Bundle Trust Board Meeting in Public Session 3 September 2019

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

1 Introduction, Welcome, Chair's Opening Remarks and Health and Safety
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 6th August 2019
Chair
Item 5 Public Board Minutes AUGUST 2019 v2.docx

6 Matters arising from the previous meeting/action log
Chair
Item 6 Public Action log August 2019.docx

7 Chief Executive Horizon Scan Including STP
Chief Executive
Item 7 CEO Report.docx

8 Patient/Staff Story
Director of Human Resources and Organisational Development

9 BREAK

10 Strategic Objectives

11 Providing consistently safe, responsive, high quality care SO1

11.10 Assurance and Risk Report Quality Governance Committee
Chair of Quality Governance Committee (Chris Gibson for Aug meeting)
Item 11.1 QGC Upward report August 2019 v2 - FINAL.doc

12 Providing efficient and financially sustainable services SO2

12.10 Assurance and Risk Report Finance, Performance and Estates Committee
Chair of Finance, Performance and Estates Committee
Item 12.1 FPEC Upward Report - Aug 19 v2.doc

12.20 Self- Assessment NHS Core Standards for Emergency Preparedness, Resilience and Response
Chief Operating Officer
Item 12.2 EPRR paper 2019 post assurance.docx

12.30 Annual Plan Update
Director of Finance and Digital
Item 12.3 Annual Plan update vs2.docx

13 Providing services by staff who demonstrate our values and behaviours SO3
No items

14 Providing seamless integrated care with our partners SO4
No items

15 Performance

15.10 Integrated Performance Report
Director of Finance and Digital
Item 15.1 Integrated Performance Report - Trust Board Final (002).pdf

16 Risk and Assurance

16.10 Risk Management report
Medical Director
Item 16.1 Trust Board - Corporate Risk Report - September 2019.docx

Item 16.1 Appendix I - Very high & High Corporate Risks - August 2019.pdf

Item 16.1 Appendix II - Moderate & Low Corporate Risks - August 2019.pdf

Item 16.1 Appendix III - Risk Scoring Guide - July 2019.pdf

16.20 Board Assurance Framework

Trust Secretary

Item 16.2 BAF 2019-20 Front Sheet September 2019.docx

Item 16.2 BAF 19-20 v27.08.19.xlsx

16.30 Update to Board Executive Voting Rights

Chair

Item 16.3 Front Sheet Voting Rights.docx

17 Strategy and Policy

18 Board Forward Planner

Trust Secretary
For Information

Item 18 Public TB Board Forward Planner 2019 v 3.doc

19 ULH Innovation

Associate Director Communications and Engagement
For Information

Item 19 Innovation report- September.docx

20 Any Other Notified Items of Urgent Business

21 The next meeting will be held on Tuesday 1st October 2019

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.

Minutes of the Public Trust Board Meeting

Held on 6th August, 2019

Boardroom, Lincoln County Hospital

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Dr Neill Hepburn, Medical Director
Mrs Liz Libiszewski, Non-Executive Director
Mr Andrew Morgan Chief Executive
Mrs Gill Ponder, Non-Executive Director
Mr Geoff Hayward, Non-Executive Director

Non-Voting Members:
Mr Mark Brassington, Chief Operating Officer
Mr Paul Boocock, Director of Estates and Facilities
Mr Martin Rayson, Director of HR &OD

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mr John Bains, Healthwatch
Mrs Victoria Bagshaw, Deputy Director of Nursing
Mr Jon Young, Deputy Director of Finance
Mrs Penny Snowden, Divisional Head of Nursing and Midwifery Family Services (item 11.3 only)

Apologies:
Mr Kevin Turner, Deputy Chief Executive
Mr Paul Matthew, Director of Finance and Procurement
Mrs Michelle Rhodes, Director of Nursing
Mrs Sarah Dunnett, Non-Executive Director

1124/19 **Item 1 Introduction**

The Chair welcomed members of staff and public to the meeting.

1125/19 **Item 2 Public Questions**

Q1 Jody Clark – On the 17th August 2019, it will have been 1,095 days since our A&E closed overnight in Grantham. I moved to Grantham when I was 11 years old. At that time, all we travelled for was major trauma. In the 30 years of living here, we have lost emergency paediactrics and maternity services, heart attacks, strokes and now overnight emergency care, even though the town has expanded considerably.

We have issues accessing the Grantham services we have overnight - the minor injuries and GP out of hours due to 111 issues, which leaves us having to travel for the simplest things, like an x-ray. All this adds pressure on the 2 remaining hospitals, that are already struggling. I understand the staffing issues and financial constraints that have persisted for the last 3 years but it still seems extremely unfair that our community is the one that is left without and in limbo until a decision is made.

So my question is - can we get a solution to this continued overnight closure to secure our overnight access is resumed before we are facing a 4th anniversary?

The Medical Director responded:

We continue to work towards a solution and this is still out to consultation. We would like as much engagement from the public as possible.

Healthy Conversation 2019 is still ongoing. Contact may be made via:

- Email – lhnt.hc2019@nhs.net
- Telephone – 01522 307307
- Address – Healthy Conversation 2019, Room 2, Wyvern House, Kesteven Street, Lincoln LN5 7LH
- Website - https://www.lincolnshire.nhs.uk/healthy-conversation

Nine engagement sessions have been held so far, ensuring that all our local areas had an opportunity to get involved. Grantham's meeting was held on 20th March 2019.

There are still opportunities to have your say. The engagement survey is still live and can be found at: https://www.surveymonkey.co.uk/r/HC2019ASR. Questions 32 and 33 will be of most interest.

In reality, this decision isn't made by the Trust as any decision will impact the entire health economy. The Community Trust is currently working on a new model and we will welcome their input in ensuring the people of Grantham have access to the right services. The ultimate decision will lie with the CCGs. Our role is then to provide what we are commissioned to provide.

It is important to highlight that the proposal is for a 24/7 service with overnight access via NHS 111. If this is agreed, then we will want to implement it as soon as possible but this has to be done alongside our healthcare partners.

Q2 Sue McQuinn – With the U.K. scheduled to leave the EU on October 31st has the board appointed a "Brexit Lead" to oversee & coordinate preparations for this event?

What specific steps have been taken to ensure continuity of care, medical supplies & equipment - deal or no deal?

Is there a contingency fund to cover additional costs that may be incurred by the Trust in the lead up to & following Brexit?

The Chief Executive responded:

The Trust has planning arrangements in place for Brexit and also an EU Exit Contingency Planning group. The Senior Responsible Officer for the Trust is the Deputy Chief Executive, and alternative Senior Responsible Officer will be identified upon the imminent retirement of the Deputy Chief Executive.

Regular communications and briefings are received from the Department of Health and there are backups from local systems. The briefings had been undertaken weekly and were daily where required. These were put on hold between the end of March due to the current timeline and work commences again for contingency planning arrangements. Key risks for the Trust are medicine supply, medical devices, consumables, workforce and data sharing. A number of the risks are not in the control of the Trust and are dependent on the national resolution of some of the issues. As part of planning there are no contingency funds at a national centre and would need to be provided at a local level. The Trust have these issues in hand and the Board receive regular updates to remain informed.

Q3 Councillor Ian Selby – 12th August 2019 marks the 3rd anniversary of the closure of our overnight A&E at Grantham Hospital and after ULHT promised to restore it when you had enough Dr's.

Then after obtaining the number of Dr's required you then reneged on that promise, you then passed the buck to pass the blame and bizarrely you then use safety reasons to justify your decisions, however our residents have been left in a dire unsafe situation that you still fail to recognise even three years later!

We will not give up the fight until you correct this injustice. So as you still stubbornly refuse to restore our overnight A&E service, will you at least offer an apology to the people of Grantham and our rural district for this dire predicament that you have left us in?

The Chief Executive responded:

The emotion and issues behind the question are understood however there remain significant emergency staffing issues. The staffing levels were shared with the Prime Minister during his visit to Pilgrim Hospital and he was shocked. The Trust do not accept the statement that it has passed the buck however regrets the upset and distress caused by the overnight closure. The Chief Executive did not accept that this had been a deliberate and wilful act to cause harm. The Trust regrets the position it has got to with Grantham Hospital however the safety and staffing issues remain.

Q4 from Liz Wilson – The question I would wish to ask of the Board and specifically, the Chief Executive, is:

"The minutes of the last Board meeting on 2nd July show that the new CEO's focus, in respect of the Acute Services Review, will be on "keeping people safe, well and close to home" (minute 945/19). Could he explain how this applies to the residents of Grantham and District for whom the "temporary" overnight closure of their hospital's A&E department will shortly be entering its FOURTH year?

The Chief Executive responded:

There is not much to add to what has previously been stated as quality and safety of the service remains the focus. The future of the hospital in the context of all services is part of the Healthy Conversation 2019 consultation. The Chief Executive recognised how long the current situation had existed and this is why there is a need to push on with a clear future for all services in the context of the Healthy Conversation 2019, this is not just about hospital services. There is a need to focus on self-care, prevention and keeping people safe and well in their own homes. Where hospital services are in place they need to be safe, staffed and meeting modern standards. There cannot be a compromise on this and there is a need to balance service delivery. The Trust understands the strength of feeling about the current situation.

Question 5 Councillor Mark Whittington – It is now almost three years since Grantham lost its overnight A&E service. Please can you state how much longer the residents of Grantham and its surrounding villages have to wait for the restoration of a twenty four hour seven day a week service and whether under the proposed new model overnight access will be walk in or via the 111 route.

The Medical Director responded:

Our response to this question is generally in line with Question 1.

It's important to remember that at present this is just a proposal and is still out to consultation. As highlighted in Q1, the CCGs will make this decision. Whilst we are keen to act, we cannot do this prematurely or in isolation. As you can see from the consultation, a 24/7 service is what is being proposed.

Regarding access, it has not yet been decided whether access will be via NHS 111 or as a walk-in service. It's important to note here that a walk-in service may not be the safest option if it causes delays in admission. For example if the presenting complaint was a heart attack, prompt attendance at the specialist service at Lincoln would be the best option. NHS 111 could tell this to the affected party rather than them attending at Grantham and being transferred following assessment which would almost certainly take longer.

1126/19 **Item 3 Apologies for Absence**

Apologies were received from the Deputy Chief Executive, Director of Nursing, Director of Finance and Procurement and Mrs Dunnett, Non-Executive Director

The Chair noted that Councillors Wootton had advised they were unable to attend the meeting and noted their apologies.

1127/19 **Item 4 Declarations of Interest**

There were no declarations of interest which had not previously been declared

1128/19 **Item 5 Minutes of the meeting held on 4th June 2019 for accuracy**

The minutes were agreed as a true and accurate record subject to the following amendments:

Mr Hayward should be recorded as present

Minute 947/19 should read Dr Gibson identified that other rural areas in the UK had begun integration of healthcare services however this had not resulted in quality and safe services and questioned how Lincolnshire would ensure quality and safety were improved.

1129/19 **Item 6 Matters arising from the previous meeting/action log**

684/19 & 886/19 – Committee KPIs – Quality Governance Committee considered during the July meeting and expect to finalise at August Committee meeting

1004/19 – Finding relating to sepsis within the CQC report – discussion held at Quality Governance Committee, dashboard awaited that reflects data to enable comprehensive discussion at Quality Governance Committee

1016/19 – CQC Feedback letter June 2019 – Review of Quality and Safety Improvement Plan content and process not yet complete. Consideration being given to completed programmes of work to determine which to move forward to next year and which groups are being sighted on the programmes. Current arrangements in place have not delivered what was expected.

1062/19 – People Strategy – Board Development session scheduled for September prior to revised strategy being presented to October Board

1068/19 &1077/19 – Continuous Quality Improvement Approach – Progress reports would be taken to the Workforce, Organisational Development and Transformation Committee

1091/19 – Improved Performance – Publicising of good news stories being undertaken – complete

1112/19 – BAF – Consideration of management of SO2bii, meeting during August to develop baseline, proposal to be taken to Trust Management Group – complete

1130/19 **Item 7 Chief Executive Horizon Scan including STP**

The Chief Executive presented the report to the Board detailing both system and Trust specific issues.

System Issues:

1131/19 As a system a review of system finances had been undertaken to determine the position, this had been about all Trusts and Clinical Commissioning Groups. There remains a gap in the savings plan that needs to be responded to by all organisations to ensure delivery of the combined control totals. Reviews of the robustness of the plans had been undertaken. A session had been arranged for Lincolnshire Chief Executives to review assurance of plans to deliver and if they would result in the year end control totals being delivered. The outcome of the review would be presented to the Lincolnshire Co-ordination Board where the level of assurance would be provided.

1132/19 NHS England and Improvement had confirmed the regional aims and priorities, these were being refined and there had been a request for stakeholders to participate in task and finish groups, the Trust had put staff forward to support the process.

1133/19 Following the publication of the NHS Long Term Plan, development of a Lincolnshire 5 year plan was underway. The expectation would be for the Lincolnshire STP to produce a local plan following national guidance and templates. A draft of the local plan would be due 27th September with the final plan being produced by 15th November. There would be a number of challenges both from the timeline but also ownership of the document. The plan would need to build on the work of Healthy Conversation 2019 and include information from all areas. The plan would need to be a Lincolnshire plan that is owned by all and supported by individual Trusts. The plan would be presented back to the Board in the following months.

1134/19 An Integrated Care System maturity matrix had been completed and one aspect of the plan had been about process and timeline for achieving Integrated Care System status by April 2021. Timescales would require a shadow Integrated Care System to be in place by April 2020, to work this back that would require preparation work to commence immediately if an Integrated Care System is what would be wanted in Lincolnshire. There would be a need to work through governance processes.

1135/19 Both the EU exit and Healthy Conversations had been discussed as part of the public questions so would not be covered within the update.

1136/19 The Lincolnshire Clinical Cabinet continues to meet regularly and feeds in to the System Executive Team meetings. The focus of the cabinet would be unwarranted clinical variation in the system with a view to ensure services are delivered and secured. Any clinical variation would need to be explained.

Trust Specific Issues:

1137/19 Due to timing the announcement of additional capital for the NHS had not been included within the written report, however confirmation had been received by the Trust late on the 2nd August that additional capital would be received. The capital would be to assist with the physical restructure of the A&E department at Pilgrim. The Trust were advised that it would be receiving £21.3m.

1138/19 The launch of the capital programme for the 20 schemes took place on the 5th August at Pilgrim Hospital during a visit and walk round from the Prime Minister and the Secretary of State for Health. The visit had been received well and welcomed by staff, it had resulted in media coverage and staff morale had been improved.

1139/19 Financially the Trust had managed to achieve plan at the end of quarter 1 however this had been due to the use of technical flexibilities, there would be no further scope to support this. If the Trust do not continue to work hard to deliver the financial plan this could result in year end being £11.6m adverse to plan. Controls needs to be in place for pay spend. The plan must be delivered and come in at £70.3m deficit, regular request for financial support continue to be made and concern remains about the achievement of the plan.

1140/19 Staff continue to work hard and face both staffing and bed issues within the A&E department. The performance of the department means that the Trust continues to be escalated to NHS England and Improvement and high impact improvement steps continued to be in place. These actions include issues for the whole system, in particular ambulance handovers. Work within the system continues to try and resolve the demand issues.

1141/19 The Chief Executive outlined the Executive Team as being one of the priorities for the Trust. An internal process to recruit an acting director had commenced following the announcement that the Director of Nursing had secured a new role at another Trust. External recruitment to both the Director of Nursing and Director of Finance and Procurement would be undertaken following the summer break.

1142/19 The Deputy Chief Executive had announced his retirement at the end of August. The Chief Executive passed on his thanks to the Deputy Chief Executive for his contribution to both the Trust and System during his time in Lincolnshire, he would be greatly missed. The Chief Executive identified that the role would not be replaced directly and that the deputy role would become an additional responsibility for an existing Director portfolio.

1143/19 Mr Bains passed a personal comment regarding the Prime Ministers visit to Pilgrim Hospital stating that he felt it had been unprofessional to see staff taking selfies with the Prime Minister and did not think this reflected well on the Trust.

1144/19 The Chair countered that the Prime Minister had been happy to have photographs taken with the staff he met and highlighted that it should not be underestimated that the morale of staff had greatly improved due to the visit. The hospital had become vibrant and alive given the positive attention.

1145/19 Mr Bains stated that the Healthwatch stance was that there remained a fundamental issue of staffing and recruitment and asked how the capital fund being given to the Trust would support this.

1146/19 The Chief Executive responded that the capital would be to support the buildings and associated environment and it had been clear that this would not answer the staffing issue. The point had also been made during media interviews by the Chief Executive however that what it would enable was the opportunity for staff to work in an environment that would be fit

for purpose. This would help to support the recruitment and retention of more staff. During the walk round the Prime Minister offered additional funding for a new fluoroscopy machine. It is unknown what conditions would be attached to any of the funding offered during the visit but the case would be made for the share of the money.

1147/19 Dr Gibson welcomed the prioritisation for reduction of health inequalities and asked if as the move towards a system approach was made if there was a sense of the heart disease, stroke and cancer priorities.

1148/19 The Chief Executive responded that there had been a public health group established so there would be a focus. The plan had been reviewed for the health inequalities and what should be considered as a health and social care group. The regional priorities had been welcomed however the local plan would pick up the local health inequalities.

1149/19 The plan had now provided clarity about how to work as a system and the impact on the Trust. The Chair identified that the timeline stated would be tight but there would need to be an opportunity as a Board to review the submission. The Chair raised concern about the ability to ensure with the public and partners in the community due to the timescales. The appropriate level of attention would need to be given as part of the overall submission.

1150/19 The Chair wished to add her own comments to the impending retirement of the Deputy Chief Executive who had been a stalwart around the Board table for a number of years. The impact would be felt both around the table and within the organisation, he was a highly respected member of the team whose legacy would be through the ongoing 2021 vision.

The Trust Board:

- **Received the report**

1151/19 **Item 8 Patient/Staff story**

Senior Chaplain David Knight, Specialist Bereavement Midwife Nicky Kirk and Matron for Nocton Ward Cathy Franklin attended the Board to present the patient story of Dorothea Singh and her son Stephan. Dorothea was unable to attend the Board however had recorded a video to share her story.

1152/19 Stephan was born at 30 weeks and cared for on Nocton Ward for 14 weeks until he died from a genetic condition. There were many reference to the great care the family received however there were some areas for learning, these were primarily about information and communication with the family.

1153/19 After Stephan's premature birth he was diagnosed with the genetic condition Edwards syndrome, there had been both religious and cultural concerns from Dorothea and as such David Knight arranged for the emergency baptism of Stephan.

1154/19 The video shown to the Board addressed the question posed to Dorothea of 'how in control of making decisions about Stephans care did you feel?

1155/19 Dorothea identified that she felt there had been 3 stages of care received. The first being the arrival of Stephan and his care as a premature baby without any other diagnosis. He had been treated as any other premature baby.

1156/19 The second stage had been the diagnosis, this became the best time for the family as Stephan was stabilised and due to the diagnosis staff were trying to do the best they could. There was an opportunity to spend time with Stephan and make memories with him, hold him and do normal activities with him such as nappy changes.

1157/19 The third stage was palliative care, the approach from the staff appeared to change. Many of the things that had been ok to do before were now not acceptable. The staff were the same, the baby was the same but the family were unclear as to why the approach was different. This had probably been due to the palliative diagnosis but this caused confusion due to the lack of explanation. The family did not understand what was happening and were pushed to make decisions that they did not necessarily want to make or agree with. They did not feel they had the opportunity to reach decisions in their own time.

1158/19 Dorothea did not feel that there had been the intention not to inform or communicate with the family but simply that staff had forgotten to provide the information.

1159/19 2-3 days prior to Stephan's death the family were introduced to Specialist Bereavement Midwife Nicky Kirk. Nicky had been able to support the practical arrangements for the family but Dorothea was sorry she had not been introduced to the family sooner to support them. There was a feeling from the family that the support and care following Stephan's death was more personal than professional as the staff were emotionally involved.

1160/19 Dorothea was grateful for the time spent in the unit and the support from the staff, she expressed that 90% of the experience had been good with great support. However there had been a number of small things that she felt could have been done to make the care and experience better.

1161/19 The Chair requested that the Boards gratitude be expressed to Dorothea for sharing her story. There had been good support received but there were lessons to be learnt from the experience. The need for better communication had been heard before along with the need to treat the whole family and not just the patient, particularly when children are involved.

1162/19 Mrs Libiszewski asked the Specialist Bereavement Midwife why she had not been involved earlier in the care. Nicky felt that this had been due to the baby being well initially and it was not considered. There had however been a number of changes implemented since Dorothea's experience. This had included Stillbirth and Neonatal Death accredited training, introduction of bereavement champions and communication with ambulance services. The family were informed about spending time out of hospital with Stephan but unfortunately he deteriorated too quickly.

1163/19 Mr Hayward noted that it appeared as though staff worked on different mandates at the transition points of the care being provided.

1164/19 Matron Franklin advised that there has been communications to staff about this as it had been clear in this instance that there should have been a multidisciplinary team meeting regarding the baby and diagnosis.

1165/19 In response to lessons learnt Family Integrated Care was being introduced, this would allow families to take temperatures, remove babies from incubators and ensure families became involved in the care being provided. The Trust already has a very robust palliative care pathway in place.

1166/19 The Deputy Chief Nurse identified the crossover of the lessons learnt in to other areas such as end of life and palliative care and would be keen to use the story in other end of life services to support other teams.

1167/19 The Chief Executive asked what support was provided to staff due to their experiences of well and unwell babies.

1168/19 The Board were advised that staff hold debriefs however the Trust do not experience many neonatal deaths. There would be an opportunity to offer counselling to staff who may need this.

1169/19 Mrs Libiszewski highlighted the impact of the chaplaincy team in the Trust and that it should not be underplayed. There had been a strong bond built and this should be recognised as a holistic approach and not just religious.

1170/19 The Chair advised that she would write on behalf of the Board to thank Dorothea for sharing her story and to assure her that there had been a legacy from her experience.

Action – Chair, 2 September 2019

The Trust Board:

- **Received the staff story**

9 BREAK

Item 10 STRATEGIC OBJECTIVES
Item 11 Providing consistently safe, responsive, high quality care SO1

1171/19 **Item 11.1 Assurance and Risk Report Quality Governance Committee**

The Chair of the Quality Governance Committee, Mrs Libiszewski, provided the assurance received by the Committee at the July meeting.

1172/19 The meeting had followed the format of the Board Assurance Framework and the objectives had been considered by the Committee.

1173/19 Infection Prevention and Control continues to perform well however the Board were asked to note the inability of wards to achieve 100% of the MiC4C cleanliness audit against the hygiene code due to financial constraints resulting in the ceasing of window cleaning.

1174/19 Review of the risk register had been undertaken by the Committee, work had commenced in relation to Aseptic Pharmacy for the development of a business case to support improvements, this would be due at the Board in the Autumn.

1175/19 The Committee noted the number of Quality Impact Assessments that had been reviewed by the relevant Executive Officers and were advised that the process had been refreshed to ensure the Divisions were embedded in the process for lower risk areas. There had been positive progress on the way to move the process forward however the Committee wished to ensure that this did not reduce the rigour of which the assessments were reviewed.

1176/19 The Pilgrim post implementation reconfiguration report was presented to the Committee and it had been noted that improvement at the site had been seen. The Committee expect to receive the Quality Impact Assessment in relation to the reconfiguration of the Lincoln site.

1177/19 An update was received on 15 Steps and the work undertaken to date. Recommendations were made by the Committee to support the programme, further updates would be received by the Committee.

1178/19 The Committee had reviewed the Clinical Negligence Scheme for Trusts standards for maternity and this would be presented during the Board meeting.

1179/19 The Safeguarding report identified some issues in relation to Disclosure and Barring Service (DBS) checks, a long standing review had been conducted in response to the Saville and

Bradbury reports identifying that 177 staff had not received a DBS check. Of those 42 had been recommended for completion of the DBS, sign off of those to be undertaken would be conducted by the Executive Team.

1180/19 Following a review of the metrics for the Committee further work would be undertaken outside of the meeting with a fully functioning dashboard expected in August. The Quality and Safety Operational Group would also require a functioning dashboard along with the Divisions. The Committee had felt it had been more difficult to narrow the suite of metrics before the feeding groups were fully formed.

1181/19 The Patient Experience Plan was received by the Committee and further work requested due to there not being a Quality Strategy in place. The Quality Strategy was being drafted and it was hoped that the patient experience plan would be built in to the delivery of the strategy.

1182/19 The Annual Complaints report was received.

1183/19 A review of all Care Quality Commission information that had been received by the Trust was undertaken and work had commenced to ensure the actions were carried out.

1184/19 The NHS Improvement feedback on committee and group observations was received by the Committee and one further report is awaited. The intention would be to pull the feedback in to a suite of actions to report back to the Committee. The feedback had been largely positive and the areas identified as requiring improvements had not been unexpected.

1185/19 The Quality and Safety Improvement Programme was being reviewed by the Chief Executive and work being undertaken with Executives to close the programme down and move to an outcome focused approach. Those items that move to business as usual would require reflecting in the relevant terms of reference of the responsible group. This would ensure accountability of the work.

1186/19 The Chair requested further clarity on the ability to comply with cleanliness audits due to the lack of window cleaning. Confirmation was provided that cleanliness audits could not be met. The Director of Estates and Facilities would undertake a review in the context of the issue raised at the Committee to determine if this could be reinstated.

Action – Director of Estates and Facilities, 3 September 2019

1187/19 The Committee received the Children and Young Peoples report and held a useful discussion. Responsibility had been delegated to the Committee from the Board to review the current paediatric position, a summary had been provided to the Board.

1188/19 The Divisional Head of Nursing and Midwifery Family Services had been present at the meeting whilst the item had been discussed. There were no specific issues to be highlighted to the Board however there had been a breadth of discussion including the significant risks around workforce. There had however been a positive step with three consultant posts offered.

1189/19 The services remains an interim model and had been reviewed in detail.

1190/19 The Chief Operating Officer questioned the length of stay of patients due to understanding that the length of stay had increased. The Medical Director advised that the Divisions were working towards an acuity based model, this remained as work in progress to discuss however the full report had included length of stay at both units. This would be included in future upward reports.

1191/19 The move to an acuity model would require Board sign off and would be discussed with the Board prior to the model being amended.

The Trust Board:

- **Received the update**

1192/19 **Item 11.2 Care Quality Commission Inspection Letter**

The Chief Executive advised the Board that the letter being presented detailing the feedback of the well led inspection had been the final part of the inspection process that had commenced with the Care Quality Commission carrying out a review of core services during June.

1193/19 The result of the inspection process would be result in a full set of ratings for the Trust and these were awaited.

1194/19 The Care Quality Commission had visited over three days from 16th July and the process had involved focus groups with staff, leadership teams and individual interviews with Board members.

1195/19 Prior to the inspection the Board had completed a self-assessment against the key lines of enquiry, this resulted in the view that the organisation would likely remain as 'requires improvement' but that improvements had been made against a number of the key lines of enquiry. Pending the receipt of the report the Board had received the feedback letter to highlight key points made from the verbal feedback.

1196/19 The Chair identified that the letter recognised the progress that the Board felt had been made but demonstrated the need for further improvement. There would be a need to see the narrative of the report and take the opportunity to respond to any factual accuracies if necessary.

1197/19 The Chief Executive advised that the letter had not reflected the first comment made as part of the verbal feedback, the lead inspector had stated 'I can see progress has been made and clearly this is going in the right direction but there is still some way to go'. The Chief Executive was interested to see if this would be reflected in the written report and ratings.

The Trust Board:

- **Received the letter**

1198/19 **Item 11.3 Maternity CNST Safety Incentive Scheme**

The Divisional Head of Nursing and Midwifery Family Services joined the meeting to present the paper to the Board.

1199/19 The paper provided evidence and assurance that the maternity service at the Trust had achieved compliance against each of the 10 safety actions. The actions had been more ambitious that the previous year with an expectation that this would increase again next year.

1200/19 The Board were asked to note that safety action 2 in relation to IT and compliance with the submission of data to the Maternity Services Data Set could not be met but had been escalated to NHS Digital who had accepted that this would not be achieved. There had been a caveat associated in order to move this forward.

1201/19 The latest position for staff training had been over 90% of every staff group having been trained with the final 2 staff being trained in the next week. This had resulted in full

compliance of safety action 8 – evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session with the last training year. The recommendation to the Board was for the Trust to report full compliance ahead of the final staff being trained.

1202/19 The Quality Governance Committee had reviewed more detail of the submission than received by the Board however had not reviewed each of the evidence files due to the quantity of data. This had however been considered by the Director of Nursing.

1203/19 The Board requested to understand the level of confidence to maintain the training levels. This had been considered and discussions held to include as a core training competence. The Workforce, Organisational Development and Transformation Committee would receive a paper to discuss and determine how the Trust proceeds to move this to core training.

1204/19 Further discussion was held regarding the concerns about the ability to provide data for action 2. The Trust are unable to deliver against the maternity data set due to challenges with the IT system, Medway. The system would be due to be upgraded in September however this had not been one of the systems that NHS Digital had been working with in relation to the requirements. A review of the system and provider would be required to ensure this became compliant.

Action – Deputy Chief Executive, 3 September 2019

1205/19 Work had commenced to prepare for the standards that would be set for the following year with a gap analysis completed between previous versions to work towards version 3.

1206/19 The Board thanked the Divisional Head of Nursing and Midwifery for the work that had been undertaken and for the progress made to achieve full compliance.

The Trust Board approved the signing of the declaration.

The Trust Board:

- **Received the report**
- **Approved the signing of the declaration**

Item 12 Providing efficient and financially sustainable services SO2

1207/19 **Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee**

The Chair of the Finance, Performance and Estates Committee, Mrs Ponder, provided the assurance received by the Committee at the July meeting.

1208/19 The financial issues reported to the Committee had been that the Trust were reporting on plan at month 3 but this had been due to technical adjustments in the first quarter. A detailed report had been received in relation to income, a key message to highlight to the Board was the issue regarding pay. A Board Development session was planned to conduct a deep dive in to pay costs and determine what action the Trust must take to get back on track for the delivery of the financial plan. The Committee had requested assurance on the actions that would be taken.

1209/19 The Committee requested evidence of how the CQUIN targets would be achieved as there was concern about failure to achieve quarter 2 if these were not progressed .

1210/19 The Committee were asked to support revenue borrowing of £5.637m and £6.284m of capital borrowing, the Committee gave support and recommended for Board approval.

1211/19 The Financial Turnaround Group reported under delivery of the Financial Efficiency Plan and changes to the process had been made to move schemes through to delivery. The biggest risk remained around workforce and recruitment which were not delivering the planned savings. The Committee requested that the Director of HR and OD attend the next meeting to provide assurance.

1212/19 An update on Progress Housing was received, this was reviewed regularly and the Committee were pleased to note that occupancy had increased in May and June resulting in no guarantee payments being made. Work continued to review how further value from payments made in the future could be achieved. An analysis was requested in relation to occupancy increase to understand this moving forward.

1213/19 The Health and Safety Group update advised the Committee of the Health and Safety Executive visit to the Trust during June. Progress was noted by them however the Committee requested sight of the report when received and the actions that would be undertaken to ensure learning was put in to practice.

1214/19 The Committee received an update from the Information Governance Group and were advised that the new Data Security and Protection Toolkit contained 116 indicators, 75% of these indicators were new. The group escalated to the Committee the ongoing issues with regard to healthcare records destruction however the Committee were advised that the new contract with RESTORE would be signed, as a result the issue would be resolved. Freedom of Information requests had been discussed and further work was required to indicate current progress. The Committee were assured that the Trust was GDPR complaint and work was being undertaken with new suppliers to ensure compliance.

1215/19 The Digital Group raised the ongoing risk of lack of capital funds to replace IT equipment. Priorities for capital funding had been discussed by the Executive Directors and a further report would be provided to the August Committee meeting along with any cyber attack risks, these would also be escalated to the Audit Committee.

1216/19 The Committee noted the issues of patching the GE servers, this work had not progressed as expected, the concern noted was due to the previous cyber attack starting on the GE servers. The risk however had been reduced due to other servers within the Trust being protected.

1217/19 The NHS Digital Maturity Self Assessment was undertaken by the Trust and provided a rating of good.

1218/19 Concerns regarding the installation of fire doors and lock down testing were raised at the Committee through the Emergency Planning update, the Committee were advised that the delay had occurred due to the manufacturing process however completion was expected in Autumn.

1219/19 The Fire Safety Group were asked to consider actions in relation to the increase in fires within the Trust. There had been a proposal to increase the rating of the fire risk however this had not been approved but a review would be taken to consider a reduction of the risk. A separate risk of arson was being assessed following a recent fire.

1220/19 There had been a 3 month improvement within emergency care however the trajectory had not been met with ambulance handovers remaining a concern. Work was being undertaken with East Midlands Ambulance Service to ensure improvements are made.

1221/19 The Committee sought further assurance on the impact and outcome of various improvement actions to gain assurance, there was a need to ensure actions taken delivered the expected benefits.

1222/19 The Trust had achieved 5 out of 9 cancer standards with the largest success being recorded for breast symptomatic with 90% achievement.

1223/19 62 day wait had declined.. Performance was expected to move back to trajectory when the June data was presented. The 104 day wait standard had not been achieved and as such would form part of future reports to the Committee. A harm review had been carried out on all of the breached patients. There had been no harm caused and the Committee had requested assurance on the impact and outcomes.

1224/19 The Trauma and Orthopaedic Trial had demonstrated improvements in waits and cancellations had slowed. The planned benefits from the trial were being achieved and again the Committee requested assurance.

1225/19 The Committee dashboard would be amended to include health and safety data, the Board Assurance Framework was reviewed and assurance ratings remained red.

1226/19 Dr Gibson requested further details on the 104 day waits asking how confident the Trust were that no harm had occurred.

1227/19 The Chief Operating Officer advised that the information reported to the Board related to any patient on the open cancer pathway over 104 days, this also included patients that did not have a cancer diagnosis. Further conversation would be held with GPs in order to ensure they become proactive in stepping patients down from the pathway.

1228/19 The Chair highlighted the pay issues that had been reported and advised that the Board would be dedicating time to the pay issue with particular focus on the Medicine Division.

The Trust Board:

- **Received the update**

Item 13 Providing services by staff who demonstrate our values and behaviours SO3

1229/19 **Item 13.1 Assurance and Risk Report Workforce and OD Committee**

The Chair of the Workforce, Organisational Development and Transformation Committee, Mr Hayward, provided the assurance received by the Committee at the July meeting.

1230/19 The Committee raised concerns regarding the key performance indicators and agency use. Action would be taken via the Performance Review Meetings to understand the detail behind how the divisions sign off agency staff usage.

1231/19 The overseas recruitment pipeline had shown results however that were long lead times relating to these staff commencing in post. The Committee recognised the need to support people coming through this route in to the Trust, support mechanisms were being reviewed to aid the retention of overseas recruits.

1232/19 The Committee were concerned about job planning and the financial efficiency implications that this would have if not completed, concerns were fed through to the Finance, Performance and Estates Committee. The Committee were advised that each Doctor had a job plan in place but that a number were not up to date or reviewed, work was underway to resolve this.

1233/19 Appraisal rates were good however the quality of them required improvement.

1234/19 The Committee received an update on the workforce medical quality, this appraised a number of areas and was being reviewed to ensure consistency of quality. An implementation plan had been developed for longer term work to resolve quality issues.

1235/19 The Junior Doctors update demonstrated that there had been more engagement with the staff group however this had not resulted in morale improvement. Further work would be undertaken to move forward.

1236/19 The Committee received the revalidation report which demonstrated that the Trust is undertaking revalidation as expected.

1237/19 Initial work had been completed in respect of the bullying and harassment staff survey results to understand where the results had stemmed from.

1238/19 Leadership Development was raised following the Care Quality Commission inspection and the report received by the Committee detailed the training programme in place. The programme in place is modular allowing staff to access as required, assurance would be required that the right staff are accessing the right modules.

1239/19 The Committee received an assurance report from the 2021 Programme Group, this would become a 5 year strategy group in due course moving away from the 2021 strap line.

1240/19 Mrs Ponder questioned what assurance could be provided that the right leadership programme is in place. The Director of Human Resources and Organisational Development advised that there was no evidence that the programme was not right and that a recent review and benchmark of the programme had been undertaken. The content of the programme was similar to that of other successful organisations. The structure of the programme continues to remain under review and reflection on the comments from the Care Quality Commission would be undertaken. It would take time to see the impact of the programme and it continues to be reliant on managers to nominate staff to attend based on a robust appraisal process identifying staff.

1241/19 Mrs Ponder suggested this was not just about attending the programme but ensuring that once completed behaviours in the workplace were different as a result.

1242/19 The Director of Human Resources and Organisational Development identified that this would be tied up in the appraisal process and would form part of the 360 review and provide a key area of focus.

1243/19 Mrs Libiszewski commented that the report appeared to focus significantly on the medical workforce and asked if there had been a review of the very low uptake of appraisals across the Trust. There had also been no update on the position for improving mandatory training compliance and what was being done to ensure staff could access the system to complete the training.

1244/19 Mr Hayward confirmed that the work plan for the Committee had been such that the focus had been the medical workforce however other items were timed on the work plan to cover the nursing workforce.

1245/19 The Director of Human Resources and Organisational Development confirmed that access to mandatory training is via ESR and is a national system and that the concerns about access issues would be reviewed.

1246/19 The Medical Director advised that if the development programme was successful for the medical workforce this would be easily rolled out to the rest of the workforce. Work was being undertaken to structure the medical workforce and competences by technical expertise and the ability to work in a large organisation. The matrix of competence would outline the expectations to be delivered both short and long term.

1247/19 Dr Gibson raised concerns about the high number of Doctors in the Trust with General Medical Council (GMC) restrictions and asked how the Trust undertake monitoring. The Medical Director advised that there were in fact only 9 locum doctors with GMC restriction. There had been an agreement at the Trust Management Group that the Trust would no longer take on any locum doctor with restrictions in place. Those in place would be worked out but consideration would need to be given to fragile services. The Trust would also put in the place the requirement for all locums to be on the specialty register prior to working in the Trust. A competency certificate is in place to provide an opportunity to develop.

1248/19 The Board discussed the refresh of the leadership development programme and the requirement for any refresh of the programme to be presented to the Board.

Action – Director of HR and OD, 1 October 2019

1249/19 The Chief Executive welcomes the focus of leadership at the Board and consideration to provide further focus would be given through a Board Development session.

Action – Trust Secretary, 3 September 2019

1250/19 The Board discussed inclusion, particularly the Black, Asian, Minority Ethnic staff and the feedback regarding the lack of development. Most of the staff learn by role modelling and have different cultural understanding. The Trust would need to ensure that those staff are provided with training to perform well within the organisation. The Trust had received the comments from the CQC well led review and held a session to commence work, the Trust had a strategy and plan in place but need to ensure this can be delivered.

1251/19 The Chair noted that there were a number of areas where assurance had been stated but the narrative did not seem to show assurance.

1252/19 The Trust Secretary confirmed that this had been identified by NHS Improvement as part of the observation feedback and would be addressed by the Committee moving forward.

1253/19 The frequency of the Committee was discussed in relation to the scale and scope of the agenda. Review and consideration of the Committee would be required.

Action – Chair, 3 September 2019

The Trust Board:

- **Received the report**

1254/19 **Item 13.2 Freedom to Speak Up Quarterly Report**

The Freedom to Speak Up Guardian presented the quarterly report to the Board.

1255/19 The report detailed referrals received between April to June 2019, numbers were noted as low during this period however had increased again during July so this was not considered to be a concern. The Trust had seen the number of referrals double in 2018/19.

1256/19 Worked continued to identify a network of champions with the Trust, currently 9 volunteers/nominations had been received. Divisions would be approached to support further work to widen the pool of individuals interested in the champion role with an aim to recruit 15 individuals across the sites.

1257/19 Work had been undertaken with the Trust's Equality, Diversity and Inclusion Lead to approach the staff networks about the champion opportunity. There had been some interest from the networks.

1258/19 The National Guardians office would be using October as the Freedom to Speak Up month and the Guardian would aim to use this month to promote freedom to speak up and the network of champions.

1259/19 As part of the Care Quality Commission Well-Led inspection the Guardian had been interviewed. There had been engagement with the Human Resources and Organisational Development teams as part of the Trusts work on bullying and harassment.

1260/19 The national guidance in relation to Freedom to Speak Up had been refreshed and the Board would receive an update on this within the next quarterly report.

The Trust Board:

- **Received the report**

Item 14 Providing seamless integrated care with our partners SO4

1261/19 **Item 14.1 Healthy Conversations Campaign 2019 – Engagement report**

The paper presented to the Board was a factual paper that had been received by all Boards and governing bodies. The paper summarised the original message, activity undertaken, media relations, public engagement events and use of social media, providing a run through of the work undertaken.

1262/19 The report details the key messages that had been identified from the events, some of the concerns included travel and transport, technology and GP services. There had been a focus from the public about the public engagement events and comments had been received about the lack of attendance at these events. In order to address these comments the report had been widened to include the social media work and summary of everyday contacts with the public.

1263/19 The report provided detail of the learning from the engagement to date. One of the key issues raised had been the branding of the STP, it had not been well liked. Some of the issues related to this had been that the public felt this was just relating to NHS services and not other partners. Integrated Care System cannot just be about the NHS, these must include social care and third sector bodies.

1264/19 The report focused on the next steps in order to move toward the production of the long term plan and any areas that may require further public engagement.

The Trust Board:

- **Received the report**

Item 15 Performance

1265/19 **Item 15 Integrated Performance Report**

The Deputy Director of Finance presented the report to the Board highlighting that there had been positive improvements made within the quality metric include harm free care being reported at 98.7% and was above the national average.

1266/19 The Trust continue to report low levels of HSMR and SHMI remains within expected limits. VTE assessment remains above expected limits of the 95% national standards and C-Difficile remains on track. There had been no reported cases of MRSA in quarter 1 of 2019/20.

1267/19 Operational performance had seen an improvement in the 4 hour A&E standard in June at 72.44%, however this remained below the local target of 73%. Ambulance conveyance performance continues to remain above plan with waits over 59 minutes reporting over trajectory.

1268/19 In May the Trust achieved 5 out of 9 cancer standards, this had increased for an achievement of 4 in April. The upward trend had been forecast to continue in to June. Nationally only 3 of the standards had been met in May, this demonstrated the positive performance for the Trust.

1269/19 The updates for finance and workforce are intrinsically linked with month 3 delivering a £5.8m deficit in line with the planned position. The achievement of the year to date position had been achieved through the use of technical flexibilities. Achievement of the plan had provided access to additional monies of £3.8m.

1270/19 Whilst the Trust had reported to plan the underlying pay position was £0.2m adverse to plan. A Board Development Session had been planned during August to focus on Medical, Nursing and agency pay bills in order to attempt to address the pay position.

1271/19 Excluding pass-through activity income overall was reported as £0.2m adverse to plan and is inclusive of significant over performance on non-elective activity which had resulted in pressure on the system.

1272/19 Mrs Libiszewski raised concern in relation to the performance of patients with fractured neck of femur being treated within 24 and 48 hours, the performance detailed in the report appeared to demonstrate a reduction in performance. Mrs Libiszewski had understood that the service delivered at Grantham Hospital would have allowed for better performance.

1273/19 The Chief Operating Officer advised that job planning issues and availability of surgeons had caused some concern for the service, work was being undertaken to resolve the issues.

1274/19 The Board requested sight of performance data in order to receive assurance of the performance of the service. This would be reported to the Finance, Performance and Estates Committee and upward reported to the Board.

Action – Chief Operating Officer, 2 September 2019

1275/19 Dr Gibson stated that whilst incidents of harm were moving in the right direction, medication errors felt as though they were high. The Deputy Chief Nurse advised that whilst the Trust were at the lower end of reporting for medicine errors there was a conflict of information which may require further exploration.

1276/19 The Chief Executive reinforced the comment made regarding the national view of the Trust being that A&E remains an issue and causes angst. A recent national escalation call had identified that the Trust would continue to receive scrutiny due to low levels of performance.

Concern had also been raised due to the national worsened picture during the summer months where improvements are normally seen prior to moving towards the winter period.

1277/19 The report was developing well and the Board would expect to see those KPIs reporting as off target within the executive summary moving forward.

The Trust Board:

- **Received the report**

Item 16 Risk and Assurance

1278/19 **Item 16.1 Audit Committee Upward Report**

Mrs Libiszewski provided the assurance received by the Audit Committee at the July meeting on behalf of the Audit Committee Chair.

1279/19 The Committee received the internal audit plan, the Trust had provided feedback on the setting of the programme and the Committee were of the opinion that the auditors were on target to deliver in a phased approach. A set of KPIs had been requested in order to manage the contract with the auditors in addition to the output. The legacy issues from the previous internal auditors had been handed over and were being managed. The Committee were assured that there was unlikely to be a backlog of issues at year end due to the planning that had taken place.

1280/19 The Committee received the Local Counter Fraud Specialist report, the Committee agreed that the annual report had been a true reflection of the work in the Trust.

1281/19 The final external audit report of the Quality Account had provided limited assurance however had been received late to the Quality Governance Committee. This had resulted in virtual sign off by the Quality Governance Committee, this had been an unsatisfactory situation. The Director of Finance and Procurement would be meeting with the external auditors to discuss the concerns.

1282/19 The Committee had received the final update on the ISA 260 and annual audit letter. The Standing Financial Instructions and Standing Orders had been received along with a revision to the Standards of Business Conduct policy following the Trust change to structures with the introduction of the Trust Operating Model.

1283/19 An update on policy management had been received and work continued to ensure this became embedded across the organisation.

1284/19 The Committee received an update on the NHS Improvement Undertakings issued to the Trust. There had been a lack of assurance in respect of the workforce plan and the Quality and Safety Improvement Plans.

1285/19 The Committee reviewed the annual report and approved submission to the Trust Board.

1286/19 The Chair noted the issues raised in relation to the NHS Improvement undertakings stating that the Chief Executive would be addressing the issues of the Quality and Safety Improvement Plans. The Workforce plan concerns would be addressed through a deep dive.

1287/19 The Board recommended a review of the undertakings to ensure clarity of what had been signed up to and ensure issues could be identified and addressed.

Action - Director of Finance and Procurement, 3 September 2019

The Trust Board:

- **Received the report**

1288/19 **Item 16.2 Audit Committee Annual Report**

Mrs Libiszewski presented the Audit Committee Annual Report to the Board on behalf of the Audit Chair.

1289/19 Mrs Libiszewski highlighted that it was good practice for Audit Committees to produce an annual report and that a self-assessment of performance during the year had been conducted. An action plan in response to the self-assessment to enhance performance. This process demonstrated compliance with the Good Governance Handbook.

1290/19 The Committee reviewed the Board Assurance Framework at each of its meetings during 2018/19 in relation to the key controls rather than the content, this is reviewed at the Board Committee meetings.

1291/19 The Trust had received a number of internal audit reports on governance arrangements during 2018/19 that had provided limited assurance, this had highlighted the need for further work to ensure assurance could be provided to the Board. The work programme for the Audit Committee sets out reporting to the Board to ensure it becomes assured against the issues raised.

1292/19 The Care Quality Commission visited the Trust and carried out a number of inspections during the year. The Trust remains in special measures of the regulators and there is a continued review process in place, reporting through the Annual Governance Statement had taken place.

1293/19 The Committee made a self-declaration against the Single Over-sight Framework at the year end and continues to strengthen governance arrangements. In order to support the function of the Committee the Trust must have clear Standing Financial Instructions and Standing Orders. The Committee had reviewed the documents and recommended approval by the Board.

1294/19 The Committee receive regular Local Counter Fraud Specialist reports in order to monitor and ensure compliance with NHS Provider Standards for Fraud, Bribery and Corruption.

1295/19 Work with internal and external auditors have been undertaken to ensure the quality of work in line with expectations and to take seriously the findings of the reports and embed change within the organisation.

1296/19 External audit concerns had been raised within the report including concerns about the Quality Account and Annual Accounts. The Committee would continue to focus on ensuring support and assurance would be provided to the Board through continued refresh and consideration of the work programme.

1297/19 There would be an increased focus on the Trust's relationship with Lincolnshire's STP governance arrangements and ensure understanding of the Audit Committee's role in partnership with the Integrated Care System.

1298/19 Representation of Chairs of the Board Committees at the Audit Committee would continue with the need to strengthen assurance reporting through written reports.

The Trust Board:

- **Received the report**

1299/19 **Item 16.3 Corporate Governance Manual**

The Trust Secretary presented the Corporate Governance Manual to the Board advising that this had been approved at the July Audit Committee for recommendation to the Board for final approval.

1300/19 Work had been undertaken with colleagues in both finance and procurement with the aim of the exercise to modernise and align the manual with best practice from across other Trusts. The Trust Secretary noted that the voting members of the Board would need to be amended to reflect the departure of the Deputy Chief Executive. A decision would need to be taken regarding which current non-voting member of the Board would become a voting member, the balance of voting members must be maintained.

The Trust Board:

- **Received the report**
- **Approved the Standing Financial Instructions and Standing Orders**

1301/19 **Item 16.4 NHSI Board Committee Observations**

The Trust Board were advised that feedback letters had been received from NHS Improvement in relation to the Committee and Board observations that had been undertaken. Identified actions had been extracted from the feedback of the Committee observations to be presented to the Board, work would be undertaken with the Committee Chairs to address the areas raised. The actions presented to the Board would be separated out for each Committee.

1302/19 The Chair advised that some amendments had been suggested to the feedback received from the observed Board in July. The actions from the feedback would be extracted for inclusion in the overall action plan.

1303/19 Specific areas identified that the Board should be made aware of included the volume and quality of papers and comments in relation to the attendance at the meeting. There would be a need for work to be undertaken within the Trust to clarify the difference between assurance versus reassurance. The relationship of the upward reports to the Board from Committees would require review to ensure these provide the assurance being sought by the Board.

1304/19 The actions would be reviewed as a whole to determine those actions required to make improvements and as a learning Board there would be a need to reflect and take these actions in to practice.

Action – Chair, 3 September 2019

The Trust Board:

- **Received the report**

1305/19 **Item 16.5 Risk Management Report**

The Medical Director presented the report to the Board.

1306/19 Key points noted included that the risk of Aseptic Pharmacy had been divided in to three distinct areas. These were harm to patients, infrastructure failure and compliance with regulations. Even with the split of the risk it remained high.

1307/19 The Medical Director advised that there had been a leak in to the Aseptic Pharmacy and as a result the unit had been closed, this had resulted in the Trust currently having no aseptic provision. Support had been sought from Northern Lincolnshire and Goole NHS Trust whilst a resolution to the issue was identified.

1308/19 The operational risk register had been reported to the Clinical Business Units to ensure this became embedded whilst improving the understanding of risk at an operational level. There would be a substantial amount of education to be undertaken with staff.

1309/19 Mr Hayward requested clarity of the reputational/compliance risk levels reported due to the disparity between the corporate and operational risk profile charts. These were reported as moderate and high risks corporately but very low and low risk operationally.

1310/19 Discussion was held regarding the overdue nature of the updates to the risk register and also the increase to risk ratings being undertaken no explanation as to why this had been amended. The Board were in agreement that it would be useful if movements in the risk ratings were detailed on the front sheet to provide clarity.

1311/19 The Medical Director stated that updates to the risk register would be completed and reported back to the Board in September.

Action – Medical Director, 3 September 2019

The Trust Board:

- **Received the report**
- **Accepted the top risks within the register**

1312/19 **Item 16.6 BAF 2019/20**

The Board considered the latest iteration of the Board Assurance Framework that had been updated by all of the Board Committees during July.

1313/19 The Chair asked the Board to consider the assurance ratings provided to determine if any of the conversations held during the meeting had affected the ratings provided.

1314/19 Mrs Libiszewski advised the Board that patient experience had been included within objective 1a – Deliver Harm Free Care, of the framework and that the Quality Governance Committee would receive updates to provide assurance.

1315/19 It was noted that assurance gaps had been identified in relation to objective 2a – Have 'zero waits' to access our services, however there had been no identification of how these would be managed. Mrs Ponder advised the Board that the Finance, Performance and Estates Committee had not yet received information about the measurement of the metric.

1316/19 The Chief Operating Officer stated that a report had been developed however a data quality review would be required prior to sharing the report with the Committee to ensure accuracy of the data reported.

Action – Chief Operating Officer, 3 September 2019

1317/19 System delivery reports were starting to be available in relation to objective 4a – Make sure the care given to our patients is seamless between ULHT and other service providers through better service integration. Consideration as to how these would be presented to Board members and ensure upward reporting through Committees would be required.

Action – Chief Operating Officer, 3 September 2019

1318/19 The Board agreed that the assurance ratings provided were an accurate reflection of the current position.

The Trust Board:

- **Received the Board Assurance Framework**
- **Noted the progress**

Item 17 Strategy and Policy

1319/19 **Item 18 Board Forward Planner**

For information

Mr Hayward suggested that there would be benefit to receiving the Clinical Strategy in September and that there would be a requirement to change the name of the 2021 Strategy to be reflective that this is a 5 year strategy.

Action – Trust Secretary, 3 September 2019

1320/19 **Item 18.1 Board Development Schedule**

For information

1321/19 **Item 19 ULH Innovation**

For information

1322/19 **Item 20 Any Other Notified Items of Urgent Business**

The Chair advised the Board that the meeting had been the last for Mr Bains as the Healthwatch representative for Lincolnshire. The Chair passed on the thanks of the Board for the contribution made by Mr Bains and for being a great advocate for the patients of Lincolnshire. The Board wished Mr Bains good luck for the future.

The next meeting will be held on Tuesday 3 September 2019, Boardroom, Lincoln County Hospital, Lincoln

Voting Members	28 Sept 2018	26 Oct 2018	30 Nov 2018	7 Jan 2019	5 Feb 2019	5 Mar 2019	2 Apr 2019	7 May 2019	4 June 2019	2 July 2019	6 Aug 2019
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	A	X	X	X	X	X	X	X	X	X
Geoff Hayward	A	X	X	A	A	A	X	A	X	X	X
Gill Ponder	X	X	X	X	X	X	A	X	X	X	X
Jan Sobieraj	X	X	X	X	X	X	X	X	X		
Neill Hepburn	X	X	X	X	X	X	X	X	X	X	X

Karen Brown	A	X									
Michelle Rhodes	X	X	X	A	X	X	A	X	X	A	A
Kevin Turner	X	X	X	X	X	X	X	X	X	X	A
Sarah Dunnett	X	A	X	X	X	X	X	X	X	X	A
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X
Alan Lockwood	X	X	X	X	X	A					
Paul Matthew			X	X	X	X	X	X	X	X	A
Andrew Morgan										X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Deadline	Completed
7 May 2019 4 June 2019	684/19 886/19	Committee KPIs	Committees to review the number of KPIs that are reported to them with a view to confirming they are required.	All Board members	4 June 2019	All committees have now considered and agreed. This will now feed review of overarching Board document.
4 June 2019	827/19	Assurance in respect of H&S actions reported to FPEC	Clarity required in relation to training etc and metrics on actions following historic regulation/prosecution	Boocock, Paul	~~02/07/2019~~ 03/09/2019	Paper provided to August FPEC. Further detail requested.
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	30/09/2019	
2 July 2019	1004/19	Finding relating to sepsis within the CQC report	Consideration of what needs to change to address the issues highlighted and how this doesn't align to data that Board had previously seen	Rhodes, Michelle	06/08/2019	Discussion held at QGC, dashboard awaited that reflects data to enable comprehensive discussion at Committee – remain open
2 July 2019	1016/19	CQC Feedback letters June 2019	QSIP not having the impact would have wanted. Need review of this and where we get assurances from. How we prevent these issues arising rather than responding to problems after the event	Morgan, Andrew	06/08/2019	Review of QSIP content and process not yet complete. Consideration being given to completed programmes of work to determine which to move forward to

						next year and which groups are being sighted on the programmes. Current arrangements in place have not delivered what was expected
2 July 2019	1039/19	Pay and FEPs	Consider first at ET how we improve position. Then time at Board	Matthew, Paul/Rayson, Martin	06/08/2019	Board Development session held and actions agreed. Complete
2 July 2019	1062/19	People Strategy	Develop some ambitious outcomes, built up with colleagues within the divisions. Through ET in first instance. Develop forward plan for rest of this year. Strategy back when ready	Rayson, Martin	~~06/08/2019~~ 01/10/19	Board Development session scheduled for September prior to revised strategy being presented to October Board
2 July 2019	1063/19	Trust Strategies	A plan to consider all strategies in a Board workshop as a totality. Include review of overall number of documents called strategies	Warner, Jayne/Morgan, Andrew	06/08/2019	Board Development session scheduled for October
2 July 2019	1068/19	Continuous Quality Improvement Approach	Use to influence the patient/staff story received at Board	Rayson, Martin	06/08/2019	Complete
2 July 2019	1076/19	Continuous Quality Improvement Approach	Actions to be translated to outcomes for inclusion within the strategy and reporting to Board to be determined	Rayson, Martin	06/08/2019	Progress reports to be taken to the W,OD & T Committee
2 July 2019	1077/19	Continuous Quality Improvement Approach	Feedback to the system that the Trust are taking forward the methodology	Rayson, Martin	06/08/2019	Progress reports to be taken to the

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

						W,OD & T Committee
2 July 2019	1091/19	Improved Performance	Publicise the good news stories in our performance. To refer to Communications	Richards, Anna	06/08/2019	Complete
2 July 2019	1103/19	Risk Register	Some areas of the risk register still out of date. Audit Committee to consider at July meeting	Dunnett, Sarah	06/08/2019	Risk Register reviewed at July meeting. Complete
2 July 2019	1111/19	BAF	SO2bi to be updated to red assurance rating	Warner, Jayne	06/08/2019	Complete
2 July 2019	1112/19	BAF	Consideration to be given to management of SO2bii due to baseline year	Matthew, Paul	06/08/2019	Meeting during August to develop baseline, proposal to be taken to Trust Management Group – complete
6 August 2019	1170/19	Patient Story	Letter of thanks to be sent to the patient for sharing their story	Baylis, Elaine	03/09/2019	Complete
6 August 2019	1186/19	QGC Assurance report	Review of window cleaning impact on cleanliness audit	Boocock, Paul	03/09/2019	
6 August 2019	1204/19	CNST Safety Scheme	Review Medway system and provider to ensure ability to become complaint with data reporting	Turner, Kevin	03/09/2019	
6 August 2019	1248/19	W,OD&T Assurance report	Refresh of the leadership development programme to be presented to the Board.	Rayson, Martin	01/10/2019	
6 August 2019	1249/19	W,OD&T Assurance report	Future Board Development session to be arranged to provide further focus to leadership	Warner, Jayne	03/09/2019	
6 August 2019	1253/19	W,OD&T Assurance report	Review and consideration of the frequency of Committee meetings	Baylis, Elaine	03/09/2019	
6 August 2019	1274/19	Integrated Performance Report	Performance data to be reported to FPEC in relation to fractured neck of femur patients being treated within 24 and 48 hours	Brassington, Mark	03/09/2019	Discussed at FPEC. Further clarity requested.

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

6 August 2019	1287/19	Audit Committee upward report	Further review of NHSI undertakings to be completed	Matthew, Paul	03/09/2019	
6 August 2019	1304/19	NHSI Board Committee Observations	Reflection of actions identified from observation feedback	Baylis, Elaine	03/09/2019	
6 August 2019	1311/19	Risk Management Report	Risk Register to be updated	Hepburn, Neill	03/09/2019	
6 August 2019	1316/19	BAF	Review of data quality in respect of metric 2a prior to reporting to FPEC	Brassington, Mark	03/09/2019	
6 August 2019	1317/19	BAF	System delivery reports to be presented to Board members and ensure upward reporting through Committees	Brassington, Mark	03/09/2019	
6 August 2019	1319/19	Board Forward Planner	Schedule Clinical Strategy for September and alter 2021 programme group name	Warner, Jayne	03/09/2019	Complete

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	3 September 2019

Title:	**Chief Executive's Report**

Author/ Responsible Director Andrew Morgan, Chief Executive

Purpose of the Report:

To provide an overview of key strategic and operational issues.

The Report is provided to the Board for:

Information	✓	Assurance	
Discussion	✓	Decision	

Summary/Key Points:

This report is for discussion and information. It provides a high level overview of both System and Trust specific issues.

Recommendations:

The Trust Board are asked to

- Note the content of this report
- Discuss progress against System and Trust specific issues and note where good progress has been made and where additional work is required.

Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (e.g. Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Requirement for further review?	

System Issues

1. The first Lincolnshire System Review took place with NHSE/I on 20th August. These reviews will be bi-monthly and are intended to avoid the need for bilateral reviews with individual organisations. This was a positive first meeting. The key points to arise were that good progress is being made on system working; further refinement is needed relating to the quality metrics; population health management should proceed at pace; a roadmap is needed to explain how the system will become an ICS by 2021; the need to ensure that the development of the local 5 year plan is not swamped by national directives; and that the system was congratulated for its cancer performance in June.

2. A system finance escalation meeting was held with NHSE/I on 14th August. There is a clear regional expectation and requirement that the system delivers the combined system control total of a deficit of £63.6m at year-end. This is before any PSF/MRET etc. funding. The escalation meeting was called because of the M3 position and the remaining £21m gap in the system's savings plan. The system needs to provide evidence of what actions it will take to deliver the system control total, provide a bridge to the year-end to evidence this and show the planned monthly trajectories. This needs to be provided to NHSE/I by 6th September. Work is underway to provide this information.

3. Linked to 2 above, further work is underway to identify the schemes and proposals that will close the savings plan gap of £21m. All organisations have been requested to put forward their ideas by 28th August, for review by a small group including Paul Matthew. These ideas are expected to range across the full areas of spend of the CCGs and should not be limited to the three main providers in Lincolnshire.

4. Work is continuing to develop the Lincolnshire 5 year plan, in line with national guidance and timescales. As mentioned earlier in this report, feedback has been provided to NHSE/I about the frequency and quantity of national guidance and how this is hampering local planning. The Lincolnshire plan will build on the work done as part of the Healthy Conversation 2019. It is anticipated that the plan will have 4 elements: a summary narrative; the strategic planning tool setting out workforce, financial and activity information; the metrics collection tool setting out planned delivery of all of the national metrics; the workforce collection tool setting out the workforce figures for the system.

5. Further work is underway to refine the NHS system governance arrangements in the county as part of the continued efforts to embed system working. These will be considered by SET and the LCB over the coming weeks. The focus of the draft proposals is around System Finances and Performance and System Planning and Strategy. The Executive governance arrangements have already been revised by SET, so these proposals relate to how assurance can be improved to involve more input by NEDs and lay members.

6. SET is refocusing it's efforts to better reflect the range of issues that require attention. Two meetings a month will focus on operational and system resilience matters; one meeting a month will focus on strategic issues; and one meeting a month will be replaced by the new Joint Working Executive Group (JWEG) comprising NHS, LCC and voluntary sector representatives. The first workshop session of the JWEG takes place on 28th August.

Trust Specific Issues

1. The M4 financial position shows a year to date deficit of £20.494m compared to a planned deficit of £19.516m. This is an adverse variance of £978k. The underlying deficit is £3.509m after taking into account technical and timing adjustments included in the year to date position. The key driver for the adverse position is pay costs, including agency costs. The Board has recently held a deep-dive session on pay to better understand the current position. The year to date position on FEP delivery is £4.955m compared to a plan of £5.104m. This is an adverse variance of £149k.

2. An urgent and emergency care escalation teleconference took place with the national director for urgent and emergency care on 16th August. These are fortnightly calls bearing in mind the continued performance issues in the system. It was acknowledged that progress is being made in Lincolnshire, although it was also noted that further work is needed on improving weekend discharges. Further information was requested on the medical staffing situation and the need to push on with the capital build at Pilgrim A&E was reinforced.

3. I have held a meeting with the University of Lincoln in order to stress how important it is that our two organisations work together on a range of mutually beneficial topics. These include the new Medical School, research, rural healthcare, technology, OD. This was a very constructive meeting.

4. I am pleased to confirm that Victoria Bagshaw has been appointed as the Acting Director of Nursing. Victoria will take up her role on Monday 23rd September when Michelle Rhodes moves to her new role in the Midlands. I would like to thank Michelle for all of her work at ULHT over a number of years. She represents everything that is good about nursing and has been a loyal and hard working colleague. Although I have only worked with Michelle for a couple of months, in that time I have come to understand how loved and respected she is by her colleagues in the Trust. I wish Michelle well in her new role.

5. I am continuing to get out and about visiting services across the Trust, in both clinical and support functions. Both are vital to the Trust. I have also been doing a lot of media work, including an interview for ITV, an interview with the Grantham Journal and a slot in the 'hot seat' on BBC Radio Lincolnshire.

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Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20th August 2019
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Gemma Coupland, Personal Assistant

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. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives.
	Assurance in respect of SO 1a Issue: Delivering harm free care <u>Source of Assurance: Quality and Safety Oversight Group –</u> Progress continued to be made by the group and divisional representation had increased. Concerns were raised on the Divisions ability to run their governance from their speciality meetings through to Divisional reports to escalate issues appropriately. The Group stated their intention to review the content of the BAF at their next meeting to facilitate input from the Divisions on the level of control and assurance. The Committee were pleased to see the group functioning as it had been intended, and providing improved assurance to the Committee. <u>Source of Assurance: Organ Donation Report –</u> The Committee were assured of the processes and governance in relation to organ donation through the annual report from the Organ Donation Committee. The Trust was in line with the national average for the referral of potential organ donors and for Specialist Nurse presence when approaching families to discuss the donation. A work plan had been produced following a gap analysis. During organ donation week (2nd to 6th September) the Trust will undertake some marketing on the sites along with increased communications regarding organ donation. This will include contributions from organ recipients. The lay Chair of the Organ Donation Committee also reported that preparations were in hand for the change to "presumed consent" which will come into force in Spring 2020. The Committee thanked the chair for

	all his work on this sensitive issue. Source of Assurance: Infection Control Upward Report – Concerns were raised on water safety, in particular closed off areas and the ability to complete a flushing regime. The Committee requested this was escalated to the Finance, Performance and Estates Committee, in particular to review closing off rooms and corridors. IPC will undertake further work regarding the dose when antibiotics are run through IV long lines. A Business Case was being drafted for funding for a Trust Decontamination Lead, this currently sits on the risk register. The Committee received the Surgical Site Infection Report for Quarter 1. The Trust needs to improve reporting to ensure compliance with statutory requirements. The SSI process is now part of GIRFT and the Committee will receive an update on additional elements within the next report. The Committee received the updated hygiene code and noted the 97% compliance in April 2019. Source of Assurance: Safeguarding Annual Report. The Committee received the annual report which also included the Statements of Intent for both Public and Staff. The Committee agreed the documents for publication. Some concerns were raised on Safeguarding training. It was noted this was an ongoing issue and was on the risk register. Further discussions would take place at the Safeguarding Committee. Source of Assurance: VTE Report – The Trust continues to perform well above the national average for VTE Risk Assessment, with June being 96.57%. A significantly lower incidence of VTE was also noted. Further assurance was required on continued care when the patient was discharged into the Community, given the number of various services available. A consistent service specification was being developed to ensure the Wards have all information required on discharge. Source of Assurance: NICE and Best Practice Report: The Committee received the report detailing the progress made although there are still a number of guidelines that await assessment. Concerns were raised within the report on participation in national audits due to further work required on the Speciality governance process. Source of Assurance: Delivery against Quality Priorities – The Committee received an update on delivery against Quality Priorities for Q1. Work was in progress to enable delivery of the quality priorities by March 2020. The Committee noted improvements required for FFT and the Committee

	requested that the next report includes details of actions required to recover delivery. Source of Assurance: QIA. – The Committee were informed that no further QIA's had been undertaken since the last report. Policy for QIA's was currently being updated to confirm the ownership for the assessment following the agreed proposal. The Committee asked for confirmation that a QIA had been completed for the planned Lincoln reconfiguration. Source of Assurance: CQUIN Update – The Committee received the report. The Trust has received full payment for Q1 as this task was to develop the milestones for the 4 quality priorities. The Trust was awaiting confirmation for the specialised CQUINS. Due to the 5th quality priority for stroke being a joint CQUIN with LCHS this was still under discussion, but criteria and milestones for 4 priorities had been agreed. Source of Assurance: Risk Report. The Committee received the report and noted the compliance risk for safeguarding had been reduced due to the change in DBS process and chaperoning. The Committee were informed that the risk associated with Aseptic pharmacy production had materialised and the unit at Pilgrim was now non-operative. The Trust was using an isolator at Grimsby for the short term until a more viable solution is found, which may include the use of a mobile unit to bring the service back on site. Source of Assurance: Incident Management – The Committee received the report. Concerns were raised regarding Ward 6A due to the increased number of incidents and it was agreed a full report would be brought to the Committee next month. In response to the request made by Trust Board in relation to Never Events, the Committee received a verbal update that briefings were being developed to share information and improve communications around Never Events. The Medical Director will bring a further report to the Committee. A recent Never Event was also discussed, this is undergoing investigation. Source of Assurance: Equality and Diversity Annual Report: - The committee received the Equality and Diversity Annual Report and noted the content. A particular focus this year had been on hearing impairment, and work on implementation of the Accessibility Information Standard will continue. The Committee approved the annual report to Board.
	Assurance in respect of other areas:- Integrated Performance Report – The Committee received a proposal for a revised set of metrics for the Committee. The Committee agreed the revised set of metrics and would receive them in future performance reports, together with a narrative to provide further assurance.

	Patient Experience – The Committee received the patient experience report for Quarter one. The top 3 themes are Communications, Appointments/ Waiting and Car Parking. Increased representation from Divisions had been seen at the recent patient experience group meetings. A task and finish group is being established to work towards improving the issues raised in the national inpatient survey. Further work was required on FFT to ensure that the quality priority remains on progress to deliver. Complaints report – The Committee received the report for quarter 1. The Trust currently had no overdue complaints. The themes are similar to those from before and the process remains timely. Further work is required to try and get the response right first time to decrease the amount of re-opened complaints (currently approx. 12%). An education programme will be developed to improve the responses written by the Divisions to improve ownership. Quality and Safety Improvement Plan – The Committee received the report which made recommendations for transferring some projects to become Divisional responsibilities. A revised set of Trust-wide projects would be included within this year's QSIP, along with any actions and recommendations arising from the forthcoming CQC report. Reports would be received on actions in response to the Section 31 and 29A letters at both the Quality Governance Committee and Trust Board. The Committee was informed that progress towards meeting the targets was on course. The Committee were informed that the Quality and Safety Improvement Group had now been disbanded and that governance for both the Trust-wide Quality and Safety Improvement Plan and Divisional quality schemes would now be taken through QSOG.. Ward Accreditation – Carlton Coleby. The Committee received a detailed report following the deteriorated position on this ward. The pivotal issues on the ward are felt be to leadership. The ward has a poor environment for the type of patients it receives, although the patient experience rates are positive. An interim leader is now in post and the Quality Matron is undertaking weekly visits to review different parameters. A further review would be undertaken in 7 weeks.
Issues where assurance remains outstanding for escalation to the Board	No items were identified for escalation
Items referred to other Committees for	The Committee requested to refer the change of use of rooms, especially in relation to water safety, to the Finance Performance and Estates

Assurance	Committee.
Committee Review of corporate risk register	The Committee reviewed the risk register noting that there had been no major changes to the document.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed since the last meeting. The Committee rated the assurances which were the responsibility for the Committee which would be escalated through the Board Assurance Framework
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. The Committee were not assured in respect of any of the strategic risk areas which aligned to it.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

Voting Members	A	S	O	N	D	J	F	M	A	M	J	J	A
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X	A
Chris Gibson Non-Executive Director	X	A	X	X	X	X	X	X	A	X	X	A	X
Alan Lockwood Int Non-Executive Director	X	X	X	X	A	X	A	A					
Michelle Rhodes Director of Nursing	D	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn Medical Director	X	X	D	X	X	X	X	X	X	D	X	X	X

X in attendance A apologies given D deputy attended

NHS
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Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 August 2019
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Jayne Warner, Trust Secretary

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. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme.
Assurances received by the Committee	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Position and Financial Recovery Plan – Pay costs Source of assurance: The Committee noted that the Trust Board had held a development session during which they had completed a deep dive in to pay costs. The session had resulted in a number of actions which would now be progressed and reported through FTG and back in to the Committee. The Committee noted that the session had led to a request for a Lincolnshire system response and actions also. The Committee were advised that the Trust were off plan by £1m. The plan still assumed the full payment of the PSF and FRF. Income was £0.1m adverse to plan but this was supported by pass through income of £0.3m. The Committee considered the financial risks. The Committee were advised of the risk around the level of repatriation income which had been included in the plan. It was not anticipated that the Trust was achieving the level of activity. Urgent care patients continued to fill beds which were the not available for elective patients. The Committee noted the submission of the Trust's return on Reference Costs by the due date. The Committee was asked to support the escalation of the approval of new borrowing to the Trust Board to the value of £4.196m revenue borrowing and £0 capital borrowing for October 2019. The Committee gave its support and recommended approval by the Board.

	Actions requested by the Committee: The Committee requested updates against the actions agreed at the Board Development session on pay costs and assurance that the reference cost data was being used to help reduce costs.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Progress Housing Reason for lack assurance: The Committee were in receipt of a report on actions being taken to minimise costs being incurred in respect of under occupancy of the progress housing accommodation. Occupancy levels had improved during May and June but the report did not provide the committee with assurances that there was understanding of how this had been achieved so that actions could be replicated and occupancy had fallen again in July. Action requested by committee: The committee detailed the specific information which they required and that this should be provided for the September meeting.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Efficiency Programme Reason for lack of assurance: The Committee were advised that there was a lack of pace and development of the plans. Action requested by the Committee: The Committee requested that the Executive Team progress the actions outlined in the paper presented to the Committee to bring the Financial Efficiency programme back on track and mitigate the risks to delivery outlined in the paper.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Estates Backlog Maintenance and Critical Infrastructure The Committee noted that fire schemes remained on track and were progressing at pace. Actions requested by the Committee: The Committee asked for more detailed assurance that the work remained on schedule at its next meeting, that the fire service had agreed to the extension of the works and for assurance on the impact of the work completed to date in ensuring that the Trust met the required standards.
	Lack of assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Health and Safety Group The Committee noted the issues that had been presented to the Trust

	estate during the recent adverse weather and the impact which this had on delivery of services. The Committee noted that the Trust had submitted evidence in respect of the HSE notice it had received in respect of working in confined spaces. The Trust would formally request that the notice be lifted. The Committee noted the update on manual handling but remained unassured that all necessary actions had been addressed and that all required staff had been trained and that processes were in place to ensure that hoists were only used by trained staff. Actions requested by the Committee: Requested a report which gave the exact detail of the judgement which had been made in the case and the detail of where the Trust was in terms of addressing each of those issues.
	Lack of Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Failure to deliver Cancer Standards Reason for lack of assurance: The Committee noted that the Trust had improved performance and achieved 7 of the 9 cancer standards. This was a significant improvement, as this level of performance had last been achieved in November 2015 and it compared very favourably to the national achievement of 3 out of 9 standards. The Committee were assured that the improvement plans were having the required impact on performance, even though we were not yet achieving all 9 standards. The Committee noted that the Trust had in place plans to achieve trajectory over the following 9 months, however there remained some extremely challenged areas. Actions requested by Committee: The Committee would continue to monitor improvement actions against the performance improvement trajectory.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent Care Improvement Actions Reason for lack of Assurance: The Trust continued to see a growth on attendances and continued to fail to meet the performance trajectory, with a 5.39% performance deterioration since June and a significant deterioration in ambulance handover delays of more than 59 minutes, amounting to 805 instances. Conveyances were up 408 compared to June, suggesting that alternative pathways to avoid conveyance were not having the required effect. Actions requested by the Committee: The Committee would continue to monitor the impact of the improvement programme and the escalation actions agreed.

	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Planned Care Reason for lack of assurance: The Committee noted that waiting lists had grown and there was increasing demand. The Committee were advised that validation vacancies being held were impacting and this was being reviewed. 52 week waiters were 0 however it was anticipated that there would be 1 52 week waiter in the next reporting period. An improvement project was underway to improve data quality and pathway management to support the sustained improvement of the 18 week standard.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Source of assurance: Self Assessment EPRR Standards The Committee received the details of the self assessment. Which demonstrated compliance with 61 of the 64 standards. Actions were in place for all areas where compliance could not be demonstrated. The Self Assessment would be presented to Board ahead of submission for validation.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Source of assurance: Procurement of E Health Record The Committee considered the proposal for the procurement of the Trusts e Health Record solution and supported that the recommendation being taken forward to Trust Board.
	Committee Dashboard The Committee agreed the dashboard whilst noting that there was still work to be done to ensure that the data presented was consistent and accurate.

Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee noted the performance data on fractured neck of femur which had been referred from the Board meeting. The Director of Operations would confirm that the performance remained within normal variation.
Committee Review of corporate risk register	Corporate risks were noted.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the SRR/BAF was reflective of the key risks in respect of the strategic objectives of the organisation. Assurances received were noted and updates were made to the BAF control gaps and mitigations.
Committee position on assurance of strategic risk areas that align to committee	The Committee received an upward report from the EU Exit Contingency Planning Group and remained assured by the plans and actions being taken in respect of potential risks associated with the EU Exit. With the escalation of planning for a no deal EU Exit in October the Committee would revert to receiving a monthly report to provide assurance. SRO for Brexit would transfer to the Chief Operating Officer following the departure of the Deputy CEO.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
Gill Ponder Non Exec Director	X	X	A	X	X	X	X	X	X	X	X	X
Geoff Hayward Non Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non Exec Director	A	X	X	X	X	X	X	A	X	X	A	X
Deputy Chief Executive	X	A	X	X	X	X	A	A	A	X	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	A	X	D	X	X	X	X	D	D
Director of Estates and Facilities	X	X	X	D	X	D	A	X	D	X	X	D

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS
NHS Trust

To:	Board
From:	Nick Leeming Head of Emergency Planning & Business Continuity
Date:	September 2019
Healthcare standard	

Title:	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)

Author/Responsible Director: Nick Leeming, Head of Emergency Planning & Business Continuity. Mark Brassington Chief Operating Officer

Purpose of the Report: To provide the Board with assurance of the level of compliance against the EPRR Core Standards and the areas of non-compliance along with actions.

The Report is provided to the Board for:

Information	√	Assurance	√
Discussion	√		

Summary/Key Points: The Trust is fully compliant on 61 of the 64 Core Standards and 3 are partially compliant. Actions and timescales have been reported for all areas of non-compliance.

Recommendations: The Board is asked to acknowledge the current level of compliance as **Substantial**

Strategic Risk Register √	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

1 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an overview of the Trust's current position in relation to being compliant against the NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR).

1.2 The Trust Board is asked to note and discuss the areas of non-compliance and consider the robust strategy for the achievement of full compliance for all standards.

2 INTRODUCTION

2.1 As part of the NHS EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

2.2 This report identifies work undertaken to ensure that the Trust is compliant with the statutory requirements placed upon it under the Civil Contingencies Act (2004). It outlines the current position of emergency preparedness and the key activities that have taken place during the last year.

3 NHS CORE STANDARDS FOR EPRR

3.1 The NHS has a statutory requirement to plan for and respond to a variety of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act (2004) details that NHS organisations must demonstrate that they can deal with any incident or emergency while maintaining services to patients.

3.2 In July 2019, NHS England produced a set of updated EPRR core standards. These are the minimum standards which all NHS Trusts must meet.

3.3 At present United Lincolnshire Hospitals NHS Trust is compliant with 61 of the 64 standards. An overview of these standards is set out in Appendix 1.

3.4 Details of each area of non-compliance, together with the actions and timeframes to achieve compliance are set out in Appendix 2. Oversight of the implementation of outstanding actions is undertaken by the Emergency Planning Group on a quarterly basis.

4 RECOMMENDATIONS

4.2 The Trust Board is asked to note the information within this paper and acknowledge the areas that require further action to ensure compliance. The Board is asked to acknowledge the current level of compliance as **Substantial**

Appendix 1: EPRR Core Standards ULHT Compliance Overview:

No.	Domains	No of Core Standards	Compliance
1	Governance	6	
2	Duty to assess Risk	2	
3	Duty to maintain plans	14	**13/14 Compliant**
4	Command & Control	2	
5	Training and Exercising	3	
6	Response	7	
7	Warning and Informing	3	
8	Cooperation	4	**3/4 Compliant**
9	Business Continuity	9	**8/9 Compliant**
10	Chemical Biological Radiological Nuclear (CBRN)	14	
	Total	64	**61**

Deep Dive Severe Weather			
DD1	Severe Weather Response	15	**14/15 Compliant**
DD2	Long Term Adaptation planning	5	
	Total	20	

Deep Dive

Each year a ‘deep dive’ is conducted to gain additional assurance into a specific area. Below provides a list of previous ‘deep dive’ topics:

2015-2016 pandemic influenza
2016-2017 business continuity
2017-2018 governance
2018-2019 command and control
2019-2020 adverse weather.

The self-assessment against the deep dive standards does not contribute to the organisation’s overall EPRR assurance rating, these are reported separately

Appendix 2:

EPRR Core Standards ULHT Compliance and Recovery Actions in detail

Ref.	Standard	Core Standard	Current Position	Action Required	Accountable Person	Timescale
Governance						
1	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio.				
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.				
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually.				
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks				

		• outcomes from assurance processes.				
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.				
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.				
Duty to Risk assess						
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.				
8	**Risk management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.				
Duty to maintain plans						
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.				
11	**Critical Incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).				
12	**Major Incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).				

13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.				
14	**Cold Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.				
15	**Pandemic Influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.				
16	**Infectious Disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.				
17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination.				
18	**Mass Casualty Surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.				

19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.				
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.				
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Fire doors currently undergoing update across whole trust this includes updating ironmongery fitted to doors which will have an impact on lockdown procedures as they may used differently depending on fire regulations	Milestones: Trust audit of fire doors completed by Sep 18. Doors fitted in critical importance completed by Oct 2019. Fire door replacement programme completed by end of 2020	Director of Estates & Facilities	The trust is undergoing a complete fire door replacement across all sites which will change the existing lockdown plans as doors are replaced and their use changed as per fire recommendations . A full site lockdown test will not be able to be tested until fire door replacement programme has been completed. As doors are replaced we will

						test zonally to ensure that the zone can be locked down utilising the new doors.
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.				
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.				

Command and Control						
24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.				
25	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.				
Training and Exercising						
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.				
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements.				

		Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.				
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation				
Response						
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.				

31	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.				
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.				
33	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.				
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.				
35	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.				
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.				

Warning and Informing						
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.				
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.				
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.				
Cooperation						
40	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.		Due to sickness and conflicting meetings there has been non attendance	AEO	
41	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.				
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies.				

		These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).				
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.				
Business Continuity						
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).				
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.				
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).				
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.		Toolkit was submitted 31 March 2019. NHDs Digital issued action plan for compliance	Deputy Chief Exec	**March 2020**
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors				

		• IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.				
52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.				
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.				
54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.				
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.				
CBRN						
56	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.				
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).				
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work				

		• List of required competencies • Arrangements for the management of hazardous waste.				
59	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	**GDH ED open from 0800-1830hrs daily**			LCH and PHB have 24/7 capability but not GDH
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.				
61	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.				
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks				
63	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents				

		• Pump • RAM GENE (radiation monitor) • Other equipment				
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.				
65	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training				
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.				
67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.				
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.				
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.				

Appendix 3 :

Deep Dive Severe Weather

Ref.	Standard	Standard	Organisation evidence	Action Required	Accountable Person
Severe Weather Response					
1	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat	ULHT Heatwave plan updated to national 2019 version		
2	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	ULHT Heatwave plan updated to 2019 version of national plan		
3	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Inclement Weather Guidance produced and going through final ratification		Director of HR and Organisational Development

4	**Service Provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Community IT systems identify vulnerable patients (e.g. people who wouldn't be able to manage their medication if a nurse couldn't get in etc). A list of these patients is pulled off the system regularly so that in the event of extreme weather or a system failure, services would be able to prioritise essential visits. For example during the heavy snow last year, community services worked closely with the army and other organisations who had 4x4's to take staff to essential visits. In extremis, organisations would look at moving the most vulnerable patients into transitional care beds if appropriate.		
5	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	ULHT works closely with neighbourhood teams to ensure patients are discharged to safe environments. A discharge MDT takes place each day including community services and adult social care.		
6	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and	ULHT Snow Clearing and Gritting procedure is activated when temperature triggers are met		

		clearance plans activated by predefined triggers			
7	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	EP Team receive all weather warnings and issue as required. Comms team also included on a warning and informing basis.		
8	**Flood Prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	For external drains at Lincoln County Hospital there is a PPM program. At Pilgrim there is close alliance with Anglian water in place due to an increased risk of flooding across the site and the Estates plant men have a regular tasking to check the drainage system. Grantham do not have a PPM for drainage in place but have never had issues with drains blocking and are not at risk of flooding, however they do have a call out system in place should any drains be blocked.		
9	**Flood Response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Strategic Coastal Flooding Plan and Inland flood plan available on trust intranet and ULHT RD pages for on call staff		

10	**Warning and Informing**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Comms have 24/7 on call in place to issue weather alerts as required		
11	**Flood Response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Evacuation plans are in place for all sites. Pilgrim Hospital is at most risk of flooding and has arrangements in place for contacting Fire Brigade and Anglian water specialists for local issues to do with flooding. During periods of inclement weather we have on call plantmen who carry out routine servicing and checks 24/7 for at risk areas and this is documented in the workplans.		
12	**Risk Assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Risks documented on ULHT risk system. Severe weather action cards are part of BC departmental plans.		
13	**Supply Chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	For clinical products we utilise NHSSC which is a national service to Hospitals and therefore we are assured via the NHSSC and the continuity plans they have. For general goods and service providers we do not have specific risk assessments for		

			severe weather responses. Where we undertake tenders or use framework contracts then business continuity clauses are included in the contracts and suppliers are required to demonstrate resilience to this as requested.		
14	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Fully involved in Beast from East which tested plans and feedback received fed into updates as per reference 3. We have also been in involved in severe flooding to 2 of our sites in June 19 and are currently incorporating lessons learned into relevant plans.		
15	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Fully agile remote system in place. Cyber EX Rosso completed 31 July 19		
Long Term Adaptation Planning					
16	**Risk Assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the	The risk of significant service disruption due to severe weather or climatic event is included on the Trust's Corporate Risk		

		organisations risk register.	Register (Datix risk ID 4438). This is currently rated as Low risk (4) on the basis of emergency plans and business continuity arrangements in place.		
17	**Overheating Risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling hierarchy	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on the risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling hierarchy. These figures are reported into the Trusts ERIC annual returns. The most serious areas such as stroke ward at LCH have had specialist environmental surveys undertaken with a view to developing mitigation plans		
18	**Building Adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	All new service development projects are designed and built to HBN and HTM standards which cover the necessary building performance specifications to ensure continuity of business.		
19	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example	All new service development projects are designed and built to HBN and HTM standards which cover the necessary building performance specifications to		

		Sustainable Urban Drainage Systems to reduce flood risks.	ensure reduced impacts on surrounding environments.		
20	**New Build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	The organisation has a board level approved Sustainable Development Management Plan and also Estates Strategy.		

Compliance level	**Definition**
Not compliant	Not compliant with the core standard. In line with the organisation's EPRR

	work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

Overall EPRR assurance rating	**Criteria**
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.

Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Martin Rayson, Director of HR and OD
Date:	September 2019

Title:	**Annual Plan update**

Author: Karen Sleigh, Head of 2021 Change Programme

Purpose of the Report:

The purpose of this report is to:

- Provide an overview of our delivery against our Annual Plan 2019/20.
- Provide an update on the progress of learning lessons from our Annual Planning to shape our next operational planning cycle.
- Outline the links with the wider system planning intentions.

The Report is provided to the Board for:

Decision	✓	Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- The Trust Board signed off the final Annual plan for 2019/20 in May 2019, there is ongoing development of the monitoring and assurance of delivery of the plan.
- The purpose of the plan is to set out the Trust's intentions for:
  - Demonstrating delivery of our services and their challenges and opportunities.
  - Setting out the vision and direction of travel, which aligns to our Five-Year Strategy.
  - Detailing plans for key services including activity, workforce and financial plans.
- Providing an overview of the planning intentions for 2020/21.
- Outlining the links to the planning within the wider system.

Recommendations

- That the Trust Board note the approach to monitoring and assurance of the delivery of our existing 2019/20 Annual Plan, together with the improvement programme approach for the delivery of our 2020/21 Annual Plan.

Strategic Risk Register The risks to delivery of our ambitions, objectives and priorities are managed through our Board Assurance Framework.	**Performance KPIs year to date** Performance metrics are managed through our Performance Framework.

Assurance Implications
This paper forms part of the governance assurance of the Trust.

Patient and Public Involvement (PPI) Implications There will be further communication and engagement to provide updates to our staff, patients and the public to communicate the delivery of our intentions.
Equality Impact There will be an Equality Impact Assessment conducted as part of the consultation and engagement processes.
Information exempt from Disclosure – Yes
Requirement for further review? Yes

1. Purpose of the Report

1.1 The purpose of this report is to provide the Trust Board with an overview of the delivery of our 2019/20 Annual Plan, together with providing an update on the progress of setting out this year's annual planning cycle.

1.2 The 2019/20 Annual Plan was agreed by the Trust Board in May 2019, with key elements of the monitoring of delivery around the Trusts objectives and tactical priorities and performance metrics, which were signed off as part of the Trust's strategic planning, which form part of the new Trust Operating Model's governance and Performance Review Meetings (PRM).

1.3 The key intentions for delivery of the 2019/20 Annual Plan are to:

- Demonstrate our delivery intentions together with our challenges and opportunities.
- Set out the vision and direction of travel, which aligns to our Five-Year Strategy.
- Detail integrated plans for key services including activity, workforce and financial plans.

1.4 We are currently embarking upon an improvement programme to deliver this years operational planning intentions, building on the lessons learned from previous years and seeking opportunities to sustain an approach to annual planning that is integrated across the Trust with a systematic monitoring, and reporting process, together with the wider system planning intentions.

2. Recommendations

2.1 That the Trust Board note the approach to monitoring and assurance of the delivery of our existing 2019/20 Annual Plan, together with the improvement programme approach for the delivery of our 2020/21 Annual Plan.

3. Summary of Key Points

Background

3.1 The Trust has signed off its first Five-Year Strategy. This has been developed over the last couple of years, building on from the "2021 route map" launched at the end of 2017, to identifying 2021 as an important milestone in our "journey to excellence".

3.2 The Trust Board has also signed off the 20219/20 Annual Plan in May 2019. Since then there has been the 'go live' with the Trust Operating Model, which has led to improved accountability and responsibility to deliver the strategic and annual planning requirements of the Trust through new ways of working.

3.3 There were various workshops held with the Trust Board and the new Divisions to set the direction for the future, pulling together strategic and tactical priorities. These have been supported by the production of scoping documents to highlight the intentions of delivery, which form part of the new ways of working governance and reporting mechanisms.

3.4 The biggest challenges for the Trust were identified in the 2019/20 Annual Plan as being:

- Recruitment of a full workforce to support the Trust's operations. The Plan has a strong focus on recruitment and retention of skilled staff, with a focus on changing the skill mix and embracing new roles.

- Under financial special measures with significant challenge in 2019/20 in reducing the deficit to a control total of £70.3m deficit. The Plan outlines the financial recovery planning to drive out a range of financial efficiency plans, which will enable the new Divisions to achieve significant reductions in operating costs.

- Additionally, the Trust is in quality special measure, with the 2018 re-inspection by the Care Quality Commission (CQC) identifying a 'requires improvement' rating. This has been followed up with the 2019 re-inspection with results expected in September 2019.

- Introduction of the Trust Operating Model from April 2019, moving from 15 Clinical Directorates to 4 Divisions. There is still transition work being undertaken to embed the new structures and roles and responsibilities with the new ways of working, with a six monthly review for October 2019.

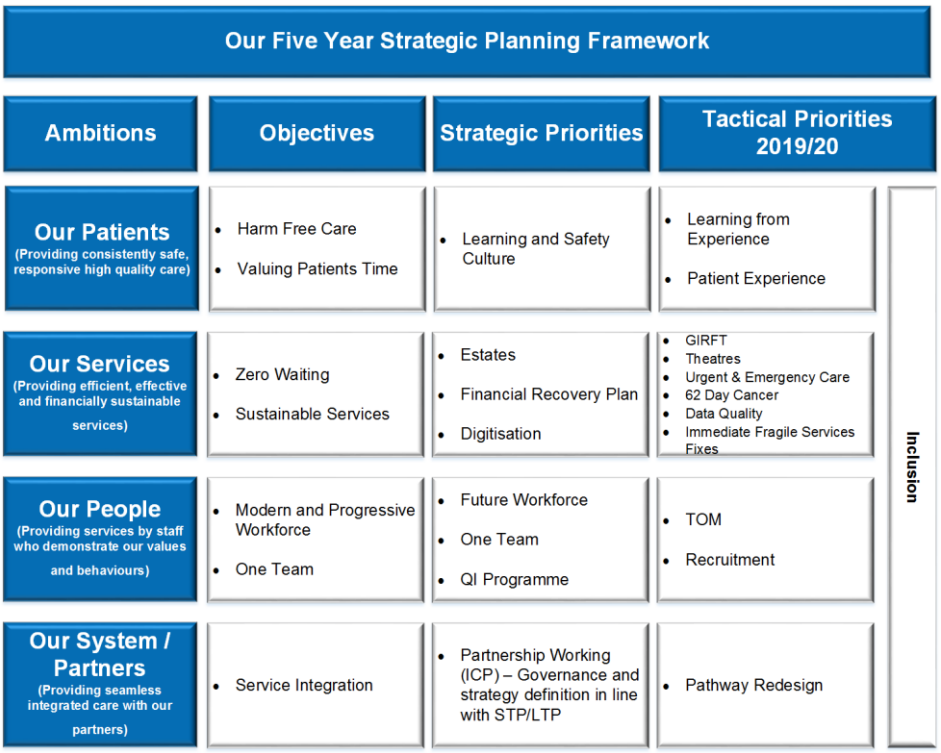
- The wider Lincolnshire healthcare system has been engaging with the whole community on proposals for improvements to services through the 'Healthy Conversation'. This will align with our future clinical redesign and will form an important part of planning intentions for 2020/21.

Summary of the key deliverables

3.5 There is a requirement to report against progress of the intended outcomes outlined in our 2019/20 Annual Plan, which represents year one of our Five-Year Strategy. This is the first report against the plan. As part of this current years planning cycle there will be work to streamline and harmonise reporting of progress as part of an integrated and systematic planning and reporting cycle.

3.6 Setting out our strategic planning framework with our objectives and priorities has provided the delivery structure for the Five-Year Strategy and the annual plans delivery against this.

3.7 The following table outlines the Strategic Framework for the Five-Year Strategy with alignment with the annual tactical priorities to be delivered in year. This report highlights the progress against the tactical priorities in **Appendix A**.



3.8 The following table outlines the key metrics to be measured as part of the Performance Review Meetings on the objectives set out for the Annual Plan. These metrics form part of the Performance Framework, a summary of progress is provided in **Appendix A**.

Objective	Measure	SRO	Baseline 18/19	Metric 19/20	Metric 23/24
Harm Free Care	1.Mortality - HSMR	MD	Within control limits	Within control limits	Within control limits
	2. Avoidable Harm –Safety Thermometer	DoN	98.5%	99%	99%
Valuing Patients Time	3. % patients seen at appointment time (within 15 mins of appointment time)	COO	33%	40%	75%
Zero Waiting	4. Patients discharged within 24 hours of PDD	COO	40%	45%	75%
Sustainable Services	5. Delivery of Financial Plan	DoF		£70.3m Deficit	Break-even
	6.% of Clinical services rated as 'delivering' or 'Excellent'	COO	-	Baseline year	-
Modern and Progressive Workforce	7. Vacancy fill rate (all staff)	DoHR	14.3%	12%	9%
One Team	8. Recommend as a place to work (staff survey)	DoHR	41%	46%	63%
	9. Recommend as a place to receive care	DoHR	47%	53%	72%
Service Integration	10. % reduction in face to face contacts in Outpatients	COO		5%	33%

Summary of enabling strategies

3.9 **Appendix B** provides an overview of the position of the delivery of our enabling strategies, which are set out in our 2019/20 Annual Plan:

Summary planning process for 2020/21

3.10 There is a planned improvement programme approach to deliver our 2020/21 Annual Plan and improve our operational and business planning processes, which will deliver against the timetable and recommend a sustainable framework for future delivery that ensures alignment to our long-term vision.

3.11 We have set up a Task and Finish Group and a Steering Group to enable the programme of delivery, with additional support for Divisions through the 'Business Partnering Model' with HR, Finance and Improvement Business Partners working together across and with Divisions. There will also be further work to ensure the identification of a supporting horizon scanning approach to identify risk, threat and harm to the delivery of our objectives and priorities, together with identifying new and emerging opportunities for consideration for next years priorities.

3.12 There are links with the wider system to ensure streamlining our plans with key deadlines through a system working group, which will be supported by a technical team and organisational representatives to run the delivery as a project.

	ULHT Planning	**System Planning**
September	• Set up the Programme Approach to Business Planning • Demand and Capacity Workshops • Horizon scanning	• Early sight of plan vs. NHSE/I involvement in development • Trust Boards comments • Draft LTP submission
October	• Draft Plans • Arrangement for 'Confirm and Challenge' meetings	• Feedback from the regions • Final draft for Trust Board
November	• Confirm and Challenge meetings • Quality and cross checking • Updates to plans	• Regional review and national executive review • Assurance • Final LTP submission
December	• Operational and technical guidance issued • Redrafted Divisional and Speciality Plans • Draft Annual Plan Prepared returns	• Operational and technical guidance issued • Publication of national implementation programme for LTP
January	• Review updates	•
February	• Draft Annual Plan to Trust Board	• First submission of draft operational plans
March	• Final Annual Plan for publication	• Final submission of operational plans

Summary of ongoing assurance

3.13 There will be an ongoing piece of work to improve the monitoring, reviewing and streamlining of reporting on the progress of the delivery of the 2019/20 Annual Plan. There will be a harmonising of the key reporting processes currently in place through the development and delivery of the 2020/21 business planning cycle.

3.14 Moving forwards, it is recommended that there is a bi-monthly reporting cycle to the Trust Board on the key progress against delivery of the 2019/20 Annual Plan.

Appendix A: Overview of delivery against the 2019/20 Annual Plan

The following report outlines the progress against the delivery of the Annual Plan objectives and tactical priorities for 2019/20. Inclusion will run through all of our priorities.

Ambition 1: Our Patients - providing consistently safe, responsive, high quality care

Our Objectives	SRO	Measure	Baseline 18/19	Metric 19/20	Metric 23/24	Progress
Harm Free Care	MD	1. Mortality - HSMR	Within control limits	Within control limits	Within control limits	ULHT's HSMR is below expected limits at 90.74. This is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits.
	DoN	2. Avoidable Harm – Safety Thermometer	98.5%	99%	99%	The current ST compliance for New Harm free Care is 99.2%.
Valuing Patients Time	COO	3. % of patients seen at appointment time (within 15 mins of appointment time)	33%	40%	75%	On target to meet the 40 % 2019/20 Metric.

Our Tactical Priorities 2019	SRO	Action	Timescale	Action Update	Lead	RAG	Recovery if Red
Learning from experience	DRHROD	• Staff views on how to improve processes to share learning • Review and analyse information from staff survey	April May	Survey completed Survey results reviewed	Sally Seeley Sally Seeley	G	

		• Devise and implement any new arrangements for sharing • Evaluate new arrangements for sharing • Workshop / masterclasses across Division / CBU / Specialities including governance • Accountability Conversations as part of the TOM OD plan • Examples of Excellence being used to recognise staff who learn from experience and raise concerns about risks to safety or quality of care	Oct Feb July Dec Dec	New arrangements for learning based on survey being devised and worked through Masterclasses for Divisions and CBU delivered as per plan. Insight session open to all staff delivered in August. Further Masterclasses booked to support Divisions.	Sally Seeley & Karen Sleigh		
Patient experience	DRHROD	Patient Experience Strategy	Due August 2019	Drafts produced to timescale but required considerable review in light of no longer being a 'strategy' but a plan and also that the Trust Quality Strategy is not yet finalised.	J Negus	**R**	Revised version developed and awaiting sign off of Quality Strategy before it can be approved.
		Framework of PIs and processes in place to engage teams in their consideration through TOM	July 2019	• Discussions held at TMG and also attendance at Divisional cabinets to secure engagement. • FAB Champions network developed. • Template for upward reporting to PXG developed and	J Negus	**G**	Although achieved this milestone there continues to be work to embed. Heat map of champions developed and direct approaches to divisions to recruit to

				implemented.			gaps.
		Work to improve communication / empathy	December 2019	• Communication First training under review. • Empathy Museum (patient & staff stories to demonstrate empathy & compassion) in development. • Real time surveying project commencing September. • OD team also having focus on compassion & empathy.	J Negus	**G**	By December will have: • Revised Comms first training plan • Empathy museum launch • First cut of data from real time surveying
		Work to protect patient time	December 2019	• The 2019 contract includes a requirement to eliminate 26 week waits for appointments and each specialty has an associated action plan to deliver this. • Partial booking processes have been reviewed to significantly reduce long waits. • 6-4-2 process is being introduced to track and monitor short notice cancellations and an escalation / notification process put into place. • Valuing patients time Quality Account objective is led by CSS. PX team meeting scheduled to ensure patients experiences and voices are included.	CSS J Negus	**A**	Although still within time there is some nervousness about capacity to achieve target of 90% of patients seen on time / within 15 minutes.

Ambition 2: Our Services – providing efficient, effective and financially sustainable services

Our Objectives	SRO	Measure	Baseline 18/19	Metric 19/20	Metric 23/24	Progress
Zero waiting	COO	4. % of Patients discharged within 24hrs of PDD	40%	45%	75%	Updates provided through the Integrated Performance Report and managed through the Trust Management Group.
Sustainable services	DoF	5. Delivery of Financial Plan		£70.3m	Break even	2018/19 and 2019/20 should be viewed as the base year and year 1 of the long term financial plan to deliver financial sustainability at the Trust. The detailed Long term Financial Plan (LTFM) will map out the requirements to address a range of issues that are driving the current financial position including; • **Staffing:** High level of agency staff and difficulty in attracting well qualified permanent staff • **Multiple sites:** Three major hospitals that are at some distance from each other. • **The Estate;** Different states of repair and their original structures limit their capability to be used for modern patient care. • **Lack of digitisation:** Many documents are still paper driven and so restrict access at multiple sites when a patient moves from one consultant to another. • **System Deficit:** the Trust need to clearly define the additional costs by Specialty of providing services in Lincolnshire. • **FSM:** exiting the FSM and therefore removing the Interest and external support costs. Operational Efficiency: The Trust needs to continuously deliver a year on year FEP of a minimum of £15m to facilitate the Trusts ability to maintain the financial position and allow the Trust to invest in services.
	COO	6. % of Clinical services rated delivering or excellent		Baseline year		Updates provided through the Integrated Performance Report and managed through the Trust Management Group.

Our Tactical Priorities 2019	SRO	Action Update
GIRFT	MD	The introduction of the National GIRFT (Getting it Right First Time) programme will be used to help inform the production of a clear strategic direction for the Trust's clinical services. The national GIRFT programme focusses on standardising variation across clinical pathways, which in turn, creates efficiencies resulting in improved patient care and financial cost savings, which can be quantified at clinical speciality level as each service is reviewed as part of the GIRFT programme. The GIRFT programme is led by frontline clinicians, and each clinical speciality is allocated a clinical lead at a national level, who then takes on the responsibility to visit all Trusts to review said specialities. The national GIRFT clinical leads are experts in the clinical specialities they are reviewing and explore & investigate local Trust level clinical data and clinical practices with their peers, discussing the individual challenges each clinical speciality faces. The output of a GIRFT clinical review is an agreed action plan to address any anomalies and opportunities identified. Delivery of the action plan is overseen internally by the ULHT Clinical Transformation Steering Group, chaired by the Medical Director. The action plans in turn are also monitored closely by the national GIRFT team, who seek assurance of delivery from the ULHT Clinical Transformation Steering Group. The GIRFT programme within ULHT is closely aligned to the ULHT Clinical Service Review Programme.
Theatre's	COO	Updates provided through the Integrated Performance Report and managed through the Trust Management Group, being managed through the Productive Services Oversight Board. The aim is to best use our funded elective capacity and doing so in partnership with the Surgical Specialties and our theatre workforce. It is not intended to be a cost improvement programme but will support the Trust in achieving a more sustainable financial position. Improvement to RTT and cancer delivery is crucial together with listening and meaningful communication to our workforce.
Urgent and Emergency Care (Q&E SDEC)	COO	Updates provided through the Integrated Performance Report and managed through the Trust Management Group. The aim is to offer safe and high quality Urgent and Emergency Care services to our patients in partnership with our partners and stakeholders. This includes access to ambulatory/frailty pathways that are able to respond to patient need. In developing services in line with national guidance and improving performance against key indicators including quality indicators, it is anticipated that this will improve the recruitment and retention rate of medical and nursing staff building a sustainable future for urgent and emergency are services in rural Lincolnshire.
62 day cancer	COO	Updates provided through the Integrated Performance Report and managed through the Trust Management Group. The key objective is to deliver the 62-day standard by November 2019. In so doing we will improve the experience and outcome of our patients and the reputation of the Trust. Delivery of this objective will support the Trust in achieving recognition as an exemplar health care provider, in particular in relation to rural communities. Key focus will be on delivering compliance in Urology, Lung, Lower GI and oncology with lessons shared across other tumour sites.
Data Quality	DoF	The Data Quality Group has been working as part of the Quality and Improvement Programme to deliver key outcomes, which has included the introduction of statistical tools to translate data to information / intelligence. There has also been ongoing work to focus on a single source of Truth (Data Warehouse) by April 2020, embedding the 'data quality' assurance model (Kite Mark) by September 2019, together with integrated performance reporting/dashboards for all ULHT Committees by September 2019, to have information owners and data guardians demonstrating ownership for data quality and information by September 2020.

Ambition 3: Our People – providing services by staff who demonstrate our values and behaviours

Our Objectives	SRO	Measure	Baseline 18/19	Metric 19/20	Metric 23/24	Progress	RAG
Modern and progressive workforce	DHROD	1. Vacancy fill rate (all staff)	14.3%	12%	9%	**Agreed actions & progress** *Implementation of stronger agency spend controls* – Central team in place. Evidence of impact on price and some bookings. Demand continues to grow. Nursing and Medicine summits held and actions agreed *Workforce planning methodology agreed* – Agreed as part of annual business planning cycle *Roll out workforce planning methodology* – On plan *Introduction of new roles* – No further action to report *Complete actions in 90 day retention plan* – Actions completed. Attrition rates reduced for Medics and AHPs. Needs to be sustained. *New sickness management system introduced* – Project manager in place, but agreed to defer implementation until 2020. Need to have confidence in establishment hierarchy first. **Overall position** Actions largely being taken, but yet to see impact on either vacancy rate or agency spend levels.	**A**
One Team	DHROD	2. Recommend as a place to work (staff survey)	41%	46%	63%	**Agreed actions & progress** *Review and then delivery of revised approach to leadership* – Revised approach discussed at TMG. Individual actions now being progressed e.g. Middle Manager Forum, coaching	**A**

						Revise 2021 Comms/Marketing Plan, then deliver – Communications continue e.g. newsletters. Review of presentation of strategy underway and comms plan will follow *Education and Learning Strategy and delivery of plans, including clarity of talent/development offer to staff* – Education Strategy be considered at TMG in September. Work continues on the offer. Nursing offer identified. Medical offer under development *Roll-out of staff charter workshops as part of Tom implementation* – Over 550 now attended staff charter workshops *Understand and take action on the issues which will ensure staff believe ULHT and its leadership care about them* – Gathering evidence - Review of staff involvement at Staff Engagement Group (August); Focus groups around bullying and harassment (September); On-going Cx walkabouts **Overall Position** The measure is based on the staff survey question. The next staff survey will run between October and December. Assessment of Amber is based on lack of evidence of impact at present	
		3. Recommend as a place to receive care	47%	53%	72%	Actions as above Not able to measure progress as yet. Measure taken from national staff survey	**A**

Our Tactical Priorities 2019	SRO	Action	Timescale	Action Update	Lead	RAG	Recovery if Red
TOM	DHROD	Move to a new Trust Operating Structure Transition	April September	New model was introduced in April Some key roles remain unfilled, notably	MB MB	**A**	Aspects of work programme are behind. Focus on recruiting to vacant roles. Exploring new

		Planning to recruiting into posts and adapting to the new Model		Clinical Director in Medicine and Clinical Leads			strategies where difficult to fill positions. Recognition that transition is taking longer than planned.
		New ways of working – governance documentation	September	Governance documentation published. Currently reviewing progress on implementation and next steps e.g. on devolution arrangements	PM		
		Develop staff in the new ways of working – OD Plan	February	Multiple workshops held with staff on aspects of the new governance arrangements. OD partner for triumverates appointed and set-up meeting held in August	MR		
Recruitment	DHROD	Scale up internal resource to delivery significant improvement to the fill rate for medical and nursing establishments	May	Resourcing team in place	DT	**A**	On transactional process, additional leadership capacity introduced Domestic nursing and AHP campaigns to begin in September
		Improved Transactional Services for Recruitment	July	Improvement action in place and additional leadership introduced to speed delivery as July completion date not achieved	KT		International recruitment being planned
		Improve substantive medical recruitment	Through 19/20	Numbers currently to plan, although full financial benefit yet to be seen	DT		
		Improve substantive	Through 19/20	Delayed decision-making means impact also likely to be delayed. Currently	DT		

		nursing recruitment Improve candidate attraction and employer brand	October	number on track however and approx. 100 NQNs starting September Work with TMP completed and STP attraction strategy work on-going	MR		

Ambition 4: Our System/Partners – providing seamless integrated care across the Lincolnshire health community

Our Objectives	SRO	Measure	Baseline 18/19	Metric 19/20	Metric 23/24	Progress
Service Integration	COO	7. % reduction in face to face contacts in Outpatients		5%	33%	Work identified as part of the wider system to progress. By 2022, the STP has built into the assumptions movement of activity from the acute hospital trust into the community and/or stopping completely as follows: • Emergency care presentations to A&E down by 27.5% • New outpatient referrals down by 21% • Elective activity down by 12% • Non-elective activity down by 10% For the year 2019/20, ULHT will reduce face to face outpatient by 5%

Our Tactical Priorities 2019	SRO	Action	Timescale	Action Update
Pathway redesign	MB	Programme to deliver the Single System Plan	Longer term	***This Programme of work is essentially the delivery of the Lincolnshire Single System Plan***. The Lincolnshire Health and Care system is signed up as a system to ***"Integrated models of clinical care".*** This direction has been adopted to ensure that we do as much as possible to keep people "well" in the community, and prevent admissions to hospital wherever possible, by caring for people in the community. It is about providing care in the right place, first time. The integrated models of care will consider patient pathway redesign for a number of services, and this will involve what is being referred to as a "***left shift of activity"*** away from ULHT into the community for delivery. An integrated Care Committee has been established for the Lincolnshire system, and this committee will oversee the implementation of the new community driven pathways of care.

RAG STATUS KEY	
Blue	Scheme completed and successfully delivered
Green	Scheme deemed to have no/minimal risks to deliverability
Amber	Scheme deemed to have moderate risks to deliverability
Red	Scheme deemed to have major risks to deliverability

Appendix B: Overview of the delivery of the enabling strategies

Enabling Strategies			
Strategy	**SRO**	**Key issues, risks or escalations**	**Current RAG**
Our patients			
Quality Strategy	**Director of Nursing**	**Being redrafted:** This strategy will set out the Trust's approach to delivering high quality safe care for our patients. Patients will be encouraged to become partners in their own care and with services designed with them.	**A**
Our services			
Clinical Strategy	**Medical Director**	**Approved:** This strategy sets out the clinical transformation required for us to lead the development of integrated care closer to home. It outlines our move to consolidate specialist care on fewer sites where it improves outcomes and safety, and the advancement of improvements through service reviews and GIRFT improvements.	**G**
Financial Strategy	**Director of Finance**	**To come:** This strategy will set out how we intend to achieve planned savings and more efficient ways of working. Through the development of new models of care and the reduction in the demand for acute services we aim to achieve a more financially sustainable position that will enable us achieve financial balance.	**R**
Digital Strategy	**Deputy Chief Executive**	**Trust Board Approved:** This strategy outlines how we will deliver the clinical systems, technology, information, resources and processes required to help us transform our clinical services and deliver the highest quality patient care. This includes detail on how we will provide secure online access in real time via a single portal that will be available to meet clinical needs.	**A**
Estates Strategy	**Director of Estates**	**Being developed (including the Environmental Strategy/Plan):** This strategy recognises remodelling buildings and infrastructure will be paramount as services change. We are working with architects and healthcare planners to take account of diverse stakeholders, new treatments and medical advances to improve the design of healthcare space and layout.	**A**
Research Strategy	**Medical Director**	**Being refreshed:** The ULHT ambition for research is to ensure that we feature nationally and internationally on the research landscape and to deliver clinical research, which provides benefit to patient care and contributes to learning in regard to the provision of healthcare within a rural setting.	**G**
Our people			
People Strategy	**Director of HR & OD**	**Being developed:** This strategy focusses on ensuring that we have the right number of people, in the right places, with the right skill mix, attitudes and behaviours, motivated and managed to perform at their best (at a price that we can afford) and engaged on high value care, focussing on recruitment and retention.	**A**
Inclusion Strategy	**Director of HR & OD**	**Being developed:** Our vision is for inclusion to be a 'golden thread' running through all that we do and say. This strategy will enable us to evidence improvements in the compliance and performance with our duties, demonstrating how a diverse workforce will promote our equality, diversity and inclusion agenda.	**A**

RAG STATUS KEY	
Blue	Scheme completed and successfully delivered
Green	Scheme deemed to have no/minimal risks to deliverability
Amber	Scheme deemed to have moderate risks to deliverability
Red	Scheme deemed to have major risks to deliverability

To:	Trust Board
From:	Paul Matthew, Interim Director of Finance & Procurement
Date:	3rd September 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for July 2019

Author/Responsible Director: Paul Matthew, Interim Director of Finance & Procurement

Purpose of the report:
To update the Board on the performance of the Trust for the period 31st July 2019, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:
Executive Summary for identifies highlighted performance with sections on key Successes and Challenges facing the Trust.

Recommendations: The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.

Strategic risk register New risks that affect performance or performance that creates new risks to be identified on the Risk Register.	**Performance KPIs year to date** As detailed in the report.

Resource implications (e.g. Financial, HR) None

Assurance implications The report is a central element of the Performance Management Framework

Patient and Public Involvement (PPI) implications None

Equality impact None

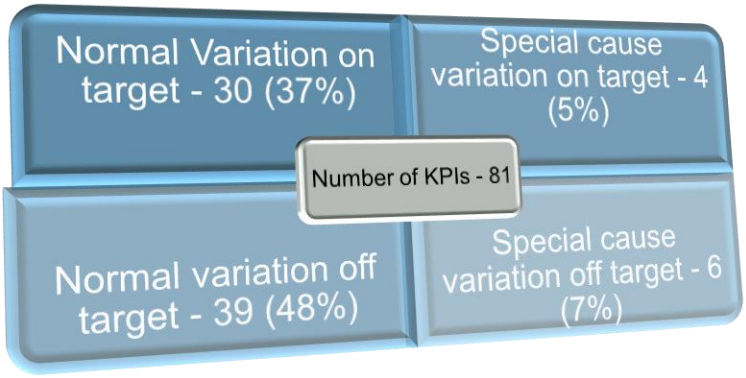
Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
August 2019

EXECUTIVE SUMMARY



Quality

HSMR (April 2018-March 2019) is 89.29 and is below expected limits, the lowest reported HSMR for the Trust.
SHMI (March 2018-February 2019) is 110.67 and is in band 2 within expected limits.
Dashboards are now developed for each division

Incident reporting rates for far in 2019 remain consistent with levels reported in 2018 (no significant increase or reduction), with an average of 1149 patient incidents reported per month, however, there were 1265 Incidents reported in July which is high for 2019. The number of Medication incidents reported in July was almost double the number in January, and the second month in a row with a significant increase; further analysis is required to understand the reasons behind this increase.
There were 39 significant harm incidents (those resulting in Moderate harm; Severe harm; or Death) reported in July, the highest number reported in any month so far this year (monthly average = 27)
The Trust declared 14 Serious Incidents in July 2019, which is in line with the monthly average in 2019 so far (compared with an average of 18 per month in 2018)
Duty of Candour (in person notification) compliance in June 2019 was 100%. Written follow-up compliance in June 2019 was 76%.

The Trust received 5 CAS alerts with deadlines for completion in July 2019 – The Trust was 100% compliant with responding to these within the deadline. There is one outstanding overdue alert which is overdue from February 2018.

Operational Performance

Zero waiting indicators in urgent care services have seen some deterioration in July against standard and did not meet trajectory. The A&E 4 hour standard worsened after a run of improvement for 3 months with ambulance handovers waiting >59 minutes also deteriorating. Ambulance conveyances increased in July far above trajectory and saw the highest levels of ambulance conveyance at Lincoln Hospital for 3 years. There were a number of positive improvements within the urgent care programme in length of stay for emergency patients, as well as streaming at Lincoln hospital, which is at its highest level ever, however this was more than offset by other factors including high bed occupancy and demands on ambulance conveyance levels.

July saw a continuation of consultation on the Lincoln Big Change reconfiguration scheme that sits alongside the 5 other urgent care improvement streams covering all aspects of the urgent care pathway.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have grown by 276 pathways from May to June 2019, which is a reduction in growth from the previous month. No single specialty area disproportionately contributed to this growth in waiting list, although three specialties Neurology, Cardiology and Ophthalmology account for 75% of total growth in waiting lists.

Overall performance against the RTT incomplete 18 week standard has deteriorated in June at 83.16% of patient pathways waiting less than 18 weeks for treatment. This is 1.32% lower than May.
In June there were no patients waiting for more than 52 weeks for their treatment. This meets the 0 tolerance trajectory and continues to reflect a substantial improvement from previous months in 2018/19.

Building on the external support provided by pathway management specialists the Trust has started its improvement project on data quality and pathway management. This scheme will support the sustained performance of RTT 18 week standard, and will help alleviate errors in pathway management that contribute to 52 week wait patient pathways.

In June the Trust achieved seven out of the nine cancer standards, nationally only three of the standards were met. This is the strongest performance since 2015 and shows the delivery of the cancer action plan system wide is having an impact.

Zero waiting indicators in cancer services showed our 62 Day Cancer performance in June seeing a great improvement from May and returning back onto trajectory for performance, although not at national standard. Although this is positive there remains a backlog of patients over 62 days and 104 days that still require treatment that must be factored into future delivery to make this sustainable.

The Trust continues to be in the top 20 of the largest providers of cancer treatments in the UK although June showed that the Trust had dropped from 12th to 20th largest number of treatments.

Both 2ww standards (2ww Suspect and 2ww Breast Symptomatic) have continued to improve and 2ww Breast Symptomatic has now been achieved. This represents a major achievement.

Finance

The Trust's control total and financial plan for 2019/20 (excluding PSF, FRF and MRET) is £70.3m. Delivery of the financial plan for 2019/20 facilitates the Trust accessing £28.9m of PSF, FRF and MRET funding resulting in a planned deficit of £41.4m.

Delivery of the planned deficit includes a Financial Efficiency Programme (FEP) of £25.6m.

The Month 4 position is as follows:

• The in-month position is a deficit of £3.5m, which is £1.0m adverse to plan - the underlying in-month position was £2.0m adverse to plan, requiring release of £1.0m of technical flexibility to deliver the in-month reported position.
• The year to date position is a deficit of £20.5m, which is £1.0m adverse to plan - the underlying year to date position was £3.5m adverse to plan, requiring release of £2.5m of technical flexibility to deliver the year to date reported position.

The key movements year to date are as follows:

• Excluding the £0.5m adverse variance on Pass-through Income, Operating Income is overall £0.4m favourable to plan.

• Excluding the £1.0m benefit from the release of Pay provisions, the underlying Pay position is £3.8m adverse to plan.

• Excluding the £0.5m favourable variance on Pass-through Expenditure and £1.5m benefit from the release of technical Non Pay savings, Non Pay is £0.2m adverse to plan.

The underlying year to date position at Month 4 position was £3.5m adverse to plan, and the year to date position has been delivered by release of £2.5m of flexibility.

The underlying pay position is £3.8m adverse to plan and the adverse movement to plan is primarily driven by Agency Pay expenditure and Medical Agency Pay is of particular concern – whilst Agency spend is of particular concern within the Division of Medicine, scrutiny of the temporary staffing usage across all staff groups and Divisions is required.

Supporting the adverse movement to plan in the underlying position removed all pay flexibility that the Trust retained in the first quarter of the financial year. However, scrutiny of the balance sheet and changes in relation to the required Injury Benefit provision have enabled £1.0m of Non Pay flexibility to be released in support of the Month 4 position.

The income position is inclusive of significant over performance on Non-Elective activity in the Medicine Division, however this has not adversely affected Elective performance to date. As the Trust implements plans to deliver backlog reductions and work with commissioners to undertake repatriation of activity the pressure on beds and resources will increase, so current Elective performance is a risk.

The income position is also inclusive of £1.7m of PSF and FRF funding for July, which is at risk if the Trust does not deliver its financial plan in the second quarter.

The Month 4 position includes (in line with the financial plan) provision for a 1% pay award for Medical & Dental staff at a cost of £333k. The actual award is now agreed nationally at 2.5% and the award will be back-dated to April 2019. The risk that the excess of the Medical & Dental pay award over and above 1% is not centrally funded is estimated to be £1.5m in 2019/20.

Overall, the Trust is £1.0m adverse to plan, and the underlying pay position and the risks in respect of income are a concern.

Workforce

The adverse variance between planned and actual pay costs YTD increased further in July driven by continued higher than planned agency costs exceeding substantive staff savings, with the actual savings on substantive pay cost reducing in July.

Total agency run rate for month four increased to a twelve month high with significant month to month increase for both medical and nurse agency driven by increased demand and not expected having regard for vacancy rate trends. Detailed analysis is being undertaken to understand these July increases and what further action needs to be taken to control agency spend.

The overall vacancy rate improved slightly (-0.2%) in July with continued recruitment improvement , however the impact of this improvement was reduced due to continued high turnover amongst key professional staff groups. Overall turnover also improved slightly in July.

Sickness absence (rolling twelve months) remained stable at 4.8% despite a higher rate of absence in July compared to July 2018 and the Non – Medical Appraisal Rate improved by four percentage points June to July.

Friends and Family Test survey results remained broadly stable with more than 90% of patients recommending treatment at the Trust, the ratio of compliments to complaints is 59:1.

Paul Matthew
Interim Director of Finance & Procurement
August 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostrum Difficile (post 3 days)	Safe	Our Patients	Michelle Rhodes	5	4	5	3	17	P		
	MRSA bacteraemia (post 3 days)	Safe	Our Patients	Michelle Rhodes	0	0	0	0	0	P		
	MSSA	Safe	Our Patients	Michelle Rhodes	2	2	0	2	5	P		
	ECOLI	Safe	Our Patients	Michelle Rhodes	8	7	4	5	18	P		
	Number of Never Events	Safe	Our Patients	Neil Hepburn	0	0	0	0	2	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	New Harm Free Care %	Safe	Our Patients	Michelle Rhodes	98%	98.70%	98.90%		98.73%	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Pressure Ulcers Category 4	Safe	Our Patients	Michelle Rhodes	0	0	0	0	0	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Michelle Rhodes	80%	76.90%	74.70%		79.33%	F		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Michelle Rhodes	80%	64.60%	74.70%		76.33%	F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Michelle Rhodes	50%	51.90%	63.10%		59.10%	P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Michelle Rhodes	100%	98.80%	95.70%		98.17%	F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Michelle Rhodes	90%	52.50%	65.60%		64.97%	F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Michelle Rhodes	17%	10.30%	12.10%		11.00%	P		
	SHMI (Latest Data Mar18 - Feb19)	Effective	Our Patients	Neill Hepburn	100	109.92	110.67		110.81	F		
	HSMR (Latest Data Apr18 - Mar19)	Effective	Our Patients	Neill Hepburn	100	89.43	89.29		89.82	P	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis Bundle compliance in A&E	Caring	Our Patients	Michelle Rhodes	90%	85.00%	78.30%		82.20%	F		
	IVAB within 1 hour for sepsis in A&E	Caring	Our Patients	Michelle Rhodes	90%	86.30%	86.90%		89.47%	F		
	Sepsis screening compliance in inpatients	Caring	Our Patients	Michelle Rhodes	90%	91.60%	80.00%		85.53%	F	A	
	IVAB within 1 hour for sepsis in inpatients	Caring	Our Patients	Michelle Rhodes	90%	57.10%	70.50%		70.73%	F		
	Serious Incidents reported (unvalidated)	Safe	Our Patients	Neill Hepburn	0	12	11	14	52	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Catheter & New UTIs	Safe	Our Patients	Michelle Rhodes	1	0	0		0	P		
	Falls (with Harm)	Safe	Our Patients	Michelle Rhodes		0.19	0.03	0.13	0.14	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Medication errors	Safe	Our Patients	Neill Hepburn	0	193	218	287	893	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Medication errors (mod, severe or death)	Safe	Our Patients	Neill Hepburn	0	19	16	36	91	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	VTE Risk Assessment	Safe	Our Patients	Michelle Rhodes	95%	97.21%	96.57%	97.53%	96.87%	P		
	Dementia Screening	Caring	Our Patients	Michelle Rhodes	90%	96.9%	96.92%		94.58%	P		
	Dementia risk assessment	Caring	Our Patients	Michelle Rhodes	90%	98.95%	98.95%		99.07%	P		
	Dementia referral for Specialist treatment	Caring	Our Patients	Michelle Rhodes	90%	100%	100%		97.62%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	92.20%	91.98%	92.16%	92.09%	F	H	
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	15.21%	15.43%	15.22%	14.66%	F		
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.80%	4.81%	4.82%	4.79%	F		
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	12.45%	12.18%	11.79%	10.44%	F		
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	72.40%	72.74%	76.00%	73.53%	F	B	
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-6009	-4019	-5126	-2808	-18065	P		
	Income	Well-Led	Our Services	Paul Matthew	36935	41522	39838	43614	165195	P		
	Expenditure	Well-Led	Our Services	Paul Matthew	-42944	-45297	-44964	-46422	-183015	F		
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	2838	1546	1342	1557	4955	F		
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	4031	1958	2875	3135	8807	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-1905	-4019	-3640	-4027	-15308	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	31.51%	30.78%		29.73%	P	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	97%	90.19%	89.30%		90.23%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	19%	28.53%	21.37%		23.33%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	80.06%	82.19%		80.65%	F		
	Friends & Family Test Maternity (Reponse Rate)	Caring	Our Patients	Martin Rayson	23%	15.09%	15.64%		14.01%	F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Martin Rayson	97%	100.0%	98.36%		99.5%	P	A	
	Friends & Family Test Outpatients (Reponse Rate)	Caring	Our Patients	Martin Rayson	14%	10.55%	11.51%		10.07%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	93.64%	93.27%		93.36%	F		
	Mixed Sex Accommodation	Caring	Our Patients	Michelle Rhodes	0	1	2		3	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	63	50		180	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Martin Rayson		487	416		1376	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	eDD sent within 24 hours	Effective	Our Patients	Neill Hepburn	95%	87.36%	94.00%	94.50%	90.93%	F		
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	2.20%	2.95%	4.18%	2.75%	F		
	Duty of Candour compliance - Verbal	Responsive	Our Patients	Neill Hepburn	100%	93.00%	95.00%		96.00%	F	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Neill Hepburn	100%	76.00%	83.00%		86.33%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	75.0%	68.22%	72.44%	67.05%	68.52%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	78%	85.08%	78.96%	69.49%	79.43%	F		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	1	0		3	P		
	18 week incompletes	Responsive	Our Services	Mark Brassington	84%	84.48%	83.16%		83.93%	F		
	Waiting List Size	Responsive	Our Services	Mark Brassington	36,718	39,895	40,171		39,895	F		
	62 day classic	Responsive	Our Services	Mark Brassington	78%	65.52%	79.08%		73.97%	P		
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	81.84%	79.80%		80.54%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	91.67%	94.59%		84.70%	P		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	97.26%	97.10%		97.42%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	100.00%	98.59%		98.49%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	90.70%	96.77%		93.92%	P		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	95.05%	94.38%		95.57%	P		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	92.11%	90.16%		94.09%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	May-19	Jun-19	Jul-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	89.21%	86.73%		84.89%	P		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	99.0%	95.56%	96.40%	94.53%	95.76%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	0.8%	1.84%	2.04%	3.30%	2.19%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	2.50%	1.71%	1.88%	5.60%	P		
	#NOF 24	Responsive	Our Services	Mark Brassington	70%	53.33%	63.49%		63.94%	F		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	95%	92.00%	87.30%		91.35%	F		
	EMAS Conveyances to ULHT	Responsive	Our Services	Mark Brassington	4923	4991	4823	5231	4991	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	197	494	494	809	608	F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	15	20	18	64	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	2.49	2.34	3.08	2.68	F		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.39	4.40	4.19	4.355	P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	2.68%	3.33%		2.78%	P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	8644	8565	9111	8465	F		
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Mark Brassington	44.0%	38.6%	34.6%	34.8%	35.63%	F		
	% discharged within 24hrs of PDD	Effective	Our Services	Mark Brassington		56.4%	58.9%	58.5%	57.07%			

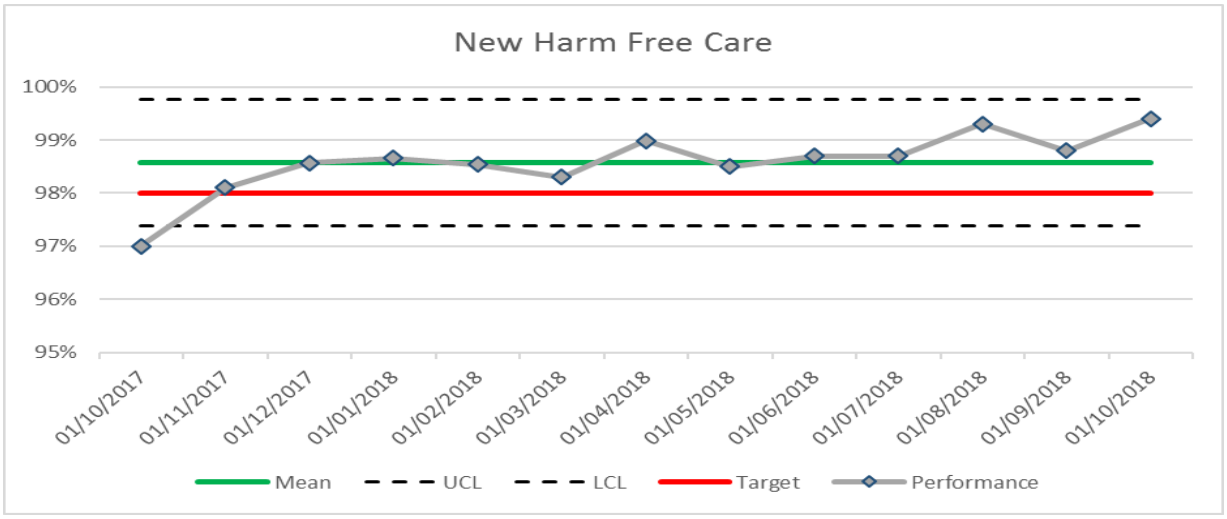
STATISTICAL PROCESS CONTROL CHARTS

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:



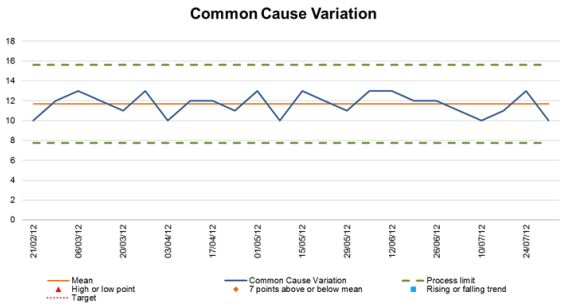
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

Within an SPC chart there are three different patterns to identify:

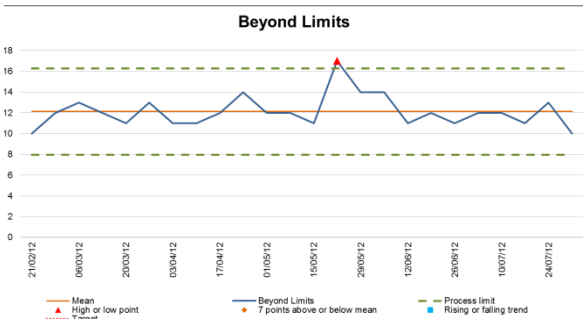
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful 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

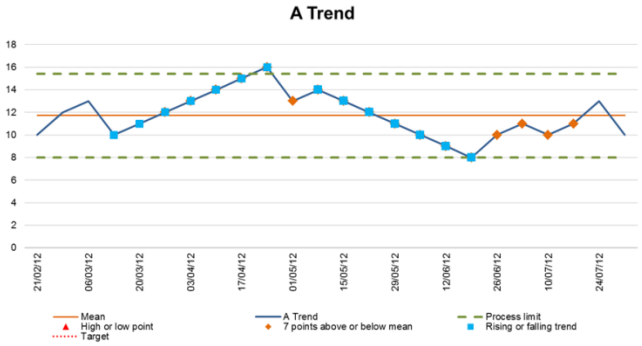


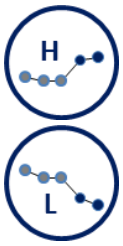
Extreme Values



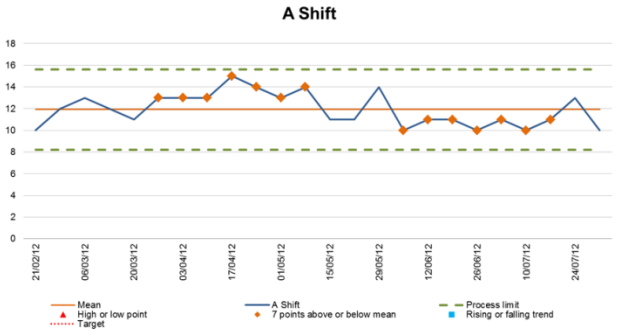
There is no Icon for this scenario.

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 data points have met or exceeded the target.

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.

HARM FREE CARE - MORTALITY

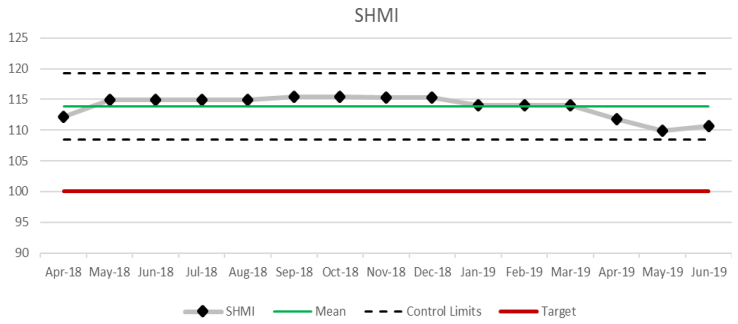
Executive Lead: Neill Hepburn

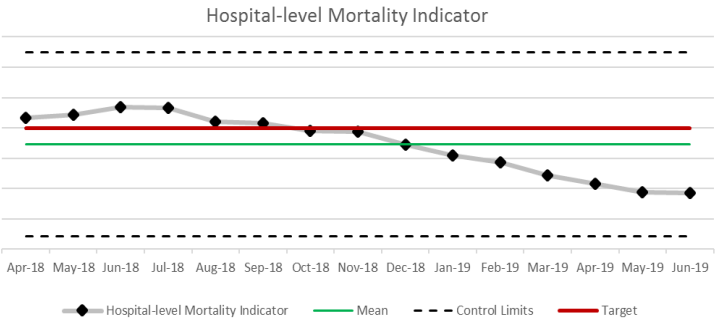
CQC Domain: Safe

2021 Objective: Our Patients

SHMI

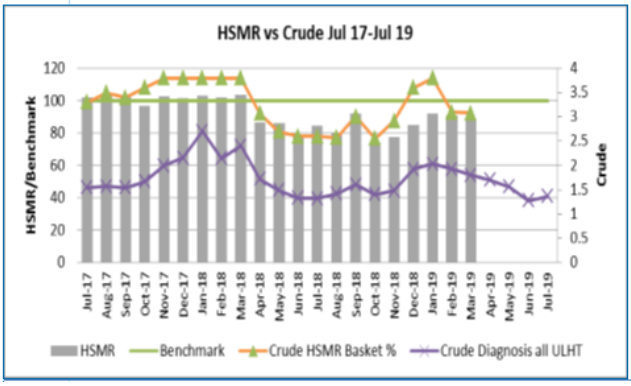
HSMR

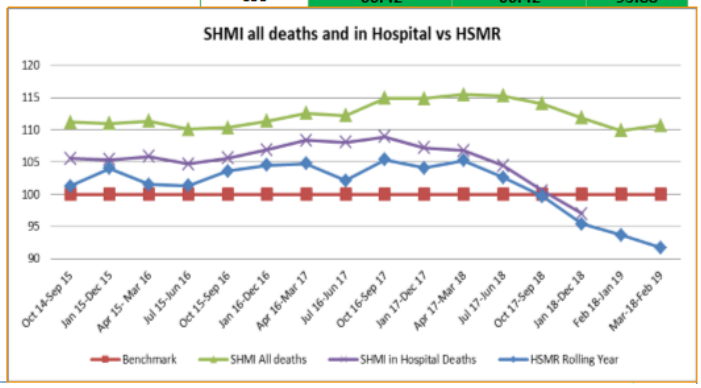




Trust/ Site	ULHT HSMR Apr 18-Mar 19 12 month	ULHT HSMR Apr 18-Mar 19 FYTD	ULHT HSMR Mar 19	ULHT SHMI Mar 18-Feb 19	Trust Crude Mortality Internal source Aug 18-Jul 19
Trust	89.29	89.29	88.41	110.67	1.62%
LCH	100.35	100.35	102.73	112.46	1.70%
PHB	85.59	85.59	84.73	116.34	1.79%
GDH	50.14	50.14	32.24	79.1	0.68%

Division	ULHT HSMR Apr 18-Mar 19 12 month	ULHT HSMR Apr 18-Mar19 FYTD	ULHT HSMR Mar 19
Medicine	83.94	83.94	80.38
Surgery	130.77	130.77	137.58
F/H	154.40	154.40	271.28
CSS	66.42	66.42	93.88





Performance Overview

Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 89.29 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits. HSMR has now been reported by divisions, where HSMR is high but not alerting is due to small numbers and high confidence intervals.

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is a Quality and Safety Improvement Programme (QSIP) to address the improvements required. 'Other Perinatal Conditions' a paper has been produced and was presented at QSG and Trust Board in March 19. A mortality process is currently being written for Family Health. Site alerts; COPD and Bronchiectasis is alerting for the Lincoln site for the third month; an in-depth review is underway.

Summary-level Hospital Mortality Index-SHMI

ULHT are in Band 2 within expected limits with a score of 110.67, which shows a slight increase from the previous reporting period. Driven by Lincoln and Pilgrim sites. Pilgrim is not alerting within HSMR, however has the highest SHMI. SHMI includes both death in-hospital and within 30 days of discharge. The data is reflective up to February 2019.

Diagnosis data for SHMI within this time period cannot be accessed at the moment.

Mortality Strategy Reduction Key Actions:

To contribute to achievement of Mortality Reduction Strategy and reduce HSMR and SHMI the Trust are taking the following actions:

- Surgical Division is currently an outlier, driven by Critical Care. Surgical Mortality reviews have previously not raised any significant concerns in care. The Trust has a low depth of coding for elective spells. An in-depth review is currently underway– 84 sets of notes have been delivered to the Lead for dissemination and a mortality proforma agreed. The results will be collated by Clinical Governance and upon the results and action plan agreed by Lead.
- In-depth Dr Foster reviews ongoing for Acute MI and Lower Respiratory Disease due to previous alerts. COPD and bronchiectasis review is now underway, COPD audit results can be found in the left hand panel this highlights areas with issues– PSG to advise on further action.
- The Community have various work streams they are undertaking to ensure out of hospital patients receive appropriate end of life care which include; End of life audits in care homes, end of life training, multidisciplinary approach to advance care planning and anticipatory prescribing, Project Echo and roll out of the ReSPECT tool kit.
- Lincolnshire health and care community have launched; Home First Prioritisation. An initiative aimed to focus on frail and over 75's out of hospital and close to there homes. Neighbourhood team have work streams in; advanced care planning in care homes, Complex Case Managers, Short term overnight carer intervention, practice Care Coordinator and Triage Practitioner. The Collaborative have asked the CCG if KPI's are being developed for these. It has been confirmed that the Mortality Summit will be reinstated.
- The CCG have developed Enhanced Health in Care Home work programme in line with National care elements.
- In-depth external reviews for Biliary Tract Disease has concluded. A preliminary report has been sent to CQC and Clinical Governance have now received the completed report from the external reviewer on the 25th July 2019 (the report can be found in the left hand panel of this report) No concerns of care were highlighted by the external reviewer. Action plan to be developed by the Gastroenterology Team for coding and documentation.
- The importance of clinical coding meeting was held; it was agreed that site based workshops will be held every two months starting in Pilgrim. Due to external speakers; Clinical Governance are awaiting availability for dates before arranging the workshops; to be held first in Pilgrim Lecture Theatre, Lincoln Lecture Theatre and Grantham PGME.
- Divisional dashboards now includes Clinical Business Unit (CBU) HSMR (reports can be found within the left hand panel of the report). CBU for TACC and Pain is currently an outlier which is driving the surgical alert.

Crude Mortality

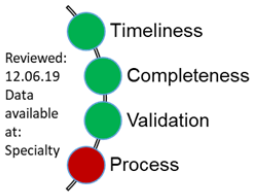
The crude mortality has decreased in July 19 to 1.36%. In rolling year August 18-July 19 crude has remained at 1.62%. A reduction in crude and an increase in Dr Foster expected mortality is the driving force behind the reduction in HSMR and hopefully this reduction will be replicated in SHMI.

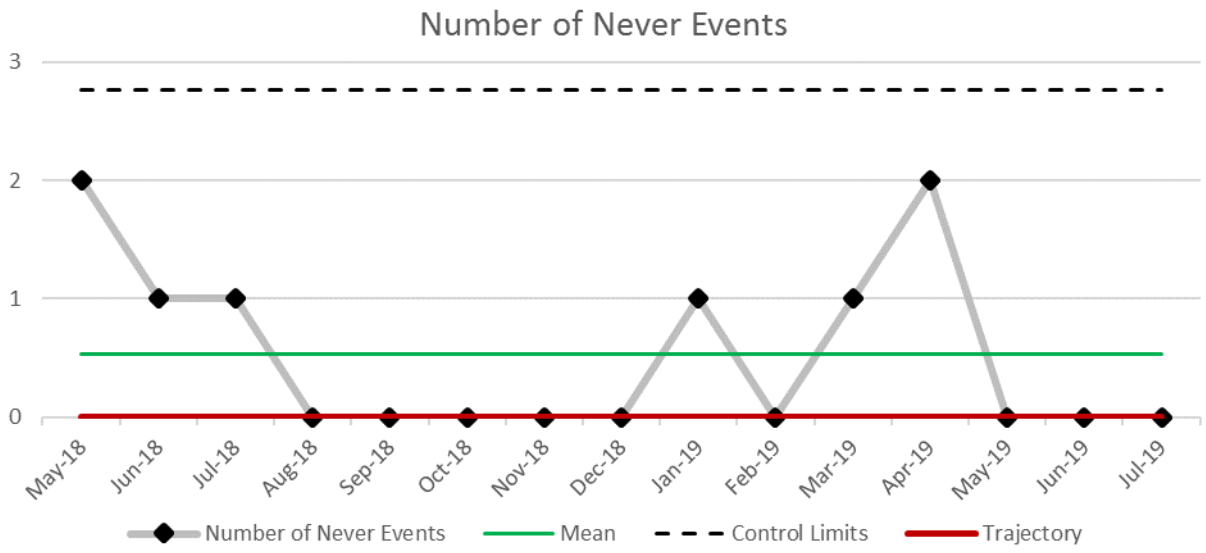
HARM FREE CARE – NEVER EVENTS

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- 2 Never Events have been declared as Serious Incidents by the Trust this financial year to the end of July 2019
- Both of these Never Events were declared in April
- 0 Never Events were declared as Serious Incidents in July 2019
- A theme has been identified in relation to wrong site surgery incidents occurring primarily outside of the theatre environment

Actions being taken to address any issues:

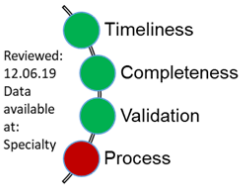
- Analysis is being undertaken of all wrong site surgery incidents reported in the last 2 years
- The application and monitoring of compliance with local safety standards for invasive procedures (LocSSIPs) is to be reviewed and strengthened
- A Never Event Summit with the CCGs is being set up for September 2019, to review learning and actions arising from recent incidents
- Changes have been made to the Datix incident report form and a Trust-wide communication is planned, to raise awareness and improve the accuracy of Never Event reporting

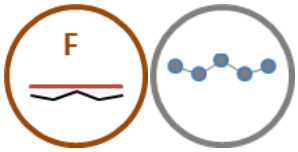
HARM FREE CARE – SERIOUS INCIDENTS

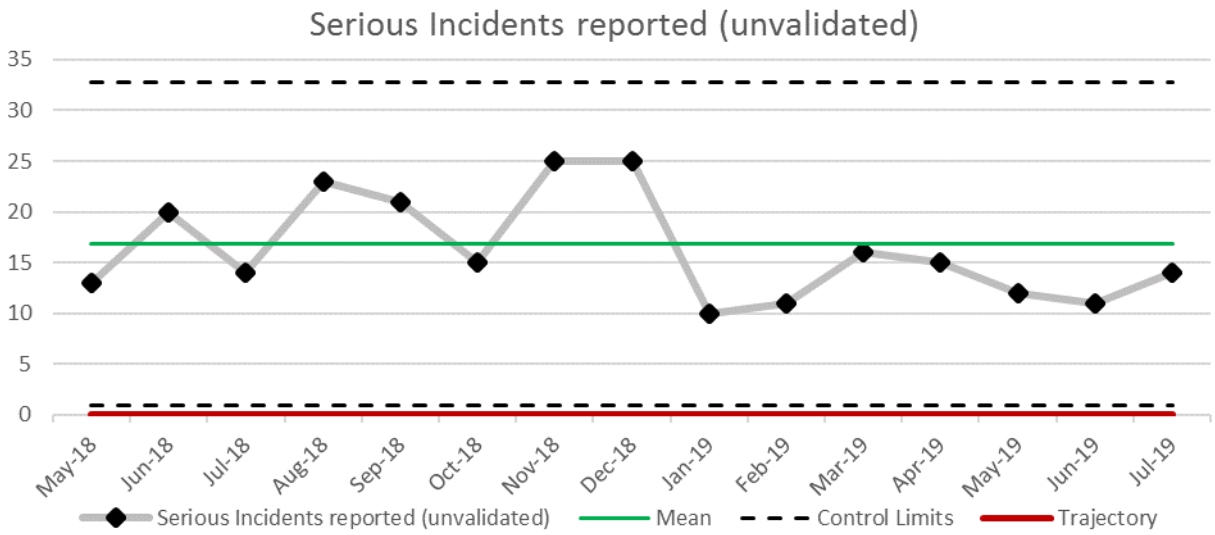
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes

- The Trust declared 14 patient Serious Incidents in July 2019
- This is consistent with the average for this financial year to date and lower than the average of 18 per month in 2018/19 and 24 per month in 2017/18
- Taken together, diagnostic & therapeutic process incidents have accounted for 31% of the Serious Incidents declared by the Trust so far in 2019/20
- Accident & Emergency at Lincoln County Hospital have declared more Serious Incidents than any other location in 2019/20 so far (20% of the Trust total)

Actions in place to recover:

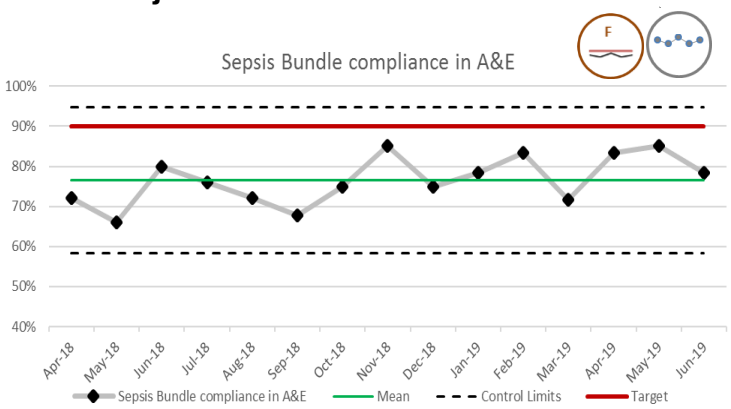
- Medicine Division has reviewed recent incident reports for A&E and reported to the Patient Safety Group; themes were identified in relation to diagnostic processes and the response to deteriorating patients, and improvement plans have been developed to address the underlying issues

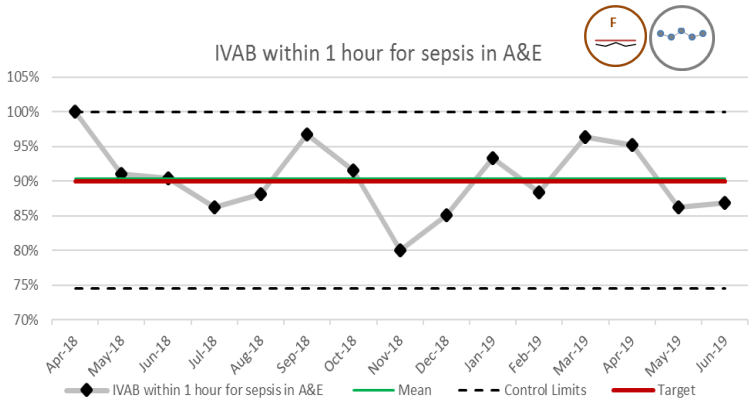
HARM FREE CARE - SEPSIS

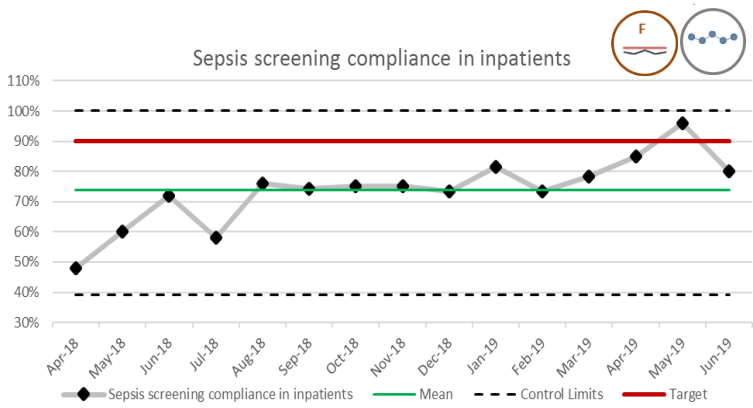
Executive Lead: Michelle Rhodes

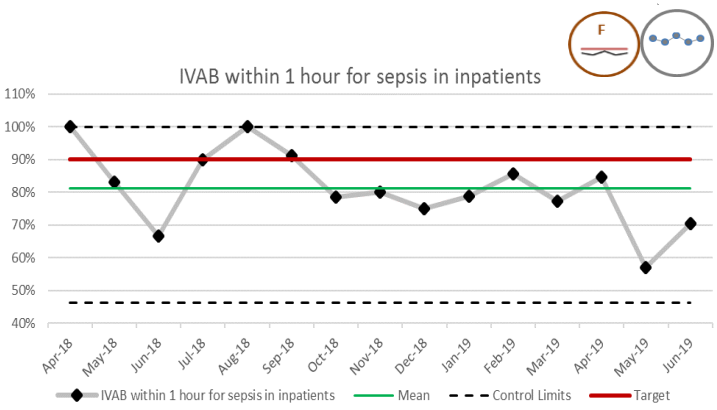
CQC Domain: Safe

2021 Objective: Our Patients









Sepsis screening

The compliance for both A&E and inpatients has demonstrated a static picture with marjinal screening decline. The themes that have been seen are similar to other months in that the nursing staff are still not selecting the non- infection option to show that the screen has been considered the cause of the raised NEWS score, further adhoc training has been given to the clinical areas and this theme is hoped to reduce in coming months following the train the trainer role out in September.

The focus for compliance screening has now switched to the ED departments where there was continued failure to reach the 90% standard. This has entailed daily reviews of missed screens with weekly reporting to include themes for missed screens and lessons learnt to feed into the departmental safety huddles and governance meetings for dissemination. This focus is hoped to predict substantial improvement moving forward.

Delivery of IV antibiotics within 60 minutes

The performance for this month for both A&E and inpatients has shown an improvement following the significant decline last month. The data sample continues to be small numbers which has a substantial effect on the percentages. From the beginning of July we have moved towards validating 100% of the data and this should stop the variances being so marked from month to month.

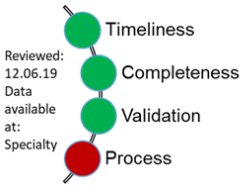
The policies for all aspects of sepsis are now out for agreement and final sign off this is hoped that this will strengthen the clinical pathways and support decision making particularly around paediatrics.

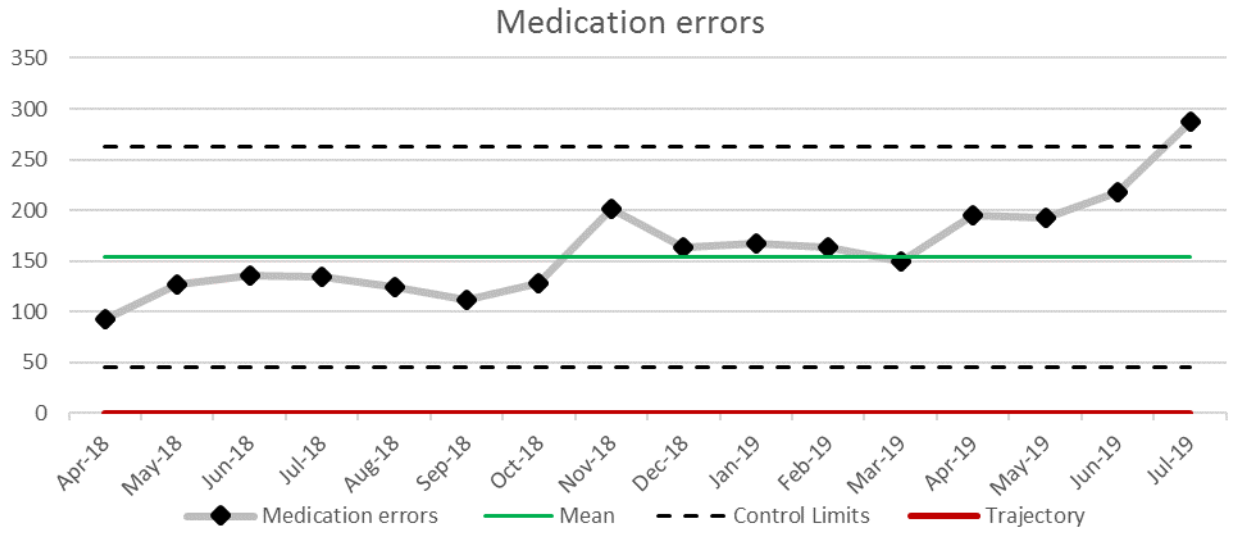
HARM FREE CARE – MEDICATION ERRORS

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes -

This data report is inclusive of all medication related incidents that were reported from 1st July 2019 to 31st July 2019. In July there were 287 medication related incidents reported via Datix.

For July the medication incident reporting rate for the Trust per 1000 bed days was 9.06. The rate is expressed as total number of medication incidents reported divided by the number of bed days in the Trust, multiplied by 1000 bed days.

The national average as displayed by Model Hospital (from data taken from NRLS, National Reporting and Learning Service) is 4.0 and the peer average is 3.4 – this figure was last updated in November 2018.

There was ONE never event relating to medication incidents reported during the reporting period.

There were no Deaths relating to medication incidents reported during the reporting period.

There was ONE Severe Harm event relating to medication incidents reported during the reporting period.

Of the 287 medication incidents reported, 12.5% were rated as causing some level of harm (calculated as medication incidents reported as causing harm or death/all medication errors x 100 – (36/287x100). The national average of medication incidents reported as causing harm or death is 10.6% and the peer average is 14%.

Organisations with an open and honest reporting culture, and where staff believe reporting incidents is worthwhile because preventative action will be taken, are likely to report a higher proportion of "No Harm" incidents than an organisation with a less mature reporting and learning culture.

Action plan to reduce harm and reduce omitted and delayed medicines

Within the Quality and Safety Improvement Plan - QS08 Medicines Management are improvement goals that ULHT will work towards to improve overall quality and safety around medicines across the organisation.

The key milestone that is relevant to this report is 'Reducing harm through the culture of safety and learning from medication related adverse events'.

To support this key mile stone there are miles stones and actions to achieve them:

1. Develop a monthly data report demonstrating the medication incident trends
   - This report will be highlighting the trends and patterns within medication incidents submitted via Datix. This report can be developed further to provide the information required by each Division and speciality.

2. Review of medication incident investigation and review process and develop SOP
   - With the support of the Risk Team we will review the process of investigation for medication incidents and ensure it links in and supports the SI policy. An SOP will be developed and shared with medical and nursing teams so that all medication related incidents are addressed appropriately.

3. Staff to do a written reflection of any medication incidence they are involved in and with their line manager agree lessons learnt and training needs.
   - With the Heads of Nursing and the quality matrons we will develop a pathway to support staff and identify any training needs.

4. Define high risk/critical medication and develop SOP for obtaining medication in and out of hours
   - The Guideline for Reducing Harm from Omitted and Delayed Medicines will be reviewed and updated will include a comprehensive guide to obtaining medicines in and out of hours.

5. Raise awareness of site duty manager and on-call pharmacist
   - As part of the review of the Guideline for Reducing Harm from Omitted and Delayed Medicines we will include information on how to utilise the site duty manager and the on-call pharmacist.

6. Educate staff that there is more than one prescription chart in use and prescription chart should move with patient if transferred
   - A piece of work needs to be done alongside the nursing teams to educate staff around the potential numbers of inpatient chart and the different types of specialist charts we have within the organisation.

<u>Further actions to be taken</u>

- In addition to these actions within the Quality and Safety Improvement Plan we have updated the Prescribing and Medicines Optimisation and Safety webpages and made them more engaging and user friendly. Within the new design we have a page dedicated to sharing learning from medication incidents and informing staff of themes and trends. There are also strategies to help combat medication related incidents.

- We have created a Facebook account to link in with the ULHT Together account and share information via that forum. This will then help to us to capture as many of ULHT staff as possible and ensure that learning reaches as far as possible.

- A specialist forum is to be set up. This forum will give opportunity to discuss medication incidents, look at the themes and trends, and allow staff to share good practice and ideas from different areas. Medicine Management Link Nurse and junior grade doctors will be given the opportunity to attend.

- To address the prescribing issues in the outpatient department individual prescribers are now being identified and are being informed directly about the error made.

- The speciality pharmacists are linking into the speciality governance meetings and are sharing their bespoke reports. From these reports actions can be discussed to support reducing harm from medication incidents.

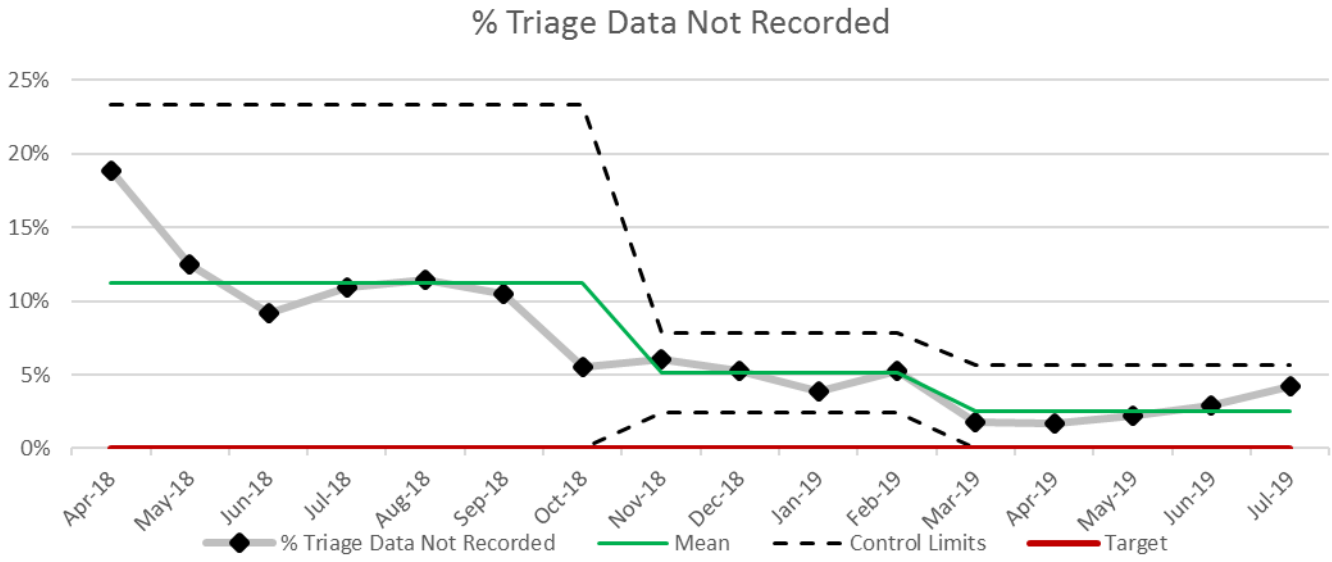
- The four Divisions are asked to support the actions required to improve prescribing within their area and to address key issues highlighted within this report to reduce harm from medication incidents.

VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Mark Brassington

CQC Domain: Effective

2021 Objective: Our Patients



Challenges/Successes

A slight reduction in compliance with data accuracy has been experienced in July at 96% versus 97% in June. Achievement against this metric is dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.

Higher levels of agency usage and temporary non-substantive staff have contributed to this deterioration in performance in July more than in previous months. This level of agency and non substantive staff on shift is unlikely to improve significantly in August.

Actions in place to recover:

The UEC Improvement Programme, continue with analysis of individual performance and productivity to highlight individual compliance and this is being addressed with staff members on an individual basis. Triage time is a key performance indicator and continues to be monitored and challenged both at a local operational delivery level 3 x daily and within the UEC programme.

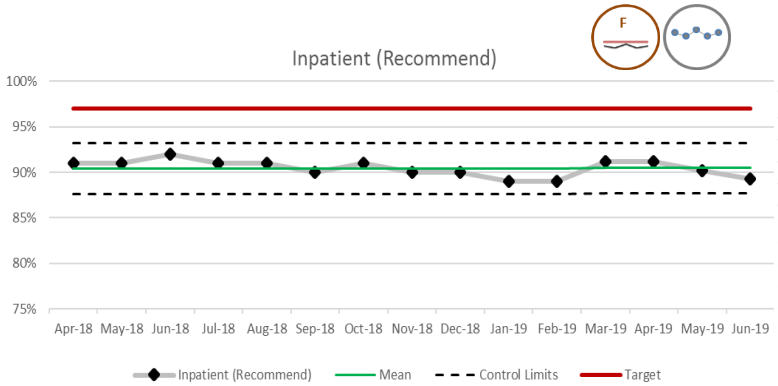
Additional support from divisional managerial teams is in place each day to ensure that all staff are accurately recording at that triage times remains a key focus of departmental leadership.

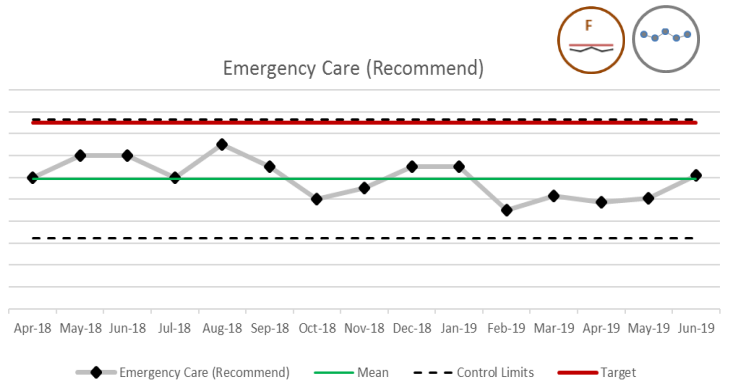
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

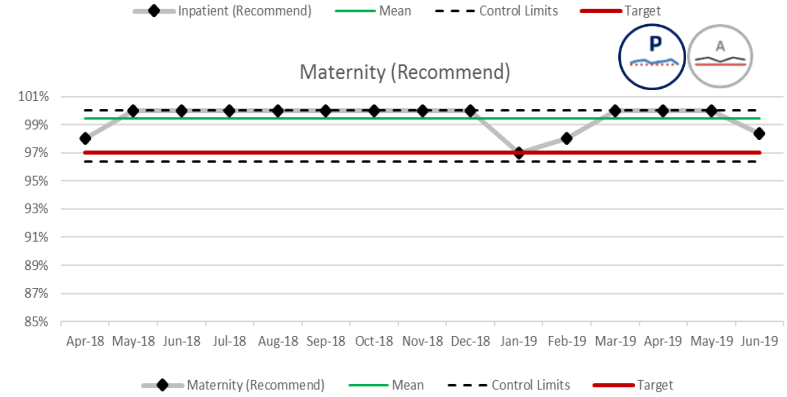
Executive Lead: Martin Rayson

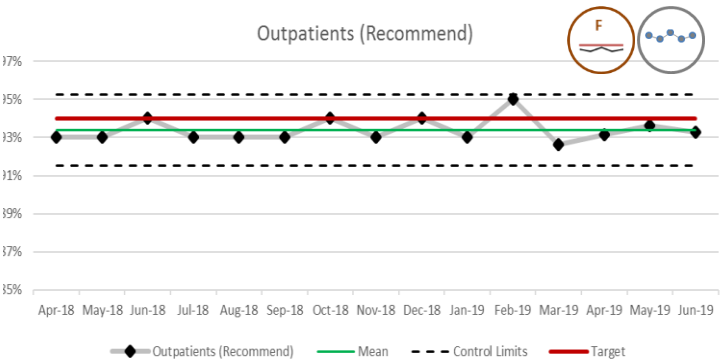
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Emergency care, inpatients and outpatients percentage FFT recommends stayed fairly consistent between April and June. 91% of patients would recommend and 4% of patients would not recommend. This was based on 7,444 ratings and 5,831 comments with 77% of comments received being positive, 5% neutral and 18% negative. Top 3 positive themes from FFT comments were clinical treatment, admission and catering.

Actions in place to recover:

Currently 64 FAB Experience Champions have been signed up across the divisions. To identify gaps across the sites, a heat map which identifies gaps will be shared across the divisions. Further patient experience walk rounds will continue from September to support the champions in their work as the champions role will be an integral part of the Patient and Carer work plan 2019-2021 and also for FAB Change19 in October 2019

The draft Patient & Carer work plan will be presented for approval to Patient Experience Group on 23rd July

Action is being taken in response to the three consistent themes from the data:

• Communications

• Appointment delays

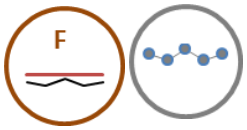
• Car-parking

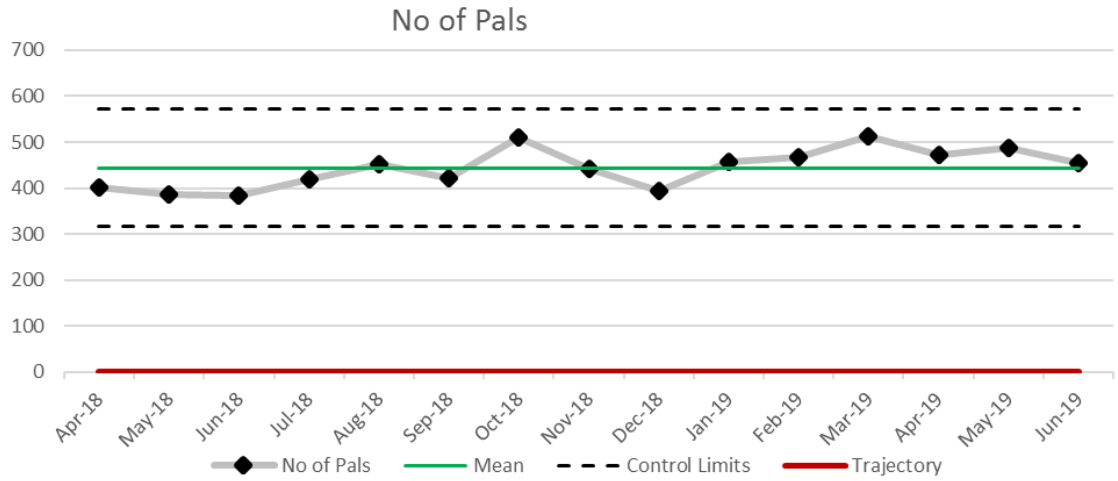
VALUING PATIENTS TIME – PALS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients





Challenges/Successes

- The top 3 themes for PALS for June were: Communication with Patients/relatives & carers, Appointment Cancellations and Car Parking
- 455 concerns were taken to PALS during. 253 for Lincoln and Louth, 44 for Grantham, 189 for Pilgrim and the remainder for community hospitals. 4 PALS concerns were escalated to formal complaints
- We reached 84,712th counting compliment within June.
- The divisional split for PALS concerns received were:
- Counting Compliments against complaints ratio – 59:1

Actions in place to recover:

Currently 64 FAB Experience Champions have been signed up across the divisions. To identify gaps across the sites, a heat map which identifies gaps will be shared across the divisions. Further patient experience walk rounds will continue from September to support the champions in their work as the champions role will be an integral part of the Patient and Carer work plan 2019-2021 and also for FAB Change19 in October 2019

The draft Patient & Carer work plan will be presented for approval to Patient Experience Group on 23rd July

Action is being taken in response to the three consistent themes from the data:

• Communications

• Appointment delays

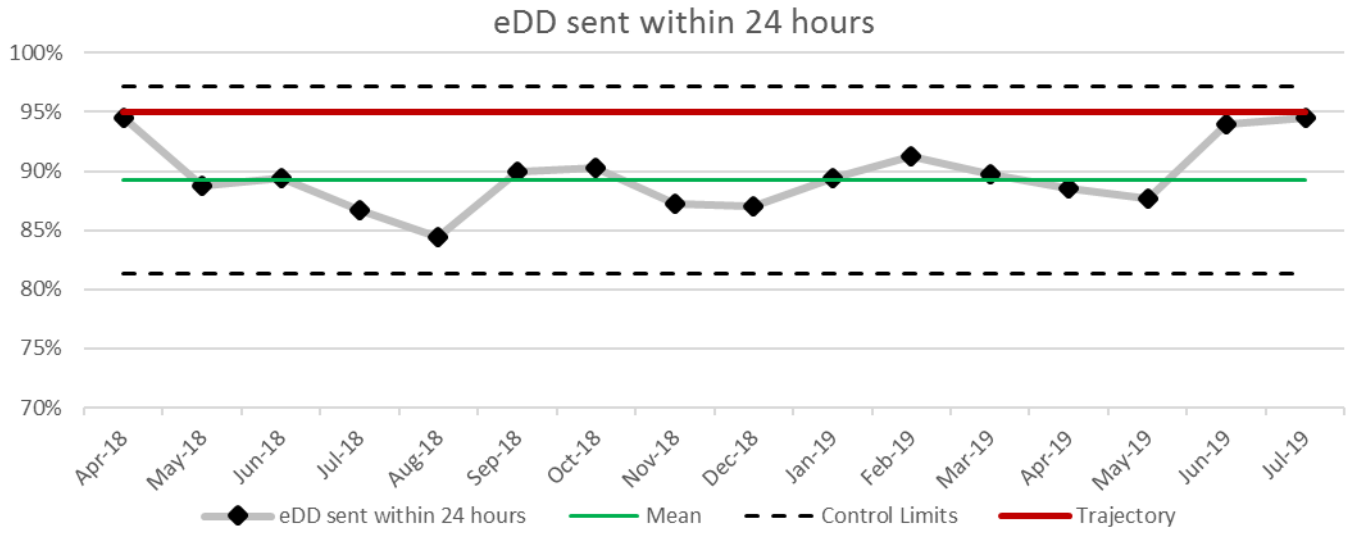
• Car-parking

VALUING PATIENTS TIME – ELECTRONIC DISCHARGE DOCUMENTS

Executive Lead: Neil Hepburn

CQC Domain: Caring

2021 Objective: Our Patients



The new eDD dashboard has been launched and the Trust is at 94.5% for July for sending eDDs within 24 hours. The dashboard enables Clinicians and wards to review their performance and review patients where the eDD was not sent within 24 hours.

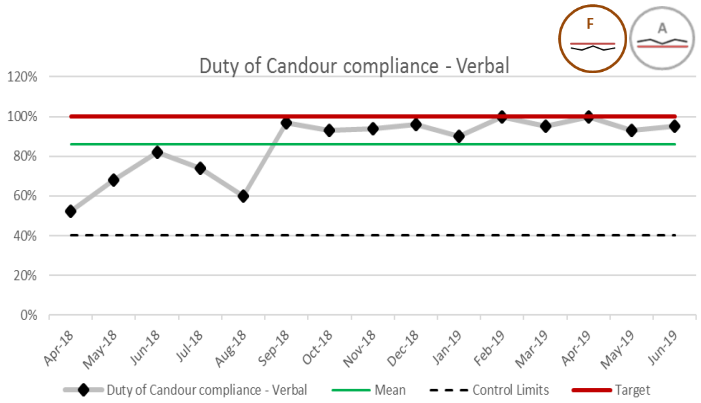
There is ongoing communication with Divisions on the importance of not sending patients home without their eDD. Performance is also discussed at Speciality Governance Meeting. Training was delivered for all new junior doctors on induction.

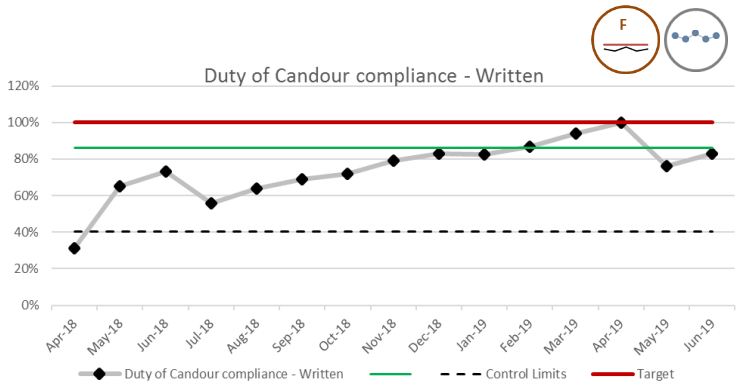
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

This was the 10th month in a row with a compliance level of 90% or more for in person notification.

Written follow-up compliance in June 2019 was 83%; this relates to 3 non-compliant incidents.

Actions in place to recover

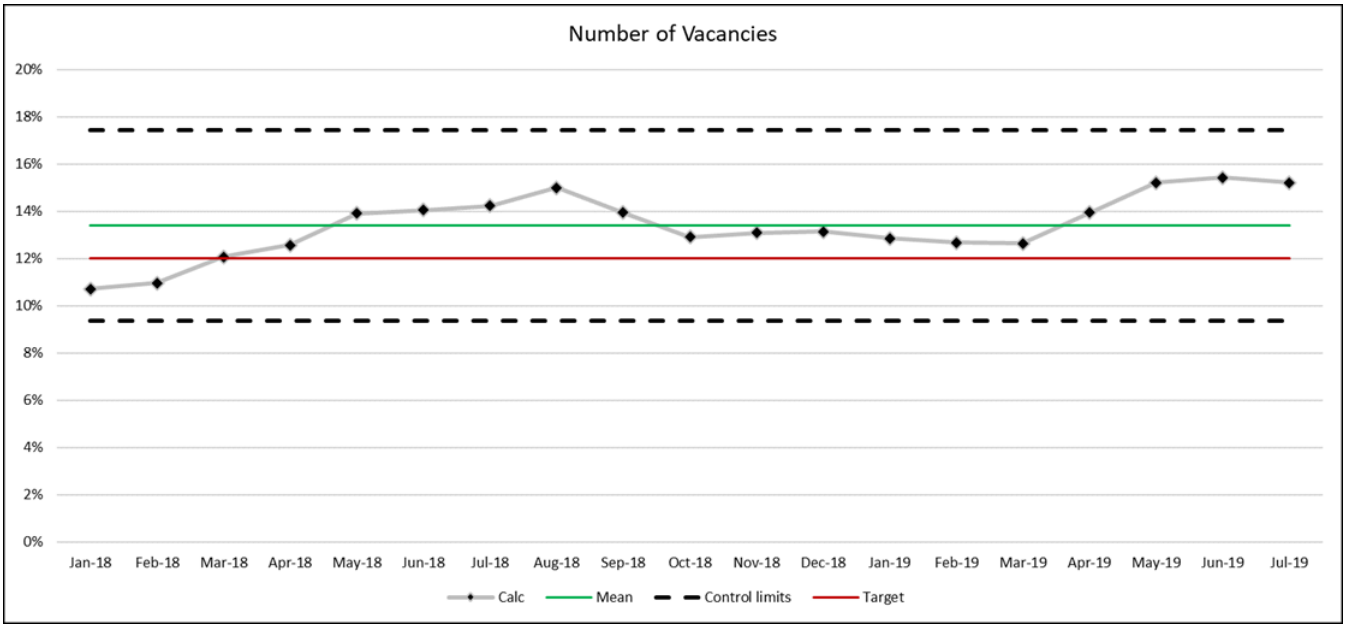
- Additional guidance has being added to the Datix system and the form has been redesigned, to support managers in accurately recording Duty of Candour compliance; these changes went live at the end of July
- Duty of Candour compliance reports are being added to each division's Datix Dashboards to assist with monitoring compliance

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People



Challenges/Successes

The overall Trust Vacancy Rate decreased slightly from 15.4% in June to 15.2% in July.

Weekly recruitment and exit tracking continues. There was a total of 9 fte of consultant and Speciality Doctors starts in July and 7.9 fte of new registered nurses. Whilst overall Turnover reduced in July and improvement was also seen in Medical and AHP rates, nursing remained flat and the rates remain above national and regional benchmarks slowing the improvement in vacancy rate from recruitment.

The Board approved a new set of employer branding concepts and creatives developed in partnership with TMP at its meeting in July.

Medical Vacancy Rate

The vacancy rate continues to improve, July is 20.0%. Staff in post at the end of July increased by 3.9 FTE and further improvement is expected in August.

There have been 46 fte of new starts (Consultant and Speciality Doctors) in the first two quarters of 2019/20.

Plan for every post is being used and has been further developed as a tool to deliver recruitment strategy and agency reduction in Child Health; the same approach for Women's Health and Breast will be implemented. FH strategy is to recruit Locum Consultants as soon as vacancy occurs. AAC panel dates planned in for next 12 months. Number of new starts planned of Consultants, Locums and Middle Grades (includes 3 Paediatric Consultants).

CSS have identified that full review of medical establishment against capacity and demand needs to be undertaken. Several NHS Locums are in the pipeline.

Further detail of Medical Vacancy Rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Radiology Consultants	7.9	47%
	Lincoln Clin Haematology IP	3.1	33%
Family Health	Lincoln Paediatrics IP	8.5	29%
	Pilgrim Paediatrics IP	4.7	24%
Medicine	Lincoln Elderly Care IP	11.2	46%
	Lincoln Respiratory Medicine IP	5.0	38%
	A&E Attenders Lincoln	12.2	32%
	A&E Attenders Pilgrim	11.0	31%
Surgery	Lincoln ENT IP	5.7	53%
	Pilgrim ENT IP	4.14	44%
	Lincoln Ophthalmology IP	3.8	27%

Nursing Vacancy Rate
This has increased slightly by 0.3%. Staff in post at the end of July decreased by 8.6 FTE despite a number of new appointments.

Establishment reconciliation and control measures in place in Family Health with planned Recruitment campaign for Children's Nursing [Ward 4A and Rainforest].

Further detail of Nurse Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Clinical Support Pan Trust Mgmt	4.0	67%
	Rheumatology Nursing	3.7	62%
	Dermatology Outpatients	3.8	52%
	Ward 7A Chemo Suite	5.6	35%
Medicine	Pilgrim AMSS	19.2	55%
	Pilgrim Stroke Unit	14.6	51%
	A&E Pilgrim	30.1	50%
	Ward 6A	10.8	47%
	Ward 7B	10.2	44%
	Ward 1	8.16	43%
Surgery	Bevan Ward	9.9	67%
	Ward 5B	10.8	46%
	Ward 9A	9.3	43%
	Ward 2	9.3	42%
	Lincoln Main Theatres	17.9	27%
Family Health	Ward 4A	14.2	43%
	Rainforest Ward	13.5	42%

AHPs Vacancy Rate
Improved by 0.9%. Staff in post increased by 3.7 fte with the number of new starts outweighing the number of exits for the first time for 12 months.
Details of notable AHP Vacancy rates are provided in the following table.

Resourcing are focusing on a recruitment campaign to target AHP's planned for third week in September.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	11.4	36%
	Pilgrim Occupational Therapy	7.1	35%

Actions in place to recover

Medical and Dental

Continued strong pipeline into Q3.

Divisions are increasingly adopting the 'plan for ever post' approach to all vacant post and there is greater triangulation with associated agency costs.

New international strategic partner to be appointed in August.

Increased focus on medical engagement to reduce turnover.

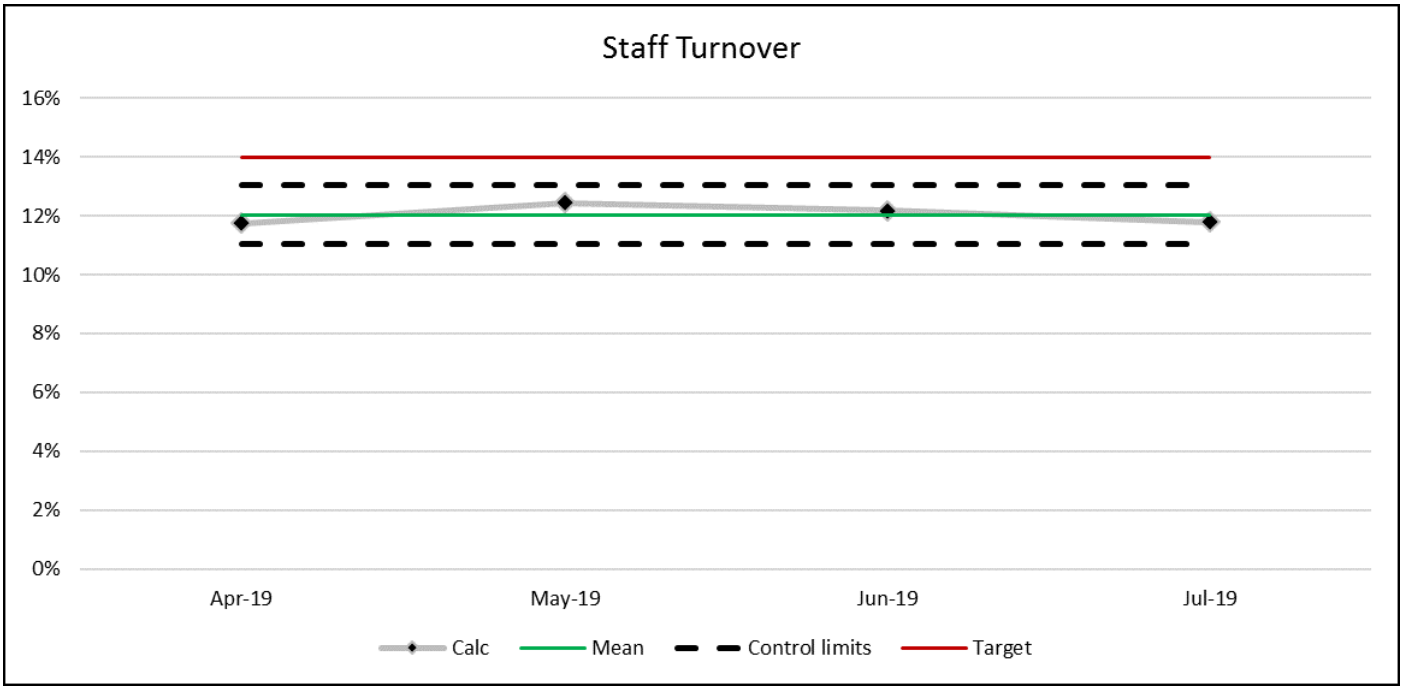
August Rotation for junior doctors expected to have positive effective on medical vacancy rate.

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

- Exit interviews: Process reviewed. Multiple changes made in the questionnaire and the process itself. Pilot launched in February 2019. Positive feedback re questionnaire and improved process. Q1 report for Apr – Jun shows a response rate of 38% up from 12%. (80 individual responses). Only 16% did not tell us their reason for leaving
- Self-rostering pilot completed. 3 wards/clinics have successfully completed it. A self-help toolkit has been developed and published on the intranet so that other interested wards can attempt self-rostering on their own.
- The current Retire and Return workshops have been agreed with the Financial Services Partner until March 2020. A small survey was designed and launched in July to seek feedback from staff on how they would like to see the workshop re-designed. A new plan for the workshop will be published in September 2019
- The first draft of the Legacy Nurse initiative has been shared with Debrah Bates, Jennie Negus and other stakeholders. It has been very well received. The initiative will launch in August 2019 and will be managed by the Nursing workforce team.
- Itchy Feet conversations has been launched. We had over 16 members of staff write to us seeking conversations with leaders. In July we had to increase the number of leaders on the panel due to the increase in the number of requests. We had 5 new requests in July bringing the total number of requests to 21 over the past 4 months. The issues raised have been 'lack of development opportunities' and 'manager related issues'.

Actions in place to recover

ULHT is putting together an engagement event for all staff called the 'ULHT Bus Station'. The Bus Station event will take place across sites during the week of the week of 16th September. During this week, the Bus will be stationed at each of the four hospital sites from 10 AM until 4 PM.

- 16th September – Lincoln (inaugural event)
- 17th September – Grantham
- 18th September – Pilgrim
- 19th September – Louth
- 20th September – Lincoln (close of event)

Over the course of the last year, various departments across the Trust have implemented a number of initiatives focussed on engagement, development and retention of staff. The ULHT Bus Station is a statement event to bring all these initiatives under one umbrella and make staff more aware of what is available to them towards building a fulfilling career within the Trust.

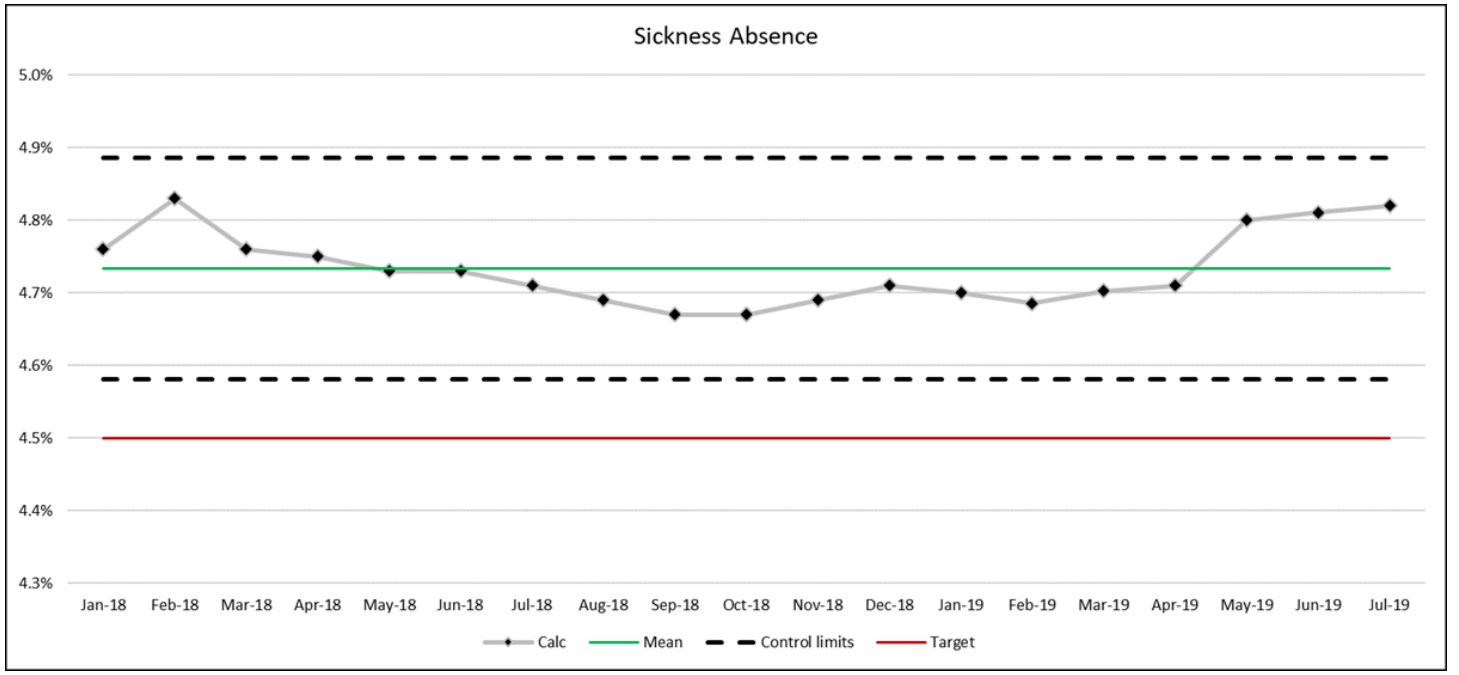
This Statement event will be centred around a ULHT branded bus to be parked on site at each hospital. The 'Bus Station' will be manned by a cross-functional team representing various departments/functions that will explain and promote the offerings and opportunities available to staff to navigate their career journey within ULHT.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

The overall sickness rate for the Trust (12 month rolling average) has been stable at around 4.8% since October 2018.

The ER Advisors are working with the Divisions and SHRBP's to work on trajectories for future sickness reporting.

Absence Reason	FTE Days Lost	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	25,725.41	£2,288,662.05	22.9
S98 Other known causes - not elsewhere classified	18,662.28	£1,592,388.77	16.6
S12 Other musculoskeletal problems	12,122.62	£1,036,143.95	10.8
S25 Gastrointestinal problems	9,032.55	£761,918.06	8.0
S11 Back Problems	7,917.37	£610,798.24	7.0

Actions in place to recover

A delegation of the ER team are visiting Manchester Foundation Hospital to review the Empactis Attendance platform. This has, over time, supported managers to manage sickness more effectively and focus on actions to bring staff back to work (in partnership with Occupational Health). Planning implementation at ULHT from third quarter 2019/20 into 2020/21.

Work is being completed with the SHRBP's to expedite recruitment processes to support redeployment in cases where employees cannot return to their substantive post due to ill-health.

Working in partnership with managers and employees to make reasonable adjustments supported by Access to Work.

Liaising with Organisational Development in relation to Staff Charter Workshops being run in hotspot areas to reiterate Trust's Values and Visions.

Bespoke one to one training sessions on absence with new managers and band 6 staff with responsibility to manage attendance.

Occupational Health to provide support to improve emotional well-being within A&E departments.

Support provided to managers to complete work-stress risk assessments and ensure this becomes an ongoing working document.

Managers being prompted to complete Maternity Risk Assessments to provide the necessary adjustments and reduce pregnancy related absence.

Concentrating on short term absence to ensure managers are setting monitoring triggers.

Management plan in place to support the hotspot area Theatres.

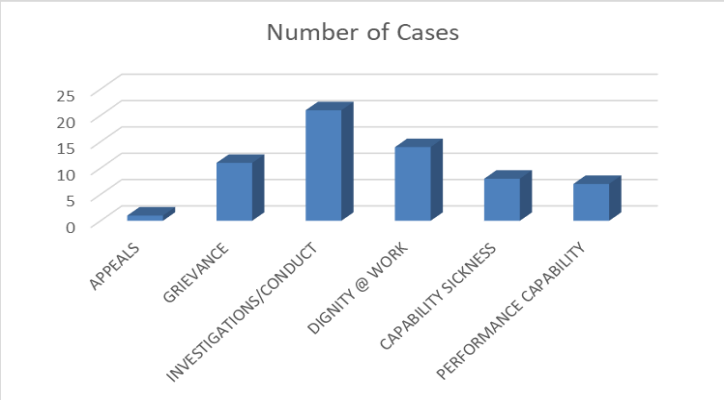
A targeted action plan in Estates and Facilities to improve attendance in place by March 2020 - already seen significant improvement in LTS levels.

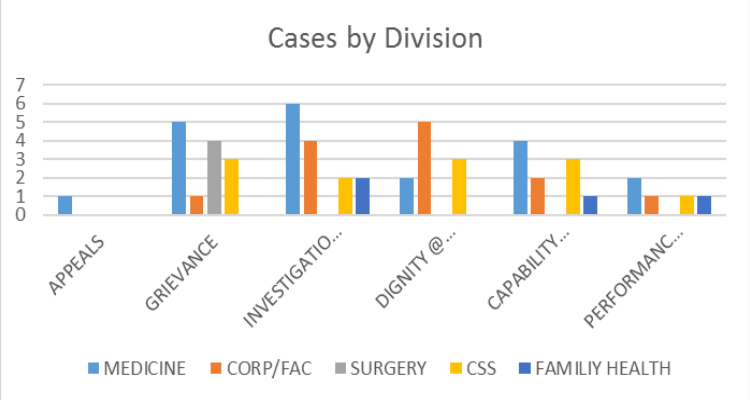
MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People





There are 53 open cases in July compared with 62 cases in June, representing an 8% decrease.

The majority of cases remain in the Medicine Division, with 20 cases (which has reduced on last month by 2)

Actions in place to recover

Carry out debrief sessions with managers following a disciplinary case which discussed better case management and including round the table conversations for difficult cases including complex health conditions.

Encourage more MDT's to look at cases prior to formal investigation or process

Implement the 'Just culture' approach – initiated review of key ER policies

Review cases, to consider if warnings can be 'accepted' without attending a formal hearing (First written only)

Revised new ER Case log, that incorporates all data required for reporting, simplifies data and ability to report more accurately

New data cleansing process implemented

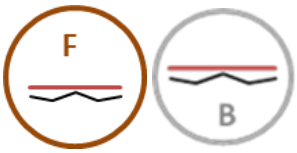
Request from Divisions for 'Packs' to be electronically PDF to managers/ employees in preparation for hearings, this will release printing time and costs

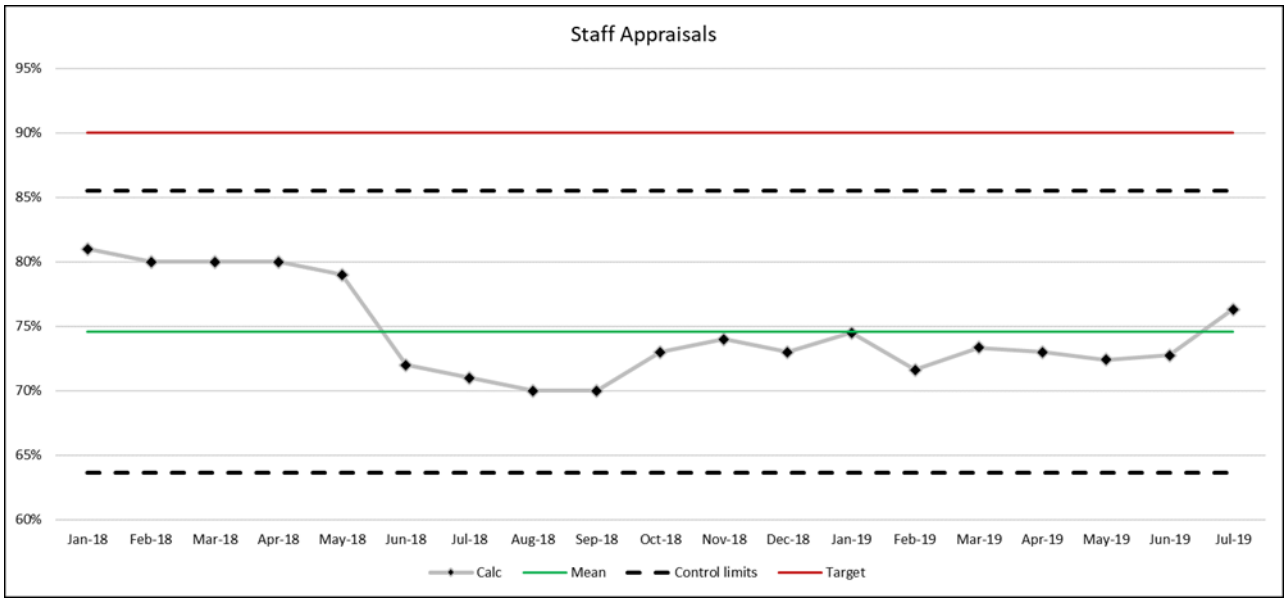
MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People





Challenges/Successes

Overall Trust performance continues to be well below the current target; however, the percentage completed is increasing.

Actions in place to recover

Revised appraisal paperwork launched in July and widely circulated

- Appraisee and appraiser training widely available across all sites
- SHRBPs working with Divisional teams to improve position

Family Health

Family Health have staff within the Management area not part of the Division, impacting on overall figures. Action from last PRM by Director of Finance to direct these staff be moved.

Estates and Facilities

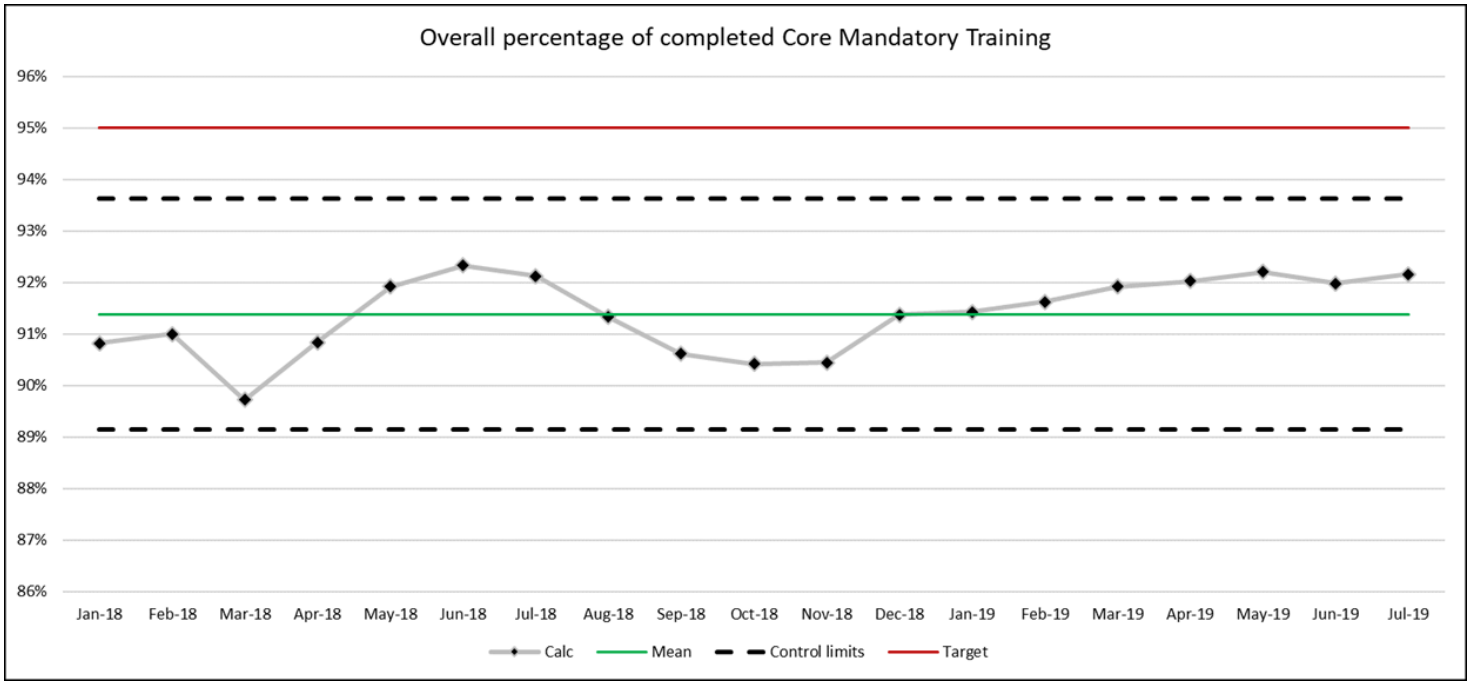
Action plan developed and implemented, briefed out, team objectives set, improvement starting to work through into figures. To support Quality of appraisal explicit link introduced of 'I support patient care by….'

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Overall compliance has increased by 0.2% in July. Most of the individual topics have improved and are now over 90%, the exceptions being :

- Information Governance 85.2%
- Resus 84.6%

Actions in place to recover

Strategic HR Business Partners to support identification & escalation of service areas with poor compliance rates.

Considering incentivising teams to complete 100% core learning – paper due to ET.

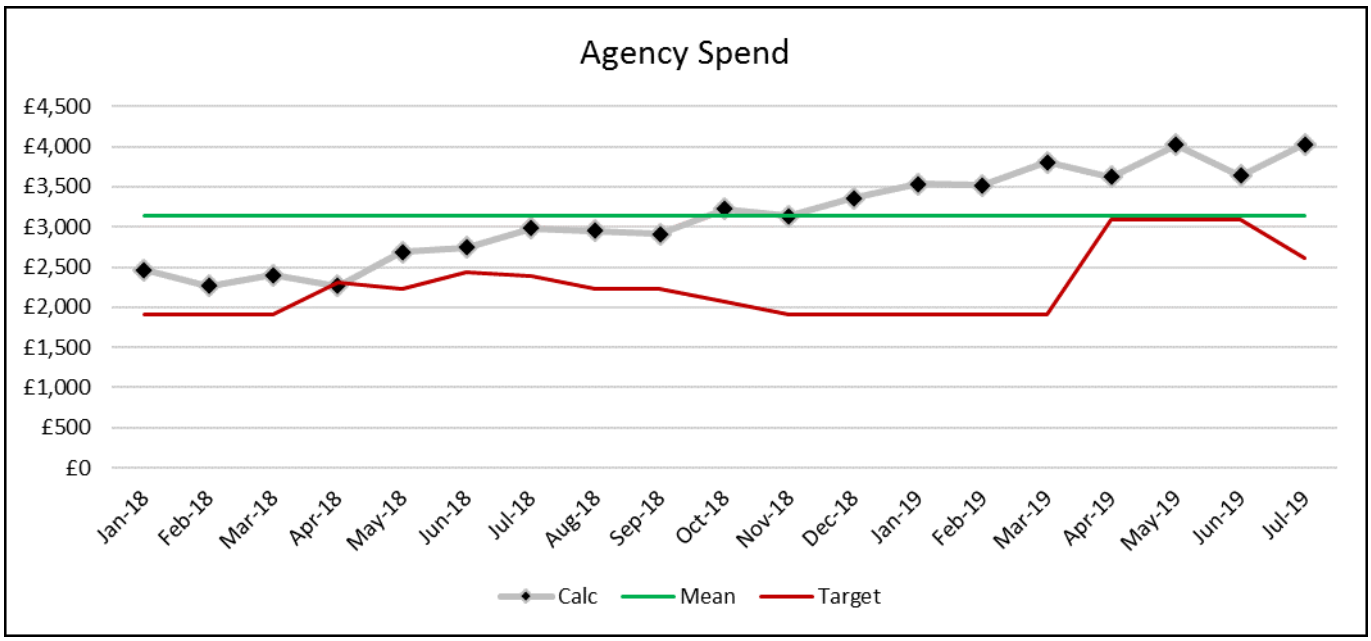
The Core Learning Panel has agreed to review all new core learning on a case by case basis.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



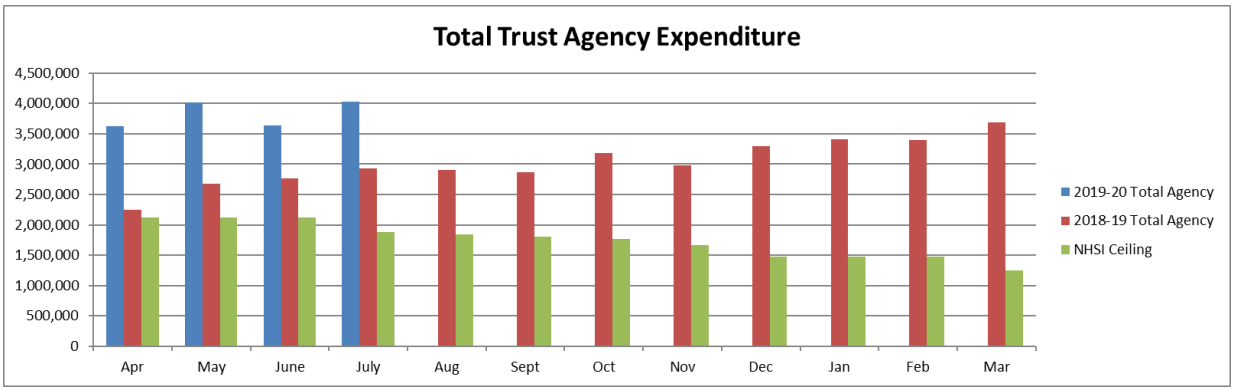
Challenges/Successes

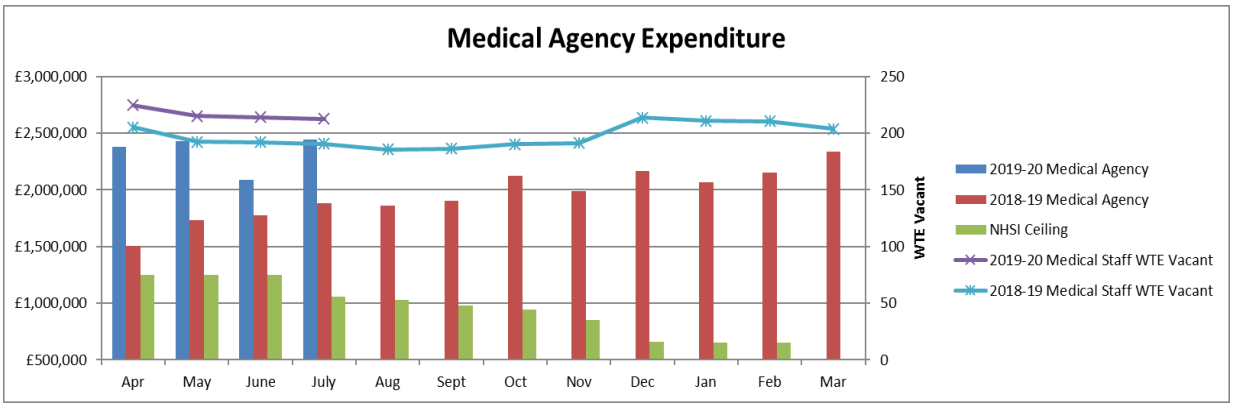
In July, Year to Date (YTD) planned pay costs deteriorated to 2.4% adverse to plan [an underlying position of 3.1% adverse to plan excluding releases] and 72.9% of income, which is 1.7% higher than plan. The adverse variance to plan for both bank and agency increased YTD with a corresponding decrease in the savings for substantive staff.

The adverse variance to plan remains driven by the higher premium cost of agency staffing and under delivery of workforce FEP.

The monthly run rate for total Agency spend increased from Month 3 to Month 4 and exceed that planned by 29% and a 12 month high.

Despite good progress against delivery plan of the medical central agency team (see below for details), Medical Agency pay costs reverted to a twelve month high after a significant reduction in June. Nursing Agency costs all rose steeply in July, a third consecutive month of rises. Further progress with the introduction of framework agencies at lower prices continued and price per nurse agency shift reduced so total cost is volume driven and out of step with vacancy rate changes



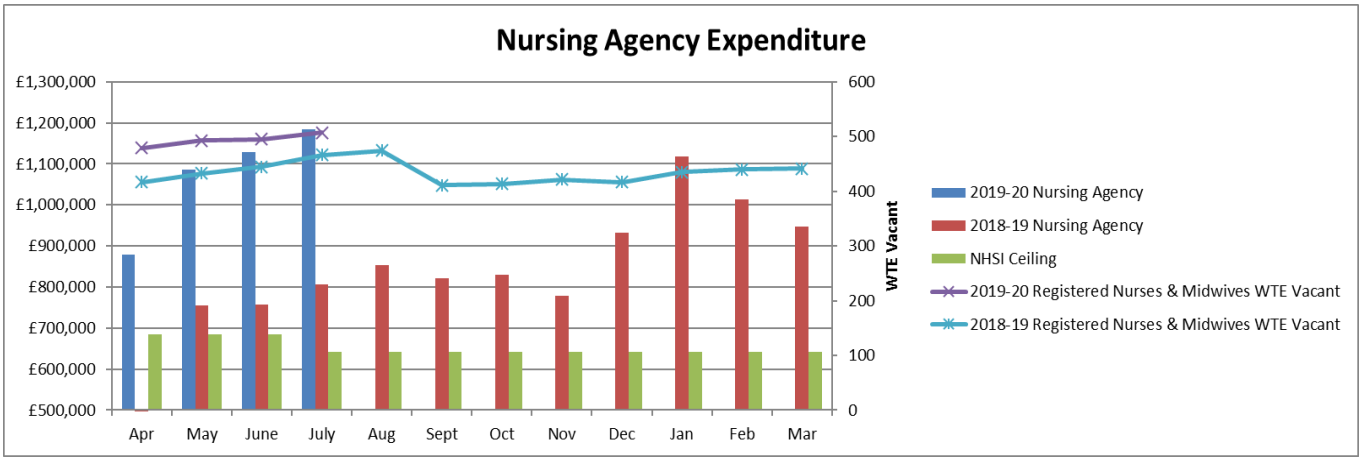


Medical agency costs increased significantly in July with a marginal improvement in vacancy rate, £ per vacant fte increased from £9,733 to £11,487 largely driven by increased volume per vacant fte (the number of requested shifts increased to 4,446 from 3,894, June to July, with a flat 97% fill rate). Rate reduction work continued and is largely positive.

The volume and cost per hour increased at Consultant level by £1.07 (two Oncology Consultants, two Radiology Consultants and 3 Stroke Consultants who are all in very difficult to fill premium rate specialties).

The cost per hour reduced across middle grade by £1.08 and is the lowest rate in the last 12 months.

Positive work on commissions control continued in July with a further £13,014 savings. In the last 12 months combined savings of £143,903 against commissions Holt tendered as part of the contract showing additional rates control.
A further £6,194 has been saved on breaks, above and beyond break policy for the month of July. This takes the total for the last 12 months to £88,068.
DE savings for the month of July were at £419,800 taking the last 12 months total to £4,090,032. The DE efficiency was at 92.4% with only 252 shifts being VAT applicable. AHP DE savings are at a total of £40,340 with £13,400 being saved in June.



The agency costs of Nursing increased for the third consecutive month in July with £ per vacant fte up from £1773 in April, £2223 in June to £2336 in July.

Further analysis below (Lincoln and Pilgrim) shows that fill rates are broadly stable but the downward movement in the percentage of shifts filled by substantive staff at Lincoln is greater than the increase in vacancy rate and the gap continues to be effectively filled by Agency with the introduction of new tier 3.5 agencies to reduce off-framework use.

LINCOLN Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Contracted staff Percentage	76%	71%	71%	73%	72%	69%	67%
Total temp percentage	20%	24%	23%	22%	22%	25%	26%
Bank percentage	11%	13%	14%	12%	11%	12%	12%
Agency percentage	9%	11%	9%	10%	11%	14%	14%
Total bank requests	540	657	665	606	640	711	749
Percentage bank fill	80%	76%	73%	76%	73%	75%	73%
Total percentage staffing against required	96%	95%	94%	95%	94%	94%	94%
Total percentage staffing without agency	87%	84%	85%	85%	83%	81%	79%

BOSTON Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Contracted staff Percentage	58%	57%	59%	59%	58%	58%	60%
Total temp percentage	38%	37%	38%	36%	38%	38%	38%
Bank percentage	11%	11%	12%	12%	11%	10%	10%
Agency percentage	27%	27%	26%	24%	27%	28%	28%
Total bank requests	679	704	664	667	686	685	665
Percentage bank fill	83%	81%	88%	83%	85%	87%	89%
Total percentage staffing against required	96%	95%	97%	96%	96%	97%	97%
Total percentage staffing without agency	69%	68%	71%	71%	69%	68%	69%

Other Agency costs remained broadly stable from June to July at just under £250k per month and is largely from investment in transformation and FEP programmes.

Actions in place to recover

The primary action to reduce agency costs is to still to reduce vacancy rates through substantive recruitment (See Vacancy Rates Section).

A deep dive into medical agency costs to understand the large swings May to July to identify the further actions that may be necessary to bring levels of spend under control. The Revised SOP for booking of medical agency in place for all division from August.

Targeted removal of Medical Umbrella companies by September 2019.

A Nurse Agency Pay Summit commissioned after M03 position is taking place w/c 12th August to bring together all key stakeholders to re-affirm current action and identify further interventions that may be necessary to bring levels the level of demand under control. These include:

- Continued introduction of tier 3.5 framework agencies to further reduce reliance on off frame work agency use;
- Enhanced nursing bank rate pilot, focused on high cost agency areas – September 19;
- Full review of rostering practice for Nursing including payments of breaks and management of annual leave – September 2019 and
- Longer term temporary nursing staffing plans to be developed to avoid higher premiums of shorter lead time requests.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Current Month			Year to Date			Forecast		
	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k
Income	42,813	43,614	801	165,318	165,195	(123)	501,616	501,616	0
Expenditure	(44,594)	(46,422)	(1,828)	(182,014)	(183,015)	(1,001)	(533,922)	(534,068)	(146)
EBITDA	(1,781)	(2,808)	(1,027)	(16,696)	(17,820)	(1,124)	(32,306)	(32,452)	(146)
Interest	(746)	(733)	13	(2,824)	(2,751)	73	(9,106)	(8,958)	148
Surplus/(Deficit)	(2,527)	(3,541)	(1,014)	(19,520)	(20,571)	(1,051)	(41,412)	(41,410)	2
Technical adjustments	1	19	18	4	77	73	14	26	12
Surplus/(Deficit)	(2,526)	(3,522)	(996)	(19,516)	(20,494)	(978)	(41,398)	(41,384)	14
EBITDA % Income	-4.2%	-6.4%	-2.3%	-10.1%	-10.8%	-0.7%	-6.4%	-6.5%	0.0%
FEPs	1,711	1,557	(154)	5,104	4,955	(149)	25,610	25,610	0

The Forecast position contained in the table above is delivery of plan, or a £41.4m forecast outturn deficit.

Overall YTD financial performance is £20.494m deficit, or £978k adverse to the planned £19.520m deficit.

EBITDA for the year to date is £17.820m deficit (-10.8% of Income).

Income overall is £123k below plan YTD. However, the income position includes income from backlog and repatriation of £2.1m, delivery of which is yet to be validated, and is a risk to the Trust. The income position also includes PSF and FRF of £1.7m for July, which is at risk if the Trust does not deliver its financial plan in the second quarter.

Overall expenditure is £1.001m adverse to plan YTD; the adverse movement in expenditure YTD is driven by Pay, because while Non-Pay is £1.798m favourable to plan, Pay is £2.799m adverse to plan.

The £2.799m adverse Pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive Pay is £1.805m favourable to plan, Bank Pay is £1.170m adverse to plan and Agency Pay is £3.435m adverse to plan. The pay position includes £333k (in line with plan) in relation to a 1% Medical & Dental pay award, which has now been agreed at 2.5% back-dated to April, and if there is no central funding for the costs of the award over and above 1% the risk to the Trust in 2019/20 is £1.5m of which £0.5m would apply YTD.

FEP delivery in-month is £154k adverse to plan and YTD delivery is £149k adverse to plan. However, in-month and YTD savings delivery have respectively been supported by £0.9m and £1.6m of non-recurrent technical savings delivery.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Actual M1	Actual M2	Actual M3	Actual M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	In Month Plan M4	In Month Actuals M4	In Month Variance	Full Year Plan Full Year	Full Year Forecast Full Year	Full Year Variance	Year to date Plan M4	Year to date Actuals M4	Year to date Variance
Income																					
NHS Clinical Income	31,497	32,935	31,772	34,034	32,371	31,955	33,257	31,600	31,366	32,443	30,414	32,038	33,557	34,034	477	385,686	385,685	(0)	129,620	130,238	619
Non NHS Clinical Income	291	273	68	388	282	282	282	281	282	282	284	389	283	388	105	3,384	3,384	0	1,129	1,020	(109)
Pass through income	4,101	4,068	3,793	4,455	4,261	4,270	4,278	4,270	4,253	4,270	4,270	4,425	4,241	4,455	214	50,710	50,711	0	16,903	16,417	(487)
Total Patient related income	**35,889**	**37,276**	**35,633**	**38,877**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**36,852**	**38,081**	**38,877**	**796**	**439,780**	**439,780**	**0**	**147,652**	**147,675**	**23**
PSF, FRF and MRET funding	1,568	1,568	1,569	1,989	1,989	1,990	2,832	2,832	2,831	3,252	3,252	3,256	1,989	1,989	0	28,928	28,928	0	6,694	6,694	0
Other Income	2,764	2,678	2,636	2,748	2,742	2,741	2,745	2,743	2,741	2,744	2,742	2,884	2,743	2,748	5	32,908	32,908	0	10,972	10,826	(146)
Total Other operating income	**4,332**	**4,246**	**4,205**	**4,737**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,140**	**4,732**	**4,737**	**5**	**61,836**	**61,836**	**0**	**17,666**	**17,520**	**(146)**
Total Income	**40,221**	**41,522**	**39,838**	**43,614**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**42,992**	**42,813**	**43,614**	**801**	**501,616**	**501,616**	**0**	**165,318**	**165,195**	**(123)**
Expenditure																					
Pay	(30,868)	(29,254)	(29,808)	(30,551)	(28,697)	(28,607)	(28,444)	(28,253)	(27,859)	(27,847)	(27,848)	(24,584)	(28,757)	(30,551)	(1,794)	(342,620)	(342,620)	0	(117,682)	(120,481)	(2,799)
Pass through non pay	(4,101)	(4,068)	(3,793)	(4,455)	(4,261)	(4,270)	(4,278)	(4,270)	(4,253)	(4,270)	(4,270)	(4,425)	(4,241)	(4,455)	(214)	(50,710)	(50,711)	(0)	(16,903)	(16,417)	487
Other Non pay	(11,363)	(11,975)	(11,363)	(11,416)	(11,572)	(11,564)	(11,559)	(11,561)	(11,581)	(11,665)	(11,659)	(13,456)	(11,596)	(11,416)	180	(140,592)	(140,737)	(146)	(47,429)	(46,117)	1,311
Total Expenditure	**(46,332)**	**(45,297)**	**(44,964)**	**(46,422)**	**(44,530)**	**(44,441)**	**(44,281)**	**(44,084)**	**(43,693)**	**(43,782)**	**(43,777)**	**(42,465)**	**(44,594)**	**(46,422)**	**(1,828)**	**(533,922)**	**(534,068)**	**(146)**	**(182,014)**	**(183,015)**	**(1,001)**
Finance costs	(643)	(679)	(696)	(733)	(756)	(749)	(782)	(767)	(808)	(812)	(767)	(766)	(746)	(733)	13	(9,106)	(8,958)	148	(2,824)	(2,751)	73
I&E - Deficit	**(6,754)**	**(4,454)**	**(5,822)**	**(3,541)**	**(3,641)**	**(3,952)**	**(1,669)**	**(3,125)**	**(3,028)**	**(1,603)**	**(3,582)**	**(239)**	**(2,527)**	**(3,541)**	**(1,014)**	**(41,412)**	**(41,410)**	**2**	**(19,520)**	**(20,571)**	**(1,051)**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	19	20	19	19	1	2	1	1	1	1	2	(60)	1	19	18	14	26	12	4	77	73
Adjusted Surplus/(Deficit)	**(6,735)**	**(4,434)**	**(5,803)**	**(3,522)**	**(3,640)**	**(3,950)**	**(1,668)**	**(3,124)**	**(3,027)**	**(1,602)**	**(3,580)**	**(299)**	**(2,526)**	**(3,522)**	**(996)**	**(41,398)**	**(41,384)**	**14**	**(19,516)**	**(20,494)**	**(978)**
Adjustments to derive underlying deficit																					
FSM Loan Interest	643	704	710	746	756	749	782	767	808	812	767	841				9,106	9,106	0			
External Support	558	558	558	75	75	75	0	0	0	0	0	0				1,900	1,900	0			
Prior Year Income & Challenges	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Profit on Disposals	0	0	0	0	0	0	(250)	0	0	0	0	0				(250)	(250)	0			
Accruals Adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Income timing adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Underlying Surplus/(Deficit)	**(5,534)**	**(3,172)**	**(4,535)**	**(2,701)**	**(2,809)**	**(3,126)**	**(1,136)**	**(2,357)**	**(2,219)**	**(790)**	**(2,813)**	**542**				**(30,642)**	**(30,628)**	**14**			

The Trust's financial plan is a deficit of £41.4m, and as at the end of July the Trust position is a deficit of £20,494k or £978k adverse to plan.

The run rate in future months is based upon plan and the table above shows that the planned run-rate in future months is markedly better than in April to July: the planned run rate from August to March averages £2,611k per month compared to an average of £5,124k per month in April to July. The improvement in the planned run-rate in future months reflects both an increase in the planned level of PSF and FRF funding and an increase in the planned level of FEP savings. Receipt of PSF and FRF funding is dependant upon delivery of the financial plan, and £1,694k of PSF and FRF in July is at risk if the Trust does not deliver its financial plan in the second quarter.

The YTD Pay position includes payment in April of a planned one off cost of £920k in relation to the Agenda for Change pay award and the benefit from releasing £1,021k of Pay accruals of which £890k was released in May.

To achieve the planned deficit, the Trust requires to deliver Financial Efficiency savings of £25.6m; savings of £4,955k have been delivered YTD against planned savings of £5,104k i.e. FEP delivery is £149k adverse to plan. However, delivery includes £2,531k of non-recurrent Technical FEP savings which have mitigated underperformance in relation to workforce savings schemes and other saving schemes.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Clinical Income Summary: YTD Month 4

	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20			2018/19	2019/20			2018/19	2019/20		
	Jul Activity Actual	Jul Activity Plan	Jul Activity Actual	Jul Activity Variance	Jul £k Actual	Jul £k Plan	Jul £k Actual	Jul £k Variance	Jul Activity Actual	Jul Activity Plan	Jul Activity Actual	Jul Activity Variance	Jul £k Actual	Jul £k Plan	Jul £k Actual	Jul £k Variance
Activity:																
Accident & Emergency	13,452	12,197	13,264	1,067	1,950	2,073	2,276	203	51,342	47,995	50,012	2,017	7,404	8,157	8,544	387
Daycases	5,607	5,880	5,715	(165)	2,993	3,133	3,160	27	22,015	21,746	22,190	444	11,387	11,590	12,100	510
Elective Spells	728	843	830	(13)	1,979	2,326	2,227	(99)	3,108	3,121	3,024	(97)	7,847	8,611	8,562	(50)
Non Elective Spells	5,978	6,153	6,665	512	10,590	11,501	13,479	1,978	23,435	24,126	25,205	1,079	41,494	45,052	51,993	6,942
Elective Excess Bed Days	110	117	284	167	26	32	85	53	463	469	548	79	114	127	156	29
Non Elective Excess Bed Days	1,729	1,645	1,458	(187)	432	431	219	(212)	6,488	6,579	4,846	(1,733)	1,570	1,724	1,136	(588)
Outpatient Firsts	26,018	26,848	26,037	(811)	3,484	3,846	3,681	(165)	99,664	99,308	98,585	(723)	13,230	14,228	14,020	(209)
Outpatient Follow Ups	33,355	34,870	34,438	(432)	2,817	3,240	3,108	(132)	130,490	128,879	128,073	(806)	11,044	11,975	11,730	(245)
Outpatient Non Face To Face	2,142	2,156	2,213	57	48	129	123	(5)	8,593	8,393	10,022	1,629	187	507	570	64
Outpatient Advice & Guidance	0	279	445	166	0	8	11	3	0	1,116	1,779	662	0	34	44	10
Critical Care	1,545	1,630	1,378	(252)	1,182	1,551	1,212	(339)	6,202	6,522	5,894	(628)	4,697	6,206	5,368	(838)
Maternity	1,025	1,028	946	(82)	813	895	876	(19)	4,070	4,110	3,783	(327)	3,435	3,580	3,502	(78)
Non PbR		79,668			3,948	3,087	3,157	70					15,282	12,347	12,401	54
Block	0	0	0	0	0	237	237	0	0	0	0	0	0	949	949	0
Shadow Monitoring	0	1,395	1,556	161	0	0	0	0	0	5,580	5,748	168	0	0	0	0
Repatriation						483	483	0						1,900	1,900	0
Backlog						54	54	0						204	204	0
Work in Progress:						0	(360)	(360)						0	(401)	(401)
Sub total without passthrough					**30,260**	**33,027**	**34,029**	**1,002**					**117,691**	**127,191**	**132,778**	**5,588**
CQUIN					616	381	399	19					2,408	1,461	1,540	79
Fines						0	(52)	(52)						0	(207)	(207)
Fines Reinvested						0	33	33						0	131	131
								0								0
Bring Lincolnshire CCG Contract to Plan						0	(1,351)	(1,351)						0	(5,923)	(5,923)
APA (calculated at quarterly billing)						0	531	531						0	915	915
								0								0
Prior Year						0		0						0		0
								0								0
Maternity Prepayment						0		0						0		0
								0								0
Total (Non Passthrough)						**33,408**	**33,589**	**182**						**128,652**	**129,235**	**583**
Passthrough					4,013	4,240.9	4,212.3	- 28.5					16,148	16,903.5	16,417	(487)
Total (Inc Passthrough)						**37,648.6**	**37,801.8**	**153.2**						**145,555.0**	**145,652**	**97**

Patient Care Income is £583k favourable to plan (all figures exclude passthrough which is c£487k adverse to plan)

For the income from patient care activities related to the APA (i.e. the Lincolnshire CCGs), Income is £0.9m favourable to plan; (this being in essence the marginal rate adjustment for Non Elective over performance – further detail below).

It should be noted that the Trust are shadowing monitoring the Lincolnshire CCGs on a PbR contract alongside the APA. The actual income levels reported at month 4 are £2.9m below the value that would have been received if the Trust was on PbR contract for the Lincolnshire CCGs. Albeit open to contract challenges and fines from Lincs CCGs.

The primary driver for the additional £2.9m that would have been accessed through a PbR contract for the Lincolnshire CCGs is Non-Elective activity in the Medicine Division. Non Electives are £5.9m reduction to the reported income position. Non Elective activity year to date is 4.5% up against plan in relation to activity and 15% in relation to income - Further details are being shared with the Medicine Division. Key specialites within NEL are General Medicine (73%), Geriatric Medicine (11%), Cardiology (6%) and Gastroenterology (5%). As a note of caution, CCGs are also querying back to ULHT the level of NEL activity and income recording that is currently being shown as they believe they are incorrect.

The backlog and repatriation assumptions included above are a key risk to the Trust. The Trust has established and now combined the Backlog and Repatriation working groups into a core group.

Critical Care income is c£800k adverse against plan. Liaison with the Division has clarified that there has been no reduction in capacity and no change in bed numbers. There has been a decreasing number of admissions after elective surgery alongside the usual variation in admission for this time period of the financial year (May to July is often quiter across the network). A work-in-progress adjustment of c£100k has been included to offset.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Activity Units														
Activity	Actual M1	Actual M2	Actual M3	Actual M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Forecast Activity	Full Year Plan	Variance
Accident & Emergency	11,989	12,740	12,019	13,264	12,197	11,801	12,197	11,801	12,197	12,197	11,405	10,292	144,096	144,096	-
Daycases	5,307	5,844	5,324	5,715	5,373	5,373	5,880	5,373	5,119	5,627	5,119	5,183	65,238	65,238	-
Elective Spells	681	807	706	830	771	771	843	771	735	807	735	904	9,362	9,362	-
Non Elective Spells	6,045	6,477	6,018	6,665	6,137	5,952	6,110	5,867	6,012	5,995	5,587	4,955	71,820	71,820	-
Elective Excess Bed Days	67	110	87	284	117	117	117	117	117	117	117	38	1,406	1,406	-
Non Elective Excess Bed Days	1,002	1,220	1,166	1,458	1,645	1,645	1,645	1,645	1,645	1,645	1,645	3,377	19,736	19,736	-
Outpatient Firsts	24,311	24,781	23,457	26,037	24,538	24,538	26,848	24,538	23,384	25,693	23,384	26,416	297,924	297,924	-
Outpatient Follow Ups	31,382	32,197	30,056	34,438	31,841	31,841	34,870	31,841	30,327	33,356	30,327	34,162	386,638	386,638	-
Outpatient Non Face To Face	2,726	2,686	2,397	2,213	2,090	2,090	2,156	2,090	2,057	2,123	2,057	494	25,179	25,179	-
Outpatient Advice & Guidance	373	437	524	445	279	279	279	279	279	279	279	- 383	3,349	3,349	-

Activity	18/19 YTD Actual M4	19/20 YTD Plan M4	19/20 YTD Actual M4	YTD Var M4	% Var M4
Accident & Emergency	51,342	47,995	50,012	2,017	4.2%
Daycases	22,015	21,746	22,190	444	2.0%
Elective Spells	3,108	3,121	3,024	- 97	-3.1%
Non Elective Spells	23,435	24,126	25,205	1,079	4.5%
Elective Excess Bed Days	463	469	548	79	16.9%
Non Elective Excess Bed Days	6,488	6,579	4,846	- 1,733	-26.3%
Outpatient Firsts	99,664	99,308	98,585	- 723	-0.7%
Outpatient Follow Ups	130,490	128,879	128,073	- 806	-0.6%
Outpatient Non Face To Face	8,593	8,393	10,022	1,629	19.4%
Outpatient Advice & Guidance	-	1,116	1,779	662	59.3%

Activity run-rates are assumed for the key POD groups.

Whilst A&E activity is lower for the first four months of 2019/20 when compared to 2018/19, this is primarily due to a change in plan in relation to assumed levels of increased activity transferring to Primary Care Streaming (i.e. a planned change between years).

A&E and Non-Elective activity levels are being raised formally with Lincolnshire CCGs given their impact upon the Trust's ability to manage flow and bed resources and their overall impact on the Trust's financial position. As a note of caution, CCGs are also querying back to ULHT the level of NEL activity and income recording that is currently being shown as they believe they are incorrect.

Non Elective activity is 4.5% up against plan YTD in relation to activity and 15% in relation to income. This Non Elective over performance is mainly within the Medicine Division and further details are being shared with the Division.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE £

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

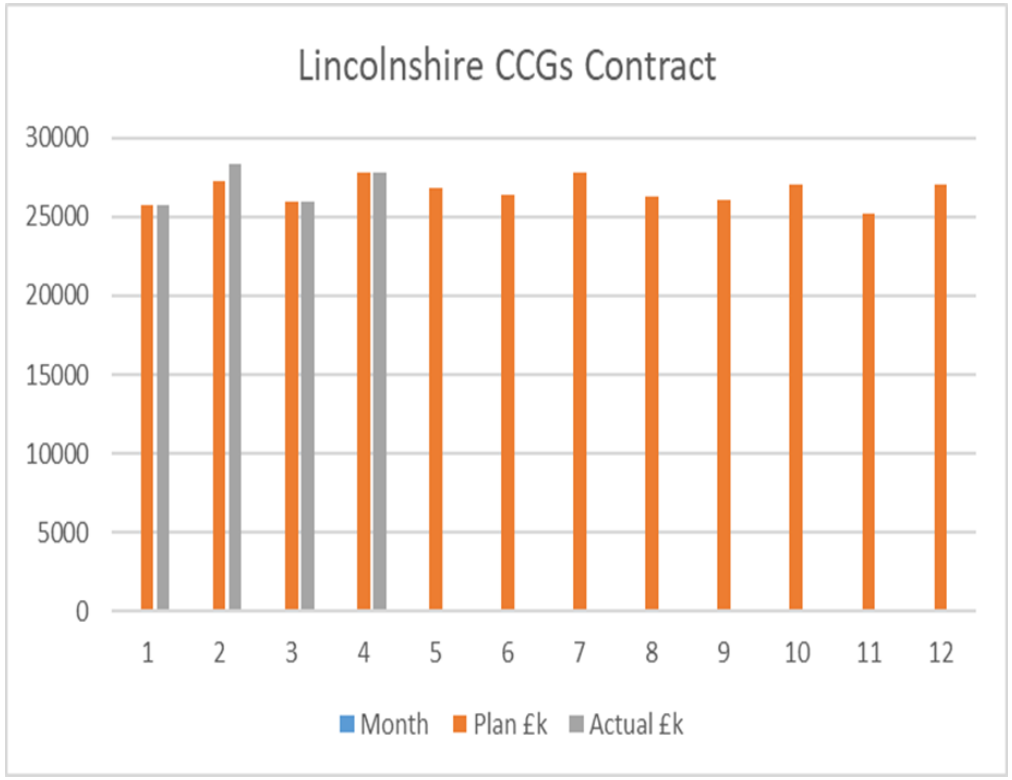
	Plan (£k)														
Income	Actual M1	Actual M2	Actual M3	Actual M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	Full Year Actual £	Full Year Plan	Variance
Accident & Emergency	2,039.2	2,167.5	2,060.7	2,276.4	2,072.9	2,005.6	2,072.9	2,005.6	2,072.9	2,072.9	1,938.3	1,694.5	24,479.6	24,479.6	0.0
Daycases	2,897.9	3,144.2	2,898.2	3,159.8	2,863.9	2,863.9	3,133.0	2,863.9	2,729.3	2,998.5	2,729.3	2,488.5	34,770.2	34,770.2	0.0
Elective Spells	1,963.1	2,295.1	2,076.3	2,227.0	2,128.1	2,128.1	2,326.1	2,128.1	2,029.0	2,227.1	2,029.0	2,276.8	25,833.7	25,833.7	0.0
Non Elective Spells	12,688.6	13,551.1	12,274.6	13,479.0	11,463.7	11,124.6	11,398.6	10,923.5	11,168.3	11,128.2	10,360.8	4,279.0	133,840.1	133,840.1	0.0
Elective Excess Bed Days	17.4	28.8	24.9	84.9	31.8	31.8	31.8	31.8	31.8	31.8	31.8	3.0	381.5	381.5	0.0
Non Elective Excess Bed Days	273.8	326.2	316.8	219.5	431.0	431.0	431.0	431.0	431.0	431.0	431.0	1,018.6	5,171.6	5,171.6	0.0
Outpatient Firsts	3,477.6	3,509.5	3,351.4	3,681.1	3,515.9	3,515.9	3,845.7	3,515.9	3,351.0	3,680.8	3,351.0	3,889.5	42,685.0	42,685.0	0.0
Outpatient Follow Ups	2,881.8	2,955.8	2,784.5	3,107.9	2,958.7	2,958.7	3,240.1	2,958.7	2,817.9	3,099.4	2,817.9	3,344.9	35,862.6	35,862.6	0.0
Outpatient Non Face To Face	152.4	149.0	145.4	123.4	126.3	126.3	128.6	126.3	125.2	127.5	125.2	63.7	1,644.0	1,644.0	0.0
Outpatient Advice & Guidance	9.5	10.8	13.0	11.1	8.5	8.5	8.5	8.5	8.5	8.5	8.5	(1.9)	102.0	102.0	0.0
Critical Care	1,380.6	1,166.6	1,608.1	1,212.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	2,389.5	18,617.6	18,617.6	0.0
Maternity	897.9	829.5	899.2	875.5	895.0	895.0	895.0	895.0	895.0	895.0	895.0	972.8	10,739.8	10,739.8	0.0
Non PbR	3,011.9	3,316.4	2,915.6	3,157.1	3,068.9	3,095.5	3,093.5	3,107.2	3,075.7	3,098.8	3,136.4	3,030.5	37,107.5	37,107.5	0.0
Block	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	2,848.4	2,848.4	0.0
Repatriation	467.2	482.8	467.2	482.8	482.8	467.2	482.8	467.2	482.8	482.8	451.6	482.8	5,700.0	5,700.0	0.0
Backlog	47.8	54.1	47.8	54.1	54.1	47.8	54.1	47.8	54.1	54.1	41.5	54.1	611.1	611.1	0.0
Work in Progress	(219.6)	(391.6)	570.6	(360.4)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	400.9	0.0	0.0	0.0
														0.0	0.0
Sub total without passthrough	32,224.5	33,833.2	32,691.7	34,029.0	31,890.3	31,488.6	32,930.5	31,299.2	31,061.2	32,125.1	30,136.1	26,624.4	380,394.7	380,394.7	0.0
															0.0
CQUIN	374.9	395.1	370.5	399.3	366.3	361.4	379.3	359.0	355.9	369.2	344.5	291.4	4,369.3	4,369.3	0.0
													0.0		0.0
Fines	(55.1)	(57.0)	(42.8)	(51.7)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	206.6	0.0	0.0	0.0
Fines Reinvested	35.2	36.4	26.6	32.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(130.9)	0.0	0.0	0.0
													0.0	0.0	0.0
Bring Lincolnshire CCG Contract to Plan	(1,610.6)	(1,308.2)	(1,652.9)	(1,350.9)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5,922.5	0.0	0.0	0.0
APA (calculated at quarterly billing)	123.5	206.4	53.8	530.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(914.7)	0.0	0.0	0.0
													0.0	0.0	0.0
Total (Non Passthrough)	**31,092.3**	**33,106.0**	**31,447.0**	**33,589.5**	**32,256.6**	**31,850.1**	**33,309.8**	**31,658.2**	**31,417.1**	**32,494.2**	**30,480.6**	**31,999.4**	**384,764.1**	**384,764.1**	**0.0**
															0.0
Passthrough	4,101.2	4,174.2	3,929.1	4,212.3	4,223.7	4,223.7	4,240.9	4,223.7	4,215.2	4,232.3	4,215.2	4,719.0	50,710.5	50,710.5	0.0
Total (Inc Passthrough)	**35,193.5**	**37,280.2**	**35,376.0**	**37,801.8**	**36,480.3**	**36,073.8**	**37,550.7**	**35,881.9**	**35,632.3**	**36,726.5**	**34,695.8**	**36,718.4**	**435,474.6**	**435,474.5**	**0.0**

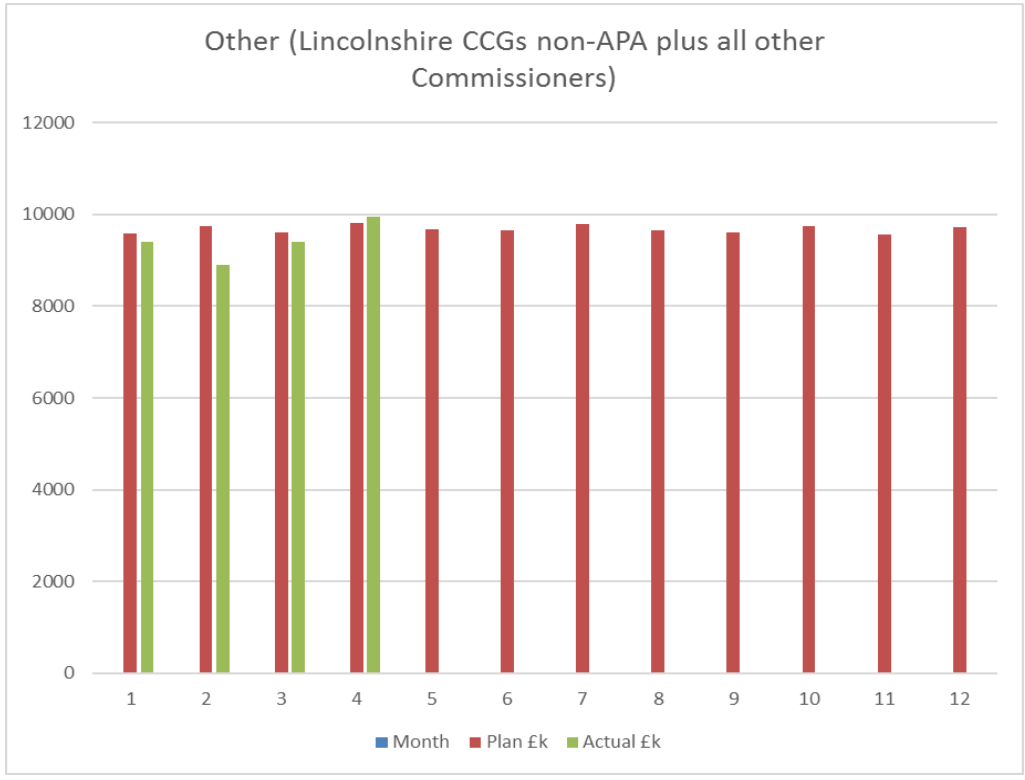
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





SUSTAINABLE SERVICES – INCOME SUMMARY AND RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Other Income Summary: YTD Month 4

	Other Income: In-Month				Other Income: Year-To-Date			
Other Income	2018/19 July £k Actual	2019/20 July £k Plan	2019/20 July £k Actual	2019/20 July £k Variance	2018/19 Apr - Jul £k Actual	2019/20 July £k Plan	2019/20 July £k Actual	2019/20 July £k Variance
NHS Patient Care Income main contract	29,718	33,342	33,818	476	121,494	129,196	129,196	0
NHS Patient care Pass through income	4,220	4,241	4,455	214	11,990	16,903	16,417	(487)
NHS Patient Care Income other	488	210	210	0	704	403	1,004	601
Non NHS other income	99	112	141	29	378	449	483	34
Non NHS Private Patients	24	17	26	9	75	71	88	17
Overseas Visitors	54	17	43	26	113	65	73	8
Injury Cost Recovery Scheme	83	142	187	45	176	565	414	(151)
Patient Care Income Total	**34,686**	**38,081**	**38,880**	**799**	**134,930**	**147,652**	**147,675**	**23**
Other Income								
Research & Development	116	100	119	19	403	399	464	65
Education & Training	1,323	1,389	1,310	(79)	5,296	5,554	5,444	(110)
Non patient services to other bodies	580	503	576	73	2,371	2,014	1,951	(63)
PSF, FRF and MRET funding	0	1,989	1,989	0	0	6,694	6,694	0
Car parking income	248	208	245	37	927	833	1,086	253
Catering income	81	75	84	9	304	299	320	21
Other Income	640	468	414	(54)	1,569	1,873	1,561	(312)
Other Income Total	**2,988**	**4,732**	**4,737**	**5**	**10,870**	**17,666**	**17,520**	**(146)**
Total Income	**37,674**	**42,813**	**43,617**	**804**	**145,800**	**165,318**	**165,195**	**(123)**

Income of £165,195k has been achieved YTD compared to planned income of £165,318k resulting in the Income position being £123k (0.07%) adverse to plan.

The income position includes £6,694k YTD in relation to PSF, FRF & MRET. Receipt of PSF and FRF is dependant upon delivery of the financial position. PSF and FRF of £1,694k for July is at risk if the Trust does not deliver its financial plan in the second quarter.

While MRET funding is £915k per quarter, the level of PSF and FRF increases every financial quarter, so that the amount of central funding at risk if the Trust does not deliver its financial plan increases every quarter. The central funding is profiled as follows:

£4,705k in Q1

£5,968k in Q2

£8,495k in Q3

£9,760k in Q4

Excluding Pass-through, for which there is an offset within Non Pay, Income is £364k favourable to plan, despite adverse variances to plan of £151k in relation to Injury Cost Recovery and £110k in relation to Education & Training.

Excluding PSF, FRF and MRET, Income has averaged £39,625k per month from April to July, and to achieve plan in August to March will require achievement of Income of £39,273k per month.

2019/20 Other Income Run Rate

	Actual & Forecast £k														
	Actual M1	Actual M2	Actual M3	Actual M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	Full Year Plan	FOT £	Variance
NHS Patient Care Income	35,706	37,120	35,653	38,621	36,739	36,332	37,642	35,977	35,726	36,820	34,791	36,552	437,679	437,679	0
Non NHS Private Patients	31	18	13	26	18	18	18	17	18	18	18	0	213	213	0
Overseas Visitors	13	13	4	43	16	16	16	16	16	16	17	8	194	194	0
Injury Cost Recovery Scheme	139	123	(35)	187	141	141	141	141	141	141	142	292	1,694	1,694	0
Patient Care Income Total	**35,889**	**37,274**	**35,635**	**38,877**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**36,852**	**439,780**	**439,780**	**0**
Other Income															
Research & Development	121	123	101	119	100	99	100	100	99	100	100	33	1,195	1,195	0
Education & Training	1,368	1,457	1,309	1,310	1,389	1,387	1,389	1,389	1,388	1,389	1,389	1,497	16,661	16,661	0
Non patient services to other bodies	480	420	475	576	503	504	504	503	504	503	503	566	6,041	6,041	0
PSF, FRF and MRET funding	1,568	1,568	1,569	1,989	1,989	1,990	2,832	2,832	2,831	3,252	3,252	3,256	28,928	28,928	0
Car parking income	250	289	302	245	208	209	208	208	208	209	208	(45)	2,499	2,499	0
Catering income	78	77	81	84	75	74	75	75	74	75	75	53	896	896	0
Other Income	547	312	288	414	467	468	469	468	468	468	467	780	5,616	5,616	0
Other Income Total	**4,412**	**4,246**	**4,125**	**4,737**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,140**	**61,836**	**61,836**	**0**
Total Income	**40,301**	**41,520**	**39,760**	**43,614**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**42,992**	**501,616**	**501,616**	**0**

SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Pay Summary: YTD Month 4								
	Pay: In-Month				Pay: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20		
Staff Groups	Jul £k Actual	Jul £k Plan	Jul £k Actual	Jul £k Variance	Apr - Jul £k Actual	Jul £k Plan	Jul £k Actual	Jul £k Variance
Substantive:								
Registered Nursing, Midwifery and Health visiting staff	6,812	7,190	7,082	108	27,555	28,926	28,671	255
Health Care Scientists and Scientific, Therapeutic and Technical staff	2,505	2,602	2,739	(137)	9,980	10,496	10,990	(494)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	4,602	4,780	4,895	(115)	17,973	19,315	19,695	(380)
Medical and Dental Staff	6,470	6,798	6,855	(57)	26,140	27,561	25,950	1,611
Non-Medical - Non-Clinical Staff	2,535	2,911	2,730	181	10,043	11,744	10,986	758
Bank:								
Registered Nursing, Midwifery and Health visiting staff	463	471	496	(25)	1,938	1,886	2,019	(133)
Health Care Scientists and Scientific, Therapeutic and Technical staff	40	44	48	(4)	175	177	179	(2)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	369	371	404	(33)	1,426	1,486	1,547	(61)
Medical and Dental Staff	781	691	1,004	(313)	3,252	3,082	3,850	(768)
Non-Medical - Non-Clinical Staff	200	177	199	(22)	698	708	914	(206)
Agency:								
Registered Nursing, Midwifery and Health visiting staff	804	876	1,185	(309)	2,803	3,678	4,270	(592)
Health Care Scientists and Scientific, Therapeutic and Technical staff	185	131	155	(24)	623	545	655	(110)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	3	17	0	17	12	47	6	41
Medical and Dental Staff	1,881	1,445	2,442	(997)	6,884	6,569	9,343	(2,774)
Non-Medical - Non-Clinical Staff	114	146	245	(99)	360	1,034	1,033	1
Apprentice levy	105	107	86	21	415	428	433	(5)
Capitalised staff	(11)	0	(16)	16	(74)	0	(61)	61
Total Pay	**27,858**	**28,757**	**30,549**	**(1,792)**	**110,202**	**117,682**	**120,481**	**(2,799)**

Pay year to date is £2,799k adverse to plan despite the release of £1,021k of non-recurrent technical savings.

The adverse movement to plan in Pay includes two key movements: £1,805k favourable movement against substantive staffing and £4,604k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £1,805k favourable to plan, this includes £996k of one-off technical benefit. Excluding the impact the one-off cost of £920k in April of the Agenda for Change pay award, the one-off technical benefits of £996k and estimate of a 1% pay award for Medical and Dental Staff, Substantive Pay has been broadly flat YTD at £24.1m per month.

The above table shows that:

1) The adverse movement to plan on temporary staffing comprises of an adverse movement to plan of £1,170k on Bank Pay and £3,435k on Agency Pay.

2) Of the £1,170k adverse movement to plan on Bank Pay, £768k (66%) relates to Medical & Dental Staff, £206k (18%) relates to Non Clinical Staff groups and £133k (11%) relates to Registered Nursing & Midwifery Staff.

3) Of the £3,435k adverse movement to plan on Agency Pay, £2,774k (81%) relates to Medical & Dental Staff and £592k (17%) relates to Registered Nursing & Midwifery Staff.

Overall, of the £2,779k adverse movement to plan on Pay, £1,931k (69%) relates to Medical & Dental, £606k (22%) relates to Healthcare Scientists and STT Staff, £470k (17%) relates to Registered Nursing & Midwifery Staff; a favourable movement of £551k in Non Clinical Staff more than offsets the adverse movements of £401k in Support to Clinical Staff.

SUSTAINABLE SERVICES – PAY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Actual m1-m4 Forecast m5 - m12 (£k)														
Staff Groups	Actual M1 £000s	Actual M2 £000s	Actual M3 £000s	Actual M4 £000s	Forecast M5 £000s	Forecast M6 £000s	Forecast M7 £000s	Forecast M8 £000s	Forecast M9 £000s	Forecast M10 £000s	Forecast M11 £000s	Forecast M12 £000s	Full Year Plan £000s	Forecast £000s	Variance £000s
Substantive:															
Registered Nursing, Midwifery and Health visiting staff	7,614	6,880	7,094	7,082	7,190	7,190	7,190	7,190	7,191	7,191	7,191	7,446	86,450	86,450	0
Health Care Scientists and Scientific, Therapeutic and	2,868	2,672	2,712	2,739	2,602	2,602	2,602	2,603	2,603	2,603	2,604	2,110	31,319	31,319	(0)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	5,127	4,787	4,886	4,895	4,780	4,780	4,780	4,780	4,780	4,780	4,781	4,401	57,557	57,557	(0)
Medical and Dental Staff	6,435	6,092	6,568	6,855	6,793	6,784	6,777	6,760	6,724	6,723	6,723	8,294	81,527	81,528	(1)
Non-Medical - Non-Clinical Staff	2,872	2,671	2,713	2,730	2,926	2,926	2,926	2,926	2,926	2,926	2,926	3,743	35,032	35,211	(179)
Bank:															
Registered Nursing, Midwifery and Health visiting staff	508	495	520	496	471	473	471	471	473	471	471	338	5,658	5,658	(0)
Health Care Scientists and Scientific, Therapeutic and	39	44	47	48	44	47	44	44	45	44	44	45	536	536	0
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	379	371	395	404	371	373	371	371	372	371	371	312	4,459	4,459	(0)
Medical and Dental Staff	1,073	893	880	1,004	675	650	368	368	368	368	368	368	7,383	7,383	(0)
Non-Medical - Non-Clinical Staff	226	233	256	199	177	177	142	142	142	142	142	143	2,121	2,121	0
Agency:															
Registered Nursing, Midwifery and Health visiting staff	877	1,082	1,127	1,185	876	876	611	611	611	611	611	610	10,686	9,687	999
Health Care Scientists and Scientific, Therapeutic and	147	177	176	155	131	131	131	131	131	131	131	1,020	1,593	2,592	(999)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	1	3	2	0	17	17	17	17	17	17	17	58	183	183	(0)
Medical and Dental Staff	2,379	2,431	2,091	2,442	1,406	1,344	498	498	498	498	498	498	15,082	15,081	1
Non-Medical - Non-Clinical Staff	216	327	245	245	146	146	71	71	71	71	71	73	1,752	1,753	(1)
Apprentice levy	119	113	115	86	107	106	107	107	107	107	106	102	1,282	1,282	0
Capitalised staff	(14)	(14)	(17)	(16)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(14)	0	(180)	180
Items included in Non pay:															
Operating expenses: research and development	(118)	(99)	(99)	(100)	(110)	(110)	(110)	(110)	(110)	(110)	(110)	(134)	(1,320)	(1,320)	0
Operating expenses: education and training	(158)	(149)	(166)	(124)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	27	(1,368)	(1,368)	0
Operating expenses: redundancy	0	0	0	0	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(25)	(60)	(60)	0
Operating expenses: Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Cost £	**30,867**	**29,256**	**29,809**	**30,549**	**28,697**	**28,607**	**27,091**	**27,075**	**27,044**	**27,039**	**27,040**	**29,547**	**342,620**	**342,621**	**(1)**

SUSTAINABLE SERVICES – NON PAY SUMMARY & RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Non Pay Summary: YTD Month 4								
	Non Pay: In-Month				Non Pay: Year-To-Date			
Non Pay	2018/19	2019/20			2018/19	2019/20		
	July £k Actual	July £k Plan	July £k Actual	July £k Variance	Apr - Jul £k Actual	July £k Plan	July £k Actual	July £k Variance
Ambulance Services	84	170	167	3	277	679	635	44
Clinical Supplies & Services	5,187	5,182	5,702	(520)	20,249	20,725	20,686	39
Drugs	410	426	(446)	872	1,917	1,757	467	1,289
Drugs Pass through	4,220	4,241	4,455	(214)	16,210	16,903	16,417	487
Establishment Expenditure	551	528	675	(147)	2,201	2,112	2,280	(168)
General Supplies & Services	1,092	489	890	(401)	3,963	2,955	3,730	(775)
Other	171	326	185	141	843	1,303	1,082	221
Premises & Fixed Plant	1,309	1,634	1,430	204	5,657	6,534	5,953	581
Clinical Negligence	1,775	1,741	1,741	0	7,098	6,964	6,963	1
Capital charges	952	1,100	1,077	23	3,882	4,400	4,321	79
Total Non Pay	**15,751**	**15,837**	**15,876**	**(39)**	**62,297**	**64,332**	**62,534**	**1,798**

Non Pay Run Rate 2019/20

Non Pay	Actual M1	Actual M2	Actual M3	Actual M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	FOT £	Plan	Variance
	Actual m1 to m4 Forecast m5 to m12 £k														
Ambulance Services	125	195	149	166	170	169	170	170	169	170	170	212	2,035	2,035	0
Clinical Supplies & Services	4,756	5,345	4,883	5,702	5,181	5,182	5,182	5,181	5,182	5,181	5,180	5,222	62,177	62,177	0
Drugs	275	392	246	(446)	610	598	592	598	619	601	596	588	5,269	5,269	0
Drugs Pass through	4,101	4,068	3,793	4,455	4,261	4,270	4,278	4,270	4,253	4,270	4,270	4,425	50,711	50,710	(0)
Establishment Expenditure	505	643	458	674	528	528	528	528	528	527	527	359	6,333	6,333	0
General Supplies & Services	1,047	817	977	889	489	489	489	489	489	589	589	(185)	7,168	7,168	0
Other	286	242	370	184	325	328	326	325	328	328	328	695	4,065	3,919	(146)
Premises & Fixed Plant	1,549	1,511	1,464	1,429	1,634	1,633	1,634	1,633	1,633	1,634	1,633	2,215	19,602	19,602	0
Clinical Negligence	1,741	1,741	1,740	1,741	1,741	1,741	1,741	1,741	1,741	1,740	1,740	1,741	20,889	20,889	0
Capital charges	1,085	1,083	1,076	1,077	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,179	13,200	13,200	0
Total Non Pay	**15,470**	**16,037**	**15,156**	**15,871**	**16,039**	**16,038**	**16,040**	**16,035**	**16,041**	**16,139**	**16,132**	**16,450**	**191,448**	**191,302**	**(146)**

Non Pay expenditure of £62,534k YTD is £1,798k favourable to planned expenditure of £64,332k.

The favourable movement to plan includes £487k in relation to passthrough, which is directly offset by an equal and opposite reduction in income.

The YTD Non Pay position also includes £1,494k of non-recurrent Technical savings.

Excluding passthrough and non-recurrent technical savings, Non Pay is £183k adverse to plan.

The Non Pay run-rate table below shows that Non Pay has averaged £15,634k per month from April to July, which is £452 per month less than the forecast run-rate of £16,086k per month from August to March required in order to remain within the planned Non Pay spend.

However, excluding non-recurrent technical savings of £1,494k YTD and passthrough expenditure of £16,417k, underlying Non Pay spend has averaged £11,903k per month and needs to average £11,828k from August to March to remain within the planned Non Pay spend i.e. a reduction of £75k per month is required in the underlying run-rate.

SUSTAINABLE SERVICES – FINANCIAL EFFICIENCY PROGRAMME SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Trust Summary Position

Financial Actuals & RAG Rating

M04

	In Month			YTD			
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	RAG
FEP	1,711	1,557	(154)	5,104	4,955	(149)	

Finance Position

YTD ACTUAL	£k	FORECAST	£k
Recurrent	2,424	Recurrent	22,829
Non Recurrent	2,531	Non Recurrent	2,781
TOTAL	**4,955**	**TOTAL**	**25,610**

Financial Commentary - Month 04 Position

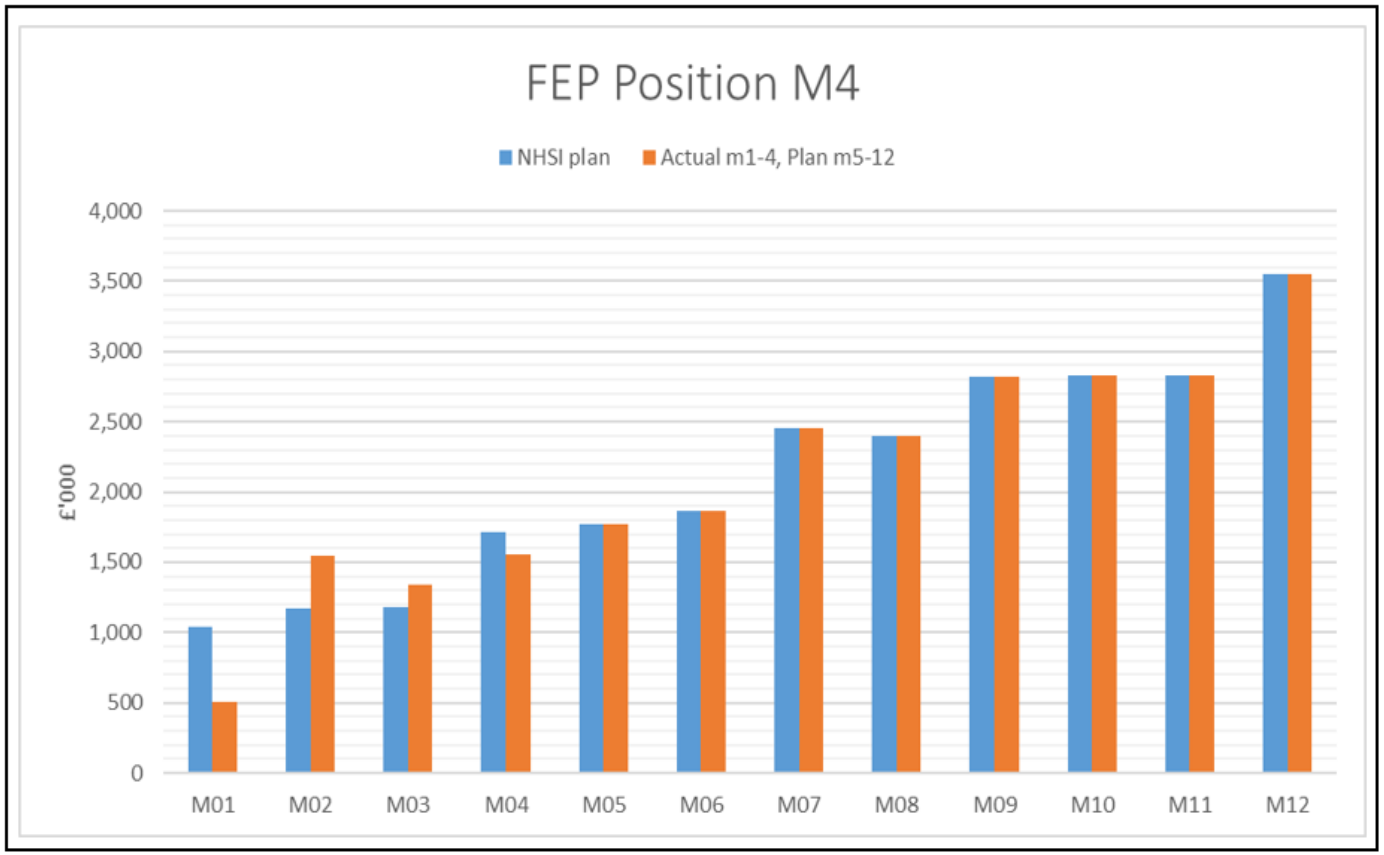
The financial plan for 2019/20 includes an efficiency programme to deliver £25.61m of savings; this includes £250k of planned non-recurrent savings in relation to the sale of the original front entrance of Grantham Hospital.

FEP savings delivery of £1,557k is reported in July; compared to planned FEP savings delivery of £1,711k, savings delivery in July is £154k adverse to plan.

YTD FEP savings delivery of £4,955k to the end of July is £149k adverse to planned FEP savings delivery of £5,104k.

However, whilst overall delivery is broadly in line with plan, the YTD FEP position is supported by delivery of £2,531k of non-recurrent Technical FEP savings. This non-recurrent FEP savings delivery is comprises of £1,022k of Technical Savings in relation to Pay, £1,493k in relation to Non Pay and £16k in relation to Income.

The delivery of non-recurrent Technical FEP savings has offset the slippage in delivery in relation to a number of planned savings schemes, most notably the Theatres and Outpatient Productivity savings schemes and Workforce savings schemes.


FEP Position M4
NHSI plan
Actual m1-4, Plan m5-12
£'000
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
M01
M02
M03
M04
M05
M06
M07
M08
M09
M10
M11
M12

SUSTAINABLE SERVICES – STATEMENT OF COMPREHENSIVE INCOME

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Statement of Comprehensive Income Outturn 2018/19, Plan 2019/20 and Forecast Outturn 2019/20

	Outturn 2018/19 £m	Plan 2019/20 £k	Forecast Outturn 2019/20 £k
Operating Revenue			
Revenue from Patient Care Activities	413.8	439.8	439.8
Other Operating Revenue	33.7	61.8	61.8
Total Operating Revenue	**447.5**	**501.6**	**501.6**
Operating Expenses			
Employee Benefits	341.7	342.6	342.6
Operating Expenses	177.0	178.1	178.1
Total - Operating Expenses	**518.7**	**520.7**	**520.7**
Operating Deficit	**-71.2**	**-19.1**	**-19.1**
Non-Operating Expenses			
Depreciation	11.5	13.2	13.2
Impairment	16.2	0.0	0.0
Interest Payable	6.2	9.1	9.1
Gains on Asset Disposal	-0.6	0.0	0.0
Total - Non-Operating Expenses	**33.3**	**22.3**	**22.3**
Retained Deficit	**-104.5**	**-41.4**	**-41.4**
Allowable adjustments against control total	16.3	0.0	0.0
total	**-88.2**	**-41.4**	**-41.4**

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Year end		Year to date			Monthly Actual 2019/20				Forecast Outurn		
	31 March 2019		31 July 2019			30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31 March 2020		
	Actual	Plan	Actual	Plan	Variance	Actual	Actual	Actual	Actual	Actual	Plan	Variance
	Month 12					Month 1	Month 2	Month 3	Month 4			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets												
Intangible assets	6,341	5,488	5,766	4,891	875	6,195	6,048	5,907	5,766	4,639	4,637	2
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	27,654	22,495	27,515	27,224	291	27,619	27,585	27,550	27,515	27,238	26,954	284
Property, plant and equipment: interests in **off-SoFP** PFI/LIFT assets	0	0	0	0	0	0	0	0	0	0	0	0
Property, plant and equipment: other	181,095	213,599	186,292	206,998	(20,706)	181,031	182,083	184,058	186,292	201,948	224,849	(22,901)
Investment property	0	0	0	0	0	0	0	0	0	0	0	0
Investments in associates and joint ventures	0	0	0	0	0	0	0	0	0	0	0	0
Other investments/financial assets	0	0	0	0	0	0	0	0	0	0	0	0
Trade and other receivables: due from NHS and DHSC group bodies	0	0	0	0	0	0	0	0	0	0	0	0
Trade and other receivables: due from non-NHS/DHSC group bodies	1,560	1,828	1,558	1,600	(42)	1,529	1,551	1,537	1,558	1,600	1,600	0
Other assets	0	0	0	0	0	0	0	0	0	0	0	0
Total non-current assets	**216,650**	**243,410**	**221,131**	**240,713**	**(19,582)**	**216,374**	**217,267**	**219,052**	**221,131**	**235,425**	**258,040**	**(22,615)**
Current assets												
Inventories	7,440	6,799	7,449	7,350	99	7,593	7,521	7,317	7,449	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	15,203	17,664	19,002	19,684	(682)	15,563	18,820	16,170	19,002	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	6,833	4,848	16,544	7,971	8,573	11,306	12,479	15,803	16,544	7,912	7,912	0
Other financial assets	0	0	0	0	0	0	0	0	0	0	0	0
Other current assets	0	0	0	0	0	0	0	0	0	0	0	0
Assets held for sale and assets in disposal groups	660	0	660	660	0	660	660	660	660	0	510	(510)
Cash and cash equivalents: GBS/NLF	7,376	6,143	1,645	990	655	3,251	2,248	1,206	1,645	4,214	4,214	0
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	10	0
Total current assets	**37,522**	**35,464**	**45,310**	**36,665**	**8,645**	**38,383**	**41,738**	**41,166**	**45,310**	**46,331**	**46,841**	**(510)**
Current liabilities												
Trade and other payables: capital	(10,791)	(4,723)	(8,790)	(2,961)	(5,829)	(8,748)	(7,764)	(7,990)	(8,790)	(2,538)	(4,466)	1,928
Trade and other payables: non-capital	(40,622)	(38,039)	(47,082)	(41,390)	(5,692)	(46,383)	(47,773)	(47,043)	(47,082)	(41,619)	(41,096)	(523)
Borrowings	(114,339)	(77,359)	(106,008)	(32,979)	(73,029)	(118,596)	(124,423)	(124,423)	(106,008)	(197,439)	(197,289)	(150)
Other financial liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions	(608)	(735)	(608)	(565)	(43)	(608)	(608)	(608)	(608)	(565)	(565)	0
Other liabilities: deferred income	(2,869)	(2,707)	(1,634)	(1,200)	(434)	(1,106)	(1,088)	(1,110)	(1,634)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	(503)	0
Total current liabilities	**(169,732)**	**(124,066)**	**(164,625)**	**(79,598)**	**(85,027)**	**(175,944)**	**(182,159)**	**(181,677)**	**(164,625)**	**(243,864)**	**(245,119)**	**1,255**
Net Current liabilities	**(132,210)**	**(88,602)**	**(119,315)**	**(42,933)**	**(76,382)**	**(137,561)**	**(140,421)**	**(140,511)**	**(119,315)**	**(197,533)**	**(198,278)**	**745**
Total assets less current liabilities	**84,440**	**154,808**	**101,816**	**197,780**	**(95,964)**	**78,813**	**76,846**	**78,541**	**101,816**	**37,892**	**59,762**	**(21,870)**
Non-current liabilities												
Trade and other payables: capital	0	0	0	0	0	0	0	0	0	0	0	0
Trade and other payables: non-capital	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	(188,196)	(228,888)	(226,484)	(299,249)	72,765	(189,662)	(191,890)	(199,326)	(226,484)	(178,323)	(178,440)	117
Other financial liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions	(2,863)	(2,911)	(2,689)	(2,932)	243	(2,865)	(2,865)	(2,989)	(2,689)	(2,825)	(2,782)	(43)
Other liabilities: deferred income	0	0	0	0	0	0	0	0	0	0	0	0
Other liabilities: other	(13,081)	(13,081)	(12,914)	(12,913)	(1)	(13,040)	(12,998)	(12,956)	(12,914)	(12,578)	(12,578)	0
Total non-current liabilities	**(204,140)**	**(244,880)**	**(242,087)**	**(315,094)**	**73,007**	**(205,567)**	**(207,753)**	**(215,271)**	**(242,087)**	**(193,726)**	**(193,800)**	**74**
Total net assets employed	**(119,700)**	**(90,072)**	**(140,271)**	**(117,314)**	**(22,957)**	**(126,754)**	**(130,907)**	**(136,730)**	**(140,271)**	**(155,834)**	**(134,038)**	**(21,796)**
Financed by												
Public dividend capital	260,042	257,563	260,042	260,150	(108)	260,042	260,042	260,042	260,040	265,318	265,318	0
Revaluation reserve	32,159	34,455	31,858	35,431	(3,573)	32,089	32,008	31,933	31,858	31,255	34,951	(3,696)
Available for sale investments reserve	0	0	0	0	0	0	0	0	0	0	0	0
Other reserves	190	190	190	190	0	190	190	190	190	190	190	0
Merger reserve	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(412,091)	(382,280)	(432,361)	(413,085)	(19,276)	(419,075)	(423,147)	(428,895)	(432,359)	(452,597)	(434,497)	(18,100)
Non-controlling Interest	0	0	0	0	0	0	0	0	0	0	0	0
Total taxpayers' and others' equity	**(119,700)**	**(90,072)**	**(140,271)**	**(117,314)**	**(22,957)**	**(126,754)**	**(130,907)**	**(136,730)**	**(140,271)**	**(155,834)**	**(134,038)**	**(21,796)**

BORROWINGS												
Current												
Borrowings: overdraft	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: PFI/LIFT obligations	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: finance leases	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: DHSC capital loans	1,889	2,429	2,570	2,562	8	1,828	1,828	1,828	2,570	**2,753**	2,636	117
Borrowings: DHSC working capital / revenue support loans	112,450	74,930	101,935	28,508	73,427	114,694	120,938	120,859	101,935	**191,520**	191,521	(1)
Borrowings: DHSC revolving working capital facilities	0	0	0	0	0	0	0	0	0	**0**	0	0
Accrued interest on DHSC loans		0	1,503	1,909	(406)	2,074	1,657	1,736	1,503	**2,703**	2,670	
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	0	**463**	462	1
Accrued interest on other (non-DHSC) loans				0	0	0	0	0	0		0	
Total current borrowings	**114,339**	**77,359**	**106,008**	**32,979**	**73,029**	**118,596**	**124,423**	**124,423**	**106,008**	**197,439**	**197,289**	**117**
Non-current												
Borrowings: PFI/LIFT obligations	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: finance leases	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: DHSC capital loans	24,283	33,343	25,863	25,842	21	24,344	25,005	25,005	(25,863)	**32,629**	32,746	(117)
Borrowings: DHSC working capital / revenue support loans	163,913	195,545	200,621	273,407	(72,786)	165,318	166,885	174,321	(200,621)	**142,688**	142,687	1
Borrowings: DHSC revolving working capital facilities	0	0	0	0	0	0	0	0	0	**0**	0	0
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	0	**3,006**	3,007	(1)
Total non-current borrowings	**188,196**	**228,888**	**226,484**	**299,249**	**(72,765)**	**189,662**	**191,890**	**199,326**	**(226,484)**	**178,323**	**178,440**	**(117)**

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£k	£k	£k
Cash balance	1,000	1,655	655

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Cash balance	4,224	4,224	0

Year to date	Plan	Actual	Variance
	£k	£k	£k
Operating Surplus	(16,696)	(17,820)	(1,124)
Depreciation	4,400	4,321	(79)
Other Non Cash I&E Items	(72)	0	72
Movement in Working Capital	(6,101)	(8,459)	(2,358)
Provisions	69	(183)	(252)
Cashflow from Operations	**(18,400)**	**(22,141)**	(3,741)
Interest received	12	51	39
Capital Expenditure	(13,770)	(10,807)	2,963
Cash receipt from asset sales	0	16	16
Cash from / (used in) investing activities	**(13,758)**	**(10,740)**	**3,018**
PDC Received	108	0	(108)
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(2,851)	(3,267)	(416)
Capital element of leases	0	0	0
Drawdown on debt - Revenue	30,076	28,156	(1,920)
Drawdown on debt - Capital	0	2,261	2,261
Repayment of debt	(328)	0	328
Cashflow from financing	**27,005**	**27,150**	**145**
Net Cash Inflow / (Outflow)	**(5,153)**	**(5,731)**	**(578)**
Opening cash balance	6,153	7,386	1,233
Closing Cash balance	**1,000**	**1,655**	**655**

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Operating Surplus	(32,306)	(32,452)	(146)
Depreciation	13,200	13,200	0
Other Non Cash I&E Items	(214)	(214)	0
Movement in Working Capital	(13,680)	(13,847)	(167)
Provisions	(81)	(81)	0
Cashflow from Operations	**(33,081)**	**(33,394)**	(313)
Interest received	36	170	134
Capital Expenditure	(38,312)	(39,976)	(1,664)
Cash receipt from asset sales	150	676	526
Cash from / (used in) investing activities	**(38,126)**	**(39,130)**	**(1,004)**
PDC Received	5,276	5,276	0
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(8,486)	(8,402)	84
Capital element of leases	0	0	0
Drawdown on debt - Revenue	59,809	59,809	0
Drawdown on debt - Capital	15,400	15,400	0
Repayment of debt	(2,721)	(2,721)	0
Cashflow from financing	**69,278**	**69,362**	**84**
Net Cash Inflow / (Outflow)	**(1,929)**	**(3,162)**	**(1,233)**
Opening cash balance	6,153	7,386	1,233
Closing Cash balance	**4,224**	**4,224**	**0**

The cash balance at 31 July 2019 was £1.6m. This includes revenue and capital cash loans drawn in April 2019 - July 2019 of £28.2m / £2.3m respectively.

The Trust has reduced the level of capital creditors from £10.8m to £8.8m.

The impact on the ability to pay suppliers has been limited as a result of the delays in the capital programme and the payment of the capital creditors.

Total revenue and capital borrowings (excluding accrued interest) at 31 July were £331m. As a consequence of this borrowing costs are anticipated to be £9.1m in I&E terms , and in cash terms £8.4m.

The financial plan assumed that from August all new and existing borrowing rates at 6% would be revised to 3.5%. In practice, whilst rates on new loans have reduced to 3.5% earlier than planned in May, existing borrowing rates have remained unchanged.

The cash balance of £1.5m at 31 July reflects a number of factors:

- the reduction in capital creditors from the year end high of £10.8m to £8.8m;

- delays in the 2019/20 capital programme.

These in turn have impacted upon the level of capital cash expenditure (plan £5.7m : actual £8.8m).

The Trust has submitted and had approved a requests to NHSI / DHSC to carry forward £9.6m into 2019/20, in relation to the Fire Safety, capital loans in respect of this totalling £2.3m were received in May 2019 and July 2019.

Revenue loans totalling of £28.2m have been drawn in the year to July 2019. This is against the backdrop of a cumulative I&E deficit to July of £20.6m.

Capital cash is supporting the overall cash position by circa £9.3m at July 2019.

The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £2.5m in March 2020

The cash forecast assumes capital borrowing of £11.7m and revenue borrowing in 2019/20 at £59.8m (£41.4m: 2019/20 deficit support; plus £9.6m 2018/19 deficit support and £8.8m PSF and FRF).

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	5,681	8,807	-3,126

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	31,817	31,817	0

Year to date	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	371	357	14
Estates - Fire	3,600	7,691	-4,091
ICT	170	465	-295
Estates - Backlog	300	224	76
Service developments	1,240	70	1,170
Total	5,681	8,807	-3,126

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	936	936	0
Estates - Fire	13,700	13,700	0
ICT	2,408	2,408	0
Estates - Backlog	3,789	3,789	0
Service developments	10,984	10,984	0
Total	31,817	31,817	0

Funding available 2019/20

The Trust has capital resources of c£32m for 2019/20 including ring-fenced funding e.g. Fire, Medical School and LED Lighting.

The Trust has very limited discretionary capital resources available, totalling c£9.0m - the discretionary capital available has been reduced due to the requirement to pay the fire loan. This leaves limited resources available to prioritise against Medical Device replacement, IT infrastructure and replacement, Estates Backlog and Service and Digital Developments.

The M4 spend incurred amounts to c£8.8m against a planned spend of c£5.7m, details below:

Facilities; Minimal spend in M4 of £224k. Majority of spend incurred links to Anti-barricading improvements (£185k) and Lincoln Heating where CQC had raised an issue following an incident with a patient (£12k). Added to this spend are starting costs of £3k and £5k for Water Access/Water Tanks and Mental Health respectively.

Fire; Expenditure on fire related schemes continues to progress at pace. Costs incurred at the end of July amounted to c£7.7m (spend in month was c£2.5m). Fire Works package 1 at LCH is £2.6m, package 2 is £1.6m, Emergency Lighting at LCH is £0.6m. Package 1 at Pilgrim amounts to £1.2m.

Medical Devices; Radiology Ultrasound machine purchase of £66k, alongside Theatre Tables (£177k) and Surgical Diathermy (£114k) - total year-to-date spend of £357k.

IT; E-Health-record costs of £207k together with Wifi spend linked to HSLI deferred monies amounting to £63k has been incurred at the end of M4 along with £89k of PC replacement and £104k on NSX Cyber Security.

Updated Phased Plan profile

A revised capital programme has been agreed following the national requirement to deliver within an STP control total. This will be reported from M5 onwards although managers are aware of their individial allocations and alterations already.

SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

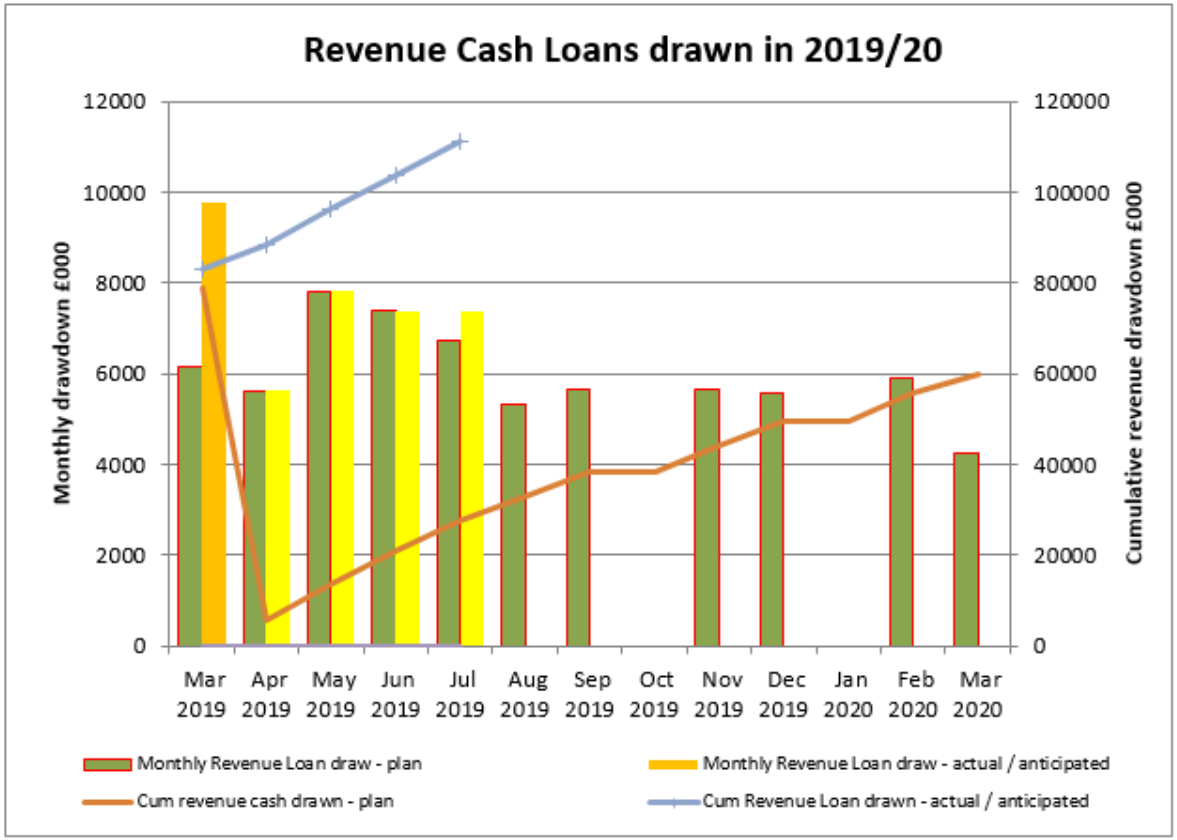
Revenue Borrowing

The Trust has drawn cash loans of £30.4m during the four months to July 2019, this is split £28.2m revenue support and £2.2m capital. This includes £7.4m deficit support relating to 2018/19.

The forecast deficit for 2019-20 is £41.4m as submitted in the plan. Revenue borrowings are planned to be £59.8m (Deficit support 19/20 - £41.4m, 18/19 - £9.6m and PSF and FRF of £8.8m).

The impact upon the Trust to pay creditors has largely been mitigated by capital cash, available due to delays in the capital programme.

Borrowing rates for new loans were reduced from 6% to 3.5% in May 2018.



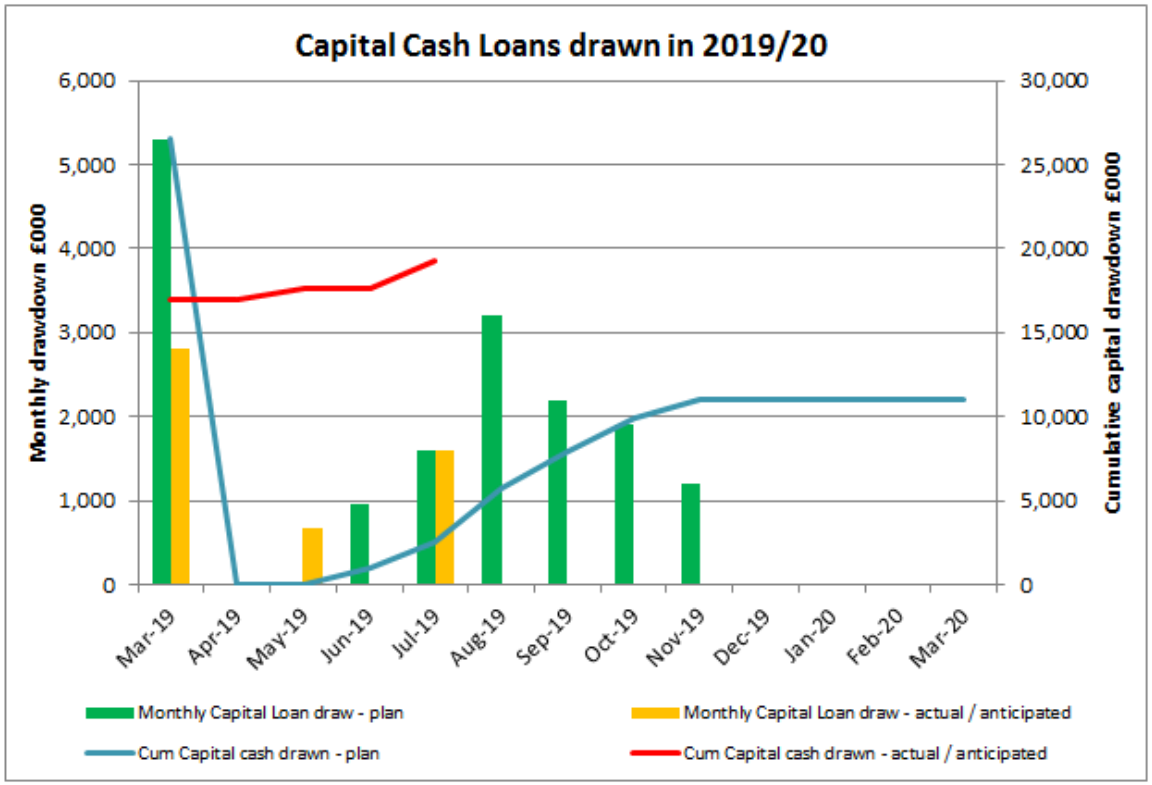
Capital Borrowing

A £26,6m capital loan was agreed in relation to the Fire Safety Capital scheme. Against this £17m has been drawn to the end of March 2019.

The capital programme remains behind plan. Having reviewed progress against the 2018/19 fire safety programme and after taking advice from estate professionals, decisions were taken in January / February to approach the DHSC via NHSI to request carry forward of £9.6m into 2019/20 along with the £2.1m loan agreed in 2017/18. NHSI agreed this carry forward in February.

The planned capital loan drawdown in 2019/20 is £11.7m as a result of this. In the four months to July, there was a capital drawdown of £1.6m in July and the capital creditors reduced to £8.8m as at 31st July 2019.

The 31st March 2019 year end capital creditor was £10.8m.



Process and approval of new borrowing:

In accordance with Trust Standing Financial Instructions (para 22.1.7):

All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Department of Health. and be approved by the Trust Board.

In addition, before processing any loan request, NHSI stipulate all requests must be supported by:

- a daily cashflow covering the next 3 months

- a Board resolution signed by the Trust CEO and Chairman.

- a separate loan agreement signed by the Director of Finance.

FPEC Committee routinely receive and scrutinise the cash position and proposed future borrowings before passing recommendation to the Board for formal approval.

The Board has previously approved borrowing for:

August 2019:

Revenue £7.925m

Capital £3.155m

September 2019:

Revenue: £5.637m

Capital £6.284m

The board is requested to approve borrowing in October 2019 in line with the draft 2019/20 financial plan for revenue and the actual spend for capital.

Revenue £4.196m Capital £0m

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Borrowings and Interest

At 31 July 2019 total 'repayable' borrowings (excluding accrued interest) were £331m, capital (£28.4m) and revenue (£302.6m).

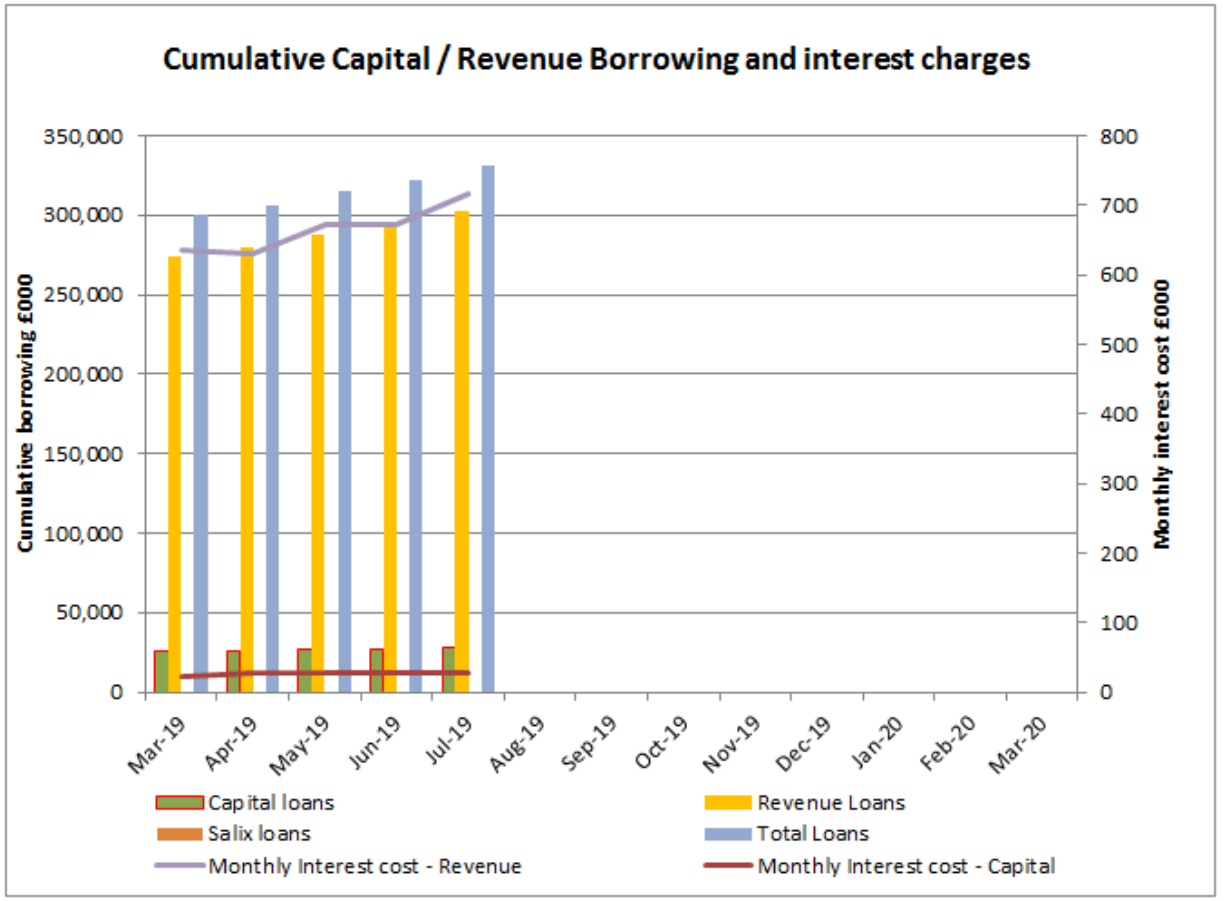
Existing loans are held at a variety of interest rates, Capital 1.1% (£9.1m) & 1.37% (£19.3m), Revenue 1.5% (£155.3m), 3.5% (£103.6m) & 6.0% (£43.4m).

(The £35.6m loan due to be repaid in November 2018 has been extended. The Trust has not yet been advised of the rate. For the purposes of the above analysis, it has been assumed this will be at 3.5%.)

Future borrowings are anticipated to be at 1.37% for capital and 3.5% for revenue.

Associated interest costs for 2019/20 are £9.1m (Revenue £8.7m / Capital £0.4m).

Changes in accounting standards in 2018/19 mean that any accrued interest July 19 - £1.5m) is now reported as part of overall borrowings on the Statement of Financial Position.



Repayments

The tables below show when the Trust is due to make repayments against existing loans:

Type	Loan £m	Final repayment		Repayment Terms
Capital	9.1	Nov-32		Repayments commencing Nov 2018 thereafter every 6 months. Annual repayment £0.7m. (Current balance £9.2m)
Capital	19.3	Aug-33		Repayments commencing Aug 2019 thereafter every 6 months. Annual repayment £0.4m.

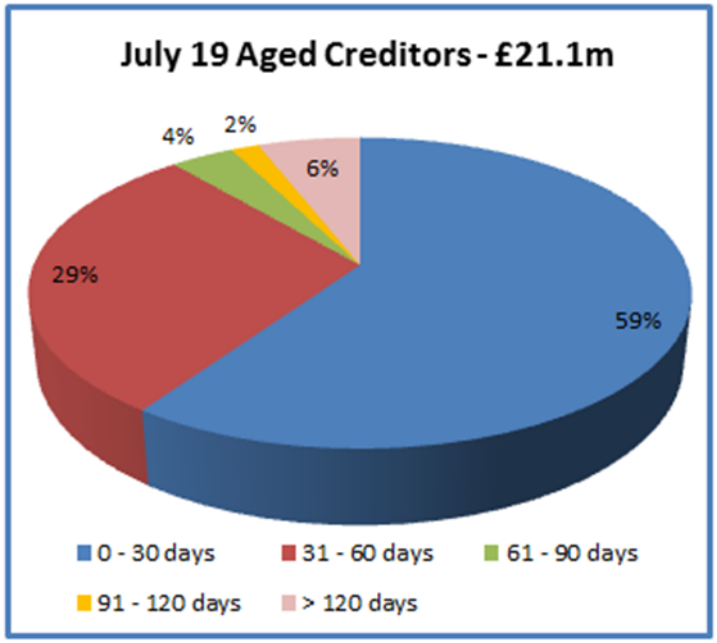
Type	Loan £m	Repayment		Loan £m	Repayment	Repayment Terms
Revenue	35.6	tbc		6.0	Feb-21	The terms of each loan state that there is to be a single one off repayment in full. It is anticipated however that some form of re-financing will take place. The means by which this might be transacted is uncertain at this stage.
	4.6	Nov-19		5.4	Mar-21	
	2.5	Dec-19		7.2	Apr-21	
	52.0	Jan-20		6.4	May-21	
	4.1	Jan-20		9.3	Jun-21	
	4.2	Feb-20		7.2	Jul-21	
	7.6	Mar-20		5.0	Aug-21	
	6.2	Apr-20		5.0	Sep-21	
	5.8	May-20		5.0	Oct-21	
	5.5	Jun-20		5.4	Nov-21	
	11.0	Jul-20		12.5	Dec-21	
	7.0	Aug-20		10.0	Jan-22	
	9.3	Sep-20		9.8	Mar-22	
	6.6	Oct-20		5.6	Apr-22	
	6.2	Nov-20		7.8	May-22	
	6.0	Dec-20		7.4	Jun-22	
	6.0	Jan-21		7.4	Jul-22	

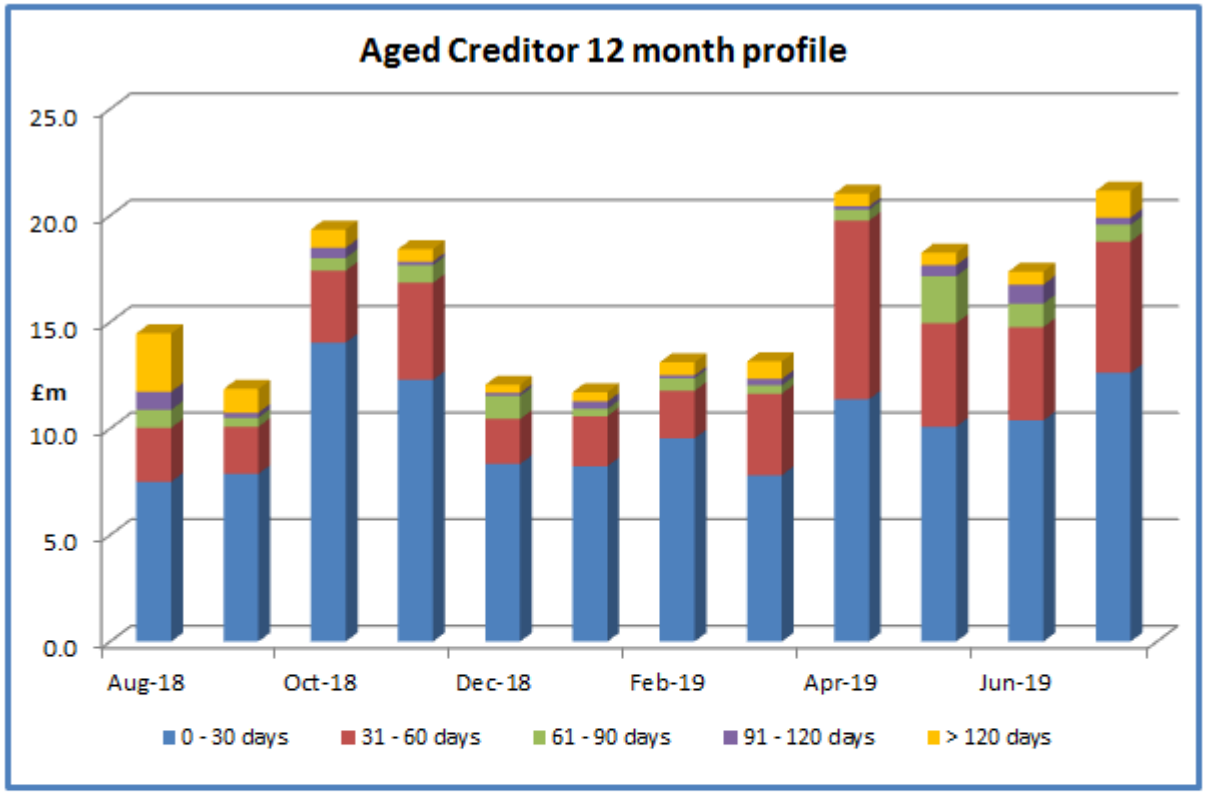
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors

Total Creditors were £21.1m at 31 July 2019, of which £8.5m were over 30 days (£1.5m > 90 days).
Focusing further upon those invoices over 30 days £2.5m (56%) relates to just ten suppliers.
The reasons for delays in payment to suppliers has been investigated and in each case the Trust is taking action where appropriate / working with the supplier and internal departments to resolve issues.

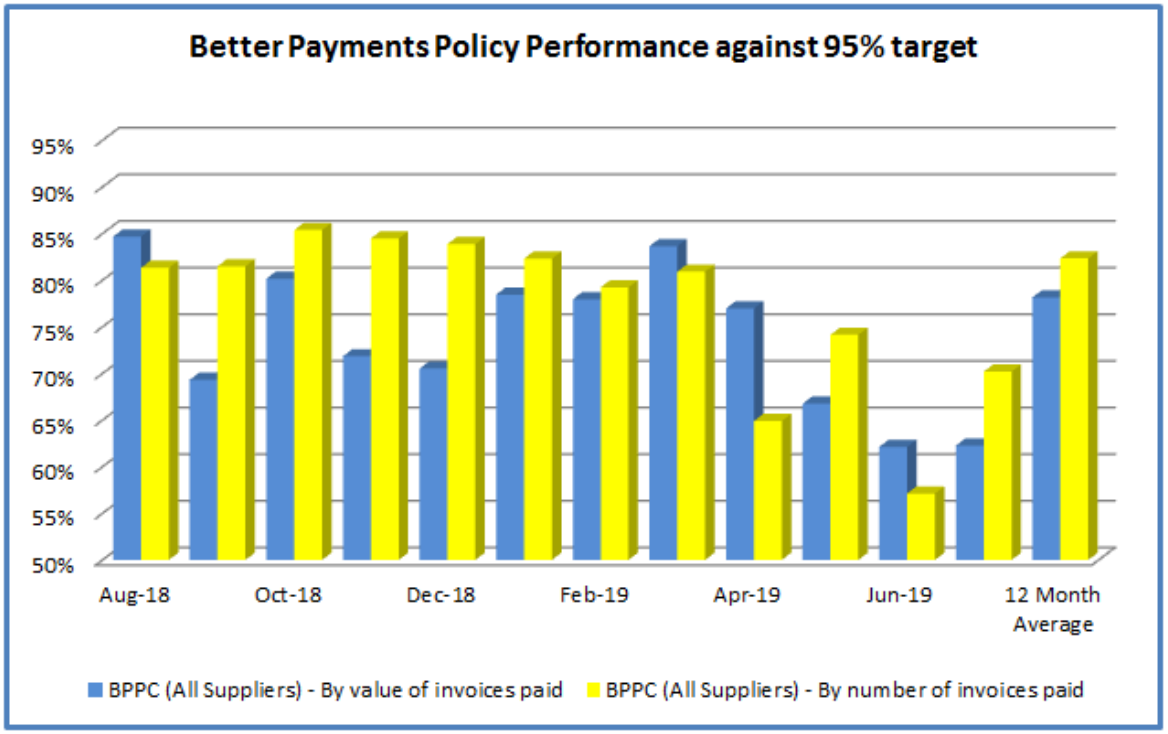
The Finance and Procurement Teams continue to enforce the policy of requiring suppliers to provide a purchase order before payment is made. At 30 June there were 531 separate invoices (£1.4m), over 90 days old spread across 181 suppliers where payment is delayed awaiting a purchase order.

SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid invoices by the due date or within 30 days (whichever is the latter).
The 12 month rolling and July 2019 performance are shown in the following table

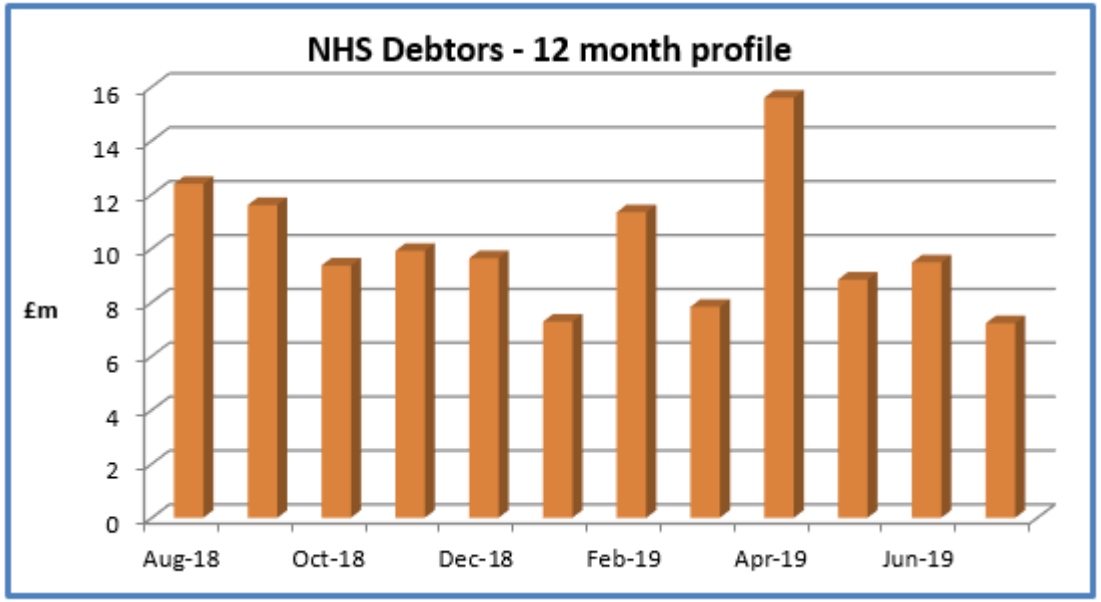
Year to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	668	14,781	38,695	63,050
Total bills paid within target	386	13,215	25,731	38,279
% of bills paid within target YTD	**57.78%**	**89.41%**	**66.50%**	**60.71%**
% of bills paid within July 2019	**94.44%**	**99.93%**	**57.06%**	**55.83%**

SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Paul Matthew

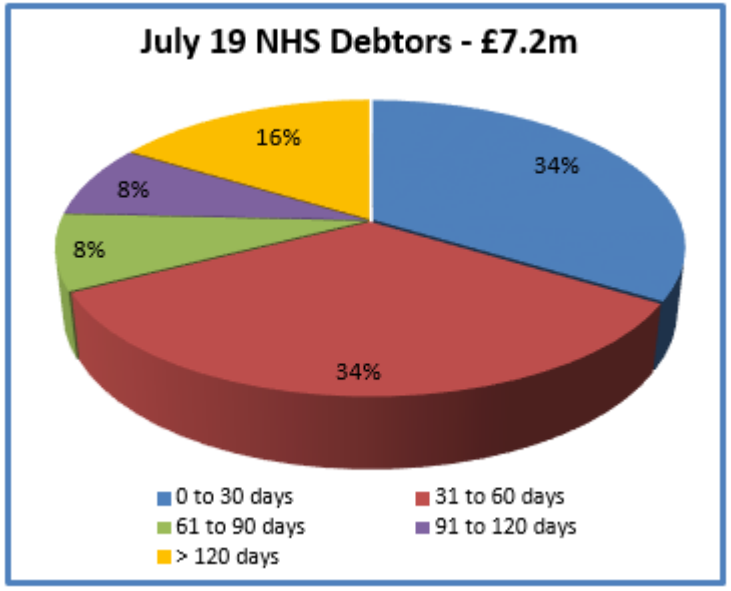
CQC Domain: Well-Led

2021 Objective: Our Services



The level of NHS debt over the last 12 months is shown in the table above, while the table left focuses upon the aged split at 31 July 2019.

The majority of debt relates to the four Lincolnshire CCGs. The split between organisational categories is shown below.



Totals shown in £000	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	1,582	861	206	131	205	2,985	336
CCGs - Other	169	270	123	41	176	779	217
Trusts - Lincolnshire	723	20	10	51	79	883	130
Trusts - Other	641	552	39	379	496	2,107	875
Other NHS	(680)	732	223	(28)	219	466	191
Total	**2,435**	**2,435**	**601**	**574**	**1,175**	**7,220**	**1,749**

The level of aged debt > 90 days has increased from £1.5m in March 19 to £1.7m at 31 July.

The largest element currently over 90 days relates to NHS Trusts where queries are unresolved with Nottingham University.

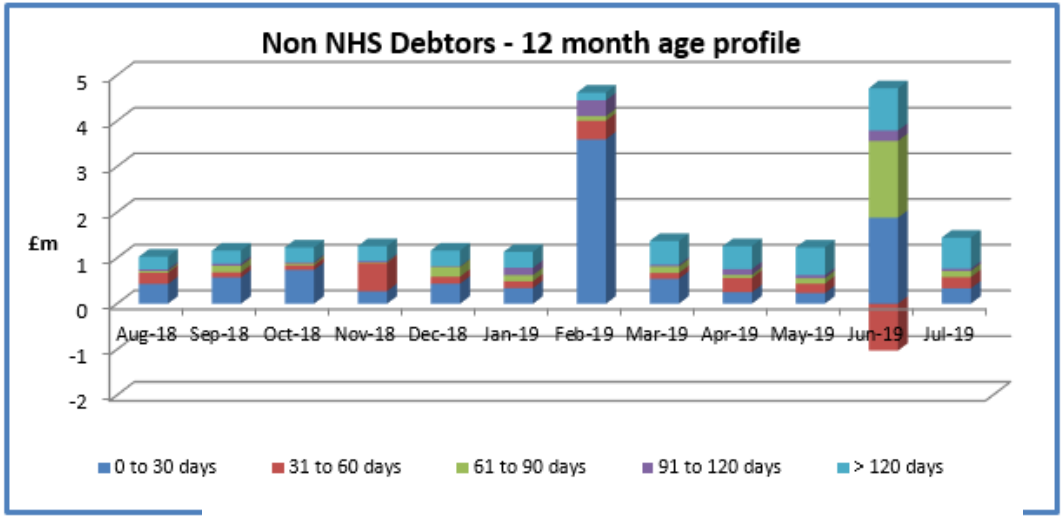
In volume terms there are 367 invoices > 90 days at 30 July 2019

SUSTAINABLE SERVICES – NON- NHS RECEIVABLES

Executive Lead: Paul Matthew

CQC Domain: Well-Led

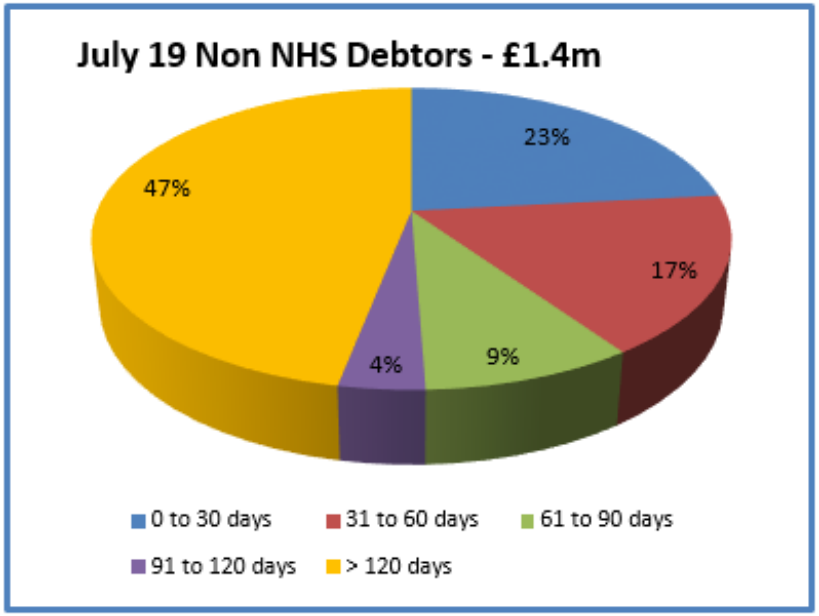
2021 Objective: Our Services



The level of Non-NHS debt over the last 12 months is shown in the table above, while the table left focuses upon the aged split at 31 July 2019.

The breakdown of debt across general category headings is shown below.

	Totals outstanding debt £'000						
Description	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
Overseas Visitors	40	4	5	13	151	213	164
Debt Collection - Overseas	0	0	0	0	123	123	123
NHS Non English	11	2	6	2	17	38	19
Misc	279	219	117	38	289	942	327
Salary Overpayments	7	20	3	0	35	65	35
Private Patients	0	0	0	0	0	-	0
Debt Collection - General	0	0	0	0	25	25	25
Agreed Installment Plans	0	0	0	0	41	41	41
Grand Total	337	245	131	53	681	1,447	734



The balance over 90 days (£0.7m) comprises relatively high volume (244) low value invoices.

Of this total £0.2m is being actively managed by the Trust Debt collection agency.

SUSTAINABLE SERVICES – FINANCIAL DASHBOARD

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Trust Dashboard Financial Performance

In Month Plan	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,328	41,786	40,391	42,813	41,645	41,238	43,394	41,726	41,473	42,991	40,962	42,869
Operating Expenditure	-46,416	-45,501	-45,503	-44,594	-44,530	-44,441	-44,281	-44,084	-43,693	-43,782	-43,777	-43,320
Efficiency	1,042	1,171	1,180	1,711	1,770	1,869	2,453	2,398	2,816	2,827	2,827	3,546
Agency	-3,086	-3,086	-3,086	-2,615	-2,576	-2,514	-2,385	-2,260	-2,002	-1,997	-1,997	-1,692
Capital	816	1,317	1,173	2,375	2,682	2,727	4,227	3,727	2,991	3,857	2,910	3,015
Operating Surplus/Deficit	-6,088	-3,715	-5,112	-1,781	-2,885	-3,203	-887	-2,358	-2,220	-791	-2,815	-451

Cumulative Plan	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,328	82,114	122,505	165,318	206,963	248,201	291,595	333,321	374,794	417,785	458,747	501,616
Operating Expenditure	-46,416	-91,917	-137,420	-182,014	-226,544	-270,985	-315,266	-359,350	-403,043	-446,825	-490,602	-533,922
Efficiency	1,042	2,213	3,393	5,104	6,874	8,743	11,196	13,594	16,410	19,237	22,064	25,610
Agency	-3,086	-6,172	-9,258	-11,873	-14,449	-16,963	-19,348	-21,608	-23,610	-25,607	-27,604	-29,296
Capital	816	2,133	3,306	5,681	8,363	11,090	15,317	19,044	22,035	25,892	28,802	31,817
Operating Surplus/Deficit	-6,088	-9,803	-14,915	-16,696	-19,581	-22,784	-23,671	-26,029	-28,249	-29,040	-31,855	-32,306

In Month Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	41,522	39,838	43,614								
Operating Expenditure	-46,332	-45,297	-44,964	-46,422								
Efficiency	510	1,546	1,342	1,557								
Agency	-3,621	-4,019	-3,640	-4,027								
Capital	839	1,958	2,875	3,135								
Operating Surplus/Deficit	-6,111	-3,775	-5,126	-2,808								

Cumulative Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	81,743	121,581	165,195								
Operating Expenditure	-46,332	-91,629	-136,593	-183,015								
Efficiency	510	2,056	3,398	4,955								
Agency	-3,621	-7,640	-11,280	-15,307								
Capital	839	2,797	5,672	8,806								
Operating Surplus/Deficit	-6,111	-9,886	-15,012	-17,820								

In Month Variance (-) adverse	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-264	-553	801								
Operating Expenditure	84	204	539	-1,828								
Efficiency	-532	375	162	-154								
Agency	-535	-933	-554	-1,412								
Capital	-23	-641	-1,702	-760								
Operating Surplus/Deficit	-23	-60	-14	-1,027								

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-371	-924	-123								
Operating Expenditure	84	288	827	-1,001								
Efficiency	-532	-157	5	-149								
Agency	-535	-1,468	-2,022	-3,434								
Capital	-23	-664	-2,366	-3,125								
Operating Surplus/Deficit	-23	-83	-97	-1,124								

In Month Variance (-) adverse %	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.63%	-1.37%	1.87%								
Operating Expenditure	0.18%	0.45%	1.18%	-4.10%								
Efficiency	-51.06%	32.02%	13.73%	-9.00%								
Agency	-17.34%	-30.23%	-17.96%	-54.00%								
Capital	-2.82%	-48.63%	-145.11%	-31.98%								
Operating Surplus/Deficit	-0.38%	-1.62%	-0.27%	-57.66%								

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.45%	-0.75%	-0.07%								
Operating Expenditure	0.18%	0.31%	0.60%	-0.55%								
Efficiency	-51.06%	-7.09%	0.15%	-2.92%								
Agency	-17.34%	-23.78%	-21.84%	-28.93%								
Capital	-2.82%	-31.11%	-71.55%	-55.01%								
Operating Surplus/Deficit	-0.38%	-0.85%	-0.65%	-6.73%								

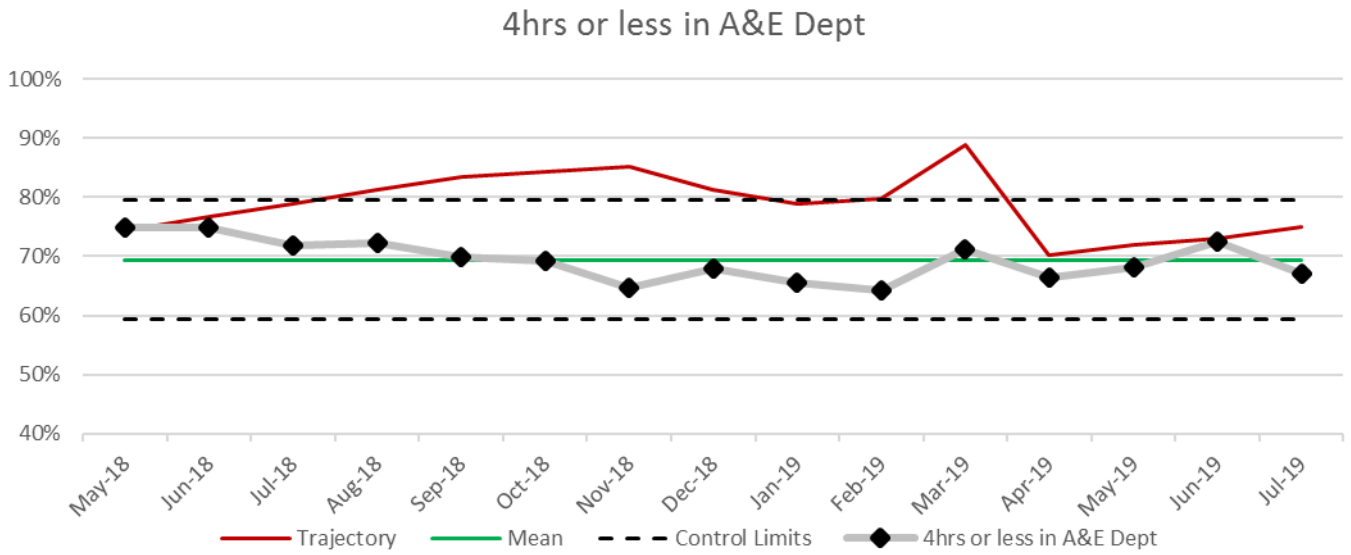
Tolerances	Green	Amber	Red
Income	0% & >%0	<0% to - 1%	< - 1%
Expenditure	0% & >%0	<0% to - 1%	< - 1%
Efficiency	0% & >%0	<0% to - 1%	< - 1%
Agency	0% & >%0	<0% to - 1%	< - 1%
Capital	0% to -/+ 5%	-/+ 5% to 10%	-/+10 %
Surplus / Deficit (-)	0% & >%0	<0% to - 1%	< - 1%

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- July's performance was 67.14% which represented a 5.3% deterioration in performance from June and was 7.86% below the agreed improvement trajectory for July.
- System streaming targets for all ED attendances are 25% at PHB and 20%. For July, the percentage of patients streamed at PHB was 20.9% a 2.8% reduction compared with June. LCH streamed 18% of patients, a 2.2% increase than June. Staff absence has contributed to the slight dip in performance at PHB in July and a fortnightly operational meeting is in place to discuss and review performance.
- A&E attendances have been higher than expected but non-elective demand has experienced a slight reduction.
- Nursing and Medical staffing levels for inpatient wards and the emergency department continue to be an area of concern. The fragility of medical staffing will improve towards the end of Q3 2019/20 beginning of Q4 2019/20 as we start to see newly appointed doctors come into post. Recruitment plans against start dates are monitored weekly.
- For July, the average number of Super Stranded Patients in the Trust was 109 a slight increase of 8 compared with June but 48 patients less than the trajectory of 159 reflecting the success of 'Long Stay Tuesday and Wednesday
- Total ULHT bed occupancy for July was 90.79%, below the target occupancy of 92%, with LCH and PHB carrying an occupancy figure; LCH 91.89% and PHB 95.78%.

Actions in place to recover:

The UEC Improvement Programme is implementing High Impact Changes (HIC) to improve performance that are monitored through the Improvement Programme Steering Group. The HIC include the following:

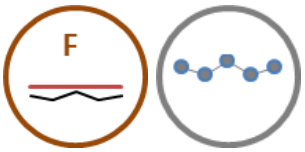
- Reduction of ambulance conveyances through alternative pathways targeting out of area first; discharge within 24 hours of PDD;
- Increasing the numbers of patients seen through primary care streaming; protecting the minors stream and focussing on delivering 4 hours through this stream;
- Long stay Tuesday and Wednesday at LCH and PHB to further reduce stranded patient numbers;
- criteria led discharge;
- increasing the numbers of patients who are seen and treated through a Same Day Emergency Care (SDEC) pathway;
- Standards for inpatient flow (SIF) eliminating unnecessary inpatient waits and medical and nursing recruitment. Progress on these areas is described in more detail in the separate Urgent Care performance paper.

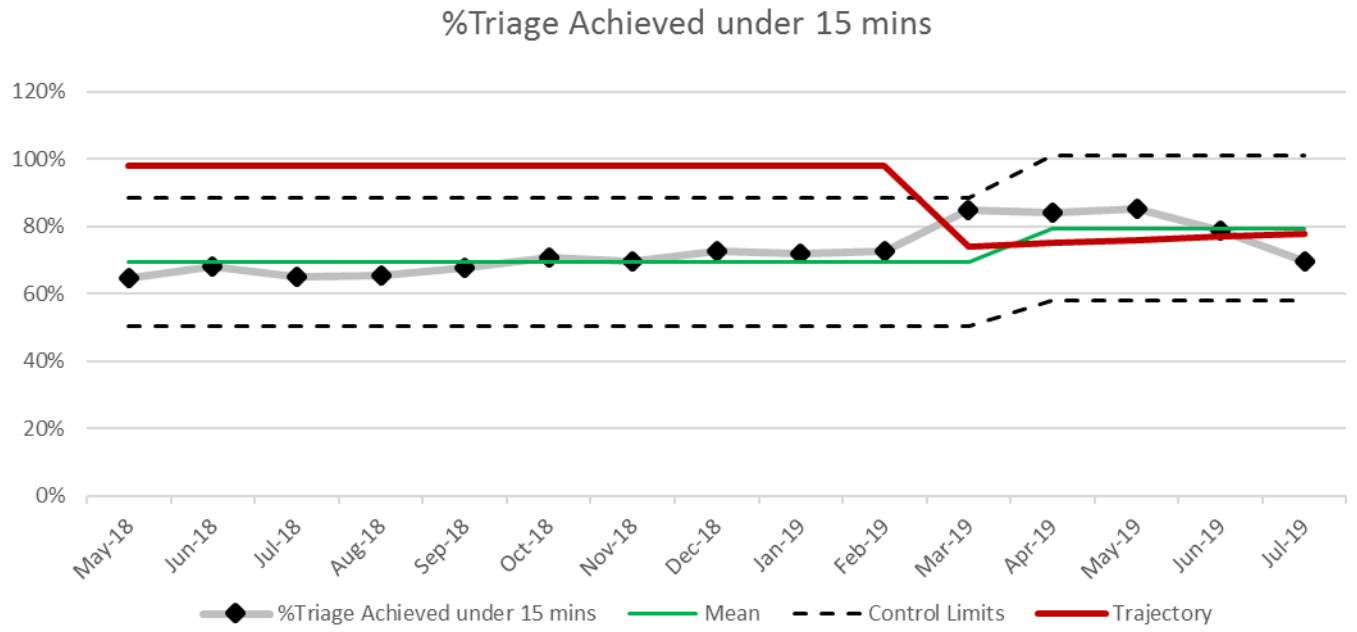
ZERO WAITING – TRIAGE ACHIEVED UNDER 15 MINUTES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- Performance across the three hospital sites demonstrated a further deterioration at LCH and PHB in July compared to June. GDH also demonstrated a deterioration in performance.
- The performance trajectory for July was 78%. Only GDH achieved this (80.43%). LCH outturn for July 68.11% (89.70% June), PHB outturn 66.14 (73.30& June)
- A key theme is delayed or non-recording of the actual time of triage.

Actions in place to recover:

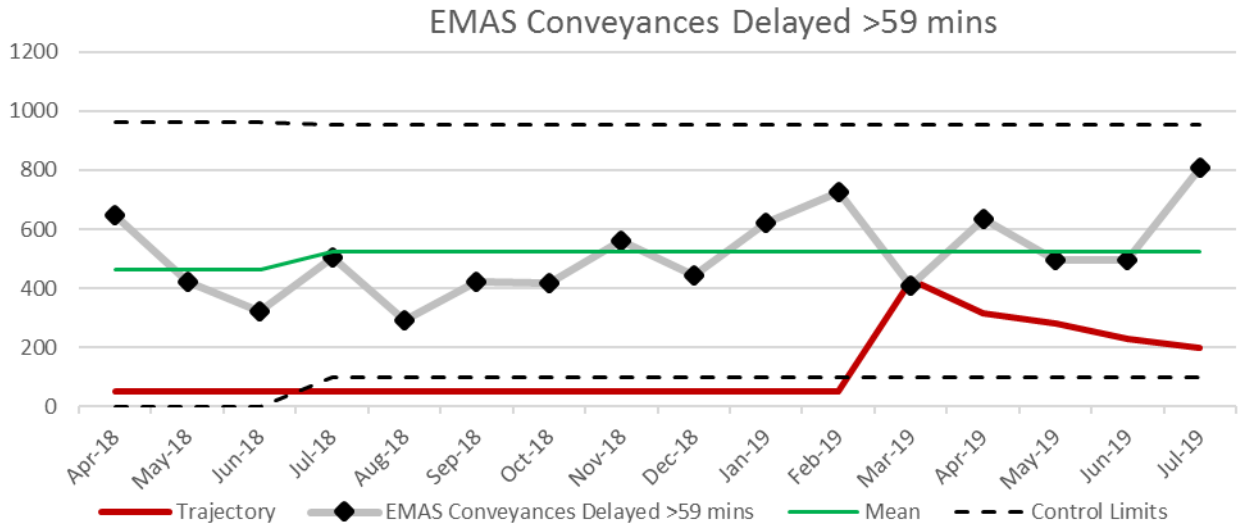
- These 2 elements are reviewed and challenged within the newly formatted Capacity and Flow meetings three time daily.
- Further work has taken place with LCH and PHB, ensuring that the 2nd triage stream is in place at LCH and protecting the triage health care support worker role within triage

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Handover delays >59 mins experienced a significant deterioration in July with 805 exceeding 59 mins compared with 494 in June, missing the trajectory of 197 by 608.
- PHB compliance against >59 minute handover deteriorated in July (198) by 84 compared with June's performance (114).
- The LCH position in July (607) has deteriorated compared with June (377) by 230.
- GDH also experienced a slight deterioration in their position in July (4) by 1 compared with June (4).
- Same Day Emergency Care (SDEC) pathways have been implemented in AEC and SAU at LCH. Gains have not yet been realised in terms of ambulance handover times but are expected to have a positive impact on performance.

Actions in place to recover

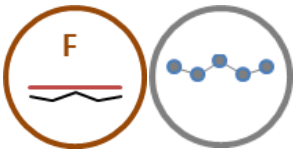
- New pathways at PHB rolled out to enable GP direct admissions bypassing ED.
- OOH remains challenging.
- Rapid Access and Treatment (RAT) models are being reviewed at both LCH and PHB hospital sites in particular the staffing models for RAT, competency and processing of patients. An example of this would be at PHB where an additional HCA has been added to the team during July and early indications is that this is having a positive impact on turnaround times. This work is still ongoing but a final outcome is expected by the end of August.
- This is a key performance indicator within the newly formatted Capacity and Flow Meetings. The routs cause for any delay is discussed.
- Site Duty Managers (SDMs) track and monitor every conveyance to ED greater than 15 minutes and record actions taken
- Daily calls remain in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.

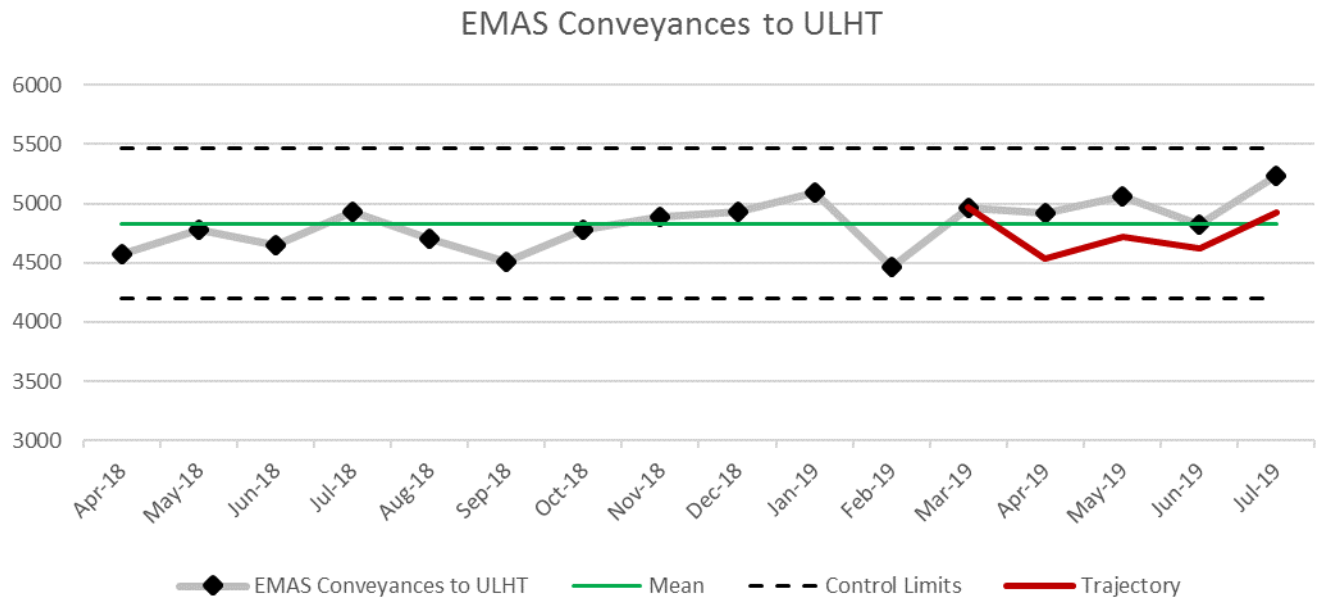
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- There was an increase overall in ambulance conveyance through July (5231) with 408 ambulances greater than in June (4823). This represents a 5.89% increase against plan (4923).
- At hospital site level LCH received 224 more conveyances in July (2759) than in June (2535); PHB received 184 more conveyances in July (2183) compared with June (1999) and GDH received the same conveyances in July as in June (289) compared with M.
- Alternative pathways to avoid conveyance have still not been realised to deliver the percentage reduction anticipated.
- There are 38 pathways currently under review.

Actions in place to recover

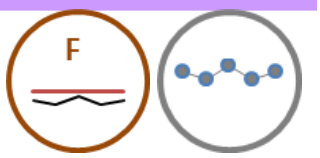
- This is a key metric within the Capacity and performance meeting held x 3 daily and has individual accountability to ensure delivery.
- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily.
- ULHT Representative and EMAS ROM / DOM control continue to apply a daily review of pressure on the departments, County profile against demand, destination of demand and attempts manage that demand. Daily intelligence is now shared routinely as to the forecast spikes in demand and this is being applied to the Emergency Department response capability.
- Conveyance numbers continue to be monitored through the Ambulance Handover Group which is chaired by NHSi
- Appropriate conveyance monitoring is now in place within EMAS with oversight by Deputy Director of Operations – Urgent Care and Daily System Call. 38 alternative conveyance pathways are being reviewed.

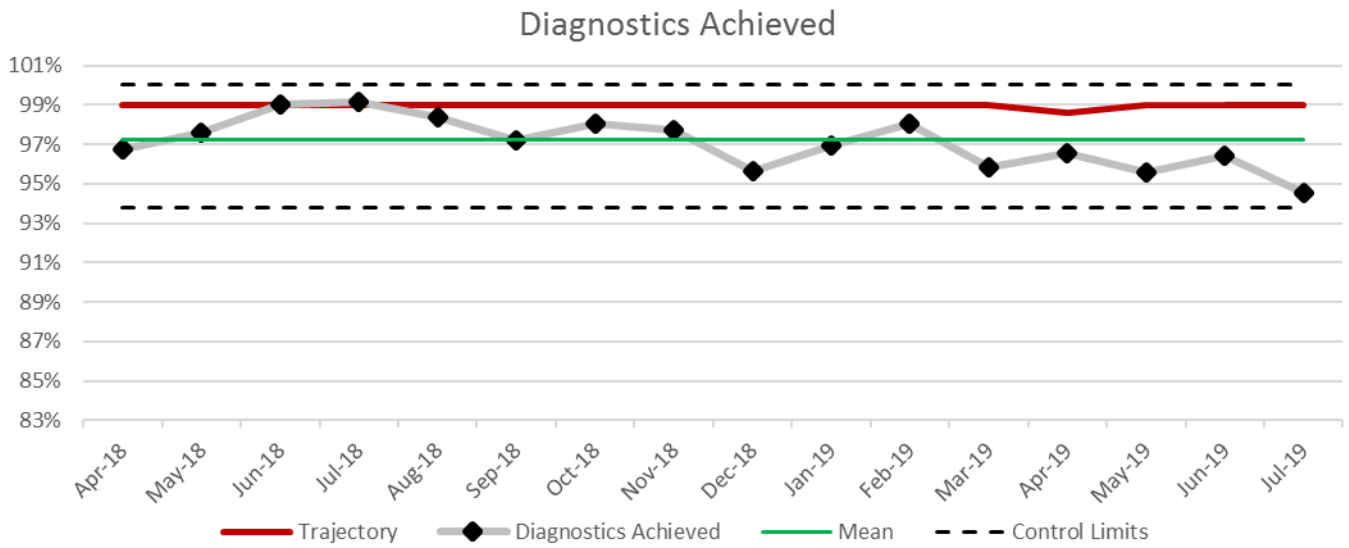
ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance has deteriorated from 96.53% in April, 95.56% May, 96.4% June to 94.53% in July 2019.

Clearly this is not acceptable and is not in line with the projected recovery trajectory, but should also be balanced with best ever diagnostic cancer performance of 88% against internal target of 80% 7day cancer performance in diagnostics.

Performance is challenged by staff retirement and sickness in Neurophysiology and Urodynamics where small teams have lost a large amount of capacity. Outsourcing teams have been brought in throughout July and should reduce the backlog .

July Split

Radiology DMO1 overall position was 99%

Endoscopy DMO1 overall position 100% Colonoscopy and flexi sig

Audiology 98.8%

Echo cardiology 84.2%

Cystoscopy 74.6%

Uro-dynamics 24.37%

Performance continues to be challenged with unreliable endoscope washers trust wide predominantly Louth and process issues in Cardiology and Urology and capacity issues with Neurophysiology.

CT Cardiac capacity is challenged, additional capacity has been provided and long term options are being investigated. Business cases have been written to replace the washes cost neutral. Increasing demand across all areas is proving to be challenging, with increased demand for complex MRI GA cases causing its own challenges. The Trust has exceeded inhouse MRI capacity and continues to outsource/buy in scanning capacity.

A new MRI scanner is being installed in September 2019 which will relieve some pressure, however we will still need a second MRI scanner in the new financial year to remove outsourcing completely.

Due to unforeseen/emergency sickness and no in-house capacity to cover, Echo Cardiology experiences a disproportionate increase in 6 week breaches during July.

Actions in place to recover

Urology

A weekly meeting has commenced between Endoscopy and Urology team to maximise capacity by picking up dropped lists. Single PWBL is being developed and will enable clearer visibility for booking in date order.

Neurophysiology

Additional capacity is being planned to start the beginning of June 2019 with an aim to reduce backlog by July 2019.

Complex Echocardiograms

Additional sessions are being planned, but this modality will remain a challenge.

MRI GA

Close working between CT and Anaesthetic department has commenced to align capacity with demand.

CT Cardiac

Working closely with cardiologists to align and maximise capacity, additional lists provided adhoc.

Echo-Cardiology

Agreement reached for peace meal rates to increase capacity to mitigate sickness, absence and increase capacity. CBU reviewing slot utilisation and anticipate improved September performance onwards.

Work is continuing to ensure that all staff understand the DM01 standards and apply best practice to delivery (e.g. we are looking to standardise procedures for managing surveillance patients).

The Trust has committed to deliver sustained compliance with the standard (99%) in 2019/20 and all staff are committed to deliver.

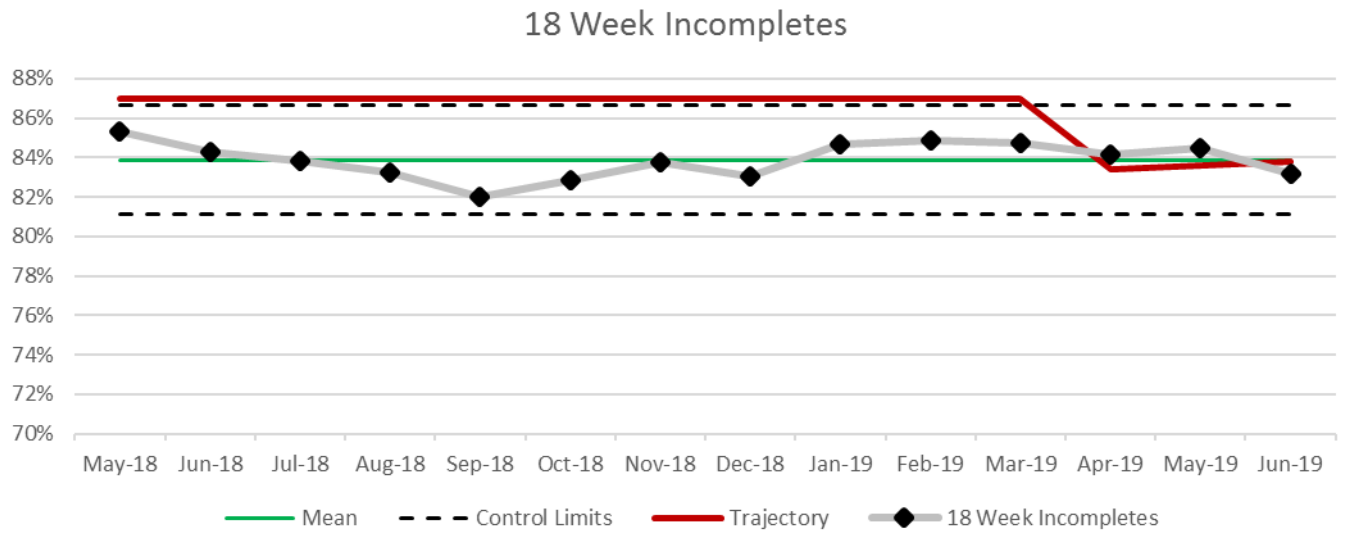
Note: Delivery of improved cancer diagnostics in a number of modalities has altered the denominator for DM01 and made delivery more challenging.

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and waiting list overall number growth suggests that improvements are required to further improve and sustain.

June saw RTT performance drop to 83.16%, below trajectory for the first time since April. This is 0.84% decrease on May. The specialities with the lowest performance against the RTT standard continue to be; Neurology (39.19%), General Medicine (67.82%) and Maxillo-Facial Surgery (50%)

Actions in place to recover:

Additional capacity created in ENT and performance shows improvement.

Continued delivery of the benefits in T&O from the reorganisation and establishment of Grantham as elective hub. Aspiring to achieve 18 weeks standard in 2019/20.

Validation software procured to ensure standardisation of process across Trust. A rollout plan to implement usage is awaiting approval.

Alignment with system elective improvement plans. These are converting into actions to support trajectories in some specialties.

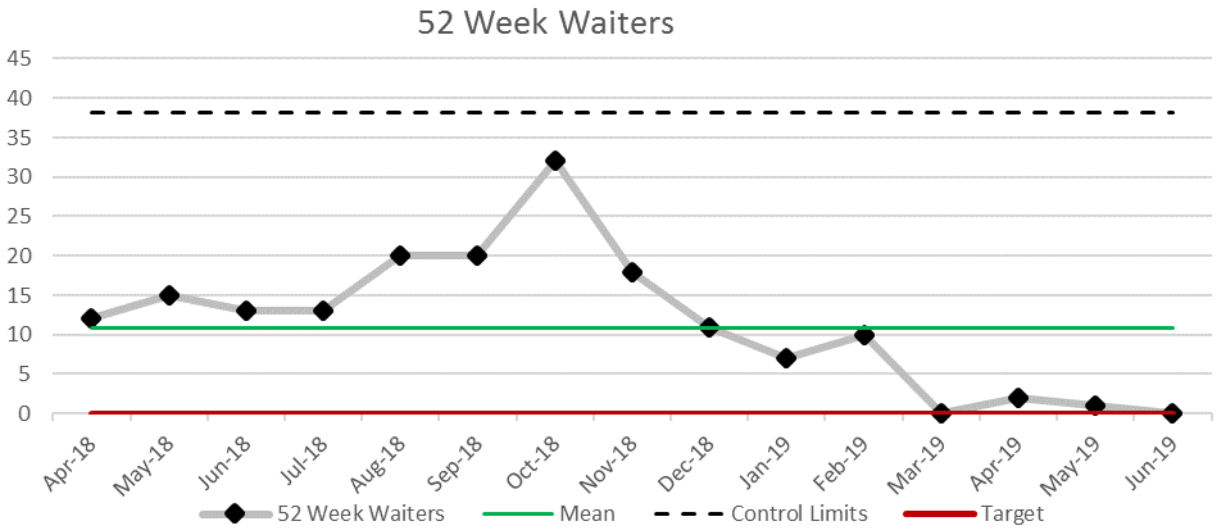
Targeted specialty specific recovery plan is being extended in Neurology. This is a significant shared priority with CCGs which includes an external provider taking via IPT, a cohort of patients between 25 – 40 weeks waiting. The introduction of GP with Special Interest (GPwSI) clinics is awaiting approval and revised pathways out of hospital and suspension of referral access (subject to regulatory approval) are awaiting confirmation to proceed.

ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

June 52 week performance – 0 patient

- This is an improvement from May where there was 1 confirmed.
- The end of June position is reported as ZERO incomplete 52 week waiters.

In order to prevent deterioration in 52 week wait patient numbers all patients are escalated at 40 weeks and above. This performance metric is being used as lead indicator for reducing 52 week wait risk

Validation and administrative error remains a key risk to the delivery of 52 week standard.

May to June showed a decrease of 25 patients waiting over 40 weeks. However, with the issues noted in Neurology and Maxillo-Facial, this is likely to increase in those specialties.

Actions in place to recover:

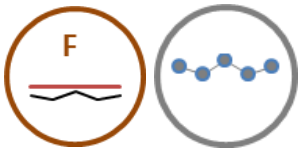
- Continued operation of weekly oversight via RTT PTL meeting and senior review of over 40 week patients.
- Recovery plans being developed in Neurology working with CCG. Commencement of transfer to BMI beginning of July.
- OMF has backlogs in dental extractions and skin. Also a mid-grade doctor is leaving in July. The division will look at replacing this doctor. Plans are being discussed to transfer the backlog out if possible to NUH or private providers.
- Validation tracking software has been procured and will be rolled out, start date anticipated to be beginning of September. An in house training programme has been developed with competency and compliance monitoring to ensure that administrative errors reduce. This will commence 29 July 2019.

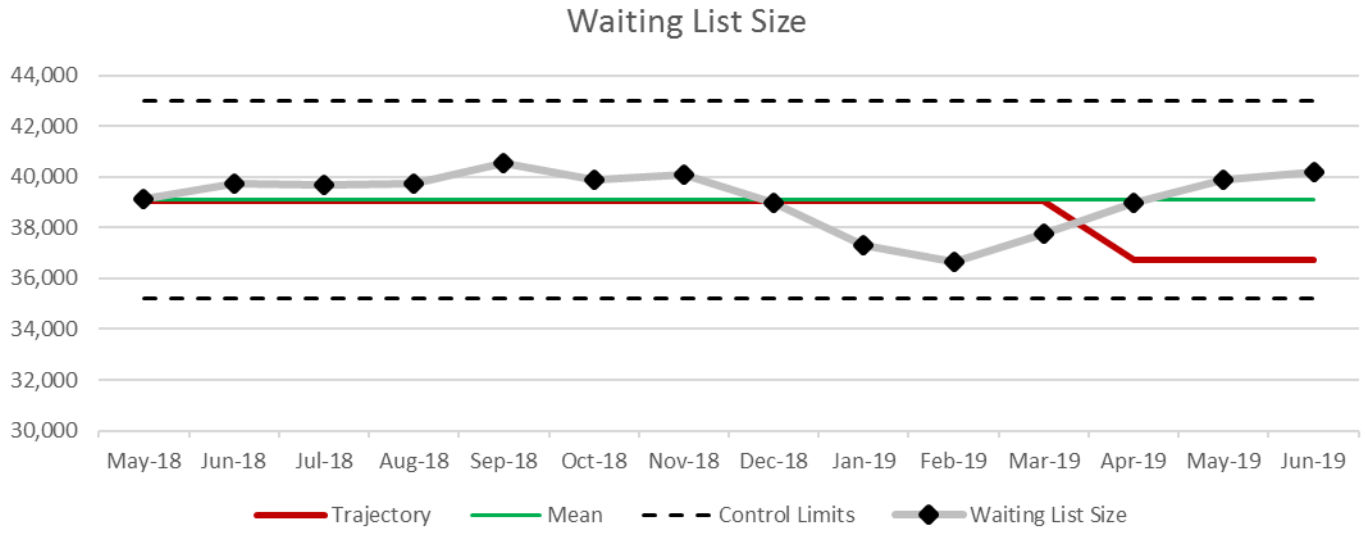
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size continued to deteriorate, with June waiting list increasing by 276 to 40,171. This is a 0.69% increase, however growth has slowed from previous month. The key drivers for this were:

- an increase in external referrals (121 more than May)
- an increase in internal referrals (168 more than May)
- less clock stops than clock starts (829)

Specialties that have had the greatest increase in waiting list size are Ophthalmology (127 growth) Dermatology (83 growth), Cardiology (17 growth).

Actions in place to recover

Analysis of incomplete waiting list to determine reason for growth. In depth analysis of cause and contributory factors such as clock starts, stops and data entry.

Divisions tasked with completing trajectories to reduce waiting time to 26 weeks. This should have a positive overall effect on waiting list size. A report to monitor progress against trajectory has been developed.

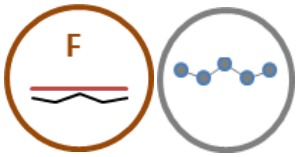
Progress will be challenged at the RTT Recovery and Delivery meeting.

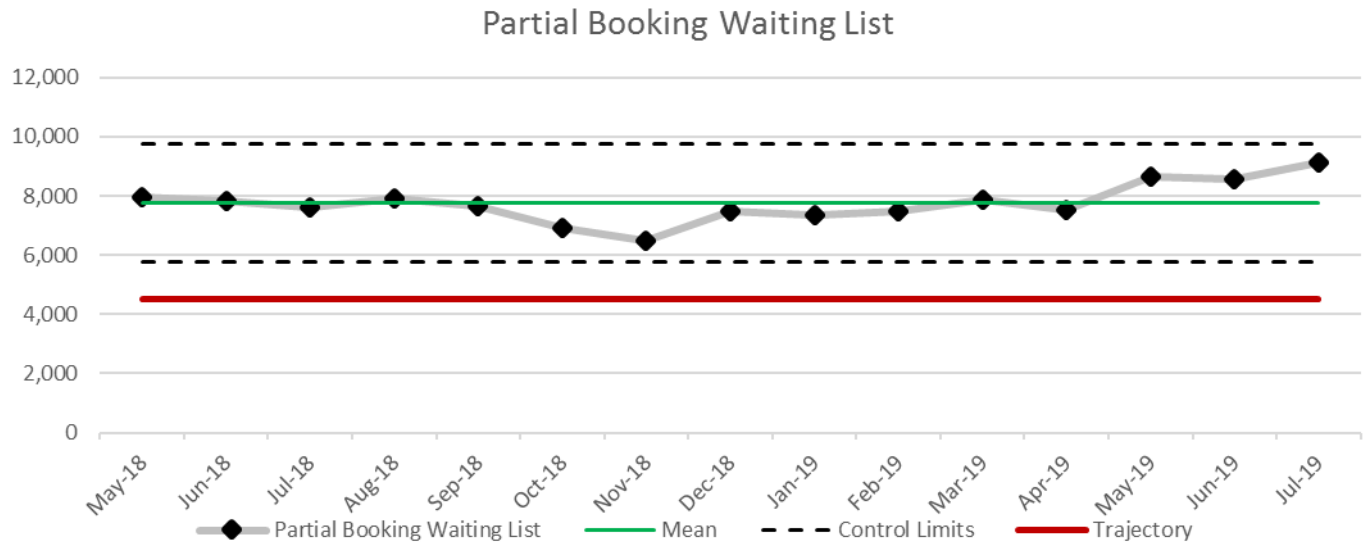
ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Neurology continues to be a fragile service and the service is continuing to use locums and outsourcing.

This helped to reduce numbers of patients on the new patient lists, so discussions taking place to focus on PBWL.

The challenge for the other speciality plans are :

- the availability of locums,
- the extra costs incurred,
- providing nursing and space for the extra capacity,
- balancing priorities due to focus on 2WW patients in Trust
- Reduction in attendances overall in Quarter 1.

Actions in place to recover:

All Divisions have been asked to provide backlog recovery plans with timescales, the majority have now been provided.

Agreed to be monitored going forward by the Chief Operating Officer as part of his delivering productive services group to ensure delivery of plans

The Divisions will be accountable to the action plans, the main themes are

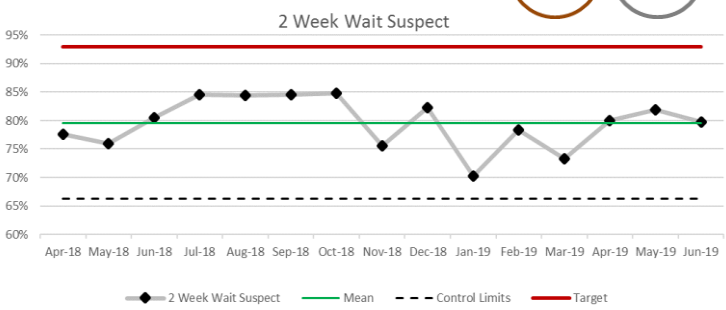
- Validation,
- Alternative patient pathways,
- Locums
- Outsourcing.

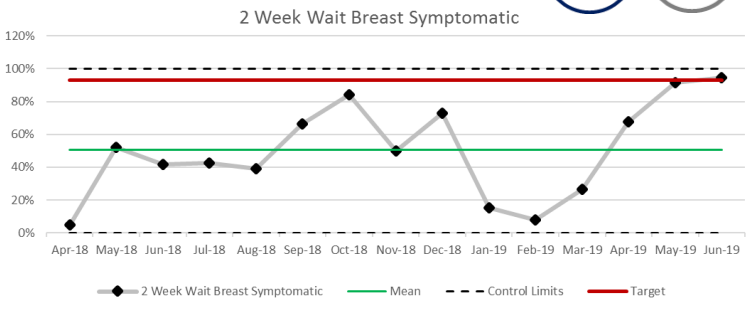
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Five tumour sites met the 14 Day standard in June (Brain, Breast, Haematology, Lung and Upper GI, with Urology just missing by 1.3%), an improvement on only three that met it in May.

The Trust has set an internal standard for a 7 Day Horizon of 60%. This standard is continuing to prove to be difficult to achieve however the ambition is to have all tumour sites accomplishing this by December 2019 in preparation for implementation of the 28 Day faster Diagnosis Standard (shadow monitoring 19/20). The Cancer Centre are supporting the Divisions through the IST Capacity & Demand modelling and working collaboratively with Access, Booking and Choice.

A new 2ww dashboard has been developed that gives the Divisions better sight of fluctuations in referrals coming in to the Trust, the number of patients waiting to be appointed and a 6 week forward view of available (empty) capacity, thereby giving them better control at the start of the pathway

July's forecast for tumour site performance is as below:

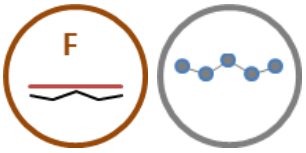
	Total	< 7 Day Prfrmnce %	< 14 Day Prfrmnce %
Brain/CNS	11	0.0	90.9
Breast	287	9.8	89.2
Breast Symptomatic	139	7.2	83.5
Colorectal	548	43.4	80.5
Gynaecology	190	23.2	67.9
Haematology	26	30.8	88.5
Head & Neck	288	35.8	91.3
Lung	75	65.3	**96.0**
Sarcoma	14	50.0	92.9
Skin	527	10.3	80.3
Upper GI	193	66.3	**94.3**
Urology	314	39.2	91.1

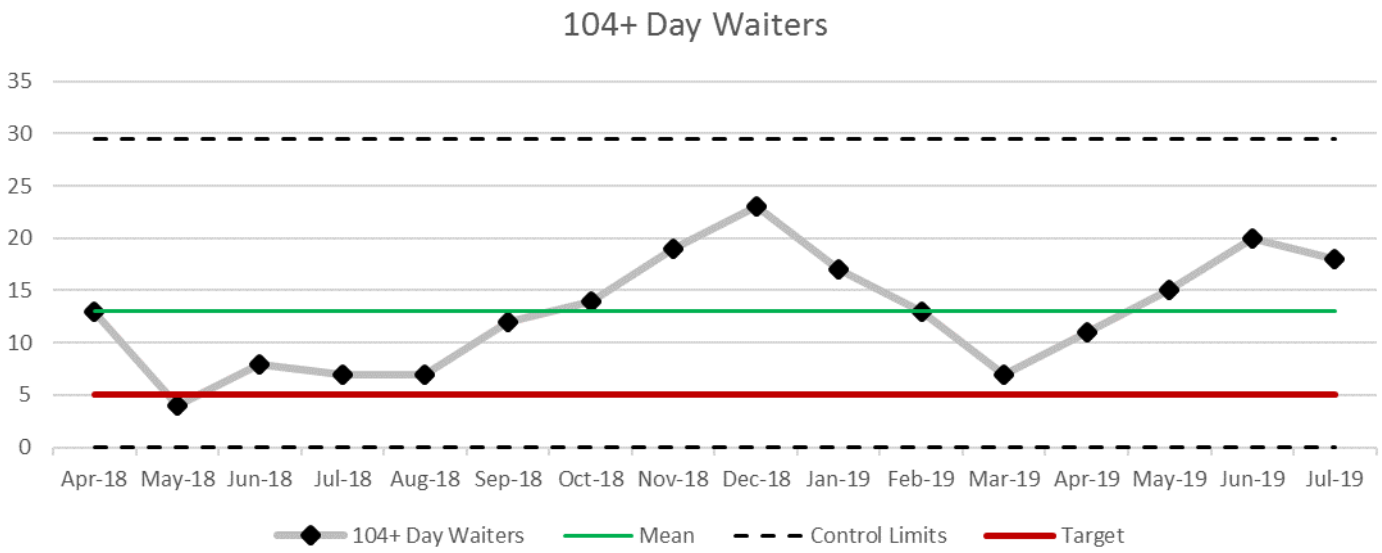
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





The number of Trust patients waiting over 104 days has been steadily increasing and there has been an increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).

A daily report is now issued to the Divisions, highlighting the volumes in their areas with the report currently being revamped to allow them immediate drill-down to patient-level detail.

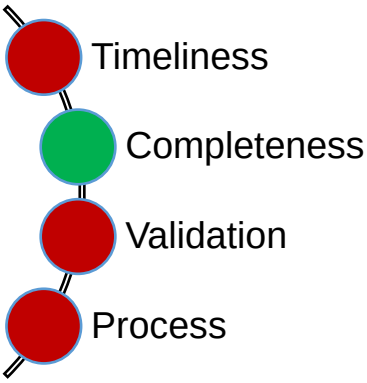
The Trust holds a twice weekly Cancer Call, chaired by the CSS Divisional Managing Director, where the 104+ patients are first to be discussed. This is a confirm & challenge meeting to ensure maximum effort is being made to reduce the length of these patients' pathways.

The 104+ day waits in the Midlands region have increased significantly in 2018/19, over and above the overall increase in activity and backlog and this trend has continued into 2019/20.

NHSI/E are looking to support trusts in addressing both the quality and performance issues relating to >104 day cancer waits.

APPENDIX A – KITEMARK

Reviewed:
1st April 2018
Data available at: Specialty level



Domain	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month. Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lag of more than one month. Where data is only available quarterly, there is a data lag of more than one quarter.
Completeness	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.	More than 3% blank or invalid fields in expected data set
Validation	The Trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is: - Accurate - In compliance with relevant rules and definitions for the KPI	Either: - No validation has taken place; or - An insufficient amount of data has been validated as determined by the KPI owner, or - Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions
Process	There is a documented process to detail the following core information: - The numerator and denominator of the indicator - The process for data capture - The process for validation and data cleansing - Performance monitoring	There is no documented process. The process is fragmented/inconsistent across the services

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	September 2019

Title:	**Corporate Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Manager

Purpose of the Report:
The purpose of this report is to enable the Trust Board to:

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- The current corporate risk profile shows that the Trust is exposed to a significant amount of risk at present, particularly in relation to financial sustainability; workforce capacity, capability and morale; and the age and condition of parts of the estate; 47% of corporate risks are currently rated Very high or High risk
- Since the last report, all corporate risks have been reviewed and those with detailed action plans are in the process of being updated with support from the Risk Management team
- The following changes have been made to current Corporate risk ratings this month:
  - The risk of services being affected by loss of staff engagement and morale (Risk ID 4083) has been increased on review, from High risk (120 to Very high risk (20)
  - There has been a reduction in safeguarding risk (ID 4146) from Very high (20) to high (12), to reflect progress made with regard to chaperone policy; DBS processes; and MCA compliance
  - Contamination and service disruption risks associated with aseptic pharmacy services remain very high due to estates infrastructure issues at Pilgrim Hospital – the unit was temporarily closed and business continuity plans are in effect following a water leak incident

Recommendations That the Trust Board considers the content of the report and advises if any further action is required.	
Strategic Risk Register Corporate risks that are considered to be of strategic significance are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risk in accordance with the Risk Management Policy is reported regularly to the Audit Committee.
Assurance Implications This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.	
Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.	
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.	
Information exempt from Disclosure – No	
Requirement for further review? No	

1. Purpose of the Report

1.1 The purpose of this report is to enable the Trust Board to:

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

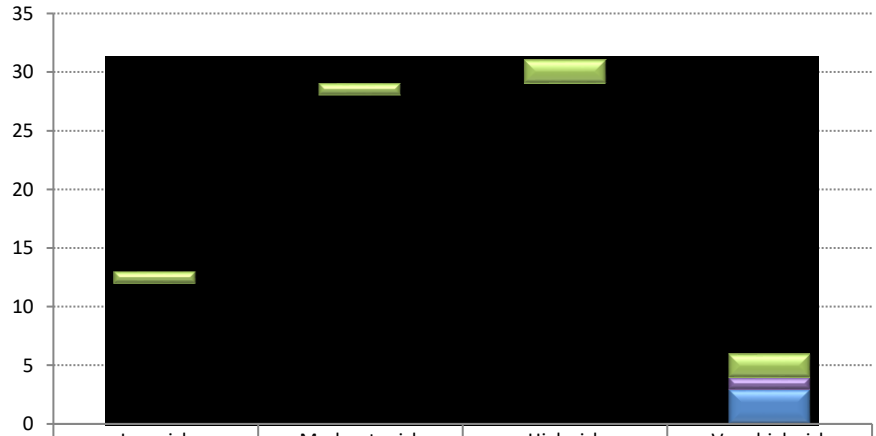
3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation.

4. Summary of Key Points

Corporate Risk Profile

4.1 **Chart 1** shows the number of corporate risks by current (residual) risk rating:



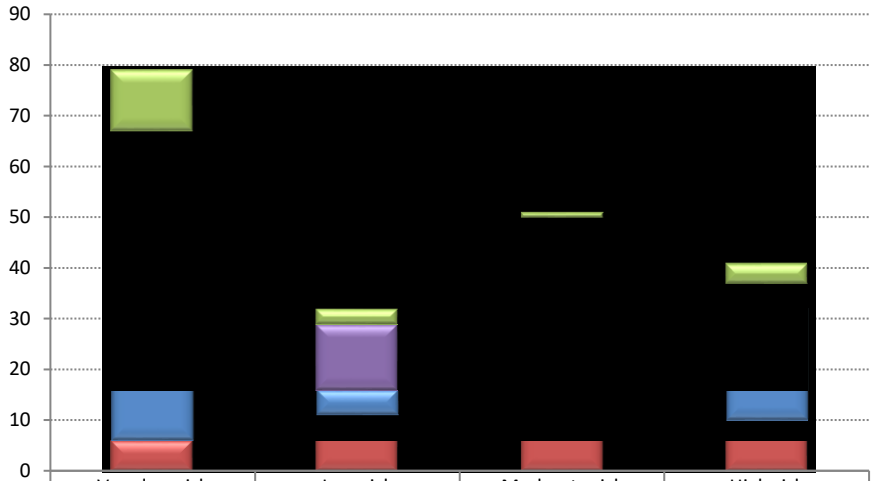
	Low risk	Moderate risk	High risk	Very high risk
Finances	1	1	2	2
Reputation / compliance	5	16	10	1
Service disruption	4	3	13	3
Harm (physical or psychological)	3	9	6	0

4.2 A report showing details of all corporate risks recorded on the Corporate Risk Register with a current (residual) risk rating of High or Very high (a score of 12 or more), along with planned mitigating actions is included as **Appendix I**. A summary of those corporate risks with a current rating of Moderate or Low risk is included as **Appendix II**.

4.3 The Corporate Risk Profile shows the extent to which the Trust is currently exposed to significant risk of all types, with 47% of risks currently rated as Very high or High.

Operational Risk Profile

4.4 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk
Finances	12	3	1	4
Reputation / compliance	27	13	13	5
Service disruption	34	5	19	22
Harm (physical or psychological)	6	11	18	10

4.5 Similar to the Corporate profile, the Operational Risk Profile shows that there is a significant amount of risk of all types at business unit level within the Trust, with 20% of risks currently rated as High.

Risk management process

4.6 Each corporate risk has an Executive lead, with overall responsibility for its management; and a Risk lead responsible for reviewing and updating the risk register. The majority are also assigned to a lead management group for regular scrutiny. All are aligned with the appropriate assurance committee of the Trust Board.

4.7 Risks are defined according to the type of consequence that would be experienced should they materialise, with a severity scale of 1 to 5 using the following definitions:

- Harm (physical or psychological) – this may be to patients (as a result of issues with care); to members of staff, or to visitors (arising from health & safety issues) and covers a range from minor injuries through to multiple fatalities
- Service disruption – which ranges from the implementation of local business continuity plans up to critical and major incidents
- Reputation / compliance – which covers the potential for individual complaints up to a fundamental loss of confidence amongst commissioners; regulators; and the government (many risks of this nature relate to compliance with national standards, regulations and contractual obligations)
- Finances – which is based on the budgetary impact, from minimal cost increases to jeopardising financial sustainability

4.8 Within each corporate risk register entry there may be several risk factors associated with identified gaps in the risk control framework. These are individually assessed and prioritised by way of a 'Component risk rating', which is shown on the attached report.

4.9 The Risk Scoring Guide, which is used to assess all risks recorded on the Trust's corporate an operational risk registers, is attached for reference as **Appendix III**.

4.10 Operational risk registers are also in place for every Clinical Business Unit (CBU) and corporate department. The provision of management information to divisional and business unit management teams is still being developed. Once in place this will facilitate more regular and routine review of operational risks and improve the level of analysis that can be done to identify areas of significant concern. Oversight of risk management at divisional level is already included with the Performance Review Meeting (PRM) process.

4.11 The availability of resources to support corporate risk management processes has been limited in recent months and continues to be so; however, additional investment has been made within Clinical Governance and recruitment has taken place, which will enable greater support to be provided to corporate and divisional leads from September 2019 onwards.

Appendix I - Very high High Corporate Risks (August 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4383	**Substantial unplanned expenditure or financial penalties (corporate)** If the Trust incurs substantial unplanned expenditure or financial penalties within the current financial year; Caused by issues with budget planning, budgetary controls, compliance with standards or unforeseen events; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Annual budget setting process. Capital investment planning process. Capital investment programme delivery & monitoring arrangements. Monthly financial management & monitoring arrangements. Contract governance and monitoring arrangements. Directorate performance & accountability framework. Key financial controls. Financial management information.	Very high risk (20)	Financial Turnaround Group	Moderate risk	31/10/2019	Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost.	Very high risk (20-25)	Finance	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	31/03/2020	
										Interest rate may increase if the Trust deviates adversely from plan in the financial year. Non-delivery of plan would also mean the Trust won't have access to FRF; PSF; and MRET (valued at £29m).	Very high risk (20-25)	Finance	Delivery of the Financial Recovery Programme; maintaining grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed.	31/12/2018	
4382	**Delivery of the Financial Recovery Programme (corporate)** If the Trust becomes unable to delivery key elements of the Financial Recovery Plan within the current financial year; Caused by issues with the design or implementation of planned cost reduction initiatives; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Financial recovery planning process. Financial Recovery Plan governance & monitoring arrangements. Directorate performance & accountability framework. Financial management information. Financial Special Measures (since September 2017). Financial Turnaround Group (FTG) oversight. Programme Management Office & dedicated Programme Manager.	Very high risk (20)	Financial Turnaround Group	Moderate risk	31/10/2019	Identified schemes for 2019/20 cover the level of efficiency required (£25.6m). If assumptions are inaccurate; or if there are capacity & capability issues with delivery; it may result in failure to deliver these schemes.	Very high risk (20-25)	Finance	Finance PMO team working with divisions to manage planned schemes and identify mitigating schemes. Additional external resource to be brought in to support delivery.	31/03/2020	
4083	**Workforce engagement, morale & productivity (corporate)** If the Trust were to lose the engagement of a substantial proportion of its workforce; Caused by issues with low morale, lack of job satisfaction or uncertainty about the future; It could result in a substantial, widespread and prolonged reduction in productivity across multiple services affecting a large number of patients and staff.	Rayson, Martin	Reputation / compliance	Very high risk	Staff Charter & Personal Responsibility Framework Staff engagement strategies & plans. Internal communications platforms (intranet; bulletins; forums). Staff survey process and response planning. People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring. Core learning programmes. Leadership development and succession planning processes. Management of change policies, guidelines, support and training. Partnership agreement with staff side representatives. Occupational health & wellbeing arrangements for staff.	Very high risk (20)		Low risk	30/11/2019	Impact of the cost reduction programme & organisational change on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.	Very high risk (20-25)	Human Resources	Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. The actions proposed provide the mitigation, but we have to recognise that this remains a tough environment in which to drive up morale. Staff survey predated launch of 2021, but there is a need to tackle vacancy gaps as well.	31/03/2020	Actions have been taken since the 2018 staff survey results against some the biggest themes emerging. Each Division has been asked to work to address the issues identified in their survey results. The Engagement Bus will be visiting each site in September. This will be accompanied by a "you said, we did" campaign. The next staff survey will be open in October 2019 and results will be available in early 2020. Review once the next set of staff survey results are available.
										Relationships with staff side representatives are challenged by the scale of organisational change required and the extent to which staff side wish to protect the status quo. There are disagreements amongst staff side representatives and not all meetings have taken place as scheduled.	Moderate risk (8-10)	Human Resources	Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. It is based on the Sandwell model and seeks to ensure proper debate, without giving staff side the capacity to prevent us moving beyond the status quo. Intention is to write to staff side to propose a further partnership meeting. Formal consultation around the new recognition agreement will begin shortly.	31/03/2020	Vote of no confidence in the Board by staff side in November 2018. Outstanding issues have been resolved, except there is a need for a facilitated discussion on future partnership working. The review of the recognition agreement has been on hold. We will resurrect this and elements of this will be controversial.
4362	**Workforce capacity & capability (recruitment, retention & skills)** If there is a significant reduction in workforce capacity or capability across the Trust; Caused by issues with the recruitment and retention of sufficient numbers of staff with the required skills and experience; It could result in sustained disruption to the quality and continuity of multiple services across directorates and may lead to extended, unplanned closure of one or more services which has a major impact on the wider healthcare system.	Rayson, Martin	Service disruption	Very high risk	Overall ULHT People Strategy & Workforce Operational Plan. Workforce planning processes & workforce information management. Medical staff recruitment framework & associated policies, training & guidance. Medical staff appraisals / validation processes. National audit & benchmarking data on the medical workforce. Nursing staff recruitment framework & associated policies, training & guidance. Allied Healthcare Professionals (AHPs) staff recruitment framework & associated policies, training & guidance. Non-clinical staff recruitment framework & associated policies, training & guidance. Bank, locum & agency staffing arrangements. Rota management systems & processes. People management policies, training & guidance. Core learning programme & training provision. Leadership development programme.	Very high risk (20)		Moderate risk	30/11/2019	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	Very high risk (20-25)	Human Resources	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.	31/03/2020	Nursing offer in place. Strategy for recruiting nurses in place, involving international and national recruitment, alongside maximising NQNs and trainee nurse associates. Review again at end of financial year.
										High vacancy rates for consultants & middle grade doctors throughout the Trust.	Very high risk (20-25)	Human Resources	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	31/03/2020	Plan for every medical post in place. Good progress on recruitment (to plan) in QTR 1 and good pipeline in QTR 2. Working with two agency partners. Review again at end of financial year.
										A significant proportion of the current clinical workforce are approaching the age at which they could retire, which may increase skills gaps and vacancy rates.	High risk (12-16)	Human Resources	Workforce plans to identify the potential risk due to the age profile in more detail, by year and service area; People Strategy includes mitigating actions; using HEE funding to bring additional capacity into OD in order to make progress on this project.	31/12/2019	Retention plan in place - aiming for 1-2% reduction in attrition in 2019/20. Review again at end of calendar year.
										The Trust is dependent on Deanery positions to cover staffing gaps with medical trainees; shortages in the medical recruitment team will impact on the next rotation if not resolved.	High risk (12-16)	Human Resources	Education Director action plan to address the issues raised.	31/12/2019	Higher number of junior doctors in August rotation. Actions to improve juniors experience identified. Review again at end of calendar year.
										NHSI propose the introduction of 2 further measures to reduce agency spend in non-clinical areas: - a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts (to use of on-framework agencies only) - A restriction on the use of admin and estates agency workers to bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	High risk (12-16)	Human Resources	Review of proposals and potential impact, to identify any required action.	31/12/2019	Action plan in place to reduce agency spend. Central medical agency team operating and impact is being felt. However agency spend is not reducing as expected. Further action being taken, particularly around nursing agency spend. Review again at end of calendar year.

Appendix I - Very high High Corporate Risks (August 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4175	**Management of emergency demand (corporate)** If the volume of emergency demand significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	ULHT operational demand management policies & procedures. Operational performance management framework & regular reporting / monitoring at divisional and corporate levels. Monthly performance report to Trust Board. Urgent and Emergency Care Board (UECB) delivery plan. Lincolnshire Sustainability & Transformation Partnership (STP) and Plan. Horizon scanning processes.	Very high risk (20)		Moderate risk	30/09/2019	• Comprehensive and effective triage • Improve time to RAT • Reduce ambulance handover delay • Improve time to 1st assessment • Effective GP Streaming • Improve non-admitted pathway compliance • Delivery of an ambulatory care model • Implementation of frailty model • Reconfiguration • Redesign the site management and bed meeting model • SAFER implementation • Effective discharge by 1000 • Reduce number of stranded and super stranded patients • Implementation of Red to Green • Implementation of Full Capacity Protocol (FCP) • Implementation of criteria led discharge	Very high risk (20-25)	Operations	Urgent and Emergency Care Programme work streams: QS04 Pilgrim EC1A Lincoln EC1B Grantham EC2 Assessment Function EC3 Site Function EC4 Inpatient Ward Function EC5 Discharge and Partnerships	31/03/2020	Project updates for each of the five work streams are brought to Recovery Steering Group meetings which take place fortnightly. The recovery steering group has now been extended to include partners, stakeholders and regulators.
4405	**Critical infrastructure failure disrupting aseptic pharmacy services (corporate)** If there is a critical failure of the infrastructure that supports aseptic pharmacy services within the Trust; Caused by issues with the age and condition of the facilities and the impact of managing increasing levels of demand; It could result in unplanned suspension of services which would have a significant and prolonged impact on a large number of patients, services, and other service providers.	Hepburn, Dr Neill	Service disruption	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Estates & Facilities Planned Preventative Maintenance programme & responsive repairs process. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates). Business continuity plans for ASU require patients to be treated outside of the Trust in the event of service disruption.	Very high risk (20)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	The Pilgrim ASU facility is18 years old, is operating at capacity and the availability of external supplies is both erratic and inconsistent. In addition, cancer care in the Trust is increasing by 10% annually and demand for aseptic preparations is predicted to outstrip current levels of availability by the end of 2020.	Very high risk (20-25)	Pharmacy	Development of a sustainable infrastructure plan for aseptic pharmacy services.	31/12/2020	Full Business Case being prepared for Trust Board in October 2019, containing proposals for a new aseptic unit; preferred option is a joint venture partnership through the STP.
										Repeated incidents of water leaks into one of the PHB aseptic rooms (tray washing room) from an upstairs toilet. If this happens and water reaches the main clean room it could result in closure of the aseptic unit for recommissioning and therefore inability to provide an aseptic service for the Trust for several months.	Very high risk (20-25)	Pharmacy	With Estates, to identify the reasons for the ongoing leaks and provide a permanent resolution to the problem; if a permanent resolution is not possible, to explore a way to identify the leaks at an early stage to minimise the risks (detection alarms are in other areas of the aseptic unit, so can this be applied to all other areas). To arrange cultures and chemical assay of the water. To request an assessment from Bernie Sanders, East Midlands Regional Quality Assurance to advise on continuation of production.	31/10/2019	Temporary closure of the aseptic unit at PHB - implementing BCP until assurance is received that the contamination is safely managed.
3520	**Compliance with fire safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with fire safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance (PPM) / testing. Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processes.	High risk (16)	Fire Safety Group	Low risk	31/10/2019	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards. The Maternity Wing has a partially compliant alarm system in need of upgrading to current standards (Any works to the Fire alarm system within the Maternity Wing are constrained by the presence of asbestos. This applies to maintenance works and any upgrade works). Detection Zones plans are also referenced as a reason for the inadequate Fire Detection System under Article 13(1) (a) & 13 (2) of the Fire Enforcement noticed served 14th June 2017.	High risk (12-16)	Estates	The Fire Alarm System at LCH is maintained by a specialist contractor and directly employed labour force. The system in some areas has been upgraded as part of services developments e.g. HDU & ICU and as part of previously funded upgrade. Programme of refurbishment and re-provision on a phased basis to install a 'loop' for the site and linking in modern equipment is underway.	31/12/2019	Phases 1, 2 and 3 complete. Phases 4 is underway and as part of these works; and to improve auditability and compliance with DDA, additional sounders and beakers are being installed. Phase 5 (Mat Wing) The Fire Alarm systems on 1st and 6th floor have been replaced, works are currently on-going to replace the Fire Alarm system within all lift lobby areas and within the 3rd floor ward area.
										Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection of patient and staff areas in accordance with statutory standards. See Fire Strategy surveys for areas affected. As referenced under article 8 in the Fire Enforcement Notices.	High risk (12-16)	Estates	Fire Strategy Plans and surveys identify where compartmentation is required. Fire compartmentation works costs are detailed within the capital plan.	31/12/2019	The work packages for the remedial works are taking place subject to availability of sufficient capital funding.
										Numerous sets of fire doors in poor condition due to wear and tear and damage where the fire resisting qualities have been reduced or negated. Under article 17(1).	High risk (12-16)	Estates	Fire Doors will be addressed as part of the Fire Action Plan from the enforcement notices received for Lincoln and Pilgrim. Fire Doors requiring replacement to be replaced with new certified fire doors. PPM inspections and ad hoc repairs to fire doors in response to serious damage, etc.	31/03/2020	Replacement programme in progress.

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										There are some areas of the estate with insufficient provisions of emergency lighting. Testing of these units is required to ensure their continuing efficiency in the event of mains failure during fire incidents. Failure to comply with testing schedules could result in unit failure in service. Additional resources required to enable full compliance with Trust policy and applicable regulations.	High risk (12-16)	Estates	Energy Performance Contract EPC being established to include full replacement of Emergency Lighting System Trust wide. EPC to be instructed to undertake replacement programme in accordance with Fire Enforcement Notice Timescales. Standby generator would come into operation to provide some essential emergency lighting.	31/12/2019	Replacement programme in progress.
										Adherence to fire safety policy, procedures, strategic approach to active and passive fire safety measures and evacuation strategy. Adherence to Fire Safety training arrangements which include recording, analysis of training needs, personal development systems in place for all staff inclusive of permanent, temporary, agency and or bank staff.	High risk (12-16)	Estates	Specific actions in relation to fire safety training & evacuation: 1. staff identified and managers informed to ensure staff attend 2. Evacuation drills to be implemented and tested. 3. New Fire safety training packages being introduced. 4. persons requiring PEEP and procedures tested during evacuation drills. 5. discussions with HR to identify an appropriate procedure to identify and inform staff outside of compliance dates, with managers cc into correspondence to ensure urgent attendance. 6. Fire safety trainer to discuss with ESR team about information required for PDR and H & S team for reporting against core modules to ensure compliance.	31/03/2020	New mandatory staff fire safety awareness module introduced.
4384	**Substantial unplanned income reduction or missed opportunities (corporate)** If the Trust experiences a substantial unplanned reduction in its income or missed opportunities to generate income within the current financial year; Caused by issues with financial planning, an unexpected reduction in demand or loss of market share; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Contract governance and monitoring arrangements. Annual budget setting & monthly management process. Monthly financial management & monitoring arrangements. Key financial controls. Financial management information.	High risk (16)	Financial Turnaround Group	Moderate risk	31/10/2019	Clinical coding & data quality issues impacting on income.	High risk (12-16)	Information Services	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	31/03/2020	
										Operational ownership of income at directorate level.	High risk (12-16)	Finance	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	31/10/2019	
										Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	High risk (12-16)	Finance	Agreed contractually that the impact of income reduction for these schemes will be on a net neutral basis for the Trust; monitored and managed through the Finance & Contracting Group.	31/03/2020	
										Activity levels increase above the plan where the Trust remains under tolerance, no additional income is received; where above tolerance only a percentage of tariff is received.	High risk (12-16)	Finance	Internal control via PRM process for monitoring and agreeing any necessary actions to manage demand; & via Finance & Contracting Group for the system to manage demand.	31/03/2020	
										Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	High risk (12-16)	Finance	System to develop robust plans and internal productivity gains to ensure there is sufficient capacity to deliver the activity; where the planned level of activity can't be achieved to secure income, the associated costs will need to be removed.	31/03/2020	
3688	**Quality of the hospital environment (corporate)** If the Trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the Trust and may lead to commissioner or regulatory intervention.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Patient Experience Committee. NHS Premises Assurance Model (PAM) Patient-led Assessment of the Care Environment (PLACE) survey & response plans. Robust defect reporting system which prioritises critical issues within available resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.	High risk (16)	Patient Environment Group	Moderate risk	31/10/2019	Due to lack of investment in the GDH site building fabric the windows, fascia and doors are in very poor state of repair, most of which are now beyond economic repair and require replacing. This causing drafts and water increase into buildings resulting in increased energy and maintenance costs.	Moderate risk (8-10)	Estates	Any dangerous windows and doors at GDH are replaced on individual basis. No identified funding.	31/12/2019	EPC contract awarded, some of these areas maybe picked up with this contract.
										Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	High risk (12-16)	Estates	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	31/12/2019	Funding and resource to be allocated.
										The air conditioning unit in Acute Care at Grantham Hospital has been condemned. Impact on patient and staff comfort.	Moderate risk (8-10)	Estates	Mobile Air Con units required for ACU at Grantham, Requested but not yet in place, no time frame and finance not agreed.	31/12/2019	Mobile heaters are in place. They are bulky and a health and safety risk, with regard to heat and trip hazard, and potential to overload electrical systems, as they are placed in large cages. They are also not very effective in a large space. they glow bright orange, lighting the unit up at night, this is effecting the sleep patterns of patients, which in turn has the potential to have a detrimental effect on their recovery.
										The drains under the 'wash up floor' at Pilgrim Hospital are failing, leading to a build up of stagnant water and food waste that attract fruit flies, mosquitos and give off a pungent odour. Over the last 5 years the pipework's under the floor have corroded and collapsed spilling out food waste into the soil underneath the floor. This has deteriorated over time and causes very bad smells and lots of drain flies. Environmental health aware and are monitoring with possible closure orders as per hygiene regulations.	Very high risk (20-25)	Estates	Excavate parts of the 'wash up floor' at Pilgrim Hospital, seal rainwater drains, remove sludge and fill the void under the main wash up area. The floor then needs to be sealed to stop any water going underneath.	31/12/2019	All drains have been removed. Potentially eliminated fly problem. Recommend sealing the floor.

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										Floor Coverings across the Trust - Many areas are 45 years old, looks tired and is damaged in areas. Frequently fails environment and PLACE audits. Sub Floor is also damaged in some cases. High risk areas include Maternity at Lincoln, Tower Block at Grantham, Theatre Corridors at Pilgrim.	High risk (12-16)	Estates	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	31/12/2019	
										LCH & GDH: Lack of resources to carry out external decoration. High level areas in the East Wing are difficult and costly to access due to requirement to erect scaffolding. Deterioration of paint finish to wooden windows and door fascias and soffits leaving timber exposed to weather. Will lead to deterioration of timber window frames and their failure with associated costs. Physical appearance very poor. Fails annually on PLACE scores.	Moderate risk (8-10)	Estates	Repairs to external decoration at LCH & GDH undertaken based on available labour, accessibility. Monitor the situation and carry out ad hoc repairs where situation dictates. Funding required for a rolling programme of external decoration, window replacement and facias.	31/12/2019	
										LCH: East Wing ward/theatre block - gutters leaking causing disruption to service and damage to fabric.	High risk (12-16)	Estates	Reactive maintenance carried out to LCH gutters as required. Some areas re-lined; Funding Required to re-line areas of guttering not already done.	31/12/2019	
										LCH: Patient bed space curtain track systems within patient areas are obsolete; sufficient hooks to hang the curtains satisfactorily are not available; not all curtain tracking is ligature safe; inadequately hung curtains can affect patient dignity as reported on PLACE.	Moderate risk (8-10)	Estates	Existing curtain hooks at LCH are "spaced out" to increased distances to allow curtains to hang. Funding required to replace the obsolete curtain rail systems.	31/12/2019	
										LCH: Failed Double Glazed Units in Windows of South Facing Wards; Windows "mist up" causing complaints from patients and staff and poor patient environment. Increased energy usage. Mold growth in some frames.	High risk (12-16)	Estates	LCH: Funding required to replace affected double glazed units of south facing wards; Estimated cost £40k+vat. Survey has been completed, need to identify funding to progress.	31/12/2019	
										LCH: Building Fabric Repairs required - East Wing.	High risk (12-16)	Estates	Ad hoc repairs to building fabric of the East Wing; Funding required for a rolling programme of repairs. Estimated cost £30K +vat	31/12/2019	
										Maternity Wing at LCH, 5th Floor Comfort Cooling. Currently no cooling provision. Areas overheated during summer period, adverse effect on patients and staff, in particular in the operating theatres.	Moderate risk (8-10)	Estates	Appoint consultant engineer to carry out detailed design and install comfort cooling system for Maternity Wing at LCH. Part of refurbishment programme.	31/12/2019	
										PLACE inspection June 2018 Trust scores reduced compared to 2017. Trust Ranking 146/152. Patient perception and concern that the environment reflects the level of care they may receive.	High risk (12-16)	Estates	PLACE Inspection reported to ET in November 2018, see attached report. Requested to scope the work required to improve the environment to an acceptable standard.	29/11/2019	
										Outpatient main reception inadequate for both staff, desk not ergonomically designed, no privacy screens for PCs therefore no patient privacy and inadequate security for staff. Noise levels from the adjoining catering outlet means confidential discussions are more difficult to undertake.	High risk (12-16)	Estates	Refurbishment work to the main outpatient desk to address staff operational issues, noise and patient confidentiality. Also to relocate the ambulance desk next to this facility to deliver a 'one stop shop'.	31/12/2019	
										During winter months with the Main Entrance being East facing, any significant cold winds are funnelled into the main entrance foyer through the door lobby. Previous actions by fitting automatic doors have failed to improve the situation. Numerous staff and patient complaints.	High risk (12-16)	Estates	To design a extension to the existing entrance that will prevent the wind funnelling into the main foyer at Pilgrim.	31/12/2019	
										GDH Tower Block Facia Boards rotten and falling off.	Moderate risk (8-10)	Estates	No mitigation possible. Removal required asap.	31/10/2019	
										Dishwasher machine Pilgrim Hospital CPU, that washing all patient and restaurant cutlery crockery, 15 years old and beyond economical repair and parts are obsolete.	High risk (12-16)	Facilities	Tender process required for replacement machine. In an emergency hand dishwashing which will require additional staff.	31/12/2019	

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										Infrastructure and doors in freezer units at Pilgrim catering, the fridge walls were installed in 1984. According to the refrigeration contractor the walls are deteriorating and losing the thermal properties to keep the cold. The doors have gaps where the seal has gone. The locks do not work, causing security issues and non compliance to keep locked for security and possible unknown contamination. The Shelter on the roof above is metal and keeps heat that causes the compressors to over work and cut out. This drastically reduces the temperature control and space for frozen stock.	High risk (12-16)	Catering (F)	Replace the insulated walls, new correct fitting doors with locks, fit meshing instead of doors on the roof to allow air flow for the compressors to function properly.	31/12/2019	
										CPU - Building Fabric at Lincoln County Hospital. The general internal fabric is deteriorating and increasingly hard to maintain in a manner compliant with food safety legislation. Structurally, drainage and ceilings are particularly at risk from failure that would compromise the provision of service.	Moderate risk (8-10)	Catering (F)	Robust defect reporting system in place. Regular local authority Environmental Health Officers inspections. PPM regime in place on all plant and environmental cleaning. HACCP system in place (monitoring and temperature checks etc.). Funding required for building repairs estimated cost £30K+vat.	31/12/2019	
										Lack of appropriate religious space for staff of different faiths resulting in difficulties in staff recruitment and retention and therefore affecting staff morale and service resilience	High risk (12-16)	Estates	Provision of additional multi faith areas at Lincoln	31/10/2019	
3720	**Critical failure of the electrical infrastructure (corporate)** If the Trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.	Boocock, Paul	Service disruption	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (16)	Electrical Safety Group	Low risk	31/10/2019	Street lighting and car park lighting cables at PHB are suffering from multiple faults due to their age.	Moderate risk (8-10)	Estates	Repairs to street lighting at PHB carried out when necessary. Need to re-wire street lighting circuits and replace light fittings. Funding dependant.	31/12/2019	
										GDH: Main LV Electrical Switch Gear (Back of Theatres) connected to Transformer Number 3 requires upgrading. Switchgear is fully loaded with no room for future expansion to the southern part of the site.	High risk (12-16)	Estates	Action Plan to be developed to upgrade main LV electrical switch gear at GDH. Any additional development to the southern half of the site will need to incorporate the replacement / upgrade of this switchgear.	31/12/2019	
										HV incoming switchgear at GDH is obsolete and requires replacement. Western Distribution have been to site to inspect their side of the switchgear. There is a possibility that in the near future they will be upgrading the incoming HV supply. This will result in the Trust having to replace our side of the switchgear.	Moderate risk (8-10)	Estates	Funding required to replace the switchgear at GDH in the event that Western Power decide to upgrade the incoming HV supply.	31/12/2019	
										Potential for failure of electrical distribution to large area of Pilgrim Hospital due to panel failure.	Moderate risk (8-10)	Estates	Complete review of the system. Accelerated replacement programme. Funding and resource required. Consider the use of thermal imaging camera.	31/12/2019	Funding and resource required. Infrastructure review carried out by DSSR across all sites. Apprx £50k cost
										Weakness of the distribution systems is the change over contactors which connect the electrical load to either the Mains or the standby generators. There are 60 around the LCH site and they cannot be maintained unless the supply is totally disconnected from the electrical supply. These emergency changeover contactors connect the emergency standby generation to the hospital electrical distribution system in the event of mains electrical supply failure. It is not possible to carry out maintenance on these without an interruption to the electrical supply to specific areas of the hospital.	Moderate risk (8-10)	Estates	Ad hoc defects addressed by Estates Team as required. Programme required for replacement of local distribution boards. Programme requirement for replacement of change over contactors with units which comprise a 'by pass' arrangement to enable maintenance to be carried out.	31/12/2019	Est cost £20k per unit. Total cost of appx £700-£800k.
										Potential for extended standby generator usage & disruption to services due to failure of obsolete LV switchgear at LCH. Switchgear is obsolete and spare parts unobtainable. Some 630A Federal Electric Fuse Switches have failed and spare parts are not available. If a failure of similar units occur large sections of the site would be on the standby generator for a considerable time, as a replacement unit is not readily available.	Moderate risk (8-10)	Estates	Old equipment is re-used where possible to maintain services. A portable 630 Switchfuse has been mounted on a frame with cables attached which could hopefully be used to temporarily replace a failed unit whilst a permanent replacement was arranged. Funding required for a replacement programme for switchgear.	31/12/2019	Estimated Cost to initially replace the Main Panel Boards: £300K+vat per unit. Appx 17-2o units in total. £3-£5m Trustwide.
										The majority of the high voltage switchgear and transformers on all three sites are oil filled. The majority of switchgear is over 40 years old and the majority of switchgear in the East Wing is over 25 years old. Generally in industry these are being replaced with vacuum and SF6 switchgear to reduce fire risks due to oil and maintenance costs.	Moderate risk (8-10)	Estates	All switchgear is regularly maintained by specialist high voltage contractor. Funding require for a programme of switchgear replacement.	31/12/2019	Estimated Cost £500k + vat. Pilgrim should be the first site to undertake.

Appendix I - Very high High Corporate Risks (August 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										Potential for disruption to clinical services as a result of Electrical Supply Distribution - Maternity Wing. Switchgear on each floor and sub mains cabling are 45 years old and obsolete. Circuit protection requires upgrading.	Moderate risk (8-10)	Estates	Completely replaced on the 1st floor and 6th floor. Asbestos removals and ceiling replacement will enable access for remedial works to remaining floors. £250k to run electrical system.	31/12/2019	Funding is not in place for a programme of Inspection & Testing of electrical installations so condition of switchgear cannot be rigorously assessed
										Lightning protection inadequately protects the buildings at Lincoln County. This is caused by the age of the buildings and protection systems that do not comply with current standards (BS EN 62305 (2-2006), IEE Wiring Regs 17th). Would lead to an impact/effect on the ability of the buildings to withstand a lightning strike	Moderate risk (8-10)	Estates	Annual inspection carried out by specialist contractor. Funding required to install a compliant Lightning protection system to these buildings.	31/12/2019	Estimated Cost £20k+ VAT.
										Potential for Mechanical & Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	High risk (12-16)	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	31/12/2019	Estimated cost £50k +vat.
										Mechanical & electrical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity	High risk (12-16)	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	31/12/2019	
										X Ray Department at GDH: Need to replace existing heater batteries and control panel with new. Controls are obsolete can no longer maintain. Heater batteries are old and starting to fail and need replacement	High risk (12-16)	Estates	Maintain and inspect on a regular basis. Capital investment required.	31/12/2019	Capital funding applied for.
										Potential for failure of Electrical Infrastructure at GDH resulting in service interruption, fire and closure of clinical services. The site has an aging electrical infrastructure and some of the switchgear is obsolete and in need of replacing. It does not comply with current IET wiring regulations (BS7671). Area affected are:- Tower Block. Rayrole room. Main Switchgear fed from Transformer no 3 (back of Theatres). Main Switchroom outside of ward 6 including Ward 6 Distribution boards. Various Distribution are obsolete and we unable to obtain spare parts for. A&E Endoscopy X-ray Department Theatres Tower Block Out-Patients Medical Physic Pharmacy Rehabilitation	High risk (12-16)	Estates	Capital investment required to upgrade electrical infrastructure at GDH.	31/12/2019	Capital funding applied for.
										High Voltage Switchgear (Switching prohibition) EFN 2016 05 - GDH has a Log and Crawford GF£ High Voltage Fuse Switch that has a switching prohibition on it. which means we cannot operate it. No contingency if this unit fails other than emergency generator which supplies limited outlets.	High risk (12-16)	Estates	Log and Crawford GF£ High Voltage Fuse Switch identified on capital programme for replacement.	31/12/2019	
										Currently one generator provides backup power to ITU (and Endoscopy and Medical air plant) at Pilgrim Hospital during a power cut. Current generator was second hand when installed 4 years ago and has failed previously on start-up. There is the capability on other generators serving critical areas to switch in another generator onto the circuit should one fail but not in this case.	Moderate risk (8-10)	Estates	Option to hire a 2nd generator at approximately £750 per week until a permanent solution is found. A back up generator is required.	31/12/2019	A capital scheme needs to be drawn up to provide further generator back up.
										Generator 1 and 2 contactor panels and associated switchgear are 40 years old and obsolete. These panels switch the generator supply onto load during a power outage to 90% of all clinical areas including the Tower Block, Theatres and A&E. Open design of the electrical panels means it is unsafe to work in panel unless isolated should a failure occur.	High risk (12-16)	Estates	Contactors tested during weekly generator tests. Replace electrical panel (design already provided during the changeover panel replacement carried out in 2015/16).	31/12/2019	No parts available should breakdown occur. New electrical panel required but financial constraint prevents replacement.

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										The majority of the electrical switchgear and distribution boards on the Pilgrim Hospital site are over 40 years old. This is in excess of the recommended replacement age found in HTM06-02. Some of the distribution boards are showing signs of overheating and many boards are full to capacity. Distribution boards do not meet any Form 4 manufacturing standards meaning maintenance is difficult without isolation. Equipment is obsolete.	Moderate risk (8-10)	Estates	Monitoring and inspection of distribution boards on PPM (staff numbers allowing). Carry out audit of switchgear and distribution boards. Replace failing and obsolete equipment.	31/12/2019	
										The LV network within blocks 0A, 0D, 0J, 0W, 0L, 0U, 0T, 0V, 0X and 0Y is full to capacity. The N+1 design capacity of the original installation no longer exists, meaning under HV fault conditions all the hospital load cannot be switched within the LV network to continue supply. There is no capacity for new schemes, etc without investing in extending the HV network and taking some of the load of the existing network and re-supply from extended HV network.	Moderate risk (8-10)	Estates	Smaller schemes requiring power can bring power in from other parts of the site, but the infrastructure cost to this is not insignificant. Increase HV network and load shed existing LV network onto new LV network fed from extended HV system.	31/12/2019	Financial constraints
										There is a risk that communications with ULHT elements at Louth will not work, because the Louth Switchboard (both equipment and cabling) is obsolete and deteriorating rapidly due to age. The impact of this is possible risk of no communication internal and externally between ULHT areas. Additionally, sound quality is poor raising a subordinate risk of errors in clinical care.	High risk (12-16)	Estates	Gap analysis to be carried out, by system owner - Arden GEM. Completing risk assessments to justify cost. Business Continuity plan to be raised. Possible solution for all ULHT areas to buy a phone possible cost of £300 pounds per phone.	31/12/2019	The maintainer (NG Bailey) is currently employing scavenging techniques to carry out repairs due to many of the parts being obsolete. ULHT have no contingency plan.
										Both CT scanners in the x-ray room at Lincoln Radiology are supplied by the same electrical switch and both cardiac rooms are supplied by another electrical switch. In order for any maintenance on these switches to occur or a failure in either switch would result in loss of power to either both CT scanners or both cardiac rooms at the same time.	Moderate risk (8-10)	Estates	To explore the possibility of changing the arrangement to the CT and Cardiac labs, so that 1 CT and 1 Cardiac lab are on one circuit and vice versa. This would provide some resilience to the trust.	31/12/2019	Engineers to carry out a feasibility study for these works.
										Transformer No 3 is exhibiting signs of overloading - the oil has had to be changed twice in the last 5 years and stem seals split in October 2017 resulting in a power loss to the Boiler House and Estates, X-ray, Education Centre, critical water plant and part of Outpatients. This is partly caused by the CHP back-feeding excess power during periods of low demand overloading the transformer. The transformer is 50 years old and parts are obsolete. It is also inefficient compared to new transformers. Cannot monitor oil levels 24/7. If another fault develops then it is possible that the transformer cannot be repaired. 8 to 12 week wait for replacement transformer to be installed if required.	Moderate risk (8-10)	Estates	Monitor transformer with 6 monthly oil condition tests. Request run time of CHP to be stopped overnight to reduce overload during this period. Check transformer oil levels. Power supply can be resumed during a failure with switching routine and move load to transformer No.4 but only for a relatively short period of time. Replace transformer No.3.	31/12/2019	
3721	**Critical failure of the mechanical infrastructure (corporate)** If the Trust experiences a critical failure of its mechanical infrastructure (including ventilation, steam, cold water, heating, medical gas pipeline systems and lifts); Caused by issues with the age and condition of the infrastructure and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.	Boocock, Paul	Service disruption	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (16)	Mechanical Infrastructure Group	Moderate risk	31/10/2019	Lift controls for lifts 9 & 10 at LCH are obsolete and the excessive heat in the motor room if affecting the ride quality of the lift. Risk to patients and visitors of malfunctioning lift.	Moderate risk (8-10)	Estates	Regular inspection and maintenance of lifts at LCH. Service contract in place. Price received to replace controllers: £30K + VAT.	31/03/2019	
										Mechanical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity.	High risk (12-16)	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	31/12/2019	
										Potential for Mechanical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	High risk (12-16)	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure: estimated cost £50k +vat.	31/12/2019	
										Potential for plant failure for Medical oxygen for all sites.	High risk (12-16)	Estates	Consider provision of a further VIE at a separate location, which would provide site resilience in the event of plant failure to original medical oxygen unit. Regular PPM and reactive maintenance.	31/12/2019	
										At Grantham Hospital, vital transportation of samples and other items around the site via the airtube system may not be possible due to the need to continue upgrading programmer to maintain the capacity of the system. Main controller is obsolete and requires replacement.	High risk (12-16)	Estates	Monitoring and continuous repair. Partial replacement of air tube stations, as and only when funding becomes available. Replacement controller added to Capital / Backlog Maintenance List.	31/12/2019	50% of stations have been replaced.

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										Maternity Lifts at Pilgrim are in poor condition and in need of further refurbishment /replacement. Risk of failure whilst in use and unavailability.	High risk (12-16)	Estates	Capital and revenue investment to refurbish Maternity lifts at Pilgrim. Safety checks in place supplementary inspections in place Comprehensive maintenance contract in place. Use of alternative lifts available.	31/12/2019	
										Mechanical ventilation (Air Handling Units) within the Maternity Wing at LCH is 45 years old and should be considered for replacement. The ductwork systems within the building have not been internally cleaned since installation due to cost and logistical constraints.	Moderate risk (8-10)	Estates	Replacement programme required for air Handling Units across the LCH site. Ductwork cleaning programme required. Estimated Cost £100k+vat Ad hoc cleaning takes place when areas have be upgraded and access was possible. Planned Maintenance carried out on AHU's.	31/12/2019	
										Potential Loss of the medical air to ICU, HDU, Cath Lab 1&2, A&E, Interventional Suite X Ray, Oncology Unit, Cardiac Short Stay at LCH. The current plant does not meet HTM02-01 recommendations, the plant is 12 years old and the manufacturers recommend a service life of 10 to 15 years.	Moderate risk (8-10)	Estates	Recommend as a minimum to install an additional air compressor to upgrade the current plant at LCH to a triplex configuration (three compressors) cost circa £22k. Replace air plant with a new triplex (three compressor) plant as recommended by the current HTM02-01, cost circa £100k together with a large cylinder backup. Increase the necessary number of back up cylinders to maintain 4 hours recommendation as per HTM02-01. Ensure our cylinder supplier (BOC) has the resources to have the required backup cylinders on site if needed and within a timely timescale.	31/12/2019	We have been informed by BOC that they can deliver cylinders to site within 4 hours including out of hours working).
										Medical Gas alarms at Pilgrim are obsolete and cannot be upgraded.	Moderate risk (8-10)	Estates	Ensure all alarms are linked to BMS system. Consider duplex panel. Funding required.	31/12/2019	£20k + VAT identified on the capital programme.
										Potential for a severe leak of heating and hot water service due to the poor condition of plastic pipework at Pilgrim. Plastic Pipework in very poor condition. Severe water leak will cause loss of heating and hot water services. Several leaks have occurred in the past.	High risk (12-16)	Estates	£50k + VAT identified in the capital plan to replace the plastic pipework at Pilgrim. Subway inspections and planned maintenance.	31/12/2019	There will be some disruption to services to allow the work to go ahead.
										Mechanical Services Valves at GDH are all of varying ages and some are over 50 years old and are no longer serviceable and are beyond economic repair. Unable to satisfactorily isolate services for maintenance. Causes isolation of large areas, wastes water and causes disruption and inconvenience to wider areas of the hospital.	Moderate risk (8-10)	Estates	Year on year replacement programme is required. Use of pipeline freezing techniques if possible.	31/12/2019	
										Existing gas main at LCH runs from maternity wing subway underground across the site under the corridor to clinic 9 was installed to feed additional areas and is grossly oversized. Risk of leaks due to age and possible condition and it is difficult to identify leaks due to limited use. It is also current guidance that natural gas pipes DO NOT pass beneath buildings.	High risk (12-16)	Estates	Disconnect the gas pipeline at LCH at the valve which is located within the Maternity wing subway and install a local Propane manifold within the courtyard adjacent to the Dental Department. Estimated Costs £5K +vat.	31/12/2019	
										Old maternity block at GDH houses 2 Wards and management offices and is serviced by 2 lifts. 1 lift has had a new motor fitted in 2015. The remaining lift is of the same age. If this lift fails then we will not be able to service 2 Wards(food, patient moves, patient admissions etc).	High risk (12-16)	Estates	Prioritisation of capital for refurbishment of lifts in old maternity block at GDH. Fully comprehensive service/maintenance contract. Defects reported on Micad and a trapped person procedure. Lift failsafe system.	31/12/2019	
										Frost batteries located within the air handling units in plant rooms 3, 9 and 10 and heater batteries in plant room 13 at LCH do not have the capacity to cope with extremely low ambient temperatures as experienced during the winter of 2010/11.	Moderate risk (8-10)	Estates	Funding required to replace frost batteries located within the air handling units at LCH with units of larger output. Estimated Cost £40K +vat.	31/12/2019	
										Medical Vacuum Plant Located in Plant Room 1 at LCH. Supplies 10 East Wing Operating Theatres, 9 wards, OPD Clinics and 4 X-ray rooms. Plant is 25 years old. Does not conform to current HTM 02-01. Replacement parts increasingly difficult to obtain. If it failed this would cause major disruption to the areas outlined above.	Moderate risk (8-10)	Estates	Replace Medical Vacuum Plant Located in Plant Room 1 at LCH with unit compliant with HTM 02-01 . Estimated Cost £55k +vat	31/12/2019	

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										Seized and Defective Isolation Valves on Mechanical Services at LCH. Risk of interruption to clinical services due to access to isolate services for maintenance.	Moderate risk (8-10)	Estates	Rolling programme required to replace Seized and Defective Isolation Valves on Mechanical Services at LCH. Use pipeline freezing techniques if possible.	31/12/2019	
										The theatres infrastructure on at least the Lincoln and Pilgrim sites needs to be reviewed in light of primary services: i.e. electrical supply / medical gases / air exchange. As new technology is introduced the loading on individual circuits is closing in on the circuit limits. Air exchange plant is running at its maximum. The provision of medical gases is stretched.	Moderate risk (8-10)	Estates	Clinical Strategy to be in place. Appoint design consultants. Map clinical requirements to functional space and engineering requirements. Produce strategy & design. Commission / construct new theatre installation.	31/12/2019	Establishing capacity within Theatres to enable design of fit for purpose infrastructure.
										Potential for failure of air conditioning plant which affects large parts of the Tower Block at Pilgrim.	Moderate risk (8-10)	Estates	Perform site survey. Allocate funding through the Facilities Capital allocations.	31/12/2019	Need to repair defective plant, (£5,000 committed to date).
										Obsolete controls to the Ventilation system within Maternity at Lincoln. The Heating and Ventilation system controls are obsolete and functionality limited. Not energy efficient and provide little or no control of temperature within Maternity Wing including Labour Ward Operating Theatre No. 1.	Moderate risk (8-10)	Estates	1. Survey of the ventilation system within Maternity at Lincoln needs to be carried out to determine the correct contract strategy. 2. Replacement programme implementation (The presence of Asbestos Containing Materials - ACM's would present difficulties). Funding required to replace existing defective and obsolete controls. Estimated Cost £30k + VAT.	31/12/2019	
										Ambulatory Care at LCH - Heating Calorifier. Only 1 unit installed. There is no means of heating the ward if this fails.	High risk (12-16)	Estates	Funding required to install additional plate heat exchangers (duty and standby) for Ambulatory Care at LCH. Estimated cost £ 80k +vat.	31/12/2019	
										Heating Pipework for Robey House at LCH is steel and is suffering from a build up of internal deposits which cause lack of circulation and therefore heating.	Moderate risk (8-10)	Estates	Replace heating system within Robey House at LCH, est £80k +vat.	31/12/2019	Some sections of ground floor pipework replaced as part of Trust Board move into this building.
										Physiotherapy Heating Calorifier at LCH is 40 years old, labour intensive to maintain and not energy efficient. Not duplex so service vulnerable if this one fails during period of very cold weather.	Moderate risk (8-10)	Estates	Funding required to install plate heat exchangers for Physiotherapy Heating Calorifier at LCH. Estimated costs £80k +vat	31/12/2019	
										Maternity Wing Drains at LCH are susceptible to blockages caused by the condition and capacity of the drains. The drainage system within the Maternity Wing is subject to higher frequencies of blockages due to capacity and condition of the drainage system. In addition users are placing inappropriate items down toilets and the presence of Asbestos Containing Materials (ACM's) present difficulties in accessing large sections of the drainage system.	Moderate risk (8-10)	Estates	Business Case to be developed for a drainage replacement programme for the Maternity Wing at LCH. Estimated Cost £200k + VAT	31/12/2019	1. Some sections have been replaced. 2. Sewage spillages are managed as they occur using agreed procedures. 3. Signs are placed adjacent to each toilet to request users not to place inappropriate items in them.
										The lifts at Lincoln County may not function correctly. This is caused by out of date components and inadequate control circuit configurations on lifts that are 20 - 25 years old this would lead to an impact/effect on Lift no. 1-6 and Lifts 9-11 in terms of overheating, fire risk and poor reliability.	Moderate risk (8-10)	Estates	Funding required for lifts at LCH. --Lifts 1-6 replace control panels at £8k each (total £48k) Replace car top controls at £900 each (total £5.4k). Replace door operator at £4.6k each (total £27.6k). Lifts 9-11 - replace control panels at £8k each (total £24k). Replace car top controls at £900 each (total £2.7k).	31/12/2019	Quotes received from Stannah Lifts.
										Contaminated Medical Vaccum Pipework resulting from upgrading and new plant fitted within the Maternity Unit	Moderate risk (8-10)	Estates	Remove the old plant and pipework from the Boiler house complex to the Maternity Wing Ground Floor. Quote obtained.	31/05/2019	
3951	**Compliance with regulations & standards for aseptic pharmacy services (corporate)** If the Trust is found by a regulator to be systemically non-compliance with regulations & standards for aseptic pharmacy services; Caused by fundamental issues with the design or application of local policies and procedures, or the quality of the facility; It could result in regulatory intervention that forces immediate closure of the facility and suspension of services, impacting on a large number of patients, services and other service providers.	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (16)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	Pilgrim Hospital ASU does not comply with national and EU standards: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	31/12/2020	Business Case in development, to be presented to Trust Board in October 2019.

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										Aseptic preparation services must have adequate resources to ensure compliance with the defined national standards as described in Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic preparation time has increased due to changes in aseptic services standards (addition of an extra disinfection stage and use of a sporicidal agent with an increased contact disinfection time).	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a service that complies with QAAPS standards. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
4497	**Contamination of aseptic products (corporate)** If the products supplied by the Trust's aseptic pharmacy services were to become contaminated; Caused by issues with hygiene standards at the production facility, or user error; It could result in significant harm and potentially the death of multiple patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS) regulatory stndards. Aseptic pharmacy lead. QAAPS states that aseptic capacity should not exceed 80%. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (15)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	Due to the current state of the infrastructure in Lincoln, and the potential risk of contamination, the Lincoln Pharmacy ASU is not fit for purpose.	High risk (12-16)	Pharmacy	Closure of the Lincoln Pharmacy ASU to avoid the risk.	28/02/2018	Lincoln Pharmacy ASU has been closed.
										Most aseptic processes are operator dependant. This means that when overcapacity there is an increased risk of calculation errors or producing contaminated products. Whilst air pressure monitoring will highlight the risk of contamination it does not give information on the actual risk. Microbial plates take 2 weeks to provide results, therefore any potentially contaminated products cannot be identified until after they have been issued and administered to patients. This is because the aseptic unit operates under Section 10 exemption from the Medicines Act and is not licensed. There is therefore no batch manufacturing and no associated quality control of batch manufactured products which would otherwise enable microbiological and chemical stability testing to take place.	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a safe service and achieve capacity levels of under 80%. CSS Division to identify resources for additional staff required. Frequent activation of BCP paces additional workload strain on staff, which further increases the associated risks. This is only sustainable for a short period of time.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
										The current condition of the aseptic facility at Pilgrim Hospital is inadequate, which increases the risk of contamination: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Implementation of a sustainable and fit for purpose aseptic services facility at Pilgrim Hospital.	31/12/2019	Business Case in development, to be presented to Trust Board in October 2019.
4300	**Availability of medical devices & equipment (corporate)** If the Trust's is unable to maintain the availability of essential medical devices and equipment; Caused by issues with capital and / or revenue planning, procurement and delivery processes or the availability of sufficient funding and resources; It could result in widespread disruption to clinical services across one or more divisions, reducing productivity and impacting on the experience of multiple patients.	Hepburn, Dr Neill	Service disruption	Very high risk	Capital and revenue planning processes. Procurement, delivery and contract management processes. Medical Device Group operational oversight. Medical device & equipment inventory. Clinical Engineering Services and Estates & Facilities equipment maintenance programmes & repairs capability. Business continuity / contingency plans for reduced availability of devices & equipment. CAS Alerts processes for managing device safety issues. Datix incident reporting & management processes for incidents.	High risk (12)	Patient Safety Group	Low risk	30/09/2019	Trust-wide issues with the availability of suitable equipment (e.g. beds / trolleys; wheelchairs; weighing scales; blood pressure cuffs) and appropriate policies, procedures & pathways supported by training for the safe care of bariatric patients.	High risk (12-16)	Corporate Nursing	To review and update where necessary policies, procedures and relevant pathways to improve the safety of care for bariatric patients across existing policy areas, including: moving & handling policy; Theatres - procedures on trolleys / tables; observation policy (e.g. right size cuff to take blood pressure); A&E; outpatients.	31/12/2019	Working group set up, involving corporate nursing, health & safety & risk, to identify required improvements.
										Lack of a centralised database for all medical devices; some records are held locally.	High risk (12-16)	Clinical Engineering	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	30/11/2019	MDSG has agreed on MEMS as the centralised medical equipment management database. Divisional engagement is underway.
										Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control.	High risk (12-16)	Clinical Engineering	Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT.	31/12/2019	BC developed and approved in principle by CRIG

Appendix I - Very high High Corporate Risks (August 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4041	**Safe and responsive delivery of Non-Invasive Ventilation (NIV)** If there are delays in the identification or treatment of patients requiring or receiving Non-Invasive Ventilation (NIV) within the Trust; Caused by issues with staffing capacity or capability, equipment availability, bed availability, the design or application of systems and processes; It could result in severe, permanent harm or the death one or more patients.	Rhodes, Michelle	Harm (physical or psychological)	Very high risk	Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting. Governance arrangements within Medicine Division. National & local audits of compliance with best practice guidelines. NIV Quality & Safety Improvement Group established with membership from Respiratory teams from all 3 sites. Carlton-Coleby Ward (LCH) is established for 4 NIV beds, with 6 NIV machines (4 installed 2009; 1 in 2011; 1 in 2018). Ward 7B (PHB) is established for 2 NIV beds, with 4 NIV machines (2 installed in 2007; 1 in 2017; 1 in 2018). Additional NIV machine available in Clinical Engineering if needed. Acute Care Unit at GDH is established for 3 NIV beds. Escalation process in place. Authorisation to increase staffing capacity through the use of Bank, overtime and agency. Oxygen saturation monitoring in place and cardiac monitoring can be accessed via the Outreach Team if any concerns re potential arrhythmia. Trust-wide staff competencies for NIV. Safecare Live system used to record patient acuity. 1x NIV-skilled nurse per shift in all areas where NIV is provided.	High risk (12)	Patient Safety Group	Low risk	30/09/2019	1. Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. 2. NIV may be the ceiling of care which would deem a patient not suitable for admission to an ICU bed; if a patient were then admitted to ICU it may be unsuitable for the patient and would be in breach of Critical Care Network agreed policies. 3. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. 4. Recruitment of nurses with required skills to vacancies on Ward 7B (PHB). 5. Inconsistent adherence to the NIV Care Pathway.	High risk (12-16)	Respiratory Medicine	1. SOP to be developed for commencement of NIV in Emergency Departments. 2. Escalation Process for Ward Based NIV Capacity developed. 3. Capacity & demand being reviewed with the aim of increasing established, trained staff levels. 4. On-going competency training in place for all nurses. 5. NIV to review audit results and agree appropriate action.	31/03/2020	Action plan kept under regular review by he NIV Group, which meets quarterly. Next meeting September 2019.
4081	**Quality of patient experience (corporate)** If multiple patients across a range of the Trust's services have a poor quality experience; Caused by issues with workforce culture or significant process inefficiencies and delays; It could result in widespread dissatisfaction and a high volume of complaints that leads to a loss of public, commissioner and regulator confidence.	Rayson, Martin	Reputation / compliance	Very high risk	Patient Experience Strategy and Workplan; Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments); Patient Experience training (leadership development programmes).	High risk (12)	Patient Experience Group	Low risk	31/08/2019	Staff engagement & ownership of patient experience feedback, staff morale and staff shortages; lack of pride or hope in working at ULHT translated as low energy and passion; communication features highly as a negative indicator within feedback; staff lacking awareness of the 'impact of self'; staff do not feel valued; workload and demand gives little time to provide the care to the standard aspired to leaving staff disappointed and dissatisfied.	High risk (12-16)	Human Resources	Deliver against Patient Experience workplan; provide service and divisional level patient experience reports that are useful, timely and meaningful, secure a FAB Experience champion in every directorate; promote & spread Academy of FAB NHS Stuff to highlight FAB patient experience quality projects and achievements - spreading celebration and enthusiasm to rebuild motivation and hope and passion; determine links between staff and patient experience and drill down to team level to support improvements and interventions; provide data that delivers confidence that this is what staff and patients are saying about their experience within that service - and then support that service to design and deliver improvements.	30/09/2019	
4142	**Safe delivery of patient care (corporate)** If there are multiple patient incidents throughout the Trust; Caused by fundamental issues with the safe and consistent application of clinical policies, procedures, guidelines or pathways; It could result in significant harm caused to a large number of patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG) & sub-groups: - Harm Reduction Group - Radiation Protection Group - Deteriorating Patient Group - Medical Devices Group - Hospital Transfusion Group - Nutrition Group Divisional Clinical Cabinets & CBU / specialty governance arrangements. Clinical staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes (including Safety Thermometer). Quality Matron team and specialist nurses (Tissue	High risk (12)	Patient Safety Group	Low risk	30/11/2019	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	High risk (12-16)	Corporate Nursing	Design & introduce refined policies and processes for the identification of & response to deteriorating patients.	30/09/2019	Regular progress reporting through Quality & Safety Implementation Group (QSIG).
										Inconsistent levels of compliance with the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs), particularly outside of the operating theatre environment, which increases the likelihood of a Never Event occurring.	Moderate risk (8-10)	Quality & Compliance	Conduct an initial review of compliance with LocSSIPs to identify areas for improvement.	31/10/2019	
										Development of the WebV system for handover has been delayed due to lack of dedicated project manager; potential adoption of the Nervecentre system is not possible until 2021. Presently there is no Trustwide handover IT system in place.	High risk (12-16)	Information & Communications Technology	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	31/03/2020	Associate Director of ICT to be invited to PSG in August to discuss project management options.
										Inconsistent application of clinical pathways and guidelines for pneumonia, leading to increased mortality risk.	Moderate risk (8-10)		Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	31/03/2020	Business case in development for audit function.
4145	**Compliance with safeguarding regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Rhodes, Michelle	Reputation / compliance	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	High risk (12)	Safeguarding Group	Low risk	30/11/2019	Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.	Moderate risk (8-10)	Safeguarding	Increase visibility of the Safeguarding team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored.	30/11/2019	Lead professional for MCA reports that although MCA audits continue to show areas of concern they are showing a significant increase in knowledge and compliance. This is supported by CCG and CQC feedback. There remains some cases where there is clear evidence of lack of compliance with policy for example SI investigation. Monitoring will continue through audit and review of incidents, complaints and concerns. On this basis risk reduced to moderate.
										Not yet consistently achieving 90% compliance with safeguarding training requirements.	Moderate risk (8-10)	Safeguarding	Confirm that safeguarding training completion continues to be included in performance framework with compliance reviewed and managers held to account through operational performance management reviews; individual accountability to be managed through appraisal process.	30/11/2019	9/8/19 Training compliance is consistently not achieving the 90% trajectory. Monitoring and reporting of this will continue through Safeguarding Group.

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.	High risk (12-16)	Safeguarding	Areas for more efficient working to be identified and improvements implemented; progress work to develop an integrated Safeguarding model for Lincolnshire that will deliver optimum benefits for Safeguarding across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority.	30/11/2019	Different models of working being explored. 9/8/19 -Additional temporary support is in place to support work required from the team. Will require a sustainable plan to meet the recommendations with in the Intercollegiate staffing guidance.
4146	**Effectiveness of safeguarding practice (corporate)** If there is a significant, widespread deterioration in the effectiveness of safeguarding practice across the Trust; Caused by fundamental issues with the design or application of local policies and protocols; It could result in multiple incidents of significant, avoidable harm affecting vulnerable people in the care of one or more directorates.	Rhodes, Michelle	Harm (physical or psychological)	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Mandatory safeguarding training (role-based) as part of Core Learning. Safeguarding Committee & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing. Learning Disability Mortality Review process (LeDeR). Safeguarding Statements of Intent (covering access to services by children, young people & adults as well as modern slavery & human trafficking).	High risk (12)	Safeguarding Group	Low risk	30/11/2019	Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration.	High risk (12-16)	Safeguarding	Develop & roll out clinical holding training for identified staff Trust-wide. Introduce debrief process. Identify trends and themes through incidents reported on Datix. Monitor training compliance rates. Introduce audit of 5 security incidents per month from September 2018. Review of chemical sedation pathway.	30/11/2019	9/8/19 Clinical Holding Level 4 training (2 day)compliance at 69% from staff identified as requiring training as virtue of their role would be responders to urgent assistance calls. In addition staff from other roles such as portering/security ,safeguarding and training have attended. 67% of identified staff have attended the level one day training. Further training dates are available and training needs analysis being refreshed to reflect staff changes and to establish if any further courses require commissioning. Outstanding staff will be monitored on an individual basis to prioritise booking and completion. Learning events/debrief process provide scrutiny(in place of audit of 5 security incidents per month).Safeguarding team are alerted to datix incidents from security or involving vulnerable patients. Monthly chemical sedation audits continue to be undertaken by Safeguarding team and show improvements in compliance.Process in place for clinical areas to escalate to Matron when chemical restraint has been used to allow for review of episode of care. Rapid Tranquilisation policy has been reviewed
										The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.	High risk (12-16)	Safeguarding	Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group to scope extent of issues and to progress pathway development.	30/11/2019	Draft pathway developed and under consultation. 9/8/19 Plan for key stakeholders to meet to agree pathway prior to submission to CESG for approval.
										There is no mandatory, core learning or core learning plus formal training programme provision within the Trust for: 1. Mental Health - awareness; responsibilities in relation to administering the Mental Health Act, ligature risk 2. Learning disability - awareness, care in hospital and reasonable adjustments 3. Autism - - awareness, care in hospital and reasonable adjustments	Moderate risk (8-10)	Safeguarding	1. Liaise with training and development department to resubmit applications for core learning. 2. Liaise with clinical education department to determine numbers and reach of HEE funded programme. 3. Refresh training needs analysis to incorporate Autism developments. 4. Ensure reflected within MHLD&A Strategy and associated work-plan.	30/11/2019	Mental Health Awareness Core learning training developed and available from 1st July 2019. As of 25th July 2019 49.66% of required staff had completed it. Compliance and impact will be monitored through MHLDA group. Update reports received by Safeguarding Group.
										Children and young people (under 18) may be admitted to an adult inpatient ward, where there is a lack of specialist paediatric care and equipment available, such as paediatric resus trolleys. The current mechanism for real time alerting to safeguarding if staff fail to follow the current policy & do not complete the necessary risk assessment is not reliable (either ad hoc or retrospectively through incident reporting); this impairs the ability to respond in a timely manner to the needs of children & young people to ensure they receive appropriate care from appropriately trained staff in the right environment. Only areas that regularly care for children receive Level 3 child safeguarding training (others received L2). It is also not clear if an emergency call for a child on an adult ward would be responded to by paediatrics on-call. Paediatrics are not routinely involved in bed management meetings in order to be made aware of outliers.	High risk (12-16)	Safeguarding	To review and update the existing policy for admission of 14-18 year olds to adult inpatient areas, so that anyone under 16 must be admitted to a paediatric ward (unless they strongly object, fully aware of the risks). Those aged 16-17 to be given the choice, once made fully aware of the risks. Risk assessment to be reviewed. Potential for enhancements to patient administration systems to be considered to reinforce policy. Engagement of paediatrics with bed management meetings to be introduced.	31/03/2020	Action plan to be reassigned to appropriate lead once in post.

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4156	**Safe management of medicines (corporate)** If there are multiple, widespread failings in the safe management of medicines across the Trust; Caused by issues with the design or application of medicines safety policies and procedures; It could result in multiple incidents of significant, avoidable harm to patients in the care of one or more directorates.	Costello, Colin	Harm (physical or psychological)	Very high risk	Medicine safety policies & procedures. Medicine management governance arrangements (including audit & performance monitoring). Medicine safety training & education programmes. Pharmacy support and advice service. Pharmacy facilities & specialist equipment. Incident reporting and investigation systems & processes (Datix).	High risk (12)	Medicines Optimisation & Safety Group	Low risk	30/09/2019	The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.	High risk (12-16)	Pharmacy	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	31/03/2020	
										Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.	High risk (12-16)	Pharmacy	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	31/03/2019	
										The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.	High risk (12-16)	Pharmacy	Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency - ward monitoring of temperatures & escalation of issues.	31/12/2019	
										Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	Very high risk (20-25)	Pharmacy	Temperatures of refrigerated medicinal products to be monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased.	31/03/2019	
										Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Moderate risk (8-10)	Pharmacy	Risk regarding unsecure storage and stock accountability of medical gas cylinders at all sites to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	30/06/2019	
4157	**Compliance with medicines management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Costello, Colin	Reputation / compliance	Very high risk	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Mandatory medicines management training as part of Core Learning for clinical staff. Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.	High risk (12)	Medicines Optimisation & Safety Group	Low risk	30/09/2019	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	High risk (12-16)	Pharmacy	Planned introduction of an auditable electronic prescribing system across the Trust.	31/03/2020	
										Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	High risk (12-16)	Pharmacy	The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	30/06/2019	
										Administration of medication by pharmacy technicians including oral, intravenous, NG and PEG - legislation, governance and training issues. The Medicines Regulations 2012 specified that parenteral products can be legally administered by persons acting under the instruction of a legally valid appropriate prescriber (as shown in Regulation 214). Pharmacy technicians could also adopt this role in clinical areas in the Trust. However, his practice has not been approved and accepted by the Trust and is not embedded into the Medicines Management policy.	High risk (12-16)	Pharmacy	To define the process for administration of medicines by pharmacy technicians and their supervision and training. To embed the process in the Medicines Management Policy.	30/09/2019	
										There is not full assurance that the new pharmacy technician roles and practices are acceptable in terms of professionally registered practice and that professional codes of practice are being correctly adhered to.	High risk (12-16)	Pharmacy	To establish the professional supervision and development of the new roles. To take advice from the General Pharmaceutical Council (GPhC) and NHSI to ensure the new roles are covered by the relevant professional codes of practice.	30/09/2019	
4476	**Compliance with clinical effectiveness regulations & standards (corporate)** If the Trust is found to be systemically non-compliance with regulations and standards for clinical effectiveness; Caused by fundamental issues with the systems and processes used for managing clinical audits, policies, guidelines and best practice; It could result in a significant loss of confidence amongst a large number of patients as well as commissioners, regulators and the general public which may lead to regulatory action and sanctions.	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Clinical governance arrangements in place at corporate level: Quality & Safety Oversight Group (QSOG) / Clinical Effectiveness Group. Clinical policies, guidelines and best practice management processes. National clinical audit programme management processes. Local clinical audit programme management processes.	High risk (12)	Clinical Effectiveness Group	Low risk	30/11/2019	Infrastructure is in place for divisional management of clinical policies; guidelines; best practice and clinical audit. Issues with time allocation within job plans for divisional leads to deliver against requirements.	High risk (12-16)	Quality & Compliance	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	31/03/2020	Report template in development.
										Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	Moderate risk (8-10)	Quality & Compliance	Integration of routine oversight of clinical effectiveness as part of the divisional Performance Review Meeting (PRM) process through the introduction of appropriate KPIs.	31/03/2020	
										Insufficient staffing resources within the established Clinical Effectiveness central support team.	High risk (12-16)	Quality & Compliance	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	31/12/2019	

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
3503	**Sustainable paediatric services at Pilgrim Hospital, Boston (Children & YP CBU)** If the Trust is unable to maintain the full range of paediatric services at Pilgrim Hospital, Boston; Caused by issues with the recruitment or retention of sufficient numbers of staff with the required skills and experience; it could result in extended, unplanned closure of the service or significant elements of it, impacting on the care and experience of a large number of patients and on the provision of interdependent services across the region.	Joachim, Suganthi	Service disruption	Very high risk	Workforce planning systems & processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.	High risk (12)	Family Health Clinical Cabinet	Low risk	30/09/2019	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	High risk (12-16)	Paediatric Medicine	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	30/03/2020	
										Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	High risk (12-16)	Paediatric Medicine	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	31/03/2020	
										Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown).	High risk (12-16)	Paediatric Medicine	Development of sustainable long-term model for paediatrics at PHB, through the STP.	31/03/2020	
4423	**Working in partnership with the wider system (corporate)** If the Trust fails to work effectively in partnership with the wider system, including other healthcare providers and commissioners; Caused by issues with the planning process, the availability of sufficient resources or the effectiveness of partnership governance arrangements; It could result in significant disruption to the provision and sustainability of multiple services that has a long term impact on the experience and quality of care for a large number of patients.	Turner, Kevin	Service disruption	Very high risk	Sustainability & Transformation Partnership (STP), including ULHT; LCHS' LPFT; & others. STP partnership governance arrangements. STP planning & delivery mechanisms. Lincolnshire Coordinating Board (including chairs of each partner organisation).	High risk (12)		Low risk	30/09/2019	Failure to work effectively in partnership may result in some ULHT services having demand that exceeds capacity; failure to work with other providers and CCGs may also result in the viability of ULHT services being jeopardised. Failure to progress on taking forward the Acute Services Review may result in some existing fragile services failing, or some services becoming fragile.	High risk (12-16)	Strategy & Change	Re-assessment of strategic risk and development of appropriate mitigations.	31/03/2020	Continued engagement with the STP delivery process through established governance arrangements.
4179	**Major cyber security attack (corporate)** If the Trust is subject to a major cyber security attack that breaches its network defences; Caused by the exploitation of an existing vulnerability or the emergence of a new type of threat; It could result in loss prolonged, widespread loss of access to ICT systems throughout the Trust which disrupts multiple services and affects a large number of patients and staff.	Humber, Michael	Service disruption	Very high risk	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital (CareCerts) ICT hardware & software upgrade programme. NHS Data Security Protection Requirements (DSPR). Corporate and local business continuity plans for loss of access to ICT systems. Mandatory major incident training for all staff (part of Core Learning). Installation of Site based Firewalls with full Traffic inspection enabled.	High risk (12)	Information Governance Group	Low risk	10/10/2019	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Moderate risk (8-10)	Information & Communications Technology	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	12/09/2019	The DPST was updated nationally to include the requirements of Cyber Essentials and other national requirement's. The Trust is working towards meeting this for march 2020 return.
										Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.	High risk (12-16)	Information & Communications Technology	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	11/09/2019	For financial year 19/20 no Trust capital has currently been provided to any Business as Usual schemes. Affecting the ability to continue in delivery schemes Move forward with in plan schemes Delays will affect the strategy as attack vectors and methods are constantly evolving
										Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Moderate risk (8-10)	Information & Communications Technology	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	11/09/2019	The BCP and Disaster plan has been updated A test of the plan is scheduled for the 31st July 2019, to desktop test the current plan.
4437	**Critical failure of the water supply (corporate)** If there is a critical failure of the water supply to one or more of the Trust's hospital sites; Caused by the age and condition of water pipes, or a major incident which damages the infrastructure; It could result in significant, prolonged disruption to multiple services throughout the site, impacting on the experience and care of a large number of patients and the productivity of a large number of staff.	Boocock, Paul	Service disruption	Very high risk	Estates Investment & Environment Group oversight. Water Safety Group operational governance. Capital & revenue prioritisation & investment procedures. Planned Preventative Maintenance (PPM) programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Appointed Authorising Engineer (Water). Emergency & business continuity plans for infrastructure failure / evacuation / relocation.	High risk (12)		Low risk	31/10/2019	The cold-water supply pipe work on all floors of the Maternity Wing at LCH is of varying sizes and manufactured from PVC. It has been in place since the construction of the building (approaching 45 years) Over time there have been a number of failures. This has been apparent at pipe work junctions and joints, and is probably as a result of adhesive degeneration. Similarly, with age, the pipe works ability to expand and contract has been reduced and the resulting 'brittleness' of the installation is increasing the risk of failure which could result in serious service interruption and contamination of other services and equipment, resulting in potential for injury and disruption to patient care.	Moderate risk (8-10)	Estates	Funding required for refurbishment of water systems throughout the Maternity Wing (estimated Cost £3M +Vat). A robust defect reporting system is in place.	31/12/2019	
										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.	High risk (12-16)	Estates	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	31/12/2019	Scheme of work and design currently being produced.
4467	**Impact of a 'no deal' EU Exit scenario (corporate)** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust.	Turner, Kevin	Service disruption	Very high risk	Dep Ch Exec appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables	High risk (12)		Low risk	31/10/2019	The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	High risk (12-16)	Pharmacy	Completion of all required actions in respect of medicines and vaccines, as detailed in the national EU Exit guidance. Specific instruction not to stockpile medicines or to prescribe extra medicines.	31/12/2019	Current Pharmacy stock holding of around 27 days. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. Options to manage the impact of the current recruitment freeze on staffing capacity in Pharmacy procurement to be considered.

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
					- medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT EU Exit Planning Group: - local risk assessment, covering: potential demand increase; supply of medicines, medical devices & clinical consumables; supply of non-clinical goods & services; EU workforce; reciprocal healthcare; research & clinical trials; data sharing & security.					The supply of medical devices & clinical consumables may be disrupted in the event of a 'no deal' EU Exit. Some parts for diagnostic machines used in Radiology & Cardiology (Cath Lab imaging systems; MRI compatible monitors – two out of support monitors, two MRIs) are obtained from Germany, which may lead to delays in fulfilling orders. There are BC plans in place, including back-up machines and some spare parts held, but not all possibilities can be covered. Availability of single-use consumable accessories for medical devices that are used constantly across the trust is also of concern.	Moderate risk (8-10)	Finance	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments. Concern that we do not have assurance about plans to manage the traffic impact of Immingham being opened up to increase port capacity – to be escalated through SCG to the Dept of Transport/Highways Agency.
										The supply of non-clinical goods and services may be disrupted in the event of a 'no deal' EU Exit. There are some concerns regarding the supply of food, as 30% comes from the EU and import delays would affect perishable goods.	Low risk (4-6)	Finance	Completion of all required actions in respect of non-clinical goods and services, as detailed in the national EU Exit guidance. The DHSC has issued updated guidance on supply of food, advising a common sense approach in the event of short-term shortages.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments.
										The supply of workforce may be disrupted in the event of a 'no deal' EU Exit. Concern emerging that under a 'no deal' scenario a DBS check for a European national maybe subject to a long delay.	Moderate risk (8-10)	Human Resources	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	31/12/2019	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Awaiting further guidance regarding professional registration. Agencies may also be reliant on EU workforce - risk assessment requested from Holt. HR to liaise with agencies providing medical staff to assess any risks throughout the EU Exit period. To consider the possibility of cancelling annual leave during the EU Exit period if planned staffing levels are not sufficiently robust.
										Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	31/12/2019	Need to understand the scale of risk, to ascertain how many patients would suddenly have to pay if reciprocal arrangements cease and who would not qualify; to pull together resource plan to meet the requirements to charge EU citizens following UK Exit.
										Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Research and Development	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	31/12/2019	All sponsors are UK-based and actively working to ensure continuity of drug supply. ULHT is not a sponsor for any of the 38 current trials. Some trial drugs come from the EU. Current trials to be risk assessed against threat from a 'no deal' scenario.
										Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	Moderate risk (8-10)	Information & Communications Technology	Completion of all required actions in respect of data sharing, processing & access, as detailed in the national EU Exit guidance. Instruction to follow advice from The Department for Digital, Culture, Media and Sport and the ICO and to complete the annual Data Security and Protection Toolkit assessment as early as possible.	31/12/2019	Local risk assessment carried out did not identify any significant data sharing implications. Latest guidance to be reviewed and potential impact re-assessed.
										Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	31/12/2019	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time). Consideration to be given to the potential that prices for some goods (e.g. food) may increase post-Brexit.
										Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Moderate risk (8-10)	Communications & Engagement	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	31/12/2019	Communication of common message regarding clinicians not writing longer prescriptions and patients' storage of medicines at home. Communications plan in progress to inform affected staff of settlement scheme and professional registration requirements. Use of traditional and social media channels, in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).
										The date of the UK's exit from the EU has been moved to 31st October 2019. Existing contingency plans may or may not be sufficient to mitigate potential impacts on the workforce; supply of medicines and medical devices; and the availability of information.	Low risk (4-6)	Emergency Planning	To review existing business continuity plans and update where necessary, in line with national and local guidance. Trust response to be coordinated through re-establishment of an executive-led task & finish group.	31/10/2019	Currently awaiting further details from the Dept of Health regarding potential impacts and any required changes to existing business continuity plans.

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4385	**Compliance with financial regulations, standards & contractual obligations (corporate)** If the Trust is found to be systemically non-compliant with financial regulations & standards & or is unable to meet its contractual payment obligations; Caused by issues with the design or application of financial and contract management policies and procedures, or the availability of sufficient cash to meet payment obligations; It could result in regulatory action and sanctions or legal action which damages the reputation of the Trust amongst key stakeholders and may lead to sustained adverse local and / or social media coverage.	Matthew, Paul	Reputation / compliance	Very high risk	Financial governance & compliance monitoring arrangements. Trust Board approval of borrowing. Scheme of delegation & authority limits. Financial management policies, procedures, systems & training. Working capital strategy; prioritisation of payroll & critical supplier payments and escalation through Trust Board to NHSI. Cash forecasting and reconciliation processes. Contingency fund balance. Self-assessment & management processes for statutory & regulatory requirements. Annual internal audit plan. External audit annual report.	High risk (12)	Financial Turnaround Group	Low risk	31/10/2019	The Trust has a financial deficit and is therefore not able to meet its statutory obligation to break even.	High risk (12-16)	Finance	In Financial Special Measures; agreed Financial Recovery Plan to return the Trust to a sustainable footing ove ther medium term.	31/03/2024	
4404	**Major fire safety incident (corporate)** If the Trust experiences a major fire safety incident; Caused by the uncontrolled spread of a substantial fire; It could result in multiple incidents of significant harm or death affecting patients, visitors and members of staff.	Boocock, Paul	Harm (physical or psychological)	Very high risk	Fire Policy. Fire Safety Group. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance PPM (Testing). Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processees.	High risk (12)	Fire Safety Group	Low risk	31/10/2019	Fire alarm systems in the Catering Dept and 1st floor theatre block (Block OJ) are conventional systems which were connected to the newly installed system 20 years ago. Trinity the maintenance contractor have highlighted the need to replace the systems due to the age of the devices and lack of support for the old alarm panels.	Moderate risk (8-10)	Estates	Replacement of detection devices & panels in the Catering Dept and 1st floor theatre block (Block OJ). Regular maintenance carried out as per recommendations of BS 5839-1:2013 and HTM 05-03 Part B.	31/12/2019	Quotations have been submitted to bring systems up to date.
										The Fire Dampers located within the ventilation system in Maternity at LCH may not operate correctly in a Fire situation. The fire dampers should be inspected and tested annually but this is not possible within the Maternity Wing as they are located within the ventilation duct work in the ceiling voids and risers. Access is restricted due the presence of ACM's. Effective operation of the fire dampers is essential to prevent the spread of fire and smoke in the event of a fire. Failure to implement the recommended schedule of testing could result in an increased risk of in-service failure of these units.	High risk (12-16)	Estates	Replacement of Fire Dampers required in Maternity Wing in accordance with developing Fire Strategy Plans.	31/12/2019	Replacement programme in progress.
										Pilgrim Hospital does not have adequate 1hr fire integrity. This is caused by the age of the structure, leading to an impact/effect on the structural integrity of the building under fire conditions potentially placing patients, staff and service users at risk of harm in the case of a major fire.	High risk (12-16)	Estates	Compliance with Fire Enforcement Notice through Statutory Fire Safety Programme implementation. Early warning system due to automatic fire detection system.	31/03/2020	As built façade scheme drawings indicate fire protection of structural elements to the perimeter of the building recently upgraded.
										Fire Dampers within the East Wing of LCH are located within ventilation system ductwork to prevent the spread of smoke and fire. A number of the dampers are connected to the fire alarm system and activate when the alarm system operates. Other dampers are controlled by a "fusible link". No regular testing regime is currently in place. This is an issue for all sites.	High risk (12-16)	Estates	Specialist contractor to carryout a survey to establish operational status and provide report of any remedial works required. Initiate remedial work programme. Implement regular testing regime.	31/12/2019	Survey undertaken 2015/16 - identified remedial works required. to be considered for backlog maintenance. Refer to EFAN.
										Some pipework & fittings in the External Underground Fire Ringmain at Pilgrim in poor condition. Water leaks could affect Fire fighting capability. RPZ valve faulty, requires repair/replacement.	High risk (12-16)	Estates	Going out to tender in new financial year replacing pipework and valve in the External Underground Fire Ringmain at Pilgrim.	31/12/2019	Specific work on RPZ valve has been completed.
										Potential inability to evacuate Trust premises in the event of an emergency in the event of poor or non-existent fire training.	High risk (12-16)	Estates	Volunteer Fire Safety Advisor. Free up Fire Safety Advisors to facilitate bespoke training. Need to substantially officially appoint additional Fire Safety Advisor. TNA (Training Needs Analysis) in place and being managed. Formal training programme to be implemented.	31/12/2019	Training in higher risk areas has commenced. Recent appointment of additional fire resource.
										Potential for water leaks causing a fire if replacement of heating, hot and cold water services in main duct is not done (under EAU corridor, GDH).	Moderate risk (8-10)	Estates	Multiple leaks repaired and patches placed on the pipework. Ensure Emergency repair kits are available onsite. Identify Capital Funding.	31/03/2020	Routine monitoring, repair as best we can when leaks occur.
										Risk of Fire to wooden clad building (AF and AG/ AE). Rheumatology is delivered from a timber clad two storey building, there is minimal fire compartmentation in the building. The building is poor state of repair. The fire doors are poorly maintained. The windows are rotten and likely to fall out. There is a risk that a fire will spread rapidly through the building horizontally and vertically. Works are planned in 2019, the condition is a cause for concern from a fire perspective and needs escalation of fire improvement works. Requires decant to allow works to take place.	High risk (12-16)	Estates	A Fire Risk Assessment is in place for the wooden clad building (AF and AG/ AE). Evacuation is staff led. A basic review of the building condition has been undertaken as a result of the issues raised in the adjacent nursery premises. Fire works are planned in this area Phase 4, package 3 - due 2019. 1. Fire Risk Assessment to be reviewed - action FSA 2. Escalate need for fire improvement works - actions FSA	31/12/2019	

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										Lack of clear policy for the prescription and management of oxygen; increased potential fire hazard, within hospital or at home.	High risk (12-16)	Corporate Nursing	Review of existing policies & procedures for prescription and management of oxygen, taking account of identified good practice and involvement of the fire service and other local partner agencies.	31/12/2019	Working group set up, involving Corporate Nursing, Health & safety and Risk to coordinate development of required policies & procedures.
3689	**Compliance with asbestos management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with asbestos management regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Trust Asbestos Core Working Group. Asbestos Awareness training for managers and operatives (Estates staff and contractors). Specialist contractor appointed to advise Trust on specific Asbestos management issues across sites. Site Survey data available on Micad. Third Party Contractor induction for both capital schemes and day to day maintenance. Annual Facefit training for specialist PPE equipment. Occupational Health reviews, lung function test. Specialist surveys prior to making any physical change to built-in environment. Air monitoring of specific areas to give assurance that controls in place are adequate. Risk Prioritised Estates Capital Programme. Restricted access where known asbestos containing materials (ACMs) exist (permit to work system).	High risk (12)	Asbestos Management Group	Low risk	31/10/2019	Asbestos Policy is overdue for review.	High risk (12-16)	Estates	Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.	31/10/2019	
										Asbestos Management Plan still to be fully developed.	High risk (12-16)	Estates	Complete development & begin implementation of Asbestos Management Plan.	31/10/2019	
										Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	High risk (12-16)	Estates	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	31/10/2019	
										Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Moderate risk (8-10)	Estates	Agree Appointed Person & structure for Asbestos management.	31/10/2019	
										Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	High risk (12-16)	Estates	Review of asbestos contractors appointment & verification of training.	31/10/2019	
										No Access areas still to be surveyed for asbestos.	Moderate risk (8-10)	Estates	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	31/10/2019	
										Potentially inaccurate survey data due to restricted access to areas.	Moderate risk (8-10)	Estates	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	31/10/2019	
3690	**Compliance with water safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with water safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Trust Water Safety Group. Oversight by Infection Prevention & Control Committee (monthly report submitted by the AE). Water safety policies, procedures & training. Duty Holder, Responsible person, Site Deputy responsible persons and competent persons in place. Appointed Authorising Engineer (Water). Chlorine Dioxide Injection water treatment. Planned maintenance regime in place including written scheme of works. Site based Risk Assessments informing the Water Safety Group Management process. Water sampling, temperature monitoring and flushing undertaken; remedial actions taken in response to positive samples.	High risk (12)	Water Safety Group	Low risk	31/10/2019	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Moderate risk (8-10)	Estates	Legionella monitoring carried out by direct labour as far as possible with competing priorities. Action required: appoint additional staff or contractor in lieu of staff to carry out work. Further actions required (subject to funding): water systems drawings are required for all sites (CAD); review and issue a Trustwide tender document for the monitoring work; to appoint a responsible person; to form a Trustwide Legionella group to consist of Facilities, Infection Prevention and Control Consultant and Nurses (sub group of Infection Prevention and Control Committee?)	31/12/2019	
										13 waste disposal units do not incorporate a 'Type A Air Gap' on the water supply inlet and therefore as they are classed as 'CAT 5 Fluid' they do not comply with the 'Water Regulations' which is a statutory regulation.	High risk (12-16)	Estates	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'. The non-compliant units to be replaced with those which comply with the Water Regulations.	31/12/2019	Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.
										Lack of compliance with ACOP L8 and HTM standards in respect of water schematics for the hot and cold water systems could impact on the Trust's ability to demonstrate compliance with statutory standards and potentially place service users at risk of poor water safety.	High risk (12-16)	Estates	Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	31/10/2019	Funding required for replacement TMVs, sinks and hand basins. Schematics produced by surveyors have not been quality assessed and have not been stitched into Estates and Facilities master CAD models. Some funding has been identified from Facilities CIP.
										Although routine checks are undertaken , the water tanks at LCH do not comply with the Water Regulations	Moderate risk (8-10)	Estates	Bid for Capital funding to replace non-compliant water tanks made May 2016.	31/12/2019	
										Trustwide Water Systems - Chlorine Dioxide Dosing System. Scotmas inform that some of the monitors are now obsolete and require replacing. BMS is now linked to Lincoln.	Moderate risk (8-10)	Estates	Specification has been out to tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	31/10/2019	In December 2017 Scotmas were the only supplier to bid on this tender.
										The Trust may not comply with drinking water guidelines and HTM04-01 at Pilgrim Hospital, because of Chlorine Dioxide dosing impurities due to lack of available maintenance.	Moderate risk (8-10)	Estates	Automatic monitors in place. It is being constantly monitored and completion of new water main which will be 2018/19. Capital investment required to mitigate this risk.	31/12/2019	Delayed completion of new water main which is required before we can gain access to complete the work required.
										The Water Safety Statutory Improvement Programme (directed by site risk assessments) may not complete on time; on going upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Moderate risk (8-10)	Estates	Stringent Water sampling and flushing programs in place. Funding required.	31/12/2019	
3687	**Delivery of an Estates Strategy aligned to clinical services (corporate)** If the Trust is not able to deliver an Estates Strategy that is aligned to clinical service strategies and development plans; Caused by issues with the design or implementation of the strategic planning or service transformation process, or	Boocock, Paul	Service disruption	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Space Utilisation Policy. Capital investment planning process and programme (prioritisation to support compliance with statutory and HSE Regulatory Requirements and manage critical infrastructure risk). Identification of age and condition of estate enabling	High risk (12)	Estates Strategy Group	Moderate risk	31/10/2019	Lack of health community clinical strategy to inform the development of the Trust's Estates Strategy. No identified resource to develop Estates Strategy.	High risk (12-16)	Estates	Develop, review and implement an Estates Strategy (aligned to the capital investment programme) with reference to the STP, ERIC data & Lord Carter's recommendations.	31/12/2019	
										Lack of awareness of cost of space to the user / service and assumption that the Trust has space readily available and fit for purpose.	Moderate risk (8-10)	Estates	Continued development and implementation of Premises Assurance Model (NHS PAM).	31/10/2019	

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	insufficient capital funding available; It could result in a significant impact on the efficient utilisation of the estate which adversely affects the performance, quality and sustainability of multiple services.				planned investment and dis-investment. Implementation of premises assurance model (NHS PAM). Leases and Property Management (SLA's) LHAC, One public estate and Trust clinical strategy relationship.					Availability of sufficient capital and revenue funds to enable delivery of projects within the Estates Strategy & support prioritisation to ensure compliance with statutory and HSE Regulatory Requirements.	Moderate risk (8-10)	Estates	Review of defined Capital Prioritisation Process used to effectively stratify statutory risks in conjunction with available capital to confirm it remains fit for purpose. EFM Directorate Financial Reporting and Capital progress reporting to Estates Environment Infrastructure Investment Committee & Investment Programme Board	31/12/2019	
										Processes for escalation of significant issues through Trust formal governance systems.	Moderate risk (8-10)	Estates	Review of Risk Reporting through core programmes to Estates Investment & Environment Group, through Finance, Performance & Estates Committee and up to Trust Board to confirm that it remains fit for purpose.	31/10/2019	
										Review required to look at the estate as leases become due for renewal and decision made on whether the lease renewal is financially viable to comply with modern day standards in relation to 3rd party occupants.	High risk (12-16)	Estates	Full review of all lease clauses with Trust Legal Advisors and tenant to agree responsibilities. Business Case to be submitted to support the review of all the leases including legal advice.	31/10/2019	
										The Baverstock House building is in a poor state of repair leading to potential claims of not meeting the Landlord obligations. The building is not compliant with our current fire strategy in line with the fire enforcement notice. The electrical infrastructure is fully loaded with no capacity and running at maximum. This could result in an electrical fire, loss of building. The social club is used as a infrastructure passing point for the electric supply to another building (Baverstock House) if there was a loss of electricity to the social club or a fire this would lead to disruption to Baverstock House (a leased property) potentially leading to loss of revenue for the Trust for both buildings. The building is leased to a third party for use as a social club/bar which has several fire risk factors including cooking and storage of flammable products. The bar is open to the general public and licenced for functions.	Moderate risk (8-10)	Estates	A dilapidation survey has been undertaken to assess the Baverstock House building condition and estimate costs to undertaken repairs. A Fire Risk Assessment has been undertaken by the Trust's Fire Safety Advisor and is due for review. A paper has been drafted for the Executive Team to consider investment in repairs and the options for a new lease. 1. Review Fire Risk Assessment - Action FSA 2. Finalise dilapidation survey and report to include estimated repair costs. 3. Review of Landlord and tenant obligations and agree with tenant responsibilities in respect of repair and maintenance.	31/12/2019	Undertaken a technical loading test which has a phase inbalance requiring further investigation. On the 1st March, one of the 32 amp MCB's in the fuse boards melted under the loading causing power disruption. Given the recent incident it is likely that until the electrical infrastructure is reviewed and additional capacity is installed there is a risk of further failures.
										Risk of non-compliance with obligations in lease to For Under Fives in respect of maintenance to the building. Key issues are poor electrical infrastructure and limited fire compartmentation. The nursery building is connected to Rheumatology and there is no fire stopping/compartmentation between the two departments. It is timber clad building which provides no fire resistance. Following the Grenfell Fire there is notice to reduce the risk posed by timber clad buildings. A fire in this building would result in a business continuity issue for the tenant who provide nursery care to children of employees on the hospital. Due to the nursery being adjacent to Rheumatology works to fire compartmentation is very difficult whilst the nursery is operation. To undertake the required fire improvement works the nursery would need to be temporarily relocated. The Trust Fire Safety Advisor is concerned about the lack of fire compartmentation in a nursery.	High risk (12-16)	Estates	A Fire Risk Assessment has been undertaken in conjunction with the Nursery owner. A dilapidation survey/schedule of condition has been undertaken. A quote for repair works has been requested by contractors currently undertaking works on the Lincoln site to address the biggest dilapidation issues e.g. to make the brick part of the building adequately water tight, full electrical test and a heating flow and return test.. 1. Fire Risk Assessment to be reviewed - Action FSA 2. Dilapidation survey report to be reviewed and updated with cost of repairs 3.Quote for works to make the brick part of the building adequately water tight, full electrical test and a heating flow and return test. 4.Review options for temporary relocation whilst fire compartmentation works are undertaken.	31/12/2019	
										To escalate to the Risk Register the lack of availability and prioritisation of meeting rooms or VC for Clinical leadership meetings.	High risk (12-16)	Estates	To review the utilisation and governance for the use of rooms and maximisation of VC within these rooms. Need to prioritise speciality governance – meeting rhythm across the governance scheme – core principles.	31/10/2019	

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ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4176	**Management of demand for planned care (corporate)** If demand for planned care (elective, outpatient and diagnostic services) significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	Divisional capacity management processes. Corporate assurance processes including weekly PTL & fortnightly recovery & delivery meetings. Specialty recovery plans. System-wide planned care group driving reduced referrals into secondary care. Annual capacity & demand planning process. Productive services work-streams including: outpatients; theatres; endoscopy.	High risk (12)		Low risk	31/10/2019	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	High risk (12-16)	Operations	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. Capital plan for estate development, space utilisation and medical equipment.	31/03/2020	Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP).
4368	**Management of demand for outpatient appointments (corporate)** If the Trust's Outpatient Services are unable consistently to manage the level of demand for appointments; Caused by issues with the design or application of demand management systems and processes; It could result in a significant reduction in the quality and continuity of outpatient services across multiple directorates and failure to achieve NHS constitutional standards, affecting a large number of patients.	Rinaldi, Dr Ciro	Service disruption	Very high risk	Governance & performance management arrangements. Outpatient Improvement Group. Clinical policies, guidelines and pathways. Staff recruitment, induction & training policies & programmes. Access management policies, guidelines & staff training. Medway patient administration system. Self-assessment & performance management processes for national requirements. Patient Tracking List (PTL) validation & management processes. Approval policy for clinic cancellation with less than 6 weeks notice (Deputy Director level). Weekly PTL meetings. Incident reporting and management systems and processes (Datix).	High risk (12)	PRM	Low risk	30/11/2019	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients.	High risk (12-16)	Operations	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	31/12/2019	Requested further information from performance team to understand discussions at PTL meetings. Information are producing an extra report for all 40week+ patients regardless of RTT status for validation, also further DQ checks have been completed on specific cohorts of patients to improve DQ.
										Capacity to record e-outcomes onto Medway in a timely manner; Consultants not taking ownership of completing e-outcomes. May lead to Missing Outcomes not being completed & consequent delayed treatment.	Moderate risk (8-10)	Operations	Short term solution to offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes.	31/12/2019	Missing Outcomes transposing of outcomes is currently about 10 days behind on LCH site. Overtime being offered to reduce timeframes. All other sites being completed within 2 working days. Increase in number of outcomes not being completed by clinicians, this is being highlighted to OMD's for action. Business case for API links agreed by CRIG, delays in implementation occurring due to upgrades by 3rd parties need to happen first. Further update due 01/10/2019.
										Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	High risk (12-16)	Operations	Clinical Directorates to provide trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans at speciality level. C&A manually drawing down referrals from ASI list.	30/11/2019	CBU Recovery plans submitted to the performance team and they are tracking performance against trajectory. Performance being monitored at Delivering Productive Services Group.
										Overdue new appointments may be incorrectly added / unvalidated on the Open Referrals worklist . The New Booking team identify 'other' new patient referrals added to the Open Referral worklist by other parties in BU's. As the New Booking Team did not make the entry they are unable to validate the referral.	High risk (12-16)	Operations	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	31/12/2019	The Trust is fully compliant with the NHSI requirement to be receiving GP requests to first consultant led appointment by eRS. It is those referrals that do not fit the specific criteria of the NHSI scheme that could lead to un-validated patients on the open referral worklist. Further work required with information support and the booking team to ensure all patients are identified and validated.
4082	**Workforce planning process (corporate)** If there is a fundamental failure in the Trust's workforce planning process; Caused by issues with the design or application of the process, the availability of accurate workforce information or the capability to utilise it; It could result in significant, prolonged disruption to multiple services across directorates and potential unplanned closure of one or more services.	Rayson, Martin	Service disruption	Very high risk	Workforce strategy & improvement plans. Workforce planning processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements.	High risk (12)		Moderate risk	30/11/2019	Capacity within the business to support the process and recognition of its priority is an inhibiting factor, which is less within the direct control of HR.	Very high risk (20-25)	Human Resources	KPMG are providing additional capacity and capability. Created temporary team to take forward work aligned to CSR. Business partners to be appointed. Skill-building planned at STP level, where we also have continued support from WSP. Escalation to FRG if necessary.	31/03/2020	Greater capacity has been created in the HR team (business partners and enhanced workforce information function) to support workforce planning. New business planning process being put in place for 20/21 and workforce planning will be an integral part of that. The Clinical Services Review process is in place and includes a workforce planning element. Workforce planning is also taking place at a system level. Further review at the end of the business planning process.

Appendix II - Moderate Low Corporate Risks (August 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4496	Financial Risk due to removal from Windows 10 national licensing agreement	Corporate	Finances	9	Moderate risk
4401	Safety of the hospital environment (corporate)	Corporate	Harm (physical or psychological)	9	Moderate risk
4403	Compliance with electrical safety regulations & standards (corporate)	Corporate	Reputation / compliance	9	Moderate risk
4486	Clinical outcomes for patients (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	8	Moderate risk
4003	Major security incident (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4043	Compliance with patient safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4044	Compliance with information governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4469	Compliance with blood safety & quality regulations & standards (corporate)	Clinical Support Services	Reputation / compliance	8	Moderate risk
4479	Safe clinical staffing levels (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4481	Safe use of patient information (corporate)	Clinical Support Services	Harm (physical or psychological)	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4363	Compliance with HR regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4389	Compliance with corporate governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4402	Compliance with regulations and standards for mechanical infrastructure (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4422	Delivery of the Electronic Patient Records project (corporate)	Corporate	Service disruption	8	Moderate risk
4424	Delivery of the Quality & Safety Improvement Plan (QSIP)	Corporate	Reputation / compliance	8	Moderate risk
4177	Critical ICT infrastructure failure (corporate)	Corporate	Service disruption	8	Moderate risk
4180	Reduction in data quality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4181	Significant breach of confidentiality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4144	Uncontrolled outbreak of serious infectious disease (corporate)	Corporate	Service disruption	8	Moderate risk
4154	Participation in important clinical research projects (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4061	Financial loss due to fraud (corporate)	Corporate	Finances	4	Low risk
4138	Patient mortality rates (corporate)	Corporate	Reputation / compliance	4	Low risk
4155	Safety of research project participants (corporate)	Corporate	Harm (physical or psychological)	4	Low risk
4386	Critical failure of a contracted service (corporate)	Corporate	Service disruption	4	Low risk
4387	Critical supply chain failure (corporate)	Corporate	Service disruption	4	Low risk

Appendix II - Moderate Low Corporate Risks (August 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4388	Compliance with procurement regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4277	Adverse media or social media coverage (corporate)	Corporate	Reputation / compliance	4	Low risk
4438	Severe weather or climatic event (corporate)	Corporate	Service disruption	4	Low risk
4439	Industrial action (corporate)	Corporate	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products (corporate)	Clinical Support Services	Harm (physical or psychological)	4	Low risk
4483	Safe use of radiation (corporate)	Clinical Support Services	Harm (physical or psychological)	4	Low risk

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Risk Management Policy Appendix I: Risk Scoring Guide

To be used when assessing risks that are recorded on the Trust risk register (Datix).

	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting a small number of patients, staff or visitors within a single location.	Low level of harm affecting a large number of patients, staff or visitors within a single location.	Significant but not permanent harm affecting multiple patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	3rd September 2019
Essential Standards:	

Title:	Board Assurance Framework (BAF) 2019/20

Author/Responsible Director: Karen Willey, Deputy Trust Secretary/Jayne Warner, Trust Secretary

Purpose of the Report:

To present the 2019/20 Board Assurance Framework

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/Key Points:

The 2019/20 BAF has been presented to the Board Committees during August, with the exception of the Workforce, Transformation and Organisational Development Committee, which meets bi-monthly. There were no material changes to the content of the framework and as such none of the assurance ratings have been amended by the Committees during their considerations in August.

The Executive Lead for strategic objective 4a – Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration, has been altered to the Chief Executive Officer to reflect the departure of the Deputy Chief Executive Officer from the Trust.

Direction of Travel of Assurance Ratings:

RAG Rating	July 2019	August 2019	Direction
Red	6	6	→

Amber	1	1	→
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise/identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2019/20 - August

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	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	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Unreliable or inaccurate data Steps not delivered within the Trust Mortality Reduction Strategy Partnership working across health care system Coding incomplete	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Dr Foster - investigations into Dr Foster alerts SHMI and HSMR National Benchmarking Reports Integrated Performance Report Speciality Governance National surveys and audit - secondary control National Audit Data - HQIP ReSPECT Care Plan Quality Account Priority 3 Incident Reviews	Speciality governance process Partnership working across health care system ReSPECT care plans not adhered to or in place No established process for cross system reviews	Trust Operating Model role out Performance review mechanisms of staff	Speciality assurance against governance guide National audit reports Audit of speciality governance Mortality Reduction Plan Quality review of medical workforce Quality review of nursing workforce Regular reporting on learning from deaths. Independent Reviews of alerting diagnosis Updates on coroner cases and preventing future deaths	System wide partnership reports - variable community buy in ReSPECT roll out not clear	Masterclass for coding Organisational Development Patient Safety Committee Clinical Effectiveness Committee Drugs and therapeutic Committee 7 day Services Mortality review group Formal report from public health workshops to be requested ReSpect update and coding update requested within next mortality report July 2019	Quality Governance Committee	A
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy Patient Experience Plan Inclusion Strategy QSOG reports Quality Account priorities 1 ,2 & 4 Hygiene Code	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Quality Strategy not approved Metric not finalised Sharing and learning not at desired level	Bi weekly meetings Harm Free care Steering Group QSIP Programme Patient experience annual plan as part of Quality Strategy Meeting to finalise metrics Infection Prevention and Control Group	Integrated Performance Report Patient Experience Dashboard and codesign of pathways with patients Quality and Safety Improvement Plan Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain as gap for time being QSOG still in development New Trust Operating Model still embedding. Patient Experience and links to Quality Strategy and how articulated in BAF	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

Ref	Objective	Metric	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
							Hygiene Code Internal Audit: Data quality of KPIs - Q4 Compliance with legislation - Q2			Infection Prevention Control exception report Equality and Diversity Patient report Inclusion strategy				
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	Systems unable to capture and report data Unreliable, incomplete or inaccurate data Insufficient clinic capacity resulting in overbooking Inappropriate clinic configuration providing duplicate appointment times Patients arriving late for their clinic appointment Poor engagement	Corporate risk ID 4368 - Outpatient demand (High)	CQC Responsive	Specialty Governance Data Quality Group Outpatient Improvement Programme Delivering Productive Services Group Internal Audit: Data quality - Q1	Data Quality Group New reporting metric Insufficient outpatient capacity to meet current demand across a number of specialties Consistency of Specialty Governance process	Data Quality workstream Performance Review Meetings Outpatient improvement programme System approach to managing planned care demand Governance team supporting embed of specialty governance port TOM implementation	Monthly Delivering Productive Services report PRM FPEC	Data quality assurance IPR	Development of data quality process prior to reporting Report from system SRO	Finance, Performance and Estates Committee	R
SO2	Providing efficient and financially sustainable services													
2a	Have 'zero waits' to access our services	% patients discharged within 24 hours of PDD	Chief Operating Officer	Systems unable to capture and report data Unreliable or inaccurate data Poor engagement with setting PDD Internal systems not efficient to support timely discharge	Corporate risk ID 4176 - Planned care demand (High)	CQC Effective	Urgent and Emergency Care Improvement Programme - workstream 4, Ward Processes and 5, Discharge and Partnerships Daily review and overview by operational services Delivering Productive Services Group	Specialty Governance Data Quality Issues New reporting metric	Data Quality workstream PRM Roll out of the TOM in line with the governance framework	Monthly Delivering Productive Services report Urgent and Emergency Care Improvement Programme update IPR	Reporting shows legitimate amendments made to dates of predicted discharge generate an artificially positive position at times.	Additional reports showing where dates have been amended are being produced, to complement the indicator and show where further improvement is required.	Finance, Performance and Estates Committee	R
2b	Ensure that our services are sustainable on a long-term basis i.e. here to stay	Delivery of Financial Plan £70.3m deficit	Director of Finance and Procurement	Efficiency schemes do not cover extent of savings required - £25.6m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure or financial penalties Failure to secure all income linked to coding or data quality issues Failure to secure contract income through backlog and repatriation schemes and inability to remove cost Activity exceeds contracted levels over and above repatriation and fails to secure all income due from commissioners	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very high)	CQC Well Led CQC Use of Resources	Financial Turnaround Group (FTG) oversight of FRP Vacancy control process Centralised agency team Financial Strategy and Annual Financial Plan Performance Management Framework Delivery of output of Clinical Service Review programme System wide savings plan Internal Audit: Finance efficiency programme - Q2 Performance Management and reporting - Q3 Education Funding - Q1	Reliance on temporary staff to maintain services, at increased cost Operational ownership and delivery of efficiency schemes, workforce reduction in particular Clinical coding & data quality issues Operational ownership of income at directorate level Lack of control over local demand reduction initiatives	Recruitment & retention initiatives to reduce reliance on temporary staff Income improvement plan for each directorate Engagement with commissioners through system wide contract management framework Improved reporting in to divisions System savings plan and delivery group Performance review process refresh through new operating model	Monthly Finance Report to Trust Board including capital and contracting FSM meetings with NHSI Scrutiny and challenge through Finance, Performance and Estates Committee Internal Performance Review Meetings Monthly NHSI Performance Review Meetings Internal Audit work reports IPR System Wide NHSE&I Performance and Escalation Meeting			Finance, Performance and Estates Committee	R

Ref	Objective	Metric	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
		% of services rated as 'delivering' *Note: 2019/20 is baseline year. % not in place, working through baseline in draft, scrutiny and road testing criteria and application, scheme of delivery and devolution* *Baseline analysis of how to manage classification of service performance - 3 levels*	Director of Finance and Procurement	Lack of capacity to establish a robust programme of work Lack of focus and attention - not nationally required, externally driven - alternative pressures	None	CQC Use of Resources	TOM Operational Group TMG Delivery Proposal taken and agreed at TMG to set baseline 6 month shadow running Internal Audit: TOM Governance - Q4	Aligned to revision to national standards 20/21 Report on milestone plan Triumvirate Plan Signed off proposal at TMG	Tracking national developments Developing shadow running of national standards as they become clear Trust Operating Model Operational Group Debate on metrics across the CBUs/Divisions Project management plan with milestones being met	FPEC Updates TMG Updates	Process not in place currently, no plan and milestones	TOM Implementation to develop and agree service rating scheme for formal agreement at TMG	Finance, Performance and Estates Committee	
SO3	**Providing services by staff who demonstrate our values and behaviours**													
3a	Have a modern and progressive workforce	Vacancy fill rate	Director of HR&OD	Inability to recruit and retain a suitably skilled workforce to meet demand resulting in unplanned and indefinite closure of multiple services across the Trust Failing to reduce high vacancy rates of consultants and doctors Reliance on deanery positions to cover staffing gaps Significant proportion of workforce approaching retirement age Inadequate workforce planning process	Corporate risk ID 4362 - Workforce capacity & capability (Very high) Corporate risk ID 4082 - Workforce planning (High)		People Strategy and Annual Workforce Plan Recruitment and retention strategies People management policies & procedures Vacancy controls Agency cost reduction plan Access to workforce business intelligence Core learning & leadership development programmes Internal Audit: Temporary Staffing Recruitment - Q3	Impact of Brexit on staff from EU countries Capacity within the business to support the process Shortage of sufficient numbers of staff in key areas, impacting on vulnerable services and potential risk to maintain safe services Talent management + succession planning arrangements Age profile of the clinical workforce Accuracy of all workforce information	Focus on nursing & medical staff engagement & development; exploration of new staffing models Review approach to recruitment to deliver at greater pace and scale Communication & engagement with EU staff & their managers Recruitment programme Development of sustainable service model -Talent Academy NHSI Retention Project Review of age profile & People Strategy to mitigate impact	People Strategy Additional resourcing support Staff survey results Data on effective application of people management policies Absence management arrangements in Trust GMC Surveys Data quality work	Medical capacity planning Delivery of People Strategy Workforce planning	Reviewing progress with Trust Management Group Completion of more detailed action plans Agreed approval of workforce planning	Workforce, OD and Transformation Committee	**R**
3b	Work as one team	Recommend as a place to work in staff survey 46% (↑ of 5%) Recommend as a place to receive care in staff survey 53% (↑ of 5%)	Director of HR&OD	A fundamental loss of workforce engagement which could result in a culture of low morale and motivation that impacts on the quality & safety of services throughout the Trust and permanently damages its reputation	Corporate risk ID 4083 - Workforce engagement (High)		Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: -Engagement of staff in 2021 programme -Opportunities for staff voice to be heard -Work on staff charter and values -Leadership and management development Staff charter and vision and values People management policies, systems, processes & training Management of organisational change policies & procedures Inclusion strategy Quality Account Priority 2 Internal Audit: Policy compliance - Q2 Mandatory training - Q2	Consistent quality of local leadership and management Staff engagement and belief in 2021 as means of bringing improvement 2018 Staff Survey suggest gap between individuals and Trust around belief that patient care is most important	Localised divisional action plans in response to staff survey results Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose Leadership and management development programmes Revamp of 2021 communications Trust-wide response to staff survey results to inform revised People Strategy	CQC report Workforce Committee KPIs including vacancy rates, appraisals, turnover, core learning, agency usage Pulse survey Staff Survey Quarterly FTSU Guardian report to Board Staffside representative feedback Report on application of people policies - Sickness absence, disciplines, grievances TB FTSU Self Assessment IA Review Public Sector Equality Duty	Guardians of Safe Working Divisional management teams, completing engagement work with staff Bullying and harassment scores are a concern, particularly for BAME staff Lack of evidence of improvement in scores around quality and consistency of leadership	Development of alternative to deliver Guardians of Safe Working responsibilities Review Divisional management teams through PRMs Project underway to understand causes of scores on bullying and harassment - initial survey and focus groups to gather intelligence - actions to follow Review of approach to leadership development, with additional actions to follow e.g. coaching, 360 appraisal and middle manager forum	Workforce, OD and Transformation Committee	**R**

Ref	Objective	Metric	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	**Providing seamless integrated care with our partners**													
4a	Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration	% reduction in face to face contacts in Outpatients 5% (Responsibility for the metric delivery sits with the Chief Operating Officer)	Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable Poor system working No single system plan	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive CQC Well Led	1st line Activity monitoring Activity plan Contract Improvement project System plan delivery System Performance Report to SET STP/SET/LCB infrastructure ASR Single system plan ICC development programme 2nd line: ICS Development 3rd line: NHS ICS Maturity Index Internal Audit: STP Governance - Q2	ASR - capital limitation System delivery method not yet mature	ASR being refreshed for resubmission System wide SROs appointed and delivery framework being established	LCB Oversight SET CEO Updates at Board Healthy Conversation		Being developed for going live in July 2019	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	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

The BAF management process

The Trust Board has assigned each strategic objective of the 2021 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 review 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 risks, to enable the committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to 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:

Effective controls may not be in place and/or appropriate assurances are not available to the Board

Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner Trust Secretary
Date:	3rd September 2019
Essential Standards:	

Title:	Trust Board Voting Rights

Author/Responsible Director: Jayne Warner, Trust Secretary / Elaine Baylis, Trust Chair

Purpose of the Report:

To agree the Executive Director voting rights of the Trust Board following the retirement of the Deputy Chief Executive.

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Information	

Summary/Key Points:

The Statutory Instrument which orders the establishment of the Trust allows (in line with all NHS Trusts) for 5 executive directors. The Trust Standing Orders identify the 5 voting executive directors for the Trust as

- Chief Executive
- Medical Director
- Nurse Director
- Director of Finance
- Deputy Chief Executive

The Chief Operating Officer, Director of HR &OD and Director of Estates and Facilities attend the Trust Board meetings in a non-voting capacity.

The Chief Executive has signalled that with the departure of the Deputy Chief Executive this role will not be replaced and the Deputy Chief Executive duties will be absorbed within the other executive roles.

The Chief Executive has proposed that the Chief Operating Officer role replaces the Deputy Chief Executive as the voting executive director on the Board and that Trust Standing Orders are amended accordingly.

Recommendations:

The Board are asked to:

- Agree that voting rights are transferred to the Chief Operating Officer with immediate effect and standing orders are amended to reflect this change.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR) N/A

Assurance Implications

Patient and Public Involvement (PPI) Implications N/A

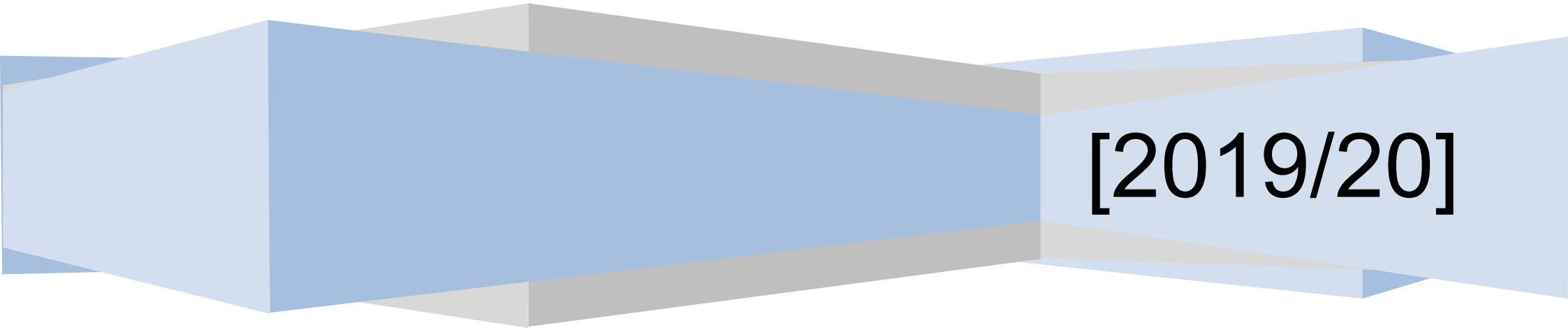
Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review?

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER



	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020									X		
BAF Sign off for 2019/20	X									X	
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											
Finance, Performance and Estates Committee	X	X	X	X	X	X	X	X	X	X	X

Assurance and Risk Report											
Financial Plan and Budgets										X	
Clinical Strategy Update					X					X	
Operational Plan Update					X		X		X		
Emergency Planning Annual Self Assessment					X						
SO 3 Providing Services by Staff Who Demonstrate our Values and Behaviours											
Workforce, OD and Transformation Committee Assurance and Risk Report	X			X		X			X		X
Staff Survey Results											X
Freedom to Speak Up Report	X			X			X			X	
Report from Guardian of Safe Working		X			X					X	
Equality and Diversity Strategy		X									
5 Year Strategy	X			X			X		X		X
SO 4 Providing Seamless Integrated Care with our Partners											

Trust has a real ‘talent’ for innovative recruitment practise

The Lincolnshire Talent Academy was formed in June 2015 as an initiative by ULHT to help attract school leavers and those perhaps looking to first embark on an NHS career, into its workforce.

Today it has evolved into an umbrella body made up of health and care organisations in Lincolnshire, delivering proactive services to aid recruitment and skills development of our current and future workforce.

As a first of its kind in the NHS, the Talent Academy is now recognised as a leading player in its field, and in addition to its core role has been commissioned by Health Education England to support other Trusts and sustainability and transformation partnerships (STPs) to develop their own regional academies across the country.

Due to its successful development and implementation within Lincolnshire, the academy has secured a number of commercial contracts for delivery of its fully-managed work experience service across the country. It has also successfully tendered to deliver the service for the Health Education England “Dr You” initiative, providing coordinated work experience opportunities for students who are considering careers within the medical profession across the Midlands and East region.

In addition, having obtained Government recognition for its wide range of apprenticeship development work across nursing, midwifery and allied health, the academy has also been asked to support the Institute for Apprenticeships and Boots PLC on the development of the national Registered Pharmacist Apprenticeship Trailblazer proposal.

At a local level, in addition to its work experience services, the Talent Academy has been involved in a number of attraction and recruitment initiatives for ULHT, engaging with over 18,500 individuals across Lincolnshire during 2018/19 through the various services delivered. These include the placement of nursing cadets, trainee nursing associates, launch of the occupational therapy and physiotherapy apprenticeships and the aspiring medics and dentistry programmes. All of these are working to attract the next new wave of hard to recruit medical personnel into the professions.

The academy is also working to transform the workforce, supporting ULHT colleagues in the identification and development of new roles in order to address skills shortages. Supporting all levels, the academy has been responsible for the introduction of the Nursing Cadet programme, which underpins the nursing development pathway leading to registered nurse and beyond. In addition, the Admin Apprentice Talent Pool will also launch soon, which is designed to provide cover for short to medium term staff absence, replacing high cost bank and agency staff. This will forms part of the Trust’s annual savings plan, whilst also developing our new talent pipeline of entrants in preparation for upcoming administration vacancies, thereby reducing the turnaround time for recruitment.

Work around existing roles is also underway, including work in pharmacy with the recommendation that the ward-based and pharmacy-based role be combined to create a multi-disciplined technician role which would incorporate rotation across both ward and pharmacy teams.

Other areas being supported include allied health, theatres, radiotherapy and clinical engineering, where new trainee degree apprentice roles have been incorporated from September 2019.

In view of the rapid transformation taking place and the opportunities they provide, the academy is also working on the implementation of its staff careers service. Designed to provide staff with impartial advice and guidance on current and upcoming development opportunities, the system is scheduled to be launched by April 2020.

Building upon the last two year's successful events, the Talent Academy is currently well into the planning stages for its third annual Lincolnshire Health and Care Careers event for the system, which will take place on Tuesday 26 November at The Engine Shed in Lincoln and will feature over 50 different health and care professions from across the system.

As an employer, the academy continues to go from strength-to-strength, working with students, schools, colleges and universities, to provide services for individuals from the age of 14 and above.

Its aim is clear – to entice and secure a new generation into the NHS, to help bolster its future and keep this vital institution shining bright well into the 21st century.