homes programme. This was a project commissioned by Health Education England (HEE), on behalf of NHS England (NHSE), to provide education for pharmacists and pharmacy technicians in order to reduce the amount of unnecessary medicines patients in care homes were receiving.

The team achieved two out of the three specific standards and were able to medically optimise patient medication that previously would have gone unchanged. Potentially leading to poor patient outcomes and increased readmission rates.

# Medical care (including older people's care)

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Staff on the respiratory ward were able to explain the actions taken from the December 2020, 'Deterioration due to rapid offload of pleural effusion fluid from chest drains' national patient safety alert. The ward now had a specific dedicated area for ultrasound guided pleural drainage to improve observation and constant monitoring of patients undergoing this procedure.

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere. There were quarterly trust wide learning to improve bulletins that were circulated to staff. These covered learning actions taken from serious incident investigations across the trust.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the last three serious incident reports for the medicine wards at Pilgrim. These were clearly written, thoroughly investigated and identified areas of good practice and areas for improvement. Staff we spoke with were aware of serious incidents within their own division and across the two sites.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made as a result of feedback. The trust had previously identified a number of serious incidents in relation to Diabetic ketoacidosis (DKA). This resulted in the diabetes ward not taking any new admissions with DKA and instead they would be cared for on the Acute Medical Short Stay (AMSS). The ward then did work to train staff and recruit additional nurses and had plans to restart taking those patients once the work had been completed. As a result of learning from incidents the respiratory wards staff were creating a pilot discharge checklist for patients going home on domiciliary non-invasive ventilation to ensure all elements of care and training were covered on discharge, thereby reducing readmission.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The deputy director of safeguarding was also part of the serious incident panel in order to identify any safeguarding concerns which may need further investigation or expert opinion.

Managers debriefed and supported staff after any serious incident. Staff we spoke with said that several of the team had undertaken human factors training. The importance of debriefing was highlighted to all staff particularly with aggressive patients or difficult situations. Debriefs were done with staff at the time of an incident where possible and then teams were offered formal training and/ or support.

# Medical care (including older people's care)

### Safety Thermometer

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed development of replacement data collection and reporting then impacted by the COVID-19 pandemic.

Staff used the safety data to further improve services. Leaders reviewed their team's performance regarding the trust quality assurance dashboard and areas for improvement were cascaded throughout staff teams. Operational performance data was collated and reviewed at the trust's divisional board meetings.

## Is the service effective?

**Good** ↑

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

There was a trust wide improving respiratory services programme which had started at the time of the inspection. The trust had recently completed a new respiratory unit at Lincoln Hospital and had plans to develop the service on the Pilgrim site. This met current best practice guidelines and standards and allowed staff to safely care for patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff working with people who were detained had support from the safeguarding team to ensure patients' rights were protected. Patients also had access to advocates who were independent from the trust who they could speak to raise concerns or queries.

At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During the inspection we observed staff offering a choice of meals for their lunch with different options available. During the inspection we spoke with patients who told us that they had plenty of choice and that the food was good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We observed these charts completed and reviewed accordingly in all the records we reviewed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain**.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who could not communicate verbally.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Staff working in the trust described how the pain team used to be based in the hospital three days a week and were now based in the community. They described them as being less visible but still able to make a referral to them and have patients assessed when required. This service was mostly identified for patients suffering chronic pain. Acute pain was managed within the hospital by medical staff or anaesthetists.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**

The service participated in relevant national clinical audits. Audits included the National Lung Cancer Audit, National Audit of Dementia, National Audit of Inpatient Falls, and National Diabetes Inpatient Audit. The service did submit some data to the Sentinel Stroke National Audit Programme but the main site for acute stroke care was at the Lincoln County Hospital so the data for Boston Pilgrim hospital was not comparable to other acute stroke units. The Trust was participating in 97% of all relevant national clinical audits and was in the process of registering for the inflammatory bowel disease audit which would make them 100% compliant.

Outcomes for patients were varied and did not always meet expectations, such as national standards. The National Lung Cancer Audit 2020 (based on 2018 data). This showed that the service performed worse than expected for all metrics. This information had identified problems with data collection, which the trust had produced an action plan to address.

However, the National audit for Dementia 2019 identified Pilgrim Hospital was in the top 75% for three out of four metrics. We were able to observe improvements in the fourth metric as all case notes we reviewed demonstrated multi-disciplinary team involvement in discussion of discharge.

The Myocardial Ischaemia National Audit Project (MINAP) Summary Report April to June 2021 data identified 97 % of patients received Primary Percutaneous Coronary Intervention (PPCI also known as angioplasty or coronary angioplasty, is a procedure used to treat the narrowed coronary arteries of the heart and angina in patients), from arrival to treatment within 90 minutes of admission. Quarterly national data was not available however, this data identified improved patient outcomes for the local population of Lincolnshire.

Managers and staff used the results to improve patients' outcomes. The trust were committed to being involved in 100% of audits in order to ensure improvements for patients. Information from audit was fed back to ward staff and learning embedded by use of a folder with recent SI's and learning and any changes of practice. Information was also cascaded through the huddles. Governance meeting minutes also provide information for ward staff. For example, an audit identified ECG results were not escalated in a timely manner this led to changes in order to improve review of these results.

From April 2020 to March 2021, patients at the Pilgrim Hospital had a higher than expected risk of readmission for elective admissions. However, this data could not be compared to other years as a result of the Covid pandemic.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time with a specific quality governance results and action plan form. We reviewed three such audits which were clear and comprehensive noting areas of improvement and meeting with national guidance and where appropriate identifying further scope for learning. Further audits were more ward based and targeted for example the trust carried out monthly sepsis audits on all the wards. These identified if there were any delays in treatment and possible reasons for this. Most wards had improved results from August to September 2021.

Outcome data was reviewed at specialty and divisional quality and safety meetings. These included learning from deaths. The reports seen included details of all national and local audits. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. We saw that action plans were in place to support improvements. For example, an action plan detailed five action points to address the results of the National lung cancer audit these were either completed or on track during our inspection.

The trust had its own internal accreditation scheme. This scheme had a clear process in place for monitoring quality in all clinical areas. Wards were RAG rated each month following completion of an audit undertaken by a matron. Once a ward had achieved the desired rating of green for consecutive months, accreditation status would be given.

**Competent staff**

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Across the medical wards a number of overseas nurses had recently been recruited. They had a bespoke support package in place to ensure they were fully supported both in work and outside of work to help them to settle into their roles and encourage them to stay. They had competencies that they had to complete before they were signed off to complete certain tasks such as intravenous (IV) medication and were also supernumerary until they were assessed as competent and felt personally competent to care for patients independently.

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'.

Junior doctors received weekly teaching and said there were no issues attending this. They described a good level of teaching from consultant staff. Senior medical staff told us that new junior doctors received teaching sessions when they started in a new department and that regular half day teaching sessions were included in their working rotas as protected time.

Therapy staff were supported by therapy support workers who worked across different therapy disciplines. Support workers completed competencies in order to develop specific skills.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they had completed extra training specific for their roles and that this was easy to access and helped them to develop.

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills.

The clinical educators supported the learning and development needs of staff. There were specialist nurses who had a remit to support staff in developing specialist knowledge and skills. This was through advice and support, training sessions and the signing off of specialist competencies. There were specialist nurses for example in respiratory, oncology and frailty.

Managers identified poor staff performance promptly and supported staff to improve. This could be done through informal support on the ward or through formal processes dependent on the concerns identified.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Throughout the inspection we saw multidisciplinary team (MDT) working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

# Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, the oncology MDT specialist nurse, radiologist, consultant surgeon and oncologist were routinely meeting together to make decisions regarding recommended treatment of individual patients. In addition, we observed that there were daily multidisciplinary board rounds held on each ward. These were attended by nursing, medical and therapy staff with a purpose of sharing up to date information about patients and making shared decisions about their care and treatment plans and discharge planning. We observed that all staff had a voice during these meetings and there was effective discussion as an MDT. Therapy staff explained that although there was pressure to discharge medically fit patients, medical staff respected therapists' opinions when they felt patients were not ready for discharge.

We observed nurse consultants working cohesively with medical colleagues to provide care and treatment across the department.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships between nursing and therapy staff, and we saw that there was a holistic approach to patient care. Therapy staff worked with nursing staff to incorporate rehabilitation into routine ward activities to ensure therapy was purposeful. As the Stroke service had relocated to Lincoln during the pandemic mobile teams of OT/physios and support staff visited all stroke patients on other wards to provide specialist rehabilitation and updating care plans for ward staff to continue targeted therapy.

There was a recognition that therapy resources were limited and that nurses could incorporate a rehabilitative approach into their care based on advice from therapists. Therapy staff worked with community rehabilitation services to coordinate safe discharge and continuation of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. During both days of the inspection we saw the mental health team working and assessing patients on the wards we visited.

Patients had their care pathway reviewed by relevant consultants.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. During the pandemic in some area's wards had completed virtual ward rounds if patient acuity allowed. This had been particularly successful within cancer services. The cardiac wards had daily ward rounds with a consultant or on Tuesdays and Thursdays with another senior member of the MDT. This ensured patients with a plan of care were consistently reviewed and allowed for the consultant to review and plan care for new patients in the emergency department or on other wards.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff described how it could sometimes be difficult to get specialities to review patients at weekends.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support available on wards. Information leaflets were available on request throughout the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to external organisations for specific support needs such as stopping smoking or drinking alcohol. Staff we spoke with told us there was 24-hour response from the alcohol liaison team.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed mental capacity assessments in patient records where there were concerns over an individual's ability to consent to care and treatment. Staff were able to explain the process for assessing a patient's mental capacity. The process was clearly documented in patient's records. For example, we reviewed the records of 10 patients who were under a DoLS application and we saw that in each case a mental capacity assessment and best interests' decisions had been completed. All MDT meetings for best interest decisions, were recorded and minuted, these remain with the patient medical notes to ensure should they be required for any legal proceedings everything is together and fully documented.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the inspection we observed staff asking for verbal consent before undertaking any care and treatment.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training was mandatory and 71% had completed this training.

Managers monitored the use of Deprivation of Liberty Safeguards and Mental Capacity Act and made sure staff knew how to complete them. Monthly audits were completed which identified good practice and wards where improvement was required. These were discussed at a safeguarding oversight meeting and support plans agreed for wards requiring targeted training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and

guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

The trust are in the process of producing an MCA checklist for complex discharges. This will support nurses and discharge coordinators to ensure they have considered any specific concerns that may be related to the individual care of a patient living with a condition that affects their mental capacity.

## Is the service caring?

**Good** 

**Compassionate care**

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us how they spent time getting to know the patient as an individual to ensure that they were aware of their wishes and how best to support them.

Patients said staff treated them well and with kindness. Patients we spoke with told us that staff were all very kind and caring “spot on above excellent care”.

Staff followed policy to keep patient care and treatment confidential. During the inspection we saw curtains being used to protect the privacy of patients when delivering any care, treatment or discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

# Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff we spoke with clearly understood patient needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us there was e-learning on End of Life Care, and the Human Factors Training that covered these conversations. Teams were also encouraged to contact the chaplain for support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff explained how they would include patients loved ones in discussions about their care if this was the wish of the patient.

The hospital had a cancer care coordinator whose role was to assess and support the holistic needs of the patient.

**Understanding and involvement of patients and those close to them**

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported that they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Some patients reported they benefited from the nurse in charge returning to them after the doctors had been to go over information and ensure full understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On all the wards we visited there was information on how patients and their families could give feedback on their care. Staff were proactive in seeking patient and relatives' views in order to improve care.

During the inspection we were told about how patients could feed into improvements they would like to be made on the wards and on one ward how they could add items onto a 'wish list' to be paid for by charitable money.

The trust used patient stories to share where care and treatment had met the expectations of patients and where there were improvements to be made.

For August across the medical division 83% of patients surveyed would recommend the trust as a place to receive care.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients gave positive feedback about the service.

# Medical care (including older people's care)

## Is the service responsive?

Good

**Service planning and delivery to meet the needs of the local people**

**The service planned and provided care in a way that met the needs of local people and the communities served.**

Managers planned and organised services, so they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were mostly appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had a frailty team who worked closely with the emergency department these patients were fully assessed with the aim to have them discharged on the same day.

There was an enhanced patient supervision policy which identified the process for identifying patients requiring additional supervision and ensuring appropriate enhanced supervision requirements were met. There were patient boards above beds which used symbols to identify if patients had special care requirements. These symbols were also used on the patient status at a glance board which was located at the ward nursing station. Symbols were used to identify if patients had dementia, were at risk of falls or required support from specialist nurses or therapy staff.

The oncology and haematology service included a specialist team of staff able to provide care treatment and holistic discharge planning. Patients could also directly return for acute reassessment as necessary to reduce emergency admissions through the emergency department.

The service relieved pressure on other departments when they could treat patients in a day. The medical care service worked closely with urgent and emergency care, the care coordination centre and the same day emergency care (SDEC) service. There was a clear inclusion criterion that patients must meet in order to be eligible for care there.

There were identified short stay wards and an acute medical unit which supported patient flow. There were regular site meetings involving medical care staff to review and discuss any blockages in the emergency department and how medical care could support these. Medical care reported its bed status at a daily bed management meeting which meant the hospital had oversight of bed capacity. Daily multidisciplinary board round meetings enabled staff to make timely decisions about patient discharge to ensure patients did not have any unnecessary length of stay days.

# Medical care (including older people's care)

**Meeting people's individual needs**

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff linked in with leads across the trust for support and guidance. They also worked closely with patient's usual care delivery teams to ensure their needs were met. The trust also had homeless support officers in the hospital.

Wards were mostly designed to meet the needs of patients living with dementia. A number of the wards had recently undergone refurbishments and had improved their accessibility for people living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff had re-introduced the 'Hello, My Name Is' campaign, with the use of placemats with ward information and ward leader and matron names were in place on 7B and were to be implemented on all gastroenterology and respiratory wards. Also wards in specialty medicine had signed up to a telephone project pilot to improve communication with patients' families.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

**Access and flow**

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients for speciality referrals and beds.

The Acute Medical Short Stay (AMSS) flow coordinator and discharge team checked all patients at the start of each shift and identified which patients were suitable to use the discharge lounge. They also used the patient board to identify what individual patients were waiting for.

The trust used the discharge lounge for a place for patients to be cared for instead of waiting in the emergency department while they were awaiting an assertive in-reach assessment (AIR - frailty assessment). Patients were reviewed against specific criteria to ensure their suitability including risk assessments and suitability for same day discharge. However, on occasion this resulted in patients, at times, being in the discharge lounge for long periods of time. In August

2021 there were 16 patients who were in the discharge lounge over 12 hours and September 18 patients. These instances were when decisions needed to be made to transfer medically optimised patients for discharge the next day or from the emergency department for an AIR review. The patients were moved to the discharge lounge overnight then were seen by the team in the morning before usually being discharged out that afternoon.

Managers and staff worked to make sure patients did not stay longer than they needed to. On the oncology/ haematology unit there was a part time discharge coordinator three days a week. At the time of our inspection an audit was in place to identify the need for this service to increase to five days a week. Staff on the ward told us that on the days that the discharge coordinator was not available flow on the ward was affected. The complex requirements of the patients also required consistent discharge planning from staff that understood any ongoing difficulties they may encounter.

The service moved patients only when there was a clear medical reason or in their best interest. There were 1016 patients moved from one medical ward to another in September 2021.

Managers and staff worked to make sure that they started discharge planning as early as possible. The average length of stay across all medical specialties was longer than expected for both elective specialties at Boston Pilgrim Hospital. Average length of stay across all the wards was 5.1 days with the longest average length of stay on the health care of the older person wards (11 days each). The average length of stay for the AMSS was 5.1 days. Patients on all wards were identified as medically fit for discharge when possible. However, access to community care was extremely limited. This meant that on occasion patients became unwell again before they could be discharged. The trust was working with community partners to increase services however this remained a challenge.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff working on the wards aimed to plan discharge when patients were admitted ensuring the process was as short as possible. However, a discharge checklist audit was to commence as patients have been discharged without all checks completed and this had contributed to complaints to PALS. Findings were to be shared with the documentation group to discuss the appropriateness of the current checklist with a view to making it more user friendly in the future.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The trust worked with the local system to make them aware of delays relating to discharge and to facilitate discharges. There were some medical wards with high numbers of medically fit patients. Staff used 'Right to Reside' information to identify where people could be discharged to. 'Right to reside' means you have the right to live in the UK. The trust had implemented 'Right to Reside' and the sharing of information with system partners. System partners joined the 6pm daily flow meeting to discuss bed availability in the community.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Occupancy across the wards was 99%.

Managers worked to minimise the number of medical patients on non-medical wards. Where medical patients were not on the speciality wards they required, there were clear processes for a medical review to continue to ensure their care and treatment was not impacted upon.

**Learning from complaints and concerns**

# Medical care (including older people's care)

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. Across the medical wards there were 122 complaints received in the last year. The most common themes were communication, delay in treatment or diagnosis and being discharged too soon.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on all wards we visited. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

Managers investigated complaints and identified themes. The average time taken to respond to complaints was 59 days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed two patient complaints in relation to medicine at Boston Pilgrim Hospital, the response addressed all points raised by the complainants, gave detailed responses and were written in a sympathetic manner.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated.

Staff could give examples of how they used patient feedback to improve daily practice. Following an increase in complaints on respiratory wards whilst visitors were not allowed on site, a contact list for patients next of kin was now in place to provide updates.

## Is the service well-led?

**Good** ↑

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Medicine had its own division within the trust's management structure. This division included all the medical wards and the urgent and emergency department. The leaders worked in a multi-professional triumvirate which included a manager, doctor and nurse. Care group senior managers and clinical leads were seen regularly in ward areas. Staff felt able to raise concerns and were confident their concerns would be listened to and acted upon. Ward staff said they were well supported by their ward managers and matrons.

# Medical care (including older people's care)

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Staff were encouraged and supported to develop their skills and take on more senior roles. There were development pathways to support staff to progress.

**Vision and Strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had five key values:

- **Patient-centered-** Putting patients at the heart of our care.
- **Safety-** Ensuring patients and staff are free from harm.
- **Excellence-** Supporting innovation, improvement and learning.
- **Compassion-** Caring for patients and loved ones.
- **Respect-** Treating our patients and each other positively.

During the inspection we observed staff to be displaying these behaviours in the care and treatment they delivered.

The trusts vision was to be outstanding and was led by the trusts board. The division's vision mirrored that of the trust. Individual wards also developed their own visions which was specific for the patients they treated and the staff they had on the ward. For example; ward 6B provided a board vision to identify 'Together Everyone Achieves More' highlighting that they were a cohesive team working hard to provide safe care to all their patients. The Bostonian ward support each other with a 'What Matters to Me' board and what mattered to them was that they provided "outstanding personalised care". A number of areas also had boards identifying small ways they could improve care by "looking after their own wellbeing" and "grabbing every opportunity to learn new things".

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

# Medical care (including older people's care)

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

Patients acknowledged a positive and caring ethos and were happy with their care.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

There were clear governance structures within the trust with good representation from all disciplines. Governance group meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the medicine group. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded.

The medicine division also had monthly dashboards which covered data from across the wards and was collated into an overall performance report for the division. This highlighted areas of good practice and areas where improvements could be made.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Risks were recorded at ward division and trust level. The top three risks identified were the safe management of emergency demand, timely provision of Non-Invasive Ventilation (NIV) and capacity to manage emergency demand. These all had control measures in place, identified weaknesses/gaps in controls, planned actions and recorded progress. Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Throughout the medicine division, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

**Information Management**

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

Data or notifications were consistently submitted to external organisations as required.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The trust used the friends and family test to gather the views of people using the service. They also gathered the views of patients and their loved ones through complaint and compliments. All of this information was gathered into a monthly report which detailed any actions and learning.

The trust also held patient panel workshops where members of the public were invited to discuss a variety of topics such as changes to services. These were a useful way for project leaders to be able to gather the views of people who would be using the services they were developing.

Where a service had been reviewed or developed, a full equality impact assessment was completed. The service also had a system community database which allowed staff to engage with different groups to gather diverse views on services.

In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

Each month a newsletter was produced to identify to all staff any patient feedback that had been received and any common themes. This information was also discussed at a monthly patient experience meeting.

All wards we visited also had poster boards to identify to patients and relatives 'you said we did'. For example, on The Bostonian ward patients identified they would benefit from radios, activity packs and extra snacks. So, the ward used some donated money to buy radios, sourced activity packs for all patients and now provide a 'snack train' daily for additional nutrition.

Daily bay inspections by the ward sister/charge nurse were having a positive effect on patient feedback as patients were happy to be cared for in a clean and tidy environment. There were also plans to reinstate ward lead ward rounds with a focus on communication.

**Learning, continuous improvement and innovation**

# Medical care (including older people's care)

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Following the last inspection, the trust had taken action to address the issues found across the service.

The trust had monthly medicine division confirm or challenge reports. These explored different measures across the trust and dependent on risk level identified drivers for change or metrics to continue to monitor. Each month these were updated dependent on risk levels and actions completed to improve the services across the trust. Areas for improvement including reducing medication errors causing moderate or severe harm and reducing agency spend for the year compared with the previous year.

The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.

# Services for children and young people

Good ↑↑

## Is the service safe?

Good ↑↑

### Mandatory training

**The service provided mandatory training in key skills to all staff. However, challenges to accessing training as a result of the Covid-19 pandemic meant not all staff were up to date.**

Nursing staff received and kept up-to-date with their mandatory training. Training was a combination of face to face training and online learning and included sepsis training and infection prevention and control. Although time to complete training was not scheduled into the rota, ward managers ensured that staff used quieter periods to complete training and the clinical educator alerted staff when they were approaching completion deadlines.

We reviewed a snapshot of compliance data on 18 October 2021 and found nursing staff on the neonatal unit and outpatients' department achieved 100% compliance for almost all of the modules which met their target of 90%. Exceptions to this were for fraud awareness which was 67% and 73% for the annual resuscitation module. The children's ward had met the 90% target in most modules and between 68% and 73% for basic life support modules.

Medical staff did not manage to keep up-to-date with their mandatory training. Medical staff had achieved between 45% and 78% compliance for mandatory updates. Medical staff said they were usually given time to complete the training but that the Covid-19 pandemic had made this more challenging than usual. Managers said that medical staff were 100% compliant with all staff having completed a level of life support training. They provided data which showed 20% of medical staff had completed life support training at European Paediatric Life support (EPLS) level and 80% had achieved Advanced Paediatric Life Support (APLS) level against a target of 100%. Managers told us that APLS courses were undertaken externally and there had been difficulty in booking APLS courses due to the Covid-19 pandemic. They had booked remaining staff for the next available course which was January 2022.

The mandatory training was comprehensive and met the needs of children, young people and staff. It included life support training which was specific to children and neonates. Band four staff (staff who were experienced in working with children but were not registered nurses such as nursery nurses and nurse associates) were trained in paediatric immediate life support (PILS).

Data provided by the trust showed that 61% of nursing staff had completed European Paediatric Life support (EPLS) training against a target of 100%. Managers told us this enabled at least one EPLS trained person on each shift. All nurses in charge had completed EPLS training. Managers were aware that the Royal College of Nursing (RCN) safe staffing guidelines states a Paediatric Assessment Unit should have Advanced Paediatric Life Support (APLS) trained staff. The trust had acquired funding for this but due to the Covid-19 pandemic, there had been no external courses available. The staff were on a waiting list to attend the course and were ensuring all nursing staff completed EPLS training in the meantime as this was internally available.

# Services for children and young people

Staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. This was a new programme being delivered to all staff which was due to be completed in 2022. Some staff on each ward and department had completed training to become learning disability and autism champions and were able to support other staff. This was an improvement since our last inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was reported to matrons by the ward managers via their monthly dashboards, and this was escalated upwards to the trust board.

### Safeguarding

**Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing staff received training specific for their role on how to recognise and report abuse. All nursing staff were trained to level three. We reviewed a snapshot of compliance data on 18 October 2021 and found nursing staff had achieved 100% compliance for safeguarding training. This exceeded their target compliance of 90%.

We observed staff acting as a chaperone for patients in outpatients.

Staff received training on preventing child abductions. This did not include scenario training at the time of our inspection.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff were knowledgeable about the provider's safeguarding policy and described trust wide safeguarding staff they could approach for guidance and advice. Staff knew where to access information about making a referral and who to contact on their ward if they had a concern. Non-qualified staff would inform the nurse in charge or the ward manager of any concerns but also knew how to access information about safeguarding, including the safeguarding policy and referral pathway. Staff knew there was a safeguarding lead who they could contact for advice or to escalate a concern.

Staff could access a division wide safeguarding supervision meeting via videoconference. This was run by the divisional safeguarding leads.

Medical staff received training specific for their role on how to recognise and report abuse. We reviewed a snapshot of compliance data on 18 October 2021 and found medical staff had achieved between 59% and 67% compliance for safeguarding modules which did not meet the trust's target of 90%. However, medical staff said they understood how to identify a safeguarding concern and how to act on it.

Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment.

Medical staff regularly held case reviews and safeguarding meetings with ward staff and other relevant agencies to discuss individual children's needs.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Matrons, ward managers and sisters reported a very good relationship with the trust's safeguarding team who provided advice and support to staff when needed. They had recently developed six safeguarding champion roles

to help support staff. Staff on the neonatal unit worked closely with the maternity unit and community team to plan for babies and mothers with known safeguarding concerns for the benefit of both baby and mother. Staff on the children's ward worked closely with community staff and other agencies when planning an admission for a child with a known safeguarding concern to ensure ongoing safety of the child during their admission.

Staff were informed of any known safeguarding concerns for individual children during the morning and afternoon handovers and discussed at ward rounds. The safeguarding team worked closely with the midwifery team and developed a template which identifies any issues quickly. The family and baby team (FAB) worked closely with the midwifery team and safeguarding teams and the neonatal unit to support families with a variety of issues.

Staff followed safe procedures for children visiting the ward. Siblings were allowed to visit but was restricted during the Covid-19 pandemic. Parents were asked to ensure visiting children remained with them at all times. Siblings were allowed in the play areas and sensory room with parental supervision.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were very clean and had furnishings which were suitable for children and were clean and well-maintained.

Cleaning materials were kept in a locked cupboard and a cleaning schedule was maintained by the housekeeping team. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned bed spaces promptly when there were vacated. Hazardous cleaning products were locked away.

All areas we visited had disposable curtains which were dated to show when they were last changed. All staff we spoke with were aware of when to change curtains more frequently.

There was a sensory room on the ward which was also kept clean and well maintained. There was a family room on the children's ward which was usually available to parents who were staying with their child and where siblings could play. This had been re-purposed during the Covid-19 pandemic to accommodate medical staff on the ward.

The neonatal unit had two parent's suites as part of their transitioning service. This enabled parents to stay overnight to become used to caring for their newborn after spending time in the neonatal unit. The suite included a double bed and bedroom furniture which was washable, a cot, kitchenette, bathroom and lounge area with TV. There was also space for siblings to visit.

The service generally performed well for cleanliness. Managers conducted regular audits to check compliance with infection prevention and control (IPC) policies. A recent cleaning audit on the ward showed 82% compliance and 98% for hand hygiene. We observed that staff washed their hands and used hand gel regularly and before and after every contact and completion of any task.

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward managers ensured that PPE was always fully available. There was a good supply and no supply issues during the pandemic. Staff and visitors complied with the trust's infection, prevention and control (IPC) processes, including additional Covid-19 precautions which were in effect across the service. Face masks and alcohol hand gel were freely available on each ward. Staff complied with social distancing precautions when required. Information for staff and visitors regarding IPC and

COVID-19 precautions was displayed across the service, including at entrances to wards. Personal protective equipment (PPE) such as gloves and disposable aprons were used in accordance with the trust's infection control policy. Staff used alcohol hand gel when entering and exiting the wards and theatres. Handwashing facilities were appropriate and accessible. All staff adhered to being bare below the elbow.

Patients with infections or at risk of harm from infections were clearly identified and supported in side-rooms. Assessments indicated the level of infection risks associated with each patient and there was clear guidance about how to prevent the spread of infection and what PPE was to be used.

When possible, patients were tested for covid prior to admission and there were procedures in place to test unplanned admissions upon arrival. Patients requiring planned surgery were tested three days before admission to the ward. There was a dedicated Covid-19 information board for staff, patients and visitors explaining how to identify symptoms and prevent its spread. There was a dedicated infection, prevention and control lead to educate staff and visitors and promote good infection control practices.

Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' stickers to show when it was last cleaned. All 17 pieces of equipment we checked were clean and labelled.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Children, young people and their families could reach call bells and staff responded quickly when called. Patients who were unable or unlikely to use call bells, such as very young patients were kept under close observation of the nursing staff.

The design of the environment followed national guidance. The service had arrangements in place to ensure children and young people wards and clinics were secure. The main entrance to the neonatal unit and ward could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity and validity of people requesting access to wards. Fire doors were alarmed so patients were unable to leave without staff being alerted. Non patient rooms and areas within the ward had dedicated key code locks to prevent unauthorised access to items which could be harmful or confidential.

The layout of the neonatal unit was such that all cots and incubators could be observed constantly. Two of the cots were designated as high dependency cots and all cots had enough space around them for staff to care for babies and for parents to sit in an armchair beside their baby. There was a separate isolation room for when this was required. All equipment was easily accessible, and all cots could be seen from the ward manager's office.

Parents had access to a shared kitchen and lounge area where they could make a hot drink and a snack. There was also bathroom and shower facilities for parents and individual lockers so that they didn't need to take all their belongings into the nursery and to avoid clutter.

There was a milk kitchen and preparation area on the neonatal unit and the ward for the safe preparation of milk feeds. There was a fridge specifically for storage of breast milk, which was kept locked.

Parents had access to breast pump equipment and access to a private room to express their milk. There was a breastfeeding resource box for mothers which provided information and clear guides, including the UNICEF national guidance. Sterilising equipment for feeding bottles was provided for individual babies and labelled with the child's name. All of the three pieces of disposable feeding equipment we checked were in date. Food products were available for babies and children and all four items we checked were in date.

Staff carried out safety checks of specialist equipment. Maintenance staff completed regular safety checks of electrical equipment. Out of 17 pieces of equipment we looked at, all apart from one had a sticker to show when it was last tested and were in date.

The service had suitable facilities to meet the needs of children and young people's families and enough suitable equipment to help them to safely care for children and young people. Cots, incubators and beds were suitable for babies and children. There was eight cleanable parent beds. Resuscitation equipment was suitable for babies and children in each of the areas, including theatre recovery and outpatients department. Play equipment was suitable for the needs of children and had 'I am clean' stickers to show it had been cleaned. There was an area within the x-ray department which had been designed for children, but this had been temporarily closed due to the Covid-19 pandemic and toys removed.

Staff had access to specialist paediatric emergency equipment in all areas we checked. A paediatric resuscitation trolley was available on all inpatient and outpatient areas, and theatres. This was checked daily. All trolleys were secured and easily accessible in an emergency. All equipment we checked was in date.

Staff had access to emergency 'grab' boxes which had been stocked by the hospital resuscitation team. This contained lifesaving medication and equipment suitable for children

Staff disposed of clinical waste safely. Sharps boxes were kept in locked rooms on the children's ward, where children did not have access. All were dated and signed by staff for traceability.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.**

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system to assist them with the early recognition of sick patients and management of any deterioration. Vital signs such as heart rate, respiratory rate, blood pressure, oxygen saturation temperature, and behaviour were used to assess each child's clinical status. This generated a scoring system which alerted staff to any potential deterioration. A Newborn early observation warning system was used on the neonatal unit which was specific to neonates (NeOWS). Staff alerted the nurse in charge of any triggers or scores which caused concern about deterioration. Medical staff would be called to review the child or neonate if required.

The ward manager conducted weekly reviews to check whether PEWS and NeOWS tools were being completed fully and alerts being followed up promptly. We looked at a snapshot of data on 18 October 2021 and found that matrons' monthly audits showed 100% compliance with criteria relating to identifying deteriorating patients and potential sepsis.

# Services for children and young people

Staff received training in caring for children requiring high dependency care and paediatric intensive care and were able to look after very sick children and babies until they could be transferred to a local hospital with higher level critical care facilities. There was a transfer process in place which involved a nationally recognised specialist team retrieval to ensure safe transfer. The retrieval team worked well with the service and provided annual training sessions for staff. The clinical educator also delivered training on recognising the sick child.

Staff completed risk assessments for each child and young person on admission using a recognised tool. Staff received training on completing risk assessments which were in booklet form and included; cot sides assessment, self-harm risk, exposure to infectious diseases, Glamorgan scale (for pressure ulcer risk) Covid-19 status, and Paediatric Yorkhill Malnutrition scale (PYMS)

Staff knew about and dealt with any specific risk issues. Staff were vigilant in checking for signs of sepsis through the use of PEWS and NeOWS tools. There was a sepsis care protocol in place for the management of patients with presumed or confirmed sepsis. One-to-one care was provided for children who needed extra care or observation, such as children who were at risk of self-harm, and those in need of high dependency level one care.

Staff were supported to become competent with recognising a deteriorating child and identifying and escalating sepsis. Staff completed a specific competency booklet on sepsis and were required to complete e-learning.

The clinical educators supported new starters by delivering a sepsis session which showed how to recognise signs of sepsis, how to complete the trust paperwork and how to escalate concerns. Until new starters completed this assessment, they were required to escalate all patients with sepsis indicators to the nurse in charge

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. Staff had access to rapid assessment with CAMHs when needed, either in person or via telephone. The children's ward had established a joint working initiative with the local NHS mental health and good links with the Child and Adolescent Mental Health Services (CAMHs). This was an improvement since last inspection. They had set up a new pathway for eating disorders and held weekly meetings with the local mental health NHS trust to review patients and were informed of any likely admissions requiring mental health support. Matrons also met regularly with the local mental health NHS trust to review all CAMHs pathways.

Children who were in the care of CAMHs at the age of 16 years onwards were able to continue being cared for on the children's ward during their transition up to the age of 18 years. A working group had been established with a matron as lead, to ensure a safe transition for this group of patients. This was an improvement since last inspection.

Staff arranged risk assessments for children or young people thought to be at risk of self-harm or suicide and sought help and advice from the safeguarding lead and medical staff where needed. Nurses used a risk assessment tool to assess patients who were at risk of suicide, self-harm or absconsion. This identified what level of staff monitoring was required to keep the patient safe from harm. Where necessary patients were allocated staff to provide continuous supervision.

Staff from the child and adolescent mental health service (CAMHs) provided support for patients who were at high risk of suicide or self-harm. CAMHs provided this additional support during day shifts.

Patients at risk of suicide, self-harm or absconsion were usually located in the patient bay nearest to the nurses' station to provide extra monitoring.

# Services for children and young people

Staff did not use chemical restraint (such as sedatives) to restrain children and young people.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Information and discharge summaries were shared with GPs, health visitors and other relevant community teams. Staff held meetings with key community staff to plan for complex discharges.

Shift changes and handovers included all necessary key information to keep children and young people safe. We observed a shift handover and saw that all relevant staff were present and detailed information was shared, including the emotional wellbeing of children.

### Nurse staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 nursing and support staff to keep children and young people safe. At the time of our inspection we saw that the wards we visited were fully staffed. Managers told us they had previously not had enough staff, but a recent recruitment had brought the staffing numbers to almost fully recruited to. Each area or department had staff who were suitably trained in children's or neonatal speciality which included paediatric life support. This included the children's ward, the neonatal unit, children's outpatients department, theatre and recovery area.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. Matrons held daily meetings across sites to review staffing rotas and this had meant some staff moved to other areas to meet the needs of other wards during the pandemic.

Ward managers planned staffing rotas and adjusted them according to the changing needs of the service and required staffing levels. The rotas were planned with one nurse to every four patients generally, one nurse to one patient for high dependency patients and one nurse to two patients for sick children. The nurse in charge was always a paediatric trained nurse and was supernumerary to enable them to oversee the running of the ward or unit. There were usually three paediatric trained or paediatric competent nurses and two non-trained staff on each shift. Paediatric nurses were nurses who had completed their nurse training specifically to care for children. All band 6 nurses had received high dependency unit (HDU) training. Adult nurses who worked in the service were given the opportunity to complete an extensive range of courses relating to children and neonates over the period of 12 months. They were assessed for competence in each area and once completed, the adult nurse held the status of 'paediatric competent'.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Ward managers and matrons sometimes worked a clinical shift to cover rota gaps and absences. Regular bank shifts were used which were often filled by staff who worked on the ward. The clinical educator worked alongside staff and sometimes filled gaps in the rota.

During the Covid-19 pandemic, staff had been frequently re-deployed to other wards and areas to cover staffing gaps. The ward managers tried to ensure any redeployment was mainly within the family health services, however some adult nurses were moved to other services and some nursery nurses were asked to look after children in the emergency department. Most staff were happy with the support provided to assist them in a new area.

The number of nurses and healthcare assistants did not always match the planned numbers. These were displayed on wallboards. We looked at a snapshot of staffing rotas for the last six months and found staffing fill rate had varied each month on the neonatal and children's ward. This ranged from 75% to 100% for qualified staff and 43% to 89% for non-qualified staff. Managers and staff told us that staffing levels had improved, but that gaps were regularly filled by current staff and managers with very little bank staff usage. Ward managers, matron and the clinical educator stepped in to fill a clinical shift where there was a significant gap.

The service had low vacancy rates. There had been a recent staffing establishment review which had not been published at the time we inspected. The ward showed a small band 5 and band 4 vacancy (less than 1 WTE) and the neonatal unit were almost fully established. This was based on a revised staffing model which was awaiting approval at the time we inspected. Staffing within the neonatal unit met the British Association of Perinatal Medicine (BAPM) standards.

The service had low turnover rates. They had reducing sickness rates, although there had been a rise in sickness during the Covid-19 pandemic. Current rates of sickness were around 2%.

The service had low rates of bank and agency nurses. We looked at a snapshot of data on 18 October for agency and bank usage during a three month period June to August 2021 and found that agency usage was between 2.5 and 2.8% and bank usage was between 4.2% and 5% for the same period. Managers limited their use of bank and agency staff and requested staff familiar with the service and made sure all bank and agency staff had a full induction and were paediatric trained or paediatric competent. Ward managers, matrons and the clinical educator also stepped in to fill staffing gaps.

### Medical staffing

**The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service did not always have enough medical staff to fill the rotas but told us they were able to keep children and young people safe. There were eight consultants across the children's services with 1.9 WTE consultant vacancy across the trust. Consultant cover was in line with the Royal College of Paediatrics and Child Health (RCPCH). On call consultants were available within 30 minutes out of hours. Medical staff told us there were sometimes gaps in the medical staff rota for middle grade and junior grade doctors which had been filled with locums who were familiar with the service. There were no gaps in the consultant rotas. Medical staff were also needed to cover admissions in the emergency department. Staff told us they did not usually have a problem getting hold of a doctor when they requested one.

We looked at the most recent data provided by the trust and found that in August 2021the service had an overall vacancy rate of 13% for medical staff and turnover rate of 9%.

Sickness rates for medical staff were low reducing. Current sickness rate for August 2021 showed 3%. This had varied between 1% and 4% during the previous 12 month period.

The service had low rates of bank and locum staff. We looked at a snapshot of data for the previous 12 months and found that locum or agency usage was consistently around 5% and bank usage was consistently between 1% and 2% In August 2021 agency usage was 5% against a target of 2% and bank usage was 4% against a target of 2%.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service used locums who were known to the service. Staff told us the locums were knowledgeable about the service and were assessible.

The service had a good skill mix of medical staff on each shift. There were always a consultant in charge, two registrars and two middle grade doctors on shift to cover the service.

The service always had a consultant on call during evenings and weekends. There was a 'hot week' consultant for children's and for neonates. There were always two registrars available and onsite each weekday and at the weekends there was one registrar on call and always available.

### Records

**Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. Records were a combination of electronic and paper. Care records and assessments were in booklet form and completed by a range of staff. All of the 10 records we reviewed, all were fully completed. Families were encouraged to bring the child's ongoing health record (red Book) with them into hospital.

Records were easily accessed by relevant staff, legible and comprehensively completed, stored securely and locked in cabinets

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff sent discharge summaries and information to health visitors, GPs, the CAMHs team and other relevant health care professionals electronically.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The pharmacy service to the wards ensured medicines' reconciliation was completed in a timely manner although this was not always possible at weekends as there is no pharmacy service to the wards.

The 10 medicines administration charts we looked at were completed fully, including allergies, weights and start, stop and review dates of antibiotics.

Ward managers reviewed medicines' charts daily and monitored adherence to policy and guidelines as part of their weekly spot checks. Matrons also included medicines checks in their monthly audits.

There was no specific policy within theatre for children and young people. However, theatres had a labelled paediatric emergency medicines pack with red grab bags. The packs were transferrable to any area caring for paediatrics and formed part of the theatre checklist prior to surgery commencing. Regular checking arrangements were in place for the packs to ensure medicines were maintained in-date. We reviewed the emergency medicines and found these were suitable for children and young people.

# Services for children and young people

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. Ward and medical staff spoke to patients and their parents about their medicines, occasionally a pharmacist would also speak to patients. Parents were encouraged to be involved in administering medicines to their children

The pharmacy team were available for advice and support during daytime hours.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Although the service did not have a dedicated pharmacist aligned to the service, they had a daily rotational pharmacist visit during the week, although this could be impacted by staffing levels. The pharmacist completed medicine reconciliation and prescription chart checks. Staff could get advice and support from a senior pharmacist if needed from Lincoln hospital.

Staff stored medicines securely in all clinical areas we visited. All medicines were locked in cupboards in locked rooms. Controlled drugs were stored correctly in locked cupboards and stock was checked by staff daily. New stock and unused stock was checked in and out by two qualified nurses and properly recorded. Medicine storage areas and cupboards were well organised and tidy and stock was regularly rotated. All medicines we checked were within their use by date. Staff kept records of medicines fridge temperatures and ambient room temperatures of their medicine rooms on the children's ward and post-natal unit. Checks were monitored by the ward sister as part of their weekly spot checks and by matron during the monthly audit.

Emergency medicines were correctly stored and easily assessible to staff where needed. This included theatre and recovery and outpatients department. The anaphylactic boxes in outpatients department were being reviewed by the new department manager. Currently they held auto-injectable devices in containers at specific locations which were easy for staff to grab if a patient experienced anaphylactic shock. Other medicines were accessed from the resuscitation trollies.

Staff followed current national practice to check children and young people had the correct medicines. Staff told us that medicines reconciliation was completed by pharmacists but not completed at weekends on the ward. Charts could be sent to pharmacy for this if needed but would be postponed until Monday if no-one was available.

Charts demonstrated medicines were prescribed and recorded appropriately. Medicines were stored securely, and we saw evidence of daily and monthly ward assurance regarding medicines management.

When children needed medicines to take home when being discharged, a medicines' chart would be taken to the pharmacy in the hospital for the prescription to be checked by a pharmacist. However, some medicines could be dispensed by staff from a small stock kept on the children's ward, which were checked with a doctor.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Staff were aware of the need to report medicines incidents and described sharing of learning across the trust. The pharmacy technician advised that alerts were handled trust-wide with senior members of the pharmacy team actioning them and recording this had occurred

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. This was part of the pharmacists' review. Ward managers checked the medicines' charts daily.

# Services for children and young people

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. This was an improvement since last inspection. Staff understood their responsibilities to raise concerns, and there was now a positive culture of reporting incidents. Managers and staff told us there was a big improvement in incident reporting and learning from incidents. Qualified staff reported incidents and near misses in line with trust policy. Junior staff reported concerns to the nurse in charge and were informed of the outcome of these. Staff of all grades were able to give examples of an incident they had heard about because learning had been shared with the teams.

The service had no never events on any wards.

Staff knew to report serious incidents and understood the duty of candour. 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.

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.

Staff received feedback from investigation of incidents if they had reported the incident. Learning from serious incidents was displayed on a clinical governance board in the staff area.

Staff met to discuss the feedback and look at improvements to children and young people's care. This was discussed at governance meetings where matrons and other leaders attended. Ward managers shared feedback with staff at ward meetings and briefings. Staff were aware of incidents which had occurred within the service.

There was evidence that changes had been made as a result of feedback. For example; a change to protocol means that a consultant always has to be present at any birth which is less than 32 weeks.

Managers investigated incidents thoroughly. Investigations were led by the risk team and the matrons. A 'learning from incidents' form was completed and learning was shared with staff by email, in team meetings, and on the clinical governance board in the staffroom. Children, young people and their families were involved in these investigations.

Managers took action in response to patient safety alerts. These were shared with staff by email and at ward meetings and daily handovers.

## Safety thermometer

**The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.**

# Services for children and young people

Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed developed of replacement data collection and reporting then impacted by the COVID-19 pandemic.

The service continually monitored safety performance and used the data to further improve services. Ward managers and matrons made a series of weekly and monthly checks and audits and shared this with leaders via a dashboard and with staff at meetings. The information was reported to the trust board.

## Is the service effective?

**Good** ↑

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Management reviewed and updated policies and clinical guidelines as part of monthly governance meetings.

Policies and guidelines were accessed via the trust's computer system by all staff. National and local guidelines were used by staff which were also easily accessible from the computer. When policies were updated and changes made to national and local guidelines, the ward manager alerted staff to the changes and asked them to complete a signed sheet once they had reviewed the changes. The five policies we reviewed on the trust's computer system had been updated within the last 12 months.

The Bliss Baby Charter is a UK framework for neonatal units to promote best practice and a high quality of family centred care. There are seven principles that neonatal units are encouraged to work towards and undertake audits to self-assess compliance. During our inspection we saw the neonatal unit complied with most of the principles. Although there was no dedicated room for mothers to breastfeed or to express milk, there were a number of private rooms where mother could use.

The service took part in external reviews to assess their services. For example, the local mental health trust had undertaken a review of the children and young people's mental health service and care provision at Lincoln County. The report had not been published at the time of our inspection, however management told us they had received positive feedback with no significant areas for improvement

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff liaised closely with the local mental health NHS trust and with the Child and Adolescent Mental Health Services (CAMHs) to ensure children and young people with mental health issues had the most appropriate care. Where required, staff had access to rapid assessment with CAMHs. One to one care was provided where needed. The children's

ward was a 48 hour short stay unit, but where necessary, some children were able to stay for longer if they were being treated by a consultant from Pilgrim Hospital regularly, or if it was in their best interest to remain in the local area for a few more days. Children and young people who needed longer term care were cared for at other local hospitals and in the community.

At handover meetings, staff referred to the psychological and emotional needs of children, young people and their families. The local mental health NHS trust and CAMHs teams liaised closely with staff prior to planned admissions. Information about a child's mental health needs was shared at handover and staff were also alerted to additional needs in the child's record.

### Nutrition and hydration

**Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Patient's nutrition and hydration needs were assessed on admission. There was a choice of food to suit children's taste. Parents were encouraged to remain with their child at mealtimes. There were dedicated children's menus in place and older children could order meals from an adult menu if they preferred. A choice of baby foods was available for young children. Staff provided food to children outside of mealtimes as required, such as after a procedure.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. There was access to a dietitian for special requirements. Where children had swallowing difficulties, staff sought advice from the speech and language therapists who would provide support.

There was a nil by mouth policy in place for patients awaiting surgery and were designated, 'nil by mouth'. Cold meals were available to patients returning from surgery and didn't want to wait for a scheduled mealtime.

### Pain relief

**Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Picture charts were used where necessary to assess pain.

Children and young people received pain relief soon after requesting it. Staff were keen to ensure children did not suffer pain for longer than necessary. We saw that staff responded promptly to a child in pain during our visit.

Staff prescribed, administered and recorded pain relief accurately. Staff supported patients to receive suitable pain management when necessary. A dedicated pain management team were available for additional advice and support.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.**

The service participated in relevant national clinical audits. For example**;** the British Thoracic Society (BTS) national audit in management of community acquired pneumonia in children.

Outcomes for children and young people were positive and consistent with national standards.

Managers and staff used the results to improve children and young people's outcomes. These were discussed in governance and other managers meetings. For example. The trust submitted data for the Avoiding Term Admissions into Neonatal units Programme (ATAIN) to Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS). Data showed there had been 13 avoidable admissions between Pilgrim Hospital and Lincoln County Hospital between September 2020 and March 2021. The trust identified that the 'warm bundle' had not been followed in some cases which contributed to an avoidable admission. A warm bundle is an initiative to prevent hypothermia immediately after birth. Measures include providing a hat for the newborn and encouraging skin to skin contact with the mother. The trust made changes and ensured the warm bundle was now in the intrapartum booklet to be followed for every birth. They were monitoring their improvement action plan.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This was an improvement since last inspection. A programme of audits had been developed. These were led by two members of the health and safety team who were managers. Doctors and junior doctors were encouraged to participate in clinical audits. Ward staff and matrons were involved in audits and checks such as accurate completion of PEWS and NeOWS charts, pain charts, and compliance with local protocols. We reviewed a snapshot of data provided by the trust for April to July 2021. Ward audits showed 100% compliance for most of the eight sections reviewed, including safeguarding and MCA checks, respect, deteriorating patient review, infection prevention and control, fluid balance, diabetes, and medication. There were some areas which scored 0% for example; privacy and dignity signs being used, skin care checks during board rounding, and having a care plan in place for nutritional needs. Staff said this may have been influenced by the acuity of patients cared for on the children's ward at the time of the audits. Matrons shared monthly ward assurance audits with the directorate to demonstrate performance.

Data provided by the trust showed that Medical staff conducted clinical audits to measure outcomes against the National Institute for Health and Care Excellence (NICE) guidelines and local guidelines. The service showed us 38 audits which had been completed within the previous 12 months. Clinicians made recommendations for change where guidelines were not being adhered to, and where improvements could be made. For example, where it was found that documentation needed to improve in an neonatal ultrasound scan audit, this was audited again to check it had improved.

Managers used information from the audits to improve care and treatment. Ward managers and matrons discussed the outcomes of weekly spot checks and monthly ward assurance audits and shared any actions for learning with staff at meetings and on governance wall boards. Managers also shared information at governance meetings and other senior meetings. Improvement was checked and monitored by the audit leads.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development.**

The clinical educators had supported the learning and development needs of staff. The clinical educator was based on the ward and worked with staff from the ward, neonatal unit, theatre and outpatients department. They provided ongoing mentorship and support, monitored competencies and provided face to face training sessions for staff at all levels. They also supported staff with higher education degrees and apprenticeships.

# Services for children and young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. All ward managers and band six nurses were paediatric trained or paediatric competent and had completed the high dependency unit (HDU) training. All other qualified nurses who were not registered paediatric nurses were expected to complete the paediatric competency programme. This was a suite of paediatric and neonate specific courses which provided them with the knowledge and experience to care for children and neonates. Nursery nurses completed paediatric or neonatal training.

Staff who cared for children in theatres, recovery and outpatients all received training to enable them to care for children and young people effectively. Knowledge and competencies were monitored by managers.

Managers gave all new staff a full induction tailored to their role and checked their competencies regularly. The trust had a preceptorship programme to support new starters, newly qualified nurses and nurses who had returned to practice. This enabled staff to be supported to develop their role specific competencies within the first 12 months of their role. We looked at the induction booklet and competency booklet and found these to be comprehensive. Nursery nurses also worked through a similar process to obtain and record their competencies gained within their role.

Consultants provided junior doctors with an induction upon joining the service.

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.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Data provided by the trust showed that, as of 30 September 2021, medical staff were 100% compliant with completing their appraisals.

The safeguarding team provided clinical supervision (support) sessions for staff where they could join a scheduled online session to talk about how they managed a safeguarding concern and to learn from others' experience. (Clinical Supervision is a formal, systematic and continuous process of professional support and learning, for practicing nurses, in which nurses are assisted in developing their practice through regular discussion with experienced colleagues with whom they can share clinical, organisational, developmental and emotional experiences.)

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some nursery staff had been supported to and fully funded to complete their nurse training through an apprenticeship.

Managers made sure staff received any specialist training for their role. This included all courses relevant to caring for children and neonates, including life support training. The clinical educator conducted two training events each year focussing on using the PEWS and NeOWS tools and on recognition of the deteriorating child. Other relevant training was provided by external stakeholders such as the child retrieval team. Leadership and management course were also available.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**

# Services for children and young people

Doctors and nurses reported effective team working and collaboration to provide care. Staff held multidisciplinary meetings to discuss children and young people and improve their care. Consultants, medical and nursing staff met with health visitors, children's community team, clinical educator, nursery nurses, outreach team, mental health colleagues and speciality medical staff such as specialist diabetes team and nutritionist, depending on the specific needs of the child. Daily consultant ward rounds included medical and nursing staff, physiotherapists, speech therapists and other health care professionals as required. The service had a family and baby (FAB) worker who worked closely with families in hospital and they also joined ward rounds and MDT meetings where required.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff regularly worked with the local mental health NHS trust and with the Child and Adolescent Mental Health Services (CAMHs) to plan for a child's admission or discharge. The service also worked closely with maternity and midwifery team, the safeguarding team, community nurses, and outreach teams.

Service leads collaborated with local teams, regional and national teams to form an East Midlands Neonatal Capacity Oversight Group (EMNCOG) to look at how neonatal capacity issues are addressed.

Staff within the neonatal unit worked with a neonatal network external to the trust. Staff could access an infant feeding coordinator as required to support the neonatal band six nurses who were also trained to support breastfeeding mothers.

We saw meeting minutes which showed representation from the trust at the East Midlands neonatal operational delivery network in July 2021. The meeting minutes demonstrated evidence of local trusts aiming to develop a consistent approach to providing care and treatment.

The trust was a participant in the Midlands and East Transition Network and East Midlands Transition Regional Action Group.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. Staff had rapid access to the CAMHs team to make assessments. Children and young people who were suicidal received a risk assessment and were not admitted to the children's ward until suitable levels of supervision could be arranged.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Consultants held ward rounds two or three times a day on the children's ward and neonatal unit. Neonates were also reviewed at least daily by a registrar. The hot week consultant reviewed patients at weekends. Children and young people were reviewed by consultants depending on the care pathway. For example, children with a long term condition or an eating disorder would see the consultant for their speciality.

The play therapists worked flexible shifts to support a wider range of hours including weekends.

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.

### Health promotion

**Staff gave children, young people and their families practical support and advice to lead healthier lives.**

# Services for children and young people

The service had relevant information promoting healthy lifestyles and support on wards/units. There was a parents support board on the neonatal unit which signposted parents to various avenues of support. A similar notice board on children's ward provided a range of information for families.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff gave examples of where they had assessed a child's competence to make their own decisions about care and knew where to get advice and support if needed.

Staff made sure children, young people and their families consented to treatment based on all the information available, and in line with legislation and guidance. Patient records we reviewed had good documentation of consent, which included obtaining formal consent for procedures and surgery. They always checked with children before they undertook tasks such as administering medicines or taking bloods.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and were aware of who to contact for support with this. MCA assessments were usually conducted by the CAMHs team for children. Staff told us they could usually access assessments quickly when needed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance. They usually asked a child's consent before carrying out a task such as taking blood and preferred to gain the child's consent and cooperation. For very young children, staff asked consent from a parent or carer. Consent for surgery and some other procedures were obtained formally in written form and recorded.

Managers monitored whether the correct procedure had been followed for children being detained under the mental health act and reported on this as part of the weekly quality and safety spot check. We were not able to review any patient records where staff had made an application for Deprivation of Liberty Safeguards as there were no children on the ward where this applied to at the time of our visit.

## Is the service caring?

**Good** 

### Compassionate care

**Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

# Services for children and young people

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff were very aware of how concerned families might feel about their child and took time to explain things thoroughly. There was a play therapist who was frequently utilised to help children and young people with distraction techniques and building trust prior to a procedure such as taking blood.

The service employed a family and baby worker (FAB) who worked with families on the neonatal unit to provide support and guidance in helping them to understand their child's condition and what support was available. The FAB worker liaised with nursing staff and other agencies to ensure the right help and advice was provided.

Children, young people and their families said staff treated them well and with kindness. All 10 families we spoke with highly praised the nursing and medical staff.

The service conducted an annual children's and young people's patient experience survey. The overall findings from the 2020 report showed a positive response about the care they received in hospital.

Staff followed policy to keep care and treatment confidential. Conversations about care and treatment sometimes took place at the bedside, however, parents were invited into a private room to discuss sensitive issues. Most conversations took place in patient rooms where the door was closed. Conversations could not be overheard.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Staff took time to ensure young people understood their care and encouraged them to contribute as much as possible in their care plan.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. They took time to listen to parents and carers about what was important to them and their child.

In the neonatal unit, staff had implemented an electronic 'ear' in the nursery. The device was programmed to signal a red light when noise levels increased above a certain level. It was thought that noise levels need to be moderated for neonates to keep them feeling safe and happy.

### Emotional support

**Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.**

Staff gave children, young people and their families help, emotional support and advice when they needed it. Nurses and medical staff took time to listen to parents, and where a family was particularly upset or bad news was being shared, staff would utilise a private room where families could have privacy to talk. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. The play therapist assisted with children who needed help to stay calm. All staff understood the need to support children who were distressed and ensured their privacy where possible.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing. The FAB worker was also available to listen to parents and provide help and advice.

# Services for children and young people

### Understanding and involvement of patients and those close to them

**Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**

Staff made sure children, young people and their families understood their care and treatment. They understood that some parents preferred to carry out some care tasks for their child themselves. They encouraged parents to take part in their child's care and carry out some of the complex care interventions. Parents received training, guidance and support to carry out care such as tube feeding and utilised a set of parent competencies in a booklet to enable parents to carry out as much or as little as they felt comfortable with.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Pictures and signs were used to help children's understanding.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Cards and comments made to staff were extremely positive and praised staff at all levels. Parents could not speak highly enough about the care their child had received. All the families we spoke with were extremely happy with their child's care and with the all aspects of the ward environment and facilities provided. There was just one exception where a parent said the evening menu could be improved.

The service provided parents rooms where parents could stay overnight with their child on the ward. There were six parent beds available where a parent could sleep next to their child's bed or cot. Parents had access to a parents kitchen and rest room, shower facilities and lockers. They were provided with basic food and refreshments and facilities to make hot drinks.

The neonatal unit had two transitional rooms where parents stayed with their neonate for a few days to get accustomed to caring for their very tiny baby. The room was furnished with a double bed, wardrobe, kitchen, lounge area with TV, and bathroom facilities. There was room for siblings to visit. Parents still had access to nursing and medical staff on the neonatal unit whilst staying in the transitional rooms.

## Is the service responsive?

**Good** ↑

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the changing needs of the local population. The children's ward had changed from being an inpatient ward to a 48 hour assessment ward. This meant that more children could be seen quickly for conditions that required a short stay in hospital and more complex cases were cared for at Lincoln County hospital or at another NHS trust where level two care was available.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was checked by ward managers during their weekly spot checks. There were enough single rooms to ensure boys and girls did not share accommodation.

# Services for children and young people

Facilities and premises were appropriate for the services being delivered. The service had sufficient isolation rooms and child specific facilities and furniture. There were private rooms available to speak with families. There were milk kitchens for feed preparation and sufficient facilities and equipment to assist breastfeeding mothers. There were play facilities and toys for children of all ages and a sensory room. Facilities for parents who wished to stay overnight were very well furnished.

Theatre services and recovery area had improved facilities for children so that children were cared for separately to adults. This was an improvement since our last inspection.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. This was through links with the CAMHS service and community mental health teams.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

A transition group was set up to drive improvements in transition of care for children up to the age of 25 years. The trust appointed a transition nurse for children with complex health needs, a consultant lead for transition and senior manager for transition from adult services. The trust has established links with the national lead transition nurse and meets with the Regional Nurse Advisor for Transition. The service has raised the profile of transition services with the trust and is progressing plans to improve transitional care for more children and young people. This is an improvement since last inspection.

Currently, children with diabetes received shared care from the age of 16 years. Children's and adult diabetes services held multi-disciplinary team (MDT) meetings to plan care and ensure a smooth transition from children's to adult services. Young people were able to transition to at their own pace in managing their condition as a young adult with supervision in an adult environment relevant to their specific needs.

Managers monitored and took action to minimise missed appointments. Outpatients managers checked missed appointments daily and contacted the child's parents or carers and the relevant health visitor if a child missed two appointments.

### Meeting people's individual needs

**The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.**

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. Although the children's ward was for stays of 48 hours or less, children with a special need or long term condition were able to stay longer if it was in their best interest to remain in a familiar environment. The criteria for this was that the child needed to be treated by a consultant from Pilgrim Hospital and known to the service.

Staff liaised closely with CAMHS and community mental health teams to plan admissions and ongoing care for children with a mental health issue or a learning disability. Staff had forged strong links with children and adolescent mental health services (CAMHS) and the local mental health NHS trust to establish improved care pathways for complex problems, including for eating disorders.

# Services for children and young people

Staff took extra care to ensure that children with a learning disability were at ease in the environment and took time to communicate with them.

Staff followed individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play leaders provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/ or distract patients from unpleasant procedures or aspects of care. The play therapists were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best.

Wards were designed to meet the needs of children, young people and their families. The layout of the children's ward and neonatal unit provided good sight of children who needed most support. The neonatal unit was a nursery whereby cots and incubators were in one large room with sufficient space between to allow for equipment and for parents to sit with their newborn. There was also an isolation room at one end of the nursery and the sister's office at the other. There were suitable furniture and facilities for parents including lockers, a kitchen, restroom and two full parents transition rooms with kitchen and ensuite facilities.

Equipment, toys and facilities were child friendly on the children's ward and there was child friendly signage. Entrances to the ward and neonatal unit were locked and only accessible via swipe card for staff. Parents and visitors were required to use the call bell to enter.

Staff supported children and young people living with complex health care needs however did not use 'this is me' type documents.

Staff followed individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play therapists provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/or distract patients from unpleasant procedures or aspects of care. The play therapists were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best. For some patients, the play leaders provided age appropriate toys and supported play, for other patients the play therapists supported with homework or communication skills. Play therapists also went to outpatients department to support and distract patients when needed.

Staff were aware of the communication needs of children and young people with a disability or sensory loss and used pictures to help them understand where needed. The service had recently installed a sensory room specifically to help children and young people with sensory loss.

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.

# Services for children and young people

Children, young people and their families could get help from interpreters or signers when needed. Staff gave examples of using an interpreter for a different language but could not remember recent examples of using an interpreter for signing.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. There were choices available to suit different preferences. Meals were mainly hot meals at lunchtime and sandwiches and cold food at teatime. There was a kitchen on the ward to prepare simple alternatives such as toast.

There was an 'All about me' booklet which was available for children to complete. This was a trust-wide booklet and not specific for children. However, it contained useful information about carers, diet, interests and other items which were relevant to children and was in an accessible format.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.**

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The children's ward was a 48 hour assessment unit where children and young people attended for short term treatment or anticipated a short recovery time from surgery. Some children who were known to the service were able to stay longer. For example, children with a long term condition such as diabetes and children with a mental health disorder awaiting a speciality bed in the community. Staff worked with other agencies to ensure a smooth transition to ongoing care when this was needed.

The neonatal unit utilised two transition rooms for parents to stay with their newborn to help them adjust to caring for their child. Leaders had implemented a project with a community team where they worked closely with specialist community nurses to enable neonates who required ongoing specialist care such as continuous oxygen, could be discharged early with the support of a specialist community nurse.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Managers and staff told us that children were always seen by a doctor within one hour of admission and within 14 hours by a paediatric consultant. Staff told us that children were always seen by a doctor within an hour of admission and that a consultant visited every day. Outpatients manager monitored wait times for children in the department.

Managers had developed or were in the process of developing pathways with partner organisations to improve access to care. For example, oncology patients had open access to receive care or treatment for any medical concerns. An eating disorders bypass pathway had been set up for patients who had a referral from their GP or another hospital.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. The Covid-19 pandemic had impacted on waiting lists for treatment and staff were working to resolve this.

Staff did not move children and young people between wards at night and only transferred children and young people to other services in the event of an urgent clinical need. Where a very sick child was transferred, a specialist transfer

team was utilised to retrieve and transfer the child. Staff worked closely with the specialist transfer team to ensure the child was properly prepared for safe retrieval and transfer. Data provided by the trust showed that in the period between October 2020 and September 2021 the service had transferred 39 children to other NHS providers. This included three children to NHS high security psychiatric accommodation.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was commenced on admission and in conjunction with parents or carers.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Staff worked closely with CAMHS and other community teams to ensure a safe and appropriate discharge.

Staff supported children, young people and their families when they were referred or transferred between services. The service didn't provide oncology services and arranged for these services to be carried out in the community or at a local hospital.

Managers monitored patient transfers and followed national standards. Transfers only occurred for clinical reasons where a child required specialist services not provided onsite.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.**

Children, young people and their families knew how to complain or raise concerns. All the parents we spoke with said they knew how to complain if they needed to. The trust shared data which showed they had 63 complaints made to the family health division during 2020/21. Only one of the complaints related to the children's services at Pilgrim Hospital.

The service clearly displayed information about how to raise a concern in patient areas. This was provided in a family folder which was handed to all parents to read.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and told us that children, young people and their families received feedback from managers after the investigation into their complaint. Learning from themes were shared at monthly divisional meetings, specialty governance meetings, and patient experience group. Staff at ward or department level heard about trends and themes at staff or ward level meetings and via the governance wall boards.

Learning was also shared through staff bulletins (Learning to Improve Bulletins), monthly divisional integrated governance reports, and complaints and the Patient Advice and Liaison Service (PALS) reports.

Managers shared feedback from complaints with staff and learning was used to improve the service. Although there had been no complaints that staff could remember, they told us that learning from complaints was shared based on other areas within the service.

Staff could give examples of how they used patient feedback to improve daily practice. The service had purchased lockers for parents, so they didn't have to carry coats and bags into the nursery on the neonatal unit.

# Services for children and young people

## Is the service well-led?

Good ↑↑

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The family health division had a leadership team which managed activity across both sites. Division leaders told us they worked well with each other and understood the challenges they all faced around quality and sustainability of services, including staffing issues.

Local leadership was provided by matrons, ward managers and department managers. Staff were extremely positive about their local leadership team and said they were visible and supportive. Matrons worked across both hospital sites and visited Pilgrim Hospital at least weekly to ensure they were visible and accessible to staff who required support. Ward managers said their matrons were in contact daily by phone and could contact the matron from the maternity division when their own matron was not at work. Senior leaders including the interim head of midwifery and nursing were also visible and made regular visits to the service.

Staff said local senior leaders were visible and would visit the ward or department and a duty manager was always available out of hours if they needed support and guidance.

At the time of our inspection, a band seven manager had just been appointed to run the children and young people outpatient services across the trust.

Managers supported staff to develop by securing funding for internal and external courses, encouraging continued professional development.

Staff told us that the chief executive for the trust had shared information effectively during the Covid-19 pandemic enabling staff to be regularly updated.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had a trust wide strategy for 2020 to 2025. This included the paediatric service provision. A family health divisional strategy highlighted specific goals for the children and young people service.

Most staff were aware of the vision and values of the trust and were able to give examples of how their work reflected the values. Staff articulated their values centred around putting the patient and their families first and being the most important person in the hospital.

# Services for children and young people

Staff were aware of the service's vision and strategy to improve services for children and young people since our last inspection, which included a recruitment strategy, forging stronger links with stakeholders in the community, implementing a transition programme, and creating new pathways for patients with mental health needs and certain long term conditions.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Senior leaders told us that local leadership at Pilgrim Hospital had improved over the last two years and was currently very robust and dynamic. Staff at ward level confirmed this and described leadership as enthusiastic and effective. Senior leaders had considered their succession planning requirements and offered leadership development to staff and had recruited into clinical leadership roles. They were actively recruiting to additional clinical lead roles for governance and for audit as part of their ongoing development plan.

Staff said they felt respected, valued and supported. They told us about how they had risen to the challenges of the pandemic in order to do their very best for patients. Many staff had been temporarily re-deployed in areas they not previously worked in but all said they were focused on the needs of patients at the time. Leaders were aware of the changes that had been required in responding to the COVID-19 pandemic had impacted on staff morale and wellbeing. Managers had tried hard to redeploy staff within the family health division. Some adult staff had worked on the maternity unit whilst some nursery nurses worked in the emergency department caring for children. When some staff reported that they didn't feel well-prepared to work in other areas, managers devised a checklist to identify which activities a children's nurse could be expected to complete in an adult area. Managers conducted risk assessments for staff which included mental health assessments prior to redeployment. Any staff member who felt strongly that they were unable to work in another area were retained on the ward or unit.

Counselling and formal support from colleagues and managers was available to all staff.

There was an open, supportive culture across the service. Staff of all grades were encouraged to speak up about any concerns and ideas for improvement were encouraged. All staff told us they felt part of the team and included in meetings and decisions about the future. Patients and their families were also encouraged to talk to the staff about any concerns they had. When something went wrong, patients received an apology and were told about any actions to prevent something similar happening in the future.

Staff told us they were proud to work for the trust and had a common sense of purpose. There was a culture of collective responsibility between teams and services, and we saw positive and supportive interactions between all staff.

Staff we spoke with said they enjoyed working on the ward and felt they were part of a good team. They told us they were supported to speak up and rise concerns without fear of reprisals.

Staff told us they felt supported by managers.

Managers and staff were given the opportunity to complete mental health first aid training to support patients and colleagues.

# Services for children and young people

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

There was a governance system in place where the trust used established systems, processes and a suite of clinical policies in conjunction with the National Institute for health and Care Excellence (NICE) guidelines to provide a set of standards for wards and departments to comply with during each stage of the patient's journey. Policies were regularly reviewed. This was an improvement since last inspection.

Children and young people services were part of the family health division. Leaders attended a variety of governance meetings where they discussed progress across the service to ensure information was escalated and cascaded to all staff within the service. These were trust wide meetings and included representatives across sites including Lincoln County Hospital and Pilgrim Hospital in Boston. Divisional leads had good links to the executive team enabling them to escalate information in a timely manner.

The family health division reported key quality, safety and performance information to the trust board monthly. At divisional level, a number of governance, finance, performance, safety, quality and risk meetings took place. These were attended by medical and nursing leaders and included relevant staff at different levels. Staff at ward level told us that key information was usually shared with them at ward meetings. However, ward meetings had been limited during the Covid-19 pandemic and were not fully utilised at the time of our inspection. Meetings were most via digital platforms and attended by the relevant leads and there was evidence of information sharing and escalation of risks, with actions to mitigate them. Consultants presented cases they had analysed because something had gone wrong. Learning was shared with the senior team. Other regular agenda items included infection prevention and control, policy and protocol review, audit outcomes and safety alerts.

Divisional level meetings were held monthly which incorporated other services such as maternity in addition to children and young people.

Paediatric, community paediatric and neonate unit governance meetings were held monthly. Divisional level business managers attended all three of these meetings as did the senior pharmacist to ensure continuity.

Consultants held regular meetings to discuss performance, clinical pathway planning and staffing.

Local team meetings were held, however, these had been significantly reduced over the Covid-19 pandemic. Staff told us there had been one meeting held via videoconferencing within the past six months. However, wider staff members could attend governance meetings to hear updates.

We reviewed a sample of meeting minutes for May, June, July, August and September 2021 and saw these were well attended. Regular agenda items included risks, incidents, serious incidents, complaints, staffing concerns, service improvements and other ongoing concerns.

Managers invited all staff to a monthly governance meeting. Other regular attendees included the pharmacist who oversaw the children's and young people service, the matron for the area, business managers, ward managers, clinical

educators and medical staff. Where ward-based staff could not attend, any information and learning was cascaded down. For example, changes to the trust policy on fever in the under-fives were shared via a PowerPoint presentation and an audit which was emailed to all staff. Where managers required confirmation that information had been read by the wider staff group, they requested confirmation via either email or a signature sheet.

Matrons and medical staff attended perinatal (during pregnancy and up to a year after giving birth) mortality and morbidity meetings and shared findings within governance meetings.

Safeguarding leads for the division demonstrated oversight of the children and young people service; they undertook record audits, delivered training and shared information to ensure all staff were aware of their responsibilities.

The service had identified areas for improvement and action plans were in place to monitor progress. Performance information was shared with the senior leadership team by the Director of Nursing.

The matron and ward manager displayed a clinical governance board which was accessible to staff. This contained information about open incidents and themes, risks on the incident reporting system and on the service risk register, and complaints and compliment themes. This had been updated for October 2021 at the time of our visit.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Risks, issues and performance was discussed at trust board level, divisional level and directorate level and information shared with staff at ward level. Each directorate maintained its own risk register, which included local ward level risks.

The family health risk register showed the highest risks for the service being related to delays and challenges in delivering services to vulnerable groups of patients, as well as challenges with staffing during the Covid-19 pandemic. The risk relating to adherence to policies and protocols had reduced over time due to actions the service had taken to improve governance over the previous two years.

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. 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.

Managers identified nurse staffing and agency spend as a risk across the sites, however, agency spend at Pilgrim Hospital was minimal. Managers had recruited staff to mitigate staffing issues and had plans to prioritise certain posts such as specialist nurses. Managers also supported the internal development of staff already employed to support staffing and retention.

The service management team identified referral to treatment times for children and young people as a risk to the service across both sites. Prior to the pandemic, the division performed much better indicating the pandemic had negatively impacted upon the division's ability to deliver this target rather than the division generally underperforming.

Service management reviewed incidents to identify themes, share immediate learning and produce root cause analysis reports. This enabled a better oversight of areas of concern, such as medicines' management. Matrons for the service told us of findings and actions from this process in order to reduce the number of incidents. We saw evidence of this within governance meeting minutes. The pharmacist with oversight for children and young people's services attended governance meetings.

Senior nurses and above received training on risk and incident management.

Band seven nurses (ward manager and clinical educator level) held weekly meetings to share information and to discuss risk and incidents.

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.

Although identified as a risk, the trust did not routinely capture the numbers of patients admitted under children and adolescent mental health care services (CAMHs). The matron had plans to start monitoring this data as part of a developing partnership with the local CAMHs.

Managers discussed the risk of respiratory syncytial virus (RSV) in terms of winter planning and Covid-19 recovery during oversight meetings.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Patient data was constantly updated electronically, such as the recording of physiological observations and medicines administration. Staff were aware of how to use and store confidential information. Managers used dashboards to manage and share performance metrics and audit outcomes. Notifications were made to external organisations when required.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

Performance information was shared and discussed at ward meetings so staff could identify any actions required to improve patient care.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients, parents or carers views whilst on the ward via an electronic device. They also participated in the national Friend and Family test.

# Services for children and young people

The service liaised with external organisations to improve care and treatment for children and young people. Service representatives attended the East Midlands neonatal operational delivery network meetings. A matron had developed positive links with the community child and adolescent mental health service (CAMHs) to support patients more effectively. Some staff went into local organisations such as schools to promote services and to build trust in healthcare staff.

Matrons completed monthly audits which included patient and staff experience. Staff audits reviewed appraisal rates, sickness rates and staff health and wellbeing.

Data from the trust showed an August 2021 survey of the junior doctor induction to the service which showed attendees found the induction a helpful and positive process.

The service worked with the University of Lincoln to create a branding and a colour scheme. They asked service users and staff to judge and choose the most appropriate design and colours. The ward will be painted in colours chosen with autistic service users in mind as research suggests that certain colours increase positive behaviours in children.

The service engaged with other agencies to improve performance and had asked the sick patient transfer service to perform a peer review. The results were not available at the time we visited but managers had received very positive initial feedback from the review.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**

The divisional and local leaders took action to make improvements in the running of the service. They had regular meetings where learning was discussed, including quality and governance meetings and daily safety huddles. There were specific meetings to discuss and learn from audit outcomes.

The management team told us that a programme of continuous improvement was underway for the service trust wide in order to mitigate risks and improve patient pathways. They spoke openly of developing the service and presented as committed to raising the profile of the children and young people service within and outside of the trust.

The senior leadership team for the service shared innovative ways to improve recruitment. This included using the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.

At the time of our inspection, medical staff told us there was no active research happening, however, a newly appointed consultant had begun to involve the service in some research projects.

The matron overseeing the paediatric wards across sites had implemented a number of initiatives. These included engaging with a local university graphic design course to design and create unified branding and décor for wards and the paediatric area within the Emergency Department. They had also developed, in conjunction with the local children and adolescent mental health service (CAMHS) pathways to support patients who presented with either diagnosed eating disorders or with disordered eating. They had also recently implemented a new initiative to enable early discharge of neonates with complex needs by working with specialist community services to provide clinical advice, monitoring and support at home. This meant that neonates who would usually continue to receive oxygen therapy and other clinical support in hospital, were able to be cared for at home much sooner.

# Services for children and young people

Staff within the children and young people service had opportunity to engage in continued professional development. We saw funding had been procured for autism training and advanced paediatric life support training (APLS). Some staff were being supported to gain formal university qualifications such as completing a paediatric nursing degree to develop their career.

Nursery nurses were offered the opportunity of funded apprenticeships which included being able complete training to become a registered paediatric nurse.

# Lincoln County Hospital

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## Description of this hospital

Lincoln County Hospital serves the city of Lincoln and the North Lincolnshire area. It provides all major specialties and a 24-hour major accident and emergency service.

Between 5 and 8 October 2021, we inspected four core services provided by the trust at this location. We carried out an unannounced inspection of urgent and emergency care, Services for children and young people, Medical care (including older people's care) and a focused unannounced inspection of Maternity.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate. We have therefore rated the key question of safe in Maternity services as requires improvement. All other ratings in Maternity services remain unchanged.

# Maternity

**Good** ➔➔

## Is the service safe?

**Requires Improvement** ➔

### Environment and equipment

**The maintenance and use of facilities, premises and equipment did not always keep people safe.**

Some areas within the maternity environment had not been adequately maintained which posed a safety risk to women, visitors and staff. For example, on the maternity ward, large wooden splinters were visible on at least three door frames leading to patient areas and two bath panels were broken and cracked. Staff told us these safety concerns had been escalated to estates but no action had been taken to make these areas safe. We escalated this during our inspection and following our inspection we received evidence to show immediate action had been taken to address these safety concerns.

Equipment that was in poor condition or non-functional was not always reported in a timely manner to enable repairs to be made. For example, women on the maternity ward told us and we saw that the window blinds in their rooms were not fully functional. They told us this impacted on their wellbeing during their admission as it affected their sleep and their privacy. We checked the blinds in 11 rooms on the maternity ward and found that none of the blinds were in full working order. Staff told us they had reported these broken blinds to the estates department. However, evidence that these had been reported by staff on the maternity ward was not provided to us. We also identified the bath lift on the labour ward was not working. We escalated this during the inspection and staff told us they were not aware that it was not working. Following our inspection, we asked for evidence to show this bath had been reported to estates. The trust evidenced this had been reported eight days after our inspection. This meant the concern regarding the bath lift was not reported in a timely manner placing women at risk of receiving inappropriate and/or unsafe care.

Facilities and equipment concerns were not always responded to in a timely manner to ensure the environment met the needs of women. One woman on the maternity ward told us the toilet in their room was out of order. Records showed this toilet had been made out of order due to a broken toilet seat which had been reported to estates in May 2021. Staff told us this room would be utilised for women with infectious conditions. However, women in this room would have to use communal toilets and bathrooms whilst the toilet was out of order, increasing the risk of spreading infections. We saw two sinks on the maternity ward had been reported to estates in July 2021 because they were blocked. These sinks had still not been fixed at the time of our inspection. Not addressing these concerns in a timely manner posed risks around infection prevention and control as less sinks were available for staff and women to wash their hands.

We found that equipment was not always used in accordance with manufacturers guidance. Fetal monitoring belts were being laundered and used with multiple women. This was against manufacturers guidance which stated these belts were not to be laundered and were for single person use only. This meant the belts were at risk of wear and tear and also at risk of becoming contaminated with infectious materials. We escalated this to the trust who immediately sought advice and stopped this process.

The service had plans to improve the estates and facilities at this hospital by 2024. This included renovating and relocating the wards. No specific start dates for this work had been agreed at the time of our inspection.

# Maternity

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration**

Staff used the Modified Early Obstetric Warning Score (MEOWS) and Paediatric Early Warning Score (PEWS) which are nationally recognised tools to identify women and babies at risk of deterioration and escalated them appropriately. Records showed and we observed timely and appropriate responses to rising early warning scores, ensuring women and babies were escalated appropriately in the event of clinical deterioration.

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk factors included; blood clot risk, carbon monoxide risks and a general risk assessment relating to whether the pregnancy was high or low risk. These risk assessments were recorded in both electronic and paper records, and were used by community and acute staff. This ensured that staff always had access to this information in the event of an emergency. We saw this was effective as staff used these paper records when the electronic records system was unavailable during part of our inspection.

Staff knew about and dealt with any specific risk issues. For example, we saw when women were identified as having a risk of developing blood clots, appropriate action was taken to reduce this risk.

In line with national recommendations, a ‘fresh eyes’ approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. A CTG measures a baby's heart rate and monitors the contractions in the womb (uterus). Fresh eyes checks were performed every hour by a second staff member during continuous fetal monitoring. This provided a safety net to reduce the risk of misinterpreting a CTG reading. Records we reviewed showed appropriate monitoring, interpretation and escalation of CTG readings.

Staff completed a mental health screen on all women and arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Every woman’s’ risk of domestic violence was also assessed during every appointment when this was appropriate. Risks associated with mental health and domestic violence were clearly recorded in the patient records and flagged on the electronic patient record system. Referrals for specialist support were made for women who were at risk of or experiencing domestic violence.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health.

Records showed that staff consistently performed swab counts in theatre and completed the World Health Organisation (WHO) checklist in line with National Patient Safety Agency (NPSA) guidelines. The WHO checklist is a global initiative that was designed and implemented to improve surgical safety. Regular WHO checklist audits were undertaken and recorded electronically which showed 100% compliance with the WHO surgical safety checklist.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery handover and the multi-disciplinary team (MDT) handover meetings. This ensured midwives and medical staff had access to key information to keep women and babies safe when handing over their care to others.

# Maternity

## Staffing

**The service had some staffing vacancies. However, shifts were covered to ensure there were enough maternity 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 and agency staff a full induction.**

The service had some staffing vacancies. Staffing data for September 2021 showed the service had 7.8% medical and 6.4% midwifery and support staff vacancies. Ongoing recruitment was in progress to address staffing vacancies and new staff were due to start working at the service before the end of the year.

Staffing rotas for August and September 2021 evidenced that actual staffing numbers did not always meet planned numbers. Staff told us this was due to sickness. However, staff also told us that if patient acuity meant any staffing gaps needed to be filled to ensure the safety of women, those shifts were always covered. Cover was provided by staff picking up additional shifts, managers and specialist midwives. Trust data showed that one to one care during labour was provided to women 100% of the time between November 2020 and October 2021.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The birth rate plus tool was used to measure and review acuity and in workforce planning. At the time of our inspection, the service (which included Pilgrim Hospital and Lincoln County Hospital) was staffed based on the trust's Birth rate Plus recommendations of 2017. Managers have since completed a birth rate plus review which recognised an increase in acuity of women admitted to the service. This report was received by the trust in March 2021. This review identified a shortfall of 3.51 whole time equivalent (WTE) midwives. A bid for the funding for the posts was in progress.

A continuity of carer (CoC) review had also been completed. CoC is an approach that aims to provide consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey. The trust had submitted a bid to fund an additional 8.69 WTE staff to support the rollout of CoC to 35% of women.

The ward managers could adjust staffing levels daily according to the needs of women. Staff reviewed acuity every four hours which meant adjustments to staffing could be made in response to an increase in acuity. Staff told us that when acuity increased, additional staffing was provided to keep women and babies safe.

Consultants and anaesthetists were always available. This included the provision of out of hours on call cover which staff told us was always provided in a timely and responsive manner.

Managers made sure all staff had a full induction and understood the service.

## Medicines

**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**

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records (MARs) contained patients' weights, allergies and the frequency, dosage and administration route of the medicines were clearly recorded.

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.

### Incidents

**Most staff recognised and reported incidents and near misses. However, systems in place to share learning from incidents were not consistently followed. However, managers investigated incidents appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.**

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.

Staff met to discuss incident feedback and look at how they could improve patient care. For example, maternity staff reviewed CTG's with consultants and learned from incidents where CTG interpretation was incorrect. This learning took place during weekly CTG meetings. This showed the service had learned from previous serious maternity incidents where CTGs had been incorrectly interpreted to prevent recurrence.

The service had no maternity never events in the 12 months leading up to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff also worked with external agencies to ensure learning from incidents was shared. The service referred relevant incidents to the maternity Healthcare Safety Investigation Branch (HSIB). Staff used recommendations from HSIB reports to improve patient safety.

# Maternity

## Is the service effective?

Good

**Evidence based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 11 clinical policies relating to the maternity department. This included; diabetes in pregnancy, hypertensive disorders in pregnancy and sepsis guidance. These were all up-to-date and reflected best practice guidance and national standards.

Managers used audits to check that staff followed agreed clinical guidance. Audits appropriately identified areas of compliance and areas for improvement. Audit areas included; assessment and management of sepsis, fetal monitoring and catheter care.

In accordance with national guidance, staff routinely referred to the psychological and emotional needs of women. We observed nursing and multidisciplinary handover meetings which evidenced this.

### Competent staff

**Effective systems were not always in place to ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

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.

Additional training in fetal monitoring was provided to all registered staff, this included CTG training. The trust's CTG training target was 90%. Training data for September 2021 showed that 76% of midwives and 70% of consultants had completed this training. Training data for trainee doctors was much lower at 27% but this was because trainee doctors had recently rotated and their training was in progress. All staff had received a reminder to complete this training in order to improve compliance rates. Support staff also told us they were able to access specialist training for their role. This included attending breastfeeding workshops to enable them to offer practical and emotional support to women.

Staff participated in multidisciplinary training and utilised external resources including those produced by the Practical Obstetric Multi-Professional Training (PROMPT) charity. PROMPT is an evidence-based multi-professional obstetric

emergencies training package that has been developed for use in local maternity units. Staff we spoke to confirmed they participated in MDT training and that the service had adapted during the pandemic and moved to virtual PROMPT training. PROMPT compliance data from November 2021 showed that 75% of midwives and 57% of medical staff had completed this training. The trust had plans to achieve their 90% target compliance rate by March 2022.

Private social media platforms were also utilised to make training more accessible to staff. For example, a social media live video showing staff how to don and doff personal protective equipment had been shared that staff could replay at a time convenient to them.

Managers gave all new staff a full induction tailored to their role before they started work and staff were supernumerary in their areas until they became familiar with the service's environment and processes.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor.

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.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us team meetings had become more accessible as they had moved to virtual meetings.

Managers identified poor staff performance promptly and supported staff to improve. Examples were shared that demonstrated this.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed these meetings and saw that risks were appropriately discussed and information was shared in a manner that promoted continuity of care.

All the staff we spoke with spoke positively about the multidisciplinary working on the wards, within the wider hospital and in the community. We saw maternity staff worked effectively with other teams within the hospital. This included working with surgical teams and paediatricians.

Staff worked across health care disciplines and with other agencies when required to care for patients. Records showed that staff referred women to other agencies such as; safeguarding, social care and mental health services.

# Maternity

## Is the service well-led?

Good

### Leadership

**Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The senior leadership team within maternity were mostly new to post since our last inspection. Staff described this as refreshing and positive. The managers and leaders we spoke with displayed enthusiasm and drive to improve maternity services for the women, babies and staff.

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved.

Managers and senior leaders displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that managers and senior leaders were visible in all the areas we visited. All the staff we spoke with told us they felt supported and valued by their managers.

### Culture

**Staff felt respected, supported and valued. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff had accepted the poor estates and facilities which meant concerns around this were not always escalated to improve patient care.**

We saw there was an open culture as most staff spoke with the inspection team openly and honestly. Staff told us there was a no blame culture and they felt able to raise concerns with their managers and freedom to speak up guardians were accessible if required. However, we found there was a culture amongst staff and leaders of acceptance of the poor estates issues such as the broken blinds. This led to a culture of under reporting these concerns.

Joint meetings and training sessions were facilitated within this service and the service at the Pilgrim Hospital site. This promoted joint working and learning between the two maternity units at the trust.

Staff promoted equality and diversity within the service. Staff told us they cared for women from minority groups. Staff understood and used the trust's systems to ensure these women and their families were able to access appropriate care.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Senior leaders from maternity services attended monthly cross site Maternity and Neonatal Oversight Group (MNOG) meetings. The purpose of the MNOG was to have oversight of maternity and neonate services to monitor if these services were safe and in line with national safety and quality standards. The group discussed key topics such as; the maternity

and neonatal monthly safety assurance report and monitored the progress and effectiveness of the local maternity improvement plan. The maternity and neonatal quality dashboard which included incidents and other safety data was also scrutinised by senior leaders and external stakeholders in the MNOG meetings. Minutes of these meetings showed that the agreed terms of reference were followed, safety and quality concerns bought to the groups were appropriately acted upon and any improvement actions were appropriately followed up.

Stakeholder feedback was discussed at MNOG. This included stakeholders such as; NHS England and Improvement and patient groups.

The MNOG fed into the trust's Quality Governance Committee (QGC). Minutes of MNOG showed that areas of concern were escalated to the Quality Governance Committee and to ensure any identified risks were appropriately captured. The QCG then fed into the board to ensure they had a regular overview of quality, safety and performance relating to all services at the trust, including maternity. Minutes from trust board meetings evidenced this.

The maternity service had a non-executive director sponsor who was the services named maternity and neonatal safety champion. This sponsor attended the MNOG meetings on a regular basis.

Staff told us that mortality and morbidity reviews were regularly completed to review and learn from deaths, incidents of sepsis and other adverse incidents. However, records did not always evidence the discussion and outcomes of these meetings. The trust were aware of this and had a plan in place to address this. These reviews were not cross site meetings, therefore this was a missed opportunity to have cross site discussions and learning from deaths and other adverse events.

### Management of risk, issues and performance

**Leaders and teams did not always use systems to manage performance effectively. They did not always ensure risks were identified, escalated and mitigated in a timely manner. The service had plans to cope with unexpected events.**

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.

We found that when risks had been identified, they were appropriately managed. Identified organisational and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. For example, staff had identified that paper CTG readings faded over time which meant there was a risk of accurate records not being maintained. This had been recorded on the risk register and appropriate mitigation plans were in place while a long-term solution was agreed. Minutes of governance meetings evidenced that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

Each area's top three risks were also shared to staff through the use of governance boards which meant staff were aware of the risks and the mitigation plans in place to address these risks.

# Maternity

A monthly maternity and neonatal quality dashboard was produced. Items covered included national safety standard performance data, such as; 10 Steps to Safety performance data (a national maternity incentive scheme used to improve safety) and saving babies lives performance data (a nationally recognised care bundle aimed at reducing perinatal mortality). Other performance data was also included in this report, including; incidents, patient feedback, complaints and staffing training compliance. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

Managers told us that staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures.

# Medical care (including older people's care)

Good

## Is the service safe?

Good

### Mandatory Training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Nursing staff received and kept up-to-date with their mandatory training. The trusts target for mandatory training was 90%, the average completion across all of the courses for medical wards was 79%. During the Covid-19 pandemic, mandatory training and been paused and at the time of the inspection was in progress of being delivered to be back to the trusts target. The trust aimed to be back to 90% completion 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 with 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 66%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that the online learning was easy to access and covered what they needed it to.

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 trusts governance structures.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing staff received training specific for their role on how to recognise and report abuse. Staff completed safeguarding mandatory training with levels completed according to their roles. 82% of eligible staff across the wards had completed safeguarding adults level 1 training, 72% had completed level 2 training and 75% had completed level 3 training. 82% had completed level 1 safeguarding children training, 73% had completed level 2 safeguarding training and 71% completed level 3 training.

# Medical care (including older people's care)

Medical staff received training specific for their role on how to recognise and report abuse. 60% of eligible staff across the wards had completed safeguarding adults level 1 training, 61% had completed level 2 training and 75% had completed level 3 training. 61% had completed level 1 safeguarding children training and 62% had completed level 2 safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff could describe caring for patients with protected characteristics and how to keep them safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could describe how they had worked with other organisations in the past to make sure that patients were protected from harm. Staff told us about how they had put measures in place to ensure patients were protected from harm and also had their individual wishes listened to.

The safeguarding team completed monthly safeguarding audits to assess the quality of safeguarding and DOLS referrals. In September 2021, three safeguarding referrals were classed as poor, eight as ok and five as good. Four DOLS referrals were classed as poor, ten as ok and 52 as good. This then helped the safeguarding team to decide where to focus their resources on to support and improving practice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with also knew who to go to if they had any queries relating to safeguarding.

Staff followed safe procedures for children visiting the ward. At the time of the inspection visitors to ward areas were restricted in line with the trusts Covid-19 pandemic response plans.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust has monthly infection prevention and control audits, these are divisional wide and compare scores both cross site and for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection we observed staff using PPE appropriately and wearing masks throughout our visit. There was also clear signage on the wards to show Covid-19 risk levels for different areas and where patients were being isolated due to infectious diseases or illnesses.

The trust also had daily bulletins which could be used to share key messages such as updates about Covid-19 and steps required to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Across the hospital it was the responsibility of the health care support workers to clean the bed areas once the patient had been moved. Staff told us that this could slow down the flow of patients into ward areas at different times. During our inspection we went to the Medical Emergency Assessment Unit (MEAU) and found five beds waiting to be cleaned.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called.

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 timescales could change and they weren't fully assured the improvements would be made.

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 was not in line with the trust policy of checking wards before they were opened.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. However, there was no telemetry available in the Medical Emergency Assessment Unit (MEAU) and to enable staff to safely monitor patients they would be required to sit in the patients bed area to monitor the screen. Staff working on the ward managed this risk by using the extra member of staff to complete these observations who would usually assist with admissions.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a high score had been calculated, indicating increased risk for the patient, they would be escalated for medical review.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. . The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE).

Staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required. If patients scored more than five on their NEWS2 then they would be seen by the critical care outreach team and if they had a score of more than seven then they would receive an immediate response by the critical care outreach team.

Staff completed monthly VTE audits, in September 2021 the audit score was 97% for medical wards. This indicated staff were following the trusts policies correctly and reducing risks for patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. If patient risk levels were high, nursing staff from the ward would accompany the patient to move to the new ward area.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information.

### Nurse staffing

**The service had enough nursing and support 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 had enough nursing and support staff to keep patients safe. Each ward staffing establishment was reviewed at least twice yearly in order to ensure meeting safe staffing standards. During our inspection the wards we visited were staffed in line with these guidelines. The trust had recruited a large cohort of overseas nurses in order to increase substantive staffing numbers. The trust also had a bank of nurses in order to ensure staff familiar with trust policies and procedures were employed where possible. Ward staff were also offered overtime where possible. However, to maintain these establishments most wards were still required to use agency staff. The trust was working towards a reduction in agency spend with increased recruitment and talent management in order to ensure skills were used for the benefit of the local population.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift. Managers populated a staffing software which determined the level of acuity and dependency for patients. This calculation informed the nurse to patient ratio and skill mix as well as quantity of registrants on duty.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing was managed across the trust by daily staffing meetings and staff could be moved to help support areas with lower staffing/higher acuity. During the inspection staff described the anxiety and stress having to move wards caused them. We were also told about staff who had left or were in the process of leaving due to the number of times there were moved from their usual place of work to work on another ward.

The number of nurses and healthcare assistants matched the planned numbers.

The service had reducing vacancy rates. At September 2021 the hospital had a vacancy rate of 15.5% for nursing, nursing associates and health care support workers. The trust had worked hard over the last year to recruit staff onto the wards and had recruited a number of overseas nurses.

The service had an increasing turnover rate. At September 2021 the hospital had a turnover rate of 18.9% for nursing, nursing associates and health care support workers. Staff told us that this was due to the impact of Covid-19 on staff.

The service had a higher than average sickness rates. At September 2021 the hospital had a sickness rate of 7.8% for nursing, nursing associates and health care support workers. Most of this sickness could be attributed to the impact of the Covid-19 pandemic.

For the medical wards the Allied Health Professional vacancy rate was 17.7%, turnover rate was 15.8% and sickness 1.8% (September 2021).

The service had reducing rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

### Medical staffing

**The service mostly had 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 locum staff a full induction.**

The service had enough medical staff to keep patients safe. However, it was necessary to rely on the use of locum staff to do this. During August and September, the total number of shifts unable to be covered was 2239. Of these 49.5% were covered by agency, 3.9% were covered by care1 bank (a collaborative regional bank arrangement with other trusts) and 37.38% were covered by internal bank.

The medical staffing did not always match the planned number. In August and September 2021, 9.1% (205) of shifts were not filled. As part of the trusts risk management, core shifts within medicine will not be left unfilled, only those shifts deemed to be low risk to patient safety would be left unfilled. If a core shift was unable to be covered through the bank, or agency, alternative mitigations were applied to ensure the shift was covered including the use of acting down arrangements.

The service had reducing vacancy rates for medical staff. Lincoln County Hospital had a vacancy rate of 16.5% for medical staff across the wards in September 2021.

The service had low turnover rates for medical staff. Lincoln County Hospital had a turnover rate of 4.4% for medical staff across the wards in September 2021.

Sickness rates for medical staff were low. Lincoln County Hospital had a sickness rate of 2.3% for medical staff across the wards in September 2021.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staffing was a key area of focus with a range of reviews and controls in place.

The service always had a consultant on call during evenings and weekends. During the pandemic some wards had also utilised virtual consultant ward rounds to ensure effective patient care decisions were made.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.**

Patient notes were comprehensive and all staff could access them easily. Notes we looked at were easy to follow and consistently filled out. The trust had standard booklets and forms to fill out for patients notes which helped staff to ensure comprehensive records were kept.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had an electronic system on which staff recorded observations, key information and treatment plans. This was accessible on all wards and enabled staff to quickly identify areas of risk and treatment plans for patients on the ward. Paper nursing and medical notes were also transferred with patients when they moved wards.

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.

### Medicines

**The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Charts demonstrated medicines were prescribed and recorded appropriately.

Some of the wards we visited had dedicated pharmacist support. However, those that did not reported that there could be delays in getting charts reviewed.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Ward and medical staff spoke to patients about their medicines, occasionally a pharmacist would also speak to patients – usually related to medicines reconciliation activity.

Medicines were not always stored safely. We found tablet blisters mixed in a box (not the original containers) in two trolleys. The trolleys however were locked so the risk was that medicines would be incorrectly picked during drug rounds not that there could be unauthorised access to medicines.

Staff followed current national practice to check patients had the correct medicines. We heard that medicines reconciliation was completed by pharmacist and pharmacy technicians but not completed at weekends on the ward. When patients were admitted over a weekend their charts were prioritised for reconciliation when pharmacy team members arrived on the ward on Monday. We heard that, due to time constraints, not all charts were reviewed by pharmacy staff daily, but patients were prioritised for review based on complexity of treatment regime, discharge and admission dates.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. During the inspection we spoke with staff who were aware of the sedation policy and aware of previous incidents within the trust. All wards now had sedation logs and staff were aware of where these were stored and when to complete them.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere. There were quarterly trust wide learning to improve bulletins that were circulated to staff. These covered learning actions taken from serious incident investigations across the trust.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the last three serious incident reports for the medicine wards at Lincoln. These were clearly written, thoroughly investigated and identified areas of good practice and areas for improvement.

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.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made as a result of feedback. The trust had previously identified a number of serious incidents in relation to Diabetic ketoacidosis (DKA). This resulted in the diabetes ward not taking any new admissions with DKA and instead they would be cared for on the Medical Emergency Assessment Unit (MEAU). The ward then did work to train staff and recruit additional nurses and had plans to restart taking those patients once the work had been completed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

### Safety Thermometer

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

# Medical care (including older people's care)

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed developed of replacement data collection and reporting then impacted by the COVID-19 pandemic.

Staff used the safety data to further improve services. Leaders reviewed their team's performance with regard to the trust quality assurance dashboard and areas for improvement were cascaded throughout staff teams. Operational performance data was collated and reviewed at the trust's divisional board meetings.

## Is the service effective?

**Good** 

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

There was a trust wide improving respiratory services programme which had started at the time of the inspection. The trust had recently completed a new respiratory unit at Lincoln Hospital. This met current best practice guidelines and standards and allowed staff to safely care for patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff working with people who were detained had support from the safeguarding team to ensure patients rights were protected. Patients also had access to advocates who were independent from the trust who they could speak to raise concerns or queries.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During the inspection we observed staff offering a choice of meals for their lunch with different options available. During the inspection we spoke with patients who told us that they had plenty of choice and that the food was good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain**.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patient who could not communicate verbally.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Matrons working across the service checked staff assessed patients' pain with a validated pain tool and appropriately responded to patients' pain during their monthly audits.

Staff working in the trust described how the pain team used to be based in the hospital three days a week and were now based in the community. They described them as being less visible but still able to make a referral to them and have patients assessed when required.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. The trust performed poorly on a number of clinical audits.**

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas. The trust carried out monthly sepsis audits on all of the wards. These identified if there were any delays in treatment and possible reasons for this. Most wards had improved results from August to September 2021.

The service participated in relevant national clinical audits. The Trust were participating in 97% of all relevant national clinical audits and were in the process of registering for the inflammatory bowel disease audit which would make them 100% compliant.

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'.

# Medical care (including older people's care)

The trust's percentage of patients on incomplete referral to treatment pathways that had waited less than 18 weeks was lower than the England average. Performance for completed non-admitted pathways was also lower than average. However, performance for completed admitted pathways was similar to the England average.

The service had a high risk of readmission. From October 2020 to September 2021 across all medical wards there was a 21.2% chance of readmission within 30 days. The risk of readmission was higher than expected for elective clinical haematology and gastroenterology at Lincoln County Hospital. However, this data could not be compared to other years as a result of the Covid-19 pandemic.

Managers shared and made sure staff understood information from the audits. The trust were committed to being involved in 100% of national audits in order to ensure improvements for patients. Information from audit was fed back to ward staff and learning embedded by use of a folder with recent SI's and learning and any changes of practice. Information was also cascaded through the huddles. Governance meeting minutes also provided information for ward staff.

The trust had its own internal accreditation scheme. This scheme had a clear process in place for monitoring quality in all clinical areas. Wards were RAG rated each month following completion of an audit undertaken by a matron. Once a ward had achieved the desired rating of green for consecutive months, accreditation status would be given.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Across the medical wards a number of overseas nurses had recently been recruited. They had a bespoke support package in place to ensure they were fully supported both in work and outside of work to help them to settle into their roles and encourage them to stay. They had competency's that they had to complete before they were signed off to complete certain tasks such as intravenous (IV) medication and also were supernumerary until they felt fully comfortable to look after patients independently.

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.

The clinical educators supported the learning and development needs of staff. Staff on the wards spoke highly of the clinical educators and how they supported them in their roles.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they had completed extra training specific for their roles and that this was easy to access and helped them to develop.

# Medical care (including older people's care)

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills.

Managers identified poor staff performance promptly and supported staff to improve. This could be done through informal support on the ward or through formal processes dependent on the concerns identified.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

On the stroke ward, The National Institute for Health and Care Excellence (NICE) guidelines state that patients should be seen by physiotherapists and occupational therapists for a minimum of 45 minutes a day five days a week. The unit was meeting this target.

During the inspection we were told of different ward areas who had recruited band five pharmacy technicians into their establishment figures. Staff told us how valuable they were on the ward and how they had helped to improve patient care and standards on the ward with their expert knowledge.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice, and to support ward staff care for patients with mental health needs. During both days of the inspection we saw the mental health team working and assessing patients on the wards we visited.

Patients had their care pathway reviewed by relevant consultants

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff described how it could sometimes be difficult to get specialities to review patients at weekends and could be difficult to get MRI’s completed at weekends.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to external organisations for specific support needs such as stopping smoking or drinking alcohol.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. On admission all patients had a capacity assessment document completed. If there were no concerns about a patient capacity a box would be ticked and no further action taken and if there were concerns a capacity assessment would be completed to help decide the required support for the patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the inspection we observed staff asking for verbal consent before undertaking any care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training was mandatory, at the time of our inspection 71% of staff had completed this training.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Monthly audits were completed which identified good practice and wards where improvement was required. These were discussed at a safeguarding oversight meeting and support plans agreed for wards requiring targeted training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. There was an audit of the mental capacity act documentation completed across the sites. In July they looked at seven records. Four were found to have capacity assessments fully completed, and three not completed or not fully completed. Following this audit actions taken were to share the findings with the ward managers.

# Medical care (including older people's care)

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

## Is the service caring?

Good

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us how they spent time getting to know the patient as an individual to ensure that they were aware of their wishes and how best to support them.

Patients said staff treated them well and with kindness. Patients we spoke with told us that staff were all very kind and caring and 'couldn't do enough for them'.

Staff followed policy to keep patient care and treatment confidential. During the inspection we saw curtains being used to protect the privacy of patients when delivering any care, treatment or discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff we spoke with clearly understood patient needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. 77% of eligible staff working at Lincoln had received this training.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff explained how they would include patients loved ones in discussions about their care if this was the wish of the patient.

The hospital had a cancer care coordinator whose role was to assess and support the holistic needs of the patient.

# Medical care (including older people's care)

### Understanding and involvement of patients and those close to them

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported that they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Some patients reported that the way that information was given to them was not always in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On all of the wards we visited there was information on how patients and their families could give feedback on their care.

During the inspection we were told about how patients could feed into improvements they would like to be made on the wards and on one ward how they could add items onto a 'wish list' to be paid for by charitable money.

The trust used patient stories to share where care and treatment had met the expectations of patients and also where there were improvements to be made.

For August across the medical division 83% of patients surveyed would recommend the trust as a place to receive care.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients gave positive feedback about the service.

## Is the service responsive?

**Good** ↑

### Service planning and delivery to meet the needs of the local people

**The service planned and provided care in a way that met the needs of local people and the communities served.**

Managers planned and organised services so they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them.

# Medical care (including older people's care)

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust had monthly reports on the number of mixed sex breaches and where they occurred across the trust. They also had policies in place on eliminating mixed sex accommodation breaches and steps for staff to take to reduce this. The main area that report mixed sex breaches was the medical emergency assessment unit (MEAU), this was due to patients being moved there quickly from the emergency department. The trust had put support in place to reduce the number of mixed sex breaches in the MEAU.

Facilities and premises were appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had a frailty team who worked closely with the emergency department and accepted patients into a health care of the older person ward, these patients were then fully assessed with the aim to have them discharged on the same day. This enables the patients to receive the care they require in an environment that is more suited to their needs and also creating space in the emergency department for new admissions. The plan moving forwards was for the area to be able to take patients and referrals direct from GPs and the ambulance service. This would mean that patients wouldn't have to attend the emergency department and would mean their care was handled by a more specialised team.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care unit, located by the ED aimed to see patients who could be assessed/treated within the day and to avoid unnecessary admissions. There was a clear inclusion criteria that patients must meet in order to be eligible for care there. Whilst we were inspecting staff told us about plans to change the environment to allow for more patients to be treated safely.

### Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff linked in with leads across the trust for support and guidance. They also worked closely with patients usual care delivery teams to ensure their needs were met.

Staff told us about how they would manage patients who were 16 or 17 and it was more appropriate for them to be cared for in the adult ward areas. They described linking in closely with the paediatric doctors to ensure the correct care and treatment was given. They also described how they would aim to treat them in a side room and facilitate parents to stay if required.

Wards were designed to meet the needs of patients living with dementia. A number of the wards had recently undergone refurbishments and had improved their accessibility for people living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients for speciality referrals and beds.

Managers and staff worked to make sure patients did not stay longer than they needed to. On the stroke unit there was a discharge coordinator role being trialled three days a week. At the time of our inspection they were completing an audit to decide whether to increase this to five days a week. Staff on the ward told us that on the days that the discharge coordinator was not available that flow on the ward was affected.

The service moved patients only when there was a clear medical reason or in their best interest. There were 1295 patients moved across the medical wards In September 2021 from the ward they were admitted to to another ward.

The trust used the discharge lounge for a place for patients to be cared for instead of waiting in the emergency department while they were awaiting an assertive in-reach assessment (frailty assessment). This resulted in patients, at times, being in the discharge lounge for long periods of time. In July 2021 there were 33 patients who were in the discharge lounge over 12 hours, August 39 patients and September 37 patients. The patients were moved to the discharge lounge overnight then were seen by the team in the morning before usually being discharged out that afternoon.

Managers and staff worked to make sure that they started discharge planning as early as possible. The average length of stay across all medical specialties was longer than expected for both elective specialties at Lincoln County Hospital. Average length of stay across all of the wards was 3.9 days with the longest average length of stay on the stroke unit (11.2 days) and Scampton ward (9.7 days). The average length of stay for the MEAU was 2.6 days from the last year. With 65 patients staying for eight days or longer.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff working on the wards aimed to plan discharge when patients were admitted to ensure the process was as short as possible.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The trust worked with the local system to make them aware of delays relating to discharge and to facilitate discharges.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Occupancy across the wards was 99%.

# Medical care (including older people's care)

Managers worked to minimise the number of medical patients on non-medical wards. Where medical patients were not on the speciality wards they required there were clear processes for medical review to continue to ensure their care and treatment was not impacted upon.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. Across the medical wards there were 77 complaints received in the last year. The most common themes were communication, delay in treatment or diagnosis and being discharged too soon.

The service clearly displayed information about how to raise a concern in patient areas. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

Managers investigated complaints and identified themes. The average time taken to respond to complaints was 53 days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed one patient complaint in relation to medicine at Lincoln County which addressed all points raised by the complainant, gave detailed responses and were written in a sympathetic manner.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated.

Staff could give examples of how they used patient feedback to improve daily practice.

## Is the service well-led?

**Good** ↑

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

# Medical care (including older people's care)

Medicine had its own division within the trusts management structure. This division included all of the medical wards and the urgent and emergency department. The leaders worked in a multi-professional triumvirate which included a manager, doctor and nurse. Care group senior managers and clinical leads were seen regularly in ward areas. Staff felt able to raise concerns and were confident their concerns would be listened to and acted upon. Ward staff said they were well supported by their ward managers and matrons.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Staff were encouraged and supported to develop their skills and take on more senior roles. There were development pathways to support staff to progress.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had five key values:

- **Patient-centered-** Putting patients at the heart of our care.
- **Safety-** Ensuring patients and staff are free from harm.
- **Excellence-** Supporting innovation, improvement and learning.
- **Compassion-** Caring for patients and loved ones.
- **Respect-** Treating our patients and each other positively.

During the inspection we observed staff to be displaying these behaviours in the care and treatment they delivered.

The trusts vision was to be outstanding and was led by the trusts board. The division's vision mirrored that of the trust.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

# Medical care (including older people's care)

Patients acknowledged a positive and caring ethos and were happy with their care.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

There were clear governance structures within the trust with good representation from all disciplines. Governance group meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the medicine group. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded.

The medicine division also had monthly dashboards which covered data from across the wards and was collated into an overall performance report for the division. This highlighted areas of good practice and areas where improvements could be made.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Risks were recorded at ward division and trust level. The top three risks identified were the safe management of emergency demand, timely provision of Non-Invasive Ventilation (NIV) and capacity to manage emergency demand. These all had control measures in place, identified weaknesses/gaps in controls, planned actions and recorded progress. Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Throughout the medicine division, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

During the inspection there was a fire alarm when we were on one of the wards. Staff handled this well and carried out their process to ensure risks to patients were kept to a minimum. There were fire risk assessments completed for all wards and these contained information on how to improve fire safety on the wards.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

Data or notifications were consistently submitted to external organisations as required.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The trust used the friends and family test to gather the views of people using the service. They also gathered the views of patients and their loved ones through complaint and compliments. All of this information was gathered into a monthly report which detailed any actions and learning.

The trust also held patient panel workshops where members of the public were invited to discuss a variety of topics such as changes to services. These were a useful way for project leaders to be able to gather the views of people who would be using the services they were developing.

In 2019 United Lincolnshire Hospitals NHS Trust (ULHT) had become the first NHS trust in the country to be formally accredited by the 'Academy of FAB NHS Stuff'. The trust now had FAB Experience Champions identified on medical wards who acted as local leads for patient experience. Some of this work was new but aimed to engage with patients, families and their carers to improve care. For example, new monthly FAB Champions feedback on activities and patient panel discussions covered all aspects of care. This information all fed into the Medicine Division Patient Experience assurance report which provided an overview of themes and actions.

When the trust developed or reviewed services they complete a full equality impact assessment. They also had a system community database which allowed staff to engage with different groups to gather diverse views on services.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Following the last inspection, the trust had taken action to address the issues found across the service.

The trust had monthly medicine division confirm or challenge reports. These explored different measures across the trust and dependent on risk level identified drivers for change or metrics to continue to monitor. Each month these were updated dependent on risk levels and actions completed to improve the services across the trust. Areas for improvement including reducing medication errors causing moderate or severe harm and reducing agency spend for the year compared with the previous year.

During the inspection we were told about how the clinical engineering department had used a 3D printer to make a copy of an ultrasound probe to help a patient who was on the autistic spectrum to desensitise themselves prior to treatment. The idea was to provide the patient with an opportunity to get comfortable with the ultrasound probe to be used during procedure and prevent any undue stress or rejection of procedure. The probe was painted to replicate the original and a skin safe silicone was used on the tip of the probe that comes into contact with the skin during procedure.

# Medical care (including older people's care)

The trust took part in a 100 day challenge with the community service to allow a smoother and more rapid (where appropriate) transition from hospital to home/community for individuals who had suffered a stroke and to allow people to be managed and to manage confidently in the community. As a result of this the team awarded a Chief Allied Health Professional Office (CAHPO) Award in October 2021 for Innovation and Delivery of Systems in relation to the 100-day challenge and all the progress they had made this year. This was one of 7 awards given out in England.

# Services for children and young people

Good ↑

## Is the service safe?

Good ↑

### Mandatory training

**Not all staff were up to date with mandatory training.**

Not all nursing staff were up to date with their mandatory training. Data from the trust as of October 2021 showed training compliance ranged from 65.3% for resuscitation training to 96% for equality, diversity and human rights training (EDHR). This was against a trust target of 95%. Only one out of thirteen core modules showed the trust target had been met (EDHR). This was, in part, due to the pandemic. We found no evidence of harm to patients as a result of the mandatory training levels.

Data from the trust showed 54% of nursing staff were trained in European paediatric advanced life support (EPALS) against a target of 100%. Whilst the target was not met at the time of our inspection, staffing was arranged to ensure at least one EPALS trained nurse on shift at all times. The trust planned to increase training compliance to 76% by December 2021.

Band four staff (staff who were experienced in working with children but were not registered nurses such as nursery nurses and nurse associates) were trained in paediatric immediate life support (PILS).

Managers had secured funding for senior nurses to undertake advanced paediatric life support training (APLS) and were waiting for spaces to become available on training courses, particularly for Safari ward (day patient ward) as the paediatric assessment unit was located there.

Managers monitored mandatory training and alerted staff when they needed to update their training. Clinical educators focussed on supporting staff to become compliant with mandatory and specialist training for their role.

Medical staff were not all up to date with their mandatory training. Data from the trust from October 2021 showed training compliance ranged from 70.6% for staff charter training to 100% for moving and handling. This was against a trust target of 95%. Only one out of thirteen core modules showed the trust target had been met, however two further modules (EDHR and Health and Safety) showed just under 95% compliance. This was, in part, due to the pandemic. We found no evidence of harm to patients as a result of the mandatory training levels.

Data from the trust showed 67% of medical staff were trained in European paediatric advanced life support (EPALS) against a target of 100%.

Data from the trust showed 33% of medical staff were trained in advanced paediatric life support (APLS) against a target of 100%.

The trust reported difficulties in booking onto APLS courses due to Covid-19. Extensions had been granted to some medical staff due to this.

# Services for children and young people

The mandatory training was comprehensive and met the needs of children, young people and staff. The modules staff completed were appropriate to the paediatric environment.

### Safeguarding

**Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although not all staff were up to date.**

Nursing staff received training specific for their role on how to recognise and report abuse. However, some staff were not up to date with this. Staff compliance with safeguarding training varied. The trust target for safeguarding training over level one was 90%. Eighty four percent of staff eligible for level two safeguarding training for both adults and children had completed this training. All staff eligible for level three training in safeguarding adults had achieved this, and 82.7% of staff were compliant with level three safeguarding children training.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were 76.5% compliant with training for safeguarding children and adults' level two. Medical staff did not complete level three safeguarding adults training routinely. They were 76.5% compliant with level three safeguarding children training. This was below the trust target of 90% for these modules.

The trust monitored training compliance; and set actions to achieve improved compliance rates.

The levels of safeguarding training undertaken by staff was appropriate as per the 'Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018) and the 'Intercollegiate document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could describe the types of abuse patients could experience. Staff were knowledgeable of the provider's safeguarding policy and described trust wide safeguarding staff they could approach for guidance and advice.

Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment. It was the medical staff responsibility to note this and to contact the person with parental responsibility.

Staff could access a division wide safeguarding supervision meeting via videoconference. This was run by the divisional safeguarding leads.

Staff followed safe procedures for children visiting the wards. Staff controlled entry to the wards via a buzzer system which allowed them to view and speak with anyone attempting to gain entry. People leaving the ward had to ask for staff to unlock the doors electronically.

We observed staff act as a chaperone for patients in outpatients.

Staff received training on preventing child abductions. This did not include scenario training at the time of our inspection.

# Services for children and young people

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The housekeeping team knew what their daily duties included and kept a cleaning schedule. Staff cleaned bed spaces promptly when there were vacated.

All areas we visited had disposable curtains which were dated to show when they were last changed. All staff we spoke with were aware of when to change curtains more frequently.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used stickers to indicate when equipment had been last cleaned. All stickers we checked were recent, indicating these were used regularly.

Hazardous cleaning products were locked away.

Staff followed infection control principles including the use of personal protective equipment (PPE). Patients with infections or at risk of harm from infections were clearly identified and supported in side-rooms. Assessments indicated the level of infection risks associated with each patient and there was clear guidance about how to prevent the spread of infection and what PPE was to be used.

When possible, patients were tested for covid-19 prior to admission and there were procedures in place to test unplanned admissions upon arrival. Patients requiring planned surgery were tested three days before admission to the ward. There was a dedicated covid information board for staff, patients and visitors explaining how to identify symptoms and prevent its spread. There was a dedicated infection, prevention and control lead to educate staff and visitors and promote good infection control practices.

All people visiting the ward had access to regular handwashing facilities and hand sanitising gel. There were handwashing prompts and instructions at the ward entrance and sinks. Additional hand sanitizing gel was available in staff areas and at bedsides.

Staff used PPE when caring for patients and consistently washed hands before and after each patient contact.

Data from hand hygiene audits demonstrated a high level of compliance for the months of July to September 2021 on both Safari and Rainforest wards.

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.

Cleaning audits for Safari ward showed between 94 and 98% compliance from November 2020 to September 2021. For Rainforest ward, compliance was worse; from 83% to 91% for the same time period. However, we did not see any incidents as a result of this; and the wards were visibly clean during our inspection.

# Services for children and young people

## Environment and equipment

**The design, and use of facilities, premises and equipment kept people safe. However, the maintenance of the environment and equipment was not always prompt. Staff were trained to use equipment. Staff managed clinical waste well. Not all weekly fire checks were completed in line with risk assessment recommendations.**

The design of the environment followed national guidance. The service had arrangements in place to ensure children and young people wards and clinics were secure. The main entrance to the neonatal unit, Safari ward, Rainforest ward and the children and young people outpatient's clinic could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity and validity of people requesting access to wards. Fire doors were alarmed so patients were unable to leave without staff being alerted. Non patient rooms and areas within the ward had dedicated key code locks to prevent unauthorised access to items which could be harmful or confidential.

Doors and fire exits were kept clear however corridors on the Rainforest ward were cluttered with equipment, PPE and linen trolleys. We saw several pieces of equipment stored on the corridors awaiting disposal or repair. Some of these items had been left for two months. Several members of staff told us that faulty equipment was not consistently disposed of promptly. This presented potential obstructions and trip hazards. On one occasion we observed a patient's feed line get caught on a piece of equipment being stored on a corridor. We raised this with staff on the ward and found this particular piece of equipment was removed the next day. However, we saw a new piece of faulty equipment had been added to the area.

Fixtures were generally well maintained; however, we saw signs of wear to the floor at the Rainforest ward entrance and to some surfaces in bathrooms and toilets on the same ward. Worn flooring could present a trip hazard and surfaces no longer impervious to spills could support the spread of infection.

Staff allocated patients with higher acuity (more serious illnesses) to beds nearest the nurses' station. Therefore, staff could easily observe such patients and action taken promptly if required.

We saw toilets and bathrooms had been fitted with safer locks to enable staff to access the bathroom if necessary, and to prevent ligatures. However, bathroom facilities did have other ligature points within such as grab handles and bars. The trust provided an environmental ligature risk assessment however this was from October 2018 for both Rainforest and Safari wards. The audits stated these should be re-completed twice per year. Therefore, this audit was out of date and may not have reflected risk accurately. Following our inspection the trust provided an up to date environmental ligature risk assessment.

Children, young people and their families could reach call bells and staff responded quickly when called. Parents told us they could access staff quickly when required.

Staff carried out daily safety checks of specialist equipment. Maintenance staff completed regular safety checks of electrical equipment. We saw two contractors attend the ward to complete an annual safety check of a hoist.

The service had suitable equipment and facilities to meet the needs of children and young people's families. Staff had access to specialist paediatric emergency equipment in all areas we checked. A paediatric resuscitation trolley was available on all inpatient and outpatient areas, including theatres. This was checked daily, weekly and where necessary monthly. All trolleys were secured with cable ties; therefore, easily accessible in an emergency. We saw all planned equipment, medication and guidance was present and in date with one exception. The one exception was in the

children and young people outpatient clinic (clinic five) whereby one laryngoscope blade (a device to open airways) was out of date as of August 2021. Staff in the department were aware of this, and it had clearly been escalated to the trust wide resuscitation team who had also recognised this as part of a recent audit. A spare was available, and all staff knew to use the in-date version which was highlighted.

Staff had access to emergency 'grab' boxes which had been stocked by the hospital resuscitation team. This contained lifesaving medication and equipment suitable for children.

There were dedicated fridges for storing expressed milk. These were locked and secure.

Staff disposed of clinical waste safely. Clinical waste was stored separately in a dedicated locked room. We checked a number of sharps boxes across all areas we visited. All were dated and signed by staff so they could be easily traced if necessary. However, we did notice some sharps boxes in clinical rooms had the slide top open leaving a space large enough for a child to put their hand inside. However, it should be noted that children and young people would never be alone in these clinical rooms.

We observed cleaning products to be accessible on Safari ward; staff stored these in the sluice room in a lockable cupboard. The sluice room was not routinely locked which is acceptable. During our inspection we found the cupboard open and unlocked. We raised this with staff at the time who immediately rectified this.

We saw on Safari ward that the last recorded weekly fire check was June 2020. The most recent fire risk assessment dated April 2020 highlighted routine checks were not being completed and recommended this be done. We requested evidence that more recent weekly fire checks had been undertaken. Following our inspection, the trust provided evidence to show the fire risk assessment had been completed in November 2021. In addition, the trust stated, during the pandemic and in response to the increased risk of fire in some ward areas relating to an increased use of oxygen, fire risk assessments were prioritised to those wards that were high risk. Safari was not identified as an area with higher levels of risk hence the delay in the fire risk assessment being undertaken.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.**

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system or the neonatal early warning scoring system (NEOWS) to record children and young peoples' vital signs and identify deterioration in these. The trust used electronic boards in inpatient areas so that staff could quickly see where patients were located, who the allocated nurse was for each patient and what their latest PEWS or NEOWS score was. The boards also showed where staff were overdue with re-assessing patients' vital signs. During our inspection we saw one occasion where a patient's observations were not taken within the required time frame. We escalated this to senior nurses who immediately addressed this.

Staff knew about and dealt with any specific risk issues. Staff knew how to identify if a patient was at risk of sepsis. If a patient scored five or more on their PEWS, staff were prompted to complete a sepsis screen. We check a sample of patient records where they had scored five or more and found that the screen had been initiated appropriately in every case.

Staff were supported to become competent with recognising a deteriorating child and identifying and escalating sepsis. Staff completed a specific competency booklet on sepsis and were required to complete e-learning.

The clinical educators supported new starters by delivering a sepsis session which showed how to recognise signs of sepsis, how to complete the trust paperwork and how to escalate concerns. Until new starters completed this assessment, they were required to escalate all patients with sepsis indicators to the nurse in charge.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk assessments for skin integrity, nutrition and falls. Managers monitored the quality of assessments regularly through audit.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. Staff could access the internal mental health team who could attend to speak with patients at any time of the day or night. Staff had access to the local mental health trust and the child and adolescent mental health service (CAMHS) during day shifts. Staff from CAMHS were starting to routinely work on Rainforest ward to support staff.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Nurses had a risk assessment tool to assess patients who were at risk of suicide, self-harm or absconsion. This identified what level of staff monitoring was required to keep the patient safe from harm. Where necessary patients were allocated staff to provide continuous supervision. Staff told us that where 1-1 continuous supervision was required, this was always covered, even if other staff had to undertake additional duties to cover.

Staff from the community-based child and adolescent mental health service (CAMHS) attended the ward to support patients with mental health conditions who were assessed as requiring one to one observation due to a high risk of suicide or self-harm. CAMHS provided this additional support during day shifts.

Patients at risk of suicide, self-harm or absconsion were usually located in the patient bay nearest to the nurses' station to provide extra monitoring.

Staff did not use chemical restraint (such as sedatives) to restrain children and young people. Physical restraint was undertaken by trained CAMHS staff where possible. Staff on the ward could call security if necessary. Data from the trust showed that a new policy regarding restraint training was being written at the time of our inspection due to previous training not meeting the needs of staff and patients. At the time of our inspection, three paediatric staff members were trained in level three clinical holding. There were no dates at this time planned for more staff to be trained but the trust were reviewing training provision. The trust told us one patient had been physically restrained in the 12 months prior to inspection.

Shift changes and handovers included all necessary key information to keep children and young people safe.

### Nurse staffing

**The service had some staffing vacancies. However, shifts were covered to ensure there were 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.**

# Services for children and young people

The service did not always have enough nursing and support staff to keep children and young people safe. The service was not fully recruited for nursing positions. However, on the days of our inspection the numbers of staff on shift matched the planned numbers to keep patients safe. The service made use of regular agency staff to support the safe staffing of the ward.

The number of nurses and healthcare assistants matched planned numbers.

The trust sent nurse staffing data for July to September 2021; on Rainforest ward for July 2021; day shift staffing rates for registered nurses (RN) was recorded at 144% and unregistered staff at 100%. Night shift staffing rates for registered nurses (RN) was recorded at 185% and unregistered staff at 100%.

Staffing rates greater than 100% were as a result of a temporary uplift to the template in response to the need for further forward planning for the anticipated increase in admissions of severely ill, very young children with the respiratory syncytial virus (RSV).

One member of staff told us that staff occasionally were moved from the ward to support children in the emergency department. This meant there was a risk that there would not be enough staff to meet the needs of patients on the ward. Similarly, staff told us that they could be moved from one area of the children and young people service to a different area to cover shortfalls. However, staff told us the staffing coverage was kept safe despite moves.

Staffing within the neonatal unit met the British Association of Perinatal Medicine (BAPM) standards.

Clinical nurse educators and ward managers worked clinically as required to support sickness or other absences during the week. Matrons could also work clinically if required.

Where nurse numbers were low; nurses could be supported by having a higher rate of unregistered staff such as nursery nurses. Nursery nurses had specific paediatric competencies and were able to work under a registered nurse's supervision.

All nurses had the skills and qualifications to keep patients safe. Where nurses had not trained specifically as a paediatric nurse; they had undertaken competency training to enable them to work safely.

Within theatres, there were enough suitably trained nurses and operating department practitioners (ODPs) to support and recover children during and after operations.

In addition to nurses, the service employed nursery nurses, nurse associates and trainee nurse associates. Nursery nurses were band four, and not registered nurses. However, they were experienced in working with children and supported the nurses by completing work such as admission paperwork, taking patient observations and general patient care. Nurse associates were also band four and had received training to achieve registration with the Nursing and Midwifery Council (NMC). They were also able to support nurses by completing a range of duties. The trust were supporting some nursery nurses to become either nurse associates or paediatric nurses. Health care assistants worked in some areas such as on wards and in the children's' outpatient service. They worked at band two and supported nursing staff. Some health care assistants had gained competencies in a range of tasks including taking blood and undertaking patient observations.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. Managers ensured that the skill mix of nurses working supported the needs of the patients, for example by having a maximum of one adult only trained nurse on shift at one time.

The ward manager could adjust staffing levels daily according to the needs of children and young people. If necessary, staff could be sent from one site to another to support fluctuating needs of different wards. The trust funded taxis for this purpose due to the distance between sites.

The service had high vacancy rates. The trust target for vacancy rates was less than 5%. In July 2021 the vacancy rate was 10.2%. In August 2021 it was 11.1% and in September 2021 it was 10.2%.

The service had actively recruited paediatric nurses to some of the vacancies and was awaiting three nurses to commence employment at the time of our inspection.

The service had increasing turnover rates. July and August 2021 data showed 10% turnover rates; whereas in September 2021, the turnover rate was 12%. The trust target for turnover rates was 12% or less.

The service had low sickness rates against the trust target of 4.5% or less. Data showed sickness rated were low.

The service had high rates of bank and agency nurses. Staff told us that they were usually supported by the same agency staff when necessary to ensure there were enough staff to meet patients' needs and considered them, 'part of the team'. Agency staff were block booked in advance. Some agency staff had been regularly working on the ward for a number of years.

Managers monitored nurse staffing and agency usage as part of the risk register.

Managers made sure all bank and agency staff had a full induction and understood the service. The clinical educator delivered a paediatric induction for new starters and bank or agency staff.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. However, medical staff were often called to attend ED out of hours. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service had enough medical staff to keep children and young people safe. The medical staff matched the planned number during our inspection. However, medical staff were requested to attend the paediatric area within the Emergency Department out of hours to support urgent cases which impacted upon the ward coverage. During our inspection, we found occasions where children had not been seen within the recommended timescales. We explored this with managers and medical staff who told us this was due to stretched staffing, particularly during busy periods. Staff told us that at times of peak activity, children were risk assessed to identify who needed to have a medical review most urgently which meant some lower risk patients did wait longer for their initial medical reviews.

The service always had a consultant on call during evenings and weekends. Consultant cover was in line with the Royal College of Paediatrics and Child Health (RCPCH). On call consultants were available within 30 minutes out of hours.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff we spoke with said any gaps in cover were managed inter-departmentally by a doctor moving to the area of greatest need. Despite medical staff sometimes being short, medical staff told us patients were kept safe.

The service had recently implemented a second specialist registrar (SpR) to work night shifts, although they were not formally on the rota. Staff told us this had made a significant difference to the workload.

The service had high overall vacancy rates for medical staff. As of September 2021, the vacancy rate was 16.8% against the trust target of 5%.

The service had high turnover rates for medical staff. As of September 2021, the turnover rate was 18.8% against a trust target of 12% or less.

Sickness rates for medical staff were low. As of September 2021, sickness rates were 0.6% against a trust target of 4.5% or less.

The service had high rates of locum staff. This was to provide additional medical support and cover over the planned establishment. Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. Data from the trust demonstrated locums received a thorough induction.

### Records

**Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. Nursing notes were contemporaneous and detailed capturing description of nursing interventions. We saw evidence of medical reviews. Staff signed and dated their entries.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Patient records were mostly paper based; staff would take the records to where they needed to be located as necessary. Some patient records were in electronic form such as clinical observations. These could be accessed by logging into a trust computer.

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.

Monthly documentation audits showed 94% compliance on Rainforest ward and 99% compliance on Safari ward for August 2021 against a target of 90%. This was an improvement on July 2021 which showed 89% compliance for Rainforest ward and 91% on Safari ward.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always follow these.**

# Services for children and young people

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We saw that managers had identified a theme of medicine errors as reported by staff including omitted medicines.

Pharmacists completed medicine reconciliation audits and omitted medicine audits trust wide; however, for July and August 2021, neither of the paediatric wards were included in the audit sent by the trust. Paediatric areas were included in an annual audit of fridge temperatures.

Matrons completed a monthly audit which included medicines management. From April to August 2021, Rainforest ward showed 100% compliance with most measures where data was submitted. The measure of recording patient allergy status in May 2021 showed 78% of records checked were compliant. For July and August 2021, staff were 60% compliant with the measure: self-administration forms are signed and in patients notes where applicable'.

Safari ward showed an overall similarly good level of compliance. An area for improvement was found in July 2021; staff were 70% compliant with the measure: self-administration forms were signed and in patients notes where applicable'.

Both controlled drug storage and missed dose audits demonstrated a high level of staff compliance April to August 2021 across both paediatric wards.

Staff on Safari ward used patient group directions (PGDs) for three medicines. PGDs are written instructions to help nurses supply or administer medicines to patients, usually in planned circumstances. We asked to see the PGDs which allowed the nurses to give these medicines however we were told these were not available as they were being re-written. Therefore, at the time of inspection there was no evidence that the nurses were working legally within the PGD framework.

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.

Controlled drugs were managed safely during our inspection. However, pharmacists completed quarterly audits which showed poor compliance with the family health directorate, under which children and young people service sits.

We saw two opened vials of medicines on top of the medicines waste bin. We raised this with a senior nurse who immediately disposed of these.

Medicines nearing expiry were clearly labelled and there was a process for returning these to pharmacy for destruction.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. A pharmacist attended each day to review the two children's' wards and the neonatal unit. They checked prescriptions and undertook audits. Pharmacy assistants attended to check stock levels.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff did not use chemical restraint on paediatric patients.

# Services for children and young people

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy. Staff gave us examples of incidents they had identified and reported. Most staff reported incidents directly using the trust electronic reporting system. Junior and administration staff reported incidents by alerting the nurse in charge who would report the incident on their behalf.

The service had no never events on any wards. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from serious incidents was displayed on a clinical governance board in the matron's office.

Managers shared learning and themes from reported incidents. For example, the sepsis officer identified areas of improvement for ward staff. This was shared, and where necessary individual staff were supported to improve their performance.

Managers produced a quarterly 'learning to improve' bulletin which including learning from serious incidents, complaints and patient experiences.

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.

Managers highlighted the importance of the duty of candour in quarterly 'learning to improve' bulletins.

There was evidence that changes had been made as a result of feedback. Following a serious incident whereby medical staff did not respond to nurse escalation of a deteriorating patient, changes had been made. Emphasis was placed on all staff developing their competency in managing deteriorating patients. Staff we spoke with told us they felt confident to professionally challenge colleagues where necessary. We saw managers actively encouraged to escalate concerns to more senior colleagues including registrars and consultants if they felt junior medical staff were not responding appropriately.

Managers investigated incidents thoroughly. We saw completed investigation reports, action plans and evidence of the learning being shared as above.

## Safety thermometer

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.**

# Services for children and young people

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed development of replacement data collection and reporting then impacted by the COVID-19 pandemic.

However, managers collected performance data and monitored the results to improve safety. This data was displayed on wards for children, young people and their families to see. However, on Rainforest ward this was out of date at the time of our inspection. We raised this with staff who said they would update it.

Staff had access to up to date data which was displayed in the matron's office.

Staff used the safety performance data to further improve services. Managers undertook regular audits which highlighted areas for improvement to drive performance and ensure patient safety.

## Is the service effective?

**Good** ↑

### Evidence-based care and treatment

**The service mostly provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers reviewed and updated policies and clinical guidelines as part of monthly governance meetings; such as relevant guidelines from National Institute for Health and Care Excellence (NICE).

The Royal College of Paediatrics and Child Health (RCPCH) sets out standards for acute general paediatric services. These include having a consultant paediatrician readily available within peak activity time periods and all children who are admitted to a paediatric department with an acute medical problem are seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission and a consultant paediatrician within 14 hours of admission. During our inspection, we found occasions where children had not been seen within the recommended timescales.

We requested audit data for time taken for medical reviews as per the above standards. The trust reported they do not routinely collect this data or audit these standards. However, an overall annual audit of the standards was completed in November 2020. This showed lesser compliance to the standards highlighted above in line with our findings on inspection; however found good compliance to other standards such as 'the general paediatric training rotas are made up of at least ten whole time equivalent posts' and 'specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians'.

The Bliss Baby Charter is a UK framework for neonatal units to promote best practice and a high quality of family centred care. There are seven principles that neonatal units are encouraged to work towards and undertake audits to self-assess compliance.

During our inspection, we saw the neonatal unit complied with aspects of the principles. There was a dedicated room for mothers to breastfeed their children or to express milk in neonates, with support for cot side expressing as per best practice guidance. However, on both wards, mothers were required to express at the bedside on the wards and in neonates. Although privacy curtains were in place, this may not have been a suitable environment for all women. Alternatively, staff told us women could use rooms such as the parents' room which was used by a variety of parents for other uses.

We requested data to demonstrate how the trust was working towards accreditation under the Bliss Baby charter. The trust told us they had submitted their supporting evidence to gain accreditation and were awaiting this at the time of inspection.

The trust had made improvements to the management of children and young people transitioning to adult services since our last inspection. Managers attended monthly meetings as part of the children and young people oversight group where progress of transition services was a set agenda item.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff worked with closely with the local mental health NHS trust to support children and young people who presented with mental health diagnoses. See 'multidisciplinary working' section for more details.

### Nutrition and hydration

**Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs. However, audit data showed staff could improve their recording of fluid and food intake.**

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. Staff used care plans to identify the best way to support patients with specific needs around food.

There were dedicated children's menus in place and older children could order meals from an adult menu if they preferred. A choice of baby foods was available for young children. Staff provided food to children outside of mealtimes as required for example after a procedure.

There were meal options available which met patients' specific cultural needs and preferences.

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.

Safari ward audit data showed better compliance; all measures were 100% compliant for the same time period except for those relating to PYMS.

There was a fasting policy in place for patients awaiting surgery and were designated, 'nil by mouth'. Cold meals were available to patients returning from surgery and didn't want to wait for a scheduled mealtime.

### Pain relief

**Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients or parents/carers we spoke with told us they had been asked about patient pain levels.

Children and young people received pain relief soon after requesting it. We saw evidence in patient records that staff asked patients about pain; and provided medicines to relieve pain where necessary.

Staff prescribed, administered and recorded pain relief accurately. Staff supported patients to receive suitable pain management when necessary. A dedicated pain management team were available for additional advice and support.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.**

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

Matrons audited monthly against eight areas for staff on Rainforest ward and Safari ward. These included: safeguarding, deteriorating patient and review, infection prevention and control, risk assessments, medication, patient experience, quality, governance and safety and workforce.

The trust sent data from April to August 2021. Compliance to the audit measures varied. The service used a RAG (red, amber, green) rating system to identify if audit results were meeting expected targets (green) overall, requiring some improvement (amber) or below expected results (red).

Several audit areas consistently scored green across both wards from April to August 2021; these included safeguarding audits and infection prevention and control audits.

Some audits had data omitted so it was not possible to rate the effectiveness of the work in that area. For example, as part of the risk assessments audit, care rounding was reviewed. Several of the measures did not have sufficient data to assess this such as 'evidence of oral care'.

We saw areas which required improvement were easily identifiable. For example, as part of the care rounding audit, we saw that on Rainforest Ward from April to June 2021, only 70% of patient records showed evidence that patients had been offered a bath or a shower in the last 24 hours.

Managers shared and made sure staff understood information from the audits. The matron who oversaw the wards spoke about how data from these audits had driven improvements. For example, in July and August 2021, audits for the deteriorating patient showed poor compliance with staff completing patient observations on time. As a result, the matron spoke to staff to explore this further and worked clinically on the ward to test out any issues with taking observations. This led to changes made in practice and new electronic devices being purchased to support staff to take timely observations.

A quality matron worked across the division; their role was to develop and audit areas to drive improvement. This role enabled new pathways to be introduced to help improve quality. The matron had a focus on deteriorating patients and sepsis. We saw sepsis screening compliance for paediatric inpatients was below the 90% target in July 2021 (80% complaint for Rainforest Ward and 54.5% complaint for Safari Ward). Administration of intravenous antibiotics for paediatric inpatients was 75% in July 2021 for Rainforest Ward (3 out of 4 children received antibiotics within 1 hour) and 0% for Safari Ward (no children received antibiotics within one hour). During our inspection, we found compliance with sepsis management had improved; staff escalated patients for screening appropriately and in line with trust guidelines. Trust audit results also showed improvement, particularly on Safari Ward. For example, within September 2021, 81.4 of patients were screened for sepsis on Rainforest Ward and 81.25% were screened on Safari Ward. One hundred percent of patients audited received antibiotics within one hour.

The service took part in external reviews to assess their services. For example, the local mental health trust had undertaken a review of the children and young people's mental health service and care provision at Lincoln County. The report had not been published at the time of our inspection; however, managers told us they had received positive feedback with no significant areas for improvement.

Data provided by the trust showed that medical staff conducted clinical audits to measure outcomes against National Institute for Health and Care Excellence (NICE) guidelines and local guidelines.

The neonatal team were working through a regional action plan to support the reduction of gestational age admission from 28 weeks to 27 weeks. The plan was progressing well at the time of inspection and quarterly assurance meetings were used to assess safety, quality and performance, as well as considering clinical outcomes, morbidity and mortality.

The service was not accredited by Bliss Baby Charter. We asked the trust for data to show how they were working towards this. The trust told us they had submitted their supporting evidence to gain accreditation and were awaiting this at the time of inspection.

**Competent Staff**

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Appraisal rates were low at the time of inspection due to a change in the delivery method. Plans were in place to address this.**

Full time clinical nurse educators supported staff with their professional development and knowledge. We saw staff competencies had been regularly assessed and recommendations for further training arranged when necessary. Clinical educators provided regular training sessions in the skills and competencies required to meet the needs of patients and worked flexibly to meet the needs of staff working outside of daytime working hours.

# Services for children and young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff had training folders which recorded their personal development and identified further training needs. Staff said they felt confident they had the skills and provide suitable care to the patients they were asked to support.

Managers gave all new staff a full induction tailored to their role before they started work. The clinical educators gave a paediatric specific induction to support new starters' competency levels. The trust had a preceptorship programme to support new starters, newly qualified nurses and nurses who had returned to practice. This enabled staff to be supported to develop their role specific competencies within the first 12 months of their role. We noted the preceptorship booklet for staff was due to review in July 2021. Nursery nurses also worked through a similar process to obtain and record their competencies gained within their role.

Consultants provided junior doctors with an induction upon joining the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection the appraisal rate was low (22%). However, this was due to a change in the system used to record appraisals. The new system had been brought in two months prior to our inspection with a plan to start the rolling year from that point. Managers had plans to bring the appraisal rate up to the trust target. For example, a number of band six (senior) nurses were due to start non-patient facing duties and had been set the task of completing appraisals for more junior staff as a priority.

Staff had regular one to one meetings, to review their performance and promote their skills and knowledge.

Managers did not hold regular team meetings for staff. One meeting had been held via video conferencing in the six months prior to the inspection. Staff told us this was due to the pandemic.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had access to regular training and guidance.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff undertook additional training to support their roles. Managers supported staff to continue with professional development to progress within their career. For example, a member of staff who supported nurses as part of their role was undergoing training to become a registered paediatric nurse.

Managers made sure staff received any specialist training for their role. Agency nurses completed appropriate competency assessments to work with children and young people.

More than 65% of the neonatal nursing workforce had completed post-graduate training in neonates intensive care units. Data from the trust showed that as of October 2021, 22 out of 33 eligible staff had completed this. This meant a 68% completion rate against the 70% target set out in the Neonatal toolkit. The trust had a plan to achieve 73% compliance.

Staff working within theatres had completed paediatric competencies. These competencies were evolved from an ED competency pack so not all competencies were relevant to theatre staff. As a result, paediatric leads had adapted the competency pack to ensure it is more relevant to theatres.

# Services for children and young people

Managers identified poor staff performance promptly and supported staff to improve. A structured approach was in place to support staff who did not meet the required levels of competency for specific areas of work.

Managers recruited, trained and supported volunteers to support children, young people and their families in the service. We observed the volunteers working within the service and saw they were familiar with the staff and the clinical areas.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Doctors and nurses reported effective team working and collaboration to provide care.

Staff within neonates told us communication and relationships with the maternity service had improved with regular meetings held.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff worked with the local child and adolescent mental health service (CAMHS) to support children and young people with mental health illnesses. Staff from CAMHS attended the wards to work with patients and a CAMHS psychiatrist was due to be based from Rainforest ward the week following our inspection.

Staff within the neonatal unit worked with a neonatal network external to the trust. Staff could access an infant feeding coordinator as required to support the neonatal band six nurses who were also trained to support breastfeeding mothers.

We saw meeting minutes which showed representation from the trust at the East Midlands neonatal operational delivery network in July 2021. The meeting minutes demonstrated evidence of local trusts aiming to develop a consistent approach to providing care and treatment.

The trust was a participant in the Midlands and East Transition Network and East Midlands Transition Regional Action Group.

The trust worked under the East Midlands Children's Cancer Network Group. Lincoln County Hospital formed part of a Paediatric Oncology Shared Care Unit (POSCU) and therefore provided inpatient supportive care (management of febrile & neutropenic child, blood products, clinical reviews) on Rainforest Ward, but not Systemic Anti-Cancer Treatment (SACT). Patients attended one of two specialist NHS trusts (a principal treatment centre) in the East Midlands to receive SACT. By being part of a POSCU, patients could receive a proportion of their cancer care at a hospital nearer to their home address.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff could access the trust mental health team to provide assessment and support if the CAMHS team was not available, or a patient was exhibiting new and acute symptoms.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

# Services for children and young people

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Consultants were always available on site between 9am and 5pm. Consultants were sometimes available between 5pm and 9pm.

The paediatric wards had two ward rounds daily. Facing the Future Audit results (2020) showed that 100% of 9am ward rounds were led by a consultant and 66% of 5pm ward rounds were led by a consultant. The expected standard is 100% of ward rounds are consultant led.

Medical cover for Safari ward was by way of medical registrar Monday to Friday 8am to 5pm. Service was then covered by a medical registrar from Rainforest Ward. During peak times, the NICU registrar could be asked to support other areas.

The neonatal unit had daily consultant led ward-rounds in which parents/guardians were encouraged to attend.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Consultants provide an on-call service out of hours with a thirty-minute response time.

Mental health support was available 24 hours a day.

The play leaders worked flexible shifts to support a wider range of hours including weekends.

### Health promotion

**Staff gave children, young people and their families practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards. The parents' room had information about common conditions and what action could be taken to improve outcomes or seek additional support and information.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff mostly supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff were aware of Gillick competence principles and could describe scenarios in which this would be used. Gillick competency enables children under the age of 16 to consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

Staff mostly made sure children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records. We spoke with two parents whose children were undergoing general anaesthetic. Both described the information provided by clinicians including risks and benefits of treatment. One parent was able to describe the alternative treatments available and the risks and benefits of them. Both parents felt sufficiently informed of the treatment and felt they had been allowed sufficient time to reach their decision.

Records showed written consent was obtained on three occasions for surgical procedures. These included risks and benefits, type of treatment and signatures and details of relevant clinician. Signatures were obtained from a person with parental responsibility.

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.

Nursing staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data from the trust showed as of October 2021, compliance with this training was 76% against a trust target of 90%.

Medical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data from the trust showed as of October 2021, compliance with this training was 64.7% against a trust target of 90%

## Is the service caring?

**Good** 

### Compassionate care

**Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. However, on Rainforest and Safari ward, staff had to have difficult conversations in either a manager's office or the parents room due to a lack of appropriate facilities.

Children, young people and their families said staff treated them well and with kindness. Managers displayed compliments from previous patients in staff areas. Themes included caring staff.

Patients told us nurses had been very kind to them. One patient told us the doctor they saw was very funny, and they liked the doctor's humour.

Play leaders were based on both Rainforest and Safari ward; and could attend other areas to provide compassionate support to patients. We observed playworkers interacting with children and young people and saw they were kind, caring and took account of patients' individual needs.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. All staff we spoke with demonstrated a non-judgemental approach to working with children with mental health conditions. Staff were familiar with the different types of behaviour children with mental health or neurological conditions may present with and were open to working effectively with parents or carers.

# Services for children and young people

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. The chaplaincy service at Lincoln County attended the ward on request from children, parents or carers.

### Emotional support

**Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.**

Staff gave children, young people and their families help, emotional support and advice when they needed it. We observed nurses, health care assistants, nursery nurses and play leaders answer questions and provide emotional support.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Play leaders actively worked with patients who were distressed. Staff had a good understanding and knowledge of patients who found certain procedures or care aspects distressing and requested the play leaders' support in advance; such as when a patient was due for a blood test. The play leaders had a good understanding of a range of distraction techniques; and were trained in specific neurological conditions such as autism awareness.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. Staff demonstrated empathy and kindness towards patients and their family.

### Understanding and involvement of patients and those close to them

**Staff mostly supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**

Parents and carers gave mixed feedback about the service. Some parents gave good feedback and almost all parents highlighted that nurses had been very caring throughout their child's visit.

Parents or carers we asked praised support staff including catering and domestic team members and felt they provided a good service.

Three parents told us they had to escalate their concerns in order to get a second parent/ carer to come in to support them whilst they supported their child. The two parents told us staff did not initially permit a second person despite the parent stating they needed the support as staff were adhering rigidly to Covid-19 visiting rules. One parent escalated to the Patient Advice and Liaison Service (PALS) and a second parent had to make numerous complaints on the ward to facilitate this.

One parent said that staff did not always come and introduce themselves as their named nurse at the start of shifts and stated they did not like to use the call bell as a nursery nurse or health care assistant answered rather than a nurse. Other parents and carers said staff introduced themselves when they entered the room or cubicle.

One parent told us they felt the doctors in particular had not provided a good service and felt diagnosis and treatment had been delayed at the hospital. They told us they did not feel their child was safe whilst at the hospital and were keen to leave.

# Services for children and young people

Managers undertook a monthly patient experience audit to understand patient experience. For August and July 2021, across Rainforest and Safari ward we saw positive reports which demonstrated staff were kind to patients and families, staff introduced themselves and staff gave enough information to patients and families.

Staff mostly made sure children, young people and their families understood their care and treatment. As in 'Effective', not all parents were consistently given information about their child in a format they could understand; such as via an interpreter. However, the majority of patients and parents or carers told us they understood the information provided to them including any instructions about caring for the patient.

Older children told us staff, including nurses and doctors, spoke directly to them rather than to their parent or carer.

We saw a positive example of a doctor updating a parent on the neonatal unit about their baby's care and treatment plans. However, the baby's mother was still in the maternity ward after giving birth and therefore wasn't able to listen to this. The doctor recognised this and took the parent in neonates to the maternity ward so both parents had the opportunity to listen to the plan and ask questions at the same time.

Staff mostly talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff could access picture cards to support communication.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw signs displayed throughout Rainforest ward asking for feedback. Where parents or carers had raised concerns or asked questions, we found staff listened to these.

## Is the service responsive?

**Good** ↑

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. Staff also worked with others in the wider system and local organisations to plan care. However, the facilities were not always suitable to provide a responsive service.**

Managers planned and organised services, so they met the changing needs of the local population. Senior leaders worked across various clinical networks to identify changing requirements of patients in order to provide an appropriate service. An example of this was the recent change of providing care to new-borns from 27 weeks' gestation, including intensive care from a previous stance of care from 28 weeks.

Staff from the community-based child and adolescent mental health service (CAMHS) attended the ward to support patients with a mental health diagnosis, or who were known to the service.

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.

Facilities and premises were not always appropriate for the services being delivered. The service did not have all facilities to easily support patients, parents and carers. For example, there was not a quiet room for breaking bad news for parents or having private discussions. Instead an office space was used which may not have presented the right tone when having difficult conversations.

Staff told us, and we saw, that storage space was limited in all areas.

We saw in waiting areas, a range of chair sizes to fit children of all ages were available. However, bariatric seating for parents or carers was not available in these areas, or in the parent rooms. Parents/carers had access to a chair which converted to a bed in all cubicles on the ward which was suitable for larger individuals. Some parents with young children chose to sleep in their child's bed and use a cot for the child to sleep in. Parents and carers on the ward did not have access to separate overnight facilities such as a 'flat'. However, patients had shorter lengths of stay on average at this hospital.

On the neonatal unit, there were three residential rooms for parents who were likely to be staying for extended periods or who were out of area.

Parents' rooms were available for use. These were recently re-opened and had social distancing guidance in place.

Some parents told us the signal to use their phone or the internet was poor, particularly on Rainforest ward. This made it difficult to communicate with family outside the hospital.

Some parents told us they did not receive any food provision when staying with their child on the ward. However, other parents had received meals, and we saw these being offered during our inspection. All parents/ carers were offered hot and cold drinks.

Some parents staying with their child were reluctant to leave their child to go to the toilet, use the parents' room or to purchase food from the hospital vending machines, or kiosk. These parents stated they would have liked nurses to stay with their child whilst they left the ward. Whilst nurses, nursery nurses and health care assistants did support where possible, they were not always able to do this as staff were often busy with clinical duties.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Managers were compiling a transition policy at the time of our inspection to create a more structured process. The trust had made an application to a charitable organisation to fund a specialist transition nurse in 2020. This was not successful; however, the charity offered other support to the post holder once in place. At the time of inspection, plans to recruit for and internally fund this role had been agreed and were being progressed. Consultant paediatrician and adult transition leads were in place at the time of inspection.

Young people who were not known to paediatric services who required medical care and treatment were located on adult wards from 16 years old. For general medical care, the children and young people's managers were not informed unless there was a specific need for input.

# Services for children and young people

When young people required specialised care outside of the children's' service such as maternity or termination of pregnancy; information was shared with the children and young people's team so support could be offered.

Patients had access to specific treatment pathways to ensure specialist support and treatment was provided.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Staff knew the procedures if a child and their parent or carer did not attend an outpatient appointment. It was the medical staff responsibility to note this and to contact the person with parental responsibility.

### Meeting people's individual needs

**The service was, in the main, inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.**

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff on the neonatal unit were able to signpost to post-natal mental health support. Staff had links with external support charities who provide emotional and financial support. There was a parent/guardian facilitated support network in place.

Wards were designed to meet the needs of children, young people and their families. Wards were decorated in child friendly ways for example with pictures on the walls. Privacy curtains were decorative and colourful to appeal to children and be less clinical. Staff wore colourful badges and lanyards. The neonatal unit had been re-furbished however we observed the other ward areas and the outpatient clinic had a more tired look. Managers told us they planned to re-decorate these areas in the future.

Staff placed a wipe clean colourful mat at each bedside which contained written and pictorial information for both patients and parents/ carers. This included information about where to buy food in the hospital, parking information and other practical advice.

All areas dedicated for children and young people had toys; however due to the Covid-19 pandemic the toys were being re-introduced into use. Outside of the pandemic, separate children's playrooms were available; these were just being prepared to be re-opened at the time of our inspection. As an alternative, play leaders and other staff brought toys to the children's' bedsides to ensure social distancing.

At the time of our inspection there was no sensory equipment readily available despite the unit providing regular services to children with autism, profound disabilities and learning disabilities.

Older children could use games consoles or watch DVDs available on the wards. These were attached to mobile units which could be wheeled round to bedsides. All patient beds had a small television screen which showed terrestrial channels until early evening. After this point, parents or carers were required to pay to access the tv. Other electronic devices such as tablets were available for patients to use also.

A patient told us they liked the facilities available such as the choice of games and activities. They said the room they were allocated was good.

# Services for children and young people

Child friendly waiting rooms in the children and young people's outpatient clinic (clinic five) and in the orthopaedic outpatient clinic (clinic 11) were ordinarily available; again, due to the pandemic, the waiting area in clinic 11 had been changed into general waiting areas which meant children were not separated from adults whilst waiting. In clinic five, the waiting area was open, and children were free to use the toys which staff regularly cleaned.

The diagnostic department where X-Rays were taken did not have any particular facilities for children such as a separate waiting area.

Staff used transition plans to support young people moving on to adult services. If patients were known to the children and young people's service; staff designed transition plans to support young people moving to adult services. Where appropriate, young people stayed under the care of their paediatrician over the age of 18 to support their ongoing care and treatment.

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.

Staff described following individual community care plans in order to support patients with learning disabilities. They highlighted the patients' specific care needs and preferences. Staff could access the local community learning disabilities team if they required additional support or guidance to meet patient's individual needs.

Play leaders provided support for all children on the wards and in outpatients. They particularly focused on patients who had additional needs as requested by nursing staff to support and/ or distract patients from unpleasant procedures or aspects of care. The play leaders were proactive and knowledgeable about how to support the needs of individual patients. They took time to get to know patients and work with them in ways which suited the patient best. For some patients, the play leaders provided age appropriate toys and supported play, for other patients the play leaders supported with homework or communication skills.

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.

Managers did not always make sure staff, children, young people and their families could get help from interpreters including British Sign Language interpreters when needed. All staff we spoke with knew how to access interpreters as per the trust policy. However, we found three occasions where interpreters were not used.

Staff were not always quick to respond to requests for them to use a transparent visor rather than a mask when communicating with parents who used lip-reading to understand spoken words.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Managers showed us pictorial aids to help with communication.

# Services for children and young people

Most inpatients had a short length of stay on the ward. Where school aged children attended for longer periods of time, staff organised education support from a local school. Electronic devices were available for children to access remote learning. If children were taking exams, staff provided private office space for this purpose.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.**

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The average length of stay for patients on Rainforest Ward, the inpatient paediatric ward, was 1.5 days from July to September 2021. This was based on 833 patients attending in this time period. The maximum length of stay was 56 days in August 2021.

Outpatient clinic 11, which was an orthopaedic clinic, saw both children and adults. However, paediatric clinics were run on mostly on Wednesdays to enable children to wait with patients of a similar age, rather than amongst adults.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The service management team identified referral to treatment times for children and young people as a risk to the service; with this not improving as quickly as was anticipated post Covid-19 pandemic. Plans including running additional clinics using a locum consultant were in place to mitigate this.

Managers monitored waiting times and made sure children, young people and their families could access emergency services when needed and received treatment within agreed timeframes and national targets. A pathway had been developed for patients attending the emergency department due to self-harm or suicide ideation or injuries in line with the children's' ward.

Managers had developed or were in the process of developing pathways with partner organisations to improve access to care. For example, oncology patients had open access to receive care or treatment for any medical concerns. An eating disorders bypass pathway had been set up for patients who had a referral from their GP or another hospital.

From June to September 2021, 14 and young people under 16 years old were placed on adult wards/areas. Eight of these were for planned treatments, and six were for emergency care.

Managers monitored that children and young people's moves between wards/services were kept to a minimum. However, when patients were admitted to Safari ward later in the evening, for example from ED, the patient could be moved again to Rainforest ward if medical staff decided an overnight stay was required. This meant an additional move for the patient. The service moved children and young people only when there was a clear medical reason or in their best interest.

Staff did not move children and young people between wards at night. Safari ward shut at 10pm; all inpatients were located on Rainforest ward overnight.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was commenced on admission and in conjunction with parents or carers.

# Services for children and young people

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Managers liaised closely with community mental health teams and social services to ensure children and young people were discharged safely. If a child or young person did not have a safe home to go to due to social care concerns, managers ensured the patient stayed as an inpatient until appropriate care was arranged.

Staff supported children, young people and their families when they were referred or transferred between services. Where a very sick child was transferred, a specialist transfer team was utilised to retrieve and transfer the child. Managers monitored patient transfers and followed national standards. From October 2020 to September 2021, 72 children and young people were transferred to other providers. One patient was transferred to a specialist psychiatric unit; 71 were transferred to an alternative acute NHS provider.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.**

Children, young people and their families knew how to complain or raise concerns. Parents and carers we spoke with gave examples of when they had raised concerns or queries.

The service clearly displayed information about how to raise a concern in patient areas. There were details of how patients and visitors could raise concerns or communicate how they found the service on Rainforest ward and also in public areas around the hospital. We found a lack of displayed information for patients or patients/carers on Safari ward about how to make a complaint.

Managers investigated complaints and identified themes. Staff could view governance boards located in managers' offices which highlighted complaint themes and trends. Managers also shared learning through divisional meetings, quarterly staff bulletins and emails. Managers shared feedback from complaints with staff and learning was used to improve the service. Data from the trust showed staff from the neonatal unit had created a colourful 'you said, we did' board to show families and carers what changes had been made following feedback.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients or parents' carers views whilst on the ward via an electronic device.

Staff could give examples of how they used patient feedback to improve daily practice. Following patient and parent/carer feedback, staff produced a mat at each bedside which contained written and pictorial information for both patients and parents/carers.

## Is the service well-led?

**Good** ↑

# Services for children and young people

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The family health division had a leadership team that oversaw the children and young people's service among other clinical areas such as maternity and gynaecology. Divisional leaders told us they worked well with each other and understood the challenges they all faced around quality and sustainability of services, including staffing issues.

Local leadership was provided by matrons, ward managers and department managers. Staff spoke positively about their local leadership team and said they were visible and supportive. Matrons worked across both hospital sites; and were flexible to attend where needed daily. Ward managers said their matrons were in contact daily by phone.

Staff said local senior leaders were visible and would visit the ward and a duty manager was always available out of hours if they needed support and guidance.

At the time of our inspection, a band seven manager had just been appointed to run the children and young people outpatient services across the trust. Staff demonstrated positivity towards this and said they had been well supported by ward management prior to this new appointment.

Managers supported staff to develop by securing funding for internal and external courses, encouraging continued professional development, and by booking agency staff to enable permanent staff to be released for training.

Staff told us that the chief executive for the trust had shared information effectively during the Covid-19 pandemic enabling staff to be regularly updated.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.**

The trust had a trust wide strategy for 2020 to 2025. This included the paediatric service provision. A family health divisional strategy highlighted specific goals for the children and young people service.

Ward managers spoke of the service vision for the future which included refurbishing areas within the service and having sliding clear doors in bays to improve infection control, privacy and reduce noise for patients. Staff were aware of plans to refurbish the environment.

Local managers focused on local plans within the wider health economy to build appropriate pathways for children and young people. Managers worked with local stakeholders across the regional area to ensure services offered were appropriate and sustainable.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

# Services for children and young people

Staff we spoke with said they enjoyed working on the ward and felt they were part of a good team. They told us they were supported to speak up and rise concerns without fear of reprisals.

Staff at all levels told us they felt supported by managers. Staff told us they felt able to support patients and focus on patients' needs.

During the pandemic, staff told us they had been asked to work in other clinical areas at times. Generally, staff told us this worked effectively; and felt they were sent to areas that suited their clinical background and competence. Staff said on occasions they had been sent to areas where they felt less confident, or felt they were expected to lead the clinical provision, such as the emergency department. Staff told us they felt confident to challenge this; and that managers supported them to address this when it happened.

Managers told us of changes to culture following staff feedback where staff reported they did not always feel appreciated. Changes included sending personal emails to say, 'thank you', rather than sending more general messages.

Managers and staff were given the opportunity to complete mental health first aid training to support patients and colleagues.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

Children and young people services sat within the family health division. Managers including directorate leadership met across a variety of governance meetings to ensure information was escalated and cascaded to all staff as necessary for both the children's' wards and the neonatal unit. These were trust wide meetings and therefore included representatives across sites including Lincoln County Hospital and Pilgrim Hospital in Boston. Divisional leads had good links to the executive team enabling them to escalate information in a timely manner. A divisional executive report was produces to share information with the board as necessary.

Divisional level meetings were held monthly which incorporated other services such as maternity in addition to children and young people.

Paediatric, community paediatric and neonate unit governance meetings were held monthly. Directorate level business managers attended all three of these meetings as did the directorate pharmacist to ensure continuity.

Consultants held regular meetings to discuss performance, clinical pathway planning and staffing.

Local team meetings were held; however, these had been significantly reduced over the Covid19 pandemic. Staff told us there had been one meeting held via videoconferencing within the past six months. However, wider staff members could attend governance meetings to hear updates.

We reviewed a sample of meeting minutes across May, June, July, August and September 2021 and saw these were well attended. Regular agenda items included risks, incidents, serious incidents, complaints, staffing concerns, service improvements and other ongoing concerns.

Managers invited all staff to a monthly governance meeting. Other regular attendees included the pharmacist who oversaw the children's and young people service, the matron for the area, business managers, ward managers, clinical educators and medical staff. Where ward-based staff could not attend, any information or learning was cascaded down. For example, changes to the trust policy on fever in the under fives were shared via a PowerPoint presentation and an audit which was emailed to all staff. Where managers required confirmation that information had been read by the wider staff group, they requested confirmation via either email or a signature sheet.

Matrons and medical staff attended perinatal (during pregnancy and up to a year after giving birth) mortality and morbidity meetings and shared findings within governance meetings.

Safeguarding leads for the division demonstrated oversight of the children and young people service; they undertook record audits, delivered training and shared information to ensure all staff were aware of their responsibilities.

The service's performance was displayed in the ward. The latest information on Rainforest ward was for April 2021 and the matron for children's service told us more recent results had been received but still required displaying. This meant that staff and visitors to the ward might not get an accurate impression of the ward's latest performance and actions required to improve. We raised this with ward on staff who told us they would update the information.

The service had identified areas for improvement and action plans were in place to monitor progress. Performance information was shared with the senior leadership team by the Director of Nursing.

The matron and ward manager displayed a clinical governance board which was accessible to staff. This contained information about open incidents and themes, risks on the incident reporting system and on the service risk register, and complaints and compliment themes. This had been updated for October 2021 at the time of our visit. We saw incident themes included medicine errors; and risks included patients with mental health diagnoses and challenging behaviour, agency spend for nursing and medical staff and clinical holding (restraining children lawfully). Complaint themes included waiting times for admission. Learning following serious incidents was also displayed on the governance board.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, managers did not collect all data relating to some specific risks.**

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.

Managers identified nurse staffing and agency spend as a risk. Senior managers acknowledged that the staffing levels at the time of inspection did not meet national standards. Managers were recruiting on an ongoing basis to mitigate this and had plans to prioritise certain posts such as specialist nurses. Managers also supported the internal development of staff already employed to support staffing and retention.

# Services for children and young people

The service management team identified referral to treatment times for children and young people as a risk to the service; with this not improving as quickly as was anticipated post Covid-19 pandemic. Prior to the pandemic the division performed much better indicating the pandemic had negatively impacted upon the division's ability to deliver this target rather than the division generally underperforming. We saw this was a strategic objective for the division to enable all referred children and young people to be treated within the 18 week target. Plans to run additional clinics using a locum consultant were in place to mitigate this.

Lead clinicians and managers discussed performance and changes to criteria within governance meetings. For example, we saw within neonatal governance meetings; changes to admission criteria for babies were confirmed. The minutes clearly documented agreement with third party organisations to support this, additional staff training and support requirements and any potential clinical or financial risks.

Service management reviewed incidents to identify themes, share immediate learning and produce root cause analysis reports. This enabled a better oversight of areas of concern; such as medicines management. Matrons for the service told us of findings and actions from this process in order to reduce the number of incidents. We saw evidence of this within governance meeting minutes. The pharmacist with oversight for children and young people's services attended governance meetings.

Senior nurses and above received training on risk and incident management. Managers produced a quarterly 'learning to improve' bulletin which including learning from serious incidents, complaints and patient experiences. This had been produced since November 2020 and covered the family health division; therefore, staff had access to learning from incidents from other clinical areas.

Band seven nurses (ward manager and clinical educator level) held weekly huddles to share information and to discuss risk and incidents.

Staff raised concern about children being referred to Safari ward from the emergency department (ED) around 8.30pm when there would be no immediate medical cover due to doctors being at handover. They were also concerned with the patient pathway on the basis children would be moved to Safari and then again to Rainforest due to Safari closing at 22:00. In addition, ward staff also reported that because of the lack of experienced clinicians in ED, children occasionally were transferred from ED acutely unwell with little recognition of the severity of the child by ED staff.

We found not all children received medical reviews in line with The Royal College of Paediatrics and Child Health (RCPCH) guidance. The trust told us they did not routinely monitor or audit waiting times for children to have a medical review. This meant the trust did not have full oversight or assurance against this measure. However, we noted medical staff did audit this standard; last completed in 2020.

Although identified as a risk; the trust did not routinely capture the numbers of patients admitted under community and adolescent mental health care services (CAMHS). The matron had plans to start monitoring this data as part of a developing partnership with the local CAMHS. In addition, the trust provided an environmental ligature risk assessment however this was from October 2018 for both Rainforest and Safari wards. The audits stated these should be re-completed twice per year. Therefore, this audit was out of date and may not have reflected risk accurately.

Managers discussed the risk of respiratory syncytial virus (RSV) in terms of winter planning and covid-19 recovery during oversight meetings.

# Services for children and young people

### Information Management

**Patient records were not always secured. However. The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The service collected information and used this to analyse performance. This meant managers could easily see where improvements could be made and where the service was underperforming. Managers could review this data in comparison to other sites within the trust.

Performance information was shared and discussed at ward meetings so staff could identify any actions required to improve patient care.

Notifications were submitted to external organisations as required.

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 records on Safari ward.

Personalised staff training records and competency assessments were stored unlocked on the ward's corridor enabling people to view staff performance information.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Matrons completed monthly audits which included patient and staff experience.

Staff audits reviewed appraisal rates, sickness rates and staff health and wellbeing. Data from July and August 2021 showed good compliance against health and wellbeing across both paediatric wards. However, an individual measure of 'staff recognition' was identified as an area of improvement. The matron told us how they had made effort to improve this element.

One hundred and eighty-one staff from the children and young people service completed the 2020 NHS staff survey. The results showed staff from this area generally felt similar to the rest of the trust. Specific areas where this core service scored lower were feeling pressured to work when unwell and 'last experience of harassment/bullying/abuse reported'. However, staff reported positively compared to the rest of the trust in areas such as not experiencing harassment, bullying or abuse from managers, patients, families or carers.

The trust collated monthly data from staff within the family health division on areas such as appraisals, wellbeing conversations, non-mandatory training, team meetings, feeling positive about working for the trust and staff experience of bullying or harassment. This enabled managers to get a wider understanding of how staff were feeling each month; although we noted the response rate was small (13%) so may not have represented the whole core service.

# Services for children and young people

Data from the trust showed an August 2021 survey of the junior doctor induction to the service which showed attendees found the induction a helpful and positive process. However, it should be noted the results were from a small sample size. Patient experience included a safety, privacy and dignity audit. For August and July 2021, both wards achieved 100% across patient experience. However, results for safety, privacy and dignity were rated as underperforming. Specific issues identified included not having privacy and dignity signs on the ward.

The service engaged with patients through gathering feedback in a variety of ways. Staff could capture patients or parents' carers views whilst on the ward via an electronic device.

Managers reviewed patient, family and carer feedback to produce an assurance report which linked in with relevant risks to the service. Information was collated from 'Friends and Family Test' (FFT) results, NHS website reviews, social media reviews, cards sent in by family, and compliment and complaints sent in via the Patient Advice and Liaison Service (PALS) and complaints team.

The service liaised with external organisations to improve care and treatment for children and young people. Service representatives attended the East Midlands neonatal operational delivery network meetings. A matron had developed positive links with the community child and adolescent mental health service (CAMHS) to support patients more effectively. Some staff went into local organisations such as schools to promote services and to build trust in healthcare staff.

The service did not actively engage with the general public at the time of inspection.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**

The management team, including directorate leads acknowledged that a programme of continuous improvement was underway for the service trust wide in order to mitigate risks and improve patient pathways. They spoke openly of developing the service and presented as committed to raising the profile of the children and young people service within and outside of the trust.

The senior leadership team for the service shared innovative ways to improve recruitment. This included using the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant.

A nurse told us that emergency grab boxes had been introduced to the ward in response to findings at our last inspection. This reduced the need for staff to visit the emergency department for emergency medicine and equipment and therefore could respond quicker to the urgent needs of patients on the ward.

At the time of our inspection, medical staff told us no active research was ongoing. At this time, recovery from the Covid-19 pandemic was being implemented across core services which may have impacted upon the time, facilities and staff resources to structure and undertake new research.

The matron overseeing the paediatric wards across site had commenced a number of initiatives since being in post. These included engaging with a local university graphic design course to design and create unified branding and décor

for wards and the paediatric area within the Emergency Department. This was being rolled out at the time of our inspection and had not yet been implemented at Lincoln County Hospital. They had also developed, in conjunction with the local children and adolescent mental health service (CAMHS) pathways to support patients who presented with either diagnosed eating disorders or with disordered eating on Rainforest ward.

Staff within the children and young people service had opportunity to engage in continued professional development. We saw funding had been procured for autism training and advanced paediatric life support training (APLS). Some staff were being supported to gain formal university qualifications such as completing a paediatric nursing degree to develop their career.

# Urgent and emergency services

**Requires Improvement** 

## Is the service safe?

**Requires Improvement** 

### Mandatory training

**The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always ensure staff were up to date with it.**

Nursing staff did not always keep up-to-date with their mandatory training. The target for compliance was 90%. There were 23 mandatory training modules for staff in total; overall, the service achieved at least the target in four of the modules as of October 2021. Of the 19 modules where the target was not met, 9 modules were 75% or below, including basic paediatric life support (47%), mental capacity act (56%), safeguarding adults level three (67%) and safeguarding children level 3 (71%). However, staff had the knowledge required to ensure patients were safe.

Medical staff did not always receive or keep up-to-date with their mandatory training. The target for compliance was 90%. There were 23 mandatory training modules for staff in total; overall, the service achieved at least the target in none of the modules. All of these modules were below 75%. The modules included basic paediatric life support (21%), mental capacity act (26%), staff charter (29%) and safeguarding children level three (30%). However, staff had the knowledge required to ensure patients were safe.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed a mix of both face to face and online training; however, it was mostly online now due to COVID-19. Staff told us that the mandatory training met the needs of patients and staff.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs and dementia. The compliance rates for mental health awareness training were 46% for medical staff and 94% for nursing staff. The compliance rates for dementia awareness were 61% for medical staff and 96% for nursing staff. However, staff had the knowledge required to ensure patients were safe.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a system which would flag up a staff member who was overdue on a mandatory training module. When the service was stretched and it was difficult to complete training during the shift, staff were offered pay to complete training in their own time at home where they could access the system.

### Safeguarding

**Staff did not always have updated training on how to recognise and report abuse but they knew how to apply it. Staff did not always use systems to appropriately identify children who may be at risk. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

Nursing staff did not always receive training specific for their role on how to recognise and report abuse. The mandatory training figures for nursing staff for safeguarding training as of (insert date) were:

- Safeguarding Children level 1 – 81%.

- Safeguarding Children level 2 - 75%.
- Safeguarding Children level 3 – 71%.
- Safeguarding Adults level 1 – 81%.
- Safeguarding Adults level 2 - 75%.
- Safeguarding Adults level 3 – 67%.

Medical staff did not always receive training specific for their role on how to recognise and report abuse. The mandatory training figures for medical staff for safeguarding training were:

- Safeguarding Children level 1 - 45%.
- Safeguarding Children level 2 - 37%.
- Safeguarding Children level 3 - 30%.
- Safeguarding Adults level 1 - 42%.
- Safeguarding Adults level 2 - 33%.
- Safeguarding Adults level 3 - 33%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Policies for the protection of adults and children were in place. They supported staff to identify different types of abuse and provided guidance on the provider's policies and procedures. Guidance supported staff to report abuse to external organisations such as the local safeguarding authority who could take action to investigate concerns. There was reference to local and national guidance and the legal responsibilities for staff. We observed good safeguarding practice take place, which included staff contacting a care worker.

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.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to demonstrate how they would make a safeguarding referral. Staff knew how to contact the safeguarding team if they needed advice. The safeguarding team remained on site throughout the pandemic and continued to offer advice and support. Staff told us they had a positive relationship with the safeguarding team.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

All areas were clean and had suitable furnishings which were clean and well-maintained on inspection. On inspection, we saw all areas of the emergency department (ED) were clean. We saw staff continuously cleaning the departments throughout the visit. Staff cleaned rooms after use before a new patient would use them. Furnishings were clean and well maintained. The service generally performed well for cleanliness.

# Urgent and emergency services

The service did not always perform well for cleanliness and other areas in audits but made improvements where necessary. Monthly audits provided to us by the service following our inspection demonstrated the service did not always meet the expected infection, prevention and control standards. These audits included several areas which included hand hygiene, general environment, storage of equipment, and sharps safety. Data demonstrated from July 2021 to September 2021 monthly compliance averaged 84.58% in July, 86.83% on August and 88.2% in September 2021. When standards were lower than expected the service put actions in place, for example, when there were issues with the ceiling tiles one month which were reported in the audit they were reported to facilities and there were repaired or replaced by the next audit was undertaken.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning records over a three month period which showed all areas had been clean as per the cleaning schedule. We observed staff cleaning cubicles following patient transfer or discharge.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen following good hand hygiene practices and washed their hands when moving between patients, along with changing gloves. There was PPE and hand gel available at all entrances of the department and staff were observed changing masks and cleaning using the hand gel. There was appropriate signage in place indicating which PPE staff needed to wear before they entered a specific area or room, including rooms where aerosol generating procedures (AGPs) were taking place. The service had an appropriate room for donning and doffing PPE. We observed staff mostly using appropriate PPE during the inspection process.

Patients were routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. A rapid assessment intervention treatment (RAIT) consultant was located in the reception area from 8am to midnight daily to stream patients into the most appropriate areas based on risk of COVID-19

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment after use before a new patient would use them. Equipment mostly had 'I am clean' labels on when staff had cleaned it.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use equipment appropriately. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called. Patients could reach the call bells in all the rooms. Staff were responsive to call bells. Patients had an accessible call bell when needed.

The design of the environment did not always follow national guidance. However, improvements had been made in order to meet to meet more of the standards. The environment standards set out in the Royal College of Paediatrics and Child Health (RCPCH) guidance, 'Facing the Future: Standards for children in emergency care settings' (June 2018) were not always being followed in the children's area of the department. The service did not have sufficient child-friendly clinical cubicles or trolley spaces to meet the need of the paediatric population including at times of peak attendance. The area was not secure with free access via the waiting room and rear entrance of ED. There were plans in place for a new dedicated children's area to be built by 2022 which would meet the national standards. The service had security staff at the front door.

Staff carried out daily safety checks of specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis kits. All were checked as per the trust policy and included all relevant equipment.

The service had suitable facilities to meet the needs of patients' families. Staff had access to a family room in the department if it was needed.

The service mostly had enough suitable equipment to help them to safely care for patients. Whilst on inspection we noticed that there were several occasions where staff were searching for an electrocardiogram (ECG) machine in order to examine a patient in the assessment area. Whilst they eventually found one, the delay took up staff time and could have potentially put patients at risk. Two out of the departments' four ECG machines were currently being repaired by the clinical engineering department.

We observed equipment was accessible and processes were in place to report equipment if it was not working. Pressure relieving mattress toppers were readily available and we saw these were used for patients at risk of pressure tissue damage. Beds could be ordered for patients where a trolley was unsuitable.

Staff disposed of clinical waste safely. We saw waste segregation in place. PPE such as aprons and gloves were disposed of in clinical waste bins. Needle sharp bins in the department were not over full and the bins were dated and signed by a member of staff.

### Assessing and responding to patient risk

**Staff did not always complete risk assessments for each patient swiftly. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. When patients initially arrived at the hospital as walk in patients they were triaged using a nationally registered triage system by a navigator nurse who could refer patients the Urgent Treatment Centre (UTC), following on from this they would move to the accident and emergency waiting area where they would be assessed and observations and risk assessments would take place. This area would also be used as a 'fit to sit' area so patients could receive treatment in this room or wait here between assessments after triage. This only happened with patients who did not require constant monitoring or a bed.

When patients arrived by ambulance, they were seen by an ambulance nurse who took handover from the paramedics and the patient would move into the assessment area of the department, where observations and risk assessments took place. Following on from this, observations would take place at regular intervals and risk assessments would be updated if needed. Paediatric patients would also be triaged to the paediatric corridor.

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. The service had made significant improvements in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021, an average of 82.3 were triaged within 15 minutes of arrival. Systems had been implemented to increase triage capacity in terms of additional rooms and ability to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival.

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.

# Urgent and emergency services

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff carried out national early warning scores 2 (NEWS2) on adult patients, we saw these had been carried out in patients' records.

Staff carried Paediatric Observation Priority Scoring (POPS) system rather that the Paediatric Early Warning Scores (PEWS). There were plans to move to the use of PEWS, however, a date for this had not been confirmed. Children's ward based staff reported that because the department used POPS and they used PEWS on the ward, it was not always possible to ascertain the clinical condition of a child prior to their transfer to the ward.

Staff were not up-to-date with adults and children's basic life support resuscitation training. As of 28 October 2021, the service had the following mandatory training compliance rates;

- Paediatric basic life support (nursing staff) - 55% (trajectory 87% in 8 weeks).
- Paediatric immediate life support (nursing staff) – 43% (trajectory 100% in 8 weeks).
- European Paediatric Advanced Life Support (nursing staff) – 63% (trajectory 83% in 8 weeks).
- Advanced life support (medical staff) – 68%.
- Advanced trauma life support (medical staff) – 52%.
- European Paediatric Advanced Life Support (medical staff) – 50%.

Staff knew about and dealt with any specific risk issues. Staff had a good knowledge of sepsis. We observed good compliance with National Institute of Health and Care Excellence (NICE) on sepsis. In records we reviewed, staff undertook a review of the patients' sepsis status where necessary when the patients NEWS2 score was high enough. The staff used trackers which noted the patients who were at risk of sepsis or the patients who had diabetes which was located at the nurse's station. Staff had access to mattresses to help patients who were at risk of pressure ulcers. Staff used yellow socks to identify patients who were at higher risk of falls if it was identified that they were at high risk of falls in their falls risk assessment.

As of October 2021, Nursing staff were mostly up to date with sepsis training (91%), however, medical staff had poor training compliance (56%).

The service did not meet the Royal College of Medicine standard 'All emergency departments treating children should have at least one PEM trained consultant'. The service did have a lead consultant for paediatric medicine.

The service had 24-hour access to mental health liaison and specialist mental health support. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours that placed them or others at risk.

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.

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.

Shift changes and handovers included all necessary key information to keep patients safe. The service had both a nursing and medical handover between each of the shifts. We observed both a nursing and medical handover and they were well attended, and all the key information was shared. The handover included key messages that the senior staff wanted staff to focus on that week. Staff would then have a more detailed handover of each patients in their specific areas where they were working.

### Nurse staffing

**The service had some staffing vacancies. However, shifts were covered with bank and agency staff to ensure there were 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 always have enough nursing and support staff to keep patients safe. Managers told us the current staffing template did not meet the demand of the service. For example, the majors' stream was particularly challenged during our inspection. One Registered nurse (RN) and one health care assistant (HCA) was allocated to cover the cubicles and walk-in patients 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.

Skill mix was a challenge for managers due to the volume of new and junior RN's. For example, new nurses could not do triage training until they had been in post six months and some international nurses were still undertaking key competencies or were still supernumerary.

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.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance as best as they could with the staff they had. Rotas were completed and reviewed regularly by a senior staff member and there was always assurance staffing levels met

national guidance. Leaders did a staffing forecast for the week ahead every Friday to ensure that they had the right establishment the following week. The senior sisters worked across sites to ensure they had the appropriate skills required at each department; this included paediatric specialist staff, paediatric trained staff and a suitable ambulance nurse. Staff would swap across sites if it was needed.

The department manager could adjust staffing levels daily according to the needs of patients. Leaders could contact the management team and other areas of the hospital or other sites if additional staff were needed. Staff could also move between different areas of the department if certain areas required additional staff. The service also made use of bank and agency staff when they were needed.

The number of nurses and healthcare assistants matched the planned numbers. On the day of our inspection, the number of registered nurses met the planned level, but the service had one less healthcare assistant. The senior sister and band seven nurses were included in the staffing numbers and working clinically to support the gaps in staffing levels to ensure all areas were covered.

The service had significant increased vacancy rates. Data provided to us by the service following the inspection demonstrated a significant increase with registered nurse vacancy rate. In April 2021 the vacancy rate was 7% which had increased to 32% in September 2021. The service was planned to meet its staffing establishment by September 2021 but due to issues with visas the service's recruitment plans were no longer on track. The adverts for nursing staff were continuing at the time of the inspection.

The service had increasing turnover rates. Data provided by the trust demonstrated in April 2021 the turnover rate was 17% and had increased to 23% by September 2021.

The service had changeable sickness rates. From April 2021 to September 2021, the average vacancy rate was 8%. The rate was higher for non-registered nursing staff which averaged 12% over the same time period.

The service had high rates of bank and agency nurses. Managers could not limit their use of bank and agency staff but requested staff familiar with the service. Staff needed to use high levels of agency staff in order to ensure safer staffing levels across the departments due to high vacancy levels. Staff used regular agency staff and at the time of inspection had block booked agency staff members. Managers made sure all bank and agency staff had a full induction and understood the service**.** Regular agency staff had access to the same systems as full time staff members.

### Medical staffing

**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 to keep patients safe. Recruitment of middle grade doctors had been a challenge; however, most positions had been recruited to at the time of the inspection and awaiting start dates. Where there were shortages and demand was high, consultants would do shifts in more junior positions.

The service did have a full establishment of consultants at the time of inspection. Consultants cover was provided Monday to Friday 8am to midnight. On call cover was provided at all other times. At times of peak demand, consultants would work extended hours.

# Urgent and emergency services

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.

The medical staff did not always match the planned number. There were gaps in the medical rota that the service was unable to fill. For example, during September 2021 there were 14 unfilled medical shifts across middle and junior grades. Medical staff told us they managed the service as safely as possible with the resources available. Medical leaders said they reviewed staffing to ensure it was 'adequate', and as safe as possible.

The service had reducing vacancy rates for medical staff. Data provided to us by the service following the inspection demonstrated a reduction in with medical vacancy rates. In April 2021 the vacancy rate was 27% which had decreased to 19% in September 2021.

The service had consistent turnover rates for career grade medical staff. Data provided to us by the service following the inspection demonstrated significant consistent turnover rates. Between April and September 2021, the turnover rate range was between 40% and 44%. There was 0% consultant turnover rate during this time, the turnover rate between all other medical grades varied between 67% and 80%.

Sickness rates for medical staff were low, however they were increasing. Data provided to us by the service following the inspection demonstrated increased but low sickness rates. In April 2021 the sickness rate was 1% which had increased to 4% in September 2021. The sickness rates had been lower and higher during this time period.

The service had continuously high rates of bank and locum staff. For example, in September 2021 there were 57 locum shifts on the junior and middle grade rota.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Locum staff we spoke with said they had a full induction with the trust and most locum staff we spoke with were regular staff members. We saw a locum doctor reading the induction paperwork for the trust before he started his shift following on from the medical handover.

The service reviewed its skill mix of medical staff on each shift. Staffing levels were discussed at handovers and medical staff were assigned areas to work based on skill mix. had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

### Records

**Records were not always stored securely. Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.**

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.

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.

Records were not always stored securely. For example, on the children's corridor, records were left unattended in the corridor which meant they could be potentially be accessed by unauthorised people.

Records were not bound together which meant there was a risk of information being misplaced. records trays were not always clearly numbered, therefore a risk the wrong patient records could go in the wrong tray.

### Medicines

**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.**

Staff did not always follow systems and processes when safely storing medicines. We observed that the medicine room door was consistently left open throughout the inspection. We reported this to the senior sister who told us she was aware of the issue and attempted to remind staff regularly to close the door. This meant unauthorised people could potentially access the medicines' room. A sign had been put on the door to remind staff that it needed closing.

Fridge and room temperatures were monitored and when the temperature was out of range it was always reported to estates.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines administration records were maintained to show medicines that had been prescribed had administered. On medicine charts we reviewed, we found allergies were recorded in all records. Medicines were administered on times indicated and antibiotics were administered in a timely fashion when indicated.

Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. We saw pharmacy team audits of controlled drug logs were regularly recorded.

Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine

We saw information about medicines administered went with the patient to ward when they were admitted from ED.

Staff reviewed patients' medicines regularly. Medical staff recorded medicines already prescribed and when last taken on the casualty card. Any medicines administered by ambulance crew were also recorded and time administered.

Staff followed current national practice to check patients had the correct medicines. We observed staff checking patients details before administering medicines.

# Urgent and emergency services

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a chemical restraint policy and procedure in place. Decision making procedures were in place to aid staff to use least restrictive measures first. A rapid tranquilisation and chemical restraint checklist was in place. Medical staff we spoke to understood the procedures. Matron audits from April 2021 to August 2021 demonstrated 100% compliance with policy where patients were administered chemical sedation.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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.**

Staff knew what incidents to report and how to report them. Throughout the inspection, managers and ED staff were able to demonstrate they knew what types of incidents to report and how to do so. Staff across the whole service knew who to escalate incidents to and all staff had access to the incident reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff reported serious incidents clearly and in line with trust policy.

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 always applied in line with trust policy. For example:

- Incident one – occurred and reported on 29 June 2021, and duty of candour applied on 16 September 2021.
- Incident two – occurred on 10 April 2021, reported on 10 June 2021 and duty of candour applied on 27 July 2021.
- Incident three – occurred 21 May 2021, reported 4 June 2021 and duty of candour was applied on 25 August 2021.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff notice boards contained information and learning relating to serious incidents which had occurred within the department and elsewhere. Staff told us they received feedback from incidents they reported. Staff could describe learning from historical and recent incidents which occurred at the service and other areas within the trust. For example, we observed learning was shared across sites following an incident resulting in a missed diagnosis of aortic dissection (a serious condition in which a tear occurs in the inner layer of the body's main artery). Managers debriefed and supported staff after any serious incident.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at monthly governance meetings and shared with staff at medical and nursing handovers. A newsletter was produced monthly where learning from incidents including serious incidents were shared with staff. Managers and staff told us they used social media platforms to communicate learning with staff to ensure learning was widely disseminated and consistently shared. Mortality and morbidity meetings took place bi-monthly where reviews of patient's care and treatment were undertaken, reviewed and learning shared. Feedback following medical examiner reviews was shared with staff at local governance meetings. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

# Urgent and emergency services

Managers completed a root cause analysis (RCA) to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCA's completed by the service. They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process. There had been lots of progress with regards to incident investigation and learning since the last inspection and much of the backlog had been cleared. Managers told us that high and moderate harm incidents were investigated in a timely manner and that progress had been made with low and no harm incidents.

Staff were supported by the risk team to investigate incidents and told us they had a positive relationship with them.

Staff undertook retrospective harm reviews for all patients who waited two hours or more on the back on ambulances before being admitted into the department.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Staff showed evidence of learning from serious incidents and there were changes seen in the department. Leaders had ensured the protocols were appropriate and made staff aware of them. They also made changes to practice and introduced additional training for staff where necessary. The service also increased access to specialised teams following incidents when it was needed. Staff then audited practice to ensure it remained up to standard. Managers debriefed and supported staff after any serious incident.

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere.

## Is the service effective?

**Requires Improvement** 

### Evidence-based care and treatment

**Clinical pathways and policies were not always updated in line with national guidance. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.**

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We observed staff following best practice guidance when following up patients with potential sepsis. Nurses carried out triage assessments in an appropriate way and had completed training in competencies. This ensured they worked to evidence-based, national guidance. We observed this in practice and nurses demonstrated adherence to their system including documentation of allergies, medical history and current condition and vital signs. However, policies were not always up to date. There were occasions where the most up to date guidance wasn't followed, 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.

The standard operating procedure and flowchart for identification of patients presenting with potential sepsis for adults had be revised following our previous inspection.

The service had a programme of monthly quality audits to assess compliance against best practice. For example, sepsis, pain management and diabetes care. Matrons completed monthly quality audits which included reviewing records,

speaking to patients and observations. This was put into a report and triangulated with daily department assurance reports to discuss with local managers to set actions to improve through monthly confirm and challenge meetings. Two hourly nurses in charge checks were completed to assess compliance with documentation throughout the shift. Issues were addressed at the time with staff and were required support from practice facilitators put in place to support learning.

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.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs**.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed patients receiving food regularly at mealtimes, as well as food and drink being provided when requested. Staff had introduced hot meal rounds three times a day for patients who were spending longer in the department in order to provide them with better nutrition.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to fluid and hydration charts in the departments and used them where necessary.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff knew how to make referrals to therapists if they were needed. These would mostly be utilised once patients moved to another area of the hospital.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff assessing patients' pain at regular intervals and saw evidence of this in patients' records. Staff used recognised pain scores throughout the patients stay in the emergency department.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed patients getting pain relief when it was requested.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this in the patient records we observed.

### Patient outcomes

**Staff monitored the effectiveness and quality of care and treatment. Outcomes from national audits were not always positive and data supplied for some national audits was incomplete. Outcomes from national audits was not always used to make improvements.**

The service participated in relevant national clinical audits. This included the Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Vital signs in adults 2018/2019.
- RCEM Audit: Feverish child 2018/2019.
- RCEM Audit: VTE in lower limb immobilisation 2018/2019.
- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Some of the data submitted to national audits was incomplete.

The service participated in the Trauma Audit and Research Network (TARN) audit. The most recent data was published for two TARN audit measures found:

- The crude median time from arrival to CT scan of the head for patients with traumatic brain injury from January 2018 – May 2021 was 54 minutes. This takes much longer than the TARN aggregate which is 33 minutes but it met an audit standard of 60 minutes.
- The risk-adjusted in-hospital survival rate following injury out of every 100 patients, from January to May 2021 was as expected with 2.6 additional survivors.

Managers and staff did not use results from national clinical audits to improve patients' outcomes. Not all managers knew what national audits the service participated in. We did not see evidence there was regular review of national audit outcomes or actions to improve.

Managers and staff carried out a programme of local audits to check improvement over time. Regular local quality audits were undertaken, and the results were fed back into the trust’s internal quality assurance systems. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Systems were in place to check and monitor performance against standards daily through nurse in charge audits and monthly assurance audits.

Managers shared and made sure staff understood information from quality audits but not national patient outcome audits. Audit results were shared with managers who provided feedback to staff in newsletters and daily huddles. However, we did not see evidence outcomes from national audits was shared with staff.

The service had a lower than expected risk of re-attendance than the England average. Between March and September 2021, the average re-attendance rate was 0.08%.

# Urgent and emergency services

### Competent staff

**The service had a plan in place to make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept an up to date record of staff competencies they had received training and sign off for. A plan was in place to train and assess staff skills in all areas. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses were junior, new to the service or were international nurses who had recently joined the services' training programme. This group of staff did not have all the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, 63% of registered nursing staff had completed training in how to effectively triage patients. The service was unable to book junior nurses on until they had undergone six months in post. There was a plan for this to be completed and two staff were booked on to training in December 2021.

All eligible registered nurses with skills to work in the paediatric area within the Emergency Department had completed level four paediatric competencies. All staff had to undergo a two-day training before being signed off as competent to work with children and young people. Managers told us staff had been trained and assessed as competent to triage and assess children and young people using POPS (Paediatric Observation Priority Score) and PEWS (Paediatric Early Warning Score) and undertake an initial assessment within 15 minutes of arrival to ED.

Junior doctors were provided with opportunities for skill development. For example, ultrasound training sessions were provided.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us and managers were able to demonstrate that all staff had a fully tailored induction for each role within the service. Agency staff also received an induction to the service. New starters received additional training on ED standards.

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, 92% medical staff had received an appraisal, however, only 56% of registered and non-registered nursing staff had received an appraisal.

The clinical educators supported the learning and development needs of staff. The service had clinical educators in place who supported staffs educational and development needs. At the time of the inspection, the service had recently employed several new overseas nursing staff members who were at various levels of competencies who the clinical educator was supporting appropriately.

Sepsis practitioners offered coaching and one to one support for staff in identification and management of sepsis. They supported the signing off of staff competencies and attended huddles to support staff knowledge.

Junior staff spoke highly of the support they had received from practice facilitators in supporting them to develop skills and undergo competency sign off.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, newly appointed band seven nurses had been booked on to leadership training to support them in the management aspect of their role.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular training which covered their learning needs. Weekly junior and middle grade doctors training sessions took place. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or through a monthly newsletter. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, band two healthcare assistants were given opportunities to provide extended skills such as completing electrocardiograms.

Managers identified poor staff performance promptly and supported staff to improve. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held meetings involving different members of staff where all the patients' needs were discussed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff at all levels and from all disciplines worked together to deliver person centred and coordinated care and support for the person with care needs. Patients in the department of the hospital had access to physio and occupational therapist support if it was required. Members of the frailty team who included occupational therapist and physiotherapy regularly visited the ward. Staff had timely access to speciality reviews.

Staff could call upon the children and young people services for advice and support and to review patients where required.

The service had developed good working relationships with the local ambulance service. We saw effective communication take place during our inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed staff referring patients for psychological assessments when they showed signs of mental ill health prior to discharge or if they presented with mental health conditions.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. There was suitable support from diagnostic services elsewhere in the hospital such as pathology, and radiology including Computerised Tomography (CT) to support the provision of care in the emergency department. Some imaging was available in the department including plain film x-ray and ultrasound. COVID-19 testing was undertaken in the department to improve the diagnosis and segregation of patients.

### Health Promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards/units.

### Consent, Mental Capacity Act and Deprivation of Liberty safeguards

**Staff did not keep up to date with Mental Capacity Act training. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**

Not all staff kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance data provided to us following the inspection showed that as of October 2021 26% of medical staff were up to date with this training. Compliance was 61% for nursing staff. This was well below the trust target of 95%. However, most staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some staff had clearly recorded they had sought consent from a patient before carrying out an intervention. Patients provided examples where staff had sought consent.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. A capacity flow chart was included in the casualty card. We saw this was completed where there were concerns about a patients capacity, however, this was not routinely completed for all patients.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could tell us what their responsibility was in relation to decision making requirements. Staff made referrals to mental health liaison services where required.

Whilst on the inspection we reviewed any ReSPECT forms that patients had in place. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. All the patients we reviewed came in with ReSPECT forms that were in place previously.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff and managers working in the paediatric area within the Emergency Department demonstrated a good understanding of consent processes for children and young people.

# Urgent and emergency services

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

## Is the service caring?

**Good**  

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients as much as possible and staff were responsive to patients needs and responded as quickly as they could.

Patients said staff treated them well and with kindness. All patients we spoke with told us staff treated them with kindness. Throughout the inspection we observed patients being treated with kindness.

Staff followed policy to keep patient care and treatment confidential. We observed staff making effort to maintain confidentiality when talking to patients throughout the inspection.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff providing emotional support and discussing patients' wellbeing in all areas of the department. Members of the chaplaincy team also visited patients in departments, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

# Urgent and emergency services

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff engage with relatives in an empathetic way, particularly when explaining to them that they were not allowed to remain in the department due to COVID-19 visitor restrictions. We also so saw staff use the relatives' room appropriately to break bad news to patients if it was needed.

### Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with generally reported they felt involved in their care and decisions and that staff were approachable and felt able to ask any questions they had.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to communication aids if they were needed and knew where to find them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were signs around the department which explained how patients and relatives could leave feedback.

Staff supported patients to make advanced decisions about their care. We saw staff made effort to contact and include family where advanced decisions had to be made. Staff told us they would discuss with patients if they were able.

Staff supported patients to make informed decisions about their care. Staff told us they provided patients with relevant information to make a decision.

The feedback from the Emergency Department 2020 survey was positive. The trust's emergency departments scored about the same as other trusts in 25 out of 38 questions and lower than others in 13 questions.

## Is the service responsive?

**Requires Improvement** ↑

### Service delivery to meet the needs of local people

**The service was mostly designed and managed in a way that always met the needs of local people and the communities it served. Managers and staff worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. The service had introduced strategies to ensure the patient went to the right place at the right time and to avoid unnecessary admissions. For example:

- An emergency physician in charge (EPIC) phone had been introduced which ambulance staff could have direct access to the EPIC to discuss whether a patient needed to come into the emergency department. Staff told us this positively impacted the number of patients being brought into hospital unnecessarily.
- An integrated streaming model was in place jointly with the urgent treatment centre (UTC) providers. The service had improved working relationships with the co-located UTC. Standard operating procedures were in place and managers met monthly to review how it was working in practice and discus cases which could have been seen by UTC rather than in emergency department (ED).
- The service had developed its same day emergency care (SDEC) model. The service promoted direct referrals to SDEC from GP and the ambulance service. Direct access to SDEC from 111 was introduced and an SDEC assessment tool had been implemented at triage to improve more effective signposting to SDEC from triage. Managers told is this model had positively impacted on flow. Managers acknowledged there was still work to do to further improve and increase its opening times to support out of hours.
- The trust had a frailty team which included medical staff and allied health professionals. The frailty visited the emergency department at least once a day in order to prevent hospital admissions, facilitate patient transfers or organise assessments in order improve the improve patient flow. This was consultant led.
- A pre-hospital practitioner (PHP) post had been introduced to oversee all ambulance conveyances to ensure their needs were being met and worked with the nurse in charge (NIC) and emergency physician in charge (EPIC) to ensure they were streamed to the most suitable area.
- A consultant was placed in the waiting area to support walk in flow, ensure patients were directed to the most suitable area and oversee the rapid assessment and treatment (RAT) stream.

Facilities and premises were mostly appropriate for the services being delivered. However they were limited by the environment which meant the paediatric area within the Emergency Department did not meet the required standards, although improvements had been made and plans were in place for a purpose built area to be built by 2022. This would also allow for extra assessment rooms using what was currently being used for the children's corridor.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. This was applicable to the integrated assessment unit.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, there was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required, and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead. The service utilised fit to sit areas where appropriate to take the pressure off majors' cubicles. Pathways were in place to ambulatory care.

### Meeting people's individual needs

**The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service did not allow visitors as a standard due to Covid-19, however if it was beneficial for a patient with additional needs they would allow one visitor. The service also allowed children to be accompanied by one adult. The safeguarding team had expanded to include specialist support for patients with learning disabilities, autism and dementia and they were accessible if needed. Staff have frequent attender pathways and there is a sign in patients notes to inform staff when patients are frequent attenders in the department. Staff had access to a mental health room if it was needed.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We did not see these were used during the inspection.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were aware of communication aids that could be used for patients who had communication difficulties. Staff told us they could access sign language support.

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.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Hot foods had been introduced for patients waiting for long periods in the department. Staff said they had access to other food types and were able to meet patient's individual preferences, staff did three food rounds during the day.

Staff did not have access to communication aids to help patients become partners in their care and treatment.

### Access and flow

**People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients fell below national standards.**

Whilst improvements had been made, patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. The service had made significant improvements in meeting national guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in the emergency department (ED). From April to September 2021, an average of 82.3 were triaged within 15 minutes of arrival. Systems had been implemented to increase triage capacity in terms of additional rooms and ability to move staff to triage at busier times. The pre-hospital practitioner (PHP) role had improved to ensure all ambulance conveyances were triaged on arrival.

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.

# Urgent and emergency services

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard. However, the service had consistently met its internal target of 50% to be seen within 60 minutes based on its medical staffing model. From March 2021 to September 2021, the average percentage of patients seen within 60 minutes was 51%. Performance had worsened slightly over this time as demand for the service had increased. The service had implemented systems to mitigate risks such as a consultant being placed in the waiting areas to reassess patients waiting more than 60 minutes.

Compliance with the RCEM guidance to see, treat, admit or discharge within a four-hour target was not always met. From February to August 2021, the trust's percentage of patients waiting over four hours from decision to admit to admission was among the worst three in the Midlands. In August 2021, 55% of patients waited between 4-12 hours to be admitted to a ward from the point of decision to admit. This was against a national average of 26%. Furthermore, in September 2021, 71 patients waited more than 12 hours in the emergency department from the decision to admit time.

Managers monitored waiting times. The emergency physician in charge (EPIC) and NIC undertook two hourly huddles where they reviewed all patients waiting and undertook assessments to ensure patients were offloaded from ambulances and moved to a safe area in the department according to acuity.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. The nurse in charge (NIC) completed an emergency department risk tool hourly which used information such as number of patients waiting at different part of the system, staffing levels and acuity to assign a risk level. There were clear escalation processes as a result of the risk rating which were reported into capacity meetings.

Patients details were added to electronic system which provided managers with oversight of the department. This was used when reviewing patients. A local ambulance service electronic board was visible in the department to show times crews arrived, inbound ambulances and expected arrival times so staff are aware.

The pre-hospital practitioner role was in place 24 hours to ensure rapid and safe handover of ambulance patients. Any ambulances that were not immediately offloaded were escalated to the department site manager.

A full capacity protocol was in place which was sensitive to departmental pressures as identified through the ED risk score. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status. We observed staff escalate appropriately.

Managers and staff worked to make sure patients did not stay longer than they needed to, however they were impacted by wider hospital and system issues. A fit to sit area was implemented so that patients who were likely to be discharged the same day could be then either discharged or transferred to ambulatory emergency care of SDEC.

The number of patients leaving the service before being seen for treatments was lower than the England and Midlands average. The service had a left with being seen rate of 5% between March and September 2021, the Midland average of 6% and England average of 6%.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed the frailty team attended the ED to assist with discharges. We observed consultants reviewing patients on ambulances with a plan to discharge where safe. There was a trust wide initiative to free up hospital beds earlier in the day and to

improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it. Daily bed meetings occurred three times a day to set actions for identifying and reviewing patients ready for discharge. Any blockages were addressed and where required senior management intervention.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff sought advice and support in discharging from the mental health liaison team. We observed a patient waiting for a mental health assessment prior to being discharged to ensure the discharge was planned appropriately to the patient's needs.

Staff did not always document their support of patients when they were referred or transferred between services. The service implemented a transfer checklist. This ensures all relevant information about the patient was shared with the incoming ward. In records we checked of recently transferred patients this documentation was only in place for two out of six patients which we saw was in place for six records we reviewed. We told the manager

Managers monitored patient transfers and followed national standards. Children and young people were transferred to other hospitals using recognised safety standards which staff understood.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff could describe the complaints process. Staff tried to resolve any issues at the time in the first instance and report it to the nurse in charge. Staff knew how to signpost to the trust complaints process.

The service clearly displayed information about how to raise a concern in patient areas. There was signage all over the department which advised patients on how to make a complaint or raise concerns if they needed to. Staff understood the policy on complaints and knew how to handle them. Staff within the service understood the complaints procedure and were able to give advice to patients on the process if they wished to make a formal complaint to the trust.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. At the time of the inspection, the service had eight open complaints, one of which was 17 days overdue. On average responses were sent to complainants within 44 days of receipt. This included a review by the complaints' manager, divisional and executive sign off. This is in line with the trust complaints' policy which states complaints will be responded to within 25 to 50 working days dependent on the complexity.

Managers shared feedback from complaints with staff and learning was used to improve the service. An action log was in place to keep track of learning actions and implementation dates. Learning and themes were shared through divisional governance meetings. Staff received feedback in daily huddles and in the departmental newsletters.

# Urgent and emergency services

Staff could give examples of how they used patient feedback to improve daily practice. For example, communication with patients and relatives was a common theme. The service had introduced regular patient comfort rounding which provided staff with an opportunity to update patients. The service had also recently introduced regular hot food service on the back of feedback for patients who experience long waits in the department.

## Is the service well-led?

**Requires Improvement** 

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Leaders had the skills and abilities to run the service. The urgent and emergency care (UEC) service sat in the medicine division and was led by a divisional clinical director, a divisional managing director and divisional nurse. However, at the time of the inspection the divisional nurse position was vacant, and recruitment was underway. Urgent and emergency care leadership consisted of a clinical lead, a general manager and deputy divisional nurse who covered all three sites across the trust.

At our last focused inspection, we found leaders did not have the skills and abilities and gaps in clinical leadership had not been addressed. We found improvements had been made following our last inspection. For example, we found:

- A divisional director had been recruited to oversee and lead the medicine and urgent care division.
- A clinical lead was in post with overall responsibility for UEC across the trust and there was a clinical director in post.
- The emergency physician in charge (EPIC) role had improved since our last inspection. Training in leadership had been provided to consultants undertaking the EPIC role which covered leadership, development of situational awareness, escalation processes, rapid handover protocol, full capacity protocol and short-term rescue protocol (STRAP). EPIC training sessions were held monthly.
- The service had recruited into band seven pre-hospital practitioner (PHP) posts. This improved management of flow in the department and oversight of safety of patients.
- The service had improved its joint working between the EPIC and Nurse in Charge (NIC) role. We observed greater team work along with operations teams and the PHP to improve flow and quality of care.

The service had strengthened local leadership by recruiting into band seven sister posts. Each band seven was assigned a lead role. For example, safeguarding, IPC, flow, sepsis and clinical education. Whilst the posts were recruited into, the post holders had not yet been able to complete the leadership elements of their role due to increased demand in the department, a junior workforce and requirement to work clinically. The matron and senior sister had an extended remit and worked clinically to enhance the safety of the department and support provision of leadership.

Staff in senior leadership positions had completed leadership training. For example, the matron and senior sister had completed Royal College of Nursing (RCN) leadership courses. New band seven nurses in post were intended to complete the RCN course and had completed leadership sessions internally.

# Urgent and emergency services

The Royal College of Paediatrics and Child Health recommends that every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. This was not in place at County hospital. Leaders told us there was a consultant who took a lead with paediatrics and there was always a consultant on duty with paediatric competencies. However, this did not meet the standards and we were not assured there was adequate leadership of the paediatric area within the Emergency Department at Lincoln County hospital.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address it. During our inspection, we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, medical staffing was a challenge. Leaders had a recruitment plan which meant all vacant post would be filled the beginning of 2022. Junior doctor training had opportunities for career escalation within the department. The service had a plan to sustain medical staffing by developing the certificate of eligibility for specialist registration (CESR) programme within the service. Furthermore, there were plans to apply for teaching status.

Leaders were visible and approachable. Staff told us the senior leadership team were visible. Senior managers including divisional directors and the deputy divisional nurse undertook regular walk rounds in the department. Managers told us they would support the day to day operation at times of peak demand.

The senior sister was visible and had a good relationship with staff.

Engagement workshops took place following our previous inspection with the aim of improving the working relationship between clinical, nursing and operational leads.

### Vision and Strategy

**The services overall vision included a specific vision at service level for what it wanted to achieve and a strategy to turn it into action. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The service did not have a specific urgent and emergency care vision and set of values. However, leaders told us they were aligned to the trust strategy. The trust vision was to provide excellent specialist care to the people of Lincolnshire and collaborate with local partners to prevent or reduce the need for people to be dependent upon services. The trust had five key values underpinning its strategy including: patient-centred care, compassion, respect, excellence and safety. During our inspection we saw examples of staff enacting these values.

The trust implemented a five-year integrated improvement plan started in 2020 aimed at delivering the trust strategic objectives. This included actions in relation to the emergency departments (ED) such as medical recruitment plans which had proved successful. Furthermore, there were workstreams that would impact ED such as becoming a university hospital, enhancing data and physical capacity, improving the environment, developing the workforce and well-led services. During our inspection we saw the impact of some of these including improving the environment and improved workforce planning.

The trust had a five-year clinical strategy and delivery plan started in 2019. In it contained a brief strategy for urgent and emergency care services to:

- ‘Maintain A&E /Emergency Department services at both Lincoln and Pilgrim Hospitals, and to add an Urgent Treatment Centre at both sites.

The service had recently had a new reception area built that acted as an initial triage area for both the ED and the urgent treatment centre. By 2022 there were plans in place to have more building work done that would create a new children’s paediatric area within the department and free up additional space by utilising the current space which is used for the children’s paediatric corridor.

The trust worked alongside health and care partners in Lincolnshire to ensure the clinical strategy was aligned with their strategic direction for the county wide health and care services. System delivery lead chairs an urgent and emergency care delivery board that the trust attended.

Staff could describe the trust vision and values; however, they were not able to tell us what they were.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt generally supported, respected and valued. Most clinical staff we spoke to spoke highly of the support they received from line managers and other leaders. Staff told us morale was low following the previous inspection, but this had significantly improved. Junior doctors spoke highly of the support and guidance they had received from consultants.

Staff generally felt positive and proud to work in the organisation. The culture encouraged openness and honesty at all levels. Most staff described how much the service had improved and one commented it was the best it had ever been for them as a place to work. Improved staffing levels and reintroduction of students was cited as reasons staff felt more positive.

The culture was centred on the needs and experience of people who use the service. Leaders completed regular walk rounds in the department to speak to patients about their experience. Matrons spoke to 10 patients as part of their assurance audits. Staff were supportive of service changes as they knew they benefited the patient. For example, the introduction of two hourly rounding was effectively implemented as staff knew this would make the service safer for patients.

Managers took action to address behaviour and performance consistent with the vision and values. During our inspection, managers acted swiftly to address feedback provided to them. For example, feedback was given to a staff member who had not completed an assessment. This was done at time and with a learning approach to positively support improvement. Managers told us they sought support from human resources for more formal management.

There was an emphasis on the safety and well-being off staff. Matrons included staff wellbeing checks in monthly assurance audits. Senior leaders provided staff with opportunities to feedback about how they are feeling. We saw staff breaks were encouraged and managers told us they monitored the number of additional shifts staff booked. The trust wellbeing team had attended the department to support wellbeing of staff. The matron had introduced coffee, cake and chat sessions for staff.

The service introduced schemes which supported staff wellbeing and staff felt leaders supported their wellbeing. Staff had access to a room if they needed a break or a drink if they were upset, this was known as the 'wobble room'. The trust opened a wellbeing hub at the hospital, however emergency department staff were unable to leave the department to attend. Due to this the wellbeing staff came and visited the department on a regular basis allowing staff within in the department the opportunity to attend. Staff told us that leaders were always checking in on staffs wellbeing and had an open door policy for staff to approach them with any issues.

There were co-operative, supportive and appreciative relationships amongst staff. Staff and teams worked collaboratively. Staff described improvements in the collaborative working between different roles. For example, there was a mutual appreciation of roles between medical and nursing staff and we observed good team working. Staff told us managers helped when the service was under pressure.

### Governance

**Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were generally clear. Local departmental speciality governance meetings were held as well as divisional business and clinical meetings. Clinical and business governance meetings were regular, well attended and covered a wide range of issues. For example, operational performance, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

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.

All levels of governance and management function effectively and interact with each other appropriately. Local governance meetings fed into a divisional cabinet meeting which had oversight of safety and quality of the service. A divisional score card with several metrics including finance, HR, people, quality, performance was in place. This was reported by divisional leaders to executives and trust board through performance review meetings and the quality and safety oversight group.

Staff at all levels were mostly clear about their roles and understood what they were accountable for, and to whom. Although it was recognised the service had introduced a new tier of band seven sisters that had not fully embedded at the time of the inspection due to pressures to work clinically.

Processes were in place to ensure relationships with partners were managed effectively. Standards operating procedures (SOPs) were in place with the local ambulance service and urgent treatment centre. These were reviewed

regularly. For example, there were routine and regular meetings with the local ambulance service as well as extraordinary meetings to address concerns of long ambulance waits. The service attended a monthly Lincolnshire providers UEC governance meeting. This was an opportunity to assess practice against the SOPs and raised and concerns to improve joint working. Minutes contained case discussions to explore the most appropriate place for patients to be treated.

The mental health liaison nurse attended departmental governance meetings.

### Management of risk, issues and performance

**Risks on the risk register were not always effectively managed and not all risks were identified and escalated to reduce their impact. Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.**

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.

Day to day identification and management of risk was done using the emergency department risk tool. Processes were in place to escalate and clear actions to be taken dependent on the level of risk. Safety issues were reviewed throughout the shift by a nurse in charge who completed an assurance checklist on each shift which covered staffing, communication of safety messages, an audit of patients, controlled drug checks, infection prevention and control checks, equipment checks and key performance indicator updates. This was regularly updated and used to address an issue with performance in real-time.

Monthly matron assurance audits were completed which provided an overview of quality, performance, staffing, patient experience and staff wellbeing. This along with departmental performance indicators was discussed with the deputy divisional nurse during confirm and challenge meetings and pulled together into a score card.

Performance in national audit outcomes were not effectively integrated into the governance structures to ensure management oversight. There was a lack of interaction between patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we saw limited evidence of consideration of patient outcomes and monitoring of improvements plans in governance meetings.

Incidents were not always investigated in a timely manner meaning there were potentially missed opportunities for shared learning. However, the service had made considerable progress is working through a backlog and a plan was in place to do this.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. For example, during the inspection the electronic systems stopped working, and staff quickly implemented actions in their business continuity plan to manage the risk and maintain oversight of the department.

# Urgent and emergency services

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but not always integrated.**

The service had an integrated score card which demonstrated performance across all areas of the service. Data was collected from various systems including electronic, audits, feedback from staff and patients. The information was analysed to form an assessment of risk and used to monitor performance overtime which was reported to the board. Local managers met with more senior managers regularly to set actions in response to these.

Clear and robust performance measures were used to assess quality and safety. Managers and staff knew what these were in relation to emergency department standards and patient care and safety. We saw the service used data to monitor performance against standards in real-time.

Electronic systems were used effectively to provide local leaders with oversight of the department. Large screens in the department provided staff with an electronic queue meant they could see where all patients were. This included vital information about numbers in the department and at which point of their journey. It also allowed nurses and consultants in charge to identify deteriorating patients and ensure they have been appropriately escalated.

The information systems were secure. The systems were integrated with the wider hospital but not always with partner organisations. For example, where the ambulance service was holding patients and monitoring observations, this was not on the service electronic system. This meant consultants and nurses in charge were reliant on being verbally updated by ambulance staff and pre-hospital practitioner of any signs of deterioration.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service used people's views and experiences to shape and improve the service. For example, the feedback was sought from patients' relatives and staff to formulate the integrated improvement plan. The feedback helped leaders develop key priorities and which to prioritise. The ED gathered patient feedback through the Friends and Family Test (FFT). The service participated in the annual emergency department survey and used feedback to improve. For example, the service used feedback to introduce hot food rounds for patients waiting in the department for long periods. We saw messages to staff in monthly departmental newsletters requiring staff to act in response to views of people using services.

Staff were actively engaged so that their views were reflected in the planning and delivery of services. For example, feedback was sought from staff to help shape the future new build of the emergency department due to start in 2022. During our inspection, staff were asked to complete an on-line survey to provide feedback and suggestions about improving the paediatric area within the Emergency Department. General feedback from staff was they felt senior management were more interested in their views providing them with more opportunities to feedback than previous.

The service worked collaboratively with external partners to build a shared understanding of challenges within the system. Regular meetings were held with key partners including the local ambulance service and urgent treatment centre providers.

# Urgent and emergency services

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Systems and processes were in place to monitor performance. Outcomes and learning were shared with staff to improve understanding and set actions for improvement. The service had improved oversight of their performance and actions to address concerns we raised at our previous inspection had resulted in improvements. For example:

- the triage process and performance had improved.
- identification and management of deteriorating patients had improved.
- two hourly intentional rounding had resulted in improvements in patients being provided with adequate nutrition, hydration and repositioning where required.
- Improvements were noted in the management of diabetic patients across the service.
- Twelve-hour trolley waits had generally reduced.

The service had made significant improvements since our previous inspection including:

- The service acted following our previous inspection to stop central corridor care of patients being normal practice.
- Improving clinical leadership through on-going training. There was improve oversight of the department and noted collaborative working between nursing and medical leaders.
- Successful medical and nursing staff improvement. The service had started the certificate of eligibility for specialist registration (CESR) route to recruit doctors which enables junior doctors from abroad to go on the specialist register held by the General Medical council (GMC) as a consultant. This was to improve recruitment and retention.
- Improved the oversight of skill mix for both medical and nursing staff by creating rotas with skills required filling.
- Departmental refurbishments, for example, the new area for triage to either the urgent treatment centre or ED.
- Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

Managers were able to tell us areas for further improvement such as development of governance and risk register oversight, continued focus on ambulance waits, continued review of medical staffing levels to improve the number of patients seen and treated within 60 minutes of arrival. The paediatric area within the Emergency Department was also seen as a further area for development in terms of governance and staffing levels.

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| **Report to:** | Trust Board |
| **Title of report:** | Quality Governance Committee Assurance Report to Board |
| **Date of meeting:** | 22 February 2022 |
| **Chairperson:** | Chris Gibson, Non-Executive Director |
| **Author:** | Karen Willey, Deputy Trust Secretary |

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| **Purpose** | This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.<br><br>This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. |
| | Assurance in respect of SO 1a<br>Issue: Deliver harm free care<br><br>**Clinical Harm Oversight Group Upward Report**<br>The Committee received the upward report noting that the Group had reviewed the clinical harm review triggers to ensure that these remained appropriate.<br><br>The Committee noted the removal of the Sepsis trigger, being advised that this was routinely monitored through other forums and removed the risk of replication.<br><br>The Committee noted the approach being taken in respect of harm reviews and the artificial intelligence system in place that supported risk stratification of patients. It was noted that with the correct risk stratification this should reduce clinical harm.<br><br>**Serious Incident Summary Report**<br>The Committee received the report noting the number of SIs and overdue actions in month. The Committee would receive the Complaints, Legal Claims, and Inquests, Incidents and Patient Advice and Liaison Service report to the March meeting that would offer triangulation of data.<br><br>**High Profile Cases**<br>The Committee received the report noting the content.<br><br>**Infection Prevention and Control (IPC) Group Upward Report**<br>The Committee received the report noting the increased assurance being received through the divisions and directorates. The Committee was pleased to note the increased level of assurance offered from the Estates Directorate in respect of ventilation and water safety. |

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| | The Committee was advised of a recent regional visit from the NHS England/Improvement IPC team that had noted sustained improvements. Whilst the Trust remained rated overall as amber an action plan was in progress and it was hoped that a full planned review in August/September would see further improvements.<br><br>The Committee was pleased to note and welcomed the involvement of the Director of Nursing with the regional team to further develop the approach and methodology used in respect of the visits.<br><br>**Children and Young People Group Upward Report**<br>The Committee received the report noting the detailed discussions that had taken place by the Group, in particular regarding the IV Morphine Policy for children which had been approved.<br><br>The Committee noted the bid for charitable funds and was advised this would support the development of areas such as sensory and therapy rooms and outdoor spaces to support children and young people's wellbeing during their stay.<br><br>**Maternity and Neonatal Oversight Group Upward Report**<br>The Committee received the report noting the discussions held by the Group and were offered an update by the Head of Nursing and Midwifery and Divisional Clinical Director in respect of the Ockenden Review.<br><br>The Committee noted that it had been a year since the report was published and there continued to be scrutiny of maternity services. There was now a requirement to resubmit the self-assessment for which the Trust had undertaken a review and reviewed the evidence that provided assurance.<br><br>The Committee noted that Trust was compliant with 117 of 123 Ockenden actions and 29 of 33 Kirkup actions, which had not previously been required to be reported. Of the 10 remaining actions, all are RAG rated amber (in progress / on track) with expected completion of all actions by the end of Quarter 2, with the exception of Personalised Care and Support Plans (PCSPs) which need further work and embedding. The outstanding actions are captured and being progressed as part of the Maternity & Neonatal Improvement Plan.<br><br>The Committee reflected on the position of the Trust noting the level of scrutiny that had been applied in the self-assessment process with some actions recorded as amber until there was sufficient assurance that the actions had been embedded.<br><br>A site visit, following submission of the evidence and self-assessment on 15 April, would be undertaken by the regional team, supported by the Local Maternity and Neonatal System to seek assurance of evidence.<br><br>The Committee noted the current scrutiny of maternity services and noted the support in place for staff to ensure that sufficient wellbeing |

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| | support was offered.<br><br>The Committee commended the self-assessment to the Board for approval.<br><br>**Nursing Midwifery and AHP Advisory Forum**<br>The Committee received the reporting noting the discussions that had been held by the Group.<br><br>The Committee was advised of the establishment of a number of cells during the pandemic, including a quality cell which had seen positive outcomes. As a result, the Committee noted that this would develop into a shared decision council in order to continue to support multidisciplinary teams working on quality issues<br><br>The shared decision council would report to the Group and upwardly through the report to the Committee regarding any areas of concern.<br><br>**Patient Safety Group Upward Report**<br>The Committee received the report noting the update offered and sought assurance on risks associated with CAS alerts in respect of equipment within the Trust.<br><br>The Committee noted that work was underway at pace to allow an understanding of the risk.<br><br>The Committee was delighted to noted that the Trust, during Patient Safety Week, would be holding an Aortic Dissection Webinar that would include a Family Representative and representatives from Think Aorta that could also be attended by people outside of the organisation.<br><br>**Medicines Quality Group Upward Report**<br>The Chair of the Group was welcomed to the Committee to present the upward report.<br><br>The Committee noted that actions in place in respect of medicines quality including the introduction of a safety bulletin and pharmacy technicians supporting the wards.<br><br>The Committee noted concern in respect of the lack of divisional attendance at the meeting noting that this did not offer assurance to the Committee in respect of medicines management.<br><br>The Committee discussed omitted or delayed medications and noted that further clarity was needed to separate out different categories such as patient choice and drug non-availability.<br><br>The Committee received the Medicines Management Update noting that a task and finish group had been established to address issues concerning medicines management. The Committee agreed that reporting would be |

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| | received directly from the group to maintain oversight and approved the recommendation that the Diabetes Task and Finish Group be concluded with outstanding actions being overseen by the Medicines Management Group.<br><br>The Committee was pleased to note that all outstanding actions in relation to medicines management would be drawn together into a single action plan that would be overseen by the Group.<br><br>The Committee approved the terms of reference of the Medicines Management Task and Finish Group. |
| | Assurance in respect of SO 1b<br>Issue: Improve Patient Experience<br><br>**Savile Action plan/Gap Analysis update**<br>The Committee received an updated action plan in respect of the original Savile Enquiry from 2012.<br><br>The Committee noted the progress that had been made since the previous update report to the Board in 2018/19. Work was underway to address areas where limited assurance was being received. The committee will add a quarterly review of this action to its cycle of business to maintain oversight.<br><br>The Committee noted the intention for the People and Organisational Development Committee to have oversight of the actions pertaining to workforce making a referral to the Committee for this to be received.<br><br>**Duty of Candour update**<br>The Committee received the monthly update noting that work continued to support improvement. Verbal compliance had increased to 81% with written compliance reported at 41%.<br><br>The Committee noted the continued review in place to ensure all written compliance was being recorded. Whilst this work was in the early stages the Committee were reassured on progress and would continue to receive monthly updates.<br><br>**Patient Experience Group Upward Report**<br>The Committee received the report and were pleased to note the improvement in the PLACE Lite ratings after a visit to MEAU following refurbishment of the area.<br><br>The Committee noted the intention to correlate the PLACE Lite outcome with patient experience.<br><br>The Committee discussed the intention to cap the number of patient moves noting that this would ensure a systematic approach to moves of medically optimised patients. |

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| | Assurance in respect of SO 1c<br>Issue: Improve Clinical Outcomes<br><br>**Clinical Effectiveness Group Upward Report**<br>The Chair of the Group was welcomed to the Committee to present the upward report.<br><br>The Committee noted the update offered and was pleased to note that the were no areas for escalation. The Committee was advised on a continued reduction in respect of VTE compliance noting that the Group had requested the VTE Lead attend the following meeting to address how this would be addressed.<br><br>The Committee were offered a verbal update in respect of clinical audit outlier alerts noting that the action plans offered to the CQC had resulted in the alerts being closed. |
| | **Assurance in respect of other areas:**<br><br>**FPEC Referral – 12-hour trolley waits – harm reviews**<br>The Committee received the referral from the Finance, Performance and Estates Committee in respect of 12-hour trolley waits and concerns relating to harms to ensure the Committee was sighted on the position.<br><br>The Committee received an update paper noting that harm reviews were conducted using the triggers in place to assess those patients who breached the 12-hour trolley wait.<br><br>The Committee was assured of the process in place to review those patients and ensure where necessary that these were escalated. It was noted however that there had been no specific triggers for these to escalate to serious incidents.<br><br>The committee has asked the Patient Experience Group to triangulate the experience of waiting in our EDs with clinical harms.<br><br>**Committee Self-Assessment methodology**<br>The Committee held discussion regarding the self-assessment methodology reflecting that this supported the Annual Report of the Trust and the Annual Governance Statement.<br><br>Work would be undertaken to develop the currently used framework to ensure each of the Board Committees was able to conduct an appropriate self-assessment in respect of governance.<br><br>**Annual Report – Committee Effectiveness**<br>The Committee received the draft report noting the content and request for comments to be offered on the report. The Committee offered some suggestions for inclusion and a final version would be presented back to the Committee. The report would support the production of the Trust Annual Report and Annual Governance Statement |

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| | **PRM Upward Report**<br>The Committee received the report noting that the Performance Review Meetings would continue to develop alongside reporting to the Committee in order that assurance could be provided.<br><br>**Integrated Improvement Plan**<br>The Committee received the report which offered the position to the end of January 2022 noting some metrics were reported on an annual basis.<br><br>The Committee discussed future reporting that would be developed to ensure the Committee were sighted on the relevant priorities, projects and metrics.<br><br>It was noted however that due to the cross over of patient safety and performance reporting across Committees the report would need to be careful developed to ensure the correct alignment to the Committee.<br><br>**Draft Quality Priorities 2022/23**<br>The Committee received a verbal update noting that the Quality Priorities for 2022/23 would be determined through the planning phase of the Integrated Improvement Plan to ensure alignment of the priorities.<br><br>Proposed quality priorities would be presented to the Committee in March and would be a subset of the Integrated Improvement Plan.<br><br>**Actions arising from CQC Inspection**<br>The Committee received the report noting that the final report had been published by the CQC and actions were in place to address those areas requiring attention.<br><br>A formal response in respect of actions would be offered to the CQC by the 10 March and the Committee noted that future reports would be offered to all Board Committees on the relevant actions against the programmes of work.<br><br>**IR(ME)R Report**<br>The Committee received the report noting the content and progress in respect of the improvement plan.<br><br>**Committee Performance Dashboard**<br>The Committee received the report noting the performance presented in the report and reflected those discussions during the meeting that had offered detail of the reported position. |
| **Issues where assurance remains outstanding for escalation to the Board** | None |
| **Items referred to other** | The Committee wished to refer to the People and Organisational |

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| **Committees for Assurance** | Development Committee actions pertaining to workforce within the Savile action plan requesting that this be received and added to the cycle of business to maintain oversight. |
| **Committee Review of corporate risk register** | The Committee noted the risk register and was pleased to receive the revised format of the risk register which offered greater clarity and understanding of the risks presented. |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | None |
| **Committee position on assurance of strategic risk areas that align to committee** | The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. No changes were recommended. |
| **Areas identified to visit in dept walk rounds** | None |

**Attendance Summary for rolling 12 month period**

| **Voting Members** | M | A | M | J | J | A | S | O | N | D | J | F |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elizabeth Libiszewski Non-Executive Director | X | X | X | X | X | X | X | A | X | X | | |
| Chris Gibson Non-Executive Director | X | X | X | X | X | X | A | X | X | X | X | X |
| Alison Dickinson Non-Executive Director | | | | | | | | | | | X | |
| Sarah Dunnett Non-Executive Director (Maternity Safety Champion) | X | X | X | X | X | X | A | X | X | A | | X |
| Neill Hepburn Medical Director | X | X | X | X | X | | | | | | | |
| Karen Dunderdale Director of Nursing | X | X | X | X | X | X | X | X | X | X | X | X |
| Simon Evans Chief Operating Officer | C | C | X | D | D | D | D | D | X | D | D | X |
| Colin Farquharson Medical Director | | | | | | X | X | X | A | X | X | X |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

**Derby Office**
Cardinal Square,
10 Nottingham Road,
Derby
DE1 3QT

09 February 2022

Dr Karen Dunderdale
United Lincolnshire Hospitals NHS Trust,
Trust HQ,
Lincoln County Hospital,
Main Entrance,
Greetwell Road,
Lincoln
LN2 5QY

Dear Karen

**Re: *NHS England and NHS Improvement Visit; 2 and 3rd February 2022.***

I would like to thank you and Natalie for organising the planned re-visit to United Lincolnshire Hospitals NHS Trust, Lincoln County Hospital, Grantham and District Hospital and Pilgrim Hospital sites for the 2nd and 3rd February. Prior to this visit the Trust were AMBER on the as NHSE/I IP internal escalation matrix, following the previous visit in July 2021. We are recommending that the trust remains on AMBER, with an offer of a follow up review at an agreed time in the near future.

During the two days we visited two/three clinical areas on each site. Your Deputy Director of Infection prevention Natalie, Karen Lead Nurse for decontamination and Lead IPN Sandra escorted us on the visit; we were joined by Jennie Clements from the CCG and Jude Robinson NHSEI. Various Matrons and managers joined us in the clinical areas. We were pleased to offer feedback directly to you and Natalie prior to leaving the Trust.

During the visit we saw improvements, particularly regarding the Estates and Facilities actions and strengthening of governance since the last visit. We would recommend further embedding of this work over the coming months.

The clinical inpatient areas visited demonstrated sustainability of the improvements from previous visits, with just a few actions requiring attention below. All the staff in these areas were welcoming and were caring and kind to your patients, while staff also supported each other with compassionate challenge.

We also visited a number of non-inpatient areas including sonography at both Grantham and Boston sites, along with the x-ray department at Grantham and the outpatient department at the Lincoln site where we identified some issues requiring immediate attention.

Good practice observed:

- Sustained improvements identified in the clinical inpatient areas.
- Improved governance and reporting in the Estates Department.

- Estates Department
    - Water, Ventilation and Decontamination Authorised Engineers and Authorised Persons are all in place.
    - Improved governance processes and reporting shared.
    - 90% of sinks have been upgraded with completion expected by the end of March 2022. Remains on risk register.
- All wards were clean and clutter free.
- Significant improvements in the housekeeper storerooms noted.
- In ward areas it was noted that staff supported each other with compassionate challenge regarding IP. And that housekeepers were an integral part of the ward team.
- Good correct documentation for IVs and urinary catheters.
- Additional welcoming staff at all entrances to the hospitals to support the reintroduction of controlled visiting. Volunteers were seen to support patients and visitors throughout the organisation.
- Availability of hand sanitizer and face masks at department entrances and appropriate areas within the departments.
- System in place for Covid-19 screening and monitoring in clinical areas.
- Most managers were able to give data regarding staff COVID risk assessments, vaccination status and LFT completion and reporting.

Further action is recommended in relation to:

- Patient mask use documentation continues to be variable across areas. Promote the patient mask wearing documentation for non-compliant patients and patients who are unable to where masks and monitor.
- Ensure sharp safety and that clinical waste disposal policies are met.
- To look at the sonography department IP and Information Governance issues identified.
- Review practices in CT scanners regarding contrast procedures to prevent a potential incident.
- Review practices in all clinical out-patient areas to assure the Board that IP standards are consistent across all patient areas. Particular attention is required in the dental and ophthalmology departments.
- Sharps safety – significant numbers of sharps bins not signed when putting together and the partial closure not used as per policy.
- Clinical waste trucks found to be unlocked with waste in and dirty inside and out. Some were outside with public access.
- Update the maximum numbers of individuals allowed in a room, as signs are missing from doors across the Trust.

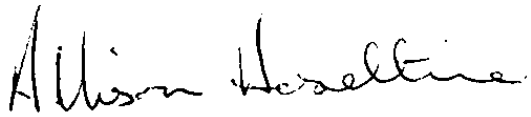
We have included further detail of the visit as an appendix to this letter. We are more than happy to continue to provide ongoing support and advice to supplement the work you are already doing. We would also advise the Trust to work with the CCG to undertake IPC led supportive visits (as a peer reviewer). We would also be willing to provide your Deputy DIPC with clinical supervision if this is something that would be useful.

We recognise you will be keen to discuss the report with the Trust Board at the next meeting on 31 March 2022 and will review your IP action plan, aligned to the Hygiene Code, to address the concerns identified.

As agreed, we will complete a follow up assurance visit, planned for the 27th of April, with a full review scheduled in August or September 2022, in the hope of supporting your ongoing IPC improvement work.

If you have any questions, please do not hesitate to contact me.

Kind regards



**Allison Heseltine**
**Assistant Director of Nursing and Quality**
**NHS England and NHS Improvement Midlands Region**

C.C.

Nina Morgan, Regional Chief Nurse and Regional Director of IPC, NHS England/NHS Improvement – Midlands.

Amanda Callow, Deputy Director of Nursing, Quality and Leadership, NHS England/NHS Improvement – Midlands.

Kirsty Morgan, Assistant Director of IPC, NHS England/NHS Improvement – Midlands.

Jennie Clements, Lead Nurse Health Protection, NHS Lincolnshire CCG.

Karen Glover, Deputy Director Of Nursing and Quality, NHS England/NHS Improvement – Midlands.

Miriam Coffie, Assistant Director of Nursing & Quality, NHS England/NHS Improvement – Midlands.

**Detailed Summary of Visit 01/02 and 02/02/2022**

The visit consisted of:

- Visit to clinical areas.
- Discussions with Staff.
- Observation of staff.

**HCAI data to date for 2021/22**

MRSA b- 2 cases. 1x identified as a contaminant and 1x currently being investigated.

Clostridioides difficile – 40 cases YTD against a trajectory of 70 to year end.

**Discussions**

**DIPC /IP Team**

- Appointed band 4 nurse associates and upgraded current team members following development. Continue to source new IP nurses and have received interest from some ward sisters. IP administrator is now in place.
- Trust feel outbreak assurance has improved.
- IP policies are all up to date.
- Decontamination Matron who had only been in post for 3 weeks at the last visit has now developed the role and works closely with the IP team. She has also bridged the links between the clinical areas and F&E departments.
- Deputy DIPC now chairs Operation IP group and C4C group.
- New IPC BAF is being completed for submission to the Board 6 monthly.
- COVID testing for inpatients articulated and triangulated by ward staff. Have introduced LFT for patients arriving at ED to allow for appropriate placement of patients within the waiting areas and department. Undertake CO2 monitoring in ED.
- Tightened processes for monitoring changes to National Policy relating to IP.
- Trust wide increased staff sickness, IP are members of the workforce cell.
- Have had enhancement incentives for housekeepers and recognition day.
- Staff released from IP Committee for November, December and January due to staffing issues; the papers were reviewed by yourself, Deputy DIPC and Microbiologist with a paper produced for the Quality Governance Committee. Thank you for sending the minutes of the last full meeting and the report to Quality Governance Committee.
- IP are members of the monthly Estates meetings.

**Estates**

- Significant pieces of work have been undertaken in the appointment of Authorised Engineers and Authorised Persons for Water Safety, Ventilation and Decontamination.
- The individual Groups for each subject now feed into both IP committee and Finance, Performance and Efficiency Committee. The Decontamination group is still being developed.
- The Water Safety, Ventilation and Decontamination groups now all monitor appropriate staffing, action plans, and policies which are now going through the ratification process.

- External companies have now been appointed to undertake work, reviews and /or monitoring as appropriate; the details of the companies have been shared with me.
- There is evidence that standards are improving across the Trust.
- and as departments they understand.
- The Estates department now fully understand their risks and have mitigations in place.
- 90% of replacement clinical sinks are in place with completion expected at the end of March 2022.
- Patient impact assessments are undertaken for all works required.
- Estates have shared the details of AE and AP, see appendix.

**Facilities**

- Improvements identified in housekeeping storerooms.
- Good links with Decontamination Matron.
- Environmental Decontamination Policy is being developed; no timescale provided.
- Formal Decontamination report has not yet been presented to IPC.
- Improving Governance but structure is still evolving, the Decontamination Group is not yet in place.
- Process in place for impacts on patients.
- Work closely with H&S specialist.
- PLACE audits undertaken monthly.
- Cleaners trolly pilot is in place, some appear not to being used fully, this will be evaluated.
- Decontamination Matron manages expectations and supports prioritisation.
- C4C in place and new cleaning standards have a task and finish group which continues.
- Clearer clarification on who cleans what has been completed which was evidenced at ward entrances.
- Ward cleaning accreditation is now fully in place.
- Wipeable cord pulls in place across the organisation.
- Accredited housekeeping training is being developed with the local college.

**Clinical Areas Visited**

**Grantham Hospital**

Belton Ward - Trust choice. This is a newly refurbished ward with the same team as Harrowby Ward we visited previously.

Positive observations

- Staff clearly working as a team and supporting each other in this area.
- IV and catheter documentation.
- Fridge temperature recording in place for kitchen and drug fridges.
- Legionnaire flushing and checking undertaken.
- COVID daily checklist including ventilation.
- Good patient mask wearing and documentation.
- Clean and clutter free. Cleaning assurance identified.
- Good standard practices of IP witnessed.
- Mattresses checked – no strike through.
- All clinical equipment was clean and appropriately labelled.

Observations requiring attention

- New call bell pulls were not quick release therefore a ligature risk.
- Sharps bins temporary closure not in use.

**X-ray Department**

Positive observations

Clean and clutter free.

- Dust free couches, trollies etc.
- Cleaning and IP posters standardised.
- Sterile equipment and contrast all stored appropriately.
- All clinical equipment was clean and appropriately labelled.
- General equipment segregated and stored well.
- Cleaning procedure for mobile x-ray machine described.

Observations requiring attention

- Christmas tree stored in a box in a room with some sterile equipment.
- Outside door to waste bins is rotten causing damp therefor not sealed to the outside.
- Clinical waste bins unlocked outside – these are used by multiple departments.

CT Scanner Dept

- Sharps bins open and unsigned.
- Positioning pads torn and covered in plastic bags held together with tape.
- Contrast run off is put back into a used bottle, suggest this is practice is reviewed to prevent a human factors safety incident.
- Ensure there is an SOP for the contrast procedure as this system is used for multiple patients.
- Significant amount of equipment/positioning pads in the area with a risk of contamination.

Sonography department

- Continue to use refillable containers for ultrasound gels despite the Patient Safety Alert being implemented.
- Computer screen shows all patients being seen, recommend Information Governance is looked at regarding this as doors are not lockable.

**Pilgrim Hospital Boston**

**Bostonian Cancer Centre**

Positive observations

- Dani centres in place but addition required in sluice and outpatient area due to contamination risk.
- Fridge temperature recording for drug and kitchen fridges in place.
- Clean and clutter free.
- Good standard practices of IP witnessed.
- Sharps bins labelled appropriately.
- ANTT Training 100% for nursing staff.

Observations requiring attention

- Waste storage bins unsecured outside, 1 found to be unlocked.
- ANTT tray required cleaning.
- Dr witnessed taking handbag into a clinical procedure room, Matron spoke to the individual.

- Asked IP to review the outpatient room as inappropriate storage and clinical procedure room as it was in use during the visit, there were boxes visible from the door and what appeared to be quantity of equipment.
- Staff mugs in the kitchen and patient mugs stored of the staff room. Please review to reduce the foot fall in the kitchen.
- Staff hydration station was uncovered in middle of ward adjacent to sanitizers.
- Maximum numbers in room posters missing.

**Ward 5A** - Surgery (this ward is awaiting refurbishment).
Positive observations
- Dani centres in place.
- Fridge temperature recording for kitchen and drug fridges.
- Donning and doffing training refreshed for all staff.
- Clean and clutter free.
- Mattresses checked– no strike through.
- Sharps bins labelled but temporary closure not in place.
- IV and catheter documentation complete.
- Maximum numbers in room posters missing.
- FFP3 Fit testing at 75% despite no AGP procedures on this ward.

Observations requiring attention
- Blood splash on clean ANTT tray.
- Cleaners' cupboard clean and tidy but a couple of extraneous items.
- Housekeepers identified as not wearing aprons for touch point cleaning, dealt with during the visit.
- Uncovered equipment in the sluice.
- Group of patients refusing to wear masks in 1 particular bay, matron supporting. Poor documentation for patients not wearing masks, matron is working on this.

**Sonography unit**
This was chosen due to the door being open on a main corridor with an unlocked computer with patient information on view.
Corridor flooring in poor condition in the main corridor outside the unit.
Positive observations
- Clinical rooms clean, tidy and clutter free.
- Appropriate ultrasound gels in place.

Observations requiring attention
- Sharps bins not signed and the partial closure not used.
- Cluttered reporting room which was also being used for the staff break at the time.
- Staff all not wearing a mask while they had their break, not all eating. There were 2 additional rooms off this which could have been used by staff at this time.
- IG breach and door unlocked, staff dd not see an issue with this when a member of your staff first raised this.
- Non waterproof positioning pads made of cotton fabric with tape stuck to it and foam pad uncovered.

**Lincoln Hospital**
On the corridor outside Greetwell ward there was a clinical waste truck unlocked and dirty inside and out, dealt with at the time.
**Greetwell Ward** – Surgery.

Positive observations

- Dani centres in place.
- Fridge temperature recording for kitchen and drug fridges.
- Legionella flushing documents completed.
- Clean and clutter free.
- Sharps bins labelled appropriately.
- Venflon and catheter documentation in place.
- Have purchased a cupboard /worktop on wheels suitable as a workstation, hydration station in cupboard and drawers. Ideal for areas where workstation cannot be built in.
- Compassionate challenge by ward manager regarding a member of non-ward staff arriving not BBE.
- Damaged patient table but there is a replacement programme in place.

Observations requiring attention

- Ward manager will review patient placement in bays so that patients have optimum space between them rather than chairs adjacent to each other.
- Too many clinical waste bins in female bay, blocking the sink.
- It was noted that some devise paperwork was incomplete from ED and assessment unit.

**Safari Ward, Childrens Day Unit**

Positive observations

- Dani centres in place.
- Fridge recording for kitchen and drug fridges.
- Clean and clutter free.
- Mattresses checked– no strike through.
- Toy cleaning SOP in place.
- Discussed mask use in staff room.
- Spoke to a locum Dr, all training and vaccination information had been provided to the agency and undertook twice weekly LFT as the permanent staff did.

Observations requiring attention

- Waste bin blocking oxygen cylinders.
- Sharps bins closure not in use, this treatment room is not locked due to emergency equipment being required, suggest risk assessment is undertaken.

**Outpatient Department**

We split into 3 teams and were taken to an area of the department by the clinical teams who decided where to take each team. There appears to be limited ventilation in all of these areas visited.

Dental suite.

Positive observations

- Resus trolly checked daily and clean.

Observations requiring attention

- No separate handwash sink in the Dental Moulding room.
- Gloves used but not aprons in the area. Dani centre required.
- Very dusty environment due to the nature of the work.
- Dental nurse carried used surgical equipment to the sluice where they were left on the worktop.

- Only use gloves, no aprons available for use in the area. She implied they didn't use them.
- Sharps bins not signed or temporary closure used.
- Staff drink in dental room, AGP may be carried out in this area. Advised it was for long cases.
- Storage on the floor in the storeroom.

**Clinic 8 – Ophthalmology**

Positive observations

- Waiting area set up well for patients to be appropriately spaced.

Observations requiring attention

- IG incident, computer with open screen in non-monitored room and notes room open.
- Dr walking between clinic rooms with gloves on, no apron used.
- Staff not BBE, watches and long sleeves.
- Staff member with gel nails and another with a necklace.
- Staff typing in an office with gloves on.
- Clinical room with dirty staff mugs, dirty mop, blood splatter on the wall by sharps bin.
- Sharps bin unsigned and temporary closure not in use.
- Sterile surgical equipment next to the above and mugs.
- Cluttered offices.
- Multiuse room – clinical and office space. Patients are taken into this area for tests. Office equipment and folders, clutter on top of lockers. Coats, bags and used mugs cluttered the area.
- Consumables stored on the floor.

**Phlebotomy area**

Positive Observations

- Sharps bins signed and temporary closures used.
- Area was clean.
- Blood bottles in date.

Observations requiring attention

- Staff did not remove gloves promptly after completing procedure with a patient.
- Staff did not sanitise hands when gloves removed,

Appendix

| | Authorising Engineer/organisation. Show appointment letter. | Authorised Person | Competent Person/trained? | Director with Board responsibility | Send last set of minutes for meeting: |
|---|---|---|---|---|---|
| **CFPP01-01 (Decon)** | Tracey Miller / AVM Contract in place until Feb 2023, Re-appointment of AE Feb 2022 following 1 year contract extension commenced 1st Feb 2022. Review of contract currently in progress. | Chris Philips<br>Paul Heath | Competent Person function is outsourced to specialist service and maintenance providers as applicable. | Karen Dunderdale, DoN DIPC | Decontamination: Group is in the process of being set up.<br>Karen Bailey support the development of the Decontamination Group and closely working with the departments and functions to assure of grip and control until all systems in place. |
| **HTM 03-01 (ventilation)** | Leigh Kowalski AE. Paul Harman Deputy AE of Turner Services | AP Course booked, 14th Feb 2022, for two nominated Estates Officers, Liam Graham and Mick Clayton.<br>Estates Officer Recruitment process ongoing, expected to be complete May 2022 where further training and appointments will be made.<br>AP support provided by AE as required. | Currently outsourced VSS, and RJ Urmson for general repairs and remedial works.<br>VTV employed for annual and 6 monthly validations of critical systems.<br>CP courses are in progress, first course completed at Lincoln site on 10th October 2021 which included 10 ULHT Maintenance staff members for across all three sites, further training planned for April 2022. | Simon Evans, COO | Ventilation: Minutes and Action Tracker – attached.<br><br>Chairs report offered to DIPC |
| **HTM04-01 (water)** | Karina Jones of ETA Projects | RP support via Paul Pattinson Interim Associate Director of Compliance (RP trained, (formal appointment to be concluded)<br><br>RP/AP training course in process of arrangement and will complete once all Estates Officer Recruitment process ongoing, expected to be complete May 2022 where further training and appointments will be made. | Water compliance – short term extensions in place for the following:<br>Chlorine Dosing – Scotmas<br><br>TMV Servicing – Veolia<br><br>All other PPM has been brought in house. Further discussions to be held with regards in-house v contracted dependent on resource. | Simon Evans, COO | Water Quality: Minutes from December WSG including Action Plan Update from the previous meeting - attached (January's meeting did not proceed due to COVID pressures.<br><br>Chairs overview report offered to DIPC |

OUTSTANDING CARE personally DELIVERED

# Appendix A

# Maternity Services: Benchmarking Report Ockenden Report / Kirkup Report

23 February 2022
Libby Grooby: Head of Midwifery
Jules Bambridge: Lead Midwife for Patient Safety

**Background**

The Ockenden and Kirkup reviews were undertaken in response to significant concerns around safety in maternity services at Shrewsbury and Telford Hospitals Trust and University Hospitals of Morecambe Bay NHS Foundation Trust. The reports made recommendations and outlined actions required by all maternity services in the UK to improve safety for women and babies. The links to the reports are provided below:

https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockdenden-report.pdf

https://assets.publising.service.gov.uk/government/uploads/system/uploads/attachment data/file/408480/47487 MBI Accessible v0.1.pdf

Following the publication of the first Ockenden report in December 2020, all Trusts providing maternity services were required to undertake a self-assessment and provide assurance (internally to the Trust Board and externally to the NHSE/I regional maternity team) as to their compliance with the 7 Immediate & Essential Actions (IEAs) within the report. The immediate response was followed by the requirement for the submission of supporting evidence of compliance in June 2021. The feedback from review of the supporting evidence submitted by ULHT was positive; reflecting the Trust's own self-assessment.

The outstanding actions from both Ockenden and Kirkup are captured and being progressed as part of the Maternity & Neonatal Improvement Plan and there has been ongoing monitoring of progress through the Maternity & Neonatal Oversight Group with upward reporting to the Quality Governance Committee and Trust Board.

One year on, Trusts have been asked to report, to the Trust Board, the LMNS and the NHSE/I regional maternity team, on progress with the remaining actions in respect of both Ockenden and Kirkup.

**Current Position**

Overall compliance following the further self-assessment exercise undertaken (the outcome of which is shown at **Appendix A1**) shows continued good levels of compliance; with ULHT maternity services meeting 117 of 123 Ockenden actions (95%) and 29 of 33 Kirkup actions (88%).

Of the 10 remaining actions (which are shown at **Appendix A2**), all are RAG rated amber (in progress / on track). Timescales for completion of each action are provided at **Appendix A2**, with expected completion of all actions by the end of Quarter 2, with the exception of Personalised Care and Support Plans (PCSPs). PCSPs represent a

significant shift in culture within maternity services and will require time to become fully embedded. Support with this work has been sourced internally from the PMO and externally from the CCG to establish PCSPs in to practice.

As outlined above, continued oversight of progress with the remaining actions, internally, will occur through the Maternity & Neonatal Oversight Group.

ULHT has also received details of the proposed national and regional approach for monitoring of Trusts' ongoing compliance with the Ockenden requirements, which at local level will be through site-based or virtual QA visits undertaken by the LMNS / CCG supported by the MVP.

The LMNS must also formally sign off the latest self-assessment, which is due by 15 April 2022.

**Quality Governance Committee Action Required:**

The Quality Governance Committee is asked to:

- note the report and progress;
- note the requirement for the submission of the Trust's self-assessment to the NHSE/I regional maternity team by the 15 April 2022 following Trust Board and LMNS sign-off;
- agree the need for any additional actions or assurance; and / or
- endorse the submission of the report to the Trust Board.

| Completion Guidance: |
|---|
| 1.Overview tab – please complete in full<br>2.Ockenden return tab – this mirrors earlier returns and requires updating on progress to 31/12/2021<br>3.Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion) |

## Internal trust governance

| | Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan | Date of Public Board update | Executive sign off of this return | | |
|---|---|---|---|---|---|
| | Yes/No | please insert date | **Date** | **Name** | **Role** |
| United Lincolnshire Hospitals NHS Trust | Yes | Tuesday, 1 March 2022 | TBA | Dr Karen Dunderdale | Director of Nursing & Deputy Chief Executive |
| Insert Trust Name | | | | | |
| Insert Trust Name | | | | | |
| Insert Trust Name | | | | | |

## LMNS sign off of the combined trust returns

| LMNS Name | Executive sign off | | |
|---|---|---|---|
| | **Date** | **Name** | **Role** |
| Lincolnshire | TBA | TBA | TBA |

## Ockenden Inital report reccomendations
## Results of Regional Update January 22

| | | | | LincoInshire |
|---|---|---|---|---|
| **IEA** | **Question** | **Action** | **Evidence Required** | **UNITED LINCOLNSHIRE HOSPITALS** |
| **IEA1** | **Q1** | Maternity Dashboard to LMS every 3 months | Dashboard to be shared as evidence. | 100% |
| | | | Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. | 100% |
| | | | SOP required which demonstrates how the trust reports this both internally and externally through the LMS. | 100% |
| | | | Submission of minutes and organogram, that shows how this takes place. | 100% |
| | | **Maternity Dashboard to LMS every 3 months Total** | | **100%** |
| | **Q2** | External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death | Audit to demonstrate this takes place. | 100% |
| | | | Policy or SOP which is in place for involving external clinical specialists in reviews. | 100% |
| | | **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total** | | **100%** |
| | **Q3** | Maternity SI's to Trust Board & LMS every 3 months | Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion | 100% |
| | | | Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed | 100% |
| | | | Submit SOP | 100% |
| | | **Maternity SI's to Trust Board & LMS every 3 months Total** | | **100%** |
| | **Q4** | Using the National Perinatal Mortality Review Tool to review perinatal deaths | Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review. | 100% |
| | | | Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. | 100% |
| | | **Using the National Perinatal Mortality Review Tool to review perinatal deaths Total** | | **100%** |
| | **Q5** | Submitting data to the Maternity Services Dataset to the required standard | Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS. | 100% |
| | | **Submitting data to the Maternity Services Dataset to the required standard Total** | | **100%** |
| | **Q6** | Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme | Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme. | 100% |
| | | **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total** | | **100%** |
| | **Q7** | Plan to implement the Perinatal Clinical Quality Surveillance Model | Full evidence of full implementation of the perinatal surveillance framework by June 2021. | 100% |
| | | | LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. | 100% |
| | | | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | 100% |
| | | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | | **100%** |
| **IEA1 Total** | | | | **100%** |

| | | | | |
|---|---|---|---|---|
| | Q11 | Non-executive director who has oversight of maternity services | Evidence of how all voices are represented: | 100% |
| | | | Evidence of link in to MVP; any other mechanisms | 100% |
| | | | Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed | 100% |
| | | | Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions | 100% |
| | | | Name of NED and date of appointment | 100% |
| | | | NED JD | 100% |
| | | **Non-executive director who has oversight of maternity services Total** | | **100%** |
| | Q13 | Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services | Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% |
| | | **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total** | | **100%** |
| **IEA2** | Q14 | Trust safety champions meeting bimonthly with Board level champions | Action log and actions taken. | 100% |
| | | | Log of attendees and core membership. | 100% |
| | | | Minutes of the meeting and minutes of the LMS meeting where this is discussed. | 100% |
| | | | SOP that includes role descriptors for all key members who attend by-monthly safety meetings. | 100% |
| | | **Trust safety champions meeting bimonthly with Board level champions Total** | | **100%** |
| | Q15 | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local | Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local** | | **100%** |
| | Q16 | Non-executive director support the Board maternity safety champion | Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken | 100% |
| | | | Name of ED and date of appointment | 100% |
| | | | Role descriptors | 100% |
| | | **Non-executive director support the Board maternity safety champion Total** | | **100%** |
| **IEA2 Total** | | | | **100%** |
| | Q17 | Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. | 100% |
| | | | Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% |
| | | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total** | | **100%** |
| | **Q18** | Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. | Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP) | 100% |
| | | | SOP created for consultant led ward rounds. | 100% |
| | | **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total** | | **100%** |
| **IEA3** | **Q19** | External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only | Confirmation from Directors of Finance | 100% |
| | | | Evidence from Budget statements. | 100% |
| | | | Evidence of funding received and spent. | 100% |
| | | | Evidence that additional external funding has been spent on funding including staff can attend training in work time. | 100% |
| | | | MTP spend reports to LMS | 100% |
| | | **External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total** | | **100%** |
| | **Q21** | 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | Attendance records - summarised | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% |
| | | **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total** | | **100%** |
| | **Q22** | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP) | 100% |
| | | **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total** | | **100%** |
| | **Q23** | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. | 100% |
| | | **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is** | | **100%** |
| **IEA3 Total** | | | | **100%** |
| | **Q24** | Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre | Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians | 100% |
| | | | SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total** | | **100%** |
| | **Q25** | Women with complex pregnancies must have a named consultant lead | Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead. | 100% |
| | | | SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. | 100% |
| | | **Women with complex pregnancies must have a named consultant lead Total** | | **100%** |
| | **Q26** | Complex pregnancies have early specialist involvement and management plans agreed | Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman. | 100% |
| | | | SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. | 100% |
| | | **Complex pregnancies have early specialist involvement and management plans agreed Total** | | **100%** |
| **IEA4** | **Q27** | Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 | Audits for each element. | 100% |
| | | | Guidelines with evidence for each pathway | 100% |
| | | | SOP's | 100% |
| | | **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total** | | **100%** |
| | **Q28** | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | SOP that states women with complex pregnancies must have a named consultant lead. | 100% |
| | | | Submission of an audit plan to regularly audit compliance | 50% |
| | | **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total** | | **75%** |
| | **Q29** | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Agreed pathways | 100% |
| | | | Criteria for referrals to MMC | 100% |
| | | | The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. | 100% |
| | | **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total** | | **100%** |
| **IEA4 Total** | | | | **96%** |
| | **Q30** | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | How this is achieved within the organisation. | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% |
| | | | SOP that includes definition of antenatal risk assessment as per NICE guidance. | 100% |
| | | | What is being risk assessed. | 100% |
| | | **All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total** | | **100%** |

| | | | | |
|---|---|---|---|---|
| **IEA5** | **Q31** | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Evidence of referral to birth options clinics | 100% |
| | | | Out with guidance pathway. | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% |
| | | | SOP that includes review of intended place of birth. | 100% |
| | | **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total** | | **100%** |
| | **Q33** | A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust) | 100% |
| | | | How this is achieved in the organisation | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | 0% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% |
| | | | SOP to describe risk assessment being undertaken at every contact. | 100% |
| | | | What is being risk assessed. | 100% |
| | | **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP** | | **83%** |
| **IEA5 Total** | | | | **93%** |
| | **Q34** | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring | Copies of rotas / off duties to demonstrate they are given dedicated time. | 50% |
| | | | Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. | 100% |
| | | | Incident investigations and reviews | 100% |
| | | | Name of dedicated Lead Midwife and Lead Obstetrician | 100% |
| | | **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total** | | **88%** |
| **IEA6** | **Q35** | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health | Consolidating existing knowledge of monitoring fetal wellbeing | 100% |
| | | | Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision | 100% |
| | | | Improving the practice & raising the profile of fetal wellbeing monitoring | 100% |
| | | | Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. | 100% |
| | | | Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post | 100% |
| | | | Keeping abreast of developments in the field | 100% |
| | | | Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. | 100% |
| | | | Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. | 100% |
| | | **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total** | | **100%** |
| | | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle | Audits for each element | 100% |

| | | | | |
|---|---|---|---|---|
| | **Q36** | Version 2? | Guidelines with evidence for each pathway | 100% |
| | | | SOP's | 100% |
| | | **Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total** | | **100%** |
| | **Q37** | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | Attendance records - summarised | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% |
| | | **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total** | | **100%** |
| **IEA6 Total** | | | | **97%** |
| | **Q39** | Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery | Information on maternal choice including choice for caesarean delivery. | 100% |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites | 100% |
| | | **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total** | | **100%** |
| | **Q41** | Women must be enabled to participate equally in all decision-making processes | An audit of 1% of notes demonstrating compliance. | 100% |
| | | | CQC survey and associated action plans | 100% |
| | | | SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. | 100% |
| | | **Women must be enabled to participate equally in all decision-making processes Total** | | **100%** |
| | **Q42** | Women's choices following a shared and informed decision-making process must be respected | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction | 50% |
| | | | SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | 100% |
| | | **Women's choices following a shared and informed decision-making process must be respected Total** | | **75%** |
| **IEA7** | **Q43** | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity** | | **100%** |
| | **Q44** | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified | 50% |
| | | | Gap analysis of website against Chelsea & Westminster conducted by the MVP | 100% |
| | | | Information on maternal choice including choice for caesarean delivery. | 100% |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites | 100% |
| | | **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total** | | **88%** |
| **IEA7 Total** | | | | **93%** |
| **WF** | **Q45** | Demonstrate an effective system of clinical workforce planning to the required standard | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | 100% |
| | | | Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. | 100% |
| | | | Most recent BR+ report and board minutes agreeing to fund. | 100% |
| | | **Demonstrate an effective system of clinical workforce planning to the required standard Total** | | **100%** |
| | **Q46** | Demonstrate an effective system of midwifery workforce planning to the required standard? | Most recent BR+ report and board minutes agreeing to fund. | 100% |
| | | **Demonstrate an effective system of midwifery workforce planning to the required standard? Total** | | **100%** |
| | **Q47** | Director/Head of Midwifery is responsible and accountable to an executive director | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director | 50% |
| | | **Director/Head of Midwifery is responsible and accountable to an executive director Total** | | **50%** |
| | **Q48** | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: | Action plan where manifesto is not met | 100% |
| | | | Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care | 100% |
| | | **Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto** | | **100%** |
| | **Q49** | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. | Audit to demonstrate all guidelines are in date. | 100% |
| | | | Evidence of risk assessment where guidance is not implemented. | 100% |
| | | | SOP in place for all guidelines with a demonstrable process for ongoing review. | 100% |
| | | **Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total** | | **100%** |
| **WF Total** | | | | **95%** |

**Kirkup report recommendations**
**Regional Update 31st December 2021**

**Those that are greyed out are superseded by Ockenden and do not need completing on**

| | | | | Lincolnshire |
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| **Kirkup Action no.** | **Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)** | **Action** | **Suggested documents that may support Trust assurance.** | **UNITED LINCOLNSHIRE HOSPITALS** |
| **1** | **R1, R13, R24** | Ensure that an open and honest approach is taken to any incident | Critical friend is allocated for every level 4/ 5 incident (SI's) | |
| | | | Women and their families are kept informed of the progress of the | |
| | | | Women and their families are invited to contribute to the investigation | |
| | | | Offering an apology | |
| | | | Ensure that all nurses and midwives are aware of their responsibilities in | |
| **2** | **R1, R13** | Review the current processes for obtaining feedback from the public to increase the information received | Offering women and their families the opportunity to make suggestions | |
| | | | Ensuring that national/ local awareness opportunities are utilised | |
| | | | Continue to support the LSA in the feedback mechanism to staff from | |
| | | | Share patient stories | |
| **3** | **R2** | Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for | Ensure a high quality training scheme is delivered | |
| **4** | | Foster a culture of shared learning between clinical departments that supports effective communication and practice development | Minutes of meetings showing MDT working | |
| **5** | **R2** | Review the current preceptorship programme | Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team. | Green |
| | | | The buddy midwife is allocated time to support the preceptee | Green |
| | | | Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is | Green |
| | | | Midwives are confident and competent to go through the gateway within the agreed timeframe | Green |
| **6** | **R2** | Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme | Utilise PMA feedback | Green |
| **7** | **R2, R3** | Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce | Develop a robust support package for new band 6 midwives | Green |
| | | | Completion of the Mentoring module | Green |
| | | | Suturing competency | Green |
| | | | IV therapy competency | Green |
| | | | Care of women choosing epidural anaesthesia. | Green |
| **8** | | Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care | Practice educator reports and feedback | Green |
| **9** | **R2** | Review the current induction programme for locum doctors | Locum policies | Amber |
| **10** | | Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | | Amber |
| **11** | **R2** | Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session. | Practice educator meeting notes, discussion with DoMS/HoMs | Green |
| **12** | **R2** | Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the | Practice educator reports and feedback | Green |
| **13** | **R2** | Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition | Incident review and feedback, related lessons learnt, training opportunities | Amber |
| **14** | **R2** | Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, | | Green |
| **15** | **R3** | Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas. | | Green |
| **16** | **R2, R3, R4** | Review and update the Education Strategy | | |
| **17** | **R3** | Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations | | Green |
| **18** | **R3** | Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or | | |
| **19** | **R5** | Develop a list of current MDT meetings and events and share with staff across the directorate | | |
| **20** | **R8** | Develop and implement a recruitment and retention strategy specifically for the obstetric directorate | MS | Amber |
| **21** | | Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas | | |
| **22** | | Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention | Chase with HR | Green |
| **23** | | Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns | | Green |
| **24** | **Only applicable to multi-site trusts.** | Improve working relationships between the different sites located geographically apart but under the same organization. | | Green |
| **25** | **R9** | Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot | | |

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| **26** | **R11, R12** | Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported | | Green |
| **27** | **R11, R12** | Including a review of the processes for disseminating and | | |
| **28** | | Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively | All consultants to have completed RCA training | Green |
| | | | Identified midwives to have completed RCA training | Green |
| | | | Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills | Green |
| | | | Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates) | Green |
| **29** | **R12** | Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 | | |
| **30** | **R12** | Ensure that all Serious Incidents (SI's)are fedback to the staff | | |
| **31** | **R12** | Identify ways of improving attendance of midwives at SI's | | |
| **32** | **R13** | Maternity Services Liaison Committee involvement in complaints | Collation of complaints reports | |
| **33** | **R14** | Review the current obstetric clinical lead structure | | |
| **34** | **R15** | Review past SI's and map common themes | Thematic reviews | |
| **35** | **R23** | Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate | Maternal deaths, stillbirths and early neonatal deaths reports | |
| **36** | **R26** | Ensure that all staff are aware of how to raise concerns | Whistle blowing staff policy | Green |
| **37** | **R31** | Provide evidence of how we deal with complaints | | Green |
| **38** | **R31** | Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area | Identifying situations where local resolution is required | Green |
| **39** | **R32** | Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations | Implementation of the A-AQUIP model | |
| **40** | **R38** | Ensure that all perinatal deaths are recorded appropriately | Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager | |
| **41** | **R39** | Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained | MBRRACE action plan | Green |

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| **1** | The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report. |
| **2** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable |
| **3** | The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015. |
| **4** | Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015. |
| **5** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015. |
| **6** | The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015. |
| **7** | The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015. |
| **8** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016. |
| **9** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015. |
| **10** | The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015. |

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| **11** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. |
| **12** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016. |
| **13** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints |
| **14** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015. |
| **15** | The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed. |
| **16** | As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015. |
| **17 & 18** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups. |
| **Recommendations for the wider NHS** | |
| **19** | In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council. |
| **20** | There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence. |
| **21** | The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England. |

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| **22** | We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives. |
| **23** | Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and |
| **24** | We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England. |
| **25** | We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission |
| **26** | We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health. |
| **27** | Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. |
| **28** | Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts. |
| **29** | Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts. |
| **30** | A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission. |
| **31** | The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman. |
| **32** | The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom* ) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council. |

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| **33** | We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health. |
| **34** | The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman. |
| **35** | The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health. |
| **36** | The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health. |
| **37** | Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health. |
| **38** | Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England. |
| **39** | There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health. |
| **40** | Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health |

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| **41** | We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives. |
| **42** | We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor. |
| **43** | We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health. |
| **44** | This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current |

**APPENDIX A2**

# RESIDUAL OCKENDEN AND KIRKUP ACTIONS AND PROGRESS

| Ockenden Report (Shrewsbury and Telford Hospitals Trust) | | | | | | |
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| **IEA** | **Q.** | **Action** | **Evidence Required** | **RAG** | **Expected Completion Date** | **Current Position** |
| **IEA4** | **Q28** | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | Submission of an audit plan to regularly audit compliance. | | April 2022 | Current project underway. Complex women are allocated a named consultant. Local action plan stipulates monthly reporting on compliance and monitoring until embedded in to practice |
| **IEA5** | **Q33** | A risk assessment should be completed at every contact and include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Personal Care and Support Plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | | September 2022 | Risk assessments completed. PCSP Task and Finish co-production group established with support from PMO and CCG to develop and implement PCSPs. |
| **IEA6** | **Q34** | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. | Copies of rotas / off duties to demonstrate they are given dedicated time. | | April 2022 | Fetal monitoring leads in place. Leads are able to demonstrate time for dedicated fetal monitoring activities but unable to document on off-duty and rotas at present. Role included in the JD of midwifery education team. Ongoing discussions with the LMNS for funding for a dedicated WTE midwife FM lead. |
| **IEA7** | **Q42** | Women's choices following a shared and informed decision-making process must be respected. | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. | | April 2022 | Birth Choices Clinic in place and women supported along these pathways. Consultant Midwife to complete audit.<br><br>Failed IOL and subsequent Cat 3 LSCS is being audited at present. This will be reported into the Maternity & Neonatal Oversight Group and if compliance is demonstrated, the action will be completed. |
| **IEA7** | **Q44** | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified. | | May 2022 | MVP have completed gap analysis on Trust website; awaiting co-produced action plan following interruption to MVP activities. This issue remains under review by the Maternity & Neonatal Oversight Group. |
| **WF** | **Q47** | Director/Head of Midwifery is responsible and accountable to an executive director. | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director. | | March 2022 | JD updated and submitted as part of Ockenden submission but not accepted. Requires review with explicit signposting. |

**APPENDIX A2**

# RESIDUAL OCKENDEN AND KIRKUP ACTIONS AND PROGRESS

| Kirkup Report (Morecambe Bay) | | | | | | |
|---|---|---|---|---|---|---|
| **No.** | **Rec.** | **Action** | **Evidence Required** | **RAG** | **Expected Completion Date** | **Current Position** |
| **9** | **R2** | Review the current induction programme for locum doctors. | Locum policies. | | April 2022 | Lead Consultant has confirmed that locum induction and training is in place. This training is being reviewed to ensure it covers all areas needed. |
| **10** | | Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | | | | |
| **13** | **R2** | Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition. | Incident review and feedback, related lessons learnt, training opportunities | | July 2022 | Training included in PROMPT, MEWS and mandatory training, incident reviews. There is divisional attendance at the deteriorating patient sub-group. Ongoing QI project to support escalation. There is an identified need to return to face to face training. Monitor QI project as currently remains a theme in SI investigations. |
| **20** | **R8** | Develop and implement a recruitment and retention strategy specifically for the obstetric directorate. | | | June 2022 | Lead Consultant to confirm details of obstetric recruitment and retention strategy and ensure oversight through clinical governance/cabinet. |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | *Trust Board* |
| Date of Meeting | *1 March 2022* |
| Item Number | *Item 8.2* |
| *Briefing Paper on the National Patient Safety Strategy* | |
| Accountable Director | *Karen Dunderdale, Director of Nursing / Deputy Chief Executive*<br>*Colin Farquharson, Medical Director* |
| Presented by | *Kathryn Helley, Deputy Director of Clinical Governance* |
| Author(s) | *Kathryn Helley, Deputy Director of Clinical Governance* |
| Report previously considered at | *Executive Leadership Team / Trust Leadership Team / Quality Governance Committee* |

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

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| Risk Assessment | *To Be Confirmed* |
| Financial Impact Assessment | *Not Yet Determined* |
| Quality Impact Assessment | *To Be Completed* |
| Equality Impact Assessment | *To be Completed* |
| Assurance Level Assessment | *Moderate* |

| | |
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| Recommendations/ Decision Required | *The Trust Board is asked to:-*<br>• *note the content of the report.* |

## 1 Introduction

This paper outlines the national position in terms of patient safety and how this is currently overseen within the Trust.

## 2 National Picture for Patient Safety

*The NHS Patient Safety Strategy; Safer culture, safer systems, safer patients (July 2019)*

In July 2019 NHSI/E published 'The NHS Patient Safety Strategy; Safer culture, safer systems, safer patients'. It had 3 strategic aims which are underpinned by the two foundations of safety systems and safety culture as follows:-

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

The actions the NHS were to take under each of the aims above are outlined below.

Insight

The NHS will:

- Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is
- Use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system
- Introduce the Patient Safety Incident Response Framework to improve the response to and investigation of incidents
- Implement a new medical examiner system to scrutinise deaths
- Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee
- Share insight from litigation to prevent harm.

Involvement

The NHS will:

- Establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care (Patient Safety Partners)
- Create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS
- Establish patient safety specialists to lead safety improvement across the system
- Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong
- Ensure the whole healthcare system is involved in the safety agenda.

Improvement

The NHS will:

- Deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions
- Deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternity death and neonatal asphyxial brain injury by 50% by 2025
- Develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use currently considered highest risk
- Delivery a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety
- Work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance
- Work to ensure research and innovation support safety improvement.

Running alongside the above was a delivery plan outlining timescales and responsibilities. However, the Covid-19 pandemic impacted on the national rollout of the strategy and in February 2021, a revision to the delivery plan was published as outlined below.

*NHS Patient Safety Strategy: 2021 Update (February 2021)*

Those elements which are of relevance to the Trust are outlined below:-

| Objective | What and By When |
|---|---|
| Support the development of a safety culture in the NHS | Local systems to set out how they will embed the principles of a safety culture on an ongoing basis.<br><br>These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHSI/E 'A Just Culture Guide' or equivalent, adherence to the well-led framework and 100% compliance declared for National Patient Safety Alerts by their action complete deadlines. |
| Deliver replacement for the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) | Local systems, including current non-reporters, to connect to the new system by end Q4 2021/22 subject to local software compatibility. |
| Implement the new Patient Safety Incident Response Framework (PSIRF) | Local systems to plan how they will prepare for and support implementation of the PSIRF. This should be informed by nationally shared early adopter experience. Initially local systems should:-<br><br>• Identify PSIRF implementation leads by Q3 2021/22<br>• Review current resource (in terms of skills, experience, knowledge and personnel) and subsequent action required from beginning Q4 2021/22, to ensure organisations across the local system are equipped to respond to patient safety incidents as described in the PSIRF, and to undertake patient safety incident investigation (PSII) as described in the PSII standards. NB – leaders and staff must be appropriately trained in responding to patient safety incidents, including PSII, according to their roles, with delivery of that training from Q4 2021/22.<br>• Develop quality governance arrangements (from Q4 2021/2) that:-<br>- Support implementation and oversight of PSIRF requirements<br>- Eliminate inappropriate PSI/SI/patient safety performance measures from all dashboards / performance frameworks |

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| | - Monitor on an annual basis, the balance of resources for patient safety incident investigation versus improvement across the local system and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk. |
| Implement the medical examiner system | Ensure deaths in all areas (in non-acute settings as well as acute trusts) are scrutinised by medical examiners by end Q1 2022/23. |
| Patient Involvement in patient safety | Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees (or equivalents) by Q1 2022/23, and elsewhere as appropriate and who will have received required training by Q1 2023/24. |
| Deliver a patient safety curriculum and syllabus that supports patient safety training and education for the whole NHS | Support all staff to receive training in the essentials of patient safety by Q1 2023/24. |
| Develop a network of patient safety specialists | Identify to the national patient safety team at least one patient safety specialist per organisation by end Q3 2020/21.<br><br>Release some patient safety specialists for learning sets as required to inform the development of training for Q1 2021/22. |

In addition to the above, there are a number of requirements linked to the National Patient Safety Improvement Programme areas of:-

- Delivering the Managing Deterioration Safety Improvement Programme (ManDetSIP)
- Deliver the Adoption and Spread Safety Improvement Programme (A&S-SIP)
- Deliver the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- Deliver the Medication Safety Improvement Programme (MedSIP)
- Deliver the Mental Health Safety Improvement Programme (MHSIP)
- Deliver the UK National Action Plan for AMR.

*Short-Medium Term Priorities for Patient Safety Specialists (April 2021)*

In April 2021, a paper was published which describes how Patient Safety Specialists (PSSs) can support implementation of the NHS Patient Safety Strategy and operational recovery during 2021/22 and outlines 9 key work programmes as follows:-

1. Development of a Just Culture
2. Reviewing and Improving systems for implementing actions from National Patient Safety Alerts
3. Improving quality of incident reporting
4. Supporting the transition from the use of the National Reporting & Learning System (NRLS) and Strategic Executive Information System (StEIS) for the reporting of incidents and serious incidents the to Patient Safety Incident Management System (PSIMS)
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. Covid-19 recovery planning.

The paper attached at ***Appendix 1*** outlines some of the actions taken with respect to each of the elements, with the exception of Covid-19 recovery planning which is covered elsewhere, along with proposed next steps. The further actions required are being pulled into a comprehensive plan along with leads and completion dates.

*Related Documents*

To support the implementation of the National Patient Safety Strategy a number of related documents have also been developed:-

- Framework for Involving Patients in Patient Safety
- National Patient Safety Syllabus
- Identifying Patient Safety Specialists
- Introductory Version of the Patient Safety Incident Response Framework
- Patient Safety Incident Response Plan Template

## 3 Current Position and Next Steps

The Director of Nursing / Deputy Chief Executive is the Board Lead for patient safety. The Medical Director is the Board Lead for safety culture. The Deputy Director of Clinical Governance is the Trust Lead Patient Safety Specialist.

It is clear from the national literature that patient safety frameworks and the development of a safety culture are inextricably linked; having the right systems and processes for patient safety will support a strong safety culture.

Whilst work to address the requirements outlined above has commenced within ULHT, there is further work to do. In order to fully meet the national requirements

surrounding the patient safety agenda and ensure a co-ordinated and cohesive approach it has been agreed that:-

- One delivery plan is developed to address the requirements of the National Patient Safety Strategy and incorporating the current safety culture programme of work. This initiative will be jointly led at Executive level by the Director of Nursing / Deputy Chief Executive and the Medical Director. Day to day delivery will be overseen on their behalf by the Deputy Director of Clinical Governance, supported by members of both the current Safety Culture Team and the Clinical Governance Team, working alongside Divisions.
- The National Director of Patient Safety recently wrote to Directors of Nursing and Medical Directors asking that Boards receive a briefing on the role of Patient Safety Specialists. It has been agreed that the Board will receive this briefing at a public board meeting. Due to timings of these meetings, this is scheduled for 1 February 2022.

## 4 Action Required

The Trust Board is asked to:-

- note the content of the report.

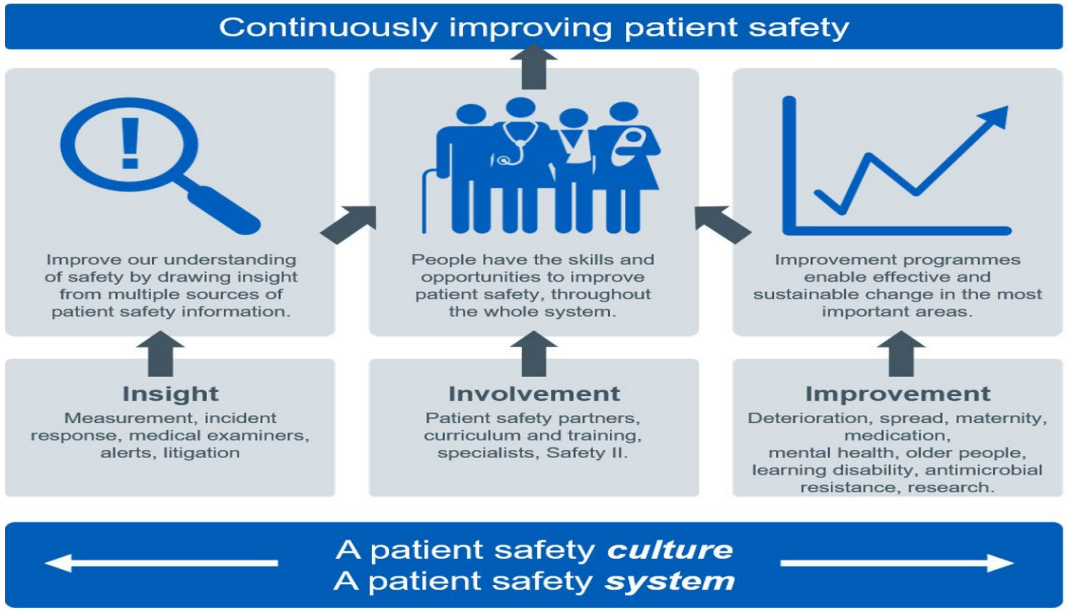
# Patient safety specialists (PSS)

Executive briefing document

2021

NHS England and NHS Improvement

# Patient safety specialists




Formally creating this role provides status and the expectation that having a patient safety specialist(s) who is fully trained in the national patient safety syllabus is standard across the NHS

Classification: Official

NHS

## Identifying patient safety specialists

August 2020

### Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

# Patient safety specialist role

- Lead patient safety experts in their organisation, working full time on patient safety
- Able to escalate immediate risks or issues to Exec team
- ‘Captains of the team’, provide dynamic senior leadership, visibility and expert support
- Work with others including: Medication safety officer (MSO), Medical device safety officer (MDSO), Maternity safety champions
- Lead /support the local implementation of the NHS patient safety strategy: insight, involvement and improvement
- Support the development of a patient safety culture and safety systems
- Work in networks to share and learn
- Lead, and may directly support, patient safety improvement activity
- Ensure that systems thinking, and just culture principles are embedded
- Support patient safety partners (Framework for involving patients in patient safety)
- Learn and develop, complete the Patient safety syllabus

# Key deliverables

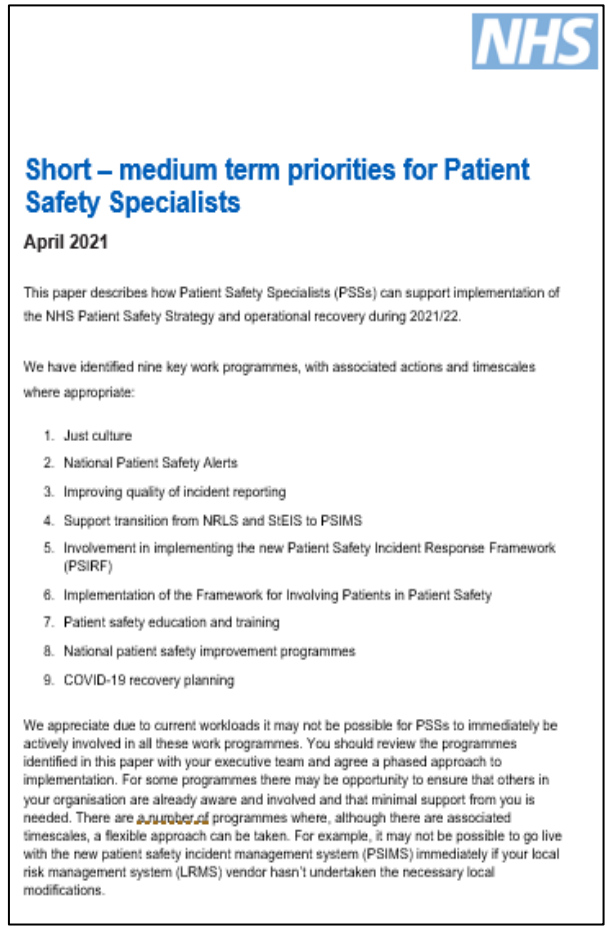
- 2019 - Role identified as part of the NHS patient safety strategy
- 2020 Mar - Patient safety specialists made a contractual requirement within the NHS Standard Contract 2021/22 section 33.7
- 2020 Aug/Nov - Identifying Patient Safety Specialists and providing nominations to NHSEI from every NHS organisation by 3011/20
- 2020 Nov – National webinars provided to support patient safety specialist training
- 2021 Apr – patient safety specialists to be full time in post
- 2021 Apr – patient safety specialist priorities document provided
- 2021 Jun - Patient safety syllabus available for patient safety specialists and training for the Board

# Early milestones

- Over 700 Patient Safety Specialists representing 96% coverage of relevant organisations
- We have held 16 national meetings – topics including:
  - National patient safety improvement programmes
  - Views on patient safety culture
  - PSIRF progress update
- Involvement in two national safety issues:
  - Beckton Dickinson infusion devices
  - Phillips device recall
- Involvement in national working groups including:
  - National Patient Safety Syllabus
  - Development of NHSX digital strategy
- Development of FutureNHS Collaboration platform (access via patientsafetyspecialists.info@nhs.net)
- Patient safety priorities document provided
- Starting to create region and ICS patient safety specialist networks

# PSS priorities (Apr-21)

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support – more information will be provided shortly



**Short – medium term priorities for Patient Safety Specialists**

**April 2021**

This paper describes how Patient Safety Specialists (PSSs) can support implementation of the NHS Patient Safety Strategy and operational recovery during 2021/22.

We have identified nine key work programmes, with associated actions and timescales where appropriate:

1. Just culture
2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning

We appreciate due to current workloads it may not be possible for PSSs to immediately be actively involved in all these work programmes. You should review the programmes identified in this paper with your executive team and agree a phased approach to implementation. For some programmes there may be opportunity to ensure that others in your organisation are already aware and involved and that minimal support from you is needed. There are a number of programmes where, although there are associated timescales, a flexible approach can be taken. For example, it may not be possible to go live with the new patient safety incident management system (PSIMS) immediately if your local risk management system (LRMS) vendor hasn't undertaken the necessary local modifications.

# Executive PSS support requirements

1. The Patient Safety Specialist was required to be identified by Apr-21. The expectation is 1FTE at band 8 range, but this may be a shared role, or more than 1FTE across large organisations
2. The PSS's name(s) has been provided to NHSEI by executive lead for patient safety
3. An executive lead for patient safety should be identified as the direct contact point for the PSS. The PSS should also link with the NED who leads on patient safety.
4. All Board members should be aware of and support the PSS's role and discuss as a board agenda item
5. The PSS priorities document (circulated Apr-21) should be reviewed and a PSS work plan agreed with the patient safety executive lead
6. The PSS should be provided with sufficient time and resources to undertake their role, network and complete the patient safety training requirements (to level 5 of the Patient safety syllabus once available)
7. There should be sufficient support/ coaching / mentoring in place for the PSS to progress their personal and leadership development

United Lincolnshire Hospitals
NHS Trust

# National Patient Safety Strategy Requirements

## Update as at 31 December 2022

Kathryn Helley, Deputy Director of Clinical Governance

OUTSTANDING CARE *personally* DELIVERED

# Priority 1 - Developing a Just Culture

**Actions Taken**

- Implementation of Human Factors Faculty of Trainers
- One day HF workshop training implemented
- “Its Safe to Say Campaign”
- Implementation of base line assessment of Safety Climate Survey- (Pascal)

**Next Steps**

- Collaborative working group with HR and OD to pull together all aspects of culture into one plan
- Implementation/Training plan for workforce
- Launch programme
- Agree utilisation of HF principles post incident management
- Agree method of implementing Just Culture into incident management process with a focus on learning.

# Priority 2 - Reviewing and Improving systems for implementing actions from National Patient Safety Alerts

## Actions Taken

- Meeting held with key stakeholders to review current Trust position, key roles and responsibilities.
- Review of policy undertaken to ensure key processes and messaging captured.

## Next Steps

- Review current processes for escalation with non-compliance.
- Review robustness of quarterly reporting into Patient Safety Group.

# Priority 3 - Improving Quality of Incident Reporting

## Actions Taken

- Incident management processes strengthened with robust twice weekly executive panels.
- Monthly upward reporting into the Patient Safety group with Divisional attendance.
- Improved Serious Incident reports with increased approval for CCG sign off.
- Daily vetting process by the central governance team to identify and escalate patient harm.

## Next Steps

- Relaunch incident reporting principles within the Trust as part of the migration to Datix Cloud with an emphasis on generating learning.
- 'The Journey of a Datix' as a platform to demonstrate to staff what happens when they submit a Datix.
- 'Its Safe to Say campaign' to be rolled out to promote safety and reporting culture.

# Priority 4 - Supporting the transition from the use of the NRLS and StEIS for the reporting of incidents and serious incidents to the PSIMS

## Actions Taken

- Current Datix Web does not support the automatic upload to LfPSE. Trust will continue to upload manually as we do now.

## Next Steps

- Business case submitted to move to Datix Cloud. Approved at CRIG and awaiting TLT confirmation.
- Further to this, implementation plan will be developed.

# Priority 5 - Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)

## Actions Taken

- Guidance expected Spring 2022 from early adopters experience.
- National recommendation not to commence work until guidance published as changes expected.
- Continue to take part in National calls to understand potential implications.

## Next Steps

- Await publication of training requirements for PSII investigations.
- Review previous 2 years incidents / complaints / PALs / claims to look for themes and identify potential areas for investigation and inclusion in PSIRP.
- Begin conversations with CCG in order to gain early understanding of new requirements.

# Priority 6 - Implementation of the Framework for Involving Patients in Patient Safety

## Actions Taken

- Case of Need and Business Case in draft format ready for presentation to ELT / TLT

## Next Steps

- Finalise Business Case
- Briefing paper to TLT / ELT
- Implementation plan to be developed

# Priority 7 - Patient safety education and training

## Actions Taken

- Level 1 and 2 training has been published.
- Currently developing a proposal regarding who would receive the training.

## Next Steps

- Proposal to be taken to ELT / TLT for approval.
- Working with IT to identify method of recording training.
- Rollout of training from 1 April 2022.

# Priority 8 - National patient safety improvement programmes

## Actions Taken

- National Patient Safety Programmes identified
- Establishing through East Midlands Collaborative, current organisational input

## Next Steps

- Agree lead for each programme
- Benchmark organisational progress against each programme
- Establishment requirement for project management

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|---|---|
| **Report to:** | Trust Board |
| **Title of report:** | People and OD Committee Assurance Report to Board |
| **Date of meeting:** | 15 February 2022 |
| **Chairperson:** | Professor Philip Baker, Chair |
| **Author:** | Karen Willey, Deputy Trust Secretary |

| | |
|---|---|
| **Purpose** | This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board.<br><br>This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board. |
| **Assurances received by the Committee** | **Assurance is respect of SO 2a**<br>**Issue: A modern and progressive workforce**<br><br>**Safer Staffing**<br>The Committee received the report noting that January had continued to be a challenging month for nurse staffing. The shortfalls being experienced were managed and mitigated on a daily basis with action taken. The challenges being faced were in the main due to the up turn in sickness absence as a result of the Omicron Covid-19 variant.<br><br>The Committee noted that Care Hours Per Patient Day had fallen short of planned hours which impacted on patient care and the ability to deliver care. There had also been a reduction in fill rates with the Committee noting that a fill rate of less than 80% had a direct impact on patient care.<br><br>Actions had included the redeployment of clinical and non-clinical staff and the continued Bank inventive scheme. It was noted however the demand for shift fill was the highest demand that had been seen.<br><br>The Committee noted that there had been an increase in patient falls and severity as a result of staffing difficulties with the Committee noting the impact on patient care as a result of reduced staffing.<br><br>**Education Funding**<br>The Committee received the report noting the update offered in respect of learning, education and development and were pleased to note that the had been agreement from the System to establish a Learning and Education Development Board.<br><br>The Learning and Education Development Board would provide transparency on the workforce development fund with an ongoing |

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| | process and oversight. Agreement was in place that this would be co-chaired by Health Education England.<br><br>Agreement had also been reached with the System that the Apprenticeship Strategy would site in the 5th pillar of the Lincolnshire People Plan, for which the Trust was responsible for leading the work.<br><br>The Committee noted the intention to appoint a Head of Education who would oversee education funding for the Trust and ensure the correct infrastructure was in place. |
| | **Assurance in respect of SO 2b**<br>**Issue: Making ULHT the best place to work**<br><br>**Staff Survey Feedback**<br>The Committee received the report noting the position of the initial review of the outcome of the National Staff Survey. The Committee were advised that benchmarking would take place once the full results were published and released from embargo.<br><br>The Committee noted the recommendations put forward within the paper for action to be taken noting that this would be presented to the Trust Board in private ahead of the release of the results.<br><br>**Guardians of Safe Working**<br>The Committee received the quarterly report from the Guardian of Safe Working noting a number of issues that had been raised by junior doctors.<br><br>Specifically these related to policy not being followed in respect of on call rest rooms being available, experience of racism and access to hot food overnight.<br><br>Action was being taken with Estates and Facilities to ensure the policy for on call accommodation was followed and rooms made available to staff as required.<br><br>The Committee were assured that actions were being taken to address the issues raised with an urgent need for a level of action to address the issue of racism, the Trust had a zero tolerance policy.<br><br>The Committee requested the use of Executive blogs to promote zero tolerance to racism and to advise how this could be reported. A solution in respect of hot food was being explored and would be progressed through the private Trust Board.<br><br>The Committee noted the request for a deep dive in to incidents in relation to workforce race equality standards in order to triangulate data with other sources including the staff survey and freedom to speak up. |

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| | **GMC Junior Doctor Survey Update**<br>The Committee received the report noting that this offered an update on internal surveys conducted by the Trust as the GMC Survey had been delayed.<br><br>In preparation for the main GMC survey the Trust conducted internal surveys in order to anticipate issues that were not being addressed.<br><br>The Committee noted a number of areas of improvements from the previous year in respect of induction, learning and teaching and education supervision. There were a number of hotspots identified where improvements were not as efficient. Work was underway to address this.<br><br>The Committee were advised of disharmony around rotas in general with under established rotas or these being released at short notice. Leave allocation was also noted as a difficult issue however there was focus on this through the medical workforce cell in order to make this more efficient.<br><br>A recent visit form Health Education East Midlands had identified a number of actions to be addressed and a re-visit was anticipated sometime in March/April.<br><br>**Culture and Leadership Project Team Upward Report**<br>The Committee noted that there had been discussions held throughout the meeting in respect of the Culture and Leadership programme of work. Actions were in place to review the current programme of work and reset this to deliver for the organisation. |
| | **Assurance in respect of SO 4b**<br>**Issue: To become a University Hospitals Teaching Trust**<br><br>No items received |
| | **Assurance in respect of other areas:**<br><br>**Draft Annual Report – Committee Effectiveness**<br>The Committee received the draft report noting the content and request for comments to be offered on the report. A final version would be presented back to the Committee that would support the production of the Trust Annual Report and Annual Governance Statement<br><br>**Committee Performance Dashboard**<br>The Committee received the dashboard noting the continued improvement in data being presented and the additional metrics that were presented alongside this. |

The additional metrics would be further developed prior to inclusion within the dashboard at future meetings.

The Committee took particular note of the performance in relation to staff sickness, mandatory training, turnover and appraisal noting that performance was not at an acceptable level. Work to address performance in these areas would be included in the objectives of the organisation and divisions in 2022/23 with trajectories for recovery.

A review of the WorkPal system would be undertaken to ensure this war fit for purpose with overlay reporting of appraisal for the medical workforce and agenda for change staff to present appraisal data.

The Committee noted concern in relation to control processes and onboarding in relation to recruitment services. The Committee noted the need to ensure capacity was in place to address areas of concern and fundamental issues. The Trust could no longer tolerate a stop start approach to addressing issues.

**People Directorate Update – Leadership overview and priorities**

The Committee received the continuation of the priorities presented in January noting that this offered an overview of organisational development.

The Committee noted the proposal of 2 new services, Employee Health and Wellbeing and Education, Learning and Development. These were proposed following consideration of staff views, data and senior leader observations.

The Committee noted the intention to review the Occupational Health Service offer following a significant focus on mandatory vaccination and Covid-19. Consideration would be given to the skill mix, operating model and a root and branch review.

The Committee were reassured that the actions described and proposals made would, along with leadership activity, achieve the desired outcomes however caution was noted in respect of number of actions being taken on.

**PRM Upward Report**

The Committee received the report noting that the Performance Review Meetings would continue to develop alongside reporting to the Committee in order that assurance could be provided.

**Board Assurance Framework**

The Committee received the Board Assurance Framework noting the updates offered. The assurance ratings remained unchanged however

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| | the Committee were hopeful that movement would be seen in the near future as further assurances were received.<br><br>**Integrated Improvement Plan**<br>The Committee received the report noting that due to the current reporting format the information offered was now historic. The Committee were pleased to note the intended refresh of reporting to ensure a focus on those areas of the IIP that were relevant to the Committee. |
| **Issues where assurance remains outstanding for escalation to the Board** | The Committee wished to escalate to the Board the need to ensure consistent focus on issues raised at the Committee with a move away from the start stop approach to activity due to operational pressure and the response to Covid-19. |
| **Items referred to other Committees for Assurance** | No items referred |
| **Committee Review of corporate risk register** | The committee received the risk register noting the current risks presented and requested that further clarification be offered in relation to the mitigated risk level. |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | No areas identified |
| **Committee position on assurance of strategic risk areas that align to committee** | No areas identified |
| **Areas identified to visit in ward walk rounds** | No areas identified |

**Attendance Summary for rolling 12 month period**

| Voting Members | M | A | M | J | J | A | S | O | N | D | J | F |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Geoff Hayward (Chair) | X | A | X | X | X | Meeting not held | | | | | | |
| Philip Baker | | | | | | | | X | X | X | X | X |
| Sarah Dunnett | X | X | X | X | X | | | X | X | X | X | |
| Gail Shadlock | | | | | | | | | | | | X |
| Karen Dunderdale | C | X | A | X | D | | | X | X | X | X | X |
| Paul Matthew | | | | | | | | X | X | X | X | X |
| Martin Rayson | X | X | X | X | X | | | | | | | |
| Simon Evans | C | C | D | A | D | | | A | A | A | A | X |
| Colin Farquharson | | | | | | | | X | X | X | X | X |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

OUTSTANDING CARE personally DELIVERED

United Lincolnshire Hospitals NHS Trust

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| **Report to:** | Trust Board |
| **Title of report:** | Finance, Performance and Estates Committee Assurance Report to Board |
| **Date of meeting:** | 21 February 2022 |
| **Chairperson:** | Dani Cecchini, Non-Executive Director |
| **Author:** | Karen Willey, Deputy Trust Secretary |

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| **Purpose** | This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.<br><br>This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. |
| **Assurances received by the Committee** | **Assurance** in respect of SO 3a A modern, clean and fit for purpose environment<br><br>**Estates Report**<br>The Committee received the report noting the further iteration to the style presented and further development that would take place to improve assurance.<br><br>The Committee noted the recent infection, prevention and control review undertaken by NHS England which had offered a positive view and comment on the estate of the organisation.<br><br>Progress was noted in respect of governance processes within the directorate including the appointment of substantive staff taking on authorised person roles.<br><br>The Committee were pleased to note the positive position relating to fire safety and the receipt of letters from Lincolnshire Fire and Rescue which demonstrated the improvements that had been made in recent years. This was the lowest level of intervention and reflected the improved relationship the Trust had with the regulator and Lincolnshire Fire and Rescue.<br><br>**Emergency Planning Group Upward Report to inc Majax Learning**<br>The Committee received the report noting that this formalised the verbal update provided to the January Committee meeting. The official report from the major incident would be presented following the workshop debrief.<br><br>The Committee noted that it was beneficial to have the update documents and noted that a formal report would be received once this had been through process. |

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| | **Health and Safety Committee Upward Report**<br>The Committee received the report noting the discussions that had taken place. Whilst it was recognised that the meeting was not quorate there had been reasonable debate with the meeting functioning well.<br><br>The Committee noted that there would be benefit in further understanding the governance of Health and Safety through the Divisions to the Health and Safety Committee. |
| | **Assurance** in respect of SO 3b Efficient Use of Resources<br><br>**Finance Report inc CRIG upward report, Contract Report and Efficiency Report**<br>The Committee received the report noting the continued position of a £1.8m System surplus.<br><br>The Committee noted the reasons for the financial position remaining broadly the same with pay continuing to be greater than plan however non-pay continued to be favourable to plan due to reduced levels of elective activity required.<br><br>The Committee noted the Cost Improvement Programme position noting that the Trust had delivered to plan year to date for H2 however further work was required to move to recurrent transformation in 2022/23. Further assurance was sought by the Committee in respect of CIP and the activity in place to deliver.<br><br>The Committee was assured on delivery of the financial plan at year end however noted the financial risks around Covid-19 and winter pressures. However, it was also noted that this was now capped due to staff availability through bank and agency.<br><br>The Committee noted the Capital, Revenue and Investment Group upward report and noted that whilst metrics were now being included benefits realised would require reporting.<br><br>The Committee noted the position presented in respect on the contract for 2022/23 being advised of the key headlines and recommended onward to the Board for approval.<br><br>**Capital Report**<br>The Committee noted the clear report that had been received that offered a clear position in relation to capital spend. There remained a significant amount of capital for delivery in the remainder of the financial year.<br><br>The Committee noted the level of assurance received in relation to the process and tracking of schemes with an expectation that the majority of the remaining capital funding would be spent by the year-end. |

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| | **Costing Update – PLICS**<br>The Committee received the report noting the update offered for the end of quarter 2. The Committee noted that the reporting period was prevalent for Covid-19 whilst the Trust had been trying to restore services which had impacted the position.<br><br>The Committee noted that there would be benefit in the reintroduction of costings against 2019/20 due to the impact of Covid-19 on the 2020/21 year. Further work was required on costings to present this to the organisation and support the efficiency programme.<br><br>**Costing Strategy**<br>The Committee received the costings strategy noting that this required clinical engagement to support the use of costings within the organisation.<br><br>The strategy would offer a framework to support engagement and improve how costing was viewed with a greater understanding about cost base that could be reduced.<br><br>The Committee supported the creation of the governance framework to gain wider engagement across the organisation noting that accountability would be held through the Trust Leadership Team and Committee. |
| | **Assurance** in respect of SO 3c Enhanced data and digital capability<br><br>**Electronic Patient Records**<br>The Committee received the report noting that the Board had been sighted on this previously and noting the national requirement to have an EPR in place by December 2024.<br><br>The Committee noted the progress of the EPR and the availability of appropriate funding to support Trusts in implementing an EPR by the national deadline. It was noted that the Trust anticipated being partially digital by the national deadline with the progress that was required.<br><br>**Digital Hospital Group Upward Report**<br>The Committee received the upward report from the Group noting the discussions that had been held particularly in relation to electronic patient record, cardiology, e-PMA and GP Radiology Requesting.<br><br>The Committee noted that the delivery of the e-PMA solution would be sooner than anticipated with completion of the roll out by March 2023. |
| | **Assurance** in respect of SO 4a Establish new evidence based models of care<br><br>No items received |

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| | **Assurance in respect of other areas:**<br><br>**Annual Report – Committee Effectiveness**<br>The Committee received the draft report noting the content and request for comments to be offered on the report. The Committee offered some suggestions for inclusion and a final version would be presented back to the Committee. The report would support the production of the Trust Annual Report and Annual Governance Statement<br><br>**Committee Performance Dashboard**<br>The Committee received the dashboard noting the current performance and continued increase in the use of bank and agency staff including price and volume growth.<br><br>The Committee noted the cash position as a result of the introduction of the new ledger system however noted that this was being resolved by the Finance Team.<br><br>The Committee noted that the indicators relating to first outpatient appointment within 4 weeks and admission by 10am remained off track and were impacting performance of planned and urgent care pathways.<br><br>**PRM Upward Report**<br>The Committee received the report noting that the Performance Review Meetings would continue to develop alongside reporting to the Committee in order that assurance could be provided.<br><br>**Integrated Improvement Plan**<br>The Committee received the report noting that this offered the position to the end of January with some elements being off track, as expected. The risks to delivery of the IIP were noted due to the lack of capacity.<br><br>There was a need to be clear about how the overall objectives were reflected within the scorecard however this would be developed as part of the year 3 IIP refresh for 2022/23.<br><br>The Committee noted the need to receive assurance on the programmes of work in place and that these were adequately resourced to deliver the expected outcomes.<br><br>**Integrated Planning Position**<br>The Committee received the report noting that this offered an overview of workforce, activity and finance considerations for the 2022/23 operational plan.<br><br>The Committee noted the planning considerations and the intention to support 3-year divisional operational planning. A focus would be afforded to the planning submission however from April 2023 work would be undertaken to develop the 3-year plan for divisions. |

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| | The Committee noted and supported the intention to establish a Planning Steering Group that would have key oversight on key recovery areas. The planning process appeared to be robust however capacity was recognised as a risk to both the delivery of a strong plan as well as delivery of performance and activity.<br><br>**Operational Performance against National Standards:**<br>**Urgent Care**<br>The Committee received the report noting the performance position in respect of 12-hour trolley waits and increased length of stay.<br><br>The Committee noted the actions in place including same day emergency care and Multi-Agency Discharge Events (MADE) in order to increase discharge and address exit blocks being experienced.<br><br>The Committee noted the requirement to be clear on actions being taken to mitigate the issues and assurance on those actions being embedded that were successful in order to improve flow and performance.<br><br>**Cancer Performance**<br>The Committee noted the report and recognised the forecast deterioration in performance had been realised with further deterioration expected in the current reporting period.<br><br>The Committee were pleased to note however that there had been a reduction in 62-day treatment backlogs with the Trust moving into the recovery phase of the Covid-19 response. A focus would be given to 104-day and 62-day treatment backlogs followed by the P2 category in planned care to reduce backlog numbers.<br><br>The Committee noted the need for clarity on the recovery trajectory in order to receive assurance. The Committee noted recovery of cancer services would be faster than that of planned care and a trajectory would be presented going forward.<br><br>It was noted that the Surgery Robot had been delivered with the first surgery having been undertaken with great success.<br><br>**Breast Service Update**<br>The Committee received a specific update in respect of breast services and noting the discussions had taken place with the East Midlands Cancer Alliance to seek mutual aid.<br><br>Breast services were challenged across the region and it was noted that whilst funding was in place offering support to the Trust, mutual aid could not be offered immediately.<br><br>The mastalgia pathway was in place to support patients who were very low risk to be seen by other services that protected the cancer 2 week wait availability. |

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| | The Committee noted the limited assurance being offered however noted the mitigations that were in place.<br><br>**Planned Care**<br>The Committee received the report noting planning guidance in respect of recovery of services noting that for the Trust this would be a 2-3 year period.<br><br>The position in respect of 104 week waits remained positive and would return to 0 by March 2022. 52-week waits had seen an increase however a plan was in place to tackle long waiting patients in the first instance.<br><br>The Committee noted the C2AI (Artificial Intelligence) system being utilised by the Trust to support classification of patients although noted that this did not replace clinical review.<br><br>National benchmarking was not in place for the additional 26 data sets that had been put in place during Covid-19 with the Committee noting that should these become national standards benchmarking would be possible.<br><br>**Internal Audit Reports – Capital Planning and Data Quality**<br>The Committee received the reports noting the outcome of the audits and oversight required recognising that the ultimate oversight of the recommendations sat with the Audit Committee. |
| **Issues where assurance remains outstanding for escalation to the Board** | None |
| **Items referred to other Committees for Assurance** | None |
| **Committee Review of corporate risk register** | The Committee received the risk register noting the risks presented noting that consideration may need to be given to the reporting of risks associated with performance that overlapped with patient harm and were sighted by the Quality Governance Committee |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | No items identified |
| **Committee position on assurance of strategic risk areas that align to committee** | As above |

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| **Areas identified to visit in dept walk rounds** | None |

**Attendance Summary for rolling 12-month period**

| **Voting Members** | M | A | M | J | J | A | S | O | N | D | J | F |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gill Ponder, Non-Exec Director | X | X | | | | | | | | | | |
| David Woodward, Non-Exec Director | | | O | X | X | X | X | X | X | X | | |
| Dani Cecchini, Non-Exec Director | | | | | | | | | | | X | X |
| Geoff Hayward, Non-Exec Director | X | A | X | X | A | | | | | | | |
| Chris Gibson, Non-Exec Director | X | X | X | X | X | X | A | X | X | X | X | X |
| Gail Shadlock, Non-Exec Director | | | | | | | | | | | | X |
| Director of Finance & Digital | X | X | X | X | X | X | X | X | X | X | X | X |
| Chief Operating Officer | D | X | X | X | X | X | X | X | X | X | X | X |
| Director of Improvement & Integration | X | X | X | X | X | A | | | | | X | X |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19
O Observing

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | Trust Board |
| Date of Meeting | 1st March 2022 |
| Item Number | Item 12 |
| Integrated Performance Report for January 2022 | |
| Accountable Director | Paul Matthew, Director of Finance & Digital |
| Presented by | Paul Matthew, Director of Finance & Digital |
| Author(s) | Sharon Parker, Performance Manager |
| Report previously considered at | N/A |

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

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| Risk Assessment | *N/A* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | • *Limited* |

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| Recommendations/ Decision Required | • *The Board is asked to note the current performance and associated actions/escalations where appropriate* |
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## Executive Summary

**Quality**

### Falls

There have been 1 fall in January resulting in death. This incident is currently being validated through the incident management process and the appropriate level of investigation will be instigated. Overall, this month, inpatient falls saw an increase of 11 from the previous month. A number of actions are being taken and can be seen further within this report.

### Pressure Ulcers

The number of category 2 PU is at 35, category 3 PU is at 3, category 4 PU is at 1 and unstageables at 8 for January 2022. A skin integrity education proposal has been developed and will be presented to Skin Integrity Group (SIG) in February. This tiered approach will provide a structured framework to develop knowledge and competency of staff groups based on the requirements of their role.

### VTE

Trust performance for January was 94.8% just below the target of 95%.

### Medications

For the month of January, the number or incidents reported in relation to omitted or delayed medications equated to 29% a slight decrease from the previous month. 18.8% of medication incidents identified that harm had been caused and is noted to be above the national average but a decrease from the previous month. A Medicines Management project group will commence from February and aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

### HSMR

The Trust HSMR is currently at 107.4 which shows an increase but overall HSMR has been seeing a reduction. Previous Dr Foster data demonstrated a lower HSMR – the Trust has contacted Dr Foster to request why the data is higher than they previously reported.

**SHMI**

The Trust is currently at 110.73 for SHMI, which is within the “as expected” range. The Trust are currently in the process with the system partners in rolling out the ME service for community deaths and learning can be generated for deaths within 30 days alongside a peer review by NHSEI for structured judgement reviews.

**Participation in National Clinical Audits**

The Trust is participating in 98% of all relevant national clinical audits. The Trust has now registered for the IBD audit which will make us 100% compliant and data collection was due to commence in October 2021 however problems have occurred with IBD logins due to a national upgrade which has now been rectified and training plans to commence in February.

**eDD**

The Trust achieved 89.5% with sending eDDs within 24 hours for January 2022 against a target of 95% with 93.4% being sent anytime within the month.

## Operational Performance

The Covid 4th wave has seen an increase demand in terms of hospitalisation with numbers of inpatients now reducing. At the time of writing this executive summary, the Trust has 47 positive inpatients, of which 1 patient is requiring Intensive Care interventions. The Peak of wave 4 saw 90 patients being treated as inpatients. The impact of the 4th wave on staff absences remains significant due to the increased prevalence of positive cases within our population. Lincolnshire has had at times the highest sickness rate in the Midlands. The current sickness absence attributed to Covid as at 4th February is 96 out of 744. The change in national isolation and testing guidance has had a significant impact.

This report covers January's performance, and it should be noted that as the demands of Wave 4 increased, the Trust has continued the Manage phase whilst acknowledging the absolute need to combine the recovery and restoration of services as per H2 planning and delivery assumptions. Guidance in how performance and recovery is approached is defined by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT. New Emergency and Planned Care Standards which are now being implemented, monitored, and reported going forwards.
On 1st January 2022 at 22.45hrs, the Trust escalated to an Internal Critical Incident where it remained unable to de-escalate for 11 days. On 11th January 2022, due to increased and unrecoverable operational pressures at LCH and a complete loss of water services event at GDH, the Trust declared a Major Incident. This declaration led to a System request for mutual aid. The Major Incident was 'stood down' to Critical Incident on 12th January and de-escalated further on 13th January to an organisational OPEL 4 – extreme pressure.
The Trust engaged with a System and Region supported MADE (Multi-Agency Discharge Event) on 20th and 21st January at LCH and 27th and 28th at PHB/GDH.
The impact of MADE at LCH led to a de-escalation from OPEL 4 to OPEL 2 within 48hrs on each site it operated on.

### A & E and Ambulance Performance

Whilst the summary below pertains to January's data and performance, the proposed new Urgent Care Constitutional Standards continue to be adopted and run in shadow form. Performance against these will be described in the supplementary Urgent Care FPEC paper. Amendments to the Urgent Care IPR dashboard were made in December and continue to be refined further as more data becomes available.
Escalations to Incident Management/Command and Control are now being recorded via DATIX.

4-hour performance for January deteriorated against December's performance of 64.67% being reported at 63.49%. The Trust's performance has been below the agreed trajectory consistently for 15 months.

There were 465 12-hr trolley wait, reported via the agreed process. This represents an increase of 29.04% from December. Sub-optimal discharges to meet emergency demand remains as the main route cause but has been compounded with increased staff absence through sickness. (Implications of this risk are captured in the Trust Risk Register)

Performance against the 15 min triage target in January demonstrated further improvement of 0.47% compared with December. 86.62% in January verses 86.15% in December.

Overall Ambulance conveyances for January were 4,242 up by 75 conveyances. 1.77% increase against December. There were 656 >59minute handover delays recorded in January, an increase of 2 from December, representing a 0.31% increase. Delays experienced at LCH and PHB are attributed to increased levels of overcrowding in EDs and managing the low, medium and high-risk IPC pathways. January demonstrated an overall increase of >120mins handover delays compared with December, 261 in January compared with 238 in December, representing an 8.82% deterioration. >4hrs handover delays decreased, 35 in January compared to 39 in December. This represents a 10.26% decrease.

**Length of Stay**

Non-Elective Length of Stay remains of concern and is the major contributor to overcrowding in EDs and the subsequent impact on ambulance handovers. The average bed occupancy for January 2022, was 90.9% vs for December 90.1% 2021. Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase of patients being identified as medically optimised patients across the entire week (7days). System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) has decreased in availability and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System. Elective Length of Stay has increased slightly in January to 2.72 days (December reported 2.59 days). This is mainly due to a higher level of complex patients accessing surgical pathways that require post-operative care period in intensive care or level 1 beds.

**Referral to Treatment**

It is important to view and read this in the context of the current National Covid Restore Agenda, and the move away from a focus on constitutional standards to the expectation of clinical urgency; a clinical risk-based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be complete improvement to statutory RTT performance for some time.

December demonstrated a decrease in performance of 0.61% to 54.97%. The Trust reported 2185 incomplete 52-week breaches for December end of month compared to 1983 in November. The Trust remains in a strong position when compared to other regional providers.

The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL. At the end of November, the Trust reported 9 patients waiting longer than 104weeks.As of 10th January the Trust has 17 patients waiting longer than 104 weeks. This has been identified as a patient choice issue.

**Waiting Lists**

Overall waiting list size has increased in December to 59,747 compared to 57,105 in November, an increase of 2642. Work continues between OPD and the CBUs regarding the returning to a standard ‘polling’ approach as part of our restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. January demonstrated a reduction (424 verses 443 in December). As of 6th February, ASI numbers have increased to 451 but is still below the agreed trajectory. The trajectory is 550.

As at 31st January 2022, the Trust reported 20,739 over 26 week waits, 8,743 over 40 week waits, 2,839 over 52 weeks and 85 over 78 weeks. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

**DM01**

DM01 for January reported a 58.88% compliance against the national target of 99%. A negative variation of 40.12% and is a 1.66% deterioration on December outturn.

**Cancelled Ops**

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. January 2022 demonstrated a 2.21% compliance. A negative variance of 1.41% against the agreed target and a deterioration of 0.39% on December 2021.

The target for not re-booking late notice cancellation of operations is zero. January 2022 experienced 31 breaches against this standard verses 21 in December 2021.

A review of the effectiveness of the 642 theatre scheduling meetings is in train, however with variations in ICU capacity as a response to internal and external pressures is improving so it is likely that performance will improve.

**Cancer**

Of the ten cancer standards, ULHT achieved two. Nationally two were met.

The current compliance trajectory is 85.40%. Trust compliance against this agreed trajectory is 42.07% %. A negative variance of 43.33%

38.90% of the 14-day breach performance was attributed to the Breast Service in respect of the One-stop appointments. A demand verses capacity gap exists and has been previously articulated with actions including mutual aid. This also applies to the Symptomatic Breast service.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62-day standards.

62 Day pathway backlogs are not reducing in line with the trajectory – 487 as of 9th February 2022 verses 550 as of 10th January 2022.

## Workforce

Mandatory Training – Mandatory training rates have remained constant over the past 2 months. Staffing challenges and the lack of protected time while on shifts is being cited as one of the main reasons for staff not completing their core learning. Some staff have also mentioned access issues from home.

Sickness Absence – Following a further peak at the beginning of February, absence figures are now continuing to drop for the first time in months and rates are now hovering at 7+% throughout the latter part of the month. The Covid absence rates have continued to also reduce, however it is important for the board to note that due to further government restrictions being lifted (as per the announcement on 21.2.22) it may give a potential risk on the Covid absences rapidly rising again.

A review of the Trusts recording and monitoring within the Absence Management System is beginning to be put in place and a new project support manager has been recruited to support the process. It is already acknowledged that managers need to ensure that the data recorded in the system is accurate and up-to-date as this will and does affect the system reporting on 'unknown' and 'no reason' absences being recorded. Work continues with the Senior HR Business Partners having access to regular reports so that they can escalate areas of concerns within their allocated Directorates and report on local absence rates.

Additional on-site Physiological support is in the final stages of being arranged with a Business Case being prepared for approval of the additional funding required.

The requirement for the mandatory Covid vaccination for employees is still on hold and pending the outcome of consultation at Parliament and guidance is still to be received in terms of staff absent from work with 'long covid' and the framework moving forward.
Staff Appraisals – Ongoing operational pressures in the Trust has impacted the appraisal completion rate to some extent. The OD team contacted over 200 people to understand the issues associated with appraisal completion and a report will be presented to TLT/ELT with the findings.

Staff Turnover - Over the past few months, we have seen an increasing trend for turnover. Operational pressures, staffing challenges and Covid has meant that an increasing proportion of staff are looking for other avenues outside the Trust. The recent staff survey results are being shared shortly and this will shed more light on staff morale and current challenges. The team are currently working on a digital solution for exit surveys so as to capture information when people leave the organisation. We are also looking at enabling face to face exit interviews.

## Finance

The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract.

The Lincolnshire system resubmitted its financial plan for H1 of 2021/22 to take account of Elective Recovery Funding (ERF). The revised H1 financial plan for the Trust is inclusive of a £1.8m surplus position, £7.6m ERF, costs of restoration of £5.8m and a requirement for the Trust to deliver cost improvement (CIP) savings of £6.4m. The Trust delivered a £1.8m surplus in H1 (in line with plan).

The Lincolnshire system has submitted a break-even position for H2 including delivery of £20m of efficiency savings. As part of the system plan, the Trust plans a break-even position in H2 including delivery of £6.0m of efficiency savings. The Trust delivered a £123k surplus position in month 10, and the Trust has YTD delivered a surplus of £1,923k (£123k favourable to plan.

The capital programme for 2021/22 currently stands at c£47.5m for the full year (inclusive of informal TIF bid notification); actual capital expenditure of £18.3m has been incurred YTD against a submitted plan YTD of £25.8m.

The month end cash balance is £67.7m which is an increase of £13.7m against cash at 31 March 2021.

**Paul Matthew**
**Director of Finance & Digital and (interim) People**
**February 2022**

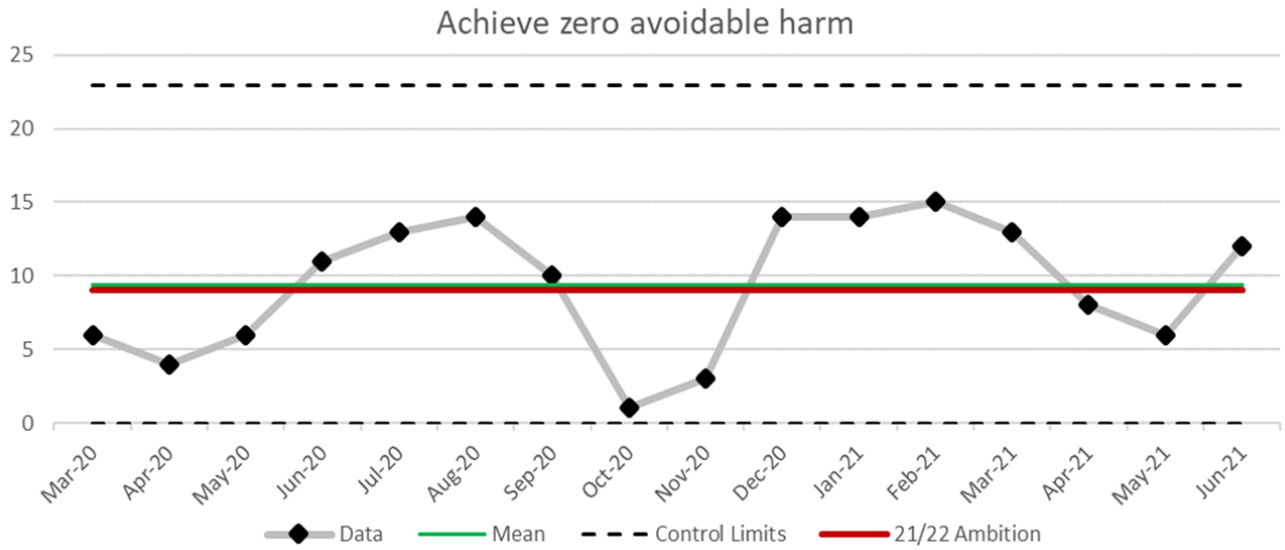
## Statistical Process Control Charts

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



## Statistical Process Control Charts

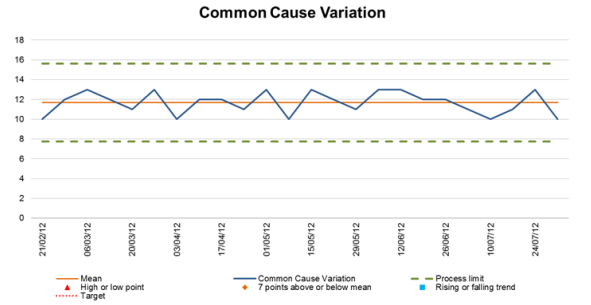
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

Within an SPC chart there are three different patterns to identify:

- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

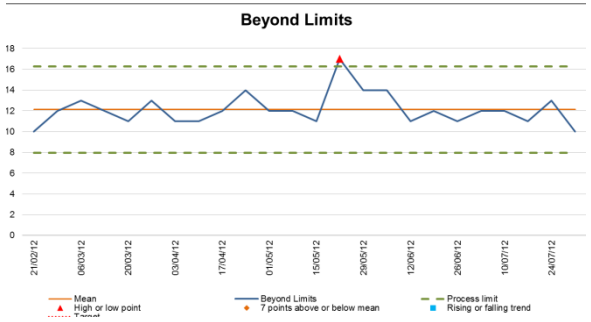
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

**Normal Variation**



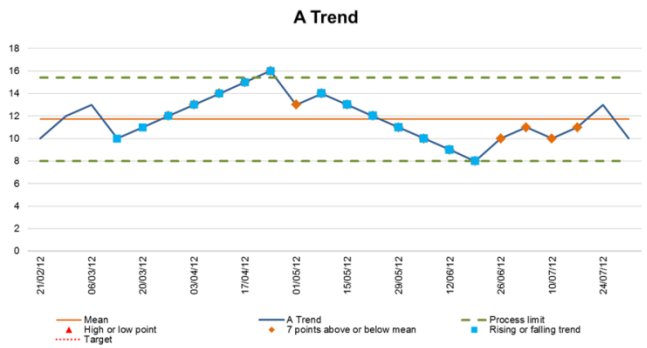

**Extreme Values**

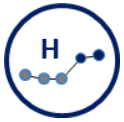
*There is no Icon for this scenario.*



# Statistical Process Control Charts

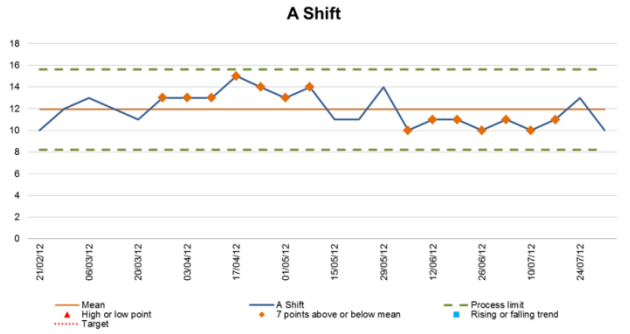
**A Trend (upward or downward)**





**A Trend (a run above or below the mean)**






**Where a target has been met consistently**

Where the target has been met or exceeded for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7


**Where a target has been missed consistently**

Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

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NHS United Lincolnshire Hospitals NHS Trust

# EXECUTIVE SCORECARD

| Strategic Goal | Domain | Measure ID | Measure | Measure Definition | Baseline | 21/22 Ambition | £'000 | 2021/2022 Nov | Dec | Jan | Latest month pass/fail to ambition | Trend variation |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Metrics | Patients | 1 | Top 25% for acute Trusts for 'Overall' Inpatient experience | Monthly Inpatient Friends and Family Test results, which are a proxy for annual inpatient experience survey. | 4th Quartile | 3rd Quartile | | 4th Quartile (89.45%) (102nd of 118) | (tbc) (90.43%) (tbc) | | F | |
| | Patients | 2 | Achieve zero avoidable harm | Serious incidents (including Never Events) of harm - Moderate, severe and death. | 15 | 9 | | 12 | 2 | 5 | P | |
| | Patients | 3 | Top 25% for SHMI | Summary Hospital-level Mortality Indicator | 4th Quartile | 4th Quartile | | 4th Quartile (111.39) (109th of 122) | 4th Quartile (110.20) (105th of 122) | 4th Quartile (110.73) (106th of 122) | P | |
| | People | 4 | Top 25% for acute Trusts across all 10 themes in the staff survey | In year monitoring via staff survey on staff morale and leadership. | | +10% improvement | | | | | | |
| | Partners | 26 | Deliver 62 day combined cancer standard (77%) | Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services. | 69.20% | 77% | | 57.10% | 54.30% | | F | |
| | Partners | 27 | Total wait in Emergency Department over 12 hours (<1% of patients) | Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances. | 3.60% | <1% | | 16.58% | 14.30% | 17.43% | F | A |
| | Partners | 28 | Urgent Treatment (P2) treatment turnaround time is less than 4 weeks | Waiting time from receiving patient referral until treatment is given. | 6.7 | <4 weeks | | 6.0 | 6.3 | 7.5 | F | |
| | Partners | 29 | Deliver Outpatient activity through non-face to face | Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient | 45.28% | >25% | | 32.92% | 32.85% | 33.41% | P | B |
| | Services | 9 | Deliver a breakeven revenue position | Financial status - Revenue monthly variance to plan | | Breakeven | £'000 | £0.00 | £0.00 | £123.00 | P | |
| | Services | 10 | Deliver £200m capital plan | Financial status - Capital monthly actual shown cumulatively | £15m | £39m | £'000 | £10,158.09 | £12,887.30 | £18,341.70 | F | |
| Local Projects | Patients | 11 | No. of medication errors causing harm is <10% | Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents. | 20% | 13% | | 20.30% | 23.20% | 18.80% | F | |
| | Patients | 12 | Reduce no. of patient fall incidents. (Last 3 month Average) | Number of Falls reported (including no harm) | 200 | 159 (-20.5%) | | 168.0 | 172.3 | 180.0 | F | H |
| | People | 13 | % of staff saying proud to work for ULHT | Staff survey on morale and leadership | | +10% improvement | | | | | | |
| | Partners | 14 | First non elective admission by 10am | Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards. | 48% | 60% | | 67.25% | 62.18% | 57.14% | F | |
| | Services | 15 | Reduce agency spend by 25% | Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - cumulative actuals | £44m | £33m (-25%) | £'000 | £30,316 | £34,171 | £38,060 | F | |
| Watch Metrics | Patients | 16 | Reduce complaints around discharge by 50% | Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled | n/a | | | | | | | |
| | Patients | 17 | Reduce complaints about the experience in A&E by 50% | Patient experience complaints about treatment of A&E | n/a | | | | | | | |
| | Patients | 18 | Time to screening and treatment for sepsis (1 hour) | Number of sepsis incidents reported - % of 8 metrics passing to 90% | 37.5% (3/8) | 62.5% (5/8) | | 50% (4/8) | 37.5% (3/8) | | F | |
| | Patients | 19 | Reduce incidence of pressure ulcers | Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable | 58 pcm | 45 pcm | | 47 | 51 | 47 | F | |
| | People | 20 | % of staff that feel trusted and valued | Staff survey on morale and leadership | | | | | | | | |
| | People | 21 | No. of managers trained in coaching skills | Staff survey on morale and leadership | | | | | | | | |
| | Partners | 22 | Increase the proportion of patients seen by a decision maker within one hour | Patient arrival to the time seeing a A&E doctor, within 1 hour. | 50% | | | 50.69% | 46.33% | 50.47% | | |
| | Partners | 23 | Reduction in the new to follow up ratio | Reduction in the number of follow up outpatient activities undertaken. | 1:2.28 | | | 1:1.58 | 1:1.56 | 1:1.52 | | |
| | Partners | 24 | First OPA within 4 weeks | Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone). | 51% | | | 40.35% | 38.60% | 34.28% | | B |
| | Services | 25 | Improve CIP performance to a minimum of 4% by 2021/22 | Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to CIP plan (H1 £6.412m) | £11.1m | £15.4m | £'000 | -£486.00 | £468.00 | £0.00 | P | |

Quality | Operational Performance | Workforce | Finance

(Grey means data unavailable, red is missing)

This executive scorecard will eventually complement the introduction of a new performance routines process, which is currently under development with Divisional executives, alongside the review and development of the IPR report. The new performance routines introduced are deploying new divisional performance scorecards, which eventually will be underpinned by business unit scorecards. All of these scorecards will complement this executive scorecard. Eventually all the reporting performance processes will be realigned to enable consistency of approach on the internal reporting Trust wide.

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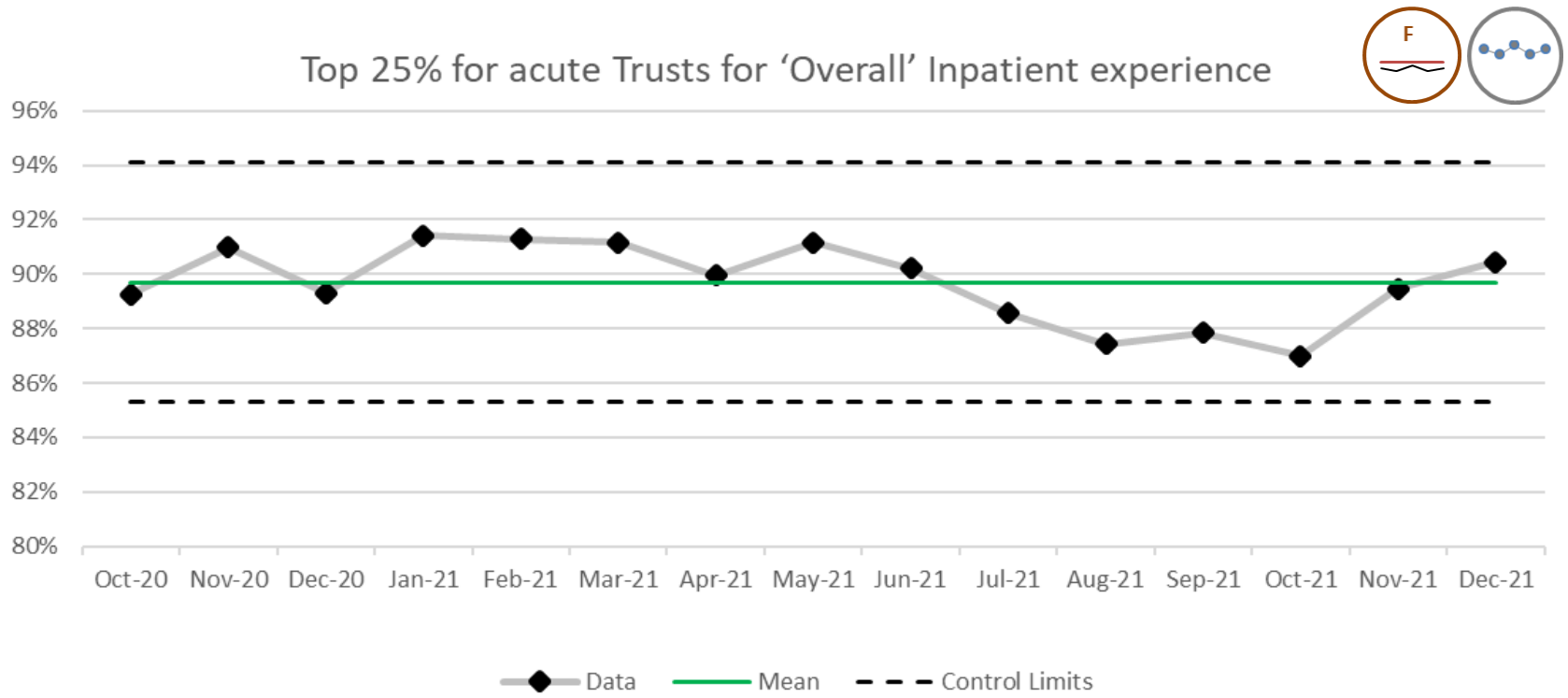
NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 90.43% ranking tbc |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 3rd Quartile |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Top 25% for acute Trusts for 'Overall' Inpatient experience

**What the chart tells us:**
We are currently at 90.43% for December.

**Issues:**
The core reasons identified within 'non-recommend' responses are:

- Waiting times
- Communication
- Staff

These themes mirror those seen within other data sources including PALs and complaints and are interrelated; for example waiting times in ED and patients not being kept informed.

**Actions:**

- Waiting times – this largely relates to ED reflecting the current and protracted challenges with capacity. A range of improvement actions are in place including optimising patient flow, admission avoidance, quality of care during long waits.
- Communication - review undertaken and working group in place with a range of actions.
- Dignity Pledges approved and to be launched in February.
- Quality Cell oversight.

**Mitigations:**

- Links made with OD to include a patient story in induction.
- Patient Experience training offer in development.
- Overarching combined national survey action plan in development.
- Divisional assurance reporting strengthened.

Quality | Operational Performance | Workforce | Finance

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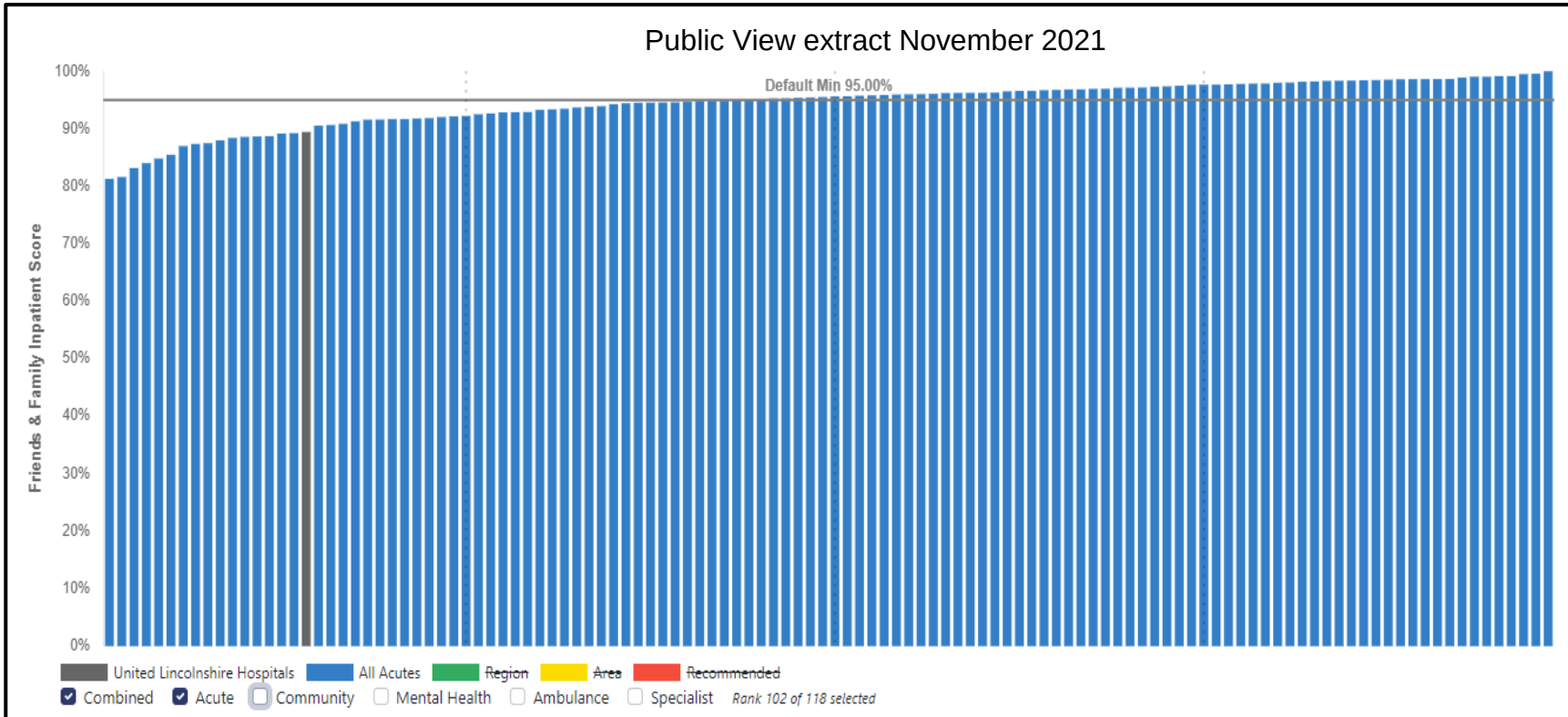
NHS United Lincolnshire Hospitals NHS Trust




| Nov-21 |
|---|
| 4th Quartile (89.45%) (102nd out of 118) |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 3rd Quartile |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Top 25% for acute Trusts for 'Overall' Inpatient experience

**What the chart tells us:**
The latest reported month in Public view November 2021 shows we are 102nd out of 118 Trusts, in the 4th quartile, against a 21/22 ambition to be in the 3rd quartile.
Rankings are Acute Trusts excluding specialised.

**Issues:**
The themes as identified above are in fact the reasons for the poor performance overall.

**Actions:**
- Drive the thematic actions as detailed above.
- Work with ward & department based FAB Experience Champions to implement local patient experience improvement activities.
- Triangulate FFT data with other data sources to extrapolate local themes and identify required actions.

**Mitigations:**
Investment in Patient Experience Team; additional Band 7 Patient Experience Manager commences March 22 bringing establishment to 2.0WTE. Post-holders will have divisional alignment to support patient experience improvements and developments.

Quality | Operational Performance | Workforce | Finance

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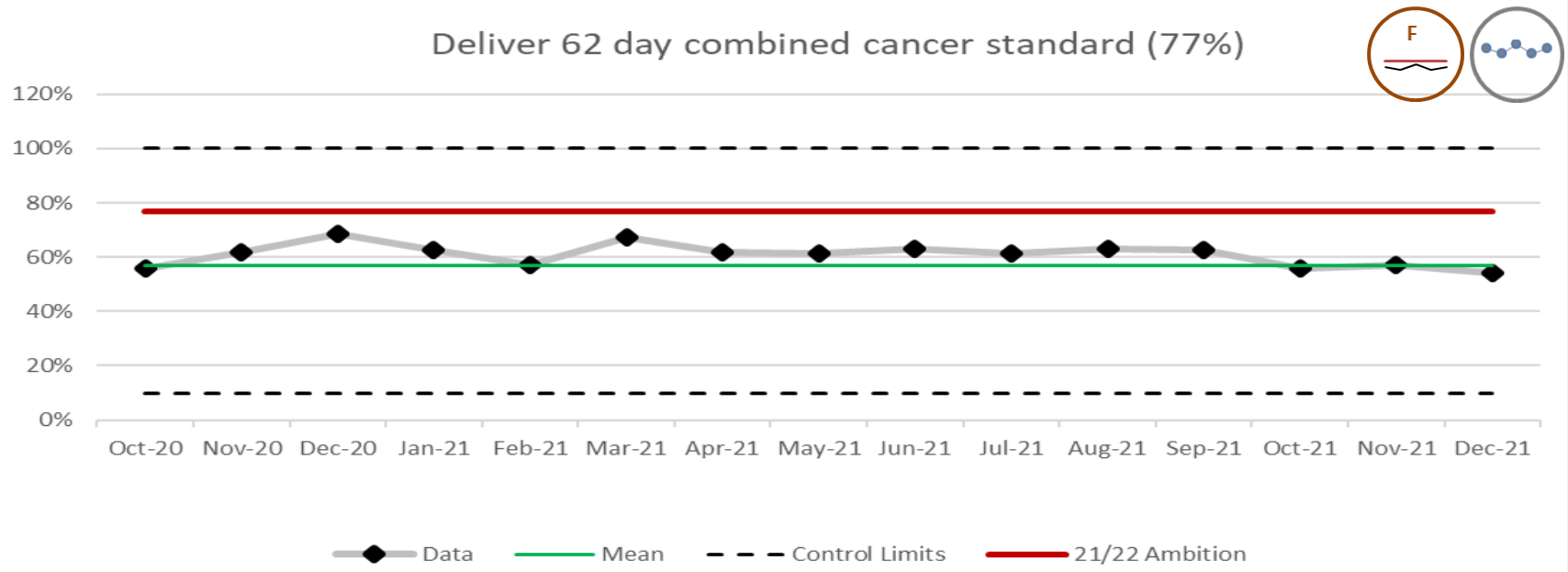
NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 54.3% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 77% |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.

## What the chart tells us:

We are currently at 54.3% against a 77% target.

## Issues:

The impact of critical and major incidents on Trust activity and patient pathways

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.

Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

## Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologists – 2 of which are with HR and due to be re-advertised and one awaiting Royal college approval before going out to advert. Two of these posts that are currently being covered by Locums.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.

Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

## Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham.

Quality | Operational Performance | Workforce | Finance

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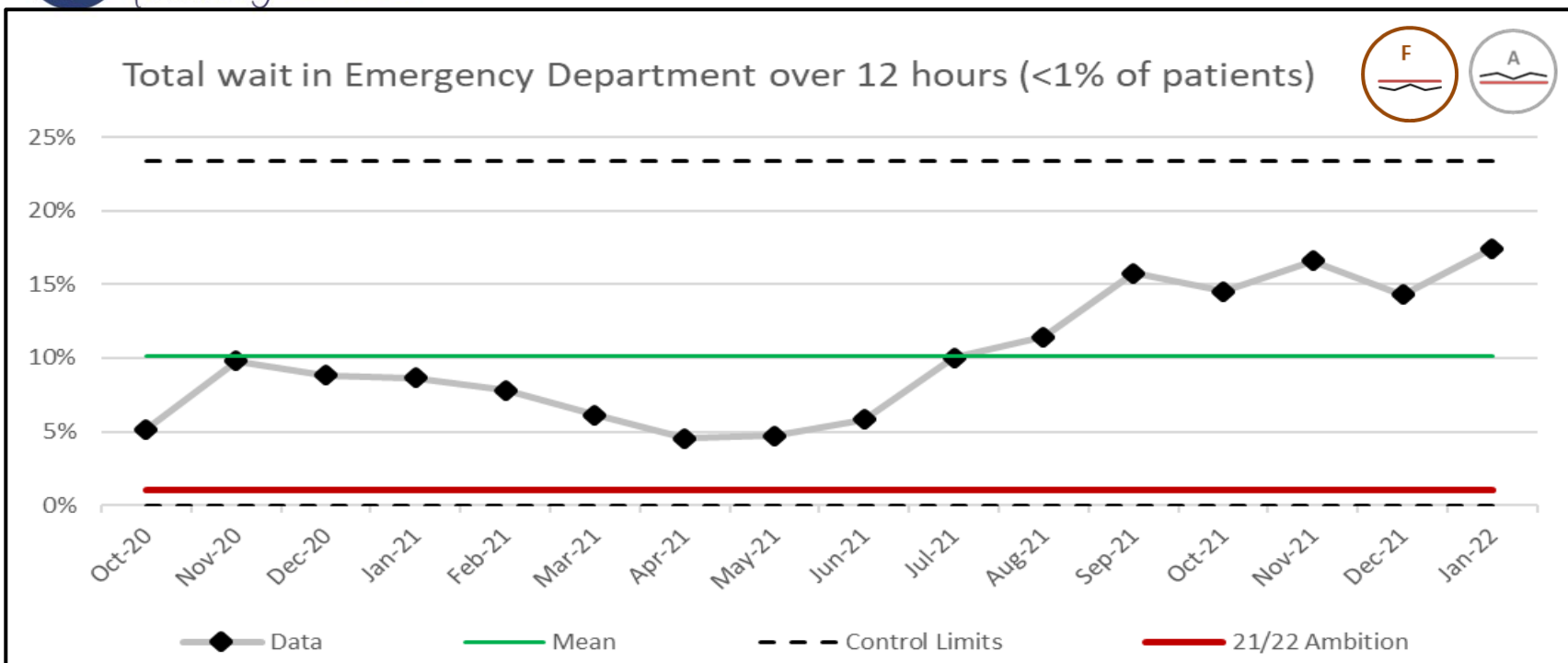
NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 17.43% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – above the mean |
| **21/22 Ambition** |
| <1% |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.

## What the chart tells us:

January experienced an increase in the numbers of patients with an aggregated time of arrival greater than 12 hours. 1453 in January compared to 1282 in December. An increase of 171
The target for this metric has not been met.

## Issues:

The main factor continues to be because of exit block due to inadequate discharges to meet the demand. A slight deterioration in the discharge profile was seen in January.
Escalation of SDEC areas (although less frequent) impacting on flow.
Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is now in place.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.
Limited ability to enact ExIT protocol due to covid contacts.

## Actions:

These actions are repetitive but remain relevant.
Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.
Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU and SAU.
All acute sites participated in MADE in January
The use of the Trust agreed ExIT procedure as part of the Full Capacity Protocol which allow each ward (agreed list) to support the care of an extra patient.

## Mitigations:

EMAS have enacted a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and transport home. Although increased overnight closures of the DL have been experienced in January
Increased CAS and 111 support especially out of hours have been further enhanced.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation. Although the ability to board patients is becoming more problematic, this is being formally review via the Quality Cell.

Quality | Operational Performance | Workforce | Finance

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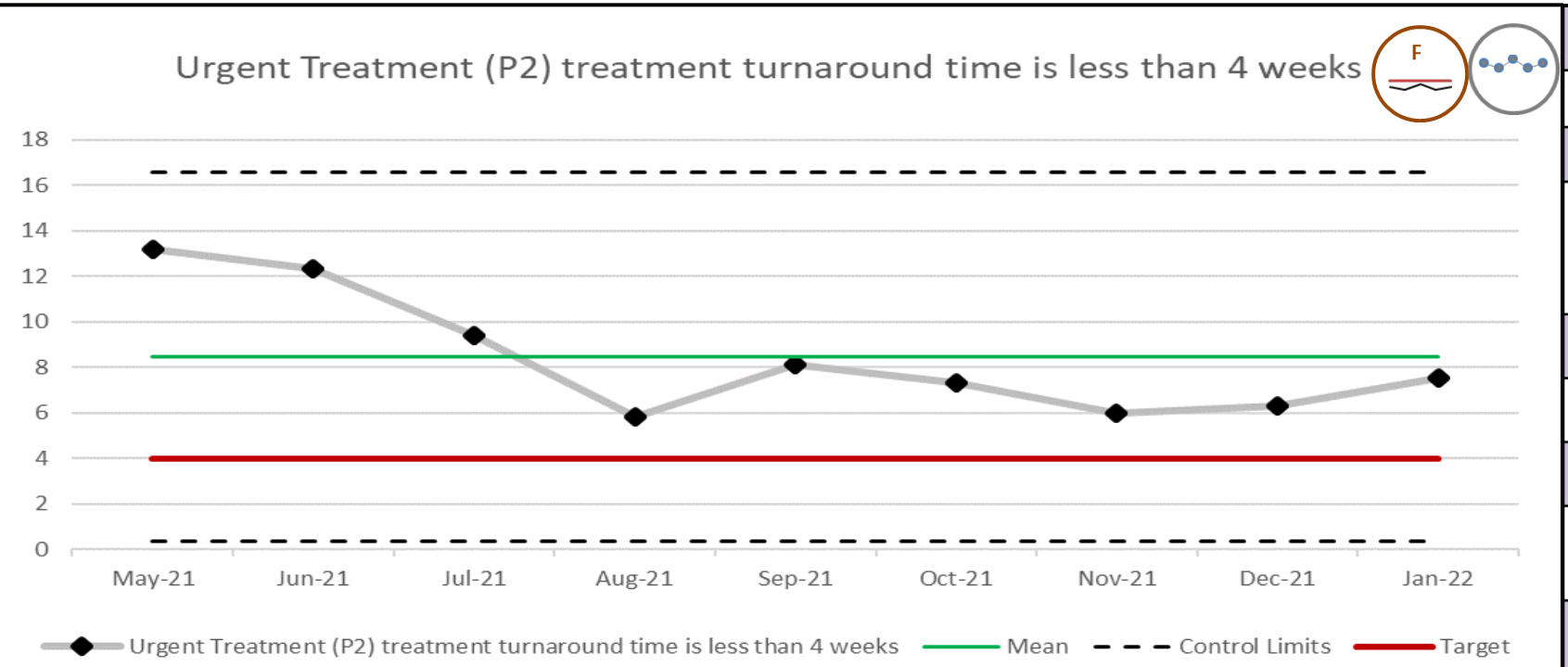
NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 7.54 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| < 4 weeks |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Average turnaround time in weeks from referral to treatment for patients categorised as P2 (procedures to be performed within 1 month).

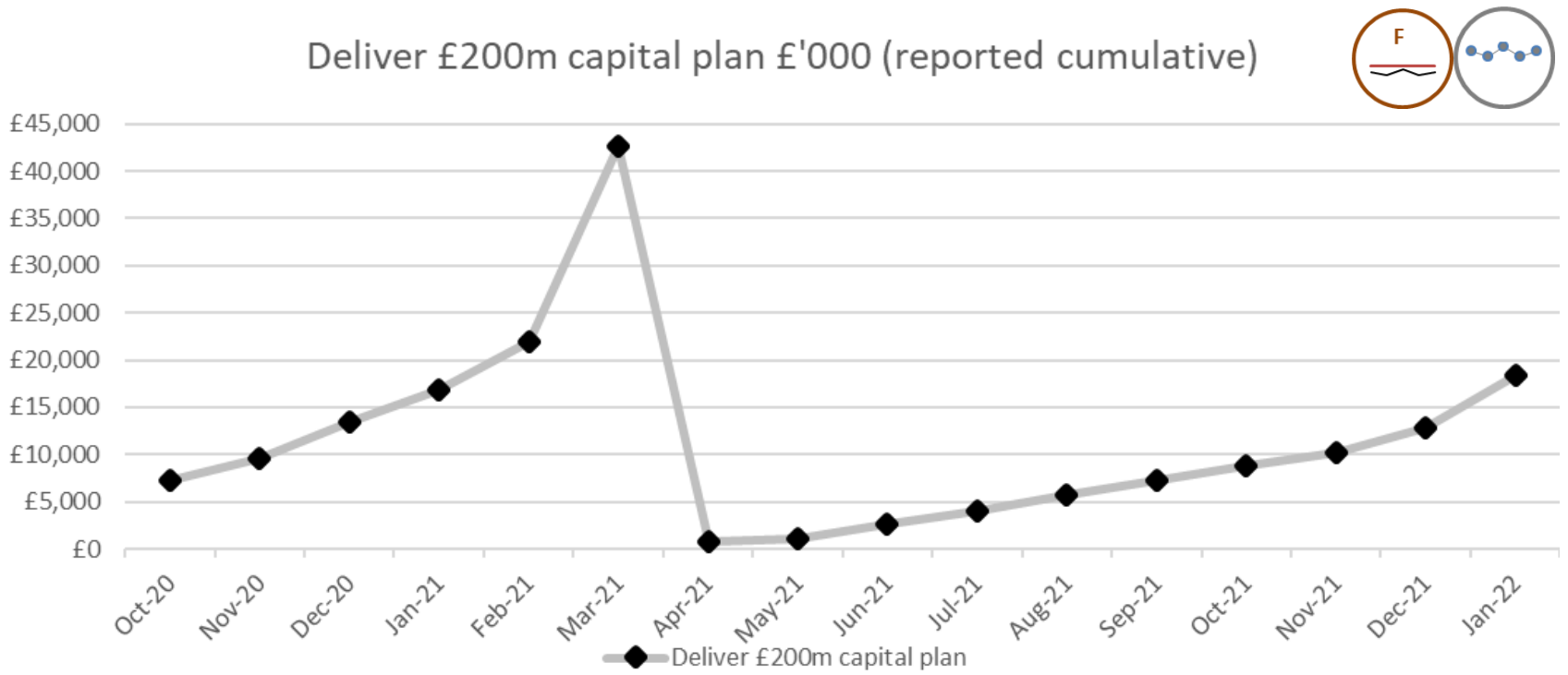
**What the chart tells us:**
General reduction in turnaround times since May 2021, although target of 4 weeks has not been met and is currently at 7.54 weeks which is deterioration of 1.24 weeks since December.

**Issues:**
The admitted position remains challenging. Wave 3/4, winter pressures and capacity challenges are impacting on service delivery, which will in turn, detrimentally effect P2 turnaround times. The largest specialty challenge remains Colorectal Surgery.

**Actions:**
Admitted patients are individually graded and allocated a priority code. The longest waiting patients, irrespective of their P code status are treated alongside urgent and P2 patients. Working to use and implement C2AI to ensure appropriate prioritisation of patients. The clinical prioritisation cell, reporting to Gold, is focusing closely on Cancer patients and overdue P2 patients and that Lincoln and Boston adult elective activity is currently focused on these cohorts.

**Mitigations:**
Further planning work to identify solutions for greater use of elective sites to reduce variation caused by emergency pressures. Close performance management of longer wait patients.

Quality | Operational Performance | Workforce | Finance




| Jan-22 |
|---|
| £18,341.70k |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| £39 Million for the year |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Finance |

**Background:**
The Trust had a revised capital programme to deliver of £49.6m, but this has now reduced by £3.6m to £47.5m, as a result of changes re TIF bids & other funding.

**What the chart tells us:**
The chart shows that in 2020/21 the majority of the capital programme expenditure was in the final quarter; it shows that expenditure in 2021/22 has similarly started slowly.

**Issues:**
The Trust has a large capital programme to deliver in 2021/22, and delivery of the programme is at greater risk if the actual expenditure profile is heavily weighted in the final two quarters.
As at the end of January, YTD expenditure of £18.3m is £7.5m behind NHSE&I plan, requiring expenditure of £29.2m in the remainder of 2021/22 to deliver the programme in full.

**Actions:**
To ensure that the capital programme will be delivered in full, the programme is being managed via Capital Delivery Group (CDG). Forecasting meetings are continually held with scheme leads highlighting areas of slippage, risk and mitigations. Details shared and schemes will be managed through CDG. Updated forecasts to be constantly under review.

**Mitigations:**
Where slippage exists, delegated authority has been provided by Trust Board to DoF and COO. Following this agreement, local decision has been reached to re-allocate based on the 'transition' year agreement at Financial Leadership Group (FLG) for 2021/22. Where this isn't possible, agree the next scheme within the 'System' based on the current known priorities.

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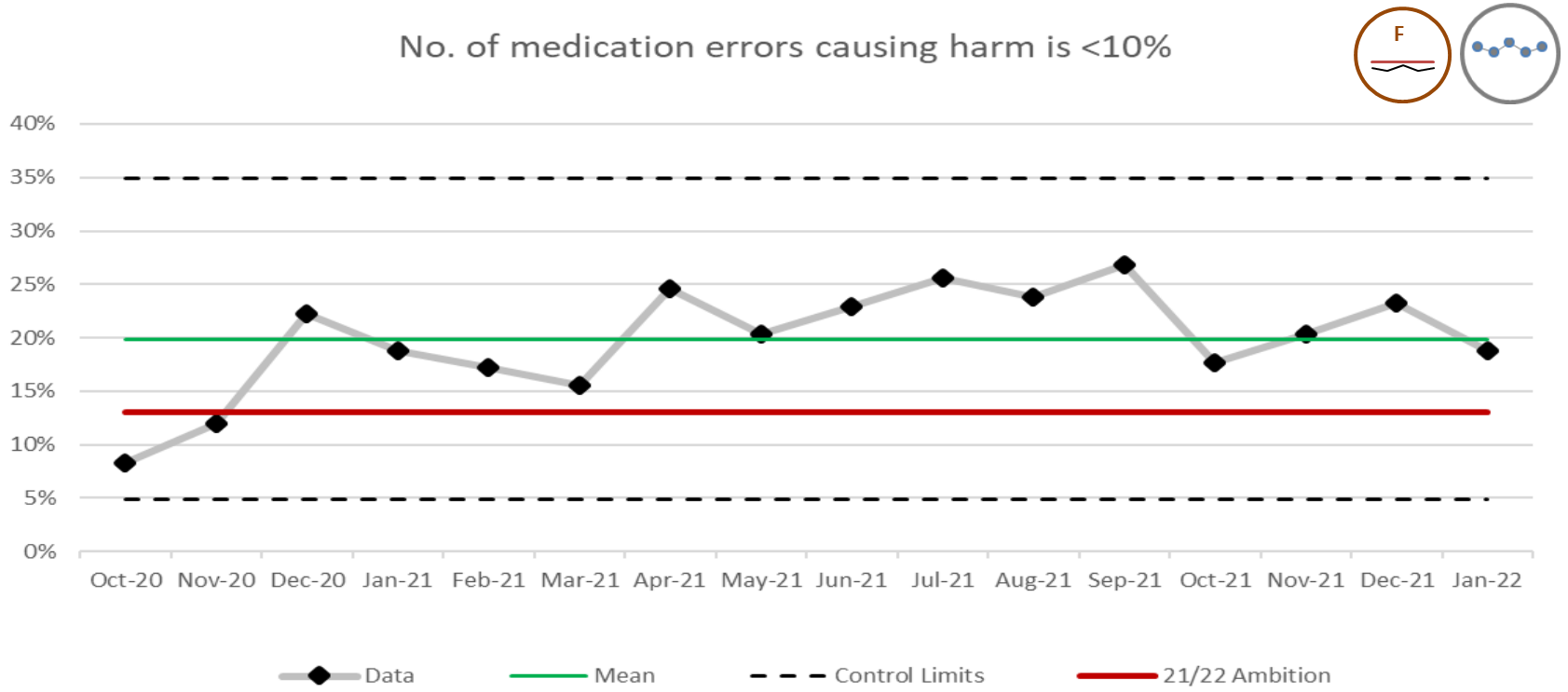
NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 18.8% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 13% |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Medical Director |

**Background:**
Percentage of medication incidents reported as causing harm (low/moderate/severe or death)

**What the chart tells us:**
In the month of Jan the number of incidents reported was 143. This equates to 4.67 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 18.8% which is above the national average of 10.8.

**Issues:**
Medication incidents causing harm is above the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

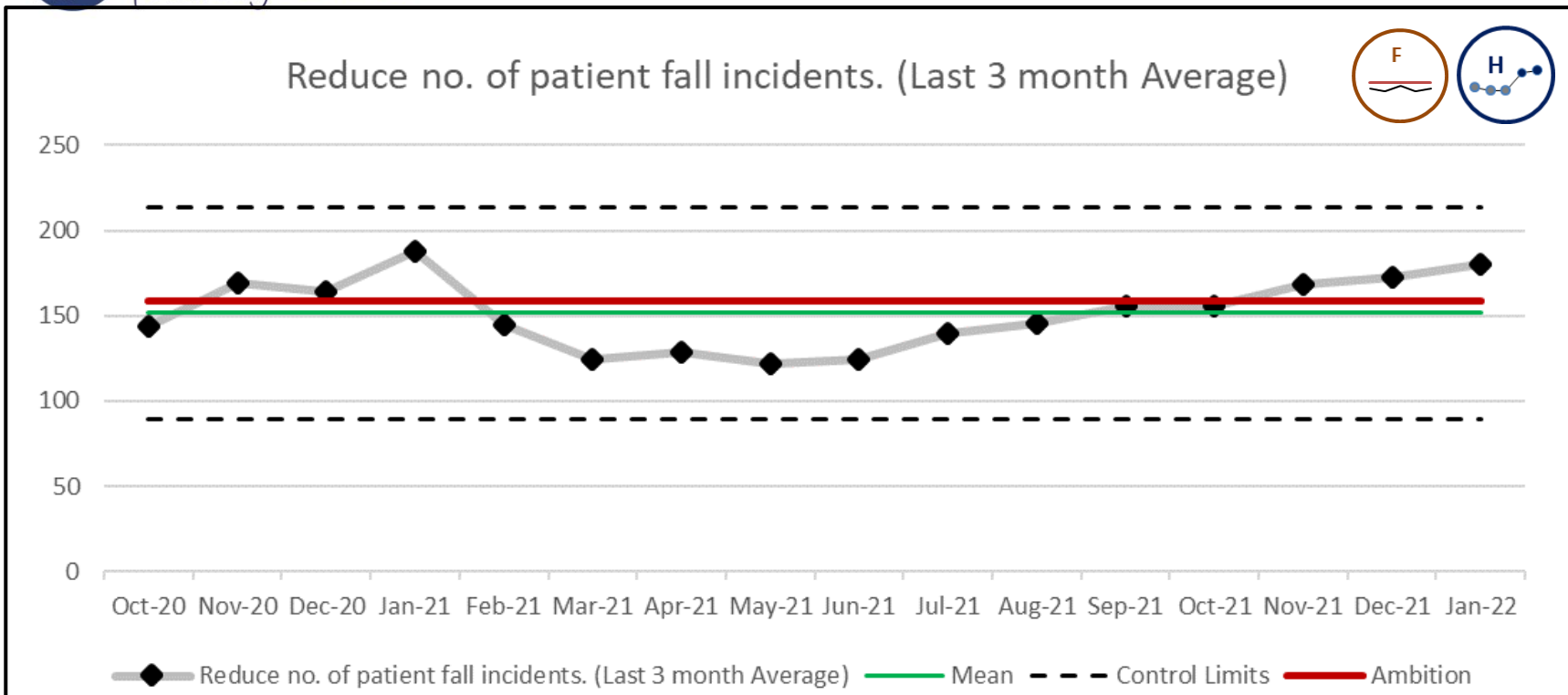
**Actions:**
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents.

**Mitigations:**
There is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that we provide to patients.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 180 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – High trend |
| **21/22 Ambition** |
| 159 |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Nursing |

## Background:

Number of falls reported (including no harm)
(Last 3 month average)

## What the chart tells us:

The actual number of inpatient falls for January has increased by 11 from December. This has contributed to an increase in the 3 monthly average which is demonstrating an upward trend currently and has not achieved ambition.

## Issues:

Themes identified that will continue to be areas of focus to improve are

- Increasing falls awareness and prevention education
- Patient / family involvement with falls prevention
- Preventing repeat falls
- Ensuring effective learning from falls incidents to prevent reoccurring themes.
- Unwitnessed falls

Assessment and consistent application of enhanced care processes remains a priority area to improve. This has been impacted further by continued operational and staffing pressures during January.

## Actions:

Emergency Departments (ED) have commenced use of a transfer sticker to support effective communication during the handover process to ensure increased awareness of patients who are vulnerable to falling.
Revised falls prevention assessment paperwork rollout plan being developed, education sessions to support use have recommenced in February.
Falls prevention training framework approved at the Nursing, Midwifery, AHP Advisory Forum (NMAAF), delivery plan now being developed.
Bespoke falls prevention training for Emergency Department has commenced to support early identification of patients vulnerable to falling.
Quality Matron team monitoring daily for patients who have had repeat falls and liaising with ward areas to ensure the risk is identified and appropriate interventions are instigated.

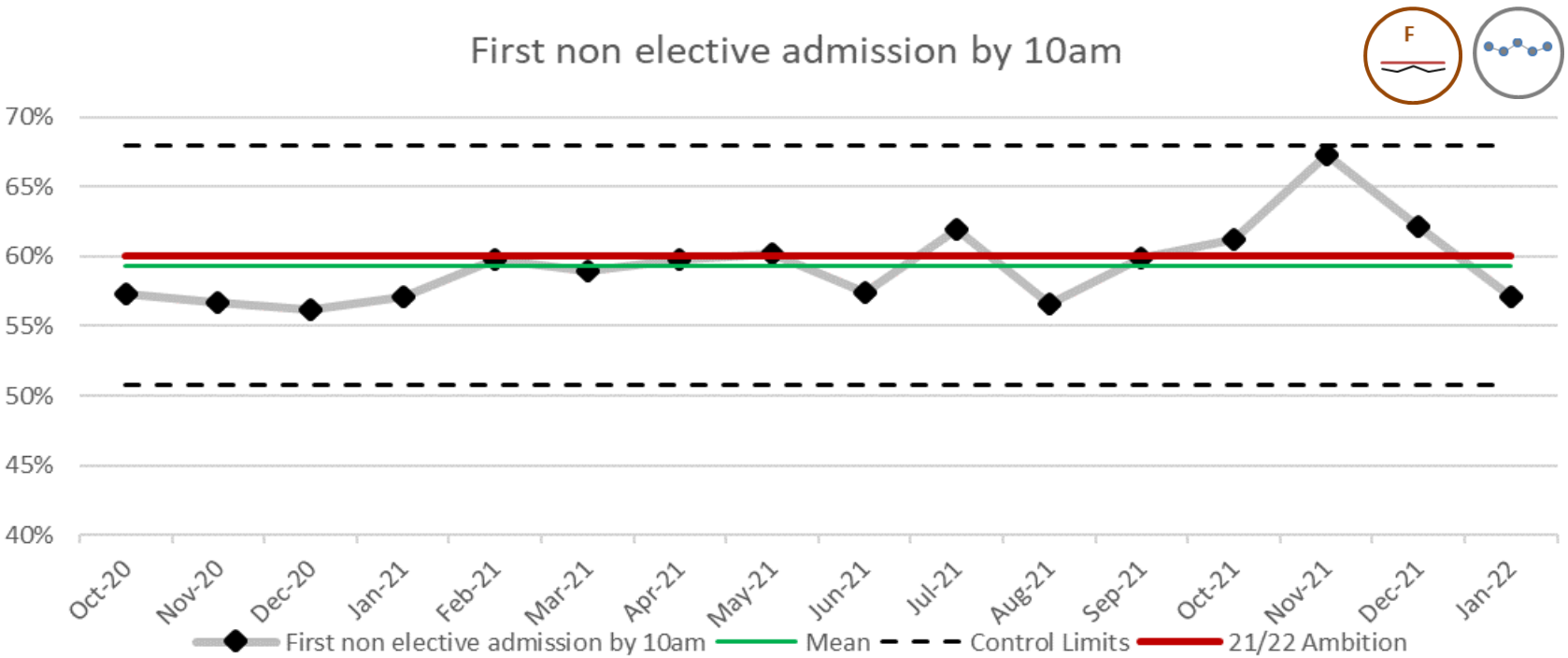
## Mitigations:

Falls prevention care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.
The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to falls prevention
Falls Prevention Steering Group are sighted on areas with increased incidences where deep dives need to be undertaken, and informed of the outcome to facilitate further support offers where necessary.
Quality Matrons provide support to areas with increased numbers of falls.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 57.14% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| < 4 weeks |
| **Achievement** |
| Metric is failing to ambition |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

The Trust target against this standard is 60% of total non-elective admission being admitted before 10am.

## What the chart tells us:

This metric achieved against the target from October 2021 to December 2021.
January experienced a decrease in the number of non-elective admission before 10am.
The compliance stated for January has been subject to additional scrutiny against the target of 60%.
The compliance against this metric is 52.97% This equates to 686 patients admitted before 10am.

## Issues:

The main factor causing this deterioration is attributed to poor flow the previous day thus leading to increased bed waits in the emergency departments in the morning.
Zero compliance against the standard of 10 discharges by 10am, sub optimal use of the discharge lounge before 10am and against the national standard of 35% of all discharges before midday.
The above is probably a more informative indicator.

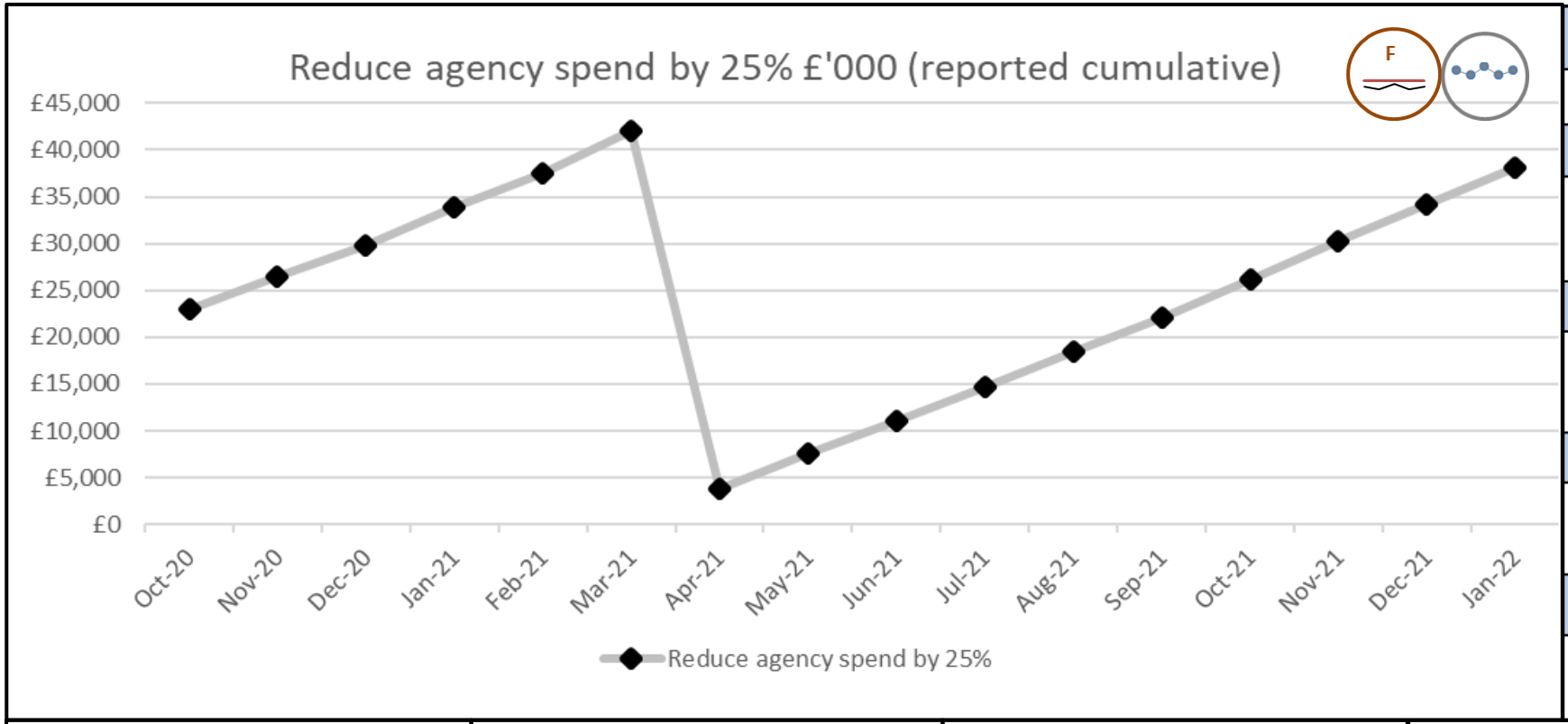
## Actions:

Effective utilisation of the Reason to Reside intelligence to optimise discharges.
Identification of '10 by 10' patients the previous day, ensuring all discharge arrangement are complete and communicated clearly.
Extended opening hours of the discharge lounge incorporating a pull model/in reach to the wards.
Forward look over 72 hours against discharge planning and readiness to leave.
Pull model by system partners to allow exit of all patients on pathway 1, 2 and 3 with a greater then 24hrs LOS post becoming medically optimised.

## Mitigations:

3 x daily updates on flow and discharge using local intelligence and reason to reside information to effect more timely morning discharges.
Early use of the discharge lounge for confirmed medically optimised discharges on pathway 1, 2 and 3.
Appropriate use of the full capacity protocol to release assessment unit capacity.

Quality | Operational Performance | Workforce | Finance




| Jan-22 |
|---|
| £38,060k |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| £33 Million for the year |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Finance |

**Background:**
Aim to reduce agency spend by 25% or £11.0m from £44.1m in 2019/20 to £33.0m in 2021/22; the Trust has an Agency Ceiling of £21m.

**What the chart tells us:**
Agency spend of £38.1m YTD in 2021/22 has exceeded the annual target spend of £33.0m with two months of the year left; if spend continues at Month 10 levels, spend will exceed 19/20 levels by £1.7m.

**Issues:**
The Trust has traditionally spent most on Medical and Dental Agency than on any other staff category. However, a continued focus upon a Plan for Every Post has meant that Medical and Dental is £0.1m favourable to the IIP plan.

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £10.5m above plan.

**Actions:**
Divisions developing detailed trajectory improvements, including the timeline for supernumerary staff transitioning into substantive roles with agency staff exiting, and agreement of the bed base and establishment to support this.

Alternative roles to fill longstanding vacancies are being reviewed, and exit plans have been requested for admin/managerial roles.

**Mitigations:**
There remains a continued focus upon Plan for Every post across all staffing categories.

The Trust also continues to review opportunities in the following areas: convert Agency staff to NHS locums; reduce our usage of higher tier agencies; reduce our reliance on Agency staff by increasing the Staff Bank.

Quality | Operational Performance | Workforce | Finance

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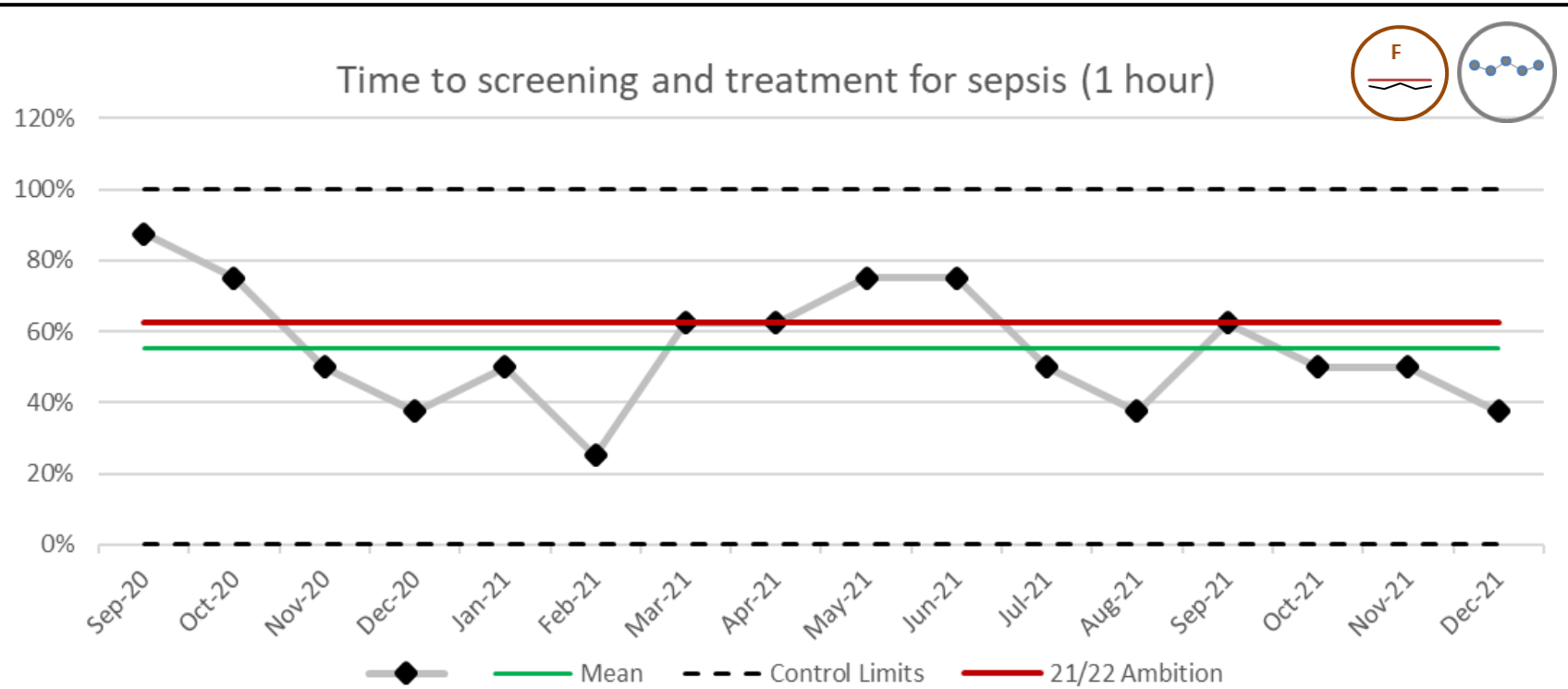


| Dec-21 |
|---|
| 37.5% (3/8) |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 62.5% (5/8) |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Number of sepsis incidents reported % of 8 metrics passing to 90% target.

**What the chart tells us:**
3 out of the 8 sepsis metrics passed to target (37.5% pass rate) against an ambition of 5 out of 8 (62.5% pass rate).

**Issues:**
There is a large increase in the number of Paediatric patients in all departments within the trust. Some areas have expressed that they are struggling to deal with the higher number of patients in their departments as well as the higher acuity and staffing issues. There is also a large changeover staff or Temporary staff being used. At present face to face training is cancelled.

**Actions:**
There are ongoing meetings between Sepsis practitioners, ED, Ward areas and Clinical Educators to address issues raised and develop action plans. There is also a large emphasis on Sepsis within all training, simulation training, PILS and EPALS.

**Mitigations:**
Sepsis Practitioner is visiting paediatric areas regularly to offer support / advice. Extra training is also being offered to all Nursing areas and Medics once training can recommence.
Data is being pulled frequently and Harm reviews are being completed for all patients with delayed Screens or bundles.

Quality | Operational Performance | Workforce | Finance

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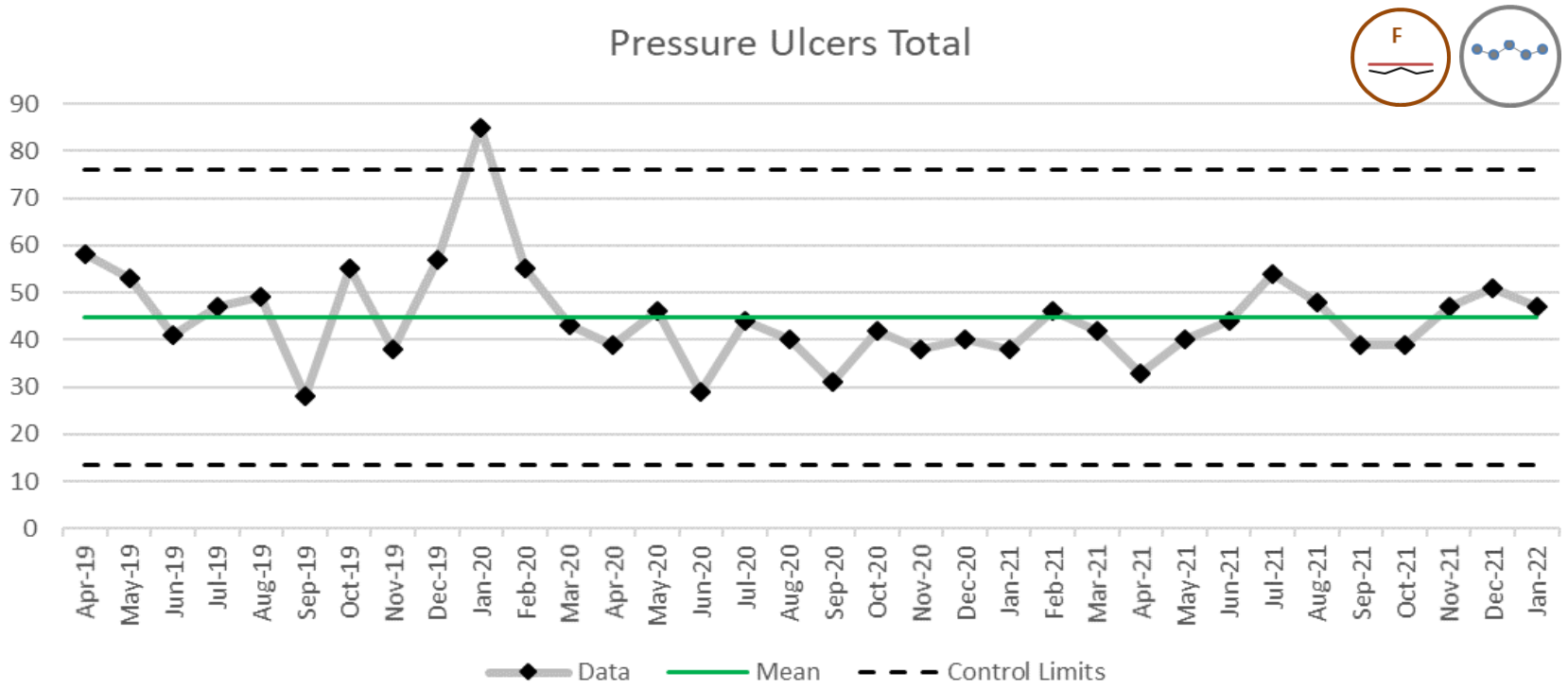


| Jan-22 |
|---|
| 47 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| 45 |
| **Achievement** |
| Metric is consistently failing to ambition |
| **Executive Lead** |
| Director of Nursing |

## Background:

Total number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable.

## What the chart tells us:

The total number of reported hospital acquired pressure ulcers for Categories 2, 3, 4 and Unstageables is 47 a decrease of 4 from December.

## Issues:

There has been one category 4 pressure ulcer reported in January. This will be investigated in accordance with the serious incident framework. This is the first category 4 reported since May 2021.

Three category 3 pressure ulcers were reported, an increase of 2 from December. These will be investigated and RCA meetings will be undertaken with the clinical teams.

There have been a decreased number of category 2 pressure ulcers in January these will be reviewed through the Datix investigation process to identify learning.

## Actions:

A RCA meeting chaired by the Deputy Director of Nursing will be undertaken to review the category 4 pressure ulcer with the teams involved across the patient's pathway of care in order to identify learning and actions to improve.

A skin integrity education proposal has been developed and will be presented to Skin Integrity Group (SIG) in February. This tiered approach will provide a structured framework to develop knowledge and competency of staff groups based on the requirements of their role.

## Mitigations:

Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.

Skin integrity care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.

The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to pressure ulcer prevention.

Quality | Operational Performance | Workforce | Finance

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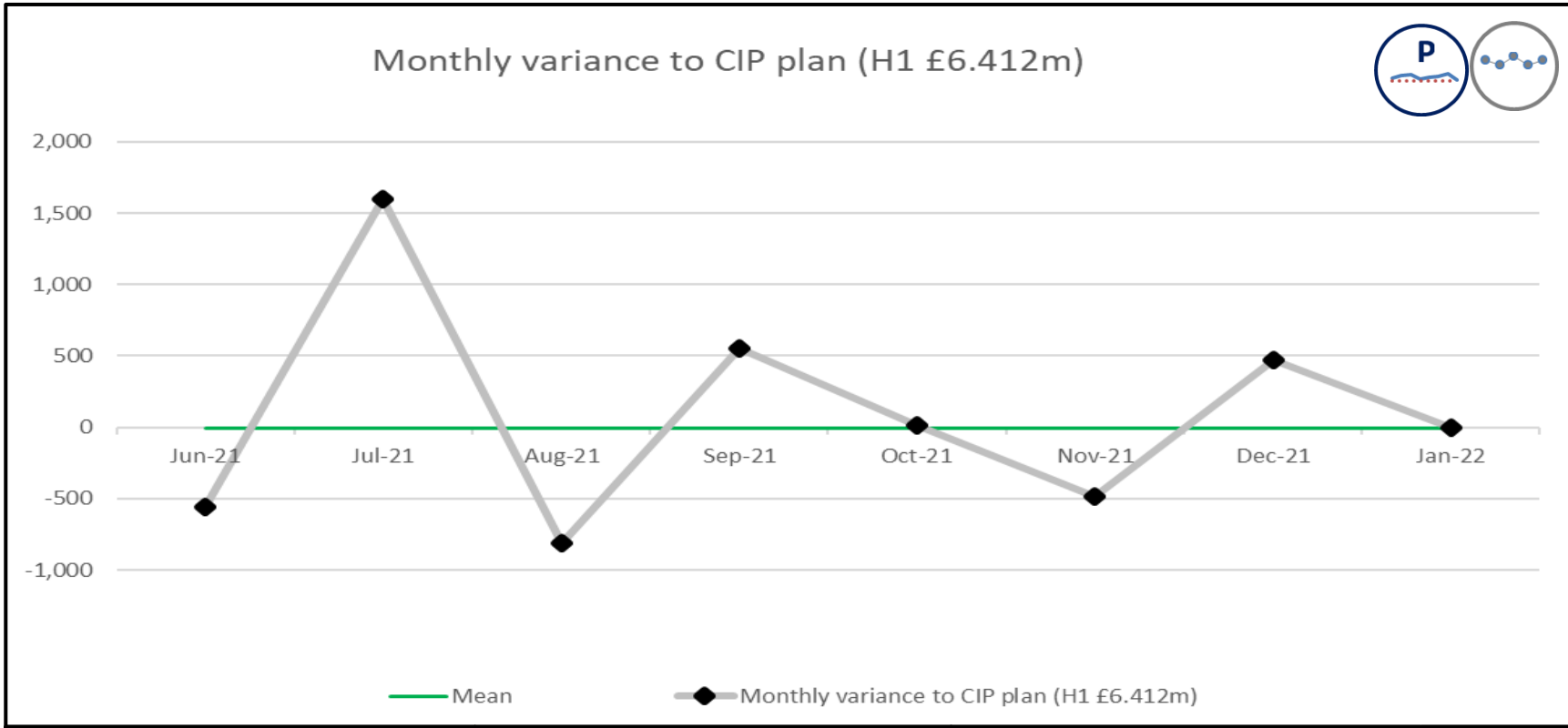


| Jan-22 |
|---|
| Variance to plan £0 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **21/22 Ambition** |
| £15.4 Million for the year |
| **Achievement** |
| Metric is failing to ambition |
| **Executive Lead** |
| Director of Finance |

**Background:**
The Trust started 2021/22 with an ambition to deliver £15.4m of efficiency savings; this assumed savings of £6.4m in H1 and £9.0m in H2

**What the chart tells us:**
In terms of overall delivery, the Trust largely met its target in H1 with actual delivery of £6.2m. However, the plan for H2 is now £6.0m, or £3.0m lower than originally planned.

**Issues:**
£5.2m of savings delivery in H1 was non-recurrent. As a result of this, the plan for H2 only includes £2.2m of planned savings delivery in H2; the majority of the savings plans in place relate to workforce.

This highlights a significant risk to achieving the financial plan in the second half of the year. The same level of non-recurrent CIP is not available for H2.

**Actions:**
Divisional Targets for the full year were set in line with the requirement to deliver £9.0m in H2, and these will remain in place and be monitored through Divisional Financial Recovery Meetings.

Recruitment to the vacant efficiency manager posts is ongoing.

**Mitigations:**
Development and delivery of recurrent schemes has been hampered by the need for divisional management colleagues to focus on operational pressures and also by the loss of efficiency managers. There will therefore be a continued requirement for non-recurrent savings while recurrent schemes are put in place, and to minimise any slippage in relation to the existing schemes in place.

OUTSTANDING CARE personally DELIVERED

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# PERFORMANCE OVERVIEW - QUALITY

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | Target per month | Nov-21 | Dec-21 | Jan-22 | YTD | Pass/Fail | Trend Variation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Deliver Harm Free Care | Clostridioides difficile position | Safe | Patients | Director of Nursing | 9 | 4 | 6 | 7 | 48 | P | |
| | MRSA bacteraemia | Safe | Patients | Director of Nursing | 0 | 0 | 1 | 0 | 2 | P | |
| | MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula | Safe | Patients | Director of Nursing | TBC | 0.01 | 0.00 | 0.07 | 0.04 | | |
| | E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula | Safe | Patients | Director of Nursing | TBC | 0.01 | 0.01 | 0.23 | 0.11 | | |
| | Catheter Associated Urinary Tract Infection | Safe | Patients | Director of Nursing | 1 | | | | 5 | | |
| | Falls per 1000 bed days resulting in moderate, severe harm & death | Safe | Patients | Director of Nursing | 0.19 | 0.16 | 0.23 | 0.07 | 0.09 | P | |
| | Pressure Ulcers category 3 | Safe | Patients | Director of Nursing | 4.3 | 1 | 1 | 3 | 10 | P | |
| | Pressure Ulcers category 4 | Safe | Patients | Director of Nursing | 1.3 | 0 | 0 | 1 | 2 | P | |
| | Pressure Ulcers - unstageable | Safe | Patients | Director of Nursing | 4.4 | 8 | 8 | 8 | 55 | F | |
| | Venous Thromboembolism (VTE) Risk Assessment | Safe | Patients | Medical Director | 95% | 94.93% | 95.58% | 94.80% | 95.82% | F | |
| | Never Events | Safe | Patients | Director of Nursing | 0 | 0 | 0 | 0 | 2 | P | |
| | Reported medication incidents per 1000 occupied bed days | Safe | Patients | Medical Director | 4.3 | 6.91 | 5.59 | 4.67 | 5.31 | P | |
| | Medication incidents reported as causing harm (low /moderate /severe / death) | Safe | Patients | Medical Director | 10.7% | 20.3% | 23.2% | 18.8% | 22.40% | F | A |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW - QUALITY

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | Target | Nov-21 | Dec-21 | Jan-22 | YTD | Pass/Fail | Trend Variation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Deliver Harm Free Care | Patient Safety Alerts responded to by agreed deadline | Safe | Patients | Medical Director | 100% | None due | None due | None due | 73.40% | P | |
| | Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag) | Effective | Patients | Medical Director | 100 | | 107.28 | 107.40 | 108.86 | F | A |
| | Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag) | Effective | Patients | Medical Director | 100 | 111.39 | 110.20 | 110.73 | 111.48 | F | A |
| | The Trust participates in all relevant National clinical audits | Effective | Patients | Medical Director | 100% | 94.50% | 98.00% | 98.00% | 96.35% | F | A |
| | eDD issued within 24 hours | Effective | Patients | Medical Director | 95% | 91.10% | 88.20% | 89.50% | 89.57% | F | B |
| | Sepsis screening (bundle) compliance for inpatients (adult) | Safe | Patients | Director of Nursing | 90% | 90.0% | 86.6% | | 89.74% | F | |
| | Sepsis screening (bundle) compliance for inpatients (child) | Safe | Patients | Director of Nursing | 90% | 73.5% | 83.0% | | 85.59% | F | |
| | IVAB within 1 hour for sepsis for inpatients (adult) | Safe | Patients | Director of Nursing | 90% | 94.0% | 96.4% | | 93.61% | P | |
| | IVAB within 1 hour for sepsis for inpatients (child) | Safe | Patients | Director of Nursing | 90% | 63.6% | 88.9% | | 84.95% | F | |
| | Sepsis screening (bundle) compliance in A&E (adult) | Safe | Patients | Director of Nursing | 90% | 91.3% | 92.8% | | 92.27% | P | A |
| | Sepsis screening (bundle) compliance in A&E (child) | Safe | Patients | Director of Nursing | 90% | 79.0% | 76.6% | | 82.49% | F | |
| | IVAB within 1 hour for sepsis in A&E (adult) | Safe | Patients | Director of Nursing | 90% | 95.2% | 95.8% | | 94.92% | P | |
| | IVAB within 1 hour for sepsis in A&E (child) | Safe | Patients | Director of Nursing | 90% | 57.1% | 71.4% | | 66.56% | F | |
| | Rate of stillbirth per 1000 births | Safe | Patients | Director of Nursing | 4.20 | 3.27 | 3.24 | 3.00 | 3.09 | P | B |
| Improve Patient Experience | Mixed Sex Accommodation breaches | Caring | Patients | Director of Nursing | 0 | Submission suspended during Covid | | | | | |
| | Duty of Candour compliance - Verbal | Safe | Patients | Medical Director | 100% | 59.00% | 70.00% | | 61.33% | F | B |
| | Duty of Candour compliance - Written | Responsive | Patients | Medical Director | 100% | 41.00% | 33.00% | | 36.89% | F | B |

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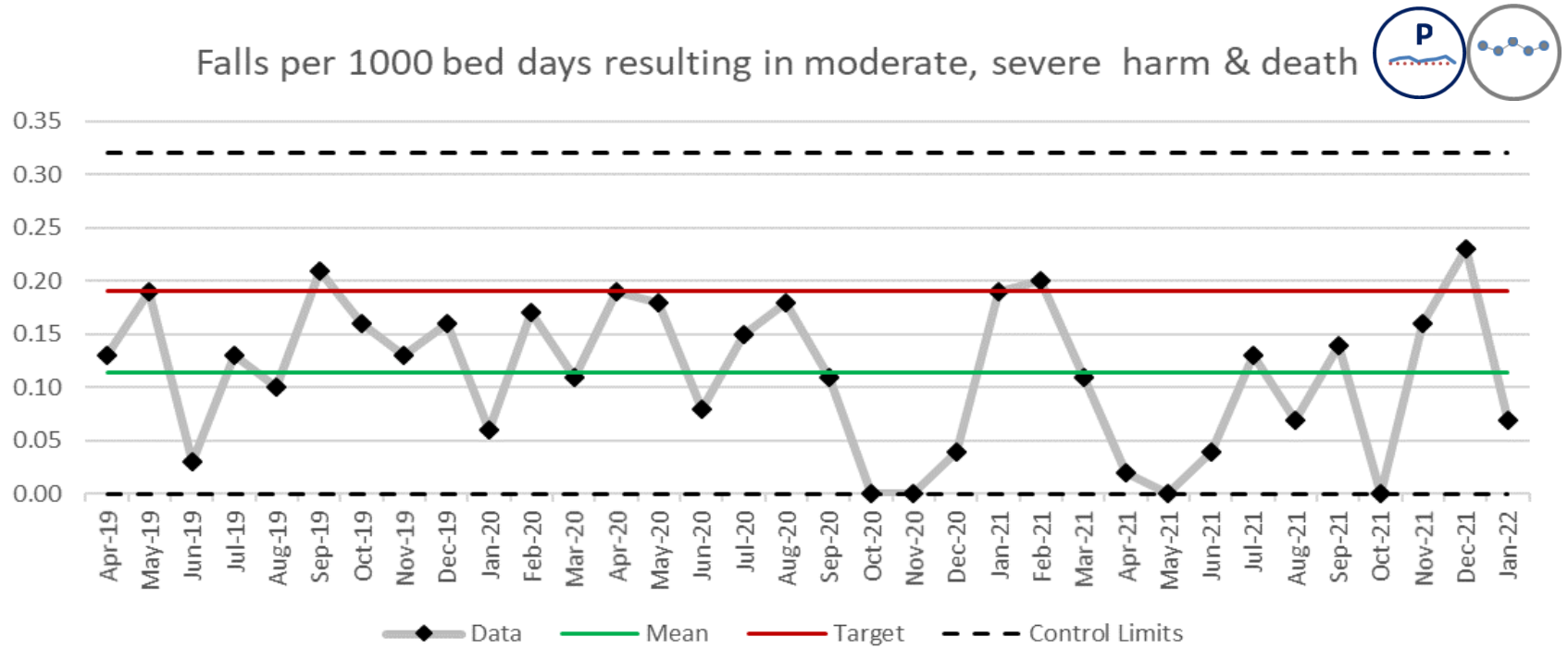
NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 0.07 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0.19 |
| **Target Achievement** |
| Metric is failing the target |
| **Executive Lead** |
| Director of Nursing |

## Background:

Falls per 1000 bed days resulting in moderate, severe harm & death.

## What the chart tells us:

We are currently at 0.07 against a target of 0.19.
There has been 1 fall incident reported with the severity recorded as death. These will be validated through the incident review process and the appropriate level of investigation instigated.
We are currently at 17 moderate harm falls incidents for Q1/Q2/Q3 against a target of ≤19 per annum, and 8 severe harm falls incidents for Q1/Q2/Q3 against a target of ≤ 17 per annum.

## Issues:

Overall, this month, inpatient falls saw an increase of 11 (December 176, January 187)

Themes identified that will continue to be areas of focus to improve are

- Increasing falls awareness and prevention education
- Patient / family involvement with falls prevention
- Preventing repeat falls
- Ensuring effective learning from falls incidents to prevent reoccurring themes.
- Unwitnessed falls
  Assessment and consistent application of enhanced care processes remains a priority area to improve. This has been impacted further by continued operational and staffing pressures during January.

## Actions:

Emergency Departments (ED) have commenced use of a transfer sticker to support effective communication during the handover process to ensure increased awareness of patients who are vulnerable to falling.
Revised falls prevention assessment paperwork rollout plan being developed, education sessions to support use will recommence in February.
Falls prevention training model approved at the Nursing, Midwifery, AHP Advisory Forum (NMAAF), delivery plan being developed with Health and Safety team support.
Bespoke falls prevention training for Emergency Department has commenced to support early identification of patients vulnerable to falling.
Quality Matron team monitoring daily for patients who have had repeat falls and liaising with ward areas to ensure the risk is identified and appropriate interventions are instigated.

## Mitigations:

Falls prevention care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.
The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to falls prevention.
Falls Prevention Steering Group are sighted on areas with increased incidences where deep dives need to be undertaken, and informed of the outcome to facilitate enhanced support offers where necessary.
Quality Matron team provide support to areas with increased incidences.

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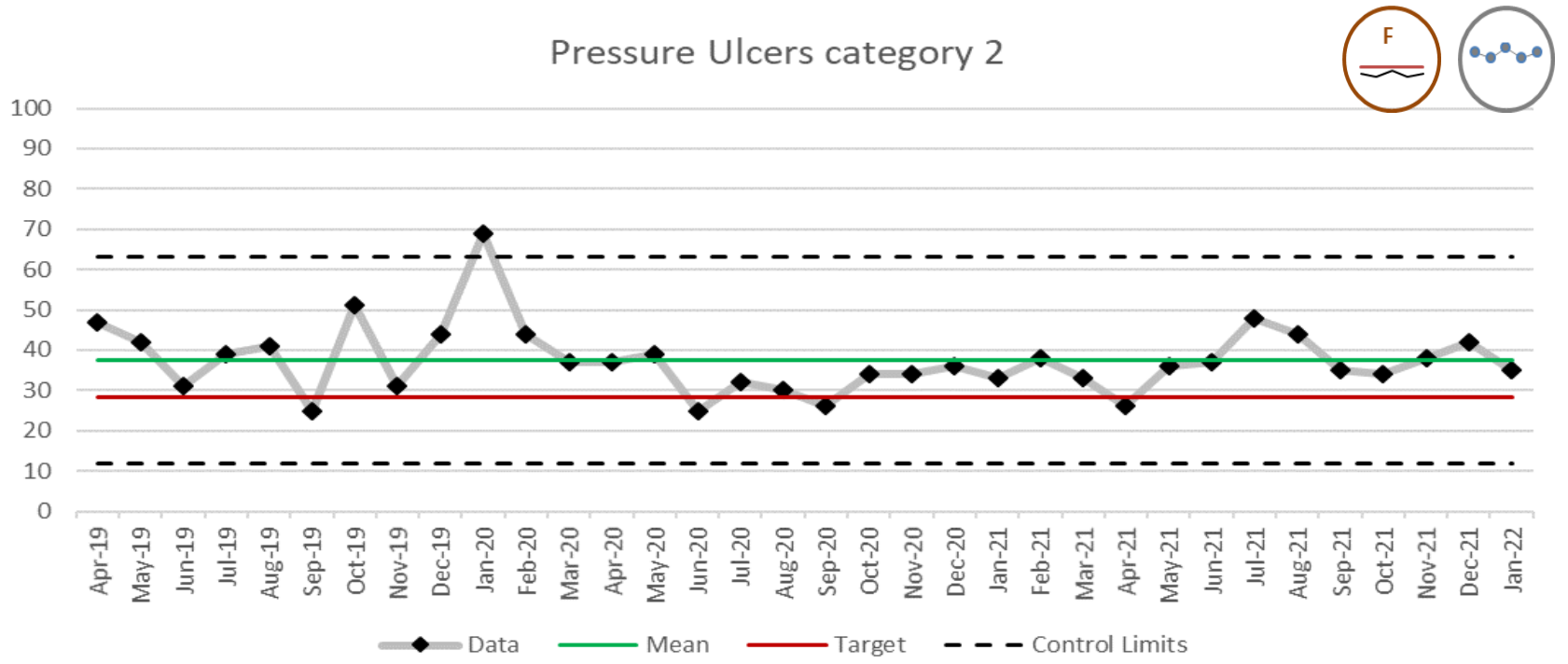



| Jan-22 |
|---|
| 35 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 28.3 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

## Background:

Pressure Ulcers Category 2.

## What the chart tells us:

We are currently at 35 against a target of 28 per month. A decrease of 7 from the month of December.

## Issues:

There have been an increased number of patients admitted with existing complex wounds, including category 4 pressure ulcers. This has resulted in a greater demand on the Tissue Viability service and ward staffing resources.

Higher numbers of category 2 damage has been reported at LCH in comparison to PHB. This has been contributed to by delayed and incomplete skin assessments within the Emergency Department (ED), resulting in skin damage being identified by the admitting wards.

Device related skin damage remains an area of focus to improve.

## Actions:

A skin integrity education proposal has been developed and will be presented to Skin Integrity Group (SIG) in February. This tiered approach will provide a structured framework to develop knowledge and competency of staff groups based on the requirements of their role.

Urgent care and quality teams are meeting and have agreed a number of initial actions to improve skin care and reduce harm from pressure damage in ED. These include:

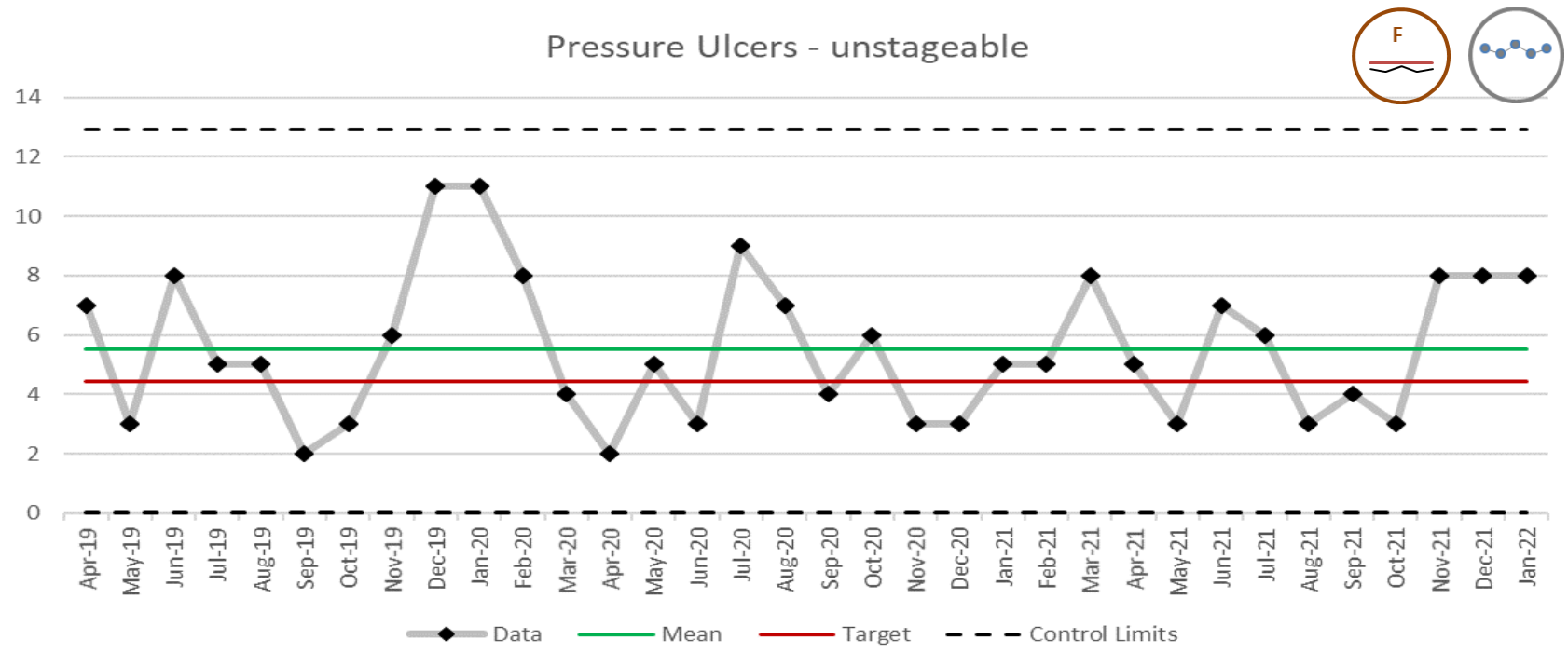
1. Additional pressure relieving equipment has been ordered
2. Replication of a successful Education programme from PHB to LCH
3. Wound care guidance and dressing pictorials at a glance to be re-shared and promoted.

The Tissue Viability team are providing an additional daily focus to ED's to support the early identification of patients vulnerable to skin damage and ensure timely implementation of appropriate pressure relieving actions.

## Mitigations:

Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.

The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to skin integrity.




| Jan-22 |
|---|
| 8 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 4.4 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Pressure Ulcers Unstageables.

**What the chart tells us:**
We are currently at 8 against a target of 4 per month. Which remains the same as last month.

**Issues: Continued**
Due to operational pressures there have been occasions when patients have spent a prolonged period of time in chairs in the ED 'Fit to Sit 'area, with limited provision to undertake skin inspections.

Effective repositioning is not consistently being undertaken in accordance with pressure relieving plans. It has been identified that at times this is due to a lack of pillow availability.

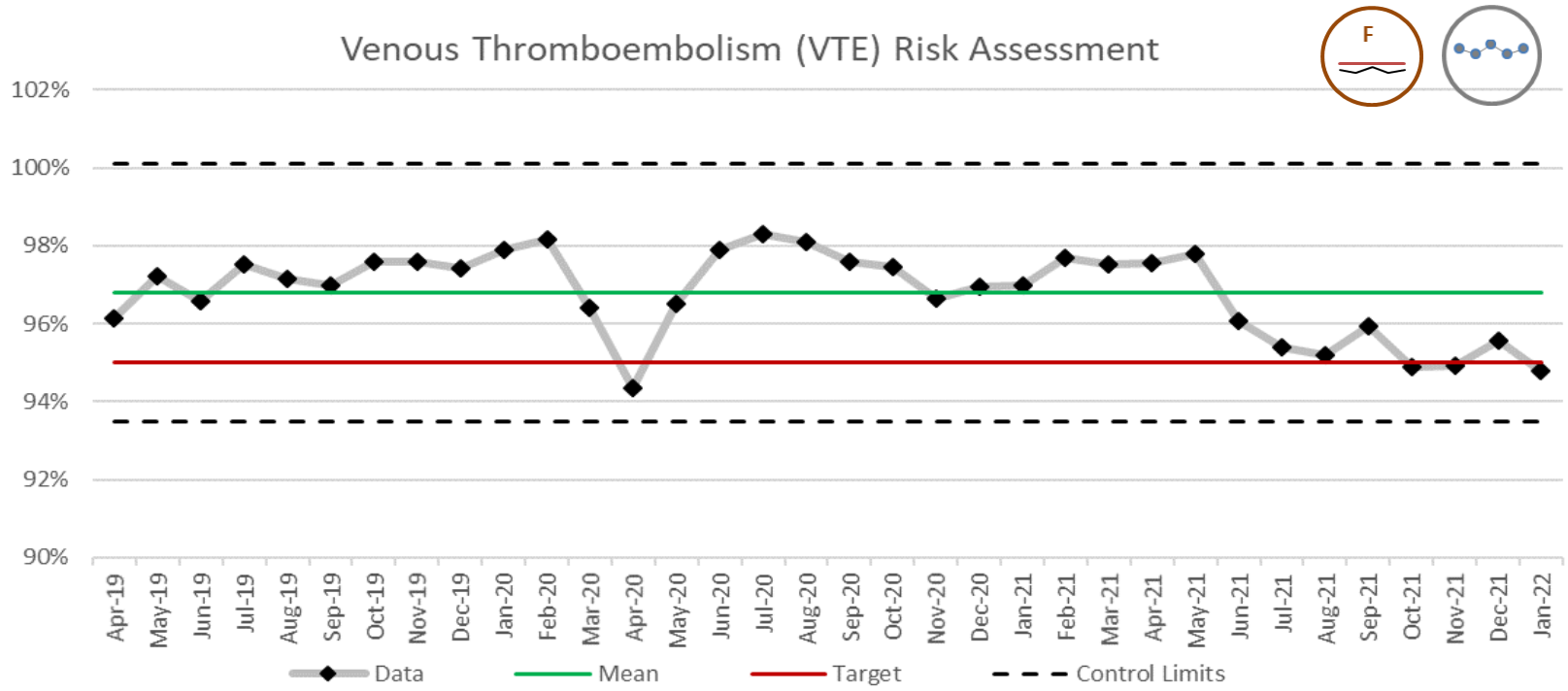
**Actions: Continued**
ED 'Fit to Sit 'area has been discussed at Quality Cell and a task and finish group will be established which will include a review of skin integrity care and resources.

Work is being undertaken with the procurement team to standardise processes relating to purchase and supply of pillows to ensure availability to support repositioning plans.

Unstageable pressure ulcers will be investigated and reviewed through the pressure ulcer incident process. Themes identified will provide further areas of focus to improve.

**Mitigations:**
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

The patient pressure ulcer incident panel also have sight of any other areas of concern that are not raised through the serious incident process.




| Jan-22 |
|---|
| 94.80% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 95% |
| **Target Achievement** |
| Metric is failing the target |
| **Executive Lead** |
| Medical Director |

**Background:**
VTE risk assessment to assess need for thromboprophylaxis to reduce risk of DVT / PE should be undertaken in 95% or more of patients.

**What the chart tells us:**
VTE risk assessment performance is just below 95% target, currently at 94.80%.

**Issues:**
As previously discussed via the VTE and Anti-Coagulation Safety Group.

**Actions:**
Actions to be proposed, implemented and monitored through the Trust's VTE and Anti-Coagulation Safety Group Meeting, which in turn reports via Deteriorating Patients Group and Patient Safety Group.

**Mitigations:**
As discussed via the VTE and Anti-Coagulation Safety Group.

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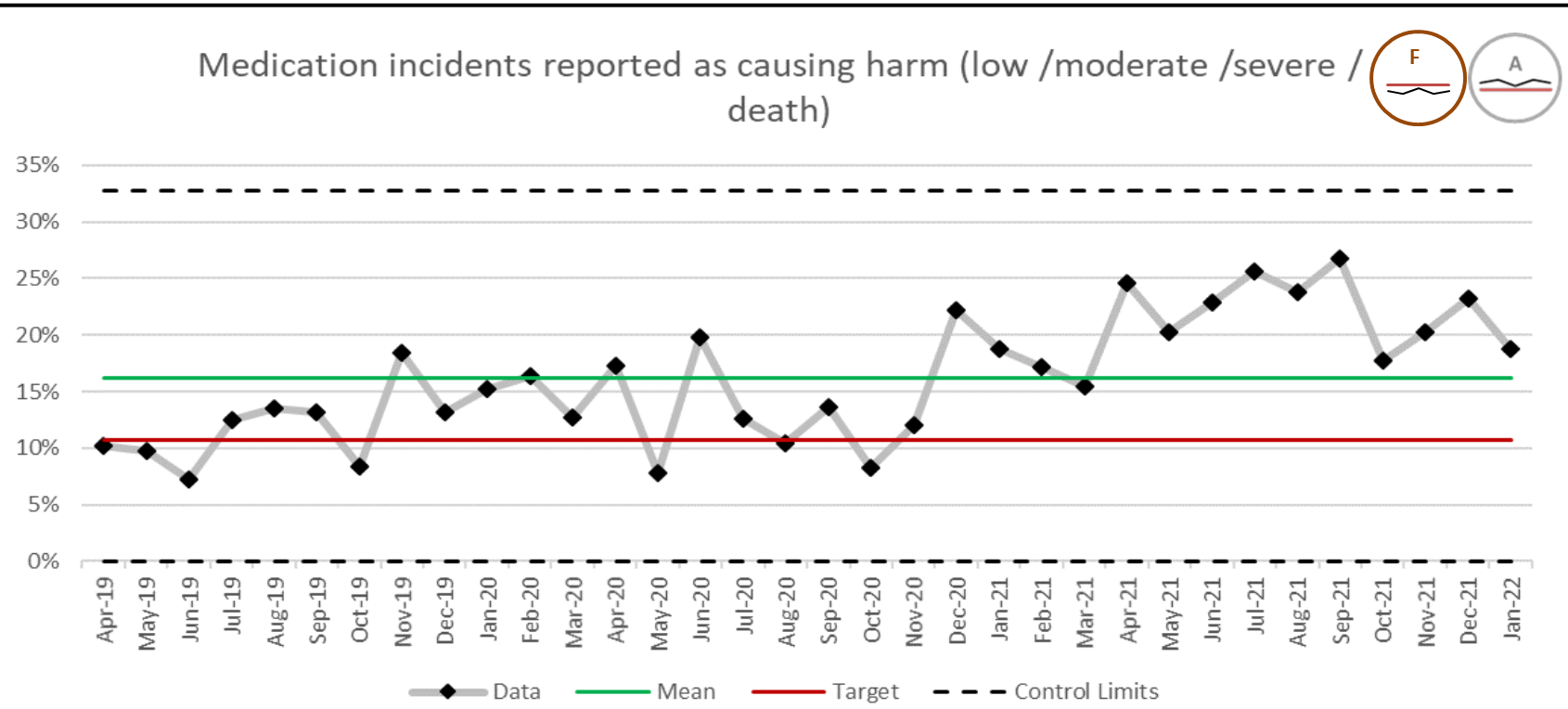


| Jan-22 |
|---|
| 18.8% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – above the mean |
| **Target** |
| 10.7% |
| **Target Achievement** |
| The metric has consistently failed to target |
| **Executive Lead** |
| Medical Director |

**Background:**
Percentage of medication incidents reported as causing harm (low/moderate/severe or death).

**What the chart tells us:**
In the month of Jan the number of incidents reported was 143. This equates to 4.67 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 18.8% which is above the national average of 10.8. This is a small reduction in incidents as compared to the previous month.

**Issues:**
Medication incidents causing harm is above the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines. There are other types of incident that are now being picked up for action via the Medicines Management Task and Finish Group.

**Actions:**
A Medicines Management project Task and Finish group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management and reduce the number and potential severity of medicines incidents. A number of actions have been proposed from this group. An internal audit into Medicines Management is also being undertaken in late February 2022.

**Mitigations:**
Amongst other mitigations, there is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that the Trust provide to patients. Other mitigations will be assessed through the Medicines Management Task & Finish work.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

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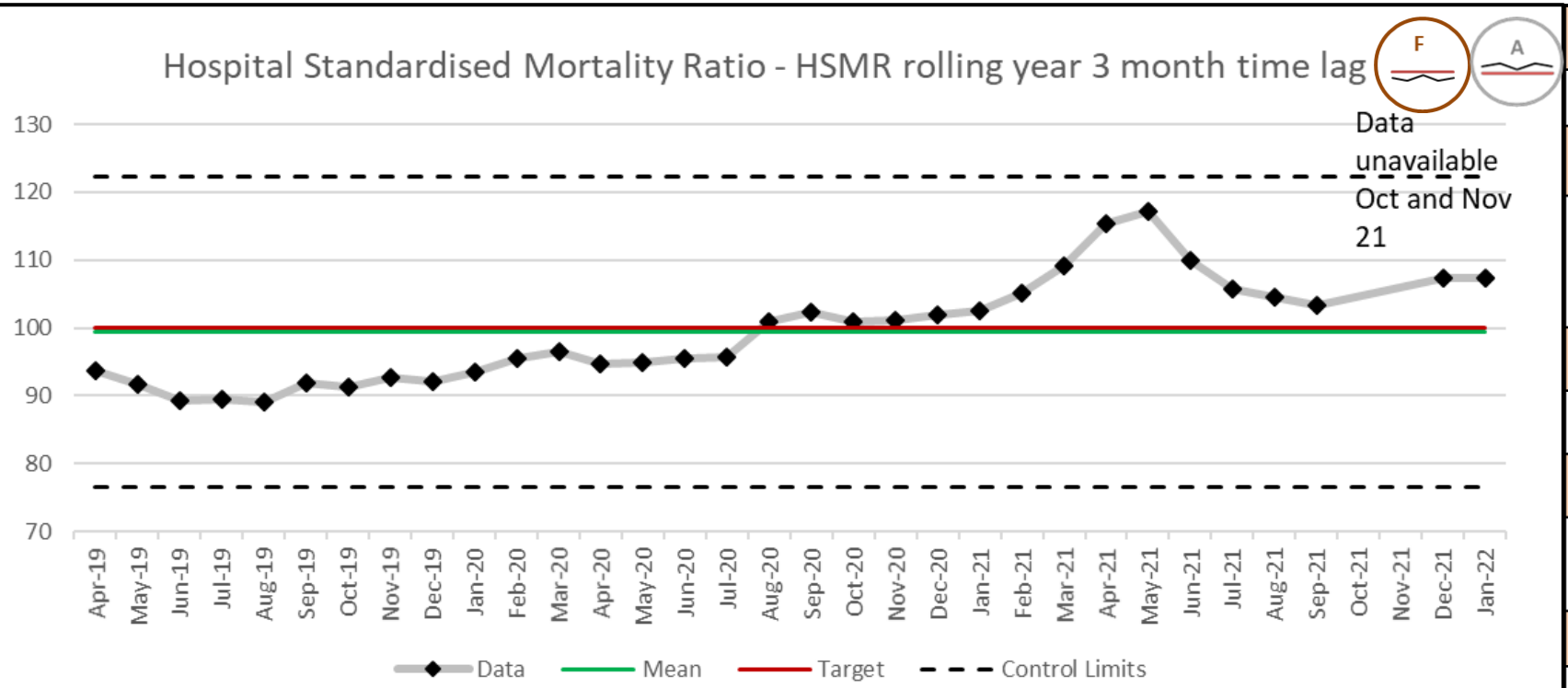



| Jan-22 |
|---|
| 107.40 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – above the mean |
| **Target** |
| 100 |
| **Target Achievement** |
| The metric has consistently failed to target |
| **Executive Lead** |
| Medical Director |

**Background:**
Since the COVID-19 pandemic the Trust's HSMR has increased compared to where the Trust was pre pandemic.

**What the chart tells us:**
The HSMR has seen an increase in the latest HSMR data but overall the HSMR is seeing a reduction compared to the peak of the COVID-19 pandemic.

**Issues:**
The Trust had not received any mortality data for the previous two months due to ongoing issues with Dr Foster.

The data received previously demonstrated a lower HSMR – the Trust has contacted Dr Foster to request why the data is higher than they previously reported.

**Actions:**
Mortality report presented at MorALS

All alerts are investigated

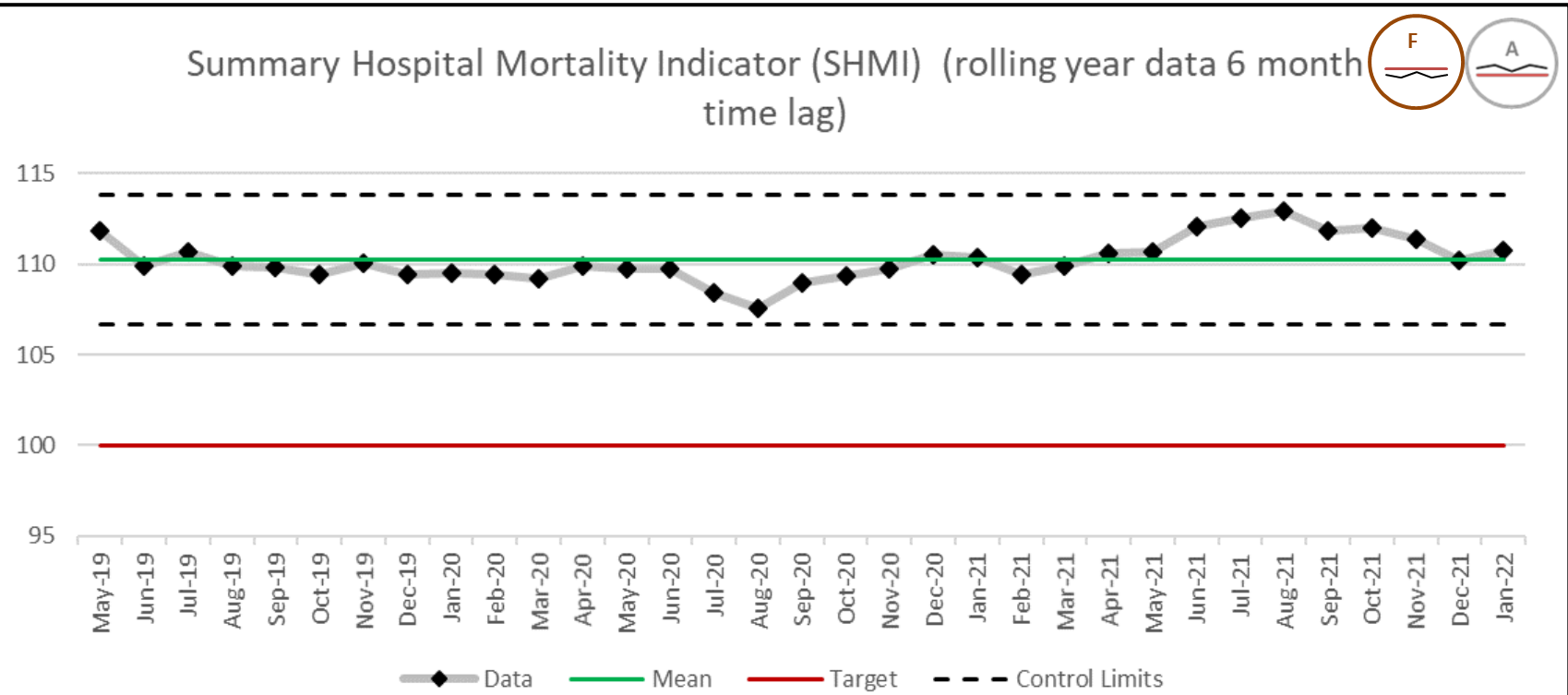
There are monthly Divisional reports produced for the Triumvirate to present at MorALS.

**Mitigations:**
NHSI/E have completed a peer review on our structured judgement and will be presenting the report at the MorALS meeting in February 2022 (January meeting cancelled due to operational pressures)

Members of the Dr Foster data team will attend the mortality meeting to explain the reasons for the difference in the HSMR data.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 110.73 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – above the mean |
| **Target** |
| 100 |
| **Target Achievement** |
| The metric has consistently failed to target |
| **Executive Lead** |
| Medical Director |

**Background:**
SHMI reports on mortality at trust level across the NHS in England using a standard methodology. SHMI also includes deaths within 30 days of discharge.

**What the chart tells us:**
The Trust's SHMI has increased during the COVID-19 pandemic but is seeing a slight reduction i.e. improvement in the SHMI. This still remains in the "as expected" range for the Trust.

**Issues:**
The COVID-19 pandemic and resulting operational pressures have impacted on the Trust's SHMI. The data period the SHMI currently reflects is from Sept 2020 – August 2021, given the 6 month data time lag. It is important to highlight that the Trust's SHMI is "as expected" or "lower than expected" for all three sites.

**Actions:**
Any diagnosis group alerting is subject to a case note review.

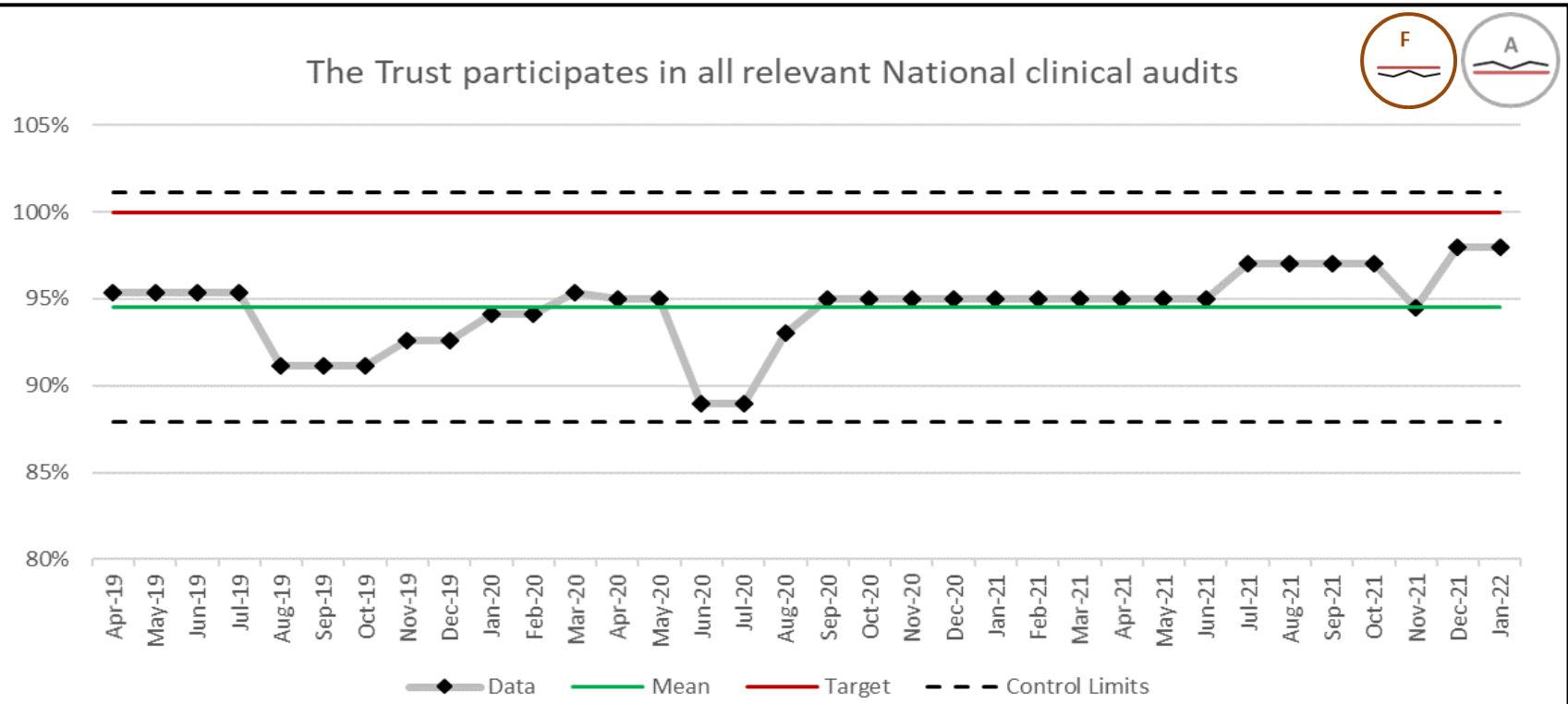
The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.

**Mitigations:**
The MEs will commence reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

Learning is shared at the Lincolnshire Mortality Collaborative Group which is attended by all system partners.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 98% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – above the mean |
| **Target** |
| 100% |
| **Target Achievement** |
| The metric has consistently failed to target |
| **Executive Lead** |
| Medical Director |

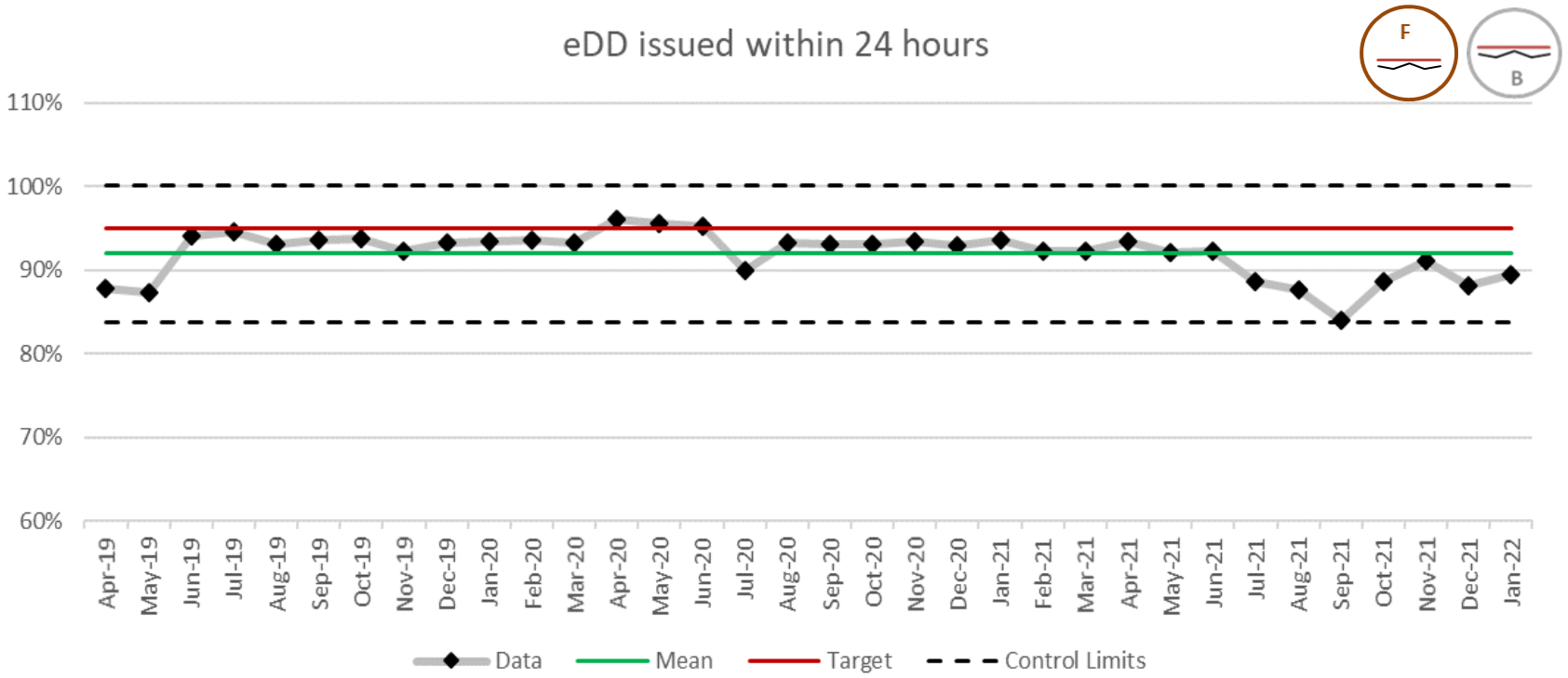
**Background:**
The Trust needs to evidence its participation in all relevant National Clinical Audits.

**What the chart tells us:**
Participation in National Clinical Audits has remained the same just under 100%, at 98%.

**Issues:**
The less than 100% achievement with this standard is specifically related to incomplete participation in the National Inflammatory Bowel Disease (IBD) Audit.

**Actions:**
Relevant actions to improve the participation in National Clinical Audits are specifically monitored by the Clinical Effectiveness Group.

**Mitigations:**
Regarding the IBD audit, access and logins to allow access to the audit database were activated in late December 2021, with training for the local IBD team to use the new web tool delayed and now taking place in February 2022. This will result in more effective participation in the IBD audit.




| Jan-22 |
|---|
| 89.5% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – below the mean |
| **Target** |
| 95% |
| **Target Achievement** |
| The metric is consistently failing the target |
| **Executive Lead** |
| Medical Director |

**Background:**
Electronic discharge documents (eDDs) to be sent within 24 hours of a patient's discharge from hospital.

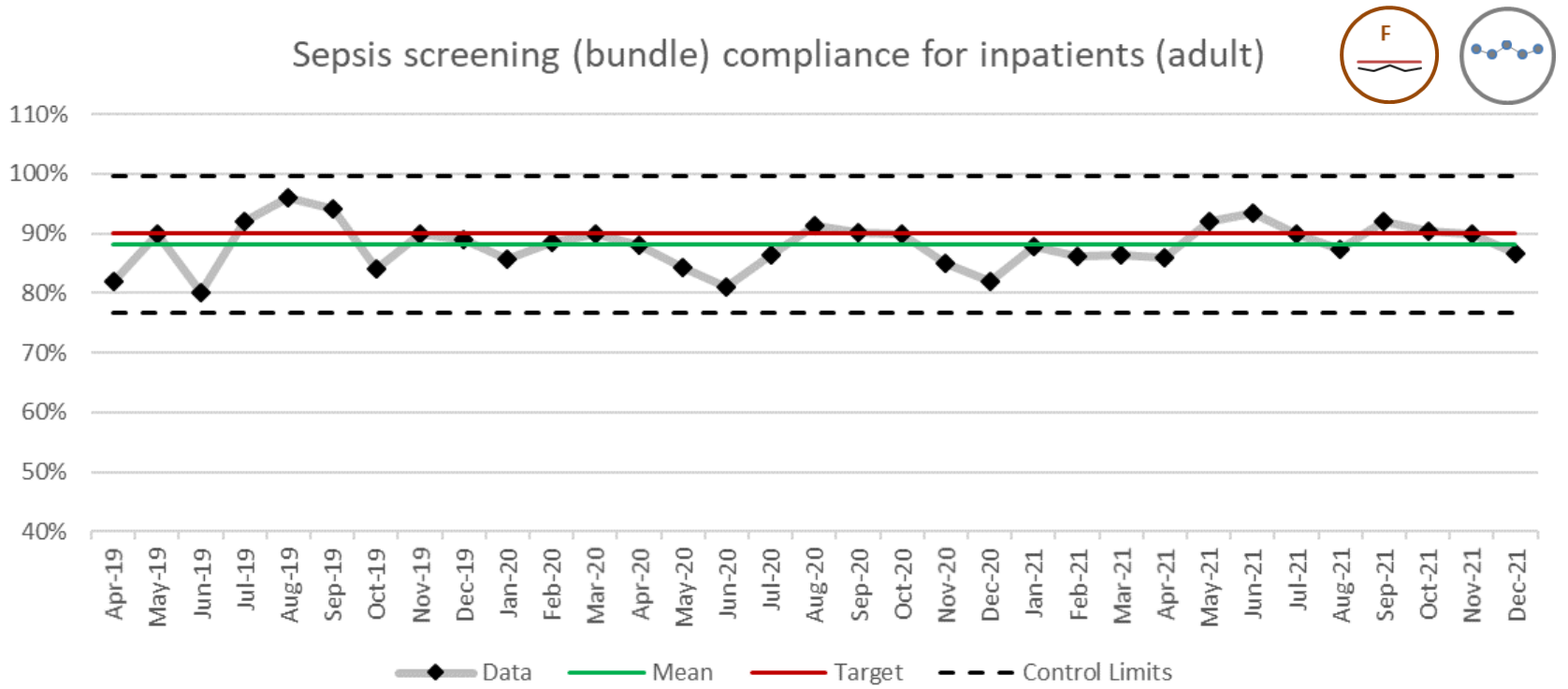
**What the chart tells us:**
The Trust is not achieving the 95% target; for January 2022, the Trust achieved 89.5% for this standard. The Trust however achieved 93.4% for eDDs sent anytime within the month of January.

**Issues:**
eDDs not being completed the day prior to the patient's discharge.

This is because of a number of factors, including considerable operational pressures on both bed capacity and staffing within the Trust.

**Actions:**
A dashboard has therefore been developed to highlight compliance at both ward and consultant level, which can then help to highlight areas of suboptimal compliance to help focus targeted work to address this.

**Mitigations:**
A proposal is being developed to how eDDs will be managed going forward within the Trust in collaboration with system partners, in combination through the eDD task and finish group.




| Dec-21 |
|---|
| 86.60% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| The metric is failing the target |
| **Executive Lead** |
| Director of Nursing |

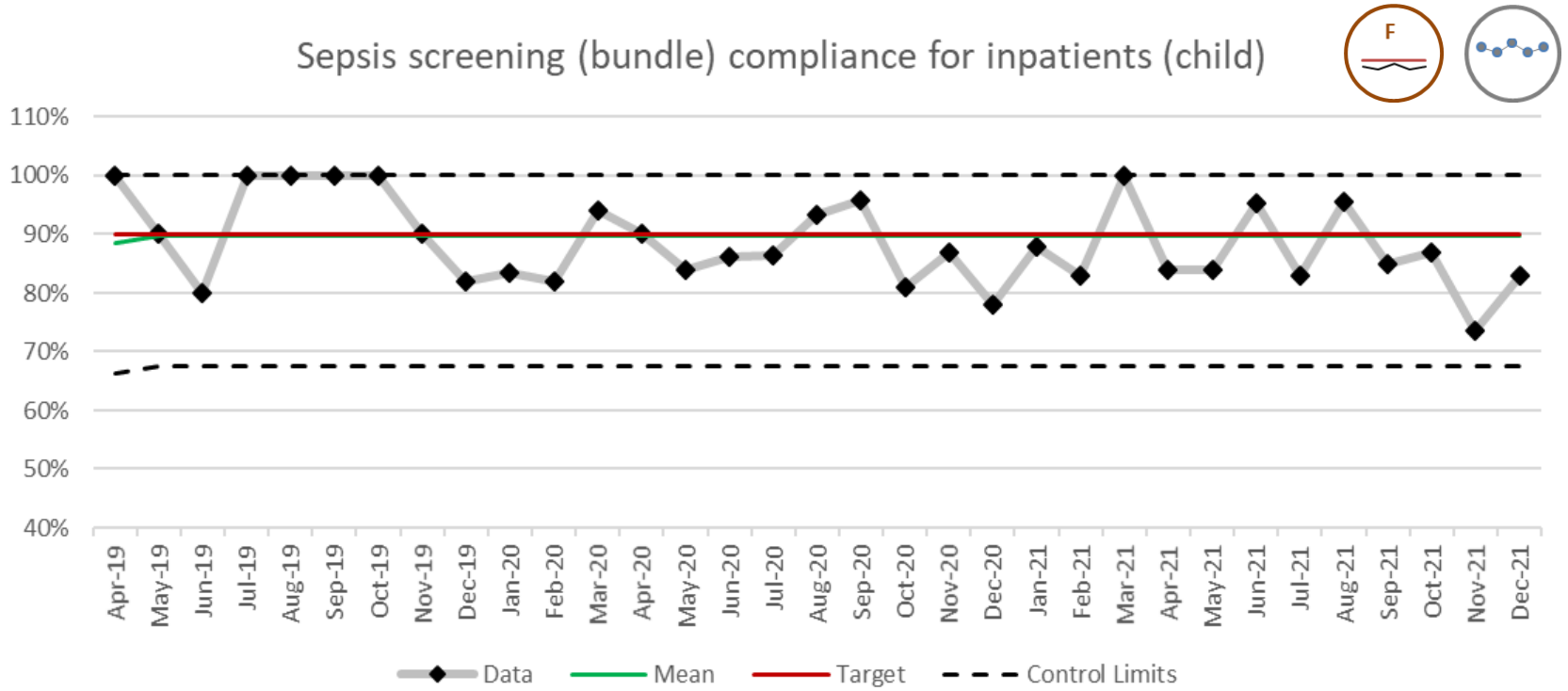
**Background:**
Sepsis screening (bundle) compliance in inpatients (adult).

**What the chart tells us:**
The current compliance is at 86.6% against a target of 90%.

**Issues:**
There has been a slight drop in compliance for adult in-patient screening and this appears to be mirrored across all sites and specialties. This is seen with both substantive and agency/bank and is primarily in non-infective causes for raised NEWS.

**Actions:**
Currently the service is running with only one practitioner whose own hours have been reduced due to redeployment. It is not possible to directly correlate this to the reduced numbers but with the appointment of a second practitioner at the end of February it will allow us to focus training on specific ward areas to support learning.

**Mitigations:**
Training has now restarted for the international nurse cohorts and the preceptorship courses and this will help support the more junior members of the team. There are now additional resources available on line including a more comprehensive sepsis workbook and a video detailing correct completion of a sepsis bundle on web v. A video has been prepared of a sepsis scenario to be released shortly.




| Dec-21 |
|---|
| 82.97% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| The metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Sepsis screening (bundle) compliance in inpatients (child).

**What the chart tells us:**
The current compliance is at 82.97% against a target of 90%.
Screening was completed on 39 of 47 children.

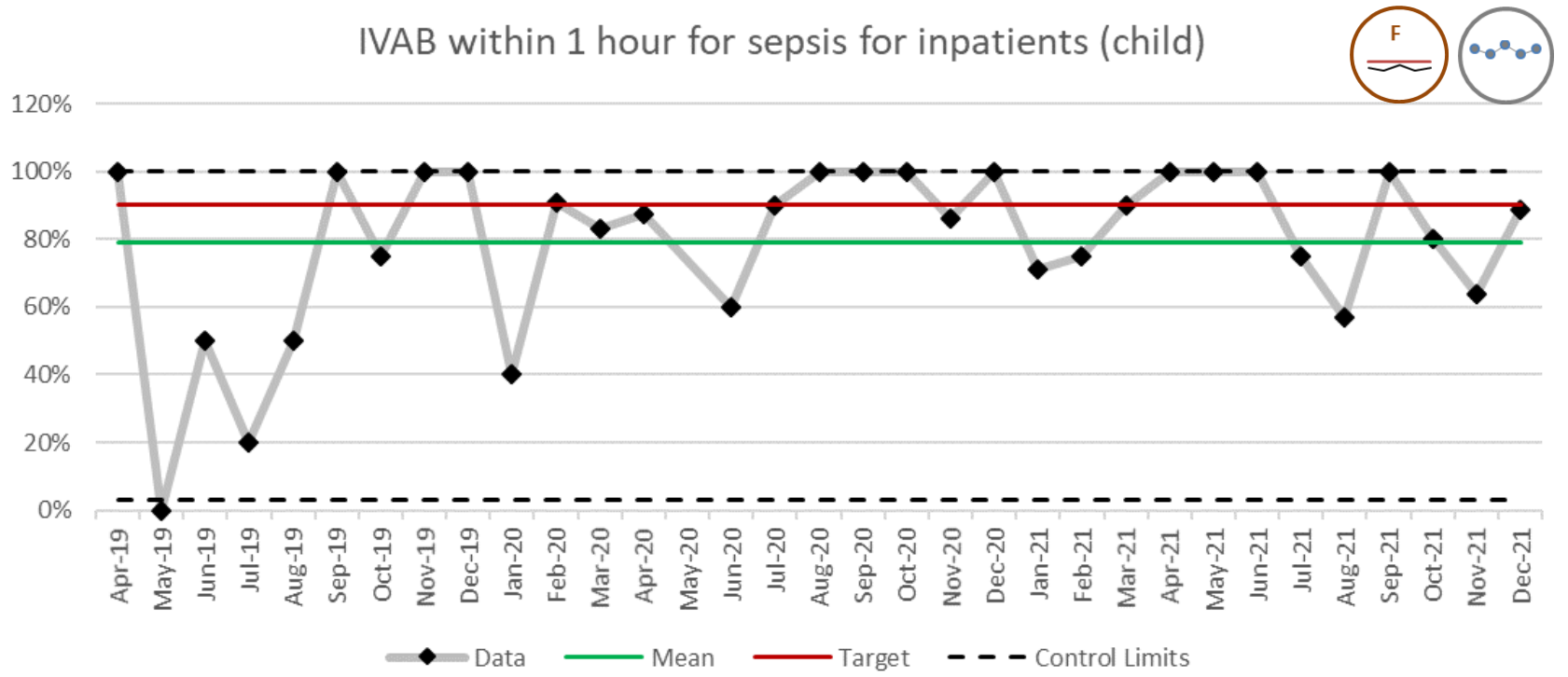
**Issues:**
The wards have had an increased number of patients and acuity during December along with staffing issues.
The majority of missed/delayed screens are non- infection. There was no harm found on any of the harm reviews done on these patients.
All current face to face training has been cancelled due to hospital site pressures

**Actions:**
The CYP Practitioner is visiting the ward regularly to offer support with Sepsis Screening.
Short sessions of face to face training are happening with staff that have been highlighted as missing a screen.
More simulation training regarding sepsis is planned as soon as this can go ahead.

**Mitigations:**
Meetings between CYP practitioner, Ward Managers & clinical educators in the paediatric areas scheduled within the next month to discuss and plan further training for the wards.
The wards are being asked to complete their own harm reviews so that lessons can be learned from them.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 88.88% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| The metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

**Background:**
IVAB within 1 hour for sepsis for inpatients (child).

**What the chart tells us:**
The current compliance is at 88.88% against a target of 90%. There were 8 out of 9 patients that received antibiotics within the one hour time frame.

**Issues:**
There was one patient that had delayed antibiotics but the cause was not found to be sepsis and there was no harm found from the delay. This was due to a delay in being able to get IV access.

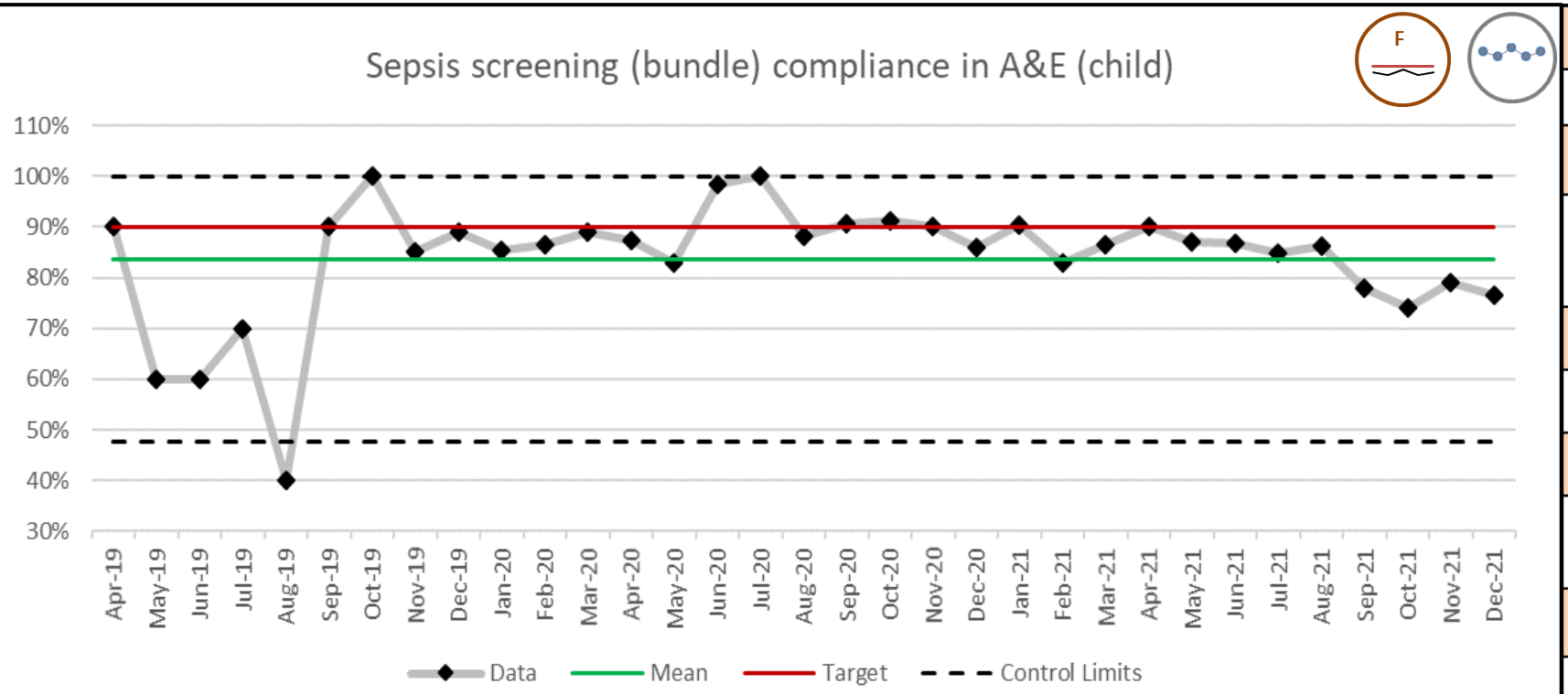
**Actions:**
A harm review was completed for this patient which concluded that no harm was caused from the delay. An IR1 has also been completed so that it can be investigated and learning points can be actioned from this. No Harm found from delay. Discussions are being held regarding further staff having cannulation training.

**Mitigations:**
Ongoing meetings taking place between CYP Practitioner, Ward Sister and Clinical Educators to highlight issues early and formulate action plans.
CYP Practitioner is also meeting with Ward Drs to discuss any issues around sepsis.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 76.60% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| The metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

**Background:**
Sepsis screening (bundle) compliance in A & E (child).

**What the chart tells us:**
Screening compliance in ED is 76.60% which is below the 90% target. 203 of 265 patients received screening for sepsis within the hour.

**Issues:**
ED has recently seen a large turnover of staff. ED is also seeing a large increase in the number of patients being seen within the department as well as a higher acuity of patients. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department. Face to face training is cancelled at present.

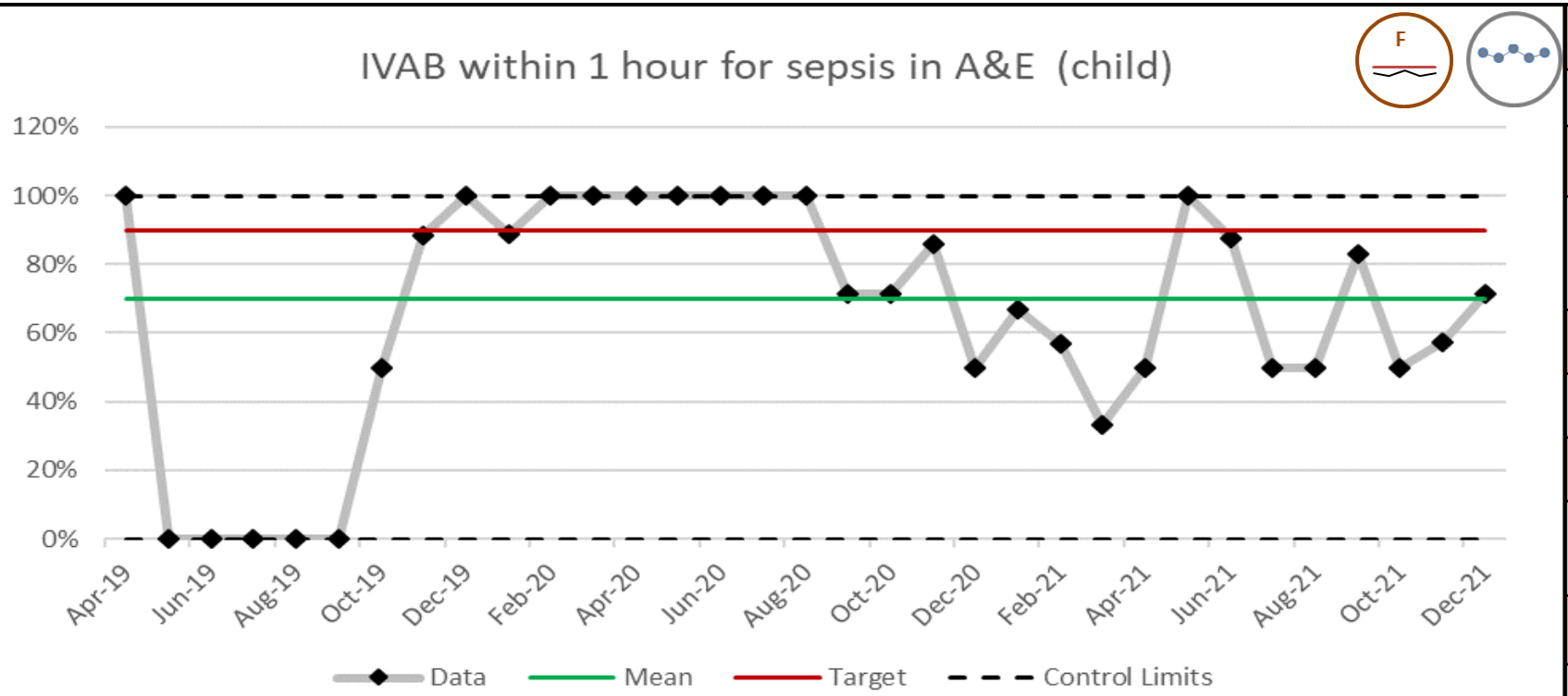
**Actions:**
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out. Sepsis Practitioner will attend morning huddles and ED meetings for support and training. There appears to be a greater issue with delayed screens at Lincoln and Grantham so the main focus will be on those two sites.

**Mitigations:**
There are ongoing fortnightly Sepsis meetings for ED at present, Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings. Issues are discussed at Governance.
Paediatric Drs and Nurses from the Ward are supporting the ED when possible.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 71.42% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| The metric is consistently failing the target |
| **Executive Lead** |
| Director of Nursing |

**Background:**
IVAB within 1 hour for sepsis in A&E (child).

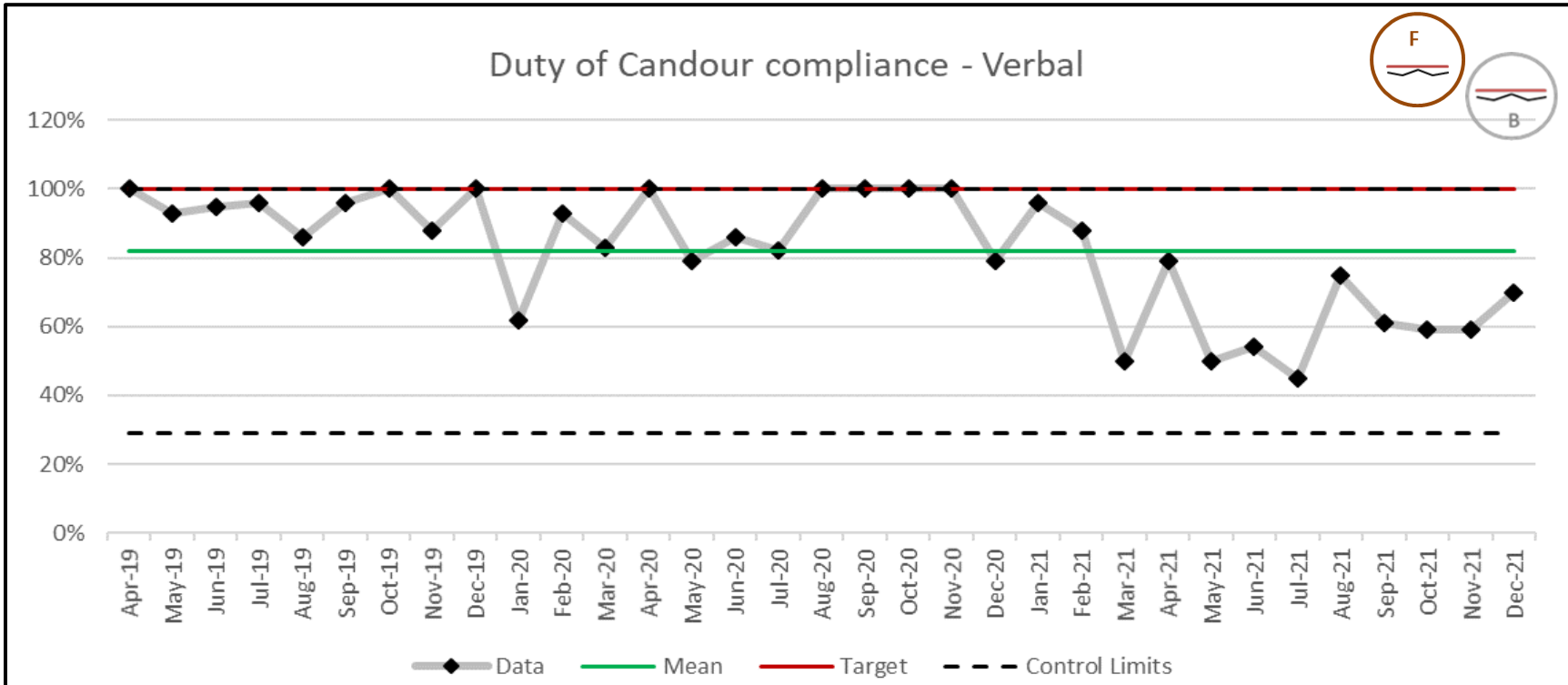
**What the chart tells us:**
The compliance in ED this month for IVAB is 71.42%, 5 of 7 children received antibiotics within the hour.

**Issues:**
The department is currently seeing a large number of children and there are often up to 20 children in the department at one time. This is a huge workload for 1 Paeds nurse and a Doctor. The staff have reported they are struggling to find time to give these in a timely manner. The ward is also very busy at present and is not always able to offer assistance.

**Actions:**
Harm reviews are being completed for all children who have delayed antibiotics. IR1 also being completed for all delays to highlight learning points. No Harm was found for the 2 children who had delayed. Children are being moved out of the department and to wards as quickly as possible. Some ED nurses have expressed an interest in being able to cannulate children and take bloods.

**Mitigations:**
Discussed at ongoing fortnightly Sepsis meeting. If ED need assistance they are phoning the paediatric wards. Wards are offering help if possible. The paediatric Sepsis Practitioner is also attending ED regularly to offer support.
Data is being pulled every other day in order to detect issues as quickly as possible and try to resolve but this is also difficult due to staffing / redeployment.

Quality | Operational Performance | Workforce | Finance




| Dec-21 |
|---|
| 70% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – below the mean |
| **Target** |
| 100% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Medical Director |

**Background:**
Verbal and Written compliance with NHS Duty of candour which applies to all patient safety incidents where harm is moderate or above.

**What the chart tells us:**
Verbal compliance for December is at 70%, against a 100% target.

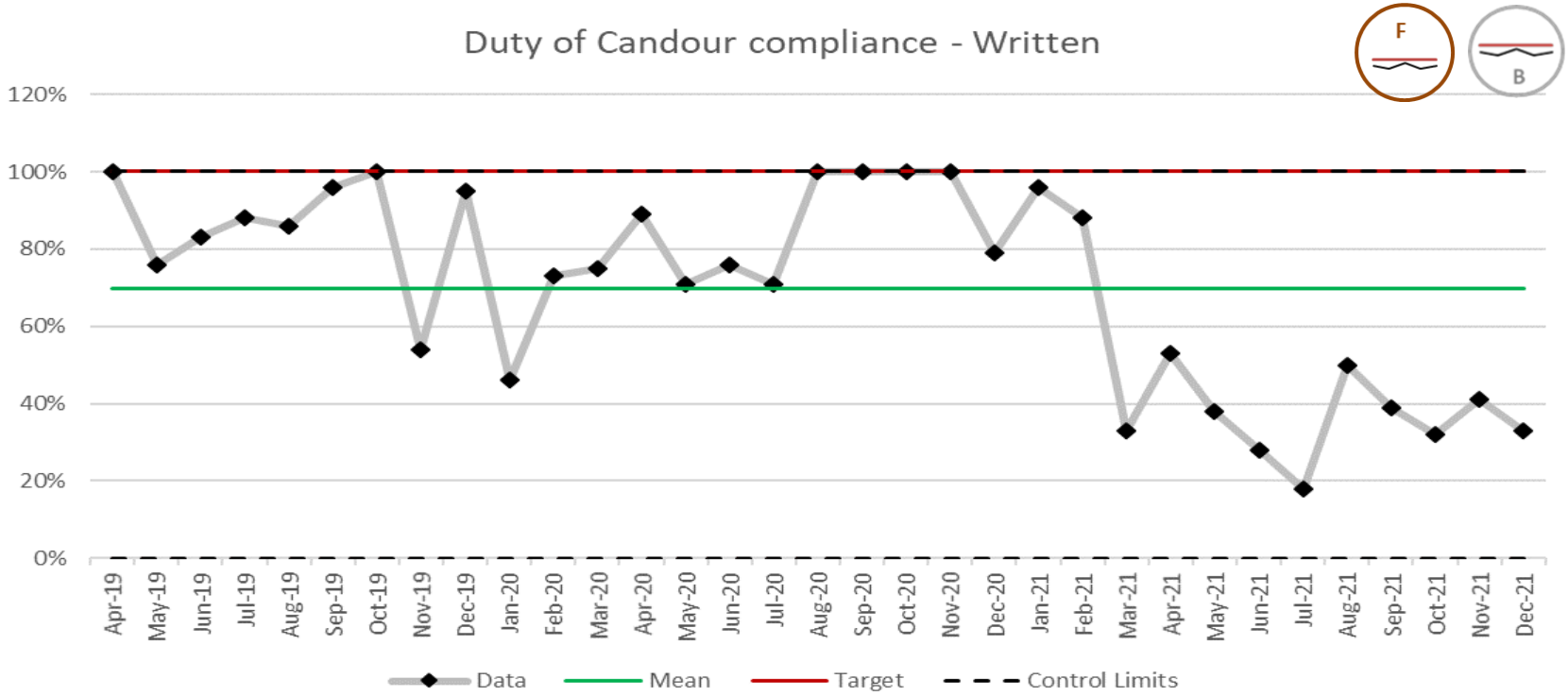
**Issues:**
Analysis in progress to understand reasons for persistent non-compliance. For example: this may be related to a recording issue, lack of understanding, or reluctance to undertake the duty of candour update.

**Actions:**
Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are now sent to Divisional Triumvirate.

**Mitigations:**
Series of briefings on Duty of Candour delivered by external provider in October / November 2021.

Completion rate for Duty of Candour Core Learning is consistently above 95%.




| Dec-21 |
|---|
| 33% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – below the mean |
| **Target** |
| 100% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Medical Director |

**Background:**
Verbal and Written compliance with NHS Duty of Candour (DoC) which applies to all patient safety incidents where harm is moderate or above.

**What the chart tells us:**
Written compliance for December 2021 is at 33% against a 100% target.

**Issues:**
Analysis in progress to understand reasons for persistent non-compliance. For example: this may be related to a recording issue, lack of understanding, or reluctance to undertake the duty of candour update.

**Actions:**
Clinical Governance team are now notifying clinical teams when a moderate harm or above incident is reported and supporting Duty of Candour completion.

Weekly Duty of Candour compliance reports are now sent to Divisional Triumvirate.

**Mitigations:**
Series of briefings on Duty of Candour delivered by external provider in October / November 2021.

Completion rate for Duty of Candour Core Learning is consistently above 95%.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Nov-21 | Dec-21 | Jan-22 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improve Patient Experience | % Triage Data Not Recorded | Effective | Patients | Chief Operating Officer | 0% | 0.06% | 0.08% | 0.07% | 0.27% | | F | | |
| Improve Clinical Outcomes | 4hrs or less in A&E Dept | Responsive | Services | Chief Operating Officer | 83.12% | 63.77% | 64.67% | 63.49% | 66.75% | 83.12% | F | B | |
| | 12+ Trolley waits | Responsive | Services | Chief Operating Officer | 0 | 254 | 330 | 465 | 1318 | 0 | F | H | |
| | %Triage Achieved under 15 mins | Responsive | Services | Chief Operating Officer | 88.5% | 86.12% | 86.15% | 86.62% | 86.40% | 88.50% | F | | |
| | 52 Week Waiters | Responsive | Services | Chief Operating Officer | 0 | 1983 | 2185 | | 12476 | 0 | F | | |
| | 18 week incompletes | Responsive | Services | Chief Operating Officer | 84.1% | 55.58% | 54.97% | | 57.34% | 84.10% | F | | |
| | Waiting List Size | Responsive | Services | Chief Operating Officer | 37,762 | 57,105 | 59,747 | | n/a | n/a | F | H | |
| | 62 day classic | Responsive | Services | Chief Operating Officer | 85.4% | 49.04% | 42.97% | | 58.06% | 85.39% | F | | |
| | 2 week wait suspect | Responsive | Services | Chief Operating Officer | 93.0% | 70.10% | 57.26% | | 74.06% | 93.00% | F | | |
| | 2 week wait breast symptomatic | Responsive | Services | Chief Operating Officer | 93.0% | 3.26% | 0.74% | | 9.74% | 93.00% | F | | |
| | 31 day first treatment | Responsive | Services | Chief Operating Officer | 96.0% | 90.76% | 89.94% | | 91.46% | 96.00% | F | | |
| | 31 day subsequent drug treatments | Responsive | Services | Chief Operating Officer | 98.0% | 99.22% | 99.27% | | 99.48% | 98.00% | P | | |
| | 31 day subsequent surgery treatments | Responsive | Services | Chief Operating Officer | 94.0% | 65.63% | 61.76% | | 72.70% | 94.00% | F | | |
| | 31 day subsequent radiotherapy treatments | Responsive | Services | Chief Operating Officer | 94.0% | 98.20% | 95.61% | | 96.68% | 94.00% | P | | |
| | 62 day screening | Responsive | Services | Chief Operating Officer | 90.0% | 78.26% | 53.85% | | 70.92% | 90.00% | F | | |

OUTSTANDING CARE personally DELIVERED

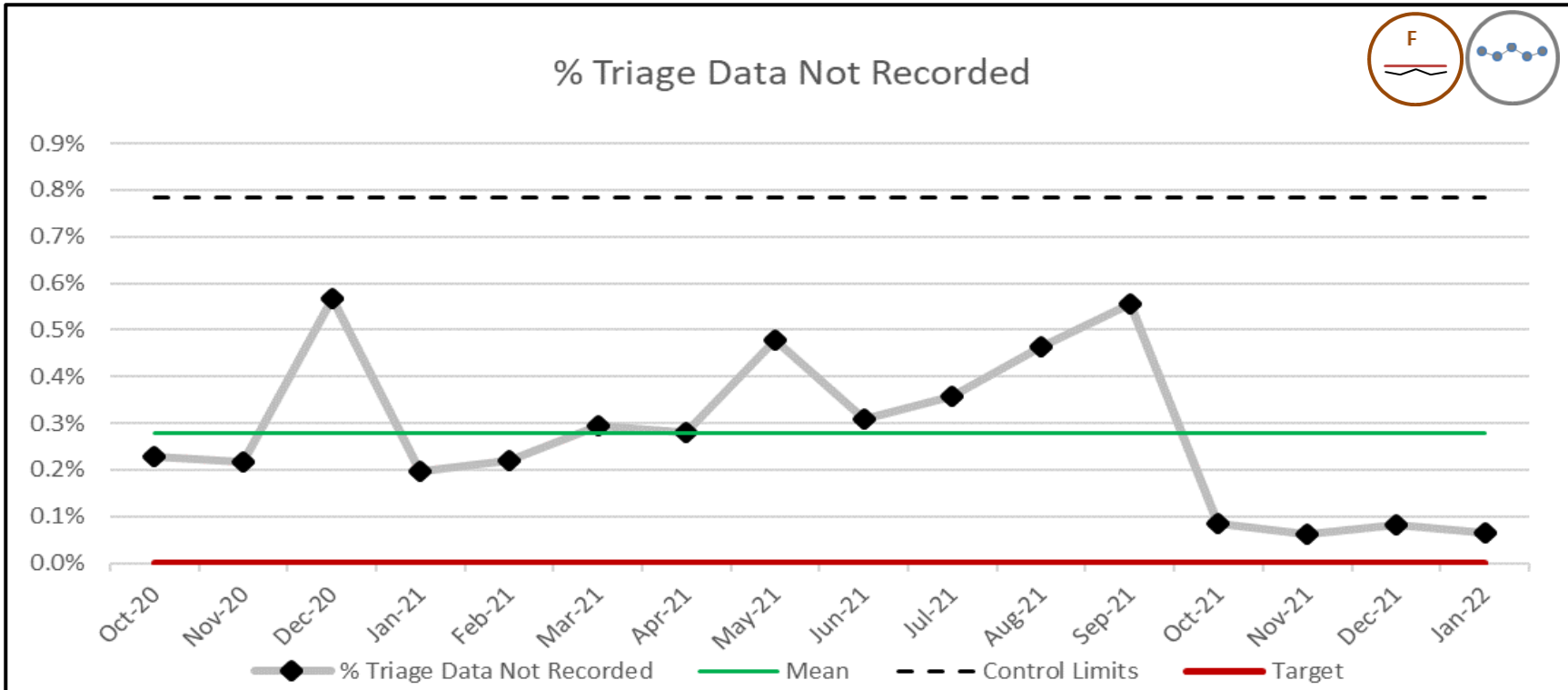
NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Nov-21 | Dec-21 | Jan-22 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improve Clinical Outcomes | 62 day consultant upgrade | Responsive | Services | Chief Operating Officer | 85.0% | 70.92% | 80.72% | | 75.17% | 85.00% | F | | |
| | Diagnostics achieved | Responsive | Services | Chief Operating Officer | 99.0% | 65.61% | 60.54% | 58.88% | 66.07% | 99.00% | F | | |
| | Cancelled Operations on the day (non clinical) | Responsive | Services | Chief Operating Officer | 0.8% | 2.45% | 1.82% | 2.21% | 2.09% | 0.80% | F | | |
| | Not treated within 28 days. (Breach) | Responsive | Services | Chief Operating Officer | 0 | 22 | 21 | 31 | 177 | 0 | F | | |
| | #NOF 48 hrs | Responsive | Services | Chief Operating Officer | 90% | 88.10% | 84.00% | 92.59% | 89.88% | 90% | P | | |
| | #NOF 36 hrs | Responsive | Services | Chief Operating Officer | TBC | 77.38% | 70.67% | 74.07% | 75.37% | | | | |
| | EMAS Conveyances to ULHT | Responsive | Services | Chief Operating Officer | 4,657 | 4,148 | 4,167 | 4,242 | 4,400 | 4,657 | P | | |
| | EMAS Conveyances Delayed >59 mins | Responsive | Services | Chief Operating Officer | 0 | 777 | 654 | 656 | 578 | 0 | F | | |
| | 104+ Day Waiters | Responsive | Services | Chief Operating Officer | 10 | 123 | 161 | 168 | 885 | 100 | F | H | |
| | Average LoS - Elective (not including Daycase) | Effective | Services | Chief Operating Officer | 2.80 | 2.67 | 2.59 | 2.72 | 2.69 | 2.80 | P | | |
| | Average LoS - Non Elective | Effective | Services | Chief Operating Officer | 4.50 | 4.82 | 4.81 | 5.01 | 4.61 | 4.5 | F | | |
| | Delayed Transfers of Care | Effective | Services | Chief Operating Officer | 3.5% | Submission suspended | | | | 3.5% | | | |
| | Partial Booking Waiting List | Effective | Services | Chief Operating Officer | 4,524 | 17,406 | 19,326 | 20,006 | 16,728 | 4,524 | F | H | |
| | Outpatients seen within 15 minutes of appointment | Effective | Services | Chief Operating Officer | 70.0% | 43.9% | 41.8% | 42.9% | 42.88% | 70.00% | F | | |
| | % discharged within 24hrs of PDD | Effective | Services | Chief Operating Officer | 45.0% | 37.1% | 36.5% | 40.8% | 40.06% | 45.00% | F | | |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Jan-22 |
|---|
| 0.07% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Percentage of triage data not recorded.

**What the chart tells us:**
The recording of triage compliance percentage is 0%.
January reported 0.07% data not recorded verses 0.08% in December January demonstrated a 0.01% positive variation compared with December.
This metric is below target but improvements have been demonstrated.

**Issues:**

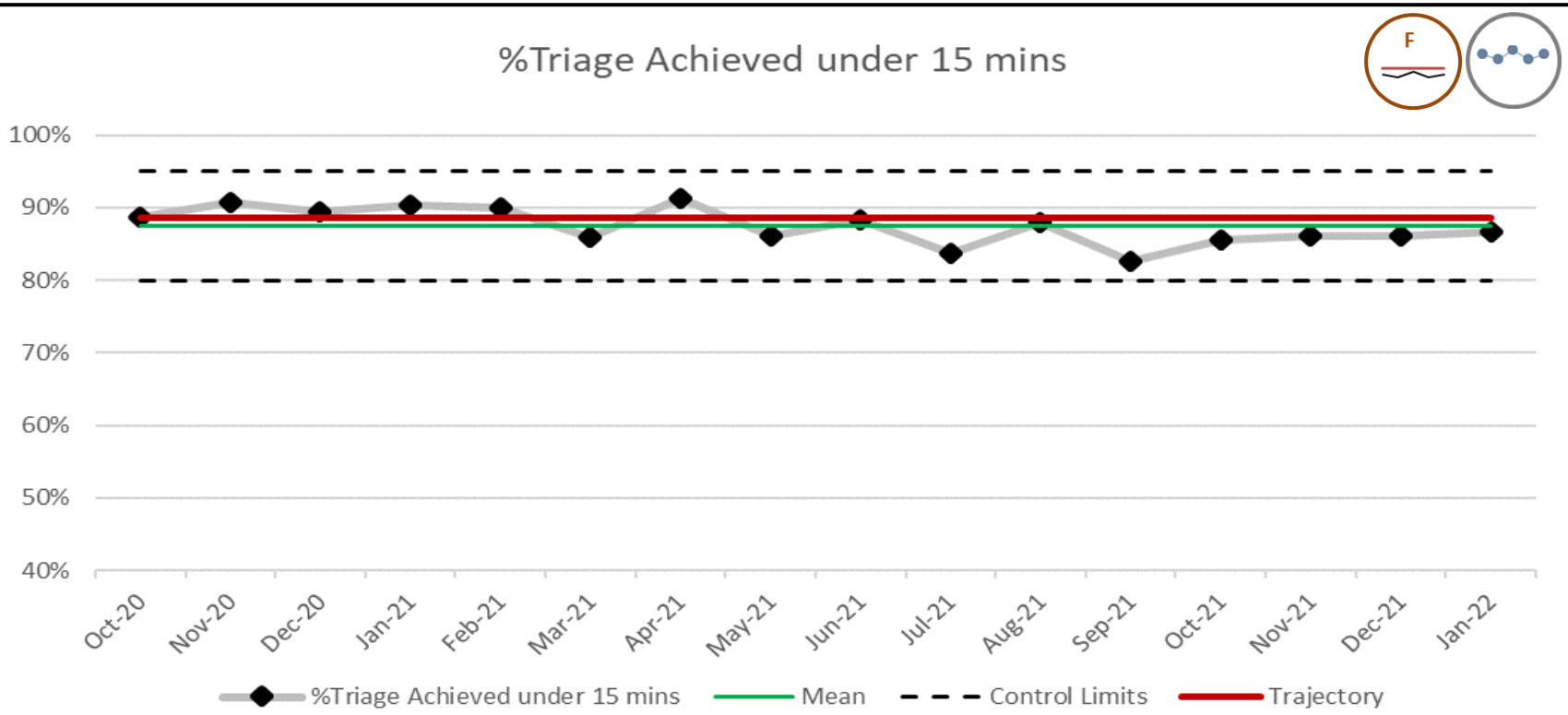
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been less problematic at all three sites.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) but a slight improvement in rostering has been seen.
- Staffing gaps and skill mix issues
- Increased demand is still cited as a causation factor.

**Actions:**

- Increased access to MTS training and time to input data is in place through a rolling teaching programme.
- Increased registrant workforce to support 2 triage streams in place.
- The move to a workforce model with Triage dedicated registrants and remove the dual role component has been more successful and consistent.

**Mitigations:**

- Earlier identification of recording delays via 3 x daily Capacity and performance meetings and Emergency Care 'Team's chat'.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit continue to undertake daily interventions regarding compliance (recording and undertaking).




| Jan-22 |
|---|
| 86.62% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 88.5% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Percentage of triage achieved under 15 minutes.

## What the chart tells us:

The compliance against this target is 88.50%.
January outturn was 86.62% which is 1.88% below the agreed target.
January demonstrated an improvement of 0.47% compared with December.
This target has not been met.

## Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 but is improving.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours but improvement is noted.

## Actions:

The actions are repetitive but remain relevant.
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

## Mitigations:

The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

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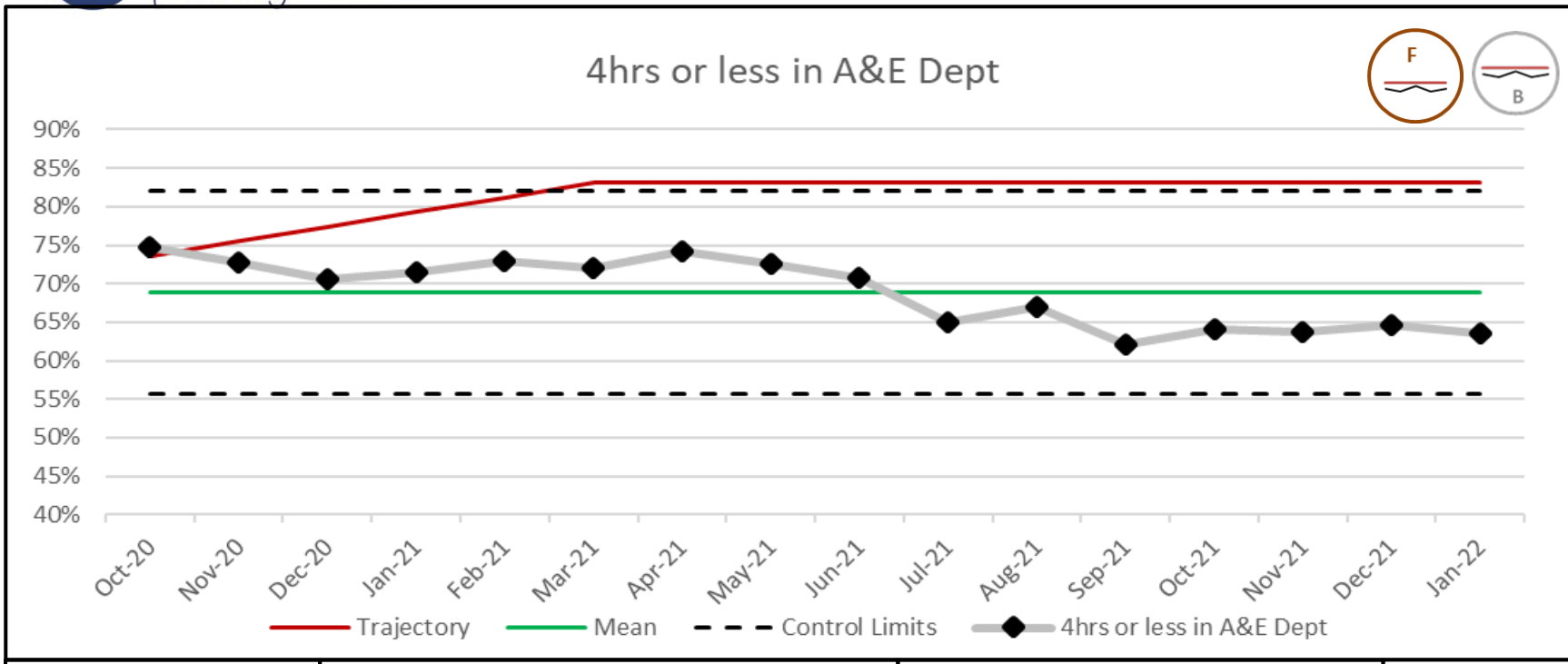


| Jan-22 |
|---|
| 63.49% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – below the mean |
| **Target** |
| 83.12% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%. This target has not been reset since April 2021.

## What the chart tells us:

The current 4-hour transit target performance for January was 63.49% 64.67% which is 19.63% below the agreed target.
January out turned at 63.49% compared to 64.67% in December A 1.18% negative variance compared to December.

## Issues:

The Emergency Departments saw a 0.93% decrease in attendances in January 2022 (150 patients) compared to December 2021. 16,040 combined attendances (ED and UTC) in January compared to 16,190 combined attendances in December.
A comparison to January 2019 denotes an increase of 11.18% (14,248 combined attendances). Against a comparison to January 2020 denotes a 2.39% increase (16,432 combined attendances).
Of the 16,040 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 10,695 and type 3 accounted for 5,345. This is a decrease on type 1 and type 3 attendances is across all 3 acute sites.
Inadequate daily discharges to meet the admission demand remains an issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

## Actions:

The actions are repetitive but still relevant
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC) Services.
Direct EMAS conveyance to SDEC services has commenced but CAD not yet updated with destination.
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions.
Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners. All delays >24hrs post optimisation are escalated for resolution.

## Mitigations:

The mitigations are repetitive but still relevant.
EMAS continue to enact a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander Out of Hours
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.
System Partners attend the ULHT 6pm Capacity Call to assist with any escalation issues.

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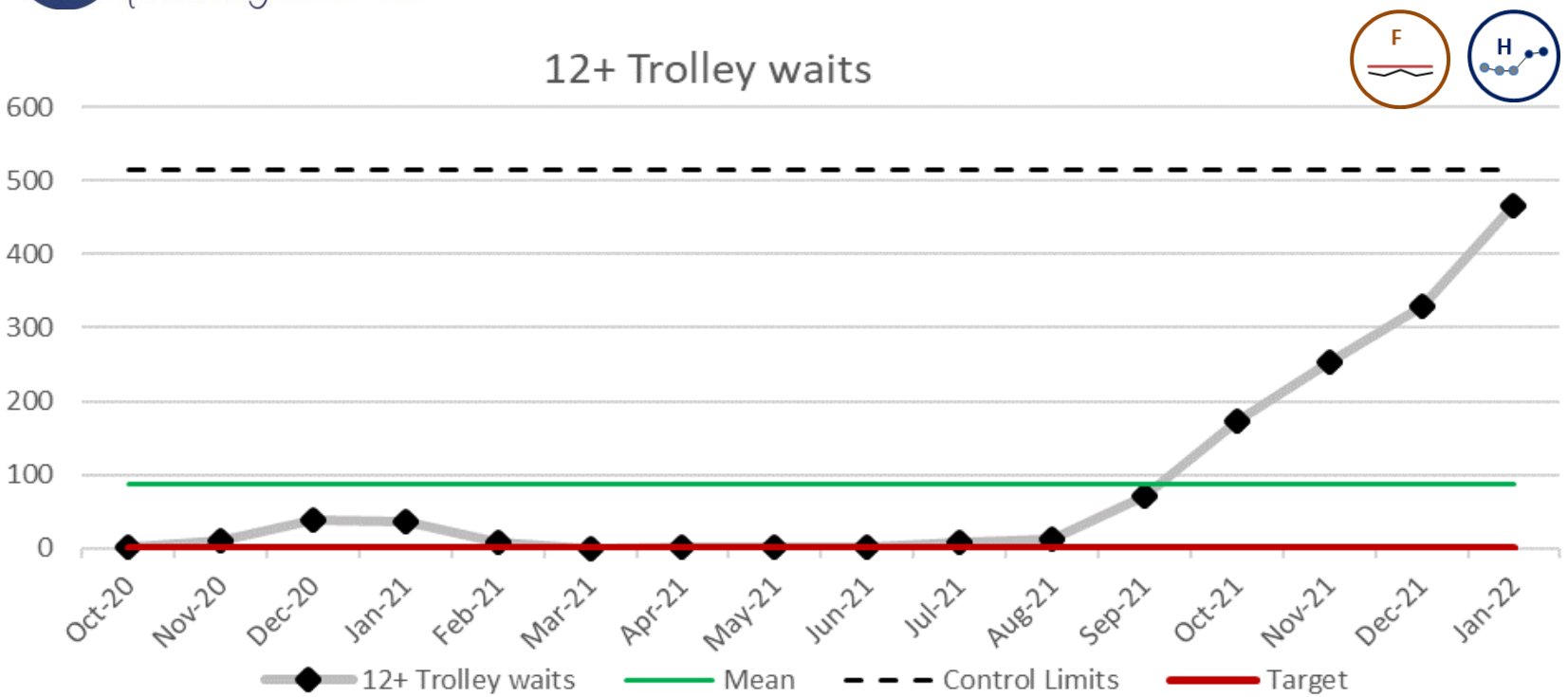


| Jan-22 |
|---|
| 465 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – high trend |
| **Target** |
| 0 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally, and nationally.

## What the chart tells us:

January experienced 465 12-hr trolley wait breaches, which is the highest ever recorded for ULHT. This represents an increase of 29.04% since December 2021. This equates to 4.34% of all type 1 attendances for January.

## Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or failure to transfer. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
January has experienced an increase in incidental positive covid cases and nosocomial transmission, which as restricted the use of several inpatients' beds, impacting further on flow.
January saw the highest number of positive covid cases since the peak of wave 3 and the number continues to rise.
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

## Actions:

The Trust continues to work closely with national regulators in reviewing and reporting these breaches.
Due to the number of 12hrs trolley waits breaches currently, harm reviews or completed by the URC team, DATIX are completed and escalations to the CCG and NHSE/I are in place.
A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times
Internal actions on admission avoidance are focussed on Same Day emergency Care and recent developments have shown a 100% increase in some areas.

## Mitigations:

All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead On Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. This has demonstrated a positive impact but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

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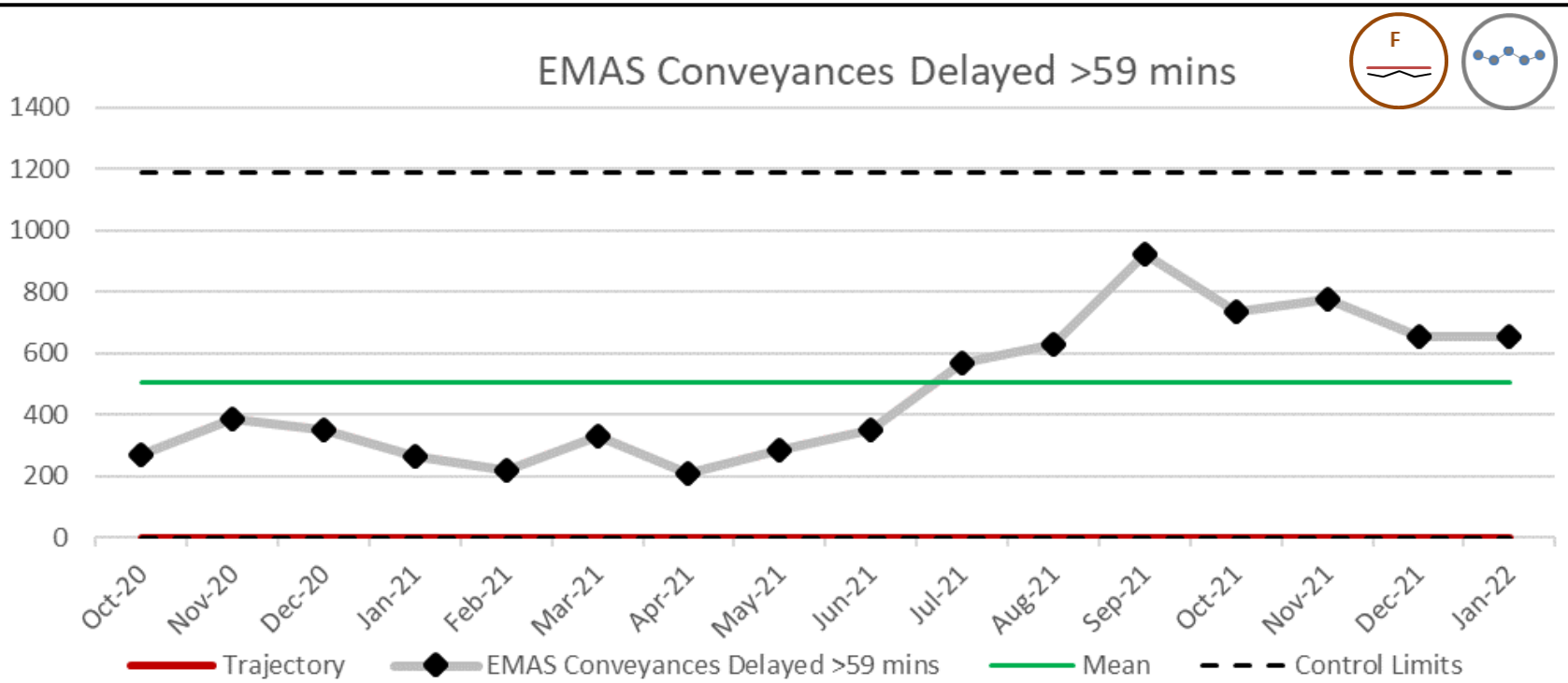



| Jan-22 |
|---|
| 656 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls. Any delays greater than 59 minutes is reportable to the CCG. There is local and national Ambulance handover delay escalation protocol.

## What the chart tells us:

January demonstrated a very slight increase in greater than 59 minutes' handover delays. 656 in January compared to 654 in December. This represents a 0.31% increase.
What the chart does not tell us is the increase of >2hrs in January 2022 (261 in January vs 238 in December) and the decrease in >4hr delays (35 in January compared to 39 in December).

## Issues:

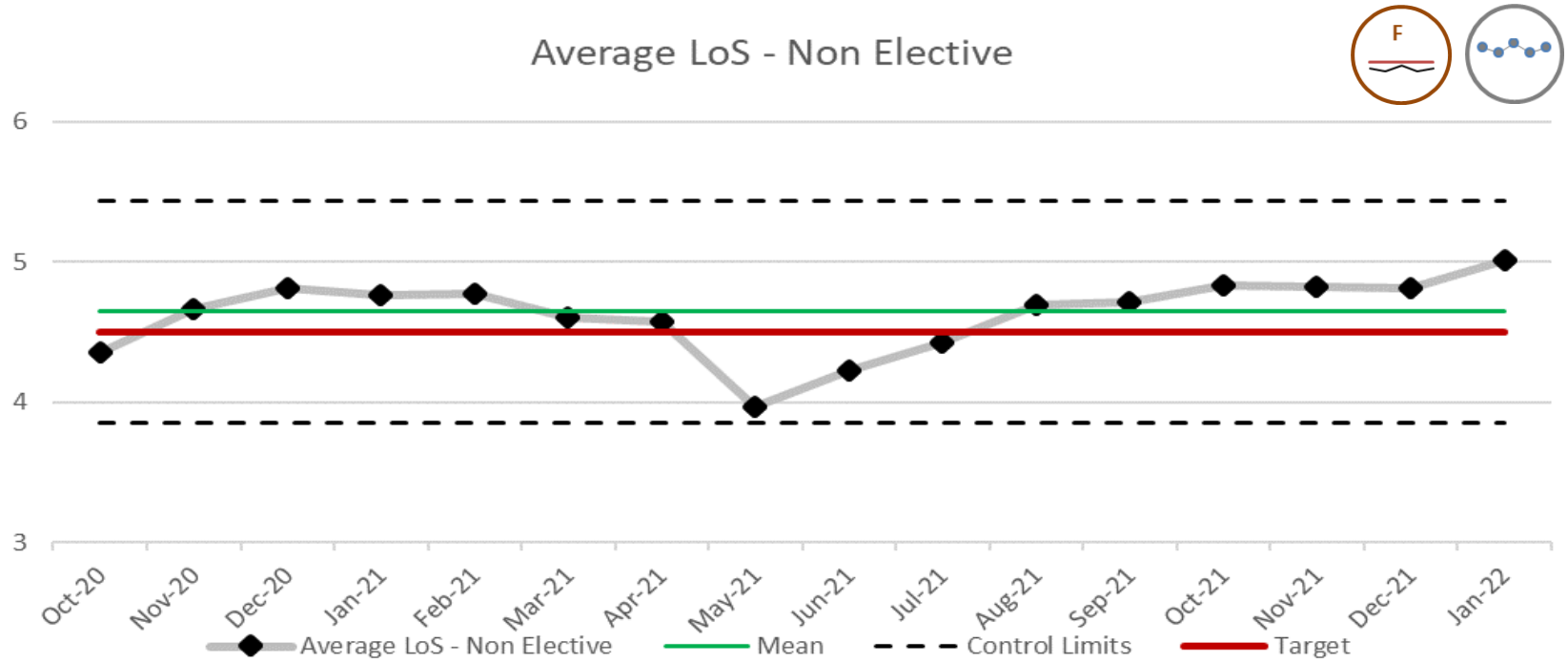
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to de-escalate due to an increased number of patients waiting for admission.
A more detailed account of >59-minute handover delays are featured in the UEC FPEC report.

## Actions:

All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical On Call Manager.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
The rapid handover protocol has now been revisited and agreed. Designated escalation areas are being identified/confirmed to assist in reducing delays in handover.
January saw formal requests from EMAS to enact the rapid handover protocol.

## Mitigations:

Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.




| Jan-22 |
|---|
| 5.01 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 4.5 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Average length of stay for non-Elective inpatients.

## What the chart tells us:

The agreed target is 4.5 days verses the actual of 5.01days in January 4.81 days in December.
This is an increase of 0.2 days
compared with December.
This is a 0.51 variance against the agreed target.

## Issues:

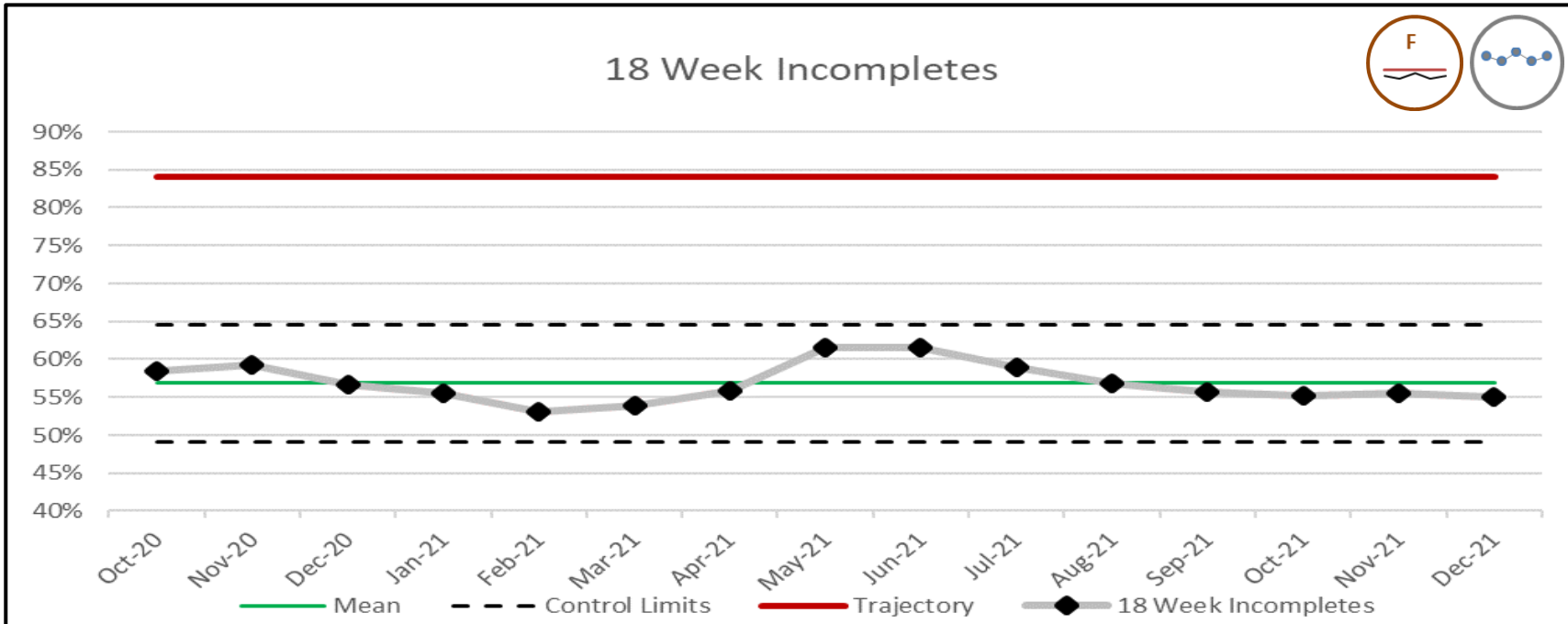
Numbers of stranded pts reduced very slightly in January at LCH, PHB and GDH – 248 Pts in January vs 249 Pts in December but super stranded increased by 20.69% – 116 Pts in January 2022 vs 92 Pts in December 2021.
Increasing length of stay of all pathways 1-3 The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process, benefits are being realised.
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharges.
Reluctance of Care Homes to admit at the weekends and to accept patients with a positive covid status or contact until the 14-day isolation is complete.

## Actions:

These actions are repetitive but still appropriate
Focused discharge profile through right to reside data.
Cancellation of elective activity and SPA time to allow for daily consultant review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner

## Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.
A new rolling programme of MADE is underway with 4 events being held in January 2022 (2 at LCH and 2 combined events for PHB and GDH).




| Dec-21 |
|---|
| 54.97% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 84.1% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background**
Percentage of patients on an incomplete pathway waiting less than 18 weeks.

**What the chart tells us:**
There is significant backlog of patients on incomplete pathways. December saw RTT performance of 54.97% against a 92% target, which is 0.61% down on November.

**Issues:**
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 4473 (increased by 320)
- Dermatology – 2798 (increased by 86)
- Gastroenterology – 2594 (Increased by 235)
- Gynaecology – 2473 (Increased by 154)
- Ophthalmology - 2010 (reduced by 51).

**Actions:**
Planned routine elective work remains challenging. Available capacity is being focussed on cancer, long waiting patients, paediatrics, day cases and patients classified as being P2.

**Mitigations:**
Patient pathways are discussed at the weekly Clinical Prioritisation Cell to determine the clinical appropriateness of patients to be booked for the forthcoming week. Patients are also being assessed for their suitability to be transferred to Independent Sector Providers and offered this choice for treatment.

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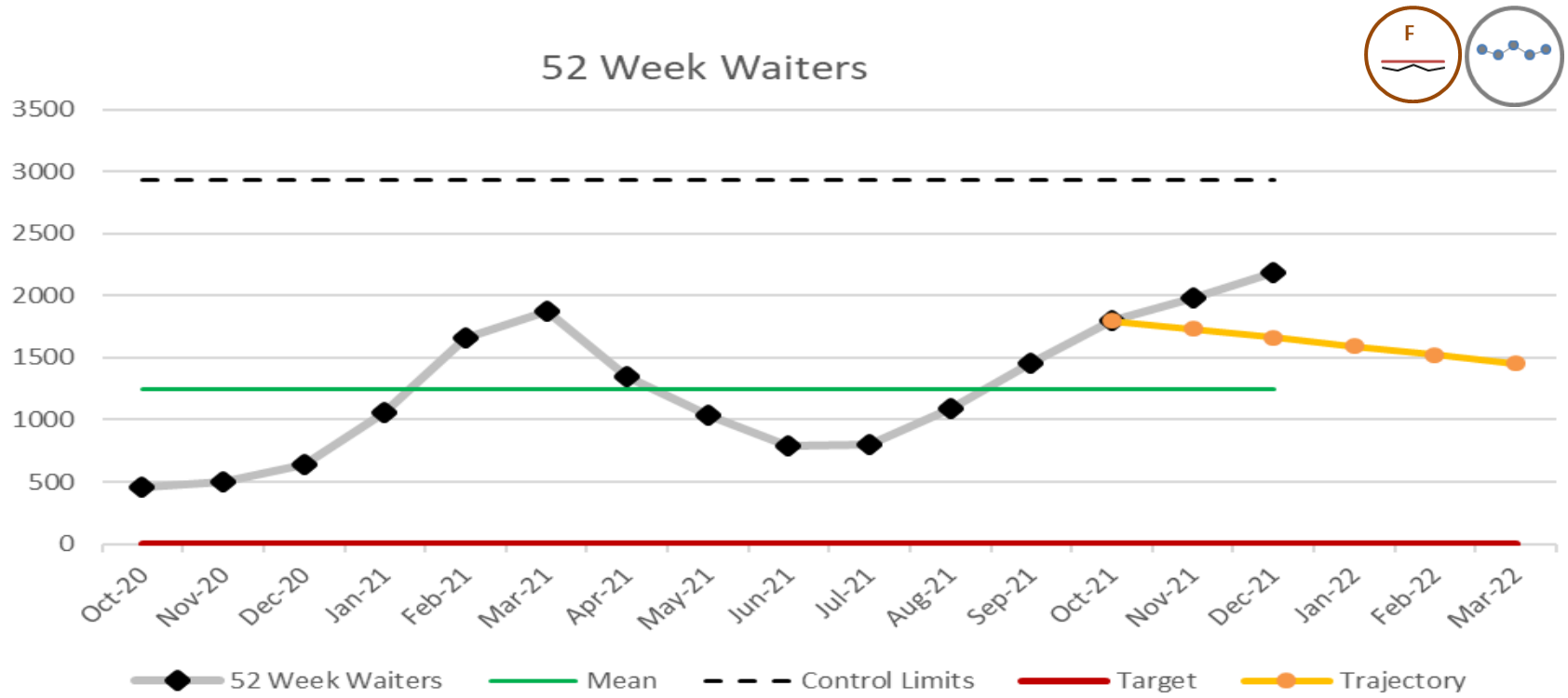


| Dec-21 |
|---|
| 2185 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Number of patients waiting more than 52 weeks for treatment.

**What the chart tells us:**
The Trust reported 2185 incomplete 52-week breaches for December. An increase of 202 from November. The number of 52-week breaches has increased considerably since August.

**Issues:**
The admitted position remains very challenging. The current capacity challenges and staffing issues are all impacting on service delivery, which is in turn, detrimentally affecting the 52-week position.

**Actions:**
Admitted patients are individually graded and allocated a priority code. It is anticipated that the introduction of C2AI will positively affect the efficiency and effectiveness of this process. All patients waiting more than 52 weeks are required to have an RCA and harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a view to streamline how the Trust administers this.

**Mitigations:**
Non admitted patients continue to be reviewed, utilising all available media.
Patients waiting 78 weeks and above are individually monitored and tracked for their urgency, wait time and priority code where applicable.

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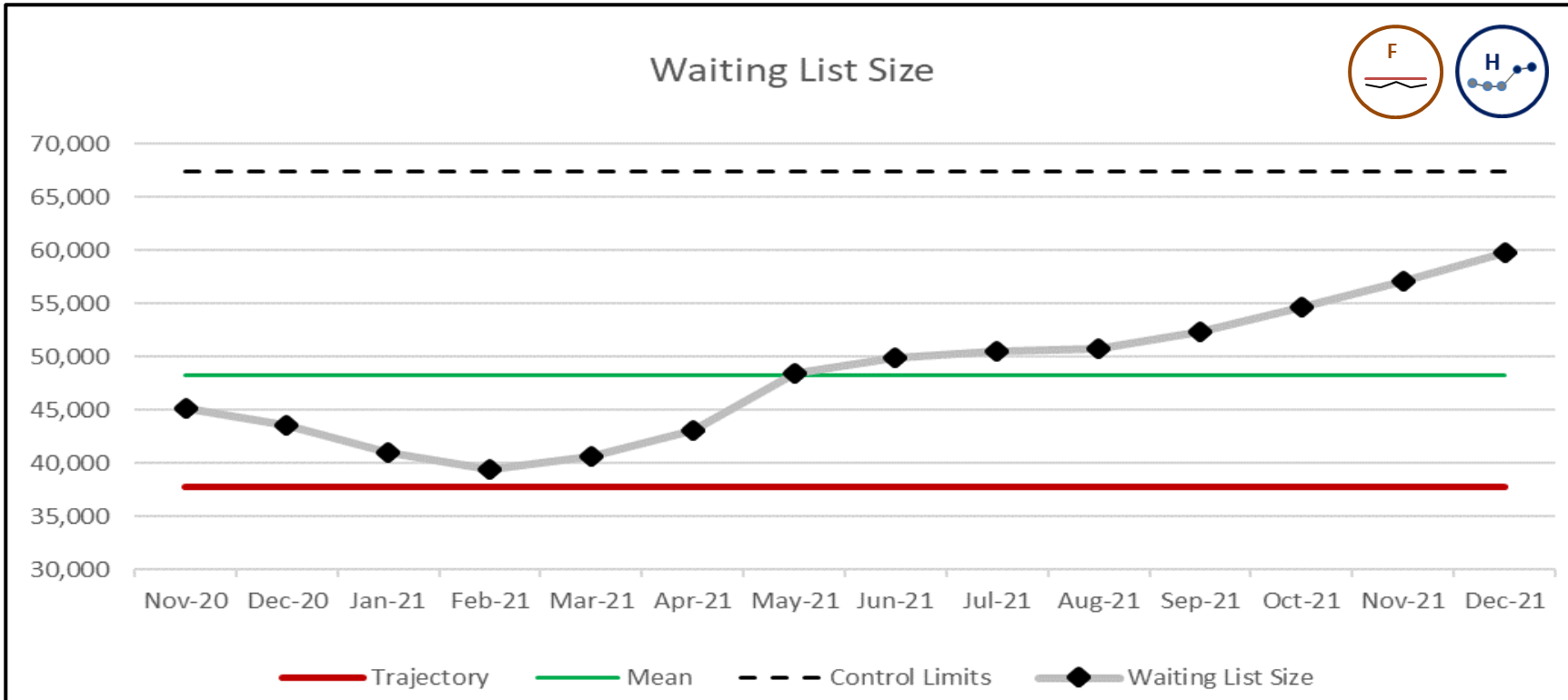


| Dec-21 |
|---|
| 59,747 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – high trend |
| **Target** |
| 37,762 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
The number of patients currently on a waiting list.

**What the chart tells us:**
Overall waiting list size has increased from November, with December showing an increase of 2642 to 59,747.
The incomplete position for December 2021 has increased by approximately 21,721 more than the reported pre pandemic size in January 2020.

**Issues:**
The trust is currently experiencing extreme pressure in its emergency service provision, necessitating the cancelation of some elective activity, which will, have a detrimental effect on waiting list size.
The top five specialties showing an increase in total incomplete waiting list size from November are:

- ENT + 435
- Neurology + 338
- Paediatrics + 260
- Gastroenterology + 237
- Colorectal Surgery + 165

The five specialties showing the biggest decrease in total incomplete waiting list size from November are:

- Ophthalmology – 55
- Maxillo-Facial Surgery + Ortho + Oral - 8
- Paed Trauma & Orthopaedics - 4
- Medical Oncology - 2
- Paediatric Urology - 1

The Trust reported 7150 over 40 week waits; an increase of 1336 on November. Patient numbers waiting over 26 weeks increased by 2039.

**Actions/Mitigations:**
The longest waiting patients at 78w+ are monitored and discussed at a weekly PTL meeting and with system partners at a weekly ICS meeting. Issues preventing the booking and treating of patients are also discussed to look at finding solutions and subsequently enable service delivery.

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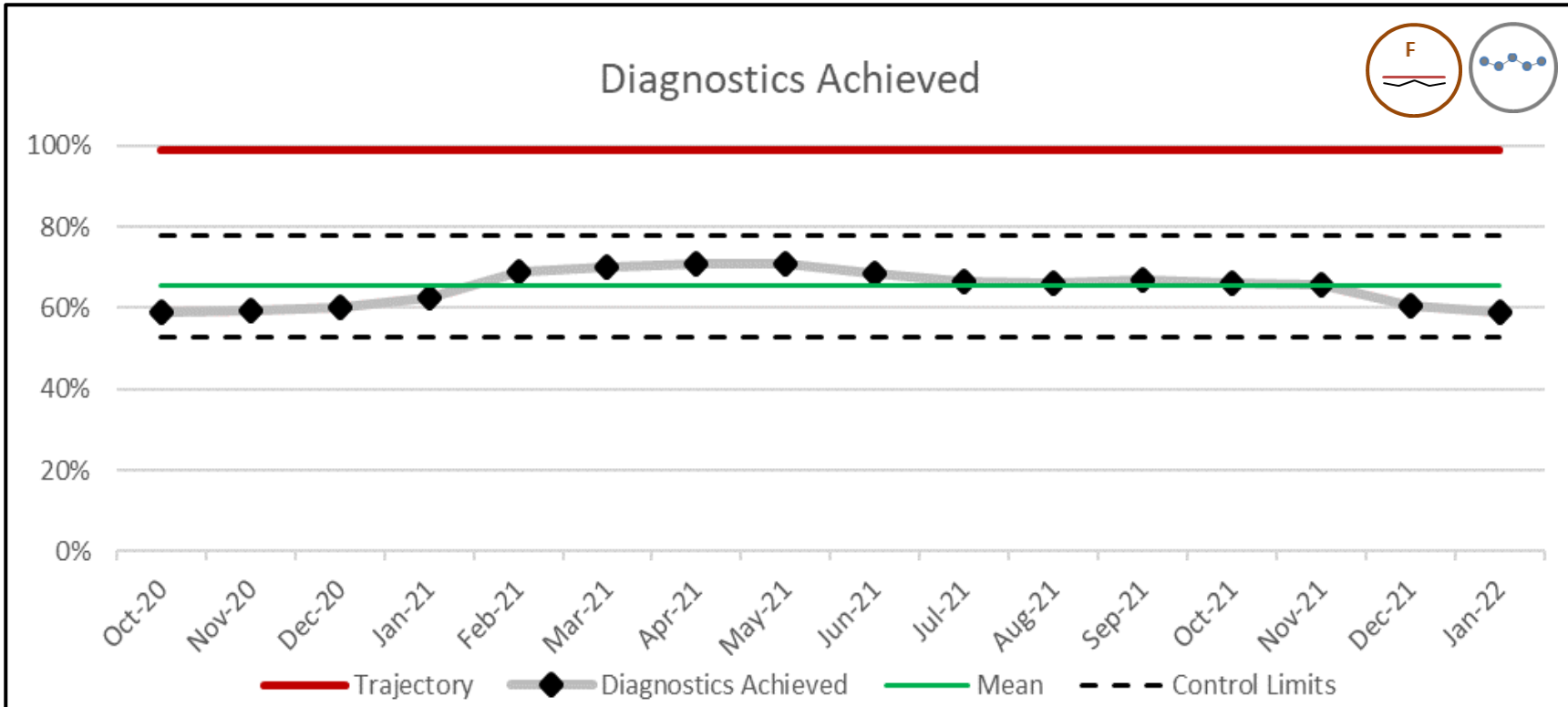



| Jan-22 |
|---|
| 58.88% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 99.00% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

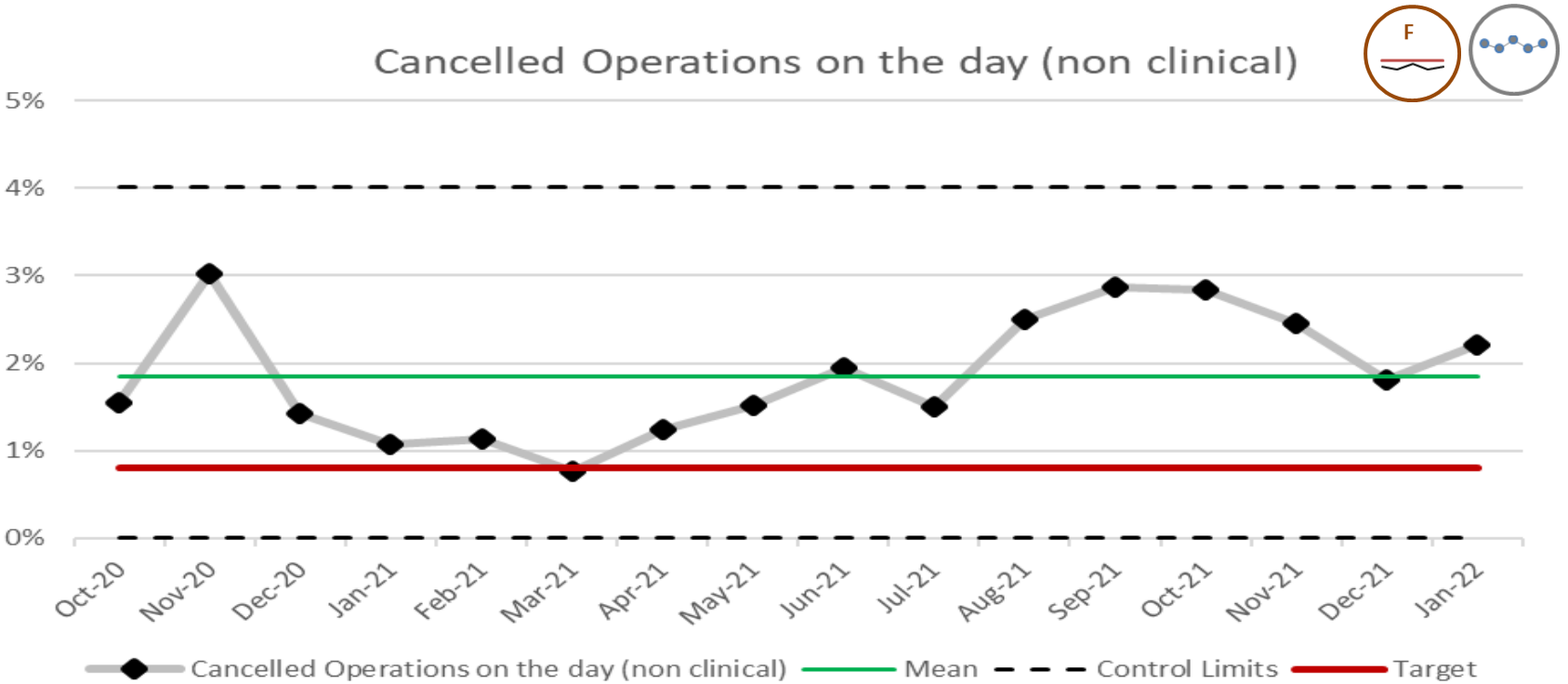
**Background:**
Diagnostics achieved in under 6 weeks.

**What the chart tells us:**
We are currently at 58.88% for January 2022 against the 99.00% target.

**Issues:**
All areas still have reduced waiting room capacity and thus reduced scanning capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. Increase demand in Ultrasound due to Mediscan being stopped by the CQC this has caused an additional 2000 scans a month from AQP, Cardiac Echoes are reducing their backlog with the additional locum support. Demand for cardiology CT, MRI, US is outstripping activity. Inpatient demand is filling the MRI scanners.

**Actions:**
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes, additional US list are happening but not enough to deal with the additional 2000 scans. 2 additional US locums have been sourced to help cover vacancy, additional demand and maternity. Ultrasound are doing additional lists at the weekend. A case of need is being completed by radiology asking for resource to deal with the additional AQP work. CT have mobile scanner at weekends, CT cardiac package moved to CT2 to allow cardiac service to resume although cardiology availability is compromised.

**Mitigations:**
All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks we are being asked to complete a clinical validation for each patient and assign a D code to that patient. Going forward every new referral will have a D code assign to that patient. This will make sure all patients are seen in clinical urgency. Additional list for ultrasound and echo. Ultrasound booking routine now to 9 weeks, MRI booking routine now to 8 weeks.




| Jan-22 |
|---|
| 2.21% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0.8% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
This shows the number of patients cancelled on the day due to non-clinical reasons.

**What the chart tells us:**
January shows an increase in patients who have had their operation cancelled on the day of surgery and therefore remains above the agreed trajectory of 0.8%.

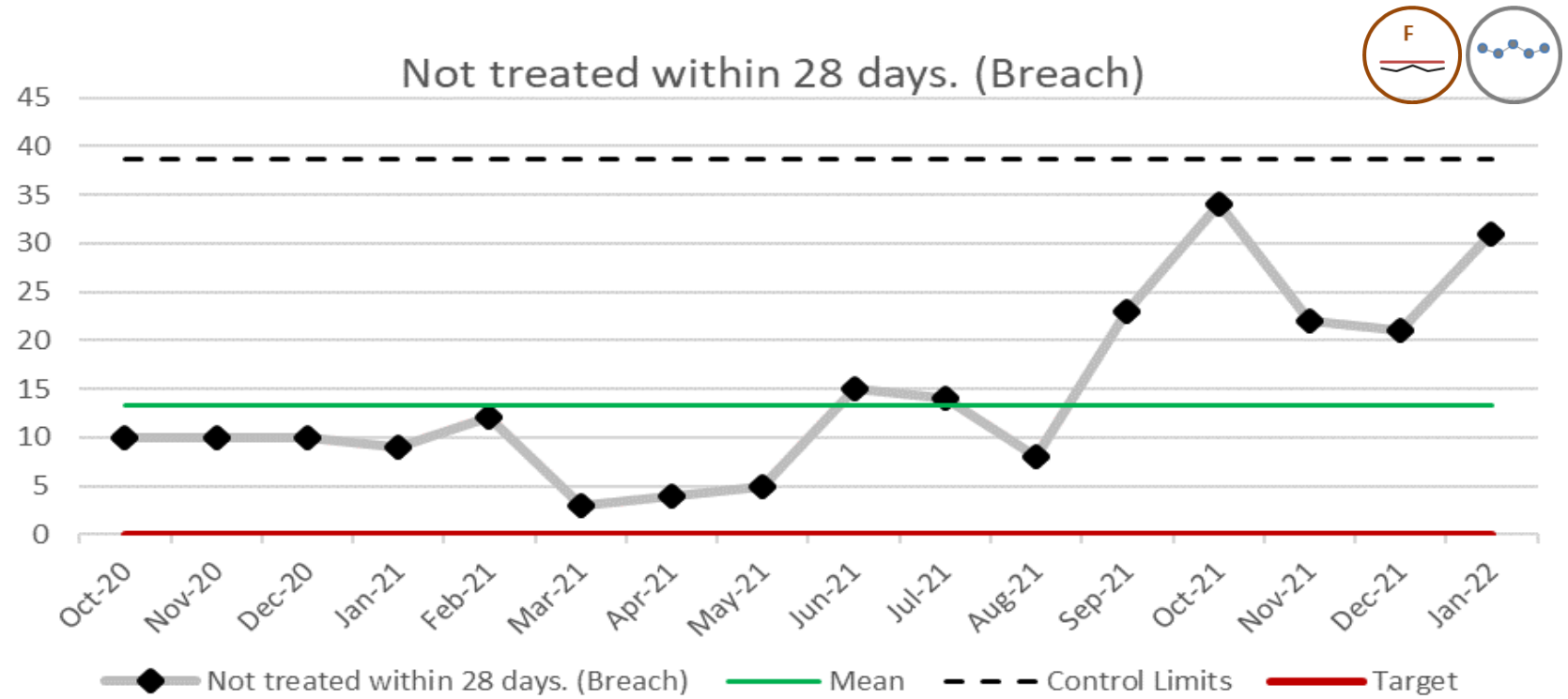
**Issues:**
The top 3 reasons for same day non-clinical cancellations for January have been identified as

- Lack of beds;
- Equipment unavailable
- Lack of surgeon

**Actions:**
Increased focus on reason for cancellation involving CBUs, Theatres and Pre Assessment.
Daily clinical prioritisation cell continues with weekly forward view to ensure patients are being booked for surgery appropriately.
CBUs facing increased challenge at 642 to ensure lists covered in advance in order so patients are booked in with appropriate timescales.

**Mitigations:**
Staffing continues to be reviewed daily with redeployment to alternative sites as required.

Reinvigoration of outsourcing for our lower priority cases, working with the CCG to increase the patients uptake of this offer – this includes a re-contact of all long waiter patients who have previously declined.




| Jan-22 |
|---|
| 31 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 0 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

This chart shows the number of breaches where patients have not been treated within 28 days of a last-minute cancellation. This is a requirement for same day cancellations.

## What the chart tells us:

The number of breaches for January is 31, which is an increase from 21 last month.
The agree target of zero has not been achieved

## Issues:

An increase in emergency demand has meant increased on the day cancellations due to bed shortages and there is reduced capacity to rebook patients due to a number of reasons (e.g. both planned and unplanned absence).

Late notice dating of patients results in reduced time for pre assessment and therefore reduced time if medical optimisation, further tests are required.

## Actions:

Waiting list and CBU will work proactively together to reschedule patients who have experienced any on the day non-clinical cancellations.

The theatre scheduler is working with digital partners to improve process for ITU bed booking to ensure they are submitted on time and correctly, ensuring improved planning for beds.

Improve booking to ensure all lists are fully utilised.

## Mitigations:

To ensure surgeons are all aware of increased L1 beds at Grantham site to aid effective planning of lists and reduced opportunities for cancellation, particularly due to bed pressures at the larger sites.

Implementation of improved processes for booking patients in conjunction with an increase in the waiting list team staffing numbers.

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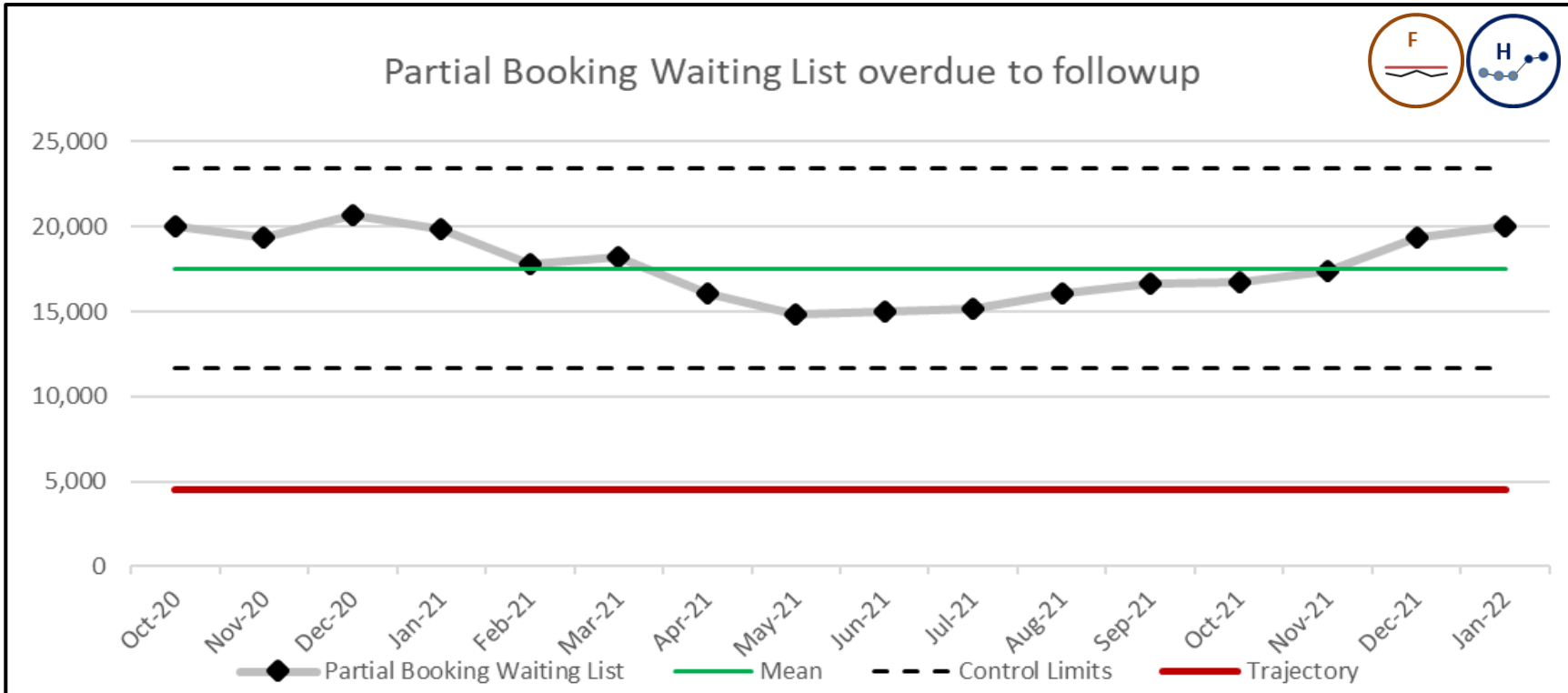


| Jan-22 |
|---|
| 20,006 |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 4,524 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
The number of patients more than 6 weeks overdue for a follow up appointment.

**What the chart tells us:**
We are currently at 20,006 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased.
Recovery work took place and reduced the number of patients overdue but this has started to increase on an upward trend since July 2021.

**Issues:**
The organisation is continually pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The fluctuating impact of covid also has an impact on conflicting priorities, increasing demand on resources, sickness levels, staffing issues, space and aligning requirements.

**Actions:**
Service recovery plans produced and updated regularly. Specialities are continuing with validation, clinical triage and exploring technological solutions, including PIFU suitability.
Clinical Harm Oversight Group are reviewing the categories of patients that require a harm review on PBWL. PBWL meeting in place to challenge capacity shortfalls. A continued review is to take place about the effectiveness of the 642 process in outpatients.

**Mitigations:**
Supporting organisational priorities taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres). The Trust cancelled all outpatient activity for a day to support the emergency pathways and patient flow.

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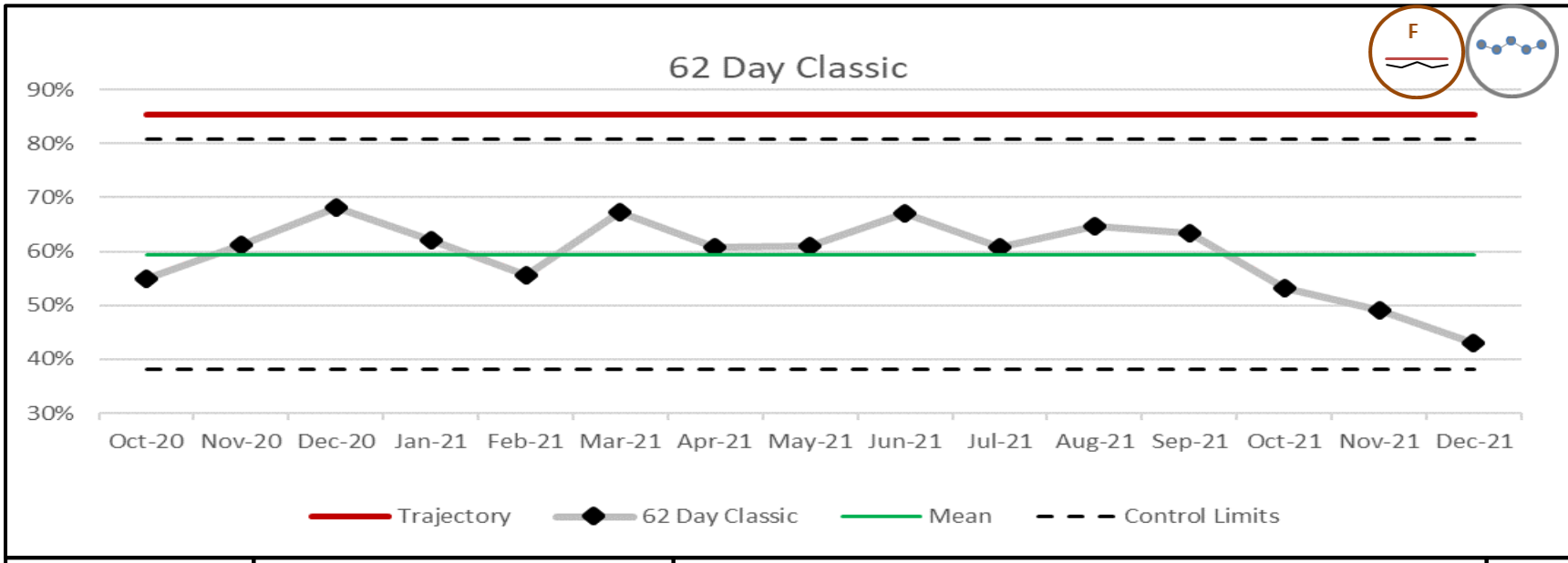



| Dec-21 |
|---|
| 42.97% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 85.4% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Percentage of patients to start a first treatment within 62 days of a 2ww GP referral.

## What the chart tells us:

We are currently at 42.97% against an 85.4% target.

## Issues:

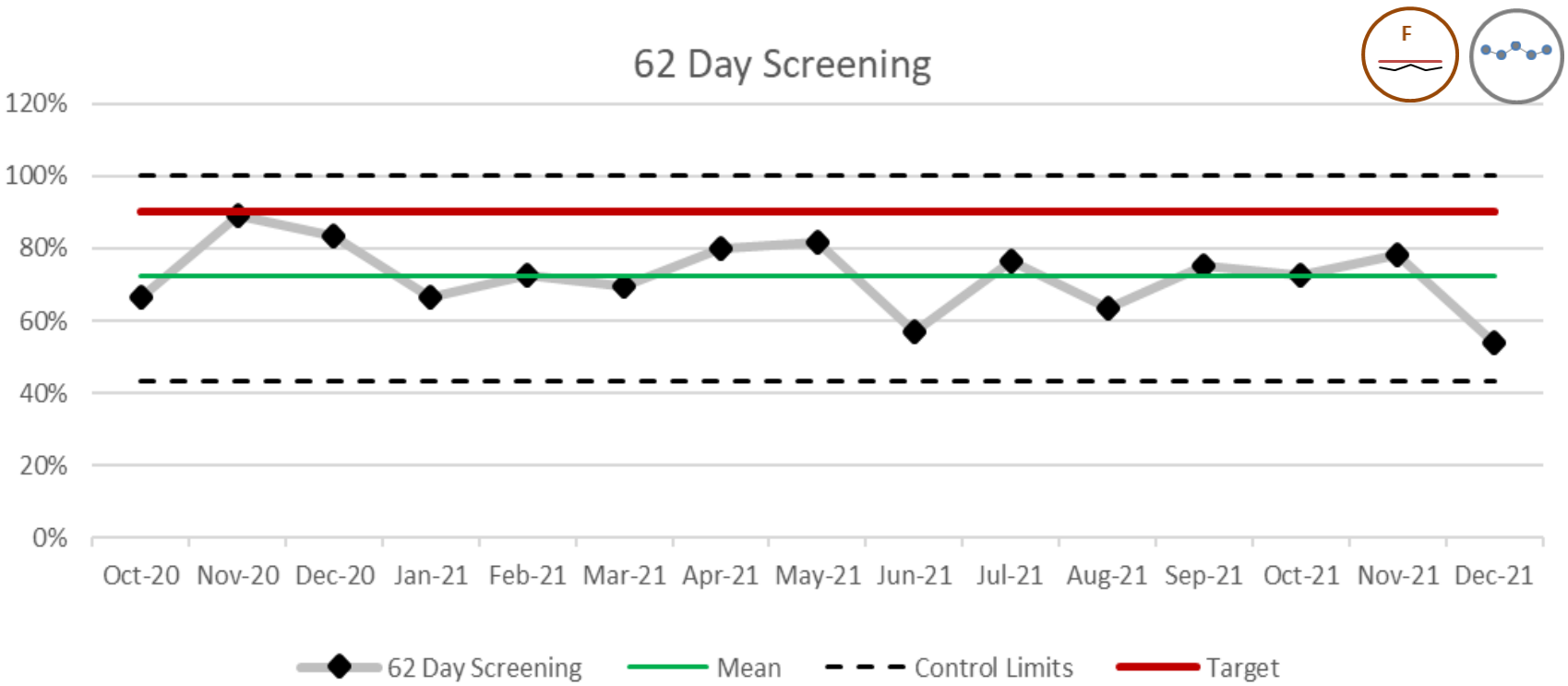
The impact of critical and major incidents on Trust activity and patient pathways
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.
Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

## Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologists – 2 of which are with HR and due to be re-advertised and one awaiting Royal college approval before going out to advert. Two of these posts that are currently being covered by Locums.
Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.
Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

## Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work.
Work has commenced on building the new theatres at Grantham.




| Dec-21 |
|---|
| 53.85% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

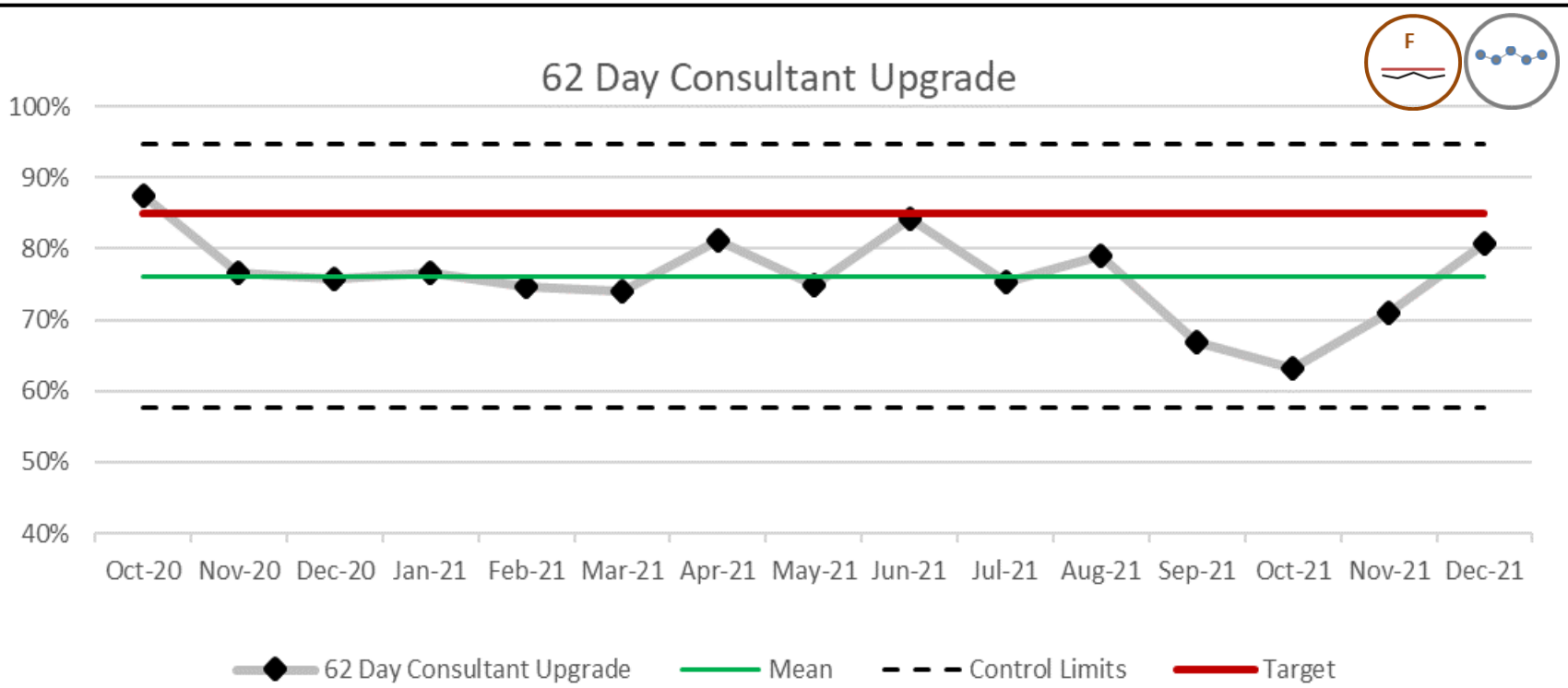
**Background:**
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

**What the chart tells us:**
We are currently at 53.85% against a 90% target.

**Issues:**
See issues on previous page – 62 day classic.

**Actions:**
See actions on previous page – 62 day classic.

**Mitigations:**
See mitigations on previous page – 62 day classic.




| Dec-21 |
|---|
| 80.72% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 85% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Percentage of patients to start a first treatment within 62 days of a consultant's decision to upgrade their priority.

**What the chart tells us:**
We are currently at 80.72% against an 85% target.

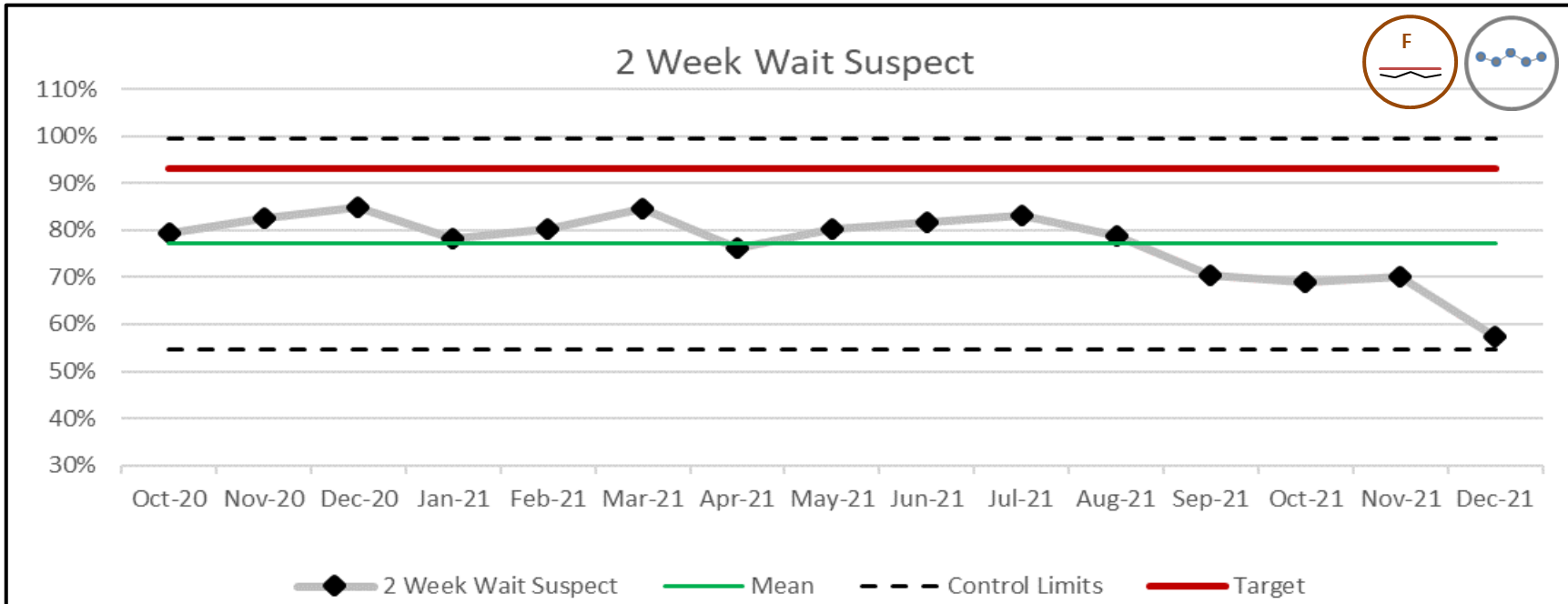
**Issues:**
See issues on previous page – 62 day classic.

**Actions:**
See actions on previous page – 62 day classic.

**Mitigations:**
See mitigations on previous page – 62 day classic.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust




| Dec-21 |
|---|
| 57.26% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 93% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Percentage of patients seen by a specialist within two weeks of 2ww referral for suspected cancer.

**What the chart tells us:**
We are currently at 57.26% against a 93% target.

**Issues:**
The Trust's 14 Day performance continues to be impacted by the current Breast Service One-Stop appointment alignment issues, with Breast performance being 2.3%: - 38.9% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (23.3%), Colorectal (25.9%), Gynaecology (46.9%), Urology (65.0%), Brain 76.5%, Upper GI (87.9%), Skin only narrowly missed out (95.3%). Head & Neck, Sarcoma and Haematology achieved the standard.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and/or capacity is available.

**Actions:**
The Trust is actively seeking to implement RDC pathways for brain, haematuria, testicular and Upper GI by March 2022. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.
Recruitment of a new diagnostic ACP is underway to improve capacity in the Urology diagnostic clinics.
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention/support.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

**Mitigations:**
Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – 2 Lung Specialty Doctors have commenced in post in Boston. A Lung Consultant due to commence in post in January 2022 has unfortunately been delayed, a revised start date is yet to be confirmed.
Within Colorectal, SDF funding has been sought to recruit 1 x Band 7 to support NURTEL clinics. Current Band 7 CNS are undertaking additional NURTEL clinics (30 slots per week – rising to 50 per week on completion of recruitment)
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

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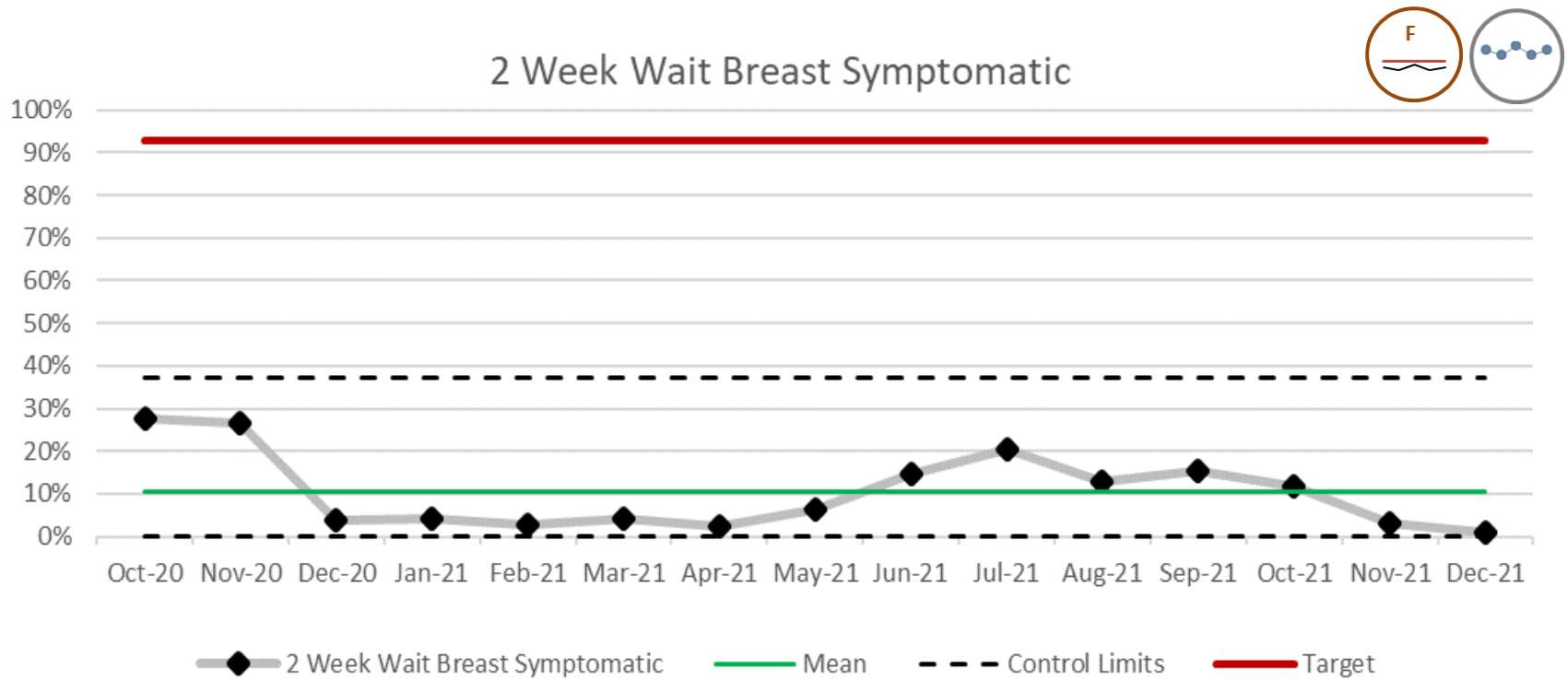


| Dec-21 |
| --- |
| 0.74% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 93% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral.

**What the chart tells us:**
We are currently at 0.74% against a 93% target.

**Issues:**
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

**Actions:**
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support.

**Mitigations:**
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

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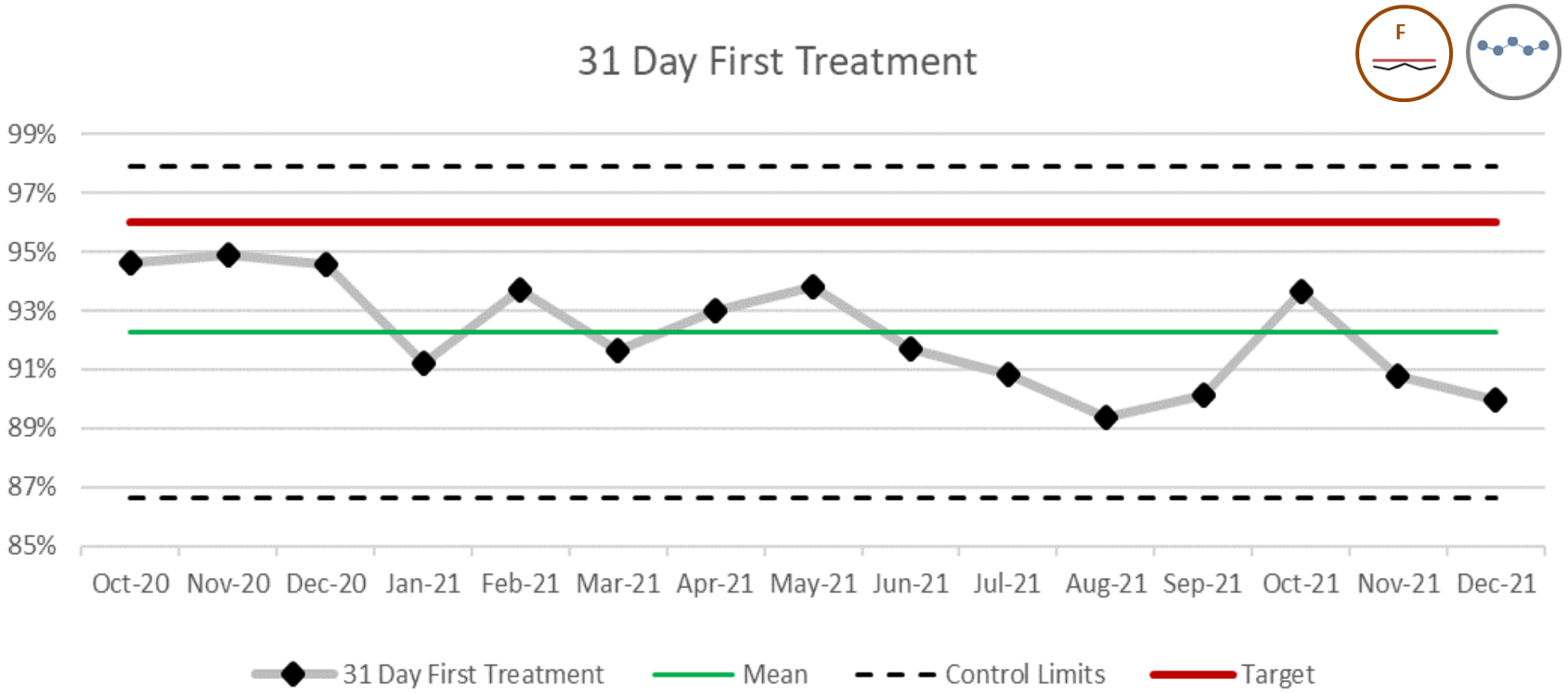



| Dec-21 |
|---|
| 89.94% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 96% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

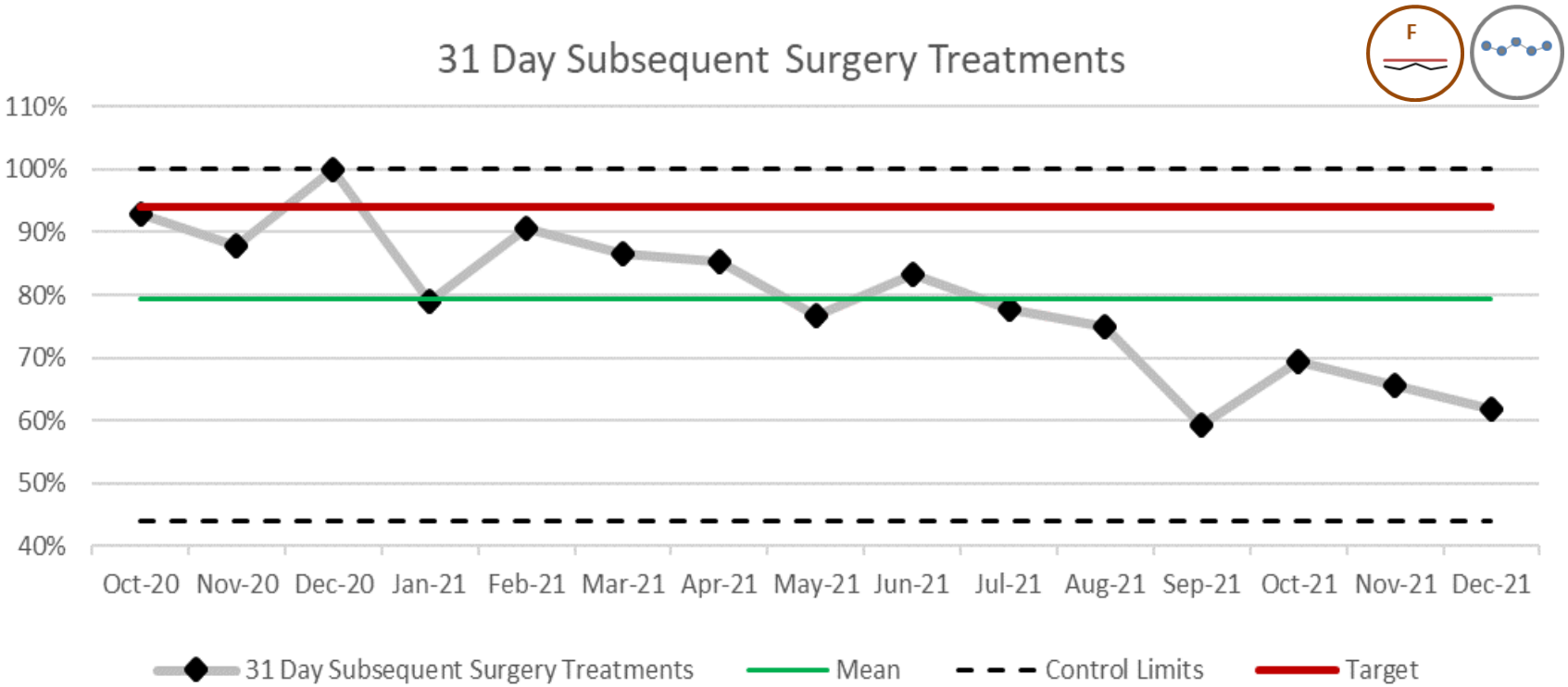
**Background:**
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

**What the chart tells us:**
We are currently at 89.94% against a 96% target.

**Issues:**
The failure of the 31 Day standards was primarily attributed to the reduction in theatre capacity).

**Actions:**
Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologists which we are awaiting Royal college approval before going out to advert. We have two of these posts that are currently being covered by Locums.
Work has commenced on building the new theatres at Grantham.

**Mitigations:**
A review of colorectal theatre list scheduling in order to better align with clinician availability continues, and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work.
Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.




| Dec-21 |
|---|
| 61.76% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 94% |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

**Background:**
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

**What the chart tells us:**
We are currently at 61.76% against a 94% target.

**Issues:**
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Drug and Radiotherapy standards, failing in the Surgery standard.

**Actions:**
See actions on previous page – 31 day first treatment.

**Mitigations:**
See mitigations on previous page – 31 day first treatment.

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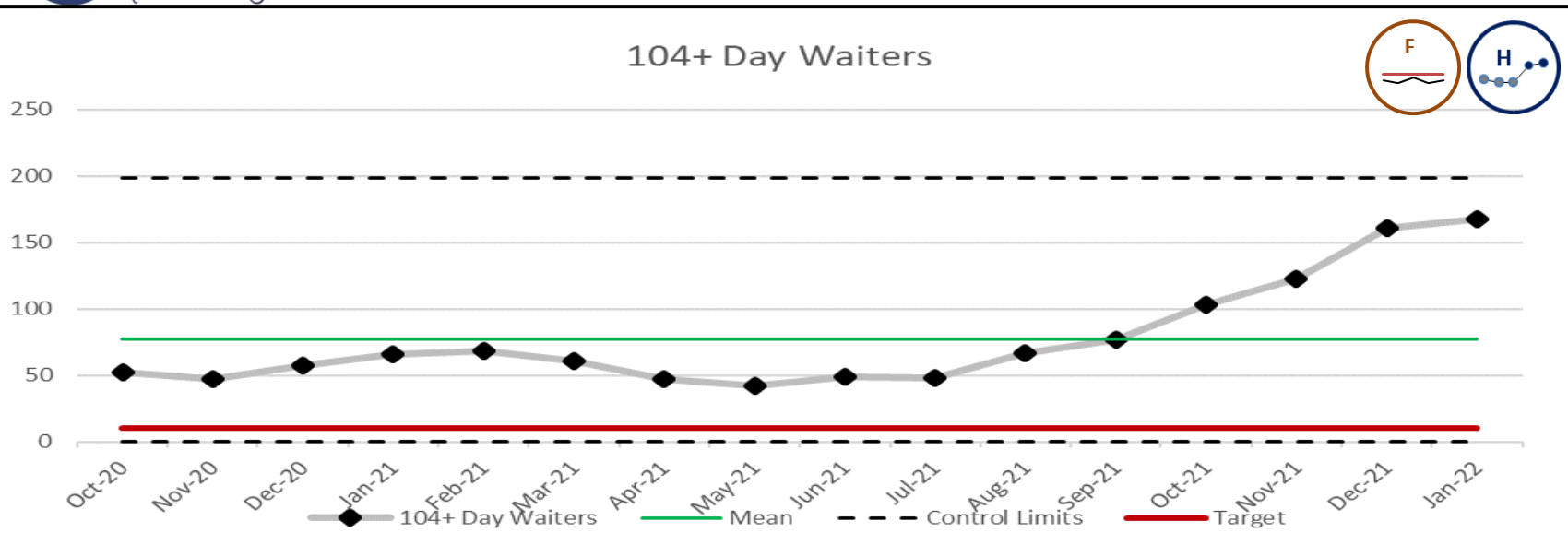


| Jan-22 |
|---|
| 168 |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – high trend |
| **Target** |
| 10 |
| **Target Achievement** |
| Metric is consistently failing the target |
| **Executive Lead** |
| Chief Operating Officer |

## Background:

Number of cancer patients waiting over 104 days.

## What the chart tells us:

As of 9th February the 104 Day backlog was at 168 patients. The agreed target is <10.

The current position by tumour site is as follows:- 111 Colorectal, 20 Urology, 9 Gynaecology, 8 Lung, 7 each Head & Neck and Upper GI, 4 Breast and 2 Haematology.

## Issues:

The impact of critical and major incidents on Trust activity and patient pathways.

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period) – this is starting to improve.

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is available. Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Upper GI, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 10% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

## Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologists – 2 of which are with HR and due to be re-advertised and one awaiting Royal college approval before going out to advert. Two of these posts that are currently being covered by Locums.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck, Skin and Lung CBU's to support clinical engagement.

Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts.

## Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham.

Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

## PERFORMANCE OVERVIEW - WORKFORCE

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Nov-21 | Dec-21 | Jan-22 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A Modern and Progressive Workforce | Overall percentage of completed mandatory training | Safe | People | Director of HR & OD | 95% | 87.76% | 88.94% | 88.82% | 89.07% | | F | | |
| | Number of Vacancies | Well-Led | People | Director of HR & OD | 12% | 11.16% | 11.18% | 10.64% | 10.83% | | P | | |
| | Sickness Absence | Well-Led | People | Director of HR & OD | 4.5% | 5.29% | 5.20% | 5.09% | 5.11% | | F | | |
| | Staff Turnover | Well-Led | People | Director of HR & OD | 12% | 13.61% | 13.99% | 13.99% | 12.66% | | F | H | |
| | Staff Appraisals | Well-Led | People | Director of HR & OD | 90% | 51.74% | 52.40% | 53.03% | 62.04% | | F | L | |

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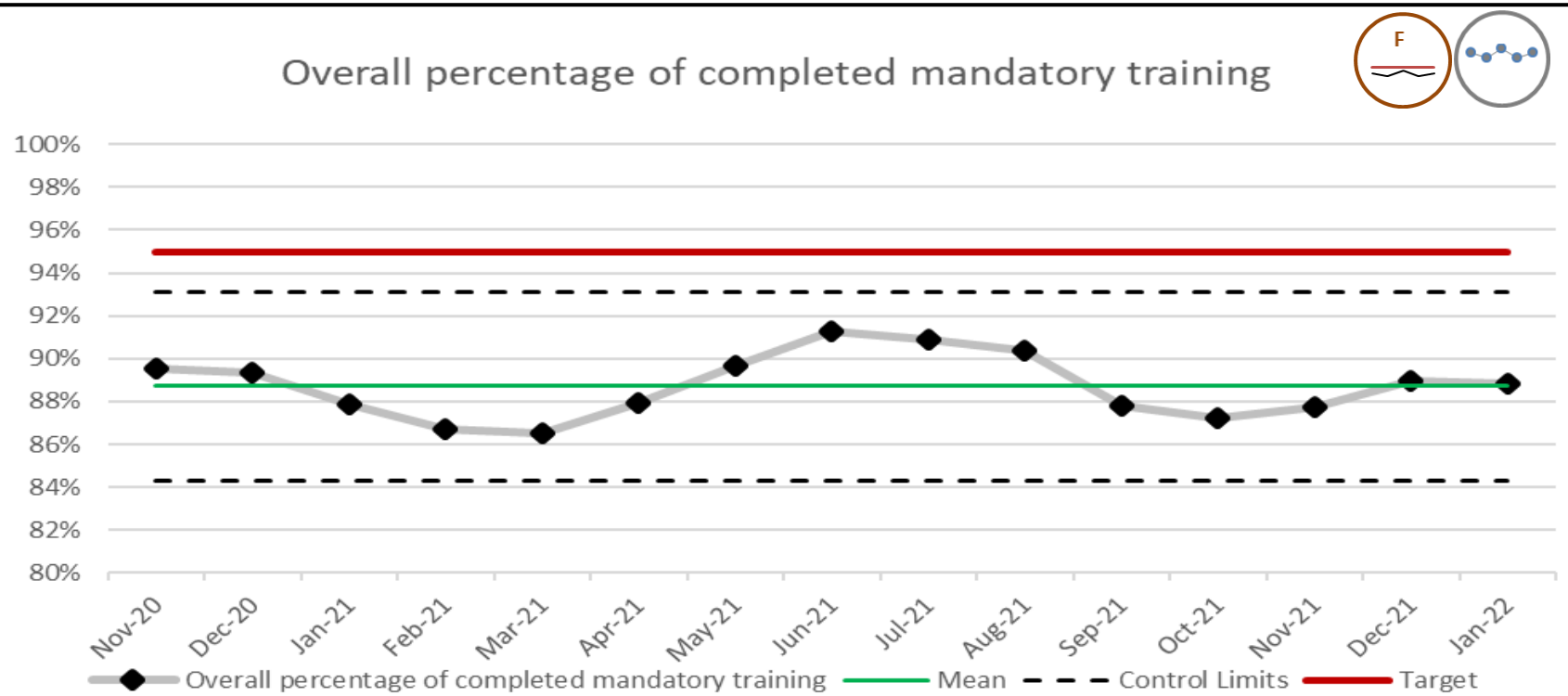


| Jan-22 |
|---|
| 88.82% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 95% |
| **Target Achievement** |
| Metric is consistently failing to target |
| **Executive Lead** |
| Director of HR & OD |

**Background:**
Overall percentage of completed mandatory training.

**What the chart tells us:**
Mandatory training has remained at 88.82% just ever so slightly lower than the completion rate for December.

**Issues:**
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- Social media posts make mention of lack of time to access core learning while on shift and difficulties to access from home.
- Medicine has the lowest compliance at 85.5%.

**Actions:**
- With the lack of a central learning and development team a risk has been added on the risk register.
- Need for a discussion around protected time for training.

**Mitigations:**
See actions

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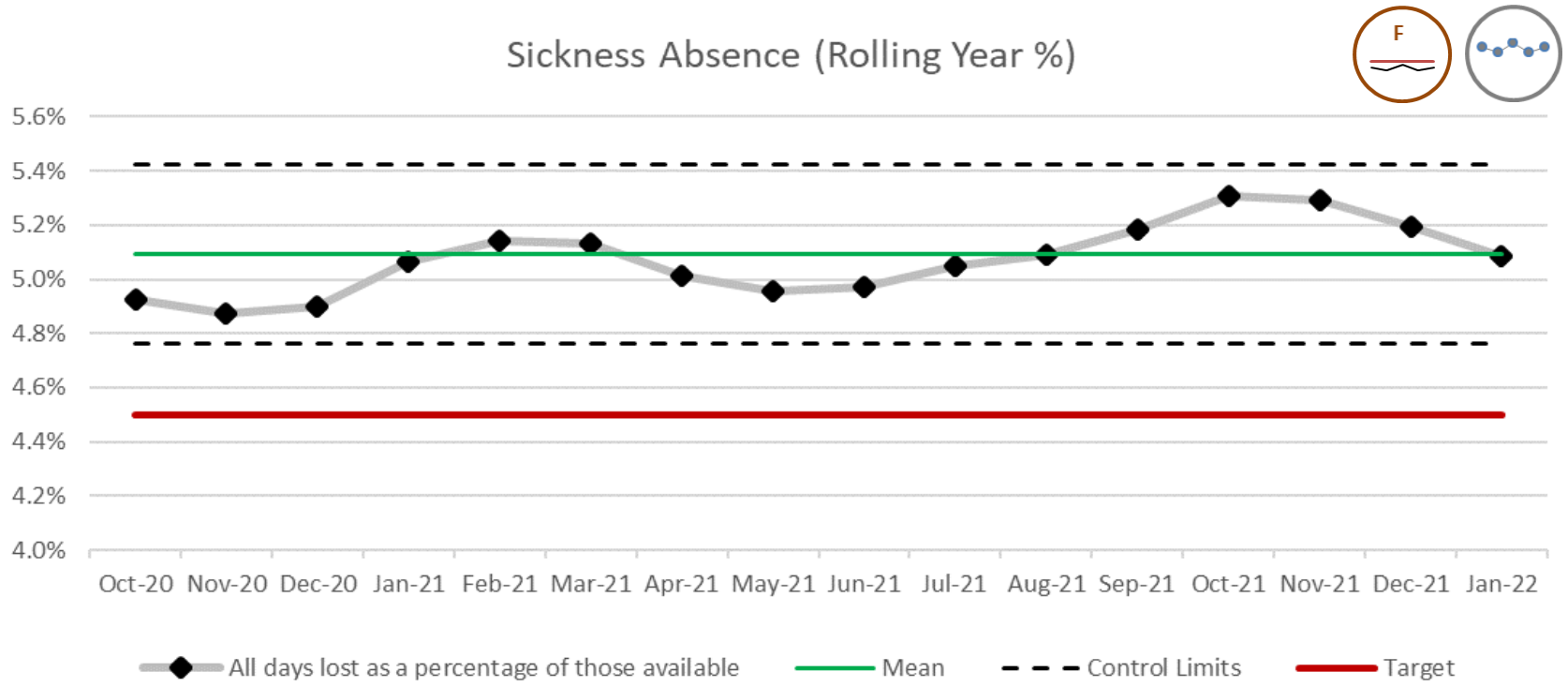


| Jan-22 |
|---|
| 5.09% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 4.5% |
| **Target Achievement** |
| Metric is consistently failing to target |
| **Executive Lead** |
| Director of HR & OD |

**Background:**
% of sickness absence rolling year.

**What the chart tells us:**
Although the trend has reduced in month the percentage is still high and above the target of 4.5% however it is at its lowest since the beginning of January.

**Issues:**
- COVID absences have decreased significantly but still remain high.
- This is reflective of the national data.
- A high proportion of absence remain 'unknown' due to AMS not being updated by managers, this remains a cause for concern in managing staff absences.
- The lift of Covid government restrictions may impact on a rise in further Covid absences.

**Actions:**
- The implementation of the revised isolation periods means people do not have to isolate as is the need for the public to wear masks outside of health settings this may impact on more health and social staff contracting Covid actions have been put into place to closely monitor this to ensure that trends in workforce absences can be reported.
- There continues to be an enhanced wellbeing offer to support the increase in staff suffering with mental health issues attributed by the pandemic.
- A review of the usage and recoding of the Absence management System is being arranged to look at issues and hot spots, the Trust will then need to focus on these to ensure that the reporting is reflective of the trusts most up-to-date position for staff absences.

**Mitigations:**
See Actions.

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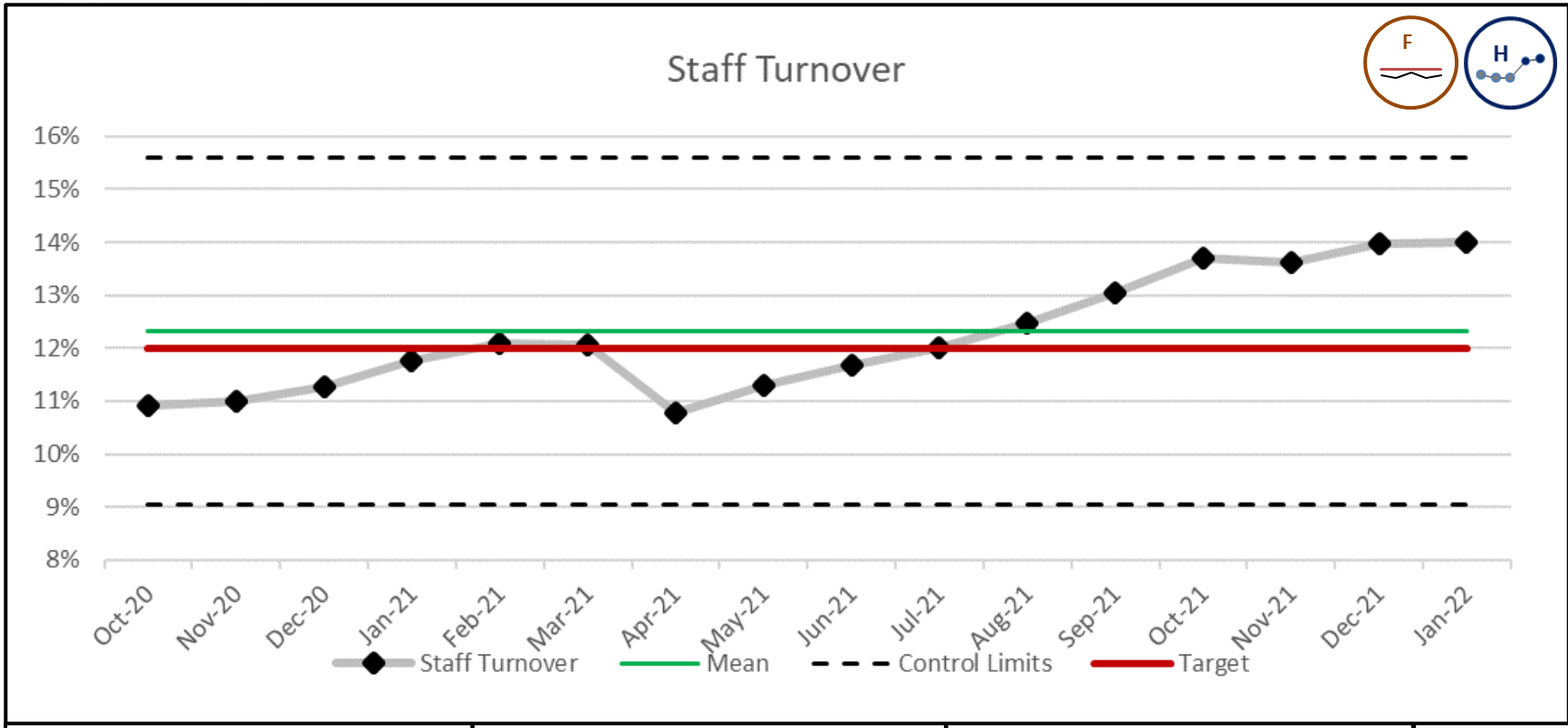



| Jan-22 |
|---|
| 13.99% |
| **Variance Type** |
| Metric is currently experiencing Special Cause Variation – high trend |
| **Target** |
| 12% |
| **Target Achievement** |
| Metric is failing to target |
| **Executive Lead** |
| Director of HR & OD |

**Background:**
% of turnover over a rolling 12-month period

**What the chart tells us:**
As expected, turnover rates continue to steadily creep up. Other partners in the system and Trusts regionally are also seeing similar increases in turnover.

**Issues:**
Analysis of exit survey data shows (completion rate of has steadily dropped over the past 3 months):

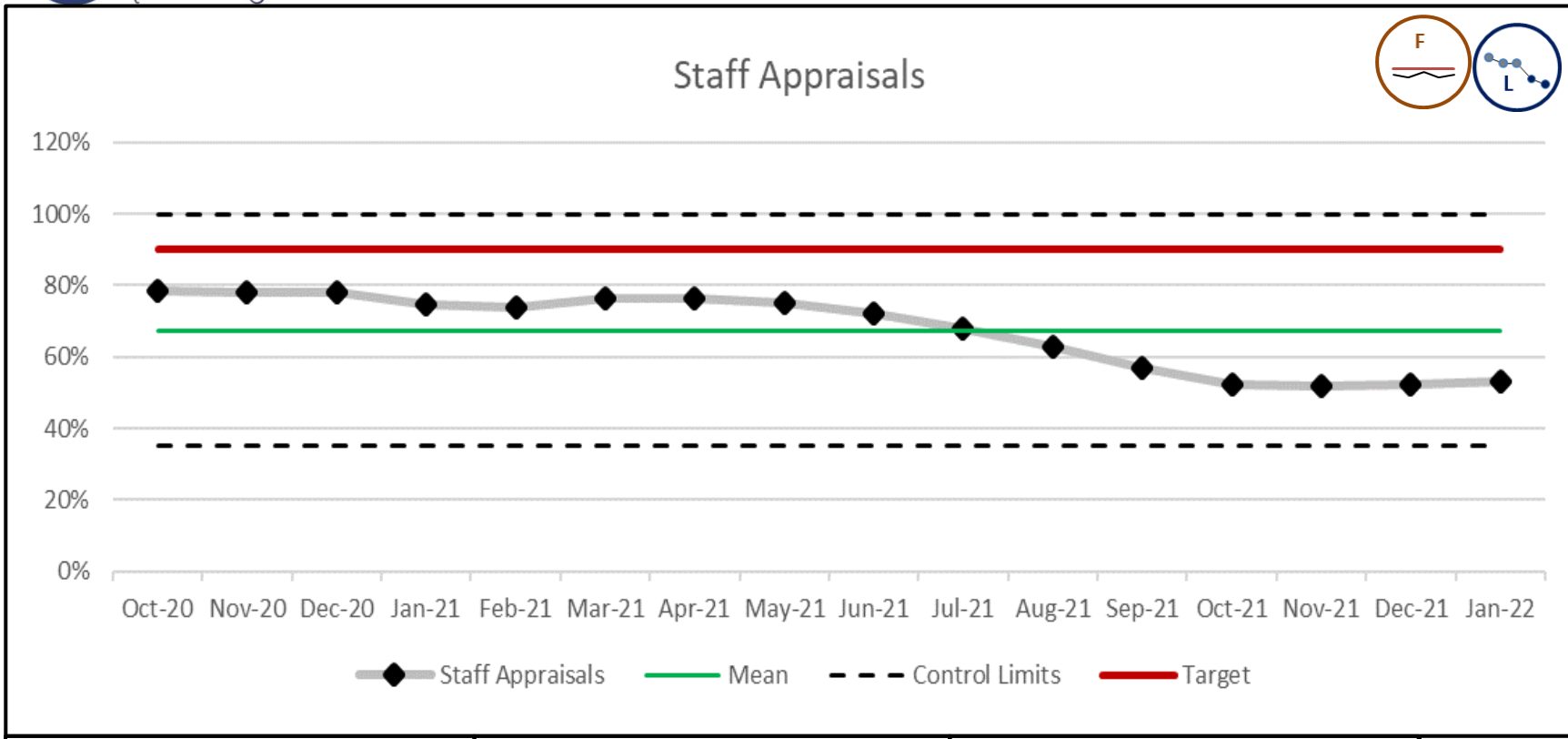
- Lack of flexible working opportunities continues to be one of the main reasons for people leaving.
- Lack of development opportunities is another key reason.

The reasons are exactly the same as last month.

**Actions:**

- Awaiting details from the recent staff survey data which will throw more light on the turnover situation.
- Working with the ICT team to create a digital exit survey to increase the completion rate.

**Mitigations:**
See actions




| Jan-22 |
|---|
| 53.03% |
| **Variance Type** |
| Metric is currently experiencing Common Cause Variation |
| **Target** |
| 90% |
| **Target Achievement** |
| Metric is consistently failing to target |
| **Executive Lead** |
| Director of HR & OD |

**Background:**
% completion is currently 53.03%.

**What the chart tells us:**
Operational pressures and staffing challenges continue to impact appraisal completion rates. The completion rate has ever so slightly increased over the past month.

**Issues:**
- Operational pressures are causing an impact on completion.
- Message understood by staff is that non-essential meetings are being stood down including appraisal discussions.

**Actions:**
- WorkPAL deep dive currently underway to understand issues with system engagement and how this can be improved
- Appraisal completion to be focussed through the divisions regardless of operational pressures – strong message to go out from Director of People and OD to the divisions.

**Mitigations:**
- A report will be published to TLT once the deep dive exercise is complete.

# Financial Position Month 10 (2021/22)
# Finance Report
# 5 Year Priority – Efficient Use of Resources

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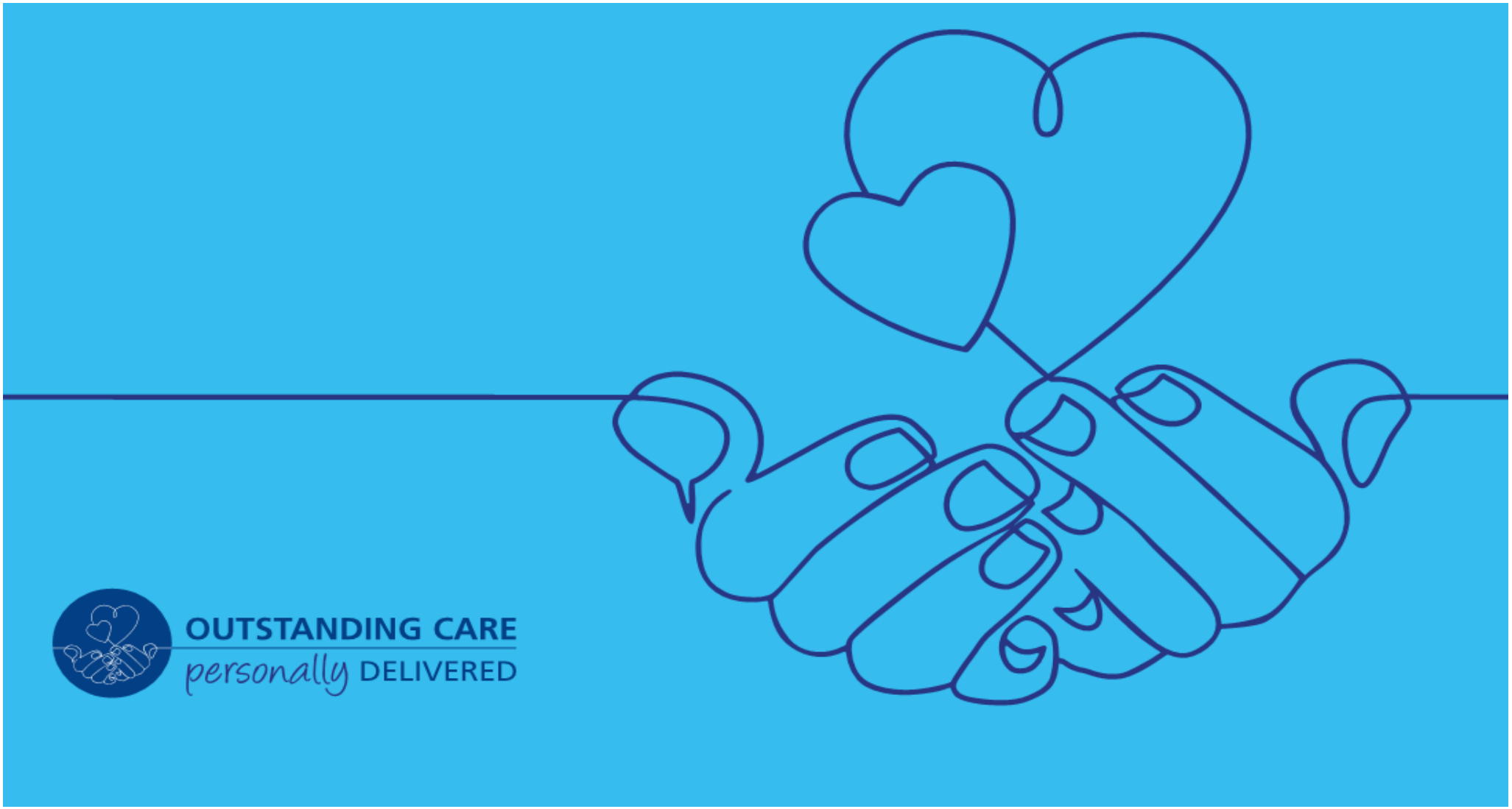
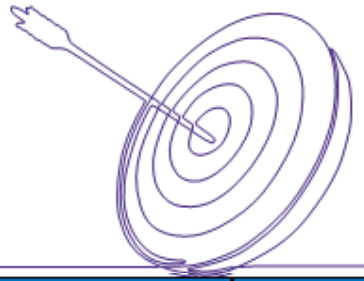



Quality | Operational Performance | Workforce | Finance

# Finance Spotlight Report (Headlines)

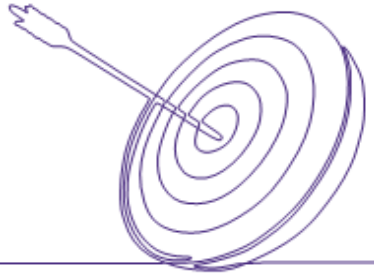


United Lincolnshire Hospitals NHS Trust

| | | Current Month | | | Year To Date | | |
|---|---|---|---|---|---|---|---|
| | | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Actual £'000 | Variance £'000 |
| | Operating income from patient care activities | 53,005 | 52,825 | (180) | 513,660 | 515,804 | 2,143 |
| | Other operating income | 2,744 | 3,007 | 263 | 26,722 | 28,198 | 1,476 |
| | Employee expenses | (36,574) | (37,308) | (734) | (353,030) | (361,958) | (8,928) |
| | Operating expenses excluding employee expenses | (18,612) | (17,549) | 1,063 | (179,506) | (174,705) | 4,801 |
| | Net Finance Costs | (619) | (569) | 50 | (6,306) | (5,853) | 453 |
| | Other gains/(losses) including disposal of assets | 0 | (337) | (337) | 0 | (215) | (215) |
| | **Surplus/(Deficit) For The Period/Year** | **(56)** | **68** | **124** | **1,540** | **1,271** | **(269)** |
| | Add back all I&E impairments/(reversals) | 0 | 0 | 0 | 0 | 93 | 93 |
| | Remove capital donations/grants I&E impact | 56 | 55 | (1) | 260 | 559 | 299 |
| 1 | **Adjusted financial performance surplus/(deficit)** | **0** | **123** | **123** | **1,800** | **1,923** | **123** |
| | Less gains on disposal of assets | 0 | 0 | 0 | 0 | (123) | (123) |
| 2 | **Adjusted surplus/(deficit) for the purposes of system achievement** | **0** | **123** | **123** | **1,800** | **1,800** | **0** |

- The Lincolnshire system delivered a £2.0m surplus in H1 inclusive of a £1.8m surplus delivered by the Trust. The Lincolnshire system has submitted a break-even position for H2 inclusive of a break-even position for the Trust in H2.
- The above table shows that (as per 1) in Month 10 the Trust delivered a £123k surplus position (£123k favourable to plan), and that the Trust has YTD delivered a surplus of £1,923k (£123k favourable to plan).
- For the purpose of measuring system financial performance, gains from disposal of assets are removed, and the above table shows (as per 2) that YTD the Trust is on plan with a surplus of £1.8m.

# Finance Spotlight Report (Key areas of focus - Income)



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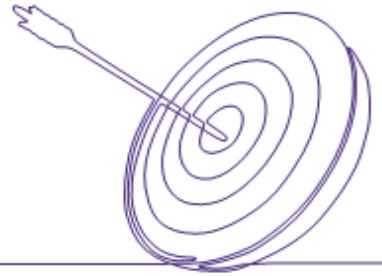
- The overall YTD Income position at Month 9 is £3.6m favourable to plan:
  - **£4.5m favourable movement re Pay award** – This movement reflects the fact that the Trust's H1 income position includes unplanned income of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 income plan.
  - **£1.8m favourable movement re other Patient Care Income** – The overall movement is driven by passthrough.
  - **£4.2m adverse movement re ERF/ERF stretch** – This movement reflects the fact that achievement of ERF was £4.2m lower than planned in H1; the financial plan for H1 assumed ERF income of £7.6m, but the Trust only achieved £3.4m of ERF income; ERF stretch of £1.56m has been achieved in the current month in line with plan.
  - **£1.5m favourable movement re Other Operating Income** – driven by additional top up funding (in relation to Covid) which is offset by additional expenditure, and over performance on variable income streams such as non patient care recharges, car parking income and catering income for which there is some offset in expenditure.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £33.1m was delivered in the current month.

# Finance Spotlight Report (Key areas of focus - Pay)



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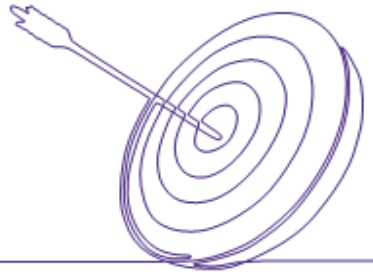
- **The overall YTD Pay position is £8.9m adverse to plan**:
  - **£4.5m adverse movement re pay award** – This movement reflects the fact that the Trust's H1 Pay position includes unplanned expenditure of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 expenditure plan.
  - **£3.0m adverse movement re Pay CIP delivery** – Savings delivery in H1 was £1.8m lower than planned, including non recurrent Pay savings of £0.6m; Savings delivery to date in H2 is £1.2m lower than planned, including non recurrent Pay savings of £0.2m.
  - **£1.1m adverse movement re Restore and Covid** – The additional costs of Covid in H1 (including the cost of bank incentive rates) were £2.0m higher than planned, but this pressure was mitigated in part by £0.9m lower than planned costs in relation to Restore; it has not been possible to provide an update re Covid and Restore costs in H2 for the Month 10 report.
  - **£0.3m adverse movement overall re other items** – A number of other adverse movements (e.g. expenditure related to top-up funding) have been partly mitigated by other upsides in the position.
- **Pay expenditure of £37.3m in January is £0.1m higher than £37.2m in December**; Substantive Pay was £0.4m lower driven by one fewer Bank Holiday, and an increase of £0.6m in Bank Pay driven by Bank Incentive rates was partly offset by a reduction of £0.1m in Agency Pay.

# Finance Spotlight Report (Key areas of focus - Other)



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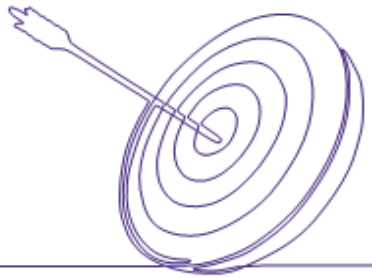
- The overall YTD Non Pay position is £4.8m favourable to plan, which is an improvement of £1.1m compared to the reported position at Month 9; overall, Non Pay expenditure of £17.5m in January was £0.5m lower than expenditure of £17.5m in December.
- In H1, the Trust planned CIP savings of £6.4m and delivered £6.2m in relation to 2021/22 savings schemes including £5.2m of non recurrent savings. The Trust's original plan required a further £9m of savings in H2, but the H2 plan submitted is based upon delivery of £6m in H2. Against the H2 CIP plan, the Trust has delivered savings of £3.8m in line with plan; see the separate CIP report for details.
- Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£49.6m at M8. TIF and SCR fund changes (c£6.0m reduction), offset by new Digital funding (c£1.4m) decreased the 'live' capital envelope to c£45.0m as at the end of M9. Diagnostic funding bids for Endoscopy and EMRAD (+c£1.1m), in addition to new TIF Digital funding (+c£0.8m) for Shared Cared Record (MVS2.0) and Disposals (£0.3m), offset by the removal of TIF Citizen Atrium from ULHT hosting (-£1.0m) has increased the 'live' capital envelope to c£46.0m as at the end of M10. Further to this is a potential decision re: TIF C2-AI allocation (+£1.2m) increasing the capital programme to c£47.5m.
- The capital plan submitted to NHSE/I has a year-to-date plan at M10 of c£25.8m. Spend incurred at M10 equated to c£18.3m, therefore schemes are behind plan by c£7.5m externally (was £9.3m) – this month the variance to plan has again improved due to in-month spend. When comparing to the agreed forecasting information that has created the 'Internal Plan' for monitoring purposes, this shows that schemes are c£3.5m behind plan (was £5.8m). Please see separate capital report for details.
- The month end cash balance is £67.7m which is an increase of £13.7m against cash at 31 March 2021.

# Finance Spotlight Report (Key areas of focus - Other)



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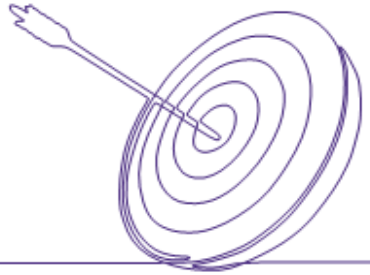
- The Trust forecasts to deliver its element of the System's financial plan i.e. a surplus of £1.8m. For the purpose of measuring system financial performance, gains from the disposal of assets are removed, and the Trust has YTD made £123k from the disposal of assets. The Trust therefore forecasts to deliver an adjusted surplus of £1.923m, so that once gains from the disposal of assets are removed it will meet its system target to deliver a £1.8m surplus. However, the mounting operational changes required to support the Trust addressing the COVID and wider NEL pressures over the coming weeks create a financial risk. In the H2 financial plan submission supporting paper (brought to FPEC last month), an indicative risk of 'winter' of £3m was identified, and further forecast analysis is contained in this report.

- BPPC performance is 91% / 86% by value / volume of invoices paid for the period April 21 – January 22 (appendix 5d). (In month performance 87%/ 73% by value / volume). During December in particular, but also January, the processing and payment of invoices has been impacted by the migration to the new finance system. In an average month, the Trust would expect to pay circa 9,000 invoices / £24m spend; in December 2,700 invoices at a cost of £3m were processed. This impact of this can be seen in the increased level of trade creditors and reduced performance against the BPPC target. Whilst not yet operating at capacity, many of the 'teething' problems with the new system have now been addressed and a steady recovery is expected.

# Finance Dashboard



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NHSI's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care. The assessment is in 5 resource areas;

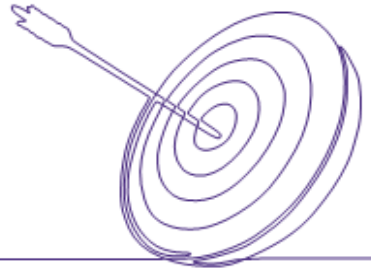
**Clinical Services**
**People**
**Clinical Support Services**
**Corporate Services, Procurement, Estates and Facilities**
**Finance**

| Metric | Rating Boundary | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| Capital servicing capacity | 2.5 | 1.75 | 1.25 | <1.25 |
| Liquidity ratio (days) | 0 | -7 | -14 | <-14 |
| I&E Margin | 1% | 0% | -1% | <=-1 |
| I&E margin distance from plan | 0% | -1% | -2% | <=-2% |
| Agency | 0% | 25% | 50% | >=50% |

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last two full financial years and the current 2020/21 position are as follows

| Finance and use of resources rating | Full Year | Full Year | Full Year | Actual | Forecast |
|---|---|---|---|---|---|
| | 31/03/2019 | 31/03/2020 | 31/03/2021 | JAN 2021 | 31/03/2022 |
| Capital service cover metric | (10.40) | (1.73) | 0.06 | 2.12 | 1.71 |
| Capital service cover rating | 4 | 4 | 4 | 1 | 1 |
| Liquidity metric | (98.73) | (128.28) | 3.71 | 2.87 | 2.91 |
| Liquidity rating | 4 | 4 | 1 | 1 | 1 |
| I&E margin metric | (19.71%) | (7.62%) | 0.38% | 0.37% | 0.32% |
| I&E margin rating | 4 | 4 | 2 | 2 | 2 |
| Agency metric | 77.00% | 110.00% | 113.00% | 117.00% | 118.00% |
| Agency rating | 4 | 4 | 4 | 4 | 4 |
| I&E margin: distance from financial plan - metric | (2.80%) | 0.70% | n/a | 0.37% | 0.04% |
| I&E margin: distance from financial plan - rating | 4 | 1 | n/a | 1 | 1 |

# Balance Sheet



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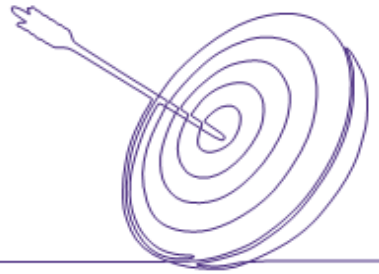
| | 31 March 2021 | 31 January 2022 | |
|---|---|---|---|
| | | Plan | Actual |
| | £000 | £000 | £000 |
| Intangible assets | 4,600 | 3,086 | 3,076 |
| Property, plant and equipment | 247,119 | 261,921 | 253,876 |
| Receivables | 2,790 | 2,781 | 2,660 |
| **Total non-current assets** | **254,509** | **267,788** | **259,612** |
| Inventories | 6,510 | 6,728 | 7,249 |
| Receivables | 25,935 | 30,823 | 22,002 |
| Cash and cash equivalents | 54,042 | 20,432 | 60,399 |
| **Total current assets** | **86,487** | **57,983** | **89,650** |
| Trade and other payables | (69,643) | (51,434) | (75,699) |
| Borrowings | (402) | (1,108) | (555) |
| Provisions | (2,056) | (2,178) | (2,196) |
| Other liabilities | (1,587) | (2,943) | (2,934) |
| **Total current liabilities** | **(73,688)** | **(57,663)** | **(81,384)** |
| **Total assets less current liabilities** | **267,308** | **268,108** | **267,878** |
| Borrowings | (3,624) | (4,437) | (3,471) |
| Provisions | (4,069) | (4,032) | (3,941) |
| Other liabilities | (12,075) | (11,655) | (11,656) |
| **Total non-current liabilities** | **(19,768)** | **(20,124)** | **(19,068)** |
| **Total assets employed** | **247,540** | **247,984** | **248,810** |
| **Financed by** | | | |
| Public dividend capital | 677,570 | 677,570 | 677,570 |
| Revaluation reserve | 27,522 | 26,942 | 26,940 |
| Other reserves | 190 | 190 | 190 |
| Income and expenditure reserve | (457,742) | (456,718) | (455,890) |
| **Total taxpayers' equity** | **247,540** | **247,984** | **248,810** |

Note 1: Payables, Receivables and Cash have each been impacted in December / January by the implementation of the new finance system and disruption to normal processing associated with the migration to any new system. These elements of working capital are expected to return to more 'normal' business levels during February / March.

Note 2: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments now confirmed for the remainder of 2021/22. They have however recovered from the extremely low levels seen in December as NCA invoices and a limited volume of other invoices have now been raised on the new system. See Appendix 5a-b

Note 3: Trade Payables including accruals increased at a reduced rate in January (£5.5m) as compared to December (12.5m). Normal weekly payment runs recommenced in early January; it will however take a period of time to clear the backlog associated with the new system implementation.
Critical suppliers have continued to be targeted to limit any potential impact upon supplies and services.
Staff related creditors are at higher levels than historically seen, with increases due to accrued annual leave (£8.3m).
Capital creditors have dropped from March (£13.0m) and are now at £5.3m. This is expected to rise significantly by 31 March 2022 as the capital programme accelerates.
BPPC and aged creditor performance have been impacted by system implementation and are reported at Appendix 5c-d.

# Cashflow reconciliation– April - January 2022



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| | Full Year 2020/21 | 31 January 2022 | |
|---|---|---|---|
| | | Plan | Actual |
| | £000 | £000 | £000 |
| Operating surplus / (deficit) | 8,778 | 6,811 | 7,331 |
| Depreciation and amortisation | 13,674 | 13,007 | 12,676 |
| Impairments and reversals | 3,121 | - | 94 |
| Income recognised in respect of capital donations | (3,923) | (500) | - |
| Amortisation of PFI deferred credit | (503) | (420) | (419) |
| (Increase) / decrease in receivables and other assets | 16,119 | (4,879) | 4,063 |
| (Increase) / decrease in inventories | 527 | (218) | (739) |
| Increase/(decrease) in trade and other payables | 16,987 | (12,637) | 10,996 |
| Increase/(decrease) in other liabilities | (2,085) | 1,356 | 1,347 |
| Increase / (decrease) in provisions | 1,556 | 114 | 40 |
| **Net cash flows from / (used in) operating activities** | **54,251** | **2,634** | **35,388** |
| Interest received | 12 | - | 5 |
| Purchase of intangible assets | (1,245) | - | - |
| Purchase of property, plant and equipment | (39,483) | (33,928) | (26,046) |
| Proceeds from sales of property, plant and equipment | 625 | - | 128 |
| Net cash flows from / (used in) investing activities | (40,091) | (33,928) | (25,913) |
| Public dividend capital received | 409,664 | - | - |
| Loans from Department of Health and Social Care - repaid | (377,859) | - | - |
| Other loans received | 2,544 | 1,520 | - |
| Interest paid | (2,522) | - | (1) |
| PDC dividend (paid)/refunded | (5,662) | (3,836) | (3,117) |
| Net cash flows from / (used in) financing activities | 26,165 | (2,316) | (3,118) |
| **Increase / (decrease) in cash and cash equivalents** | **40,325** | **(33,610)** | **6,357** |
| Cash and cash equivalents at 1 April - brought forward | 13,717 | 54,042 | 54,042 |
| **Cash and cash equivalents at period end** | **54,042** | **20,432** | **60,399** |

Note 1: Cash held at 31 January was £60.4m against a plan of £20.4m.

Note 2: Principle reasons for the cash variance to plan of £40.0m are:

- a shortfall of £7.9m against planned capital payments, linked to delays in the capital programme.
- The continued block contract regime suppressing receivables.
- Increases through December / January in trade payables and accruals linked to the implementation of the new finance system and delayed supplier payments.

Note 3: Underlying cash balances remain significantly increased on 2019/20 levels primarily due to:

- the continued block payment regime
- Receipt in March 21 of £7.1m to cover future outgoings associated with accrued annual leave.
- Delays in the capital programme.

Note 4: Cash balances are expected to remain at similar levels for the reminder of 21/22 with the drawdown of circa £30m PDC associated with the capital programme.

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *Tuesday 1 March 2022* |
| Item Number | *Item 13.1* |
| **Strategic Risk Report** | |
| Accountable Director | *Dr Karen Dunderdale, Director of Nursing / Deputy CEO* |
| Presented by | *Dr Karen Dunderdale, Director of Nursing / Deputy CEO* |
| Author(s) | *Paul White, Head of Risk and Governance* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *Multiple – please see report* |
| Financial Impact Assessment | *None* |
| Quality Impact Assessment | *None* |
| Equality Impact Assessment | *None* |
| Assurance Level Assessment | *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | *Trust Board is invited to review the report and advise on any areas of strategic risk requiring further action* |

## Executive Summary

- This Strategic Risk Report focuses on the highest priority risks to strategic objectives currently being managed within the Trust (those with a rating of Very high, 20-25).
- There are 9 active risks that are rated Very high (20-25) and 22 rated High (15-16); 84% of the new risk register (193 risks) have a current rating of Moderate (8-12).
- The following significant risks are now rated as Very high and included in this report:
  - The accuracy and availability of patient records, and information about medication, both are now rated as Very high (20).
  - Delays to the processing of echocardiograms is also now rated as Very High (20).
- The risk of staff absence due to contracting Covid-19 has been reduced from Very high risk (25) to High risk (15) on review.
- The risk relating to the UK Government mandate for compulsory Covid-19 vaccinations within healthcare, previously rated as Very high risk (25) is to be reviewed now that the policy has been revoked and has therefore not been included as a significant risk this month.
- Trust Board are advised that the new risk register that was introduced in January 2022 is now in the process of being reviewed within each division and corporate directorate, therefore details of significant risks presented in this report may be subject to change as risk descriptions are validated and up to date information is considered
- A revised approach to reporting on risk to each of the assurance committees of the Trust Board has now been established, with a focus on significant risks to each strategic objective within the remit of each committee
- The Risk Management Policy has now been updated to reflect the way the risk register is being utilised; the revised Policy was considered by the Risk Register Confirm and Challenge Group on 23 February 2022 and final comments have been requested to enable it to be approved and published

**Purpose**

The purpose of this report is to enable the Trust Board to:

- Review the management of significant risks to strategic objectives.
- Evaluate the effectiveness of the Trust's risk management processes.

## 1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). Details of all active Very high and High risks (15-25) are provided in **Appendix A**. Moderate and Low risks (12 and below) are managed at divisional level.

1.2 There are several areas of Very high risk that have been included in previous Strategic Risk Reports and are currently being reviewed and updated by the risk leads in order to ensure that they reflect the areas of most risk, rather than a generic risk. These risks are therefore not included in this month's report:

- Managing emergency demand – a new draft risk register for Accident & Emergency was reviewed and discussed at the February meeting of the Risk Register Confirm and Challenge Group, where it was agreed that this continues to be an area of significant risk for the Trust; further work is now taking place within Medicine Division, supported by the Clinical Governance team, to refine and validate each risk using the most up to date information available and reflecting the extent of mitigating action that is being taken
- Delays to planned care as a result of service changes during the Covid-19 pandemic – this is being assessed at specialty level, again supported by the Clinical Governance team as part of the review of new risk registers within each division, to identify those areas where there is the greatest risk of patient harm and will be subject to review at the March meeting of the Risk Register Confirm and Challenge Meeting.

## 2. Trust Risk Profile

2.1 There 219 active risks currently recorded on the Trust risk register. There are 9 risks with a current rating of Very high (20-25). **Chart 1** shows the number of active risks by current risk rating:

| Very low (1-3) | Low (4-6) | Moderate (8-12) | High (15-16) | Very high (20-25) |
|---|---|---|---|---|
| **0** (0%) | **16** (7%) | **193** (84%) | **12** (5%) | **9** (4%) |

### Strategic objective 1a: Deliver harm free care

2.2 Significant active risks to this objective:

| Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date of latest review |
|---|---|---|---|---|
| 4622 | If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients. | Very high risk (20) | - Safety Culture Project, part of Integrated Improvement Plan (IIP)<br>- Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS)<br>- Upgrade current DatixWeb risk management system to Datix CloudIQ | 08/11/2021 |

**Strategic objective 1c: Improve clinical outcomes**

2.3 Significant active risks to this objective:

| Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date of latest review |
|---|---|---|---|---|
| 4731 | If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm | Very high risk (20) | Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use. | 26/01/2022 |
| 4828 | If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a reduced likelihood of a positive clinical outcome and possibly causing serious patient harm | Very high risk (20) | Planned introduction of an auditable electronic prescribing system across the Trust. | 26/01/2022 |
| 4646 | If the Trust is not consistently compliant with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm. | Very high risk (20) | Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP):<br>1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV.<br>2. Provision of ring-fenced beds for NIV.<br>3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards.<br>4. Provision of NIV service (ED) which meets the BTS Quality Standards.<br>5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards.<br>6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt. | 14/12/2021 |

| Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date of latest review |
|---|---|---|---|---|
| 4789 | If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome | Very high risk (20) | Review and realignment of systems and processes to ensure that the team efficiency has been optimised. External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service | 03/02/2022 |
| 4825 | JAG Accreditation deferred for Lincoln due to poor state of current Lincoln Endoscopy accommodation | Very high risk (20) | Case of need for immediate remedial works required, plan to take to September CRIG<br>Estates strategy and plans for replacement of current accommodation within the next 2 years | 08/12/2021 |

**Strategic objective 2a: A modern and progressive workforce**

2.4 Significant active risks to this objective:

| Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date of latest review |
|---|---|---|---|---|
| 4669 | If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience | Very high risk (20) | Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding. | 02/11/2021 |
| 4670 | If the Trust is unable to recruit and retain sufficient numbers of consultants & middle grade doctors then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience | Very high risk (20) | Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff. | 02/11/2021 |

2.5 The risk relating to the UK Government mandate for compulsory Covid-19 vaccinations within healthcare, previously rated as Very high risk (25) is to be reviewed now that the policy has been revoked.

**Strategic objective 2b: Making ULHT the best place to work**

2.6 Significant active risks to this objective:

| Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date of latest review |
|---|---|---|---|---|
| 4667 | If issues such as workload; work-life balance; organisational change; and cost reduction; are not managed effectively then it could have a significant negative impact on the morale of a substantial proportion of the workforce, resulting in increased turnover / increased absence / reduced productivity / reduced quality. | Very high risk (20) | Focus on the "People" Strategic Objective in the IIP. This focuses on "modern and progressive workforce" and being the "best place to work". Series of projects and programmes being worked up to deliver agreed outcomes. | 03/11/2021 |

## 3. Conclusions & recommendations

3.1 Whilst there are still some significant risks relating to the Covid-19 pandemic, particularly regarding the potential impact on employees and staffing levels, the new risk registers are also starting to highlight some other areas of concern that represent more traditional risks within healthcare:

- Recruitment and retention of medical and nursing staff.
- Workload management and staff morale.
- The accuracy and availability of clinical information.

3.2 There are also some specific clinical risks that have been highlighted by divisions as the new risk registers are reviewed and updated:

- The care of patients requiring Non-Invasive Ventilation (NIV).
- Delays in processing echocardiograms.
- Renewal of the Trust's JAG accreditation for Endoscopy at Lincoln County Hospital.

3.3 Risks due to the level of emergency demand, including overcrowding within A&E and limited bed availability; along with delays to planned care as a result of changes to services made during the pandemic; are also recognised as significant and are being reassessed so that appropriate action can be taken to address them.

3.4 The Trust Board is invited to review the report and advise of any further action required at this time to improve the management of strategic risks or to strengthen the Trust's risk management framework.

**Appendix A: Details of all active Very high and High risks (15-25)**

| Strategic Objective | ID | Risk Type | Manager | Handler | Lead Oversight Group | Opened | Rating (inherent) | Source of Risk | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a. Deliver Harm Free Care | 4622 | Patient safety (physical or psychological harm) | Karen Dunderdale | Kathryn Helley | Patient Safety Group | 09/04/2018 | 20 | Risk assessments | Corporate | Nursing Directorate | Clinical Governance | Trust-wide | If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experence or a poor clinical outcome affecting a large number of patients. | National Policy:<br>- NHS National Patient Safety Strategy<br>- NHS National Reporting and Learning System (NRLS)<br><br>ULHT Policy:<br>- Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy (approved April 2019, due for review April 2022)<br><br>ULHT governance:<br>- Trust Board assurance through Quality Governance Committee (QGC) and sub-groups" | - Recurring themes in patient safety incidents, complaints, PALS & claims (e.g. patient falls SIs; pressure ulcer incidents; DKA incidents)<br>- Recurring themes in audits / reviews of risk / incident / complaints / claims management" | 08/11/2021 | Extremely likely | High | Very high risk | 20 | - Safety Culture Project, part of Integrated Improvement Plan (IIP)<br>- Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previoulsy called PSIMS)<br>- Upgrade current DatixWeb risk management system to Datix CloudIQ" | [08/11/2021 13:31:36 Datix Admin] - Safety Culture Project provides regular highlight reports to Patient Safety Group<br>- DatixCloudIQ has been approved for connection to the new national learning system<br>- Case of need for Datix CloudIQ produced and approved in principle; next steps to be decided" | Low risk | 31/01/2019 | | 31/12/2021 |
| 1a. Deliver Harm Free Care | 4646 | Physical or psychological harm | Karen Dunderdale | Donna Gibbins | Patient Safety Group | 14/12/2021 | 20 | Policy/Protocol Issues, Risk assessments | Medicine | Specialty Medicine CBU | Respiratory Medicine | Trust-wide | If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm. | National policy:<br>- NICE Guideline NG115 - COPD in Over-16s: diagnosis and management<br>- NICE Quality Standard QS10 - COPD in Adults<br>- British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV<br><br>ULHT policy:<br>- Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting<br>- NIV-trained clinical staff<br>- Dedicated NIV beds (Respiratory wards)<br><br>ULHT governance:<br>- Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine<br>- Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme | - Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents<br>- Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21<br>- Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21<br>- NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 | 14/12/2021 | Extremely likely | High | Very high risk | 20 | Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP):<br>1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV.<br>2. Provision of ring-fenced beds for NIV.<br>3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards.<br>4. Provision of NIV service (ED) which meets the BTS Quality Standards.<br>5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards.<br>6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt. | [14/12/2021 14:54:14 Paul White] New Specialist Respiratory Unit with adjoining Respiratory ward now open at LCH. Plans for development of the facility at PHB scheduled from Feb / Mar 22. | Low risk | 30/09/2022 | 30/09/2022 | 31/03/2022 |
| 2b. Making ULHT the best place to work | 4667 | Service disruption | Paul Matthew | Claire Low | | 11/01/2022 | 25 | Risk assessments | Corporate | People and Organisational Development | Operational HR | Trust-wide | If issues such as workload; work-life balance; organisational change; and cost reduction; are not managed effectively then it could have a significant negative impact on the morale of a substantial proportion of the workforce, resulting in increased turnover / increased absence / reduced productivity / reduced quality. | Staff Charter & Personal Responsibility Framework<br>Staff engagement strategies & plans.<br>Internal communications platforms (intranet; bulletins; forums).<br>Staff survey process and response planning.<br>People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring.<br>Core learning programmes.<br>Leadership development and succession planning processes.<br>Management of change policies, guidelines, support and training.<br>Partnership agreement with staff side representatives.<br>Occupational health & wellbeing arrangements for staff. | Staff survey results.<br>Staff 'pulse check' results.<br>Staff absence rates.<br>Staff turnover rates.<br>Complaints received regarding staff attitude / behaviour. | 03/11/2021 | Quite likely | Extreme | Very high risk | 20 | Focus on the "People" Strategic Objective in the IIP. This focuses on "modern and progressive workforce" and being the "best place to work". Series of projects and programmes being worked up to deliver agreed outcomes. | Some improvement in the results of the staff survey. Still below average for acute trusts. Less than 50% of staff would recommend ULHT as a place to work. Considerable work still to be done on morale, but this is the thrust of the Integrated Improvement Plan and a number of workstreams within it. Progress on projects delayed owing to COVID, but as part of managing the incident we have introduced new approaches to interacting with staff and feedback has been positive. | Low risk | 31/03/2022 | 31/03/2022 | 31/03/2022 |
| 2a. A modern and progressive workforce | 4669 | Service disruption | Paul Matthew | Karen Taylor | Workforce Strategy Group | 12/01/2022 | 25 | Workforce Metrics | Corporate | People and Organisational Development | Operational HR | Trust-wide | If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience | ULHT policy:<br>- Nursing workforce planning processes<br>- Nursing recruitment framework & associated policies, training & guidance<br>- Nursing rota management systems & processes<br>- Nurse Bank & agency temporary staffing arrangements<br>- Workforce management information<br><br>ULHT governance:<br>- Trust Board assurance through People & OD Committee / lead Workforce Strategy Group<br>- Divisional workforce governance arrangements | Nursing vacancies & turnover rate.<br>Nursing staff survey results relating to job satisfaction / retention. | 02/11/2021 | Quite likely | Extreme | Very high risk | 20 | Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding. | Workforce supply is a workstream in the Integrated Improvement Plan reflecting the priority within the NHS National People Plan. Programmes have been delayed by COVID. However vacancy rates have reduced over the last three months. The Director of Nursing has initiated a Nurse Transformation Programme to look at demand and supply issues around nursing. | Moderate risk | 31/03/2022 | 31/01/2023 | 31/03/2022 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2a. A modern and progressive workforce | 4670 | Service disruption | Paul Matthew | Karen Taylor | Workforce Strategy Group | 12/01/2022 | 25 | Workforce Metrics | Corporate | People and Organisational Development | Operational HR | Trust-wide | If the Trust is unable to recruit and retain sufficient numbers of consultants & middle grade doctors then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience | ULHT policy:<br>- Medical workforce planning processes<br>- Medical recruitment framework & associated policies, training & guidance<br>- Medical rota management systems & processes<br>- Medical staff locum temporary staffing arrangements<br>- Workforce management information<br><br>ULHT governance:<br>- Trust Board assurance through People & OD Committee / lead Workforce Strategy Group<br>- Divisional workforce governance arrangements | Medical staff vacancies & turnover rate.<br>Medical staff survey results relating to job satisfaction / retention. | 02/11/2021 | Quite likely | Extreme | Very high risk | 20 | Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff. | Plan for every medical post in place. Pre-COVID was strong pipeline for medical recruitment. Focus of IIP. We are restoring recruitment processes and using Teams to run AAC panels. Vacancy rate for medical staff reducing. | Moderate risk | 31/03/2022 | 31/03/2023 | 31/03/2022 |
| 1c. Improve clinical outcomes | 4731 | Physical or psychological harm | Simon Evans | Lee Parkin | Clinical Effectiveness Group | 13/01/2022 | 20 | Risk assessments | Clinical Support Services | Outpatients CBU | Choice, Access and Booking | Trust-wide | If patient records are not complete, accurate, up to date and available when needed by clinicians then it could lead to delayed diagnosis and treatment, reducing the likelihood of a positive clinical outcome and possibly causing serious harm | - Clinical Records Management Policy (approved June 2021, due for review June 2022)<br>- Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Medical Records Group - CSS Division | Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records.<br>Reported incidents involving availability of patient records issues. | 26/01/2022 | Extremely likely | High | Very high risk | 20 | Design and delivery of the Electronic Document Management System (EDMS) project, incorporating Electronic Patient records (EPR). Interim strategy required to reduce the risk whilst hard copy records remain in use. | OBC for EPR is being produced in line with NHSE/I guidance. Hoping to have Board sign off and funding in early 2022, with project start 2nd quarter 2022. To discuss / agree interim approach. Reviewed by Risk Register Confirm & Challenge Group, 26 Jan 22. Rating increased to 20, risk lead changed to Prof lead for Outpatients. Oversight to be via Medical Records Group. | Low risk | 30/06/2018 | 31/03/2023 | 30/06/2022 |
| 1c. Improve clinical outcomes | 4789 | Physical or psychological harm | Tracey Wall | Clare Spendlove | Clinical Effectiveness Group | 16/01/2022 | 20 | Risk assessments | Medicine | Cardiovascular CBU | Cardiology | | If there is a significant delay in processing of Echocardiograms, which is impacted by staff shortages and inefficient processes, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm and a poor clinical outcome | Weekly review and monitoring of OP activity /utilisation data<br><br>Monthly meeting with CSS to review performance; secure any additional available capacity<br><br>Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell | DMO1 activity - monthly review<br>Backlog consistently increasing<br>C&A Team remain short-staffed due to vacancies<br>-referrals being late added onto Medway leaving CBU with no visibility of the referrals for the first part of their pathway.<br>- Issues with CBU not having visibility of demand to allow adequate proactive planning of additional clinic sessions.<br>- CBU being unable to accurately forecast activity performance against standards e.g. DM01<br>-wasted clinic slots | 03/02/2022 | Extremely likely | High | Very high risk | 20 | Review and realignment of systems and processes to ensure that the team efficiency has been optimised.<br>External company (Meridian) engaged for 10 week period to enable a deep dive and improvement plan to be implemented for the service | Meridian on week 4 of 10 week support.<br>Number of measures being developed to improve pathways/flow<br><br>Inboxes streamlined across sites<br><br>weekly meetings in place to review and track progress | Low risk | 31/03/2022 | 31/03/2023 | 30/06/2022 |
| 1c. Improve clinical outcomes | 4825 | Regulatory compliance | Simon Evans | Ian Fulloway | Clinical Effectiveness Group | 16/01/2022 | 25 | Risk assessments | Clinical Support Services | Diagnostics CBU | Endoscopy | Lincoln County Hospital | JAG Accreditation deferred for Lincoln due to poor state of current Lincoln Endoscopy accommodation | JAG accreditation process<br>Endoscopy operational policies & procedures | Self assessment against JAG accreditation criteria | 08/12/2021 | Quite likely | Extreme | Very high risk | 20 | Case of need for immediate remedial works required, plan to take to September CRIG<br>Estates strategy and plans for replacement of current accommodation within the next 2 years | Factual accuracy report received 27/10/21 and service response provided 28/11/21.<br>Awaiting final report and letter. | Low risk | 31/07/2021 | 31/03/2022 | 31/03/2022 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1c. Improve clinical outcomes | 4828 | Physical or psychological harm | Colin Farquharson | Colin Costello | Medicines Quality Group | 17/01/2022 | 20 | Risk assessments | Clinical Support Services | Pharmacy CBU | Pharmacy | Trust-wide | If information about patient medication is not accurate, up to date and available when required by Pharmacists then it could lead to delays or errors in prescribing and administration, resulting in a reduced likelihood of a positive clinical outcome and possibly causing serious patient harm | National policy:<br>- NICE Guideline NG5: Medicines optimisation, etc.<br><br>ULHT policy:<br>- Policy for Medicines Management: Sections 1-8 (various approval / review dates)<br><br>ULHT governance:<br>- Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) | Medication incident analysis<br>Audit / review of medicines management processes - the Trust currently uses a manual prescribing process across all sites, which is inefficient and restricts the timely availability of patient information when required by Pharmacists. | 26/01/2022 | Extremely likely | High | Very high risk | 20 | Planned introduction of an auditable electronic prescribing system across the Trust. | Funding approved for Electronic Prescribing and Medicines Administration (EPMA). Project plan has been developed, implementation from Oct / Nov 21.<br>Reviewed at Risk Register Confirm & Challenge Group 26 Jan 22. Rating increased to 20. | Low risk | 31/03/2022 | 30/09/2022 | 30/06/2022 |
| 1a. Deliver Harm Free Care | 4623 | Regulatory compliance | Karen Dunderdale | Kathryn Helley | | 05/03/2018 | 16 | Risk assessments | Corporate | Nursing Directorate | Clinical Governance | | If an inspection by the Care Quality Commission (CQC) finds that the Trust is significantly non-compliant with regulations and standards for Clinical Governance it may result in sanctions such as a warning, improvement or prohibition notice; or a financial penalty. | National policy:<br>- NHS Serious Incident Framework (2015)<br>- NHS Never Event Policy and Framework (2018)<br>- NHS Patient Experience Framework (2012)<br>- NHS Central Alerting System (CAS)<br>- National Institute for Health and Care Excellence (NICE) pathways and guidance<br>- NHS National Clinical Audit and Patient Outcomes Programme (NCAPOP) & National Quality Improvement and Clinical Audit Network (NQICAN)<br><br>ULHT policy:<br>- Incident Management Policy & Procedures (updated September 2021, due for review September 2023)<br>- CAS & FSN Management Policy (approved July 2020, due for review July 2023)<br>- Learning from Deaths Mortality Review Policy - approved March 2020, due for review April 2025<br>- Clinical Audit Policy and Strategy 2020-25<br>- Complaints & PALS Policy (approved April 2021, due for review April 2024)<br>- Quality Impact Assessment process<br><br>Governance arrangements:<br>- Trust Board assurance through Quality Governance Committee (QGC) & sub-groups<br>- Clinical governance framework at divisional, Clinical Business Unit (CBU) and specialty levels<br>- CCG oversight & assurance framework" | - Audits of compliance with ULHT clinical governance policy<br>- Data monitoring against national clinical governance requirements:<br># Duty of Candour (Regulation 20, Health & Social Care Act)<br># NHS Central Alerting System (CAS) notifications<br># National clinical audit participation rates<br># NICE guidelines self assessment completion rates" | 08/11/2021 | Quite likely | High | High risk | 16 | - Quality Impact Assessment (QIA) Policy and Procedures to be developed and introduced<br>- Development of Patient Safety Incident Response Plan (PSIRP) for implementation in 2022<br>- Review of Duty of Candour compliance issues & development of improvement plan" | [08/11/2021 13:35:24 Datix Admin] - QIA Policy and Procedures awaiting approval October 2021<br>- Serious Incident Framework to be replaced by new Patient Safety Incident Response Framework (PSIRF) from 2022 (date tbc, delyaed due to Covid pandemic)" | Low risk | 31/12/2021 | | 31/12/2021 |

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| 1a. Deliver Harm Free Care | 4624 | Physical or psychological harm | AD4 (Deleted User) | Sarah Addlesee | Patient Falls Steering Group | 08/11/2021 | 16 | Aggregation of Incident/Claims & Complaints/PALS | Corporate | Nursing Directorate | Corporate Nursing | Trust-wide | If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result. | National policy:<br>- NICE Clinical Guideline CG161: Assessment and prevention of falls in older people (2013)<br>- PHE Falls and fracture consensus statement: Resource pack (2017)<br><br>ULHT policy:<br>- Falls Prevention and Management Policy (approved April 2021, due for review March 2023)<br><br>ULHT governance:<br>- Frailty lead nurse / lead Quality Matron<br>- Weekly Falls Investigation Panel / Training package tiered approach / Weekly spot check audits / Monthly Quality Metrics Dashboard meetings /ward review visits<br>- Patient falls steering group / Nursing, Midwifery & AHP Forum / Quality Governance Committee | - Frequency, location and severity of patient falls incidents reported<br>- Audits of compliance with Trust policy / evaluation of training / training compliance rates | 09/02/2022 | Quite likely | High | High risk | 16 | • Improvement plan implemented by all Divisions, led by QM, monitored through Patient Falls Prevention Steering Group (FPSG).<br>• Introduction and rollout of 'Think Yellow ' falls awareness visual indicators.<br>• Patient story included within FPSG workplan.<br>• Introduction of new falls prevention risk assessment and care plan documentation<br>• Falls prevention training and education framework developed, delivery to commence 2022.<br>• Analyse trends and themes in falls data to inform the need for targeted support and interventions.<br>• Utilisation of Focus on Fundamentals programme<br>• Enhanced care policy and associated processes review.<br>• Revised falls investigation process and documentation.<br>• Overarching action plan for divisional and serious incidents, monitored through FPSG | Weekly Falls Investigation Panel embedded / Falls Prevention Steering Group meets monthly / Falls improvement work ongoing across the Trust and focused pieces of work identified through the steering group / training package approved at NMAAF in Jan 22. | Low risk | 31/12/2021 | 31/03/2023 | 30/06/2022 |
| 1a. Deliver Harm Free Care | 4625 | Patient safety (physical or psychological harm) | Karen Dunderdale | Natalie Vaughan | Infection Prevention and Control Group | 05/06/2018 | 16 | Risk assessments | Corporate | Nursing Directorate | Infection Prevention and Control | | If the Trust's infection prevention and control measures are not effective and an outbreak of serious infectious disease occurs it could result in serious harm affecting a large number of patients, staff and visitors across multiple hospital locations. | National Policy:<br>- DH Hygiene Code 2008 (2015)<br>- NHS National Standards of Healthcare Cleanliness (2021)<br><br>ULHT Policy:<br>- Infection Prevention and Control Management and Operational Policy (approved August 2021, due for review August 2024)<br># Mandatory infection control training as part of Core Learning<br>- Management of Infection Outbreak or Incident Policy (approved July 2020, due for review July 2023)<br>- Infection Prevention Surveillance Policy (approved April 2021, due for review April 2023)<br><br>ULHT Governance:<br>- Infection Control Committee & sub-group governance structure (Decontamination Group; Water Safety Group)<br>- Executive lead - Director of Infection Prevention & Control (DIPC) - Director of Nursing:<br># Deputy Director of Infection Prevention & Control (DDIPC)<br># Infection Prevention & Control Team (IPCT)<br># Infection Prevention Link Practitioners (IPLPs)<br><br>Contract management of 3rd party service providers:<br>- Sterile services (Steris)<br>- Microbiology services (Pathlinks)" | - Volume and severity of infection outbreaks<br>- Reported patient safety incidents of hospital acquired infection (frequency, severity & location)<br>- Infection control compliance monitoring / auditing" | | Quite likely | High | High risk | 16 | - Estates team reviewing plans to make negative pressure rooms HTM compliant.<br>- Identify and implement (with Pathlinks) an upgrade or replacement for the Cognos system." | | Low risk | 31/12/2021 | | 31/12/2021 |

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| 2c. Well led services | 4661 | Reputation | Jayne Warner | Jayne Warner | | 10/01/2022 | 20 | Risk assessments | Corporate | Trust Headquarters | Corporate Secretary | | If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO) | National policy:<br>- Data Protection Act 2018<br>- NHS Digital Data Security & Protection Toolkit<br><br>ULHT policy:<br>- Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices<br><br>ULHT governance:<br>- Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group<br>- Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles | Internal audit review of data protection / PIA processes | 01/11/2021 | Quite likely | High | High risk | 16 | Review of the data protection / privacy impact assessment process and governance, to include education and communication to raise staff awareness of the required process. | Process and documentation reviewed and updated; these are now GDPR compliant. Further action required to address governance issues.<br><br>Reference to DPIAs in Data Security and Awareness mandatory training.<br>Long standing issue of IG not being made aware of new systems or changes in processes that require assessment under Data Protection legislation. Educating staff across the Trust is required.<br><br>Changes to legislation due to Brexit means that any data leaving the UK has greater risks associated. If a DPIA is not conducted then this could have an impact on availability of that data. | Low risk | 31/03/2022 | 31/01/2023 | 31/03/2022 |
| 3b. Efficient use of our resources | 4664 | Finances | Paul Matthew | Jonathan Young | | 11/01/2022 | 20 | Risk assessments | Corporate | Finance and Digital | Finance | Trust-wide | If the Trust does not significantly reduce its reliance upon a large number of temporary agency and locum staff in order to maintain the safety and continuity of clinical services, then it could have a substantial adverse impact on the ability to contain costs within the STP and Trust income envelope. | ULHT policy:<br>- Financial strategy<br>- Annual budget setting process<br>- Capital investment planning process, programme delivery & monitoring arrangements<br>- Key financial controls<br>- Financial management information<br><br>ULHT governance:<br>- Financial review meetings held monthly with each Division<br>- Divisional performance & accountability framework | Budget monitoring - temporary agency / locum staff | 26/10/2021 | Quite likely | High | High risk | 16 | Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment | Impact of COVID on services, staff and subsequently the cost base, including increased use of incentive rates, agency staff and high cost consumables and drugs. COVID cost forecasts included in financial planning to provide oversight, control and governance. | Moderate risk | 31/03/2022 | 31/03/2023 | 31/03/2022 |
| 2a. A modern and progressive workforce | 4671 | Service disruption | Paul Matthew | Claire Low | Workforce Strategy Group | 12/01/2022 | 16 | Workforce Metrics | Corporate | People and Organisational Development | Operational HR | Trust-wide | If a substantial proportion of the Trust's workforce tests positive for Covid-19, or are required to self-isolate in accordance with government guidelines, then it may not be possible to maintain some services resulting in significant short-term disruption affecting the care of a large number of patients | National policy:<br>- Government policy / guidelines on Covid testing and isolation<br><br>ULHT policy:<br>- Working Safely - Covid-19 Policy (Health & Safety Policy), approved July 2021<br>- Temporary staffing processes (bank / agency / locum)<br>- Emergency planning processes and workforce contingency arrangements for Major, Critical and Business Continuity Incidents<br><br>ULHT governance:<br>- Trust Board assurance through People & OD Committee / lead Workforce Strategy Group; Health & Safety Group<br>- Operational workforce governance arrangements | Frequency of workforce-related Major / Critical / Business Continuity incidents.<br>Staff absence rates (Covid-related).<br>Temporary staff usage rates. | 02/11/2021 | Quite likely | High | High risk | 16 | Occupational Health staff health checks & testing regime; Health and well-being offer to staff; Implementation of new Absence Management System (Empactis); use of bank / agency staff to fill rota vacancies; & operational command structure for Covid response. | Re-launch of staff health and well-being offer. Empactis launched with corporate staff in August and rolled out through to February 2020. Sick leave cover due to Covid is currently one of the top 4 reasons for use of temporary staff. | Moderate risk | 31/03/2022 | 31/03/2023 | 31/03/2022 |
| 1a. Deliver Harm Free Care | 4741 | Physical or psychological harm | Colin Farquharson | Aurora A Sanz Torres | Patient Safety Group | 13/01/2022 | 20 | Risk assessments | Clinical Support Services | Cancer Services CBU | Oncology | Trust-wide | Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung<br>Clinical oncology - head and neck, skin, upper GI (RT only) | Cancer services operational management processes & clinical governance arrangements<br>Medical staff recruitment processes<br>Agency / locum arrangements | Monitoring tumour site performance data | 26/11/2021 | Quite likely | High | High risk | 16 | Need to undertake a workforce review, oncology still a fragile service, continuing to work with HR to source consultants | Raised at Cancer delivery and performance (CCG present).<br>CSM spoken with Advanta re requirements. | Low risk | 31/03/2022 | 30/09/2022 | 31/03/2022 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2a. A modern and progressive workforce | 4780 | Service disruption | Simon Evans | Anita Parmar | Workforce Strategy Group | 16/01/2022 | 20 | Risk assessments | Medicine | Cardiovascular CBU | Stroke | | Risk of not being able to maintain effective stroke provision across ULHT due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels.<br>Stroke risk summit undertaken 2019.<br>Designated TRUST FRAGILE SERVICE | Ongoing recruitment activity to attract perm and locum resources. No success with overseas or local tertiary centre recruitment<br><br>Temporary Service change during COVID has consolidated to a single site hyper-acute service- approved by Executives in December 2019<br><br>Protocol in place for access to Thrombolysis Trolley on each site.<br><br>Acute Care Practitioners (ACP's) appointed and undergoing Masters Level Education and Training currently. Integrated into Cardiology ACP Workforce to ensure supported management & education. Business case being developed to secure funding for ACP workforce | monthly service review in place<br><br>primarily assessed on rota gaps / ability to maintian services across both sites | 12/11/2021 | Quite likely | High | High risk | 16 | Monthly review of provision in place<br><br>ongoing recruitment campaigns for vacancies<br><br>expansion of ACP workforce ( business case beig developed) to increase medical capacity to support consultant workforce | ongoing deficit in Stroke Consultant staffing. Recruitment to substantive posts unsuccessful. Only 2 substantive consultants out of 6 in post. National Market shortage<br>.Increased reliance on agency locums with significant financial impact<br>Increased pressure on current workforce as service demands have not reduced<br>ASR consultation adding pressure due to lack of uncertainty on outcome.<br>Increase in staff turnover due to service instability<br><br>daily ward round commitments amended to every other day to create capacity | Moderate risk | 31/03/2022 | 30/09/2022 | 31/03/2022 |
| 1a. Deliver Harm Free Care | 4648 | Physical or psychological harm | Simon Evans | Keiron Davey | Fire Safety Group | 15/12/2021 | 20 | Risk assessments | Corporate | Estates and Facilities | Fire and Security | Trust-wide | If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services. | National policy:<br>- Regulatory Reform (Fire Safety) Order 2005<br>- NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03)<br><br>ULH policy:<br>- Fire Policy (approved April 2019, due for review April 2022):<br># Personal Emergency Evacuation Plans (PEEPs), approved April 2017<br>- Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training<br>- Major Incident Plan<br>- Estates Planned Preventative Maintenance (PPM) programme<br><br>ULH governance:<br>- Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group<br>- All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity<br>- Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service<br>- Weekly fire safety team meetings concerning risk assessments and risk register<br>- Capital risk programme for fire<br>- Reporting of local fire safety incidents (Datix) generated through audit programme<br>- Authorising Engineer for Fire<br>- Health & Safety Committee & site-based H&S committees | Results of fire safety audits & risk assessments, currently indicate:<br>- Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements<br>- Fire risk assessments indicate lack of compartmentation within some sleeping risk areas<br>- Age of fire alarm systems at all 3 sites (beyond industry recommendations)<br>- No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites)<br>- Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation)<br><br>Reported fire safety incidents (including unwanted fire signals / false alarms).<br><br>Fire safety mandatory training compliance rates. | 02/02/2022 | Reasonably likely | Extreme | High risk | 15 | - Statutory Fire Safety Improvement Programme based upon risk.<br>- Trust-wide replacement programme for fire detectors.<br>- Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection.<br>- Capital investment programme for Fire Safety being implemented on the basis of risk.<br>- Fire safety protocols development and publication.<br>- Fire drills and evacuation training for staff.<br>- Fire Risk assessments being undertaken on basis of risk priority.<br>- Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit.<br>- Staff training including bespoke training for higher risk areas<br>- Planned preventative maintenance programme by Estates | New Fire Alarm installed within Lincoln maternity Tower Block. Automatic openable vents for smoke removal to be installed by End of Jan 2022.<br>Fire Risk assessments being undertaken on basis of risk priority.<br>Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit.<br>Damper installation within ICU, Rainforest, Lancaster, Ashby to be completed Mid December 2021. | Low risk | 31/03/2022 | 31/12/2022 | 30/06/2022 |

**Appendix A: Details of all active Very high and High risks (15-25)**

| Strategic Objective | ID | Risk Type | Manager | Handler | Lead Oversight Group | Opened | Rating (inherent) | Source of Risk | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a. Deliver Harm Free Care | 4654 | Physical or psychological harm | Simon Evans | Keiron Davey | Fire Safety Group | 06/01/2022 | 25 | Risk assessments | Corporate | Estates and Facilities | Fire and Security | | If flammable and / or explosive substances or large quantities of combustible products are stored inappropriately (i.e. Not in accordance with DSEAR or risk assessments), then it could lead to a major fire resulting in multiple casualties and extensive property damage | National policy:<br>- Regulatory Reform (Fire Safety) Order 2005<br>- NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03)<br>- Dangerous Substances & Explosive Atmospheres Regulations (2002)<br><br>ULH policy:<br>- Fire Policy (approved April 2019, due for review April 2022) & related procedures / protocols / records<br>- Fire & Security Team / Fire Safety Advisors<br>- Medical Gas Pipeline Systems and Medical Gas Cylinder Management Policy (July 2019)<br>- Control of Substances Hazardous to Health (CoSHH) Policy & Procedures (August 2021)<br><br>ULH governance:<br>- Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group<br>- All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity<br>- Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service<br>- Weekly fire safety team meetings concerning risk assessments and risk register<br>- Capital risk programme for fire<br>- Reporting of local fire safety incidents (Datix) generated through audit programme | Fire safety compliance audits, currently indicate:<br>- Acetylene storage adjacent to Pathology at Lincoln County (3rd party use, Path Links / NLAG).<br>- Large quantities of hand gel containing 70-80% ethanol, stored in quantities of 1,000l+ on all 3 sites.<br>- Large quantities of combustibles stored on all 3 sites (waste / cardboard).<br>- High levels of oxygen storage in clinical environments, due to higher oxygen use on wards using CPAP devices.<br><br>Fire safety incidents involving flammable / combustible materials. | 02/02/2022 | Reasonably likely | Extreme | High risk | 15 | Cease storage of acetylene cylinders.<br><br>Education & informing of local managers on safe storage and control measures for flammable and combustible materials (where storage is required).<br><br>Ceased decanting of ethanol products in restricted spaces (e.g. small cupboards). | Acetylene cylinders issue - Estates have ceased all internal use of acetylene; area adjacent to Path Links - regional service provision being withdrawn by NLAG to allow removal of cylinder.<br><br>CoSHH signage installed in all affected areas as indicated by risk assessments. | Low risk | 31/03/2022 | 31/03/2023 | 30/06/2022 |
| 2c. Well led services | 4659 | Reputation | Paul Matthew | Jayne Warner | | 10/01/2022 | 15 | Aggregation of Incident/Claims & Complaints/PALS | Corporate | Trust Headquarters | Corporate Secretary | Trust-wide | If there is under-reporting of information governance incidents, or a lack of learning from incident investigations, then it is difficult for the Trust to make an accurate assessment of the extent of risk exposure and put in place effective mitigation, resulting in an increased likelihood of similar incidents occurring in the future | National policy:<br>- NHS Digital Data Security & Protection Toolkit<br><br>ULHT policy:<br>- Information Governance Policy (approved May 2018, due for review May 2021) & supporting appendices<br>- Incident Management Policy and Procedures (approved September 2021, due for review September 2024)<br><br>ULHT governance:<br>- Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group<br>- Senior Information Risk Owner (SIRO) / Caldicott Guardian / Data Protection Officer (DPO) / Chief Information Officer (CIO) roles | Frequency, type and severity of IG incidents<br>Internal audit of IG incident reporting processes | 01/11/2021 | Extremely likely | Medium | High risk | 15 | To identify a means of evaluating the IG incident reporting culture, including the possibility of conducting a regular staff survey to measure understanding of and confidence in the reporting and investigation process & enhancements to the incident report form & trackers on Datix. | Datix incident form requires review to inform configuration for upgrade to Datix Cloud IQ in 2022. | Low risk | 31/03/2022 | 31/12/2022 | 31/03/2022 |
| 3a. A modern, clean and fit for purpose environment | 4858 | Service disruption | Michael Parkhill | Stuart Whitehead | Water Safety Group | 10/02/2022 | 25 | Risk assessments | Corporate | Estates and Facilities | Estates | Pilgrim Hospital, Boston | If there is a critical failure of the water supply to Pilgrim Hospital then it could lead to unplanned closure of all or part of the hospital, resulting in significant diruption to multiple services affecting a large number of patients, visitors and staff | Estates Infrastructure and Environment Committee (EIEC).<br>Estates risk governance & compliance monitoring process.<br>Emergency Planning Group / Major Incident Plan and departmental business continuity plans. | Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site. | 10/02/2022 | Reasonably likely | Extreme | High risk | 15 | Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital.<br>Install additional supply to provide resilience. | Scheme of work and design currently being produced. | | 30/10/2020 | 31/03/2023 | 30/06/2022 |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *1 March 2022* |
| Item Number | *Item 13.2* |
| *Board Assurance Framework (BAF) 2021/22* | |
| Accountable Director | *Andrew Morgan Chief Executive* |
| Presented by | *Jayne Warner, Trust Secretary* |
| Author(s) | *Karen Willey, Deputy Trust Secretary* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *Objectives within BAF referenced to Risk Register* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | • *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* |
| | |
| | |

## Executive Summary

The relevant objectives of the 2021/22 BAF were presented to all Committees during January and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees.

The following assurance ratings have been identified:

| Objective | | Rating at start of 2021/20 | Previous month (December) | Assurance Rating (January) |
|---|---|---|---|---|
| 1a | Deliver harm free care | Red | Amber | Amber |
| 1b | Improve patient experience | Red | Amber | Amber |
| 1c | Improve clinical outcomes | Red | Amber | Amber |
| 2a | A modern and progressive workforce | Amber | Red | Red |
| 2b | Making ULHT the best place to work | Red | Red | Red |
| 2c | Well led services | Amber | Amber | Amber |
| 3a | A modern, clean and fit for purpose environment | Red | Amber | Amber |
| 3b | Efficient use of resources | Green | Amber | Amber |
| 3c | Enhanced data and digital capability | Amber | Amber | Amber |
| 4a | Establish new evidence based models of care | Red | Amber | Amber |
| 4b | To become a University Hospitals Teaching Trust | Red | Red | Red |

# United Lincolnshire Hospitals NHS Trust
# Board Assurance Framework (BAF) 2021/22 - January 2022

| Strategic Objective | Board Committee |
|---|---|
| Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities | Quality Governance Committee |
| People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT | People and Organisational Development Committee |
| Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate | Finance, Performance and Estates Committee |
| Partners: To implement integrated models of care with our **partners** to improve Lincolnshire's health and well-being | Trust Board |

| Assurance Rating Key: | |
|---|---|
| **Red** | Effective controls may not be in place and/or appropriate assurances are not available to the Board |
| **Amber** | Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient |
| **Green** | Effective controls are definitely in place and Board are satisfied that appropriate assurances are available |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SO1** | **To deliver high quality, safe and responsive patient services, shaped by best practice and our communities** | | | | | | | | | | | | |
| | | | | | | Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG) | Human Factors training delayed due to Covid-19<br>Definition of Safety Culture Ambition<br><br>Operational pressures have meant that meetings have not taken place. | External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition to go to the Executive team in February. Online Human Factors training commenced December 2021 and monitored through ESR.<br><br>Bite size Human Factors Teams sessions were piloted in December to maintain training opportunities.<br><br>Project lead continues to review project and complete highlight reports as appropriate | Safety Culture Surveys Action plans from focus groups and Pascal survey findings.<br><br>Monthly update reports to the Patient Safety Group and upwardly reported to QGC Theatre Safety Group reporting progress against a Quality Improvement plan to PSG.<br>"It's Safe to Say" Campaign launch by March 2022. | | Where possible, safety conversations have been taking place with staff. "Safe to Say" Campaign focus groups have been continuing with formal launch planned for March 2022. | | |
| | | | | | | Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG) | Operational pressures have meant that QGC meeting has been reduced. | All papers have been considered and discussed by exception.<br><br>Assurances provided to QGC include feedback from gold and relevant cells as outlined below. | Upward reports from QGC sub-groups<br><br>6 month review of sub-group function | | | | |
| | | | | | | Effective sub-group structure and reporting to QGC in place (CG) | Due to operational pressures, not all sub-groups have met and others have had a reduced agenda. | All papers have either been discussed by exception or a chair/vice chair upward report completed following review of the papers.<br><br>Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate.<br><br>Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell. | Sub-Group upward reports to QGC | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG) | Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated. | Planned programme of IPC policy development and update in line with Hygiene Code requirements. | IPC policies have been reviewed, written and ratified by the IPCG. IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamination and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code | Some aspects of reporting require further development. | Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a | Deliver Harm Free Care | Director of Nursing/Medical Director | Failure to manage demand safely<br><br>Failure to provide safe care<br><br>Failure to provide timely care<br><br>Failure to use medical devices and equipment safely<br><br>Failure to use medicines safely<br><br>Failure to control the spread of infections<br><br>Failure to safeguard vulnerable adults and children<br><br>Failure to manage blood and blood products safely<br><br>Failure to manage radiation safely<br><br>Failure to deliver planned improvements to quality and safety of care | 4558<br>4480<br>4142<br>4353<br>4146<br>4556<br>4481 | CQC Safe | Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG).<br><br>Infection Prevention and Control BAF in place and reviewed monthly (IPCG) | Non-compliance with some aspects of the Hygiene Code. | Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC.<br>IPC policies have been updated / developed / written in line with the timetable.<br>•Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course.<br>• Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG<br>• Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes. | IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation | Some aspects of reporting require further development. | Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings. | Quality Governance Committee | **Amber** |
| | | | | | | Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG (PSG) | Gaps in the number of structured judgement reviews undertaken<br><br>Impact of Covid-19 on coding triangles | Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Mortality team to the Divisions. | National Clinical Audits<br><br>Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback | Due to national issues, Dr Foster data has not been available. | Local data sources are used where possible. | | |
| | | | | | | Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG) | Clinical harm review processes not all documented & aligned with incident reporting Recognition of a skills gap for investigations at different levels of the organisation | Implementation of a Clinical Harm Delivery Group reporting into the Clinical Harm Oversight Group.<br><br>Appointment of a Clinical Harm and Mortality Manager<br><br>Investigation training will be addressed as part of the implementation of the PSIRF and National Patient Safety Strategy. | Incident Management Report<br>Quarterly harm report to PSG<br>Bi-weekly executive level Serious Incident meeting<br>Learning to Improve Newsletters<br>Patient Safety Briefings<br>Divisional Integrated Governance reports | PSG currently do not receive assurance reports from the Divisions as their governance process reports to their PRM | Divisions present focussed pieces of work to PSG on an ad hoc basis as requested by the group. There is strong Divisional representation at PSG each month. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Failure to provide a safe hospital environment<br><br>Failure to maintain the integrity and availability of patient information<br><br>Failure to prevent Nosocomial spread of Covid-19 | | | Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG) | Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is now being made within all four Divisions. Operational pressures continues to impact on delivery. | Individual Divisional meetings now in place; quarterly reporting to PSG<br><br>Additional support provided to medicine from the Safety Culture Team. | Audit of compliance | Audit of compliance not currently in place | Review will occur through the Divisional meetings with quarterly reporting to PSG.<br><br>Links now in place with the Clinical Audit team to progress. | | |
| | | | | | | Medicines Quality Group in place with a focus on reducing medication errors<br><br>Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit | Lack of e-prescribing leading to increase in patient safety incidents due to medication errors<br><br>COVID / operational pressures have impacted on the pace and progress of delivery of the agreed improvement actions | Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes.<br><br>Medical Director led Medicines Management Task & Finish Group convened to ensure the required pace and progress of delivery of the Improving the Safety of Medicines Management IIP. Divisional representation at the Task & Finish Group confirmed as Divisional Clinical Director or Divisional Nurse. Action / Delivery Group also in place and meeting fortnightly to progress actions and reporting to the Task & Finish Group. | Upward Report from the Medicines Quality Group to QGC<br><br>Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group | Medicines Quality Group have not been receiving reports regarding progress with the medicines management IIP; there has been a lack of Divisional attendance at the Medicines Quality Group | Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place | | |
| | | | | | | Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. (MNOG) | Recent increase in incidents.<br><br>Issues with the environment.<br><br>Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions. | External independent input in to SI process.<br><br>Thematic review of SIs and complaints undertaken - recommendations to be progressed as part of the Maternity & Neonatal Improvement Plan.<br><br>Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered.<br><br>Issues with the Medway system being progressed at local and system level. | Monthly Maternity & Neonatal Assurance Report.<br><br>Maternity & Neonatal Improvement Plan.<br><br>Executive & NED Safety Champions in place and work closely with local Safety Champions.<br><br>NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. | Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed. | Monitoring of compliance against trajectory for recovery training will occur through MNOG. | | |
| | | | | | | Appropriate policies and procedures in place to ensure medical device safety (PSG) | Lack of assurance regarding staff training on the medical devices | Implementation of a central database of medical device user training records | | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. (Ensuring early detection and treatment of deteriorating patients) (PSG) | Number of incidents occurring regarding lack of recognition of the deteriorating patient<br><br>Maturity of some of the sub-groups of DPG not yet realised<br><br>Observation policy has now been reviewed and is out for approval. | Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA<br><br>Observation policy ready to go to next NMAAF | Audit of response to triage, NEWS, MEWS and PEWS<br>Sepsis Six compliance data<br>Audit of compliance for all cardiac arrests<br>Upward reports into DPG from all areas | | | | |
| | | | | | | Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG) | New funding needed to continue restraint training delivery.<br>Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT | Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues | Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group | NO active Restraint training available within the trust | Paper to CRIG ( End November) regarding funding for new Restraint training proposal<br>Datix being monitored by safeguarding team to ensure review of any restraint incidents | | |
| | | | | | | Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG) | Gap in current policy identified meaning that not all responses from divisions are received / recorded. | Task and Finish Group set up to review processes and improve compliance. This has led to improvement in compliance, however further work still required.<br><br>Any relevant alerts are also discussed at gold as appropriate. | Quarterly report to PSG with escalation to QGC as necessary.<br><br>Compliance included in the integrated governance report for Divisions. | | | | |
| | | | | | | Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF) | | | | | | | |
| | | | | | | Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG) | Training provision for Divisional Clinical Governance Leads<br>No formal job description of roles and responsibilities for Clinical Governance Leads | Role based TNA being devised for Clinical Governance leads<br><br>Draft role description for a Clinical Governance Lead developed for consultation. | Minutes of Divisional Clinical Governance meetings with upward reporting within the Division<br>Divisional Integrated Governance Report<br>Support Offer in place from the central CG team for the Divisions | Minutes demonstrate some Divisional Clinical Governance meetings need strengthening | Implementation of standard ToR, agendas and reporting | | |
| | | | | | | Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG) | | | Monthly report to QGC and Trust Board on Must and Should dos | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
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| 1b | Improve patient experience | Director of Nursing | Failure to provide a caring, compassionate service to patients and their families<br><br>Failure to provide a suitable quality of hospital environment | 3688<br>4081 | CQC Caring | Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG) | Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity<br><br>Meeting stood down due to operational pressures. | The group meets monthly, has developed a work reporting plan<br><br>Papers reviewed and Chair's report provided.<br><br>Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate.<br><br>Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell. | Upward reports to QGC monthly and responds to feedback<br><br>Review of ToR in July 2021<br>Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group<br><br>Patient Experience Group upward report | Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG. | Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21 | Quality Governance Committee | **Amber** |
| | | | | | | Patient Experience & Carer plan 2019-2023 (PEG) | Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review. | Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level.<br><br>Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG | Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports. | Limited assurance until the plan is reviewed. | Plan is being reviewed with a draft final date of end of January 22. | | |
| | | | | | | Quality Accreditation and assurance programme which includes section on patient experience. (PEG) | Lack of alignment of findings in accreditation data to patient experience plans.<br><br>Ward / Dept review visits paused due to operational pressures | Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required.<br>Matrons audits continue to take place.<br><br>Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate. | Reports to PEG and upwardly to QGC | Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue. | Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can in-reach to provide support. | | |
| | | | | | | Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG) | Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement. | Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging<br>Sensory Loss group upwardly reports to Patient Panel. | Upward reports and minutes to the Patient Experience Group<br><br>IIP reporting to Support & Challenge group. | Diversity of patient engagement and involvement. | CCG colleagues exploring development of a Health Inequalities cell to combine efforts in reaching out. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert reference group established, Cancer Board recruiting in the New Year and discussions to continue with Gastroenterology & CYP (Expert Families) | | |

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| | | | | | | Care after death / last offices Procedure & Guidelines<br>Sharing information with relatives<br>Visiting Procedure<br>Patient information (PEG) | Inconsistency in applying end of life visiting exceptions. | Swan resource boxes distributed to all areas<br><br>Wedding boxes created for a number of key wards and within Chaplaincy services.<br>Exceptions guidance re-issued.<br>Monitor through complaints & PALs. | Report to PEG through complaints & PALs reports; upward reports from Visiting Review working group. | Visiting experience section within complaints & PALs reports. | Complaints/PALs reports to include visiting concerns; divisional assurance reports to include visiting related issues. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL. | | |
| | | | | | | Inclusion Strategy in place (PEG) | Lack of diversity in patient feedback and engagement | Equality, Diversity and Inclusion Lead is member of Patient Experience Group. | EDI 1/4rly report to PEG; | EDI Reports not being received by PEG | Head of Pt Experience to discuss with EDI lead to agree a way forward. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project. | | |
| | | | | | | Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG) | PLACE Lite Process needs to be embedded as Business as Usual | PLACE Lite visits are being scheduled for the year across the organisation. | PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC | National PLACE programme currently paused due to pandemic; | PLACE Lite continues & reports to PEG. | | |
| 1c | Improve clinical outcomes | Medical Director | Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes | 4558 | CQC Responsive CQC Effective | Clinical Effectiveness Group in place as a sub group of QGC and meets monthly (CEG).<br><br>CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups.<br><br>Quality of reporting into CEG has improved and is increasingly robust. | Pandemic and operational pressures has meant that meetings have been sporadic. When meetings occur attendance has generally improved. Control gap to remain in place until regular CEG meetings are back in operation. | If papers are still received and meeting stood down, chair and Vice Chair will review papers and produce Chairs report for QGC. Where papers have not been received, Chair and Vice Chair will review work programme and identify priority papers to be produced, standing all others down.<br><br>Any risks to quality and safety are discussed at the relevant cell meeting, e.g., quality cell and issues escalated to gold as appropriate.<br><br>Quality Impact Assessments undertaken as part of the response to operational | Effective upward reporting to QGC | Upward reporting may not be comprehensive due to reduction in meetings. | Chair and Vice Chair will ensure oversight of priority areas through the review of agenda items and required papers. | Quality Governance Committee | **Amber** |
| | | | | | | Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG) | GIRFT activity continues to be reduced nationally due to the pandemic. | Quarterly reports to Clinical Effectiveness Group<br><br>GIRFT team in place to support divisions and ensure that appropriate activity takes place. | Upward reports to QGC and its sub-groups<br><br>KPIs in the integrated governance report<br><br>Process in place for feedback to divisions | Current reporting has tended to focus on process rather than improved outcomes. | Request from CEG for future reports to show improved outcomes as a result of GIRFT activity. | | |
| | | | | | | Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC (CEG) | There are outstanding actions from local audits<br><br>Due to operational pressures, quoracy has been an issue. | Audit Leads present compliance with their local audit plan and actions.<br>Support being provided from central team to close outstanding overdue actions<br>Job role description for Clinical Audit Leads has been developed and workshops planned with leads, led by the Medical Director. | Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions | Clinical Audit Leads may not attend to present their updates meaning that reporting to QGC is not as up to date as expected. | Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate Meeting to take place with Medical Director and Audit Leads to discuss role and expectations, however attendance has been impacted by operational pressures. | | |

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| | | | | | | National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG) | Due to operational pressures, clinicians have been unable to collect all data for national audits. | In agreement with the Medical Director, it was agreed that audit team support would be directed at national audits for the foreseeable future, leading to reduced support to local audit. | Reports from the National Audit Programmes including outlier status where identified as such<br><br>Relevant internal audit reports<br>Reports identify where practice has improved but also where it has not improved. | None identified | None identified | | |
| | | | | | | Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG) | There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines. | Process in place for escalation if required within the Clinical Divisions. | Reports on compliance with NICE / Tas demonstrating improved compliance. | None identified | None identified | | |
| | | | | | | Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG) | None identified. | None identified. | Quarterly reports to CEG and upwardly reported to QGC | Business Units not sighted on their performance due to national reporting being stood down during COVID-19 | National reports to be presented at Governance Meetings once produced | | |
| | | | | | | Process in place for implementing requirements of the CQUIN scheme. | Currently stood down | Currently stood down | Currently stood down | Currently stood down | Currently stood down | | |
| | | | | | | Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG) | Staff may not access emails to review newsletters | Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust. | | | | | |
| **SO2** | **To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT** | | | | | | | | | | | | |
| | | | | | | NHS people plan & system people plan & five themes:-<br>- Looking after our people<br>- Belonging in the NHS<br>- New ways of working & delivering care<br>- Growing for the future<br>- Leadership and Lifelong Learning (from 2022/23) | Awaiting sign off of system people plan (delivery plan reviewed and objectives agreed annually in Q4) | System People Team<br>System Workforce Cell | System PP - Each 'pillar assigned system lead<br>Progress/assurance reported to People Board (quarterly)<br><br>Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan<br><br>Setting priorities 22-23 - away day (18/03) | | | | |
| | | | | | | Workforce planning and workforce plans | Overall vacancy rate declining but increasing for clinical roles. | IIP Project - Embed robust workforce planning and development of new roles | Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division. | Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues. | Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment. | | |

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| 2a | A modern and progressive workforce | Director of People and Organisational Development | Vacancy rates rises<br><br>Turnover increases<br><br>Sickness absence rises<br><br>Under-investment in education & learning<br><br>Failure to engage organisation in continuous improvement<br><br>Failure to transform the medical & nursing workforce | 4362 | CQC Safe<br>CQC Responsive<br>CQC Effective | Recruitment to agreed roles - plan for every post | | Pipeline report shows future vacancy position<br><br>International nurse recruitment & cohort recruitment | Internal Audit - Recruitment follow up<br><br>Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff | | | People and Organisational Development Committee | **Red** |
| | | | | | | Focus on retention of staff - creating positive working environments<br><br>System retention role secured (8a) appointment pending | IIP projects on hold | IIP Projects<br>Appraisal - deep dive planned Dec21<br>Mandatory training - currently in scope<br>Talent management - held<br><br>National Talent Management Framework launched, Lincs system identified as pilot site for launch | Regional Midlands Talent Board<br><br>Model Employer ambition<br>appraisal/mandatory training compliance | Appraisal and training compliance levels not at expected level<br><br>Appraisal Improvement Plan (Mar'22) to address low compliance / improve quality of conversations and process | | | |
| | | | | | | Embed continuous improvement methodology across the Trust | | Training in continuous improvement for staff | | | | | |
| | | | | | | Reducing sickness absence | Sickness absence rate higher than average | Embedding of AMS | Sickness/absence data<br><br>Turnover rates<br><br>Vacancy rates | Various reports (Sitrep, Gold, STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under. | The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting. | | |
| | | | | | | Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation | IIP projects in early stage of delivery | IIP projects - education and learning<br><br>Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education | Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year | | | | |
| | | | | | | NHS People Plan & System People Plan & five themes:-<br>- Looking after our people<br>- Belonging in the NHS<br>- New ways of working & delivering care<br>Growing for the future | Awaiting sign off of system people plan<br><br>Delivery of IIP projects in early stage of delivery | People Plan - in draft<br><br>System EDI Strategy underway<br><br>5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning) | | | | | |
| | | | | | | Reset and alignment of Trust values & staff charter (with safe culture)<br>Resetting ULH Culture & Leadership | Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action | Leading Together Forum - regular bi-monthly leadership event<br><br>Delivery Plan and actions to be confirmed further to results of Leadership Survey | Culture and Leadership Programme Group upward report | Delivery of agreed output | Improved function of group and reporting to be in place for November report | | |

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| 2b | Making ULHT the best place to work | Director of People and Organisational Development | Further decline in demand<br><br>Weak structure (to support delivery)<br><br>Lack of resource and expertise<br><br>Failure to address examples bullying & poor behaviour<br><br>Lack of investment or engagement in leadership & management training<br><br>Perceived lack of listening to staff voice<br><br>Under-investing in staff engagement with wellbeing programme<br><br>Failure to respond to GMC survey<br><br>Ineffectiveness of key roles<br><br>Staff networks not strong | 4083 | CQC Well Led | Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc. | | Reviewing the way in which we communicate with staff and involve them in shaping our plans | Staff survey feedback - engagement score, recommend as place to work | | | People and Organisational Development Committee | **Red** |
| | | | | | | Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) | | Continue to implement new leadership programme e.g. training on well-being conversations | Pulse surveys - " Have your say"<br><br>Number of staff attending leadership courses | | Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities<br>NB. L&M apprenticeship on going | | |
| | | | | | | Perception of fairness and equity in the way staff are treated | EDI Group (report to PODC) live from Dec 2021 | IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation<br><br>EDI Group membership reset - to ensure representation and coverage | Council of Staff Networks<br><br>Internal Audit - Equality, Diversity and Inclusion<br><br>NHS NNSS | WRES/ WDES/MRES | Currently developing WRES and WDES action plans and internal audit to deliver the first actions for the 31.12.21<br><br>WRES/WDES and Internal Audit actions being monitored through Committee | | |
| | | | | | | Staff networks | Some staff networks stronger than others | Continued work to embed the networks and provide them with effective support | Protect our staff from bullying, violence and harassment - measure through National Staff Survey | | Governance for EDI Recruitment process for SN Chair/VC - Feb'22 | | |
| | | | | | | Demonstrate that we care and are concerned about staff health and wellbeing | | | System Health & Wellbeing Board<br>Linc People Board | OH KPIS to be agreed (for reporting to PODC)<br><br>System Hub activity<br><br>Wellbeing activity (upward report to PODC) | Commence reporting from 2022 | | |
| | | | | | | Focus on junior doctor experience key roles:-<br>- Freedom to speak up Guardian<br>- Guardian of safe working<br>- Well-being Guardian | | Junior doctor forum | Dedicated resource in place for GOSW and FTSUG.<br><br>Trust Chair has taken role of Well being Guardian.<br><br>Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee.<br><br>GOSW and FTSUG invited in person to Committee | | Junior Dr Survey results (alignment with NNSS21 findings) | | |

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| 2c | Well led services | Chief Executive | Current risk register configuration not fully reflective of organisations risk profile<br><br>Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose | 4277<br>4389 | CQC<br>Well Lead | Delivery of risk management training programmes 4 sessions during Oct / Nov 21<br><br>Risk Register Confirm and Challenge Group ToRs<br><br>Upgrade to datix system<br><br>Full Risk Register review | Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures | Consider at January meeting | Third party assessment of well led domains<br><br>Internal Audit assessments<br><br>Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.<br><br>Completeness of risk registers<br><br>Annual Governance Statement | | | Audit Committee | **Amber** |
| | | | | | | Shared Decision making framework | | | Number of Shared decision making councils in place | 8 councils established. Target for 2021 was 6 | | | |
| | | | | | | Implementing a robust policy management system<br><br>Additional resource identified for policy management post<br><br>Reports on status by division and Directorate<br><br>Updated Policy on Policies Published<br><br>Guidance on intranet re policy management reviewed and updated | Move of policies in to sharepoint reliant on progress with Trust intranet. Timeline delayed through Covid<br><br>Review of Divisional policy status reports not progressed due to covid pressures | Review of document management processes<br><br>New document management system - SharePoint<br><br>Reports generated form existing system<br><br>All policies aligned to division and directorates<br><br>Single process for all polices clinical and corporate | Fortnightly ELT report monitoring actions.<br><br>Quarterly report to Audit Committee including data on in date policies<br><br>CQC Report - Well Led Domain | | | | |
| | | | | | | Ensure system alignment with improvement activity | | | | | | | |

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| **SO3** | **To ensure that services are sustainable, supported by technology and delivered from an improved estate** | | | | | | | | | | | | |
| 3a | A modern, clean and fit for purpose environment | Chief Operating Officer | Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue) | 3720<br>3520<br>3688<br>4403<br>3690 | CQC Safe | Develop business cases to demonstrate capital requirement in line with Estates Strategy | Business Cases require level of capital development that cannot be rectified in any single year. | Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates Strategy<br><br>Estates Strategy sets out a framework of responding to issues and management of risk.<br><br>Capital Delivery Group has oversight of the delivery of key capital schemes. | Capital Delivery Group Highlight Reports<br><br>Compliance report to Finance, Performance and Estates Committee<br><br>Updates on progress above linked to the estates strategy. | Infrastructure case has tackled £9.6M of the overall £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year | Estates improvement and Estates Group review compliance and key statutory areas.<br><br>Progress against Estates Strategy/Delivery Plan and IIP<br><br>Delivery of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure.<br><br>Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. | Finance, Performance and Estates Committee | **Amber** |
| | | | | | | Continual improvement towards meeting PLACE assessment outcomes | PLACE assessments have been suspended and delayed for a period during COVID | Use of PLACE Light assessments and other intelligence reports. | PLACE Light Assessments | PLACE/Light do not provide as deep an assurance review as PLACE with limited input. | Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response. | | |
| | | | | | | Review and improve the quality and value for money of Facility services including catering and housekeeping | Value for Money schemes have been delayed during COVID | | MiC4C cleaning inspections<br><br>Staff and user surveys<br><br>6 Facet Surveys | 6 Facet Survey are not recent and require updating.<br><br>6 facet survey review commencing in Jan 22. Specification drafted for full 6 facet survey with tender process to start in Jan 22 | IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not.<br>The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.<br><br>Review of 6 Facet Surveys will commence as part of HIP Bid (Referral in Estates Strategy) | | |

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| | | | | | | Continued progress on improving infrastructure to meet statutory Health and Safety compliance | H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation | Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.<br><br>Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Officer/Director of Estates and Facilities. Upward reporting to Finance, Performance and Estates Committee<br><br>Med gas, Critical ventilation, Water safety group, electrical safety group, medical gas group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation. | Reports from authorised engineers<br><br>Response times to urgent estates requests<br><br>Estates led condition inspections of the environment<br><br>Response times for reactive estates repair requests<br><br>Progress towards removal of enforcement notices<br><br>Health and Safety Committee upward report | | | | |
| 3b | Efficient use of our resources | Director of Finance and Digital | Efficiency schemes do not cover extent of savings required.<br><br>Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at substantially increased cost<br><br>Failure to achieve recruitment targets increases workforce costs<br><br>Unplanned expenditure (as a result of unforeseen events and operational pressures in H2)<br><br>National requirements and Trust response to Restoration | 4382<br>4383<br>4384 | CQC Well Led<br><br>CQC Use of Resources | Delivering £12.4m CIP programme in 21/22 | Operational ownership and delivery of efficiency schemes | Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans. | Delivery of revised CIP<br><br>Achievement of both ULHT and STP financial Plan | Ability of clinical and operational colleagues to engage due to service pressures. | Gaps are being reviewed monthly with Divisions through FRMs | Finance, Performance and Estates Committee | **Amber** |
| | | | | | | Delivering financial plan aligned to the Trust and Lincolnshire System financial plan / forecast for 2021/22 | Urgent and unplanned Restore and Covid related costs | Lincolnshire STP financial plan<br><br>Lincolnshire System collective management of financial risk<br><br>Savings plan, monitoring and reporting. | Delivery of the Trust and System financial plans for 21/22 | Granular detailed CIP implementation plans. | Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group. | | |
| | | | | | | Reduce agency spend by 25% from the 19/20 baseline as per IIP priority | Reliance on temporary staff to maintain services, at increased cost | Centralised agency & bank team | Delivery of the IIP 25% agency reduction target. | Granular detailed plan for every post plans. | Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC | | |
| | | | | | | Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q1 22/23 | Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 and 21/22 cost collection exercise being reduced related to COVID. | Refresh of internal costing and SLR information for roll out in the Trust from Q1 22/23. Supported by refreshed costing strategy. | SLR and PLICs information | Ability of clinical and operational colleagues to engage due to service pressures. | Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP | | |
| | | | | | | Implementing the CQC Use of Resources Report recommendations | Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID. | Refresh of internal costing and SLR information for roll out in the Trust from Q1 22/23. Supported by refreshed costing strategy. | SLR and PLICs information | Ability of clinical and operational colleagues to engage due to service pressures. | Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports. | | |

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| | | | and Recovery and third COVID wave. | | | Working with system partners to deliver the Lincolnshire financial plan for H1 and H2 21/22 and 22/23. | Urgent and unplanned Restore and Covid related costs | Lincolnshire System financial plan<br><br>Lincolnshire System collective management of financial risk<br><br>Savings plan, monitoring and reporting. | Delivery of the Trust and System financial plans for 21/22. | Granular detailed CIP implementation plans. | Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group. | | |
| | | | | | | Detailed workforce and activity modelling aligned to resource requirements to support Trust and System Restoration. | Impact of Wave 3 and 4 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan. | Trust Restoration plan and through Restoration and Recovery daily Trust meetings.<br><br>Lincolnshire System activity plan<br><br>Lincolnshire System collective management of restoration of planned care activity | Reporting against the Trust and System Restoration plan and national Trajectories. | | | | |
| 3c | Enhanced data and digital capability | Director of Finance and Digital | Tender for Electronic Health Record is delayed or unsuccessful<br><br>Major Cyber Security Attack<br><br>Critical Infrastructure failure | 4177<br>4179<br>4180<br>4182<br>4481 | CQC Responsive | Improve utilisation of the Care Portal with increased availability of information - | Cyber Security and enhancing core infrastructure to ensure network resilience.<br><br>. | Digital Services Steering Group<br><br>Digital Hospital Group<br><br>Operational Excellence Programme<br><br>Outpatient Redesign Group | Number of staff using care portal | Schemes paused to enable tactical response to Covid-19. Progress now being made again.<br><br>. | Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces.<br><br>EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal. | Finance, Performance and Estates Committee | **Amber** |
| | | | | | | Commence implementation of the electronic health record | Roll-out IT equipment to enable agile user base<br><br>Redeployment of staff as a result of Trust response to Covid-19. | Digital Services Steering Group<br><br>Digital Hospital Group<br><br>e-HR Programme Steering Group | Delivery of 20/21 e HR plan | | EPR OBC to be approved by NHSE/I<br><br>OBC requirements being worked through with NHSE/I | | |
| | | | | | | Undertake review of business intelligence platform to better support decision making | | | Delivering improved information and reports<br><br>Implement a refreshed IPR | IPR refresh being completed in July 2021 for June 2021 reporting. | Steady implementation of PowerBI through specific bespoke dashboards and requests. | | |
| | | | | | | Implement robotic process automation | Lack of expert knowledge available within and to the Trust (experts in short supply nationally)<br><br>Business case development on hold due to capacity issues | | | | | | |
| | | | | | | Improve end user utilisation of electronic systems | Business case for additional staff under development | | | | | | |
| | | | | | | Complete roll out of Data Quality kite mark | | | Ensuring every IPR metric has an associated Data Quality Kite Mark | Information improvements aligned to reporting needs of Covid-19. | A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SO4** | **To implement integrated models of care with our partners to improve Lincolnshire's health and well-being** | | | | | | | | | | | | |
| 4a | Establish new evidence based models of care | Director of Improvement and Integration | Failure of specialty teams to design and adopt new pathways of care<br><br>Failure to support system working<br><br>Failure to design and implement improvement methodology | | CQC Caring<br>CQC Responsive<br>CQC Well Led | Supporting the implementation of new models of care across a range of specialties | Specialty strategies not in place | Requirement for specialty strategies now part of strategy deployment and will commence Q1 22/23 | Reports<br>-ELT / TLT<br>-Committees<br>-Board<br>-System<br>-Region | Impact of specialty changes | New performance framework will address and the upward report regarding IIP | Finance, Performance and Estates Committee | **Amber** |
| | | | | | | Improvement programmes for cancer, outpatients and urgent care in progress | Recovery post COVID and risk of further waves<br><br>Urgent Care Transformation team not yet established | Outpatient Improvement Group<br><br>Cancer Improvement Board<br><br>Urgent and Emergency Care Board. | Improvement against strategic metrics<br><br>% of patients in Emergency Department >12 hrs (Total Time)<br><br>Delivery against 62 day combined standard<br><br>Urgent Treatment (P2) turnaround time<br><br>Deliver outpatient activity non face to face | | Reporting via FPEC | | |
| | | | | | | Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans. | Engagement exercise required to seek further views regarding the proposed revised model | CYP Group re-established | Board report July 2021 | | | | |
| | | | | | | Urology Transformational change programme - complete | | | Board report July 2021 | | | | |
| | | | | | | Pre op Assessment Modernisation | Engagement exercise required to seek further views regarding the proposed revised model | Pre assessment project group | IIP report to FPEC - monthly | | | | |
| | | | | | | Support Creation of ICS - Lincolnshire designation July 2022 | Delay to review and adoption of legislation | Weekly ICS meetings<br><br>Provider Collaborative Steering Group | SLB reports and upward reports by CEO / Chair | | | | |
| | | | | | | Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team | Awaiting outcome of themes from consultation | Attendance at Consultation Steering Group once in place | SLB reports and upward reports by CEO / Chair | | | | |
| | | | | | | Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress | Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability. | ELT/TLT oversight<br><br>Board / system reporting | Weekly ELT updates<br>Monthly TLT updates<br>Quarterly board reports<br>Quarterly board development sessions | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4b | To become a University Hospitals Teaching Trust | Director of Improvement and Integration | Failure to develop research and innovation programme<br><br>Failure to develop relationship with university of Lincoln and University of Nottingham<br><br>Failure to become member of university hospital association | | CQC Caring<br>CQC Responsive<br>CQC Well Led | University Hospital Teaching Trust Status<br>Developing a business case to support the case for change | | The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC. | Progress with application for University Hospital Trust status | | R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department. | People and Organisational Development Committee | **Red** |
| | | | | | | Increasing the number of Clinical Academic posts | With the criteria change in June 2021 we are no require to demonstrated increased clinical academics and RCF funding | Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions. | Numbers of Clinical Academic posts<br><br>RD&I Strategy and implementation plan agreed by Trust Board | | | | |
| | | | | | | Improve the training environment for students | Ensuring that, due to the revised UHA guidance we are able to offer the facilities required for a functioning clinical academic department | The gaps are being managed through the revision of the library and training facilities.<br><br>This will meet the criteria within the UHA guidance | GMC training survey<br><br>Stock check against checklist<br><br>Internal Audit - Education Funding | | | | |
| | | | | | | Developing an MOU with the University of Lincoln | This is now a requirement of the UHA guidance. Historically this has not been required. | Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy.<br><br>MOU will be developed once the Joint Strategy has been signed off. | RD&I Strategy and implementation plan agreed by Trust Board | | | | |
| | | | | | | Develop a portfolio of evidence to apply for membership to the University Hospitals Association | | Portfolio of evidence is being captured and is available on the shared drive | | | | | |

**The BAF management process**

The Trust Board has assigned each strategic objective of the 2021/22 Strategy to a lead assurance Committee. Outcomes under each strategic objective are aligned to a lead Committee or reserved for review by the Trust Board.

The process for routine reviews and update of the BAF is as follows:

- The corporate risk register is maintained by the Lead Executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from Committees
- The lead assurance Committee (or Trust Board, where applicable) reviews the management of risks to each required outcome (as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by Executive Leads
- The lead Committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead Committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each Committee will receive regular reports from specialist groups, Executive leads and other sources which provide management information and analysis of relevant key risk, to enable the Committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to the Committees should first have been reviewed and approved by the Executive Lead.

When deciding on the assurance rating for each outcome the following key should be used:

| | |
|---|---|
| **Red** | Effective controls may not be in place and/or appropriate assurances are not available to the Board |
| **Amber** | Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient |
| **Green** | Effective controls are definitely in place and Board are satisfied that appropriate assurances are available |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *1 March 2022* |
| Item Number | *Item 13.3* |
| **Board Committee Arrangements** | |
| Accountable Director | *Elaine Baylis, Chair* |
| Presented by | *Jayne Warner, Trust Secretary* |
| Author(s) | *Jayne Warner, Trust Secretary* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *N/A* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Significant* |

| | |
|---|---|
| Recommendations/ Decision Required | • *Board are asked to note the revised Committee membership arrangements* |
| | |
| | |

## Executive Summary

In response to some changes in Board membership the Chair has conducted a review of Non-Executive Director Committee membership.

The Board are asked to note the membership of each Board Committee moving forward with immediate effect.

**Audit and Risk Committee**
Sarah Dunnett Chair
Philip Baker ( PODC Chair)
Dani Cecchini (FPEC Chair)
Chris Gibson (QGC Chair)

**Quality Governance Committee**
Chris Gibson Chair
Sarah Dunnett ( Maternity Champion)

**People and OD Committee**
Philip Baker Chair
Gail Shadlock

**Finance Performance and Estates Committee**
Dani Cecchini Chair
Gail Shadlock

**Remuneration Committee**
Elaine Baylis Chair
Sarah Dunnett
Philip Baker
Dani Cecchini
Chris Gibson
Gail Shadlock

**Charitable Funds Committee**
Sarah Dunnett Chair
Chris Gibson