# Bundle Trust Board Meeting in Public Session 6 July 2021

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

1 Introduction, Welcome and Chair's Opening Remarks
*Chair*

2 Public Questions
*Chair*

3 Apologies for Absence
*Chair*

4 Declarations of Interest
*Chair*

5.1 Minutes of the meeting held on 1 June 2021
*Chair*
Item 5.1 Public Board Minutes June 2021v1.docx

5.2 Matters arising from the previous meeting/action log
*Chair*
Item 5.2 Public Action log June 2021.docx

6 Chief Executive Horizon Scan
*Chief Executive*
Item 6 Chief Executive's Report, 060721.docx

7 Patient/Staff Story
*Director of Nursing*

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee
Item 8.1 QGC Upward report June 2021v1.doc

8.2 Infection Prevention and Control Annual Report
*Director of Nursing/ Director of Infection Prevention and Control*
Item 8.2 IPC Annual Report front cover.docx
Item 8.2 IPC Annual Report V1 7.5.2021 (Final Draft post IPCG).docx

8.3 Safeguarding Annual Report
*Director of Nursing*
Item 8.3 Front Cover Safeguarding Annual Report.docx
Item 8.3 Safeguarding annual report 2020 2021 14.06.2021 - QGC version.docx

8.4 Complaints Annual report
*Director of Nursing*
Item 8.4 Complaints Annual Report 2020-2021 V4.docx

8.5 CQC Actions (must and should do)
*Director of Nursing*
Item 8.5 2021-06-22 CQC Must Do Should Do Progress Report Board.docx
Item 8.5 Copy of CQC Must Do Should Do Actions V18.xls

8.6 Paediatric Temporary Pathway
*Deputy Chief Executive*
Item 8.6  Pilgrim PAU Model May 2021.docx
Item 8.6 Front Sheet- SSPAU&HSC.docx

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| 9 | Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT |
| 9.1 | Assurance and Risk Report from the Workforce and Organisational Development Committee<br>Item 9.1 POD - Upward Report - June 2021.docx |
| 10 | Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate |
| 10.1 | Assurance and Risk Report from the Finance, Performance and Estates Committee<br>Item 10.1 FPEC Upward Report June 2021 v1.docx |
| 11 | Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing |
| 11.1 | Stroke Temporary Pathway Update<br>*Chief Operating Officer*<br>Item 11.1 Stroke Temporary COVID Pathway Board Update June 21 v3.docx |
| 11.2 | Trauma and Orthopaedics Project Update<br>*Deputy Chief Executive*<br>Item 11.2 ULHT Trauma and Orthopaedics hot and cold site pilot evaluation 2122 FINAL.docx |
| 11.3 | Urology Pathway Update<br>*Deputy CEO*<br>Item 11.3 Front Sheet - Urology patient engagement v2.docx<br>Item 11.3 Urology consultation.pdf |
| 12 | Integrated Performance Report<br>Item 12 Integrated Performance Report - Trust Board V2.docx |
| 13 | Risk and Assurance |
| 13.1 | Audit Committee Upward Report<br>Item 13.1 Audit Committee Upward Report.docx |
| 13.2 | Risk Management Report<br>Item 13.2 Trust Board - Strategic Risk Report - June 2021 v1.docx |
| 13.3 | Board Assurance Framework<br>Item 13.3 BAF 2021-22 Front Cover July 2021.docx<br>Item 13.3 BAF 2021-2022 v29.06.2021.xlsx |
| 13.4 | Learning from Judicial Review<br>*Chief Executive*<br>Item 13.4 Learning from Judicial Review.docx |
| 14 | Any Other Notified Items of Urgent Business |
| 15 | The next meeting will be held on Tuesday 3rd August 2021 |

*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 Trust Board Meeting

Held on 1 June 2021

Via MS Teams Live Stream

**Present**

**Voting Members:**
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital
Dr Karen Dunderdale, Director of Nursing
Mrs Sarah Dunnett, Non-Executive Director

**Non-Voting Members:**
Mr Simon Evans, Chief Operating Officer
Mr Martin Rayson, Director of People &OD

**In attendance:**
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Dr Maria Prior, Healthwatch Representative
Ms Cathy Geddes, Improvement Director, NHSE/I

**Apologies**
Mr Geoff Hayward, Non-Executive Director
Mr David Woodward, Non-Executive Director

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| 801/21 | **Item 1 Introduction**<br><br>The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.<br><br>In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner. |
| 802/21 | The Chair moved to questions from members of the public.<br><br>**Item 2 Public Questions**<br><br>**Q1 from Vi King**<br><br>**I have heard that there will be a delay restoring some of the services at Grantham Hospital, due to not having enough staff. Please can I ask why the assessment of available staff was not done sooner? The restoration was announced March 2021. So why has it taken until the end of May 2021 for the Trust to acknowledge this issue?**<br><br>The Chief Operating Officer responded: |

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| | It was pleasing to note that the report to be presented to the Board at this meeting detailed the expectation to fully restore services without experiencing delays.<br><br>The team had an enormous job to reverse the changes undertaken this time last year and it was noted that restoration of services would see an increase in provision of services at the Grantham site.<br><br>**Q2 from Jody Clarke**<br><br>**With many of the Grantham Hospital restoration plans determined by staffing challenges.**<br>**What vacancies are still needed to restore the remaining services and what measures are being taken to attract substantive staff over locum/agency reliability?**<br><br>The Chief Operating Officer responded:<br><br>The Trust had vacancies across all groups including this time last year and this position was fully expected to reduce over time in line with work being undertaken to recruit. There were a number of recruitment activities underway including International Recruitment and staff returning to Grantham who had previously worked there. Overall there was an expectation there would not be any vacancies that would stop services from being opened.<br><br>The Chief Operating Officer thanked the team who had been working since December to understand how services might be restored in line with previous Board papers. Work had been undertaken to look at services whilst considering that the Trust continued to operate in a Covid-19 environment and to ensure there was the right skill mix to deliver.<br><br>The Director of Nursing supported the response from the Chief Operating Officer noting there had been an anticipation of a number of vacancies, not only at Grantham but across the Trust. There had been proactive work to consider all vacancies and it was noted that there had been vacancies before the changes due to Covid-19 had been made.<br><br>As alluded to there were a number of actions being undertaken some of which related to expressions of interest of bank staff for fixed or permanent contracts at Grantham. The Trust were also approaching staff who had been redeployed from Grantham to seek their preferences for working at the site. Whilst the Trust wished to honour those preferences there was a need to ensure patient safety and to support all vacancies across all sites. Conversations were being held with both staff and Staff Side representatives.<br><br>The Director of Nursing noted that there had been a number of International Nurses who had joined the Trust and agency staff would inevitably form part of workforce currently. An action plan was in place to support vacancies across the Trust however there had been specific work taking place for a number of months in order to ensure services would be restored. |
| 803/21 | **Item 3 Apologies for Absence**<br><br>Apologies for absence were received from Mr Geoff Hayward, Non-Executive Director and Mr David Woodward, Non-Executive Director |
| 804/21 | **Item 4 Declarations of Interest**<br><br>The Chair noted that Mr David Woodward had joined the Trust Board on an interim basis as a Non-Executive Director. Due to technical issues Mr Woodward was unable to join the Board meeting however his declarations were noted by the Board. |

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| 805/21 | Mr Woodward had declared to the Trust interests as a Non-Executive Director of the Board of Hinckley and Rugby Building Society, Director of Hinckley and Rugby Financial Services Limited and Trustee of Consumers' Association. |
| 806/21 | **Item 5.1 Minutes of the meeting held on 4 May 2021 for accuracy**<br><br>The minutes of the meeting held on 4 May 2021 were agreed as a true and accurate record. |
| 807/21 | **Item 5.2 Matters arising from the previous meeting/action log**<br><br>The Chair noted that there updates had been provided on the action log and no items required review. |
| 808/21 | **Item 6 Chief Executive Horizon Scan including STP**<br><br>The Chief Executive presented the report to the Board noting that the reporting of system and Trust issues was becoming increasingly intertwined. |
| 809/21 | The Board were advised that the financial plan for the year, recognising that this was operating on a half year 1 and half year 2 basis, had been submitted with a balanced half 1 for both the system and the Trust. It was noted the both plans had underlying risks that increased remarkably moving in to half 2 of the year. This specifically related to the revision to a more normal financial regime that would take place at the end of half 1. |
| 810/21 | Work was being undertaken as a system and with regional colleagues to ensure all were sighted on the level of risk and the actions being taken. |
| 811/21 | The Chief Executive advised that national feedback on the pre-consultation business case for the Acute Services Review was awaited. This had been through regional and national process and awaited ministerial sign off prior to the Clinical Commissioning Group being able to commence public consultation. |
| 812/21 | Developments continued in relation to the Integrated Care System (ICS) that had replaced the Sustainability and Transformation Partnership from 1 April 2021. Subject to legislation and the second reading of the Bill in Parliament, which was now not expected until July, it was anticipated that the ICS would become a formal statutory body from April 2022. |
| 813/21 | Recruitment to the System Improvement Director as part of Lincolnshire going in to the Recovery Support Programme continued. This programme would replace special measures and the entry and exit criteria to be applied were currently being determined. Whilst not yet agreed it appeared that status Quality Special Measures for the Trust and the system financial position would influence the direction of travel and exit criteria. |
| 814/21 | The Chief Executive noted the recent Quarterly System Review Meeting with NHS England (NHSE) advising that progress in Lincolnshire had been acknowledged with the improvement in the position of the system. There was an expectation that the effective working developed during the pandemic would continue as well as the need to submit the elective recovery work and tackling of the financial positon. |
| 815/21 | The Chief Executive advised the Board of the Trust issues noting there had been a further positive Transitional Monitoring Arrangement (TMA) review focusing on the Well Led domain. A number of positive TMAs had been undertaken which was positioning the Trust well for a more formal inspection from the Care Quality Commission (CQC). |

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| 816/21 | The Chief Executive noted that as yet a date for inspection was not known however statutorily an inspection and sign off from the CQC would be required before there could be consideration of the exiting of the Trust from quality special measures. |
| 817/21 | The Trust had opened the new Urgent Treatment Centre (UTC) at Lincoln County Hospital following work commencing in November 2020 and completing in May 2021. This had been a quick piece of work resulting in an impressive facility managed by Lincolnshire Community Health Services NHS Trust. The Trust took the opportunity, whilst Professor Van Tam was visiting the Trust so tour the UTC and other areas of the site. |
| 818/21 | The Chief Executive advised the Dr Colin Farquharson would start with the Trust on 2 August 2021 and that Dr Neill Hepburn had agreed to continue in the Medical Director position until this time. The Trust were also out to market via Executive Search firm Odgers Berndtson to seek a new Director of People and Organisational Development as the current Director would be leaving the Trust at the end of July. |
| 819/21 | The Chair offered thanks to the Chief Executive, Medical Director and Chief Operating Officer for the successful Quarterly System Review Meeting and to those involved in the TMAs. The Board were making a good representation of the Trust in the forums and it was hoped that this was building confidence with regulators. |
| 820/21 | Thanks were also offered to all involved in the build of the UTC in a short time frame and to the standard delivered.<br><br>The Trust Board:<br>• **Noted the update and significant assurance provided** |
| | **Item 7 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities** |
| 821/21 | **Item 7.1 Assurance and Risk Report Quality Governance Committee**<br><br>The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 18 May 2021 meeting noting that the Committee worked to the 2020/21 Board Assurance Framework objectives. The Committee would work to the 2021/22 objectives from the June meeting. |
| 822/21 | The Committee noted the substantial work by the Patient Safety Group to report to the Committee and it was noted that there were increasing concerns relating to the quality of clinical records. This had been referred by the group to the Clinical Records Group. The Committee were aware of the intention of the Trust to move to electronic records however felt that there was a need to improve the quality of records ahead of this. |
| 823/21 | The Committee saw an improvement in the management and completion of actions in relation to Serious Incidents and were pleased to see that there was learning being shared across the system. |
| 824/21 | A comprehensive upward report was received from the Safeguarding Group with the Committee pleased to see the establishment of a Mental Health Oversight group which would strengthen the Trusts approach to mental health, learning disabilities and dementia. There were also improvements in place to recruit to the team in order to provide focus to this work and support frontline staff and patients. |

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| 825/21 | The Committee were beginning to see improved reporting form the Patient Experience Group who were now gaining a better understanding of the approach of the group with a work programme now in place. This was supporting the group to understand what work needed to be done proactively as the Trust changed care pathways. |
| 826/21 | The Committee received the quarterly complaints report noting that further work was required to triangulate reporting to the Committee, this was scheduled to take place. |
| 827/21 | Mrs Libiszewski noted that the Committee were now receiving patient stories on a monthly basis however the story received by the Committee was of less than good care within maternity services. The Head of Midwifery and the team were trying to reach out however this had been received anonymously. More details were trying to be gathers in order that learning could be embedded across the system. |
| 828/21 | The Committee received a number of Maternity and Neonatal Oversight Group reports noting that the group were starting to get in to the detail of improving care. It was noted that the group now has patient representation. |
| 829/21 | Positive feedback had been received on the Maternity Clinical Negligence Scheme for Trusts (CNST) with the Board seeing the submission ahead of this being made in July. Work was being undertaken to cross check the submission and data with support being offered by the Non-Executive Director Maternity Safety Champion. |
| 830/21 | Mrs Libiszewski noted that the Committee continued to receive on a regular basis the Trust action plan in relation to the Ockenden report. |
| 831/21 | A verbal update had been received from the Non-Executive Director Maternity Safety Champion with the Committee noting that written reports would be received at future meetings to triangulate information form the oversight group and meetings with clinical teams. |
| 832/21 | The Committee received an update in relation to Clinical Audit which was delegated from the Audit Committee noting that further work would be undertaken to ensure that the Trust were not over committing. |
| 833/21 | The Committee received the draft Quality Account noting that there had been uncertainty of the requirement to publish an account, late guidance had been received by the Trust with the Committee noting the 30 June submission deadline remained. |
| 834/21 | The Board had delegated to the Committee the final sign off of the Quality Account and the Board were advised of the requirement to offer a significant report. The Trust continued to seek stakeholder engagement however it would not be possible to offer the 30 day timescale for response. All stakeholders had agreed, despite timescales, to provide comments on the report. |
| 835/21 | The Board were advised that the priorities within the Quality Account were aligned to the Integrated Improvement Plan with the intention to deliver against these. The priorities were identified as Improving Respiratory Services, Developing a Safety Culture and Improving Patient Experience. |
| 836/21 | The Committee considered the report and provided a number of recommendations in order to strengthen the report. The final report would be received for sign off prior to the submission deadline. The Board were advised that there was no requirement for the Quality Account to be audited this year. |

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| 837/21 | The Committee considered the report as an accurate reflection of the care delivered by the Trust and reflective of information received by the Committee in year. Mrs Libiszewski asked that the Board continued to all the Committee to approval the final report. |
| 838/21 | The Committee received the risk register and agreed the risks. The Committee understood that the risk register continued to be developed and looked forward to receiving the revised format at a future meeting. |
| 839/21 | The Chair was pleased to see the focus on Non-Invasive Ventilation and Clinical Harm Reviews by the Committee also noting the Trusts ability to continue clinical audit. |
| 840/21 | The Chair offered thanks to those involved in the development of the Quality Account allowing the Trust to publish in the way required and to stakeholders for flexing arrangements to support the Trust. |
| 841/21 | The Chair noted that the Board supported the continued delegation of authority to the Committee to sign off the Quality Account at the June Meeting.<br><br>The Trust Board:<br>• **Received the assurance report** |
| | **Item 8 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT** |
| 842/21 | **Item 8.1 Assurance and Risk Report People and Organisational Development Committee**<br><br>The Chair for the People and Organisational Development Committee, Mrs Dunnett provided the assurances received by the Committee from the 12 May 2021 meeting which had considered the 2020/21 objectives 2a, 2b and 4c. |
| 843/21 | The Committee were assured in relation to nursing staffing levels across the Trust noting the progress being made through the Nursing Workforce Transformation Programme. |
| 844/21 | The Committee received the Birth Rate Plus report with Mrs Dunnett noting that this would be discussed by the Board. The Committee noted the reduction in ratio levels and the reflection of this being due to the acuity of women. The Committee were assured that recruitment was in place to meet the small increased needed initially with a larger increase required for continuity of carer. |
| 845/21 | The Committee received the quarterly Guardian of Safe Working report and were assured of the proactive approach being taken to the matters being raised and of the development of the relationship between the Guardian and junior doctors. |
| 846/21 | The Committee saw positive improvement in performance relation to sickness absence following the introduction of the absence management system. Improvements were also seen regarding appraisals with the Committee noting the introduction of WorkPal. The effectiveness of the system was yet to be seen but would be monitored by the Committee. |
| 847/21 | The Committee were assured of the work being undertaken to review core learning noting that a future report was expected. |
| 848/21 | The Committee had monitored progress against the internal audit recommendations with the Committee receiving monthly reports. |

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| 849/21 | Concern had been raised regarding the job matching process with issues relating to staffing the committee that looked at the process. Work was ongoing with the divisions to address the matter. |
| 850/21 | The risk register was considered by the Committee and accepted noting the current review being undertaken. |
| 851/21 | Dr Gibson asked if WorkPal would be able to link personal and Trust objectives for staff. |
| 852/21 | The Director of People and Organisational Development advised that this was possible and had been a factor in the purchase of the system. |
| 853/21 | The Chair noted the onward referral from the Committee to the Board regarding the Birth Rate Plus paper and was pleased to see that the referrals of job matching and core learning from the Quality Governance Committee had been addressed.<br><br>The Trust Board:<br>• **Received the assurance report** |
| 854/21 | **Item 8.2 Nursing and Midwifery Framework**<br><br>The Director of Nursing presented the framework to the Board noting that this had been developed over the past year with engagement from staff who had been asked what outstanding care looked like and how it would be known that it was being delivered. |
| 855/21 | The Director of Nursing advised that hundreds of responses had been received to the questions with the senior Nursing and Midwifery Team distilling the feedback in to 4 pillars, these being Improving patient safety, Ensuring positive patient experience, Enhancing professionalism and Improving clinical leadership closest to the patient. |
| 856/21 | The framework set out the pillars, the aim of each area and the measurable objectives to be achieved over the 5 years of the framework. |
| 857/51 | The Director of Nursing noted that the framework had been launched on 12 May, International Nurses Day and in support of Midwifery Day. This had been endorsed by the Quality Governance Committee and was presented to the Board to seek support and adoption across the Trust. |
| 858/21 | The Chair noted the strong articulation of what good care looks like and was delighted that this had been drafted by the nursing teams. |
| 859/21 | The Chief Executive welcomed the framework and co-production with staff however stated there were a large number of objectives and asked how progress would be monitored against the objectives to know if there was delivery of the aspirations. |
| 860/21 | The Director of Nursing advised that this would be principally monitored through the Nursing, Midwifery and Allied Health Professional Forum (NMAAF) noting however that as the Trust started to deliver the Integrated Improvement Plan a number of the objectives within the framework would be met. |
| 861/21 | A number of elements would be done through the Outstanding Care Improvement System and work being carried out through the culture and leadership programme. There was an |

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| | expectation that a quarterly report would be received by NMAAF and upwardly reported to the Quality Governance Committee and Board. |
| 862/21 | Discussions were also taking place with the Allied Health Professional (AHP) community in order to consider an AHP framework.<br><br>The Trust Board:<br>• **Received the framework noting the significant assurance** |
| 863/21 | **Item 8.3 Birth Rate Plus**<br><br>The Director of Nursing presented the report to the Board noting that the report had been seen in detail by the People and Organisational Development Committee, Maternity and Neonatal Oversight Group and upwardly reported to the Quality Governance Committee. |
| 864/21 | The Board were advised that the Trust had bene staffing midwifery services to the outcome of the report carried out in 2017 and following the review of adult inpatient areas last year it felt pertinent to review the midwifery workforce. |
| 865/21 | The output of the review was presented to the Board with the Director of Nursing noting that there was an understanding in the service that there had been a decrease in births but an increase in acuity and dependency of the women being cared for. |
| 866/21 | There had been an increase in rations from 1:27 to 1:23 in line with the dependency however there was confidence this could be achieved. |
| 867/21 | The Continuity of Carer model being worked towards had been taken in to consideration and detailed within the conclusion and recommendations was the need to staff an additional 3.51 whole time equivalent. Work was being undertaken to move staff and workloads in order to be able to meet this at the current time. |
| 868/21 | Work in response to the outcome of the Ockenden report was being undertaken with a submission of an expression of interest to support the update of continuity of care as the Trust rolled out to 35%. There was a level of confidence in the submission put forward. |
| 869/21 | The Chair sought assurance that health inequalities had been considered as part of the benchmarking data and the criteria used was reflected in the calculations made. |
| 870/21 | Mrs Libiszewski noted that this had been received by the Quality Governance Committee however reflected on the moderate assurance given to the paper asking if this was due to the requirement for continuity of carer funding from the bid. Mrs Libiszewski was keen to understand the position should the bid not be successful. |
| 871/21 | The Director of Nursing advised the moderate assurance was due to the current gap in requirements and the need for this to be filled. The expression of interest would result in some funding however the level was not yet known. Funding would be allocated with high risk services receiving a larger share this year. Services such as those delivered by the Trust that were not high risk would receive a smaller share. Going forward there would be a fair share of the allocation of funding. |
| 872/21 | There was confidence in meeting the 35% level through Ockenden and the Trust were working through the 5 year plan to move to full continuity of carer with this needing to be considered through the Trusts financial governance arrangements. |

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| 873/21 | Dr Gibson noted that it could be useful to understand the background acuity data and if this was likely to continue. |
| 874/21 | The Director of Nursing noted that this linked to health inequalities advising that there was a raft of epidemiological data available to Public Health England that was considered by the Maternity and Neonatal Board and viewed by the Trusts Maternity and Neonatal Oversight Group. |
| 875/21 | Conversations within the system had commenced regarding the wider population with work starting with the Local Maternity and Neonatal System and governance arrangement in place with the Regional Midwife, this was at early stages however would consider quality and safety linked to the wider population. |
| 876/21 | There had been discussion about prevention and working with the female population before they entered maternity services and this work was being pulled together which could be upwardly reported to the Quality Governance Committee. The Director of Nursing also confirmed that health inequalities had been considered as part of the Birth Rate Plus review and included within the data. |
| 877/21 | The Chair noted the recommendations within the report inviting Board members to accept the recommendations as outlined and support the direction of travel.<br><br>The Trust Board:<br>• **Received the report noting the moderate assurance**<br>• **Noted the finding from the Birth Rate Plus report**<br>• **Supported the proposal to develop a 5 year plan** |
| | **Item 9 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate** |
| 878/21 | **Item 9.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**<br><br>The Chair of the Finance, Performance and Estates Committee, Dr Gibson provided the assurances received by the Committee from the 20 May 2021 meeting noting that the Committee worked to the 2020/21 Board Assurance Framework objectives. |
| 879/21 | The Committee noted the significant improvement in the quality of reporting from Estates both in terms of the level of detail and the actions in place to improve. The Committee were however disappointed to note the recent PLACE assessment outcome that had seen poor scores for privacy, dignity and well-being. |
| 880/21 | It was noted that some of this was determined by the design of the hospitals and that the ward refurbishment programme would begin to address some of the concerns. |
| 881/21 | A number of Authorising Engineers had been appointed and were now identifying issues and enabling a roadmap to be developed which offered a clearer sense of priorities to address the estates backlog. |
| 882/21 | The Committee noted the finance issues as discussed in the Chief Executives report noting the £900k deficit in month 1 which was due to the delivery of cost improvement plans (CIP) later in the year. The Committee noted the need to ensure delivery of £4m CIP in quarter 2. |

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| 883/21 | The Committee noted the financial issues caused due to Covid-19 and the inability of a number of Doctors to return to the United Kingdom due to travel restrictions. This had resulted in significant agency costs being incurred in order to backfill. |
| 884/21 | The Committee noted the reintroduction of the medical and nursing workforce transformation programmes that would support the issues being faced. |
| 885/21 | Elective recovery funding had been made available from NHSE with the Trust intending to put in a bid. This would require achievement of elective activity above threshold. |
| 886/21 | The Committee received a full and comprehensive capital plan which had been received earlier in the year with this offering detail of the proposed division of capital monies. |
| 887/21 | A detailed breakdown of revenue planning had been received which looked to the remainder of the financial year. The submission of the system plan included a breakeven position with £9.5m of risk associated with the plan. The system as a whole would need to address the risk. |
| 888/21 | The Committee noted the gradual improvement in overall performance as Covid-19 moved to an endemic issue. The Committee were made aware of the national move from treating patients based on waiting times towards treating on clinical urgency noting that whilst this as a necessary part of restoration and recovery this would affect performance reporting. |
| 889/21 | This would make monitoring progress more difficult however the Trust would follow national planning guidance and reporting mechanisms. |
| 890/21 | The Committee noted concern regarding the ability to recover the backlog in 2 week wait breast services noting that there had been a review conducted by NHSE/I and a summary report would be provided to the Committee. The Trust had increased capacity within the service to support the reduction of the backlog. Excluding breast performance the Trust was performance about 92% for 14 day performance. |
| 891/21 | The Committee also noted the 62 day wait backlog which had plateaued particularly in relation to Urology, ENT and Colorectal. An increase in the acuity of patients being seen at Grantham Hospital would support the recovery. |
| 892/21 | The Committee received an update in relation to Urgent Care noting the new standards for urgent care performance being put in place nationally, the Trust had already been using these in shadow form.<br><br>The Trust Board:<br>• **Received the assurance report** |
| 893/21 | **Item 9.2 Annual Plan (Integrated Improvement Plan Year 2)**<br><br>The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board noting that the report was presented for approval of the plan to then allow focus of the delivery in the financial year 2021/22, |
| 894/21 | The report offered assurance to the Board of the process followed to develop the plan taking in to account the year 1 position of the Integrated Improvement Plan (IIP) which runs 2020-2025. |

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| 895/21 | The Board noted that Covid-19 had impacted the delivery of year 1 of the plan and a close down report had been offered to the Finance, Performance and Estates Committee. |
| 896/21 | The plan took in to account any areas the required more progress whilst addressing the system needs and requirements along with national planning guidance. Therefore the year 2 IIP addressed all of requirements put on the organisation. |
| 897/21 | The plan included 4 objectives as outlined as part of the IIP with the Board being advised that these remained unchanged for the period of 2020-2025. The plan outlines a number of 5 year priorities that would remain in place for the duration and strategic metrics which would measure progress. |
| 898/21 | The year 2 plan offered a number of priority areas where work would be undertaken in year. 4 strategic initiatives which were must do cannot fail would be Executive led would use the large scale transformation methodology. These would be multi-year projects but may not run for the full 5 years of the plan. |
| 899/21 | There were 5 local projects where the whole organisation would be invited to be involved in bringing about improvement using the continuous improvement methodology. Major projects would be delivered by divisional colleagues, specialties, Executives and the Board with a number of areas identified where it was believed there was a need to bring improvement. Major projected would run for 1 year. |
| 900/21 | The Director of Improvement and Integration noted that the Trust had a commitment to the Outstanding Care Together Programme which would be the vehicle to ensure improvements were brought about. There would be clear oversight offered via the Committees on a monthly basis with oversight of progress being offered to the Board on a quarterly basis. |
| 901/21 | The Chair was pleased to hear that there was an understanding of how progress would be monitored noting that the detail had been seen previously with the Board involved in the development and had influenced the content.<br><br>The Trust Board:<br>• **Received the report noting the significant assurance**<br>• **Adopted Year 2 of the Integrated Improvement Plan within the organisation** |
| | **Item 10 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing** |
| 902/21 | **Item 10.1 Grantham Restoration**<br><br>The Chief Operating Officer presented the report to the Board noting that the update described the completion of 3 phases of the restoration of services. |
| 903/21 | This restoration represented a substantial amount of the previous model of care before the temporary changes put in place in June 2020 now restored and working safely with many patients accessing services. |
| 904/21 | The Chief Operating Officer was seeking confirmation from the Board to proceed to the final stage of restoration of services at the end of June which would put in place elements of urgent care and medical admissions. There were also some other smaller services which would be put in place at a similar time if not before. This represented the last stage of the restoration of Grantham services. |

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| 905/21 | The Chief Operating Officer advised the Board that the elements of risk associated with this had been addressed through responses to the public questions. |
| 906/21 | Mrs Libiszewski noted that this would significant increase the footfall on the site and sought assurance that there was confidence in the ability to maintain infection prevention and control (IPC) measures. |
| 907/21 | The Chief Operating Officer noted that the relationship with the Director of Public Health and the team had been maintained and some of the research done prior to the decision in March to restore services had been renewed. There has been progress in the vaccination programme and reduced number of Covid-19 both in the general public and hospital had given greater confidence to operate with a greatly reduced risk to patients not contracting or becoming acutely unwell due to Covid-19. |
| 908/21 | The research had suggested the need to continue to pay attention to IPC with no recommendation to mix groups of potential Covid-19 and non-Covid-19 in the same clinical areas. |
| 909/21 | A number of changes in the design of how Grantham Hospital would operate had been made in order to address this. |
| 910/21 | The Director of Nursing advised that there had been a significant increase in IPC presence on the site and the team were walking the floors to follow the patient journeys in various departments. This had supported planning and infrastructure with the need to put in place clear signage to allow people in to the site and allow segregation. |
| 911/21 | In line with national guidance the Trust continued to follow hands, face, space and ventilation and this would continue. |
| 912/21 | The Chair thanked colleagues for the work done and to restore services and offered thanks to all partners in Grantham who had made facilities available to the Trust at short notice to support the temporary changes that had been made.<br><br>The Trust Board:<br>• **Received the report noting the significant assurance**<br>• **Supported the reintroduction of the emergency and elective pathways on 30th June 2021** |
| 913/21 | **Item 10.2 University Teaching Hospitals Status**<br><br>The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board noting that the paper was seeking support for the ambition to become a University Teaching Hospital by 1 April 2022. |
| 914/21 | This was seen as an exciting opportunity for the organisation to support the vision to provide outstanding care, personally delivered. It was clear that research, education and training had an important part to plan in achieving this vision. Achievement of the status would enable the Trust to become a more attractive employer and to provide cutting edge treatments. |
| 915/21 | There was a desire to bring the application to the fore of the process to achieving the vision and this was now seen as a spring board to achieve the ambitions set out by the organisation. This had previously been considered an end point in achieving the vision however it was hoped that this could be a statement of intent. |

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| 916/21 | The Board were advised that there was local support within the system, regionally and nationally for the Trust to progress. There had been positive initial conversations with the University of Lincoln and with other organisation who had been through the process. |
| 917/21 | There was a clear process that would need to be followed and would require the Trust to become a member of the University Hospitals Association, the criteria for which had been shared in the paper and evidence would be required against this to achieve. |
| 918/21 | The Director of Improvement and Integration acknowledged the ambitious timeline and a number of key risks associated with achievement had been identified however it was believed that these could be mitigated to work towards the 1 April 2022. |
| 919/21 | The Chair noted that the paper was an exciting read and was pleased to see the level of ambition whilst recognising the risk. |
| 920/21 | Mrs Libiszewski noted the challenge however was keen that this did not just focus on medical staff but encompassed nursing, midwifery and AHPs and asked if there was representation of these groups on the steering group. Mrs Libiszewski also asked how the Trust would promote the activity of researching in to, as opposed to conducting research, to ensure there were academic shared posts across all professions in order to truly be a University Hospital as opposed to an extension of the medical school. |
| 921/21 | The Director of Improvement and Integration noted that conversations had been held with the University of Lincoln and both parties had been clear about this not being a status on the back of the medical school. This would be a strategic relationship covering all disciplines. |
| 922/21 | There was a need to develop a joint strategy a part of the process and this would articulate the areas believed to be priorities for the organisations, this was expected to be broad. The Director of Nursing, Clinical Lead for Therapies and representatives from pharmacy, research and medical education were involved. The steering group was broad and looked more widely than the medical school. |
| 923/21 | Dr Gibson noted that there was significant evidence that suggested University Hospital organisations had better clinical outcomes and better aspects for recruitment, this was not just academic but at the heart of everything the Trust wished to achieve. |
| 924/21 | The Director of Improvement and Integration noted that there were a range of opportunities to have joint appointments at a range of levels and seniority across both organisations. These were currently being explored as it was felt that whilst not formalised, there were already a number of joint appointments in place and functioning. |
| 925/21 | Mrs Dunnett was supportive of the proposal noting the opportunity for the Trust and asked what funding may be required to support the initial investment and application along with recurring funding that may be needed to maintain the status. |
| 926/21 | The Director of Improvement and Integration noted that the financial implications of the application were still being considered with a further understanding of the financial position being available in the next report to the Board. Work on existing joint appointments would need to be finalised before offering any consideration of the costs. Infrastructure would be required within the research and development team which was being considered. |
| 927/21 | It was noted however that research activity should fund the infrastructure and as such there would need to be a clear view of how to deliver recurrent costs to the organisation, it was however too early to pass comment on this. |

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| 928/21 | The Director of Nursing noted that this was an important director of travel and offered huge opportunities to the organisation, not least of all fostering a culture of learning and professionalism and the ability to be at the forefront of cutting edge treatment and technology. |
| 929/21 | The Medical Director also supported the direction of travel in order to improve the quality of work and to embrace the whole clinical and supporting community on the Trust. Traditionally this had been medically centred activity but should not be solely medically focused. |
| 930/21 | The joint appointment issue had been ongoing for some time and a number of joint appointments existed within the organisation. The Medical Director noted that research was a net contributor to the Trust, even though this was a small amount. Building on this would likely be a contributor to the Trust and an opportunity that needed to be grasped. |
| 931/21 | The Director of Finance and Digital noted there were 3 sources of funding to be balanced including Trust revenue, charitable funds for which supporting research was an objective and the opportunity to grow research. There was detailed work to be undertaken to plan through and a number of sources of funding available. This underpinned the part of the journey to finance and quality sustainability. |
| 932/21 | The Director of Finance and Digital also reflected on the importance of digital services as part of this and what could be brought to this through the digital service. |
| 933/21 | The Chair noted that the Trust would be joined in late July by Professor Phil Baker as a Non-Executive Director and chair of the People and Organisational Development Committee. Given the experience of Professor Baker the Chair suggested early conversations took place regarding reporting to the Board. |
| 934/21 | The Chair noted the limited assurance offered by the paper due to the stage of development noting the risks identified however acknowledged the support of the Board for this to be taken forward.<br><br>The Trust Board:<br>• **Received the report noting the limited assurance**<br>• **Supported the ambition for 1 April 2022 go live** |
| 935/21 | **Item 11 Integrated Performance Report**<br><br>The Director of Finance and Digital presented the report to the Board noting that this included the new executive scorecard. |
| 936/21 | Further work would be required on the scorecard however this started to build through the process of the new way of measuring performance within the Trust. It was noted that work had been undertaken on the key performance indicators related to the Quality Governance Committee resulting in the quality domains having been updated. |
| 937/21 | Further refinement of the Integrated Performance Report would be undertaken over the coming months with a focus to resolve this operationally. The Board were advised that a successful first round of new Performance Review Meetings had been held with divisional colleagues. |
| 938/21 | Dr Prior noted that there were a list of challenges to performance and to reduce backlog detailed within the report, 3 of which related to patient behaviour however it was noted that the actions to recover did not address these challenges. |

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| 939/21 | The Chief Operating Officer advised that the Trust were aware of some of the impact that delays in confidence in accessing services was having on patients with cancer services of greatest concern. |
| 940/21 | The Trust had had in place for some time a specialist nurse with a remit for mental health support and support for patients who have had issues with confidence and concerns. The role was supported by the East Midlands Cancer Alliance with a number of patient pathways and patients seen to support patients to gain access who would not have done so a year ago. This was positive but it was the start of the journey in knowing the full impact of Covid-19 on mental health and accessing acute services. |
| 941/21 | The Chief Operating Officer also noted that there had been an overall impact in confidence in accessing acute services and there would be a need to see what would happen as Covid-19 inpatients reduced alongside the number of positive patients in the community. Health inequalities would also need to be considered and the Trust were looking at referral patterns to see the impact. An initial review had shown that Lincolnshire had fared better than other regions with patients continuing to access services. Due diligence was being undertaken to ensure there had been accurate data capturing but this appeared to be reinforced regionally. |
| 942/21 | Mrs Libiszewski noted that the executive scorecard had been received by the Quality Governance Committee and asked if there was an intention to standardise the report format and utilise SPC charts. |
| 943/21 | The Director of Finance and Digital advised that this would move to SPC charts noting that the report had been the product of work with external support and this now required moving to the Trust format. |
| 944/21 | It was anticipated that the format would be updated and presented to in July with June data. It was also noted that there was need to include definitions on the scorecard to ensure a clear understanding of the information presented.<br><br>The Trust Board:<br>• **Received the report and limited assurance noting current performance** |
| | **Item 12 Risk and Assurance** |
| 945/21 | **Item 12.1 Risk Management Report**<br><br>The Director of Nursing presented the report to the Board noting that there were 3 very high risks within the report. |
| 946/21 | The first risk related to the impact of Covid-19 and remained a very high risk. Whilst it was recognised that the Trust had very few Covid-19 positive patients and no recent outbreaks caution remained due to the development of other variants. At this time it was felt that this should remain as a very high risk. |
| 947/21 | The Director of Nursing noted that appendix 1 of the report offed all of the strategic risks.<br><br>The Trust Board:<br>• **Accepted the top risks within the risk register**<br>• **Received the report and noted the moderate assurance** |

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| 948/21 | **Item 12.2 Board Assurance Framework**<br><br>The Trust Secretary presented the report to the Board noting this offered the close down of the 2020/21 Board Assurance Framework (BAF) and first iteration of 2021/22 BAF. |
| 949/21 | The Trust Secretary advised that the Committees had received the 2020/21 BAF during May for the final time with Board members recalling that the 2021/22 BAF had been discussed at the Board Development session in May. Discussion had focused on how the BAF was aligned to Year 2 of the IIP objectives. |
| 950/21 | The Executive Directors and teams had commenced work on the 2021/22 BAF which would be considered by the Committee in June. |
| 951/21 | The Chair noted the year end position of the 2020/21 BAF and was keen to ensure aligned of items being carried forward to the 2021/22 BAF. |
| 952/21 | The Trust Board endorsed the closure of the 2020/21 BAF noting the progress made demonstrated the ability of colleagues to progress despite the impact of Covid-19. |
| 953/21 | The Chair reflected on the work to develop the 2021/22 BAF noting that this developing well in respect of the controls and gaps noting however that objective 4b – advancing professional practice with partners, had not been carried forward. |
| 954/21 | The Director of Improvement and Integration noted that this could be reviewed again however it was felt that this was covered through other areas of the BAF and had been an area of duplication. It was noted that work had either been completed or was now considered business as usual and as such the objective had been taken out. This would however be reviewed to ensure this had been the right approach.<br><br>The Trust Board:<br>• **Received the report and noted the limited assurance**<br>• **Endorsed the closure of the 2020/21 Board Assurance Framework**<br>• **Accepted the 2021/22 Board Assurance Framework** |
| 955/21 | **Item 13 Any Other Notified Items of Urgent Business**<br><br>There were no other notified items of urgent business |
| 956/21 | The next scheduled meeting will be held on Tuesday 6 July 2021, arrangements to be confirmed taking account of national guidance |

| Voting Members | 11 June 2020 | 7 July 2020 | 4 Aug 2020 | 1 Sept 2020 | 6 Oct 2020 | 3 Nov 2020 | 1 Dec 2020 | 2 Feb 2021 | 2 Mar 2021 | 16 Mar 2021 | 6 Apr 2021 | 4 May 2021 | 1 June 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elaine Baylis | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Chris Gibson | X | X | X | A | X | X | X | X | A | X | X | X | X |
| Geoff Hayward | A | A | A | A | A | A | X | X | X | X | X | A | A |
| Gill Ponder | X | X | X | X | X | X | X | X | X | X | X | A | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neill Hepburn | X | A | X | X | X | X | X | X | X | X | X | X | X |
| Sarah Dunnett | X | X | X | X | X | X | X | X | X | X | A | X | X |
| Elizabeth Libiszewski | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Paul Matthew | X | X | A | X | X | X | X | X | X | X | X | X | X |
| Andrew Morgan | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Mark Brassington | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Karen Dunderdale | X | X | X | X | X | X | X | X | X | X | A | X | X |
| David Woodward | | | | | | | | | | | | | X |

**PUBLIC TRUST BOARD ACTION LOG**

Agenda item: 5.2

| Trust Board date | Minute ref | Subject | Explanation | Assigned to | Action due at Board | Completed |
|---|---|---|---|---|---|---|
| 4 February 2020 | 077/20 | Assurance and Risk Report Quality Governance Committee | Review of TOM and governance to be presented to the Board | Evans, Simon | ~~07/04/2020~~ 03/08/2021 | Further work commissioned. Report now expected Summer 2021 |
| 2 March 2021 | 259/21 | Staff Covid-19 Story | To develop a regular plan of activities, such as back to the ward, through staff engagement and organisational development activity | Rayson, Martin | 04/05/2021 | Annual engagement plan being developed by the OD Team including plans for regular opportunities for staff in support teams to visit and support clinical areas. To be considered by Trust Leadership Team in May |
| 6 April 2021 | 579/21 | Staff survey | Consideration to be given to triangulation of data between staff survey results and quality measures | Rayson, Martin | 01/06/2021 | Work being undertaken with Information Services to determine how information can be triangulated |
| 6 April 2021 | 596/21 | Smoke Free Policy | Post implementation review following relaunch to be presented to the Board | Rayson, Martin | 02/11/2021 | |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | *Public Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item number 6* |
| **Chief Executive's Report** | |
| Accountable Director | *Andrew Morgan, Chief Executive* |
| Presented by | *Andrew Morgan, Chief Executive* |
| Author(s) | *Andrew Morgan, Chief Executive* |
| Report previously considered at | *N/A* |

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

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

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

### System Overview

a) The ICS Design Framework has been published by NHS England. This sets out the action that local systems need to take to create statutory Integrated Care Systems with effect from 1st April 2022. The framework covers both the ICS Partnership and the ICS NHS Body but is predominantly concerned with the latter. The framework contains guidance relating to people and culture, governance and management arrangements, the role of providers, clinical and professional leadership, working with people and communities, accountability and oversight, financial allocations and funding flows, data and digital standards and requirements, managing the transition to the statutory ICS. All of the guidance is subject to legislation, which has yet to pass through Parliament.

b) NHS England has also published the final details of the NHS System Oversight Framework (SOF) for 2021/22. This includes details of the Recovery Support Programme (RSP) that the Lincolnshire System is entering. One aspect of the RSP is the need to appoint an experienced System Improvement Director (SID). Following a national recruitment process, Keith Spencer will be the SID for Lincolnshire. Keith has worked for the NHS for 30 years and his most recent post was as the Director of Integration and Delivery for the Hillingdon system in North West London. The SOF also necessitates a Memorandum of Understanding between NHS England and the Lincolnshire ICS. This is currently under discussion.

c) It is anticipated that the Lincolnshire System will be part of the Recovery Support Programme for no more than 12 months. As part of this, the detail of the success criteria and thus the exit criteria from the RSP are being agreed with NHS England. These are likely to focus around ULHT exiting Quality Special Measures following an inspection by the CQC and the system having a financial improvement plan for the period September 2021 through to March 2024, with evidence of delivery against the H1 and H2 financial plans in 2021/22. These exit criteria are under discussion with NHS England.

d) The Acute Services Review (ASR) pre-consultation business case has now been approved by NHS England. This means that the CCG can now pull together the materials and the process for a public consultation. It is anticipated that this will go to a Board meeting of the CCG within the next couple of months.

### Trust Overview

a) At the end of M2, the Trust was reporting a year to date deficit of £1.8m. This was in line with the H1 financial plan. The plan is based on falling deficits during Q1 and growing surpluses in Q2, resulting in break-even at the end of H1.

b) The CQC will be inspecting the radiotherapy and interventional radiology departments at Lincoln County Hospital on 6th and 7th July. This is as part of the CQC's proactive Ionising Radiation (Medical Exposure) Regulations

(IRMER) inspection programme. The inspection will be conducted virtually and will involve four two-hour sessions.

c) The Trust was delighted to reaffirm its commitment to the Armed Forces and their families by re-signing the Armed Forces Covenant on 22nd June. The Armed Forces Covenant is a promise that those who serve or have served in the Armed Forces, and their families, are treated fairly. It provides an opportunity for employers to confirm publicly that they recognise the value serving personnel, regular and reservists, veterans and military families contribute to our society and communities.

d) The Trust has appointed a new full-time Freedom To Speak Up Guardian (FTSUG). Shazia Parveen is a nurse by background and she is currently the Deputy FTSUG at University Hospitals of Derby and Burton NHS Foundation Trust.

e) The Trust participated in National Volunteers Week between the 1st and 7th June. The Trust has excellent volunteers who provide a valuable service to both patients and staff. Long Service Awards were presented to 16 volunteers who have a combined 146 years of service between them. The longest serving volunteer has been with the Trust for 32 years and counting. The Trust now has a total of 188 volunteers and are ready to take on more.

f) A new Council of Staff Networks has been established in an effort to maximise the input and added-value of the Trust's staff networks. This new group allows the Chairs and Vice-Chairs of the Networks (BAME, LGBT, Women, Mental and Physical Lived Experience, Military) to come together with the CEO and the Equality and Diversity Team.

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| **Report to:** | Trust Board |
| **Title of report:** | Quality Governance Committee Assurance Report to Board |
| **Date of meeting:** | 24th June 2021 |
| **Chairperson:** | Liz Libiszewski, Non-Executive Director |
| **Author:** | Karen Willey, Deputy Trust Secretary |

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| **Purpose** | This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.<br><br>This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. |
| | Lack of Assurance in respect of SO 1a<br>Issue: Deliver harm free care<br><br>**Infection Prevention and Control Group Upward Report**<br>The Committee received the report noting the progress that was being made and the increased assurance being provided to the Committee.<br><br>The Committee were pleased to note the progress and endorsed the position of Infection Prevention and Control despite the impact of the pandemic on the Trust.<br><br>**Infection Prevention and Control Annual Report**<br>The Committee were pleased to receive the annual report noting the quality of the paper which articulated the significant work that had taken place under the leadership of the Director of Nursing/Director of Infection Prevention and Control (IPC).<br><br>The Committee noted that the Clinical Commissioning Group had conducted a visit to Pilgrim Hospital from an IPC perspective which had a positive outcome. The Trust had also requested that NHS England/Improvement return to undertake a revisit of the site, this was due to take place at the end of July.<br><br>The Committee thanked the IPC team for developing a high quality report and for the work that had been undertaken during the year. The Committee commended the report to the Board.<br><br>**Medicines Quality Group Upward Report**<br>The Committee received the report noting the clarity of the report provided to the Committee. Whilst the roadmap had not been received the Committee were advised that where required actions were being taken to address identified issues. |

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| | Work was ongoing to complete the NICE TA's which were fundamental to the quality of practice.<br><br>**Patient Safety Group Upward Report**<br>The Committee received the report noting that the group had considered mortality and the deteriorating patient.<br><br>The Committee were disappointed to note that an update on Non-Invasive Ventilation had not been received by the Group however noted that this would be discussed at the next meeting with additional assurance to be provided to the Committee.<br><br>**Clinical Harm Review**<br>The Committee received the report noting that this offered some triangulation of data and demonstrated that the Trust was not an outlier in respect of time to treat patients.<br><br>The Committee noted the intention to report the information to the Board following the primary review being conducted by the Committee as part of the delegated responsibility.<br><br>**Serious Incident Summary Report**<br>The Committee noted that a number of downgrades were being reported with an intention to include themes and trends in future reports.<br><br>**Significant Patient Safety Related Cases Summary Report**<br>The Committee received the report noting that the emphasis of the report had been realigned to ensure this focused on patient safety.<br><br>The Committee noted the need for further detail to be included with the report in order that the Committee were clearly sighted on the issues being faced.<br><br>**CLIPS Report**<br>The Committee welcomed the new report noting this offered an overview of the key data on Complaints, Legal Claims and Inquests, Incidents and Patient Advice and Liaison Service that had occurred and reported during quarter 4 of 2020/21.<br><br>The Committee noted the triangulation within the report of the data presented noting concern regarding discharge. A discharge cell had been established covering all pathways in order to address concerns.<br><br>The report would be further developed and the Committee looked forward to receiving the updated version at future meetings.<br><br>**Claims and Inquests**<br>The Committee received the report noting that further development of the report would be required in order to ensure this included detailed information and national benchmarking in order to enable triangulation of |

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| | data.<br><br>**Children and Young People Oversight Group Upward Report**<br>The Committee received the report from the group noting this was the second report that had been received. The report was comprehensive and demonstrated the development of the group.<br><br>**Approach to Nosocomial Covid Death Reporting**<br>The Committee received the report noting that work was underway to understand the approach being taken by other organisations.<br><br>The Committee noted that the Trust had received guidance from the NHS England/Improvement regional office in February 2021 and were progressing work whilst further national guidance was awaited.<br><br>The Committee were advised that since August 2020 Medical Examiners had reviewed all deaths that had occurred in the Trust, therefore any patient who had died with probable or definite onset had had an ME review.<br><br>**Safeguarding Annual Report**<br>The Committee received the annual report noting the significant work that had been undertaken to develop the report to offer more detail than had previously been received.<br><br>The Committee noted that developments within the service continued to be made with concern noted on the achievement of safeguarding training. The Committee were aware that this was a wider issue than safeguarding due to resource concerns within the core learning team.<br><br>The Committee were pleased to receive the comprehensive report that offered assurance to the Committee which comprehensively offered updates on the next steps that the team would be taking.<br><br>The Committee thanked the Deputy Director of Safeguarding for his leadership and the impact this had had on both the team and within in the organisation.<br><br>The Committee endorsed the report to the Board. |
| | Lack of Assurance in respect of SO 1b<br>Issue: Improve Patient Experience<br><br>**Maternity and Neonatal Oversight Group Upward Report**<br>The Committee received the upward report and series of reports from the Group.<br><br>The Committee noted the progress towards meeting standards in respect of the neonatal improvement action plan and Anaesthesia Clinical Services Accreditation (ACSA) standards. The action plan being in place would support the Trusts submission for CNST. |

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| | The Committee noted that there were a number of red actions within the plan however these were due to be achieved by September 2021.<br><br>The Committee received and ratified the British Association of Perinatal Medicine (BAPM) Educational Plan for neonatal services.<br><br>The Committee noted the progress being made and the evidence which had been significantly reviewed internal to maternity services and the external triangulation to offer an objective review.<br><br>The Committee accepted all reports presented including the written report from the Non-Executive Director (NED) Maternity Safety Champion. The report was appended to the upward report to be received by the Board.<br><br>**Approach to Clinical Negligence Scheme for Trusts**<br>The Committee received the proposal on the approach to the sign off of the CNST submission which would be due on 15th July.<br><br>The Committee were assured that the Trust would be compliant with all standards and evidence had been quality assured by the Clinical Commissioning Group, NED Maternity Safety Champion and Deputy Director Clinical Effectiveness. The Committee supported the recommendation for CNST sign off.<br><br>**Patient Experience Group Upward report**<br>The Committee received the report noting the work relating to the Outstanding Care Together Programme was in progress.<br><br>The Committee were keen that learning was shared and embedded across the organisation.<br><br>**Patient Story**<br>The Committee received the patient story relating to the Clinical Support Division and was presented by the Cancer Care Coordinator for Breast.<br><br>The story focused on the positive experience and outcome for a patient diagnosed with breast cancer. The Cancer Care Coordinator had undertaken a Holistic Needs Assessment and gone above and beyond in supporting the patient to ensure she was properly and safely housed.<br><br>The Committee were pleased to receive such a positive story noting the enthusiasm of the staff member and requesting that this be shared within the organisation as an area of good practice. The story detailed partnership working but with a focus on the patient and ensuring their needs were fully met and supported.<br><br>**Complaints Annual Report**<br>The Committee received the annual report noting that work that had taken place during the year despite the impact of Covid-19. |

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| | The Committee noted the requirement for the report to be received by the Board and published on the Trusts' website. |
| | Lack of Assurance in respect of SO 1c<br>Issue: Improve Clinical Outcomes<br><br>**Clinical Effectiveness Group Upward report**<br>The Committee received the report noting this offered a comprehensive updated and demonstrated that traction was starting to be seen. |
| | **Assurance in respect of other areas:**<br><br>**Clinical Audit – Gastric Surgery outlier**<br>The Committee received a verbal update in relation to the Gastric Surgery Clinical Audit for Colorectal Surgery due to concerns being raised that this had identified the Trust as an outlier.<br><br>The Committee received assurance that appropriate action had been taken as a result of the outcome of the audit and a review of mortality conducted. The Committee noted that due to the length of time for the national audit to be completed this did not offer real time data.<br><br>Consideration was being given to the introduction of a tool to support ongoing review.<br><br>**Board Assurance Framework**<br>The Committee received the 2021/22 Board Assurance Framework noting the strengthened narrative.<br><br>The Committee after consideration of the papers presented agreed to put forward to the Board an improved rating for objective 1a from red to amber.<br><br>The Committee were pleased to note that effective controls were in place and the papers presented were offering a significant level of assurance.<br><br>**Committee Performance Dashboard**<br>The Committee received the dashboard noting concern that some indicators could not be correlated and that further clarity was required within the executive summary.<br><br>The Committee explored a number of indicators in order to seek assurance of the current position and were advised that work continued in order to ensure that the report was improved.<br><br>**Performance Review Meeting Upward Report**<br>The Committee received the upward report noting that the new style PRMs had now commenced and reporting from these in place.<br><br>The Committee noted concern that the report did not offer the expected |

| | |
|---|---|
| | triangulation of information being presented through the PRM meetings and to the Committee.<br><br>**Integrated Improvement Plan**<br>The Committee received the detailed report and scoping booklet with the Committee noting the need to better understand how the relevant programmes would be embedded in to the reporting groups.<br><br>It was noted that there was work to be done in order to achieve this with the Committee noting that it would be beneficial to see through the report the allocation of the programmes to the relevant groups. This would detail for the Committee where assurances would be seen.<br><br>**Topical, Legal and Regulatory Update**<br>The Committee received the report for the first time noting that this offered an insight in to current issues that the Committee needed to be sighted on.<br><br>The Committee were advised that reports would be presented on a quarterly basis with input being sought from service leads. The Committee requested that future reports detailed actions being taken by the Trust as a result of any topical, legal or regulatory updates.<br><br>**Quality Impact Assessments**<br>The Committee received the report noting the improved reporting and the inclusion of the 42 major projects contained within the Integrated Improvement Plan.<br><br>The Committee were advised that Equality Impact Assessments would be included from the July meetings and would be included within reporting going forward.<br><br>**Quality Account – Final**<br>The Committee received the final Quality Account for approval noting that the statements from stakeholders had been received.<br><br>The Committee noted that the Quality Account accurately reflected the position of the Trust and asked that the patient experience objective was urgently developed to include SMART measures.<br><br>The Committee approved the Quality Account for sign off on the Trust Boards behalf by the Chair and Chief Executive.<br><br>**Internal Audit Reports**<br>The Committee received the Complaints, Risk and Serious Incident Internal Audit reports noting the levels of assurance offered within each report.<br><br>The Committee noted the disappointment expressed by the Complaints Team as a result of the audit however it was recognised that this had not reviewed the strengthened processes recently put in place by the team. |

| | |
|---|---|
| | **CQC Must and Should Do Actions**<br>The Committee received the report noting the proposal being made for a report to be received by the Trust Board. The Committee accepted the recommendation that an Executive Summary be provided to the Trust Board with the detailed reporting continuing to be received by the Committee. |
| **Issues where assurance remains outstanding for escalation to the Board** | None |
| **Items referred to other Committees for Assurance** | The Committee referred the issue of clinical records to the Finance, Performance and Estates Committee as had been raised through the Patient Safety Group Upward Report |
| **Committee Review of corporate risk register** | The Committee reviewed the risk register accepting the risks and noting that the revised format of the risk register was due to be adopted |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | None |
| **Committee position on assurance of strategic risk areas that align to committee** | The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. |
| **Areas identified to visit in dept walk rounds** | Department walk around currently suspended. |

**Attendance Summary for rolling 12 month period**

| **Voting Members** | J | A | S | O | N | D | J | F | M | A | M | J |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elizabeth Libiszewski Non-Executive Director | X | X | X | X | X | X | X | X | X | X | X | X |
| Chris Gibson Non-Executive Director | X | X | X | X | X | X | X | X | X | X | X | X |
| Sarah Dunnett Non-Executive Director | | | | | | | | X | X | X | X | X |
| Neill Hepburn Medical Director | X | X | X | X | C | X | X | X | X | X | X | X |
| Karen Dunderdale Director of Nursing | X | X | X | D | X | A | X | X | X | X | X | X |
| Simon Evans Chief Operating Officer | X | A | X | D | C | C | C | C | C | C | X | D |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Public Trust Board* |
| Date of Meeting | *6th July 2021* |
| Item Number | *Item 8.2* |
| *IPC Annual Report* | |
| Accountable Director | *Karen Dunderdale. Director of Nursing/ Director of Infection, Prevention and Control* |
| Presented by | *Natalie Vaughan, Deputy Director of IPC* |
| Author(s) | *Natalie Vaughan, Deputy Director of IPC* |
| Report previously considered at | *Quality Governance Committee* |

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

| | |
|---|---|
| Risk Assessment | |
| Financial Impact Assessment | |
| Quality Impact Assessment | |
| Equality Impact Assessment | |
| Assurance Level Assessment | |

| | |
|---|---|
| Recommendations/ Decision Required | • *The Board are asked to receive and approve the Annual IPC Report* |
| | • |
| | |

# Director of Infection Prevention and Control Annual Report

# 2020-2021

## Version Control

| | |
|---|---|
| **Version** | **1** |
| **Type** | **Draft Annual Report** |
| **Directorate** | **Corporate** |
| **Author** | **Mrs Lisa Carroll – Interim Deputy DIPC** |
| **Contributors** | Dr Bethan Stoddart - Consultant Microbiologist and IPC Doctor<br>Mrs Balwinder Bolla - Consultant Antimicrobial Pharmacist<br>Mrs Natalie Vaughan – Deputy DIPC<br>Mrs Vivien Duncanson – Senior IPC Nurse<br>Mr Stephen Kelly – Head of Occupational Health and Wellbeing<br>Mr Wayne Mckintosh – Estates and Facilities Engagement Lead<br>Mr John Killeen – Associate Director of Estates and Facilities |
| **Approving Person** | **Dr Karen Dunderdale Director of Nursing and DIPC** |
| **Approval Date** | **IPCG 19.05.21** |

**Contents**

## 1. Summary and Highlights

The Director of Infection Prevention and Control (DIPC) Annual Report details infection prevention and control performance activities within United Lincolnshire Hospitals Trust for the year 2020-2021.

The report outlines the Trust's zero tolerance approach to reducing the risk of avoidable Healthcare Associated Infections (HCAIs) for patients, the challenges and the steps taken to reduce risk. United Lincolnshire Hospitals Trust (ULHT) is committed to leading on and supporting initiatives to reduce HCAI.

Good Infection prevention and Control (IPC) practice is essential to ensure that people who use the Trust's services receive safe and effective care. Effective IPC practices require the hard work and diligence of all staff, clinical and non-clinical. Good practice must be applied consistently by everyone.

The publication of the Trust's annual report is a requirement to demonstrate good governance and public accountability. In addition, it highlights the role, function and reporting arrangements of the DIPC and the IPC team.

Throughout the reporting period the Trust has been responding to the global COVID-19 pandemic. COVID-19 has brought significant challenges to the healthcare system and the impact on patients and staff has been significant. This report will detail the Trusts response and plans going forward as the approach moves from managing a pandemic to COVID-19 becoming endemic in our population.

With the COVID-19 pandemic seeing the country in lock down for large portions of the year, there have been no outbreaks of diarrhoea and vomiting related illnesses or influenza reported and a significant reduction in other respiratory illnesses such as RSV.

The Trust has seen significant improvements in compliance with the Code of practice on the Prevention and Control of Infections and The Hygiene Code. The Trust is compliant with all except two criterions which relate to estates and policies. In these areas, which are partially compliant, a plan is in place to address this and mitigation is in place to reduce any risks.

| | Compliance criterion<br>What the registered provider will need to demonstrate | RAG rating |
|---|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. | |
| 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. | |
| 3 | Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. | |
| 4 | Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion. | |
| 5 | Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. | |
| 6 | Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. | |
| 7 | Provide or secure adequate isolation facilities. | |
| 8 | Secure adequate access to laboratory support as appropriate. | |
| 9 | Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. | |
| 10 | Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection. | |

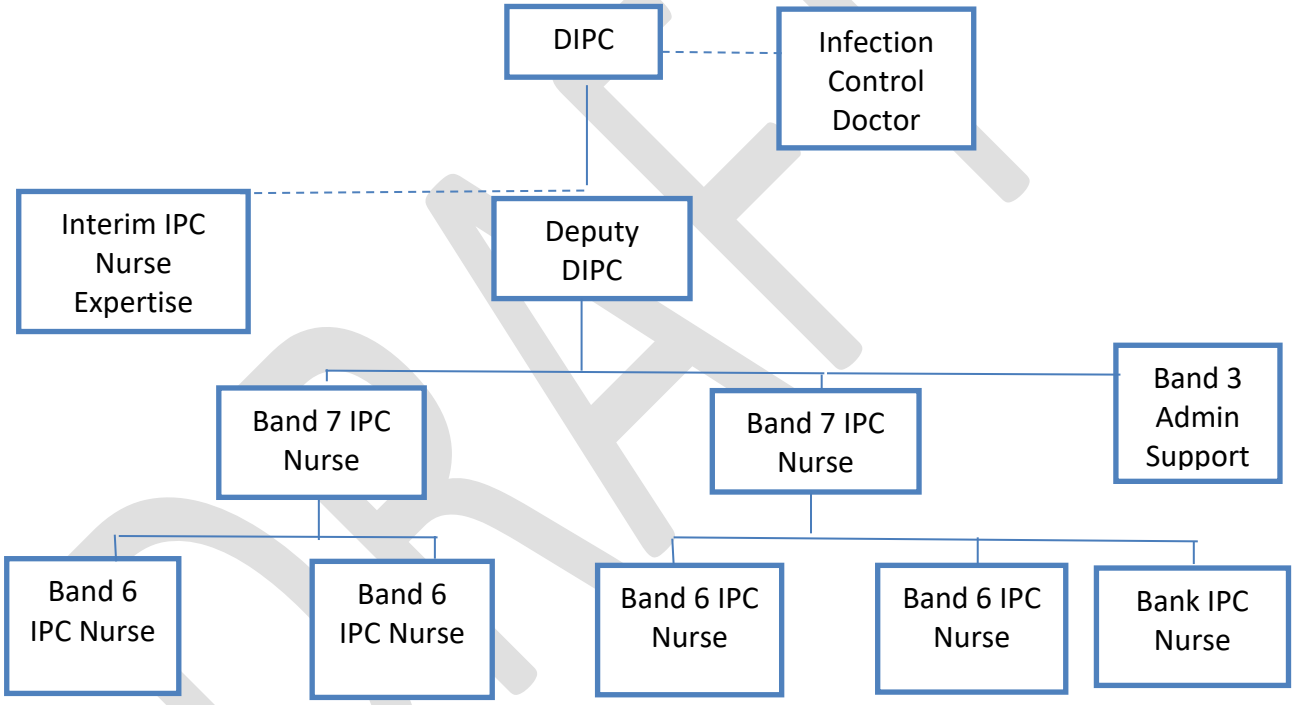
## 2. Infection Prevention and Control Arrangements

***The IPC Team***

The Director of Infection Prevention and Control holds board level responsibility for all matters relating to the safe delivery of IPC care and practice.

The Deputy DIPC provides operational leadership to the IPC Team which is predominantly site based. At the end of 2020 an interim Deputy DIPC came into post as the original post holder moved roles into the CCG.

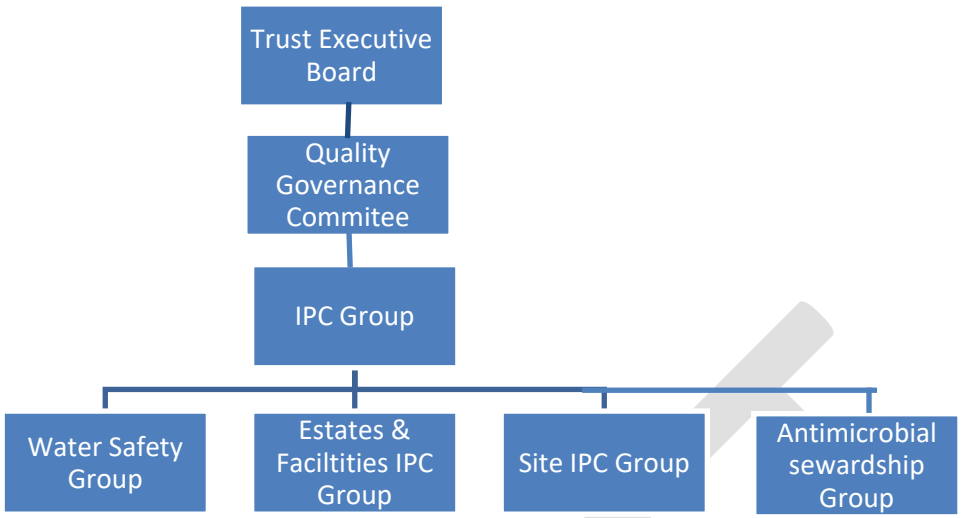
The current IPC structure is as follows:




***IPC Governance, Assurance and reporting structure***

The Trust Infection Prevention Control Group (IPCG) provides strategic direction for the prevention and control of Healthcare Associated Infections in United Lincolnshire Hospitals NHS Trust. It performance manages the organisation against the Trust's Infection Prevention and Control Strategy and ensures that there is a strategic response to new legislation and national guidelines. The group seeks assurance from the divisions and ensures compliance with the Health and Social Care Act (2008).

A number of sub-groups report into the IPCG and the IPCG provides upwards assurance to the Quality Governance Committee and Trust Executive Board.




***COVID-19 Assurance***

During the COVID-19 pandemic and this reporting period additional IPC meetings have been embedded in the IPC governance structure.

A daily IPC Cell meeting has provided assurance regarding the maintenance of staff and patient IPC safety and practice relating to the pandemic. It has overseen the development of IPC practice and guidelines in line with national guidance. Ward assurance logs were implemented early in the pandemic and assurance provided through the IPC cell.

A member of the IPC team has been an integral member of the daily COVID-19 GOLD meetings to ensure escalation of any areas of concern and provide assurance regarding actions being taken.

## 3. Healthcare Associated Infection Performance

### 3.1 Mandatory reporting

The Trust continues to report on the infections required by the mandatory surveillance programme facilitated by Public Health England:

- Clostridioides *difficile* infection (CDI)

- Meticillin-resistant Staphylococcus *aureus* (MRSA) blood stream infections (bacteraemia)
- Meticillin-sensitive Staphylococcus *aureus* (MSSA) bacteraemia
- Escherichia *coli* blood stream infection
- Klebsiella *species* blood stream infection
- Pseudomonas *aeruginosa* blood stream infection

National criteria are applied to establish whether cases of these infections are attributable to the Trust (hospital onset or healthcare associated).

For bacteraemia cases when the sample is taken on the day of admission or the following day it is considered to be community onset but samples taken after that time are considered to be hospital onset.

For CDI the thresholds for attribution changed from 1 April 2019 meaning there are now four categories of infection:

- Hospital onset healthcare associated: cases that are detected in hospital three or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the Trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the Trust reporting the case in the previous 12 weeks but not in the most recent 4 weeks.
- Community onset community associated: cases that occur in the community (or within 2 days of admission) when the individual has not been an in-patient in the Trust reporting the case in the previous 12 weeks.

The first two categories count as attributed to the Trust reporting the case (healthcare associated).

For the reporting period of 2020-2021 the Trust had a target of 5% reduction in all Healthcare Associated Infection (except COVID-19).

### 3.2 MRSA Bacteraemia

Staphylococcus *aureus* is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important that we screen some groups of high risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide

special skin wash and nasal cream that helps to get rid of MRSA. This measure reduces the risk of an infection developing.

The Trust has reported four Trust acquired MRSA Bacteraemia during the year 2020-2021. Nationally there is a zero tolerance to MRSA Bacteraemia.

This is an increase of one from the reported cases in 2019-2020, where the Trust reported three Trust acquired MRSA Bacteraemia.

One case occurred at Pilgrim Hospital in May 2020; one case was identified in January 2021 at Lincoln Hospital and two cases, one at Lincoln and one at Pilgrim hospital were identified in February 2021.

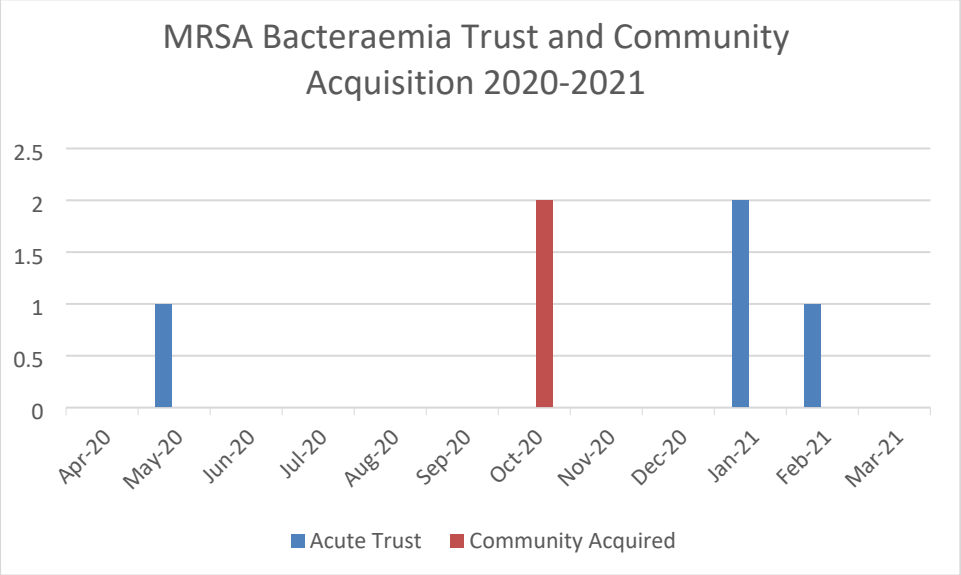
For each of the cases a root cause analysis (RCA) and either a Deputy DIPC or DIPC review has been undertaken with the relevant clinical teams to identify areas of concern, ensure actions are taken to prevent recurrence and the lessons are learnt and shared with the wider health care team.

Following the DDIPC/DIPC of three of the four cases, two were identified as being avoidable and one case was unavoidable.

The reviews identified a need to revise and update the documentation regarding the insertion of invasive lines and the taking of blood cultures. This has been undertaken and the policy and documentation amended accordingly. An invasive lines group has been established.

**MRSA Bacteraemia per site 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Louth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Lincoln** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| **Pilgrim** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| **Grantham** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 |
| **Cumulative Total** | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 4 | 4 |




### 3.3 MSSA Bacteraemia

MSSA is a strain of Staphylococcus *aureus* that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

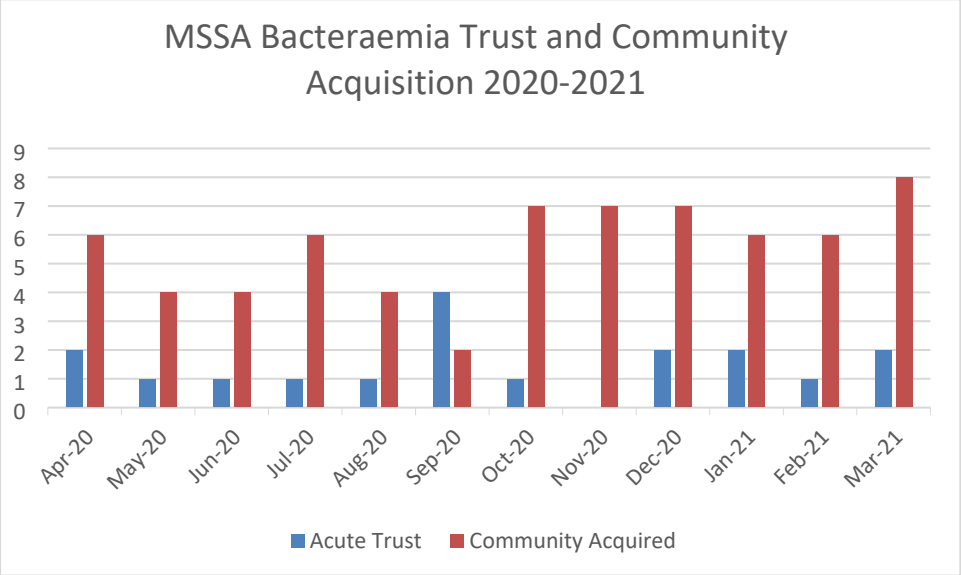
The Trust has reported nineteen Trust acquired MSSA Bacteraemia during the year 2020-2021.

**Trust attributable MSSA Bacteraemia 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Louth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Lincoln** | 0 | 1 | 1 | 0 | 1 | 2 | 1 | 0 | 1 | 1 | 1 | 1 |
| **Pilgrim** | 2 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 1 | 1 | 0 | 1 |
| **Grantham** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 2 | 1 | 1 | 1 | 1 | 5 | 1 | 0 | 2 | 2 | 1 | 2 |
| **Cumulative Total** | 2 | 3 | 4 | 5 | 6 | 11 | 12 | 12 | 14 | 16 | 17 | 19 |

**Community attributable MSSA Bacteraemia 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community attributed** | 6 | 4 | 4 | 6 | 4 | 2 | 7 | 7 | 7 | 6 | 6 | 8 |
| **Cumulative Total** | 6 | 10 | 14 | 20 | 24 | 26 | 33 | 40 | 47 | 53 | 59 | 67 |




In 2019-2020 the Trust reported 18 Trust acquired MSSA Bacteraemia and 82 Community acquired. Trust acquired rates have remained unchanged from the previous year.

### 3.4 Clostridium *difficile* infection

Clostridioides *difficile* is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and Clostridium *difficile* can then multiply and produce toxins which cause symptoms such as diarrhoea.

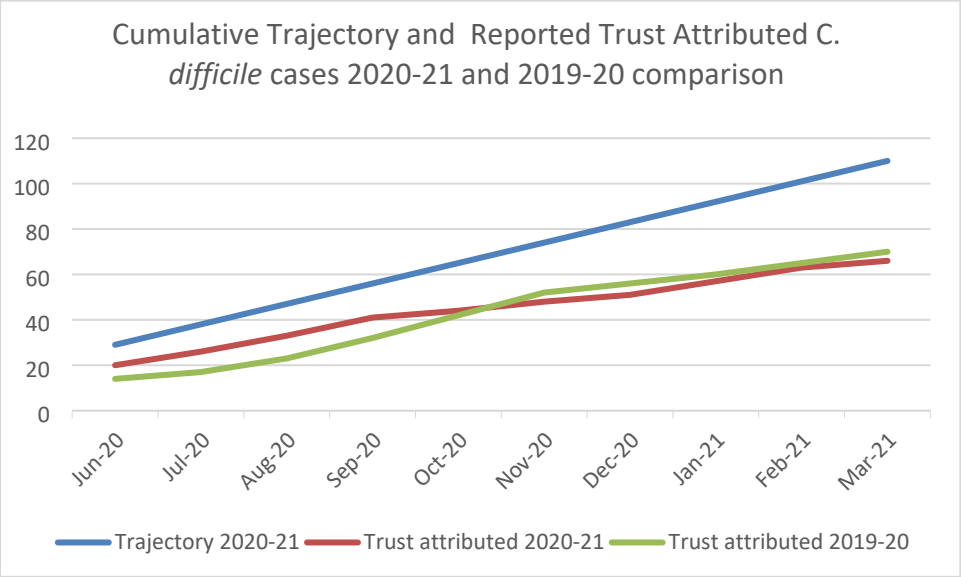
For 2020-2021 the Trusts target for C. *difficile* was set by NHSE at no more than 110 cases in the year. The Trust set an internal target of no more than 66 cases.

The Trust has reported 66 Trust attributable cases of C. *difficile* in 2020-2021.

**C. *difficile* data for 2020-2021**

| 2020/21 | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trajectory | 10 | 10 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |
| Actual acute cases | 10 | 4 | 6 | 6 | 7 | 8 | 3 | 4 | 3 | 6 | 6 | 3 |
| +/- Trajectory | 0 | -6 | -4 | -3 | -2 | -1 | -6 | -5 | -6 | -4 | -3 | -6 |
| Acute Cumulative actual | 10 | 14 | 20 | 26 | 33 | 41 | 44 | 48 | 51 | 57 | 63 | 66 |
| Community cases | 4 | 2 | 2 | 4 | 2 | 5 | 1 | 3 | 3 | 2 | 0 | 1 |
| Cumulative Total Across Lincolnshire Health economy | 14 | 20 | 28 | 38 | 47 | 60 | 64 | 71 | 77 | 85 | 91 | 95 |

In 2019-2020 the Trust reported 70 Trust attributable cases of C. *difficile.* This represents a 5.7% reduction in cases from the previous year and a reported figure that is 40% below the expected trajectory of 110 for the year.




### 3.5 Escherichia *coli* blood stream infection

Often referred to as E. *coli,* this is part of the normal gut flora and can commonly cause urinary, biliary or gastrointestinal tract related infection leading to blood stream infection (E. *coli* blood stream infection).

Some E. *coli* are enzyme producers known as extended spectrum beta lactamase (ESBL) which increase the resistance to multiple antibiotics.

Attention to insertion and care of urinary catheters, audits, education and reporting of catheter associated urinary tract infection are directed to further reduce healthcare associated infection and E. *coli* blood stream infection.

There is no national threshold for E. *Coli* infection rates.

The Trust has reported thirty-four E *Coli* blood stream infections during the year 2020-2021. This is a 32% reduction on 2019-2020, when the Trust reported fifty-one E *Coli* blood stream infections.

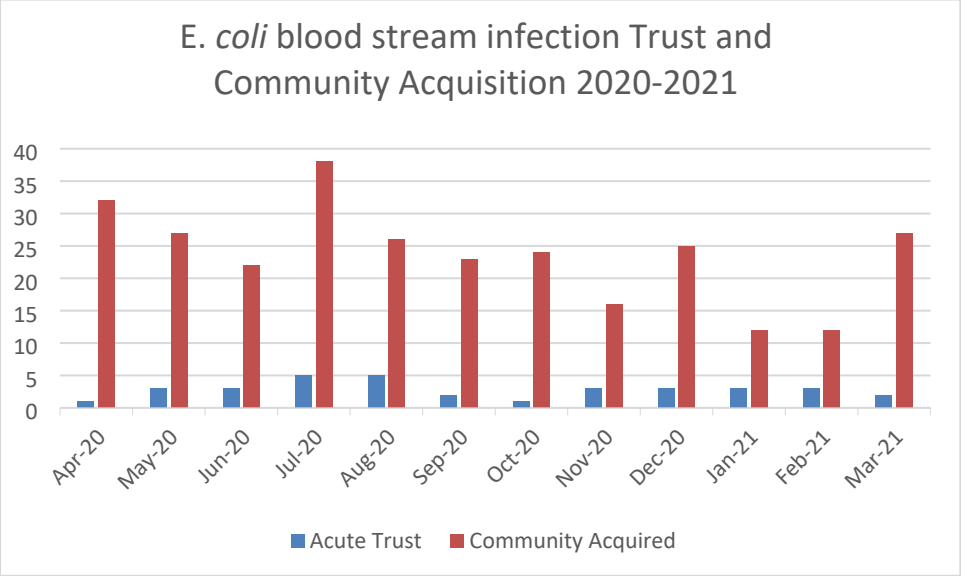
**Trust Attributable E. *Coli* blood stream infection 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Louth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Lincoln** | 1 | 2 | 3 | 4 | 4 | 1 | 1 | 1 | 2 | 0 | 3 | 1 |
| **Pilgrim** | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 2 | 1 | 3 | 0 | 1 |
| **Grantham** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | 1 | 3 | 3 | 5 | 5 | 2 | 1 | 3 | 3 | 3 | 3 | 2 |
| **Cumulative Total** | 1 | 4 | 7 | 12 | 17 | 19 | 20 | 23 | 26 | 29 | 32 | 34 |

**Community attributable E. *Coli* blood stream infection 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community attributed** | 32 | 27 | 22 | 38 | 26 | 23 | 24 | 16 | 25 | 12 | 12 | 27 |
| **Cumulative Total** | 32 | 59 | 81 | 119 | 145 | 168 | 192 | 208 | 233 | 245 | 257 | 284 |




### 3.6 Klebsiella *species* blood stream infection

Klebsiella *species* belong to the family Enterobacteriaceae. Klebsiella *species* are commonly associated with a range of healthcare associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

There is no national threshold for Klebsiella *species* infection rates.

The Trust has reported thirty-one Klebsiella *species* blood stream infections during the year 2020-2021

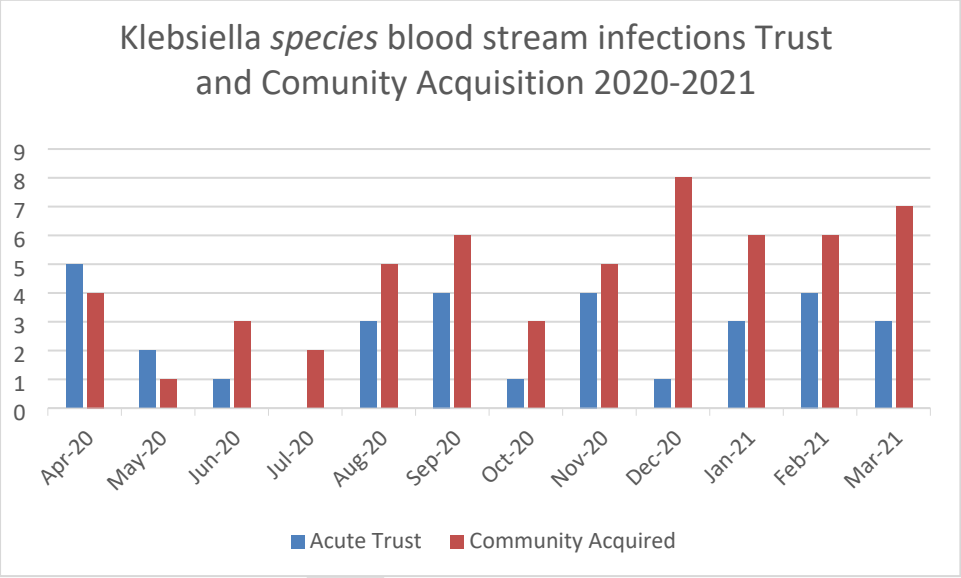
This is a 45% increase from 2019-2020 when the Trust reported seventeen Klebsiella *species* blood stream infections.

**Trust Attributable Klebsiella *species* blood stream infection 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Louth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Lincoln** | 1 | 0 | 1 | 0 | 2 | 3 | 1 | 3 | 1 | 2 | 4 | 2 |
| **Pilgrim** | 4 | 2 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| **Grantham** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 5 | 2 | 1 | 0 | 3 | 4 | 1 | 4 | 1 | 3 | 4 | 2 |
| **Cumulative Total** | 5 | 7 | 8 | 8 | 11 | 15 | 16 | 20 | 21 | 24 | 28 | 31 |

**Community attributable Klebsiella *species* blood stream infection 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community attributed** | 4 | 1 | 3 | 2 | 5 | 6 | 3 | 5 | 8 | 6 | 6 | 7 |
| **Cumulative Total** | 4 | 5 | 8 | 10 | 15 | 21 | 24 | 29 | 37 | 43 | 49 | 56 |




### 3.7 Pseudomonas *aeruginosa* blood stream infection

Pseudomonas is a type of bacteria that is found commonly in the environment, including soil and in water. Of the many different types of Pseudomonas, the one that most often causes infections in humans is called Pseudomonas *aeruginosa*, which can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.

There is no national threshold for Pseudomonas *aeruginosa* infection rates.

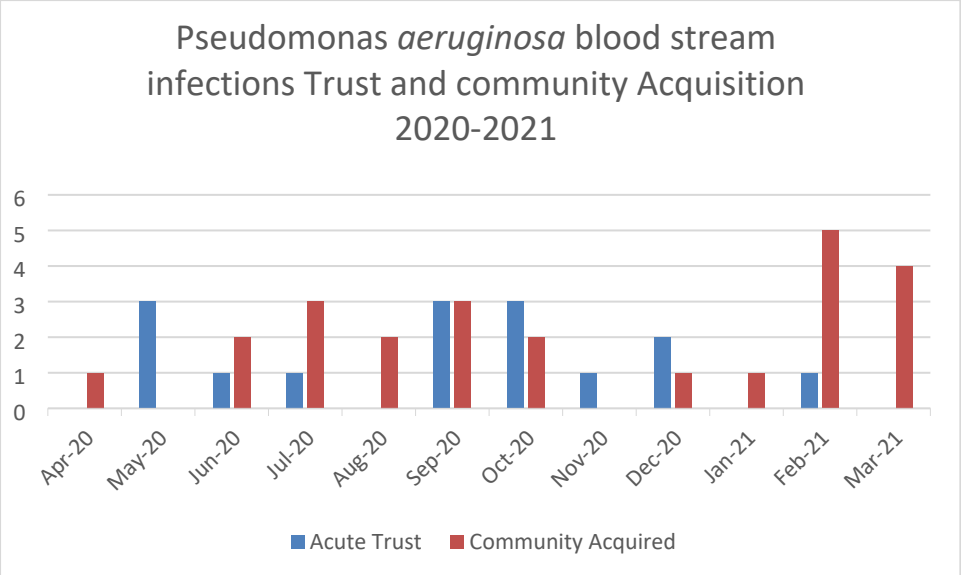
The Trust has reported fifteen Pseudomonas *aeruginosa* blood stream infections during the year 2020-2021. This is a 21% reduction on 2019-2020, when the Trust reported nineteen Pseudomonas *aeruginosa* blood stream infections.

**Trust Attributable Pseudomonas *aeruginosa* Bacteraemia 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Louth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Lincoln** | 0 | 1 | 1 | 1 | 0 | 3 | 2 | 0 | 1 | 0 | 0 | 0 |
| **Pilgrim** | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 |
| **Grantham** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 0 | 3 | 1 | 1 | 0 | 3 | 3 | 1 | 2 | 0 | 1 | 0 |
| **Cumulative Total** | 0 | 3 | 4 | 5 | 5 | 8 | 11 | 12 | 14 | 14 | 15 | 15 |

**Community attributable Pseudomonas *aeruginosa* blood stream infection 2020-2021**

| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community attributed** | 1 | 0 | 2 | 3 | 2 | 3 | 2 | 0 | 1 | 1 | 5 | 4 |
| **Cumulative Total** | 1 | 1 | 3 | 6 | 8 | 11 | 13 | 13 | 14 | 15 | 20 | 24 |




### 3.9 *Surgical Site Infection (SSI) Surveillance*

Due to the COVID-19 pandemic elective activity has been greatly reduced during the reporting period. This has resulted in no meaningful data being reported, published or analysed by the Trust during the 2020-2021 period.

The Trust re-convened the Surgical Site Surveillance group in March 2021 to ensure as elective activity returns to the Trust SSI data is collected, reported nationally and data utilised to improve patient care.

### 3.10 COVID-19

On the 12th March 2020 the World Health Organisation declared a global pandemic and the Trust received their first COVID-19 positive patient on the 17th March 2020. The United Lincolnshire Hospitals Trust has throughout the period 2020-2021 covered by this report responded to this pandemic.

On 5th March 2020, in response to the Covid-19 pandemic, the Trust enacted the Pandemic Flu plan and elements of the Major Incident Plan and put in place Command and Control systems. The infection prevention and control governance structure was adjusted to support the Trust and staff to safely manage the IPC requirements. Daily IPC Cells were established, chaired by the DIPC or Deputy DIPC to provide support, guidance, implementation of IPC policy and practice relating to COVID-19, manage outbreaks and provide assurance to the Trust board.

Panel meetings with NHSE/I were established to provide assurance and to share and learn lessons from other Trusts.

Throughout the pandemic the Trust has followed national guidance for all matters relating to infection, prevention and control.

During the pandemic the IPC Team moved to seven day working to ensure appropriate support was available every day to the Trust.

In June 2020 Grantham District General Hospital was established as a green site. This enabled urgent elective work and services such as chemotherapy to continue. All other services were either ceased or re-located to other sites in line with national guidance.

Patients admitted to Grantham Hospital are required to have a swab for COVID-19 72 hours prior to surgery and to self-isolate prior to admission.

Staff either only work on the Grantham site or if they are required to work on other sites, do not do so on the same day as working at Grantham.

All elective care activity other than urgent treatment as defined by national guidelines was stopped.

Lincoln and Pilgrim Hospitals implemented green and blue pathways in March 2020. Green pathways accept patients who have no known contact or symptoms of COVID-19 and test negative and blue pathways admit those with known contact or symptoms of COVID-19 and those who have tested positive. Dedicated COVID-9 wards for the care of patients admitted

with COVID-19 either as their primary reason for admission or because they have tested positive on admission to hospital were quickly established early in the pandemic.

Emergency Departments implemented streaming at the front door and patients are triaged to either the green or blue areas on arrival at the departments.

***Testing for COVID-19***

All non-elective admissions to Lincoln and Pilgrim Hospitals are swabbed for COVID-19 on admission, at day 3 and days 5-7 of admission, in line with national guidance.

In December 2020 the Trust introduced lateral flow testing for all patients requiring admission in the Emergency Departments and have subsequently introduced other rapid tests such as SAMBA and LumiraDX. This reduces the time patients are required to spend in the emergency Departments and provides a reliable mechanism for ruling out COVID-19 and ensuring those who test positive are isolated promptly.

Twice weekly lateral flow testing of patient facing staff was introduced in December 2020. To the 31st March 2021 71027 lateral flow tests have been completed.

***COVID-19 related admissions***

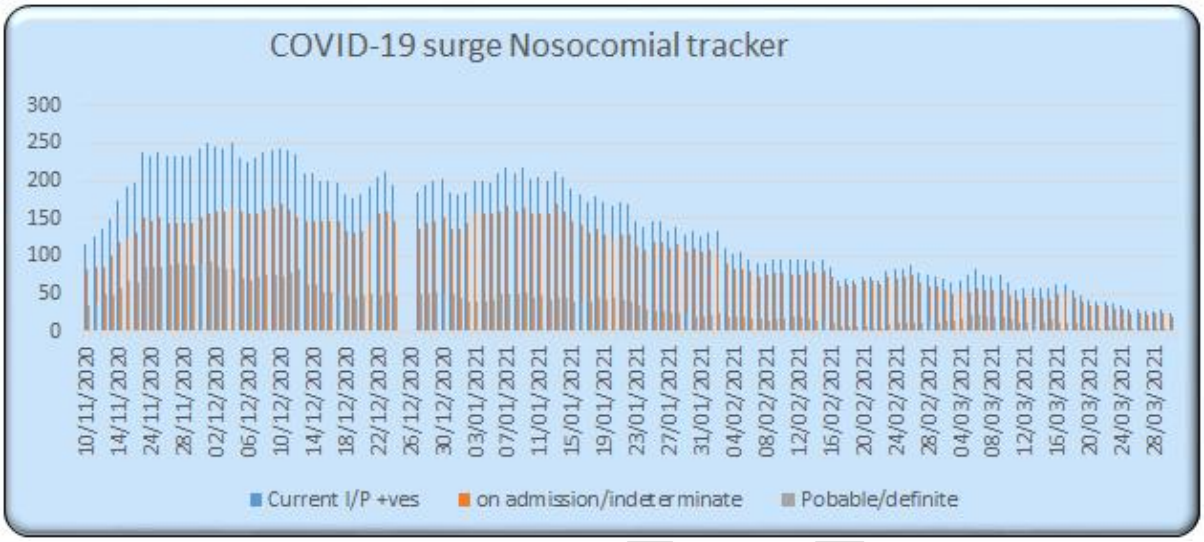
In November 2020, wave 2 of the pandemic, the number of patients in beds within the Trust with COVID-19 surpassed the previous peak in wave 1. Wave 2 saw more than 250% of the number of patients admitted during wave 1.

In total, up to the 31st March 2021, the Trust has cared for 3019 COVID-19 positive patients.

Sadly, during the pandemic, to the 31st March 2021, 826 patients have died as a result of COVID-19 within the Trust.

***Nosocomial spread***

The Trust has monitored closely nosocomial rates and put measures in place to reduce the spread of COVID-19 within the Trust.




Daily audits are undertaken in all wards and departments to ensure compliance with PPE, social distancing, environmental cleaning, hand hygiene, ventilation and the wearing of masks by patients. As new guidance has been published the ward assurance logs have been updated to reflect this.

Spot checks and audits are undertaken by the Quality Matrons and Divisional Nurses and the Infection Prevention and Control Team.

Posters are in place throughout the Trust with the key messages of hands, face, space. All main entrances are manned by Trust staff to greet visitors, ensure they use the hand gel and provide them with an appropriate face mask to wear.

Visiting has been restricted through the pandemic in order to reduce transmission with visiting only taking place on compassionate grounds and in line with national guidance.

The cleaning teams have expanded to provide support 24 hours per day with increased cleaning of all touch points and enhanced cleaning in areas caring for COVID-19 positive patients or where patients have been in contact with a COVID-19 positive individual.

In December 2020 the Trust introduced ‘Ring the bell for Clinell’. Four times per day all wards and departments pause when a bell is rung and clean the area around them. All members of the team, clinical and non-clinical, take part.

The Trust has a COVID-19 action plan which is overseen and assurance gained through the IPC Group. Each division takes responsibility for ensuring the actions identified through audits and review of guidance as it is published or updated, are implemented and embedded in practice.

The national Board Assurance Framework published by NHSE in May 2020 and updated in December has been completed and is updated on a monthly basis. The Trust is compliant or

has actions in place to ensure full compliance with all elements of the framework. An assurance report is provided to the Trust Board each month.

***Project Salus***

In January 2021 the Trust launched Project Salus. The aim of the project is to safely restore speciality based wards and a resumption of business as usual as move from managing COVID-19 during a pandemic to living with it being endemic in our population.

The trust is aligning with the national guidance of triaging and caring for patients in the categories of high, medium or low risk within their required speciality. This revised way of working will be rolled out during the financial year 2021-2022

### 3.11 Outbreaks

***Panton Valentine Leukocidin (PVL) MRSA***

In March 2020 two babies tested positive on the neonatal unit at Pilgrim Hospital for PVL MRSA. A third case was identified in May 2020 and an outbreak was declared. An outbreak meeting was held and immediate control measures put in place. The control measures included screening of all babies and staff on the Pilgrim site. This outbreak was reported externally to the CCG and CQC.

An external review was requested and a plan was put in place for clinicians from the University Hospitals of Coventry and Warwick to undertake this. Due to the pandemic the clinicians have been unable to undertake this visit. The Trust has recently appointed a new Deputy DIPC from another organisation and they will be undertaking a review of the service in April 2021.

In February 2021 two patients on the Intensive Care Unit (ICU) at Pilgrim Hospital developed a PVL MRSA of the same type. An outbreak meeting was held to review the cases and identify any lessons learnt.

Lessons learnt and actions identified during the outbreak meeting were shared with the ICU team and with the wider Trust at the IPC Group meeting, to ensure wider Trust learning.

## 4. Policies and Guidelines

During 2020-2021 the IPC Team have produced Guidance at a Glance documents for key IPC practice. The fourteen one page documents provide staff with a quick reference guide relating to specific IPC policies.

A project has been established during the year to review and update all IPC policies and resource has been sourced to focus on this.

Nineteen IPC policies have been updated during 2020-2021.

In addition to the updating of policies and provision of guidance at a glance, posters have been developed and made available in all clinical areas detailing IPC messages. These have been further supported by publication of a daily IPC bulletin for all staff.

## 5. Audit Programme

In August 2020 the Trust introduced a Front Line Ownership (FLO) audit programme as the standardised IPC audit tool for all wards and departments. The audit programme was rolled out to all wards and departments in a staged approach from August 2020.

The FLO audits focus on ten key areas of practice: hand hygiene, general environment, patients immediate bed space, isolation of infected patients, dirty utility / linen and waste disposal, ward kitchen, sharps safety, storage areas, clean utility and treatment room, patient equipment, clinical practice.

The audits are undertaken on a monthly basis and results, themes and actions reported to the IPC Group for assurance.

***FLO Audit Results – average total percentage per division per site***

(≤ 84% = red; 85-90% = amber; 91–100% = green)

| Site | Division | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
| Pilgrim | CSS | | | | | 94.50% | 93% | 94% | 93.50% | 96.40% | 98.70% | 96% | 96.70% |
| Lincoln | CSS | | | | | 91% | 89.50% | 89.50% | 94.20% | 95.80% | 95.50% | 97% | 97.60% |
| Grantham | CSS | | | | | 96.50% | 96% | 98.30% | 98.50% | 95.50% | 98.30% | 98.50% | 99.70% |
| Louth | CSS | | | | | 96.50% | 96% | 98.30% | 98.50% | 95.50% | 98.30% | 98.50% | 100% |
| | | | | | | | | | | | | | |
| Pilgrim | Family Health | | | | | 94.70% | 93.80% | 95.60% | 96.20% | 97.10% | 98.30% | 97.40% | 97.80% |
| Lincoln | Family Health | | | | | 90.70% | 92.40% | 94.90% | 93.80% | 92.60% | 94.20% | 93.70% | 93% |
| Grantham | Family Health | | | | | closed | closed | closed | closed | closed | closed | closed | closed |
| Louth | Family Health | | | | | NA | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Medicine | | | | | 86.50% | 89.60% | 91.60% | 91% | 89.10% | 88.60% | 93.60% | 94.80% |
| Lincoln | Medicine | | | | | 89.30% | 91.30% | 90.20% | 91.10% | 93.90% | 93.80% | 92.50% | 93.20% |
| Grantham | Medicine | | | | | NA | NA | NA | NA | NA | NA | NA | NA |
| Louth | Medicine | | | | | NA | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Surgery | | | | | 86% | 87% | 83% | 91% | 93.80% | 92.20% | 94% | 94.00% |
| Lincoln | Surgery | | | | | 89.20% | 91% | 86.80% | 81.20% | 85% | 93% | 93.40% | 92.20% |
| Grantham | Surgery | | | | | 98% | | 96% | 89% | 97% | | | 97% |
| Louth | Surgery | | | | | | | | | | | 100% | 100.00% |

***Hand Hygiene Audit Results – average total percentage per division per site:***

| Site | Division | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
| Pilgrim | CSS | | | | | | 98.1% | 98.3% | 98.80% | 99.50% | 99.50% | 95.7% | 98.60% |
| Lincoln | CSS | | | | | | 80.00% | 97.30% | 99.40% | 99.60% | 100.00% | 100% | 100% |
| Grantham | CSS | | | | | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100% |
| Louth | CSS | | | | | | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100% |
| | | | | | | | | | | | | | |
| Pilgrim | Family Health | | | | | | 98.60% | 98.60% | 98.40% | 97.80% | 99.00% | 98.80% | 96.40% |
| Lincoln | Family Health | | | | | | 100.00% | 98.70% | 99.50% | 100.00% | 100.00% | 100.00% | 100% |
| Grantham | Family Health | | | | | | closed | closed | closed | closed | closed | closed | closed |
| Louth | Family Health | | | | | | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Medicine | | | | | | 83.10% | 90.00% | 91.5% | 91.40% | 93.40% | 94.80% | 95.60% |
| Lincoln | Medicine | | | | | | 95.70% | 97.40% | 95.20% | 99.00% | 97.60% | 98.10% | 95.30% |
| Grantham | Medicine | | | | | | NA | NA | NA | NA | NA | NA | NA |
| Louth | Medicine | | | | | | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Surgery | | | | | | 95% | 96.7% | 95% | 96.70% | 100.00% | 98.2% | 100% |
| Lincoln | Surgery | | | | | | 95.8% | 95.50% | 100.00% | 100% | 98.8% | 100.00% | 96.30% |
| Grantham | Surgery | | | | | | 87% | 97% | 97% | 97% | 93% | | 100% |
| Louth | Surgery | | | | | | NA | NA | NA | NA | NA | NA | 100% |
| Site | Division | | | | | | | | | | | | |
| | | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
| Pilgrim | CSS | | | | | | 98.1% | 98.3% | 98.80% | 99.50% | 99.50% | 95.7% | |
| Lincoln | CSS | | | | | | 80.00% | 97.30% | 99.40% | 99.60% | 100.00% | 100% | |
| Grantham | CSS | | | | | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| Louth | CSS | | | | | | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| | | | | | | | | | | | | | |
| Pilgrim | Family Health | | | | | | 98.60% | 98.60% | 98.40% | 97.80% | 99.00% | 98.80% | |
| Lincoln | Family Health | | | | | | 100.00% | 98.70% | 99.50% | 100.00% | 100.00% | 100.00% | |
| Grantham | Family Health | | | | | | closed | closed | closed | closed | closed | closed | closed |
| Louth | Family Health | | | | | | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Medicine | | | | | | 83.10% | 90.00% | 91.5% | 91.40% | 93.40% | 94.80% | |
| Lincoln | Medicine | | | | | | 95.70% | 97.40% | 95.20% | 99.00% | 97.60% | 98.10% | |
| Grantham | Medicine | | | | | | NA | NA | NA | NA | NA | NA | NA |
| Louth | Medicine | | | | | | NA | NA | NA | NA | NA | NA | NA |
| | | | | | | | | | | | | | |
| Pilgrim | Surgery | | | | | | 95% | 96.7% | 95% | 96.70% | 100.00% | 98.2% | |
| Lincoln | Surgery | | | | | | 95.8% | 95.50% | 100.00% | 100% | 98.8% | 100.00% | |
| Grantham | Surgery | | | | | | 87% | 97% | 97% | 97% | 93% | | |
| Louth | Surgery | | | | | | NA | NA | NA | NA | NA | NA | NA |

## 6. Antimicrobial Stewardship (AMS)

The Trust Antimicrobial Stewardship Strategy Group (ASSG) meets every month to track progress and actions against the ULHT Antimicrobial Stewardship strategy. The forum allows dialogue with IPC Team, clinicians, Path Links, sepsis leads, acute care practitioners, and primary care around antimicrobials specifically. Despite the challenges of COVID-19, attendance and engagement via MS Teams has enabled continuation of Trust wide engagement with Antimicrobial Stewardship over the pandemic.

AMS Lincolnshire has been recognised and recommended by NHSI Antimicrobial Resistance leads for UK as a great model for other local health economies to develop the same, and collaboration through this group enabled procurement and establishment of the Antimicrobial App, Microguide®, which allows quicker access to guidelines and correct prescribing recommendations at the patient bedside. In addition to the Trust Antimicrobial Guidelines devised by Path Links and the various local guidance on managing specific

infections, there is a Trust Antimicrobial Prescribing Policy which is also accessible through Microguide.

ULHT has 5 Key Performance Indicators used as antimicrobial prescribing standards applied in the Trust for AMS, as part of our work to tackle AMR.

Restricted antimicrobials are managed by simple but effective means, with support from the pharmacy department and numerous prescriber quality improvement projects under Antimicrobial Consultant supervision. 'Pink slip supplies' of sepsis antibiotics are available on each low risk ward, whereas high risk wards keep those antibiotic wards as stock. This is to provide a suitable compromise and working solution to ensuring correct antimicrobials are available for immediate use, versus the AMR challenges of not being able to track how ward stock is used. An audit undertaken of all 'Pink slip supplies' in 2020, suggests that this scheme is working very well, and no changes are recommended.

The antimicrobial pharmacy team remain a very well utilised as a service from various staff groups. Having various means of contacting the team has enabled an ongoing influence in maintaining a basic level of antimicrobial stewardship on ward and clinical areas. This has been greatly facilitated by the pharmacy staff, where ward pharmacists and technicians signpost inappropriate or questionable prescribing, unusual or suspicious requests for antimicrobials, dosing queries, allergy queries, etc., and staff in the department have worked with us to co-ordinate ward stock and pink slip supplies, especially in light of the rapid ward changes and designation of COVID / non-COVD wards. The Post Graduate Medical Education Centre have been extremely supportive in sharing key educational messages with all prescribers and recruiting several junior doctors to antimicrobial prescribing audits in problem areas to facilitate a ward based approach. All in all, this pandemic has brought out a strengthened collaborative approach to ensuring antimicrobial stewardship and improving patient outcomes.

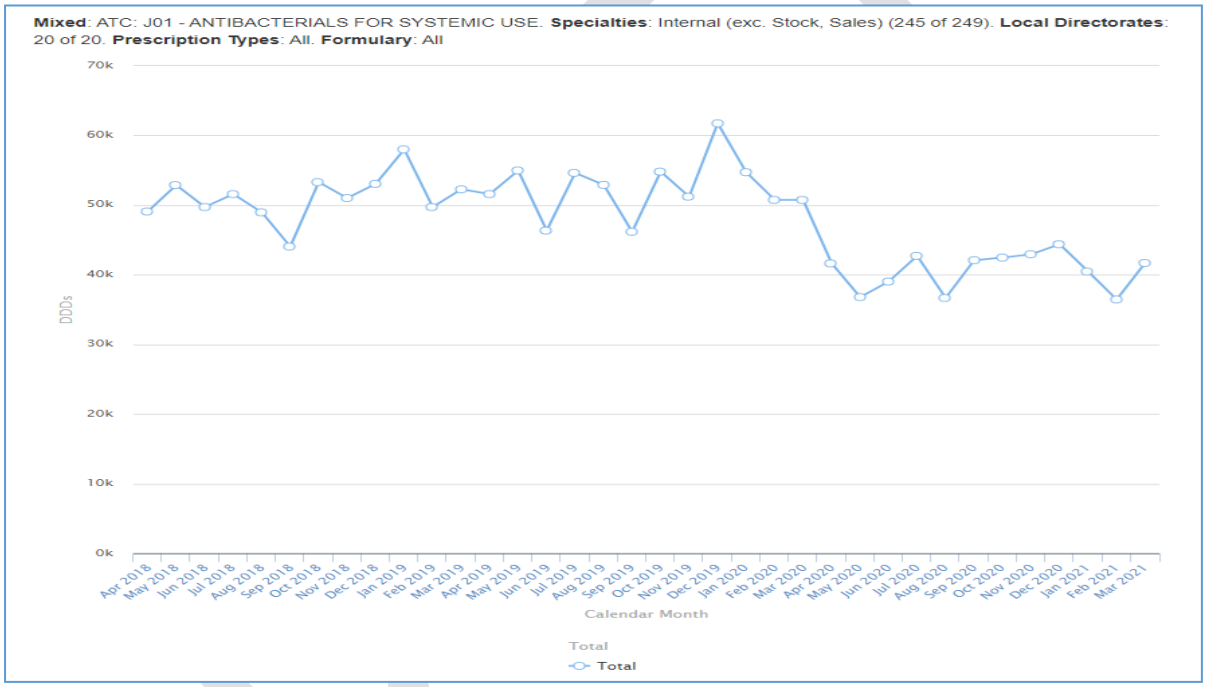
Communications and surveillance of COVID trials and treatments has also been part of the response to the pandemic, with rapid messages shared through the Trust SBAR where appropriate, including creation of specific antimicrobial guidelines for managing Pneumonia secondary to COVID19 infection. Surveillance on the use of Antimicrobials, and COVID treatments is shared at ASSG and reports are available from the Antimicrobial Team. These are generally consumption reports for the Trust as ULHT has limitations of not having electronic prescribing in place yet, but some reports, such as the surveillance on Remdesivir is more detailed.

Training and education on AMS for various staff groups were revised to create video teaching, to allow for a more socially distanced and virtual form of teaching programme, in light of COVID. This also helped ensure that staff who were off sick were able to access the sessions at a later date and complete this part of the curriculum.

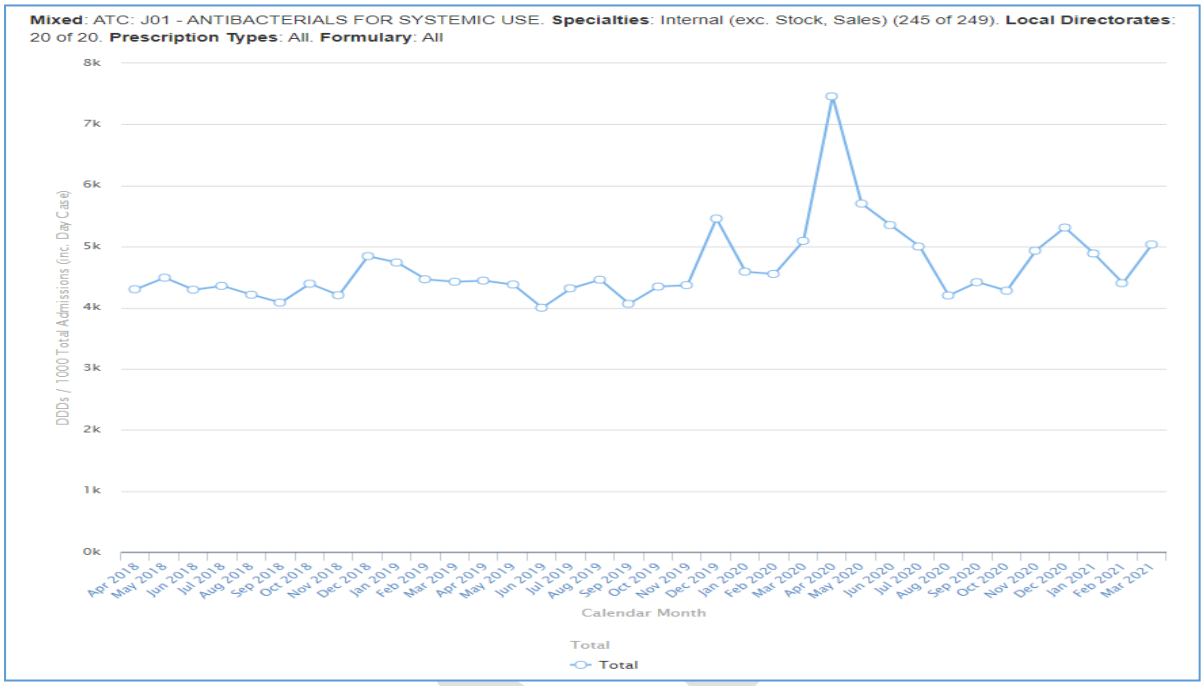
The Chief Operating Officer requested maximum capacity functioning of the OPAT service as a bed enabler during the COVID-19 Pandemic, as a means of keeping patients safe, and has

appreciation of the role this could play in the restore and recover plan for ULHT. Whilst there have been some issues with staffing and home nursing capacity, significant efforts to increase patient uptake have still resulted in exceeding the trajectory of service activity by 28% over 2020/21.

The first graph below gives oversight of raw value of antimicrobials used over this period. The significant drop in antimicrobial use during the first wave of COVID-19, mirrors the fall in Trust bed numbers that was rapidly implemented. The second graph highlights there was actually a significant increase in antimicrobial use during that time. It is clear that more patients were on antimicrobials than usual. This will reflect the reduction in elective admissions that do not require urgent antimicrobial treatment and the steep increase in non-elective emergency admissions that do. This correlates with an increase in activity and demand in the antimicrobial team with a significant increase in calls for antimicrobial advice, for COVID and non-COVID patients.



*Consumption trend for systemic antibacterial use, corrected against Trust wide activity, over April 2018 to March 2021 (please note there is a 3-month time lag on verification of Trust activity, so Jan-Mar 21 is conditional data).*

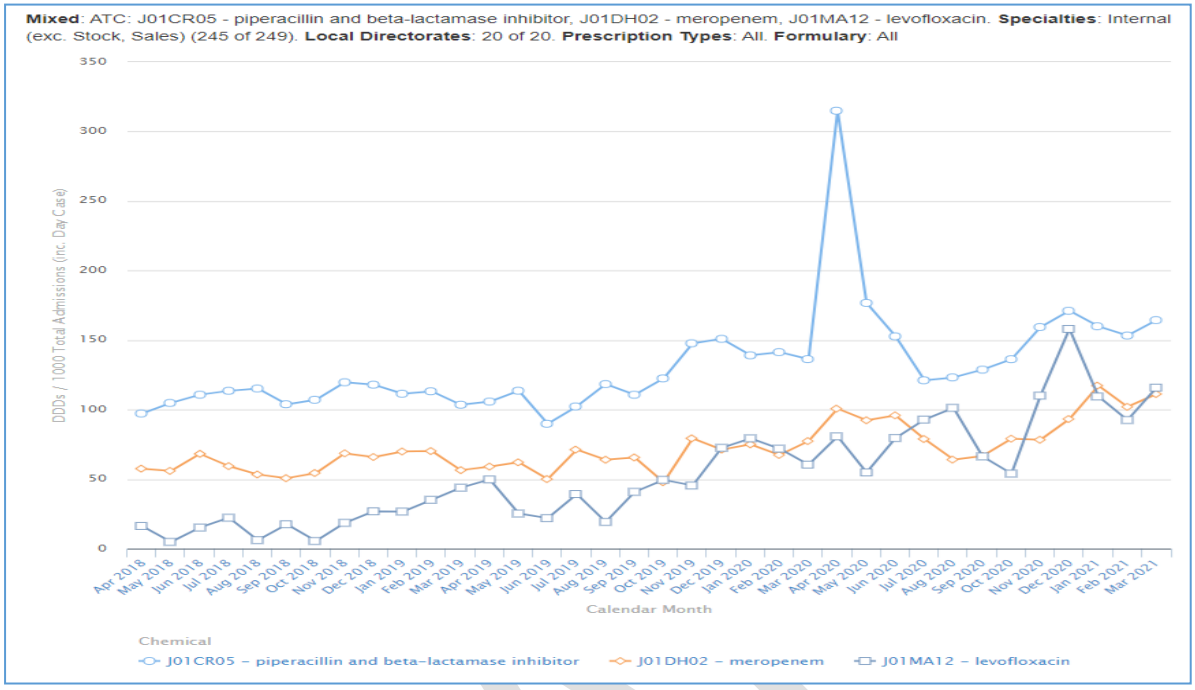



Antibacterial use accounts for most of the antimicrobial agents used in terms of quantity. There is always an increase in use over the winter pressures period due to the nature of patient presentations with chest infections in particular over this period. A second peak is seen in March 2020, coinciding with COVID-19. Benchmarking our consumption over the course of the year, it is noted that the trend is in keeping with other Trusts across the East Midlands region, and nationally.

Surveillance on consumption of Piperacillin-tazobactam, meropenem, and levofloxacin is shown in the graph below.

A peak in piperacillin tazobactam use is seen around the time of the first surge, where serious case presentations were not responding to co-amoxiclav and standards of care with dexamethasone in such cases was not yet established. Levofloxacin use has increased steadily since January 2019 as expected following increased recommendation in the antimicrobial guidelines for Adults. Over the summer months, when cases of COVID-19 were lower, there is a dip in consumption of all three agents, rising again with the second surge, albeit not as steeply, as the management of COVID-19 patients now had more robust national guidance, prescriber confidence in understanding the course of illness and more awareness of the local COVID-19 antimicrobial guidelines. Surveillance of other antimicrobials recommended in the guidelines for pneumonia secondary to COVID-19, for less severe cases, or as step down options, reveal a similar trend.

**Consumption trend for piperacillin-tazobactam, meropenem and levofloxacin, corrected against Trust wide activity, over April 2018 to March 2021 (please note there is a 3-month time lag on verification of Trust activity, so Jan-Mar 21 is conditional data).**




Every year, doctors, junior pharmacists and any interested staff are encouraged to join audits on antimicrobial stewardship.

| Examples of antimicrobial audits conducted over this year |
|---|
| **5KPIs on MEAU at LCH** Understanding prescribing issues in real terms on acute medicines unit. Identified meaningful ways of supporting antimicrobial prescribing by prescribers, to see quality improvement.<br><br>**5KPIs on AMSS at PHB** Antimicrobial Prescribing a recurring issue as identified by repeat and prolonged PII audits this year. Aim of audit was to understanding prescribing issues in real terms on acute medicines unit..<br><br>**Penicillin allergy snapshot audit** to ascertain completeness and accuracy of penicillin allergy documentation on ULHT prescription charts.<br><br>**Penicillin allergy incidents audit** looked into the frequency of DATIX incidents filed over the year 2020/21, and investigated the patient cases to understand if the patient came to harm, whether correct actions were taken, and also whether allergy status was amended where patients had received doses in error and not had an adverse reaction.<br><br>**Sepsis 72-hour review audit (rolling monthly)** following on from the Sepsis AMR CQUIN over 2017-19, we have kept this work going as a good checkpoint of practice and to target areas for improvement. Standard is 90% for all relevant factors to be considered and actioned.<br><br>**Pink slip supply audit**<br><br>**Remdesivir audit** to track use of Remdesivir for COVID19 treatment and patient outcomes. |

The progress made this year is reassuring for further development post pandemic. The antimicrobial pharmacy team is anticipating further support to allow expansion of OPAT and assist STP wide antimicrobial stewardship. The exciting development of having effective technology to guide prescribing, and reflections from the COVID-19 pandemic offer good hope and promise of strengthened partnerships, communication and collaboration.

## 7. Laboratory Service

Unsurprisingly, the COVID-19 pandemic has shaped the laboratory year.

During the year 2020-2021, Path Links laboratories built the SARS-CoV-2 testing service up to being capable of processing approx. 1000 tests per day, and since testing started has processed just under a quarter of a million COVID-19 swabs as at the end of March 2021. This service has been provided as part of the Midlands and East 2 pathology network, and during the pandemic there has been close working to provide a sustainable Pillar 1 SARS-CoV-2 testing service across the East Midlands. The bulk of the tests have been undertaken using PCR batch analysers, principally the Abbott M2000, and latterly the Abbott AlinityM. A rapid molecular testing capability has also been developed employing the Cepheid GeneXpert and the Cambridge university developed SAMBA test. This capability will be further developed in 2021-22. Antibody testing has been undertaken by the blood sciences department of Path Links, and has supported diagnostics and the surveillance undertaken within the SIREN study.

Just as many other health services have had to change their way of working as a consequence of COVID-19, so has the microbiology laboratory. These have been because of the need to prioritise COVID-19 testing, and because of the health and safety impact on the laboratory.

In March 2020, the recommendations of the IBMS and RCPath on demand management in the microbiology laboratory were locally adapted. These were widely communicated, and allowed for prioritisation of SARS-CoV-2 testing by the laboratory during the pandemic peaks.

Health and safety of staff working within the laboratory has been a priority, and many interventions have been undertaken including facilitation of social distancing, installation of microbiology safety cabinets, air-handling and ventilation, and new primary tube testing for urine microscopy which minimises aerosol production. These have enabled the laboratory to return to an almost complete repertoire of tests, with volume of testing being driven by demand rather than restricted by capacity. The extra demands relating to COVID-19 have placed the microbiology directorate under considerable staffing pressures as no extra staff have been allocated to cover the ongoing increase.

The clinical microbiologists have worked closely with the IPC and operational teams to minimise risk and disruption relating to COVID-19 and other pathogens.

Despite the challenges of COVID-19, the laboratory successfully underwent UKAS surveillance inspections, and has retained accreditation under ISO15189. The laboratory staff undertook a huge amount of work to enable this positive outcome. There is a comprehensive laboratory

handbook, and laboratory SOPs based on national standard methods which are available on request. WebV, the laboratory reporting IT system, has been updated this year, offering enhanced audit trails, more intuitive formats and new modules available. There is ongoing monitoring of KPIs for turnaround times of key sample types, including MRSA screens and C difficile tests, and there are no significant concerns.

Overall this has been a challenging year, but the laboratory service has risen to those challenges and continues to provide high quality services with a low cost per test.

## 8. Estates and Facilities

The Estates and Facilities team have adapted and changed working patterns and processes to respond to the COVID-19 pandemic and have been an integral part of the Trusts response.

During 2020 an Estates, Facilities and IPC Group was formed which reports into the Trusts IPC Group. This group has provided focus on achieving compliance with the Hygiene Code.

A programme of ward enhancements has been undertaken during the year. This has seen vital work undertaken to improve the environment for patients and staff, including the fitting of doors on bays to ensure a COVID secure environment and improve privacy and dignity for patients.

In December 2020 the Trust purchased Derby doors to reduce the risk of COVID-19 transmission in areas where bay doors were not already in place.

The deep cleaning team has been expanded in response to COVID-19 and provides cover 24 hours per day. A business case has been prepared to ensure this continues as we move from COVID-19 being managed as a pandemic to being endemic in our population.

The Housekeeping team have completed training in Cleaning for Confidence to ensure all staff understand the importance of the use of correct cleaning techniques and safe working practices. This will continue to be rolled out to all clinical staff groups across the Trust during 2021-2022.

Cleanliness audits are undertaken by Facilities with Matrons/Sisters in line with the National Standards of Cleanliness using the Credits for Cleaning Micad audit tool (MiC4C). During the pandemic the frequency of audits has been increased in areas where there have been declared outbreaks of COVID-19. MiC4C audit data is reviewed and assurance regarding cleanliness gained through monthly reporting to the IPC Group.

Average MiC4C Audit Scores (%) by site 2020-2021:

| | Apr 2020 | May 2020 | Jun 2020 | Jul 2020 | Aug 2020 | Sept 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Jan 2021 | Feb 2021 | Mar 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grantham** | 95.42 | 94.83 | 92.91 | 83.63 | 80.71 | 89.28 | 93.87 | 93.69 | 93.59 | 94.08 | 93.20 | 94.16 |
| **Lincoln** | 86.55 | 87.52 | 87.64 | 88.27 | 87.39 | 88.50 | 85.08 | 85.60 | 87.66 | 88.41 | 89.98 | 90.49 |
| **Pilgrim** | 92.52 | 88.43 | 89.83 | 88.55 | 85.93 | 86.60 | 89.09 | 90.96 | 94.30 | 94.02 | 90.42 | 92.07 |

## 9. Water Safety

During 2020-2021 the Trust has undertaken a review of water systems management. The Water Safety Policy, Water Safety Plan and Written Scheme Plan have been reviewed in line with the Authorising Engineers assessment. The internal audit programme has been revised and the audit programme implemented.

A Water Safety Group is in place and reports into the IPC Group. A senior member of the Estates and Facilities team is a core member of the IPC Group and a monthly report is submitted to the group for assurance.

An Estates Matron has provided a link between the wards and departments and the estates and facilities team to ensure that the requirements for water flushing are in place and staff understand the potential risks and the requirements to minimise the risk of water borne pathogens posing a healthcare risk.

Water sampling is undertaken across all sites. Where samples identify water borne pathogens remedial actions to ensure decontamination are undertaken and Point of Use filters are installed.

***Water systems audit compliance data:***

| | | Inspections | % | Remedials | % |
|---|---|---|---|---|---|
| ULHT | Number of applicable Items | 85 | 37.65 | 80 | 38.75 |
| | Compliant | 24 | 28.24 | 21 | 26.25 |
| | Non-Compliant | 8 | 9.41 | 10 | 12.50 |

| DISCIPLINE | Item Ref. | ITEM | FREQUENCY | Last Year | | REMEDIAL WORKS STATUS BY MONTH (HOMERTON HOSPITAL) - 2021-2022 | | | | | | | | | | | | | | | | | | | | | | | | Inspections Compliant (Y/N) | Remedials Compliant (Y/N) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | APR | | MAY | | JUN | | JUL | | AUG | | SEP | | OCT | | NOV | | DEC | | JAN | | FEB | | MAR | | | |
| | | | | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | I | R | | |
| Water Systems | 1 | Monthly Monitoring of Sentinel & Representative Outlets Including HWS, CWS, Shower, Mixer & Tanks | Monthly | | | | | | | | | Y | | | | | | | | | | | | | | | | | | Y | |
| | 2 | Monthly Water Temperature Monitoring & Servicing of Medical Baths | Monthly | | | | | | | | | | | | | | | | | | | | | | | | | | | Y | Y |
| | 3 | Weekly Water Quality sampling (pseudomonas) in augmented care & Visual Inspection of Hot & Cold Outlets | Weekly | | | | | | | | | Y | | | | | | | | | | | | | | | | | | Y | Y |
| | 4 | Weekly / Monthly Alternate Standby/Duty Booster & Circulation Pumps & Verification of Auto Changeover Frequencies | Weekly | | | | | | | | | | | | | | | | | | | | | | | | | | | N | N |
| | 5 | Monthly Sentinel & Representative Outlet Chlorine Dioxide Dosing Concentration Check | Monthly | | | | | | | | | | | | | | | | | | | | | | | | | | | Y | Y |
| | 6 | Quarterly Servicing of Chlorine Dioxide Dosing System Equipment | 3 monthly | | | | | | | | | Y | | | | | | | | | | | | | | | | | | Y | Y |
| | 7 | Quarterly Shower Head and Hose Replacement Programme | 3 monthly | | | | | Y | | | | | | | | | | | | | | | | | | | | | | Y | Y |
| | 8 | Annual Test and Service of Anti Scalding Devices - TMV's & Blending Valves Including Cleaning/Replacing Strainers & Fail Safe Test | Annual | | | | | | | | | | | | | | | | | | | | | | | | | | | N | Y |
| | 9 | Annual Inspection of Water Calorifiers and Plate Heat Exchangers | Annual | | | | | | | | | | | | | | | | | | | | | | | | | | | Y | Y |
| | 10 | Monthly Inspection & Temperature Check of Calorifiers | Monthly | | | | | | | | | Y | | | | | | | | | | | | | | | | | | Y | Y |

A centralised tracker of Legionella Risk assessments has been completed in 2020-2021 to support the capital works programme, ensure compliance, and manage the estates risk management of buildings.

Water Hygiene (Legionella Awareness) courses have run via Teams across all sites during 2020-2021. Training was open to all staff and has been well attended supporting the cascade of water hygiene awareness and roles and duties of all employees.

The Trust intends to implement L8Guard during 2021-2022 as the system for providing oversight and assurance on water flushing in all areas. The focus on infrastructure maintenance such as tank cleaning, drop test for storage awareness and temperature control monitoring will continue into the next financial year.

## 10. Occupational Health

### Seasonal Influenza

The influenza vaccine is offered annually to all Trust employees during the National Flu Campaign season (Sept – Feb).

In 2020/2021, 89.9% of frontline staff received a flu vaccine.

Support was provided by 'peer vaccinators' and clinics occurred regularly to support all shift patterns and weekends.

### Hepatitis B, Measles and Chickenpox (Varicella Zoster - VZ) Vaccination

The Occupational Health Department has an established vaccination programme, offering vaccination against Hepatitis B, Measles and Chickenpox for all HealthCare Workers who have patient contact or undertake exposure prone procedures

A process is in place to ensure compliance with Trust policy and escalation where staff do not attend for vaccination or complete a course.

### Sharps Injuries & Accidents involving Exposure to Blood & Body Fluids

For the year 2020/2021 there were 197 inoculation injuries reported.

| Site | Number of inoculation injuries reported |
|---|---|
| Lincoln | 104 |
| Pilgrim | 66 |
| Grantham | 27 |
| Total for ULHT | 197 |

The high risk areas are theatres and the Emergency Departments with injuries to nurses, Doctors and Healthcare Support Workers being reported during the year.

The reasons given for the injuries occurring were due to the incorrect disposal of sharps and an injury occurring during or immediately after performing a procedure.

During the year 2020/2021 two members of staff required commencement of post exposure prophylaxis (PEP) following inoculation injuries that were deemed to be from a high risk patient/incident. Both were able to discontinue PEP following conformation on the source that no blood borne viruses were detected.

As highlighted in this report, the incorrect disposal of sharps is the main reason for inoculation injuries at ULHT. The Occupational Health Department will be undertaking an audit early in

the year 2021/2022 pertaining to the disposal of sharps and take any required actions to assure the Trust of safe sharps management.

**Covid-19 Vaccinations.**

The Trust was one of the original 50 hub sites to receive the first doses of the Pfizer vaccine. In line with national guidance the vaccination programme has been rolled out and over 8000 Trust staff have been vaccinated as of the end of March 2021.

By the end of March 2021 700 staff were identified as the Trust having no record of them receiving a vaccine. 465 of these have been contacted. Following this contact only 57 staff did not want to receive the vaccine. The remaining staff had either already received one dose of the vaccine from an alternative source, agreed to be vaccinated, wanted more information prior to accepting the vaccine or in the case of a very small number of staff, had a medical condition that had resulted in a Consultant advising them they should not receive it.

## 11. Training

During the period 2020-2021 there has remained a focus on training in all aspects of Infection Prevention and Control which has included specific COVID-19 related training.

The Trust has supported the introduction of the NHSE Cleaning for Confidence. In order to ensure the training was accessible to all those who do not have ease of access to IT, workbooks were produced replicating all aspects of the online training. Training started with the Housekeeping teams and will continue to be rolled out cross the Trust to all clinical staff during 2021-2022.

In order to support the completion of IPC Mandatory training the IPC team developed work books covering all aspects of the mandatory training requirements. This has enabled staff to complete the training in a timely fashion whilst working under the pressures of a pandemic.

To support clinical staff in understanding the requirements for the decontamination of equipment, an A to Z guide has been developed and is available on the intranet and in clinical areas for staff to refer to.

In October 2020 the IPC team led a week of focus on fundamentals, with learning opportunities for all staff throughout the week. This included ‘Cee the difference’, a novel training tool developed by the IPC team whereby staff are asked to identify IPC breaches from a picture scenario and an opportunity for staff to join educational events hosted by the Infection Prevention Society.

The IPC team have through the year supported training related to COVID-19. This has included training in the selection and donning and doffing of appropriate Personal Protective Equipment, managing outbreaks and educating staff on the changes to practice as a result of the pandemic.

All staff are required to complete IPC Mandatory Training. Trust compliance data can be found in the table below.

| Division | IPC Mandatory Training Compliance Figures 2020-2021 |
|---|---|
| Clinical Support Services | 88.66% |
| Corporate | 87.29% |
| Corporate Finance | 28.57% |
| Director of Estates & Facilities | 80.06% |
| Family Health | 88.30% |
| Medicine | 81.62% |
| Surgery | 86.26% |
| **Overall Trust compliance** | **85.33%** |

## 12. Forward Plan 2021– 2022

During 2021 -2022 the Infection Prevention and Control team will expand as a business case to increase the size of the team to provide longer days and sustained weekend cover, was approved in March 2021.

An Estates, Facilities and Decontamination Lead Nurse post was advertised in March 2021 and will be appointed to in early 2021-2022.

A new WebV IPC module will be implemented by May2021 to support the IPC team in reporting and managing all infections.

From a laboratory services perspective, we will continue to aim to fill the two vacant Consultant posts, whilst continuing 24/7 availability of clinical microbiology advice.

The laboratory plans to Introduce MALDI-ToF bacterial identification and will continue to develop the molecular testing service. Business cases for automated sensitivity testing and development of the molecular testing repertoire including joint cases with IPC for *C difficile* PCR testing will be developed.

The IPC Trust wide audit programme for 2021-2022 was ratified at the IPC Group in March 2021 and the programme of audit for the year will commence in April 2021, reporting to the IPC Group.

The Trust IPC Objectives for the next financial year have been agreed and the programme will be led by the Deputy DIPC and IPC Team with assurance to IPC Group.

The IPC objectives for 2021-2022 are detailed in the table below and provide a clear focus for the year ahead.

| Number | Objective |
|---|---|
| 1 | Develop infection prevention and control organisational and Divisional Governance arrangements |
| 2 | Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. Code of Practice on the prevention and control of infection |
| 3 | Further development of surveillance of healthcare associated infections and performance |
| 4 | Investigate and manage the risks posed by novel infectious diseases (specifically COVID-19) to promote patient safety and prevent and reduce the risk of cross transmission |
| 5 | Investigate and manage the risks posed by the emergence of multi-drug resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission |
| 6 | Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance |
| 7 | Establish and sustain (new and improved) standards of cleanliness in line with National Standards of Healthcare Cleanliness. Development and implementation of hydrogen peroxide total room decontamination |
| 8 | Progress decontamination, water safety and ventilation requirements as sub-groups of the Infection Prevention and Control Group to ensure patient safety requirements |

## 13. Conclusion

2020-2021 has been an unprecedented year with IPC being at the forefront of the COIVD-19 pandemic response.

We will continue to reflect and ensure we learn any lessons from managing the pandemic, prepare for any further surges and continue to play our part as we move to COVID-19 being endemic in our population.

Despite the challenges of COVID-19, systems and process for the management of all infections have been reviewed and updated, new audit processes and tools implemented and governance arrangements and assurance strengthened.

We look forward to growing the IPC team and further developing IPC systems, process and practice across the Trust over the next year.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Public Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *8.3* |
| **Safeguarding Annual Report** | |
| Accountable Director | *Karen Dunderdale*<br>*Director of Nursing* |
| Presented by | *Craig Ferris*<br>*Deputy Director of Safeguarding* |
| Author(s) | *Craig Ferris*<br>*Deputy Director of Safeguarding* |
| Report previously considered at | *Quality Governance Committee*<br>*22 June 2021* |

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

| | |
|---|---|
| Risk Assessment | *Insert risk register reference: 4145/4146* |
| Financial Impact Assessment | *Not available at present however LPS will have an impact during the latter part of the 2021 financial year* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | The Quality Governance Committee is asked to: |
| | • *Receive the Safeguarding Annual report* |
| | • *Approve the Plans for 2021 - 2022* |

| Executive Summary |
|---|

The purpose of the report is to provide the Trust with a Safeguarding annual report of the work undertaken during 2020 -2021 giving assurance that the Trust is compliant with its safeguarding duties and those responsibilities specified under section 11 of the Children Act 2004, NHS Assurance Framework 2015 and current safeguarding adult legislation.

Present proposed developments for 2021 – 2022 based on local, regional, and national safeguarding agenda

The report demonstrates the continued performance of the trust within the safeguarding arena which covers Safeguarding Children (Child Protection, Domestic Abuse, FGM, County Lines, Allegations against staff), Safeguarding adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and the PREVENT strategy.

Whilst managed within the Nursing Directorate the safeguarding agenda threads through all aspects of the Trust business and the trust play an active part within the wider safeguarding multiagency partnerships

Issues to note:

- Liberty Protects Safeguards
- Safeguarding training targets still below required levels however post March 2021 levels continue to rise steadily

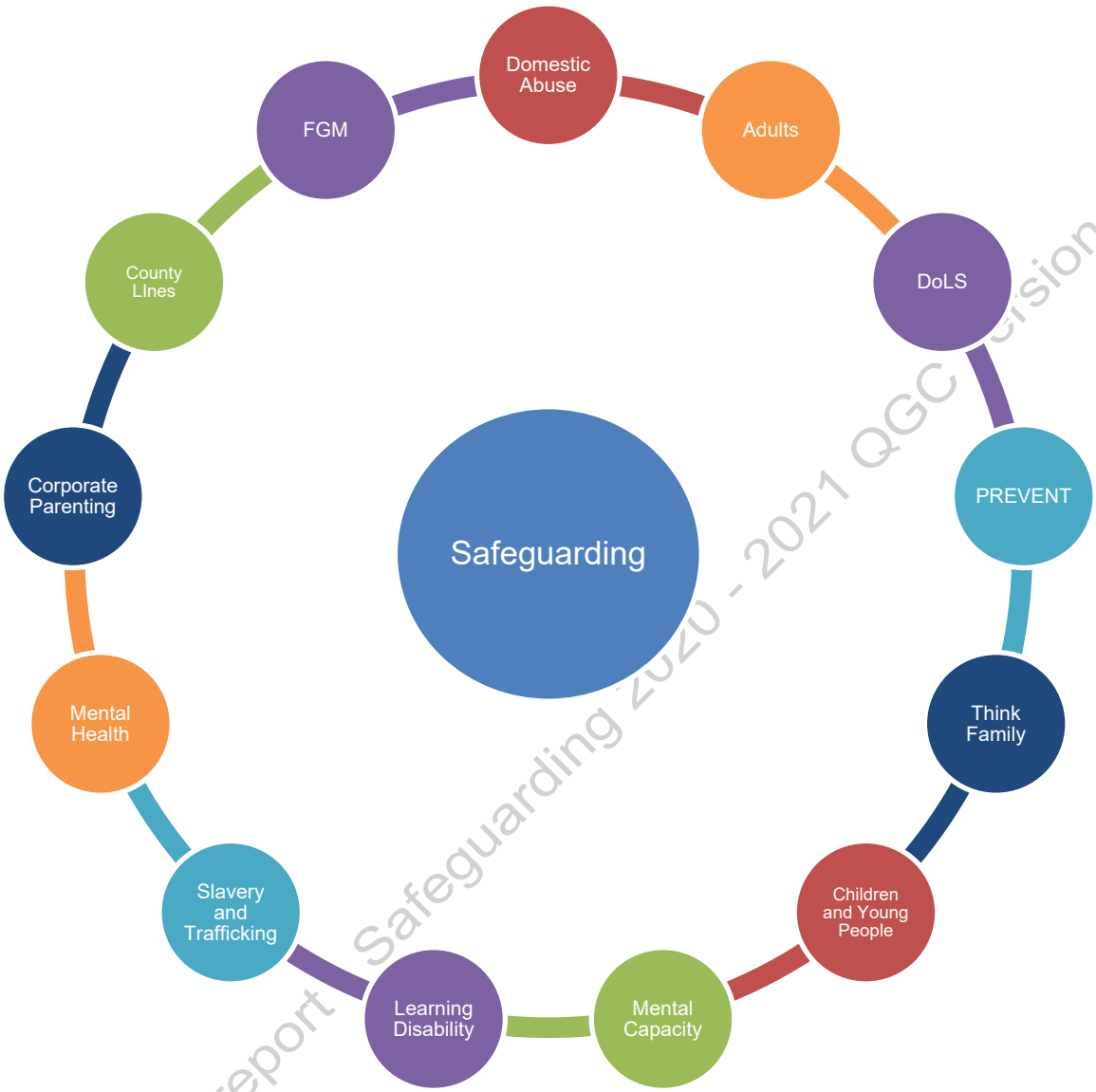
Since 2020 there has been a plan to replace the current Deprivation of Liberty Safeguards with a new process entitled 'Liberty Protects Safeguards'. Guidance has been delayed due to the pandemic and at present will not be available until the summer of 2021 with a potential launch date of April 2022. Until the guidance is published it is not possible to predict the impact on the trust, but it is widely expected to have a financial and workload effect on the trust. Once guidance is published and launch dates are formalized a business case will be rapidly developed to support the role out

Safeguarding training remains a challenging area and although there is a steady overall rise in compliance this is slower than expected ( in part due to some technical difficulties brought about by e-learning modules) therefore this will remain a key focus for 2021 -2022.

NHS
United Lincolnshire Hospitals
NHS Trust

# Safeguarding and Mental Capacity Annual Report 2020 - 2021

OUTSTANDING CARE
personally DELIVERED



## Foreword

As the Executive Lead for Safeguarding, I am pleased to introduce United Lincolnshire Hospitals NHS Trust's Safeguarding and Mental Capacity Annual Report for 2020/21. Over the past year, the Trust has continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community and emergency services. All of this is against the backdrop of an unprecedented pandemic which started in March 2020.

In October 2019 the Care Quality Commission (CQC) published its re-inspection findings. The Trust received an overall rating of 'requires improvement' with 'good' across both Grantham and District Hospital and County Hospital, Louth. Patients consistently found our staff to be caring, and said that they were treated with dignity, respect and kindness.

The Trust has set out clear strategic objectives and values through our integrated improvement plan. We aspire to provide outstanding care personally delivered which is of the highest quality in collaboration with everyone who uses and delivers our services. Everything we do involves and prioritises our patients, and their families and carers.

Safeguarding these people and their rights is the thread that runs through all that we do as a Trust. This report highlights how we achieve this and sets out our commitment to the coming years' Safeguarding agenda.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust's Safeguarding Statement of Intent for 2020/21 is published on our website.

The Trust has specialist Safeguarding and Mental Capacity staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse and radicalisation. They work tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our committed and caring staff, volunteers and Safeguarding team for their dedication in working alongside and providing protection, guidance and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Dr Karen Dunderdale

**Director of Nursing and Executive Lead for Safeguarding**

## 1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2020 - 2021 with regard to safeguarding children and adults, Prevent, Mental Capacity and Deprivation of Liberty Safeguards (DOLs) and the proposed areas of development for 2021 - 2022.

## 2.0 Legislative Background

The NHS Outcomes Framework 2020 identifies that sustainable quality improvements are achieved when the focus is on outcomes, rather than being process driven. The DOH Outcomes Framework sets out five overarching high-level outcome domains for quality improvements.

| | |
|---|---|
| Domain 1 | Preventing people from dying prematurely; |
| Domain 2 | Enhancing quality of life for people with long-term conditions; |
| Domain 3 | Helping people to recover from episodes of ill health or following injury; |
| Domain 4 | Ensuring that people have a positive experience of care; and |
| Domain 5 | Treating and caring for people in a safe environment and protecting them from avoidable harm. |

In terms of safeguarding the key domains are:

Domain 4: Ensuring people have a positive experience of care,
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability and Assurance Framework (NHS England 2019) sets out the safeguarding roles, duties and responsibilities of all NHS health care organisations.

The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Safeguarding forms part of the NHS national contract (service condition 32 - Safety and Safeguarding) and the CCG monitors our performance via contract monitoring processes.

NHS England Safeguarding agreed a range of safeguarding programmes which were included in the NHS England Standard Contract for 2020 – 2021.

## 2.1 Safeguarding Children

Since the statutory inquiry into the death of Victoria Climbié (2003), and the first Joint Chief Inspectors' report on Safeguarding Children (2002) highlighted the lack

of priority status given to safeguarding, there has been a consistent process of review and change of legislation.

In 2020 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

*Safeguarding and promoting the welfare of children* is defined in Working Together to Safeguard Children (2018) as

- protecting children from maltreatment.
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; *and*
- taking action to enable all children to have the best outcomes

Safeguarding Children is everyone's responsibility, Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

*This is a standard requirement within all ULHT contracts of employment*

At an organisational or strategic level, key features which must be adopted by NHS organisations (monitored by the Local Children Safeguarding Partnerships and Commissioners) are:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Service developments that takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children
- Effective information sharing.
- CQC Standard 7: Safeguarding people who use services from abuse

*An audit of Section 11 duties is undertaken by the Safeguarding Children Partnership and any subsequent action plans will be monitored in line with the current governance arrangements. The most recent section 11 submission took place in February 2021 and the trust are awaiting a formal outcome of the moderation process later in 2021; which will be reported to the Safeguarding and Vulnerabilities Oversight Group.*
*All areas demonstrated a good level of compliance*

## 2.2 Safeguarding Adults

The passing of the Care Act 2014 has meant significant changes in the way adult safeguarding operates across ULHT. The safeguarding process has now been placed on a statutory footing and the requirements placed on our organisation have become more clearly defined.

The term vulnerable adult has been replaced by "Adult at Risk" and the definition of safeguarding adults has changed to:

*"The process of protecting adults (18 years plus) with care and support needs from abuse or neglect".*

In the same section the key role played by public organisations in safeguarding adults at risk is also noted.

The victim in the process is now the "adult at risk", the perpetrator "the alleged source of risk" and a written "Safeguarding Alert" is now termed a "Safeguarding Concern"

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality of care individuals receive. This segues neatly with our own health service requirement for "Candour" as set down in ULHTs Incident Management Policy (ULHT-MD-GOV-IM-POL) and in line with the Trusts statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Act also places the duty on public organisations like ULHT to take action when abuse or neglect is suspected or known and underlines the duty to ensure that all staff are trained in safeguarding proportionate to their roles and responsibilities. Both of these are explicit in ULHTs Safeguarding Policy's and training plans.

### 2.2.1 Implications for Safeguarding Vulnerable Adults

The Act sets out the statutory framework for adult safeguarding, including local authorities' responsibilities, and those of the local partners. In many cases the requirements of the Act are already fulfilled and expand across not just safeguarding but also cover some of our more vulnerable clients such as those with dementia and learning disabilities

**Safeguarding Principles**

**Principle 1 – Empowerment**
Presumption of person led decisions and consent

**Principle 2 – Protection**
Support and representation for those in greatest need

**Principle 3 – Prevention**
Prevention of neglect harm and abuse is a primary objective.

**Principle 4 – Proportionality**
Proportionality and least intrusive response appropriate to the risk presented

**Principle 5 – Partnerships**
Local solutions through services working with their communities

**Principle 6 – Accountability**
Accountability and transparency in delivering safeguarding

## 2.3 PREVENT

### 2.3.1 What is PREVENT?

The Counter-terrorism and Security Act 2015 placed PREVENT on a statutory footing. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of **PREVENT** is to stop people becoming terrorists or supporting terrorism and again transitions into vulnerable children & adults who are groomed and exploited to carry out acts of violence against others

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

- **PURSUE**: to stop terrorist attacks
- **PREVENT**: to stop people becoming terrorists or supporting terrorism
- **PROTECT**: to strengthen our protection against a terrorist attack
- **PREPARE**: to mitigate the impact of a terrorist attack.

The Health Service is a key partner in **PREVENT** and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

**PREVENT** has 3 national objectives:

- **Objective 1:** respond to the ideological challenge of terrorism and the threat we face from those who promote it
- **Objective 2:** prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- **Objective 3:** work with sectors and institutions where there are risks of radicalization which we need to address

The Health Sector contribution to PREVENT will focus primarily on **Objectives 2** and **3**.

PREVENT training undertaken in line with Objectives 2 and 3 is known as **Health WRAP** training.

### 2.3.2 Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

## 3.0 Designated and Named Professionals for the Trust and its Commissioners

**3.1 Children** - The terms designated and named professionals (children) are clearly defined in Working Together 2018 as professionals with specific roles and responsibilities for safeguarding children.

All Clinical Commissioning Groups are required to have a designated doctor and nurse whose responsibility it is to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the commissioned area, which includes all providers. The designated professionals are also in place to provide professional advice on matters relating to safeguarding children for other professionals, NHS Commissioners, Local Authority children's services and the safeguarding children partnerships. The Designated Professionals for Lincolnshire are employed within the CCG and provide this support to the Trust.

All NHS Trusts must identify a named doctor, a named nurse and a named midwife (where maternity services are provided) for safeguarding with the focus of named professional on safeguarding children within their own organisation. *These professionals are in post within the Trust and include a lead anaesthetist* for safeguarding children as recommended by the Royal College of Anaesthetists (2012)

**3.2 Adults –** Following the publication of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2015) there is now an expectation that Designated (CCG) and Named professionals (ULHT) for safeguarding adults are in place. ULHT have been proactive in the development of the safeguarding adult service and as such the *Deputy Director for Safeguarding holds the strategic lead for both children and adults and the Trust has a Named professional responsible for safeguarding adults and Mental Capacity Act supported by a specialist nurse.*

## 4.0 The ULHT Safeguarding Team

The Safeguarding Team has been in place for several years and are now responsible for Child Protection (ULHT), Adult Protection (ULHT), MCA/DOLS and the PREVENT agenda (ULHT) and pending further funding will also take the lead for Mental Health, Learning Disability, Autism and Dementia.

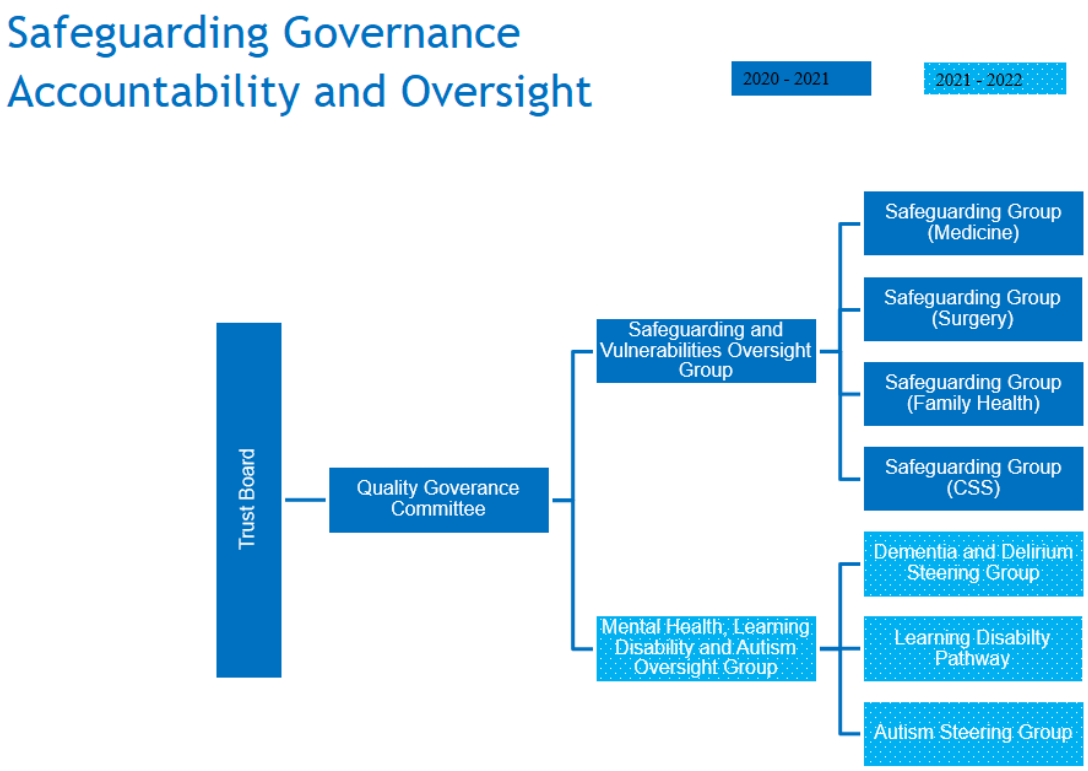
*A full structure of the current safeguarding team and proposed changes can be found at appendix 1*

## 5.0 ULHT Safeguarding Governance Arrangements

The responsibility for safeguarding rests ultimately with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Dr Karen Dunderdale, Director of Nursing) and a Non-executive Director.

The Trust has a Safeguarding and Vulnerabilities Oversight Group (SVOG) which reports to the Quality Governance Committee (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Deputy Director of Safeguarding and the divisional groups are chaired by a senior manager within the division.

**Figure 1**




## 6.0 Local Safeguarding Children Partnership Board (LSCP) and Local Safeguarding Adult Board (LSAB)

Safeguarding Children Partnership and Safeguarding Adults Boards were set up as statutory bodies under a national model led by the local authority until a government review of their role in 2016. This led to changes in relation to Safeguarding children, bringing about a shared responsibility for safeguarding amongst the identified three lead partners (Local Authority, Police and CCG) and the change to *Local Safeguarding Arrangements* which allow some flexibility based on local needs.

They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people /adults at risk of abuse. They do this by coordinating the safeguarding work of member agencies so that it is effective; monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnership / Adult Board within Lincolnshire both have Independent Chairs and membership has been reviewed ensuring that attendance is at the required levels and members have sufficient seniority

*The Trust is represented by the Deputy Director of Safeguarding at the Partnership/Board and there is representation by other key professionals on the subgroups.*

## 6.1 LSCP Key areas of action

- Tackling Child Exploitation and understanding emerging themes of abuse
- Enhancing the Emotional Wellbeing of Children and Young People
- Promoting Healthy Relationships
- Working Together to Recognise Risk Making Behaviours
- Identify and Reduce the Impact of Neglect on Children and Young People.
- Identify and Reduce the Impact of Domestic Abuse on Children, Young People and their Families.

## 6.2 LSAB Key areas of action

- Develop and improve our early help and preventive practice.
- Develop effective community and service user engagement.
- Develop a quality and assurance framework and to measure and demonstrate policy success.
- Continue to develop the ethos and practice of Making Safeguarding Personal (MSP); and,
- Learn from reviews and put service improvements into practice.

ULHT are actively involved in all the above areas by way of delivering the topic areas within training and/or sitting on operational groups to actively target the perpetrators and support the victims of abuse.

## 7.0 Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Serious Adults Review (SAR) / Domestic Violence Homicide reviews (DVHR)

### 7.1 Children

Child Safeguarding Reviews have been in place for many years and nationally about 100 take place every year. A review is always carried out by the Safeguarding Partnership *when a child dies and abuse or neglect is known, or suspected,* to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect. The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change in order to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how

a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

A review is commissioned by the LSCP and involves setting up a multi-agency review panel of senior and experienced managers, with an independent chair, to ensure objectivity and impartiality. The panel must produce a report to the LSCP on lessons learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

The report goes to the trust safeguarding and vulnerabilities oversight group and Ofsted / CQC and national oversight panel for their scrutiny and response. All relevant agencies are expected to produce and implement an action plan, based on the recommendations, which is overseen by the LSCP Significant Incident Group.

*During 2020 - 2021 the Trust has been involved in no new reviews however there are three reviews (JBR2016 / SCR2018H / SCR2019J) still outstanding for the final sign off. All Trust actions are complete.*

*During this period the Trust has submitted information to support three Lincolnshire and one bordering LSCP rapid review. The outcome of each of the Lincolnshire rapid reviews resulted in a decision that the criteria for undertaking a SCR had **not** been met. These decisions were validated by the National Panel. ULHT was not required to participate in the bordering LSCP review, due to lack of relevant in-scope involvement.*

## 7.2 Adults

Safeguarding Adult reviews within the safeguarding adult's process are still relatively new and since 1st April 2015 form part of a statutory process. The criteria for undertaking a SAR is similar to that of the children's review. ULHT is currently involved in one review which is - (SARDHR2015E) a joint SAR and DHR however three reviews have been completed and published during 2020 – 2021

https://www.lincolnshire.gov.uk/downloads/download/183/lsab-overview-report---rj

https://www.lincolnshire.gov.uk/downloads/download/169/lsab---safeguarding-adults-review-helen

https://www.lincolnshire.gov.uk/downloads/download/186/lsab---sar-long-leys-court

*There is one action yet to be completed for ULHT*

## 7.3 Domestic Violence Homicide Reviews (DVHR)

A DVHR is very similar in nature to a children's or adults review however takes place *when a death occurs in a young person (16 & 17 years) or an adult and the cause is Domestic Violence*. At present ULHT are currently involved in two DVHR identified in 2020 however both are yet to commence.

At this present time there are a further eight reviews (DHR2015D / DHR2017N / DHR2018L / DHR2018P / DHR2018Q / DHR2019R / DHR2019F) still outstanding for national sign off. *There are no outstanding actions for the trust.*

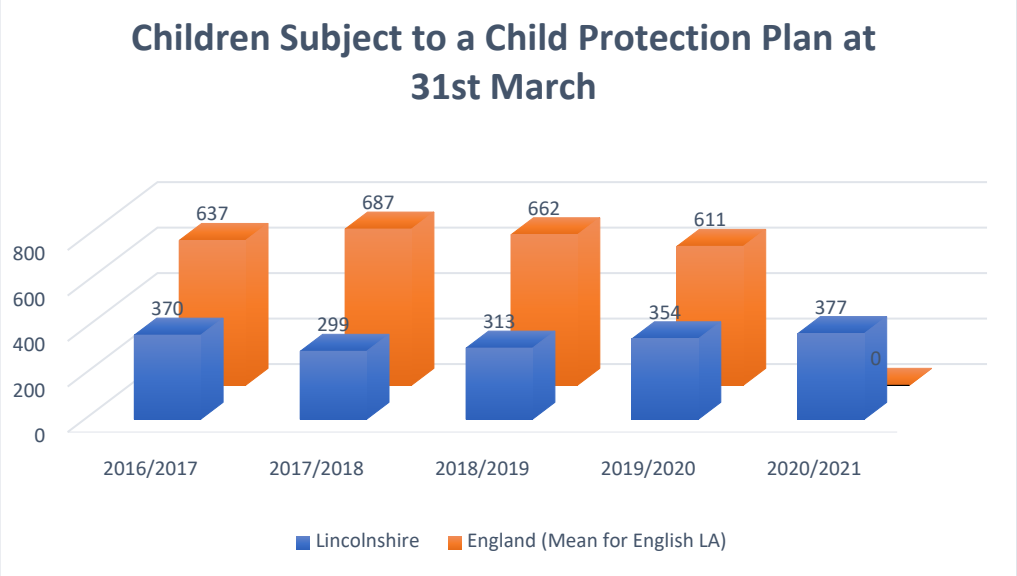
## 8.0 Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary on a daily basis Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, however the numbers of children on plans (figure 2) has remained relatively consistent over the previous 3 years although the national trend does demonstrate a steady rise in numbers often related to poverty and deprivation. As yet the impact of the pandemic is not ascertained, and it is not possible to predict if there will be a significant shift in the annual figures.

Children on a child protection plans are identified within the trust on Medway and also via the Lincolnshire Care Portal.

During this period there has been a noticeable increase in the number of unborn babies who have become subject to child protection / court proceedings and as such there as been a significant impact on the midwifery workload

**Figure 2**
**Number of children having a child protection plan within the Local Authority area who may be receiving services from ULHT (April 2016– March 2021)**
*(England Mean 20/21 not available at time of report)*



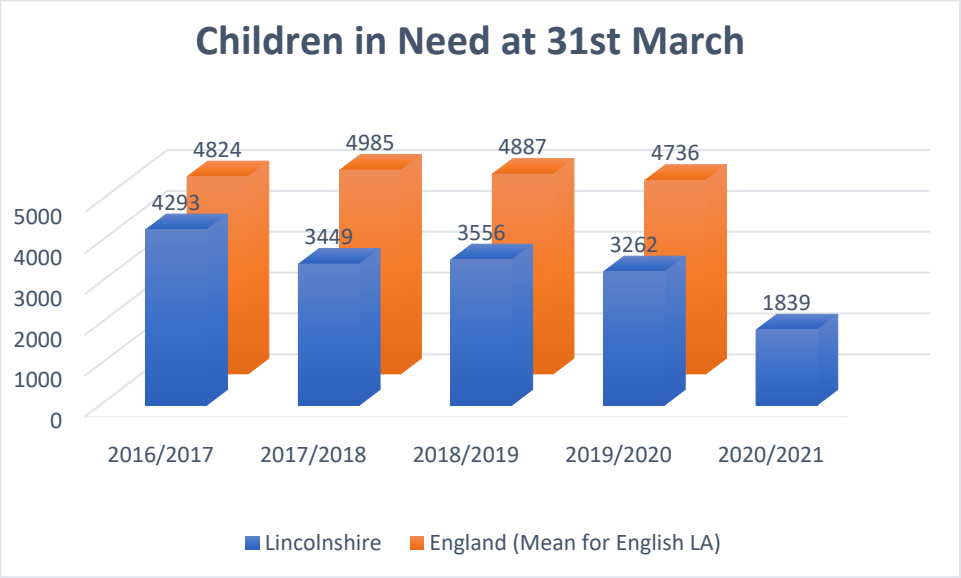

## 8.1 Child in Need

Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in

figure 3 demonstrates the number of children in need across Lincolnshire with a drop in numbers over the last 12 months.

Lincolnshire has focused its support offer on 'Early Help' which is designed to assist children and family at an earlier stage and prevent them from reaching the child in need stage

**Figure 3**
**Number of children classed as a Child in Need within the Local Authority area who may be receiving services from ULHT (April 2016– March 2021)**
*(England Mean 20/21 not available at time of report)*






## 8.2 Children in Care

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs, however, often remain unmet and as a result, many children and young people who are in care continue to experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.

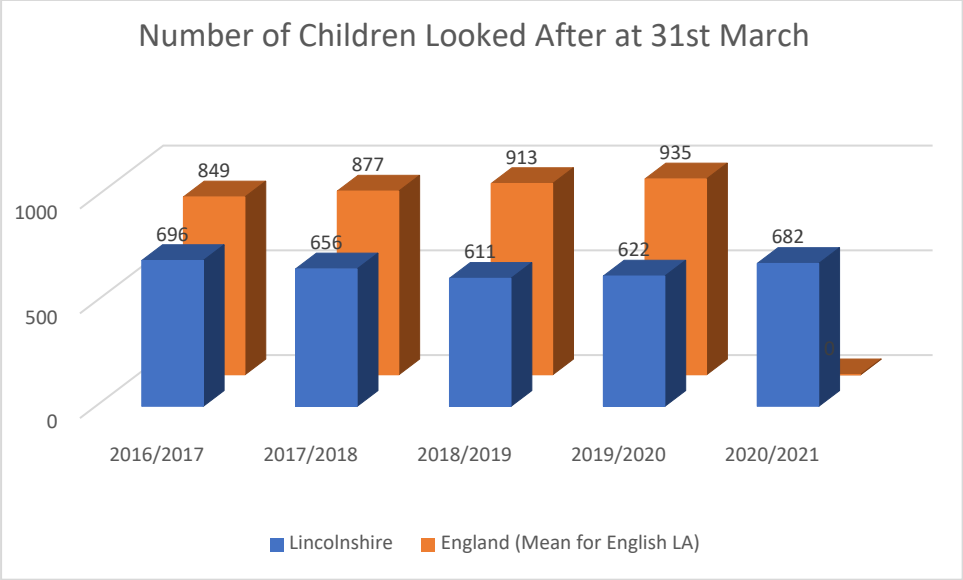
ULHT does not directly provide the children looked after health service however many of these children will access the services within ULHT by way of A+E or Paediatrics and research demonstrates that children in care will continue to have a high levels of Adverse Childhood Experiences (ACES) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

Due to the demographics of Lincolnshire the Trust may also provide services to other young people who are placed in care within Lincolnshire from other Local authority areas.

Children within the trust are identified within the Lincolnshire Care Portal

**Figure 4**

**Number of children classed as a Children in Care within the Local Authority area who may be receiving services from ULHT (April 2016– March 2021)**
*(England Mean 20/21 not available at time of report)*




*A review of the safeguarding flagging systems in the trust will take place during 2021 – 2022 to ensure that information is shared across as many areas as possible*

## 8.3 Child Protection Information Sharing System (CP-IS)

ULHT has in place systems for flagging high risk cases (e.g. Child Protection/Looked After Children/Domestic Abuse and Child Exploitation) within its Admission Systems. Following the development of the National CP-IS system, ULHT completed work with our Local Authority Partners to introduce this system into unscheduled care/Maternity settings Trust-wide, in line with NHS Digital's deadline of 31st March 2019. Currently, a CP-IS notification is triggered when an NHS number is entered into Medway; with relevant information being stored within the Lincolnshire Care Portal for clinical staff to access in order to determine the current level of Social Care involvement and facilitate appropriate liaison. Training was provided for clinical staff in line with each of the relevant areas 'going live'; with supplementary pathways and user guides created to support usage. Upon attendance, additional SG alerts are then placed onto the patient's Medway record to ensure non-scheduled care settings are aware of their Safeguarding status.

The following table provides data relating to the number of attendances for which a CP-IS alert was triggered:

| Year | Number of attendances | Comments |
|---|---|---|
| (Dec) 2018-2019 | 67 | Roll-out commenced in GDH A&E on 6/12/2018; with further roll-out to LCH/PHB areas undertaken during February and March 2019. |
| 2019-2020 | 574 | |
| 2020-2021 | 388 | Lower patient footfall during phase 1 of COVID may have contributed to a lower number of attendances than was noted during 2019-20. |

For future reports, we will be able to demonstrate the ratio/split between CP, LAC and Unborn CP attendances.

In 2020, an audit was undertaken to assess Practitioner compliance with the CP-IS pathway. The audit demonstrated a degree on noncompliance brought about by staff turnover, impact of the pandemic and lack of staff understanding. *As a result of this additional training has been provided and a 6-monthly audit programme implemented with the next audit planned for May 2021.*

## 9.0 Adult at risk

Adult protection continues to expand with increasing workload not only within the safeguarding team but impacting on the general roles within the Trust i.e. Complaints / PALS, Matrons, and operational staff.

The number of referrals raised by the Trust varies. There is a greater emphasis on making safeguarding personal and involvement of the patient since the Care Act 2015. In the interests of making safeguarding personal, it is good/expected practice to discuss concerns with the adult at risk prior to a referral being raised in order that consent is gained, and the person's views sought. When this is not completed during the time in hospital opportunities may be missed to ascertain views and wishes whilst when they are alone and in a relatively safe place.

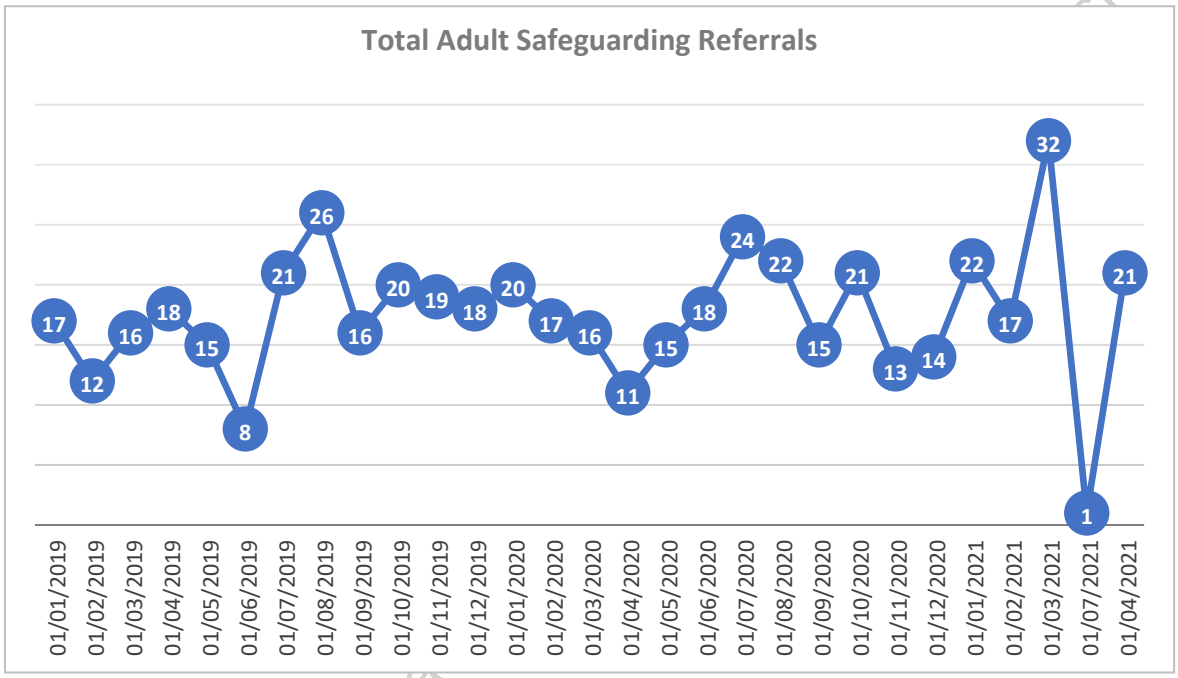
ULHT requires further work in this area, referrals can be rejected as staff do not always meet this requirement and ongoing work is required to ensure compliance with the making safeguarding personal agenda which will be re-audited by the LSAB

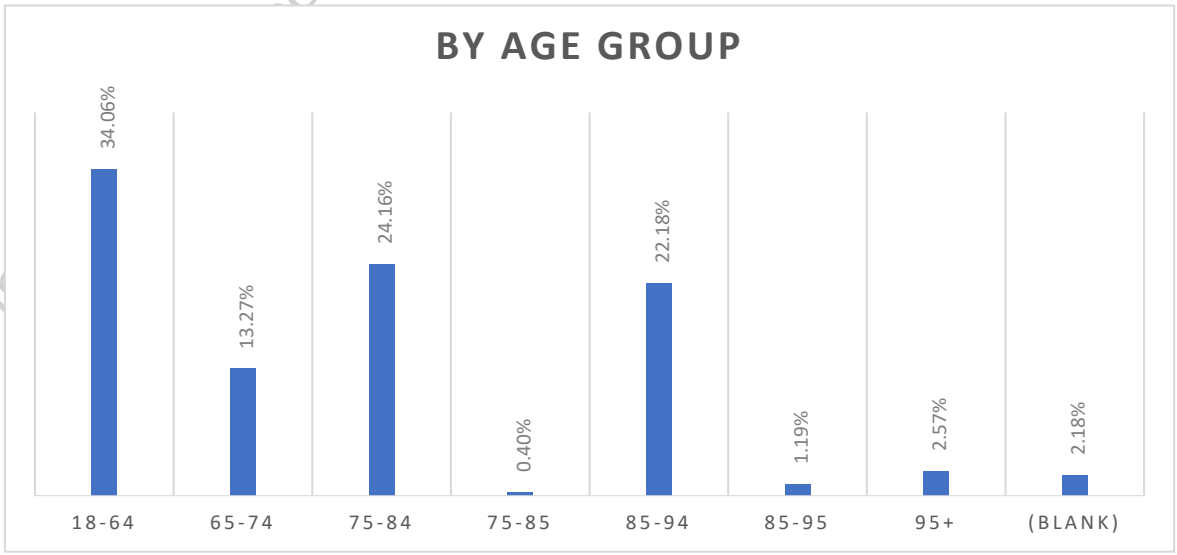
The number of safeguarding adult cases raised against the Trust is also variable in number with several referrals being made against the Trust which do not meet the safeguarding adult criteria as specified by the Association of Directors of Adult Social Services (ADASS) and Care Act 2015. These are therefore re-directed to another suitable avenue of investigation (i.e. PALS / Complaints) or indeed back to the originating referrer

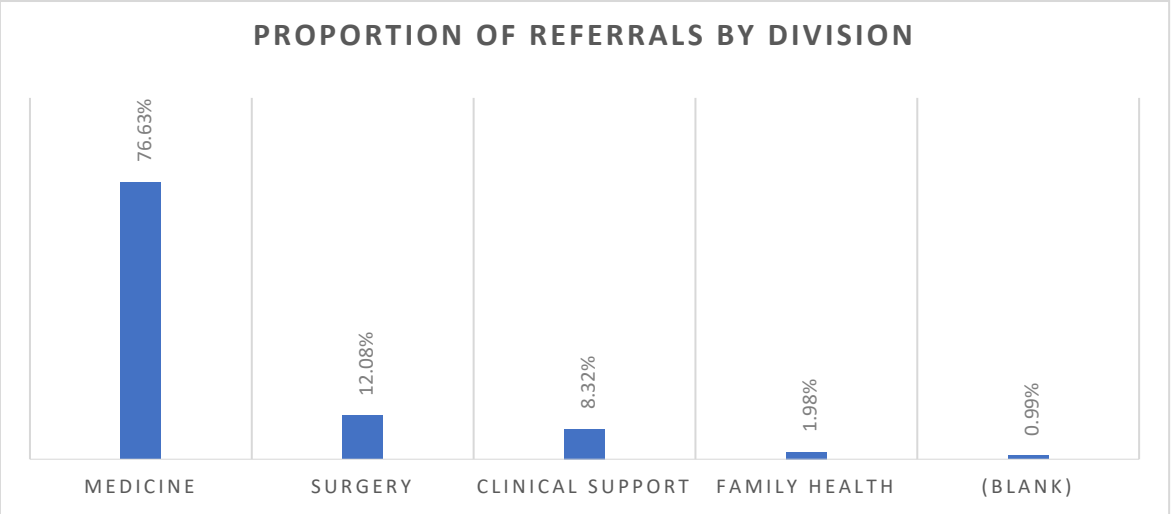
General trends from these investigations highlight issues of variable nursing care, lack of co-ordinated discharge and poor communication / record keeping and pertain to most staff groups Whilst there have been a number of cases involving chemical sedation these have reduced following a clear plan of work.

The Named professional meets monthly with the CQC and separately with the CCG and LA to ensure that there is an open and honest dialect maintained and works on the premise of 'no surprises.

**Figure 5**
**Number of safeguarding adult referrals made by ULHT to the Local Authority (January 2019 – March 2021) including age breakdown and divisional breakdown**






## 10.0 Legal statements / Court process

The safeguarding team have continued to strengthen and develop its remit of supporting staff in statement writing and court attendance. The current trend to produce more legal statements / requests for records continues and is also impacted on with the growing area of work from the Court of Protection.

The ongoing supportive relationship / process between safeguarding and the legal / data protection team continues to work well however some improvements are in the planning to ensure that court orders are met in a more timely manner and given the ongoing increase in requests, there is a potential risk that the resource within the data protection team will not be able to maintain the timeliness of the process.

Other teams adversely affected by this increase are Paediatrics and Emergency Departments across site with pressures being placed on paediatricians and frontline clinicians to provide reports in greater detail and in a much shorter timescale.

The Court of Protection (CoP) is a court in England and Wales that can make decisions on behalf of people who lack the capacity to make their own decisions and the court mainly deals with decisions about a person's welfare, property, or medical treatment.

Whilst the mental capacity act code of practice confirms some of the situations when decisions must be taken to the Court of Protection (Section 8.18), not all scenarios are covered including cases where there is a dispute about whether a particular treatment will be in a person's best interests.

The Court of protection has issued guidance which states that if force or restraint is required an application to court may be required and if the force or restraint amounts to a deprivation of liberty then the authority of the court will be required to make this deprivation of liberty lawful.

ULHT have taken three cases to the CoP in the past year - one due to a significant dispute requiring urgent medical treatment and was granted on the same day and two due to the extent of restraint required for conveyance to the Trust and during the treatment. The Trust were also heavily involved in a forth case about treatment

of a patient with an eating disorder. The Safeguarding adult lead supported front staff with the coordination and legal aspects of the case and acted as liaison for trust solicitors. All three cases were supported by the CoP and the Trust received positive feedback including "Mrs Justice Gwyneth Knowles concluded the judgement by saying 'I want to thank those involved with x's care. It' is obvious to me that they have had her best interests at the fore at all times.' And from Mr Justice Holman " I am immensely grateful for the speed with which they (ULHT) have all engaged with this case and the thoroughness and efficiency with which they have done so in light of the time constraints

## 11.0 Safeguarding Clinical Supervision

### 11.1 Children

Effective clinical supervision is important to promote good standards of practice and support individual staff members. Supervision allows time for reflective practice and is a vital component in the protection of children. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time, and ensure each individual child has an effective plan of action. The Safeguarding team provide direct supervision to professionals (Individual and Group) which includes reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching, development and pastoral support.

At present safeguarding supervision is managed and recorded by the safeguarding team however *a review of this process is currently underway in order to identify staff where supervision is mandated and will be managed by way of ESR (compliance / noncompliance) making the process more transparent and increasing the governance of this aspect of support*

### 11.2 Adults

Whilst less prescriptive, safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case by case basis and during the pandemic has been delivered via teams. As safeguarding adult / MCA is embedded, safeguarding supervision for adult cases is noticeably a bigger part of the work of the team.

## 12.0 Training and learning

Safeguarding training has always been a high priority to the Trust and has been delivered in a variety of ways and at different levels across the organisation. A new training plan was introduced for safeguarding children and safeguarding adults in 2020 to accommodate restrictions imposed by the COVID-19 pandemic and bringing the trust in line with statutory guidance, adding some additional topic areas.

At the beginning of the pandemic all training stopped due to being traditionally delivered via classroom attendance and as a result compliance figures within the trust reduced by approximately 10% and for a period of 6 months remained static. During this period the safeguarding team developed and rolled out e-learning and local podcasts for all topic areas to ensure that where possible, staff could complete

training and the trust was able to not only reduce the impact of the pandemic on safeguarding training but improve the level of compliance.

The reported training levels with the Trust as of 31st March 2021 were as follows

| KPI Description *(A measurable value that demonstrates the success of your change, to include trajectory to achieve target* | Measures *(How will this be Measured)* | Target *(Desired level of performance)* | Progress *(Current progress measured)* *END March 2021 figures* | KPI Target date |
|---|---|---|---|---|
| Safeguarding training compliance to reach 90% for Safeguarding children level 1 | Monthly training report | 90% | 86% ↓ | June 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding children level 2 | Monthly training report | 90% | 76% ↓ | Sept 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding children level 3 | Monthly training report | 90% | 78% → | Sept 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding children level 4 | Monthly training report | 90% | 86% → Additional new staff member added so expected | Sept 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding adults level 1 | Monthly training report | 90% | 86% ↓ | June 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding adults level 2 | Monthly training report | 90% | 76% ↓ | Sept 2021 |
| Safeguarding training compliance to reach 90% for Safeguarding adults level 3 | Monthly training report | 90% | 57 % ↑ *(increase over 5 month)* | Jan 2022 |
| Training compliance to reach 90 % for MCA / DOLS | Monthly training report | 90% | 69% ↑ | Sept 2021 |
| Training compliance to reach 90% for PREVENT basic level | Quarterly training report | 90% | 86% ↓ | Sept 2021 |
| Training compliance to reach 90% for PREVENT Higher level | Quarterly training report | 90% | 78% → | Sept 2021 |

* the Safeguarding Children/Adults e-learning and MCA e-learning are made up of several modules including 'Paediatric consent' and 'Domestic Abuse'. Both of these modules were removed in November 2020 by Health Education England and as a result several hundred staff have been unable to formally complete the training and requires the core learning team to manually input the compliance ( target date for completion of this is 30th June 2021) this has had an adverse impacted on the compliance figures

*An action for 2021 – 2022 is to achieve the targets set above.*

## 13.0 Safeguarding issues within Pregnant Women

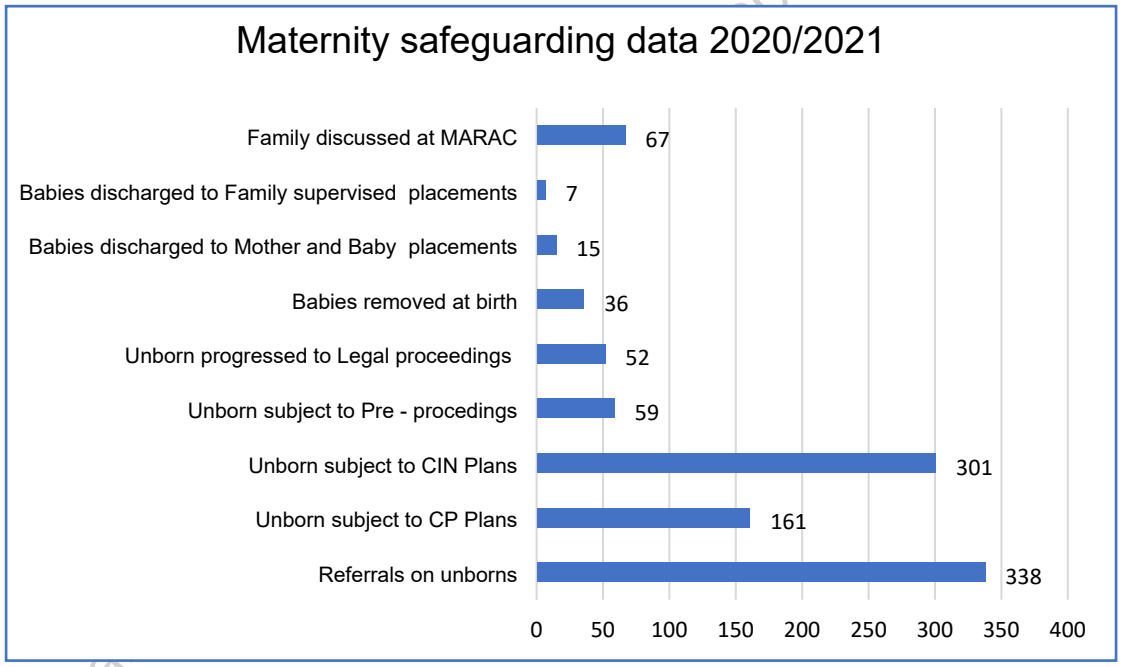
The Maternity Safeguarding team consists of 2 midwives, the Named Midwife for Safeguarding and a Safeguarding Midwife.

The role of the Safeguarding Midwives is to support clinical and managerial staff in performing their safeguarding duties and responsibilities through advice, escalation of concerns to / from other agencies and effective feedback and support from safeguarding meetings and forums. They provide specialised knowledge, guidance, training and support to all staff within United Lincolnshire Hospitals NHS Trust regarding safeguarding unborn / new-born, children, young people, vulnerable adults and domestic abuse.

The Safeguarding Midwives manage a Safeguarding Database that all Midwives and Neonatal staff have access to and holds information on each woman / family where there are safeguarding concerns for unborn and/or siblings in order to assist staff to safely care for women and their babies with safeguarding risks.

The Safeguarding Midwives co-ordinate and monitor high risk cases, attend multi-agency meetings and ensure robust birth plans are in place for all unborn who are subject to Child Protection plans and those within Pre-birth legal proceedings.

**Figure 6: Safeguarding Specific Maternity data**




The Named Midwife for Safeguarding has been instrumental in rewriting the Lincolnshire Pre-birth Protocol, alongside colleagues from the Local Authority, that launched in November 2020. The main change from the previous protocol is that when it is deemed that an unborn should be managed under the Public Law Outline, the case now follows a pre-proceedings pathway whereby Social Care convene a Pre-birth Protocol strategy meeting by 23 weeks' gestation, attended by the Safeguarding Midwives. Once the decision is made that the unborn child will be subject to the pre-proceedings process, the case is managed as Child in Need (s17, CA 1989) and an Initial Child Protection Conference in no longer convened.

This approach avoids any duplication or dual processes for the expectant parents and helps to alleviate stress for the expectant mother, which in turn reduces additional risk to the unborn child.

This new process within Lincolnshire is extremely innovative and very different to the majority of pre-birth protocols across other areas of the country. The protocol hopes to offer pregnant women within ULHT a more transparent and less traumatic experience in relation to their pregnancy when there are significant safeguarding concerns which is being managed within the legal arena.

## 14.0 Female Genital Mutilation (FGM)

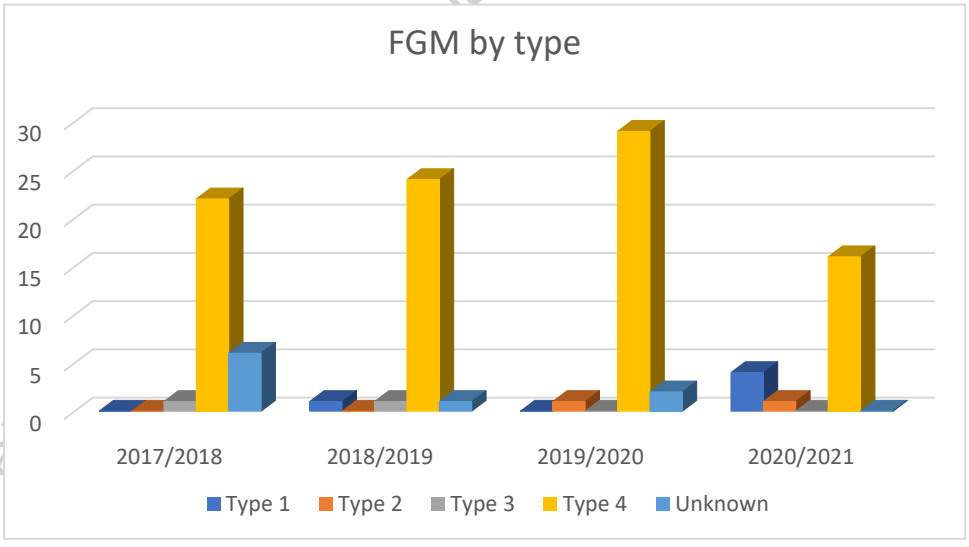
Whilst the issue of FGM affects women / girls across all operational services the midwifery and Gynaecology teams are key within early identification and reporting of this specific area of abuse. The trust has in place an FGM policy and specific working guidance for paediatrics and midwifery.

From 1st April 2015, and in line with National Guidance, the Trust began to routinely submit FGM data. This data is submitted monthly to the Trust's Information Support team for onward submission to NHS Digital.

Between April 2020 and March 2021, the Trust reported 20 cases of FGM: of which 16 were Type 4 (piercings); 4 were Type 1 and 1 was Type 2 FGM. All cases reported were reported by adults and those reporting Type 1 or Type 2 had undergone the FGM as children in their countries of origin.

*For those Type 1 and Type 2 cases, appropriate safeguards were initiated in respect of the unborn: with the Trust also complying with the appropriate NHSE alerting protocols*.

**Figure 7: FGM specific data by WHO type classification**




## 15.0 Domestic Violence / Multi-agency Risk Assessment Conference (MARAC)

Domestic Abuse costs the country's economy £15.8 billion a year. The cost to health, housing and social services, criminal & civil legal services is estimated at 3.9 billion and of this the NHS spends £1.73 billion.

ULHT is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and Safeguarding Midwives and also at the Domestic Abuse Operational and Strategic Boards by the Named Nurse for Safeguarding and the Deputy Director for Safeguarding, respectively.

## 15.1 Key Facts

The Crime Survey for England and Wales (CSEW) estimated that for the year ending in March 2020, 28% of women and 14% of men aged 16 to 74 had experienced some form of domestic abuse since the age of 16.

Domestic abuse has a significant impact upon the communities and public services of Lincolnshire. The latest available estimates from the Crime Survey for England and Wales (CSEW) suggest 5.5% of adults aged 16-74 will have experienced domestic abuse in the last year ending March 2020. This national figure would equate to roughly 30,200 adults aged 16-74 suffering domestic abuse in Lincolnshire (assuming a similar prevalence in Lincolnshire compared to the England and Wales average).

Domestic abuse remains an underreported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e. police, health professionals, or local council department). 17% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics)

More than one in four women has experienced at least one incident of domestic violence in England and Wales since age 16 (equivalent to 4.8m women)

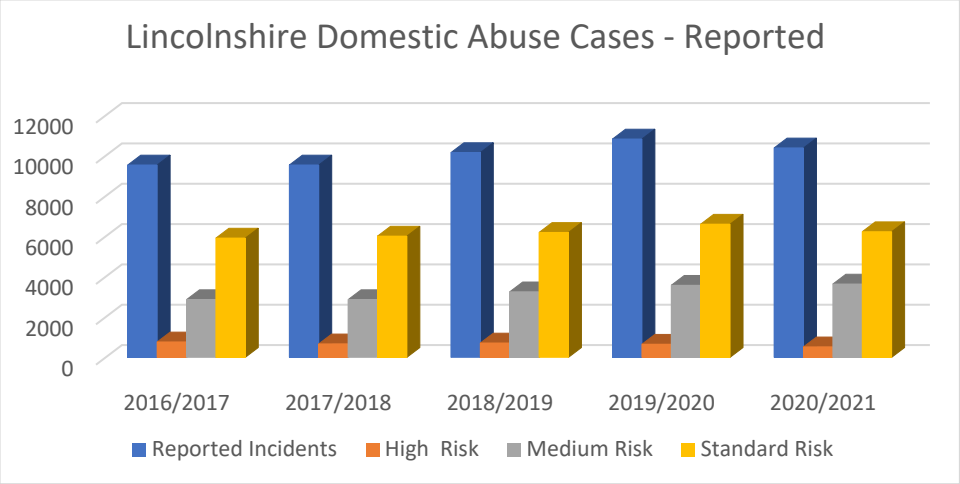
- Approximately 1 million women a year experience at least one incident of domestic violence, equating to nearly 20,000 women a week
- On average a woman will experience 35 assaults before going to the police
- 2 - 3 women a week are killed by their current or former partner
- 1 in 7 males will experience domestic violence and abuse
- Domestic violence often starts or intensifies during and after pregnancy
- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of 16
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period of time, suffering more severe injuries as a result of the violence
- Domestic violence and abuse in teen relationships is increasingly recognised as a serious issue. Research now suggests that women between the ages of

16 and 25 are at highest risk.

## 15.2 Domestic abuse in Lincolnshire

In the last five years, on average there are over 10,000 domestic abuse incidents reported to Lincolnshire Police every year. Of these, circa 6,000 are standard risk incidents, equivalent to around 3 in 5 domestic abuse incidents reported. The proportion of reported incidents that are graded as high risk has been falling, while the proportion graded as medium risk has increased. Improvements in recording practice will have contributed to this.

**Figure 8: Domestic Abuse Cases**




## 15.3 Domestic abuse and children

The true number of victims of domestic abuse is likely to be higher when children are included. CSEW figures suggest that 41% of partner abuse victims suffered abuse while their children were in the house, and that 21% of victims disclosed that the children did see or hear what happened. (Source: Office of National Statistics) If only one child was present at each of the 21% of domestic abuse victimisations in Lincolnshire each year, this would mean that 5,500 children witnessed domestic abuse in their home each year. This means that the true number of Lincolnshire residents affected by domestic abuse each year is likely to be upwards of 35,700 adult victims and child witnesses.

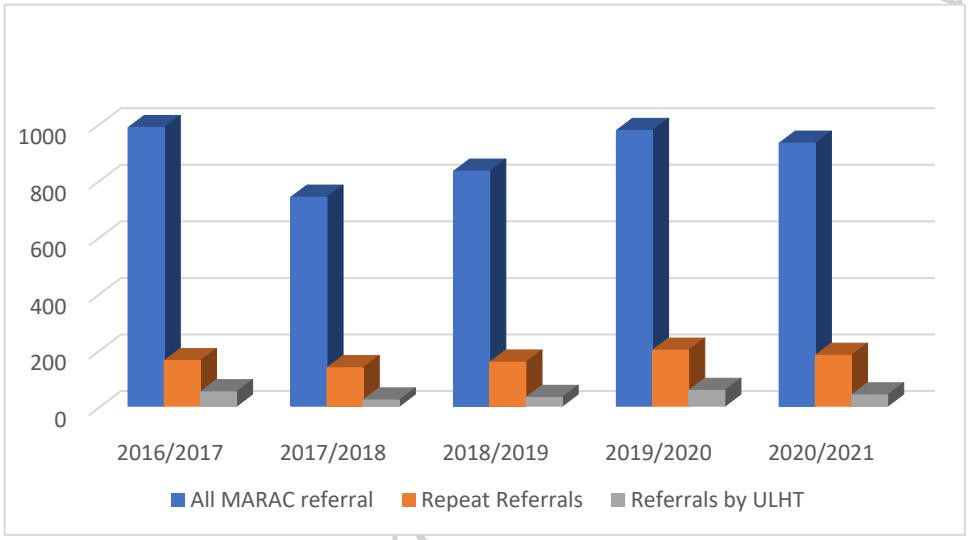
The relatively high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and safeguarding referrals are being made for child witnesses as well as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in children's social care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for

Education) Domestic abuse has also specifically been identified as a factor in 54% of all serious case reviews, which investigate child deaths relating to maltreatment, abuse, and neglect. (*S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

## 15.4 MARAC cases

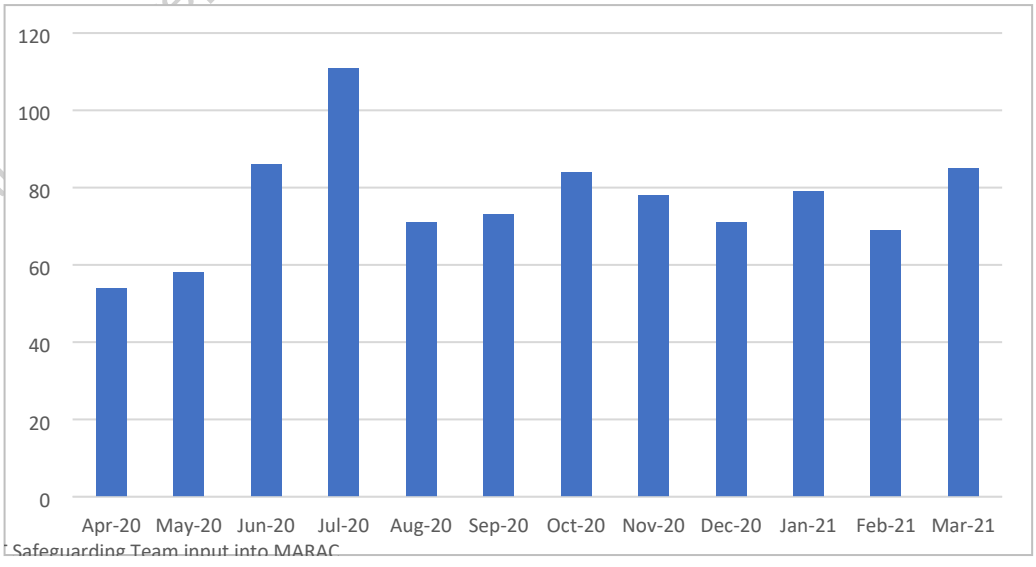
There were 930 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner agencies in 2020-2021. On average 238 referrals are made to MARAC every quarter (last three years ending March 2021).

**Figure 9: MARAC Referrals – all risk levels**




MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months the team have continued to attend all MARAC meetings.

**Figure 10: MARAC cases attended by Safeguarding Professionals**



Since the introduction of the Statutory Domestic Homicide Reviews in April 2011 there have been 18 cases involving 27 deaths that have met the criteria for a domestic homicide review in Lincolnshire.

## 15.5 Domestic Abuse support

Based virtually within the safeguarding team there are 2 Independent Domestic Violence Advocates (IDVA) employed by EDAN Lincs who provide 1:1 work with victims and support staff.

Across Lincolnshire there were just fewer than 2,000 referrals for adult victims of domestic abuse to specialist outreach support services in Lincolnshire (provided by EDAN Lincs) during 2020/21. In addition, during the 9 months April 2020 to December 2020 a further 6,648 people contacted the EDAN Lincs helpline or online chat for one off advice regarding domestic abuse.

## 16.0 PREVENT Lincolnshire Profile

Lincolnshire is classified as a low-level area however this does not mean that no risk exists.

There has been a drive to ensure Women be equally considered as being as capable and motivated to plan and conduct terrorist attacks as men.

The threat from Islamist extremism remains the most likely source of violent attack in the UK, despite local intelligence and referrals being much lower and *within Lincolnshire Right-wing extremism occupies the majority of staff time and is the greatest risk in Lincolnshire despite the national trend.*

Attacks by self-initiated terrorists (lone actors working independently to a network) is a national priority, having increased significantly in recent years and reflected a trend towards low-complexity attacks (e.g. bladed weapons and vehicles). The solitary and unpredictable nature of this type of perpetrator, combined with short planning times, means attacks can be difficult to disrupt

Lifestyle changes during the pandemic have most likely led to an increased targeting of young people online. Propaganda based on conspiracy theories can also make for complex assessments.

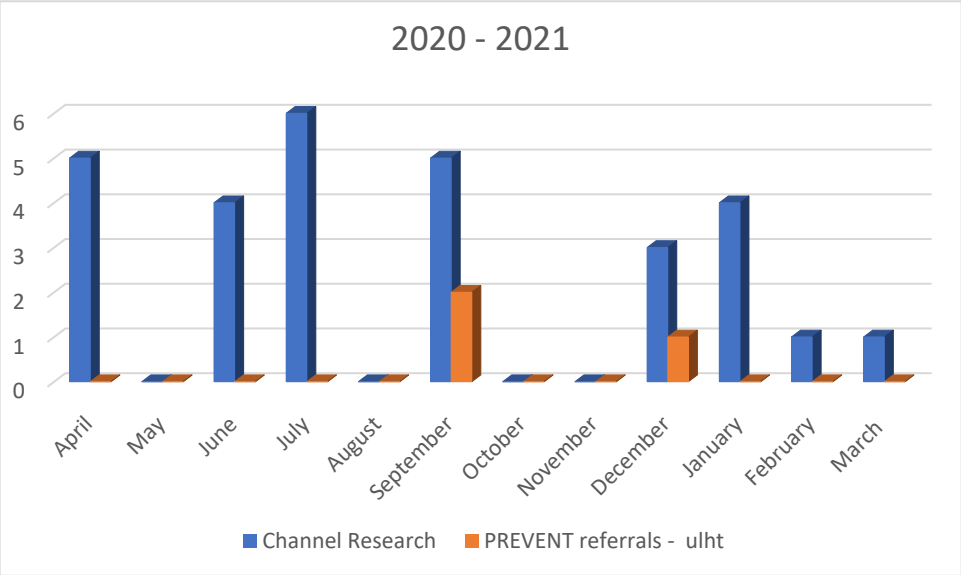
The majority of referrals (37%) related to people with a perceived vulnerability to radicalisation, due to mental ill health, age, abuse etc.

Nearly all referrals related to males, and the highest proportion of subjects were aged between 12 and 16. Female referrals are below the national average. The extent of their involvement in terrorism and extremism represents a significant intelligence gap.

Lincoln, followed closely by Boston, generated most referrals, likely due to population density. Mirroring this trend, Lincoln saw the most hate crime/incident reports

ULHT raised three Prevent referrals in this period.

**Figure 11: Number of PREVENT referrals made by ULHT and data analysis cases as part of Channel Process (April 2020 – March 2021)**




## 17.0 Multi-Agency Public Protection Panel (MAPPA)

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders under the provisions of the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison Services and a number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.

There are 3 categories of MAPPA-eligible offender:

- Category 1 - registered sexual offenders.
- Category 2 – mainly violent offenders sentenced to 12 months or more imprisonment or a hospital order; and
- Category 3 – offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks on Medway with processes in place for potential disclosures based on risk.

**Figure 12: Lincolnshire Area** *MAPPA Eligible offenders on 31st March 2020 (2021 figures are not yet available)*

| Category 1 Registered Sex offender | Category 2 Violent offenders | Category 3 Other dangerous offenders | Total |
|---|---|---|---|
| 810 | 193 | 5 | 1008 |

## 18.0 Persons in Positions of Trust (PiPoT)

Each year the Trust receives information which pertains to allegations of abuse / situations of concern about staff member's behaviour that take place both within their working life and their personal life.

Information comes in many forms – via PALS, from statutory agencies or from other members of staff within the Trust.

When this situation arises, several processes take place within the Trust and joint decisions are often made between human resources, operational services and the safeguarding team. As part of this process the safeguarding team will follow the PiPoT process whereby we follow specific safeguarding procedures to ensure that these concerns are shared with and at times investigated by our statutory partners

During 2020 – 2021 the Trust dealt with 16 allegations

***(specific data is not provided within this report due to the small numbers making the possibility for individuals being identified)***

## 19.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DOLs

### 19.1 Background

The Deprivation of Liberty Safeguards was introduced in 2009 and are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves.

The Mental Capacity Act provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person's best interests and empowering people to make their own decisions wherever possible.

The Deprivation of Liberty Safeguards is set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This section of the annual report provides an update to the Trust in respect of compliance with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in line with the CQC's approach to regulation under the Health and Social Care Act.

### 19.2 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) came into force in October 2007 and provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and

powers in respect of the decision-making process. The MCA applies to young people aged 16 and over.

The Mental Capacity Act provides:

*A duty to treat an incapacitated person in accordance with their best interests.*
*Limited ability to restrain an incapacitated person in accordance with their best interests but is only lawful where:*

- *It is necessary to prevent harm.*
- *Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.*

To lawfully deprive an incapacitated person of their liberty, even in their best interests, the trust must follow the statutory DoLS process and obtain an authorisation in line with the Act

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.
- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interest'.

The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

- Appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.

- The Court of Protection is a specialist court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.

- Lasting Power of Attorney (LPA) enable people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including healthcare decisions) and property and affairs, an LPA must be registered with the Office of the Public Guardian before it can be used.

- Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question, it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

## 19.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the *least restriction* on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation)
- Staff exercising complete and effective control over the care and movement of a person for a significant period.
- Staff exercising control over assessments, treatment, contacts, and residence.
- Decisions being made that the person will not be released into the care of others or permitted to live elsewhere unless the staff considers it appropriate.
- The refusal of a request by a carer for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person losing autonomy because they are under continuous supervision and control.

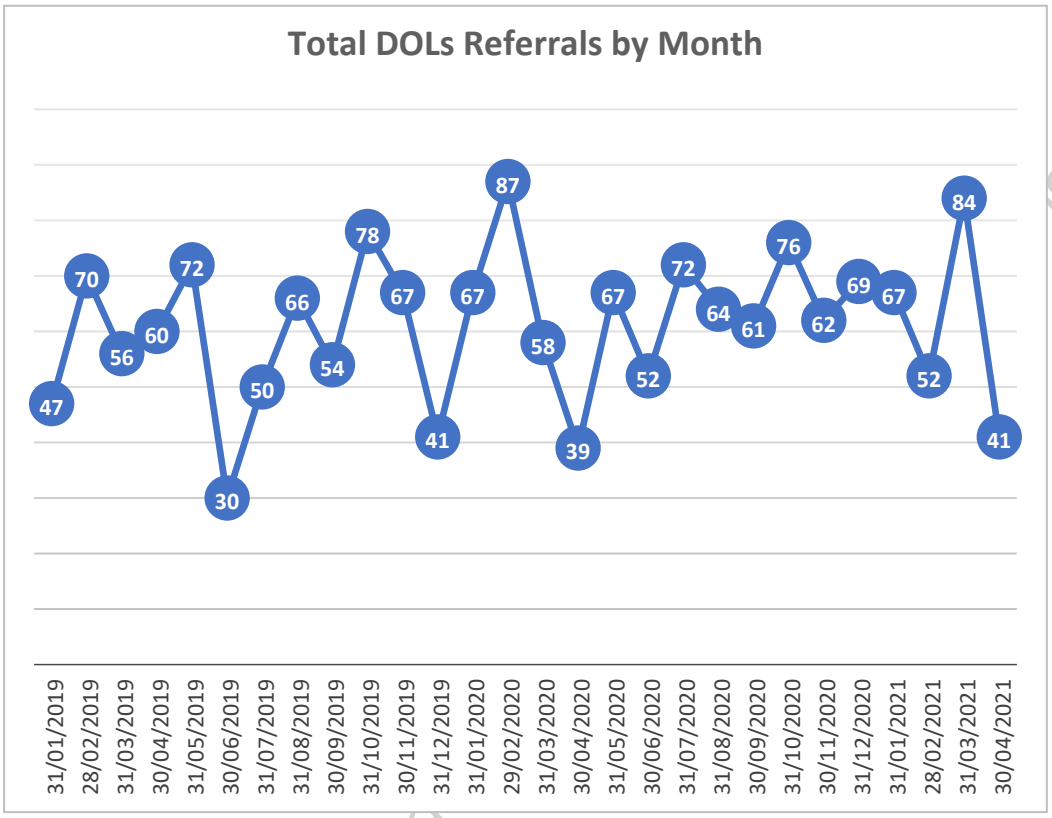
Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

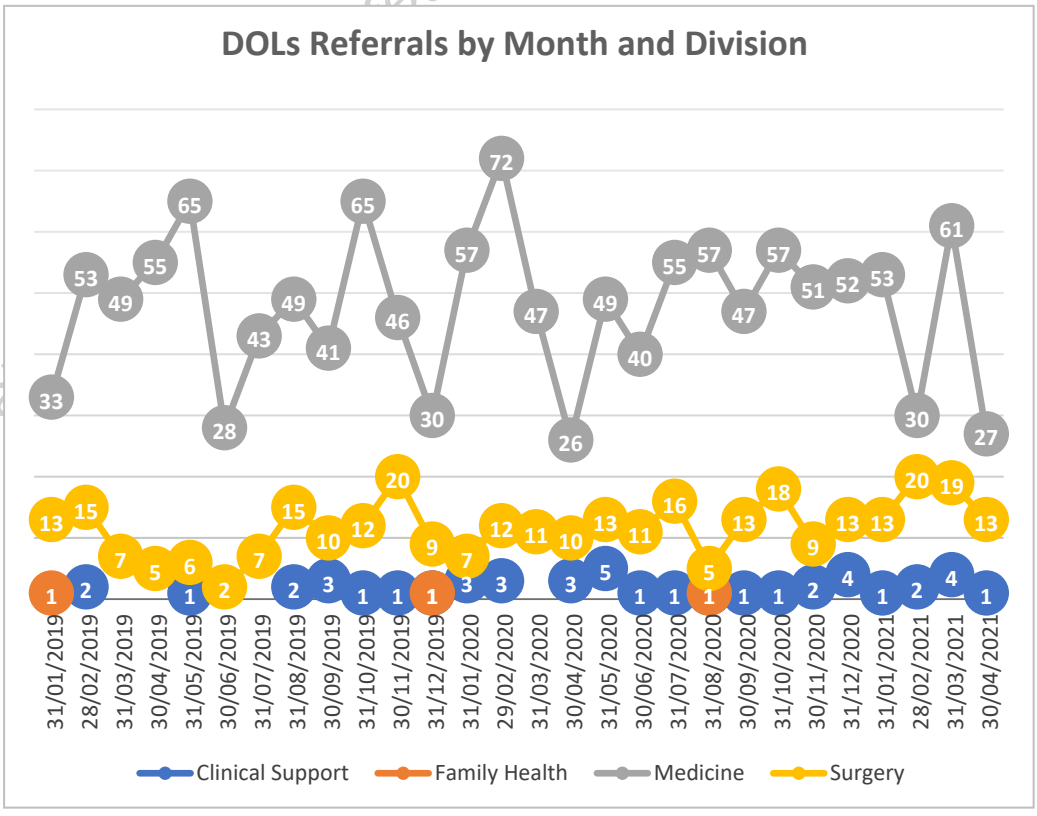
Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:

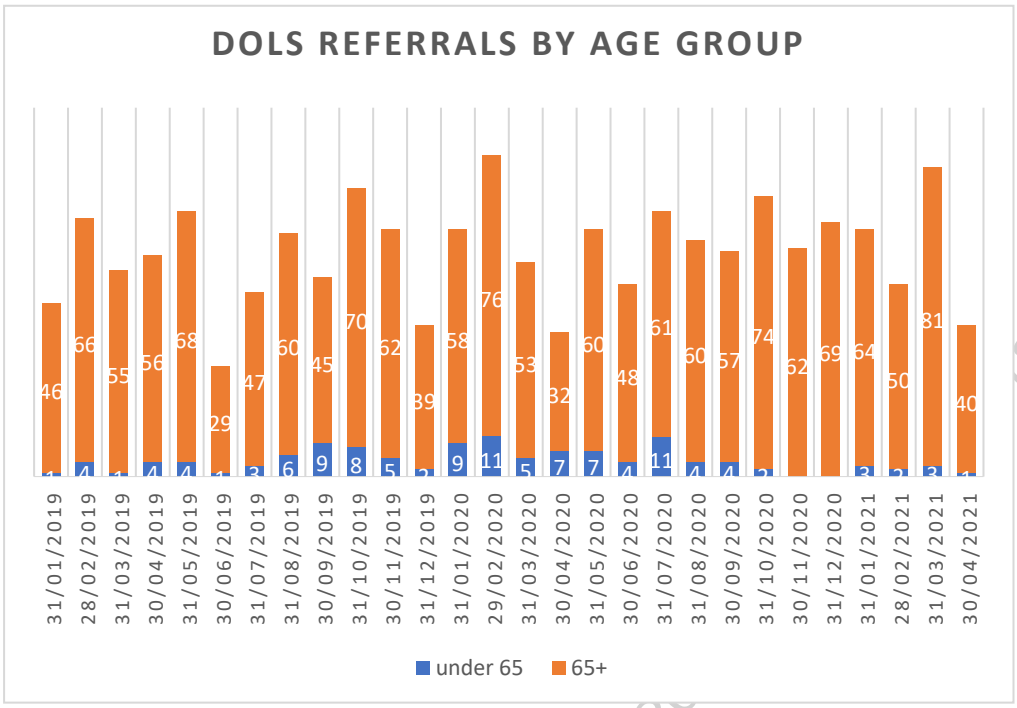
- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty?
- Is the patient receiving treatment for a mental disorder?
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid a deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

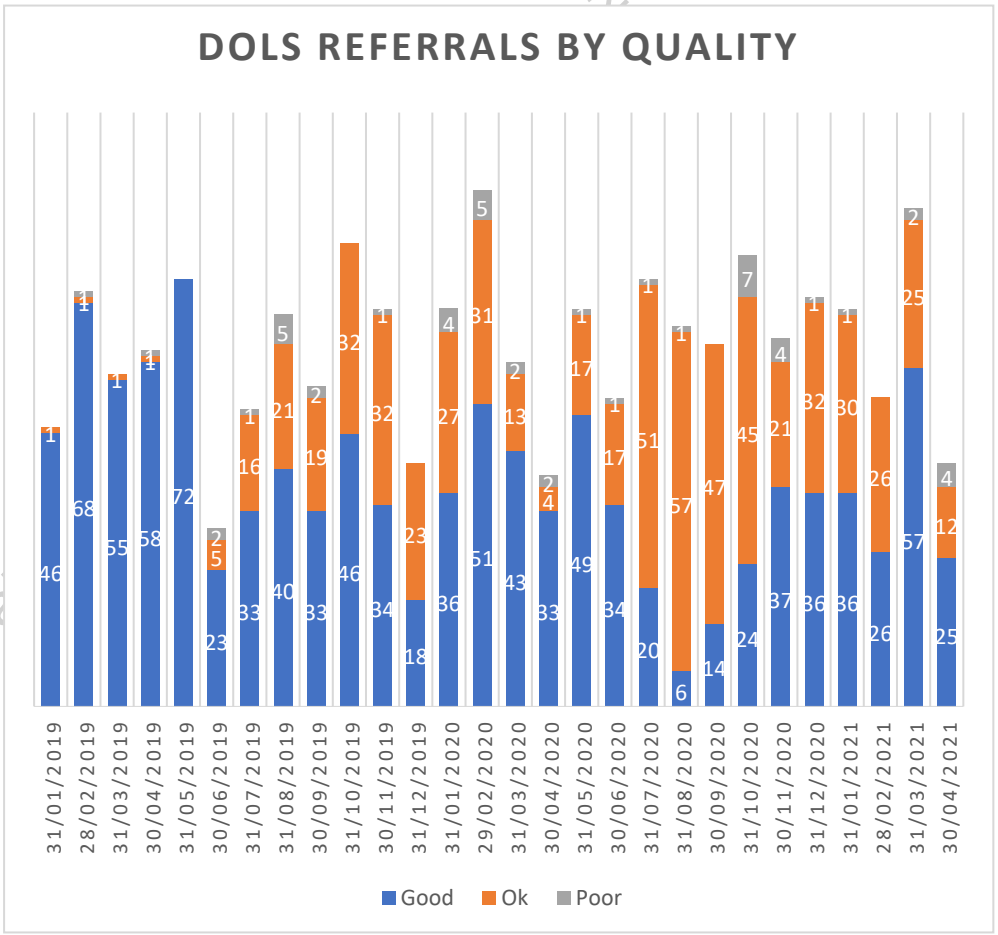
The Trust is responsible for ensuring that it does not deprive a person of their liberty without an authorisation and must comply with the law in this respect.

**Figure 13: The number of DoLs referral made between January 2019 and April 2021 including a break down for Divisional activity, Quality of completion and Age**




DOLS REFERRALS BY AGE GROUP
31/01/2019
28/02/2019
31/03/2019
30/04/2019
31/05/2019
30/06/2019
31/07/2019
31/08/2019
30/09/2019
31/10/2019
30/11/2019
31/12/2019
31/01/2020
29/02/2020
31/03/2020
30/04/2020
31/05/2020
30/06/2020
31/07/2020
31/08/2020
30/09/2020
31/10/2020
30/11/2020
31/12/2020
31/01/2021
28/02/2021
31/03/2021
30/04/2021
under 65
65+


DOLS REFERRALS BY QUALITY
31/01/2019
28/02/2019
31/03/2019
30/04/2019
31/05/2019
30/06/2019
31/07/2019
31/08/2019
30/09/2019
31/10/2019
30/11/2019
31/12/2019
31/01/2020
29/02/2020
31/03/2020
30/04/2020
31/05/2020
30/06/2020
31/07/2020
31/08/2020
30/09/2020
31/10/2020
30/11/2020
31/12/2020
31/01/2021
28/02/2021
31/03/2021
30/04/2021
Good
Ok
Poor

## 20.0 Safeguarding Risks

Following the CQC inspection of the 11th June – 18th July 2019 and subsequent publication of the report dated 17th October 2019 the trust was identified as having the following risks in relation to Safeguarding / Mental Capacity Act.

- 4145 - Compliance with safeguarding regulations and standards
- 4146 - Effectiveness of safeguarding practice

During 2020/2021 the safeguarding team have been actively involved with working against these objectives which are monitored as part of the ongoing improvement plan (attached)

PMO_2020_003
Highlight Report Apr

## 21.0 A review of 2020 – 2021

The last 12 months have been a challenge for everyone across the United Kingdom in a way that no one could have envisaged. Across the safeguarding system new ways of working have needed to be developed to help support our most vulnerable in society as well as provide a wider level of support to all staff within the trust and external safeguarding teams.

The normal pattern of safeguarding across Lincolnshire has changed and meant that some of its residents did not access services as normal and to some extent in the initial 6 months safeguarding issues became less visible to our teams.

To try and address this level of invisibility the safeguarding team were able to make the following adjustments based on service and client need:

- Maintain an increased availability of support and supervision to staff via face to face / teams / telephone even when team redeployment was required during COVID
- Created and amended alternative shortened pathways and processes to support staff in managing SG cases during the pandemic
- Reviewed all safeguarding training requirements to ensure that it continued to meet statutory guidance and staff were not required to undertake unnecessary training
- Developed high quality alternative training packages to allow staff to maintain their compliance in the absence of face to face training sessions
- Developed IIP/PID projects and progressed same
- Acted as first line contact for our local authority colleagues specifically in the area of MCA and DOLs due to face to face client contact note taking please within the hospital setting
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC etc.
- Fully embedded the Safeguarding governance process across all divisions ensuring that safeguarding remained at the forefront of operation business
- Maintained a fully appointed team with levels of sickness well below the trust average

- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks
- Successfully developed a business case to ensure that the Trust is able to deliver a safeguarding service (child protection / adult protection / MCA / PREVENT/learning disability / autism and mental health) over the coming years
- Support the data protection team in delivering requests made by the judicial system
- Undertake a comprehensive review of the chemical sedation policy
- Facilitated 2 Court of Protection cases ensuring successful treatment was provided to the patient
- Involved in the launch and development of a physical healthcare group for people with Learning disability to facilitate decision making around healthcare to the most complex cases
- Supported the MARZIPAN group for eating disorder patients of which the Trust has seen an increase in admissions
- Worked with Browne Jacobson as a co-chair in the development of a shared insight safeguarding group open to all UK safeguarding staff.
- Provided greater support with chairing complex MDT meetings and Best interest meetings.
- Produced guidance to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Worked in collaboration with the Local Authority to agree processes which facilitated safe presentation of children for CP Medical examinations and to protect children with no appropriate adult due to COVID-19 related inpatient admission.

## 22.0 Safeguarding Developments for 2021-2022

- Maintain momentum to achieve 90% across safeguarding training areas
- Review and benchmark safeguarding supervision to ensure that the targets of achievement in this area are not unreasonable and embeds a reportable assurance process
- Appoint to new team structure and continue regular review to ensure it remains fit for purpose
- Develop rollout process for Liberty Protects Safeguards as guidance allows and identify any risks to the trust that the new legislation may pose (including possible business case for increased funding for this new process)
- Presently the national guidance is being written and until this is published it is not possible to fully understand the impact on the Trust. (see appendix 2 for timeline)
- Develop and embed pathways for clients with learning disability / autism across trust services
- Develop a process of court craft and legal updates for staff who are required to attend court
- Embed the training of MCA/DOLS ensuring that there is a better understanding of best interest planning and that staff are able to more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements
- Audit adult concerns submissions to ensure compliance with 'Making Safeguarding Personal'

## 23.0 Conclusion

This report demonstrates the continued development and increased awareness of safeguarding children and safeguarding adults' issues within the Trust. The Trust continues to respond to the rapid national and local pace of change as well as maintaining an input external to the Trust.

Looking ahead to 2021 – 2022 and following recent changes to the Mental Capacity Act, the DOLS process will be replaced (April 2022) with the Liberty Protects Safeguards (LPS). Whilst still awaiting national guidance the trust will aim to ensure that the transition is as seamless as possible and the LPS process will be embedded within the new and progressive safeguarding function of the team

*Financially the launch of the LPS will in effect remove the onus and costs of deprivation from the local authority to the Trust and a business case will be developed as soon as the relevant guidance is available*

The safeguarding governance structures continue to be effective and the forums are actively managing the current action plans as well as moving services forward however these will be continually reviewed to ensure that the structures remain fit for purpose.

The forthcoming year promises to be full of further developments and challenges for both the team and the Trust

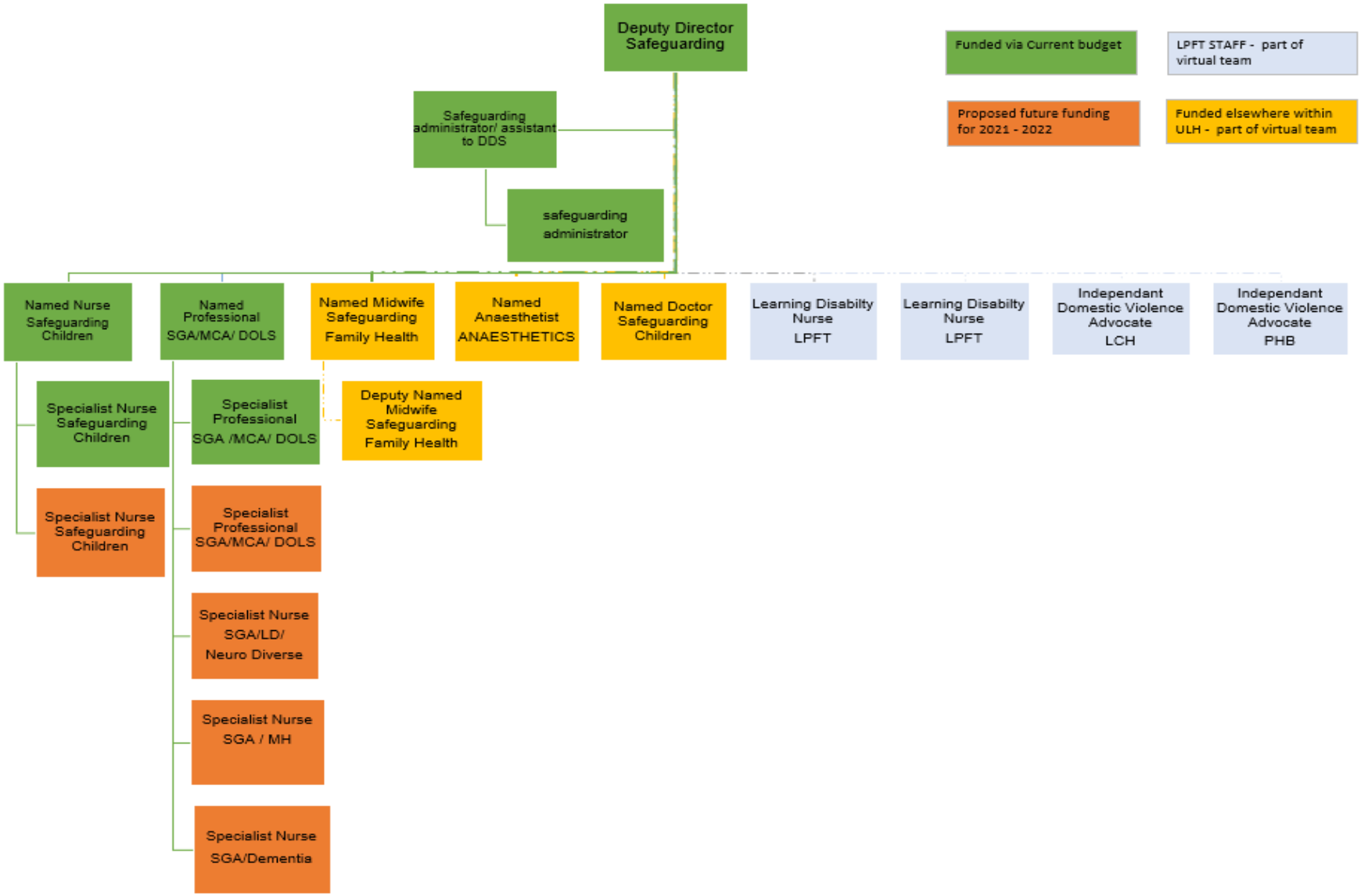
## 24.0 Recommendations

It is recommended that the Quality Governance Committee

i) Receive the safeguarding report prior to submission to the Trust Board
ii) Approve the plans for 2021 - 2022

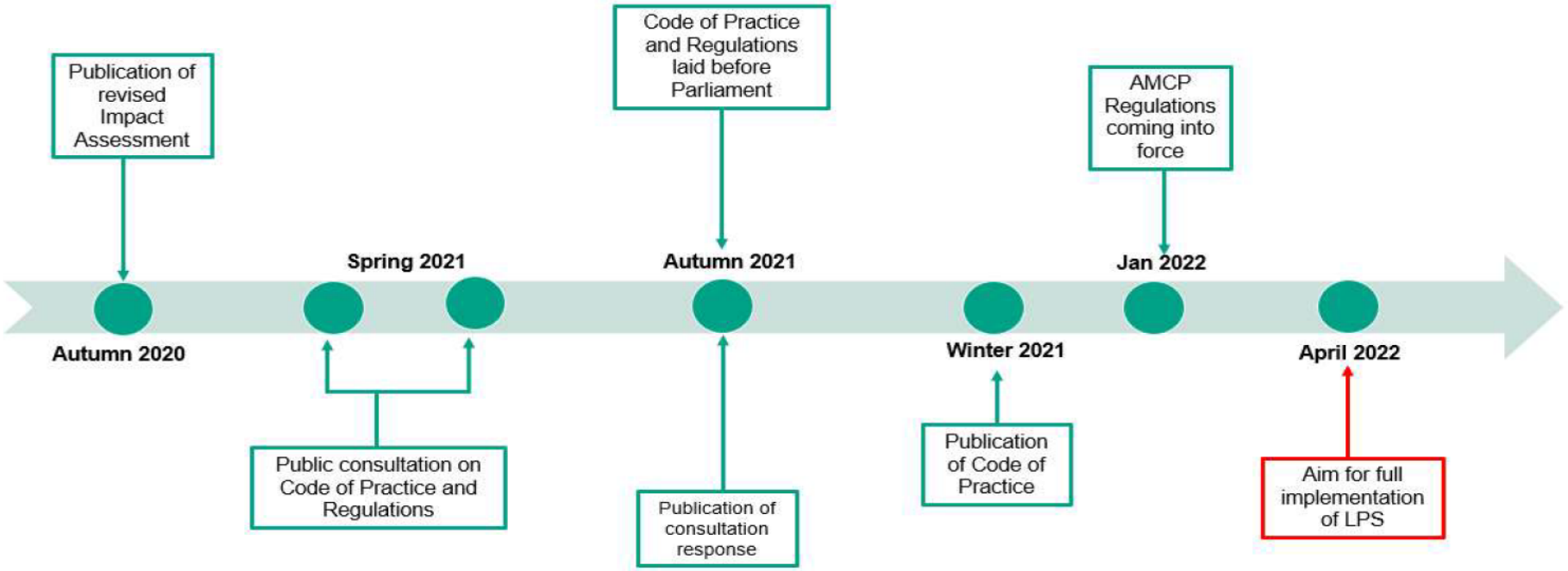
**APPENDIX 1**

# Safeguarding Team - propose structure April 2021 - March 2022



**APPENDIX 2**

## Planned milestones for Liberty Protection Safeguards



United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item 8.4* |
| *Complaints Report 2020-2021* | |
| Accountable Director | *Dr Karen Dunderdale, Director of Nursing* |
| Presented by | *Kathryn Helley, Deputy Director of Clinical Governance* |
| Author(s) | *Claire Tarnowski, Complaints Manager* |
| Report previously considered at | *Patient Experience Group*<br>*Quality Governance Committee* |

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

| | |
|---|---|
| Risk Assessment | *3487* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | *Trust Board to note the contents.* |

## Executive Summary

### 1. Introduction

Complaints and PALS enquiries are a key source of feedback for the Trust and inform us about our patients' views regarding the quality of services and care provided. All formal complaints received are taken seriously and are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure. All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than waiting to receive a formal written complaint and our PALs services support this process.

Complaint responses are reviewed by the Executive Leadership Team who are involved in reviewing, approving and signing completed responses. Quarterly complaints and PALS reports are presented and discussed at the Trust's Patient Experience Group and Quality Governance Committee. It is imperative that complainants feel that they are treated with respect and receive an open, honest and timely response to their concerns. Complaints response times are monitored by the Complaints Department and the Executive Team.

All complaints are allocated either 35 or 50 working days to respond to the complainant, which includes cases where the complainant is not satisfied with their first response. However, should it become apparent that the investigation may take longer we will contact the complainant and explain the reasons for the delay and a further date will be agreed. The Complaints Team are continuously reviewing their processes to ensure timely and high quality complaint responses are formulated. All complaint responses are quality assured by the Senior Management Team in Clinical Governance and by the Triumvirate prior to sending to the Executive Leadership Team for final sign off. It is anticipated these processes will reduce the number being re-opened.

This report provides information on the complaints received in the Trust between 1 April 2020 and 31 March 2021. It provides a summary of the complaints received, the areas concerned, the main issues raised and trends identified, and the actions

taken in response or those planned for the future. It also reviews our performance against agreed response targets and the number of complainants who came back dissatisfied following receipt of their initial response.

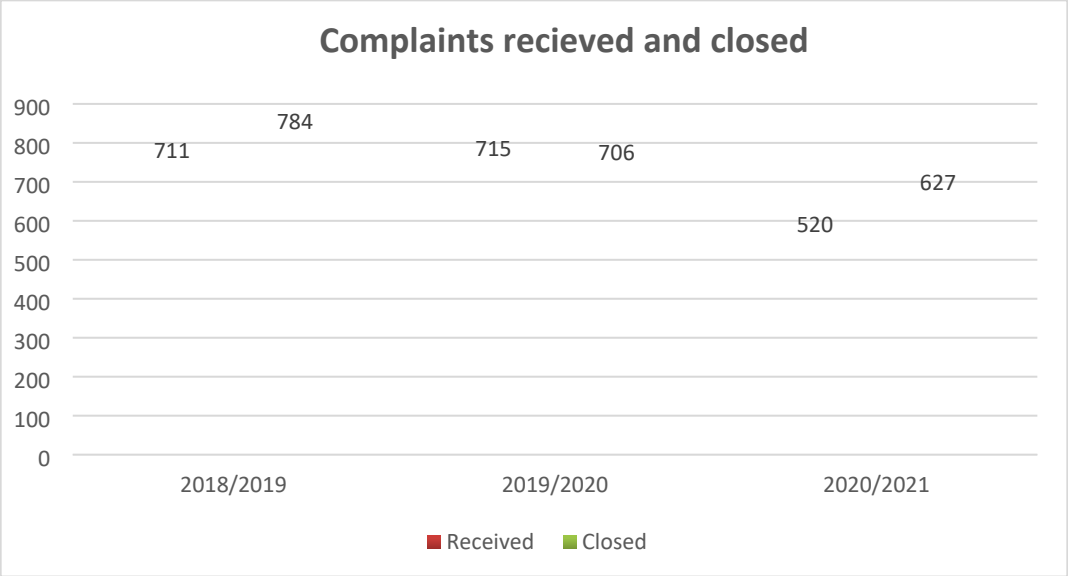
## 2. Complaints Received and Outcomes

During 2020-2021 the Trust received 520 Complaints, however, there were 627 complaints responded to within that period. Of the 627 complaints that were closed, 127 cases were carried over from the previous financial year. Of the 627 cases 200 were completed within the agreed timescale. 100% of complaints received by the Trust were acknowledged within 3 working days. The acknowledgment is confirmed by either an email or telephone call and these are followed up with a letter.

The following outcomes were assigned:

- 168 (26.8%) being fully upheld
- 285 (45.4%) partly upheld
- 154 (24.6%) not upheld
- 20 (3.2%) were withdrawn by the complainant

The chart below gives a comparison of complaints received by the Trust and the number responded to for the preceding 3 years.

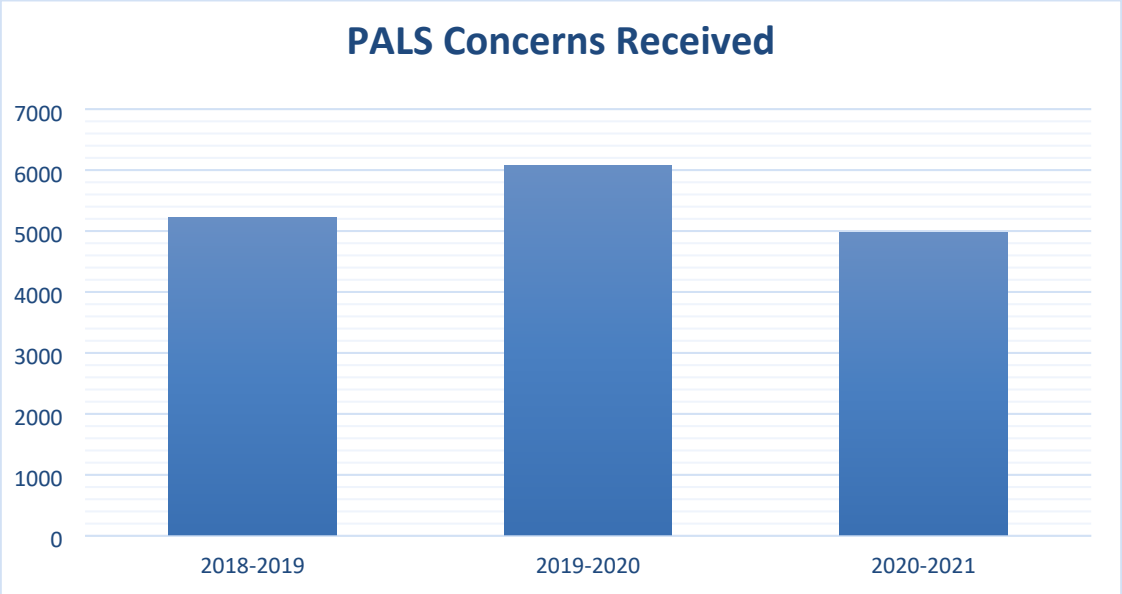


During 2020-2021, there has been a significant reduction in the number of complaints received by the Trust, which may be attributed to the COVID-19 pandemic. During the COVID-19 pandemic, we endeavoured to continue to respond to the complainants within the agreed timescale.

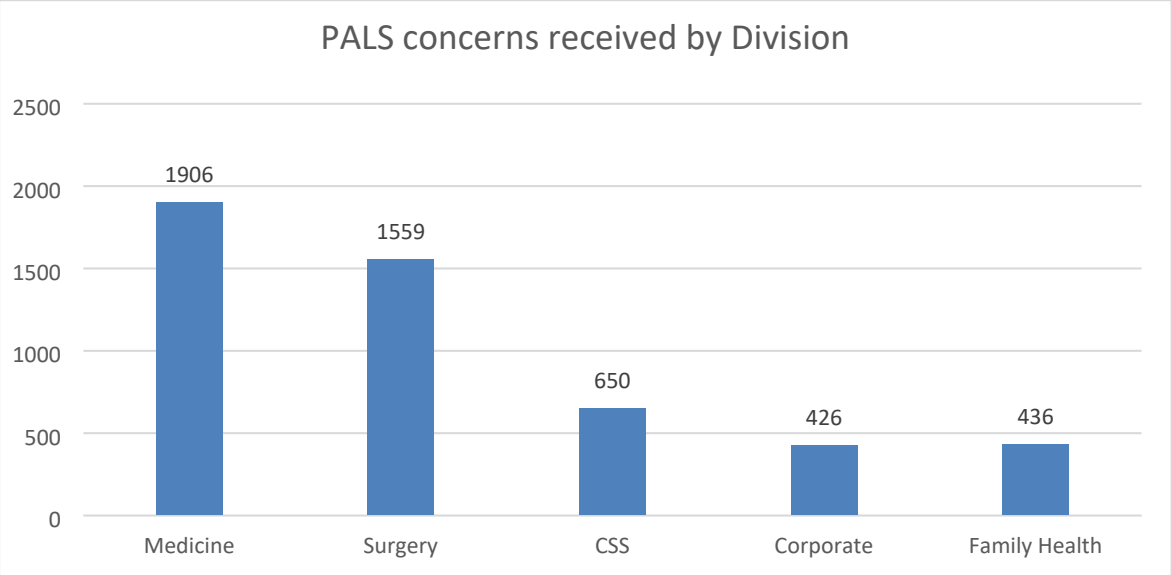
### 3. PALS Received

During 2020-2021 the Trust received 4,977PALS enquiries which is a reduction of 1103 from the previous year, however, the impact of COVID-19 and the reduction of patients being able to visit the hospital may also have had an impact on this reduction.

The chart below details the number of PALS enquiries received by the Trust during 2018-2019, 2019-2020 and 2020-2021.



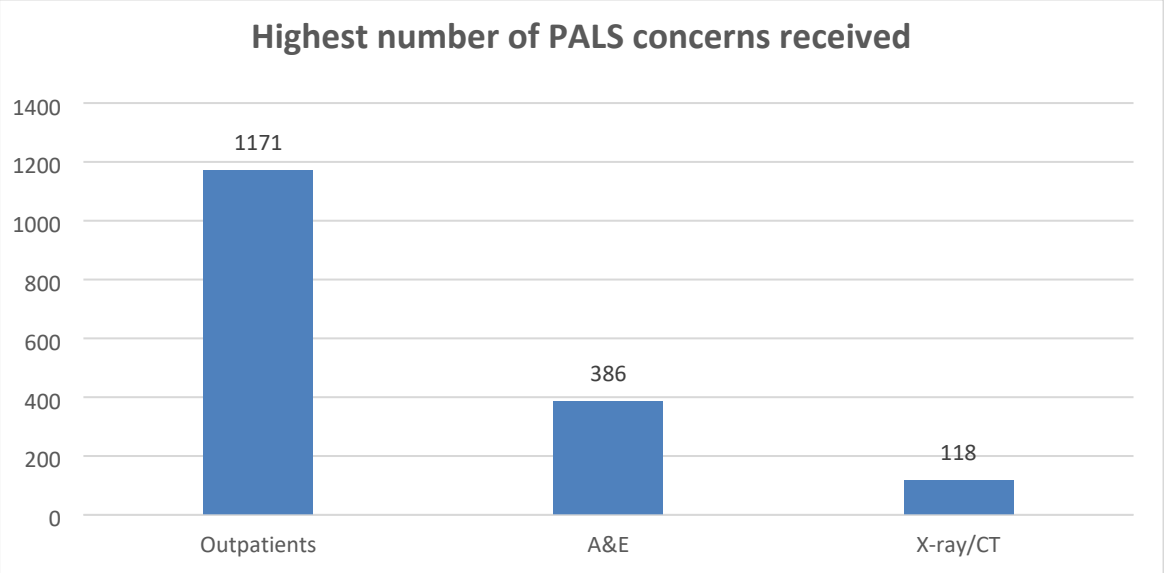
The chart below highlights the PALS Concerns received by each Division during 2020-2021.




Open PAL concerns

There are 5 PALS concerns that remain open from 2020-2021. These cases are complex cases and there is work ongoing to resolve these.

The chart below highlights the areas within the Hospital with the highest number of PALS concerns received during 2020-2021.



The following themes were identified within Outpatients:

- Delay in appointments
- Poor communication with Patients
- Communication with relatives and carers
- Delay in giving information and result

The following themes were identified within A&E:

- Lost property
- Poor communication with patient
- Communication with relatives and carers
- Security issues during COVID-19

The following themes were identified within X-ray/CT:

- Poor communication with patients
- Cancellations/refusal to undertake X-ray /CT
- Wait for appointment/length of wait

**Poor communication:**

Poor communication features in all of the above areas. During the COVID-19 pandemic staff on the wards faced competing demands on their time as they tried to balance delivering high standards of care alongside answering calls to loved ones to provide them with updates. Due to these concerns being raised the Trust has implemented the communication work stream, of which various pilots have been implemented to improve communication with families' eg mobile phones so patients can speak to their relatives and having detailed times when families can call wards.

**Lost Property:**

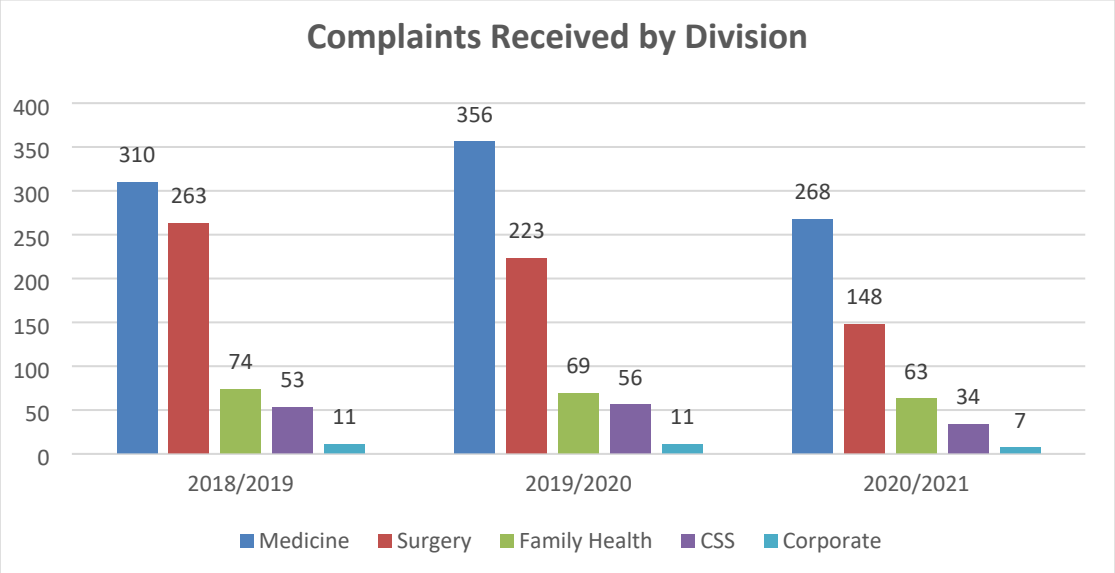
During the COVID-19 pandemic many patients had multiple wards moves and the property lists were not always completed or updated during the moves. This resulted in property being misplaced or lost. The Trust has produced a Patient Property Policy which is to be adopted Trustwide. This will ensure that all patients' property is recorded correctly within the medical notes and updated if a patient is moved to a different area. This will potentially reduce the number of PALS concerns and Complaints received by the Trust.

**Delay in Appointments:**

During the COVID-19 pandemic numerous patients' appointment were cancelled or rescheduled. Numerous strategies were employed to inform patients and reassure them that their appointment would be rescheduled at a later date. Due to issues with patients having difficulties contacting the appointments department for an update, additional staff have been employed to ensure that calls are being answered and patients are updated accordingly. Appointments letters have also been updated giving contact numbers where they can call to obtain an update.

**4.Complaints Received by Division**

Complaints received by the Division during 2018/2019, 2019/2020 and 2020/2021.

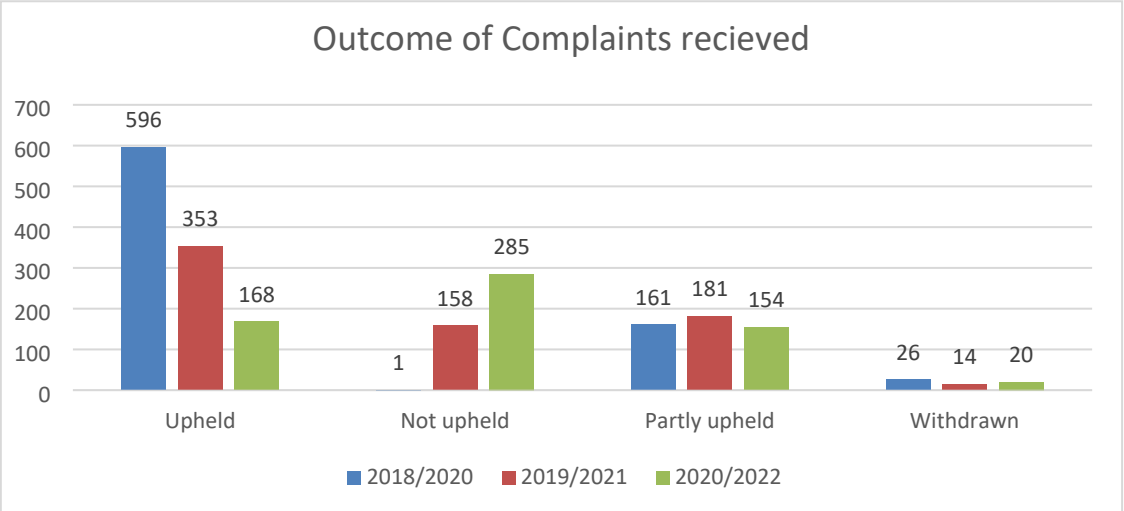


The chart above highlights Medicine Division received the highest number of complaints year on year. Whilst there is an increase in complaints for Medicine from 2018/2019 to 2019/2020, there was a significant reduction during 2020/2021.

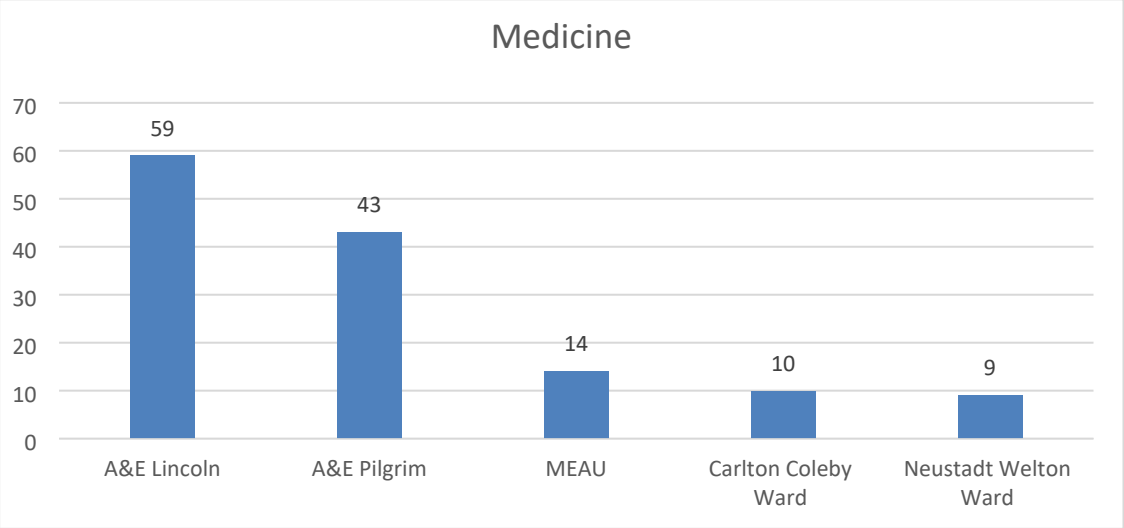
There has also been a reduction year on year for Surgery and Family Health. Surgery has seen a decrease of 33.6% in complaints received in 2019-2020 and 2020-2021, however, the impact of COVID-19 and the reduction of patients being admitted to have surgery may also have had an impact on this reduction.

Of the complaints that were responded to during the previous 3 years, the chart below depicts the outcomes for each year. For 2020-2021 the number upheld had reduced significantly. The number not upheld increased proportionately.

Outcomes of complaints received



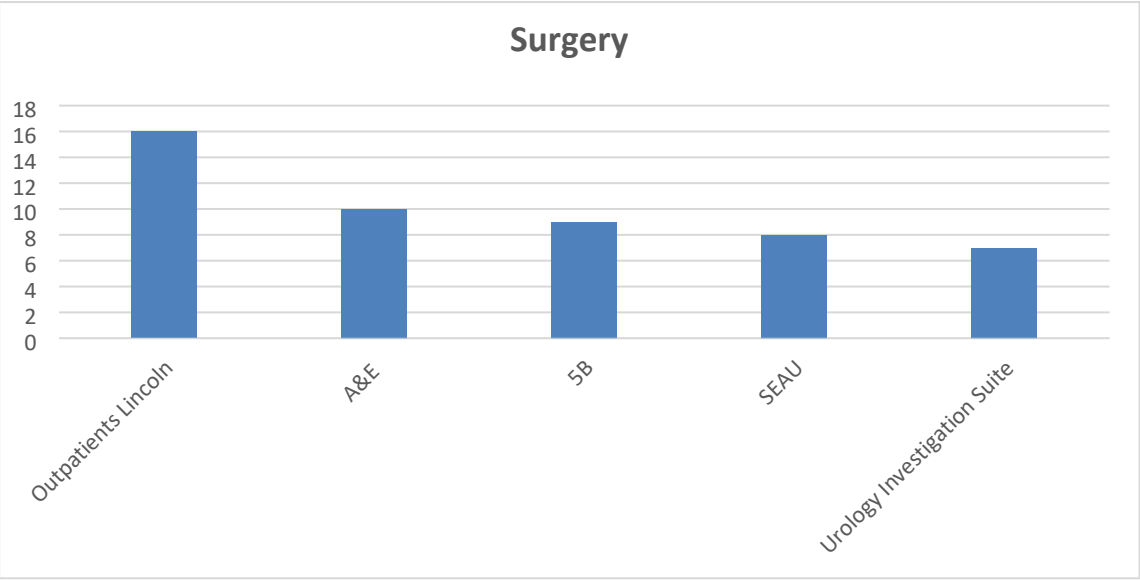

The charts below demonstrates the highest number of complaints received for each Division during 2020-2021.




Accident and Emergency Departments across Lincoln and Pilgrim received the highest number of complaints across all Divisions during 2020-2021.

The following themes were identified within the Medicine Division:

- Missed fracture
- Inadequate pain relief
- Cannula left insitu
- Inappropriate discharge
- Staff not using gloves or using gel in between Patients
- Poor communication with patients and families

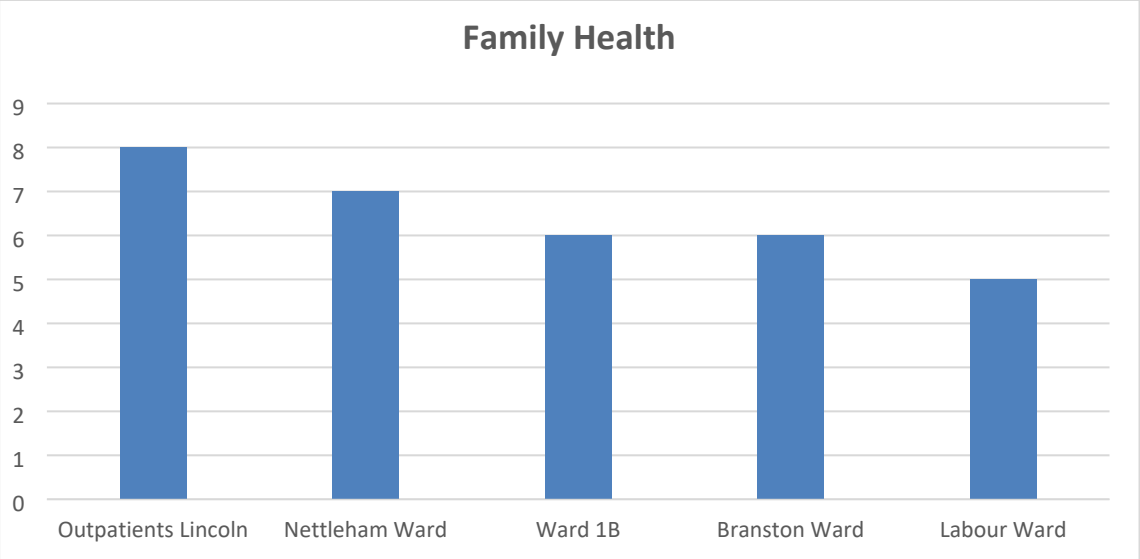


A&E – These relate to surgical patients pathway

Outpatients at Lincoln received the highest number of complaints during 2020-2021.

The following themes were identified within the Surgical Division;

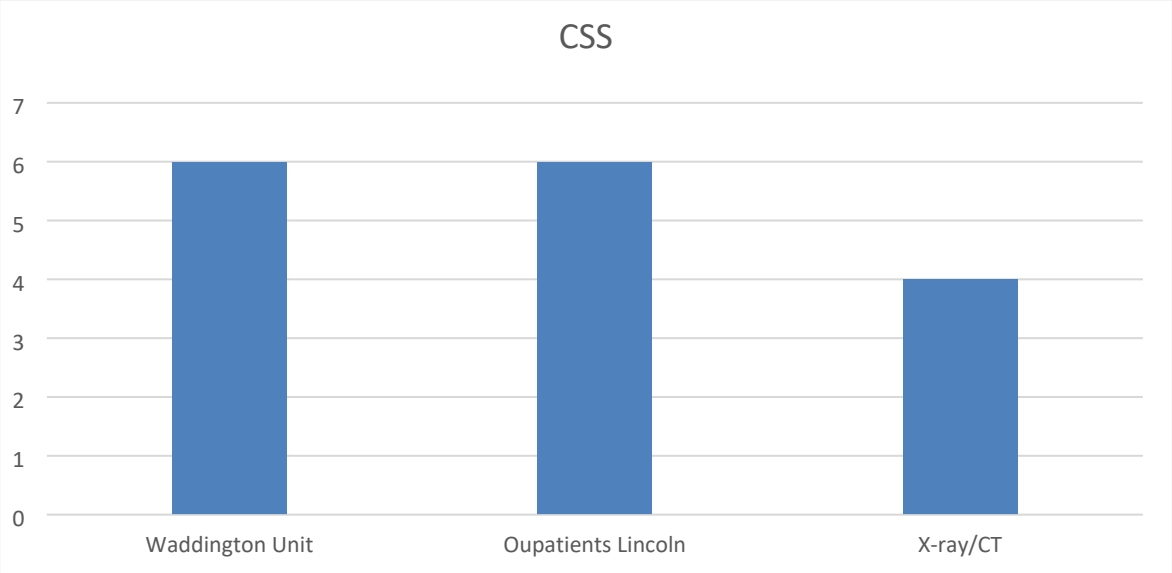
- Failure to diagnose a fracture
- Poor communication regarding fracture management
- Delayed cancer diagnosis
- Poor communication with patients and relatives




Outpatients at Lincoln received the highest number of complaints for Family Health.

The following themes were identified within the Family Health Division:

- Delay in receiving 2 week wait appointments
- Delay to undertake scans or x-ray
- Failure to obtain appropriate consent from patients
- Poor communication with patient and family and not being kept informed
- Values and behaviours of staff



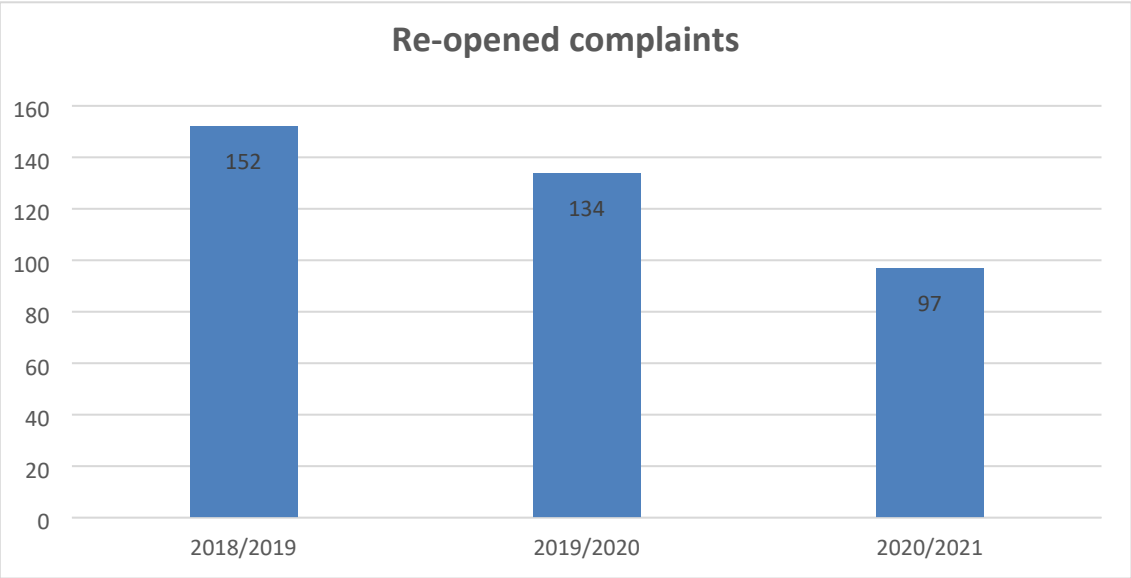

Waddington Unit received the highest number of complaints for CSS

The following themes were identified within the CSS Division:

- Poor communication/breaking bad news
- Delayed appointments
- Attitude of nursing staff
- Delayed treatment

**4. Complaints re-opened**

The chart below depicts the number of reopened cases of the 627 that were closed in 2020-2021.




Reasons detailed below why cases were re-opened:

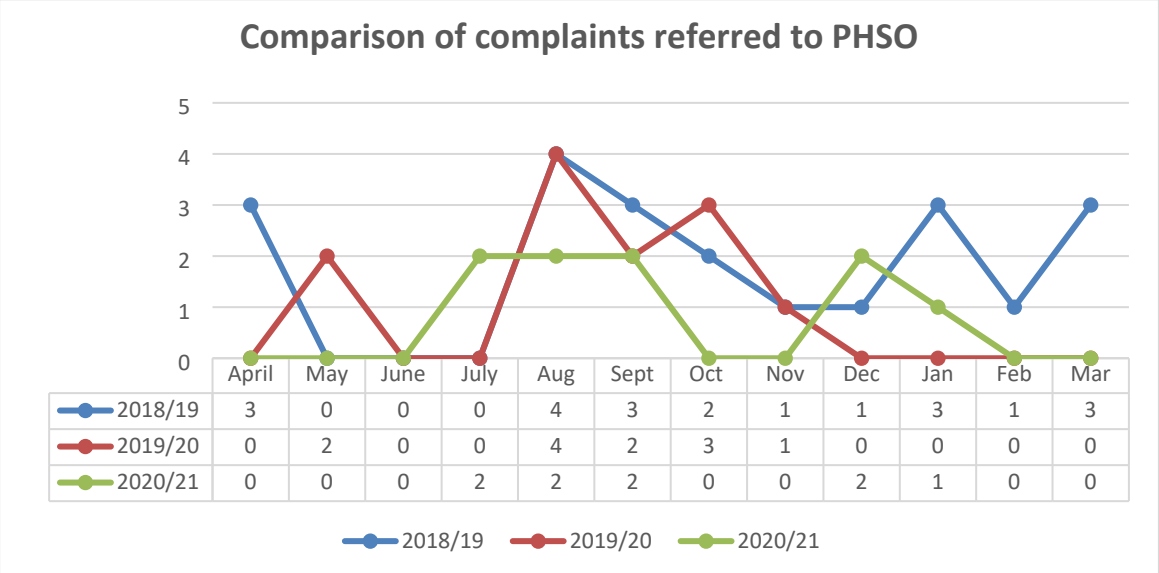
- Dissatisfied with contents of the first response
- Requesting clarity on the information provided
- Accepting an offer of a meeting
- Initial response has raised further concerns

There has been a reduction in the number of re-opened complaints year on year. 97 complainants who received their first response during 2020-2021 requested further information following their initial response. The reduction may be an impact of the COVID-19 pandemic and the reduction of complaints received in 2020-20201.

## 5. Complaints referred to PHSO

If complainants remain dissatisfied they have the right to approach the Parliamentary and Health Service Ombudsman (PHSO). The PHSO will assess each case and make a decision as to whether they will provide an independent review of the complaint.

The chart below highlights the number of cases that were referred to the PHSO during 2020-2021 in comparison to the previous two financial years.




| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018/19 | 3 | 0 | 0 | 0 | 4 | 3 | 2 | 1 | 1 | 3 | 1 | 3 |
| 2019/20 | 0 | 2 | 0 | 0 | 4 | 2 | 3 | 1 | 0 | 0 | 0 | 0 |
| 2020/21 | 0 | 0 | 0 | 2 | 2 | 2 | 0 | 0 | 2 | 1 | 0 | 0 |

- 2018 -2019 there were 21 referred to PHSO
- 2019-2020 there were 12 referred to PHSO
- 2020-2021 there were 9 referred to PHSO

There has been a reduction in the number of cases referred during 2020-2021, however, this may be due to the impact of COVID-19 and the reduction of patients being admitted to our hospitals. The quality of responses have significantly improved and therefore the PHSO have been satisfied that the Trust have investigated these thoroughly and no further action was required by the Trust.

## 6. Open Complaint Actions

In December 2020, the Complaints Team reviewed the complaints open actions. A proposal was submitted to Quality Governance Committee to close 'business as usual' actions. The Triumvirate within each Division were sent the 'business as usual' actions to agree closure. The Divisions receive a weekly list of their open actions as part of their weekly complaint report.

The Complaints Team have developed clear processes to ensure actions are evidenced and closed within the appropriate timeframe. There were 1707 open complaint actions as of December 2020 and currently there are 173 and work is ongoing to aid closure of these. The Triumvirate are now responsible for identifying

actions from the complaints responses to enable work streams to be aligned and robust actions to be developed. The number of open actions are displayed below:

| | January 2021 | February 2021 | March 2021 |
|---|---|---|---|
| Medicine | 799 | 250 | 35 |
| Surgery | 473 | 90 | 72 |
| CSS | 105 | 0 | 1 |
| Family Health | 232 | 67 | 65 |

## 7. Shared Learning and Communication

The Trust has implemented a number of processes to improve shared learning across the Trust. Listed below are examples of how we are sharing and embedding learning and the future plans:

- Implementation of quarterly 'Learning to Improve' Bulletins for each Division and an overarching Trust bulletin to share learning within and across Divisions & the Trust commenced in October 2020.
- Patient Safety Briefings are circulated via email to all clinical staff when significant transferrable learning is identified from a complaint.
- Dedicated learning section on the Clinical Governance intranet page.
- Monthly triangulation meetings in place for each Division as identified in the Corporate Offer to the Divisions.
- Clinical Governance meetings held at Speciality, Clinical Business Unit and Cabinet level, supported by the Clinical Governance team, as a forum to discuss learning.
- Introduction of a monthly Divisional Integrated Governance report with executive summary identifying themes, trends and learning for each Division
- Relaunch of the "Analysing and Learning" policy will be undertaken in the first quarter of 2021. In addition to this, the Trust is developing an aggregated analysis report of all patient safety incidents, complaints, claims and Coroners inquests.

## 8. Changes in Practice from Complaints

One of the aims of complaints is to ensure that learning occurs in order to continually improve services for future patients. Below are some examples of changes that have occurred as a result of complaints during 2020/22.

- Alignment with the Dementia Training Standards Framework set out by NHS Health Education, England. The framework sets out how NHS organisations should care for patients with dementia and aims to support the development and delivery of appropriate and consistent dementia education and training for our staff
- Training was developed for doctors to perform ward based chest drain insertion
- In-house pharmacist in A&E to improve medication compliance
- An Accountability handover document was developed to improve Health Care Support Staff documentation
- Due to consultant to consultant referrals being mislaid and not actioned causing a delay in chemotherapy for patients, a new process has been adopted. The secretary will process the referral letter, which will require the signature and instruction from the consultant. If there is no instruction or signature the secretary will bring this to the attention of the consultant to prevent any near misses and delay in treatment.
- As a result of the delays, Ultrasound are currently undergoing an expansion to incorporate two additional scan rooms. This will allow for an increase of scans to be undertaken.
- A review of the post-partem bleeding guidelines to ensure a second scan is considered even when the previous scan was normal to ensure correct diagnosis.
- Development of an electronic referral system for patients identified with ulcers who require review by diabetic foot team.
- All complaints are discussed at the Speciality Governance Meetings and the Complaints Team request the evidence for the actions prior to closing. All

open actions are included in the weekly complaints Divisional Tracker and the monthly Integrated Governance Report.

- The communication work stream are commencing various pilots to improve communication with families' eg mobile phones so patients can speak to their relatives and having detailed times when families can call wards.
- Patient property policy being updated to ensure robust processes for the safekeeping of personal items is adhered to.
- Ongoing conversations with the Outpatient Managers to implement processes to resolve patient concerns.

**9. Complaints Processes**

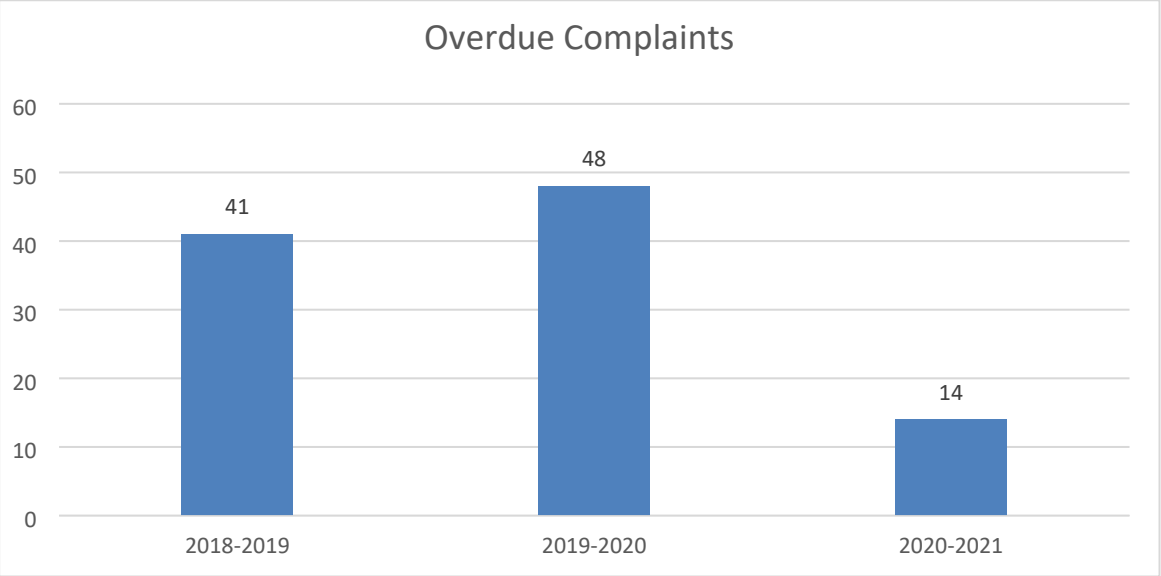
During 2020-2021, the Complaints Team have continually reviewed their processes to ensure timely and high quality complaint responses are formulated. The Complaints Team have completed and successfully achieved their external accredited assessment in Complaints Handling and Investigations.

Each Division have been allocated their own dedicated Complaints Team. This helps to develop good relationships and engagement within the Division and provides consistency when supporting with the co-ordinating of complaints received by the Trust. The Complaints and PALS Manager sends weekly complaints report and Statistical Process Control (SPC) charts to each Division detailing their compliance with responding to complaints within the agreed timeframe.

**10. Response Times**

The Complaints Team have reduced the backlog of overdue complaints, at the end of 2019-2020 where there were 48 complaints that were not responded to. Complainants were also waiting a protracted time for their response. There are currently 14 complaints, which have breached their agreed timescale. 7 of these have been completed and are awaiting sign off. Whilst the number of overdue complaints has reduced significantly only 32% of complainants received their response in the agreed timescale, however, the majority of responses missed their due date between 1-6 days. The Complaints Team are improving their responses to stop complaints passing their due date.

## 11. Overdue complaints




The Complaints Team previously only utilised the 35 working days response time for complaints, however, complex complaints do take longer to investigate and respond and should have been allocated 50 working days. The Complaints Team now utilise both timescales depending on their complexity. Going forward, this will enable the Complaints Team to increase their compliance with responding to complaints within the agreed timescale going forward.

The Complaints Manager has weekly meetings with each Division to review their overdue complaints and ensure completion of complaints that are due within the coming weeks. The Complaints Team will continue to work closely with the Divisions to support in responding to complaints within the agreed timescales.

## 12. Internal Audit of Complaints Process

During 2020-2021 Internal Audit conducted a review of the management of complaints. The objective of the review was to provide an independent assessment of the key risks and operational effectiveness of the Trust's arrangements in the management of complaints, and how lessons learned are shared across the organisation to maximise learning.

The Trust received partial level of assurance, they recognised the Trust had made significant progress improving its complaints processes and improving the oversight of actions, however, further action is required to improve compliance with the timescales and the effective sharing of lessons learnt.

**13. Summary**

The primary themes remain largely the same as the last financial year, with the most common being clinical treatment, communication, attitude, delays and appointment issues. However, the actions outlined in this report demonstrate that trends are acted upon and the complaints received in the Trust are used to inform pieces of work aimed at improving the patient experience. The responses provided invariably outline action(s) that have been taken in response to the concerns raised or explain what is planned as a result of issues identified during the investigation.

Policy and procedure and the way in which complaints are recorded and dealt with is harmonised across Trust sites. We have systems in place to systematically review the complaints received and ensure that investigations are undertaken appropriately, in line with legislation, and escalated within the Trust as necessary. The data collected is used to inform reports, is disseminated amongst Divisional teams and taken to various Groups and committees to inform ongoing work within the Trust.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item 8.5* |
| *CQC Must Do and Should Do Actions and Regulatory Notices* | |
| Accountable Director | *Karen Dunderdale, Director of Nursing* |
| Presented by | *Karen Dunderdale, Director of Nursing* |
| Author(s) | *Kathryn Helley, Deputy Director of Clinical Governance*<br>*Louise Hobson, Head of PMO* |
| Report previously considered at | *Quality Governance Committee – 22/06/2021*<br>*CQC Steering Group – 16/06/2021* |

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

| | |
|---|---|
| Risk Assessment | *Link to strategic risks:-*<br>*4405; 4083; 4175; 3688; 3951; 4156; 3503; 4041; 4081; 4145; 4300; 4476* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *Through governance process of IIP.* |
| Equality Impact Assessment | *Through governance process of IIP.* |
| Assurance Level Assessment | *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | • *The Trust Board is asked to note the activity that has occurred since the last report.* |
| | • *The Trust Board is asked to note the progress of delivery of improvements against the CQC 'Must Do' and 'Should Do' actions.* |

## Executive Summary

To provide the Trust Board with an update on CQC activity.

The report and executive summary (Appendix A) provide an update on the current month's performance against the CQC 'Must Do' and 'Should Do' actions.

The report also provides details of other CQC activity taking place within the Trust.


## 1. Introduction

The CQC published its inspection report in October 2019 following the July 2019 Core Inspection. The Trust has been taking action to address these areas for improvement. This paper and attached appendices provides the Trust Board with a summary of progress. It also includes information related to other activities undertaken with and related to the CQC since the Core Inspection referred to above.

## 2. Progress to Date

### 2.1 Monitoring Process

Appendix A attached provides an executive summary outlining the position of the must and should do actions and any risks to delivery. This activity is monitored through the weekly CQC Steering Group.

### 2.2 Progress Against Must Do and Should Do Areas for Improvement

Progress against all the areas for improvement has been documented and an Executive Summary has now been embedded within the CQC Action Plan to support in pointing out key points, high risks and issues and progress against actions (Appendix A). Also within the report is an overarching view of all the risks and issues (Appendix B). Full details of the risks and issues can be found in the Executive Summary in Appendix A.

Since the last reporting period, the focus has been on supporting and helping clinical Divisions to prepare for their forthcoming CQC Evidence Review Panels by way of a preparatory session. The preparatory sessions are chaired by the Deputy Director of Clinical Governance and supported by the NHSEI Improvement Director and Head of PMO. Please see below timetable outlining clinical Divisions dates for their prep session and when their CQC Evidence Review Panel is taking place.

| Division | Preparatory Session | CQC Evidence Review Panel |
|---|---|---|
| Clinical Support Services | 08/06/2021 (cancelled due to operational site pressures)<br>15/06/2021 | 28/06/2021 |
| Family Health | 03/06/2021 | 24/06/2021 |
| Medicine | 04/05/2021<br>18/05/2021 | 25/05/2021<br>10/06/2021 |
| Surgery | 08/06/2021 | 05/07/2021 |

All clinical Divisions who have undertaken their preparatory session have found the session very useful and helpful in preparing for the impending CQC inspection and ensuring that all 'Must Do' and 'Should Do' actions are well evidenced and if not what mitigation is in place to address the action.

The CQC Evidence Review Panels are jointly chaired by Dr Karen Dunderdale, Director of Nursing and Dr Neill Hepburn, Medical Director.

To note, from the initial prep sessions there has been some movement of the BRAG status of the 'Must Do' and 'Should Do' actions with some improving where the evidence supports this and others reducing whist evidence is gathered.

Any CCQ 'Must Do' and 'Should Do' actions requiring escalation, continue to be fed into the weekly CQC Steering Group and escalated appropriately to the Executive Team Leadership (ELT) forum through the regular Highlight Report.

2.3 Other Regulatory Activity

| Area | Lead | Current Position |
|---|---|---|
| Section 31 – Urgent and Emergency Care | Tracey Wall, Head of Nursing | The Trust continues to report fortnightly to the CQC on progress against the issues identified in the Section 31 notice.<br><br>Work is currently taking place to complete the CQC templates to vary or remove a licence condition. It is anticipated that these will be submitted to the CQC by mid July 2021 at the latest. |
| Section 29a – Children and Young People / Children and Young People KLOEs | Simon Hallion, Managing Director | Update on progress towards meeting the issues identified in the Section 29a and the KLOEs was submitted to the CQC on 8 March 2021 and a meeting held on 16 March 2021. Correspondence received from the CQC has recognised the significant improvements seen through this process.<br><br>A CQC focus group with Family Health took place on 14 June 2021. |

| | | |
|---|---|---|
| IPC Assurance Framework | Karen Dunderdale, Director of Nursing | Call undertaken with CQC early 2020/21 regarding the Emergency Support Framework. This led to the development of the IPC BAF which is monitored through the Infection Control Committee. |
| Patient First – Pressure Resilience in Emergency Medicine | Tracey Wall, Head of Nursing | Patient First Self-assessment shared with the CQC. Awaiting feedback. |
| Medicines Management | Colin Costello, Chief Pharmacist | Call held with the Pharmacy team. Follow up call held with ELT and Triumvirate on 8 February 2021. |
| Well Led TMA | Andrew Morgan, CEO | Evidence against the KLOEs submitted on 29 April 2021. TMA meeting took place on 6 May 2021. |
| Medical Care TMA | Carl Ratcliffe, Managing Director | TMA call undertaken on 25 March 2021 with evidence submission occurring on 19 March 2021. Verbal feedback was positive. Subsequent request from the CQC for focus groups to be undertaken with staff from medicine wards. These focus groups have commenced. |

2.4 Preparation for Impending CQC Inspection

A number of activities are currently taking place in order to prepare for our impending CQC inspection. These include

- *Staff Briefing Sessions* – these sessions commenced on 15 June 2021 and aim to share with staff what happens on a visit and how they can prepare themselves.
- *Time to Shine* – teams are being asked to consider what they are proud of and 'Time to Shine' posters demonstrating all the excellent work being undertaken are being displayed across the Trust.
- *Lunch and Learn* – these sessions, although not specifically for the CQC, will support staff in understanding more about a range of topics such as safeguarding, risk, management of the deteriorating patients, etc.
- *Ward Boards* – work has taken place with the wards to devise quality & safety and clinical governance ward boards.
- *Best Practice Folders* – folders have been devised for wards to use to collect any evidence of good practice, innovations, etc, in order that they can showcase the work that they are undertaking

- *Clear the Clutter* – provision has been put in place so that wards and departments can contact the Estates and Facilities team to arrange for any unwanted items to be collected, therefore leaving spaces free from clutter.

In addition, and as mentioned above, at the request of the CQC, a number of focus groups are planned to allow staff the opportunity to speak to the CQC. Initially these have been focussed on children & young people and medicine, however plans are in place for general focus groups in the run up to a visit. Details of these are as follows:-

- Monday 14 June at 12.30pm – Children's Services, Trustwide
- Thursday, 17 June at 9.30am – Johnson, Lincoln
- Monday, 21 June at 4pm – AMSS, Boston
- Thursday, 24 June at 4pm – Johnson, Lincoln
- Thursday, 8 July 12.30pm – AMSS, Boston

**3. Conclusion/Recommendations**

In conclusion, actions have been and are being taken to close existing conditions and warning notices with the CQC and progress improvements against 'Must Do' and 'Should Do' actions.

Progress and risk continue to be monitored through the fortnightly CQC Steering Group and issues escalated through to ELT and to the Quality Governance Committee and Trust Board as required. Support will continue to be provided by the corporate teams including the collation of the supporting evidence.

The Trust Board is asked to note CQC associated activity, the progress against the delivery of improvements mapped to the CQC 'Must Do' and 'Should Do' actions and the risk to delivery of the remaining actions.

**Appendix B – Overview of Number of Issues and Risks**

| Monthly Issue Summary | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date | Number of Issues | Very High | High | Moderate | Low | Very Low | Closed |
| Jun 2021 | 2 | 1 | 0 | 0 | 1 | 0 | 1 |
| May 2021 | 2 | 1 | 0 | 0 | 1 | 0 | 1 |
| Apr 2021 | 2 | 1 | 0 | 0 | 1 | 0 | 1 |
| Mar 2021 | 2 | 1 | 0 | 0 | 1 | 0 | 1 |
| Feb 2021 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |
| Jan 2021 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |

| Monthly Risk Summary | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date | Number of risks | Very High | High | Moderate | Low | Very Low | Closed |
| Jun 2021 | 5 | 0 | 1 | 1 | 3 | 0 | 3 |
| May 2021 | 5 | 0 | 1 | 1 | 3 | 0 | 3 |
| Apr 2021 | 5 | 0 | 1 | 1 | 3 | 0 | 3 |
| Mar 2021 | 5 | 0 | 1 | 1 | 3 | 0 | 3 |
| Feb 2021 | 3 | 0 | 0 | 1 | 1 | 1 | 1 |
| Jan 2021 | 3 | 0 | 0 | 1 | 1 | 1 | 1 |

# CQC Must Do / Should Do Actions

**Executive Lead:** Karen Dunderdale, Director of Nursing
**Senior Responsible Officer:** Kathryn Helley, Deputy Director of Clinical Governance
**Progress Review Date As At:** 09-06-2021

## Background

In preparation for the Trust's CQC Well-Led Announced Inspection, during June 2019 the Trust underwent a series of unannounced CQC inspections for five of our core services. The core services were:-

> Maternity
> Children & Young People
> Urgent & Emergency Care
> Critical Care
> Medicine

Following the unannounced visits the Trust's Well-Led Inspection took place in July 2019 and the CQC published its inspection report in October 2019. Within the CQC's published report there are a number of Must Do and Should Do actions to be undertaken for each of the core services. In addition the Trust underwent their Winter Pressure Assessment in January 2020 of their Emergency Departments at both Lincoln and Pilgrim Hospitals. The CQC sent its inspection report to the Trust in February 2020.

The purpose of this document is to provide the governance and assurance on the progress being made to date around these actions.

## Summary / Key Points

> The focus since the last reporting period has been to help and support clinical Divisions prepare for their forthcoming CQC Evidence Review Panels which have been jointly chaired by Dr Karen Dunderdale, Director of Nursing and Dr Neill Hepburn, Medical Director. All divisions have received their initial panel meeting at the time of writing this report.

There is currently one action rated as red. This relates to the following 'should do' action:-

*'Trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date'.*

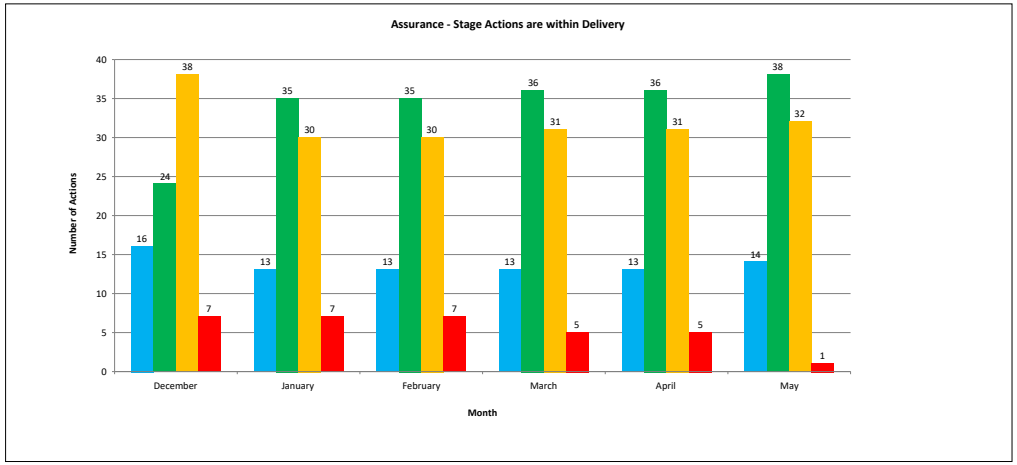
The policy for this has been developed and a rollout plan is being developed.

## Issues

> (High) There is slow pace in the delivery and receiving demonstrable progress updates of the Pharmacy CQC expectations for Must Do and Should Do actions. **Mitigation:** Escalated to ELT. Post mitigation to be included following conversations with Executive Leads.

## Risks

> (High) Corporate Policies: As a result of insufficient workforce capacity to deliver the management process and monitoring of corporate policies, there is slow progress being achieved. **Mitigation:** A business case is being writtent asking for more resource input. This will be presented to Executive Leads of which a time is to be confirmed.
> (Medium) Pharmacy Services: There is potential if the Pharmacy issue (see above) does not have adequate mitigation strategy in place, this is open for further new risks to be raised for the Trust. **Mitigation:** Awaiting ELT response following CQC Steering Group escalation.



Family Health Division

Children & Young People Clinical Business Unit

# Proposal for the next stage development of the Paediatric Assessment Unit model at Pilgrim Hospital Boston

May 2021

**Background & Overview**

ULHT Board agreed an interim model for the delivery of Paediatric inpatient services at Pilgrim Hospital (PHB) which was introduced in August 2018. The interim model, agreed with the system, was a response to safety concerns at that time in relation to challenges in both Medical and Nursing staffing, and the resultant HEEM removal of Tier One and Two trainees from full time duties at the site.

The initial interim model delivered a 24/7 children's environment where the focus of staffing was around the core daytime / early evening activities, anticipating reduced staffing overnight for any child who could not quickly be discharged. This 24/7 model was necessary to support both the unselected Emergency Department and Maternity Service, with its access to the Special Care Bay Unit. An initial consideration had been for the unit to only remain open for 12 hours each day, however this was not supported by an external review by the Royal College of Paediatrics and Child Health (August 2018), noting the specific needs of the local community, and its indicators of deprivation. The actual model agreed sought to assess and discharge all children presenting at Boston within a 12-hour time frame, with children requiring longer inpatient periods transferred to Rainforest Ward at Lincoln County Hospital. A private ambulance was commissioned to provide this transfer service, although the ambulance was unable to transfer sicker/unstable children.

It is worth noting that the descriptor of the '12-hour' model has caused a significant level of anxiety within the local community, particularly for those who believed that the unit was only physically open for 12 hours each day. As indicated, that suggestion to address the immediate need was never implemented, and a 24/7 offer has always been in place.

By the Spring of 2019 operational delivery of the PHB PAU did not strictly adhere to the described 12-hour PAU model. The absence of an immediate HDU-level ambulance transfer service meant that sicker (non-intensive care) children needed to receive the early phase of their care at PHB, and an increasing number of families began to refuse transfer to Lincoln in situations where they did not see a clinical need to leave site. This "parental choice" group were responding to personal experience (or close family/friend experience) of a high proportion of transfers resulting in assessment with immediate discharge.

By the time of the CQC Inspection of Paediatric Services in June 2019 it was apparent to inspectors that the service was not observing the full 12-hour PAU model and, in the absence of an agreed alternative model, the CQC formally observed that the service was working counter to the principle of transfer at 12 hours. The Division has been open, since commencement of the Trust Operating Model, that the 12-hour LOS was not able to be delivered for all patients – reflecting the limitations on ambulance service and the patient choice dynamic.

Over the intervening two-year period, a more sustainable longer-term model of care has been actively developed alongside successful recruitment into both the Medical and Nursing Teams. The Family Health Division, in Autumn 2019, issued the clinical team with a formal agreement on the circumstances in which they were supported in keeping patients beyond a 12 hour LOS. As a result of these developments (which are recognised to have delivered service stability) HEEM have now agreed that our Tier One medical placements will recommence on a full time basis in August 2021 (subject to introduction of an innovative package of time with other professional groups, and a one-year review to show successful programme delivery).

An overview of the development and proposals for this modernised approach for Paediatric Services at Pilgrim Hospital is captured in Appendix One (attached) previously agreed as a sensible direction of travel with the Executive Leadership Team.

Trust Board are today asked to consider its support for the revised interim model for Paediatric care at Pilgrim Hospital, moving the service towards a Short Stay Paediatric Assessment Unit, with an average length of stay below 24 hours. The remit of this unit will be to deliver both an assessment and short term observation function, with the option of some children with defined care plans (outlined in the attached paper) remaining on the unit beyond 48 hours.

The Division, and clinical teams, believe that the described model delivers a (Short Stay) PAU that reflects national best practice, using early decision-making processes to actively assess, treat and discharge patients to avoid the need for a traditional in-patient ward approach. It enables most children and young people to receive their full care needs at PHB and safely supports the operation of an un-selective ED in that hospital (ASR goal). Our successful recruitment has been positively impacted by an ability to describe a modern model of urgent care delivery for children that is exciting for medical and nursing staff (the 12-hour model did not support recruitment).

Alongside the evolution of the Pilgrim PAU model, the Children & Young People CBU has been working to develop a PAU function at Lincoln delivering out of the Safari Unit which became operational as part of the Trust Winter Planning in November 2020 (pilot to test model). The longer-term ambition for this model reflects the NHSE/I priority of ‘Reducing Variation’ in service and pathway delivery, by delivering trust wide Paediatric Emergency Assessment processes.

## Activity Overview

The role and function of the Short Stay Paediatric Assessment Unit has within its objectives the need to actively pull children from the Emergency Department (when clinically appropriate), to take appropriate direct GP referrals and to assess, stabilise and treat for a safe discharge in a timely manner from the SSPAU.

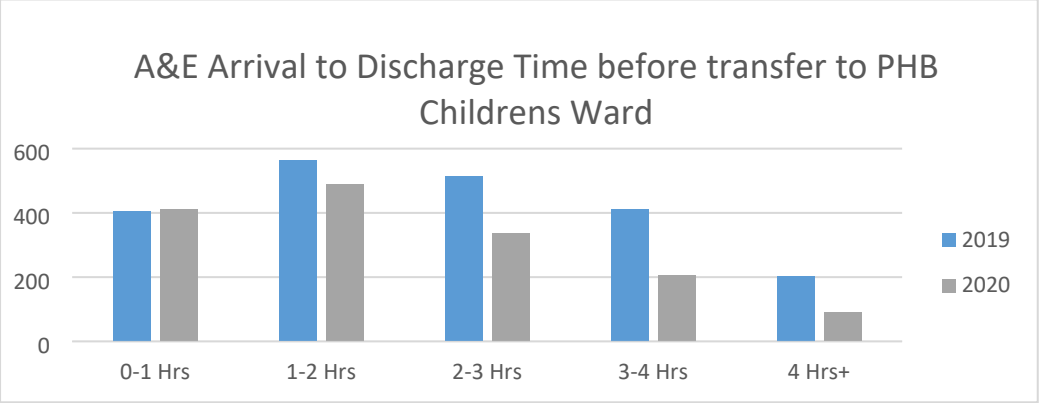
To measure success, length of stay in both the Emergency Department and SSPAU are reported.

### Transfer from the Emergency Department

The reported data shows an improved position in relation to the length of time children are remaining within the Emergency Department as the new SSPAU model has begun to fully embed.

In 2020, 58.7% of children requiring transfer to the SSPAU were moved there from ED within the first 2 hours of their pathway. This compares to 46.2% in the previous year. Whilst a number of children are remaining in the Emergency Department beyond four hours, this figure has reduced to under 6% in the last 12 months (9.7% in previous year).

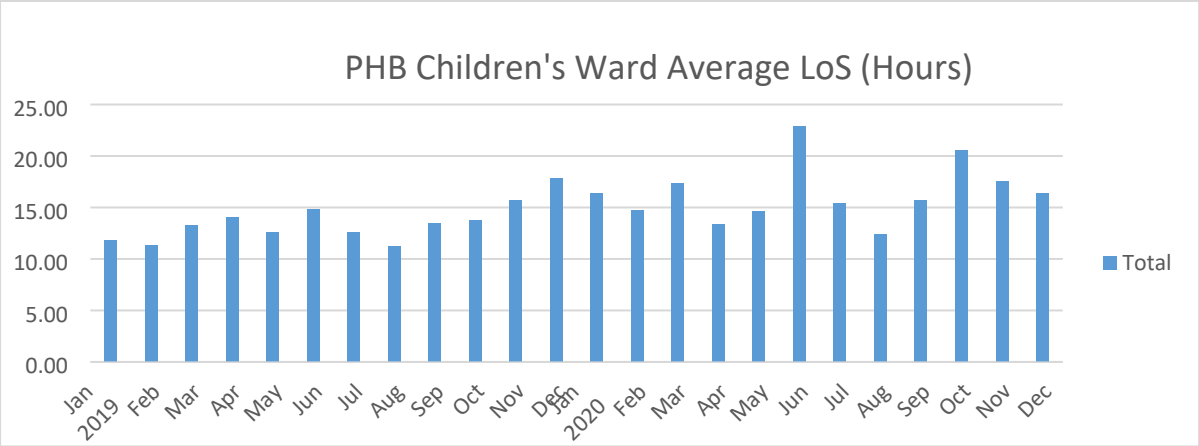
| | Childrens Ward Start Date | | |
|---|---|---|---|
| **A&E Arrival to Discharge Time** | **2019** | **2020** | **Grand Total** |
| **0-1 Hrs** | 407 (19.4%) | 412 (26.8%) | 819 |
| **1-2 Hrs** | 563 (26.8%) | 490 (31.9%) | 1053 |
| **2-3 Hrs** | 513 (24.4%) | 338 (22.0%) | 851 |
| **3-4 Hrs** | 413 (19.7%) | 207 (13.4%) | 620 |
| **4 Hrs+** | 203 (9.7%) | 90 (5.9%) | 293 |
| **Grand Total** | **2099** | **1537** | **3636** |




### SSPAU Length of Stay

During 2019, excluding the Winter period (Nov to Jan) the average length of stay in the Unit sat below 15 hour's duration. LOS in the winter will always be impacted by children with

respiratory illness, and one of the challenges of the initial model was that it masked the inability to transfer such children by declaring the 12-hour maximum LOS. The revised model is explicit in describing the circumstances in which patients may need to remain at PHB and reassures that pathways, staffing and decision-making are focussed on safe management of these exceptions. With the onset of the Covid19 pandemic the Trust took the view that patient transfers needed to be minimised as part of the management of Infection Prevention and Control. As a result, patients will by necessity have stayed for longer periods of time in the PHB SSPAU, however the monthly average LOS has still not exceeded 24 hours, and only in two months exceeding 20 hours.




**Staffing Position**

Since production of the attached update paper (August 2020) the overall staffing position for the Boston SSPAU model has further improved:

- Consultants: working to a 1:8 rota with six substantive, one temporary contract (retired and returned) and one NHS locum in place. Plans for further recruitment in development, including support for internal progression from our Tier Two. Hot week Consultant rota continues to offer on-site care through to 10pm introduced to strengthen decision making and support incoming locum Middle Grade doctors.
- Middle Grade: working to a 1:8 rota with one recent vacancy out to advert. This tier is supported by MTI training roles, but with no rotational trainees from the deanery.
- Junior Tier: approval for full time return of 5 HEEM training posts from August 2021 (one year evaluated trial) with three substantive non-training posts filled to support a 1:8 rota. One APNP trainee progressing to full qualification in June 2020 to further strengthen the rota.
- Nursing: Review of required nursing for a 12 bed emergency pathway unit, with 4 day case / escalation beds has reduced the required staffing for a full 19 bed ward, and the team is fully established, with existing Band 4 staffing supported to attend degree nurse training in the coming year as part of succession planning.

Agreement from HEEM for return of junior tier doctors linked to planned innovative package of training with all participants undertaking periods of time with CAMHS, Therapies and

Community Nursing/Paediatrics in line with new national training vision. The Trust will be one of the first nationally to trail and implement this model of training.

**Broader Context of Service Delivery**

In line with the NHSE priorities the development of the Pilgrim SSPAU model sits alongside the development of a PAU model at Lincoln, delivered utilising the Safari Unit. The ambition of the service is to reduce variation of experience across the services delivered by the Trust, this will lead to a shared model for the operation of PAUs on the two hospital sites.

The Lincoln PAU model has been operating in its pilot form since November 2020, as part of the Trust Covid19 Second Wave & Winter Planning arrangements.

Work is now underway to review the Community Nursing offer across the Trust, with a view to improving access to services that will further support safer, speedy discharge and admission avoidance pathways.

Both of these projects are being managed as part of the Trust Evolution Group processes, with governance through to the Family Health Divisional Cabinet and broader Trust planning.

**Discussions around the emerging model**

The Division has participated in a number of discussions with representatives of the community served by Pilgrim Hospital, to discuss the emerging revised model for a SSPAU and its' impact on local access to paediatric services and the sustainability of the SCBU (a requirement for local consultant-led maternity services). These have included:

- **SOS Pilgrim** – The Divisional triumvirate (initially with Anna Richards in attendance) have met with representatives of SOS Pilgrim on several occasions. Quite quickly the representatives seemed to be assured that the triumvirate were looking to safeguard services at PHB, although we were clear that this was in the context of an appropriate PAU rather than a reversion to a traditional in-patient model. Our discussions were positive in that the SSPAU model was shown to minimise transfers off-site to those where there was a clinical rationale, and that the emerging model had been utilised to successfully recruit medical and nursing staff – creating a stable base for paediatric services on the site. The positive recruitment of paediatric medical staff clearly offered stability to the neonatal SCBU at PHB, the retention of which was always a key concern for SOS Pilgrim.
- **Health Scrutiny Committee (HSC)** – The Division have been present in discussions with HSC on three occasions, twice in support of the ULHT Medical Director in provision of updates on the PHB PAU model, and once with the CCG to give a more general overview of health services for C&YP. In all discussions we were open in describing the evolution of the PHB PAU to a service which maximised local care provision by embedding the PAU ethos (early and active assessment and treatment) whilst moving away from the fixed 12 hour LOS. We were always clear that a PAU model will involve a (hopefully small) proportion of patients being transferred for

more appropriate clinical care. Early descriptions of the emerging SSPAU approach (no HSC meetings have been attended since the first wave of the pandemic) were positively commented on by HSC members.

- **Lincolnshire Big/Healthy Conversation** – Divisional representatives attended each of the events arranged by the CCG in the Boston locality (early 2020) at which we were asked to participate in discussions about services for C&YP and maternity for the people served by Pilgrim Hospital. We discussed the principles of the SSPAU model and were able to reassure them that we were already working to an operational model that was around a 24 hour LOS, and had reduced the number of clinical transfers away from PHB to a level that no longer required the dedicated ambulance provision. We updated on positive recruitments to the PHB service, and reassured them that the SCBU was staffed and working back to national designations. All participants were positive on the openness of our contributions and reassured that we were working to provide an appropriate model for residents. One councillor was challenging in the discussions but his contribution in all round table groups was the same.
- **Lincolnshire Children and Young People's Transformation Board** – The Division holds membership of the C&YP Transformation Board (co-chaired by local authority/CCG) which meets on a monthly basis for partner organisations to oversee the development of C&YP services in the County. Partners have been regularly updated on the plans for PHB and have been supportive.

The development of the ULHT Paediatric Assessment Unit Model (to deliver at both Lincoln and Boston) has included the engagement of involved health professionals, and a 'Staff Survey' around the impact and quality of the model is currently being undertaking across both the Pilgrim and Lincoln sites.

The PHB clinical team have worked hard to embed a strong PAU and, in developing this SSPAU model they have actively recognised that the local service can be sustained without reversion to a traditional in-patient ward. New staff (including consultants) have been recruited to work the SSPAU model and the team have rightly developed pride in their early decision making for C&YP presenting to the site.

The CYP Team have now purchased iPads with inclusion of an App aimed at securing real time patient / parent service feedback at point of discharge to feed into the quality dashboard. The specific detail of this feedback will feature on the 'You said, we did' information boards in our Paediatric environments as well as informing future social media activity.

As we have finalised the proposals around the revised interim SSPAU model, ELT noted the potential need for either engagement, further involvement or consultation to adopt the SSPAU as the on-going model for the PHB site, and we were advised to make contact with ASR colleagues to consider the need for/type of intervention. Regular meetings are now established and Anna Richards is involved to link across to ULHT engagement planning. It is felt that some form of involvement will be appropriate.

**Recommendations and Next Steps**

1. Board are requested to support the revised interim model for Paediatric care at Pilgrim Hospital, confirming the move of the service towards a Short Stay Paediatric Assessment Unit, with an average length of stay below 24 hours (with alongside observation capacity) with the option of some children with defined care plans (outlined in the attached paper) remaining on the unit beyond 48 hours.

Subject to the support of Board the following actions are proposed:

- Final review of the model, to ensure that a clear condition specific SOP is in place to define which children transfer and at what stage of their care plan;
- Further data analysis and financial modelling to support a final presentation to Board, and to support external discussions of the proposed model;
- Engagement with internal and external partners via existing planning processes including the ULHT Children & Young People's Oversight Group, Partnership Children & Young People Transformation Board, and Acute Service Review planning groups to progress to a long term agreement on the revised model of care for PHB.
- Continued engagement with service users and the public in line with any required consultation processes that will be decided by HOSC.

**Nick Edwards**
**Deputy General Manager**
**Children & Young People CBU**

**Simon Hallion**
**Divisional Managing Director**
**Family Health Division**

**20th May 2021**

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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| Meeting | *Public Trust Board* |
| Date of Meeting | *July 2021* |
| Item Number | *Item 8.6* |
| ***Pilgrim Hospital Paediatric Model – Public Engagement*** | |
| Accountable Director | *Mark Brassington* |
| Presented by | *Mark Brassington* |
| Author(s) | *Anna Richards/Simon Hallion* |
| Report previously considered at | *Health Scrutiny Committee*<br>*23 June 2021*<br>*Supported 12 week engagement with public* |

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

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| Risk Assessment | *Insert risk register reference* |
| Financial Impact Assessment | *Completed* |
| Quality Impact Assessment | *In place* |
| Equality Impact Assessment | *In place* |
| Assurance Level Assessment | • *Significant* |

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| Recommendations/ Decision Required | • *Board to support the proposal to move to a 12 week public engagement to seek acceptance of the Short Stay PAU model at Pilgrim Hospital.* |

## Executive Summary

At the ULHT Board meeting in June, 2021, the Board supported the formal adoption of a revised Short Stay Paediatric Assessment Unit (SSPAU) model as the new “interim” model of care. The Trust furthermore supported the recommendation that the SSPAU should be progressed as the permanent model for the paediatric service at Pilgrim Hospital.

On 23 June, 2021, the Trust’s Deputy Chief Executive along with representatives of the Family Health Division attended the Lincolnshire Health Scrutiny Committee (HSC) to present the SSPAU model and to seek guidance from the HSC on the appropriate level of public engagement/consultation to allow the SSPAU to be confirmed as the long term model of service at Pilgrim Hospital.

Members of the HSC were uniformly supportive of the proposal and they supported the Trust in developing a service specific public engagement process to allow the community to understand and provide feedback on the SSPAU model. The process will allow the ULHT Board to review feedback and determine whether there is support to enable adoption of the model as sought.

HSC members commended the Trust on the limited but positive engagement which was used to develop the SSPAU model, in particular the links with SOS Pilgrim representatives, and they encouraged the Trust to replicate in future planning initiatives.

The Trust Board are therefore requested to consider the advice of the HSC and to support the design and implementation of a 12 week engagement programme to seek public support for the SSPAU model at Pilgrim Hospital.

**Purpose**
To enable an engagement with the population served by Pilgrim Hospital, and their representatives, to explain the SSPAU model and seek their comments and support.

**Key messages**
Positive reception of the proposal by HSC members support the Trust in moving to adopt the SSPAU model subject to the engagement process.

Work is underway to design the appropriate engagement programme.

**Conclusion/Recommendations**
The Trust Board has already supported the SSPAU model as the appropriate model for Pilgrim Hospital’s paediatric service, it is therefore recommended that the advice of the HSC is accepted and followed.

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| **Report to:** | Trust Board |
| **Title of report:** | People and OD Committee Assurance Report to Board |
| **Date of meeting:** | 16th June 2021 |
| **Chairperson:** | Geoff Hayward, Chair |
| **Author:** | Karen Willey, Deputy Trust Secretary |

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| **Purpose** | This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board.<br><br>This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board. |
| **Assurances received by the Committee** | **Assurance is respect of SO 2a**<br>**Issue: A modern and progressive workforce**<br><br>**Safer Staffing**<br>The Committee received the report noting that the establishment review due to be conducted during July would offer focus to the emergency departments, theatres and the paediatric model. A review across maternity services would be required as a result of the Birth Rate Plus work.<br><br>The Committee were advised that care hours per patient day was now the standard reporting mechanisms however due to redeployment anomalies were being seen. As such the Trust continued to use fill rates alongside this in order to triangulate data.<br><br>The Committee noted that the 95% fill rate adopted across the Trust was close to being met with the support of the temporary workforce.<br><br>It was noted that the Nursing Workforce Transformation Programme had recommenced with a specific focus on agency spend which had seen an increase. Work was being undertaken with the Divisional Leads in order to determine trajectories to reduce spend.<br><br>Technical actions were being taken to increase the visibility of shifts available to agencies, the impact of which was not yet being seen through reporting. |

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| | The Committee were assured of the level of confidence in the data presented and were advised through the triangulation of data that there was no correlation between staffing and quality.<br><br>**Workforce Planning Update**<br>The Committee were advised that regular updates would be provided as workforce planning became embedded as business as usual through the year 2 integrated Improvement Plan project.<br><br>The Committee noted the return due to NHS England/Improvement of a 6 month workforce projection which the Trust had been able to complete due to the plan for every post and pipeline work that had been undertaken.<br><br>The Committee were pleased to note that whilst there had been no requirement it had been possible to ensure alignment with finance, particularly in relation bank and agency reduction and how this would translate in to whole time equivalents.<br><br>Whilst there had only been a requirement for a 6 month submission and a further due for the remainder of the year the Trust were starting to return to a yearly workforce submission with an aim to achieve a plan that would cover 2-3 years.<br><br>The Committee were assured of the submissions due and were pleased to note the pipeline work that had enable the Trust to make the submission and supported future workforce planning. The Committee noted the evolving process of workforce planning recognising that this was currently in its infancy.<br><br>**Gender Pay Gap**<br>The Committee received the report noting that this offered the 2019/20 data along with the 2020/21 data which would not require reporting until March 2022.<br><br>There had been a delay in reporting the 2019/20 data due to Covid-19. The information presented demonstrated that the medical workforce continued to be dominated by male staff with female staff dominating the lower grades which impacted the pay gap, |

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| | The Trust would seek to address the gaps of representation through talent management work to ensure those with talent were encouraged and supported to progress.<br><br>It was noted that due to the gender split in the workforce, payments under the clinical excellence award scheme had not progressed as hoped despite the steps the Trust had taken.<br><br>The Committee were advised that for both 2019/20 and 2020/21 standard awards had been made under the clinical excellence award scheme. A full review of the process to ensure this was fair and consistent was being carried out.<br><br>The Women's Network had been engaged in discussions and were content with the actions being taken to address the gender pay gap. |
| | **Assurance in respect of SO 2b**<br>**Issue: Making ULHT the best place to work**<br><br>**Guardian of Safe Working Annual Report**<br>The Committee received the annual report from the Guardian of Safe Working noting that there had been a reduction in issues raised in the first half the year with an increase being seen as the Trust returned to business as usual.<br><br>The Committee were advised of the issues raised to the Guardian which included rota gaps however this was being addressed through a rota cell project.<br><br>The Committee noted the successful engagement of the Guardian with the Junior Doctors and the confidence in those raising concerns directly with the Deputy Medical Directors and through incident reporting.<br><br>The Committee were pleased to not the investment in the Doctors Mess and rest areas following the receipt of funding to the Trust to upgrade the facilities. It was noted however that further work to complete the upgrades would be required to fully implement the British Medical Association Charter.<br><br>The report demonstrated the progress made in conjunction with Junior Doctors with the Committee noting the need to ensure that actions were |

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| | followed up and completed. Outcome of actions should be built in to the annual report.<br><br>**Employee Relations Activity Update**<br>The Committee received the report noting that there remained a high number of cases open, a number of which were outside of formal process.<br><br>There had been a severe impact due to Covid-19 with all activity halted during wave 2. This had had a significant impact on the ability to progress cases.<br><br>The Committee noted the decrease in investigation time however there had been an increase in cases involving other sectors. The Trust were reviewing prioritised cases to consider the appropriateness of cases being stepped down.<br><br>The Committee requested detail of the cases being considered for step down to be reported to the next meeting in order to ensure that there was fair and equitable treatment in doing so. Moving forward the Trust would be moving to the application of just culture and mutually agreed outcomes in order to bring matters to a resolution. |
| | **Assurance in respect of other areas:**<br><br>**Policy Position update**<br>The Committee received an update in respect of policies requiring review and the associated timetable for these to be updated. The Committee noted that these policies can take longer to approve due to the need to ensure engagement is undertaken with Trade Unions.<br><br>**Draft Terms of Reference and Work Programme**<br>The Committee received the draft terms of reference and work programme that had been aligned to the 2021/22 objectives noting that further work would be completed to ensure appropriate reporting groups fed in to the Committee and offered assurances.<br><br>**Board Assurance Framework**<br>The Committee received the 2021/22 Board Assurance Framework noting that further work on the population of the framework would take place throughout the year and objectives were progressed and delivered. |

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| | The Committee were keen to ensure that identified controls were correctly worded.<br><br>**Committee Assurance Report**<br>The Committee received the report noting that the NHS People plan and priorities aligned with overall planning guidance that had been issued and detailed the recovery of staff alongside services.<br><br>The Committee were assured that the Trust Integrated Improvement Plan reflected the 4 programmes within the NHS People Plan.<br><br>Feedback from the Wellbeing weeks had been reviewed and it was noted that Covid-19 had offered and opportunity for the Trust to further develop the wellbeing offer to staff.<br><br>There was positive improvement in the overall vacancy rate with some improvement being seen in respect of clinical vacancies. The Committee noted concern in relation to Allied Health Professionals and the recruitment pipeline however were advised that future recruitment activity was positive.<br><br>The Committee were pleased to note that the Trust were now able to on board international nurses from India following a pause due to the Delta variant of Covid-19.<br><br>The Committee were advised of the risk to the achievement of job planning by the 30th June however it was noted that there would be no further extension to the deadline. Focus would be provided in the remaining time to make further progress and offer capacity and prioritisation with the Divisions.<br><br>The Committee noted the upward trend in achievement of mandatory training. Plans and trajectories were in place for all Divisions to ensure clinical elements of training were in place. Conversations remained ongoing in respect of tailoring metrics for clinical staff.<br><br>The Committee received the Disciplinary Policy noting the requirement for this to be considered and endorsed by the Committee and for approval to be received from the Trust Board.<br><br>The policy had been updated with the intention to reflect both best practice and the adoption of Just Culture within the Trust. There had |

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| | been significant consultation of the policy and the equality analysis had been completed.<br><br>The Committee noted the requirement for simple and clear guidance to be in place to support managers in delivering the requirements of the policy.<br><br>**Trust Executive Scorecard**<br>The Committee received the Trust Executive Scorecard for information<br><br>**Future of NHS People Services**<br>The Committee received an update on the Future of NHS People Services noting that the shape of Human Resources and Organisational Development would need to be finalised going forward.<br><br>Discussions that had been held by the Trust had not been identified nationally in respect of the consistency of management and support of HR and OD. The Committee were pleased that these discussions were now taking place at a national level noting that this would likely result in more central direction and control that had previously been in place.<br><br>As discussions progressed and developed the Trust would keep a watching brief to determine how this would align with the Integrated Improvement Plan and the Trust priorities.<br><br>**Update on actions relating to existing workforce risks**<br>The Committee noted the report and were offered updates on the actions being taken in relation to existing risks. The Committee noted that there was further work to consider the risks and actions being taken to confirm if these should remained on the risk register. |
| **Issues where assurance remains outstanding for escalation to the Board** | No issues identified |
| **Items referred to other Committees for Assurance** | No items referred |

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| **Committee Review of corporate risk register** | The committee received the risk register noting the reconfiguration of the risk register that was currently being undertaken. |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | No areas identified |
| **Committee position on assurance of strategic risk areas that align to committee** | No areas identified |
| **Areas identified to visit in ward walk rounds** | Department walk around currently suspended. |

**Attendance Summary for rolling 12 month period**

| **Voting Members** | **J** | **A** | **S** | **O** | **N** | **D** | **J** | **F** | **M** | **A** | **M** | **J** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Geoff Hayward (Chair) | X | X | X | X | X | X | X | A | X | A | X | X |
| Sarah Dunnett | X | X | X | X | X | X | A | X | X | X | X | X |
| **Non-Voting Members** | | | | | | | | | | | | |
| Martin Rayson | X | X | X | X | X | X | X | X | X | X | X | X |
| Simon Evans | X | D | D | D | C | C | C | C | C | C | D | A |
| Karen Dunderdale | X | X | X | X | C | C | C | C | C | X | A | X |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

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| **Report to:** | Trust Board |
| **Title of report:** | Finance, Performance and Estates Committee Assurance Report to Board |
| **Date of meeting:** | 26 June 2021 |
| **Chairperson:** | David Woodward, Non-Executive Director |
| **Author:** | Karen Willey, Deputy Trust Secretary |

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| **Purpose** | This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response.<br><br>This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme.<br><br>The Committee worked to the 2021/22 objectives. |
| **Assurances received by the Committee** | **Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment<br><br>**Estates Statutory Compliance Report**<br>The Committee received the report noting the ongoing improvements in reporting. Updates had been provided to the Committee in relation to PLACE assessments and whilst it was recognised that Covid-19 had impacted the Trust continued to run PLACE Lite assessments in line with the national steer.<br><br>A greater degree of focus was now being provided in relation to health and safety with more indicators within the report offering greater assurances.<br><br>The Committee were advised that formal correspondence had been received from Lincolnshire Fire and Rescue advising of the removal of the fire enforcement notices. The Trust were now working on the action plans in place to address the remaining issues. Whilst the issues were not fully resolved the removal of the notices reflected the work conducted over the recent years.<br><br>The Committee noted within the report a suggestion of areas to be explored in depth by the Committee with a meeting agreed to take place in order to determine appropriate reporting for the Estates agenda.<br><br>**Health and Safety Group Assurance Report**<br>The Committee noted the progress that had been made in respect of the Group noting that the first meeting of the Health and Safety Committee was due to take place in July. There was assurance that the meeting would be attended by Staff Side and be quorate. |

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| | **Assurance** in respect of SO 3b Efficient Use of Resources<br><br>**Finance Report**<br>The Committee received the report noting two items of concern, these being the pay bill and delivery of Cost Improvement Plans. The Committee were advised however that actions were in place to address the concerns.<br><br>The Committee held detailed discussion regarding the report noting in particular the impact on the Trust due to missing outcomes data capture. The Committee were advised that the issue was being discussed with the Divisions through the Financial Review Meetings and agreed to present a more detailed update to the July Committee in order to offer clarity on the issues being faced.<br><br>The Committee were pleased to note the progress the Trust had made with the restoration of services noting that the Trust were exceeding the threshold of the planning guidance. This was a positive position for the Trust and reflected the efforts that teams had gone to in order to support restoration.<br><br>**2020/21 Patient Level Information Costings (PLICS) Q1 – Q3 and National Cost Collection**<br>The Committee received the reports noting the update in relation to PLICS which offered assurance on the work being undertaken whilst drawing together the impact of Covid-19 across services.<br><br>The Committee noted that the report offered 9 months of data with a full year of data due to be presented to the Committee at the August meeting. It was however noted that the use of 2020/21 data would be limited due to Covid-19.<br><br>The Committee noted the reference cost submission that was due to be made in September. As the financial position was closed the PLICS report would be used to inform the submission. The Committee noted that sign off of the submission had, following a pause during Covid-19, been delegated to the Director of Finance and Digital. This would however be presented prior to sign off to the Committee and on to the Board.<br><br>**Capital, Revenue and Investment Group Upward Report**<br>The Committee received the upward report from the group noting the need for the report to be further developed to include benefits realisation and payback.<br><br>The Committee noted that this would form part of the development of the group and the documents being presented. |

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| | **Assurance** in respect of SO 3c Enhanced data and digital capability<br><br>**Digital Hospital Group Assurance Report**<br>The Committee received the report noting concern regarding an incident impacting power supply that had been discussed by the Group due to the level of risk.<br><br>It was noted that a root cause analysis was being conducted with the Committee due to be advised of the outcome to ensure that assurance was received and learning shared. |
| | **Assurance** in respect of SO 4a Establish new evidence based models of care<br><br>**Nuclear Medicine Reconfiguration**<br>The Committee received the paper in relation to the reconfiguration of the nuclear medicine service supporting the paper and the recommendations to progress.<br><br>The paper offered a clear view of the current service and the options considered in order to progress. A quality impact assessment and equality impact assessment would be developed as part of the process to account for any impact that may been seen and appropriate engagement activity would be undertaken. |
| | **Assurance in respect of other areas:**<br><br>**Committee Performance Dashboard**<br>The Committee received the dashboard noting that this was not yet fully populated.<br><br>There were concerns regarding the baseline and 21/22 ambitions not being aligned to current indicators for the year within the executive scorecard. The Committee noted that this remained a work in progress and further discussions were due to take place with a complete dashboard will be completed in July and available to the Committee in August.<br><br>The Committee were advised that some national performance measures showed that these were failing however this had been due to the impact of Covid-19. Whilst national indicators were not being met the Trust were performing well against the restoration profile.<br><br>The Committee reflected that the report was offering reassurance over assurance and a request was made that identified actions being taken and timescales in order that assurance could be provided to the Board and the Committee could hold the Executive Directors to account<br><br>**Performance Review Meeting (PRM) Upward report**<br>The Committee received the report noting that this was part of the transition journey in to the new way of working at the PRMs. |

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| | The Trust were now working to the new PRM methodology which would result in the Divisions being focused on the objective, priorities and major projects within the Integrated Improvement Programme and that make up the divisional scorecards.<br><br>The September PRMs would see the new methodology fully embraced and working against the scorecards which would allow assurance to be offered to the Committee.<br><br>**Operational Performance against National Standards**<br>The Committee received three performance reports covering planned, urgent and cancer care.<br><br>The Committee noted in relation to planned care the move away from the 18 week referral to treatment and 52 week wait constitutional standards. New standards were being put in place that would focus on clinical priority rather than waiting times.<br><br>The Committee noted the position of the Trust in volunteering to pilot an artificial intelligence system to support risk scoring of patients waiting. This would release clinical time for patients to be seen.<br><br>The urgent care update offered to the Committee indicated the continued desire of the Trust to reduce waiting times within the emergency departments. The Trust were looking to set a trajectory that would see a reduction to 1% of patients waiting over 12 hours within the department over a 4-5 month period.<br><br>It was recognised that the report currently offered reassurance to the Committee and the introduction of the trajectory and progress updates would offer assurance. It was noted that there may be national standards set in the future however the Trust wished to have a standard that was ambitious.<br><br>The Committee received the standard report in relation to cancer care noting the headway being made in the 62 day waits. The Committee were advised that due to a lag in reporting there would be a deterioration seen in May and June of the standard. The Committee recognised that this deterioration was as a result of substantial elements of the service being reinstated.<br><br>The Committee noted the continued difficulties with the breast 2 week wait standard however were advised of the significant input that had been made in to breast services to address this. Movement was being seen with a reduction in demand alongside the changes made in the service. |

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| | **Integrated Improvement Plan**<br>The Committee received the report noting that this offered a clear update to the Committee and detailed the amount of work that was ongoing.<br><br>The Committee noted that there would be benefit in the dependencies between projects being detailed within the report and were advised this work was currently underway. Further detail would be available as the Trust moved through the 4 week reporting cycle.<br><br>**Board Assurance Framework**<br>The Committee received the Board Assurance Framework for 2021/22 and following discussions and review of the papers presented to the Committee discussed the accuracy of the RAG ratings against each objective.<br><br>The Committee agreed to objective 3b being presented to the Board as amber to reflect the concerns noted regarding delivery of the cost improvement plans and expenditure.<br><br>**Outstanding Internal Audit Actions update**<br>The Committee received the report noting the updates offered and sought assurance that timescales could be achieved.<br><br>**Draft Terms of Reference and Work Programme**<br>The Committee received the documents noting a number of refinements within the work programme to ensure reporting to the Committee was explicit.<br><br>**Topical, Legal and Regulatory Update**<br>The Committee received the report for the first time noting that this offered a useful update to the Committee. The Committee agreed to receive an update on a quarterly basis. |
| **Issues where assurance remains outstanding for escalation to the Board** | No additional items to raise. |
| **Items referred to other Committees for Assurance** | None |
| **Committee Review of corporate risk register** | The Committee received the risk register |
| **Matters identified which Committee recommend are escalated to SRR/BAF** | No items identified |
| **Committee position on assurance of strategic** | As above |

| | |
|---|---|
| **risk areas that align to committee** | |
| **Areas identified to visit in dept walk rounds** | Department walk around currently suspended |

**Attendance Summary for rolling 12-month period**

| **Voting Members** | J | A | S | O | N | D | J | F | M | A | M | J |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gill Ponder, Non-Exec Director | X | X | X | X | X | X | X | X | X | X | | |
| David Woodward, Non-Exec Director | | | | | | | | | | | O | X |
| Geoff Hayward, Non-Exec Director | X | X | X | X | X | A | X | X | X | A | X | X |
| Chris Gibson, Non-Exec Director | X | X | X | X | X | X | X | X | X | X | X | X |
| Director of Finance & Digital | X | X | X | X | X | X | X | X | X | X | X | X |
| Chief Operating Officer | A | D | X | X | C | C | X | X | D | X | X | X |
| Director of Improvement & Integration | | | A | X | C | C | C | C | X | X | X | X |

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19
O Observing

United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board Meeting* |
| Date of Meeting | *6th July 2021* |
| Item Number | *Item 11.1* |
| *Stroke Temporary COVID Pathway Board Update* | |
| Accountable Director | *Mark Brassington*<br>*Director of Improvement & Integration, Deputy CEO* |
| Presented by | *Mark Brassington*<br>*Director of Improvement & Integration, Deputy CEO* |
| Author(s) | *Anita Parmar*<br>*Deputy General Manager*<br>*Cardiovascular Medicine CBU* |
| Report previously considered at | *Trust Leadership Team* |

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

| | |
|---|---|
| Risk Assessment | *4487* |
| Financial Impact Assessment | |
| Quality Impact Assessment | *Completed* |
| Equality Impact Assessment | *Completed* |
| Assurance Level Assessment | • *Moderate* |
| Recommendations/ Decision Required | • *Note the content of the paper and future review in September 2021.* |
| | |
| | |
| Executive Summary | |

**Pre Covid stroke pathway**

Pre covid, hyper acute and acute stroke provision was being provided on both the Lincoln and Pilgrim sites but with significant challenges in shortfall in both the medical and nursing workforce.

**Change in stroke pathway**

A temporary Stroke Pathway was implemented on 8th April 2020 as a result of the COVID-19 pandemic. This was an emergency response, required due to a significant shortfall in consultant medical staffing resulting from sickness or locum withdrawal (only 3 out of 8 being available), particularly relating to the COVID pandemic along with a significant shortfall in the nursing workforce.

The temporary pathway saw the consolidation of hyper-acute stroke services (intensive nursing, medical and therapy care for the first 72 hours following the onset of stroke ) within ULHT down to a single Hyper-Acute Stroke Service on the Lincoln County Hospital site, where it had previously been delivered at both Lincoln and Pilgrim Hospital in Boston.

The change was to hyper-acute stroke only, with acute (post 72 hours up to 7 days) and rehabilitation care taking place on both the Lincoln and Boston hospital sites.

**Review of change in pathway**

During the last 14 months, all Lincolnshire patients requiring thrombolysis (dissolution of a blood clot) or mechanical thrombectomy (technique of removing a blood clot from the artery through a catheter) have accessed this care at Lincoln hospital.

The Sentinel Stroke National Audit Programme (SSNAP) is a national programme which measures the quality and organisation of the stroke care across England Wales and Northern Ireland. There are a number of domains within the audit that are assessed covering responsiveness, quality and clinical outcomes with ratings from A through to D, with A being the highest rating. The SSNAP data from April to September 2020 demonstrated ratings of `A` and `B` respectively, giving assurance that the responsiveness, timeliness and quality of care have not been affected by the temporary pathway change.

The stroke service has had a more challenging time during the 2nd wave of the pandemic, with a temporary loss of the physical Stroke Unit to provide COVID positive capacity to the Lincoln site. This did result in stroke patients being located across multiple wards, impacting adversely on both patient experience and also leading to missed opportunities for early rehabilitation intervention. The latest data sets reflect this position.

Plans were put in place to return the stroke service to their Stroke Unit on 22nd February 2021.

**Process for review of change**

Throughout the year, 4 reviews of the temporary COVID pathway have taken place plus an internal Stroke Risk Summit. COVID Gold Command have authorised all pathway modifications and the Regional Director for Stroke Medicine, along with system partners, have also been involved in aspects of the pathway changes.

Patient engagement has been difficult in light of the emergency response to the pandemic, but some patient engagement did take place at a Trust Patient Forum in Summer 2020, with an acknowledgement from the public that this temporary change was to secure and maintain safe stroke services for Lincolnshire patients.

**Conclusion and next steps**

In conclusion, the workforce challenges faced by this fragile service continue and at this time, it is not possible to return the hyper-acute service to a 2 site model.

The Clinical Business Unit cannot give assurance that a robust service could be maintained and all of the clinical criteria set for such a service cannot be met. It is therefore essential that the temporary pathway remains in place with regular review meetings continuing.

It is proposed that the current model is retained in the short term, pending the up-coming Acute Services Review (ASR) consultation on the future of the stroke service.

## Background

The stroke service is acknowledged as one of ULHT's fragile services, particularly due to the fact that the service is reliant upon a significant locum and agency workforce. During the COVID-19 Level 4 pandemic, it became necessary to consolidate the hyper-acute stroke service onto a single hospital site in Lincolnshire. This was an emergency measure due to a significant loss of medical workforce- at one point only 3 out of 8 consultants were available for work. This meant that the running of 1:4 Consultant On-Call rotas to support 2 hyper-acute admitting sites was no longer possible.

## Pathway change

The pathway for stroke patients from the Boston catchment area was changed in agreement with our partner organisations; EMAS and North West Anglia Foundation Trust (NWAFT). The temporary pathway agreed involved patients flowing to both Lincoln County Hospital and Peterborough City Hospital. Clear repatriation pathways were put in place for patients to return to the Boston site at around 72 hours (end of the hyper acute phase) to undergo local stroke rehabilitation. The temporary pathway change was supported by a Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA)process and agreed by COVID Gold Command. This pathway has been live since 8th April 2020. A summary of the temporary changes implemented to the stroke pathway was shared at the August 2020 public Trust Board meeting.

## Pathway reviews

The temporary pathway change has undergone four reviews; one in July 2020, a second in September 2020, a third in February 2021 and a fourth in June 2021 to ascertain if there is still a continued requirement for this temporary pathway. On all four occasions the conclusion has been that the pathway needs to remain in place due to the fragility of the medical and nursing workforce.

A Stroke Risk Summit was held in late September 2020 with executive representation (Medical Director and Director of Operations) and a subsequent multi-agency meeting took place in October 2020 with the inclusion of the Regional Director for Stroke Services, following the need to alter patient flows marginally to release some pressure on Peterborough City Hospital. This action was taken and has had a minimal impact upon Lincoln County Hospital.

More recently, the stroke service has faced significant challenge with the temporary loss of the Stroke Unit on the Lincoln Site. The Stroke Unit understandably featured as part of the Trust's COVID capacity plan and became a COVID positive medical ward for a period, necessitating the move of stroke patients to a temporary location on Carlton-Coleby Ward. This was problematic and coincided with a peak in stroke admissions resulting in stroke patients being managed over up to 14 locations / ward bases within the trust. The ability to repatriate patients back to the Boston site also ceased for a period of time whilst the Boston Stroke Unit also became a COVID positive ward. A temporary Hyper Acute Stroke Unit was established on Johnson

Ward (cardiology unit) at Lincoln hospital to maintain safety at that time. Nonetheless, the capacity constraints that COVID brought to the Lincoln site adversely impacted patient care, with access to specialist stroke rehabilitation being diminished and missed opportunities to optimise patient care, which is reflected in the SSNAP performance from October 2020. From Monday 22nd February 2021 the stroke service was returned to the Stroke Unit on the Lincoln site, which enabled the service to reconsolidate its activity on the unit. The next quarters SSNAP data will evidence a corresponding improving picture in performance.

**Activity / Clinical Outcomes / Patient Engagement / Workforce**

**Activity**

The Clinical Business Unit (CBU) has implemented a robust tracking system that monitors all EMAS conveyances of BeFast +ve patients who would have previously been taken to Pilgrim hospital. In total, from the 8th April 2020 to the 31st March 2021 1,338 patients have been impacted by the pathway change. The number of patients that would otherwise have been managed at Pilgrim were transferred to other hospital sites is as follows:

| Provider | Number of Stroke Cases Transferred to |
|---|---|
| ULHT – L,incoln County Hospital | 754 |
| NWAFT – Peterborough City Hospital | 402 |
| Other providers (7 providers in total) | 115 |

It is important to note that not all conveyances under the “beFast+” guideline will be strokes, they will incorporate stroke mimics and also patients with balance problems.

A total of 212 patients have been repatriated back to Pilgrim during this period, after the hyper-acute stroke care, to complete their rehabilitation.

**Clinical Outcomes**

All patients who have been eligible for thrombolysis have received their treatment within the thrombolysis window of 4.5 hours. Any patients eligible for mechanical thrombectomy have also met the 6 hour time window for conveyance to the tertiary centre in Nottingham. There have been no patient complaints relating to the temporary service change.

During the period April to June 2020 the nationally reported SSNAP data demonstrates that Lincoln County Hospital achieved its highest ever SSNAP rating – an A rating. This demonstrates that the responsiveness, quality and clinical outcomes associated with the care provided delivered to a very high standard. The 2nd quarter data shows a very small deterioration in score to a B rating (1 point off an A rating) but with no significant areas for concern. Between the period October 2020 – March 2021, there was a deterioration in rating down to a C, which relates to the internal trust management of the second wave of COVID which resulted in the stroke unit needing

to be relocated and a number of patients needing to be managed across a number of wards. The stroke ward was moved back on the 24th February. There has been a steady improvement in the performance since then. We expect the SSNAP data for the next quarter to evidence this.

| SSNAP DATA | Apri - June 20 | July - Sept 20 | Oct - Dec 20 | Jan - Mar 21 |
|---|---|---|---|---|
| SSNAP Scoring Summary | Lincoln County (190) | Lincoln County (190) | | |
| SSNAP LEVEL | A | B | C | C |
| SSNAP Score | 86 | 80 | 64.6 | 68 |
| | | | | |
| Team-Centred Total KI Level | A | B | C | C |
| Team-Centred Total KI Score | 86 | 80 | 70 | 68 |
| Case ascertainment band | 90%+ | 90%+ | 90%+ | 90%+ |
| Audit compliance band | 93.5 | 92.1 | 88.9 | 91.4 |

**Patient Engagement**

Due to the emergency nature that precipitated the temporary pathway change, it was not possible to consult with patients ahead of the pathway change. During the summer of 2020 a number of patient panels were arranged by the Service Innovation Team and the QIA relating to the COVID stroke pathway was explained by the clinical lead to a patient panel, and there was opportunity for challenge and clarification at that time. The feedback from patients was positive and there was a general understanding that the changes were to safeguard patients and enable them to access vital life-saving services safely during the pandemic.

**Workforce**

**Medical**

| Consultant / Speciality Doctor Establishment | 6.0 wte | Provision |
|---|---|---|
| In Post | 3.0 wte | Substantive |
| | 2.0 wte | NHS Locums long-term |
| | 3.0 wte | Agency Locums |

**Note: There is currently a single Trustwide On-Call Rota running as 1:6 as not all Locums take part in the on call rota**

The service has struggled with the recruitment to the consultant and speciality doctor posts. There are only two substantive consultants in post, which has been the case prior to the start of the pandemic. With the variability of skills sets and the reliability/availability of the locum and agency staff, it has not been possible to establish a robust medical rota provision across both sites. We have been successful

in recruiting on substantive consultant who will take up their position in July bringing the number of substantives up from 2 to 3. There are still 5 posts vacant which are being filled through a mix of NHS locums and agency. The consultant workforce therefore remains fragile with only 38% being substantive consultants and the skills mix currently not adequate to enable the service to run safely.

**Nursing**

| Nursing Establishment | Vacancy rate as at Jan 20 | Vacancy rate as at May 21 |
|---|---|---|
| Boston Stroke Unit | 40% | 33% |
| Lincoln Stroke Unit | 19% | 19% |

Whilst good progress has been made in reducing the overall vacancy rate across nursing, with a mixture of international recruitment and local recruitment, there is an average lead in time of 6 months for staff to become upskilled in the basic requirements for the speciality and up to 12 months for hyper acute services. The ongoing gaps that remain with the nursing workforce add a further level of risk to safe service provision across the sites.

ACP workforce is currently at establishment of 5.8 wte, but the establishment is acknowledged as inadequate for the current workload. A business case is under development to secure an increase in resource.

**Therapies**

The ULHT therapy provision (OT and physio) across both sites, whilst having vacancies, remain stable overall and are performing well within the SNAPP indicators.

**Workforce Summary**

Whilst the consultant staffing number is improving, this still remains an unstable position. Locum fill has remained variable and there have been weeks where the service has again been run by only 3 consultants.

In order to be able to safely staff 2 hyper-acute admitting sites there has to be sufficient medical cover to provide:

- 24/7 on call services to both sites (40 miles apart)
- Shopfloor weekend cover at both sites from 08:00 to 18:00 hours
- Daily ward rounds Monday-Friday in addition to the weekend ward cover above
- Daily TIA clinics

With staff members spread across 2 sites running a rota with appropriate compensatory rest is not possible. Added in to the mix the variability of locum cover, assurance cannot be given from the CBU that it would be able to provide a robust and sustainable service at both sites.

Nurse staffing remains an acute concern with a significant pressure on utilisation of bank and agency to fill the gaps despite having rolling adverts out for the vacancies.

The Stroke ACP workforce also remains extremely vulnerable. They are demonstrating high levels of sickness, plus an increasing workload with the added pressure of staff members undertaking their Masters Training.

**Conclusion**

The conclusion of all four reviews of this temporary COVID pathway have been to confirm that the pathway is still relevant and still required in order to maintain a safe, responsive stroke service for ULHT and our patients. It is therefore recommended that this pathway remains in place at this time with continued, planned regular reviews. It is not possible currently to provide assurance that a safe, robust and sustainable hyper-acute service can be maintained if we were to revert back to 2 separate admitting sites at this time. A further review is planned for September 2021.

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NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | Trust Board |
| Date of Meeting | 6th July 2021 |
| Item Number | Item Number 11.2 |
| *Trauma and Orthopaedics hot and cold site pilot evaluation update* | |
| Accountable Director | Mark Brassington |
| Presented by | Mark Brassington |
| Author(s) | **Chloe Scruton**, General Manager, Urology, Trauma and Orthopaedics and Ophthalmology |
| Division Sponsor(s) | **Mr Vel Sakthivel**, Clinical Lead, Trauma and Orthopaedics<br>**Mark Lacey**, Managing Director, Surgical Division |
| Report previously considered at | Trust Leadership Team (TLT) |

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

## 1. Purpose

The purpose of this paper is to provide the Trust with an update of the hot and cold site pilot within Trauma and Orthopaedics. The previous evaluation paper titled 'EMEE ULH Board Paper Hot and Cold Evaluation' was submitted to the ULHT Trust Board in April 2019 following which, an extension to the hot and cold site pilot was granted until April 2020.

The data presented within this paper includes activity up to Feb 2020 prior to the impact of COVID-19 which caused the significant disruption to activity and reporting mechanisms available within the Trust. The report would have been presented at the beginning of the last FY but because of the pandemic response it was not appropriate at the time.

COVID -19 Pandemic pilot impact

Due to the impact of the COVID-19 pandemic on capacity and implementing social distancing restrictions the Key Performance Indicators were unable to be measured during March 2020 to present date. During the pandemic the trust continued to run the E trauma service for urgent/emergency patients which enabled the faster treatment of non-elective outpatients.

Mitigation

To support elective outpatients, video conferencing and telephone clinics were set up and these were fully utilised. The Consultants also carried out virtual reviews where necessary. For elective and daycase procedures, national guidelines stipulated the prioritisation of patients in relation to the length of time a patient could safely wait for surgery. This process was driven along with the management of theatre utilisation by a designated COVID elective cell.

As the trust moves through restoration phase, the orthopaedic service have resumed full theatre and outpatient capacity across all sites. The orthopaedic hot and cold site pilot can now be resumed and measured against the KPI's (shown in section 4).

## 2. Case for Change (pre-Orthopaedic pilot and before the Covid-19 pandemic)

Nationally there had been a deterioration in the number of patients seen within the 18-week standard (national target being 92%). Lincolnshire CCG was performing better than the national average however it was below the national target. Between April 2017 and February 2020 Lincolnshire's performance reduced from 89.5% to 82.7%.

At United Lincolnshire Hospitals NHS Trust (ULHT) there was an extensive recovery programme in place to move towards the national 92% target including delivery of additional outpatient clinics over and above core capacity. In addition, the clinical divisions completed a range of further actions to improve processes within individual speciality areas and increase capacity in order to support the required improvements in the key planned care metrics. The actions supported improved performance, however given the current configuration of services and limited separation of elective and non-elective services attainment and sustainment of this target continued to be a challenge.

Historically ULHT had struggled with delivering the optimal mix of capability, capacity and resources across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked working. Over recent years ULHT has experienced pressure on elective beds from medical emergencies all year round.

Alongside this, there was high nursing and medical vacancies exist across ULHT in the Orthopaedics (elective and non-elective) service (15 %of nursing posts and c.10% of medical posts vacant).

Prior to the pilot in orthopaedics, where a 'hot' and 'cold' site model was trialled, analysis showed that 30% of planned orthopaedic patients (c.900 patients) had their activity cancelled every year due to non-elective admissions. Around half of these (c.450 patients) had their surgery cancelled on the day of surgery. Cancellation of surgery at any time leads to poor patient experience and satisfaction, however being cancelled on the day of surgery is extremely distressing for patients and their families.

This mismatch between elective capacity and demand across ULHT meant patients are treated at hospital sites that may not be their closest geographically or go to the independent sector (over 3,000 per year) to access elective orthopaedic services (still funded by the NHS).

Patients going out of county to the independent sector for elective orthopaedic surgery also has financial implications for the health system as a whole as funding allocated to the Lincolnshire Clinical Commissioning Group is not being spent on local services.

The new NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate hot site allows improved trauma assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

## 3. Background

United Lincolnshire Hospitals NHS Trust volunteered to drive forward the GIRFT hot and cold site pilot given the high level of patient benefits and improved clinical outcomes which best practice evidence suggests could be achieved. The Trust was part of Phase 2, which included three other trusts (King's College London, East Kent and Royal Cornwall).
Before commencing the pilot, the Trust faced a number of fundamental clinical, operational and financial challenges with its T&O services. The T&O services operated across four hospital sites at Lincoln, Grantham, Pilgrim and Louth with performance being suboptimal and poor patient satisfaction with the inefficient services. The orthopaedic pilot commenced on Monday 20 August 2018 with the following arrangements:

- All appropriate elective cases to be undertaken at Grantham Hospital with dedicated ring fenced beds on Ward 2.
- All fractured Neck of Femurs (#NoFs) to be managed at Lincoln and Pilgrim hospitals.
- Trauma to remain at Grantham Hospital for the duration of the trial.

## 4. Key Performance Indicators (KPI's)

In the original evaluation of the pilot, the KPI's below were recommended for the Trust to adopt in the form of a reporting dashboard to enable monitoring of desirable/undesirable impacts and drive performance improvements in terms of quality, safety, patient experience and use of resources. To date this dashboard has not been created, however, performance against the elective KPI's are regularly monitored and performance against these are highlighted below in 'Success Factors'.

In order to agree and implement the KPI's for 'Trauma' and 'Impact on ED', the information required to track these will form part of the eTrauma system which the Trust implemented as a permanent solution from October 2020. Information gathered from this system will allow the Trust to track current baseline performance and work on key areas to ensure improvement.

Pilot key performance indicators:

- Elective (see section 5)
  - Total admissions
  - No of primary hip operations
  - No of primary knee operations
  - Length of stay, all hip surgery (including revisions)
  - Length of stay, all knee surgery (including revisions)
  - On the day cancellations
- Trauma (monitoring currently being gathered via eTrauma)
  - Total admission – trauma per week
  - Length of stay for trauma patients
  - Bed days for trauma patients
  - Wait for upper limb trauma surgery (from acceptance of referral)
  - 100% patients reviewed by senior Orthopaedic clinical decision maker daily
- Impact on ED (monitoring currently being gathered via eTrauma)
  - Breaches – 4 hour target attributed to T&O
  - Percentage of T&O patients seen within 30 mins of referral
  - Patients transported from ED to other sites by ambulance
  - Patients transferred from ED to other sites by own transport

## 5. Success factors

At the beginning of the pilot the following success factors were agreed upon to ensure as a Trust, it was easily identifiable whether the changes implemented would have the desired impact on our patients, our staff and our services.

Set out below are the agreed success factors, together with timescales for delivery set in April 2019 and the performance to Feb 2020. Performance past this date has not been include due to the impact of COVID-19 and subsequent uncontrolled variables.

The grey boxes shaded below indicates the month the success factors were planned to be achieved. Highlighted in green is where the planned achievement target was met and highlighted in red is where this was missed/not achieved.

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| Success factors | Current baseline | Target Outcome | Stretch target | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Overall result |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| Patient satisfaction (to be quantified) | Currently monitored qualitatively through feedback received | FFT results<br><br>90% | | | | | | | | | | | 95% | 95% | Exceeded target outcome |
| Staff satisfaction | Not collected | Repeat survey monkey quarterly | | | | | | | | | | | | | To be quantified |
| | | | | | | | | | | | | | | | |
| RTT admitted | 69.14 | 92% | | 72.46 % | 76.91 % | 77.56 % | 86.23 % | **Target 85%** 87.10% | 87.04 % | 87.67 % | 86.76% | **Target 92%** 83.28% | 80.53 % | 80.60 % | Requires sustained improvement |
| RTT non-admitted | 85.27 | 92% | | 89.27 % | 85.67 % | 85.99 % | 86.63 % | **Target 92%** 90.06% | 91.20 % | 90.89 % | 92.33% | 92.25% | 90.05 % | 88.83 % | Requires sustained improvement |
| RTT combined | 80.12 | 92% | | 84.70 % | 83.49 % | 84.08 % | 86.54 % | 89.44% | 90.33 % | 90.22 % | **Target 92%** 91.17% | 89.89% | 88.05 % | 87.15 % | Failed to meet outcome target |
| Overall waiting list size | Reduction required | | | 2,895 | 2,731 | 2,758 | 2,824 | 2,821 | 2,876 | 2,862 | 2,932 | 2,988 | 3,064 | 2,958 | Requires reduction |
| Length of stay (hips) | 2.5 | <2 | 2.5 | 2 | 2 | 1.7 | 1.8 | **Target <2** 1.8 | 1.5 | 1.5 | 1.5 | 1.3 | 1.4 | 1.3 | Exceeded target outcome |
| Length of stay (knee) | 2.5 | <2 | 2.5 | 2 | 2 | 2 | 1.8 | **Target <2** 1.8 | 1.7 | 1.7 | 1.8 | 1.6 | 1.8 | 1.9 | Exceeded target outcome |
| Day case total hip replacement (THR) total knee replacements (TKR) | 0 | | | | | | | **X** first daycase TKR | | | | **X** first daycase THR | | | Exceeded target outcome |

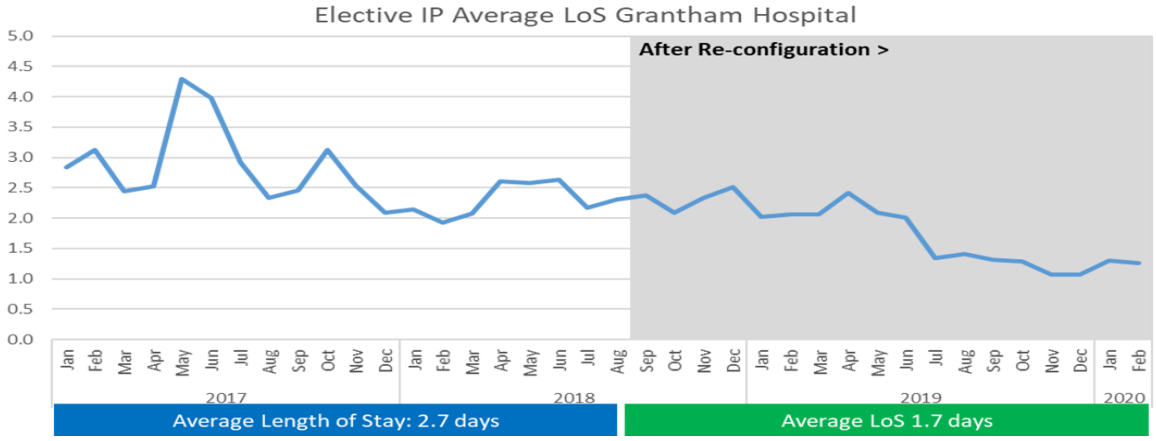
| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cemented hips (over 70s | 78% | >80% | >87% | 95.65 % | **Target 80% 95.83 %** | 96.15 % | 90% | 83.33% | 82.76 % | 76% | 88.23% | 83.33% | 77.77 % | **Target 87%** 88.46 % | Exceeded target outcome |
| No of joints per session (Grantham only) | 1.9 | 2 | 2.5 | 1.9 | 1.9 | 1.8 | 1.9 | **Target 2** 2 | 2 | 2 | **Stretch target met 2.5** | 2.5 | 2.5 | 2.5 | Exceeded target outcome |
| Av. cases per session (TW) | TBC | 2.5 | 2.5 | 3.1 | 3 | 2. | 2.9 | 3.2 | 3.1 | 3 | 3 | 2.9 | 3 | 2.9 | Exceeded target outcome |
| Theatre utilisation (Grantham only) | 73% | 85% | | 80.48 % | 78.97 % | 73.1% | 72.63 % | **Target 85%** 82.02% | 81.46 % | 85.80 % | 88.59% | 80.82% | 85.68 % | 84.73 % | Requires sustained improvement |
| Cancellations - general beds (Grantham only) | 1 | 0 | | **Target 0 0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Exceeded target outcome |
| Cancellations - admin error (Grantham only) | 1 | <2% | | 0.1% | 0.1% | **Target <2%** 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | Exceeded target outcome |
| Cancellations - lack of time (Grantham only) | 2 | <2% | | 1.7% | 1.7% | **Target <2%** 1.7% | 1.7% | 1.7% | 1.7% | 1.7% | 1.7% | 1.7% | 1.7% | 1.7% | Exceeded target outcome |
| Cancellations - equipment (Grantham only) | 1 | <0.8% | | 0.6% | 0.6% | **Target <0.8%** 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | Exceeded target outcome |
| Step down at Sleaford | N.A. | 8 beds | 16 beds | | | | | 8 | | | | | | | Failed to meet outcome target |
| #NOF BPT | | 95% BPT | | | | | | Target 95% | | | | | | 50.3% | Failed to meet outcome target |

## 6. Key Successes

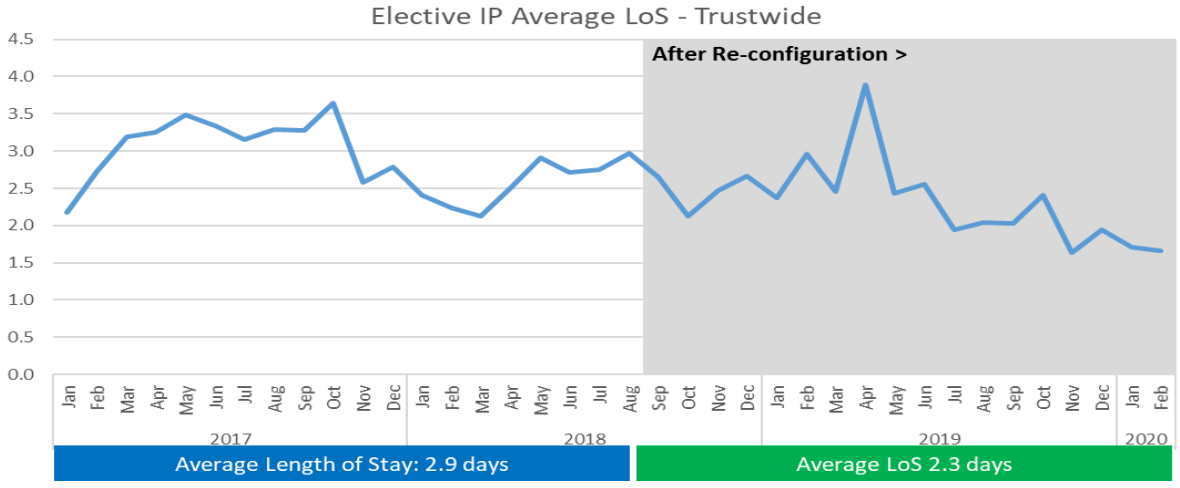
Reduction in length of stay (LoS)

A reduction in the Orthopaedic elective length of stay at Grantham Hospital has been achieved from 2.7 days to 1.7 days. A marginal increase in LoS was seen in January 2020, this was due to hip and knee revision surgery commencing in Grantham.

An enabler to the reduced length of stay is the commencement of total hip and total knee replacements being undertaken at Grantham as day-case procedures. Patients having these procedures as day-cases are followed up via telephone to ensure their outcome is as planned.

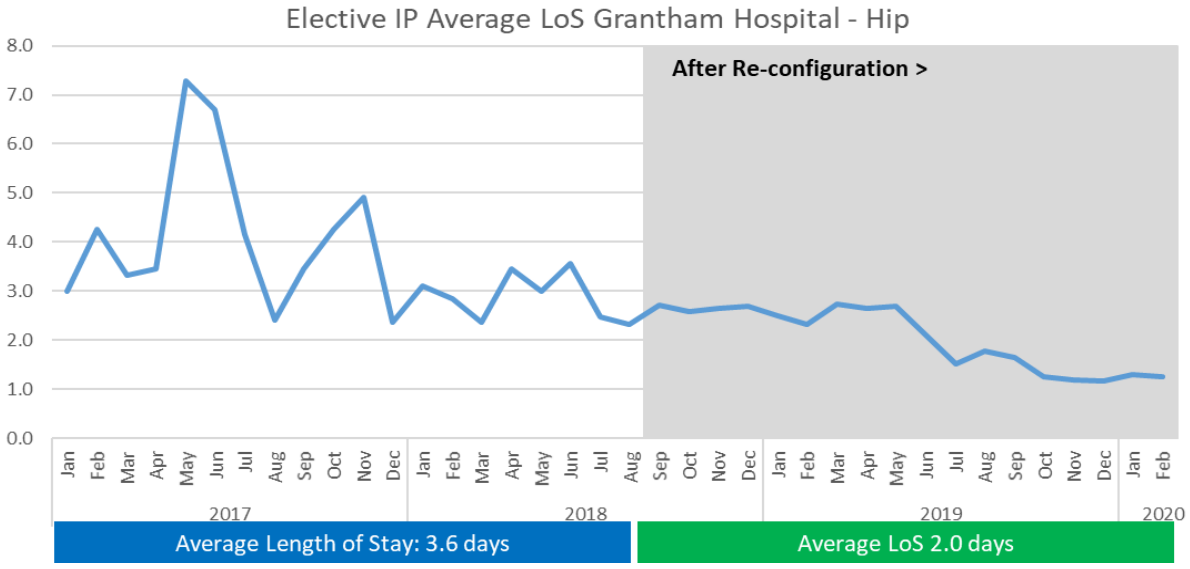



A reduction in the Trustwide Orthopaedic elective length of stay as been achieved from 2.9 days to 2.3 days.

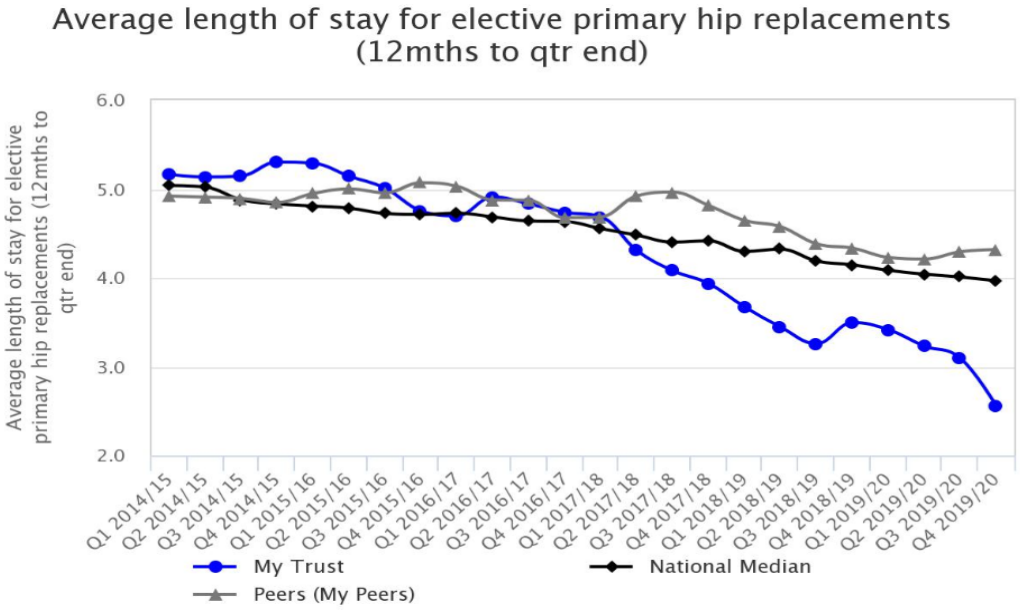


Primary hip replacement length of stay

The length of stay for primary hip replacements at Grantham hospital has now reduced to an average of 2.0 days compared to 3.6 days before the reconfiguration commenced. In February 2020, length of stay is now reported to be 1.3 days (see graph below).

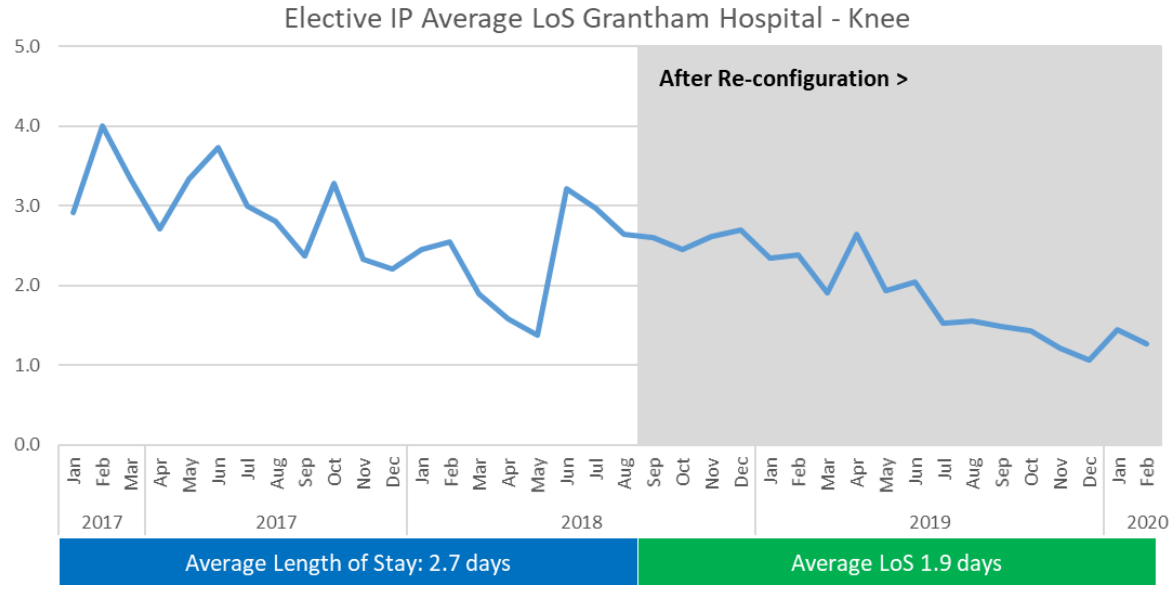



As the graph below demonstrates, ULHT is performing significantly better than both our peer Trusts and the national median for primary total hip replacements length of stay.

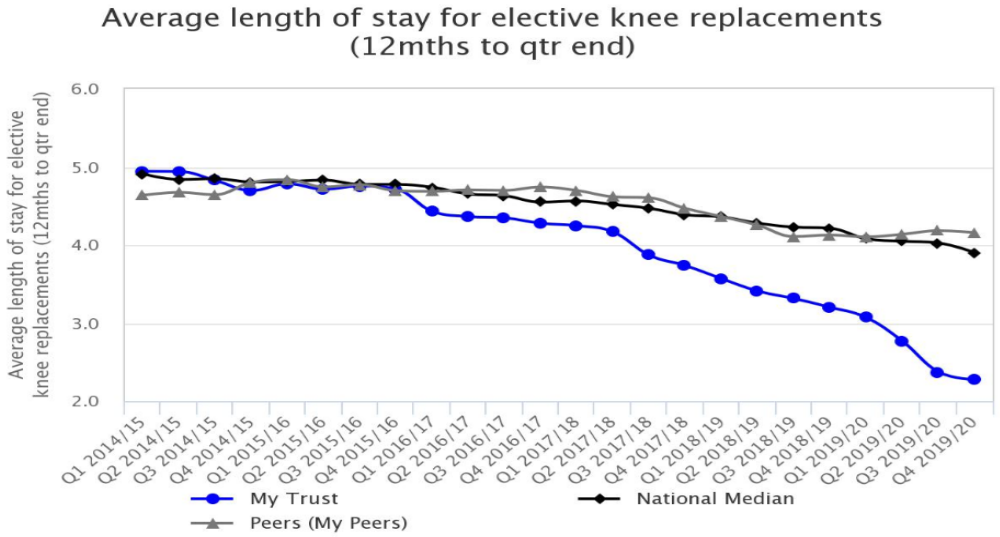


Primary knee replacement length of stay

The length of stay for primary knee replacements at Grantham hospital has also reduced to an average of 1.9 days compared to 2.7 days before the reconfiguration commenced. Length of stay at Grantham Hospital has outperformed all other pilot Trusts within the GIRFT 'hot and cold site' programme.



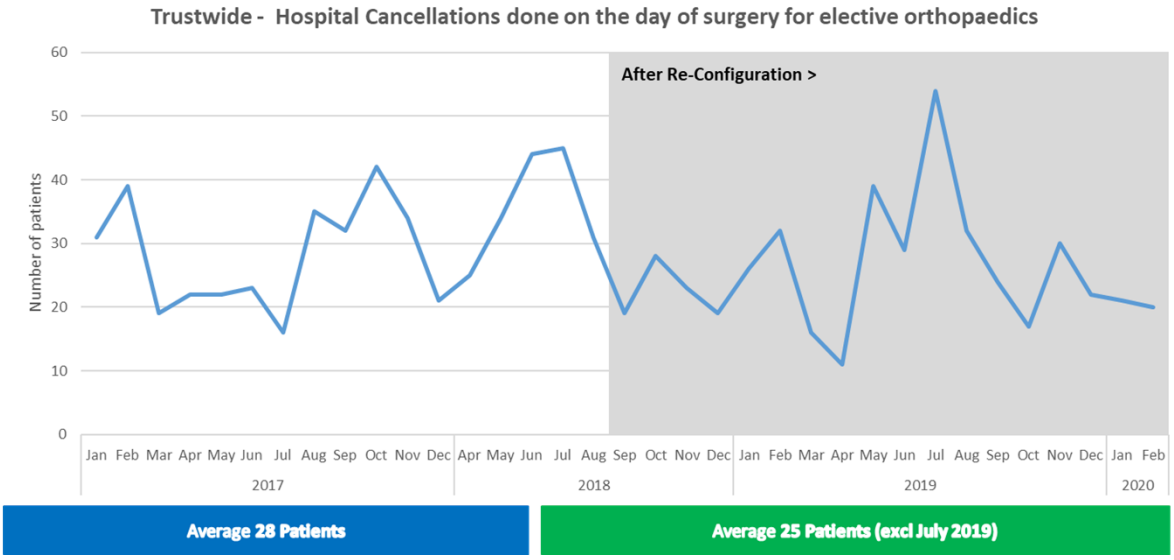

As the graph below evidences, length of stay for total knee replacements also far exceeds the national median and our peer trusts, mirroring the achievement in the reduction of length of stay for total hip replacements.




Trust wide cancellations on the day

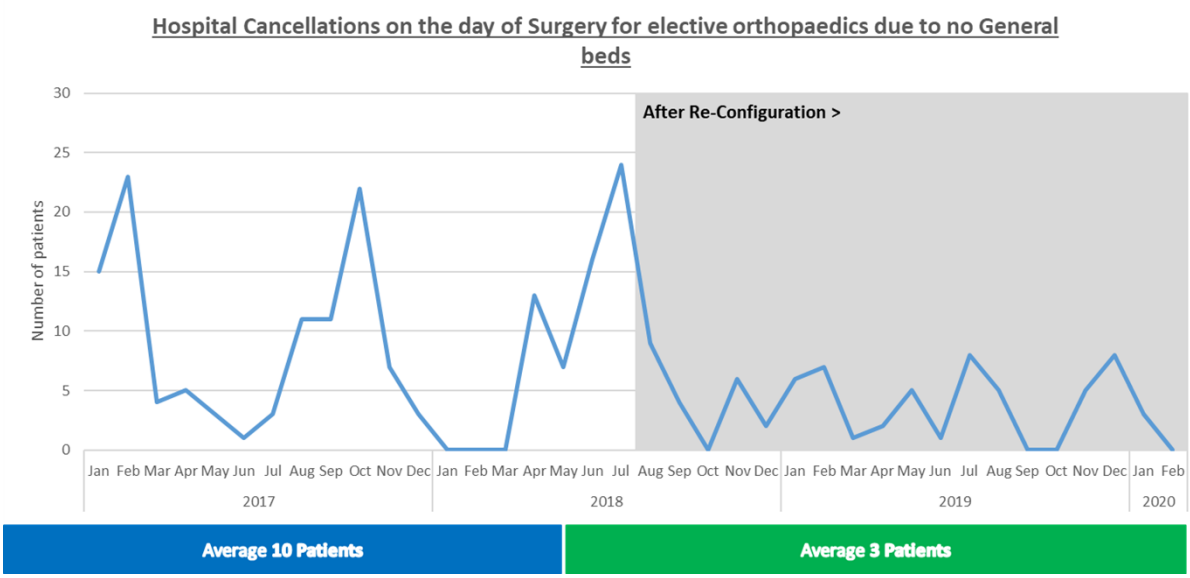
Before the pilot commenced, between January 2017 and July 2018 the average number of elective orthopaedic patients who had their surgery cancelled on the day each month was 28. The highest in any one month was 43 patients. Since the orthopaedic pilot commenced the Trust wide cancellation rate on the day for non-clinical reasons has reduced to an average of 25 patients (July 2019 data was

excluded from the average figure due to the abnormally extreme adverse weather conditions).



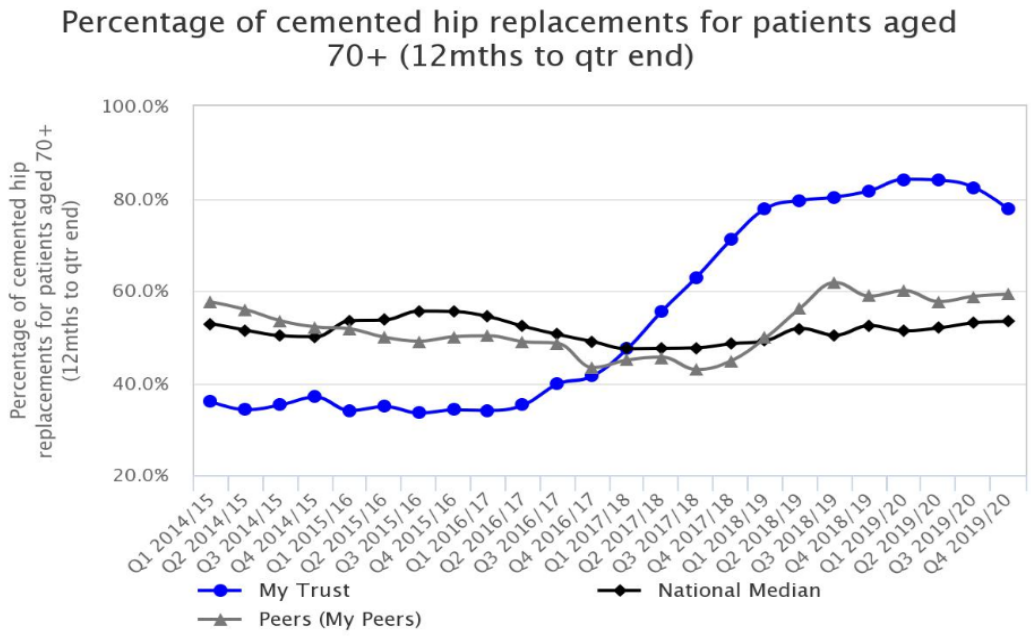

## Cancellations on the day (lack of general beds)

The Trust wide average cancellation rate on the day due to a lack of beds was 10 patients each month before the reconfiguration. This has now reduced to 3.3 patients per month cancelled on the day due to lack of beds across the Trust. However, cancellations on the day at Grantham due to lack of beds is nil.




## Cemented hips (over 70's)

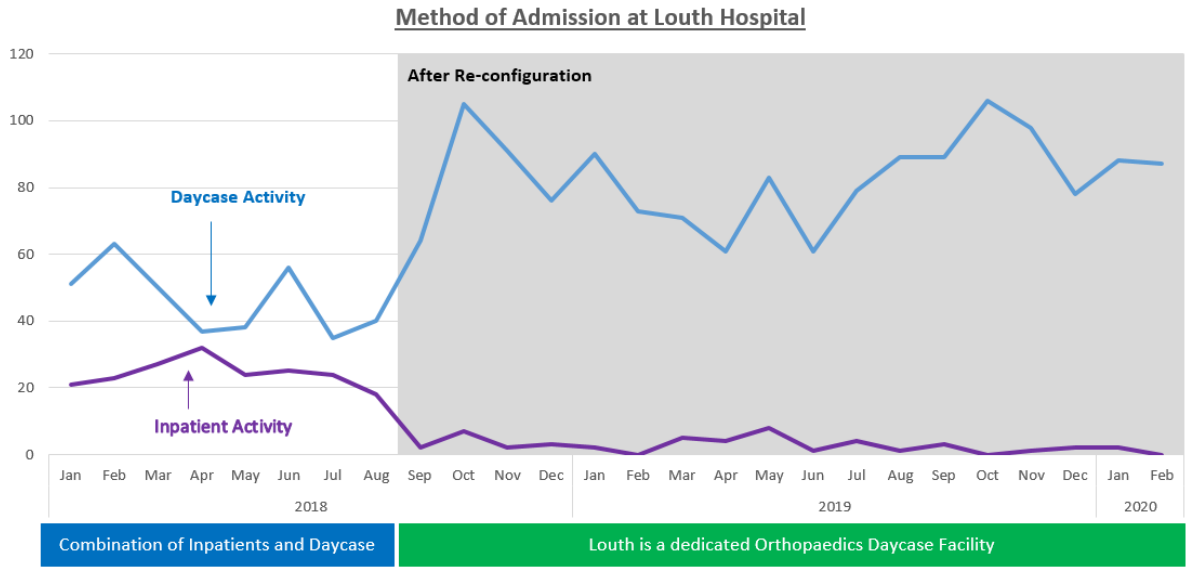
This is a GIRFT recommendation that the Trauma and Orthopaedics department tracked as part of the success factors of the pilot. As well as the outcome target of 80% of patients over the age of 70 to have a cemented hip replacement been achieved, the stretch target of 87% has also been achieved.



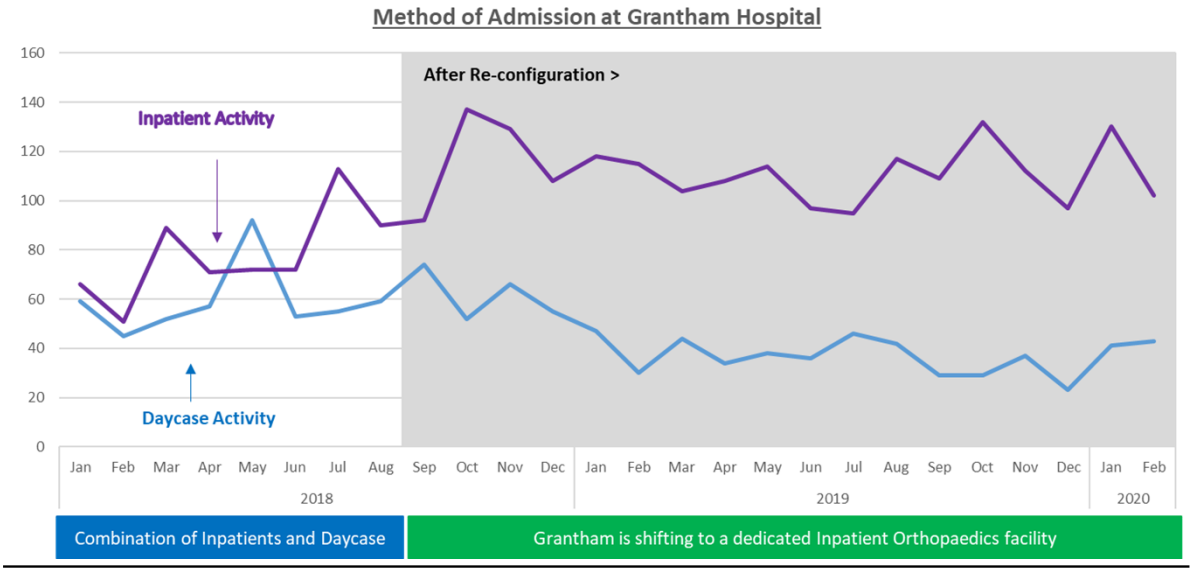

Throughout the pilot it has been shown that the consolidation of elective orthopaedic services at Grantham Hospital (together with a greater focus on day cases at Louth) can deliver a reduction in the amount of time people wait to have their surgery as well as the potential to increase the number of patients treated by ULHT. It has also shown people are prepared to travel to have their elective surgery if it means they will have their operation quicker.

Set out below is the admission method at Louth County Hospital. The graph below sets out the increasing level of day-case orthopaedic work at this site as it transitioned to a dedicated day-case unit. Through the pilot Louth has increased the number of day cases from an average of 41 a month to 99 a month.

## Method of Admission




Set out below is the admission method at Grantham Hospital. The graph below sets out the increasing level of inpatient orthopaedic work and reduction in day cases in line with the decisions made.



## 7. Areas for improvement

Issue 1. RTT
Although the targets for RTT non-admitted and admitted have been achieved since the pilot, this has not been sustained nor has the department met the overall RTT combined target of 92%. In December 2019, the CCG advised the Trust to reduce Trauma and Orthopaedics elective activity during the last quarter of the financial year, this adversely impacted our RTT performance.

Mitigation
In order to recover the current position and ensure achievement of the target, weekly PTL meetings are in place to ensure all patients are validated and tracked through their pathways.

Issue 2. Consultant on call
Previous job plans meant that when a Consultant was on-call they would lose their elective capacity.

Mitigation.
With the implementation of the new 'hot week' model of on-call, this allows 15% of activity to remain in place compared to the previous on-call model. This is a model that is now replicated Trustwide within Trauma and Orthopaedics. Through the orthopaedics pilot the workforce model has changed and been sustained in a number of areas:

- The consultant on-call model at Grantham has been removed and the on-call function is now provided by SAS orthopaedic doctors. The on-call SAS team report into the receiving 'hot' site (Lincoln or Pilgrim) for support if required. The receiving sites alternate on 3-weekly intervals.
- The Trauma and Orthopaedics SAS doctors and consultants who are based at Grantham are now part of the ULHT wide (Lincoln, Pilgrim and Grantham Hospitals) orthopaedic rota.
- Orthopaedic consultants now operate across multiple sites as part of the ULHT wide Orthopaedic team.
- The pilot workforce model has successfully removed all agency doctor usage ULHT wide. Before the pilot, agency doctors were used to cover one consultant post, Foundation doctor posts and SAS doctor posts.
- The current workforce in the pilot model still carries one consultant vacancy, two SAS doctor vacancies and two Foundation doctor posts, however all of these vacancies are covered through the new workforce model, without the need to bring in agency doctors.

Issue 3. BPT and #NOF performance
This is an area where a decline in performance has been seen since the beginning of the pilot. From April 2020, BPT has now changed to include femoral shaft and distal femur fractures.

Mitigation
A task and finish group has commenced with all key stakeholders in order to recover this performance which has a patient quality impact for patients admitted with #NOF.

The department has a newly appointed #NOF lead at Lincoln County Hospital and a Trustwide #NOF lead for the department. These roles will be paramount in ensuring good practice is shared across the sites to guarantee improved performance.

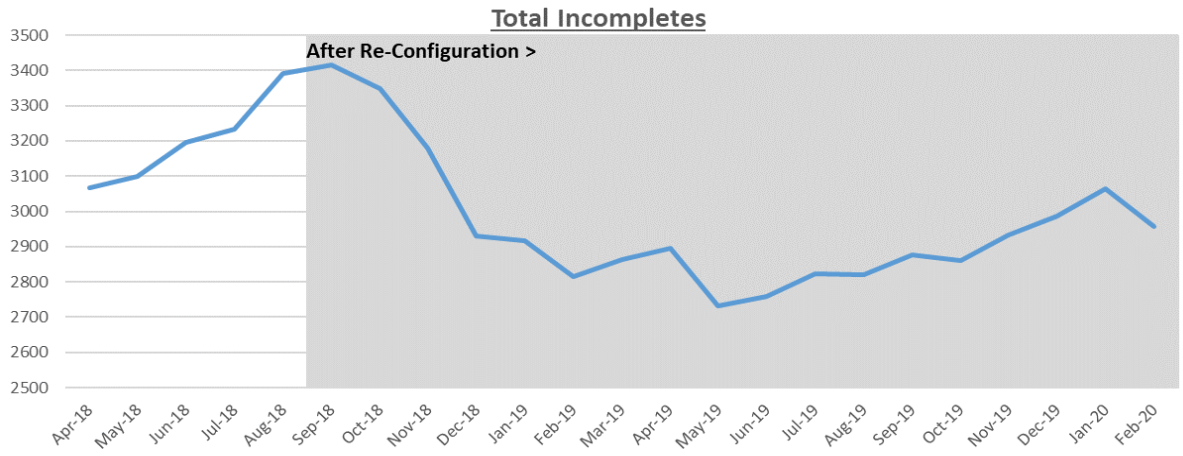
## 8. Engagement - Patient and staff satisfaction

Patient satisfaction is captured through FFT for which Ward 2 always have extremely positive feedback. However, since the pilot commenced, the department has not regularly sought the views of the staff in the form of a questionnaire. Although verbal feedback from staff is extremely positive the department still needs to be able to collect and quantify feedback from all staff groups affected by the pilot.

## 9. Patient Access

One of the risks identified at the start of the pilot was whether patients would be prepared to travel 30 miles or more to have their elective treatment at Grantham Hospital. However, on review of all the patient feedback received on the orthopaedic pilot no reference or issues were highlighted with travelling or transport delays. This is certainly a positive outcome, given concerns around access and travel to services raised by some members of the public during engagement events.

Overall waiting list size



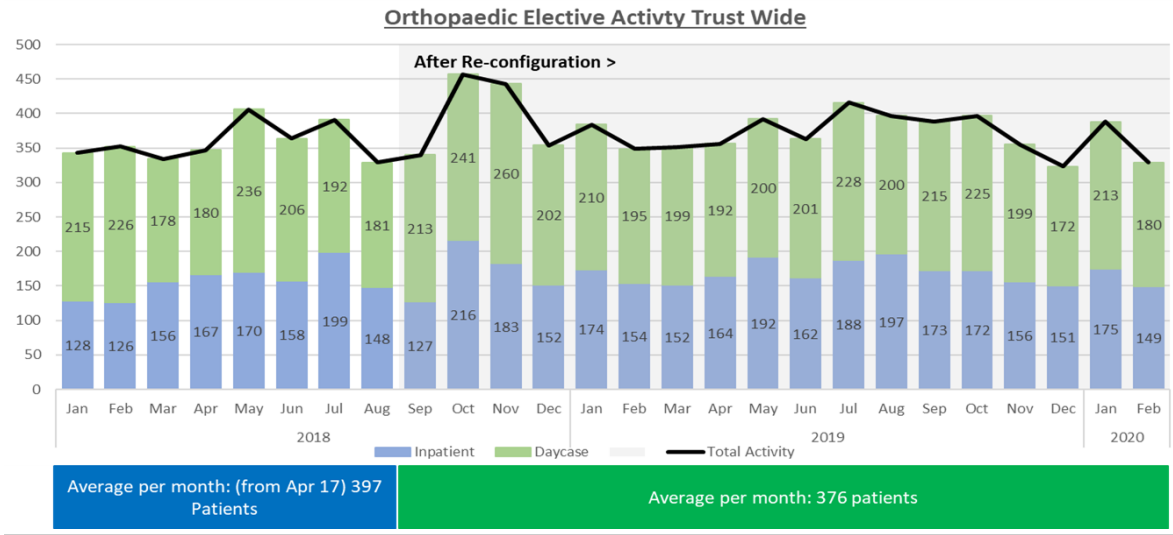

Since April 2019 the highest performing RTT month for Trauma and Orthopaedics was Nov 2019 (91.17%), this month also saw one the highest overall waiting list sizes (2,932 patients).

As the waiting time is shorter on the non-admitted pathway i.e. wait to first appointment and subsequent follow up, the Trust is now attracting more referrals. All outpatient elective clinics are full and theatre efficiency has improved. In order maintain RTT and to reduce the waiting list size, due to the efficiencies already made the department now need to improve productivity by operating on Saturdays and Sundays.

Monthly monitoring will be undertaken on all the identified areas of improvement and revised target dates will be set for achievement of these. Monthly performance against the original outcome targets will be reported through the Clinical Business Unit (CBU) performance review meetings which are chaired by the Surgical Triumvirate Team.

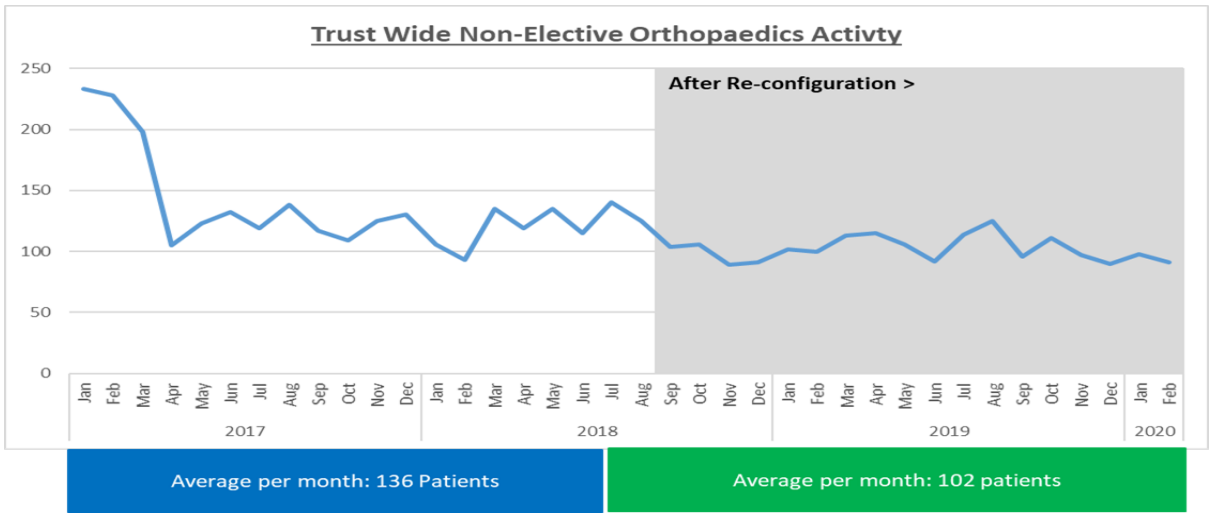
Elective Orthopaedic Activity

The Trust wide elective orthopaedic activity increased from an average of 397 patients each month to 411 patients after the trial commenced, although this gradually returned down to 376 in the present day (see graph below). The CBU has experienced a number of challenges. One of the main challenges experienced was at the start of the reconfiguration, it was agreed to have 14 less trust wide theatre lists per week for orthopaedics. As you can see from the numbers in the graph below this was successfully mitigated within the capacity allocated.

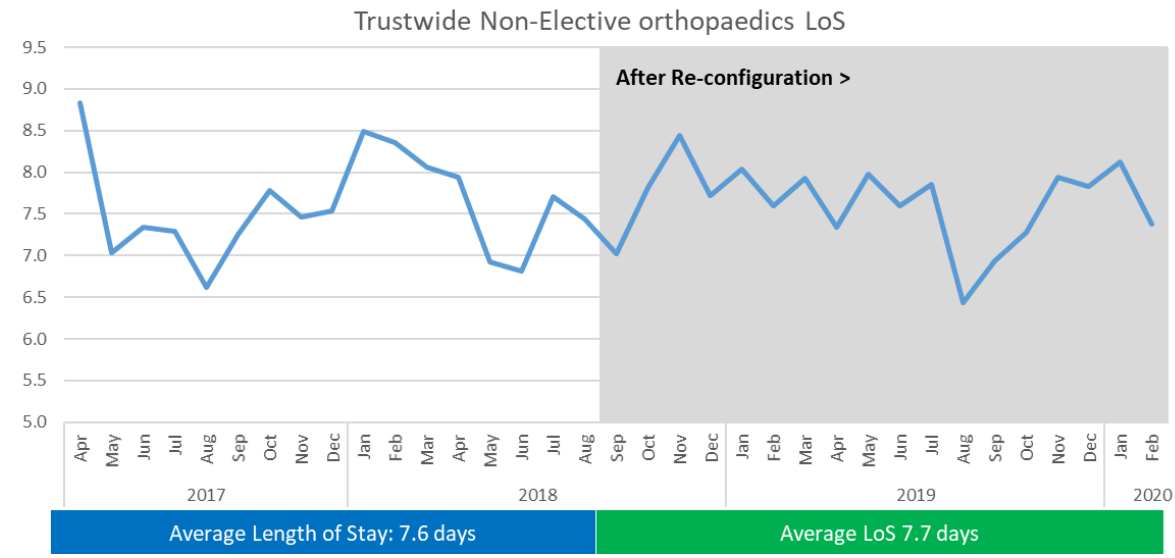



## Non-Elective Orthopaedic Activity

Whilst the Orthopaedic pilot primarily focused on the elective orthopaedic services, some trauma remained at Grantham Hospital with the major trauma continuing to take place at Lincoln and Boston. Set out below is the activity and LoS for non-elective activity.




The average number of trauma patients seen after the start of the trial has reduced from 136 to 102 patients per month. This drop in activity could be due to a number of reasons including a new hot clinics established to take orthopaedic injuries rather than patients being seen in ED.




The length of stay for trauma after the reconfiguration commenced shows a slight increase from 7.6 to 7.7 days.

## 10. Finance

Through the current Orthopaedics pilot all appropriate elective orthopaedic cases are being undertaken at Grantham Hospital with dedicated ring fenced beds on site and Louth Hospital has become a dedicated day case centre.
The pilot has been running since August 2018 and as well as delivering improved quality of care and patient outcomes has delivered a number of efficiency and productivity benefits, including:

- The reliance on interim locum medics across the four sites has been reduced to zero reducing the average employment cost of medics from £108.5k to £105.8k. This results in a cost reduction of £247k;
- Improvements in productivity in theatre throughput has allowed the medical workforce to be reduced to 86.11 wte from 90 wte resulting in a saving of £412k;
- Elimination in the use of agency nursing staff has resulted in saving of £918k.
- A reduction in cancelled procedures on the day from 9.4 to 4.6 (Trust wide);
- Reduction in utilisation of theatres so that 2 theatres (1 at Lincoln County 1 at Boston/Pilgrim) could now be relinquished;
- A reduction to zero “On the day” cancellations at Grantham Hospital;
- Reduction in LOS at Grantham Hospital from 2.7 to 1.7 days; and
- A movement of all non-complex elective activity from Lincoln County to Grantham.

The financial impact of the Orthopaedic pilot across ULHT sites are set out below.

### Financial impact of Orthopaedic services change - Grantham

| Orthopaedic Service – Grantham | | | | | | |
|---|---|---|---|---|---|---|
| Cost Category | Establishment Pre-Pilot | | Service Model Post-Pilot | | Difference | |
| | WTE | Cost £k | WTE | Cost £k | WTE | Cost £k |
| Medical Staffing | 19.00 | 2,261 | 17.11 | 1,712 | -1.89 | 549 |
| Nursing | 36.83 | 1,310 | 34.38 | 815 | -2.45 | 495 |
| Administration | 7.61 | 167 | 7.09 | 175 | -0.52 | -8 |
| Non-Pay/Recharges | - | 3,572 | - | 2,974 | - | 598 |
| **Totals** | **63.44** | **7,310** | **58.58** | **5,676** | **-4.86** | **1,634** |

### Financial impact of Orthopaedic services change - Louth

| Orthopaedic Service – Louth | | | | | | |
|---|---|---|---|---|---|---|
| Cost Category | Establishment Pre-Pilot | | Service Model Post-Pilot | | Difference | |
| | WTE | Cost £k | WTE | Cost £k | WTE | Cost £k |
| Medical Staffing | 3.00 | 238 | 3.00 | 217 | 0.00 | 21 |
| Nursing | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 |
| Administration | 3.00 | 59 | 0.00 | 0 | -3.00 | 59 |
| Non-Pay/Recharges | - | 970 | - | 1,259 | - | -289 |
| **Totals** | **6.00** | **1,267** | **3.00** | **1,476** | **-3.00** | **-209** |

### Financial impact of Orthopaedic services change – Pilgrim (Boston)

| Orthopaedic Service – Pilgrim Boston | | | | | | |
|---|---|---|---|---|---|---|
| Cost Category | Establishment Pre-Pilot | | Service Model Post-Pilot | | Difference | |
| | WTE | Cost £k | WTE | Cost £k | WTE | Cost £k |
| Medical Staffing | 34.00 | 3,126 | 34.00 | 3,424 | 0.00 | -298 |
| Nursing | 68.88 | 2,865 | 59.88 | 2,202 | -9.00 | 663 |
| Administration | 12.45 | 287 | 15.14 | 393 | 2.69 | -106 |
| Non-Pay/Recharges | - | 4,692 | - | 3,867 | - | 825 |

| Totals | 115.33 | 10,970 | 109.02 | 9,886 | -6.31 | 1,084 |
|---|---|---|---|---|---|---|

**Financial impact of Orthopaedic services change – Lincoln County**

| Orthopaedic Service – Lincoln County | | | | | | |
|---|---|---|---|---|---|---|
| Cost Category | Establishment Pre-Pilot | | Service Model Post-Pilot | | Difference | |
| | WTE | Cost £k | WTE | Cost £k | WTE | Cost £k |
| Medical Staffing | 34.00 | 4,140 | 35.00 | 3,760 | 1.00 | 380 |
| Nursing | 74.36 | 3,040 | 82.08 | 3,280 | 7.72 | -240 |
| Administration | 18.26 | 439 | 19.79 | 429 | 1.53 | 10 |
| Non-Pay/Recharges | - | 5,192 | - | 3,813 | - | 1,379 |
| **Totals** | **126.62** | **12,811** | **136.87** | **11,282** | **10.25** | **1,529** |

The financial impact as a result of the total Orthopaedics service changes is a savings of £4.04m and is set out in the table below.

**Financial impact of total Orthopaedic services changes**

| Orthopaedic Service – Overall Summary | | | | | | |
|---|---|---|---|---|---|---|
| Cost Category | Establishment Pre-Pilot | | Service Model Post-Pilot | | Difference | |
| | WTE | Cost £k | WTE | Cost £k | WTE | Cost £k |
| Medical Staffing | 90.00 | 9,765 | 89.11 | 9,113 | -0.89 | 652 |
| Nursing | 180.07 | 7,215 | 176.34 | 6,297 | -3.73 | 918 |
| Administration | 41.32 | 952 | 42.02 | 997 | 0.70 | -45 |
| Non-Pay/Recharges | - | 14,426 | - | 11,913 | - | 2,513 |
| **Totals** | **311.39** | **32,358** | **307.47** | **28,320** | **-3.92** | **4,038** |

Within the £4m savings quantum there is an element relating to recharges of £2.5m. These covered the cost of services charged to Orthopaedics relating to their utilisation of Theatres. Through efficiencies in waiting list management, scheduling and the reduction in cancellations the Orthopaedics service has been able to relinquish 2 theatres (1 at Boston and 1 at Lincoln County). This has reduced the charge to Orthopaedics for support services and overheads as the Orthopaedic service now consumes less theatre space.
Whilst those costs still exist within ULHT's cost base they will be recycled to whichever service now utilises the vacated theatre space. As part of ASR Phase 2 the Orthopaedic service plans to repatriate activity currently delivered by the Independent Sector or other NHS providers. If achieved this will bring in additional income and enable a bigger contribution to overheads from the Orthopaedic service.

## 11. Key risks

There are a number of potential risks to the continued success of the programme identified and the top three are listed below:

- Impact of COVID-19 and the restoration plans for Trauma and Orthopaedics elective pathways. Grantham District Hospital is being used as a 'green site' for cancer and clinically urgent elective.
- Trauma theatre 'in session' utilisation has been adversely impacted during COVID-19. Due to this, trauma patients are having their operations delayed, non-elective length of stay is increasing and #NOF patients are not having their surgery within the 36 hour 'time to theatre' target for BPT.
- From April 2020 - Inclusion of the whole femur in BPT performance which means an increased number of patients need their surgery within 36 hours of admission to meet the BPT 'time to theatre' target.

## 12. Next steps

To ensure performance recovers and remains on track, the Trauma and Orthopaedics department require a dedicated dashboard to be implemented which includes all KPIs and success measures. The aim is that this dashboard can be reviewed in real time to assess performance and give the CBU triumvirate team the ability to identify issues and rectify. Currently rectification of performance going off track does not happen until the end of month by which point, performance is already adversely affected.

The aim is this dashboard will include all success factors as outlined above. The targets and expected month of achievement is expected to be achieved in early 2022.

The top five priority areas are:

- Recovery of Trauma and Orthopaedics elective and non-elective KPI's in order to achieve pre COVID-19 pandemic performance.
- Focus on resources and improved financial position, including the new BPT for the femoral shaft and distal femur fractures and the BPT for #NOF.
- Step down facility for #NOF.
- Repatriation of Trauma and Orthopaedic activity and to obtain a lead provider contract.
- Supporting urgent and emergency care pathway in anticipation of increasing urgent care activity, rebound and COVID-19 peaks as lockdown measures are relaxed.

Phase two – Future Plans

To achieve lead provider status we would look to creating additional capacity at the Grantham Hospital site to allow for the full shift of Orthopaedic day case and elective activity currently seen at ULHT's sites planned under the proposal and support further repatriation of patients going to the independent sector for Orthopaedic surgery.

## 13. Other successes

- **2nd April 2019** – GIRFT getting it right first time public publications shared
- **June 2019** – First Trust wide Trauma and Orthopaedic business meeting with all disciplines represented
- **Aug 2019** – First year anniversary of the reconfiguration - Staff Celebratory Event
- **8th August 2019** – Featured in ULHT news & events public publication
- **13th August 2019** – Article published in the HSJ outlining the successes of the ULHT hot and cold site reconfiguration
- **21st August 2019** – GIRFT team and Professor Briggs visit to the Trust for GIRFT Litigation and reflection a year on from the reconfiguration commencement
- **December 2019** – Implementation of audit for '6 simple fractures' which has now created a Trustwide pathway, this reduces new fracture face to face attendances in the fracture clinic by 11%
- **February 2020** – Implementation of a 'hot week' model of on-call to ensure the continuity of care for Trauma inpatients and those requiring trauma surgery and reduce the amount of elective session cancellations
- **February 2020** – featured in GIRFT national speciality report on Orthopaedics Public Publication
- **4th February 2020** – first 10 total joint replacement operated on in one day/2 all-day theatres.
- **March 2020** – planned closure of Ward 2, elective Orthopaedic ward on a Sunday due to reduced length of stay
- **April 2020** – re-adjustment of theatre capacity to free up one elective Orthopaedic theatre at Pilgrim Hospital, Boston, with no predicted loss to activity or income.
- **June 2020** – planned implementation of pre-recorded hip and knee classes for patients to reduce attendances to the hospital
- **June 2020** – Gold approval for the trial of eTrauma which will allow improved pathway between A&E, UTC and the Trauma and Orthopaedic fracture clinics

## 14. Recommendations

In order to achieve the KPI's outlined in this report and to recover T&O to February 2020 position, it is recommended that approval is granted to extend the Trauma and Orthopaedics pilot until the outcome of the Acute Service Review (ASR) is known.

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| | |
|---|---|
| Meeting | *Public Trust Board* |
| Date of Meeting | *6th July 2021* |
| Item Number | *Item 11.3* |
| ***Urology Pathway Update*** | |
| Accountable Director | *Mark Brassington, Deputy Chief Executive and Paul Matthew, Director of Finance and Digital* |
| Presented by | *Chloe Scruton, General Manager and Anna Richards, Associate Director of Communications & Engagement* |
| Author(s) | *Chloe Scruton, General Manager and Anna Richards, Associate Director of Communications & Engagement* |
| Report previously considered at | *Health Oversight Scrutiny Committee Trust Leadership Team* |

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

| | |
|---|---|
| Risk Assessment | *Clinical Risk Analysis completed to inform QIA/EIA, along with Benefits Analysis.* |
| Financial Impact Assessment | *Financial Impact - £300k savings pa as a result of agency use reduction* |
| Quality Impact Assessment | *All identified QIA elements fall below the level of 15. No areas of significant risk. All have been mitigated to a low level. QIA demonstrates clear benefits as a result of the proposal. Waiting to be finalised and signed off.* |
| Equality Impact Assessment | *EIA has formed part of the new proposed model QIA. Waiting to be finalised and signed off.* |

| Assurance Level Assessment | *Insert assurance level*<br>• *Moderate* |
|---|---|

| Recommendations | • *Support for the continuation of the proposed reconfiguration* |
|---|---|
| | *Support for the continued engagement* |

## Executive Summary

As part of our ongoing commitment to continually improving hospital services, the Urology department are currently undertaking a patient engagement exercise to review the reconfiguration proposal of both planned and emergency urology services across Lincolnshire's hospitals.

Taking into account patient experience insight, expert clinical advice, discussions with partners and available data, we are proposing that Lincoln County Hospital in future receives all emergency urology admissions seven days per week. Currently, Lincoln receives all emergency urology admissions at the weekends with emergency admissions at both Lincoln and Pilgrim hospitals during the week. Under this proposal, Pilgrim hospital would continue to see emergency urology patients, but if the patient needs admission or surgery they would be transferred to Lincoln County Hospital if they are medically stable to do so.

We believe that this change would increase our capacity to perform planned surgery without disruption, better meet the needs of our emergency cases and see and treat more people.

The Health Oversight Scrutiny Committee have received the reconfiguration proposal and will share their response in July 21. The engagement exercise is underway until 23rd July 21. Following engagement, the Urology specialty plan to bring the engagement outcome to Trust Board in August for review and decision

# Hospital urology services consultation- have your say

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# Introduction

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As part of our ongoing commitment to continually improve hospital services, we are currently undertaking a review of both planned and emergency urology services across Lincolnshire's hospitals.

Currently, planned urology services are delivered from Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and County Hospital, Louth.

Emergency urology admissions at the weekends go through one single site- alternating between Lincoln and Pilgrim hospitals- with emergency admissions at both Lincoln and Pilgrim hospitals during the week.

Taking into account patient experience insight, expert clinical advice, discussions with partners and available data, we are proposing that Lincoln County Hospital in future receives all emergency urology admissions seven days per week.

We believe that this change would increase our capacity to perform planned surgery without disruption to patients, better meet the needs of our emergency cases and see and treat more people.

**We now want to hear from you about your views around this proposed change.**

# Background

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At present, our consultants and middle grade doctors within the urology service are required to perform planned surgery and be on-call for urgent surgical requirements at the same time. This concerns us because:

- Our consultants and middle grade doctors become exhausted as they can receive urgent on-call requests during the night and be expected to perform planned surgeries the next day.
- They can be performing a planned surgery during the day and be called out to perform an emergency surgery.
- This impacts on our ability to respond as quickly as we would like to emergency surgical needs.
- It also causes us to have to cancel planned surgeries at short notice - typically, we cancel over 1,300 operations across ULHT every year for urology-related procedures.

# Background 2

NHS
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Our proposal would be to create a separation of duty, so that our consultants would be either on-call or scheduled to perform planned surgery. They would not be required to fulfil both duties at the same time.

In order to successfully implement this rota, we need to look at the location of urology surgery provision across the county.

**Patient viewpoint**

Analysis of patient experience data from between January and November 2020 shows that over 90% of patients would recommend the service to Friends and Family.

But issues captured during Friends and Family surveys and Patient Experience feedback focusses on access to urology services, cancellations of appointments and appointment delays. The reconfiguration of the service will aim to address these concerns.

# What is being proposed

United Lincolnshire Hospitals NHS Trust

**Emergency surgery**

In the proposed model of service, if you were to have an urgent urological condition requiring admission to the  Emergency Department by ambulance, you would be taken directly to Lincoln County Hospital. Lincoln County Hospital would have the resources to be able to attend to your needs quickly with access to the on-call consultant.

This would be the case seven days a week.

If you attend the Emergency Department at Pilgrim hospital with a urology condition as a walk-in, you would be assessed as normal.  If you were then diagnosed with an urgent urinary condition, providing your condition is stable, you would be transferred to Lincoln County Hospital by ambulance for treatment and surgical intervention as required.

In this event, your treatment would not be delayed. The team at Pilgrim hospital would ensure that any immediate requirements in terms of medication and stabilisation were administered, prior to transfer to Lincoln County Hospital.

In the event your condition could not be stabilised and you were considered not medically fit for transfer, you would be admitted to Pilgrim hospital for your treatment and the on-call consultant would be required to attend to you at that location.

# What is being proposed

United Lincolnshire Hospitals NHS Trust

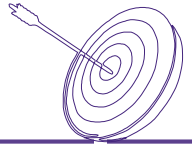
**Planned surgery**

At the moment, a choice of location is given for you to have your planned surgery. This can be at Pilgrim Hospital, Boston, Grantham and District Hospital, Lincoln County Hospital or County Hospital, Louth. You normally choose to have your surgery at the location with the shortest waiting time. This would not change. You would still have a choice as we would continue to provide planned surgery at all of our sites

**Follow-up care/outpatient appointments**

There are no changes proposed to the location of follow-up appointments, post treatment/surgery. You would still be able to attend the hospital of your choice for your follow-up appointments. There would not be any impact on you in terms of access to services and distance of travel.

# Details of the proposed changes



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| | Stays the same | Proposed change |
|---|---|---|
| Lincoln | • Elective and day case theatre lists<br>• Urology investigation suite services<br>• Outpatient services<br>• Receiving site for emergency procedures<br>• Non elective inpatients and elective inpatients | • Receiving site for Trustwide emergency procedures<br>• Urology dedicated emergency theatre list<br>• Dedicated urology assessment unit |
| Pilgrim | • Elective and day case theatre lists<br>• Urology investigation suite services<br>• Outpatient services<br>• Elective inpatients | • Dedicated urology assessment unit<br>• Non elective admissions to be admitted at Lincoln |
| Grantham | • Elective and day case theatre lists<br>• Urology investigation suite services<br>• Outpatient services<br>• Elective inpatients | • Weekday increase of elective and day case theatres<br>• Elective level 1, once appropriate infrastructure in place |
| Louth | • Day case theatre lists<br>• Urology investigation suite services<br>• Outpatient services<br>• Lithotripsy | • Nothing – all services at Louth to remain the same |

# Activity levels

United Lincolnshire Hospitals NHS Trust

The table below shows a summary of activity, comparing the current position by site with the proposed future model.

| Day case and elective demand | | | |
|---|---|---|---|
| **Location** | **Current** | **Proposed** | **Annual Change** |
| Louth | 638 | 638 | No change |
| Grantham | 216 | 916 | 700 increase |
| Lincoln | 1,534 | 710 | 824 reduction |
| Pilgrim | 988 | 1,112 | 124 increase |

| Non elective demand | | | | |
|---|---|---|---|---|
| **Location** | **Type** | **Current** | **Proposed** | **Annual Change** |
| Lincoln | Overnight | 650 | 1,034 | 384 increase |
| | Same Day | 313 | 313 | No change |
| Pilgrim | Overnight | 384 | 0 | 384 reduction |
| | Same Day | 233 | 233 | No change |

# Cancelled operations

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Average data from 2017 to 2020 inclusive showing the quantity of cancelled urology procedures, including who cancelled the procedure, what the timeline was and the headline reasons.

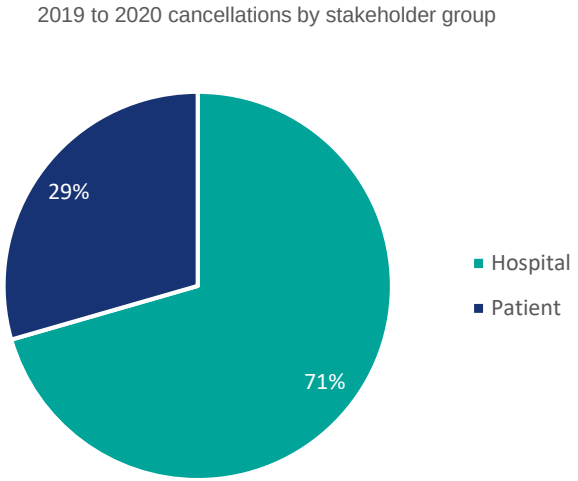
**Around 1,900 cancelled procedures annually.**

- 1,300 cancelled by the hospital
- 600 cancelled by the patient

**Around 25% of procedures are cancelled on the day of the planned procedure.**

**Around 10% of hospital cancelled procedures are due to lack of available beds**

**Around 7% of hospital cancelled procedures are due to lack of surgeon availability**



# Elective and day case hospital location data

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The data below provides an overview of where patients currently have urology procedures based on the GP practice that referred them. The data confirms that patients attend the hospital based on the shortest lead time and not necessarily the hospital closest to them. This evidence supports the hypothesis that patients are offered a choice of location for their procedure.

Lincoln

**72%**

patients with a GP postcode prefix of LN1 to LN6 had their procedure at Lincoln County

Pilgrim

**76%**

patients with a GP postcode prefix of PE had their procedure at Pilgrim

Grantham

**37%**

patients with a GP postcode prefix of NG had their procedure at Grantham

Louth

**32%**

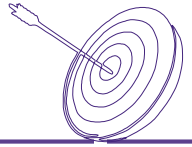
patients with a GP postcode prefix of LN11 to LN13 had their procedure at Louth

# Patient benefits at a glance

United Lincolnshire Hospitals NHS Trust

- Reduced waiting list and pathway times for cancer patients.
- Reduced patient waiting times.
- Reduction in cancelled procedures.
- Reduction in non-elective admission and overall bed usage.
- Continuity and consistency of care.
- Work with system to provide best care for Lincolnshire patients.
- Stepped-up urology assessment unit.
- Improved flow from emergency department.

# Seeking your views



United Lincolnshire Hospitals NHS Trust

To offer up your views about these proposals, and contribute to shaping our urology service:

- Fill in our ULHT Urology Survey
- Attend one of our virtual consultation meetings, using the links below:
    - Friday 21 May 2pm-3pm
    - Wednesday 9 June 6.30pm-7.30pm
    - Thursday 24 June 10am-11am
    - Tuesday 13 July 10am-11am
    - Tuesday 20 July 6.30pm-7.30pm

This consultation exercise closes on Friday 23 July 2021.

If you require an accessible version of our consultation materials, please contact communications@ulh.nhs.uk or call 01522 573986.

| | |
|---|---|
| Meeting | Trust Board |
| Date of Meeting | 6th July 2021 |
| Item Number | Item 12 |
| Integrated Performance Report for May 2021 | |
| Accountable Director | Paul Matthew, Director of Finance & Digital |
| Presented by | Paul Matthew, Director of Finance & Digital |
| Author(s) | Sharon Parker, Performance Manager |
| Report previously considered at | N/A |

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

| | |
|---|---|
| Risk Assessment | *N/A* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Limited* |

| | |
|---|---|
| Recommendations/ Decision Required | • *The Board is asked to note the current performance. The Board is asked to approve action to be taken where performance is below the expected target.* |
| | |
| | |

## Executive Summary

**Quality**

**Medication Incidents reported as causing harm**

May has seen a slight reduction in medication incidents with harm at 20.3% against a trajectory of 10.7%. The number of incidents causing some level of harm (low /moderate /severe / death) has remained consistent with the last 12 months, however is higher than the national median. All pharmacists aligned to each Divisional CBU are currently working with the wards and departments to identify issues contributing to this higher level of reporting.

**Patient Safety Alerts responded to by agreed deadline**

The following NatPSA was issued on the 13th August 2020 – Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults with a completion date of the 13th May 2021. The alert came with 4 specific actions which have only been partly completed.
Joint leads in place from Pharmacy and the Medical Directors office. NatPSA has been escalated through the appropriate sub-groups and a response will be chased in the next week.
The central Clinical Governance team are in the process of reviewing policy and procedures, including upward reporting, for all NatPSA.

**Mortality**

**HSMR**

HSMR for the rolling 12 months is showing at 117.08 for the Trust which is an increase from the previous month and is now showing in the 'High' banding. Due to the Covid-19 pandemic the rises in the HSMR were expected. COVID-19 deaths are being attributed to a diagnosis group (Viral infection), which is not included within the HSMR 56 Basket Diagnosis Groups. However, should a patient have COVID-19 included as a secondary diagnosis, these are included. Trajectory for monthly HSMR is showing a gradual decline, month-by-month as we exit wave two of the pandemic.

**SHMI**

ULHT are in Band 2 within expected limits with a score of 110.64 a minimal increase from the last reporting period. SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to December 2020.

**The Trust participates in all relevant National Clinical Audit**

The % participation National Clinical Audit rate has remained at 95% again for the month of May. Actions to recover are in place and will be monitored through the Clinical Effectiveness Group.

**eDD**

The Trust achieved 92.10% compliance with sending eDDs within 24 hours for May 2021. 96% were sent anytime during the month of May 2021. Paediatrics remain an outlier and actions in place to recover can be seen below.

**Sepsis based on April 2021 Data**

1. **Sepsis screening compliance inpatient (Adult)**

Screening compliance for adult inpatients has remained static at 86% against a trajectory of 90%. The majority of missed screens are for non- infective patients. Missed screens that were attributable to Agency nurses have increased and this is a new theme from previous months. A scoping piece of work is underway to assess the preparedness of Agency nurses prior to the commencement with the Trust.

2. **Sepsis screening compliance inpatient (Child)**

Screening compliance for child inpatients has decreased to 84% for the month of April against a trajectory of 90%. Harm reviews have been undertaken and found that no harm has been caused as a result of the compliance due to the children having alternative causes.

3. **Intravenous antibiotics within an hour (Paediatric ED)**

Compliance for Children's antibiotics within an hour in ED has increased to 50% for the month of April against a trajectory of 90%. This equates to one missed antibiotic from two cases. The main driver for this poor compliance continues to be the ongoing issue of whether this should be given in the ED or by the paediatricians on the ward. Actions to recover have been taken and can be seen below in the exception report.

**Duty of Candour – April 2021 Compliance**

The Trust achieved 79% compliance with the Duty of Candour in March 2021, for in person notification (verbal) and 52% compliance for written follow-up. This equated to 4 non-compliant verbal and 9 non-compliant written follow-ups from 19 incidents that were notifiable.

**Operational Performance**

On 5th March 2020, in response to the Covid-19 pandemic, the Trust enacted the Pandemic Flu plan and elements of the Major Incident Plan and put in place Command and Control systems. This response continued until 1st August when nationally the national Emergency Response Level was reduced to Level 3. This signified the start of the Recovery Phase of the response to Covid-19 pandemic.

Operational performance for the periods from August 2020 where data is available reflects the Recovery Phase where services are being reinstated as part of this Phase 3 Recovery programme. From August 1st this recovery commenced with ambitions to returning to pre-Covid-19 levels of waiting lists, response times and constitutional standards, in line with expectations as set out in Sir Simon Stevens' letter of 31st July 2020.

However, the Covid-19 2nd wave has impacted significantly against the Trusts plans, posing challenges across both non-elective and elective pathways, including cancer, and resulting in the intermittent pausing of the green pathways at both Lincoln and Pilgrim hospitals. The Grantham Green Site largely remained in operation.

This report covers April and May performance, and it should be noted that as the demands of Wave 2 have diminished, the Trust has now moved into a phase of restoration of services and is now guided by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT. Additionally new Emergency care standards are now being implemented, monitored and reported going forwards.

**A & E and Ambulance Performance**

Whilst the summary to below pertains to May data and performance, the Urgent Care Constitutional Standards are being reviewed and will be outlined in the Urgent Care FPEC paper. This will include recommendations in terms of amending the Urgent Care IPR dashboard.

4-hour performance for May deteriorated against April's performance of 74.23% being reported at 72.56%. This was 10.6% against the holding trajectory from March. This is the seventh time in ten months the Trust's performance has been below the agreed trajectory.

There was one 12 hr trolley wait, reported via the agreed process. This breach was considered avoidable.

Performance against the 15 min triage target demonstrated a 5.1% deterioration in May down from 91.15% in April to 86.05%. The recording of triage deteriorated marginally by 0.2% in May when compared with April's performance, the lowest performance since December.

Ambulance conveyances for May were, 4843, up 7.48% against April. There were 285 >59minute handover delays recorded in May a deterioration of 78 from April. Delays experienced at LCH are attributed to volume and conveyance pattern, however this pattern is well known and consistent and familiar to the department. All handover delays continue to be reported to the CCG by EMAS but done so in the context of the overall site position.

Work continues with the System to reduce overall ambulance conveyances to ULHT. Dedicated UEC Project Management resource has been supported by the Innovation and Integration Team, to support the UEC Trusts Teams to effect sustainable change with a particular focus on SDEC to aid improved bed flow.

Implementation of Project Salus is now complete.

**Length of Stay**

LoS for non-elective admissions improved again in May 3.97 ALOS 4.58 ALOS compared with 4.58 ALOS in April, and has now dipped below the target of 4.50

An 8 week intensive discharge support programme in place led by ECIST/NHSe/I has now concluded.

Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase in discharge of medically optimised patients across the entire week (7days).

**Referral to Treatment**

It is important to view and read this in the context of the current National Covid Restore Agenda, and the move away from a focus on constitutional standards to the expectation of focus upon cancer and clinical urgency; a clinical risk based patient selection process as opposed to selection based upon the longest waits being the current restore national priority. Within this context it is unlikely that there will be significant improvement to statutory RTT performance for some time.

April demonstrated another small improvement in performance increased performance by 1.89% to 55.82%. The Trust reported 1349 incomplete 52 week breaches for April end of month, (an improvement of 528) and down from 1877 in March. The Trust remains in a relatively strong position when compared to other regional providers.

The Cancer/Elective Cell continued to meet three times weekly throughout April with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18 week RTT PTL.

The Trust continues to develop its processes for Clinical Harm reviews including over 52 week waits with a specific group established, led by the chief Operating Officer and Medical Director to review refine and develop robust governance processes and assurance.

**Waiting Lists**

Overall waiting list size has increased in April by 2,459, to 43,119. The number of incomplete pathways is now approx. 14,087 more than in March 2018, however there remains a large cohort of patients remaining on the Trust's ASI list that are not accounted for in this figure. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our post wave 2 restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. As of week commencing 14th June ASI numbers had reduced from circa 10,300 to 4,784 and remains marginally ahead of trajectory.

The Trust reported 3,178 over 40week waits a reduction of 132 from March, although the numbers of patients waiting over 26 weeks increased by 1030 from March. The

longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

**Diagnostics**

Diagnostics access performance continues to gradually improve with April's performance reported at 71.00%69.91% against March's performance of 69.91%.

Endoscopy, continues to book cancer patients within 7-10 days and is now also booking routines, with improvements in Gastroscopy reporting only 3 breaches in April compared to 18 breaches in March; 85 in February and 298 in January; Cystoscopy also improved, from 194 in January; 114 in February; 74 in March and 65 in April.

CT experienced a slight increase in breaches in April at 153 (following increased demand in April) compared with 118 breaches in March compared with 146 in February and 306 in January.

Neurophysiology LCH reported 19 breaches in April compared with 74 breaches in March; 96 in February and 456 for January , and Pilgrim reporting 13 breaches in April compared with 121 in March and 177 in February.

Audiology - Audiology Assessments had 19 breaches for April following a significant increase in ENT referrals.

Cardiology continues to be challenged with echocardiography having 2804 breaches IN April compared with 2641 breaches in March; 2051 in February. Echocardiography Stress /TOES improved again with 39 breaches in April against, 55 in March; 58 breaches in February and 105 in January.

Cardiology remians the main concern for the DM01 standing at 27.5% and is adversely affecting the overall position. (DM01 Performance with cardiac excluded is 90.8%)

**Cancer**

The Cancer Data and Summary within this paper reflect the data and time period of the Cancer Standards Performance – Monthly Update Paper and therefore should note the content and context will be the same.

Patients waiting more than 62 and 104 days remains an absolute priority. Performance for April decreased by 6.4% compared with March for the 62 Day Classic Cancer Target achieving 60.8% below the national average (75.4%) and was in line with the forecast of circa 60% made in April. Early indications are that May performance will further deteriorate to circa 55%.

As of the 10th June there were 188 patients in the 62 day backlog (down from 216 and a peak of 441); 42 patients over 104 days (down from 47 and from 163 in mid-July). Approximately 24% of these patients require support from the Pre Diagnosis CNS (down from 34%). Colorectal, Head and Neck, and Urology remain the most challenged specialties. It should be noted as part of restoration increasing access to theatre lists along with a more assured availability of Level 2 post-operative HDU beds will support driving this back log down. In addition the Trust has been successful in appointing two Head and Neck consultants with one commencing in post in April 21 and the other in

July 21, as well as the successful appointment of two Medical Oncologists, commencing in post in July and October 21 respectively. In the meantime an agency medical oncologist will be in post from May.

There are increasing numbers of inappropriate referrals owing to GPs utilising the 2ww pathway without having had a face to face consultation with patients. This has been raised with the CCG via the Planned Care Board. Patient compliance remains a challenge in a number of areas.

The Trust did not achieve the 31 day treatment performance which deteriorated slightly and continued to be affected by Covid-19 and reductions in theatre and ITU capacity combined with an ongoing reluctance of a high number of patients who were unfit or unwilling to engage with the NHS.

In addition to the speciality clinical capacity post Covid, challenges include an ongoing resistance to travel; available capacity across the ULHT sites; patient engagement and compliance with swabbing and isolation guidance; and limited OPD capacity owing to social distancing and cleaning guidance.

**Workforce**

Mandatory Training - The trend for completion of mandatory training is upwards, following a significant dip during COVID. There is both a focus on achieving specific targets for completion (95% for IG training for example) and generally through management teams. A review of core learning is underway to ensure staff profiles are correct.

Sickness Absence - The 12 month rolling absence figure is being impacted by COVID. The trend is now downwards, but may be affected again by a Wave 3. We continue to embed the new AMS system which underpins good practice in sickness management, as well as focusing specifically on absence due to stress to reduce further absence levels.

Staff Appraisals - The medical appraisal rate is 98%. The AfC rate is extremely disappointing. We are using the launch of the new WorkPal system as a means to address the inhibitors to delivering to target. There is a Divisional focus too on ensuring appraisal completion. Pay progression should not be allowed unless appraisals and training are up-to-date. These factors should ensure higher completion rates in the future.

Agency Spend - Whilst there was a reduction in agency spend in May and levels of spend are lower than in 20/21, the target of a 25% reduction will not be achieved unless there is a step change in spend levels. This is the focus of groups established for nursing and medical spend and there is also a line by line review of other agency spend

## Finance

The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract.

The Lincolnshire system submitted a breakeven financial plan for H1 of 2021/22; the system submission is inclusive of a breakeven position for the Trust and a requirement for the Trust to deliver efficiency savings of £6.2m in H1.

The Trust submitted its financial plan for H1 2021/22 on 24th May, this aligns to and supports the Lincolnshire system financial plan.

The Trust has delivered a £0.9m deficit for the month of May (in line with plan) and a £1.8m deficit year to date (in line with plan).

Capital expenditure as at M2 of the financial year equated to c£1m against a submitted plan of c£3.2m.

The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May and subsequently the remaining c£10m agreed at FPEC (May meeting) thereby completing the agreed capital programme that has been shared with all key stakeholders.

The month end cash balance is £53.1m which is a decrease of £0.9m against cash at 31 March 2021.

**Paul Matthew**
**Director of Finance & Digital**
**June 2021**

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NHS United Lincolnshire Hospitals NHS Trust

# EXECUTIVE SCORECARD

## EXECUTIVE SCORECARD

| | | | | | | | 2020/2021 | | 2021/2022 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Goal | Domain | Measure ID | Measure | Measure Definition | Baseline | 21/22 Ambition | Mar | Apr | May | Latest month pass/fail to ambition | Trend variation |
| Strategic Metrics | Patients | 1 | Top 25% for acute Trusts for 'Overall' Inpatient experience | Results in recommending our services to friends and family | 4th quartile | 3rd quartile | 91.16% | 89.95% | 91.17% | | |
| | Patients | 2 | Achieve zero avoidable harm | Serious incidents (including Never Events) of harm - Moderate, severe and death. | 15 | 9 | 13 | 8 | 6 | P | |
| | Patients | 3 | Top 25% for SHMI | Summary Hospital-level Mortality Indicator | 4th quartile | 4th quartile | Q4 (109.90) | Q4 (110.57) | Q4 (110.64) | P | |
| | People | 4 | Top 25% for acute Trusts across all 10 themes in the staff survey | In year monitoring via staff survey on staff morale and leadership. | | +10% improvement | | | | | |
| | Partners | 26 | Deliver 62 day combined cancer standard (77%) | Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services. | 69.20% | 77% | 67.20% | 61.60% | | F | |
| | Partners | 27 | Total wait in Emergency Department over 12 hours (<1% of patients) | Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances. | 3.60% | <1% | 6.15% | 4.55% | 4.71% | F | A |
| | Partners | 28 | Urgent Treatment (P2) treatment turnaround time is less than 4 weeks | Waiting time from receiving patient referral until treatment is given. | 6.7 | <4 weeks | | | | | |
| | Partners | 29 | Deliver Outpatient activity through non-face to face | Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient | | 25% | 39.11% | 37.41% | 35.39% | P | B |
| | Services | 9 | Deliver a breakeven revenue position | Financial status | | Breakeven | | | | | |
| | Services | 10 | Deliver £200m capital plan | Financial status | £15m | £39m | | | | | |
| Priority Objectives | Patients | 11 | No. of medication errors causing harm is <10% | Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents. | 20% | 13% | 15.54% | 24.64% | 20.30% | F | |
| | Patients | 12 | Reduce no. of patient fall incidents | Number of Falls reported (including harm). | 200 | 159 (-20.5%) | 135 | 138 | 141 | P | |
| | People | 13 | % of staff saying proud to work for ULHT | Staff survey on morale and leadership | | +10% improvement | | | | | |
| | Partners | 14 | First non elective admission by 10am | Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards. | 48% | 60% | 58.96% | 59.76% | 60.23% | P | |
| | Services | 15 | Reduce agency spend by 25% | Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). | £44m | £33m (-25%) | | | | | |
| Watch Metrics | Patients | 16 | Reduce complaints around discharge by 50% | Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled | n/a | | | | | | |
| | Patients | 17 | Reduce complaints about the experience in A&E by 50% | Patient experience complaints about treatment of A&E | n/a | | | | | | |
| | Patients | 18 | Time to screening and treatment for sepsis (1 hour) | Number of sepsis incidents reported | 37.5% (3/8) | 62.5% (5/8) | 62.50% | 62.50% | | P | B |
| | Patients | 19 | Reduce incidence of pressure ulcers | Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable | 58 | 45 | 42 | 33 | 40 | P | |
| | People | 20 | % of staff that feel trusted and valued | Staff survey on morale and leadership | | | | | | | |
| | People | 21 | No. of managers trained in coaching skills | Staff survey on morale and leadership | | | | | | | |
| | Partners | 22 | Increase the proportion of patients seen by a decision maker within one hour | Patient arrival to the time seeing a A&E doctor, within 1 hour. | 50% | | 55.47% | 57.32% | 56.48% | | |
| | Partners | 23 | Reduction in the new to follow up ratio | Reduction in the number of follow up outpatient activities undertaken. | 1:2.28 | | 1:1.53 | 1:1.48 | 1:1.42 | | |
| | Partners | 24 | First OPA within 4 weeks | Number of outpatients seen within 4 weeks of their referral to hospital. Includes all types of referrals (2WW, Urgent, Routine), nurse led or consultant led services. | 51% | | 44.31% | 37.70% | 52.01% | | B |
| | Services | 25 | Improve CIP performance to a minimum of 4% by 2021/22 | Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) | 1.7% | | | | | | |

This executive scorecard will eventually complement the introduction of a new performance routines process, which is currently under development with Divisional executives, alongside the review and development of the IPR report. The new performance routines introduced are deploying new divisional performance scorecards, which eventually will be underpinned by business unit scorecards. All of these scorecards will complement this executive scorecard. Eventually all the reporting performance processes will be realigned to enable consistency of approach on the internal reporting Trust wide.

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# PERFORMANCE OVERVIEW

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | Target per month | Mar-21 | Apr-21 | May-21 | YTD | Pass/Fail | Trend Variation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Deliver Harm Free Care | Clostridioides difficile position | Safe | Patients | Director of Nursing | 9 | 3 | 4 | 2 | 6 | P | |
| | MRSA bacteraemia | Safe | Patients | Director of Nursing | 0 | 0 | 0 | 0 | 0 | P | |
| | MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula | Safe | Patients | Director of Nursing | TBC | 0.08 | 0.11 | 0.07 | 0.09 | | |
| | E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula | Safe | Patients | Director of Nursing | TBC | 0.08 | 0.08 | 0.14 | 0.11 | | |
| | Catheter Associated Urinary Tract Infection | Safe | Patients | Director of Nursing | 1 | N/A | 0 | 0 | 0 | | |
| | Falls per 1000 bed days resulting in moderate, severe harm & death | Safe | Patients | Director of Nursing | 0.19 | 0.11 | 0.02 | 0.00 | 0.01 | P | |
| | Pressure Ulcers category 3 | Safe | Patients | Director of Nursing | 4.3 | 1 | 1 | 1 | 2 | P | B |
| | Pressure Ulcers category 4 | Safe | Patients | Director of Nursing | 1.3 | 0 | 1 | 0 | 1 | P | |
| | Pressure Ulcers - unstageable | Safe | Patients | Director of Nursing | 4.4 | 8 | 5 | 3 | 8 | P | |
| | Venous Thromboembolism (VTE) Risk Assessment | Safe | Patients | Medical Director | 95% | 97.53% | 97.57% | 97.80% | 97.69% | P | |
| | Never Events | Safe | Patients | Director of Nursing | 0 | 0 | 0 | 0 | 0 | P | |
| | Reported medication incidents per 1000 occupied bed days | Safe | Patients | Medical Director | 4.3 | 5.56 | 5.25 | 4.8 | 5.03 | P | |
| | Medication incidents reported as causing harm (low /moderate /severe / death) | Safe | Patients | Medical Director | 10.7% | 15.5% | 24.6% | 20.3% | 22.45% | F | |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | Target | Mar-21 | Apr-21 | May-21 | YTD | Pass/Fail | Trend Variation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Deliver Harm Free Care | Patient Safety Alerts responded to by agreed deadline | Safe | Patients | Medical Director | 100% | none due | none due | 0% | 0.00% | F | |
| | Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag) | Effective | Patients | Medical Director | 100 | 109.11 | 115.45 | 117.08 | 116.27 | F | H |
| | Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag) | Effective | Patients | Medical Director | 100 | 109.90 | 110.57 | 110.64 | 110.61 | F | |
| | The Trust participates in all relevant National clinical audits | Effective | Patients | Medical Director | 100% | 95.00% | 95.00% | 95.00% | 95.00% | F | A |
| | eDD issued within 24 hours | Effective | Patients | Medical Director | 95% | 92.30% | 93.40% | 92.10% | 92.75% | F | |
| | Sepsis screening (bundle) compliance for inpatients (adult) | Safe | Patients | Director of Nursing | 90% | 86.4% | 86.0% | Data not available yet | 86.00% | F | |
| | Sepsis screening (bundle) compliance for inpatients (child) | Safe | Patients | Director of Nursing | 90% | 100.0% | 84.0% | Data not available yet | 84.00% | F | |
| | IVAB within 1 hour for sepsis for inpatients (adult) | Safe | Patients | Director of Nursing | 90% | 92.0% | 93.0% | Data not available yet | 93.00% | P | |
| | IVAB within 1 hour for sepsis for inpatients (child) | Safe | Patients | Director of Nursing | 90% | 90.0% | 100.0% | Data not available yet | 100.00% | P | |
| | Sepsis screening (bundle) compliance in A&E (adult) | Safe | Patients | Director of Nursing | 90% | 91.9% | 94.0% | Data not available yet | 94.00% | P | A |
| | Sepsis screening (bundle) compliance in A&E (child) | Safe | Patients | Director of Nursing | 90% | 86.5% | 90.0% | Data not available yet | 90.00% | P | |
| | IVAB within 1 hour for sepsis in A&E (adult) | Safe | Patients | Director of Nursing | 90% | 92.0% | 95.0% | Data not available yet | 95.00% | P | |
| | IVAB within 1 hour for sepsis in A&E (child) | Safe | Patients | Director of Nursing | 90% | 33.3% | 50.0% | Data not available yet | 50.00% | F | |
| | Rate of stillbirth per 1000 births | Safe | Patients | Director of Nursing | 4.20 | 2.86 | 2.89 | 3.12 | 3.01 | P | B |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Mar-21 | Apr-21 | May-21 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A Modern and Progressive Workforce | Overall percentage of completed mandatory training | Safe | People | Director of HR & OD | 95% | 86.49% | 87.90% | 89.64% | 88.77% | | F | | |
| | Number of Vacancies | Well-Led | People | Director of HR & OD | 12% | 9.88% | 9.60% | 8.50% | 9.05% | | P | | |
| | Sickness Absence | Well-Led | People | Director of HR & OD | 4.5% | 5.13% | 5.01% | 4.96% | 4.98% | | F | | |
| | Staff Turnover | Well-Led | People | Director of HR & OD | 12% | 12.07% | 10.78% | 11.31% | 11.05% | | P | | |
| | Staff Appraisals | Well-Led | People | Director of HR & OD | 90% | 76.43% | 76.42% | 74.92% | 75.67% | | F | A | |
| | | | | | £'000 | £'000 | £'000 | £'000 | £'000 | | | | |
| | Agency Spend | Well-Led | People | Director of HR & OD | TBC | -£4,546 | -£3,848 | -£3,718 | -£7,566 | | | H | |

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Mar-21 | Apr-21 | May-21 | YTD | | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improve Patient Experience | Mixed Sex Accommodation breaches | Caring | Patients | Director of Nursing | 0 | 0 | 1 | 0 | 1 | | P | | Timeliness, Completeness, Validation, Process |
| | % Triage Data Not Recorded | Effective | Patients | Chief Operating Officer | 0% | 0.30% | 0.28% | 0.48% | 0.38% | | F | | |
| | Duty of Candour compliance - Verbal | Safe | Patients | Medical Director | 100% | 50.00% | 79.00% | | 79.00% | | F | | |
| | Duty of Candour compliance - Written | Responsive | Patients | Medical Director | 100% | 33.00% | 53.00% | | 53.00% | | F | | |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

## PERFORMANCE OVERVIEW

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Mar-21 | Apr-21 | May-21 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improve Clinical Outcomes | 4hrs or less in A&E Dept | Responsive | Services | Chief Operating Officer | 83.12% | 71.98% | 74.23% | 72.56% | 73.39% | 83.12% | F | B | |
| | 12+ Trolley waits | Responsive | Services | Chief Operating Officer | 0 | 0 | 2 | 1 | 3 | 0 | F | | |
| | %Triage Achieved under 15 mins | Responsive | Services | Chief Operating Officer | 88.5% | 85.96% | 91.15% | 86.05% | 88.60% | 88.50% | F | | |
| | 52 Week Waiters | Responsive | Services | Chief Operating Officer | 0 | 1877 | 1349 | | 8369 | 0 | F | H | |
| | 18 week incompletes | Responsive | Services | Chief Operating Officer | 84.1% | 53.94% | 55.82% | | 56.59% | 84.10% | F | B | |
| | Waiting List Size | Responsive | Services | Chief Operating Officer | 37,762 | 40,660 | 43,119 | | n/a | n/a | F | | |
| | 62 day classic | Responsive | Services | Chief Operating Officer | 85.4% | 67.23% | 60.76% | | 64.95% | 85.39% | F | | |
| | 2 week wait suspect | Responsive | Services | Chief Operating Officer | 93.0% | 84.51% | 76.09% | | 84.39% | 93.00% | F | | |
| | 2 week wait breast symptomatic | Responsive | Services | Chief Operating Officer | 93.0% | 4.07% | 2.30% | | 33.11% | 93.00% | F | B | |
| | 31 day first treatment | Responsive | Services | Chief Operating Officer | 96.0% | 91.62% | 92.98% | | 93.95% | 96.00% | F | | |
| | 31 day subsequent drug treatments | Responsive | Services | Chief Operating Officer | 98.0% | 99.24% | 99.13% | | 98.67% | 98.00% | P | | |
| | 31 day subsequent surgery treatments | Responsive | Services | Chief Operating Officer | 94.0% | 86.67% | 85.42% | | 88.25% | 94.00% | F | | |
| | 31 day subsequent radiotherapy treatments | Responsive | Services | Chief Operating Officer | 94.0% | 95.00% | 98.95% | | 93.21% | 94.00% | P | | |
| | 62 day screening | Responsive | Services | Chief Operating Officer | 90.0% | 69.57% | 80.00% | | 49.91% | 90.00% | F | A | |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

# PERFORMANCE OVERVIEW

| 5 Year Priority | KPI | CQC Domain | Strategic Objective | Responsible Director | In month Target | Mar-21 | Apr-21 | May-21 | YTD | YTD Trajectory | Latest Month Pass/Fail | Trend Variation | Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Improve Clinical Outcomes | 62 day consultant upgrade | Responsive | Services | Chief Operating Officer | 85.0% | 73.96% | 81.21% | | 79.60% | 85.00% | F | | |
| | Diagnostics achieved | Responsive | Services | Chief Operating Officer | 99.0% | 69.91% | 71.00% | | 58.09% | 99.00% | F | | |
| | Cancelled Operations on the day (non clinical) | Responsive | Services | Chief Operating Officer | 0.8% | 0.76% | | | 1.44% | 0.80% | P | | |
| | Not treated within 28 days. (Breach) | Responsive | Services | Chief Operating Officer | 0 | 3 | | | 121 | 0 | F | | |
| | #NOF 48 hrs | Responsive | Services | Chief Operating Officer | 90% | 100.00% | 90.14% | 92.42% | 91.28% | 90% | P | | |
| | #NOF 36 hrs | Responsive | Services | Chief Operating Officer | TBC | 100.00% | 78.87% | 81.82% | 80.35% | | | | |
| | EMAS Conveyances to ULHT | Responsive | Services | Chief Operating Officer | 4,657 | 4,588 | 4,481 | 4,843 | 4,662 | 4,657 | F | | |
| | EMAS Conveyances Delayed >59 mins | Responsive | Services | Chief Operating Officer | 0 | 328 | 207 | 285 | 246 | 0 | F | A | |
| | 104+ Day Waiters | Responsive | Services | Chief Operating Officer | 5 | 61 | 47 | 42 | 45 | 10 | F | | |
| | Average LoS - Elective (not including Daycase) | Effective | Services | Chief Operating Officer | 2.80 | 2.57 | 2.55 | 3.21 | 2.88 | 2.80 | F | | |
| | Average LoS - Non Elective | Effective | Services | Chief Operating Officer | 4.50 | 4.61 | 4.58 | 3.97 | 4.28 | 4.5 | P | | |
| | Delayed Transfers of Care | Effective | Services | Chief Operating Officer | 3.5% | Submission suspended | | | | 3.5% | | | |
| | Partial Booking Waiting List | Effective | Services | Chief Operating Officer | 4,524 | 18,220 | 16,046 | 14,830 | 15,438 | 4,524 | F | L | |
| | Outpatients seen within 15 minutes of appointment | Effective | Services | Chief Operating Officer | 70.0% | 48.8% | 44.4% | 41.7% | 43.20% | 70.00% | F | | |
| | % discharged within 24hrs of PDD | Effective | Services | Chief Operating Officer | 45.0% | 42.3% | 42.8% | 44.8% | 43.80% | 45.00% | F | | |

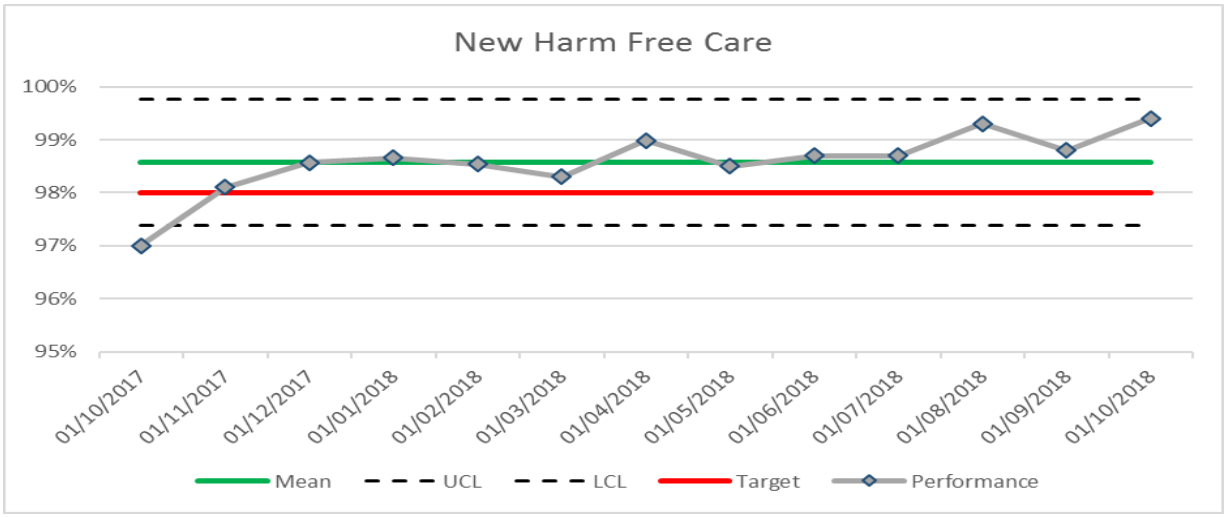
# STATISTICAL PROCESS CONTROL CHARTS

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:



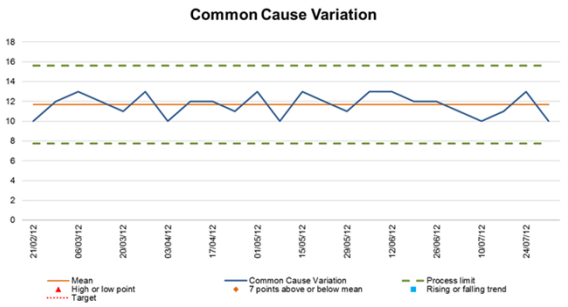

Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

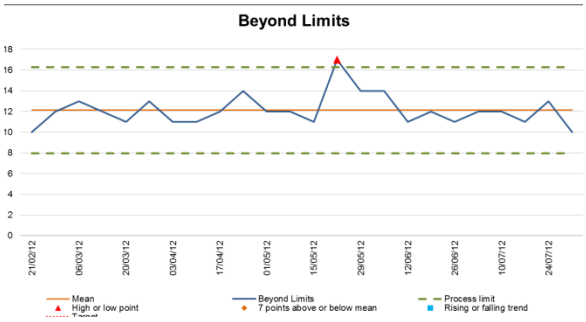
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

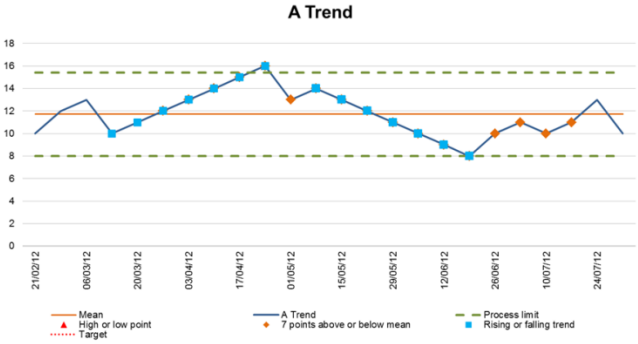


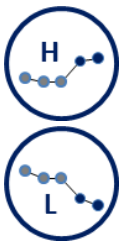

**Extreme Values**



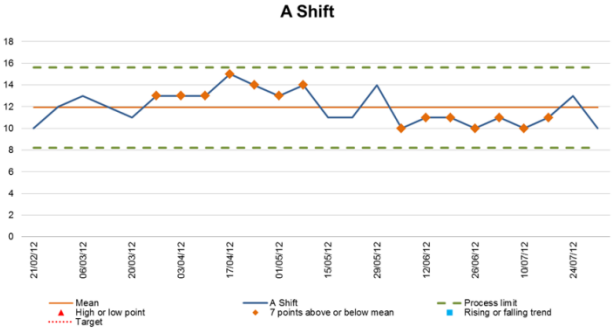

*There is no Icon for this scenario.*

**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 consistentl**

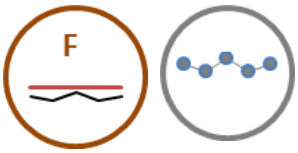
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

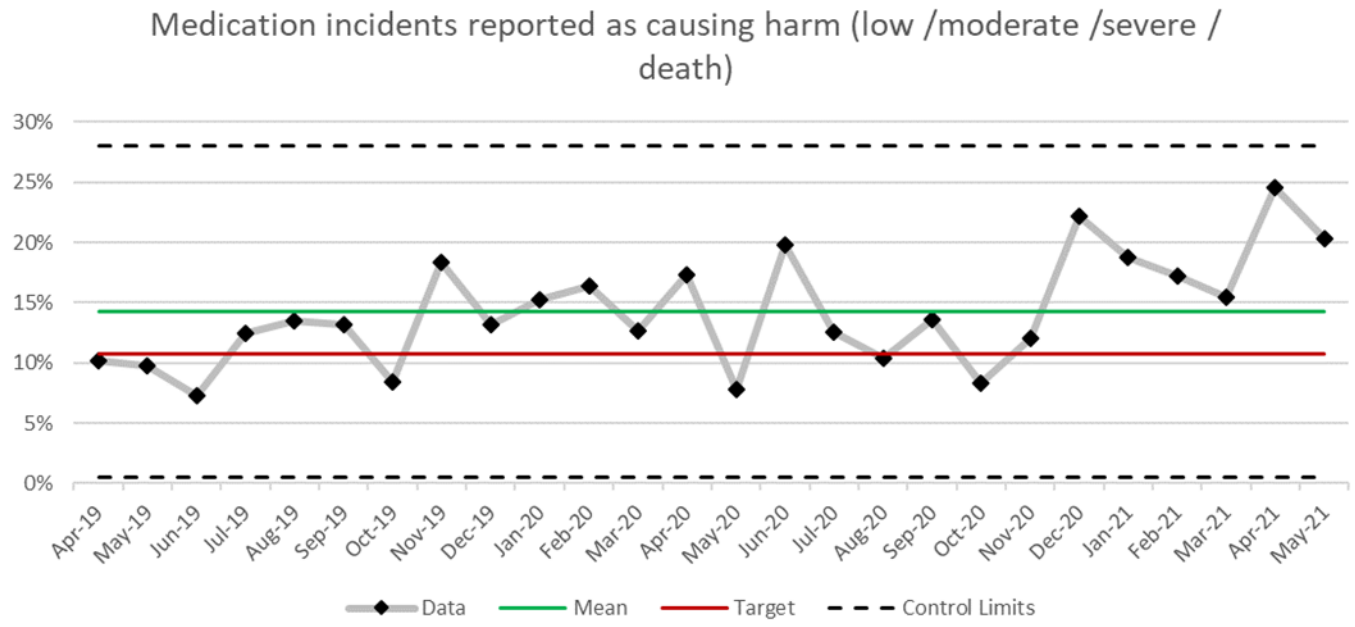
# DELIVER HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

**Executive Lead:** Medical Director

**CQC Domain:** Safe

**Strategic Objective:** Patients




## Challenges/ Successes

In the month of May the number of incidents reported was 133. The number of incidents causing some level of harm (low /moderate /severe / death) has remained consistent with the last 12 months, however is higher than the national median.
We know that staffing has been a significant issue with staff being redeployed.

## Actions to Recover

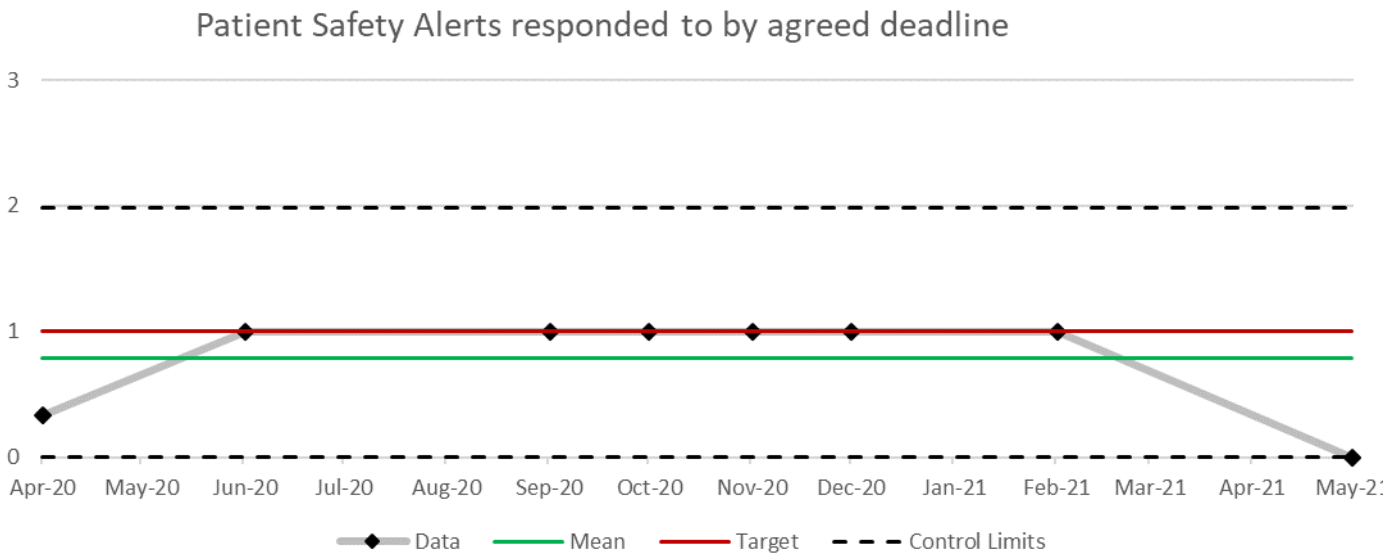
Each CBU pharmacist has been sent the medication incident reports and will work with wards to make improvements.

# DELIVER HARM FREE CARE – PATIENT SAFETY ALERTS

**Executive Lead:** Director of Nursing

**CQC Domain:** Safe

**Strategic Objective:** Patients




Challenges/Successes

The following NatPSA was issued on the 13th August 2020 – Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults with a completion date of the 13th May 2021. The alert came with 4 specific actions which have only been partly completed.

Actions in place to recover:

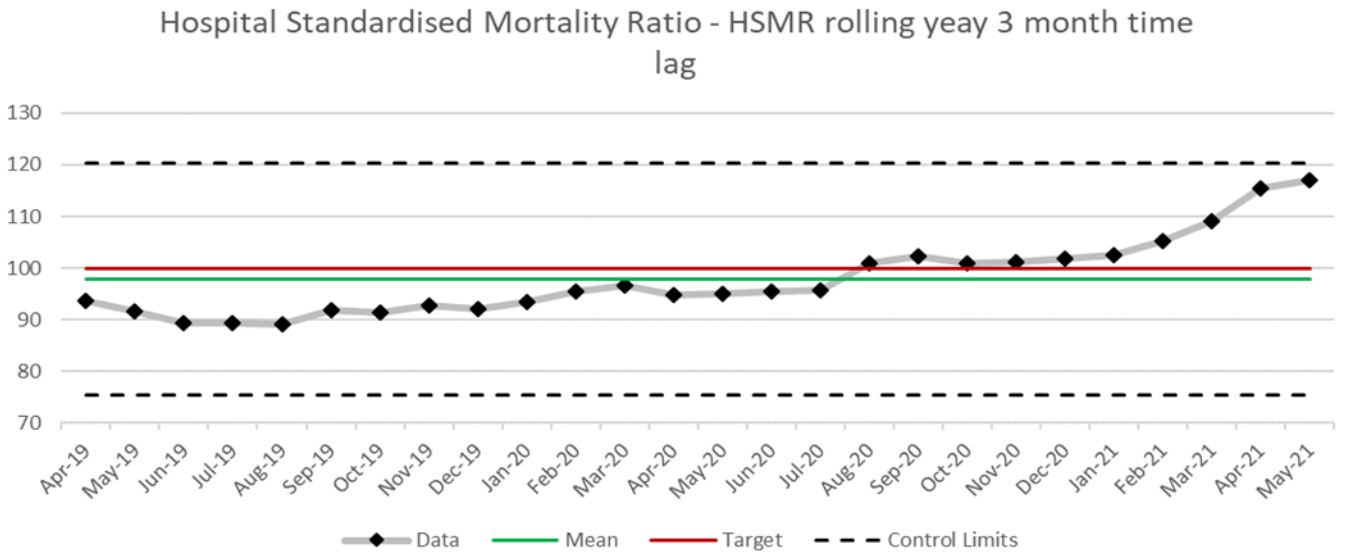
Joint leads in place from Pharmacy and the Medical Directors office. NatPSA has been escalated through the appropriate sub-groups and a response will be chased in the next week.
The central Clinical Governance team are in the process of reviewing policy and procedures, including upward reporting, for all NatPSA.

# DELIVER HARM FREE CARE – MORTALITY HSMR

**Executive Lead:** Medical Director

**CQC Domain:** Effective

**Strategic Objective:** Patients




## Challenges/Successes

ULHT's HSMR for the rolling 12-months is at 117.08 which is within the 'High' banding.
COVID-19 deaths are being attributed to a diagnosis group (Viral infection), which is not included within the HSMR 56 Basket Diagnosis Groups. However, should a patient have COVID-19 included as a secondary diagnosis, these will be included within the HSMR.
Trajectory for monthly HSMR is showing a gradual decline, month-by-month as we exit wave two of the pandemic.

Alerts:

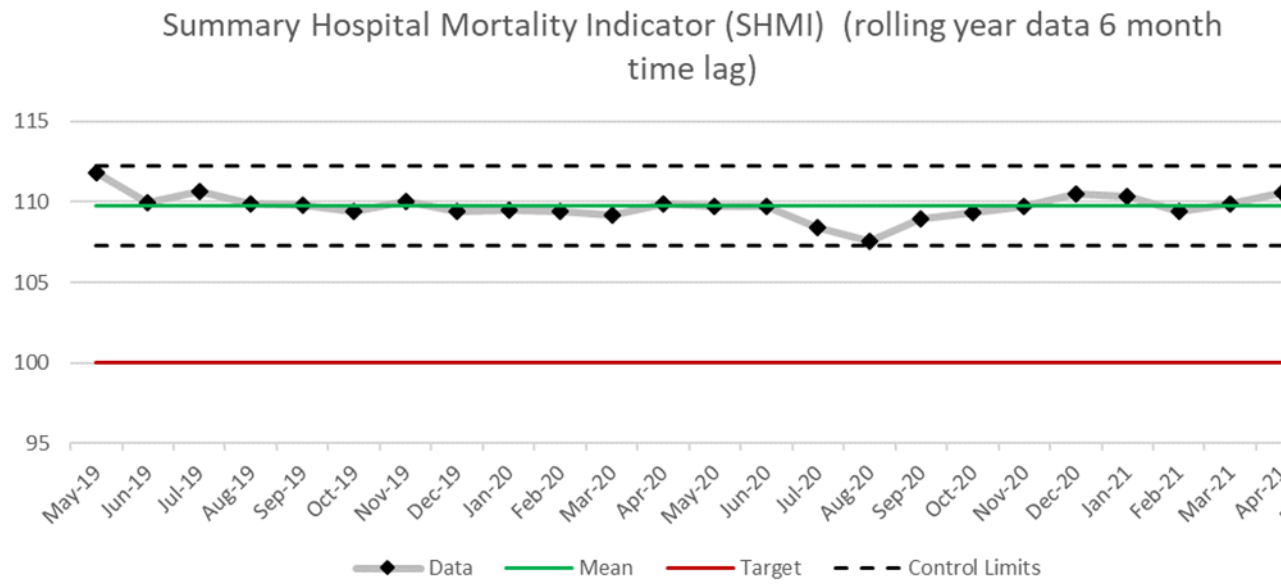
| Primary Diagnosis Group | Trust/Site | Spells | HSMR | Months Alerting | Comments |
|---|---|---|---|---|---|
| Acute and unspecified renal failure | TRUST | 782 | 131.36 | 2 | Second month alert at Trust and Lincoln, Diagnostic review of Dr Foster data and case note reviews being presented at MorALS in June 2021 |
| Acute bronchitis | TRUST | 755 | 159.00 | 2 | Second month alert at Trust<br>Third month alert at Lincoln<br>Clinical Governance reviewing cases and findings being presented at MorALS in June 2021 |
| Biliary tract disease | TRUST | 1457 | 159.59 | 1 | First month alert at Trust and Lincoln. |
| Cardiac dysrhythmias | TRUST | 1268 | 170.13 | 2 | Second month alert at Trust<br>Third month alert at Lincoln |
| Chronic obstructive pulmonary disease and bronchiectasis | TRUST | 878 | 140.80 | 2 | Second month alerting at both Trust and Lincoln. |
| Coronary atherosclerosis and other heart disease | TRUST | 680 | 251.21 | 4 | Fourth month alert at Trust, second month alert at Lincoln.<br>Division of Medicine has been requested to provide assurances at the next MorALS meeting. |
| Fluid and electrolyte disorders | TRUST | 496 | 148.94 | 1 | First month alert at Trust and Pilgrim. |
| Other liver diseases | TRUST | 329 | 211.35 | 8 | A casenote review has been completed by Dr Tony Norman, with a paper presented at MorALS.<br>Actions/Recommendations from the paper will be reviewed at a later MorALS. |
| Pleurisy pneumothorax pulmonary collapse | TRUST | 297 | 191.93 | 4 | Diagnostic review has been completed which identified failings in documentation and coding, potentially increasing HSMR. |
| Septicemia (except in labour) | TRUST | 1509 | 123.74 | 7 | Clinical Governance has held meetings with the Sepsis Practitioners to discuss this issue and a casenote review has been completed, with a paper presented at MorALS. |

# DELIVER HARM FREE CARE – MORTALITY SHMI

**Executive Lead:** Medical Director

**CQC Domain:** Effective

**Strategic Objective:** Patients




Challenges / Successes:

ULHT SHMI is in Band 2 within expected limits with a score of 110.64 (SHMI includes both deaths in-hospital and within 30 days of discharge).
The data is reflective up to December 2020.

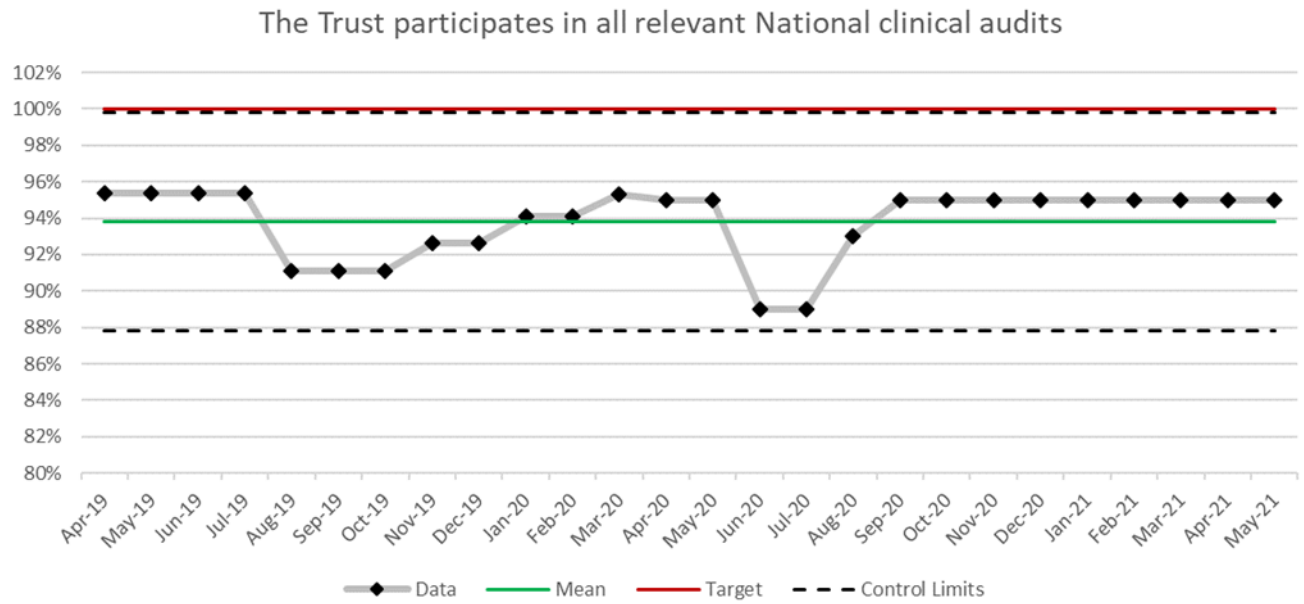
- Current in-hospital SHMI is 102.64.
- NHS Digital are excluding all data in regard to COVID-19.
- An extract from NHS Digital shows that 3.0% of spells (2065 spells), have been excluded due COVID-19 coding. The national average is 3.1%.

# DELIVER HARM FREE CARE – THE TRUST PARTICIPATES IN ALL RELEVANT NATIONAL CLINICAL AUDITS

**Executive Lead:** Medical Director

**CQC Domain:** Effective

**Strategic Objective:** Patients


The % participation National Clinical Audit rate has remained at 95% for the month of May 2021 compared to a target of >98% the following is not compliant with data submissions;

- None Participation in the National IBD audit has been clarified with the Clinical Director for Medicine the Trust is in the process of registering to participate in this audit.
    - The IBD specialist nurses will be collecting the biologics data – NHS digital access to submit data underway

Elective procedures cancelled in line with NHS England Guidance

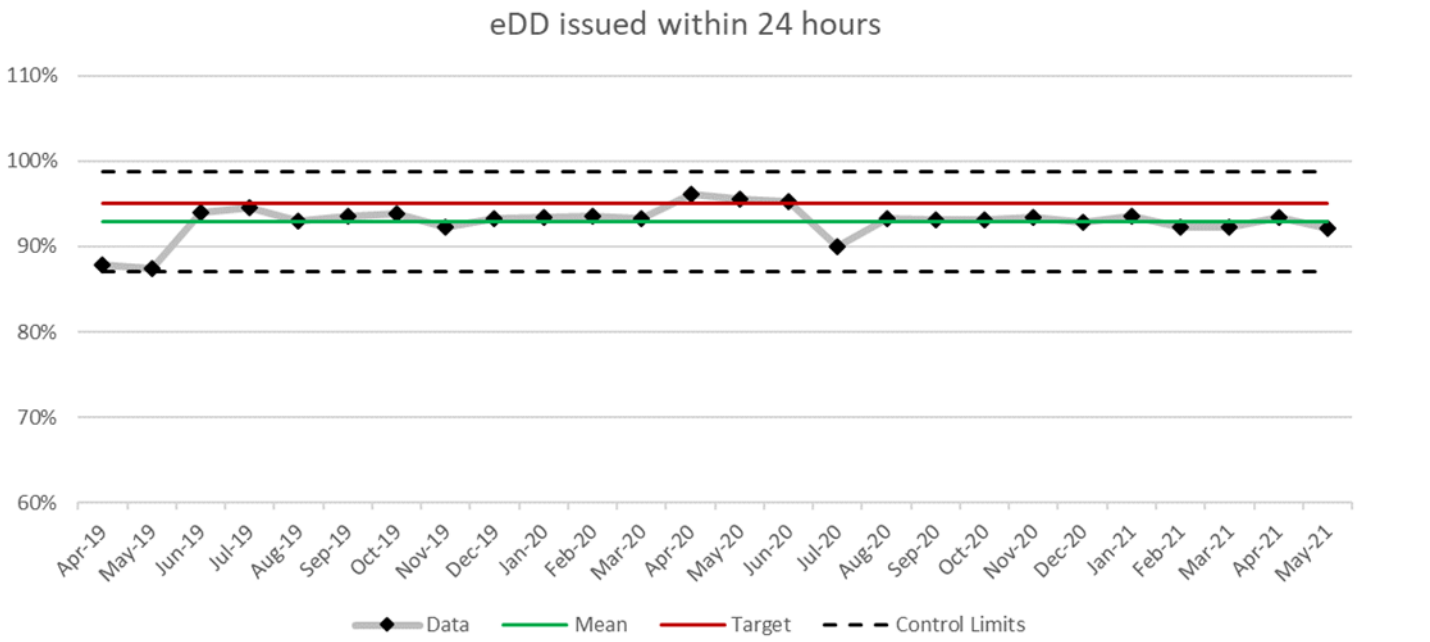
- Procedures that are now taking place this should improve participation as the Trust returns to normal working.

# DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

**Executive Lead:** Medical Director

**CQC Domain:** Effective

**Strategic Objective:** Patients




Challenges/Successes

The Trust achieved 92.1% compliance with sending eDDs within 24 hours for May 2021. 96% were sent anytime during the month of May 2021.

Actions in place to recover:

Paediatric eDD template is being streamlined.

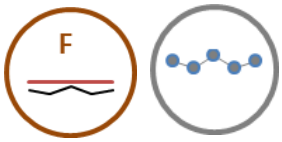
Actions implemented within paediatrics to help improve compliance.

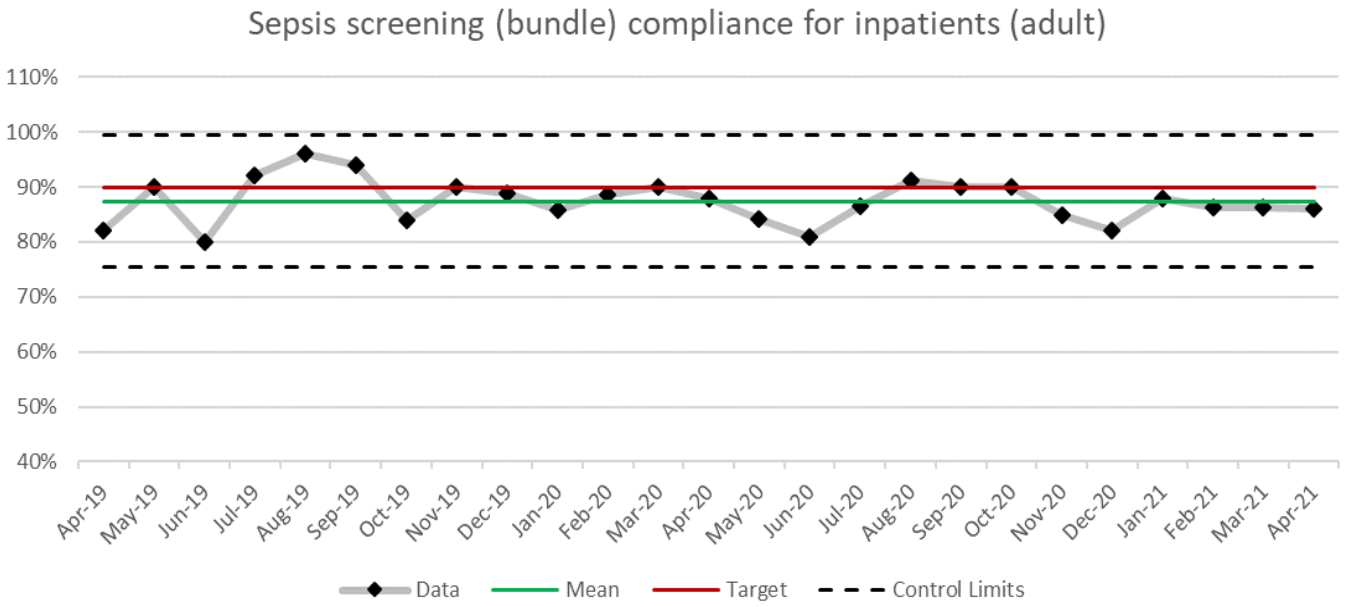
# DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

**Executive Lead:** Director of Nursing

**CQC Domain:** Safe

**Strategic Objective:** Patients




Challenges/Successes

The compliance for April has remained static with 86%. The medical wards still face considerable challenges as services are restored and this is reflected in a slight dip in compliance. The majority of missed screens are for non- infective patients. Missed screens that were attributable to Agency nurses have increased and this is a new theme from previous months

Actions in place to recover

The relaxation of ward restrictions has allowed for the sepsis practitioners to re-commence teaching in the clinical area and this should improve engagement and provide targeted support. The roll out of the Train the Trainer programme has been on hold for the last year however the sepsis practitioners presented to the panel in May and the additional face to face sepsis module has been approved. The principle of ward/department Trainers is expected to boost engagement and provide local support for areas.

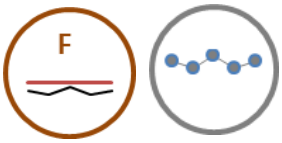
A survey that will gauge the preparedness of Agency nurses prior to commencement with the Trust has been devised and sent out to all agency staff this will assist in ensuring they receive the support that they require. No results have been received from this at present.

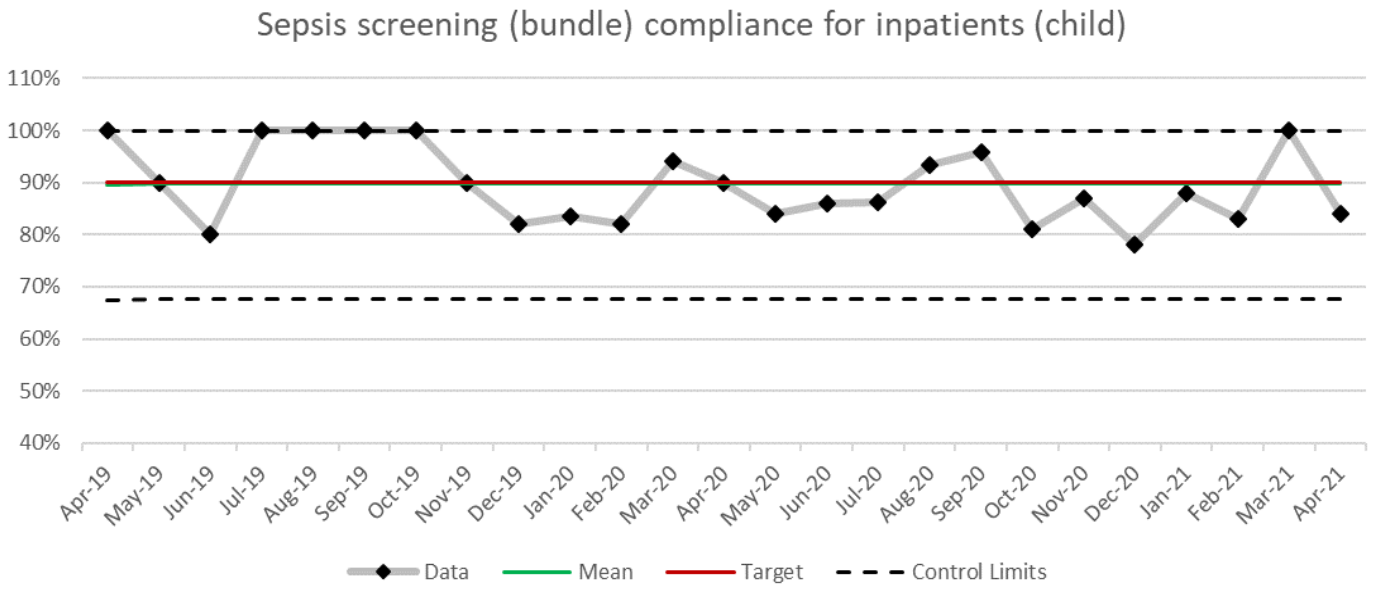
# DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

**Executive Lead:** Director of Nursing

**CQC Domain:** Safe

**Strategic Objective:** Patients




Challenges/successes

There was a decrease in patient screening in inpatients during April which brought us just below the 90% required standard. This has coincided with an increase in the number of patients being seen, but actually means that in terms of numbers, more screens have been delayed / missed. Harm reviews were completed for all missed screens and no harm was caused. All of the missed or delayed screens had an alternate cause which were not Sepsis. Pilgrim returned all their harm reviews, Lincoln have yet to nominate a new Sepsis Link nurse so these were done by the Sepsis nurse.

Actions in place to recover

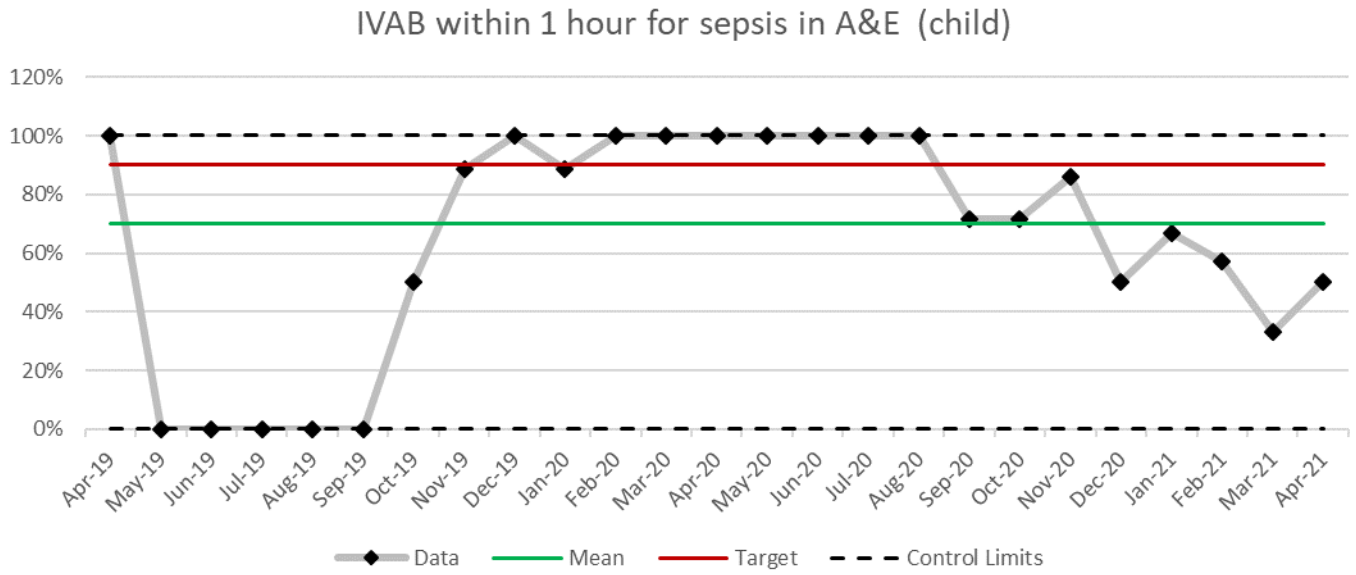
Lincoln are currently looking at allocating a Sepsis Link Nurse for both of their inpatient units in order to help with compliance, auditing and training. The CYP Sepsis practitioner is making regular visits to all inpatient areas in order to help with any problems that may arise with any screening /bundle completion. Simulation training is being organised for all inpatient areas. Sepsis training is also being organised for all Drs in inpatient areas. This will be carried out via teams.

# DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR IN A & E

**Executive Lead:** Director of Nursing

**CQC Domain:** Safe

**Strategic Objective:** Patients




Challenges/Successes

The compliance for IV antibiotics in ED (child) has increased slightly to 50% but this is still well below the 90% standard. There was 1 missed antibiotics out of 2 patients requiring them. There is still a reluctance to treat in the department despite being advised by a Paediatrician to do so. A Harm reviews was completed on the patient, there was no harm caused and the child was treated with IV antibiotics once on the ward.

Actions in place to recover

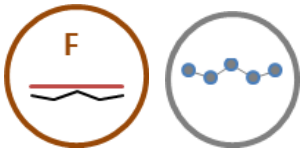
This has been addressed at consultant level via the governance process and it has now been mandated that patient move should not happen prior to completion of the sepsis bundle. There are now ongoing quarterly trust wide meetings between ED and the Paediatric areas to help enable better team working between the two. Adult Nurses at Boston have also attended two Paediatric focused study days in which Sepsis and Case studies around Sepsis have been discussed. It is hoped that this training can be carried forward to Lincoln also. Simulation training of Sepsis in Children has now taken place on both sites.

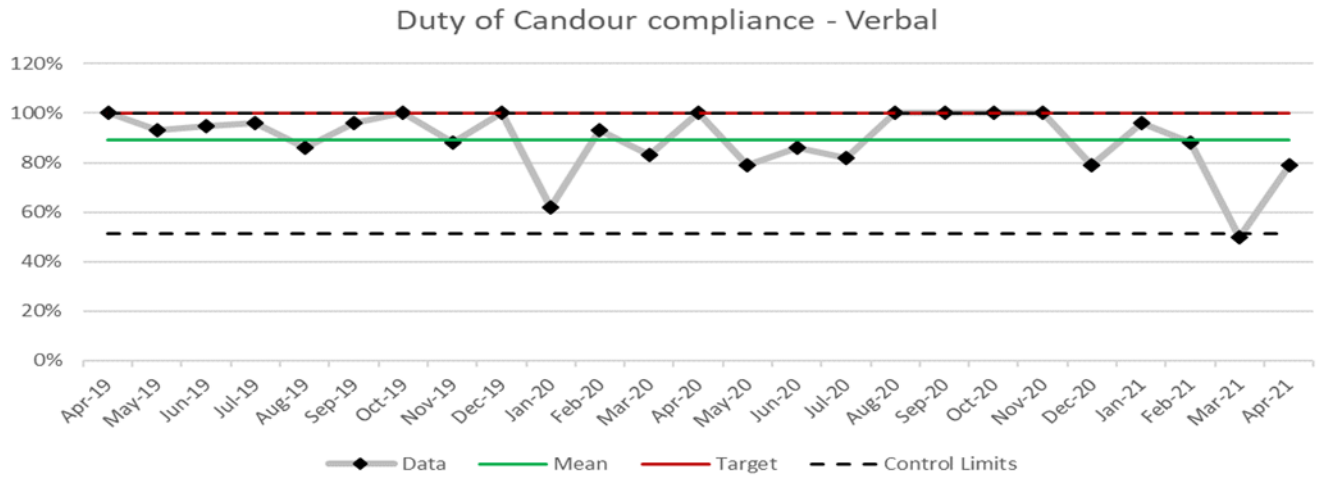
# IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

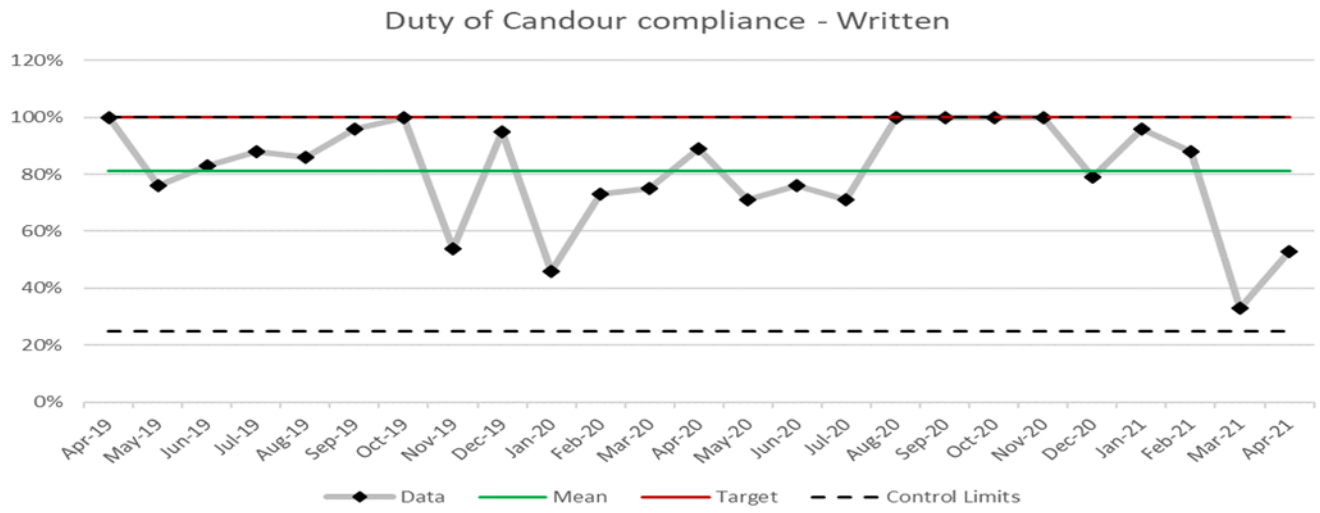
**Executive Lead:** Director of Nursing

**CQC Domain:** Caring

**Strategic Objective:** Patients




Challenges/Successes

- The Trust achieved 79% compliance with the Duty of Candour in April 2021, for in person notification (verbal) and 52% compliance for written follow-up.
- There were 4 non-compliant verbal and 9 non-compliant written follow-ups from 19 incidents that were notifiable.
- 3 of the non-compliant verbal incidents occurred within Medicine Division; 1 incident occurred in CSS.

Actions in place to recover:

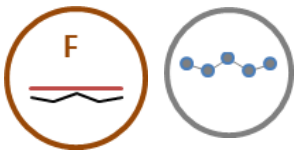
1. All handlers of moderate and above harm incidents will be contacted through Datix by the Risk and Incident Administrator to initiate verbal DoC and an offer of written DoC letter – this will be carried out daily.
2. Each Friday a report of all outstanding DoC (verbal and written) containing the incident location and incident handler sent to each clinical lead of the Divisions for action and also the Assistant Director of Clinical Governance for ongoing monitoring.

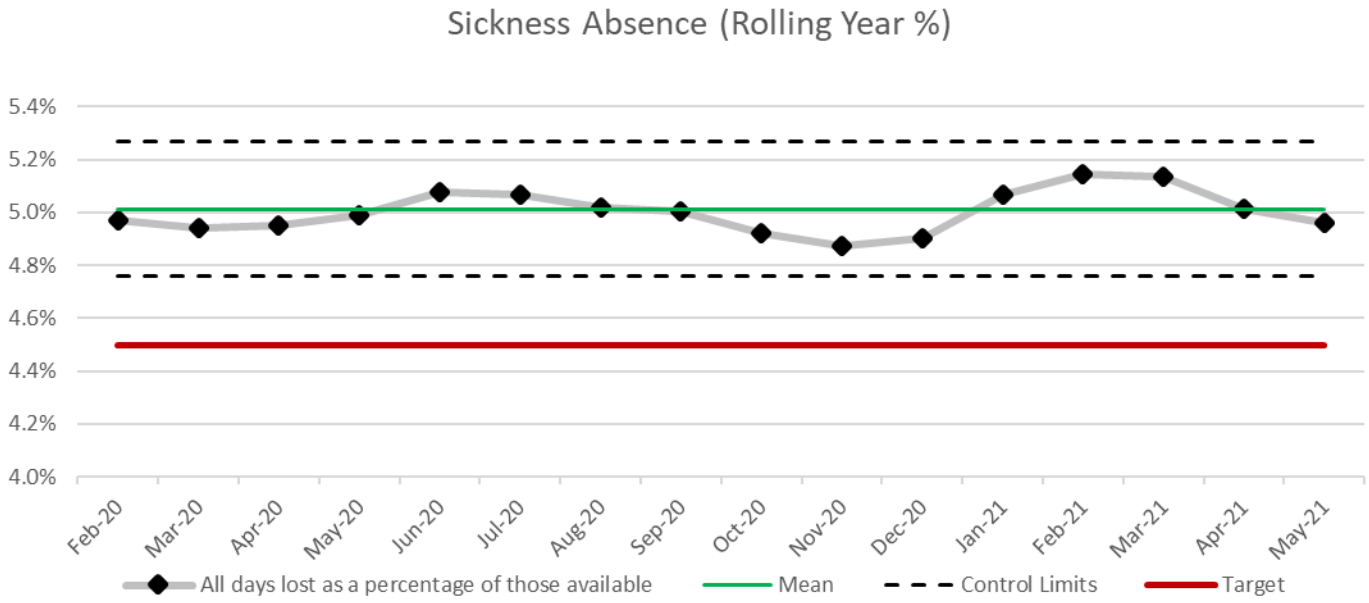
# A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

**Executive Lead:** Director of HR & OD

**CQC Domain:** Well-Led

**Strategic Objective:** People




Sickness has reduced as again as the impact of COVID on the 12-month rolling absence rate declines. We continue to use our new Attendance Management System (AMS) as the means by which we can reinforce the good practice which enables us to manage sickness absence most effectively and thereby reduce absence levels.

Alongside this, we are focused on the issue of prevention. In light of expectations around a COVID wave 3, we are pleased about levels of COVID vaccination take-up

We are currently planning the delivery of the COVID booster to healthcare staff in Lincolnshire. We do not yet know when this will take place. We have decided to take responsibility for our own staff, rather than use the public vaccination programme. In this way we believe we can best protect staff and patients. We are planning now so that we can be prepared for a rapid response. We intend to visit more locations, rather than rely on the two hospital hubs to maximise quick take-up.

We are also planning the flu campaign which will commence in September and hope to exceed the 90% take-up we achieved in 2020/21.

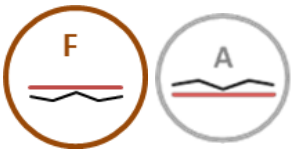
Alongside this, we have developed a new wellbeing plan for 2021/22, with input from our Board Wellbeing Guardian. This has a significant focus on early intervention to address any issues relating to stress and mental health. Prevention also links to the work on culture and leadership and particular the consistent application of compassionate and inclusive leadership.

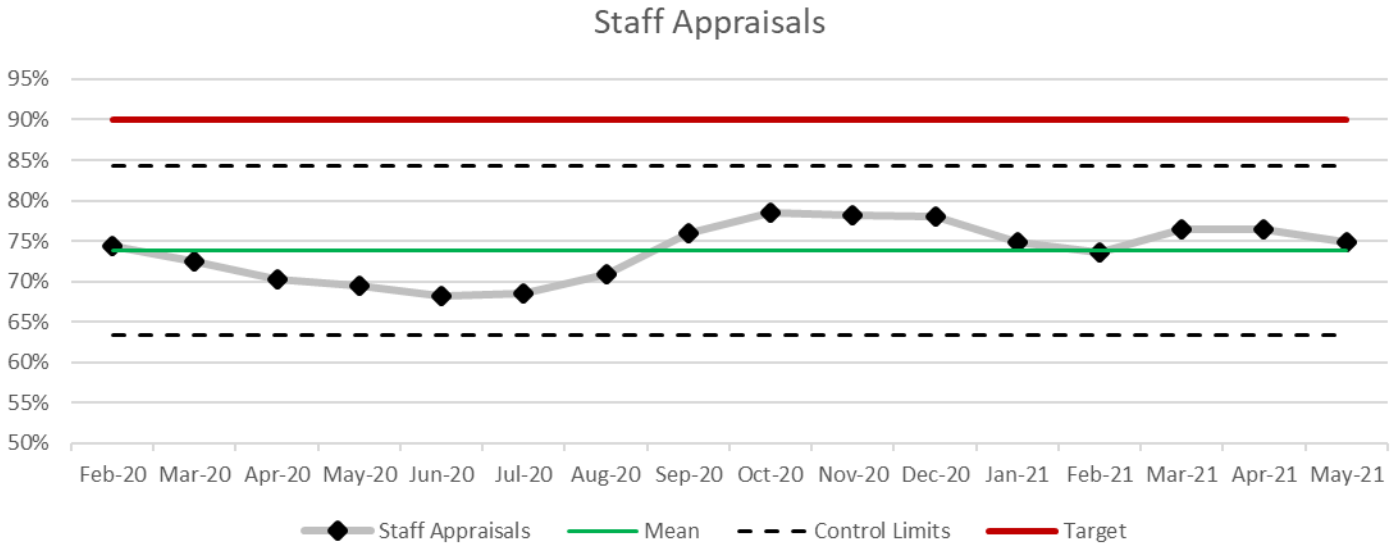
# A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

**Executive Lead:** Director of HR & OD

**CQC Domain:** Well-Led

**Strategic Objective:** People




Medical appraisal are at 98%, which is very positive. However AfC appraisal rates are not improving which is extremely disappointing. The requirement for staff to have had an appraisal as a trigger for pay progression, should have a positive impact on completion rates. However, low completion rates has been a problem for a long period of time. The challenge appears to be structural and behavioural.

The launch of the new WorkPal system (on 11th May), which will underpin our approach to individual performance management going forward, is an important moment to seek to re-set the dial on appraisal. It is identifying where managers have significant more staff to appraise than our policy recommends (12 max). It is also simple to use and allows us to pre-populate objectives for some groups of staff (such as housekeepers), thereby overcoming some of the perceived barriers to conducting appraisals.

There is a reporting functionality, which enables managers to get real-time information on whether appraisals are being conducted by their reports and to review the quality of appraisals.

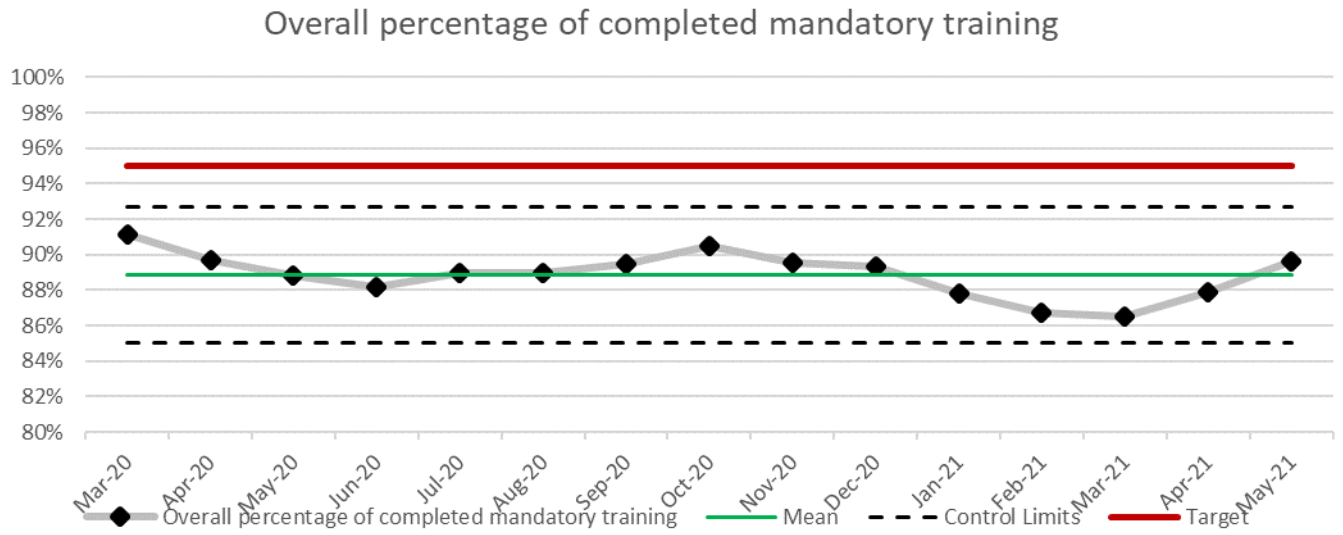
The implementation team are working with Divisions/Directorates on teething problems around implementation and to address some of the fundamental challenges to the success of the appraisal process.

# A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

**Executive Lead:** Director of HR & OD

**CQC Domain:** Well-Led

**Strategic Objective:** People


There has been a strong recovery in terms of completion of core learning. Detailed reports are regularly shared with Divisions and Directorates and discussed in Management Teams, facilitated by the HR Business Partners. Fire Safety and Information Governance are a particular focus to ensure we achieve targets set for those individual modules.

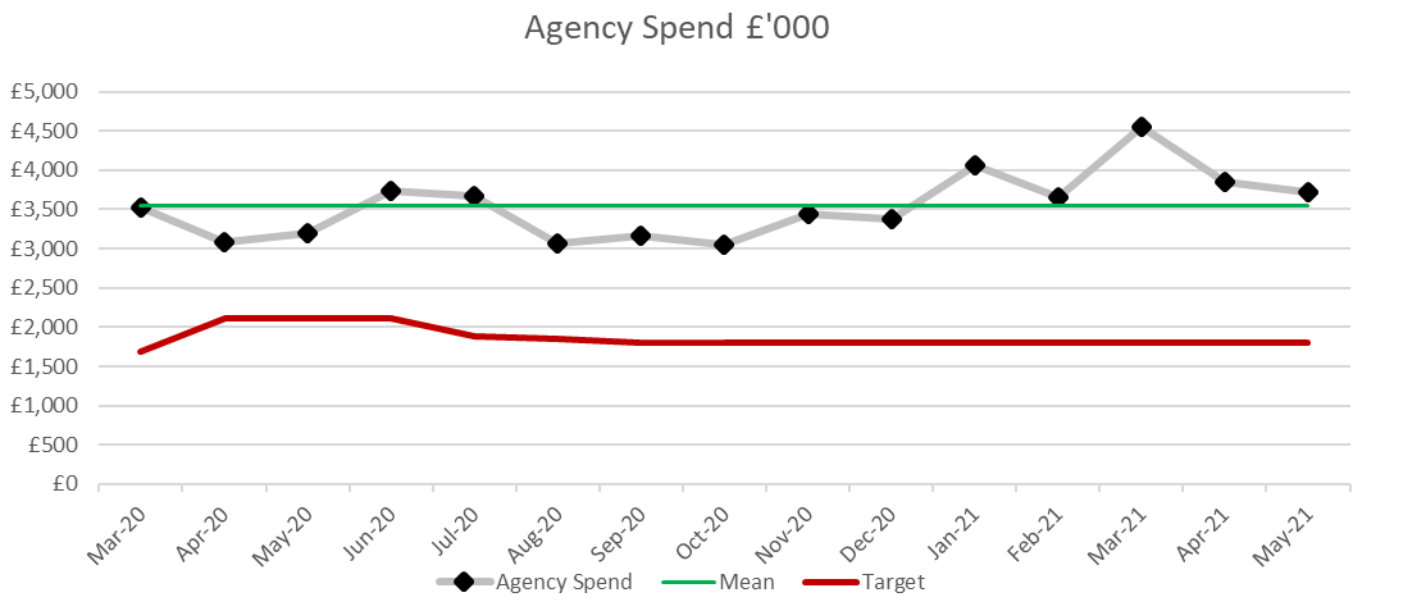
There is an on-going review of core learning to ensure that the requirements on staff groups around core learning plus in particular are appropriate. New software has been acquired which should improve the lay-out and performance of the core learning platform and a timetable for delivering new modules being developed. Finally there have been some issues around the depletion of admin support owing to sickness, which does pose a risk to the maintenance of compliance records and this is being addressed.

# EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

**Executive Lead:** Director of HR & OD

**CQC Domain:** Well-Led

**Strategic Objective:** People




There was a further small reduction in agency spend between April and May. The agreed target is a 25% reduction on spend levels in 21/22 compared to the last financial year. The reduction seen is well short of that which we will need to deliver in order to achieve the agreed target.

Medical agency spend did increase in May, but is running consistently below 2020/21 levels, as a consequence of the work undertaken around medical bank and rates. Nursing agency spend also declined in May, as expected. However, as indicated above, rates of improvement do not at present give confidence around delivery of the agreed target.

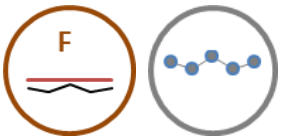
The Nursing Workforce Transformation Group is in place and is focused on exercising control over nursing agency spend. A meeting was held in w/c 21st June to explore the actions necessary to achieve the step change reduction in medical agency spend required to deliver the agreed target.

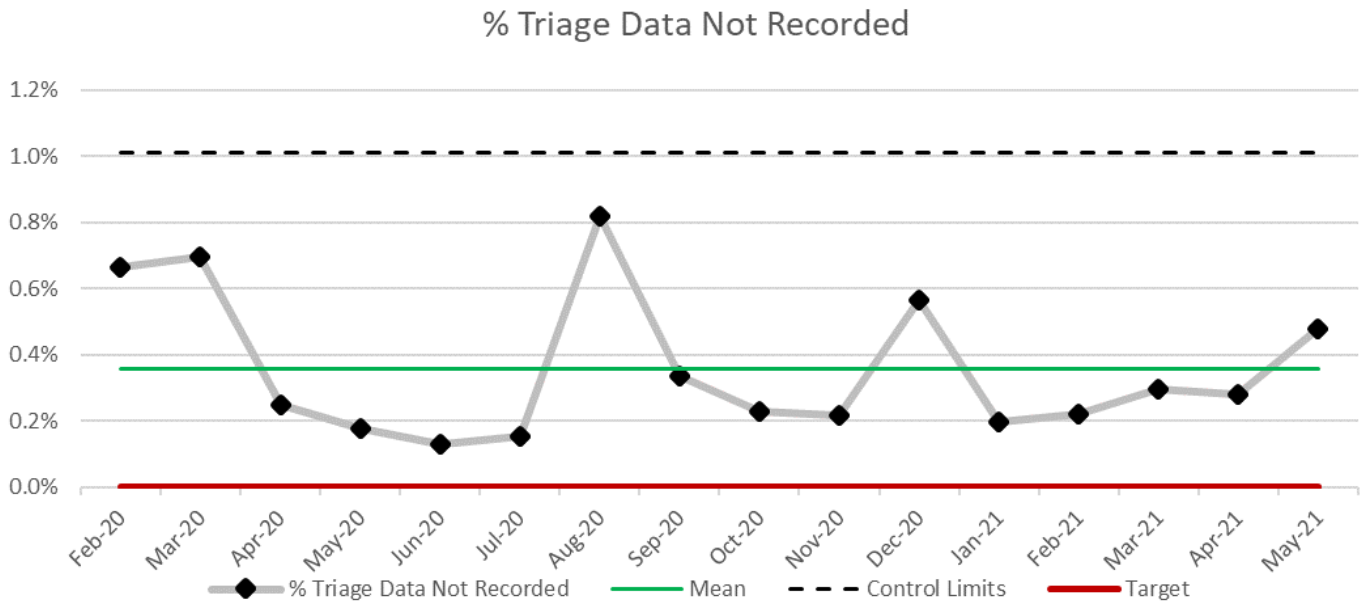
# IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Effective

**Strategic Objective:** Patients




Challenges/Successes

- May demonstrated a 0.20% negative variation in performance compared with April. This is the worst performance since December 2020.
- Deterioration has been seen at both LCH and PHB.
- Skill mix, training and higher demand have been cited a causation for the deterioration.

Actions in place to recover:

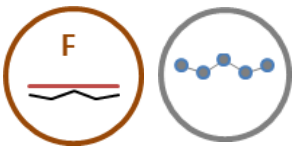
- Emergency Department staffing levels are reviewed by the staffing Hub x 2 daily and an emphasis on securing templated staffing is in place. The newly applied indicator will assist this.
- Training continues to be in place, but a reduced number of MTS trained staff is being highlighted.
- The Deputy Divisional Nurse and Lead Nurse for Urgent and Emergency have undertaken a further intervention regarding triage compliance (recording and undertaking) at PHB and LCH. This is demonstrating a positive impact.
- The actions against this metric to ensure compliance and assure safety are overseen by the Clinical Lead, General Manager and Deputy Divisional Nurse responsible for Urgent and Emergency Care, in conjunction with the Emergency Department Lead Nurses, Matrons and Non-Clinical Support Teams.
- Both LCH and PHB have instigated an Urgent and Emergency Care 'Teams Chat' that escalates recording performance. This is proving beneficial.

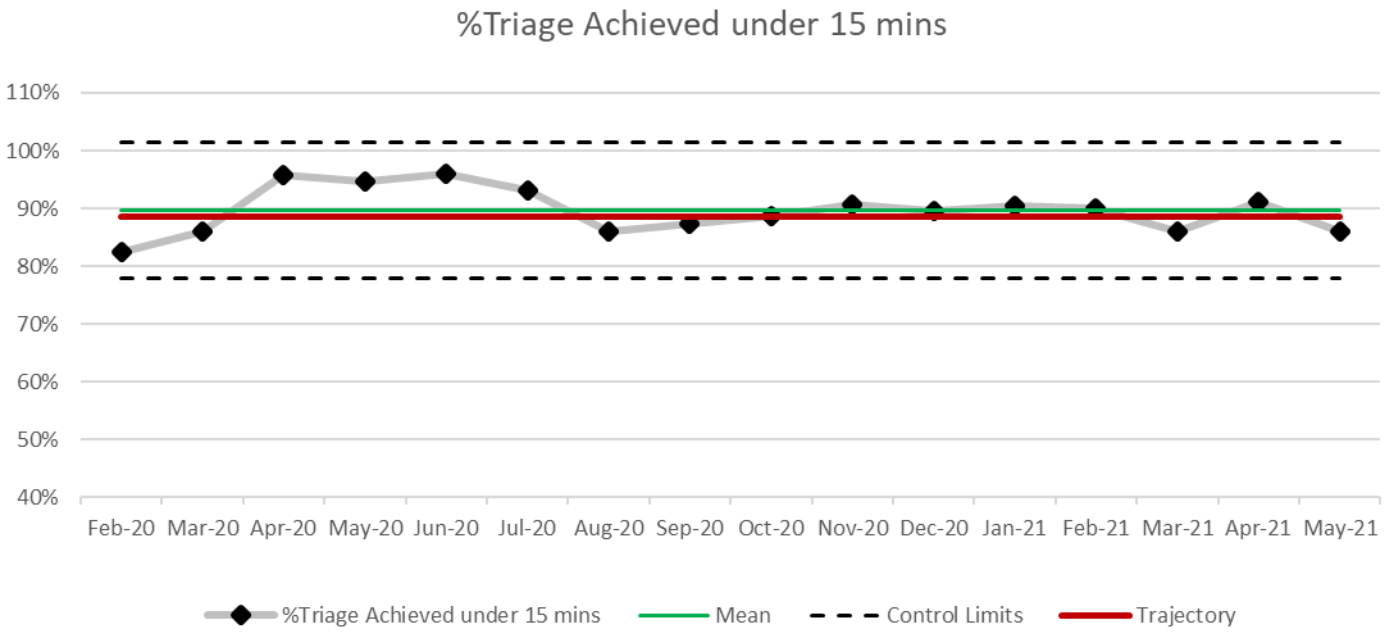
# IMPROVE CLINICAL OUTCOMES – % TRIAGE ACHIEVED UNDER 15 MINS

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services




Challenges/Successes

- % Triage achieved under 15 minutes has demonstrated a deterioration in May. 86.05% in May compared to 91.15% in April. A negative shift of 5.1%.
- The newly applied indicator added to the capacity and performance meetings as demonstrated inconsistency in the availability in provision of sufficient staff trained in triage per shift to meet the nationally agreed compliance target at both PHB and LCH.
- LCH performance for May was 84.3% compared to 91.6% in April (a negative variance of 7.3%). PHB was 89.3% in May compared to 91.2% in April (a negative variance of 1.9%). This is now below the agreed trajectory of 88.50%
- The UEC Operational Leads continue to be proactive in addressing recording compliance in real time but May has experienced significant deterioration out of hours and particularly at LCH.
- This metric continues to be captured as part of the daily and weekly CQC assurance reporting and performance is discussed daily by clinicians as part of the ED safety huddles led by the Deputy Divisional Nurse for Urgent an Emergency Care and now the newly appointed General Manager for Urgent and Emergency Care. In addition, the recently appointed 8a Senior Nurse Leads is beginning to see an impact.

Actions in place to recover

- The focus must remain on achievement of this safety metric.
- Clear action and recovery plans are scrutinised at the four times daily Performance and Capacity meetings.

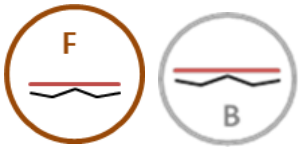
  Staffing deficits that may impact on the ability to maintain a second triage stream both in and out of hours are highlighted daily and every attempt is made to resolve this.

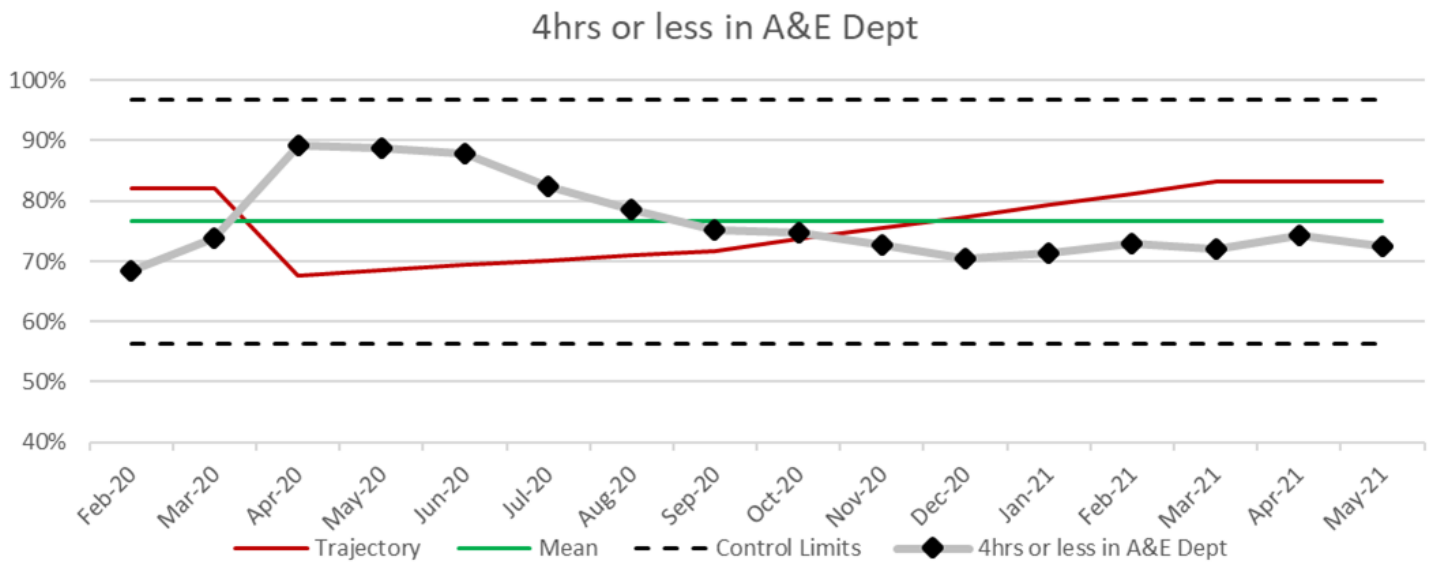
# IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services




Challenges/Successes

The data and performance applied to this report is at day 2 of the national reporting cycle. A completed validation of the 4hr standard is by day 7 of the reporting cycle.

Comparison data for UEC attendances – May 2019 (pre covid) was 15,013. May 2020 was 12,302 and May 2021 19,367. This is an overall increase against pre-covid activity of 7.75%

- May ED type 1 and streaming saw 19,367 attendances verses 17,002 in April (+2,365 attendances). This represents a 12.22% increase. By site LCH experienced a 12.95% increase in attendances, PHB saw an increase of 12.38%. Grantham also experienced an increase in UTC attendances of 10.44%
- May overall outturn for A&E type 1 and primary care streaming delivered 72.56% against an agreed trajectory of 83.12%.
- This demonstrates a deterioration in performance of 1.67% compared with April outturn.
- Performance continues below the agreed trajectory by 10.56%. 2021/2022 performance trajectories have not been agreed yet due to the review of the Urgent Care Constitutional Standards. A Local performance trajectory is being put forward in the Urgent Care FPEC paper pending national guidance and performance expectations.
- By site, for May, LCH delivered 69.61%, a 0.37% deterioration on April's performance (69.98%), PHB delivered 66.11%, a deterioration of 3.63% on April's performance (69.74%). GDH achieved 98.12%, a deterioration of 0.61% compared to April (98.73%). This includes type 1 and type 3 activity.
- The highest days of delivery by the Emergency Departments only was on 7th May when LCH achieved 64.74% and 2nd May when PHB achieved 75.40%. The performance uplift from the UTCs was 12.33% at LCH (77.07%) and 9.53% at PHB (84.93%). Conversely, the lowest days of delivery by the Emergency Departments only was 6th May when LCH only achieved 38.89%

and 29th May, when PHB only achieved 25.35%. The performance uplift from the UTCs activity was 17.22% (56.11%) and 26.93% (52.28%) respectively.

- Streaming at GDH, LCH and PHB experienced 648 >4hr transit time breaches in May compared with 355 in April, an increase of 293 and overall deterioration of 45.22%. The highest number of breaches proportionate to attendances was PHB. Steaming experienced an increase of 1600 attendances in May. 9943 compared with 8343 in April. This represents a 16.09% increase.

Actions in place to recover:

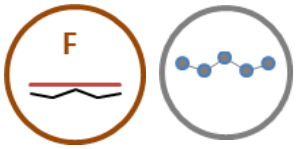
- The restoration of services and the recovery of elective care are underway. The revised Urgent and Emergency Care Delivery Programme led by General Manager, continues at pace, with the overall outcome of reducing the burden on our Emergency Departments. The focus continues to be placed upon improved access to ambulatory pathways (SDEC), reduced conveyance to the Emergency Departments via EMAS by securing alternative treatment pathways (although demand and conveyances are increasing) and system wide pathways for older persons and those needing to access Mental Health support.
- A new national set of metrics will be introduced in November. The Trust will commence monitoring against the new quality and safety metrics in shadow form from July.
- The Trust has now completed the 8-week intensive support programme supported by NHSe/i and ECIST to ensure timely discharges and has demonstrated increased numbers of discharges from the pilot wards at LCH. A roll our plan is being developed.

# IMPROVE CLINICAL OUTCOMES – 12HRS + TROLLEY WAITS

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services





Challenges/Successes

- The Trust experienced and recorded 1 x 12hr hour trolleys waits in May compared to 2 in April. Following clinical validation, this was determined to be a true breach. This was reported as per the local and regional agreement and processes.
- This breach was considered avoidable.
- The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating, Urgent Care.
- A daily review of all potential 12hr trolley waits is in place should this be required. This is led by the Chief Operating Officer. All involved specialities are expected to attend.
- System Partners and Regulators remain actively engaged and offer practical support in situational escalations. There have been no declared critical incidents in May.

Actions in place to recover:

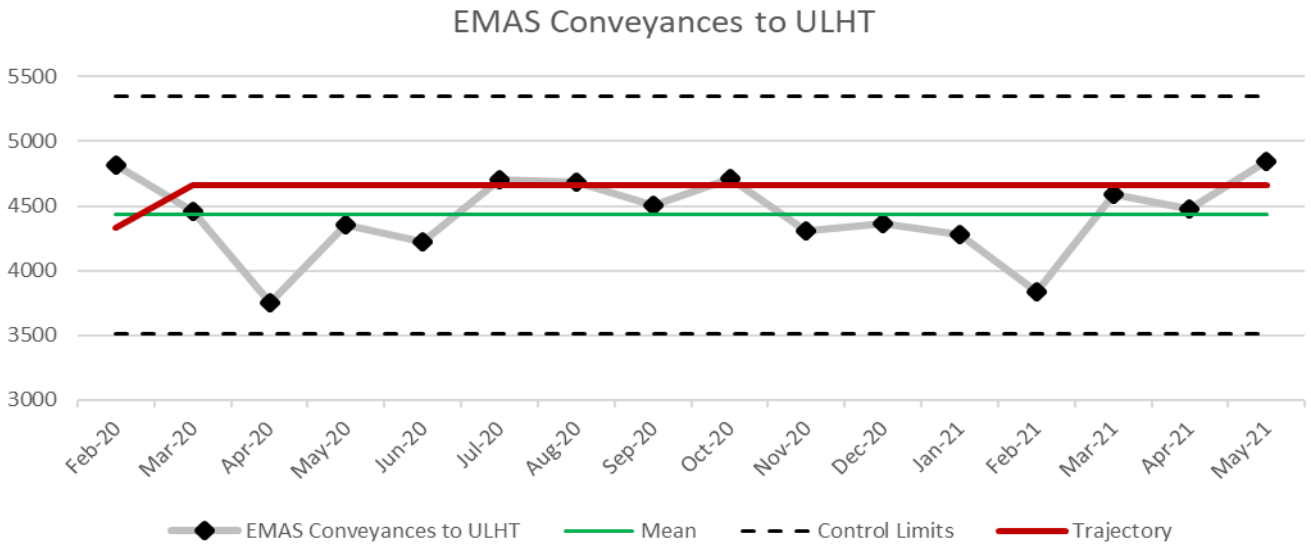
- Through the 4-x daily Capacity and Performance meetings, plans against the flow interventions required avoid any potential 12hr trolleys are agreed and the responsibility/accountability to secure and ensure effective and timely intervention is held by the relevant CBU.
- A multi-disciplinary approach to unblock discharge delays across all sites on pathways 1, 2 & 3 is in place and is robust. Twice daily System MDT meeting are in place and have become very effective. The ULHT Trust wide Discharge Lead ensures traction and delivery
- Every inpatient without a true reason to reside is now featured through the 4-x daily Capacity and Performance Meetings. Each CBU is held to account.
- Continued monitoring of stranded and super stranded patients occurs weekly at both LCH and PHB.
- The internal Discharge Cell chaired by the Trust wide Lead Nurse for Discharge, supported by the Deputy Chief Operating Officer – Urgent Care and the Director for Patient Safety are, alongside the Divisions, challenges the pathway zero discharge processes. There is an intensive support programme led by ECIST and NHSe/i providing challenge, confirm and rigor to our processes.
- Each System Partner is held to account for any patient in the Emergency Departments that do not require admission to ULHT. Timescales for securing onward non-acute care is both managed and escalated.

# IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services


Challenges/Successes

- Ambulance conveyances for May were 4843 compared to 4481 in April. This represents a 7.48% increase in conveyances across LCH and PHB. GDH saw a reduction on conveyance.
- By site, LCH conveyances were 2747 in May compared with 2541 in April, a 7.5% increase, PHB was 2083 in May compared with 1901 in April, an increase of 8.74%. GDH experienced a conveyance reduction of 15.39%. 33 conveyances in May compared to 39 in April
- Conveyance deflects were put in place from LCH to PHB and PHB to LCH during May. Bespoke deflects from GDH were assessed and agreed daily with EMAS and either the Deputy Chief Operating Officer, Urgent Care or the Operations Lead Nurse. The overall position of PHB and LCH determined the deflect destination.
- Load share for conveyances from GDH to PHB and LCH is more balanced but requires constant monitoring by both the Trust Operational Teams, the UEC CBU and EMAS.
- We continue to work with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated daily.
- The use of CAS for advice and admission avoidance options appears to have increased and subsequent benefits are being realised but not to the extent expected.

Actions in place to recover

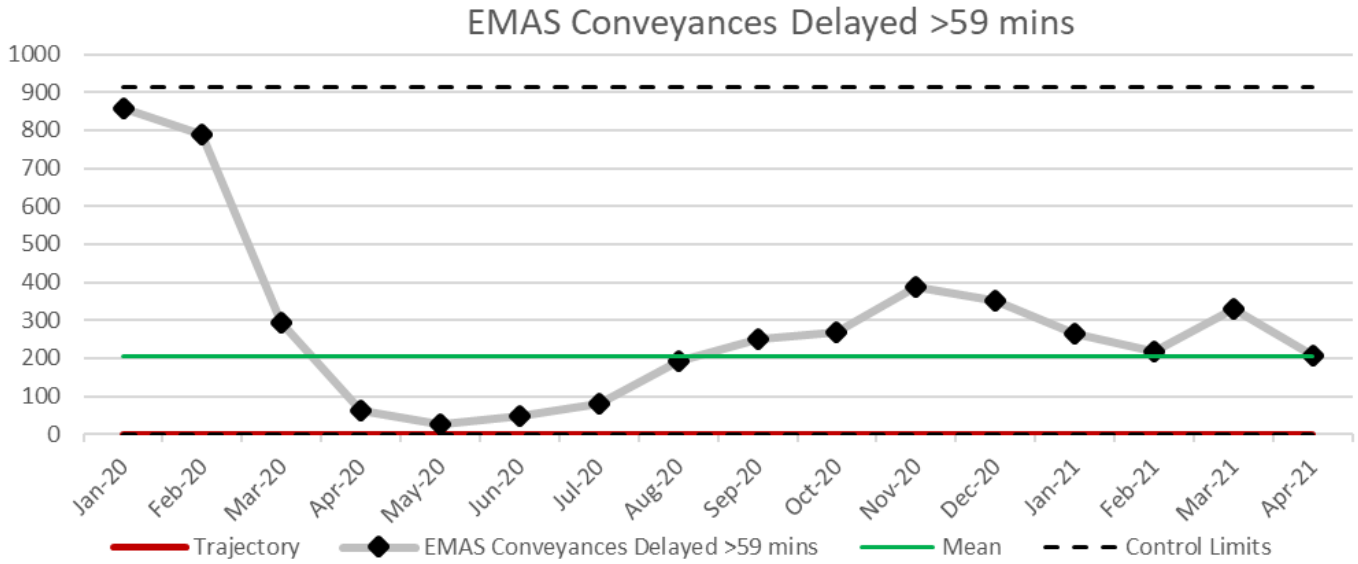
- Recovery plans are in place by the Trust for urgent and emergency care (UEC) which include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in Ambulance handover. The benefits of these alternative streams have still yet to be fully realised.
- Increased resourcing of CAS by LCHS which includes an extended criterion continues to develop.
- Increased use of and streaming to the UTCs is in place and some benefits are being seen although the pathways and extended criterion needs to be more robust.
- An increase to the overall footprint of our Emergency Departments is currently underway with secured funding.
- System Partners are committed to delivering a reduction on the overall burden on the Acute Trust.

# IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services


Challenges/Successes

- May reported 93.21% of handovers at LCH were <59 minutes and 92.22% at PHB. This is a deterioration against the April performance.
- May reported 285 >59-minute hand over delays. This is an increase of 78 on the April figure of 207. This represents a 27.37% increase in >59-minute ambulance handover delays. LCH had 91 >59-minute ambulance conveyances in May compared with 124 in April. This represents a 26.62% reduction compared with March. PHB had 194 > 59-minute ambulance handover delays in May compared to 83 in April. This represents a 57.22% increase.
- May demonstrated a decrease in >120mins handover delays overall by 14.93%. >120 mins at LCH in May was 15 compared to 37 in April, a decrease of 59.50%. PHB >120 mins increased from 30 in April to 42 in May, an increase of 28.58%
- Delays experienced at LCH and PHB can be attributed to volume and conveyance pattern. However, the pattern is well known and consistent. This familiar to the departments.
- Robust relationships exist with the Lincolnshire EMAS Divisional Operations Manager, Clinical Site Manager, ULHT Operational Silver Commander and Operational CCG Silver to ensure any concerns are raised.
- Daily System Calls are in place at 10.30am where number of conveyances, conveyance avoidance and handover delays are discussed.
- All handover delays >59 mins are reported to the CCG by EMAS but are done so in context of the overall site position.

Actions in place to recover

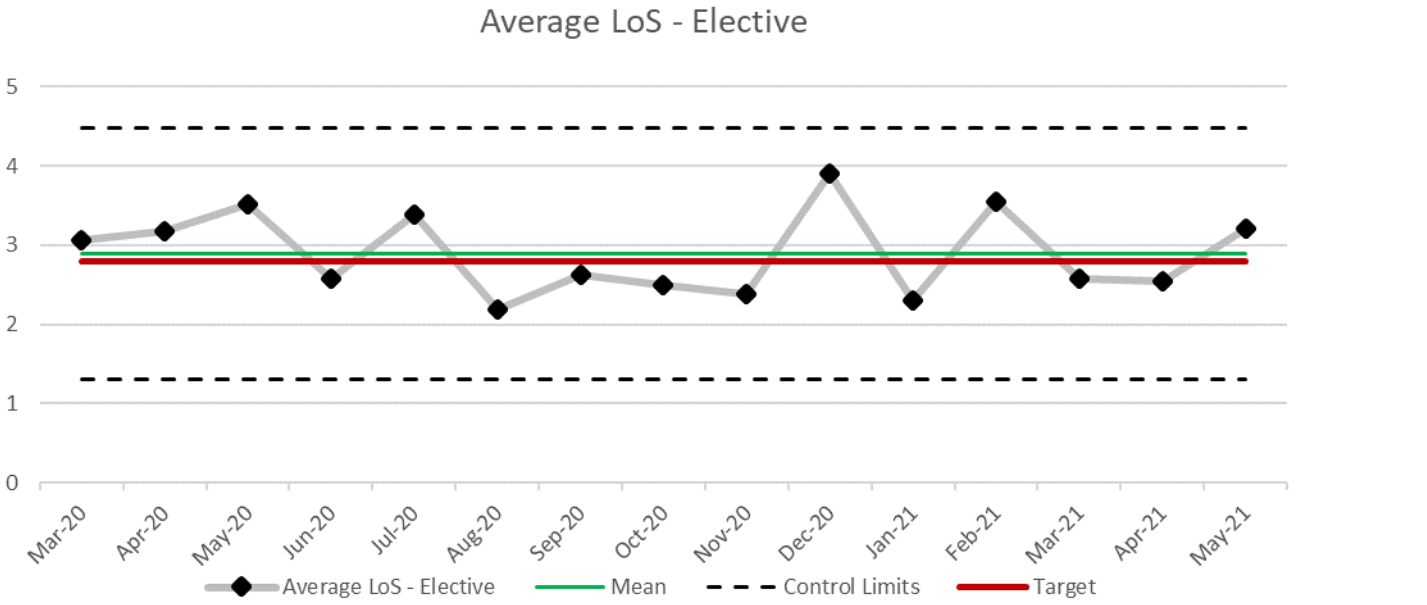
- As part of restore and recovery and following confirmation of additional monies to enhance our urgent care facilities, work has progressed at pace to bring these plans to fruition. This will result in larger footprints for RAT. This measure will ensure a significant reduction >59mins handover delays for both LCH and PHB.
- Dedicated UEC Project Management resource has been supported by the Innovation and Integration Team. This support will ensure the UEC Trust Teams to affect a sustainable change with a particular focus on SDEC to reduce unnecessary admissions and generate improved bed flow.
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways via Think 111 and CAS but more work is required.
- All ambulances approaching 30 minutes post arrival are escalated to the Clinical Site Manager (CSM) if there is no robust plan to 'off load'. The Clinical Site Manager (CSM) will work to resolve locally and will escalate to the Silver Commander if the handover delay protocol will be breached.

# IMPROVE CLINICAL OUTCOMES – AVERAGE LOS ELECTIVE

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Effective

**Strategic Objective:** Services




Challenges/Successes

- Overall increase in LOS noted during May likely due to increased volume of admissions
- Patients are not being placed on speciality wards due to site pressures, and reduced surgical bed-stock
- Complexity of procedures increased due to patients waiting for surgery for longer with conditions deteriorating
- Enhanced care pathways not in place across all sites – i.e. in orthopaedics lower LOS in joint replacements at Grantham than in LCH as LCH not adopted enhanced post-operative pathway
- Staffing factors;
  - Higher vacancy factor in certain surgical wards mean higher numbers of agency staff who are less experienced and proactive at managing LOS
  - Skill mix in certain areas mean higher levels of inexperienced staff in surgical areas leading to less proactive management of LOS
  - Surgical staff moved to other areas within the hospital to staff specialties outside of surgery

Actions in place to recover

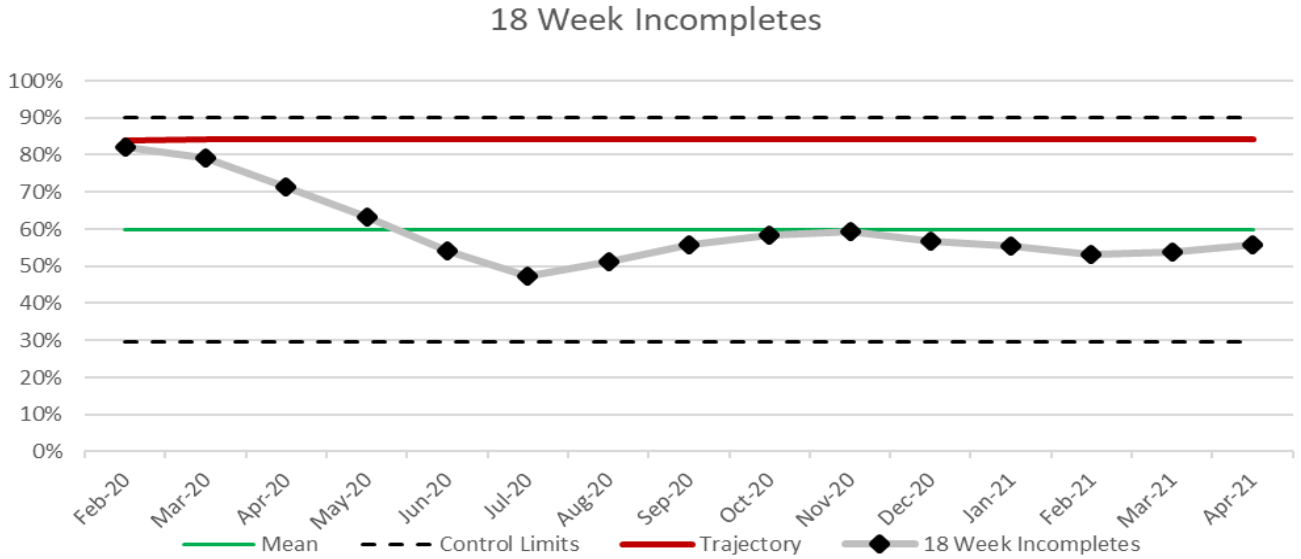
- Twice weekly forward staffing meetings in place to review nursing numbers and skill mix across all surgical areas and address critical gaps both in numbers and in skill mix.
- Undertaking a focused review of care pathways across all sites to align practice and therefore reduce LOS
- Where required areas such as SAL and DCU are escalated to 7 day working to ensure daily elective management of surgical cases ensuring daily reviews and optimising discharge potential
- TNA completed for the Division during the month of June to optimise staff training and development over the next 12 months
- Plan for every Post Meetings insitu to review recruitment/retaining of staff
- Trauma Assessment Unit is being opened over June/July – pulling patients from ED and ensuring admission avoidance.

# IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services


Challenges/Successes

RTT performance is currently below trajectory and standard.

April saw RTT performance of 55.82% which is 1.89% up on March.

120 – Ent was the lowest performing specialty, however performance increased from 36.09 % last month to 40.79% (+4.70%). Neurology is performing slightly worse this month with a 0.25% decrease from 54.65% last month to 54.40% in April.

The five specialties with the highest number of 18 week breaches at the end of the month were:

- Ophthalmology - 3601 (Increased by 61)
- Ent - 2675 (Increased by 120)
- Gynaecology – 1630 (Increased by 145)
- Trauma & Orthopaedics - 1562 (Reduced by 114)
- Dermatology- 1444 (Increased by 73)

Actions in place to recover:

Performance across most specialties is showing a slight increase, despite incompletes numbers waiting over 18 weeks increasing slightly overall.

As the figures above show, Ophthalmology performance has declined together with ENT, Gynaecology and Dermatology. Trauma & Orthopaedics however, has shown a slight increase in performance. The re-introduction of routine elective work for non-admitted activity continues to utilise video and telephone consultations, with face to face appointments being set up where required.

Admitted routine elective work remains challenging, with available capacity being focussed on cancer.

Specialties achieving the 18 week standard for April were:

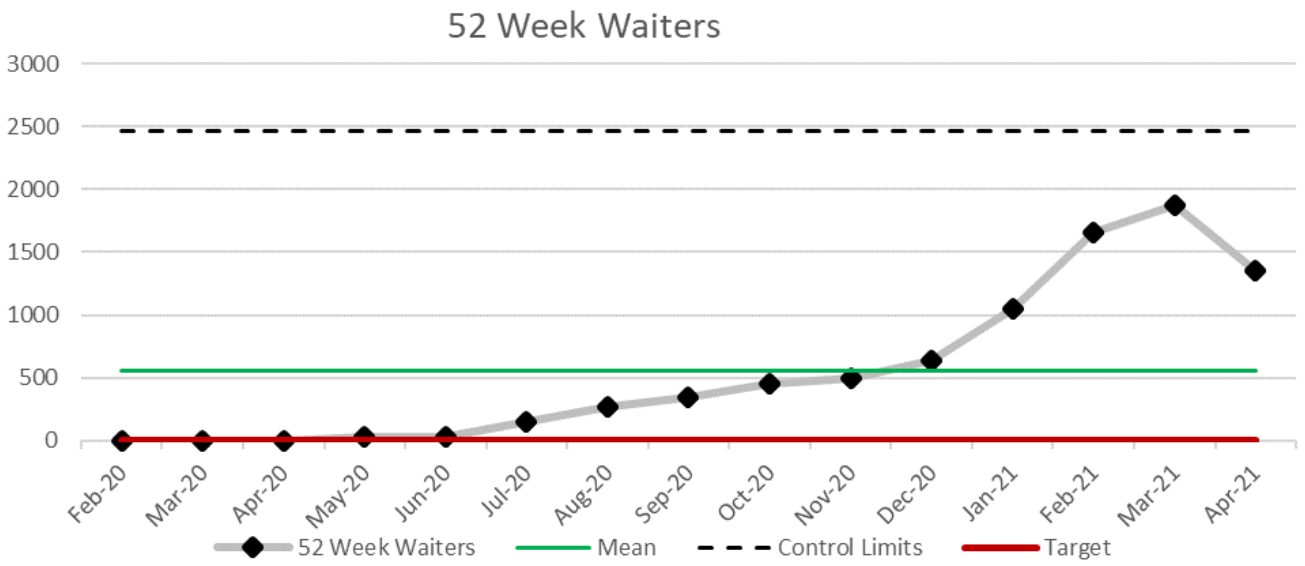
- Breast Surgery - 92.95%
- Critical Care Medicine - 100.00% (1 pathway)
- Clinical Haematology - 93.74%
- Clinical Physiology - 100.00%
- Hepatology - 100.00%
- Transient Ischaemic Attack - 100.00%
- Medical Oncology - 100.00%
- Clinical Oncology - 98.44%

# IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services




Challenges/Successes

The Trust reported 1,349 incomplete 52 week breaches for April end of month. A decrease of 528 from March. Focus is on these patients at the weekly PTL meeting to ensure that every patient is monitored and where appropriate virtual clinical assessment is made. Due to the high volume of long waiting patients, validation of these is very challenging.

A higher level, bi-weekly, RTT Recovery and Delivery meeting continues in order to monitor the situation.

Harm reviews will be completed by the relevant division for each patient. A root cause analysis (RCA) will be completed as a whole, covering all patients within a specialty that have waited longer than 52 weeks for treatment due to the effect of the pandemic.

The Clinical Harm Oversight group, led by the Chief Operating Officer continues to gives focus on the improvement in the recording and monitoring of the harm review process.

Discussions around the reasons for 52 week breaches are being had; particularly looking at the quality and accuracy of data entry. The 18 week/RTT team continue to work on a training programme to address these issues and assist the divisions.

Actions in place to recover

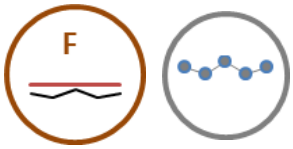
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

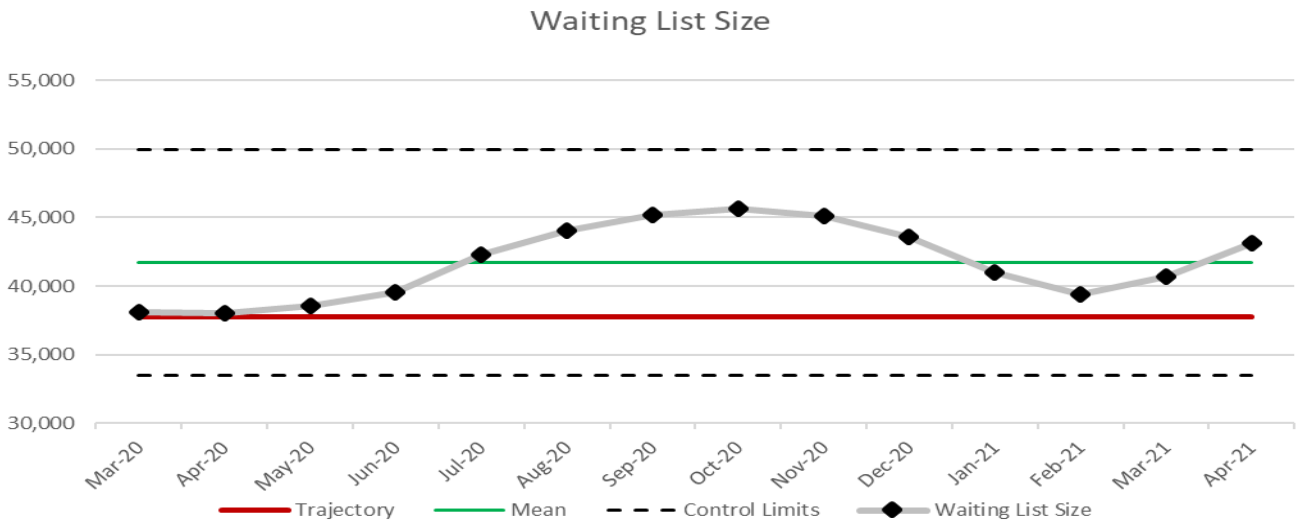
# IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services




Challenges/Successes

Overall waiting list size has increased from March, with April showing an increase of 2,459 to 43,119. The incompletes position for April is now approx. 4,087 more than the March 2018 (39,032) target. Patients who are currently on the ASI list, are be added to the open referrals waiting list, which will increase overall waiting list size.

The top five specialties showing an increase in total incomplete waiting list size from March are:

- 301 - Gastroenterology +602
- 120 - Ent +520
- 330 – Dermatology +416
- 100 - General Surgery +307
- 502 – Gynaecology +228

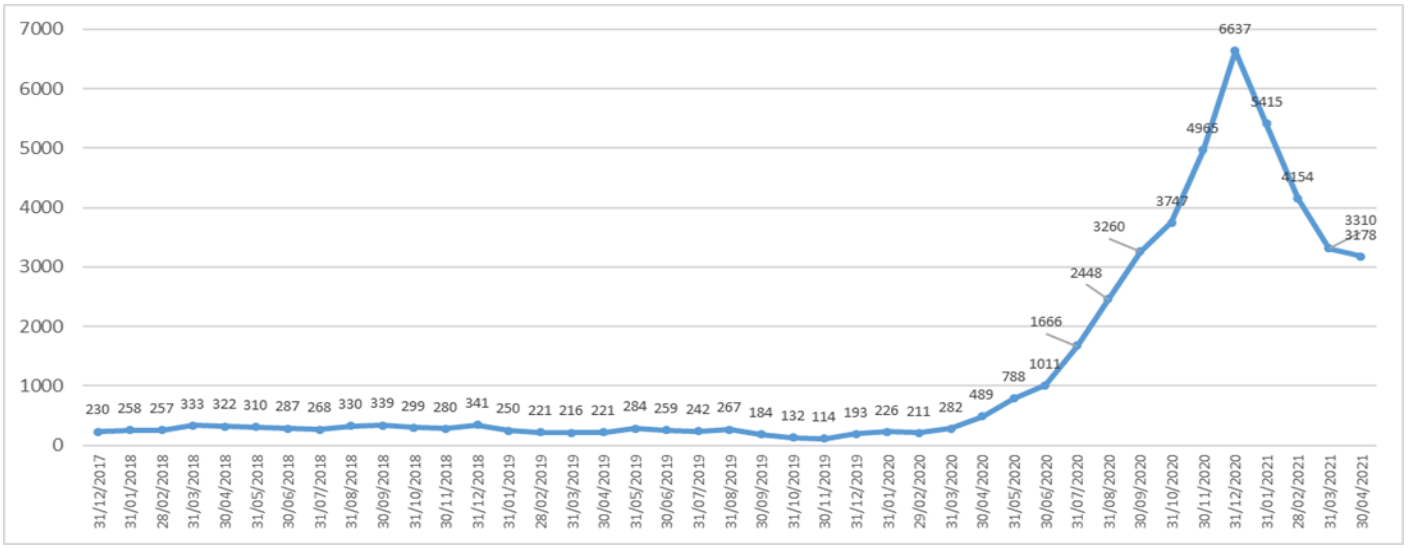
The five specialties showing the biggest decrease in total incomplete waiting list size from March are:

- 103 - Breast Surgery - 239
- 110 - Trauma & Orthopaedics -178
- 290 - Community Paediatrics - 87
- 104 - Colorectal Surgery - 42
- 314 - Rehabilitation Service - 34

Actions in place to recover

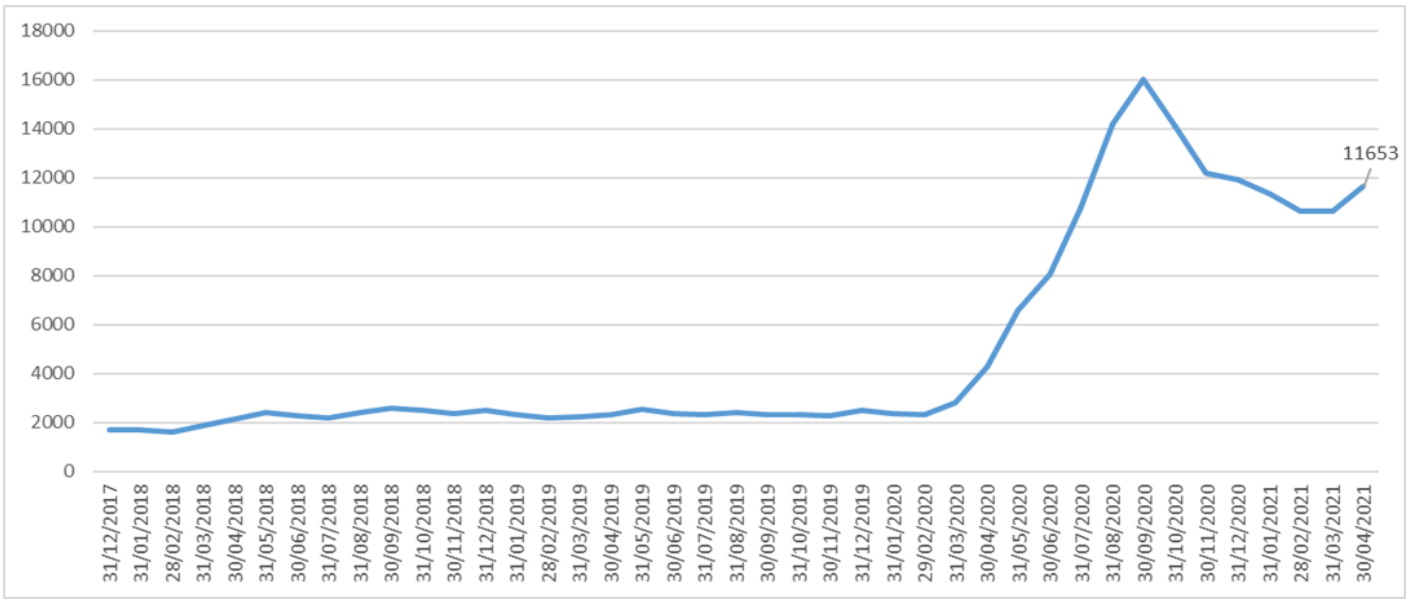
The longest waiting patients continue to be tracked and discussed at the weekly PTL meeting. April showed 3,178 patients waiting 40 weeks and above as the chart below shows. March to April saw a decrease of patients waiting over 40 weeks, -132. Sixteen specialties reduced their position compared to last month, with Ophthalmology showing the best improvement of -101 patients. The largest increase was Dermatology +127.

Total Number of Incomplete Patient Pathways at 40 Weeks and Above for ULHT by Month




The chart below illustrates incomplete patient pathways waiting 26 weeks and above. Progress up to 30th April, shows an increase of 1030 patients from March. Twelve specialties decreased their position with the largest decrease being seen in Urology, - 61. The largest increase was seen in Ophthalmology, +357.

Total Number of Incomplete Patient Pathways at 26 Weeks and Above for ULHT by Month




Total Number of Incomplete Patient Pathways at 80 Weeks and Above for ULHT

At the end of April, ULHT reported 59 pathways as waiting over 80 weeks for first definitive treatment.

- 100 - General Surgery 22
- 502 - Gynaecology 15
- 120 - Ent 8
- 144 - Maxillo-Facial Surgery 4
- 110 - Trauma & Orthopaedics 4
- 107 - Vascular Surgery 3
- 143 - Orthodontics 1
- 130 – Ophthalmology 1
- 300 - General Medicine 1

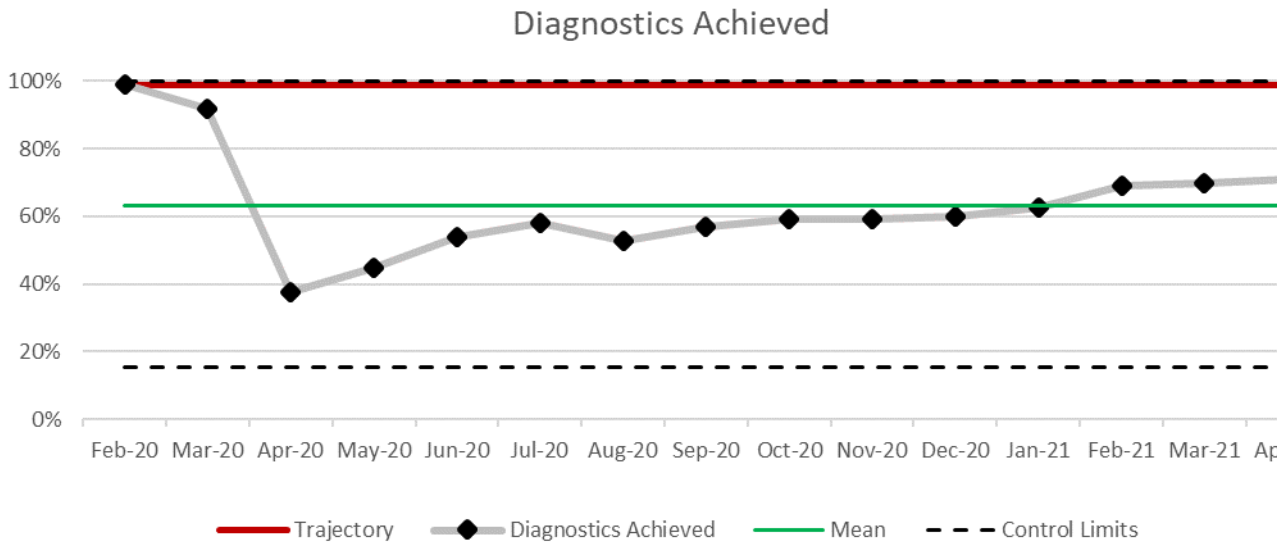
These patients are discussed at a weekly meeting with NHSE/I and CCG colleagues.

# IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services




DM01 71.00% which is an improvement from last month of 69.91%

Challenges/Successes:

**CT**
Slight increase in breaches within CT within increase from 118 to 153. This will be due to patient's choice and cardiologist's capacity
CT activity has increased from 6159 – 6232 which would indicate an increase in demand through April

**MRI**
46 breaches in March compared to 57 in March, majority these are cardiac and general anaesthetic patients

**Physiological Sciences**
Neurophysiology - peripheral neurophysiology LCH is reporting 19 for April compared to 75 in March
Audiology - Audiology Assessments had 19 breaches in April breaches in March this will be due to the increase in the ENT referrals
Waiting lists are monitored weekly
Neurophysiology at Pilgrim this reporting 13 breaches in April compared to 121 in March.

**Endoscopy**
Gastroscopy had a much to improve position of only 3 breaches in April compared to 18 in March
Cystoscopy carried out within endoscopy had 65 breaches in April compared to 74 breaches in March (Ramsay Outsourcing stopped end march) Phil Brown looking into additional funding may slow up recovery.
Colonoscopy had 392 breaches in April compared to 492 in March in. These are the planned patients all live patients are being carried out within 41 days.

**Cardiology**

Cardiology – echocardiography had 2804 breaches for April compared to 2641 for March
Cardiology - echocardiography Stress /TOES had 39 breaches in April compared to 55 in March

The main concern for the DM01 for the trust is the cardiac position as this is pulling the overall performance down.

DM01 Performance with cardiac excluded is 90.8%

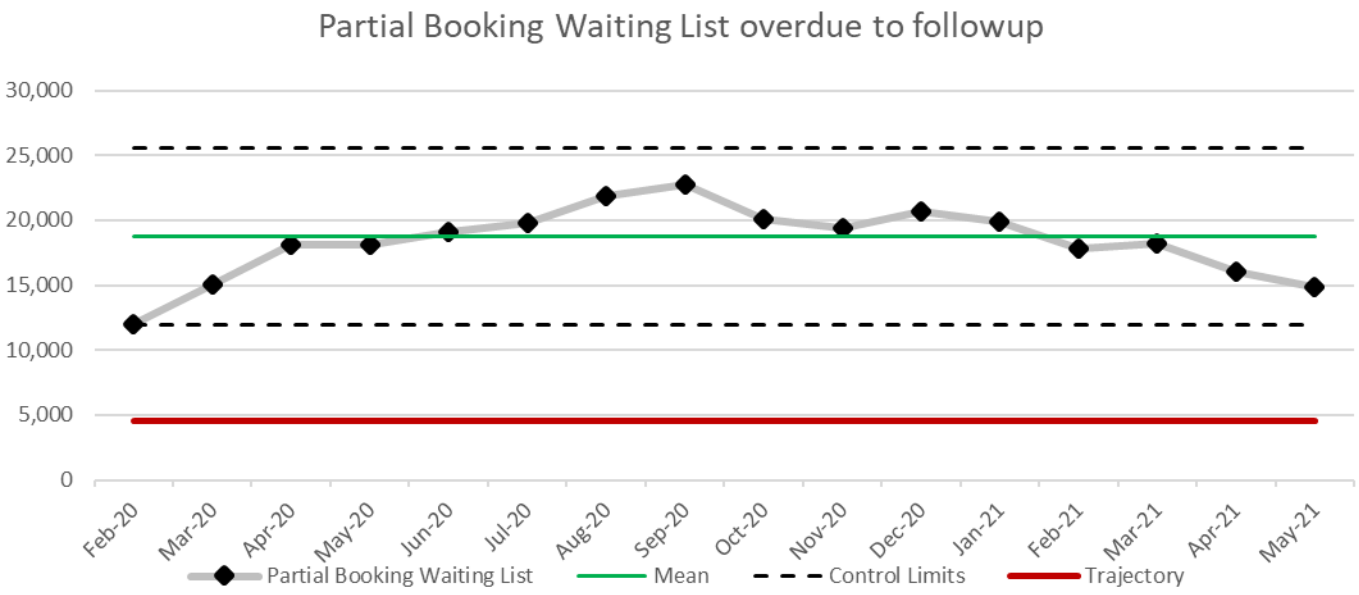
DM01 Cardiac performance 27.50%
DM01 Endoscopy performance 63.40% (Small waiting list)
DM01 Neurophysiology performance 93.30%
DM01 Radiology performance 96.50%
DM01 Audiology performance 95.50%

# IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

**Executive Lead:** Chief Operating Officer

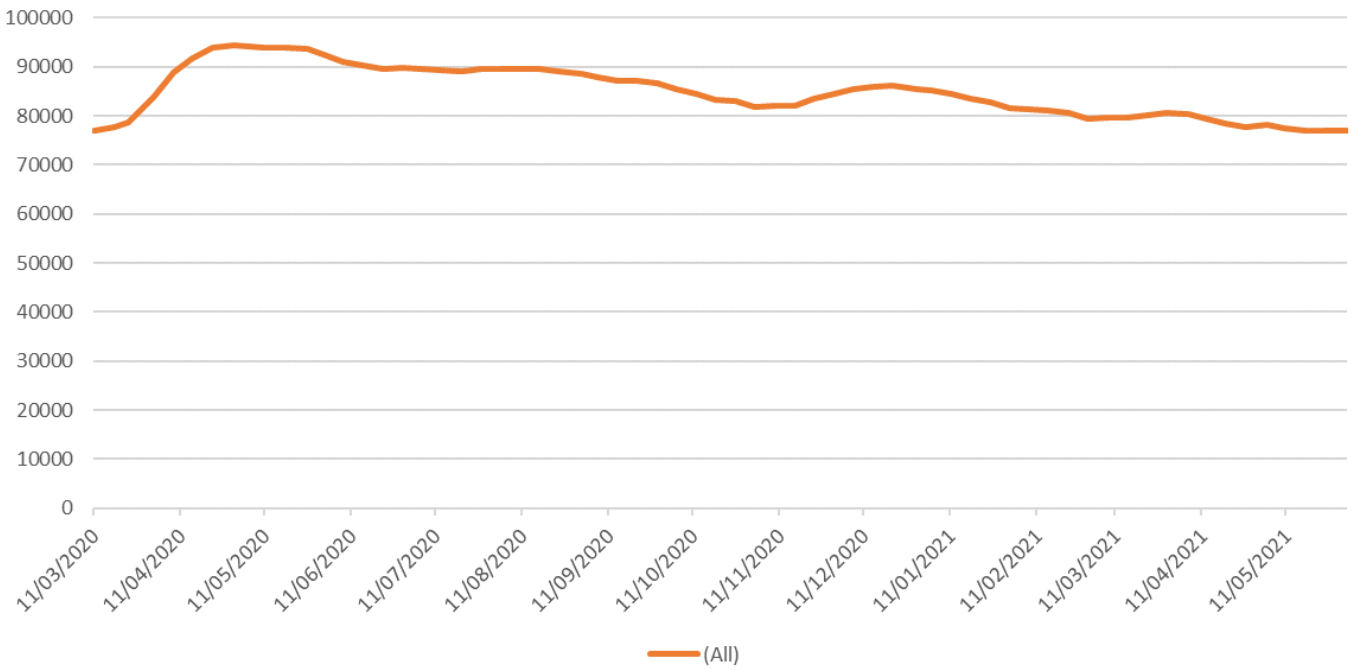
**CQC Domain:** Responsive

**Strategic Objective:** Services



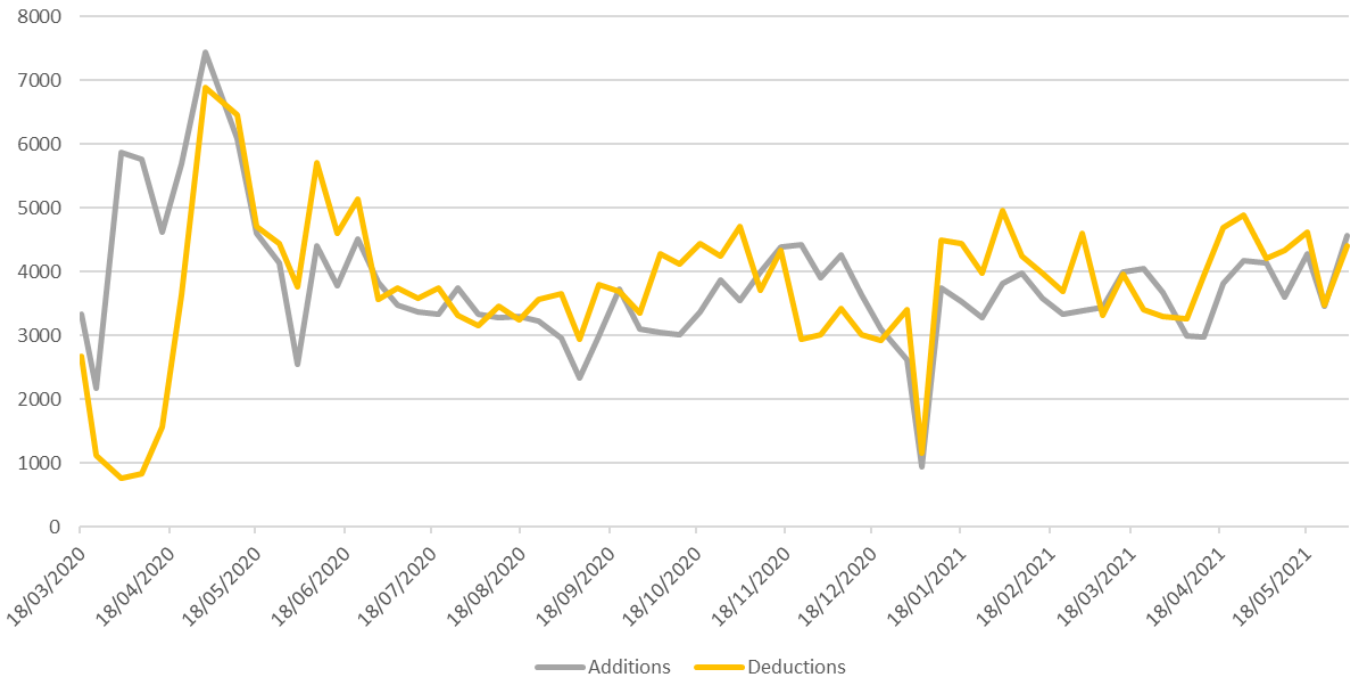

Challenges/Successes:

The Trust has been working hard to reduce the PBWL since the significant increases to PBWL due to the number of Covid patients. The main challenge is to balance the Trust priorities and resources to maintain the downward trend in patients on the PBWL. The continued work on reducing the PBWL is being successful and is being monitored to ensure this work continues.



Actions in place to recover:

The Trust has implemented the majority of specialty restoration plans with the remainder planned to be restored in line with the National guidance. The plans are focused on clinical urgency and increasing activity levels within agreed social distancing restrictions. The fortnightly PBWL meeting is continuing to monitor progress, challenge and offer support were necessary. The majority of specialities continue with the administrative validation, clinical triage, and the scaling up of technology enabled care. The plans will continue to be reviewed looking at the appropriate use of validation, PIFU (patient Initiated Follow Ups) and video consultations / telephone consultations.

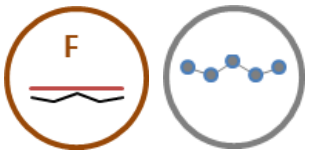


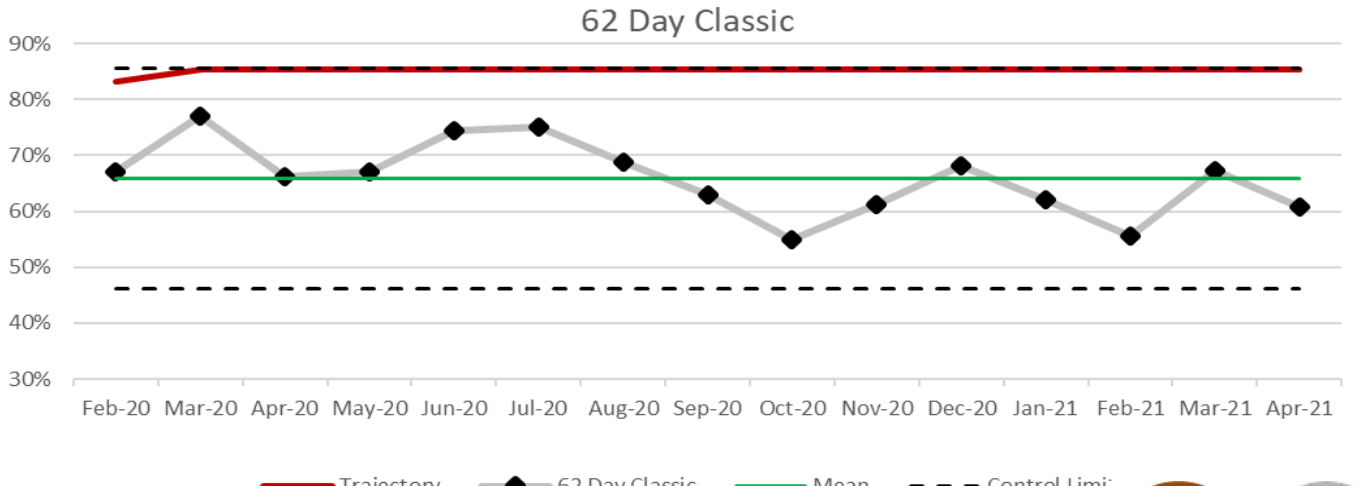
# IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

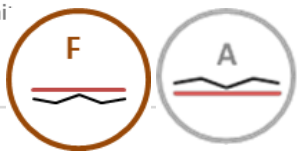
**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

**Strategic Objective:** Services

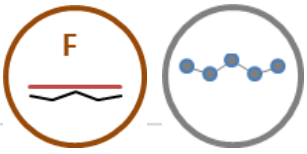




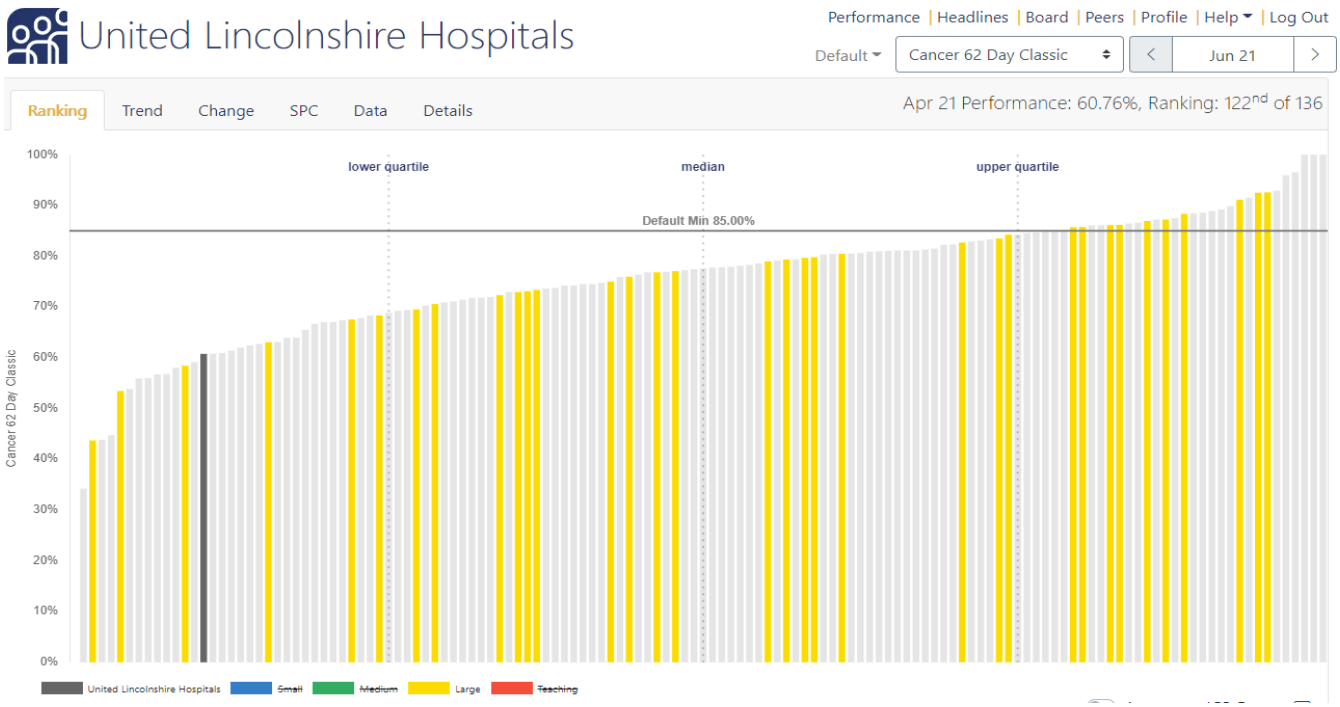




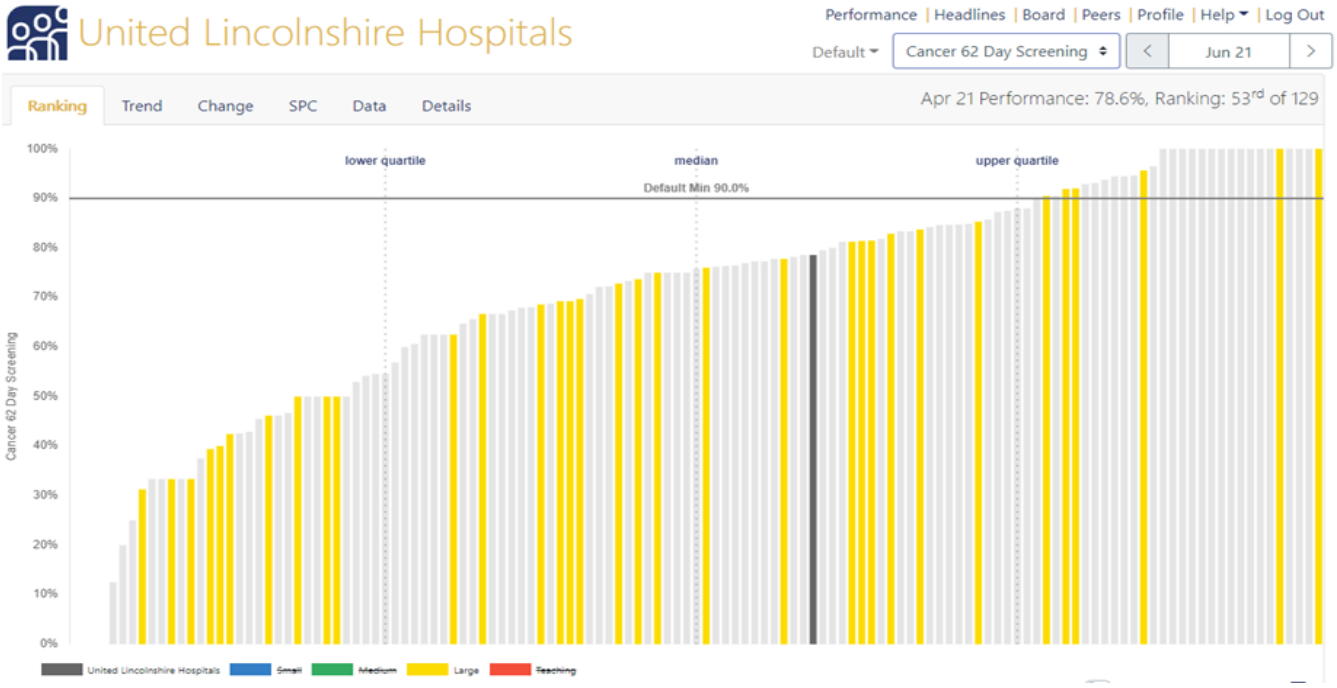
## Challenges/Successes

In April our 62 Day Classic performance decreased by 6.4% compared to March, at 60.8% placing us both below the national average (75.4%) and in the lower quartile.

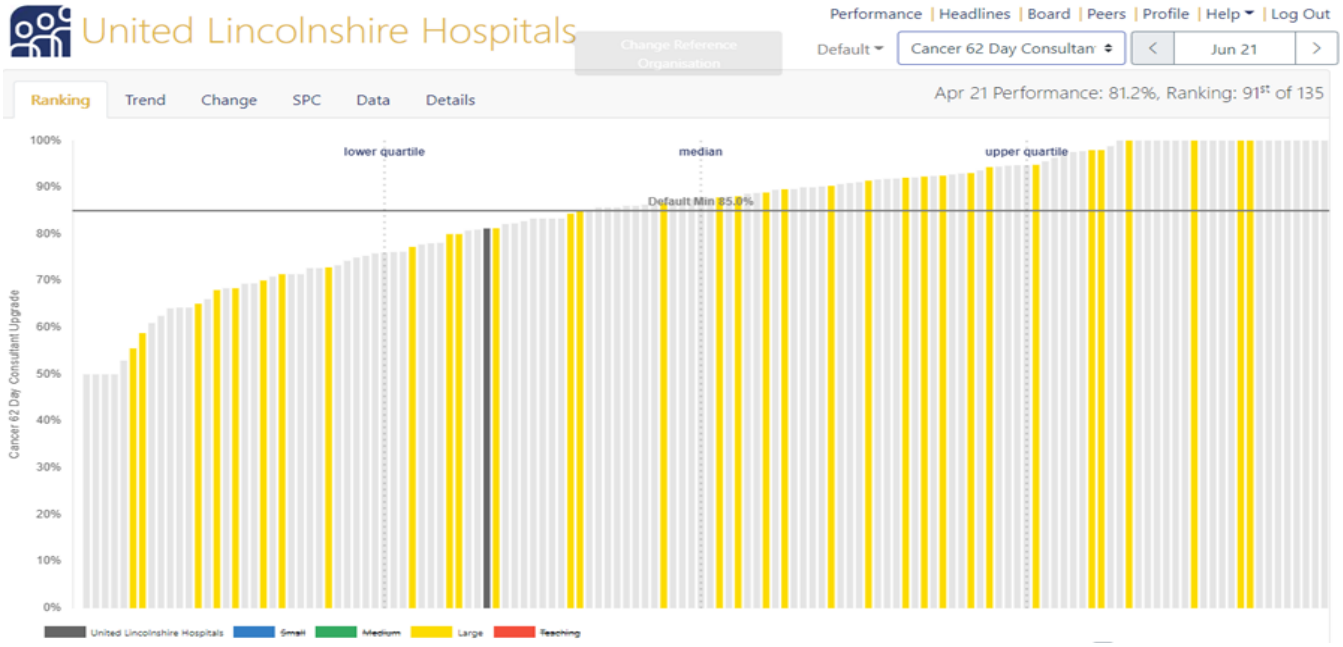
## 62 Classic




## 62 Screening



62 Upgrade




Early indications are that our May 62 Day Classic performance will be circa 55%.

Challenges to our performance include:

- Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period)
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient) can add to patient anxiety and reluctance to attend
- Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas
- Inappropriate referrals from GPs (eg not having face-to-face appointment prior to referral)
- Patients not willing to travel to where our service and / or capacity is
- Patient acceptance & compliance with swabbing and self-isolating requirements
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions - pre-covid level theatre capacity is not expected to be achieved until circa end July 2021.
- Less access to Independent Sector capacity unlike other regional colleagues
- Increase in backlogs due to COVID-19 wave 2 impact on our services
- Managing backlogs significantly in excess of pre-COVID levels for Colorectal and Head & Neck.
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients

Actions in place to recover:

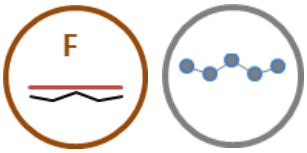
- 28 Day standard identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham
- Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August
- Increase in internal radiology reporting capacity.
- Increase in CTC capacity whilst we have the relocatable and modular staffing from 336 pcm to 530 pcm. No remaining backlog waiting to be booked and it is anticipated that patients will be scanned within 7 days by the end of June / beginning of July.
- Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual.
- A Nurse endoscopist has been appointed on Bank and is supporting weekend lists and BSCP
- 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant, so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.
- Replacement of Pilgrim decontamination unit began in February. Now complete and went live on 24th May.
- Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway.
- 2 H&N consultant posts have been recruited, 1 started in April 2021, and another is due to start in July 2021.
- 2 substantive Medical Oncologists have been recruited to. One due to start in July 2021(covering Breast, Renal and Urology) and another due to start in October 2021 (covering Gynae and Breast). One agency Medical Oncologist will be in post for 6 months, commenced 24th May (covering UGI / LGI and CUP).

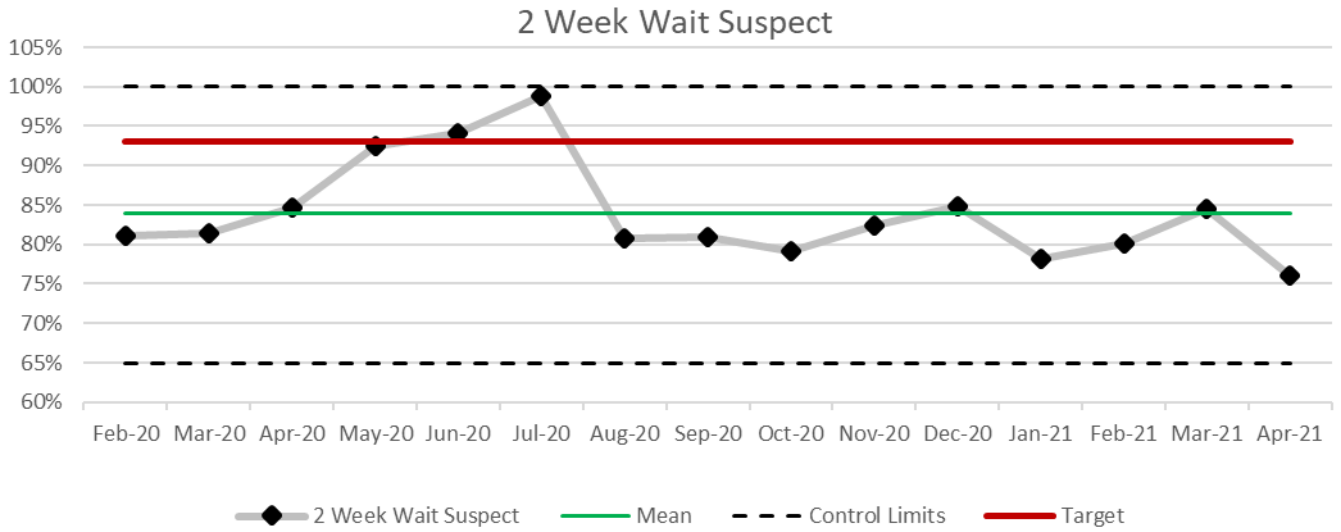
# IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

**Executive Lead:** Chief Operating Officer

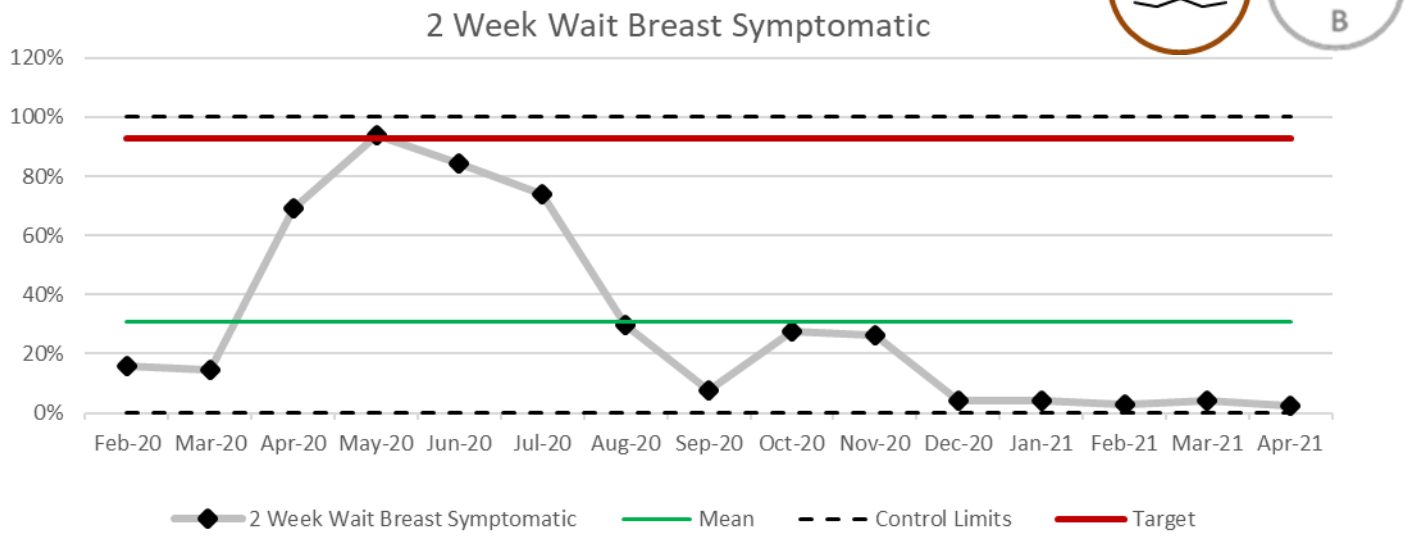
**CQC Domain:** Responsive

**Strategic Objective:** Services





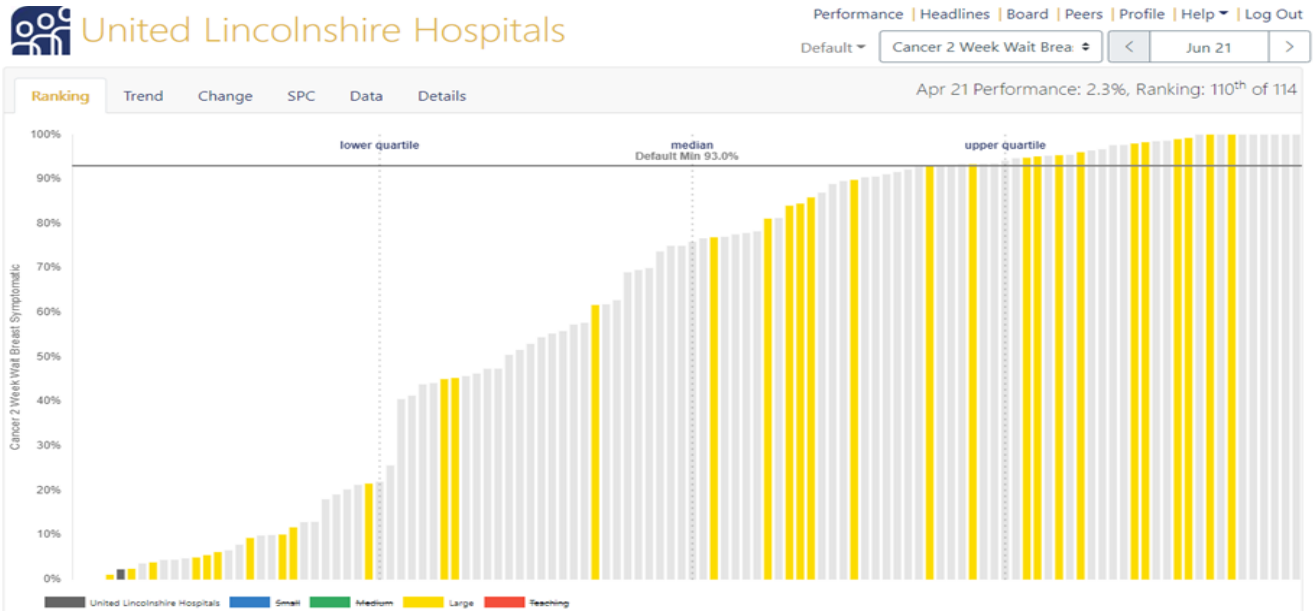



Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 64% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Gynaecology (60.7%), Lung (72.7%), Upper GI (84.21%), Haematology (85.7%), and Urology narrowly missed (91.1%). All other tumour sites achieved the standard. The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

## 14 Day Suspect Cancer


## 14 Day Breast Symptomatic




## Actions in place to recover:

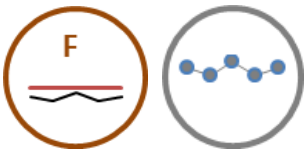
- Work continues to align all the 2ww Referral forms to NG12.
- Breast Services review and “deep dive” (following final report from NHSI support).
- Gynaecology Direct Access ultrasound pathway – awaiting date for commencement.
- Lung Direct Access pathway now Trust wide.
- Pilot to appoint Lung patients within 48 hours trialled.
- Pilot of triaging all Skin 2ww referrals due to commence in July.
- Upper GI Direct Access pathway – Looking to implement in July / August.
- Bladder and testicular pathway – scoping to revert to direct access pathway and Haematuria to one stop clinics. Clinical sign off took place on 09/06/2021.

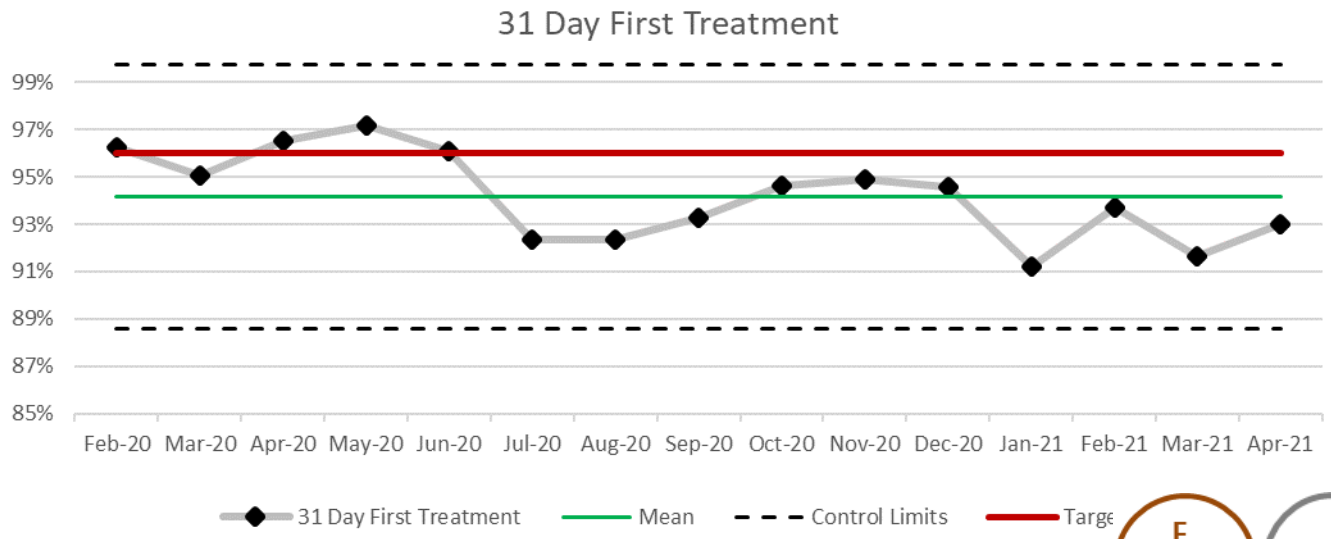
# IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

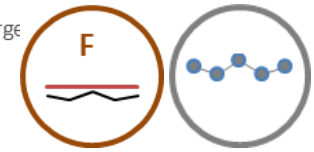
**Executive Lead:** Chief Operating Officer

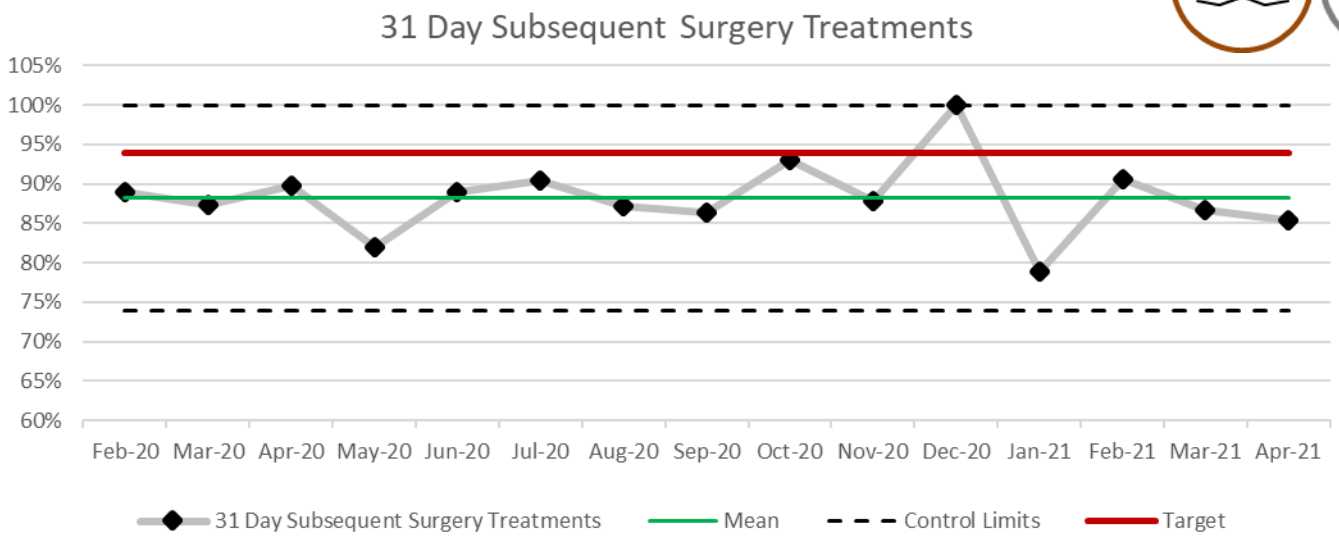
**CQC Domain:** Responsive

**Strategic Objective:** Services



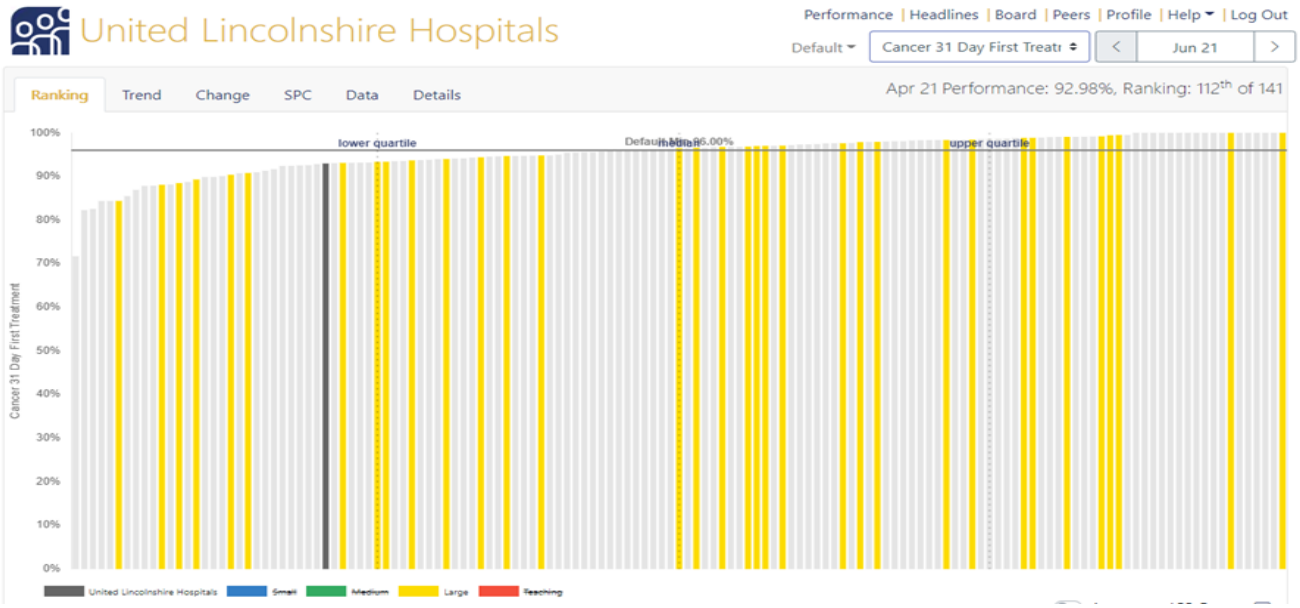



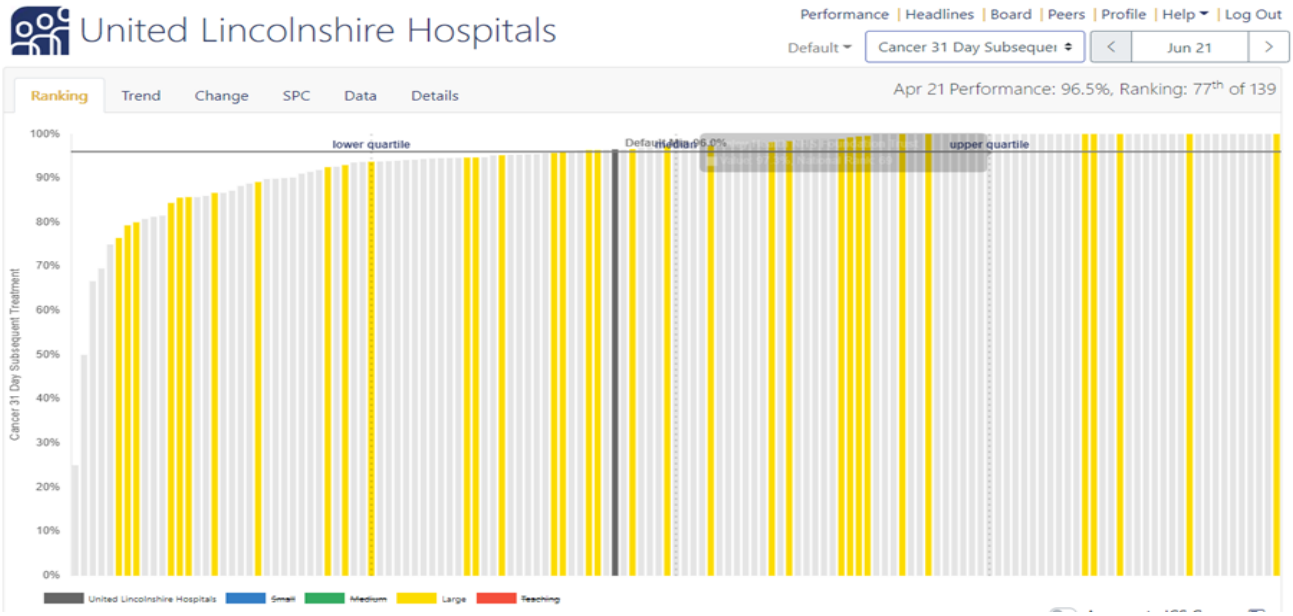

Challenges/Successes

The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity). For the subsequent standards the Trust was successful in the Drug and Radiotherapy standards, only failing in the surgery standard.

31 First




31 Subsequent




Actions in place to recover:

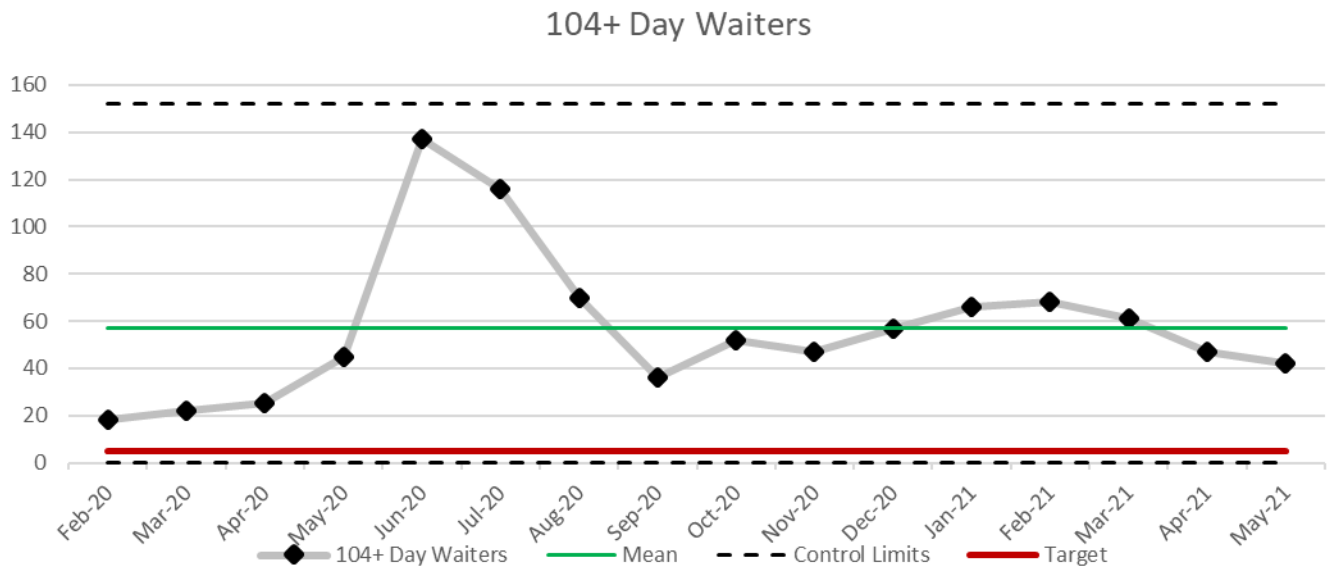
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- 2 H&N consultant posts have been recruited to, 1 started in April 2021, and another is due to start in July 2021.
- 2 substantive Medical Oncologists have been recruited to. One due to start in July 2021(covering Breast, Renal and Urology) and another due to start in October 2021 (covering Gynae and Breast). One agency Medical Oncologist will be in post for 6 months, commencing 24th May (covering UGI / LGI and CUP).

# IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

**Executive Lead:** Chief Operating Officer

**CQC Domain:** Responsive

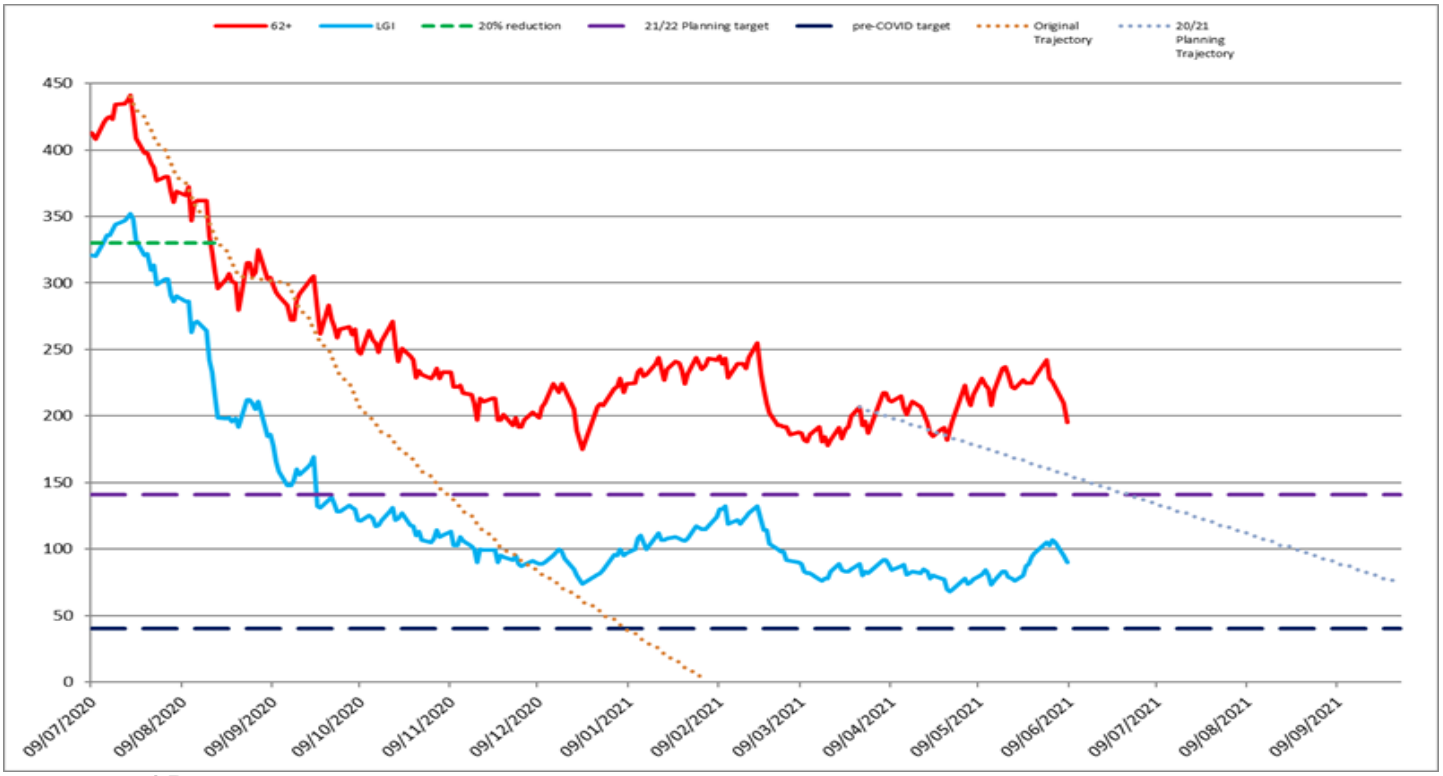
**Strategic Objective:** Services




Challenges/Successes

Though the backlog has been reducing, it has not been at the speed required.

- As of 10th of June the 62 Day backlog is at 188 patients (from 441, target – below 40) **57% Reduction.**
- In August' 20 Colorectal patients accounted for c.70% of backlog and is now c.51%.
- Of the other tumour sites, Head & Neck, remains an outlier compared to pre-COVID levels.



104 Day Waiters as of 10th Of June is at 42 (from 163, target – below 10) **74% Reduction**

- 20 Colorectal
- 7 Urology
- 6 Head & Neck
- 3 each Haematology and Upper GI
- 2 Lung
- 1 Gynae

Approx 24% of these patients require support from the Pre Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway. Work to enhance the early identification of these patients is ongoing.

Challenges to reducing the backlogs:

- Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period).
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient) can add to patient anxiety and reluctance to attend.
- Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
- Inappropriate referrals from GPs (eg not having face-to-face appointment prior to referral).
- Patients not willing to travel to where our service and / or capacity is.
- Patient acceptance & compliance with swabbing and self-isolating requirements.
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions -pre-covid level theatre capacity is not expected to be achieved until circa end July 2021.
- No access to Independent Sector capacity unlike other regional colleagues.
- Very limited success in identifying additional surgical capacity, in or out of region, through the East Midlands Cancer Alliance Surgical Hub.
- Increase in backlogs due to COVID-19 wave 2 impact on our services.
- Managing backlogs significantly in excess of pre-COVID levels for Colorectal and Head & Neck.
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients

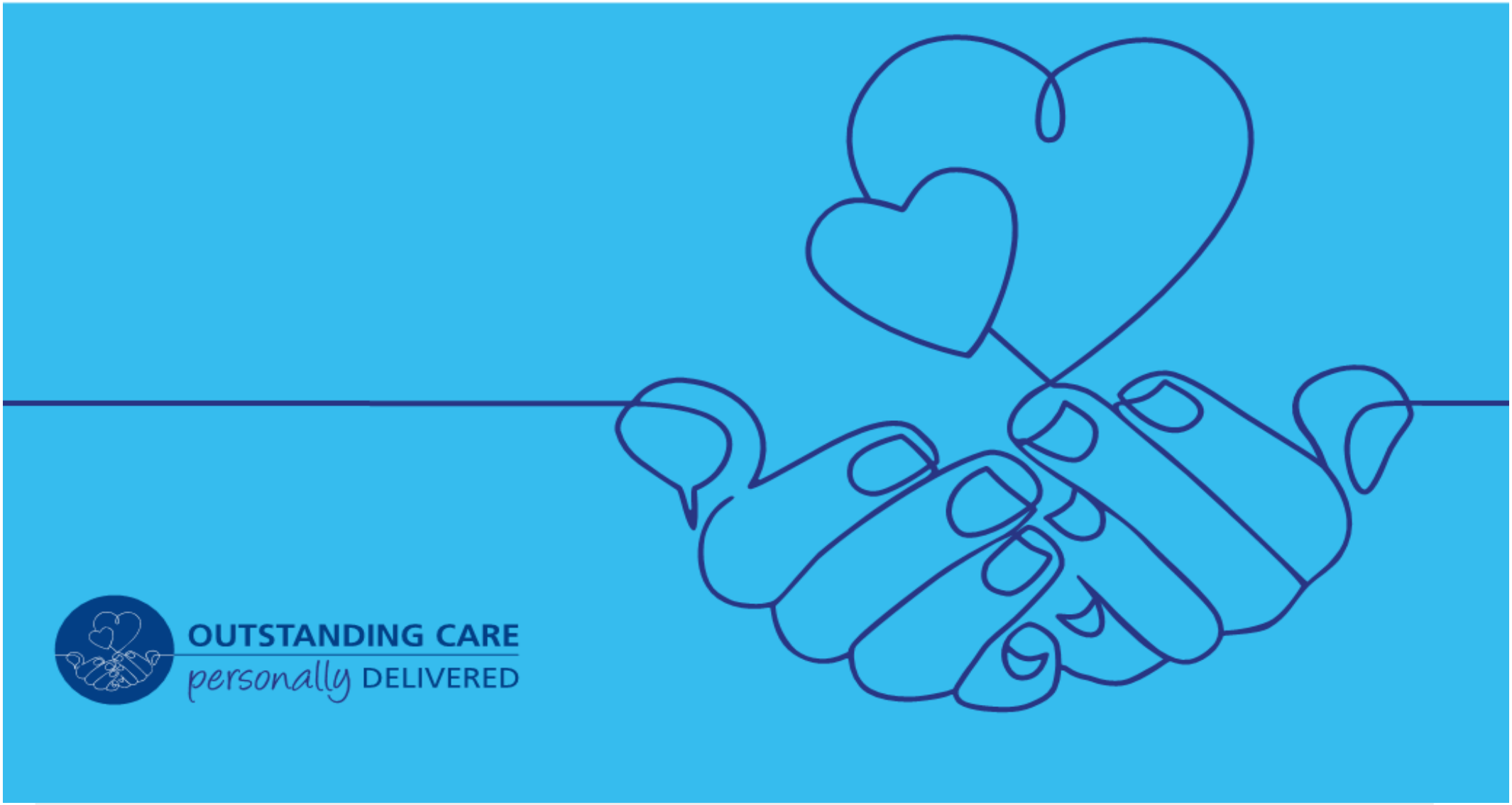
<u>Actions in place to recover:</u>

- 28 Day standard identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.

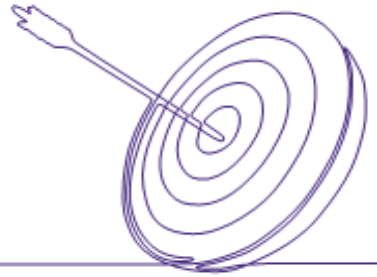
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August.
- Increase in internal radiology reporting capacity.
- Increase in CTC capacity whilst we have the relocatable and modular staffing from 336pcm to 530 pcm. No remaining backlog waiting to be booked and it is anticipated that patients will be scanned within 7 days by the end of June / beginning of July.
- Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual.
- A Nurse endoscopist has been appointed on Bank and is supporting weekend lists and BSCP.
- 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant, so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.
- Replacement of Pilgrim decontamination unit began in February. Now complete and went live on 24th May.
- Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway.
- 2 H&N consultant posts have been recruited, 1 started in April 2021, and another is due to start in July 2021.
- 2 substantive Medical Oncologists have been recruited to. One due to start in July 2021(covering Breast, Renal and Urology) and another due to start in October 2021 (covering Gynae and Breast). One agency Medical Oncologist will be in post for 6 months, commenced 24th May (covering UGI / LGI and CUP).

# Financial Position Month 2 (2021/22)
# Finance Report
# 5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



# Finance Spotlight Report

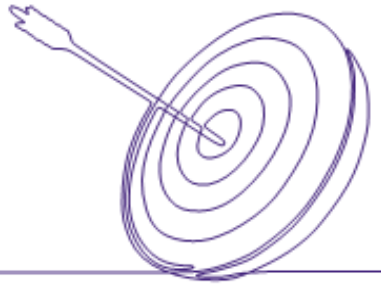


NHS
United Lincolnshire Hospitals
NHS Trust

| | Current Month | | | Year To Date | | |
|---|---|---|---|---|---|---|
| | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Actual £'000 | Variance £'000 |
| Operating income from patient care activities | 49,237 | 49,362 | 125 | 98,994 | 99,110 | 116 |
| Other operating income | 2,569 | 2,660 | 92 | 5,306 | 5,406 | 100 |
| Employee expenses | -35,387 | -35,105 | 282 | -70,557 | -70,276 | 281 |
| Operating expenses excluding employee expenses | -16,603 | -17,208 | -605 | -34,293 | -34,898 | -605 |
| Net Finance Costs | -639 | -640 | -1 | -1,250 | -1,251 | -1 |
| Other gains/(losses) including disposal of assets | 0 | 7 | 7 | 0 | 7 | 7 |
| **SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR** | **-823** | **-924** | **-101** | **-1,800** | **-1,902** | **-102** |
| Remove capital donations/grants I&E impact | -44 | 57 | 101 | 12 | 114 | 102 |
| **Adjusted financial performance surplus/(deficit)** | **-867** | **-867** | **0** | **-1,788** | **-1,788** | **0** |

- The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract.
- Without the planned system support, funding for lost Other Operating Income and top up block funding, the Trust would have reported a Year End deficit of £196.8m.
- The Lincolnshire system submitted a breakeven financial plan for H1 of 2021/22; the system submission is inclusive of a breakeven position for the Trust and a requirement for the Trust to deliver efficiency savings of £6.2m in H1.
- The above table shows that the Trust has delivered a £0.9m deficit for the month of May (in line with plan); the above table also shows that the Trust has delivered a £1.8m deficit year to date (in line with plan).

# Finance Spotlight Report (continued)



NHS
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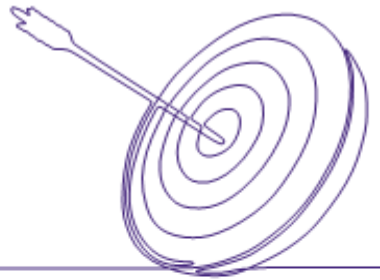
NHS Trust

- The current month and YTD Income positions are both £0.2m favourable to plan; the favourable Income position includes variable top-up funding for drugs and devices, and income to offset the costs of the Covid Vaccination Programme.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £33.4m was delivered in the current month, such that actual activity delivered is £15.7m lower than the income the Trust received. However, the income is inclusive of COVID, Top Up, Restore and BAU allocations.
- The current month and YTD Pay positions are both £0.3m favourable to plan; the favourable Pay position includes slower than planned growth in activity volumes and investment.
- The YTD Pay position does not include an accrual for the A4C pay award as this has not been agreed nationally, pay award costs are anticipated to be offset by an income stream.
- The May Pay position includes an estimate of £0.4m for the cost of Bank Holiday Enhancements for the two Bank Holidays in May, an accrual of £60k per month as an estimate of the YTD impact of the Flowers Case, and £0.2m in relation to the cost of the Covid Vaccination Programme in April.
- The May Pay position includes expenditure of £3.7m on Agency staff and £3.2m on Bank staff; this represents a reduction of £1.3m compared to March (if we remove the impact of technical items at year end); This is broadly aligned to plan, but reductions are required in Q2 to deliver the CIP target.

# Finance Spotlight Report (continued)



United Lincolnshire Hospitals NHS Trust

- The current month and YTD Non Pay positions are both £0.6m adverse to plan.
- Non Pay expenditure of £17.7m in April and £17.2m in May is broadly aligned to spend of £17.4m in March (if we remove the impact of technical items at year end).
- The reduction of £0.5m in the Non Pay position from April to May reflects £0.1m in relation to non recurrent Injury Benefit costs in April, a reduction of £0.1m in relation to the Rapid Recruitment project, and a reduction of £0.5m in drugs spend.
- In 2021/22, efficiency savings will be referred to as CRES (Cost Reduction Expenditure Savings) rather than as CIP. For Month 2, no CRES delivery is reported in relation to 2021/22 schemes; £0.4m has been delivered in relation to the FYE of 2020/21 schemes.
- Capital expenditure as at M2 of the financial year equated to c£1m against a submitted plan of c£3.2m.
- The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May and subsequently the remaining c£10m agreed at FPEC (May meeting) thereby completing the agreed capital programme that has been shared with all key stakeholders.
- The month end cash balance is £53.1m which is a decrease of £0.9m against cash at 31 March 2021.

# Finance Dashboard

NHS
United Lincolnshire Hospitals
NHS Trust

NHSI's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care. The assessment is in 5 resource areas;

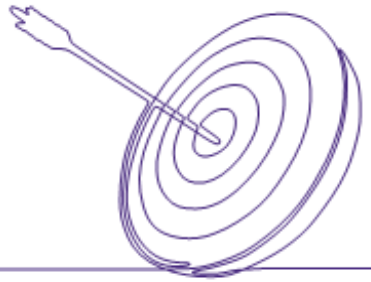
**Clinical Services**
**People**
**Clinical Support Services**
**Corporate Services, Procurement, Estates and Facilities**
**Finance**

| Metric | Rating Boundary | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| Capital servicing capacity | 2.5 | 1.75 | 1.25 | <1.25 |
| Liquidity ratio (days) | 0 | -7 | -14 | <-14 |
| I&E Margin | 1% | 0% | -1% | <=-1 |
| I&E margin distance from plan | 0% | -1% | -2% | <=-2% |
| Agency | 0% | 25% | 50% | >=50% |

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last two full financial years and the current 2020/21 position are as follows

| Finance and use of resources rating | Full Year | Full Year | Full Year | Actual |
|---|---|---|---|---|
| | 31/03/2019 | 31/03/2020 | 31/03/2021 | YTD MAY 2021 |
| Capital service cover metric | (10.40) | (1.73) | 0.06 | 1.42 |
| Capital service cover rating | 4 | 4 | 4 | 3 |
| Liquidity metric | (98.73) | (128.28) | 3.71 | 3.27 |
| Liquidity rating | 4 | 4 | 1 | 1 |
| I&E margin metric | (19.71%) | (7.62%) | 0.38% | (1.70%) |
| I&E margin rating | 4 | 4 | 2 | 4 |
| Agency metric | 77.00% | 110.00% | 113.00% | 116.00% |
| Agency rating | 4 | 4 | 4 | 4 |
| I&E margin: distance from financial plan | 4 | 1 | n/a | n/a |

# Capital Spend



United Lincolnshire Hospitals NHS Trust

| Scheme Summary | YTD Plan £000 | YTD Actual £000 | YTD Variance £000 |
|---|---|---|---|
| Fire | 400.0 | 166.9 | 233.1 |
| Estates - General | 190.0 | 168.2 | 21.8 |
| Estates - Ward Refurbishments | 0.0 | 1.0 | -1.0 |
| Estates - Medical School | 0.0 | 7.1 | -7.1 |
| Estates - Lincoln & Pilgrim ED - Stage 1 | 111.0 | 119.7 | -8.7 |
| Estates - Lincoln ED - Resus - Stage 2 | 400.0 | 56.2 | 343.8 |
| Estates - EPC | 0.0 | 6.2 | -6.2 |
| Estates - CIR | 1,140.0 | 187.6 | 952.4 |
| Medical Equipment | 200.0 | 0.0 | 200.0 |
| Digital | 572.0 | 300.4 | 271.6 |
| Service Developments | 200.0 | 0.0 | 200.0 |
| Pilgrim A&E / UTC | 34.0 | 22.0 | 12.0 |
| Funding yet to be allocated | 0.0 | 0.0 | 0.0 |
| Total | 3,247.0 | 1,035.2 | 2,211.8 |

| Scheme Summary | Full Year Plan £000 | Forecast Actual £000 | Forecast variance £000 |
|---|---|---|---|
| Fire | 2,251.0 | 2,251.0 | 0.0 |
| Estates - General | 1,969.6 | 1,969.6 | 0.0 |
| Estates - Ward Refurbishments | 1,450.0 | 1,450.0 | 0.0 |
| Estates - Medical School | 2,400.0 | 2,400.0 | 0.0 |
| Estates - Lincoln & Pilgrim ED - Stage 1 | 712.0 | 712.0 | 0.0 |
| Estates - Lincoln ED - Resus - Stage 2 | 8,000.0 | 8,000.0 | 0.0 |
| Estates - EPC | 1,520.4 | 1,520.4 | 0.0 |
| Estates - CIR | 4,033.5 | 4,033.5 | 0.0 |
| Medical Equipment | 1,781.3 | 1,781.3 | 0.0 |
| Digital | 4,258.4 | 4,258.4 | 0.0 |
| Service Developments | 1,349.4 | 1,349.4 | 0.0 |
| Pilgrim A&E / UTC | 3,981.0 | 3,981.0 | 0.0 |
| Funding yet to be allocated | 0.0 | 0.0 | 0.0 |
| Total | 33,706.6 | 33,706.6 | 0.0 |

All key stakeholders are involved in ensuring schemes are monitored and managed. Exception reporting on issues shared with CDG fortnightly.

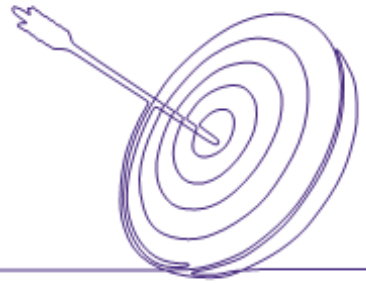
Capital funding levels for 2021/22 agreed, with a plan of c£33.7m. Trust Board, in May, agreed the initial allocation of c£23m and FPEC subsequently agreed the allocation of the remaining c£10m. All key stakeholders have been informed of the finalised capital programme.

The capital plan submitted to NHSE/I has a year-to-date plan at M2 of £3.2m. Spend incurred at M2 equated to c£1m, therefore schemes are behind plan by c£2.2m.

Key areas of variance are:

- CIR scheme installation, electrical/water/LST radiators, progressing but behind submitted plan by c£1m. Re-assessing specifications to ensure correct tenders are shared causing temporary delays in spend being incurred.
- Lincoln ED Resus scheme behind submitted plan by £0.3m.
- Digital Schemes £0.3m behind plan.
- Fire schemes delayed due to assessment of works required, causing £0.2m variance
- Medical Devices behind plan by £0.2m due to late allocation of funds. Orders being raised and purchases made.

# Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

| | 31 March 2021 | 31 May 2021 | |
|---|---|---|---|
| | | Plan | Actual |
| | £000 | £000 | £000 |
| Intangible assets | 4,600 | 4,292 | 4,285 |
| Property, plant and equipment | 247,119 | 248,210 | 245,971 |
| Receivables | 2,790 | 2,781 | 2,785 |
| **Total non-current assets** | **254,509** | **255,283** | **253,041** |
| Inventories | 6,510 | 6,728 | 6,701 |
| Receivables | 25,935 | 23,074 | 24,145 |
| Cash and cash equivalents | 54,042 | 43,696 | 53,127 |
| **Total current assets** | **86,487** | **73,498** | **83,973** |
| Trade and other payables | (69,643) | (57,868) | (66,270) |
| Borrowings | (402) | - | (402) |
| Provisions | (2,056) | (2,178) | (2,235) |
| Other liabilities | (1,587) | (2,943) | (2,870) |
| **Total current liabilities** | **(73,688)** | **(62,989)** | **(71,777)** |
| **Total assets less current liabilities** | **267,308** | **265,792** | **265,237** |
| Borrowings | (3,624) | (4,026) | (3,624) |
| Provisions | (4,069) | (4,040) | (3,983) |
| Other liabilities | (12,075) | (11,991) | (11,991) |
| **Total non-current liabilities** | **(19,768)** | **(20,057)** | **(19,598)** |
| **Total assets employed** | **247,540** | **245,735** | **245,639** |
| **Financed by** | | | |
| Public dividend capital | 677,570 | 677,570 | 677,570 |
| Revaluation reserve | 27,522 | 27,406 | 27,406 |
| Other reserves | 190 | 190 | 190 |
| Income and expenditure reserve | (457,742) | (459,431) | (459,527) |
| **Total taxpayers' equity** | **247,540** | **245,735** | **245,639** |

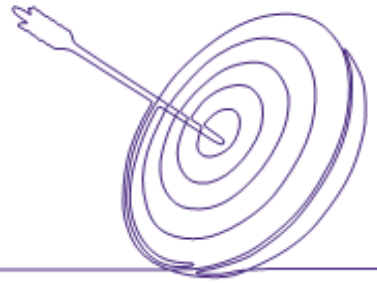
Note 1: The financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

Note 2: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments for the first half of 2021/22.

Note 3: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave and the Flowers liability due to be paid out in September.

Note 4: Trade Payables remain below pre-pandemic levels with the Trust continuing to pay suppliers well within the 30 day target. Staff related creditors are however at higher levels than historically seen, with increases due to annual leave (£8.1m) and 'Flowers' accruals (£1.4m). Capital creditors have dropped from March and are now at £4.9m.
BPPC for April was 92% / 88% as measured by value / volume of invoices paid.

# Cashflow



NHS
United Lincolnshire Hospitals
NHS Trust

| | Full Year 2020/21 | 31 May 2021 | |
|---|---|---|---|
| | | Plan | Actual |
| | £000 | £000 | £000 |
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | 8,778 | (553) | (658) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 13,674 | 2,564 | 2,509 |
| Impairments and reversals | 3,121 | - | - |
| Income recognised in respect of capital donations | (3,923) | (100) | - |
| Amortisation of PFI deferred credit | (503) | (84) | (84) |
| (Increase) / decrease in receivables and other assets | 16,119 | 2,870 | 1,795 |
| (Increase) / decrease in inventories | 527 | (218) | (191) |
| Increase/(decrease) in trade and other payables | 16,987 | (2,885) | 3,498 |
| Increase/(decrease) in other liabilities | (2,085) | 1,356 | 1,283 |
| Increase / (decrease) in provisions | 1,556 | 122 | 122 |
| **Net cash flows from / (used in) operating activities** | **54,251** | **3,072** | **8,274** |
| **Cash flows from investing activities** | | | |
| Interest received | 12 | - | - |
| Purchase of intangible assets | (1,245) | - | - |
| Purchase of property, plant and equipment | (39,483) | (13,418) | (9,196) |
| Proceeds from sales of property, plant and equipment | 625 | - | 7 |
| Net cash flows from / (used in) investing activities | (40,091) | (13,418) | (9,189) |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | 409,664 | - | - |
| Loans from Department of Health and Social Care - repaid | (377,859) | - | - |
| Other loans received | 2,544 | - | - |
| Interest paid | (2,522) | - | - |
| PDC dividend (paid)/refunded | (5,662) | - | - |
| Net cash flows from / (used in) financing activities | 26,165 | - | - |
| **Increase / (decrease) in cash and cash equivalents** | **40,325** | **(10,346)** | **(915)** |
| Cash and cash equivalents at 1 April - brought forward | 13,717 | 54,042 | 54,042 |
| **Cash and cash equivalents at period end** | **54,042** | **43,696** | **53,127** |

Note 1: The financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

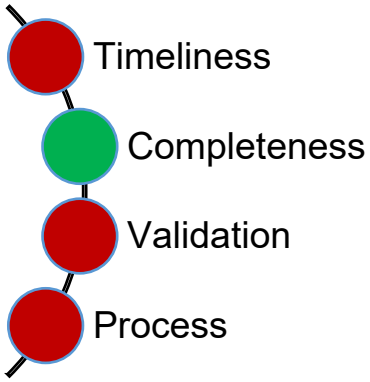
Note 2: The format presented here is as presented within the final accounts. This will be replaced for the June report by a receipts and payments style cashflow.

Note 3: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave and the Flowers liability due to be paid out in September.

Note 4: The cash position has remained relatively steady since March, the only notable movement being a reduction in capital creditors from £13.1m to £4.9m.
This is compensated by an increase in the level of trade creditors > 30 days.

# 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.<br>Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month.<br>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.<br>Where data is only available monthly, there is a data lag of more than one month.<br>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.<br>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.<br>A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is:<br>- Accurate<br>- In compliance with relevant rules and definitions for the KPI | Either:<br>- No validation has taken place; or<br>- An insufficient amount of data has been validated as determined by the KPI owner, or<br>- 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:<br>- The numerator and denominator of the indicator<br>- The process for data capture<br>- The process for validation and data cleansing<br>- Performance monitoring | There is no documented process.<br>The process is fragmented/inconsistent across the services |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item 13.1* |
| **Audit Committee Upward Report** | |
| Accountable Director | *Sarah Dunnett, Audit Committee Chair* |
| Presented by | *Sarah Dunnett, Audit Committee Chair* |
| Author(s) | *Jayne Warner, Trust Secretary* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *N/A* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Assurance level*<br>• *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | • *Ask the Board to note the upward report and the actions being taken by the Committee to provide assurance to the Board on strategic objective 2c* |

## Executive Summary

The Audit Committee met via MS Teams on the 7 June 2021, the meeting was held specifically to sign off the outstanding internal audit reports and to receive the Head of Internal Audit (HOIA) Opinion ahead of signing off the final accounts and annual report at Trust Board on the 9th June 2021.

The Committee considered the following items:

**Internal Audit Annual Report and Draft HOIA Opinion**

The Committee received the annual report and Head of Internal Audit Opinion.

The overall head of internal audit opinion was partial assurance with three key areas identified as high risk:

- Pharmacy and medicines management
- Control of overpayments to leavers
- Weaknesses in the Estates control environment

The Committee noted that whilst the number of actions implemented had improved a recommendation had been made that progress on implementing recommendations should be strengthened.

The Committee were concerned about the ownership of audit actions at Executive level. Executives with responsibility for the areas of high risk would be invited to attend the audit committee to provide assurance that action was being taken.

The Committee noted that the Head of Internal Audit Opinion had been used to inform the annual governance statement.

**Internal Audit Strategic Plan**

The Audit Committee received and approved the Internal Audit Plan for 2021/22 as the final plan.

**Internal Audit Reports**

The Committee received the following reports

- Payroll Host Report – significant assurance
- Serious Incident Report – partial assurance
- Complaints Report – partial assurance
- Risk Report – partial assurance
- Estates Report - No assurance

The Committee asked that the reports were presented to the relevant committee for consideration of the recommendations.

The Committee noted that the risk report concluded that the fundamental and key elements for managing risk were in place as part of the overall governance framework, but embedding remains and issue, particularly at a divisional level.

The Estates review considered the design and operation of controls over the Trust's management of estates. The review concluded that the current processes do not provide assurance to the Board.

The review identified a number of significant themes which overall create weaknesses in control. The report summarises the findings into five key priority areas. The report makes a number of recommendations to strengthen controls which have been responded to in an action plan

It was agreed that the Audit Committee would consider the report in detail at its meeting in July with the relevant officers in attendance. The Committee asked that the Board reflect on whether the issues highlighted should have been alerted at an earlier stage

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item 13.2* |
| **Strategic Risk Report** | |
| Accountable Director | *Dr Karen Dunderdale, Director of Nursing* |
| Presented by | *Dr Karen Dunderdale, Director of Nursing* |
| Author(s) | *Matt Hulley, Risk & Incident Manager* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *Multiple – please see report* |
| Financial Impact Assessment | *None* |
| Quality Impact Assessment | *None* |
| Equality Impact Assessment | *None* |
| Assurance Level Assessment | *Moderate* |

| | |
|---|---|
| Recommendations/ Decision Required | *Trust Board is invited to review the report and identify any areas of strategic risk requiring further action* |

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all Very high risks (those rated 20-25) have been updated with available data, as evidence of the current extent of risk exposure
- The effect of the 'Delta Variant' on ULH services requires careful monitoring
- 71% of all strategic risks are now overdue their review date. This will be addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.

**Purpose**

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

- Review the management of significant strategic risks.
- Evaluate the effectiveness of the Trust's risk management processes.

## 1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. They are comprised of two distinct layers, which are defined in the Trust's current Risk Management Strategy as:

- Strategic risk register – used to manage significant risks to the achievement of Trust-wide or multi-divisional objectives.
- Operational risk registers – used to manage significant risks to the objectives of divisional business units and their departments or specialties.

1.2 This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of the full strategic risk register is also provided for reference. Of note 71% of all strategic risks are now overdue their review date. This will be addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.

## 2. Strategic Risk Profile

2.1 There is 1 strategic quality & safety risk with a current rating of Very high risk:

| | | | |
|---|---|---|---|
| **Risk title (ID)** | Local impact of the global coronavirus (Covid-19) pandemic (4558) | | |
| **Current risk rating** | Very high (25) | **Risk lead** | Natalie Vaughan |
| **Lead group** | Infection Prevention & Control Group | | |

Key Risk Indicators (KRIs):

- Total number of Covid-19 inpatient admissions – as of 25 June 2021 there had been 3,074 Covid-19 inpatient cases within ULHT; this is an increase of 8 since 4 June.
- Number of current inpatient admissions due to Covid-19 – 0 at Lincoln and 2 at Pilgrim as of 25 June 2021; this follows the trend of reduction from previous months.
- Patient deaths due to Covid-19 – total of 837 as of 25 June 2021, compared with 835 at the 6 June 2021
- Serious Incidents where the pandemic response is a contributory factor – to the end of May 2021 there were 30 completed SI investigations that cited the pandemic response; an average of 3.5 incidents per month between March and July 2020; an average of 1 per month between August and December 2020 with a declining average of 0.5 incidents per month within 2021. No further SIs relating to Covid have been declared since April 2021
- Covid-related incidents – between March 2020 and June 2021 there were 1,143 incidents that cited the pandemic response as a factor, with higher than average numbers between November 2020 and January 2021; this includes 17 Moderate harm incidents linked to the pandemic response; 15 Severe harm; and 2 Deaths

Gaps in control & mitigating actions:

- England Covid alert level is at Level 3 (epidemic is in general circulation)
- Cases of the Delta variant of COVID-19 are increasing across the country and the situation is being monitored closely.
- Intensive care capacity to be increased to 200% if required
- 3 vaccines have now been approved by the MHRA and are being rolled out across the country; there are several approved treatments for Covid-19 symptoms that are now in use.
- Operational Gold Command in place to manage the ULHT response – control protocols is use for site access; PPE use; social distancing; patient admissions & discharges; staff rapid testing; use of essential equipment & oxygen
- Essential information to all staff is now being provided to staff through the weekly ULHT Bulletin which has replaced the SBAR

2.2 There is 1 strategic finance, performance or estates risk with a current rating of Very high risk:

| | | | |
|---|---|---|---|
| **Risk title (ID)** | Capacity to manage emergency demand (4175) | | |
| **Current risk rating** | Very high (20) | **Risk lead** | Simon Evans |
| **Lead group** | Divisional Performance Review Meetings (PRMs) | | |

Key Risk Indicators (KRIs):

- A&E waiting times against the constitutional standard – 4-hour performance for May was 72.56% a deterioration against April's performance of 74.23% This is the seventh time in ten months the Trust's performance has been below the agreed trajectory
- Ambulance conveyances for May were 4843, up 7.48% against April. The Trust saw an increase in >59-minute ambulance handover delays, with 285 in May a deterioration of 78 from April.

Gaps in control & mitigating actions:

- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place

2.3 There is 1 strategic people & organisational development risks with a current rating of Very high risk:

| | | | |
|---|---|---|---|
| **Risk title (ID)** | Workforce engagement, morale & productivity (4083) | | |
| **Current risk rating** | Very high (20) | **Executive lead** | Martin Rayson |
| **Lead group** | Workforce Strategy Group | | |

Key Risk Indicators (KRIs):

- Staff appraisal rates – was 74.92% in May and 76.42% in April and 75.67% YTD against a target of 90%
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

- Work on morale is part of the Integrated Improvement Plan and a number of work-streams within it, including introduction of an individual performance management/appraisal e-learning programme from November & implementation of new WorkPal online appraisal system, which has been deferred to the New Year.

- New approaches to interacting with staff during Covid response; feedback has been positive and was reflected in results from the NHS Pulse Survey.

2.5 A summary of all current strategic risks is included as **Appendix 1**.

## 3. Conclusions & recommendations

3.1 The highest priority risks at present continue to relate to the Covid-19 pandemic and the potential impact on patients; staff; visitors and the continued provision of a full range of clinical services. There remains considerable uncertainty as to the future course of the pandemic and the risk posed to the Trust. The effect of the 'Delta Variant' on ULH services requires careful monitoring

3.2 The Trust Board is invited to review the report and advise of any further action required at this time to improve the management of strategic risks or to strengthen the Trust's risk management framework.

**Appendix 1** - Summary of all risks recorded on the Strategic Risk Register:

| ID | Title | Risk Type | Rating (current) | Risk level (current) | Review date |
|---|---|---|---|---|---|
| 4083 | Workforce engagement, morale & productivity | Reputation / compliance | 20 | Very high risk | 30/06/2021 |
| 4175 | Capacity to manage emergency demand | Service disruption | 20 | Very high risk | 31/12/2020 |
| 4558 | Local impact of the global coronavirus (Covid-19) pandemic | Harm (physical or psychological) | 25 | Very high risk | 31/03/2021 |
| 4556 | Safe management of demand for outpatient appointments | Harm (physical or psychological) | 12 | High risk | 30/06/2021 |
| 4481 | Availability & integrity of patient information | Service disruption | 12 | High risk | 31/12/2020 |
| 4581 | Heating (Trust Wide) | Harm (physical or psychological) | 12 | High risk | 31/03/2021 |
| 3520 | Compliance with fire safety regulations & standards | Reputation / compliance | 12 | High risk | 30/09/2021 |
| 4081 | Quality of patient experience | Patient experience | 12 | High risk | 31/12/2020 |
| 4082 | Workforce planning process | Service disruption | 12 | High risk | 31/03/2021 |
| 3689 | Compliance with asbestos management regulations & standards | Reputation / compliance | 12 | High risk | 31/03/2021 |
| 4043 | Compliance with patient safety regulations & standards | Regulatory compliance & standards (including performance targets) | 12 | High risk | 31/03/2021 |
| 4145 | Compliance with safeguarding regulations & standards | Regulatory compliance & standards (including performance targets) | 12 | High risk | 31/03/2021 |
| 4146 | Effectiveness of safeguarding practice | Patient safety (physical or psychological harm) | 12 | High risk | 31/03/2021 |
| 4157 | Compliance with medicines management regulations & standards | Reputation / compliance | 12 | High risk | 30/06/2021 |
| 4181 | Significant breach of confidentiality | Reputation / compliance | 12 | High risk | 31/12/2020 |
| 4179 | Major cyber security attack | Service disruption | 12 | High risk | 31/12/2020 |
| 4176 | Management of demand for planned care | Service disruption | 12 | High risk | 31/12/2020 |
| 4362 | Workforce capacity & capability (recruitment, retention & skills) | Service disruption | 12 | High risk | 30/06/2021 |
| 4437 | Critical failure of the water supply | Service disruption | 12 | High risk | 31/03/2021 |
| 4405 | Critical infrastructure failure disrupting aseptic pharmacy services | Service disruption | 12 | High risk | 30/06/2021 |
| 4406 | Critical failure of the medicines supply chain | Service disruption | 12 | High risk | 30/06/2021 |
| 4423 | Working in partnership with the wider healthcare system | Service disruption | 12 | High risk | 31/12/2020 |
| 4401 | Safety of the hospital environment | Harm (physical or psychological) | 12 | High risk | 31/03/2021 |

| | | | | | |
|---|---|---|---|---|---|
| 4402 | Compliance with regulations and standards for mechanical infrastructure | Reputation / compliance | 12 | High risk | 31/03/2021 |
| 4403 | Compliance with electrical safety regulations & standards | Reputation / compliance | 16 | High risk | 31/03/2021 |
| 4404 | Major fire safety incident | Harm (physical or psychological) | 16 | High risk | 30/09/2021 |
| 4480 | Safe management of emergency demand | Harm (physical or psychological) | 16 | High risk | 31/12/2020 |
| 4383 | Substantial unplanned expenditure or financial penalties | Finance | 16 | High risk | 30/09/2021 |
| 4300 | Availability of medical devices & equipment | Medical equipment | 16 | High risk | 31/12/2020 |
| 4156 | Safe management of medicines | Harm (physical or psychological) | 16 | High risk | 30/06/2021 |
| 4142 | Safe delivery of patient care | Patient safety (physical or psychological harm) | 16 | High risk | 31/03/2021 |
| 4144 | Uncontrolled outbreak of serious infectious disease | Patient safety (physical or psychological harm) | 16 | High risk | 31/12/2020 |
| 4044 | Compliance with information governance regulations & standards | Reputation / compliance | 16 | High risk | 30/06/2021 |
| 3690 | Compliance with water safety regulations & standards | Reputation / compliance | 16 | High risk | 31/03/2021 |
| 3720 | Critical failure of the electrical infrastructure | Service disruption | 16 | High risk | 31/03/2021 |
| 3688 | Quality of the hospital environment | Reputation / compliance | 16 | High risk | 31/03/2021 |
| 4003 | Major security incident | Harm (physical or psychological) | 16 | High risk | 31/03/2021 |
| 4424 | Delivery of planned improvements to quality & safety of patient care | Regulatory compliance & standards (including performance targets) | 8 | Moderate risk | 31/12/2020 |
| 4476 | Compliance with clinical effectiveness regulations & standards | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4441 | Compliance with radiation protection regulations & standards | Reputation / compliance | 8 | Moderate risk | 30/06/2022 |
| 4389 | Compliance with corporate governance regulations & standards | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4397 | Exposure to asbestos | Harm (physical or psychological) | 8 | Moderate risk | 31/03/2021 |
| 4398 | Compliance with environmental and energy management regulations & standards | Reputation / compliance | 8 | Moderate risk | 31/03/2021 |
| 4399 | Compliance with health & safety regulations & standards | Reputation / compliance | 8 | Moderate risk | 30/09/2021 |
| 4351 | Compliance with equalities and human rights regulations, standards & contractual requirements | Reputation / compliance | 8 | Moderate risk | 31/03/2021 |
| 4352 | Public consultation & engagement | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4353 | Safe use of medical devices & equipment | Patient safety (physical or psychological harm) | 8 | Moderate risk | 31/12/2020 |
| 4363 | Compliance with HR regulations & standards | Reputation / compliance | 8 | Moderate risk | 31/03/2021 |

| | | | | | |
|---|---|---|---|---|---|
| 4368 | Efficient and effective management of demand for outpatient appointments | Reputation / compliance | 8 | Moderate risk | 30/06/2021 |
| 4382 | Delivery of the Financial Recovery Programme | Finance | 8 | Moderate risk | 31/03/2021 |
| 4182 | Compliance with ICT regulations & standards | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4177 | Critical ICT infrastructure failure | Service disruption | 8 | Moderate risk | 31/12/2020 |
| 4180 | Reduction in data quality | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4138 | Patient mortality rates | Reputation / compliance | 8 | Moderate risk | 31/03/2021 |
| 4141 | Compliance with infection prevention & control regulations & standards | Regulatory compliance & standards (including performance targets) | 8 | Moderate risk | 31/12/2020 |
| 3503 | Sustainable paediatric services at Pilgrim Hospital, Boston | Service disruption | 8 | Moderate risk | 01/09/2021 |
| 3687 | Implementation of an Estates Strategy aligned to clinical services | Service disruption | 8 | Moderate risk | 31/03/2021 |
| 3721 | Critical failure of the mechanical infrastructure | Service disruption | 8 | Moderate risk | 31/03/2021 |
| 3722 | Energy performance and sustainability | Finance | 8 | Moderate risk | 31/03/2021 |
| 3951 | Compliance with regulations & standards for aseptic pharmacy services | Reputation / compliance | 8 | Moderate risk | 30/06/2021 |
| 4579 | Delivery of the new Medical Education Centre | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4384 | Substantial unplanned income reduction or missed opportunities | Finance | 8 | Moderate risk | 30/09/2021 |
| 4502 | Compliance with regulations & standards for medical device management | Regulatory compliance & standards (including performance targets) | 8 | Moderate risk | 31/12/2020 |
| 4526 | Internal corporate communications | Reputation / compliance | 8 | Moderate risk | 31/12/2020 |
| 4528 | Minor fire safety incident | Harm (physical or psychological) | 8 | Moderate risk | 30/09/2021 |
| 4553 | Failure to appropriately manage land and property | Finance | 8 | Moderate risk | 31/03/2021 |
| 4486 | Clinical outcomes for patients | Harm (physical or psychological) | 8 | Moderate risk | 31/12/2020 |
| 4497 | Contamination of aseptic products | Harm (physical or psychological) | 10 | Moderate risk | 30/06/2021 |
| 4061 | Financial loss due to fraud | Finance | 4 | Low risk | 31/12/2020 |
| 4277 | Adverse media or social media coverage | Reputation / compliance | 4 | Low risk | 31/12/2020 |
| 4385 | Compliance with financial regulations, standards & contractual obligations | Reputation / compliance | 4 | Low risk | 30/09/2021 |

| | | | | | |
|---|---|---|---|---|---|
| 4386 | Critical failure of a contracted service | Service disruption | 4 | Low risk | 31/12/2020 |
| 4387 | Critical supply chain failure | Service disruption | 4 | Low risk | 31/12/2020 |
| 4388 | Compliance with procurement regulations & standards | Reputation / compliance | 4 | Low risk | 31/12/2020 |
| 4438 | Severe weather or climatic event | Service disruption | 4 | Low risk | 31/12/2020 |
| 4439 | Industrial action | Service disruption | 4 | Low risk | 31/12/2020 |
| 4440 | Compliance with emergency planning regulations & standards | Reputation / compliance | 4 | Low risk | 31/12/2020 |
| 4467 | Impact of a 'no deal' EU exit scenario | Service disruption | 4 | Low risk | 30/06/2021 |
| 4469 | Compliance with blood safety & quality regulations & standards | Regulatory compliance & standards (including performance targets) | 4 | Low risk | 31/12/2020 |
| 4482 | Safe use of blood and blood products | Patient safety (physical or psychological harm) | 4 | Low risk | 31/12/2020 |
| 4483 | Safe use of radiation (Trust-wide) | Harm (physical or psychological) | 4 | Low risk | 30/06/2022 |
| 4514 | Hospital @ Night management | Service disruption | 4 | Low risk | 31/12/2020 |
| 4567 | Working Safely during the COVID - 19 pandemic (HM Government Guidance) | Reputation / compliance | 4 | Low risk | 30/06/2021 |
| 4400 | Safety of working practices | Harm (physical or psychological) | 6 | Low risk | 30/09/2021 |

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item 13.3* |
| *Board Assurance Framework (BAF) 2021/22* | |
| Accountable Director | *Andrew Morgan Chief Executive* |
| Presented by | *Jayne Warner, Trust Secretary* |
| Author(s) | *Karen Willey, Deputy Trust Secretary* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *Objectives within BAF referenced to Risk Register* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Limited* |

| | |
|---|---|
| Recommendations/ Decision Required | • *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure* |
| | • *Board to accept the change to the ratings for objectives 1a and 3b* |
| | |

## Executive Summary

The relevant objectives of the 2021/22 BAF were presented to all Committees during June and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. The rating for objectives 1a and 3b have been amended by the relevant Committees following review and discussion as a result of the papers presented.

The Quality Governance Committee have rated objective 1a as amber, from red, as effective controls are now thought to be in place and papers presented to the Committee are offering significant assurance.

The Finance, Performance and Estates Committee rated objective 3b as amber, from green, to reflect the concerns noted regarding delivery of the cost improvement plans and expenditure.

The Board are asked to consider the BAF and the RAG ratings presented and confirm the acceptance of the change of ratings.

The following assurance ratings have been identified:

| Objective | | Rating at start of 2021/20 | Previous month (May) | Assurance Rating (June) |
|---|---|---|---|---|
| 1a | Deliver harm free care | R | R | A |
| 1b | Improve patient experience | R | R | R |
| 1c | Improve clinical outcomes | R | R | R |
| 2a | A modern and progressive workforce | A | A | A |
| 2b | Making ULHT the best place to work | R | R | R |
| 2c | Well led services | A | A | A |
| 3a | A modern, clean and fit for purpose environment | R | R | R |
| 3b | Efficient use of resources | G | G | A |
| 3c | Enhanced data and digital capability | A | A | A |

| | | | | |
|---|---|---|---|---|
| 4a | Establish new evidence based models of care | R | A | A |
| 4b | To become a University Hospitals Teaching Trust | R | R | R |

# Board Assurance Framework (BAF) 2021/22 - June 2021

| Strategic Objective | Board Committee |
|---|---|
| Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities | Quality Governance Committee |
| People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT | People and Organisational Development Committee |
| Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate | Finance, Performance and Estates Committee |
| Partners: To implement integrated models of care with our **partners** to improve Lincolnshire's health and well-being | Trust Board |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SO1** | **To deliver high quality, safe and responsive patient services, shaped by best practice and our communities** | | | | | | | | | | | | |
| | | | | | | Group, lead & plan in place to support the delivery of an improved patient safety culture (Developing a Safety Culture) (PSG) | Patient Safety Walk Rounds and Human Factors training delayed due to second wave of Covid-19<br>Definition of Safety Culture Ambition | Human factors training is now rescheduled for June 2021<br>2nd Wave of Pascal Survey to commence in ED<br>External Saftey Culture company engaged to deliver focus groups at all levels through the organisation and support development and strategy | Trust Wide Accreditation Programme Reports<br><br>Safety Culture Surveys<br>Action plans from focus groups and survey findings<br>Update reports to the Patient Safety Group | Organisational understanding of Safety Culture | Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee. | | |
| | | | | | | Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG) | Revised governance and reporting arrangements currently being embedded with some groups reporting into the sub-groups still in their infancy. | Review of Quality Governance Committee and Sub-group structures undertaken.<br>Review to be undertaken once revised mechanisms have been in place for 6 months. | Upward reports from QGC sub-groups | Upward reports from groups reporting into sub-groups require some strengthening. | Template for groups reporting to sub-groups to be designed. | | |
| | | | | | | Patient Safety Group which is a sub group of the Quality Governance Committee in place meeting monthly. (PSG) | Disruption to existing governance arrangements during the pandemic<br>Divisional representation at PSG especially Medical input<br>Maturity of PSG subgroups and effectiveness | Patient Safety Group & sub-group meetings have continued to take place throughout the pandemic<br>Review of information being fed into the sub groups<br>Divisional triumvirates currently reviewing meeting attendance | Quality and Safety Risk Report<br>Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group<br>Patient safety indicators in the IPR | | | | |
| | | | | | | Infection Prevention and Control Committee in place and meeting monthly (IPCG) | Disruption to development of IPCG due to COVID-19 pandemic. Requirement to progress Divisional IPC assurance and monitoring processes. Requirement to develop the IPC service and Team via a consultation process. Need to develop Estates related sub groups (decontamination, water safety and ventilation). | 2022/21 IPC Key Objectives in line with the requirements of the Hygiene Code. Divisional roles and responsibilities framework. Progressing with an IPC service and Team consultation and funding secured to significantly expand and strengthen IPC Team. Redefined IPC audit and incident analysis processes. Strengthening of Estates progress reporting and recruitment of Estates and Facilities and Decontamination Lead. | IPCG agenda in line with IPC Key Objectives and Hygiene Code. IPC service and Team consultation is progressing. Divisional and Estates progress and exception reporting. Recruitment of Estates and Facilities and Decontamination Lead. | Some aspects of Divisional and Estates reporting require further development.<br>Insufficient IPC Team resource to currently provide the appropriate support to the Divisions and develop the IPC service. Awaiting the Estates and Facilities and Decontamination Lead to commence in post. | IPC identified gaps are being managed and monitored by reporting and gap analysis to the IPCG.<br>Development progression via consultation and recruitment processes. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG) | Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated. | Planned programme of IPC policy development and update in line with Hygiene Code requirements. | IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation | Not all policies have been produced or updated. Some aspects of reporting require further development. | Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings. | | |
| | | | | | | Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). | Non-compliance with some aspects of the Hygiene Code. | Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC.<br>IPC policies to be updated / developed / written in line with the timetable.<br>•Recruited into Estates and Facilities/Decontamination Lead post with a start date of June/July 2021.<br>• Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve compliance with new National Standards of Cleanliness directive<br>• Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes. | IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation | Not all policies have been produced or updated. Some aspects of reporting require further development. | Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a | Deliver Harm Free Care | Director of Nursing/Medical Director | Failure to manage demand safely<br><br>Failure to provide safe care<br><br>Failure to provide timely care<br><br>Failure to use medical devices and equipment safely<br><br>Failure to use medicines safely<br><br>Failure to control the spread of infections<br><br>Failure to safeguard vulnerable adults and children<br><br>Failure to manage blood and blood products safely<br><br>Failure to manage radiation | 4558<br>4480<br>4142<br>4353<br>4146<br>4556<br>4481 | CQC Safe | Infection Prevention and Control BAF in place and reviewed monthly (IPCG) | Non-compliance with some aspects of the Hygiene Code as above | Restoration and Project Salus. Gap analysis with development plan is produced as detailed above | Progress and gap analysis reports to IPCG, QGC, PMO, E&F/IPC and Site groups and other forums | Work is progressing with regards to environmental infrastructure, water safety and ventilation. Decontamination work will progress when the Lead commences in post. IPC audit and RCA investigations require some further development at Divisional level | Reporting to and monitoring by IPCG and other related forums. | Quality Governance Committee | R |
| | | | | | | Defined and separate care pathways in place for urgent and planned care to aim to prevent and reduce the risk of nosocomial infection (IPCG) | The required care pathways are in place or under development | Identified via the implementation of Project Salus in line with PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations. | Operations and Divisional data and reporting. | Some embedding of the implementation of Project Salus requirements as services come back on line | Reporting to and monitoring by IPCG and other related forums, e.g. Operations and Divisional | | |
| | | | | | | Elective care patients assessed by test and symptoms to be Covid-19 risk minimised (IPCG) | Elective care patients are assessed as per the low risk category requirements documented in the PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations. | Identified via the implementation of Project Salus in line with PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations. | Operations and Divisional data and reporting. | Some embedding of the implementation of Project Salus requirements as services come back on line | Reporting to and monitoring by IPCG and other related forums, e.g. Operations and Divisional | | |
| | | | | | | Mortality group in place which meets monthly (PSG) | Disruption to existing governance arrangements during the pandemic<br>Embedding Structured Judgement Process consistently across the Divisions | Mortality Group meetings have continued throughout the pandemic; MorALS Group is now in place & reporting to Patient Safety Group<br>SJR Training has been provided<br>Divisions are being supported to provide learning to MoRals | Mortality Report<br>Datix module to complete SJR's<br>Lincs Collaborative meeting minutes<br>Divisional engagement at the monthly MoRals meeting | | | | |

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| | | | ~~Failure to manage radiation~~ safely<br><br>Failure to deliver planned improvements to quality and safety of care<br><br>Failure to provide a safe hospital environment<br><br>Failure to maintain the integrity and availability of patient information<br><br>Failure to prevent Nosocomial spread of Covid-19 | 4484 | | Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) (PSG) | Gaps in the number of structured judgement reviews undertaken<br><br>Impact of Covid-19 on coding triangles | Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021 | National Clinical Audits<br><br>Dr Foster alerts<br>HSMR and SHMI data | | | | |
| | | | | | | Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG) | Clinical harm review processes not all documented & aligned with incident reporting | Task and finish group in place to agree required changes to harm review processes and documentation<br>Appointment of a Clinical Harm and Mortality Manager | Incident Management Report<br>Quarterly harm report to PSG<br>Bi-weekly executive level Serious Incident meeting<br>Learning to Improve Newsletters<br>Patient Saftey Briefings<br>Divisional Integrated Governance reports | | | | |
| | | | | | | Theatre Safety Group developed<br>(Ensuring safe surgical procedures) (PSG) | Disruption to existing governance arrangements during the pandemic | Theatre Safety Group has not met during the pandemic; group has re-started, reporting to PSG. Pascal survey results are feeding into theatre safety work | | | | | |
| | | | | | | Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG) | Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust | Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG | | Audit of compliance not currently in place | Review will occur through the Task & Finish group and reported upwards to PSG | | |
| | | | | | | Medication safety Group in operation (Reduce medication errors)<br>(Improving the safety of medicines management)<br>(Review of Pharmacy model and service) (PSG) | Lack of e-prescribing leading to increase in patient safety incidents | Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes | Upward Report of the:<br><br>Medicines Quality Group | | | | |
| | | | | | | Medical devices safety group in place which received relevant reports (PSG) | | | | | | | |
| | | | | | | Appropriate policies and procedures in place to ensure medical device safety (PSG) | Lack of assurance regarding staff training on the medical devices | Implementation of a central database of medical device user training records | | | | | |

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| | | | | | | Appropriate policies and procedures in place to recognise and treat the deteriorating patient. (Ensuring early detection and treatment of deteriorating patients) (PSG) | Number of incidents occurring regarding lack of recognition of the deteriorating patient - monthly update to the DPG required<br>Maturity of some of the sub-groups | Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA | Audit of response to triage, NEWS, MEWS and PEWS<br>Sepsis Six compliance data<br>Audit of compliance for all cardiac arrests<br>Upward reports into DPG from all areas<br>Observation policy | Observation policy overdue review | Observation policy under review with expected update to the next DPG in July | | |
| | | | | | | Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG) | Sedation group<br>New funding needed to continue restraint training delivery.<br>Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months | Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues | | | | | |
| | | | | | | Dementia steering group relaunched April 2021 to provide oversight and direction in relation to Dementia and Delirium pathway. (SVOG) | Dementia pathway not in place. Dementia training Level 2 and level 3 currently in development - training strategy being written | Dementia Level 1 training available and achieving 90%+. Joint work ongoing between ULHT and partners. | | | | | |
| | | | | | | Safeguarding and Vulnerability Oversight Group (SVOG) established and meet Bi-monthly (reporting to QGC) with divisional Safeguarding. (SVOG) | Safeguarding training remains below expected level. | Training plans developed and in place for Safeguarding Children and Safeguarding Adults. Training redeveloped to mitigate for Covid and data monitored by Deputy Director Safeguarding and SVOG with appropriate escalation taken to divisional leads. | Upward Report of the: Safeguarding Group Safeguarding, DoLS and MCA training and monitored monthly with appropriate escalation<br>system issues continue to be a problem with e-learning which require manual updating of each staff record - additional staff member agreed to assist with completion however unable to give a completion date at this present time | | | | |
| | | | | | | Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF) | | | | | | | |

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| | | | | | | Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG) | Training provision for Divisional Clinical Governance Leads<br>No formal job description of roles and responsibilities for Clinical Governance Leads | Role based TNA being devised for Clinical Governance leads<br>Roles and responsibilities being addressed through the Medical Director's office | Minutes of Divisional Clinical Governance meetings with upward reporting within the Division<br>Divisional Integrated Governance Report<br>Support Offer in place from the central CG team for the Divisions | | | | |
| | | | | | | Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG) | Second round of CQC Confirm and Challenge sessions were cancelled due to second wave of Covid-19, however these have now recommenced. | Confirm and challenge meetings have now re-commenced.<br>Robust processfor assessing evidence to demonstrate achievement has been developed. | Monthly report to QGC on Must and Should dos | Further work required to strengthen the reporting. | | | |
| | | | | | | Appropriate medical records management systems and processes in place (? Move to 3c - enhanced digital capability) | Current issues identified in relation to management of paper medical records | Implementation of an Electronic Patient Record (EPR) system; Group involving Dep DoN has met to begin to work on management of paper medical records | | | | | |
| | | | | | | Maternity Transformation (MNOG) | New control - to be discussed at next MNOG meeting. | | | | | | |
| | | | | | | Development and implementation of new pathways for Paediatric services (CYPOG) | New control - to be discussed at next CYPOG meeting. | | | | | | |
| | | | | | | Trust wide Children's standards (CYPOG) | New control - to be discussed at next CYPOG meeting. | | | | | | |
| | | | | | | Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly<br>Robust Complaints and PALS process in place (PEG) | Patient Experience Group reistated in its new format and ToR, the group needs to develop its maturity | The group meets monthly, has developed a work reporting plan | Upward reports to QGC monthly and responds to feedback<br>Review of ToR in July 2021<br>Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group<br>Patient Experience Group upward report | Complaints & PALs Policy under review and will come to April meeting | Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee | | |
| | | | | | | Patient Experience & Carer plan 2019-2023 | Number of objectives in the plan paused due to Covid | Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level | Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports. | | | | |

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| | | | | | | Patient Experience Intranet page | Intranet page requires updating;number of areas out of date and new information needs adding | Patient Information remains on the issues log for the Patient Experience Group until completed | | | | | |
| | | | | | | Ward and dept review visits as part of Quality Accreditation and assurance programme | | | New process commenced end April 2021. Patient Experience Reports to be generated ahead of visit and patient experience team and patient representatives included within visit teams<br>Each visit includes elements of patient experience. A report will go to Patient Experience Group, NMAAF and QGC as per committee frequency for oversight and assurance | | | | |
| | | | | | | Patient Panel meeting monthly and reporting into the Patient Experience Group.<br>(Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers) (PEG) | Patient Panel is a new group and not yet reached maturity in its business<br>Staff training in relation to communication and engagement | Panel is chaired by Head of Patient Experience, has an agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging<br>IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care. | Upward reports and minutes to the Patient Experience Group<br>Real time patient and carer feedback<br>User involvement numbers<br>National patient surveys<br>Number of locally implemented changes as a result of patient feedback | IIP projects update | | | |
| | | Director of | Failure to provide a caring, compassionate service to patients and their families | 3688 | | | | | | | | Quality Governance | |

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| 1b | Improve patient experience | Director of Nursing | patients and their families<br><br>Failure to provide a suitable quality of hospital environment | 3688<br>4081 | CQC Caring | Care of the dying patient guidelines and procedures (PEG)<br>Visiting Procedure Post Pandemic with associated booking script, booking templates, information leaflet, posters and internal and external communications | Guidelines updated to consider COVID precautions. Swan Scheme resources lost during ward moves. Experience of death and dying study showed staff distress and anxiety is significant. | Swan resource boxes being developed for distribution to all areas during May. Wedding boxes created for a number of key wards and iwthin Chaplaincy services. Experieince of death and dying recommendations being taken forward through wellbeing initiatives and a focus during Dying Matters week 10-16 May | Special Palliative Care Team and Lead Nurse for End of Life Care are developing an outline business case for the CCG to strengthen the resource available in the Trust to increase capacity in the team in order to provide training and education to ward staff. The Deputy Director of Nursing is linked into this work for oversight SUPERB Patient Experience Dashboard Patient Experience indicators in the IPR Care Opinion | | | Quality Governance Committee | R |
| | | | | | | Inclusion Strategy in place and in date (PEG) | Lack of diversity in patient feedback and engagement | Equality, Diversity and Inclusion Lead is member of Patient Experience Group. Engagement events scheduled with Sensory Impairment Group (27.04.21), Traveller Community and BAME community groups (24.05.21). Reaching out to Eastern European community groups. Review of all relevant policies relating to Patient Experience underway | Patient Experience report; ED&I Lead reports | | | | |
| | | | | | | Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG) | PLACE Lite Process needs to be embedded as Business as Usual | PLACE Lite visits are being scheduled for the year across the organisation. Each visit includes a patient representative on the team. This will result in a visit report which goes to the newly established PLACE Group.<br><br>Monthly review meetings of the Matrons Quality Metrics with the DoN and DDoN<br><br>Estates works planned across Lincoln, Pilgrim and Grantham hospitals to address identified through the PLACE survey (Patient-Led Assessment of the Clinical Environment) - including decoration of walls, windows & fascias; flooring; and bed space curtains / track systems. | Patient Experience Team are members of PLACE Group. PLACE report to go to Patient Experience Group quarterly<br>Matron Quality Metrics<br><br>Estates attendance and updates at the fortnightly CQC meetings | Patient Experience Plan 2020 – 2023 in date. Intranet updated. Plan to be added to April agenda and upwardly reported to QGC.<br><br>Multi-agency working group scheduled 09.03.21 for review of Carers Policy.<br><br>PLACE Lite report to April meeting. | | |

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| 1c | Improve clinical outcomes | Medical Director | Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes | 4558 | CQC Responsive CQC Effective | Getting it Right First Time Reviews are undertaken (CEG) | Due to Covid there is a delay in implementing GIRFT recommendations | Quarterly reports to Clinical Effectiveness Group<br><br>GIRFT project Manager in post | Upward reports to QGC and its sub-groups<br><br>KPIs in the integrated governance report | Divisions not having oversight of their workstreams | Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee.<br><br>Workstreams to be presented at PRMs | Quality Governance Committee | R |
| | | | | | | Clinical Effectiveness Group in place and meets monthly (CEG) | The function of Clinical Effectiveness Group is evolving | Agenda reviewed on a meeting by meeting basis to ensure that all priority items are covered 2020/21 work plan developed with Terms of Reference | National audit status Commpliance with local and national audits | Divisions to commence reporting from July 2021 | | | |
| | | | | | | Clinical Audit Group in place and meets monthly (CEG) | There are outstanding actions from local audits | Audit Leads present compliance with their local audit plan and actions | Reports generated detailing status of local audits and number of open actions | Clinical Audit Leads may not attend to present their updates | Rolling attendance in progress and names of Clincial Audit Leads not attending will be escalated to the Triumvirate | | |
| | | | | | | National and Local Audit programme in place and agreed (CEG) | Audit findings do not always demonstrate the necessary improvements | Increased focus on reporting outcomes from audit<br><br>Revision of Clinical Audit Policy to strengthen<br><br>Introduction of the Clinical Audit Group attended by Clinical Audit Leads | Reports from the National Audit Programmes Relevant internal audit reports<br><br>Relevant internal audit reports | The Trust has been notified of outlier status due to data quality | Clincial Audit Team is expanding and they will ensure there are robust processes for data collection and validation of data prior to national submission | | |
| | | | | | | Process for monitoring the implementation of NICE guidance and national publications in place (CEG) | There are a number of pieces of guidance for which the baseline assessments are still required | Increased resources to help clear backlog of NICE guidelines and technical appraisal assessments | Reports on compliance with NICE / Tas | There remains a number of completed baseline assessments with outstanding actions | Dedicated staff within Clinical Governance until June 2021 to help close outstanding actions | | |
| | | | | | | Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG) | Due to Covid elective surgery was cancelled, number of submissions lower than expected (expected number based on previous years hips & Knee replacement) | The Trust has implemented project Salus and the restoration of services will be increase number of elective surgery cases which in turn will increase number of PROMS. | Quarterly reports to CEG and upwardlty reported to QGC | Business Units not sighted on their performance due to no reporting during COVID-19 | National reports to be presented at Governance Meetings once produced | | |
| | | | | | | Divisional governance meetings in place (NICE) (CEG) | Triumvirate not fully appraised of their compliance with audit and NICE | Within the Integrated Governance Report compliance with NICE and audit is included | Quarterly Divisional Reports from Divisions to be presented at CEG | Divisions to commence reporting to CEG from July 2021 | | | |
| | | | | | | Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG) | Staff may not access emails to review newsletters | | | | | | |

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| **SO2** | **To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT** | | | | | | | | | | | | |
| 2a | A modern and progressive workforce | Director of People and Organisational Development | Vacancy rates rises<br><br>Turnover increases<br><br>Sickness absence rises<br><br>Under-investment in education & learning<br><br>Failure to engage organisation in continuous improvement<br><br>Failure to transform the medical & nursing workforce | 4362 | CQC Safe<br>CQC Responsive<br>CQC Effective | NHS people plan & system people plan & four themes:-<br>- Looking after our people<br>- Belonging in the NHS<br>- New ways of working & delivering care<br>- Growing for the future | Awaiting sign off of system people plan | | Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year | | | People and Organisational Development Committee | **A** |
| | | | | | | Embed robust workforce planning and development of new roles | Overall vacancy rate declining but increasing for clinical roles. | | | | | | |
| | | | | | | Recruitment to identify roles - plan for every post & cohort recruitment | | Pipeline report shows future vacancy position<br><br>International nurse recruitment & cohort recruitment | | | | | |
| | | | | | | Focus on retention of staff (Delivery of annual appraisals and mandatory training) | | | Modern Employer targets<br><br>Rates of appraisal/mandatory training compliance | | | | |
| | | | | | | Creating a framework for people to achieve their full potential (Creating a framework for people to achieve their full potential- Talent Management) | | Core Learning Review<br><br>Roll out of workpal | | | | | |
| | | | | | | Embed continuous improvement methodology across the Trust | | | Staff survey feedback | | | | |
| | | | | | | Reducing sickness absence | Sickness absence rate higher than average | Embedding of AMS | Sickness/absence data<br><br>Turnover rates<br><br>Vacancy rates | | | | |
| | | | | | | Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation | IIP projects in early stage of delivery | Delivery of IIP projects as set out in controls | Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year | | | | |

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| 2b | Making ULHT the best place to work | Director of People and Organisational Development | Further decline in demand<br><br>Failure to address examples bullying & poor behaviour<br><br>Lack of investment or engagement in leadership & management training<br><br>Perceived lack of listening to staff voice<br><br>Under-investing in staff engagement with wellbeing programme<br><br>Failure to respond to GMC survey<br><br>Ineffectiveness of key roles<br><br>Staff networks not strong | 4083 | CQC Well Led | NHS People Plan & System People Plan & four themes:-<br>- Looking after our people<br>- Belonging in the NHS<br>- New ways of working & delivering care<br>Growing for the future | Awaiting sign off of system people plan<br><br>Delivery of IIP projects in early stage of delivery | Delivery of IIP projects as set out in controls | | | | People and Organisational Development Committee | R |
| | | | | | | Trust values & staff charter - Resetting our Culture & Leadership programme | Poor staff survey results in 2020 (although in pulse survey more positive) | Creation of Learning Together Forum | | | | | |
| | | | | | | Reviewing the way in which we communicate with staff and involve them in shaping our plans | | Review findings of comms survey | Staff survey feedback - engagement score, recommend as place to work | | | | |
| | | | | | | Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT) | | Continue to implement new leadership programme e.g training on well-being conversations | Pulse surveys - " Have your say"<br><br>Number of staff attending leadership courses | | | | |
| | | | | | | Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation | | | WRES/ WDES Data | | | | |
| | | | | | | Staff networks | Some staff networks stronger than others | | Protect our staff from bullying, violence and harassment - measure through National Staff Survey | | | | |
| | | | | | | Embed programme focused on staff wellbeing | | | Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan<br><br>Number of Schwartz rounds completed (once implemented) | | | | |
| | | | | | | Focus on junior doctor experience key roles:-<br>- Freedom to speak up Guardian<br>- Guardian of safe working<br>- Well-being Guardian | Identified FTSU capacity in Trust as insufficient | Budget identified for post and recruitment exercise commenced for full time FTSU Guardian<br><br>Junior doctor forum | GMC junior doctor survey | | | | |

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| 2c | Well led services | Chief Executive | Current risk register configuration not fully reflective of organisations risk profile<br><br>Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose | 4277<br>4389 | CQC<br>Well Lead | Delivery of risk management training programmes | Training delayed due to Covid-19 | Corporate support offer made to divisions | Third party assessment of well led domains<br><br>Internal Audit assessments<br><br>Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurnace with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.<br><br>Completeness of risk registers<br><br>Annual Governance Statement | | | Audit Committee | A |
| | | | | | | Shared Decision making framework | Councils suspended due to Covid-19 | | Number of Shared decision making councils in place | 8 councils established. Target for 2021 was 6 | Feedback tools to review progress/success | | |
| | | | | | | Implementing a robust policy management system | | Review of document management processes<br><br>New document management system - SharePoint<br><br>Single process for polices | Numbers of in date policies | Movement on policies still not fast enough | Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary<br><br>Report to Audit Committee quarterly<br><br>Report to ELT fortnightly | | |
| | | | | | | Ensure system alignment with improvement activity | | | | | | | |
| **SO3** | **To ensure that services are sustainable, supported by technology and delivered from an improved estate** | | | | | | | | | | | | |
| | | | | | | Develop business case to demonstrate capital requirement | Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year. | Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21<br><br>Capital Delivery Group has oversight of the delivery of key capital schemes. | Capital Delivery Group Highlight Reports | Infrastructure case has tackled £9.6M of the overall £100m+ backlog. | Estates improvement and Estates Group review compliance and key statutory areas.<br><br>Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure.<br><br>Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. | | |

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| | | | | | | Delivering environmental improvements in line with Estates Strategy | | Estates improvement forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed. | | Collation of Audits across all areas during Covid are partial due to availability of high viral load areas. | | | |

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| 3a | A modern, clean and fit for purpose environment | Chief Operating Officer | Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue) | 3720<br>3520<br>3688<br>4403<br>3690 | CQC Safe | Continual improvement towards meeting PLACE assessment outcomes | PLACE assessments have been suspended and delayed for a period during COVID | | PLACE assessments | PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid. | | Finance, Performance and Estates Committee | R |
| | | | | | | Review and improve the quality and value for money of Facility services including catering and housekeeping | Value for Money schemes have been delayed during COVID | | MiC4C cleaning inspections<br><br>Staff and user surveys<br><br>6 Facet Surveys | 6 Facet Survey are not recent and require updating. | IPC Cell/Group and upward reporting of cleanliness is reported through to QGC.<br>Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not.<br>The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill. | | |
| | | | | | | Continued progress on improving infrastructure to meet statutory Health and Safety compliance | | Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. | Reports from authorised engineers<br><br>Response times to urgent estates requests<br><br>Estates led condition inspections of the environment<br><br>Response times for reactive estates repair requests<br><br>Progress towards removal of enforcement | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3b | Efficient use of our resources | Director of Finance and Digital | Efficiency schemes do not cover extent of savings required.<br><br>Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at substantially increased cost<br><br>Failure to achieve recruitment targets increases workforce costs<br><br>Unplanned expenditure (as a result of unforeseen events)<br><br>National requirements and Trust response to Phase 3 - Recovery and second COVID wave. | 4382<br>4383<br>4384 | CQC Well Led<br><br>CQC Use of Resources | Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m. | Operational ownership and delivery of efficiency schemes | Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21 | Delivery of revised CIP<br><br>Achievement of both ULHT and STP financial Plan | Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May) | Gaps are being reviewed monthly with a view to reintroduce as soon as operational pressures allow. | Finance, Performance and Estates Committee | A |
| | | | | | | Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22 | Urgent and unplanned Restore and Covid related costs | Lincolnshire STP financial plan<br><br>Lincolnshire STP collective management of financial risk<br><br>Savings plan, monitoring and reporting. | | | | | |
| | | | | | | Reduce agency spend by 25% from the 19/20 baseline as per IIP priority | Reliance on temporary staff to maintain services, at increased cost | Centralised agency & bank team | | | | | |
| | | | | | | Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2 | | | | CQC Use of Resources - paused due to COVID | | | |
| | | | | | | Implementing the CQC Use of Resources Report recommendations | | | | | | | |
| | | | | | | Working with system partners to deliver the Lincolnshire Plan. | | | | | | | |
| | | | | | | Detailed activity modelling aligned to resource requirements to support Trust and System Restoration. | | Internal Audit:<br>Integrated Improvement Plan<br>CIP - Paused<br>Temporary Staffing - Complete<br>Education Funding - TBC<br>Estates Management - Q4<br>Workforce Planning - Complete | | | National guidance has been focused on recovery, cost control, projections and system working. Further guidance in respect of 21/22 is expected in due course. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
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| 3c | Enhanced data and digital capability | Director of Finance and Digital | Tender for Electronic Health Record is delayed or unsuccessful<br><br>Major Cyber Security Attack<br><br>Critical Infrastructure failure | 4177<br>4179<br>4180<br>4182<br>4481 | CQC Responsive | Improve utilisation of the Care Portal with increased availability of information - | Cyber Security and enhancing core infrastructure to ensure network resilience.<br><br>. | Digital Services Steering Group<br><br>Digital Hospital Group<br><br>Operational Excellence Programme<br><br>Outpatient Redesign Group | Number of staff using care portal | Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible.<br><br>. | Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. | Finance, Performance and Estates Committee | A |
| | | | | | | Commence implementation of the electronic health record | Roll-out IT equipment to enable agile user base<br><br>Redeployment of staff as a result of Trust response to Covid-19. | | Delivery of 20/21 e HR plan<br><br>Number of RPA agents implemented | | | | |
| | | | | | | Undertake review of business intelligence platform to better support decision making | | | Delivering improved information and reports<br><br>Implement a refreshed IPR | IPR paused in line with IIP work and expected to be in place for M1 reporting 21/22 | Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform | | |
| | | | | | | Implement robotic process automation | | | | | | | |
| | | | | | | Improve end user utilisation of electronic systems | | | | | | | |
| | | | | | | Complete roll out of Data Quality kite mark | | | Ensuring every IPR metric has an associated Data Quality Kite Mark | Information improvements aligned to reporting needs of Covid-19. | Workplan being drafted to ensure compliance, delayed by resource availability. | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SO4** | **To implement integrated models of care with our partners to improve Lincolnshire's health and well-being** | | | | | | | | | | | | |
| 4a | Establish new evidence based models of care | Director of Improvement and Integration | Failure of specialty teams to design and adopt new pathways of care<br><br>Failure to support system working<br><br>Failure to design and implement improvement methodology | | CQC Caring<br>CQC Responsive<br>CQC Well Led | Supporting the implementation of new models of care across a range of specialties | | | Reports<br>-ELT / TLT<br>-Committees<br>-Board<br>-System<br>-Region | | | Finance, Performance and Estates Committee | A |
| | | | | | | Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres was on hold, and has been included in 21/22 plans | | Outpatient Improvement Group<br><br>Cancer Improvement Board<br><br>Urgent and Emergency Care Board. | Improvement against strategic metrics<br><br>% of patients in Emergency Department >12 hrs (Total Time)<br><br>Delivery against 62 day combined standard<br><br>Urgent Treatment (P2) turnaround time<br><br>Deliver outpatient activity non face to face | | | | |
| | | | | | | Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans. | | CYP Group re-established | | | | | |
| | | | | | | Urology Transformational change programme | | Urology steering group in place reporting through IIP | | | | | |
| | | | | | | Pre op Assessment Modernisation | | | | | | | |
| | | | | | | Support Creation of ICS - Lincolnshire designation 1st April 2021 | | Weekly ICS meetings<br><br>Provider Collaborative Steering Group | | | | | |
| | | | | | | Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team | | Weekly ASR meetings | | | | | |
| | | | | | | Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress | | OCTP Exec led pillar meetings continue<br><br>ELT/TLT oversight<br><br>Board / system reporting | | | | | |

| Ref | Objective | Exec Lead | How we may be prevented from meeting objective | Link to Risk Register | Link to Standards | Identified Controls (Primary, secondary and tertiary) | Control Gaps | How identified control gaps are being managed | Source of assurance | Assurance Gaps - where are we not getting effective evidence | How identified gaps are being managed | Committee providing assurance to TB | Assurance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4b | To become a University Hospitals Teaching Trust | Director of Improvement and Integration | Failure to develop research and innovation programme<br><br>Failure to develop relationship with university of Lincoln and University of Nottingham<br><br>Failure to become member of university hospital association | | CQC Caring<br>CQC Responsive<br>CQC Well Led | University Hospital Teaching Trust Status<br>Developing a business case to support the case for change | | | Progress with application for University Hospital Trust status | | | People and Organisational Development Committee | R |
| | | | | | | Increasing the number of Clinical Academic posts | | | Numbers of Clinical Academic posts<br><br>RD&I Strategy and implementation plan agreed by Trust Board | | | | |
| | | | | | | Improve the training environment for students | | | GMC training survey<br><br>Stock check against checklist | | | | |
| | | | | | | Developing an MOU with the University of Lincoln | | | RD&I Strategy and implementation plan agreed by Trust Board | | | | |
| | | | | | | Develop a portfolio of evidence to apply for membership to the University Hospitals Association | | | | | | | |

## 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:

R — Effective controls may not be in place and/or appropriate assurances are not available to the Board

A — Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

G — Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

| | |
|---|---|
| Meeting | *Trust Board* |
| Date of Meeting | *6 July 2021* |
| Item Number | *Item* |
| **Learning from Judicial Review** | |
| Accountable Director | *Andrew Morgan Chief Executive* |
| Presented by | *Jayne Warner, Trust Secretary* |
| Author(s) | *Jayne Warner, Trust Secretary*<br>*Anna Richards, Associate Director Comms and Engagement* |
| Report previously considered at | *N/A* |

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

| | |
|---|---|
| Risk Assessment | *Objectives within BAF referenced to Risk Register* |
| Financial Impact Assessment | *N/A* |
| Quality Impact Assessment | *N/A* |
| Equality Impact Assessment | *N/A* |
| Assurance Level Assessment | *Insert assurance level*<br>• *Significant* |

| | |
|---|---|
| Recommendations/ Decision Required | • *To note the actions taken to improve public involvement processes* |
| | |
| | |

## Executive Summary

In September 2020 the Trust were made aware that a High Court challenge had been made against the decision to create the Grantham Green site including the temporary changes to urgent and emergency care in June 2020. The Covid-19 pandemic required the Trust to rapidly reconfigure services and provide care in new and different ways. During the initial emergency response quick decision making was needed to increase capacity and maintain essential services and the urgency of the situation meant that the process to involve or engage the public was abbreviated.

The original claim was made against the Trust and NHS Lincolnshire CCG on four grounds. At the initial hearing the Court did not give permission for the claim to proceed. At a Renewal Hearing in November 2020 permission was granted by the Court for the claim to proceed on two grounds, with the Trust as the sole defendant.

The Trust made the decision to restore services at its Board meetings in February and March 2021, in advance of the Judicial Review outcome.

On 16th April 2021 the Trust received the Judgement handed down by Mr Justice Linden following a hearing in the High Court on the 4th March 2021. The claimant Jayne Dawson had been given permission by the Court to argue two grounds, namely that:

- In coming to its decision, the Defendant breached section 242(1B)(b) and (c) of the National Health Service Act 2006 by failing to make arrangements which secured that service users were involved (a) in the development and consideration of the proposals for the designation of the Hospital as a Green site and (b) in the making of the Decision itself ("Ground 1");

- The Decision was irrational or disclosed an improper purpose or was insufficiently reasoned. In the event, before me the challenge on Ground 2 was limited to a complaint that the Decision was inadequately reasoned which, it was said, "gives rise to the inference that the decision was irrational and/or was taken for an improper purpose". ("Ground 2")

The Trust defended the claim but accepted the Judgement which upheld ground 1 and rejected ground 2. The full Judgement can be found by following this link https://www.bailii.org/

The Trust awaits the court decision on costs relating to the case.

The Trust regrets that it did not involve service users sufficiently whilst making temporary changes to our services to protect the health and wellbeing of our patients during the COVID-19 pandemic. The Trust apologised to anyone who would have liked to have been more involved in the development of the plans.

The issue in this case was the process by which the decision to create a Grantham Green site was reached, rather than the merits of the decision itself. The claim that the decision itself was unsound was rejected, and the judgement makes clear that the decision was perfectly rational and was taken in good faith and for proper purposes.

The Judge also commented that there was evidence that numerous patients welcomed the changes and that this was unsurprising given that the decision itself had a great deal to commend it and appears to have been beneficial to many members of the community in Lincolnshire.

The Trust undertook to reflect on the Judge's ruling and amend and improve public involvement processes for the future.

The Trust has revisited the machinery through which the Trust will demonstrate how engagement with service users informs its plans and has developed a more structured approach to ensuring that we meet our legal duty to involve our patients and public on major service change, under Section 242 of the NHS Act 2006.

Our duty is to ensure that patients and the public are involved in the planning of service provision, the development of proposals for change and decisions about how services operate.

The governance arrangements should:

- Cover the geographical area affected
- Take account of the range of services under consideration and their interdependencies
- Reflect the responsibilities of the service provider
- Support decision makers to be open minded on proposals

Understanding Impact

The Trust will consider the impact of changes to services in our hospitals. It will allow service users and the public to influence the plans through specific involvement processes being put in place. We will also continue to be informed and build on patient experiences through regular engagement meetings with patient experts and subject matter experts.

This will specifically include work to expand organisational knowledge of public engagement and the legal duty to involve, with additional training on public engagement for members of the Trust Communications and Engagement Team, delivered by the Consultation Institute.

Communicating Clearly

Briefings describing the proposals for services will be shared publicly and with all stakeholders. Details will be available on the public website, through social media and views will be gathered.

We have taken a ‘business partnering’ approach to embedding a member of the Trust’s Communications and Engagement Team within each of our Clinical Divisions, to ensure that they can identify early opportunities to engage on any proposed service changes, and advise the Division directly on the public and patient involvement requirements.

In addition, the Trust has recently set up Action Delivery Groups for Divisions and large programmes of work, to ensure a formal process is in place for proposed service change, to ensure adequate engagement and involvement is carried out, as well as QIA and EIA processes. Members of the Communications and Engagement Team are invited to these meetings in an advisory capacity.

Once opportunities to engage have been identified, we have an arrangement in place with our NHS System Engagement Lead to advise on delivery of an appropriate level of engagement to meet our duty to involve. At present, this advice is offered on the basis of an informal agreement, but a formal agreement around system engagement support is being explored at present.

Using Feedback

All responses received will be considered independently and will be fairly reported to allow them to influence the proposals which are put before the Trust Board. The public are also able to raise questions at the Trust Board meetings.

Agree Approach

The Trust Board will be asked to make a decision on services at its meetings in public which can be joined through the link on our website. Appropriate arrangements will also be put in place for when/if Board meetings cease to be online only. Public questions for Board meetings can be submitted to the Trust Secretary ahead of the meetings.

In conclusion, the Trust is updating its standard operating procedures relating to public and patient involvement, to reflect the Judicial Review outcome. These changes will be kept under review to ensure that they follow best practice.