Bundle Trust Board Meeting in Public Session 1 October 2019

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

1 09:15 - Introduction, Welcome, Chair's Opening Remarks and Health and Safety
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 09:45 - Minutes of the meeting held on 3rd September 2019 for accuracy
Chair
Item 5 Public Board Minutes SEPTEMBER 2019 v1.docx

6 09:55 - Matters arising from the previous meeting/action log
Chair
Item 6 Public Action log September 2019.docx

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

8 10:05 - Patient/Staff Story
Director of Human Resources and Organisational Development

9 BREAK

10 Strategic Objectives

11 10:20 - Providing consistently safe, responsive, high quality care SO1

11.1 Assurance and Risk Report Quality Governance Committee
Dr Gibson
Item 11.1 QGC Upward report September 2019.doc

12 Providing efficient and financially sustainable services SO2

12.1 Assurance and Risk Report FPE Committee
Gill Ponder
Item 12.1 FPEC Upward Report - Sept 19.doc

12.2 EU Exit Contingency Planning
Chief Operating Officer
Item 12.2 Trust Board - EU Exit Contingency Planning Report - October 2019.docx
Item 12.2 Appendix I - EU Exit Risk - September 2019.pdf
Item 12.2 Appendix II - MoU Medicines.pdf

13 11:00 - Providing services by staff who demonstrate our values and behaviours SO3

13.1 Assurance and Risk Report WOD Committee
Geoff Hayward

WFOD Committee due to take place on 30/9/19 - verbal update to be provided at Trust Board

13.2 Equality Diversity and Inclusion Annual Report
Dir of HR &OD
Item 13.2 Equality Diversity Inclusion Annual Report Cover Sheet.doc
Item 13.2 Annual Report Equality Diversity Inclusion.docx

13.3 NHS Workforce Race Equality Standard
Dir of HR & OD
Item 13.3 Cover WRES Report.docx
Item 13.3 WRES Report.pdf

13.4 NHS Workforce Disability Equality Standard

Dir of HR & OD

- Item 13.4 Cover WDES Report.docx
- Item 13.4 WDES Report ULHT.docx
- Item 13.4 Appendix A.pdf
- Item 13.4 Appendix B.pdf

13.5 Rainbow Badge - Board Pledge

Dir of Finance and Digital

- Item 13.5 Cover Board Pledge to the NHS Rainbow Badge Scheme_01_10_2019.docx
- Item 13.5 Board Pledge to the NHS Rainbow Badge Scheme_draft_1.docx

13.6 Smoke Free ULHT

Dir of HR & OD

- Item 13.6 Board Paper - Smoke Free - 1-10.doc
- Item 13.6 Appendix A - Smoke Free Policy v10.0 July 2019.doc
- Item 13.6 Appendix B - ULHT Smokefree consultation survey feedback.docx
- Item 13.6 Appendix C - Smokefree implementation comms plan 2019-20.docx

14 11:40 - Providing seamless integrated care with our partners SO4

14.1 Fragile Services

Medical Director

- Item 14.1 TB Fragile Services 011019v3.0.docx

14.2 Medical School Update

Medical Director

- Item 14.2 Education Board Report - 20.09.19 V3.docx

14.4 Healthy Conversations Feedback

Chief Executive

- Item 14.3 LCB front sheet HC2019 update report September 19.docx
- Item 14.3 HC2019 Update Report - September 19 12.9.19 FINAL2updated.docx

15 12:20 - Performance

Director of Finance and Digital

- Item 15 Integrated Performance Report - Trust Board.pdf

16 12:40 - Risk and Assurance

16.1 Risk Management Report

Medical Director

- Item 16.1 Trust Board - Corporate Risk Report - October 2019 pdf.pdf
- Item 16.1 Appendix I - Very high & High Corporate Risks - September 2019.pdf
- Item 16.1 Appendix II - High Operational Risk Summary - September 2019.pdf
- Item 16.1 Appendix III - Risk Scoring Guide - July 2019.pdf

16.2 12:55 - Board Assurance Framework 2019/20

Trust Secretary

- Item 16.2 BAF 2019-20 Front Sheet October 2019.pdf
- Item 16.2 BAF 19-20 v24.09.19.xlsx

16.3 NHS Improvement Board Observations and Actions

Chair / Trust Secretary

- Item 16.3 Front Sheet NHSI Board Observations.docx
- Item 16.3 NHS I Private and public Board Observation Feedback - FINAL.pdf
- Item 16.3 NHSI Board observation action plan.docx

17 Strategy and Policy

18 13:05 - Board Forward Planner

Trust Secretary
For Information

- Item 18 Public TB Board Forward Planner 2019 v 4.doc

19 ULH Innovation

Assistant Director Communications
For Information

Item 19 Innovation report - October.doc

20 Any Other Notified Items of Urgent Business

21 The next meeting will be held on Tuesday 5th November 2019

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

Agenda Item 5

Minutes of the Public Trust Board Meeting

Held on 3rd September, 2019

Boardroom, Lincoln County Hospital

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Mrs Liz Libiszewski, Non-Executive Director
Mrs Sarah Dunnett, Non-Executive Director
Mrs Michelle Rhodes, Director of Nursing
Mr Paul Matthew, Director of Finance and Digital

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Dr Gurdip Samra, Deputy Medical Director

Apologies:
Mr Geoff Hayward, Non-Executive Director
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director

1323/19 **Item 1 Introduction**

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

1324/19 **Item 2 Public Questions**

Q1 from Jody Clark

I saw in the HSJ article about NWAT's annual report, saying about the increase in Grantham patients accessing treatment at Peterborough City Hospital over the last 2 years;

"North West Anglia Foundation Trust's 2018-19 annual report, published this month, revealed that 1,381 additional patients from the Grantham area arrived at its Peterborough City Hospital, 906 were walk ins and 475 arrived by ambulance. This represents a 13.4 per cent increase on the year before, when there were 1,217 additional attendances from Grantham, comprising 832 walk ins and 385 by ambulance.

Attendances by Grantham patients accounted for 2.9 per cent of Peterborough's A&E workload in 2018-19, up from 2.6 per cent."

This is just one of the 'out of county' hospitals that Grantham patients are accessing. Are you aware that so many patients are not using Lincolnshire hospitals? Do you know the numbers? Or would only the clinical commissioning groups know the full picture?

A declaration of interest was declared by Mrs Dunnett who is a Non-Executive Director at North West Anglia Foundation Trust who were referred to in the question.

The Chief Operating Officer responded:

During the early months of the change to the opening hours the two most affected hospitals by attendances had been Nottingham and North West Anglia Foundation Trust however these attendances were in line with expectations.

The figures were regularly reported to the Trust Board and contact continues to be maintained with colleagues from neighbouring Trusts. The media story had been noted and the impact on North West Anglia Foundation Trust however patients from Lincolnshire had previously accessed Peterborough hospital prior to the changes at Grantham. The growth in patients to 163 equates to 3 patients a week, this is at a time when United Lincolnshire Hospitals NHS Trust have also seen a significant growth in attendances. There is an underlying growth that is being seen in access to emergency care. As an organisation we do not specifically review the figures but do consider these with the Commissioners and remain aware of the activity at other hospitals for both planned and emergency care.

Q2 from Councillor Ian Selby

Taking away our overnight A&E was a cut too far and a cut too deep. Let me make it abundantly clear. What we want at Grantham Hospital is a fully functioning 24/7 Accident and Emergency provision as our priority and nothing less and without the redirecting of patients with minor injuries to other Hospitals that has been happening for a long time now. I can read through the media spin that you put on having Urgent care services and I believe your goal is to create Grantham as a Cottage Hospital.

Are you now planning another nail in the coffin of our Hospital with the removal of the F1 & F2 junior doctors, thereby having another severe knock on effect with other services at our Hospital? Can you therefore give us a 100% categorical assurance that you will not our remove F1 & F2's from Grantham Hospital?

The Deputy Medical Director responded:

The foundation programme is a national programme for Doctors and in relation to Grantham the allocation for the year is 15 foundation Doctors, who arrived at the Trust for induction on 6th August. They would remain with the Trust for a 12 month period, it should be noted that the number of Doctors to Grantham had increased by 1 from the previous year.

Health Education East Midlands are responsible for determining the number of Foundation 1 and 2 Doctors who come to the region, there had been a suggestion of a reduction to the area but this had not been seen. Any change to the programme would take two years to be realised. The current numbers remain the same for the region. The Trust cannot provide 100% assurance on the numbers remaining as this is a decision which would be outside of the Trust's control.

Q3 from Alison Marriott

My question is please can we see the paediatric reports which go to the quality governance committee and copied to the board, as the reports are referenced in the board meeting minutes but the public can't see them. Having met with Andrew today I believe in the interests of openness, transparency, building trust with the public and

ensuring that Lincs has the services we need (on a sustainable footing), that this information should be publicly available.

The Deputy Medical Director responded:

The Trust remained committed to being open and transparent. The Board had taken the decision that the continued monitoring of the paediatric service should return to business as usual and as such the reports produced would follow the appropriate route through the Trust governance process and be considered at the Quality Governance Committee.

The Board agreed that the Trust Communications Team and the Family Health Division would establish a route through which information about the paediatric service could be shared with the public.

Q4 from Liz Wilson

The CEO has been reported in the press as saying he wants to find a solution to the continued "temporary" overnight closure of the A&E department at Grantham Hospital. Would he be able to:

a) **Share what vision, if any, he has for this service in the future at Grantham**
b) **Explain why there appears to be no action of any sort being taken to resolve the matter until progress is made on the Healthy Conversation proposals, when, for example, action has been taken at Pilgrim to respond to paediatric issues, and a trail for orthopaedic surgery at Grantham has been put in place without having to wait for the STP to be finalised and implemented?**

Due to the absence of the Chief Executive Ms Wilson agreed to defer her question to the October Board to allow the Chief Executive to respond.

1325/19 **Item 3 Apologies for Absence**

Apologies were received from the Chief Executive, Medical Director, Mrs Ponder, Non-Executive Director and Mr Hayward, Non-Executive Director

1326/19 **Item 4 Declarations of Interest**

Dr Gurdip Samra, the Deputy Medical Director declared that he is a Trustee at the Butterfly Hospice Trust and a Governor at the Queen Elizabeth School

1327/19 **Ward Accreditation**

The Board presented Ward Accreditation Certificates to representatives from Greetwell Ward and Ashby Ward.

1328/19 **Item 5 Minutes of the meeting held on 6th August 2019 for accuracy**

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

1227/19 – Last sentence should read – Further conversation would be held with GPs in order to ensure we can be more proactive in stepping patients down from the pathway.

1329/19 **Item 6 Matters arising from the previous meeting/action log**

684/19 & 886/19 – Committee KPIs – All committees have now considered and agreed. This will now feed review of overarching Board document – complete

827/19 – Assurance in respect of H&S actions reported to FPEC – Paper provided to August FPEC, further detail requested

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

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

1039/19 – Pay and FEPs – Board Development session held and actions agreed – Complete

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

1076/19 – Continuous Quality Improvement Approach – Progress reports to be taken to the W, OD & T Committee

1077/19 – Continuous Quality Improvement Approach – Progress reports to be taken to the W, OD & T Committee

1170/19 – Patient Story – Letter of thanks sent to the patient – Complete

1186/19 – QGC Assurance report – Review being carried out on the cleanliness of windows, internal windows form part of the national audit, not external. Proposal to increase frequency of window cleaning being developed to be presented to CRIG for funding

1204/19 – CNST Safety Scheme – Provider given opportunity to meet the required elements to submit the data. Difficulty experienced as to a clear resolution for the required data. Wider conversation were required with the provider to resolve in the future. Updates would be presented via the IT update to FPEC. A joint approach with the provider and NHS Digital would be undertaken to understand requirements – Complete

1249/19 - W, OD & T Assurance Report – Focus to leadership to be built in to future Board Development session programme – Complete

1253/19 – W, OD & T Assurance Report – Committee meeting to be held monthly – Complete

1274/19 – Integrated Performance Report – Discussed at FPEC and further clarity requested

1287/19 – Audit Committee upward report – Concerns about the ability to deliver the undertakings raised. Further discussion would be held at ET regarding the risks associated with meeting the NHSI undertakings and a paper would be presented to the October Audit Committee – Complete

1304/19 – NHSI Board Committee Observations – The Chair and Trust Secretary met to review feedback received. Individual Committees would be responsible to work through the actions identified. Feedback from the observed Board had been received and would be presented to the October meeting and reviewed in 6 months - Complete

1311/19 – Risk Management Report – Complete

1316/19 – BAF – Review of metric complete, data quality is not perfect but data would be reported in the IPR. Actions are in place to improve the data quality over time – Complete

1317/19 – BAF – System delivery reports to be shared with Board. Agreement needed to be reached on how these could be reported.

1319/19 – Board Forward Planner - Complete

1330/19 **Item 7 Chief Executive Horizon Scan including STP**

In the Chief Executive's absence the Chief Operating Officer presented the Chief Executive Horizon Scan and advised that there were no specific issues to raise with the Board but asked that the continued challenged financial position was noted. Work remained ongoing to close the financial gap.

1331/19 Month 4 reporting showed that the financial position remained adverse to plan. The gap continued to be reduced however significant work was still required to assure the system of the delivery of the schemes and the control total across the system.

1332/19 Dr Gibson stated that it would be useful to understand what action was being taken to progress the Trust towards the achievement of being a teaching hospital and how this would be supported by the University of Lincoln.

1333/19 The Chair acknowledged that this would be worth consideration by the Board. A report would be prepared for the next meeting.

Action - Medical Director 1 October 2019

1334/19 The Chair advised that the journey to an Integrated Care System was moving forward with the Chairs beginning to review the partnership arrangements. A joint working executive group had met, including NHS Executives, Council and Voluntary Sector representative. The meeting had been positive and attended by all executive leads, further meetings had been planned to progress this work. The meetings had demonstrated the commitment being made to move to integrated services.

1335/19 Work remained ongoing for the 5 Year Plan and the first draft submission would be required shortly. Feedback from the Healthy Conversations events had been utilised to develop the engagement section of the plan.

1336/19 The Chair confirmed that Victoria Bagshaw had been appointed as Acting Director of Nursing and would commence in post on Monday 23rd September.

The Trust Board:

- **Received the report**

1337/19 **Item 8 Patient/Staff story**

Patient Experience Manager Sharon Kidd, Deputy Director of Operations Andrew Prydderch and Clinical Services Manager Michael Bland attended the Board to present the patient story and the use of online patient feedback to improve care.

1338/19 A review had been posted on the Care Opinions website by a patient during their stay at Lincoln County Hospital.

1339/19 The Patient Experience Manager explained that the Care Opinion website was the default mechanism for receiving patient feedback but allowed rapport to be built with the patient due to the opportunity to provide responses.

1340/19 To date the Trust had received 3,785 stories posted on the site with 18,800 read by the public in the past 4 weeks.

1341/19 The Trust have a number of staff subscribers who are able to respond to the comments from patients providing direct feedback.

1342/19 On the 22nd July a patient posted comments about their experience within the Trust. The patient had been admitted due to symptoms of a stroke and waited 12 hours in A&E. The patient required a MRI scan however the paperwork was not completed upon admission and caused delay in receiving the scan.

1343/19 The patient had requested to go home and return to the hospital due to living only 5 minutes away however the Doctor wanted the patient to remain to ensure that she was not treated as an outpatient, which may have resulted in the scan taking 1-2 weeks to be completed. The approach to having the patient remain in the bed is an NHS wide approach and Doctors ensuring the best care for their patient however this approach does not support those patients waiting in A&E who require a bed.

1344/19 Throughout the patients experience there had been poor communication, lessons learnt had been that there was a need to change culture and ensure that Doctors understand the impact on both the individual patient and those patients in A&E who required a bed.

1345/19 Mr Bland stated that the culture change would need to ensure that Doctors were confident that patients could go home and return to the hospital for tests. The outpatients process required improvement to reduce waiting times and also a process would be required for those patients who did not require a bed to receive tests quickly.

1346/19 The MRI Service Lead would be considering an ambulatory MRI pathway in order to support the change of culture in order to allow patients to go home and return for a scan. It had been identified that there appeared to be a small number of patients admitted to undergo tests that did not require a stay in hospital.

1347/19 Dr Gibson found it a powerful approach to be able to discuss the issues with the patient so quickly and asked if this could be done regularly or if this had been a fortunate occasion to be able to respond.

1348/19 Mrs Kidd advised that part of her role meant that she was notified of the stories posted on the website, these would then be signed posted to the appropriate individual to address and post the response. The result of the contact with the patient did not resolve the complaint fully the patient felt supported through the process.

1349/19 Mrs Libiszewski asked if there had been anything done about the comment from the patient sitting on a hard chair, had this been an elderly frail patient there could have been consequences.

1350/19 It was agreed that a review of the Fit to Sit chairs would be undertaken with consideration given to changing these. The Deputy Director of Operations and Clinical Services Manager would take this action away.

1351/19 The Board would be interested to receive an update from the changes to the pathway once in place.

The Trust Board:

- **Received the staff story**

9 BREAK

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

1352/19 **Item 11.1 Assurance and Risk Report Quality Governance Committee**

The Deputy Chair of the Quality Governance Committee, Dr Gibson, provided the assurance received by the Committee at the August meeting.

1353/19 HSMR remains in a very good position and harm free care had been reported at 98.7%. The Committee continue to rate the Board Assurance Framework as amber due to the work still needed to finalise the Quality Strategy and system reporting.

1354/19 The Quality and Safety Oversight Group meeting was showing evidence of being better established and a written report with data had been received by the Committee.

1355/19 Dr Gibson highlighted those areas reported to the Committee on which the Committee could not be assured. The Trust did not have a Decontamination Lead, a business case was being developed. Surgical site infection was not reporting as fully compliant however action was being taken to address this.

1356/19 The very high risk in relation to aseptic production had been noted by the Committee as a result of the closure of the Trusts facility. Temporary facilities were being utilised at Grimsby, which had mitigated the risk in the short term and there was the potential for a mobile facility at the Trust.

1357/19 The Committee had received the Equality and Diversity Annual report and approved the content for submission to Trust Board.

1358/19 The Quality and Safety Improvement Plan had been received by the Committee and it was noted that this would require close review for the coming year. Governance for this would be taken through the Quality and Safety Oversight Group.

1359/19 The Committee were verbally assured of the progress against the Section 31 and 29A letters received from the Care Quality Commission and the Committee requested that regular reports were received to provide assurance.

1360/19 The Director of Finance and Digital advised the Board that a mobile unit for Aseptic Pharmacy had now been secured and the order placed. This would result in production being brought back on site at Pilgrim. The lead time for the unit would be around 6 weeks, this would include the delivery and commissioning of the unit.

1361/19 The Chair requested the timescale for completion of the Quality Strategy. The Director of Nursing advised that this had been further developed to provide more patient focus and the metrics had been updated to include those signed off at the previous Quality Governance Committee.

1362/19 The draft would be circulated for comment and presented to the Quality Governance Committee in September for consideration.

1363/19 The Director of Nursing also confirmed that the performance dashboard for the Committee had been signed off however the release of the NHS Oversight Framework had resulted in additional metrics that would be required. As such the quality metrics had been updated and were due to be reported back to the Committee in September.

1364/19 The Chair requested confirmation that the issue relating to the water safety closed off areas and flushing had been escalated to the Finance, Performance and Estates Committee.

1365/19 Dr Gibson advised that this had been raised verbally however there had been a query about how best this was handled between the Committees to enable a timely response. This would be resolved outside the meeting.

The Trust Board:

- **Received the update**

Item 12 Providing efficient and financially sustainable services SO2

1366/19 **Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee**

The Deputy Chair of the Finance, Performance and Estates Committee, Dr Gibson, provided the assurance received by the Committee at the August meeting in the absence of the Committee Chair.

1367/19 The strategic objectives remain red rated and the Board were advised that performance values were not meeting expected performance.

1368/19 The Committee were concerned regarding the underlying adverse pay trend and the Committee were to review the actions that had been identified during the pay deep dive Board Development session.

1369/19 Concerns were raised in relation to the financial efficiency programme, the lack of pace and ability to translate ideas to plans and plans to actions. The concerns would be raised at the Executive Team meeting and the Executive Team would be asked to consider a plan to address the concerns.

1370/19 Urgent Care pressures continued to grow and ambulance conveyances had reached a 3 year high. The bed occupancy in relation to this growth was not planned and this had resulted in some growth to waiting lists. The Urgent Care Improvement Programme would be the route for action to be taken to address the issues.

1371/19 The Trust had achieved 7 of the 9 national cancer standards, this was the best position for the Trust in 4 years. The Board were asked to note that nationally only 3 of the standards were being met. This places the Trust in the top quartile of patients being seen and demonstrates the positive performance of the Trust.

1372/19 The Committee reviewed the EU Exit preparedness and would continue to review this at all future Committee meetings. The Board were asked to note that the Senior Responsible Officer responsibility for EU Exit had been transferred to the Chief Operating Officer following the retirement of the Deputy Chief Executive.

1373/19 The Chair requested clarity of the progress housing position as this appeared to be an area of loss of income.

1374/19 The Director of Finance and Digital advised the Board to note the contractual position of the Trust with Progress Housing and stated that within the contract the Trust were required to pay a minimum monthly rental. Demand remained different for each site and is dependent on what is available at each of the sites. During May and June the occupancy rates were met and as such a guarantee payment was not required to Progress Housing. Work was underway with the provider to reconfigure the available space to enable more families to occupy the premises, as this was where the Trust had identified more demand.

1375/19 There was a need to understand the contract further to determine what action can be taken, the issues were mainly driven by excess stock at Grantham.

1376/19 The Director of Estates and Facilities advised that work was underway to develop longer term solutions.

The Trust Board:

- **Received the update**

1377/19 **Item 12.2 Self-Assessment NHS Core Standards for Emergency Preparedness, Resilience and Response**

The Chief Operating Officer presented the Trust self-assessment to the Board advising that it had been discussed at the Finance, Performance and Estates Committee. The self-assessment was required to be presented to the Board prior to the assurance meeting being held with NHS Improvement/NHS England.

1378/19 The Board were presented with a summary of the self-assessment due to the detail contained within the report. The Trust were reporting compliance with 61 out of 64 core standards and partial compliance with the remaining three.

1379/19 Plans are in place to resolve the three areas of partial compliance. The first area of partial compliance is the ability to maintain compliance with lockdown, this had been delayed due to the manufacture of the new fire doors and the fitting of the critical doors through the fire door replacement programme. Timescales for the completion of the fire door installation and lockdown testing are known, full lockdown cannot yet be achieved.

1380/19 Attendance at the Local Health Resilience Partnership meetings had been difficult to achieve for a number of reasons however partial compliance would be resolved through increased attendance at the meetings.

1381/19 The Data Protection and Security Toolkit submission to NHS Digital had resulted in an action plan being sent to the Trust for completion. The Emergency Planning Group would monitor the action plan and an external assurance meeting was due to take place on 16th September.

1382/19 Confirmation was requested that evidence supported the compliance ratings that had been provided. The Chief Operating Officer confirmed that evidence supports each of the areas and that the Trust had appropriately reported the position. The external assurance meeting would test the evidence submitted.

1383/19 The Chair requested a position update regarding inclement weather. The Director of Human Resources and Organisational Development advised that this would be reviewed however was not part of the core standards.

The Trust Board:

- **Received the self-assessment**

1384/19 **Item 12.3 Annual Plan Update**

The Director of Finance and Digital presented the update to Board.

1385/19 Section 3.12 relating to internal planning would need to be aligned with key deadlines of system planning, detailed information supporting the alignment of the Trust's planning with the system plans. The Divisions would be required to drive the development of the plan and the report demonstrated delivery against the 2019/20 annual plan.

1386/19 The Director of Human Resources and Organisational Development confirmed the commitment to deliver the plan with an output that is valuable to the Trust and Divisions. Work continues to tie the annual planning process to the 5 year strategic plan and the future use of True North.

1387/19 In order to ensure the Board are efficient with the development and planning process a Board Development session would be beneficial to complete the strategic aspect of the work, this would then set the direction for the Divisions.

Action – Trust Secretary, 1 October 2019

1388/19 Mrs Libiszewski identified that the report was not clear in respect of the Getting It Right First Time programme and where this reports to within the Trust. Service integration and performance had been detailed but did not provide clarity about what the Trust were doing but provided a focus on principles.

1389/19 The Director of Finance and Digital indicated that the report required further development in order to provide the detail that would be required. Work would be undertaken with the responsible officers in order to bring the report to a more meaningful position.

1390/19 The Chair identified that the Workforce Committee had been updated to include transformation and it was felt that this would be where the Getting It Right First Time programme should be reported. The paper had provided an overview and identified progress that had been made however there is numerous activity being undertaken which had not been highlighted. There would be an expectation that the next report would provide more detail and reporting would be bi-monthly with the next report due in November.

1391/19 Dr Gibson stated that read across to numeric targets would be easier if they were detailed within the report to avoid the need to cross check to the IPR.

The Trust Board:

- **Noted the update**

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

No Items

Item 14 Providing seamless integrated care with our partners SO4

No Items

Item 15 Performance

1392/19 **Item 15 Integrated Performance Report**

The Director of Finance and Digital presented the report to the Board identifying that the Trust's HSMR rate continues to be below the expected limits and the lowest ever reported for the Trust.

1393/19 Incident reporting remains consistent with 2018 levels. There had been 39 significant harm incidents reported in July, this was the highest rate reported in a month to date. A review to understand the reason for the increase would be required.

1394/19 Verbal Duty of Candour continues to be reported at 100% with written follow-up compliance remaining static at 76%. Further work would be undertaken to understand why this had not improved.

1395/19 Zero waiting indicators in Urgent Care had deteriorated during July and the trajectory had not been met. The 4 hour wait standard had worsened and ambulance conveyance had reached the highest level seen for three years.

1396/19 Length of stay for emergency patients had improved and streaming had reached the highest level seen to date. Work would continue with Lincolnshire Community Health Services NHS Trust to further progress. The positive improvements however had been offset by other factors including high bed occupancy and demands on ambulance conveyance levels. Work would be required with East Midlands Ambulance Services NHS Trust.

1397/19 The Lincoln Big Change reconfiguration continues to move forward.

1398/19 Referral to Treatment waiting lists had grown by 276 during June and showed a slight reduction from performance in May. Referral to treatment 18 week standard deteriorated at 83.16% however was lower than May by 1.32%. There were no patients in June waiting more than 52 weeks.

1399/19 During June 7 of the 9 cancer standards were achieved, nationally only 3 standards were met. This had been the strongest performance for the Trust since 2015. There may be some deterioration in the future of the achievement of the standards. The Trust remained in the top 20 of the largest cancer service providers.

1400/19 2 week waits continue to improve and 2 week wait Breast Symptomatic had been achieved, focus to take this forward and sustain would require work.

1401/19 The Trust reported the financial position which at month 4 was the first month off plan at £978k adverse to plan. Non recurrent items totalling £2.5m had been used.

1402/19 The non-pay position was as expected however the income position required consideration. The Trust had reconfirmed the commitment as part of the system to achieve the system control total in order to achieve funds from the centre.

1403/19 Grip of the pay bill would be required to deliver the level of efficiency that had been identified, an increase in the pace of the efficiency delivery programme would be required to support this. The Trust is taking the right action however a focus on the larger item to be delivered would be needed along with capability and capacity issues being addressed. The conversations within the system are about how staff are used across the wider system to focus on system priorities to deliver.

1404/19 The Trust's overall vacancy rate had seen an improvement in July however the impact of the improvement was reduced by the continued high turnover of staff. Sickness absence rates remained flat at 4.8%.

1405/19 Friends and Family Test survey results were reported at more than 90% of patients recommending treatment at the Trust. The ratio of compliments to complaints was 59:1.

1406/19 The Director of Nursing provide an update in relation to quality, identifying that a different set of quality metrics had been signed off and these would be included going forward, the new metrics would provide greater clarity. The NHS Oversight Framework metrics would also be included during discussions.

1407/19 Disappointment was expressed in relation to the performance data for sepsis in both Accident and Emergency and on the wards. The was due to the technology not being accurate for recording although there was also a compliance issue with staff and screening not being recorded appropriately. This had resulted in performance data demonstrating under delivery. All sepsis policies had been re-written and were out for comment prior to a relaunch in the coming weeks, staff would be held more closely to account for delivery and compliance.

1408/19 The Deputy Medical Director requested that the Board note that reporting of mortality was binary and the trend in HSMR continued to reduce, the Trust's crude mortality rate had also reduced. This had been the 12th month of reduction however this still required further reduction.

1409/19 A community wide review of mortality was due to be undertaken and a request for the report to be received by the Trust had been made. This would be reviewed through the Quality Governance Committee.

1410/19 The Director of Finance and Digital advised that key performance indicators were being reviewed as part of the IPR refresh due to the length of report presented to the Board. The work would separate out those areas to be presented to each of the Committees to ensure they were correct prior to bringing the data back in to the Board. This would be in place by the next financial year.

1411/19 The Chief Operating Officer highlighted a number of operational performance challenges faced during July. Overall demand had increased, particularly in relation to conveyance demand which had impacted on financial performance. Compared to the previous year the Trust had seen an increase of 11% of patients who were occupying beds following admission from A&E.

1412/19 During July the Trust required 70 additional beds for non-elective patients compared to the previous year. This had come at a time when staffing was also significantly challenged. Daily conversations are held in order to ensure appropriate staffing levels for the number of patients on each site.

1413/19 Year to date the Trust had cancelled over 350 patients for planned operations on the day, put in to the context of under performance on unplanned care, this had demonstrated the cause and effect on the level of demand the Trust were seeing. There is a need to overcome the issues in order to achieve sustainability.

1414/19 The Chair highlighted that this would be reviewed through the Emergency and Urgent Care Board, conversation with the ambulance service would also be required as part of the review. Once complete this would need to be presented to the Board for assurance.

1415/19 The Chief Operating Officer confirmed that conveyances was one of the high impact actions due to the significant increase. An audit of those patients who attended the emergency department had been undertaken and a significant number of patients conveyed could have attended a community service. There would be consideration to opening up further pathways

to assist with the demand. The use of the Clinical Assessment Service could have a positive impact on the number of conveyances received in to the Trust.

1416/19 Communication to the ambulance teams on the road would be vital to achieving a decrease in conveyances should further pathways be opened up.

1417/19 Additional schemes to support winter pressures, including social care, would be discussed and the winter system plan would be presented to the Board.

1418/19 The Chair queried if the Lincoln Big Change quality impact assessment had been received. The first draft had been completed with the quality impact assessment due for submission to the Quality Governance Committee once completed.

1419/19 Mrs Libiszewski queried the number of Never Events due to another being verbally reported at the previous Board meeting and wished to understand when this had been reported as it had not been included within the report.

1420/19 The Director of Finance and Digital acknowledged that this had not been included due to the reporting date however the team had been aware of the event and would in future include the detail even if this would not yet be reported through the data at the time.

1421/19 Confirmation was requested on the overspend being shown in relation to the fire works. The overspend was based on the original plan that had been an estimate however the position was positive as this would be phased throughout the year.

1422/19 The Chair highlighted the improved narrative being shown within the report and did not wish to lose sight of the narrative as part of the refresh of the report. The increase of kite marks against the data had been useful. Operational performance continued to be challenging, as such a Board Development session would be scheduled to review in totality.

Action – Trust Secretary, 1 October 2019

The Trust Board:

- **Received the report**

Item 16 Risk and Assurance

1423/19 **Item 16.1 Risk Management Report**

The Deputy Medical Director presented the risk report to the Board indicating that there had been some changes to the register.

1424/19 The safeguarding risk on the register had been reduced from very high to high based on the progress of the chaperone policy. The staff engagement and morale risk had increased to a very high risk.

1425/19 The actions to mitigate the very high risk in relation to staff engagement would be set out in the People Strategy which would be presented to the Board later in the year.

1426/19 Mrs Libiszewski raised the inclusion of risks from the Divisions, identifying that there was a need to understand how these risks were being portrayed. An inclusive review of the current risk register would be required to ensure that the Board understood how the register had been populated. The Risk Manager would be invited to the Board to ensure detailed discussion could be held regarding the inclusion of the divisional risks.

Action – Trust Secretary, 1 October 2019

1427/19 There had been clear interest from the Divisions at the previous Quality and Safety Oversight Group that they would like to provide feedback on the Board Assurance Framework which would provide a divisional perception of risk for the Board.

1428/19 Given the interest from the Divisions on risk and the Board Assurance Framework since the introduction of the Trust Operating Model in April there would be benefit to reviewing the support in place for the Divisions.

1429/19 The Board noted the updated report and the changes that were set out in the overview report acknowledging that there were now 6 top risks for the Trust.

The Trust Board:

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

1430/19 **Item 16.2 BAF 2019/20**

The Board Assurance Framework was presented to the Board as an update and had been reviewed and updated through the Board Committees. There had been no material changes during August and the assurance ratings had remained static.

1431/19 The Chair indicated that it would be useful before the end of the calendar year to see movement on the ratings where possible.

The Trust Board:

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

1432/19 **Item 16.3 Update to Board Executive Voting Rights**

The Chair presented the paper to the Board identifying that as a unitary Board a number of members would be able to exercise voting rights. The retirement of the Deputy Chief Executive resulted in a voting position being vacant.

1433/19 The decision had been taken not to replace the Deputy Chief Executive position with the duties being added to an existing Directors portfolio. It was proposed that the Trust Board voting rights would be transferred to the Chief Operating Officer.

1434/19 The Trust Board approved the transfer of the voting rights to the Chief Operating Officer with immediate effect, the standing orders would be amended to reflect the change.

The Trust Board:

- **Received the report**
- **Approved the voting rights to be transferred to the Chief Operating Officer with immediate effect**

Item 17 Strategy and Policy

1435/19 **Item 18 Board Forward Planner**

For information

1436/19 **Item 19 ULH Innovation**

For information

1437/19 **Item 20 Any Other Notified Items of Urgent Business**

The Chair expressed the Boards gratitude to the Director of Nursing at her last Board meeting prior to the commencement of her new role. The Board conveyed their appreciation for the work and commitment undertaken during the last 10 years at the Trust by the Director of Nursing.

The Chair thanked the Director of Nursing for her relentless focus on quality improvement and for being a great role model for the staff within the Trust, especially the nursing staff.

The next meeting will be held on Tuesday 1 October 2019, Boardroom, Lincoln County Hospital, Lincoln

Voting Members	**26 Oct 2018**	**30 Nov 2018**	**7 Jan 2019**	**5 Feb 2019**	**5 Mar 2019**	**2 Apr 2019**	**7 May 2019**	**4 June 2019**	**2 July 2019**	**6 Aug 2019**	**3 Sept 2019**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	X	X	X	X	X	X	X	X
Geoff Hayward	X	X	A	A	A	X	A	X	X	X	A
Gill Ponder	X	X	X	X	X	A	X	X	X	X	A
Jan Sobieraj	X	X	X	X	X	X	X	X			
Neill Hepburn	X	X	X	X	X	X	X	X	X	X	A
Karen Brown	X										
Michelle Rhodes	X	X	A	X	X	A	X	X	A	A	X
Kevin Turner	X	X	X	X	X	X	X	X	X	A	
Sarah Dunnett	A	X	X	X	X	X	X	X	X	A	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X
Alan Lockwood	X	X	X	X	A						
Paul Matthew		X	X	X	X	X	X	X	X	A	X
Andrew Morgan									X	X	A

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Deadline	Completed
7 May 2019 4 June 2019	684/19 886/19	Committee KPIs	Committees to review the number of KPIs that are reported to them with a view to confirming they are required.	All Board members	4 June 2019	All committees have now considered and agreed. This will now feed review of overarching Board document. Complete
4 June 2019	827/19	Assurance in respect of H&S actions reported to FPEC	Clarity required in relation to training etc and metrics on actions following historic regulation/prosecution	Boocock, Paul	~~02/07/2019~~ 03/09/2019	Paper provided to August FPEC. Further detail requested.
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	~~30/09/2019~~ 5/11/2019	National update not available as at 24 Sept 2019
2 July 2019	1004/19	Finding relating to sepsis within the CQC report	Consideration of what needs to change to address the issues highlighted and how this doesn't align to data that Board had previously seen	Rhodes, Michelle	06/08/2019	Revised dashboard data agreed by QGC in Sept.
2 July 2019	1016/19	CQC Feedback letters June 2019	QSIP not having the impact would have wanted. Need review of this and where we get assurances from. How we prevent these issues arising rather than responding to problems after the event	Morgan, Andrew	06/08/2019	Review of QSIP content and process underway.
2 July 2019	1062/19	People Strategy	Develop some ambitious outcomes, built up with colleagues within the divisions. Through ET in first instance. Develop forward plan for rest of this year. Strategy back when ready	Rayson, Martin	~~06/08/2019~~ 01/10/19	Strategy being considered at 30 Sept W&OD.

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

2 July 2019	1076/19	Continuous Quality Improvement Approach	Actions to be translated to outcomes for inclusion within the strategy and reporting to Board to be determined	Rayson, Martin	06/08/2019	Progress reports to be taken to the W,OD & T Committee- Complete
2 July 2019	1077/19	Continuous Quality Improvement Approach	Feedback to the system that the Trust are taking forward the methodology	Rayson, Martin	06/08/2019	Progress reports to be taken to the W,OD & T Committee - Complete
6 August 2019	1186/19	QGC Assurance report	Review of window cleaning impact on cleanliness audit	Boocock, Paul	03/09/2019	Proposal to increase frequency of window cleaning being developed to be presented to CRIG for funding
6 August 2019	1204/19	CNST Safety Scheme	Review Medway system and provider to ensure ability to become complaint with data reporting	Paul Matthew	03/09/2019	Provider given opportunity to meet the required elements to submit the data. Difficulty experienced as to a clear resolution for the required data. Wider conversation were required with the provider to resolve in the future. Updates would be presented via the IT update to FPEC. A joint approach with

						the provider and NHS Digital would be undertaken to understand requirements – Complete
6 August 2019	1248/19	W,OD&T Assurance report	Refresh of the leadership development programme to be presented to the Board.	Rayson, Martin	01/10/2019	
6 August 2019	1249/19	W,OD&T Assurance report	Future Board Development session to be arranged to provide further focus to leadership	Warner, Jayne	03/09/2019	Focus to leadership to be built in to future Board Development session programme – Complete
6 August 2019	1253/19	W,OD&T Assurance report	Review and consideration of the frequency of Committee meetings	Baylis, Elaine	03/09/2019	Committee meeting to be held monthly – Complete
6 August 2019	1274/19	Integrated Performance Report	Performance data to be reported to FPEC in relation to fractured neck of femur patients being treated within 24 and 48 hours	Brassington, Mark	03/09/2019	Discussed at FPEC. Further clarity requested.
6 August 2019	1287/19	Audit Committee upward report	Further review of NHSI undertakings to be completed	Matthew, Paul	03/09/2019	Concerns about the ability to delivery the undertakings raised. Further discussion would be held at ET regarding the risks associated and a paper presented to the October Audit

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

						Committee – Complete
6 August 2019	1304/19	NHSI Board Committee Observations	Reflection of actions identified from observation feedback	Baylis, Elaine	03/09/2019	The Chair and Trust Secretary met to review feedback received. Individual Committees would be responsible to work through the actions identified. Feedback from the observed Board had been received and would be presented to the October meeting and reviewed in 6 months - Complete
6 August 2019	1311/19	Risk Management Report	Risk Register to be updated	Hepburn, Neill	03/09/2019	On agenda - complete
6 August 2019	1316/19	BAF	Review of data quality in respect of metric 2a prior to reporting to FPEC	Brassington, Mark	03/09/2019	Review of metric complete, data quality is not perfect but data would be reported in the IPR. Actions are in place to improve the data quality over time – Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

6 August 2019	1317/19	BAF	System delivery reports to be presented to Board members and ensure upward reporting through Committees	Brassington, Mark	03/09/2019	System delivery reports to be shared with Board. Agreement needed to be reached on how these could be reported
6 August 2019	1319/19	Board Forward Planner	Schedule Clinical Strategy for September and alter 2021 programme group name	Warner, Jayne	03/09/2019	Complete
3 September 2019	1333/19	Chief Executive Horizon Scan	Progress towards achievement of being a teaching hospital and how this would be supported by the University of Lincoln to be reported to the Board	Hepburn, Neill	01/10/2019	Agenda item
3 September 2019	1387/19	Annual Plan update	Board Development session to be arranged to support development and planning process	Warner, Jayne	01/10/2019	To be built in to future Board Development session programme – Complete
3 September 2019	1422/19	Integrated Performance Report	Board Development session to be arranged to review totality of operational performance	Warner, Jayne	01/10/2019	To be built in to future Board Development session programme – Complete
3 September 2019	1426/19	Risk Management Report	Risk Manager to be invited to the Board to ensure detailed discussion of divisional risks	Ward, Jayne	01/10/2019	

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	1 October 2019

Title:	**Chief Executive's Report**

Author/ Responsible Director Andrew Morgan, Chief Executive

Purpose of the Report:

To provide an overview of key strategic and operational issues.

The Report is provided to the Board for:

Information	✓	Assurance	
Discussion	✓	Decision	

Summary/Key Points:

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

Recommendations:

The Trust Board are asked to

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

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

System Issues

1. On Monday 16th September the first medical students arrived at the University of Lincoln. The Health Minister Edward Argar and a number of local NHS Trust CEOs and Medical Directors were present to greet this first cohort of students for the new Medical School.

The ground-breaking ceremony for the new Medical School takes place on 23rd September.

2. Work is continuing to develop the Lincolnshire Long Term Plan. This will build on the work done through the Healthy Conversation as well as incorporating the national targets and priorities. The first draft of the plan needs to be submitted to NHSE/I by 21st September and the final plan by 15th November. There is considerable work underway locally to both produce the plan and ensure that it goes through the right local engagement and assurance processes before it is submitted to NHSE/I.
3. Two further Healthy Conversation public engagement events are due to take place before this phase of the Healthy Conversation is closed. These events are in Grantham on 9th October and Boston on 10th October.
4. The system has been subject to further regional escalation as a result of the poor Urgent and Emergency Care (UEC) performance. The key issues that are being addressed by the UEC Delivery Board are delivery of the existing high impact actions; ensuring the Clinical Assessment Service has sufficient capacity and tackling ambulance conveyance numbers and handover delays.
5. The 7th System Executives Forum (SEF) takes place on 24th September. The SEF enables all the Executive Teams across the NHS in Lincolnshire to come together to ensure co-ordinated effort, delivery and alignment on key issues. The main items for consideration are delivery of 19/20 plans; the ICS; the Long Term Plan; collaborative support functions; revised NHS governance arrangements.
6. Further work is underway on the development of Neighbourhood working across the county. This is being led by Carolyn Nice from LCC who is now working 3 days per week as part of a joint post between the County Council and the NHS. This work will look at operational delivery; accountability; impact; the role of Primary Care Networks; population health management; data; behaviour change; and the overall strategic direction as part of the emerging Integrated Community Care work.
7. The LCB has agreed outline revised governance arrangements for the NHS system that will enable the more active participation of NEDs and Lay Members in the work of the STP. This will be discussed in more detail at the NED/Lay Member event on 9th October. In the meantime SET will address how these new arrangements will be supported by Executives. It was also agreed that LCB will revert to monthly meetings bearing in mind the depth and breadth of issues on the system agenda.

Trust Specific Issues

1. The draft CQC report following the Trust's inspection in June and July 2019 was received on 19th September. The Trust has ten working days in which to respond with any factual accuracy queries. The report is being scrutinised for accuracy and it is anticipated that the final report will be published in the next few weeks.
2. The year to date financial position is a deficit of £26.4m versus a planned position of a deficit of £23.3m. This is an adverse variance of £3.2m. These figures include PSF, MRET etc. The main drivers are a pay variance of £5.9m (after excluding a £1m positive technical adjustment) and the FEP year to date position being delivery of £5.9m of savings against a planned position of £6.9m. Urgent work is underway to address the pay variance and to maximise the delivery of the FEP schemes that have been agreed.
3. Following discussion with the Local Medical Committee, it has been agreed that more effective engagement needs to be put in place between GPs and ULHT clinicians at local level. This will allow better communication on pathway developments as well as day to day operational issues. The recent introduction of local Primary Care Networks (PCNs) will be used as the mechanism for this improved dialogue.

4. The vacancy for the Trust's substantive Director of Finance and Digital is now live. The NHS Leadership Academy Executive Search division are leading the process on behalf of the Trust. The Director of Nursing vacancy will go live in October.
5. A very successful staff wellbeing and development opportunities week was held in the week commencing 16th September. This involved the use of a double-decker bus as part of an initiative called the ULHT Bus Station. The bus visited the Trust's sites across the week and was used to engage with staff about the many wellbeing and development opportunities available across the Trust.

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18th August 2019
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives.
	Assurance in respect of SO 1a Issue: Delivering harm free care <u>Source of Assurance: Quality and Safety Oversight Group –</u> Progress continued to be made by the Quality and Safety Oversight Group. Concerns were raised around a number of wards, in particular leadership of these. The group had a strong grip on divisional investigation required in relation to incidents to ensure that these were completed in a timely manner. Use of the risk register by the Divisions was in the early stages and training would be required to ensure it was used appropriately. A refresh of governance was due to take place to support the divisions. <u>Source of Assurance: Mortality and Learning from Deaths –</u> The Committee noted the continued reduction for HSMR and SHMI whilst acknowledging that there had been a slight increase in crude mortality. The Committee were advised that the Trust are no longer required to conduct monthly NHS Improvement system wide mortality calls due to the Trusts improved position. <u>Source of Assurance: Safeguarding Quarter 1 –</u> The Committee received the Q1 reported noting that the largest issue had been compliance against training. The Committee noted that the medical photography risk and QS07 project had been closed. The Committee requested the inclusion of clinical holding and restraint training, relevant patient experience and CQC required actions to be explicit in future reporting. <u>Source of Assurance: Medical Devices –</u> The Committee received the update position noting that the business case had been agreed at CRIG to support increased resourcing however there was no funding to support

	and that this would need to be identified through the division. The concern had been added to the risk register and placed at a 12. The Committee requested an update on the specific requirements following the incident resulting in the need to ensure improvements. The Medical Devices Group did not support the movement of this work stream to business as usual from the QSIP programme. The Committee asked for assurance on how the actions required would be reported. Source of Assurance: Incident Management – The Committee received the report. Reporting remained static and there were no overdue serious incidents. Oversight remained of the divisional investigations to ensure that these were being undertaken. The increased medication incidents had been attributed to an increase in reporting but the Medicines Optimisation Group has been requested to investigate and report back in its regular report. Duty of candour remained static at 90% however this required constant maintenance. The Committee discussed the latest never event, year to date 3, noting that there had been no patient harm and immediate steps had been taken and communicated across all sites. The serious incident report was being produced and would be received by the Committee. Source of Assurance: QIA. – The Committee were informed that a live tracker was now in place. A clear process had now been established to ensure that there would be less risk to the submission of retrospective QIAs. Work had been undertaken with the Estates team around the projects however there was uncertainty if this was embedded as yet. There was a good process in place however this would require further embedding. The Committee has yet to receive the QIA for the Lincoln reconfiguration. Source of Assurance: Lessons Learnt – The Committee received the report noting that this had set the scene for the Trust demonstrating the current position and future aspirations to ensure learning from claims incidents, litigation and complaints. The foundations were in place to carry out analyses and the implementation of learning could now be undertaken. Triangulation meetings were being held and future meetings would see the attendance of the Trusts legal providers to provide support. Source of Assurance: NHS Resolution Claims Data – The Committee received the annual data from NHS Resolution in relation to claims. This linked to the Lessons learnt paper and demonstrated the position of the Trust and would support the triangulation of data. Source of Assurance: Risk Report – The Committee received the report and noted that there had been no material changes to the register.

	The Committee were informed that the risk associated with Aseptic pharmacy production was due to be mitigated by a temporary unit being placed at the Pilgrim site. This would take a number of weeks to commission, this solution would not result in full capacity but would provide mitigation. The Committee asked for there to be reflection on why this action had not been considered before. The Committee sought assurance that the Quality and Safety Oversight Group reviewed the high operational risks and requested that the due dates be reviewed by the Divisions. The Committee agreed that both elements of objective 1a – mortality and harm free care remained as amber rating.
	Assurance in respect of other areas:- <u>Quality Governance Performance report –</u> The Committee received the revised dashboard noting the significant work undertaken in relation to the data being reported. The data had been back dated to April 2018 in order to ensure representative reporting. The release of the NHS Oversight Framework had resulted in the inclusion of further metrics to the dashboard. The Committee noted the requirement to ensure that other Board Committees were aware of their responsibilities to ensure the delivery of the Quality Account priorities. Staff metrics contained within the Committees dashboard would be removed and included within the Workforce, Organisational Development and Transformation Committee dashboard. <u>NHSI Feedback – Medicines Optimisation and Safety Group –</u> The Committee received the final feedback from the NHS Improvement observed groups. The feedback received had resulted in work undertaken with the Chair of the group to implement the actions identified by NHSI. The Committee noted that urgent action would be required to ensure improvements were made as this is a key area that the Committee relies on for assurance due to the control framework issue. The Committee asked for a full consolidated action plan on all of the relevant NHS Improvement reports. <u>Quality and Safety Improvement Plan –</u> The Committee received the report which identified the key programme objectives. The plan presented to the Committee was aspirational and would require finalisation and the embedding of actions as a result of the publication of the latest expected CQC report. The Committee noted the need for the terms of reference for the relevant groups to be aligned to the plan in order to ensure oversight through the Committee. <u>CQC Section 29 and 31 –</u> The Committee received the reports prepared for the CQC in response to the section 29a and 31 notices received by the

	Trust. The data in relation to the section 29a has been received by the CQC and further communication regarding the outcome is yet to be received. <u>Quality Strategy –</u> The Committee reviewed the Quality Strategy and noted that this was not in a state of readiness to be received by the Board. This would be late being presented to the Board however the Committee wished to ensure that this strategy was a true representation of the aspirations of the Trust. The Committee requests the permission of the Board to present the Strategy in December.
Issues where assurance remains outstanding for escalation to the Board	No items were identified for escalation
Items referred to other Committees for Assurance	The Committee requested to refer the control framework issue relating to the NHS Improvement observation feedback in relation to the Medicines Optimisation and Safety Group and all of the relevant reports be considered by the Audit Committee.
Committee Review of corporate risk register	The Committee reviewed the risk register noting that there had been no major changes to the document.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed since the last meeting. The Committee rated the assurances which were the responsibility for the Committee, both remain Amber, which would be escalated through the Board Assurance Framework
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee were not assured in respect of any of the strategic risk areas which aligned to it.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

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

Neill Hepburn Medical Director	D	X	X	X	X	X	X	D	X	X	X	X

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	19 September 2019
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Position and Financial Recovery Plan – Pay costs Reason for lack of assurance: The Committee were advised that the Trust was adverse to plan at the end of Month 5 by £3.2m, an increase of £2.2m from Month 4. The position still assumed the full payment of the PSF and FRF, which are dependent on hitting our Control Total. The Committee considered the financial risks noting that there was no further non-recurrent funds available. Unless corrective action is taken the monthly run rate would remain at the current £2.2m over plan. The pay bill would need to be brought in line with plan along with pace being brought to the efficiency programme. The Committee noted that pay was adverse to plan, with agency spend continuing to rise. Agency spend was £4.9m over plan. An additional cost pressure from the Medical and Dental Pay award will affect the Trust due to an increase from 1% as planned to 2.5%. The Trust expects to receive an allocation to cover this but haven't yet received detail of this to enable us to establish whether there is an impact on the financial position. The Committee was asked to support the escalation of the approval of new borrowing to the Trust Board to the value of £7.89m revenue borrowing and £0 capital borrowing for November 2019. The Committee supported and recommended approval by the Board. Actions requested by the Committee: The Committee requested further action be taken by the Executive Team to ensure spend is brought back

	under control in order to deliver the planned £70.3m deficit
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Efficiency Programme Reason for lack of assurance: The Committee were advised of the continued risk to delivery due to lack of pace in development and delivery of the efficiency plans. The Trust was £1m behind plan and £2.5m of brought forward savings and technical adjustments had been utilised. No further such opportunities were available to support delivery of the plans. The Committee remain highly concerned about the lack of delivery of the FEP. Action requested by the Committee: The Committee requested an update from the Executive Team on the actions being taken to bring schemes through to delivery and to deliver the full FEP plans agreed at the start of the year.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Assurance report from Information Governance Group The Committee received the upward report from the Information Governance Group noting the main concerns in relation to health records destruction and the Data Security and Protection Toolkit. A recovery plan remained in place for the toolkit due to non-compliance with 6 elements of the plan. Whilst timescales had slipped, plans were in place to recover by the end of March 2020 when the annual plan was due. There remained a lack of assurance regarding the health records destruction policy and the IG Group had requested that the Health Records Group complete the destruction policy by November. Lack of assurance had been received in respect of Freedom of Information requests and the inability to provide progress reports to the group on timeliness of responses. Subject Access Requests had increased since the introduction of GDPR and there being no charge levied on the requests. The IG Group had agreed to introduce a charge for excessive requests. As a result of the position on subject access and freedom of information requests, the Trust had received increased interest from the Information Commissioners Office, who had received complaints about overdue responses. A process to demonstrate compliance was due to be developed by November.

	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Cyber Security and Phishing Campaign The Committee noted that communications continued regarding the risk of phishing and that this had been included within core training and HR newsletters. The lessons learned from the phishing campaign carried out by Trust auditors demonstrated that the Trust had similar issues to other organisations. A further campaign would be undertaken utilising tools from NHS Digital, which would be wider than the original campaign. This would highlight weaknesses and allow a comparison of results to be undertaken with other Trusts. The Trust intended to conduct a wider cyber security campaign along with the STP, utilising campaign material from Anglian Water who had run a successful campaign with their staff. Action requested by committee: Feedback to Audit Committee the actions taken as a result of the phishing and cyber security audit outcomes.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Estates Update Reason for lack of Assurance: The Committee requested that the Critical Failure of Mechanical Infrastructure paper be brought back in order to detail how the risks identified within the paper were being managed including capital prioritisation. The Committee noted the Estates Dashboard identifying that the read across to the risk register was not consistent. A review against the risk register would be undertaken to ensure consistency. The Committee received an update on the Progress Housing contract and noted that decreased occupancy during January and April was due to medical trainee change over dates. Increased occupancy during May and June 2019 was a result of increased overseas recruitment activity. An annual review meeting with Progress Housing discussed opportunities to ensure that the Trust achieved better value for money from the occupancy agreement and a number of actions had been put in place to achieve this. The Committee were assured that work was actively being undertaken to minimise occupancy guarantee payments. The Committee would continue to receive upward reports on progress through the Estates Group.

	The Committee received a verbal update on fire noting that the spend year to date remains positive. Manufacturing continues at pace and circa 3k doors have been installed out of circa 4.5k. A recent review by the Fire Service confirmed that progress was positive. Additional resources were being put in place to support fire safety training to release Fire Safety Officers to conduct risk assessments due for completion. The Committee received an update on the Trust's application for a Salix loan to replace the Combined Heat and Power unit at Lincoln which had not been approved because the proposed projects did not achieve the required level of carbon savings for Salix to support it. To proceed, the Trust would either have to meet the costs or add further projects to increase the carbon savings and meet the loan criteria. A proposal was put forward to the Committee for installation of a new gas supply at Pilgrim, this would realise the carbon savings required. This work would have to be done by 2024 anyway, due to changes in legislation. The installation would ensure a robust and reliable gas supply, support plans to extend the A&E department and save circa £220k per annum. The Committee were asked to support the recommendation to the Board for additional borrowing from Salix of £1.4m to incorporate the gas supply project. The total loan proposed would be £5.1m. The Committee gave its support and recommended approval by the Board for the additional borrowing of £1.4m
	Lack of assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Health and Safety Group Reason for lack of Assurance: The Committee received the report from the Health and Safety Executive audit of the Trust. The Committee were advised that training figures had to be loaded manually and as such a report would not be available until Autumn 2019. Actions requested by the Committee: The Committee requested that further work be undertaken on the report to ensure that assurance was provided.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent and Emergency Care Improvement Programme Reason for lack of Assurance: The Committee were advised that the trajectory in August had been missed by 8% however there had been a 7% improvement in the minors streams. Ambulance conveyance remained high with a growth of 8% against 2018/19. An influx of conveyances was being seen from outside of normal areas.

	In order to reduce the number of conveyances to the Trust, a trial has commenced with the community trust to direct lower acuity patients through CAS to community beds. Pre-hospital practitioners based at Lincoln had been put in place on limited days to improve ambulance handover. The Committee noted the 7% increase (circa 2000 patients) in patients admitted against 2018/19. This equated to 70 extra beds. High impact actions were in place to focus on the minors' stream, same day emergency care, long stay reviews , discharges and length of stay. The impact expected from these actions was not being seen due to the significant increase in activity. Work continued at system level to reduce the level of demand. Action requested by the Committee: The Committee requested assurance that the actions were delivering the impact expected.
	Lack of Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Delivery of Cancer Performance Reason for lack of Assurance: The Committee noted that the Trust had achieved 3 of the 9 cancer standards during July, which was comparable to national performance of the standards, but was down from the 7 standards achieved the previous month. The Committee noted the actions that had taken place during July and August, which included treating some longer waiting patients and were assured that actions would continue to achieve trajectory if the tumour sites delivered the level of activity planned to meet demand. Availability of staff and equipment was a risk to this plan. The Committee noted that active contract negotiations were being sought in relation to the pathology contract. Support had been offered by the regulator to the Trust in order to aid a resolution. The shortening of pathway to diagnosis would enable more consistent performance. Action requested by the Committee: The Committee requested an update on plans to increase activity levels at the next meeting.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Source of assurance: Data on A&E Clock Stops The Committee received an update on the A&E clock stops in relation to the counting error identified by the auditors within the Quality Account. Following an audit of the data, the issues were rectified to ensure correct recording of times. If the times had been recorded correctly, performance would have been worse by 0.14%.

	The Division would continue to conduct audits on a quarterly basis to ensure recording accuracy and embedded compliance against the recommendations from the audit report.
	Committee Dashboard The Committee received the dashboard that had been populated further, but validation of the data would be required. The Committee noted the drop in cancer standards demonstrated in the dashboard against the previous months positive achievement, this had reflected the previously raised concerns of sustainability of the standards.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	Corporate risks were noted.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the SRR/BAF was reflective of the key risks in respect of the strategic objectives of the organisation. Assurances received were noted and updates would be made to the BAF to reflect discussion.
Committee position on assurance of strategic risk areas that align to committee	The Committee received a verbal report from the Chief Operating Officer following the national EU Exit meeting. The key risk for the Trust would be the supply chain with the expectation of some disruption and delays. National contingency plans were in place. The expectation is for Trusts to resolve issues locally and bolster EU Exit Teams to support the time following the EU Exit. There will be additional scrutiny of organisations in respect of charging overseas visitors for inpatient secondary care resulting in the need to strengthen the Overseas team for a short term period.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S
Gill Ponder Non Exec Director	X	A	X	X	X	X	X	X	X	X	X	X
Geoff Hayward Non Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non Exec Director	X	X	X	X	X	X	A	X	X	A	X	A
Deputy Chief Executive	A	X	X	X	X	A	A	A	X	X	X	
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X

Chief Operating Officer	X	X	A	X	D	X	X	X	X	D	D	X
Director of Estates and Facilities	X	X	D	X	D	A	X	D	X	X	D	X

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

Agenda Item 12.2

To:	**Trust Board**
From:	Chief Operating Officer
Date:	October 2019

Title:	**EU Exit Contingency Planning Report**

Responsible Director: Mark Brassington, Chief Operating Officer

Author: Paul White, Risk Manager / Nick Leeming, Head of Emergency Planning

Purpose of the Report:
The purpose of this report is to provide the Trust Board with an update on contingency planning for the possible scenario of a 'no deal' UK exit from the European Union (EU)..

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance	✓	Information	✓

Summary/Key Points:

- The UK Government is putting contingency plans in place at a national level, in the event that the UK leaves the EU in 2019 without a deal in place; under current arrangements, the UK will leave the EU on 31st October 2019
- The Department of Health & Social Care has issued guidance for providers and commissioners to enable local contingency arrangements to be put in place
- The Trust has previously set up an EU Exit Contingency Planning Group, chaired by the Deputy Chief Executive as Senior Responsible Officer (SRO), to oversee contingency planning arrangements and compliance with national and regional requirements
- This group had been stood down in recent months, and will now be reinstated in order to review and where necessary update the Trust's contingency plans; The Chief Operating Officer is the new SRO for EU Exit
- Included with this report is an updated risk register
- The highest priority areas are:
    - **medicines supply** (due to reliance on supply for the EU and the scale of potential impact) – a national Memorandum of Understanding has been developed to support transfer of medicines between providers if needed;
    - **medical devices and consumables** (due to reliance on supply from the EU of single use consumables and spare parts for devices in Cardiology and Radiology);
    - **workforce** (due to the range of ways in which the workforce may be affected, with an emerging concern that DBS check for a European national maybe subject to a long delay);
    - **finance** (capacity to deal with a potential increase in overseas visitor screening and billing/payment processing

Recommendations:

- That the Trust Board considers the content of the report and identifies if any further action is required to give assurance that ULHT is suitably prepared for the risks associated with a 'no deal' EU Exit

Agenda Item 12.2

Strategic Risk Register The risk of Trust services being disrupted in the event of a 'no deal' EU Exit is recorded on the corporate risk register.	**Performance KPIs year to date** Not applicable to this report.
Resource Implications (e.g. Financial, HR): The work of the EU Exit Contingency Planning Group is managed using existing resources. Any additional costs incurred in relation to EU Exit contingency planning will be accounted for.	
Assurance Implications The content of this report will enable the Trust Board to take an appropriate level of assurance regarding the effectiveness of contingency planning arrangements that are being put in place in the event of a 'no deal' EU Exit.	
Patient and Public Involvement (PPI) Implications Any significant and prolonged disruption to services as a consequence of a 'no deal' EU Exit scenario would have major implications for the quality and timeliness of patient care, and the public reputation of the Trust.	
Equality Impact There is no indication that EU Exit contingency planning arrangements will have a differential impact on any group or groups with protected characteristics.	
Information exempt from Disclosure – Yes	
Requirement for further review? FPEC & Trust Board to be kept up to date.	

1. Purpose of Report

1.1 The purpose of this report is to provide the Trust Board with an update on contingency planning for the possible scenario of a 'no deal' UK exit from the European Union (EU)..

2. Background

2.1 The UK is now due to leave the European Union on 31st October 2019.

2.2 Action is being taken at a national and regional level to ensure that appropriate contingency plans are in place in order to minimise the potential disruption to UK infrastructure, services and businesses.

2.3 NHS England and NHS Improvement intend to run another round of regional EU Exit workshops in September to support local planning. In advance of these workshops they will be hosting a series of teleconferences to ensure EU Exit SROs and other senior colleagues working on local EU Exit preparations are sighted on the latest developments and any actions required in the coming months.

2.4 The UK Government will be continuing with its multi-layered approach to continuity of supply, involving a range of activities including (but not limited to) warehousing, buffer stocks and procurements for extra ferry capacity, including an express freight service for medicines and medical products.

3. Recommendations

3.1 That the Trust Board considers the content of the report and identifies if any further action is required to provide assurance that ULHT is suitably prepared for the risks associated with a 'no deal' EU Exit scenario.

4. ULHT contingency planning

4.1 The Senior Responsible Officer (SRO) for Brexit within the Trust is now the Chief Operating Officer. A Contingency Planning Group is to be reinstated to oversee Trust preparations to manage associated risks. The operational lead is the Head of Emergency Planning.

4.2 The risk of significant disruption to Trust services in the event of a 'no deal' EU Exit scenario has been added to the Corporate Risk Register (Risk ID 4467) and is currently rated as 12 (High risk). This reflects the previous SRO's assessment that, despite extensive contingency planning arrangements there is such a high degree of uncertainty surrounding the potential implications at a national level that there remains a reasonable likelihood of some substantial disruption to ULHT services. A copy of the risk register entry is attached as **Appendix I**.

4.3 The EU Exit Contingency Planning Group has reviewed all of the actions set out in the EU Exit Readiness Guidance against current arrangements in place within the Trust and populated and returned the national data collection template.

4.4 The Trust has recently completed and returned an updated assessment to the Midlands EU Exit team. This assessment highlighted the following areas of concern:

- Capacity within the overseas visitor team in finance to deal with the potential increase in screening and billing/payment processing if there are no reciprocal arrangements in place; the Overseas Visitors Manager has been tasked with ensuring that relevant front line training is delivered ahead of the EU exit date
- Issues with traffic possible in the north of the county towards Scunthorpe due to Operation Wellington; escalation arrangements are being discussed with Northern Lincolnshire & Goole NHS Foundation Trust (NLAG)
- Confirmation is awaited that suppliers have arrangements in place for continued supply of medical radioisotopes

4.5 A Memorandum of Understanding (MoU) has been developed by NHS England / NHS Improvement to support the safe operational transfer of medicines between NHS providers in order to meet patient needs in the event of a shortage. A copy of the MoU is attached for reference as **Appendix II**.

4.6 The EU Exit Contingency Planning Group will be reinstated and will meet regularly to ensure that all necessary arrangements are in place to maintain continuity of Trust service throughout the EU Exit period. The Chair of the Group ensures that regular updates are provided to the System Executive Team (SET) and, along with the Head of Emergency Planning continues to liaise with the contingency planning cell of the Local Health Resilience Partnership (LHRP) via a weekly teleconference to ensure that plans are aligned. The LHRP reports through to the Local Resilience Forum (LRF) to ensure there is a coordinated response amongst all partner agencies.

4.7 Regular updates will be provided to the Finance, Performance & Estates Committee (FPEC) and Trust Board to highlight new information and developments.

Appendix I - EU Exit Risk (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Risk review date	Weakness/Gap in Control	Lead specialty	Description	Component risk rating	Action lead	Action due date	Progress
4467	**Impact of a 'no deal' EU Exit scenario (corporate)** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust.	Turner, Kevin	Service disruption	Very high risk	Dep Ch Exec appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables - medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT EU Exit Planning Group: - local risk assessment, covering: potential demand increase; supply of medicines, medical devices & clinical consumables; supply of non-clinical goods & services; EU workforce; reciprocal healthcare; research & clinical trials; data sharing & security.	High risk (12)		Low risk	31/10/2019	The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	Pharmacy	Completion of all required actions in respect of medicines and vaccines, as detailed in the national EU Exit guidance. Specific instruction not to stockpile medicines or to prescribe extra medicines.	High risk (12-16)	Costello, Colin	31/12/2019	Current Pharmacy stock holding of around 27 days. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. Options to manage the impact of the current recruitment freeze on staffing capacity in Pharmacy procurement to be considered.
										The supply of medical devices & clinical consumables may be disrupted in the event of a 'no deal' EU Exit. Some parts for diagnostic machines used in Radiology & Cardiology (Cath Lab imaging systems; MRI compatible monitors – two out of support monitors, two MRIs) are obtained from Germany, which may lead to delays in fulfilling orders. There are BC plans in place, including back-up machines and some spare parts held, but not all possibilities can be covered. Availability of single-use consumable accessories for medical devices that are used constantly across the trust is also of concern.	Finance	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	Moderate risk (8-10)	Pogson, Barry	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments. Concern that we do not have assurance about plans to manage the traffic impact of Immingham being opened up to increase port capacity – to be escalated through SCG to the Dept of Transport/Highways Agency.
										The supply of non-clinical goods and services may be disrupted in the event of a 'no deal' EU Exit. There are some concerns regarding the supply of food, as 30% comes from the EU and import delays would affect perishable goods.	Finance	Completion of all required actions in respect of non-clinical goods and services, as detailed in the national EU Exit guidance. The DHSC has issued updated guidance on supply of food, advising a common sense approach in the event of short-term shortages.	Low risk (4-6)	Pogson, Barry	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments.
										The supply of workforce may be disrupted in the event of a 'no deal' EU Exit. Concern emerging that under a 'no deal' scenario a DBS check for a European national maybe subject to a long delay.	Human Resources	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	Moderate risk (8-10)	Tidmarsh, Darren	31/12/2019	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Awaiting further guidance regarding professional registration. Agencies may also be reliant on EU workforce - risk assessment requested from Holt. HR to liaise with agencies providing medical staff to assess any risks throughout the EU Exit period. To consider the possibility of cancelling annual leave during the EU Exit period if planned staffing levels are not sufficiently robust.
										Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Finance	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	Low risk (4-6)	Hills, Mr Colin	31/12/2019	Need to understand the scale of risk, to ascertain how many patients would suddenly have to pay if reciprocal arrangements cease and who would not qualify; to pull together resource plan to meet the requirements to charge EU citizens following UK Exit.
										Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Research and Development	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	Low risk (4-6)	Leeming, Nick	31/12/2019	All sponsors are UK-based and actively working to ensure continuity of drug supply. ULHT is not a sponsor for any of the 38 current trials. Some trial drugs come from the EU. Current trials to be risk assessed against threat from a 'no deal' scenario.
										Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	Information & Communications Technology	Completion of all required actions in respect of data sharing, processing & access, as detailed in the national EU Exit guidance. Instruction to follow advice from The Department for Digital, Culture, Media and Sport and the ICO and to complete the annual Data Security and Protection Toolkit assessment as early as possible.	Moderate risk (8-10)	Tute, Mrs Maria	31/12/2019	Local risk assessment carried out did not identify any significant data sharing implications. Latest guidance to be reviewed and potential impact re-assessed.
										Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Finance	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	Low risk (4-6)	Hills, Mr Colin	31/12/2019	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time). Consideration to be given to the potential that prices for some goods (e.g. food) may increase post-Brexit.
										Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Communications & Engagement	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	Moderate risk (8-10)	Richards, Anna	31/12/2019	Communication of common message regarding clinicians not writing longer prescriptions and patients' storage of medicines at home. Communications plan in progress to inform affected staff of settlement scheme and professional registration requirements. Use of traditional and social media channels, in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).

Appendix I - EU Exit Risk (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Risk review date	Weakness/Gap in Control	Lead specialty	Description	Component risk rating	Action lead	Action due date	Progress
										The date of the UK's exit from the EU has been moved to 31st October 2019. Existing contingency plans may or may not be sufficient to mitigate potential impacts on the workforce; supply of medicines and medical devices; and the availability of information.	Emergency Planning	To review existing business continuity plans and update where necessary, in line with national and local guidance. Trust response to be coordinated through re-establishment of an executive-led task & finish group.	Low risk (4-6)	Leeming, Nick	31/10/2019	Currently awaiting further details from the Dept of Health regarding potential impacts and any required changes to existing business continuity plans.

Memorandum of Understanding between NHS provider organisations to support safe access to medicines during times of shortages

Introduction

Over recent years access to medicines has been impacted by occasional, but growing numbers of pharmaceutical product shortages. These may be associated with manufacturing issues, natural disasters or other global factors.

The NHS has always been given clear instructions not to stockpile medicines in times of potential shortage as this activity would have the serious potential to exacerbate and/or create new shortages.

To support the ongoing management of medicine supply and shortages, NHS England and NHS Improvement (NHSE&I) have been working closely with the Department of Health and Social Care (DHSC) and the Medicines and Healthcare Products Regulatory Agency (MHRA) to facilitate the safe and effective use and distribution of medicines between secondary care providers, while maintaining patient safety and service provision.

A Memorandum of Understanding has been developed to support the safe operational transfer of medicines from one legal entity (i.e. an NHS provider) to another in order to ensure patients, wherever possible, can receive the medicines they require.

Trusts should only utilise this MOU in certain scenarios, where they do not hold a Wholesaler Dealer licence as outlined in the scenario models in the document. Some local NHS organisations may have similar documentation in place and these are intended to formalise and support these existing arrangements.

Memorandum of Understanding (MoU)

This MoU has been developed for local adoption and agreement between NHS provider Chief Pharmacists within the seven NHS English regions to support the safe operational transfer of medicines from one legal entity (NHS providers **ONLY**) to another to ensure patients, wherever possible, receive the medicines they require.

The MoU participants are listed in Appendix A.

Requests for medicines in an emergency

The NHS provider Pharmacy department requesting the medicine may be able to obtain this via the following mechanisms listed below in the table. These options should **ONLY** be used for medicines identified by the Department of Health and Social Care medicines supply team or the NHS England and NHS Improvement (NHSE&I) Commercial Medicines Unit as in short supply nationally.

(Normal wholesaler out of hours or other on-call arrangements and Service Level Agreements should be followed if the product required **is not** identified by DHSC/NHS E Commercial Medicines Unit as a shortage medicine)

Potential options:

Option 1	Medicines supplied through wholesale supply utilising the supplying hospital pharmacies MHRA WDA(H) – Wholesale Dealers Authorisation (Human).
Option 2	Medicines dispensed against a prescription (for use by a specific patient of another NHS Provider organisation) utilising the supplying hospital pharmacy's registration as a pharmacy with the General Pharmaceutical Council (GPhC).
Option 3	Utilising the MHRA definition of onward supply of medicines in order to meet patient's individual needs as an appropriate part of 'Provision of healthcare services' by a hospital pharmacy.

Wherever possible, for all options, a Signed Order should be provided to the supplying hospital. In the case of a dispensed item requiring a patient's name and (potentially) directions the original prescription must be provided to the supplying hospital within 48 hours.

It should be noted that:

The Medicines and Healthcare products Regulatory Agency (MHRA) takes the view that the supply of medicines by community and hospital pharmacies to other healthcare professionals in the UK who need to hold small quantities of medicines for treatment of, or onward supply to, their patients represents an important and appropriate part of the professional practice of both community and hospital pharmacy. (See Appendix B). Community and hospital pharmacies may also need to obtain small quantities of a medicine from other pharmacies to meet a patient's individual needs. Both these activities are considered, by the MHRA, to fall within the definition of provision of healthcare services. In such circumstances, the MHRA will not deem such transactions as commercial dealing and pharmacies will not be required to hold a WDA(H) provided the transaction meets all of the following criteria:

- it takes place on an occasional basis,
- the quantity of medicines supplied is small,
- the supply is made on a not for profit basis and
- the supply is not for onward wholesale distribution.

In addition:

- There is a professional responsibility on all registered pharmacy professionals to undertake due diligence to ensure that all medicines supplied for patient use are sourced from suitable suppliers that abide by the principles of Good Distribution Practice (GDP).
- Not all activities may be covered by an MHRA WDA(H) e.g. cold chain or unlicensed medicines may be excluded.
- For dispensed items clinical screening should be undertaken by the requesting hospital as full clinical information is available to that team.
- Supplying hospitals will ensure safe systems are in place for checking medicines supplied in terms of accuracy.
- Prescriptions may be faxed to support speed of supply however the original must be provided to the supplying pharmacy within 48 hours to meet the current legal framework.

- All signed orders and prescriptions must be clearly marked as to their urgent nature.

Transport:

The provider requesting the medicines supply must arrange suitable transport. It is recommended a courier is used for transporting medicines and for those items requiring refrigeration/other cold chain storage that adequate measures are taken to ensure safe transport.

**NB MHRA WDA(H) holders would not be expected to provide out of hours validated transport as this activity is not part of their normal activities.

Ordering & Invoicing:

The hospital receiving the medicine will arrange for a suitable purchase order to be sent to the supplying hospital who will invoice using standard operating procedures for that trust.

Such inter-hospital recharging should be at actual acquisition costs with minimal additional handling charges. Where supplied outside 'normal wholesaling' handling charges should not be excessive as such a transaction would be considered as profiteering.

Appendix A: Memorandum of Understanding Participants:

NHS Provider organisation	NHS ODS code	MHRA WDA(H) holder (Yes/No)	General Pharmaceutical Council registered pharmacy (Yes/No)	Contact name and signature	Date signed
TBC					

Add additional pages as required

Appendix B. MHRA Guidance on the Repeal of Section 10(7) of the Medicines Act 1968

Introduction

With effect from 14 August 2012, Section 10(7) of the Medicines Act 1968 has been repealed. Section 10(7) provided an exemption in UK law from the requirement for a pharmacist to hold a Wholesale Dealer's Licence (WDA(H)) if they trade in medicines in certain circumstances. Its repeal was necessary in order to comply with EU legislation, in particular, Articles 77(1) and 77(2) of Directive 2001/83/EC which require anyone undertaking wholesale dealing activities to hold an authorisation.

This note provides guidance for pharmacists working in registered pharmacies and in hospitals on how MHRA, as the regulator responsible for the enforcement of EU legislation, will address the implications of the necessary repeal of Section 10(7) for the supply of licensed medicines by pharmacy other than direct to the public.

The legislation governing supply of medicines

The legislation and underpinning guidance requires persons trading in medicines to hold a WDA(H) and to apply Good Distribution Practice (GDP) standards and have a suitably experienced "Responsible Person" named on the licence to ensure that medicines are procured, stored and distributed appropriately. The legislation also ensures that medicines can only be supplied to other wholesale dealers, pharmacists or other persons authorised or entitled to supply medicines to the public. These rules also serve to provide confidence in the medicines supply chain by regulating the transit of medicines from manufacturer to patient.

How this applies to supply of medicines by pharmacy in the UK

MHRA is concerned to ensure that the repeal of the Section 10(7) exemption does not adversely impact on arrangements for supply of medicines in the UK. In determining how to address this issue, MHRA has taken careful account of the particular arrangements for delivery of healthcare in the UK which involve a wide range of individuals and in a diverse range of locations. In particular:

- Many healthcare professionals and others authorised or entitled to supply medicines to the public in the UK need to hold small quantities of medicines for local healthcare provision and look to a local community or hospital pharmacy to supply them as part of their professional practice.
- In contrast, some pharmacies engage in commercial trade in medicines, not solely as part of their professional practice within the UK healthcare system.
- Pharmacists may also occasionally need to obtain small quantities of a particular medicine or medicines from another pharmacist in order to meet the needs of individual patients.

MHRA enforcement

MHRA takes the view that the supply of medicines by community and hospital pharmacies to other healthcare professionals in the UK who need to hold small quantities of medicines for treatment of or onward supply to their patients represents an important and appropriate part of the professional practice of both community and hospital pharmacy. Also, community and hospital pharmacies may need to obtain small quantities of a medicine from other pharmacies to meet a patient's individual needs. Both these activities are considered by MHRA to fall within the definition of provision of healthcare services. In such

circumstances, provided the transaction meets all of the following criteria MHRA will not deem such transactions as commercial dealing and pharmacies will not be required to hold a WDA(H):

- it takes place on an occasional basis,
- the quantity of medicines supplied is small,
- the supply is made on a not for profit basis and
- the supply is not for onward wholesale distribution.

Conversely, pharmacies who wish to engage in commercial trading in medicines are entitled to do so only if they hold a WDA(H) and comply with all the relevant requirements. As the authority responsible for enforcement MHRA will take appropriate action to enforce the requirement of the legislation and will require any commercial trade in medicines to be undertaken only by holders of a WDA(H).

These restrictions do not apply to the exchange of stock between pharmacies that are part of the same legal entity, although where a legal entity holds a WDA(H) as one (or more) of its pharmacies is involved in the commercial trade of medicines, the supplying pharmacy must also be named on the WDA(H) if the stock supplied is for the purposes of wholesale.

Guidance on the need for a WDA(H), the application process and a downloadable application form are available on MHRA's website.

http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Manufacturersandwholesaledealerslicences/index.htm (applications)

http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Informationforlicenceapplicants/Licenceapplicationforms/Wholesaledealerslicencesapplic ationforms/index.htm (forms and guidance)

http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Feespayablefortheregulationofmedicines/Feesforwholesaledealer'slicences/index.htm (fees)

http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodDistributionPractice/Theinspectionprocess/index.htm (the inspection process)

http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2013:343:0001:0014 :EN:PDF (Good Distribution Practice)

Appendix C Potential secondary care supply scenarios

Scenario #	Description	Questions	Position
1	• Hospital A has stock of shortage drug. • Hospital B has a patient requiring supply of this shortage drug and a prescription has been written by Hospital B clinicians using the internal Hospital B Authorisation to Supply (Also Known as a Hospital outpatient prescription). • Hospital B confirms with Hospital A that they have stock and that the patient can come and have the Hospital B prescription dispensed as a private prescription. • Patient travels to hospital A with the prescription and has supply made. Hospital A makes arrangement to recharge hospital B for the drug supplied PLUS appropriate handling change	If Hospital A is NOT a registered pharmacy with the General Pharmaceutical Council (GPhC) can they legally make this supply?	Dispensing against a private prescription is a 'retail supply', whereas dispensing against an NHS prescription is supplying 'in circumstances corresponding to retail supply'. In normal situations both would require the pharmacy in hospital A to be registered as a pharmacy with the GPhC.in order to make a supply against a prescription from hospital B. Hospital pharmacies can make supplies to their patients without the need to register with the GPhC because such supplies are regarded as being made 'in the course of the business of the hospital ' In emergency situations, acting in the best interests of the patient of hospital B, hospital A could make the case that dispensing the prescription and supplying medicines in this scenario is in the 'course of the business of the hospital' ;[that business being treating patients and acting in patients' best interests] and that in this emergency situation they could make the supply without being registered with the GPhC. Pharmacy professionals must, at all times, adhere to the GPhC's standards for pharmacy professionals (https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017_0.pdf) and must be able to use their professional judgement when deciding whether or not to make a supply in the best interests of patients.

			**NB hospital B Replenishing hospital A's stock (once available again) would be a wholesale activity because there is no prescription and should not routinely happen
2	• Hospital A has stock of shortage drug. • Hospital B (within 10 miles) has in-patients requiring this drug for use in the hospital. Hospital B has a prescription written for the shortage drug. • Hospital B confirms with Hospital A that they have stock and arranges to order supply to be transported to Hospital B • Hospital A makes arrangement to recharge Hospital B for the drug supplied PLUS appropriate handling and transport costs	Can hospital A supply hospital B? Hospital A does NOT have an MHRA Wholesale Dealers license (<50% of NHS Trusts in England are licensed as wholesalers) and are not registered with the GPhC as a pharmacy (30% of NHS trusts in England are not)	Hospital A would be generally considered to be wholesale dealing. However, as hospital A does not have a WDA (H) and would therefore be using the supply process termed as being in "circumstance corresponding to retail supply" and considered by MHRA to fall within the definition of provision of healthcare services, relying on MHRA's guidance on the repeal of section 10(7). The MHRA will not deem such transactions as commercial dealing and pharmacies will not be required to hold a WDA(H) provided the transaction meets all of the following criteria: • it takes place on an occasional basis, • the quantity of medicines supplied is small, • the supply is made on a not for profit basis and • the supply is not for onward wholesale distribution. A template Memorandum of Understanding has been developed to support this process.
3	• There is a general shortage across the UK of a specific drug, Through the NHS E/I data systems that provide stock level data it can be seen that one hospital has the equivalent of 3 months stock for the country (either due to change in clinical practice/ordering error or other reason).	Can the hospital with stock supply other NHS Organisations across the country? Can the supplying Wholesaler have the stock	This would be a wholesale activity and would be subject to holding a WDA. Licensed WDA holders do operate a returns policy. This will range from 24 Hours to 5 working days. If it is outside this period, then stock would be unlikely to be able to be returned to the supplying wholesaler.

	• The Hospital with the stock does not have an MHRA WDA and is not registered with the GPhC. • There is a clinically urgent need for this excess stock to be distributed across the country.	returned to them to then distribute through normal channels /through an 'allocation' approach?	https://mhrainspectorate.blog.gov.uk/2016/05/05/refrigerated-medicinal-products-part-2-transportation-packing-temperature-management-the-use-of-third-party-couriers-and-returns-some-things-to-consider/ https://mhrainspectorate.blog.gov.uk/2016/01/26/refrigerated-medicinal-products-part-1-receipt-and-storage-some-things-to-consider/
4	• The Manufacturing Authorisation Holder has minimal stock of a hospital only drug. • There is a need to closely control the stock supplied to NHS Providers. • The MAH does not use the wholesaler distribution network/or the wholesalers cannot control the supply as closely are required. • It is proposed to utilise a restricted number of NHS provider trusts across the UK (Based upon historical usage data) to hold stock and then supply to other NHS organisations located within geographically adjacent areas. • Not all areas have trusts with MHRA WDA's which would leave the East of England without a source of the drug.	Can a NON-MHRA WDA holder be utilised to ensure supply can be made?	No – This would not be acceptable in terms of current legislation. Both the Department of Health & Social Care and NHS England hold an MHRA WDA(H). It may be possible for either entity to instruct a third party to procure and supply medicine(s) e.g. DHSC would own the stock but the stock is physically held by another WDA holder and DHSC instructs on its movement. This would require case by case consideration by the regulator.

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To:	The Trust Board
From:	Tim Couchman, Equality, Diversity and Inclusion Lead
Date:	20th September 2019
Standard	Equality Act 2010 and Public Sector Equality Duty 2011

Title:	Equality, Diversity and Inclusion Annual Report 2018-2019

Author: Tim Couchman, Equality, Diversity and Inclusion Lead
Responsible Director: Martin Rayson, Director of Human Resources and Organisational Development

Purpose of the report:

The Equality, Diversity and Inclusion Annual Report 2018-2019 has been approved by the Quality Governance Committee and Workforce and Organisational Development Committee in August and September 2019 respectively.

It is with pleasure that the Equality, Diversity and Inclusion Annual Report 2018-2019 is now presented to the Trust Board with the request for final approval, before being placed in the public domain on the Trust's website.

The report is provided to the Board for:

Decision	X	Discussion	
Assurance	X	Information	X

Summary/key points:

The publication of an Equality, Diversity and Inclusion annual report is one of the requirements of the Public Sector Equality Duty 2011 (Equality Act 2010, section 149).

In the annual report the Trust's significant and continued progress in relation to its equality, diversity and inclusion work throughout 2018-2019 is

documented. Among the wide range of projects, work and initiatives undertaken in 2018-2019, the primary highlights of 2018-2019 have been:

- ✓ Implementation of the 'Hearing Lincolnshire's Hidden Voices' model of equality engagement.
- ✓ The strengthening of our staff networks.

As 2019-2020 commenced, the Trust Board has highlighted that inclusion is a priority for the current year and beyond. We look forward to continuing with the development and embedding of our equality, diversity and inclusion work.

Recommendations:

The Trust Board receives and approves the Equality, Diversity and Inclusion Annual Report 2018-2019 for further publication on the Trust's website.

Agenda Item 13.2

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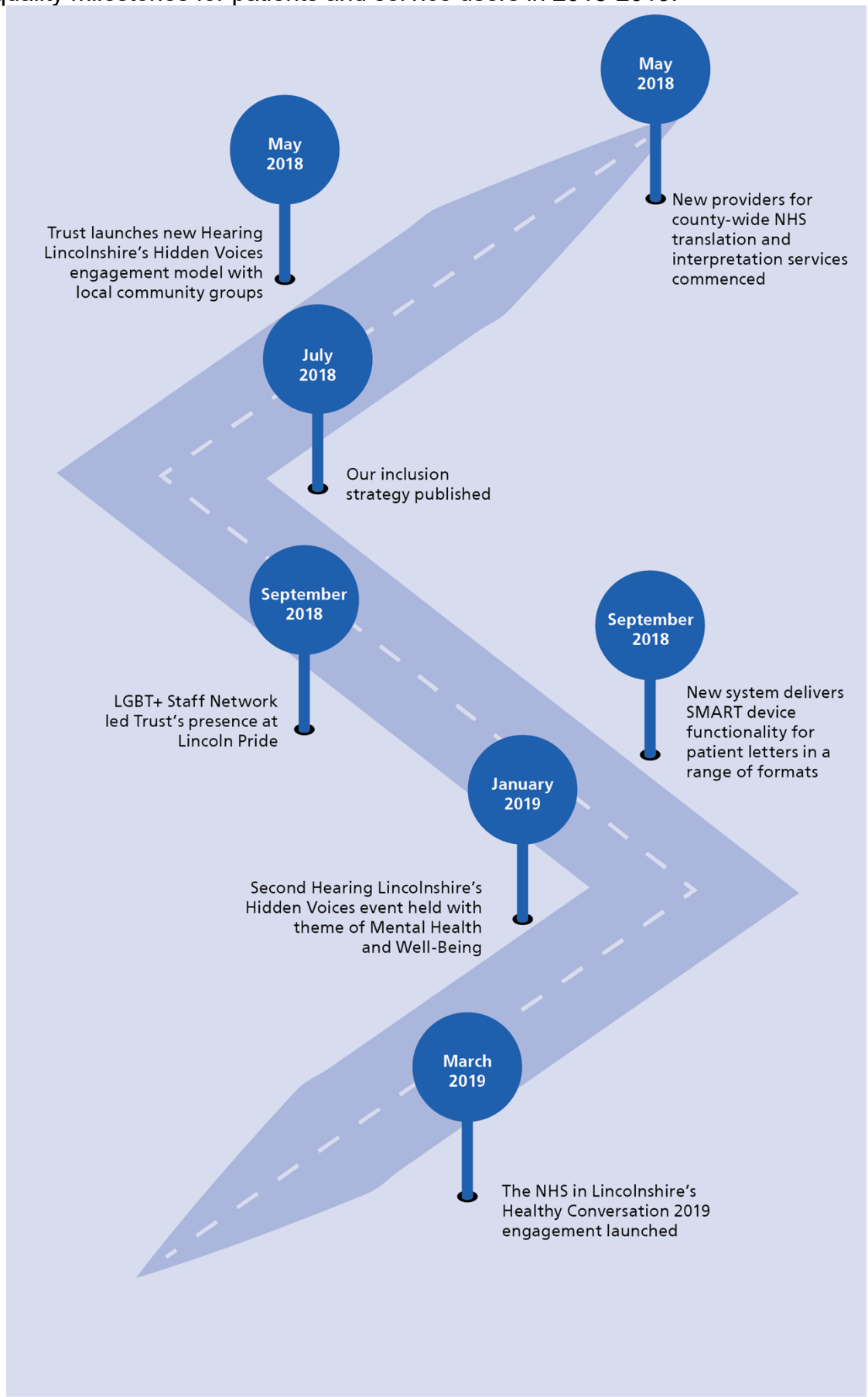
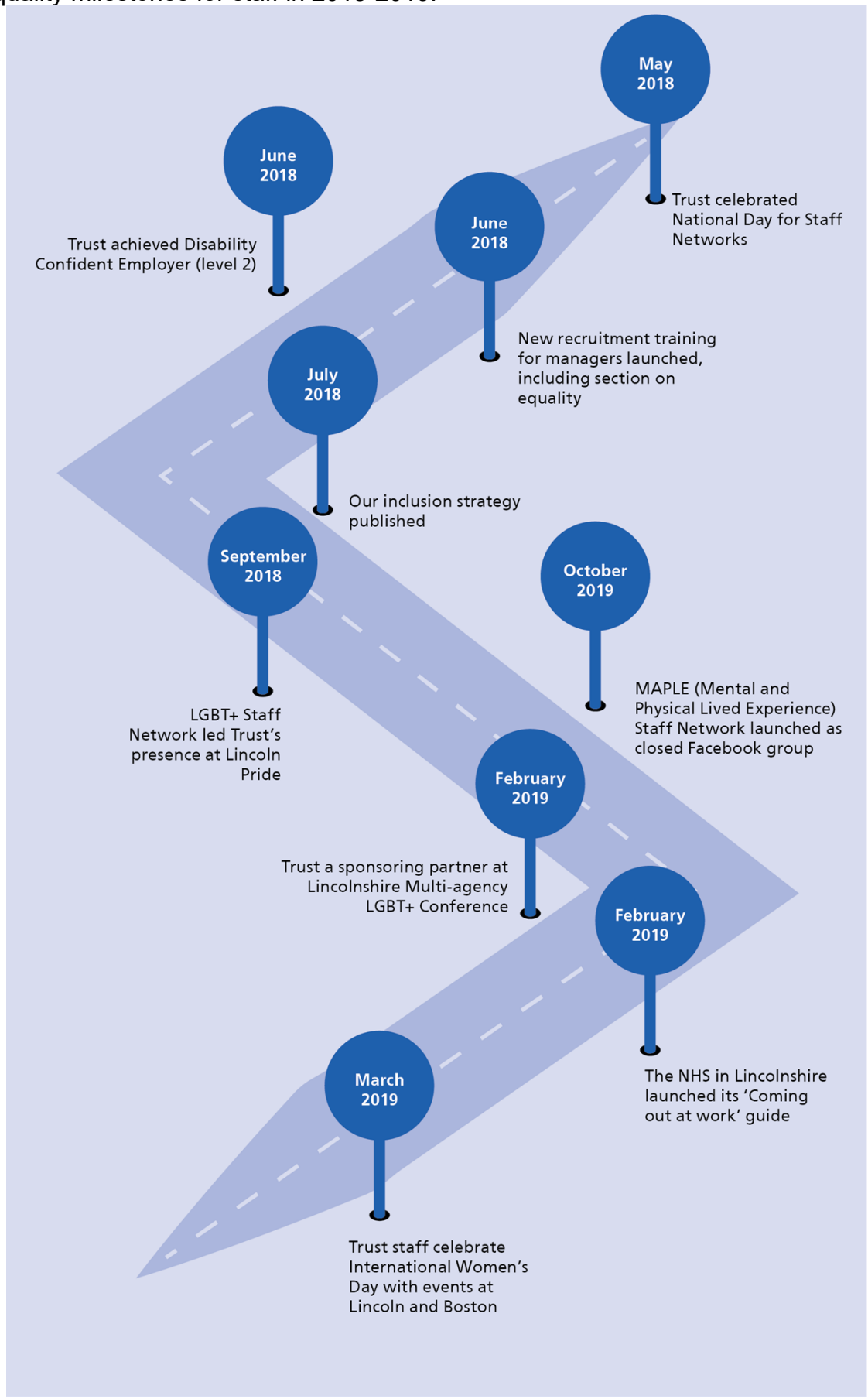
Equality, Diversity and Inclusion

Annual Report, 2018-2019

Key equality milestones for patients and service users in 2018-2019:



Key equality milestones for staff in 2018-2019:



‘Hearing Lincolnshire’s Hidden Voices’ equality engagement events – new in 2018-2019:

To read more about our new and exciting ‘Hearing Lincolnshire’s Hidden Voices’ equality engagement events, please visit our website: https://www.ulh.nhs.uk/about/equality-diversity/hearing-lincolnshires-hidden-voices-equality-engagement-events/

You said:	We did:
Introduce deaf awareness training for key staff.	Sourced deaf awareness training with Topp Language Solutions and scheduled for first groups of A&E staff in June 2019.
Improve interpretation services for sensory impairment.	Commissioned a new provider, Topp Language Solutions, from Spring 2018.
Empower hearing impaired patients by offering patient call system showing patient’s name on a screen, rather than only relying on names being called out.	Implemented new screens on Out-Patient Departments at Boston and Lincoln (Grantham to follow).
The waiting times between referral from GP to first appointment at the nearest Gender Dysphoria Clinic are too long.	Commenced engagement with local trans support groups and the Nottingham NHS Gender Dysphoria Clinic.
All hospital appointment letters should be available in large print.	Appointment letters available in fonts 16, 18 or 24 (from September 2018).
Only having screen alerts in Out-Patient Departments is challenging for sight-impaired people.	We have introduced sensory impairment alerts at the Out-Patient Department self-check-in booths and use verbal calls, as well as visual alerts to call patients.
Ashby Ward, Lincoln is very good for complex needs.	Passed this information on to the ward lead on Ashby Ward.

Delivery of our Equality Objectives 2018-2019:

Our Equality Objective:	What we did:
For our patients and service users:	
We will seek to improve the service we provide when people raise concerns and complaints. This will commence with a survey of the experience of people who have raised concerns.	Unfortunately, the baseline information from an equality perspective was too small to be of meaningful significance. Therefore, in 2019-2020 we will provide people who make a complaint with the voluntary option to share whether they believe their complaint is related to one of the protected characteristics of the Equality Act 2010.
We will improve our communication with people living with a disability through implementation of the Accessible Information Standard.	In 2018-2019 we have delivered some significant improvements for our patients, these include: ✓ Appointment letters available in font sizes 16, 18 and 24. ✓ Appointment letters available securely through SMS / SMART technology and linking to the patient's assistive technology. ✓ Continued improvement of service through the Eye Clinic Liaison Officer (ECLO) Service on all hospital sites. ✓ Introduction of a new interpretation provider for sensory impairment.
For our local communities:	
We will seek to understand and improve the experience of carers by undertaking a carer survey.	Unfortunately, as the carer survey relies on volunteers to carry out the survey, we have struggled with capacity issues. We will continue this in 2019-2020. However, we have undertaken significant work to develop our support of carers: ✓ An increase in the use of our Carers' Badge scheme.

	✓ Carer information and support is a key part of our Ward Accreditation programme. ✓ Producing a Carer Information Pack is part of our FAB Champion role (currently have 63 FAB Champions in Trust). ✓ We have a close working relationship with Lincolnshire Carers First. ✓ Commitment to open a Carers Hub at Pilgrim Hospital, Boston achieved in 2018-2019.
We will seek to better understand the needs and experiences of protected groups within our communities through a structured approach to stakeholder engagement.	In 2018-2019 we innovated, and launched, in partnership with NHS Lincolnshire East CCG the 'Hearing Lincolnshire's Hidden Voices' model of equality engagement. In our first two events we heard from local people represented by: ✓ Trans community ✓ Deaf Community ✓ Sight loss charities ✓ Migrant community ✓ Carers First ✓ Alzheimer Society (Dementia) ✓ Headway (Brain injury) ✓ Autism Partnership ✓ Veterans Mental Health Services (more detailed information about our events is contained in this annual report)
For our staff	
We will hear and act upon the voice of staff from protected groups by enabling and supporting staff equality networks.	In 2018-2019 members of the Trust's executive team commenced actively sponsoring staff networks. We continued to develop and support our existing staff networks: ✓ LGBT+ (lesbian, gay, bisexual and trans)

	✓ BAME (black, asian and minority ethnic) ✓ Armed Forces In September 2018, our MAPLE (mental and physical lived experience – disability) staff network launched as a closed Facebook group. It is envisaged that meetings will commence in 2019-2020. Following successful events on International Women's Day in March 2019, staff interest for a network for women commenced. These aspirations will be continued in 2019-2020.
We will engage with our staff networks to develop plans to ensure our workforce is broadly representative of the communities we serve at all levels of the Trust.	We undertook the NHS Employers 'Measuring up: your community and your workforce' data comparison. The results were presented to the LGBT+ and BAME Staff Networks for consideration. Both networks did not believe the report provided any cause for concern or further action. It was requested that the data comparison is undertaken annually, so that emerging trends can be identified. The NHS Employers workforce data comparison for 2018-2019 is included in this annual report.
For our Trust	
We will improve the cultural competence of our staff by commencing delivery of equality related training.	Since 2017 all staff commencing at the Trust undertake equality, diversity and inclusion (incl. human rights) training as part of their induction. Since 2017 all staff are required to undertake an equality, diversity and inclusion (incl. Human Rights) e-learning training package every three years. In 2018-2019 the completion rates for all staff (excluding doctors in training) was 94.64%. Compliance rates for doctors in training by hospital site were:

	✓ Boston – 95% ✓ Grantham – 100% ✓ Lincoln – 100% In July 2018, the Trust launched a new training package for recruiting managers and this includes a bespoke session on equality, diversity and inclusion in recruitment. A further and ongoing review of our training will continue in 2019-2020.

1. INTRODUCTION

The United Lincolnshire Hospitals NHS Trust provides a wide range of acute hospital services to the socially, ethnically and culturally diverse population of the historic county of Lincolnshire. Lincolnshire is the second largest county in England and although the three primary hospital sites are based in the main urban centres in the county, the Trust provides acute hospital services for the population of this large and rural county.

The financial year 2018-2019 has been a time in which the Trust made significant progress in relation to demonstrating its commitment to improving equality, diversity and inclusion for our patients and service users, our communities and our staff.

Since 2017 the Trust has been implementing its strategic 2021 plan.

The Trust's 2021 vision, ambitions, outcomes and values – excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust is proud to be one of the country's largest rural Trusts in England. We offer a wide range of services which are part of a wider system of health and care across the county. The essence of our vision for our services is continuous improvement of our quality, safety and consistency of patient care which is financially sustainable, which meet the needs now and for the future.

Our 2021 vision
Excellence in rural healthcare

Striving for excellence

Our 2021 ambitions	Our patients	Our services	Our staff
Our outcomes	Providing consistently safe,	Providing efficient, effective and financially	Providing services by staff who demonstrate our

	responsive, high quality care	sustainable services	values and behaviours

Delivering excellence

Our 2021 improvement programme
• Quality and safety improvement • Clinical services development • Productive hospital • Workforce and organisation development • Financial efficiency and estates

In the summer of 2018 we were pleased to publish 'Our Inclusion Strategy'. In this document we set out our strategic vision for all our work around the equality, diversity, inclusion and human rights agenda. Our inclusion strategy is aligned to the Trust's wider 2021 plan, and is indeed one of the suite of strategies which underpins and enables delivery of the 2021 Plan. A copy of our inclusion strategy can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/

As part of the Public Sector Equality Duty 2011, we have developed a suite of equality objectives for the duration of 'Our Inclusion Strategy'. Our equality objectives are grouped around; (i) our patients and service users, (ii) our local communities, (iii) our staff and (iv) our Trust. Some of our equality objectives are 'stand-alone' and will be delivered within a financial year, but many of our equality objectives are designed to grow and develop throughout the course of our inclusion strategy. We are confident that delivery of our inclusion strategy and the equality objectives will enable us as a Trust to realise our vision for equality, diversity and inclusion to be a 'golden thread' running through, and central to, how we work together to provide sustainable high quality patient-centred care for all people living in Lincolnshire. The detail of our vision for equality, diversity and inclusion can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/equality-diversity-inclusion-2021-vision/

In this annual report we highlight our successes and challenges during 2018-2019, our performance in relation to our statutory, mandatory and regulatory requirements, and our commitment to continue the journey of improvement in relation to equality, diversity and inclusion for all patients, service users and staff in the future.

2. GOVERNANCE AND REGULATION OF EQUALITY, DIVERSITY AND INCLUSION (INCL. HUMAN RIGHTS) AT THE TRUST

The Trust has governance and regulatory frameworks and mechanisms in place to ensure that transparent assurances are provided in relation to the discharging of equality duties.

2.1 Equality, Diversity and Inclusion Operational Group and Equality, Diversity and Inclusion Engagement Network

An Equality, Diversity and Inclusion Forum was established in 2016 and met six times per annum. The forum was chaired by our Chief Executive and membership comprised of a range of professional colleagues from clinical and corporate services, Trust members and staff-side representatives.

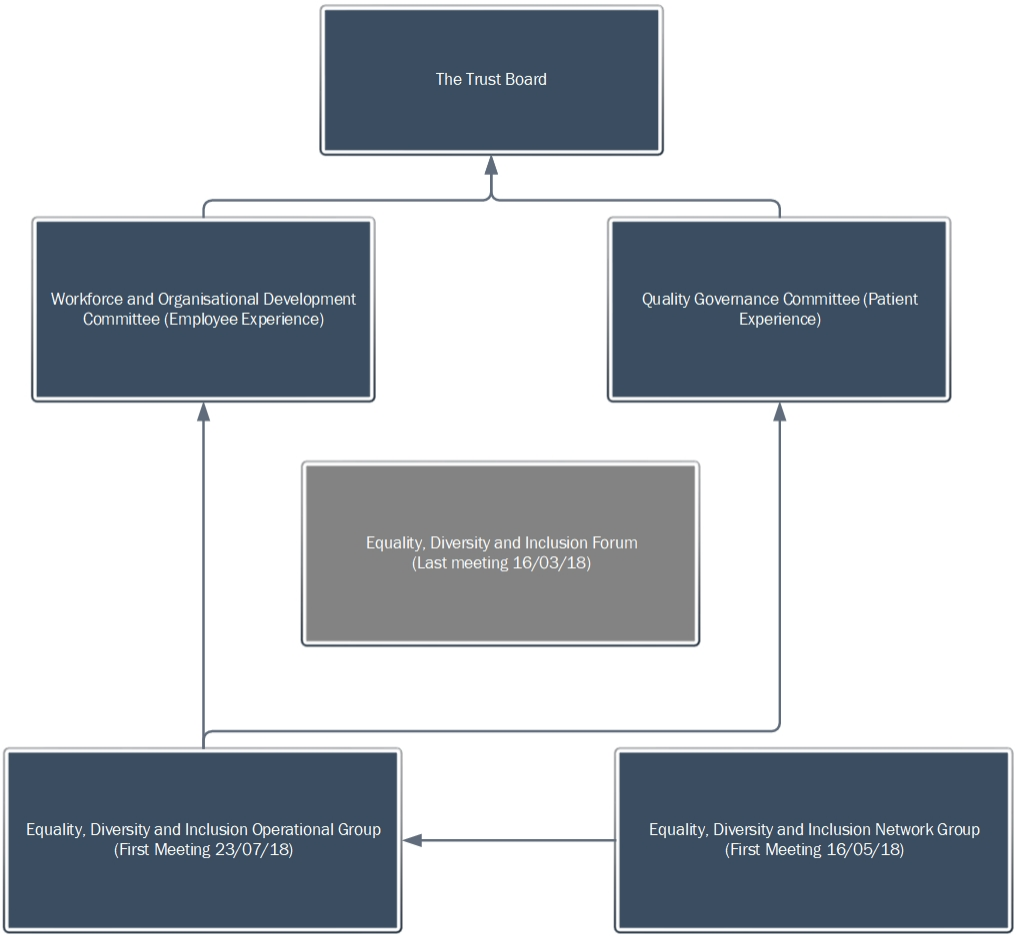
The forum reported to the Trust Board via the assurance committee framework; the Quality Governance Committee in relation to equality matters relating to patients and service users, and via the Workforce and Organisational Development Committee in relation to equality matters relating to staff.

Towards the end of 2017-2018, it was recognised by the members of the equality, diversity and inclusion forum, that the forum had realised its primary aim of delivering a structured and renewed focus around the equality, diversity and inclusion work. It was agreed that it was time for the group to separate its work into two workstreams.

From the first quarter of 2018-2019, the work has comprised of two components: the Equality, Diversity and Inclusion Operational Group, and the Equality, Diversity and Inclusion Engagement Network.

The Engagement Network focuses primarily on the engagement with patients, service users and staff across the inclusion agenda and reports into the Operational Group. Outwardly facing the Engagement Network has branded its activity under the banner of ‘Hearing Lincolnshire’s Hidden Voices’ and more information about this exciting development will follow later in this report. The Operational Group leads and drives the change required in relation to the inclusion agenda in active support of the Trust’s 2021 Excellence in Rural Healthcare vision. The governance arrangements for the Operational Group will be the same as for the equality, diversity and inclusion forum.

As we move into 2019-2020, with the launch of the new Trust Operating Model (TOM), the aforementioned structure for our work around equality, diversity and inclusion is agile and will be aligned to the TOM.



2.2 Assurance reporting to the NHS Clinical Commissioning Group (CCG)

The Trust has continued to nurture and develop the excellent working relationship with the NHS Lincolnshire East CCG and provides a quarterly assurance report to the commissioners.

Throughout 2018-2019, the Trust has been able to provide the CCG with sufficient assurance in relation to the delivery of its statutory and mandatory equality duties in all areas. We are pleased that the number of areas the Trust has been rated as 'achieving' in relation to our statutory and mandatory equality duties has steadily increased through the year and we have plans in place to ensure the small number of areas rated as 'developing' are able to demonstrate 'achieving' in a reasonable timeframe.

2.3 Care Quality Commission (CQC)

The latest CQC inspection report was published in July 2018. Overall the Trust was rated as 'Requires Improvement'.

During the inspection the Trust's performance in relation to equality, diversity and inclusion was also reviewed. The following statement is taken from the CQC report:

"There was evidence of significant amount of work undertaken by the Equality & Diversity lead since he commenced the role in 2016. The key challenge was to articulate the

outcomes, embed the actions and effectively engage with staff. It was not clear the degree to which the trust engaged with its BME Network (or similar forum) as a means of sustained and meaningful engagement to influence the trust to mainstream equalities. We saw a number of actions in progress

• Equality strategy was currently in draft and undergoing internal and external consultation.
• Development of a unified equalities action plan for patients and workforce.
• EDS2 grading consultations.
• Engaging executive directors with staff equality networks.
• The Trust was establishing good links with the local NHS economy to focus attention on equality matters." (p. 20 of the full CQC report)

It is encouraging that the CQC inspectors were able to see evidence of the progress the Trust is making in relation to the equality, diversity and inclusion work. The need to continue on this journey of improvement is acknowledged by the Trust and the next stages of our work are focussed around evidencing meaningful engagement and ensuring the equality work is mainstreamed throughout the organisation.

3. STATUTORY DUTIES – EQUALITY ACT 2010 AND PUBLIC SECTOR EQUALITY DUTY (PSED)

When the Equality Act 2010 came into statute, it brought together and harmonised all previous equalities legislation. The Equality Act 2010 is the primary piece of legislation around equalities. The Public Sector Equality Duty (PSED) forms part of the Equality Act 2010 (section 149) and is applicable to NHS, and other public sector bodies. The PSED came into force in 2011.

The Trust is fully committed to caring for all patients, service users, their families and carers, and staff in a manner which embraces, respects, promotes and celebrates inclusion and cultural diversity.

The Equality Act 2010 requires specific provision is made to consider the impact of services and activity for people who identify with one or more of the nine protected characteristics, and for public sector bodies to take proactive steps to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it and
- Foster good relations between people who share a protected characteristic and people who do not share it

These are referred to as the three aims of the General Equality Duty.

The protected characteristics and other groups
The Equality Act 2010 brought together previous gender, race and disability duties and extended the protection from discrimination to nine protected characteristics.

Over and above the nine equality groups protected from discrimination under the Equality Act 2010, we also have a duty of care to all our service users and staff, who may be vulnerable to potential discrimination.

Protected characteristic groups	Other potentially disadvantaged groups, people living with / in
Age	Carer responsibilities
Disability	Military service
Gender reassignment	Homelessness
Marriage and civil partnership	Poverty
Pregnancy and maternity	Geographical isolation
Race	Long-term unemployment
Religion or belief	Stigmatised occupations (for example men and women involved in prostitution)
Sex	Drug use
Sexual orientation	Limited family or social network

The Trust has a duty to engage with the communities it serves and to work with partner organisations to understand, mitigate and remove any potential discrimination and demonstrate its commitment to improving health equalities and removing health inequalities, as articulated in the Health and Social Care Act 2012.

3.1 Publication of an equality, diversity and inclusion annual report

As part of the public sector equality duty the Trust publishes this annual report in relation to equality, diversity and inclusion. The equality, diversity and inclusion annual report includes a wide range of information, including some higher level patient / population data (appendix one), staff / local population demography comparison (appendix two) and Trust volunteer data (appendix three).

Once approved by the Trust Board the annual report is published on the Trust's website (https://www.ulh.nhs.uk/about/equality-diversity/equality-diversity-and-inclusion-annual-report/)

3.2 Publication of an Inclusion Strategy, including equality objectives

In 2017-2018 the equality, diversity and inclusion forum led on the production of 'our inclusion strategy'. A range of stakeholders, including patient and service user groups and staff groups, were given the opportunity to contribute to the strategy.

Setting and delivering equality objectives is a further statutory requirement on the Trust as a public sector organisation. Equality objectives for the duration of our inclusion strategy are contained within the document.

Our inclusion strategy was published at the beginning of July 2018 and is available on the Trust's website (https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/)

3.3 Equality Analysis

Equality analysis is the mechanism through which the Trust is able to demonstrate 'due regard' to the Equality Act 2010 and the meeting of its equality duties in relation to all Trust business and activity. Equality analysis ensures that all protected characteristics and other groups at potential risk of health inequality are proactively considered in the Trust's services and business.

The Trust has a system of Equality Analysis in place and from 2017-2018 significant papers and documents going to the Trust Board should be supported by an equality analysis, through which the potential equality related impacts are identified, mitigated and removed.

To further support Trust staff in completing a high quality equality analysis, an equality analysis e-learning training package was produced in 2018-2019. Following a successful pilot of the new training, it is scheduled to be implemented from April 2019.

3.4 Gender Pay Gap Reporting

From March 2018 a new statutory requirement in relation to gender pay gap reporting was introduced. The Trust publishes information about the gender pay gap, which can be found on the government website at https://gender-pay-gap.service.gov.uk/viewing/employer-%2cJsMFYg7WneN899EGpfEDYg!!/report-2017
The associated report and proposed actions can be located on the Trust's website at https://www.ulh.nhs.uk/about/equality-diversity/gender-pay-gap-reporting/

3.5 Staff Equality Networks

The general duties of the Equality Act 2010 are to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a characteristic and those who don't
- Foster good relations between people who share a characteristic and those who don't

It is recognised that staff equality networks are an excellent mechanism through which the general duties of the Act can be supported in relation to staff from the protected groups and other groups at potential risk of inequality.

Since 2017 the Trust has launched a number of staff networks and through 2018-2019, the networks have continued to be strengthened. Each of the staff networks is led by members of staff and has a network chair, vice-chair and terms of reference. A significant and positive development of our staff networks in 2018-2019, is that each staff network now has member of the Trust's executive team as a sponsor. Each executive sponsor supports and 'champions' the work of their respective network and their role is supported by an executive sponsor brief.

The Trust currently has three established staff networks:

- LGBT+ (Lesbian, gay, bisexual and transgender) staff network, with Paul Matthew as the executive sponsor.
- BAME (Black, Asian and Minority Ethnic) staff network, with Kevin Turner as the executive sponsor.
- Armed Forces Staff Network, with Dr Neill Hepburn as the executive sponsor.

In 2018-2019 the Trust commenced work to form a staff network to support disabled staff members. The network is called MAPLE (Mental and Physical Lived Experience) and Paul Boocock is the executive sponsor for this emerging group. The network launched initially as a closed Facebook group in the autumn on 2018 and we look to commencing meeting in 2019-2020.

On the 8th March 2019 the Trust held two successful events for staff on International Women's Day. These events gave impetus to the development of a staff network for women. These plans will be further developed by our staff in 2019-2020.

The Trust is immensely proud of our staff networks and is committed to support their work and further development in the future.

4. MANDATORY DUTIES - NHS STANDARD CONTRACT

4.1 Implementation of the NHS Equality Delivery System (EDS2)

Implementation of EDS2 is mandated for all NHS organisations in the NHS Standard Contract.

"The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty."[1]

The EDS2 is a toolkit designed around four primary goals:

- Goal 1 – Better health outcomes
- Goal 2 – Improved patient access and experience
- Goal 3 - A representative and supported workforce
- Goal 4 – Inclusive leadership

The EDS2 is implemented in a three-staged process:

- Self-assessment
- Peer reviewed assessment
- Stakeholder reviewed assessment

[1] NHS England, EDS2 website https://www.england.nhs.uk/about/equality/equality-hub/eds/

In 2018-2019 the Trust completed a full review of its EDS2 work and the full EDS2 report can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/nhs-equality-delivery-system-eds2/. In 2018-2019, it has been encouraging that the NHS Lincolnshire East Clinical Commissioning Group confirmed the Trust had improved from 'developing' to 'achieving' in its commitment and delivery of the EDS.

In 2018-2019 NHS England undertook a thoroughgoing review of the NHS EDS2 and the Trust's Equality, Diversity and Inclusion Lead has been actively involved in the wider engagement of the EDS. It is expected that NHS England will launch a revised and new version of the EDS in 2019-2020. The Trust is prepared and looks forward to implementing the new EDS.

4.2 Implementation of the NHS Workforce Race Equality Standard (WRES)

The WRES is designed to help NHS organisations understand and actively address differences in the experience between Black, Asian and Minority Ethnic (BAME) and white staff. Built around nine indicators, the WRES provides a robust reporting framework and supports NHS organisations to address and close any gaps through the development and implementation of action plans for improvement.

The WRES was implemented in 2015 and since 2017, through the establishment of the BAME Staff Equality Network, the voices of BAME members of staff have been heard and acted upon in relation to the Trust's commitment to improving race equality. This has been an exciting development and we look forward to building on this important work as we move forward with integrating the staff equality networks in a meaningful manner.

In 2018 the Trust's Equality, Diversity and Inclusion (ED & I) Lead completed the first national NHS England WRES Expert programme. Supported by Kevin Turner, Deputy Chief Executive and BAME Staff Network executive sponsor, the ED & I Lead has received specialist training and become part of a national network of WRES Experts.

Information about the Trust's WRES work can be located on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-race-equality-standard-wres/

The primary WRES actions for 2018-2019 have been in relation to recruitment data (WRES indicator 2) and discrimination as reported by staff through the national NHS Staff Survey (WRES Indicator).

WRES Indicator 2 (Recruitment):

The primary mechanism to support improvement action in relation to WRES Indicator 2 (Recruitment) has been the implementation of a new and more sophisticated HR recruitment system called TRAC. The TRAC system is now fully implemented and comes with enhanced WRES reporting functionality. As the Trust prepares to produce and submit its WRES report for 2018-2019, we will be able to draw upon more detailed data in relation to recruitment and be able to identify specific areas of concern where targeted action needs to be undertaken.

In order to further support our recruiting managers, new recruitment training was implemented in the summer 2018 and this includes a bespoke section about equality,

diversity and inclusion in recruitment. This training has been scheduled throughout 2019-2020 and as an act of positive action, BAME members of staff who are recruiting managers have been actively encouraged to undertake the training through the BAME Staff Network.

WRES Indicator 8 (Discrimination):

The WRES comprises nine indicators; indicators 1 – 4 are taken from the Trust's HR data systems; indicators 5 – 8 are taken straight from the national NHS Staff Survey and indicator 9 appertains to the Trust's senior leadership.

For the first time in 2018-2019 the BAME Staff Network requested that the Trust reviewed one of the NHS Staff Survey related indicators, indicator 8 (discrimination). It is recognised that achieving improvement in the NHS Staff Survey related indicators requires significant focus and commitment. It has been encouraging that members of the BAME Staff Network have not only risen to this challenge, but worked together to develop an insight questionnaire, which will not only enable the Trust to understand better the experience of BAME staff in relation to discrimination by managers, team leaders and colleagues, but in embracing BAME and white staff, will have significant impact for all staff. Further, this work is aligned to a larger project being undertaken by the organisational development team in relation to the culture of the Trust.

As the year 2018-2019 drew to a close, the insight questionnaire relating to discrimination was in draft format and will be implemented following final approval by the BAME Staff Network and senior leadership in the Trust.

It is encouraging that the BAME Staff Network continues to grow and develop its work in relation to the WRES, although it is recognised that there remains more work to do in 2019-2020 and beyond.

4.3 Implementation of the NHS Accessible Information Standard (AIS)

The AIS came into force for all NHS organisations in July 2016. In 2018-2019 the Trust has continued to make significant progress in relation to the full implementation of the AIS.

One of the main areas of work which actively supports the implementation of the AIS, has been the introduction of the ECLO (Eye Clinic Liaison Officer) Service on all Trust's sites. Although implemented in November 2017, in 2018-2019 the ECLO Service has its first full financial year of activity. The ECLO Service is hosted by the Trust and is a service delivered in partnership with the Royal National Institute of Blind People (RNIB), Lincoln and Lindsey Blind Society and NHS England.

In 2018-2019 the ECLO Service has supported and helped a significant number of people affected by sight impairment. The ECLO Service offers people affected by sight impairment and their relatives / carers practical and emotional support in coming to terms with sight impairment. The ECLO Service report 2018 – 2019 is included as a link below:

ECLO ULHT Annual Report 18-19.pdf

A further significant development in the implementation to the AIS in the Trust, has been the introduction of a range of communication options for patients within our primary patient IT-systems. This means our patients are able to request their patient appointment and other communication in a range of Arial (sans serif) font sizes and other accessible formats.

Another significant development has been the introduction of the option for patients to receive their hospital correspondence to their SMART device through a secure SMS message. Once a patient accepts a message to their SMART device, the letter can be opened and / or emailed to the person's email address and make full use of the assistive technology on the person's own computer equipment. This also means, for example, that a person living with sight impairment can elect to have their correspondence in a font size suitable to their needs and moreover, the technology also has a Browsealoud function, which allows for the correspondence to be read to the person (this also includes a range of the top spoken languages in Lincolnshire).

As we move into 2019-2020, we will undertake a thoroughgoing review of all our work around the AIS to ensure we are delivering communication to our patients in formats which meet their needs.

Parallel to this, the new translation service for people with sensory impairment, provided by Topp Language Solutions (TLS), was implemented in 2018. Through engagement with people from the local deaf communities, the Trust has been delighted to hear how well received the new, structured and innovative service provided by TLS has been. In 2019-2020 we will continue to build on the successes of this new service to benefit and improve the experience of our patients and service users with hearing impairment.

4.4 Provision of a system for delivery of interpretation and translation services

Further to point 4.3, alongside interpretation and translation services for people living with sensory impairment, the new Lincolnshire-wide approach to interpretation and translation services makes provision for those accessing our NHS services who require foreign language support.

The new service provided by DA Languages was fully implemented by August 2018. As we move into 2019-2020 we will seek to undertake a satisfaction survey with our patients and service users to ensure the services provided meet with their approval.

4.5 Launch of the NHS England Workforce Disability Equality Standard (WDES)

In early 2019 NHS England launched the WDES. Similar to the WRES, the WDES comprises of a set of metrics against which NHS Trusts must report and following analysis of the local data, and in partnership with staff members, develop actions for improvement.

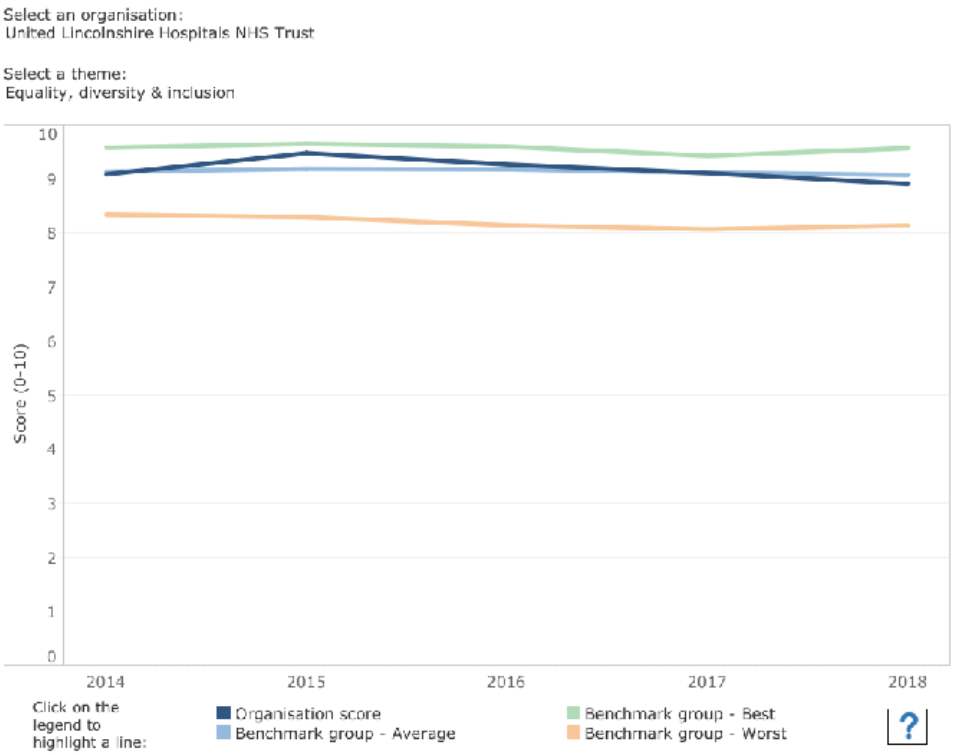
Although NHS England has designated the reporting in 2019 as a trial year for the implementation of the WDES, NHS organisations are expected to submit their first annual report and action plan to the 1st August 2019. The Trust will work on the collation and completion of its first WDES report and submit to NHS England in a timely fashion. Further, we look forward to working with our emerging MAPLE staff network to agree and deliver actions of improvement to support our disabled staff.

Further information about the WDES can be found on the NHS England WDES website: https://www.england.nhs.uk/about/equality/equality-hub/wdes/

5. THE NHS STAFF SURVEY 2018

In 2018 the Trust provided all staff members with the opportunity to participate in the nationally led NHS Staff Survey. We have been encouraged by the increase in the numbers of staff completing the staff survey (up from 33% in 2015, to 39% in 2016, to 45% in 2017, to 46% in 2018) this means we have an increasing quality of feedback from our staff in relation to their experience of being employed by the Trust.

It is with disappointment that we note that in general terms the overall rating for the theme equality and diversity in the national staff survey has again deteriorated and sadly fallen below the national average for Trusts we are benchmarked against. The infographic below illustrates this:



The overall theme of equality, diversity and inclusion in the NHS Staff Survey comprises of the ratings our staff provided in the four areas of experience of:

- Career progression and promotion.
- Discrimination from patients, service users or the public.
- Discrimination from managers, team leaders or colleagues.
- Adequate adjustments being made to support the employee undertake their role.

Each of the questions and feedback will be analysed in more detail and further action for improvement identified and undertaken.

Set in the bigger picture, in general terms, the Trust's Staff Survey responses have sadly deteriorated in 2018. Although it is positive that our overall results for equality and diversity remain significantly above the worst performing organisations in our benchmarked group, we are not satisfied that our overall results are deteriorating and indeed in 2018 we have fallen below the national average scores for equality and diversity.

As we enter 2019-2020, we will undertake further detailed analysis of the equality and diversity results from the national staff survey and engage with staff groups, through our staff networks, to understand why our staff are feeling less positive about the overall equality and diversity indicators and how we can work with our staff to improve their experience.

6. Our Equality Objectives for 2018-2019 and beyond

The setting, monitoring and delivery of equality objectives form part of our Public Sector Equality Duty. Our equality objectives for 2018-2019 and 2019-2021 are contained within our inclusion strategy (https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/).

The Equality, Diversity and Inclusion Operational Group leads on the monitoring of progress against all our equality objectives. The delivery of our equality objectives for 2018-2019 has already been documented at the beginning of this report.

Building on the last year's equality objectives, our equality objectives for 2019-2020 are as follows:

For our patients and service users

Year 2 2019-2020
Objective 1
We will improve the experience of patients living with dementia by implementing a dementia bundle.
Outcome 1
The outcome of this will be that choice and independence of people living with dementia will be enhanced during their hospital stay at United Lincolnshire Hospitals NHS Trust.
Objective 2
We will demonstrate improvement in communication with people living with disability through full implementation of the Accessible Information Standard.
Outcome 2
The outcome of this will be that people living with disability will receive communication relating to their health needs in the format they require. This will be confirmed through active engagement with patients, service users and key stakeholders.
Objective 3
We will expand equality monitoring within our primary patient information systems to ensure as many of the protected characteristic groups as possible are included.
Outcome 3
The outcome of this will be that all patients will be able to inform the trust of their equality monitoring information and have the assurance

that specific needs relating to the protected groups will be understood and addressed by the Trust**.**

Objective 4
We will improve the experience of Lesbian, Gay, Bisexual and Trans (LGBT+) patients and service users through the implementation of the Sexual Orientation Monitoring Standard.
Outcome 4
The outcome of this will be that the health needs of LGBT+ people will be known and provided for in a dignified and appropriate manner.

For our local communities:

Year 2 2019-2020
Objective 1
We will improve the quality and consistency of the interpretation and translation services we provide by implementing a countywide approach to this service.
Outcome 1
The outcome of this will be that patients and service users who require interpretation and translation services, will have the assurance that these services will be provided in a more consistent manner across NHS provider organisations.
Objective 2
We will improve our engagement with people from protected groups within communities by actively engaging on their terms.
Outcome 2
The outcome of this will be that people from the protected groups will feel empowered to engage with the healthcare system and feel confident that their voices are heard.

For our staff

Year 2 2019-2020
Objective 1
We will improve the experience of our BAME (Black, Asian and Minority Ethnic) staff by engagement and implementing the actions resulting from the WRES (Workforce Race Equality Standard).
Outcome 1
The outcome of this will be staff feeling empowered to shape the improvement of their experience and see improvement in the NHS staff survey.
Objective 2
We will improve the experience of our staff living with disability by engagement and implementing the actions resulting from the WDES (Workforce Disability Equality Standard).
Outcome 2
The outcome of this will be that the Trust has informed information about the experience of our staff living with disability and will develop actions to improve the experience of these members of the workforce.

For our Trust

Year 2 2019-2020

Objective 1

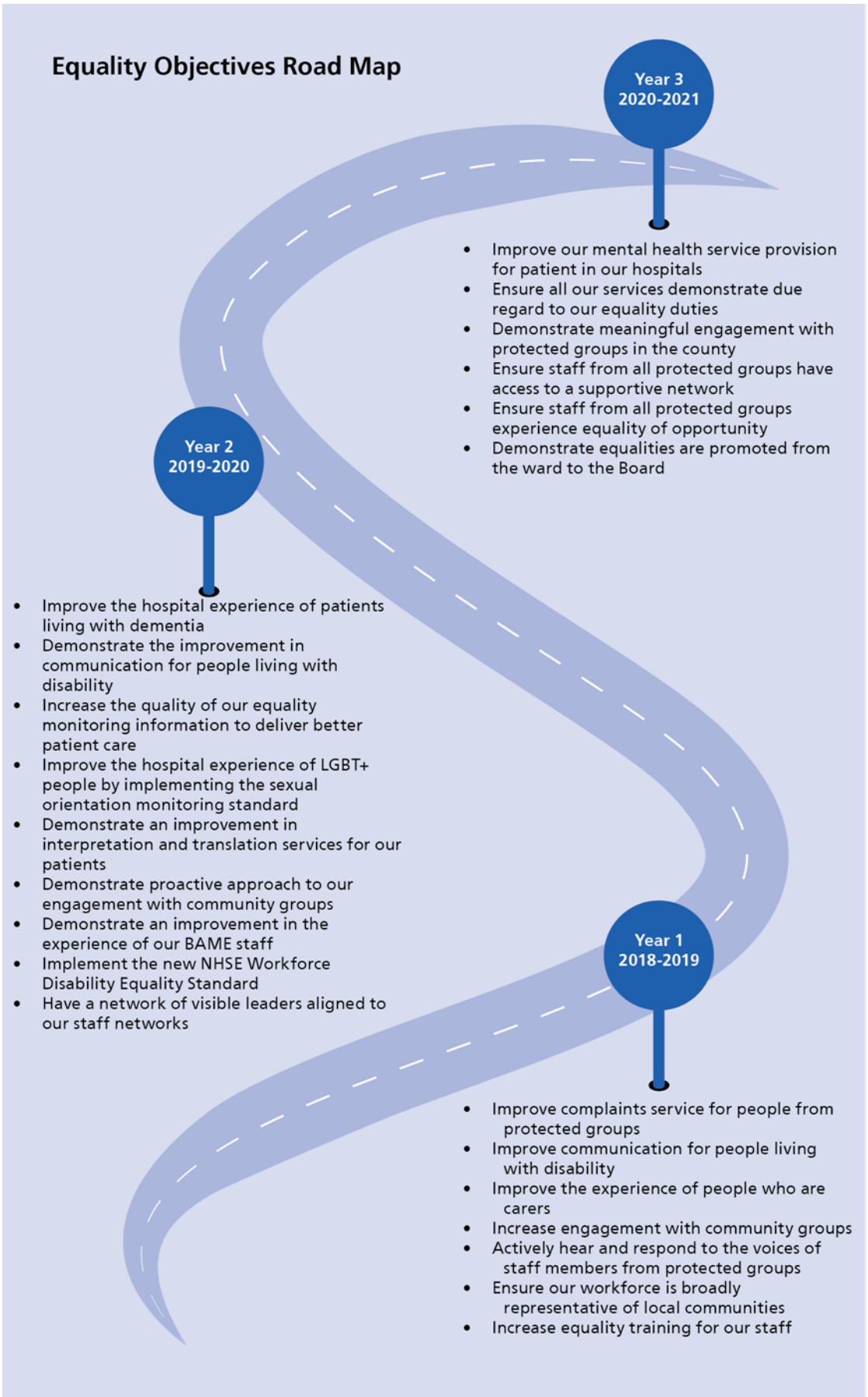
We will have a network of visible leaders / champions / allies aligned to the staff equality networks.

Outcome 1

The outcome of this will be that all protected groups will know and understand that they are taken seriously and that staff from the protected groups will be able to let their expertise and lived experience inform the policy and process of the Trust.

Performance and delivery of the equality objectives will be articulated in an annual action plan and be monitored and measured by engagement with key stakeholders and through the governance arrangements for the equality, diversity and inclusion agenda, as already highlighted in this annual report.

The equality objectives for 2019-2020 form the second phase of a suite of equality objectives in our three year inclusion strategy. An overview of our equality objectives from 2018-2021 can be seen in the road map infographic on the next page:


Equality Objectives Road Map
Year 3
2020-2021
Improve our mental health service provision for patient in our hospitals
Ensure all our services demonstrate due regard to our equality duties
Demonstrate meaningful engagement with protected groups in the county
Ensure staff from all protected groups have access to a supportive network
Ensure staff from all protected groups experience equality of opportunity
Demonstrate equalities are promoted from the ward to the Board
Year 2
2019-2020
Improve the hospital experience of patients living with dementia
Demonstrate the improvement in communication for people living with disability
Increase the quality of our equality monitoring information to deliver better patient care
Improve the hospital experience of LGBT+ people by implementing the sexual orientation monitoring standard
Demonstrate an improvement in interpretation and translation services for our patients
Demonstrate proactive approach to our engagement with community groups
Demonstrate an improvement in the experience of our BAME staff
Implement the new NHSE Workforce Disability Equality Standard
Have a network of visible leaders aligned to our staff networks
Year 1
2018-2019
Improve complaints service for people from protected groups
Improve communication for people living with disability
Improve the experience of people who are carers
Increase engagement with community groups
Actively hear and respond to the voices of staff members from protected groups
Ensure our workforce is broadly representative of local communities
Increase equality training for our staff

7. Conclusion

Having established good foundations for, and reinvigorated, the Trust's equality, diversity and inclusion work since 2016, 2018-2019 has been a year of building on these firm foundations. It has been an exciting and productive year in relation to the development of this important work, as we seek to ensure all Trust business, whether for patients and service users, communities or for our staff, is not only aligned to the Trust's 2021 Plan, but also underpinned by a commitment to being a fully inclusive organisation.

Of all the many achievements in 2018-2019, the primary highlights of the year have been:

- Implementation of the 'Hearing Lincolnshire's Hidden Voices' model of equality engagement.
- The strengthening of our staff networks.

It is encouraging that the Trust continues to receive positive affirmation from its commissioners and regulator, that the plans and progress have set the organisation on the right path for continued compliance and improvement. It was encouraging that the Trust's ED&I Lead completed the first national NHS England WRES Expert programme and we look forward to further developing our work around race equality. Further, as we move into 2019-2020, it is a privilege that the Trust ED&I Lead has been requested to join the steering group for the national NHS Employers' Diversity and Inclusion Partner Programme. Engagement with this new programme not only confirms the Trust's commitment to improving equality, but also gives the Trust opportunity to share local expertise at a national level.

As 2019-2020 commences, the Trust's leadership's commitment that inclusion is a strategic priority for the year, gives confidence that the United Lincolnshire Hospitals NHS Trust will deliver its plans, vision and strategy in relation to equality, diversity and inclusion.

Tim Couchman, Equality, Diversity and Inclusion Lead
June 2019

Appendix 1: Headline Lincolnshire population data

In the 2011 census the population of Lincolnshire was 713.653 (Source: ONS via Lincolnshire Research Observatory).

2015: Lincolnshire population estimated to be 736.700 (Source: ONS 2015 Mid Year Population Estimates/ GP Registrations April 2015 (NHS-HSCIC)). The rate of Lincolnshire's population growth has increased in recent years but latest figures show that it is below the national rate of growth.

Protected equality characteristic	Lincolnshire population	Population projections and other information
Age	0-15 years of age: 121.878 (17.08%) 16-64 years of age: 443.924 (62.20%) 65+ years of age: 147.851 (20.72%) The average age in Lincolnshire is 43 years. ONS Census 2011	The ONS reports that between 2005 and 2015, the age demographic of Lincolnshire has changed as follows: 0-19 years of age from 23% to 22% 20-64 years of age from 57% to 58% 65+ years of age from 19% to 22%
Disability	43 % rated their health as very good 36% rated their health as good 15.10% rated their health as fair 4.60% rated their health as bad 1.30% rated their health as very bad ONS Census 2011	20.40% stated their health affected their day-to-day activities. 8.70% of people aged 16-64 years (working age) stated their health affected their day-to-day activities ONS Census 2011
Gender reassignment	It is telling that there is a lack of good quality statistical data	

	regarding trans people in the UK. Current estimates indicate that some 650,000 people are “likely to be gender incongruent to some degree”. Source: Transgender Equality First Report of Session 2015–16, House of Commons Women and Equalities Committee	
Marriage and civil partnership	27.80% stated they were single (having never been married of in a civil partnership) 51.50% stated they were married 0.20% stated they were in a same sex civil partnership 2.40% stated they were separated 8.10% stated they were widowed / surviving civil partner 10.0% stated they were divorced / civil partnership dissolved ONS Census 2011	Marriage (Same Sex Couples) Act 2013, with the first same sex marriages taking place from March 2014.
Pregnancy and maternity	In 2015 there were 7.773 live births in Lincolnshire.	In 2015 there were 35 still births in Lincolnshire
Race	The largest population in the county is White: British/English/Scottish/Northern Irish/Welsh at 93.0% The largest minority group in the county is White: other at 4.0% The Black, Asian and minority ethnic population in Lincolnshire is 2.4%	The potential impact of Brexit on EU nationals (White: other) living and working in Lincolnshire is currently unquantifiable and unknown.

	ONS Census 2011	
Religion and belief	ONS Census 2011: Buddhist – 0.20% Christian – 68.50% Hindu – 0.20% Jewish – 0.10% Muslim – 0.40% Sikh – 0.10% Other religion – 0.40% No religion – 23.10% Religion not stated – 7.10%	Lincolnshire's data mirrors a national data trend which evidences a reduction in religious affiliation, but an increase in people stating no religion or the religion is not stated.
Sex	51 % female 49 % male Source: LPFT	
Sexual orientation	The ONS stated that in 2015 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB)	The ONS figures are challenged by a number of groups, with estimates ranging between 5 – 10 % (for example, Stonewall, Kinsey Report, and the Treasury (Civil Partnership Act).
Carers	11.10% stated they were unpaid care providers. 2.9% reported this activity is more than 50 hours per week. ONS Census 2011	

Appendix 2: NHS Employers Measuring up: your community and your workforce – comparative data report:

In late 2017, NHS Employers launched their Measuring up: your community and your workforce comparative data tool.

The tool is designed to support the Trust in ensuring it is developing a workforce that is representative of the local population, as fairly as possible. Drawing on regional population data from the most up-to-date sources (i.e. census and other surveys), the tool compares the Trust's workforce data with the local population demography. By undertaking an analysis of the data, then Trust can identify areas where gaps might exist and develop appropriate positive action to ensure a representative workforce is developed.

In the report below, the workforce data for the end of 2018-2019 is compared with local data. For the purposes of this report, the Trust has reviewed our data with the STP: Lincolnshire data. In general terms it is encouraging that broadly we can evidence a fairly representative workforce or have an understanding of the reasons our Trust data is in variance with the local population demography.

The following points are highlighted and noted:

Age: Whilst broadly representative, it is noted that in the age group <25 the Trust is under represented and is encouraged to think about its attraction strategy for the group. The reality that from age 45 and above, there is an over-representation in the workforce, when compared with the local population, makes positive action all the more important.

Ethnicity: The Trust is proud to attract employees from a range of ethnic backgrounds and thereby contribute to the cultural diversity of the county. We recognise our employee data for non-white ethnic backgrounds is higher than the local population and that many of these people are members of our clinical workforce. It is also encouraging that our white, other members of the workforce, is broadly representative of the local demography.
Our BAME Staff Network reviews and advises the Trust in relation to this report and further positive action will ensue in 2019-2020.

Gender: Like most, if not all, NHS organisations, the Trust employs a majority female workforce (80%). Compared to the local population demography, this is by far the largest variance. As an act of positive action, the Trust is advised to consider promoting career opportunities to the local male population.

Disability: The comparative data for this protected characteristic is unhelpful. However, the not disclosed / unknown categories in the Trust data are high and through the implementation of the Workforce Disability Equality Standard (WDES) in 2019, we have an opportunity to improve the self-disclosure rates in our workforce.

Religion & Belief: Again, whilst broadly representative, the categories not disclosed / unknown and other remain high and positive action should be considered to improve this. Further, with nearly a quarter (23.07%) of people in the local population declaring themselves as identifying with 'Atheism' consideration for their support whilst in hospital, needs to be considered.

Sexual orientation: Nationally the data sources for sexual orientation show significant variance. It is hoped that with NHS England launching the Sexual Orientation Monitoring Equality Standard, that improvements in appropriate care for people can be developed and delivered.

The full report can been accessed below:

NHS Employers Full-Report_31_03_2

Agenda Item 13.2
Appendix three:

Equality monitoring data for Trust volunteers to 14 May 2019:

Gender

Females	190	71%
Males	79	29%
total	269	100%

Ethnicity

British	119	46%
English	88	34%
Scottish	<11	2%
Welsh	<11	1%
British Asian	<11	0%
British Bangladesh	0	0%
Ashkenazi Europe	<11	0%
French	<11	0%
Pakistani	<11	0%
Irish Republic	<11	0%
Danish	<11	0%
Polish	<11	0%
Asian	<11	0%
Chinese	<11	0%
Indian	<11	1%
Latin America	0	0%
Sri Lanka	0	0%
South Africa	0	0%
Refused	<11	0%
Not Given	43	16%
total	269	100%

Disability

No	186	69%
Yes	13	5%
Unspecified	53	20%
Not Declared	17	6%
total	269	100%

Age

0-20	<11	1%
21-25	11	4%
26-30	<11	1%
31-35	<11	1%
36-40	<11	1%
41-45	<11	1%
46-50	<11	3%
51-55	<11	3%
56-60	11	4%
61-65	32	12%
66-70	63	23%
71+	105	40%
not recorded	14	5%
total	236	100%

Agenda Item 13.2

To:	The Trust Board
From:	Tim Couchman, Equality, Diversity and Inclusion Lead
Date:	23 September 2019
Healthcare standard	NHS Workforce Race Equality Standard (WRES)

Title:	Workforce Race Equality Standard (WRES) Data Report and proposed Actions

Responsible Director: Martin Rayson, Director of HR & OD
Author: Tim Couchman, ED&I Lead

Purpose of the report:

To furnish the members of the Trust Board with this year's WRES data report and proposed actions for improvement and request approval of the WRES to facilitate publication of this year's WRES data on the Trust's website, as required by NHS England.

To provide assurance to the Trust Board, that the Trust is meeting its contractual requirements in relation to the WRES.

The report is provided to the Board for:

Decision	X	Discussion by email	X
Assurance	X	Information	

Summary/key points:

The WRES was introduced by NHS England in 2015 and forms part of the NHS Standard contract. Further, alongside the newly implemented Workforce Disability Equality Standard (WDES), NHS England as committed to the WRES in the NHS Long Term Plan.

The WRES data was submitted directly to NHS England WRES Team ahead of the 31st August 2019 deadline. This current report provides the

Trust Board with the WRES data, a brief analysis of the data and the proposed actions for improvement.

WRES indicators 1 – 4, & 9 are taken from our own workforce data sources. WRES indicators 5 – 8 are taken directly from the 2018 NHS Staff Survey, as reported by our staff.

It is of encouragement that we note a marked improvement in WRES indicators 2 – 4 in the current year. We believe this is due to a continued commitment to improving our processes (e.g. new TRAC system for recruitment) and attention to the oversight of our processes.

It is, however, noted with disappointment, that the four NHS Staff Survey related indicators (Indicators 5 - 8) have all deteriorated in the current reporting cycle.
When we place these indicators in the wider context of the entire NHS Staff Survey, the Trust acknowledges an overall general decline in the responses our staff provided in relation to their experiences across a wide range of themes.
In WRES Indicator 5 we note a significant deterioration in the self-reported experience of our BAME staff. It is noted that for indicators 6 - 8 although there is a deterioration in the scores and the self-reported experience for BAME staff is worse, the percentage gap between white and BAME staff remains similar to last year's report.

In early 2019, the NHS England WRES Team published the document ‘A Model Employer’. In this document, challenges for BAME people in attaining senior leadership positions in the NHS are highlighted and a suite of positive actions proposed to begin to redress this imbalance and unfairness, throughout the duration of the NHS Long Term Plan, are articulated. In September 2019 all NHS organisations in England will be furnished with their Model Employer aspirations to work towards.

Following consultation with the BAME Staff Network in August 2019, the following actions for improvement have been identified and the detail for achieving delivery is being identified:

Indicator 1, 4 & 9: Implementation of the A Model Employer and commencement of the work towards achieving the Trust’s aspirations. Work on this will commence as soon as the Trust’s aspirations have been received from NHS England WRES Team (expected late September 2019).

Indicator 2: A detailed analysis of the TRAC data, to gain a better understanding of the stages in the recruitment process, with a view of identifying actions to support and ensure equity for BAME and white candidates.

Indicator 8: To complete the work commenced by the BAME Staff Network around the discrimination survey and work with members of the Organisational Development Team to build on this work.

Recommendations: It is recommended that the members of the Trust Board approve the WRES Report to facilitate publication on the Trust's website, as required by NHS England.

Strategic risk register: 4351	
Equality impact: This report is related to race, which is one of the protected characteristics of the Equality Act 2010, and proposes actions to improve the experience of BAME staff.	

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

United Lincolnshire Hospitals NHS Trust (RWD)

Date of report: month/year

August 2019

Name and title of Board lead for the Workforce Race Equality Standard

Martin Rayson, Director of Human Resources and Organisational Development

Name and contact details of lead manager compiling this report

Tim Couchman, Equality, Diversity and Inclusion Lead (tim.couchman@ulh.nhs.uk)

Names of commissioners this report has been sent to (complete as applicable)

NHS East Lincolnshire Clinical Commissioning Group

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Kamljit Obhi, Equality, Diversity and Human Rights Assurance Manager (Kamljit.obhi@nhs.net)

Unique URL link on which this Report and associated Action Plan will be found

https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-race-equality-standard-wres/

This report has been signed off by on behalf of the Board on (insert name and date)

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

As the Trust has continues to embed the Workforce Race Equality Standard (WRES), we have worked to improve our processes and oversight of the processes. Of particular relevance for our 2018-2019 WRES report has been the implementation of the WRES dashboard in the Electronic Staff Record (ESR) system, which has enhanced functionality to specifically support indicators 1 and 2, and also the TRAC system in relation to recruitment (Indicator 2). TRAC has enhanced WRES functionality and not only provides us with more robust data, it also allows us to interrogate our data in more detail, so that we can identify areas we need to focus our improvement actions.

Compared to the latest census data (2011) it is evident that the United Lincolnshire Hospitals NHS Trust (ULHT) employ more BAME (Black, Asian & Minority Ethnic) staff, than the combined rate of BAME residents in the seven local authority areas covered by the Trust. The evidence remains clear, that the percentage of BAME medical staff is significantly higher than represented in the local population and the wider

b. Any matters relating to reliability of comparisons with previous years

In this current reporting cycle, we have moved to utilising the new WRES dashboard on the ESR system. The result of this is a small variance in pay bands 1 and 2 between clinical and non-clinical staff. This is due to a difference in coding locally and nationally. From this report onwards, we have aligned our local coding to the national coding, as utilised in the WRES dashboard on ESR.

In the 2018 NHS staff survey, we have again seen an increase in the numbers of our staff completing the staff survey (up from 45% in 2017, to 46% in 2018). However, it is disappointing that in 2018 all four of the staff survey indicators in the WRES have deteriorated since 2017. Sadly this is indicative of a general deterioration in the Trust's staff survey results and the organisation is working through the divisional structures, with the support of the Organisational Development Team and the BAME Staff Network, to understand and address the concerns in our workforce.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

7688

b. Proportion of BME staff employed within this organisation at the date of the report

11.56%

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

The percentage remains at around 99.3%.

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

Upon appointment to the Trust, all staff are provided with the opportunity to self-report their ethnicity, alongside the other equality characteristics. As the Trust has now implemented ESR self-service, once appointed, all staff are encouraged to ensure their information is kept up-to-date and complete. Whilst all staff have this ability, due to practical issues of staff turnover and personal choice, it is unlikely that a figure of 100% will be achieved.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

It remains a priority to encourage staff to share their equality monitoring information and this is reinforced both at staff induction and through the equality, diversity and inclusion core learning (every 3 years).

4. Workforce data

a. What period does the organisation's workforce data refer to?

April 2018 - March 2019

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	11.56% Please refer to appendix 1	11.78%	The percentage of BAME staff employed by the Trust has reduced slightly (0.22%) in the last 12 months. Compared with the population of Lincolnshire, this figure remains significantly higher than the percentage of BAME people resident in the county. The Trust is proud to be attracting and retaining a diverse workforce.	The Trust will commence planning and implementation of A Model Employer from Autumn 2019. One of the first steps in this, will be the BAME staff network assisting in the production of a baseline of our data in relation to understanding where the first steps of positive action need to be focussed.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	1.15	1.66	A figure higher than 1.0 indicates that white candidates are more likely than BAME candidates to be appointed from shortlisting. It is encouraging to note, that our data for the current year shows a significant improvement in this indicator. We believe this is due to two main factors: 1) The introduction of the TRAC systems to manage the recruitment process (this system	With the TRAC system firmly embedded in the Trust, we need to continue to review our data. The new training for recruiting managers will continue to be delivered. During 2019-2020 the BAME Staff network will support in undertaking an analysis of the TRAC recruitment data, to better understand the stages of recruitment and propose areas to focus
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	1.25	1.65	A figure higher than 1.0 indicates that BAME staff members are more likely to enter the formal disciplinary process that white staff. It is encouraging to see that our data shows a significant improvement for the second year in a row. It is believed that an improvement in the management and oversight of policy and processes by the Employee Relations Team are	We will continue to focus on the oversight of the formal disciplinary process. We will review whether our policy imperative remains fit for purpose.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	1.27	1.36	A figure higher than 1.0 indicates that white staff are more likely to access non-mandatory training and CPD when compared with BAME staff. It is encouraging that for the second year in a row, our data shows an improvement, although the Trust needs to continue the journey of improvement.	With the establishment and growth of the BAME Staff Network, the Trust has been able, as an act of positive action, to ensure BAME staff affiliated to the network are made aware of significant local regional and national training opportunities. Further, members of the network themselves offer practical and coaching support to their colleagues in writing and submitting training

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 29.60% BME 30.30%	White 28.60% BME 26.30%	It is noted with disappointment that all four of the staff survey indicators in the WRES have deteriorated in the current cycle. Although this needs to be set in the context of a deterioration in the wider staff survey, the Trust needs to develop	The specific challenges of the WRES Staff Survey indicators need to be integrated into the wider issues relating to the culture of the organisation, as being led by the Organisational Development Team.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 32.30% BME 37.40%	White 27.12% BME 32.46%	It is noted with disappointment that all four of the staff survey indicators in the WRES have deteriorated in the current cycle. Although this needs to be set in the context of a deterioration in the wider staff survey, the Trust needs to develop	The specific challenges of the WRES Staff Survey indicators need to be integrated into the wider issues relating to the culture of the organisation, as being led by the Organisational Development Team.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 78.30% BME 72.30%	White 83.42% BME 78.36%	It is noted with disappointment that all four of the staff survey indicators in the WRES have deteriorated in the current cycle. Although this needs to be set in the context of a deterioration in the wider staff survey, the Trust needs to develop	The specific challenges of the WRES Staff Survey indicators need to be integrated into the wider issues relating to the culture of the organisation, as being led by the Organisational Development Team.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 8.50% BME 19.10%	White 6.71% BME 16.17%	It is noted with disappointment that all four of the staff survey indicators in the WRES have deteriorated in the current cycle. Although this needs to be set in the context of a deterioration in the wider staff survey, the Trust needs to develop	The BAME Staff Network has actively supported the Trust in developing and implementing an insight survey to better understand the ways in which our staff feel discriminated against. The survey ran in July to mid-August 2019 and the
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	-11.6%	-6.2%	It is acknowledged that the voting membership of the Board is entirely white.	In early 2018-2019 the Deputy Chief Executive became the BAME Staff Network Executive Sponsor and has been very active and proactive in this role. He has raised the apparent lack of diversity of the Board with Board members and

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

The development and growth of the BAME Staff Network and the appointment of an Executive sponsor for the network have been significant factors in the current reporting cycle. This journey is continuing as we have entered 2019-2020, with the Board identifying inclusion as a top priority in the current year and moving forward.
The Trust was proud to support and sponsor the Equality, Diversity and Inclusion (ED&I) Lead on the first WRES Expert Programme, from which he graduated in November 2018. The ED&I Lead will continue to be supported and sponsored in this role and has indeed already taken an active role in the WRES Experts' regional work.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

The WRES action plan, based on the data in this report and aligned to the Trust's EDS work and corporate equality objectives, will be developed and produced with the BAME staff network in August / September 2019 and following sign-off by the Board, be published on the Trust's equality website at the following link: https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-race-equality-standard-wres/

Appendix 1:

ULHT STAFF INPOST WRES DATA AS AT 31ST MARCH 2019 (Excludes Bank Staff)

	Clinical Medical & Dental		
Grade	**%age White Staff**	**%age BME Staff**	**%age Not Known / Stated**
Associate Specialist	18.75%	81.25%	0.00%
Consultant	36.68%	59.56%	3.76%
FY1	32.35%	61.76%	5.88%
FY2	19.44%	66.67%	13.89%
GPCA/Hospital Practitioner	80.00%	20.00%	0.00%
Medical Director	100.00%	0.00%	0.00%
Specialty Doctor	12.21%	81.68%	6.11%
Specialty Registrar	31.33%	50.67%	18.00%
Staff Grade	0.00%	100.00%	0.00%
Total	**29.43%**	**62.80%**	**7.77%**

	Clinical Non Medical & Dental		
Grade	**%age White Staff**	**%age BME Staff**	**%age Not Known / Stated**
Band 1	0.00%	0.00%	0.00%
Band 2	92.88%	6.15%	0.98%
Band 3	96.26%	3.21%	0.53%
Band 4	96.40%	3.60%	0.00%
Band 5	86.98%	11.98%	1.04%
Band 6	95.13%	4.63%	0.23%
Band 7	95.45%	3.59%	0.96%
Band 8A	93.75%	6.25%	0.00%
Band 8B	91.67%	4.17%	4.17%
Band 8C	90.00%	10.00%	0.00%
Band 8D	100.00%	0.00%	0.00%
Band 9	0.00%	0.00%	0.00%
VSM	100.00%	0.00%	0.00%
Nursing Cadet Apprentice	94.74%	5.26%	0.00%
Total	**91.66%**	**7.56%**	**0.78%**

	Non Clinical		
Grade	%age White Staff	%age BME Staff	%age Not Known / Stated
Apprentice	100.00%	0.00%	0.00%
Band 1	95.26%	3.28%	1.46%
Band 2	97.08%	2.19%	0.73%
Band 3	97.11%	2.44%	0.44%
Band 4	99.31%	0.35%	0.35%
Band 5	95.10%	4.20%	0.70%
Band 6	95.79%	2.11%	2.11%
Band 7	95.89%	4.11%	0.00%
Band 8A	90.24%	9.76%	0.00%
Band 8B	100.00%	0.00%	0.00%
Band 8C	93.33%	6.67%	0.00%
Band 8D	100.00%	0.00%	0.00%
Band 9	75.00%	25.00%	0.00%
VSM	100.00%	0.00%	0.00%

To:	The Trust Board
From:	Tim Couchman, Equality, Diversity and Inclusion Lead
Date:	23 September 2019
Healthcare standard	NHS Workforce Disability Equality Standard (WDES)

Title:	Workforce Disability Equality Standard (WDES) – Data report, analysis and proposed actions for improvement.

Responsible Director: Martin Rayson, Director of HR & OD
Author: Tim Couchman, ED&I Lead

Purpose of the report:

To furnish the members of the Trust Board with the first WDES data report, analysis and proposed actions for improvement.

To confirm to the Trust Board, that the Trust is meeting the requirements of the new WDES in the first year of implementation and proposing initial actions for improvement.

To request that members of the Trust Board approve the WDES data report, analysis and proposed actions for improvement, as required by NHS England, before publication on the Trust website.

The report is provided to the Board for:

Decision	X	Discussion by email	X
Assurance	X	Information	

Summary/key points:

"The Workforce Disability Equality Standard (WDES) is an important step in the NHS and is a clear commitment in support of the Government's aim of increasing the number if disabled people in employment.

The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled staff. The information will be used by NHS organisations to understand their performance, develop specific local actions, and measure progress, against the WDES metrics." (NHS England, WDES)

Launched in January 2019, the WDES is mandated in the NHS Standard Contract for all NHS Trusts and Foundation Trusts from April 2019. The WDES is based on the principles of the Workforce Race Equality Standard (WRES) and the NHS in England has committed to both equality standards in the NHS Long Term Plan.

Further information about the WDES can be located on the NHS England WDES website: https://www.england.nhs.uk/about/equality/equality-hub/wdes/

Methodology:

The data for the first WDES report was collated and prepared in the first quarter of 2019-2020. The data was verified and submitted electronically to NHS England using a pre-prepared Excel spreadsheet: Appendix A

Parallel to this an electronic WDES report template was completed and submitted to NHS England using their electronic reporting hub: Appendix B

This current report provides an overview of the data by metric, analysis and proposed actions for improvement in relation to the experience of disabled staff.

Recommendations:

It is recommended that the members of the Trust Board accept the attached report and approve for publication on the Trust's website, as required by NHS England.

Strategic risk register: 4351	

Equality impact: This report is related to disability, which is one of the protected characteristics of the Equality Act 2010, and proposes actions to improve the experience of disabled staff.

United Lincolnshire Hospitals NHS Trust

Agenda Item 13.4

Workforce Disability Equality Standard (WDES)

Data report, analysis and proposed actions for improvement

2018-2019

Agenda Item 13.4
Background:

"The Workforce Disability Equality Standard (WDES) is an important step in the NHS and is a clear commitment in support of the Government's aim of increasing the number if disabled people in employment.

The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled staff. The information will be used by NHS organisations to understand their performance, develop specific local actions, and measure progress, against the WDES metrics."[1]

Launched in January 2019, the WDES is mandated in the NHS Standard Contract for all NHS Trusts and Foundation Trusts from April 2019. The WDES is based on the principles of the Workforce Race Equality Standard (WRES) and the NHS in England has committed to both equality standards in the NHS Long Term Plan.

Further information about the WDES can be located on the NHS England WDES website: https://www.england.nhs.uk/about/equality/equality-hub/wdes/

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Parallel to this an electronic WDES report template was completed and submitted to NHS England using their electronic reporting hub – (appendix B)

This current report provides an overview of the data by metric and proposed actions for improvement in relation to the experience of disabled staff.

[1] NHS Workforce Disability Equality Standard (WDES), *Template Guidance and Information,* p. 3

Agenda Item 13.4
Metric 1:

Percentage of staff in NHS Agenda for Change (A4C) pay bands or medical and dental subgroups and very senior managers (VSM), including executive board members, compared with the percentage of staff in the overall workforce.

Total number of staff employed within the organisation on 31 March 2019: 7688

Percentage of disabled staff: 2.90%
Percentage of non-disabled staff: 84.06%
Percentage not declared / unknown: 13.04%

Percentages of staff by pay band / professional group clusters:

Non-clinical staff:

	Disabled staff	Non-disabled staff	Disability status not know / undeclared
Cluster 1 (A4C bands 1-4)	4%	83%	13%
Cluster 2 (A4C bands 5-7)	4%	88%	8%
Cluster 3 (A4C bands 8a – 8b)	5%	84%	11%
Cluster 4 (A4C bands 8c – 9, & VSM	0%	93%	7%

Clinical staff:

	Disabled staff	Non-disabled staff	Disability status not know / undeclared
Cluster 1 (A4C bands 1-4)	3%	82%	15%
Cluster 2 (A4C bands 5-7)	3%	86%	11%
Cluster 3 (A4C bands 8a – 8b)	2%	85%	13%
Cluster 4 (A4C bands 8c – 9, & VSM	3%	76%	21%
Cluster 5 (Medical and dental staff, consultants)	1%	83%	16%

Cluster 6 (Medical and dental staff, non-consultant career grades)	0%	90%	10%
Cluster 7 (Medical and dental staff, trainee grades)	2%	71%	27%

An initial analysis of the data above shows significant percentages in each of the clusters where disability status is unknown or not declared. When this data is cross-referenced with the 2018 NHS Staff Survey, a self-declaration of 20% of staff identifying as disabled is noted. There might be many reasons for this disparity.

The NHS England WDES Team is encouraging all organisations to take meaningful steps to increase self-declaration rates as one of their actions for improvement in this current financial year.

Agenda Item 13.4
Metric 2:

Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

	Shortlisted *n*	Appointed *n*	Appointed %	Relative likelihood of appointment from shortlisting (Non disabled / disabled)
Disabled	348	32	9.2%	1.29
Not disabled	6775	801	11.8%	
Total	7123	833	11.7%	

A figure > 1.0 indicates that non disabled people are more likely to be appointed from shortlisting than disabled people.

This means that in 2018-2019, to a likelihood on 1.29 non disabled people were appointed from shortlisting than disabled people. This is in spite of the Trust's commitment to being a Disability Confident Employer and the guaranteed interview scheme for disabled people who meet the essential criteria for the post.

Agenda Item 13.4
Metric 3:

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

	Substantive workforce* *n*	Formal capability *n* (2017-18 & 2018-19) +	Relative likelihood of entering formal capability process
Disabled	219	0.5	1.93
Non-disabled	6355	7.5	
Total	6574	8.0	

* Please note this metric on the NHS England WDES spreadsheet does not account for disability status unknown. This has been raised with the WDES Team.
+ Please note, as numbers for this process are relatively small, this metric is based on data from a two year rolling average (similar to the WRES disciplinary metric).

A figure > 1.0 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

This means that between 2017-2019, to a likelihood on 1.93 non disabled people were more likely to enter the formal capability process than non-disabled people.

Please note, that for the first year of the WDES only formal capability cases relating to performance were reviewed and reported. Guidance is awaited from the WDES Team as to whether from 2020 onwards both performance and ill-health related formal capability processes will be reported on in the WDES.

Agenda Item 13.4
Metric 4a – NHS Staff Survey Metric

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i) Patients / service users, their relatives or other members of the public
ii) Managers
iii) Other colleagues

	Disabled *n*	Disabled %	Non-disabled *n*	Non-disabled %
Patients / service users, their relatives or other members of the public	590	36.3%	2492	27.4%
Managers	584	28.1%	2469	17.0%
Other Colleagues	580	33.8%	2471	21.4%

Agenda Item 13.4
Metric 4b – NHS Staff Survey Metric

Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Disabled *n*	Disabled %	Non-disabled *n*	Non-disabled %
312	41.7%	929	42.3%

Agenda Item 13.4
Metric 5 – NHS Staff Survey Metric:

Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Disabled *n*	Disabled %	Non-disabled *n*	Non-disabled %
362	68.5%	1528	80.0%

Agenda Item 13.4
Metric 6 – NHS Staff Survey Metric:

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disabled *n*	Disabled %	Non-disabled *n*	Non-disabled %
426	37.1%	1337	27.1%

Agenda Item 13.4
Metric 7 – NHS Staff Survey Metric:

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Disabled *n*	Disabled %	Non-disabled *n*	Non-disabled %
588	28.2%	2503	38.4%

Agenda Item 13.4
Metric 8 – NHS Staff Survey Metric:

Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Disabled *n*	Disabled %
308	64.9%

Agenda Item 13.4
Metric 9a – NHS Staff Survey Metric:

The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Disabled *n*	Disabled Engagement Score	Non-disabled *n*	Non-disabled Engagement Score	Trust Engagement Score
591	6.1	2515	6.6	6.5

Agenda Item 13.4
Metric 9b

Has your organisation taken action to facilitate the voices of disabled staff in your organisation to be heard?

Yes.

In the autumn of 2018 we launched a MAPLE (Mental and Physical Lived Experience) staff network, initially as a closed Facebook group. This small group of staff engage regularly through the group.

Paul Boocock, Director of Estates and Facilities is the MAPLE network executive sponsor and it is envisaged that we will support the group in establishing physical staff network meetings in 2019-2020.

Agenda Item 13.4
Metric 10 – Board representation metric

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By Executive membership of the Board

At 31st March 2019 all voting members and executive members of the Board had self-declared as non-disabled or their disability status was unknown.

Disability status, as with all equality monitoring information, can be declared at the time of appointment to the Trust, or updated on ESR self-service or through the Human Resources Team at any time.

Agenda Item 13.4
Actions for improvement:

Following the submission of the WDES data to the NHS England WDES Team at the end of July 2019 and the publication of this report, it is proposed that the Trust commits to two primary actions for improvement in the current financial year:

1) Undertake meaningful steps to improve staff self-disclosure rates around disability.
2) Support the emerging MAPLE staff network and enable physical meetings of the group to commence in 2019-2020.

The detailed steps to facilitate point 1 will be agreed and implemented with the support of the HR & OD Team and the emerging MAPLE staff network members. The detailed timeline for the start of meetings of the MAPLE staff network to be agreed with the MAPLE network members and with the support of Paul Boocock, MAPLE network executive sponsor.

Tim Couchman
Equality, Diversity and Inclusion Lead
September 2019

RWD United Lincolnshire Hospitals NHS Trust v2.0

					31st MARCH 2019													
					DISABLED				NON-DISABLED				DISABILITY UNKNOWN OR NULL				OVERALL STAFF	
					Total Disabled		% Disabled / ratio		Total Not Disabled		% Not Disabled / ratio		Total Unknown or Null		% Unknown or Null / ratio		Total	
METRIC	INDICATOR	DATA ITEM		MEASURE	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Notes
1	**Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2019**		**1a) Non Clinical Staff**																
		1	Bands 1	Headcount	8	8	3%	3%	180	180	69%	69%	72	73	28%	28%	260	261	
		2	Bands 2	Headcount	25	24	5%	5%	439	440	83%	83%	64	65	12%	12%	528	529	
		3	Bands 3	Headcount	13	13	3%	3%	403	403	90%	90%	30	30	7%	7%	446	446	
		4	Bands 4	Headcount	10	10	3%	3%	241	241	83%	83%	39	39	13%	13%	290	290	
		5	Bands 5	Headcount	4	3	3%	2%	124	124	87%	87%	15	16	10%	11%	143	143	
		6	Bands 6	Headcount	4	4	4%	4%	85	84	89%	88%	6	7	6%	7%	95	95	
		7	Bands 7	Headcount	5	5	7%	7%	64	63	89%	88%	3	4	4%	6%	72	72	
		8	Bands 8a	Headcount	3	3	7%	7%	35	35	85%	85%	3	3	7%	7%	41	41	
		9	Bands 8b	Headcount	0	0	0%	0%	19	19	83%	83%	4	4	17%	17%	23	23	
		10	Bands 8c	Headcount	0	0	0%	0%	15	14	100%	100%	0	0	0%	0%	15	14	
		11	Bands 8d	Headcount	0	0	0%	0%	4	5	100%	100%	0	0	0%	0%	4	5	
		12	Bands 9	Headcount	0	0	0%	0%	3	4	100%	100%	0	0	0%	0%	3	4	
		13	VSM	Headcount	0	0	0%	0%	4	3	67%	60%	2	2	33%	40%	6	5	
		14	Other	Headcount	0	0	0%	0%	4	4	67%	67%	2	2	33%	33%	6	6	
		15	Cluster 1 (Bands 1 - 4)	Total	56	55	4%	4%	1263	1264	83%	83%	205	207	13%	14%	1524	1526	
		16	Cluster 2 (Band 5 - 7)	Total	13	12	4%	4%	273	271	88%	87%	24	27	8%	9%	310	310	
		17	Cluster 3 (Bands 8a - 8b)	Total	3	3	5%	5%	54	54	84%	84%	7	7	11%	11%	64	64	
		18	Cluster 4 (Bands 8c - 9 & VSM)	Total	0	0	0%	0%	26	26	93%	93%	2	2	7%	7%	28	28	
			1b) Clinical Staff																
		19	Bands 1	Headcount	1	1	0%	0%	206	206	72%	72%	80	79	28%	28%	287	286	
		20	Bands 2	Headcount	42	41	3%	3%	1097	1097	84%	83%	174	176	13%	13%	1313	1314	
		21	Bands 3	Headcount	8	8	4%	4%	167	166	87%	87%	16	16	8%	8%	191	190	
		22	Bands 4	Headcount	2	2	1%	1%	135	133	87%	87%	18	18	12%	12%	155	153	
		23	Bands 5	Headcount	58	55	4%	4%	1227	1242	85%	85%	156	157	11%	11%	1441	1454	
		24	Bands 6	Headcount	27	27	3%	3%	795	795	87%	87%	88	87	10%	10%	910	909	
		25	Bands 7	Headcount	5	4	1%	1%	384	386	87%	87%	52	52	12%	12%	441	442	
		26	Bands 8a	Headcount	2	3	2%	2%	108	107	86%	84%	16	17	13%	13%	126	127	
		27	Bands 8b	Headcount	0	0	0%	0%	27	27	90%	90%	3	3	10%	10%	30	30	
		28	Bands 8c	Headcount	0	0	0%	0%	18	18	78%	78%	5	5	22%	22%	23	23	
		29	Bands 8d	Headcount	1	1	13%	13%	5	5	63%	63%	2	2	25%	25%	8	8	
		30	Bands 9	Headcount	0	0	0%	0%	1	1	100%	100%	0	0	0%	0%	1	1	
		31	VSM	Headcount	0	0	0%	0%	2	2	100%	100%	0	0	0%	0%	2	2	
		32	Medical & Dental Staff, Consultants	Headcount	2	2	1%	1%	214	213	83%	83%	41	42	16%	16%	257	257	
		33	Medical & Dental Staff, Non-Consultants career grade	Headcount	0	0	0%	0%	151	149	90%	90%	16	17	10%	10%	167	166	
		34	Medical & Dental Staff, Medical and dental trainee grades	Headcount	6	5	2%	2%	193	193	71%	71%	71	72	26%	27%	270	270	
		35	Other	Headcount	3	3	11%	11%	23	23	85%	85%	1	1	4%	4%	27	27	
		36	Cluster 1 (Bands 1 - 4)	Total	53	52	3%	3%	1605	1602	82%	82%	288	289	15%	15%	1946	1943	
		37	Cluster 2 (Band 5 - 7)	Total	90	86	3%	3%	2406	2423	86%	86%	296	296	11%	11%	2792	2805	
		38	Cluster 3 (Bands 8a - 8b)	Total	2	3	1%	2%	135	134	87%	85%	19	20	12%	13%	156	157	
		39	Cluster 4 (Bands 8c - 9 & VSM)	Total	1	1	3%	3%	26	26	76%	76%	7	7	21%	21%	34	34	
		40	Cluster 5 (Medical & Dental Staff, Consultants)	Total	2	2	1%	1%	214	213	83%	83%	41	42	16%	16%	257	257	
		41	Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	Total	0	0	0%	0%	151	149	90%	90%	16	17	10%	10%	167	166	
		42	Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	Total	6	5	2%	2%	193	193	71%	71%	71	72	26%	27%	270	270	
2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** Note: i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.	43	Number of shortlisted applicants	Headcount		348				6775									
		44	Number appointed from shortlisting	Headcount		32				801									
		45	Relative likelihood of shortlisting/appointed	Auto-Populated		0.09				0.12									
		46	Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff	Auto-Populated				1.29											A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.
3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year (2017/18 and 2018/19). ii) This Metric is voluntary in year one.	47	Number of staff in workforce	Headcount		219				6355									
		48	Number of staff entering the formal capability process	Headcount		0.5				7.5									
		49	Likelihood of staff entering the formal capability process	Auto-Populated		0.00				0.00									
		50	Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	Auto-Populated				1.93											A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.
4	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. The data for this Metric should be a snapshot as at 31 March 2019**	51	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	Number of Respondents/%	590	590	36.3%	36.3%	2492	2492	27.4%	27.4%							
		52	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Number of Respondents/%	584	584	28.1%	28.1%	2469	2469	17.0%	17.0%							
		53	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Number of Respondents/%	580	580	33.8%	33.8%	2471	2471	21.4%	21.4%							
		54	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	Number of Respondents/%	312	312	41.7%	41.7%	929	929	42.3%	42.3%							
5	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**	55	% of staff believing that the Trust provides equal opportunities for career progression or promotion.	Number of Respondents/%	362	362	68.5%	68.5%	1528	1528	80.0%	80.0%							
6	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**	56	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Number of Respondents/%	426	426	37.1%	37.1%	1337	1337	27.1%	27.1%							
7	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**	57	% staff saying that they are satisfied with the extent to which their organisation values their work.	Number of Respondents/%	588	588	28.2%	28.2%	2503	2503	38.4%	38.4%							
8	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**	58	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Number of Respondents/%	308	308	64.9%	64.9%											
9a	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**	59	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Number of Respondents/Score	591	591	6.1	6.1	2515	2515	6.6	6.6					6.5	6.5	

9b	**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)** Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.	60	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)	(yes) or (no)		Yes													
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** • By Voting membership of the Board **The data for this metric should be a snapshot as of 31st March 2019**	61	Total Board members	Headcount		0				9				6			15		
		62	*of which: Voting Board members*	Headcount		0				6				6			12		
		63	*: Non Voting Board members*	Auto-Populated		0				3				0			3		
		64	Total Board members	Auto-Populated		0				9				6			15		
		65	*of which: Exec Board members*	Headcount		0				6				3			9		
		66	*: Non Executive Board members*	Auto-Populated		0				3				3			6		
		67	Number of staff in overall workforce	Headcount		222				6382				989			7593		
		68	Total Board members - % by Disability	Auto-Populated		0%				60%				40%					
		69	Voting Board Member - % by Disability	Auto-Populated		0%				50%				50%					
		70	Non Voting Board Member - % by Disability	Auto-Populated		0%				100%				0%					
		71	Executive Board Member - % by Disability	Auto-Populated		0%				67%				33%					
		72	Non Executive Board Member - % by Disability	Auto-Populated		0%				50%				50%					
		73	Overall workforce - % by Disability	Auto-Populated		3%				84%				13%					
		74	Difference (Total Board - Overall workforce)	Auto-Populated		-3%				-24%				27%					
		75	Difference (Voting membership - Overall Workforce)	Auto-Populated		-3%				-34%				37%					
		76	Difference (Executive membership - Overall Workforce)	Auto-Populated		-3%				-17%				20%					

Response ID ANON-VQQ5-M751-Q

Submitted to **Workforce Disability Equality Standard (WDES) online reporting form**
Submitted on **2019-07-22 15:10:40**

Trust information

1 Name of organisation:

Name of organisation::
United Lincolnshire Hospitals NHS Trust

2 Date of report:

Month/year::
July 2019

3 Name and title of the Board lead for the Workforce Disability Equality Standard:

Name and title of Board lead for the Workforce Disability Equality Standard::
Martin Rayson, Director of Human Resources and Organisational Development

4 Name and contact details of the lead compiling this report:

Name and contact details of lead compiling this report:
Tim Couchman, Equality, Diversity and Inclusion Lead
tim.couchman@ulh.nhs.uk

5 Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

Yes

If yes, please provide details::
We attained Disability Confident Employer (level 2) in June 2018 and are a Mindful Employer.
We have recently started to establish a disability staff network called MAPLE (Mental and Physical Lived Experience)

Trust information

6 Name and contact details of the commissioner(s) this report will be sent to:

Name and contact details of commissioner(s) this report will be sent to:
Kamljit Obhi
NHS Lincolnshire East CCG / Optum
kamljit.obhi@nhs.net

7 Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published:

Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published::
https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-disability-equality-standard-wdes/

8 Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified:

Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified::
01.10.2019

9 Total number of staff employed within the organisation on 31 March 2019:

Total number of staff employed within the organisation on 31 March 2019:
7688

% Disabled staff::
2.90%

% Non-disabled staff::
84.06%

% Unknown/Null::
13.04%

% Other::
0

% Prefer not to say::
0

Data quality

10 Did your organisation undertake the NHS Staff Survey in the past year?

Yes

Full staff survey

11 Give the total number and % of responses to the NHS Staff Survey in your organisation:

Give the total number and % of responses to the NHS Staff Survey in your organisation::
Sent to 7407 staff
3401 (46%) returned

12 Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation:

Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation::
591 Disabled staff responded - 19% of survey respondents

13 Do your staff have access to the ESR self-service portal?

Yes

Metric 1 - Workforce representation

14 Please describe any challenges that your organisation has experienced in reporting data for this Metric:

Please describe any challenges that your organisation has experienced in reporting data for this Metric::
No challenges in reporting data for this metric experienced. However, it would be helpful, if the WDES Team could include rows at the bottom which auto-calculate the data for the entire workforce, expressed as a figure and a percentage.

15 Have any steps been taken in the last 12 months within your organisation to improve the declaration rate for disability status on ESR?

No

16 Please share any examples of interventions that have increased declaration rates at your organisation:

Please share any examples of interventions that have increased declaration rates at your organisation::
None undertaken in the reporting year. Plans being developed for 2019-2020.

Metric 2 - Shortlisting

17 Please describe any challenges that your organisation has experienced in reporting data for this Metric:

Please describe any challenges that your organisation has experienced in reporting data for this Metric::
No challenges faced in reporting this data.

18 Has your organisation signed up to the Disability Confident Scheme?

Yes

Level 2 - Employer

19 Does your organisation use a Guaranteed Interview Scheme?

Yes

Metric 3 - Capability

20 Did your organisation submit data for Metric 3 this year?

Yes

If yes, please describe any challenges that your organisation has experienced in reporting data for this Metric::
As required in the dataset for this first reporting year, we have reported on performance related capability. We did not experience any challenge in reporting for this metric., although we have a question for you: As the data return only has fields for disabled or non-disabled staff (and not unknown) this means a significant number of our staff are not included in the calculation. Does this not affect the ultimate result?

If no, please explain why you did not submit data for this year::
n/a

21 Is capability on the grounds of ill health and capability on the grounds of performance managed by different policies in your organisation?

Yes

If yes, please state the policies::
Capability Policy - performance
Managing Attendance Policy - ill health

22 What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?

What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?:
I think it would be important to initially keep them separate, but the question of when and how ill health are linked to performance is equally important to understand.

Metric 4 - Harassment, bullying and abuse

23 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:
This data is taken straight from the staff survey. As a Trust we are concerned with all staff reporting experience of harassment, bullying or abuse. We are particularly concerned to note our disabled staff are reporting a higher incidence of experiencing harassment, bullying or abuse.

24 Has your organisation compared Staff Survey results against other datasets that may be held, e.g. bullying and harassment advisers, Freedom to Speak Up guardians, grievances, etc.

Yes

If yes, please provide further details on what comparison your organisation has undertaken::
Our Organisational Development Team a looking at the wider picture around bullying, harassment and abuse in the organisation. Recently our BAME Staff network devised an insight questionnaire for all staff in relation to discrimination and we will review the results and triangulate the findings.

25 Please summarise any actions taken to reduce harassment, bullying and abuse in relation to Disabled staff:

Please summarise any actions taken to reduce harassment, bullying and abuse in relation to disabled staff::
As above, this work is commencing.

Metric 5 - Career promotion and progression

26 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:
This data is taken straight from the NHS Staff Survey. We are concerned to note that our disabled staff believe to a lesser degree (68.5%), than our non-disabled staff (80%), that the organisation provides equal opportunities for career progression or promotion.
We need to think about how we can actively start to address this disparity.

27 Does your organisation provide any targeted career development opportunities for Disabled staff?

No

If yes, please provide further details::

Metric 6 - Presenteeism

28 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:
This data is taken straight from the NHS Staff Survey. It is of concern that over a quarter (27.1%) of non-disabled staff state they have felt under pressure to come to work, despite not feeling well enough to perform their duties. It is however, of greater concern that our disabled staff have felt this to an even greater degree (37.1%). The Trust needs to consider a robust manner in which it can respond to the reported concerns.

29 Does your organisation provide any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?

No

If yes, please provide further details::

Metric 7 - Staff satisfaction

30 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:
Data for this metric is taken from the staff survey. It identifies a difference in satisfaction on about 10% between disabled and non-disabled staff. As a Trust we need to establish ways in which we can start to engage with staff in a meaningful manner, to better understand their experience and work with our disabled staff to improve.

31 Does your organisation provide any targeted actions to increase the workplace satisfaction of Disabled staff?

No

If yes, please provide further details::
.

Metric 8 - Reasonable adjustments

32 Are there any issues with the data for this Metric?

Are there any issues with the data for this Metric?:
Data for this metric is taken from the staff survey. As a Trust we need to engage with our disabled staff to understand and improve their experience.

33 Does your organisation have a reasonable adjustments policy?

No

34 Are costs for reasonable adjustments met through centralised or local budgets?

Local

35 Has your organisation taken action to improve the reasonable adjustments process?

Yes

If yes, please provide further details::
Whilst we don't have a specific Reasonable Adjustment Policy, reasonable adjustments are covered in detail in our Managing Absence Policy and included in our training for recruiting managers. We will review whether we need to strengthen our policy imperative around reasonable adjustments.

Metric 9 - Disabled staff engagement

36 Are there any issues with the data (9a) or evidence (9b) for this Metric?

No

If yes, please provide details::

37 Does your organisation have a Disabled Staff Network (or similar)?

Yes

Not Answered

If you answered yes to the above, please give details of the expected timescale.:

Metric 10 - Board representation

38 Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric:

Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric::
There were no challenges in collecting or reporting this data. However, we are concerned that as the number for this metric are small, that individuals could potentially be identified.

39 Does your Board have a champion for disability equality?

Yes

If yes, with their permission, please provide name and position of the Board/Executive champion/sponsor::
Paul Boocock, Director of Estates and Facilities, is the Executive sponsor for our MAPLE (Mental And Physical Lived Experience) - disability, staff network.

To:	The Trust Board
From:	Tim Couchman, Equality, Diversity and Inclusion Lead
Date:	24 September 2019
Healthcare standard	Sexual Orientation Monitoring Standard (SOMS)

Title:	ULHT's pledge to the national NHS Rainbow Badge initiative

Responsible Director: Martin Rayson, Director of HR & OD
Author: Tim Couchman, Equality, Diversity and Inclusion Lead

Purpose of the report:

To provide the Trust Board with a draft ULHT pledge to the national NHS Rainbow initiative for discussion / amendment / confirmation and approval.

The report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Information	

Summary/key points:

Context:

- A NHS Rainbow Badge initiative is a national scheme innovated by a group of leading clinical staff from across the UK supported by NHS England.
- 82 Acute Trusts in the UK have already signed up to the scheme.
- 51 further Acute Trusts (incl. ULHT) in the process of signing up to the scheme.
- Over 150,000 NHS staff proudly wearing the NHS Rainbow badges.
- At ULHT we implemented a 'soft launch' through the LGBT+ Staff Network in early September, to test our systems and processes.
- Over 400 ULHT staff have already signed up.

- The 'official' launch will take place at the Senior Leadership Forum on 27th September 2019.
- Although focussed around LGBT+ inclusion, absolutely supports the wider inclusion work.

Key principles of the scheme:

- ***Wearing the badge is a responsibility!***
- The aim is to actively break down barriers LGBT+ people face.
- Simple, visual symbol identifying its wearer as someone who an LGBT+ person can feel comfortable talking to about issues relating to sexuality or gender identity.
- It shows that the wearer is there to listen without judgement and signpost to further support if needed.
- Aims to demonstrate that the wearer is aware of the issues that LGBT+ people face when accessing healthcare.
- Resources to support the scheme are provided for all who wish to sign-up to the scheme including organisations to signpost people to
- Project emphasises that ULHT promotes an environment that is open, tolerant and inclusive.
- By signing up, you acknowledge why the project is needed, and what your responsibility entails.

Organisational pledge to support the individuals and teams who have signed up to the scheme:

- Request that the Trust Board consider demonstrating organisational sign-up to this important national scheme through an organisational pledge (draft attached).

Recommendations:

It is recommended that the Trust Board receive the attached draft organisational pledge and discuss / amend, confirm and approve a final version of the pledge for use across the Trust.

Equality impact:
The NHS Rainbow Badge initiative is primarily focussed around the protected characteristics sexual orientation and gender reassignment, although through alignment to a fully inclusive approach to our equality work, people from all protected characteristic groups are embraced, welcomed and will ultimately benefit from this exciting national scheme.

Agenda Item 13.5

ULHT's Pledge to the NHS Rainbow Badge Initiative:

The NHS Rainbow Badge Initiative is a positive, yet discreet, way for staff within the Trust to demonstrate that they are aware of the challenges that LGBT+ people may face when accessing healthcare and show their commitment to be welcoming and supportive of LGBT+ people.

At ULHT we support of this initiative wholeheartedly and confirm that staff wearing a badge:

* Have identified themselves as someone who an LGBT+ person can feel comfortable talking to about issues relating to sexuality or gender identity.
* Understand the responsibility of wearing the rainbow badge and supporting LGBT+ people.
* Are there to listen without judgement and signpost to further support, if needed.
* Demonstrate commitment to the Trust's Core Values and Inclusion Strategy, to foster an inclusive environment for all patients and staff, regardless of sexual orientation or gender identity.

We will promote ULHT as an inclusive workplace where staff can be themselves, should they wish.
We will champion LGBT+ equality within the Trust by ensuring the needs of LGBT+ patients, service users and staff are met.

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Martin Rayson, Director of HR/OD
Date:	1st October 2019
Essential standards	

Title:	**ULHT As A Smoke Free Trust**

Author/Responsible Director: Stephen Kelly - Occupational Health and Wellbeing Service

Purpose of the report:

Following consultation with the public and staff, it is proposed that from Monday the 6th of January smoking will no longer be permitted anywhere on United Lincolnshire Trust grounds, buildings, entrances, car parks or in cars by anyone including patients, clients, visitors, staff and contracted workers.

This reflects national public health and NHS guidance.

The Trust is committing to being smoking-free and creating an environment which actively encourages staff, service users and visitors to stop smoking and remain smoke-free. This is reflected in our Smoke Free Policy.

The report is provided to the Board for:

Decision	√	Discussion	
Assurance		Information	

Summary/key points:

The paper outlines the rationale for the recommendation to commit to being smoke free from 6th January 2020, including the support for this approach through consultation. It considers and rejects any formal exemptions, but recognises that based on Public Health England (PHE) guidance, vaping outside of buildings should be allowed.

It is clear that enforcement will be the biggest challenge and outlines how we might achieve our aims in the policy. Assisting people to stop smoking must be our priority and the paper sets out the programmes we already have in place,

which will be at the heart of the communication campaign we will mount leading up to January, which will maximise our chances of a successful implementation and minimise risk.

Recommendations:

Smoking is to be banned on all Trust sites from the 6th January to comply with public health guidance (NICE PH48 – Smoke Free Premises).

Staff, patients, their carer's, relatives and contractors will be asked to abstain from smoking on Trust premises. Inpatients will be supported with choices to aid quitting or abstinence while they receive inpatient care.

Strategic risk register

Risks in not accepting the recommendations:

- Failure to implement NICE guidance.
- Commissioners opt to commission from totally smoke-free providers, in line with NICE Guidance.

Risks in accepting the recommendations:

- Reputational, as some patients may oppose the Policy and its implication is that patients and staff will smoke on the street. The expectation is that staff may be more accepting of a policy that clearly reinforces the raison d'etre of a health organisation.

Performance KPIs year to date

None

Resource implications (e.g. Financial, HR)

The cost of signage to support the implementation of the policy is £19,000. Funding is being sought from Charitable Funds.

(Please note this does not include cost for audible signs or policing the policy) Supply and fitting of these is estimated at £1500 each and the proposal is for 10 audible signs at key entrances and exits to trust building.

Assurance implications

There are implications for the health and well-being of our patients and staff. These will be overwhelmingly positive, but implementation will not be without challenges. Compliance with NICE guidance and national guidance.

Data collection via Datix on smokers challenged by staff at all sites which result in an aggressive reaction verbal or physical, by which staff feel threatened.

Compliance with enforcement of smoke free environment. Evidence of onward referral to Lincolnshire Stop Smoking Service.
Patient and Public Involvement (PPI) implications The Trust Communications team have engaged with staff, service users and key stakeholders staff to obtain their views and comments on how to successfully deliver a smoke-free environment across ULHT. The team undertook a survey from May to July 2019 to establish the views of staff, patients, service users and the public about plans to introduce smoke free sites.
Equality impact: An impact assessment has been undertaken and is included as part of the Policy. There are no equality implications around its implementation.
Information exempt from disclosure: No
Requirement for further review? Review Smoke Free Trust implementation, planned for late January 2020.

1. Background

1.1. United Lincolnshire Hospitals NHS Trust (ULHT) as a healthcare provider and major employer in Lincolnshire is committed to promoting public health and creating an environment that minimises the health risks to members of the public, patients and staff who access or provide our services.

1.2. ULHT endorses the principle that, whilst smoking is a matter of personal choice and that not all smokers will wish to cease smoking, where an individual smokes is of public concern.

1.3. It was agreed in 2017 to look at the option of becoming a smoke free Trust and that there should be no smoking in any ULHT buildings, or on the site as a whole. Our decision to go Smoke Free is also in line with The Health Act (2006) and The National Institute for Health and Care Excellence (NICE) 2013 guidelines which state that all hospital sites should be 100% Smoke Free. As a Trust, we are behind many other NHS Trusts in implementing a smoking ban on our sites.

1.4. Our Smoke Free Policy is attached at Appendix A. This has been developed through the Health and Safety Committee. Our policy and plans have been informed by the experience of other Trusts.

1.5. The Trust recognises there are challenges in implementing and enforcing a no smoking policy. This is based on the experience of other Trusts. The Board received a report in February 2019 on this issue and agreed to have a period of consultation with members of the public and staff on the principle of being a smoke free site and how we might implement this, if agreed.

2. Consultation

2.1. In the February Board paper we envisaged that consultation would take place between mid-March and mid-April. The consultation period was actually May to the end-July to ensure we maximised the opportunity to get stakeholder views and 800 responses have been received.

2.2. The results of the consultation is included at Appendix B. The response to the question *Do you believe ULHT should become completely smoke free?* is not as clear cut as we might have expected, but 56% were in favour. In terms of the mix between staff and public, staff were more supportive of the policy, but generally there were few significant differences between the two groups in terms of their views. The particular challenge, where either patients or public are distressed and allowing the smoking of a cigarette might assist from a patient safety perspective, was identified as a potential issue by the staff.

2.3. There was greater support for allowing vaping in designated areas. The greatest challenge identified around implementation was in terms of enforcement and the suggestion was made that this could best be achieved by policing the policy.

2.4. Those consulted recognised the need that any enforcement around smoke-free needed to be accompanied by further efforts to encourage people to stop smoking. Within the consultation results there are also some valuable pointers to the communication campaign that would need to precede the implementation of the Policy.

2.5. Staff were specifically asked what we should do for staff who wished to smoke in their breaks. Providing smoking shelters was the most popular response, followed by requiring staff to leave the hospital site if they wished to smoke.

3. Implementing Smoke Free

3.1 It is recommended that the Trust becomes smoke free across all its sites from 6th January 2020. This recommendation is made for the following reasons:

1. Failure to do so would mean that the Trust would be non-compliant with PHE, NHS England and NICE guidance.

2. We would not be contributing to a reduction in premature mortality and would be perpetuating health inequalities in the local population.

3. We would be at odds with LCHS and LPFT, who are smoke free Trusts and with whom we share sites.

4. Commissioners may opt to commission from totally smoke-free providers, in line with NICE Guidance.

5. We would continue to expose our staff to second hand smoke.

6. It will improve the image of the Trust if we do not have smokers at the entrance of our buildings and contribute to creating a tidier environment.

3.2 We would recommend implementation in the New Year to allow for sufficient time to prepare (e.g. signage) and for a communications campaign to run in advance.

3.3 There is some support for providing designated areas for smoking and potentially “smoking shelters”, which many employers have provided. This does have some attraction, but we already have designated smoking areas and this has not stopped smoking outside our front entrances. Ensuring security at designated sites/shelters would also be an issue and it will be a simpler message and less complex to enforce if we simply ban smoking on all parts of our sites for patients, public and staff.

3.4 The Trust Safeguarding Committee are concerned that the policy around smoke free will create significant issues for the Trust management of patients behaviour who have Mental Health or capacity issues and may lead to an increase in the use of restraint and restrictions. The recommendation though is to allow no exemptions in the policy. LPFT do not have any exemptions and to do so creates a complication, where a simple and clear policy will be most helpful. It is recognised though that in very exceptional circumstances and based on a risk assessment on patient safety grounds, a pragmatic approach may need to be taken for an individual where it is judged that allowing a cigarette to be smoked in the right environment and under supervision, may significantly reduce risk to that patient and/or staff.

4. Vaping

4.1 On the basis of simplicity of approach, it would also be helpful to ban vaping on Trust sites as well. However we have taken Public Health England (PHE) advice, which indicates that cigarettes and vaping should be treated differently. The Smoking Policy therefore states:

Smoke free means that smoking, is not permitted anywhere within hospital buildings or grounds.
The use of E-Cigarettes or Vaporisers will only be permitted in external areas in the Trust grounds. We would ask that you consider other people and do not use them in close proximity to other people
The use of E-Cigarettes or Vaporisers is not permitted inside any building or structure on the Trust sites.
The charging of any E-Cigarettes or Vaporiser devices is prohibited in the Trust

5. Enforcement

5.1 Enforcing the policy is recognised as the most challenging aspect of implementation. The failure to enforce restrictions which are already in place and are clearly signed, at the entrances of our hospital buildings, means that smoking there is self-perpetuating. The experience of other Trusts is that, without enforcement it is more difficult to achieve the impact desired.

5.2 The Policy as written envisages that staff should play a part in enforcement. It states that staff are asked to:

politely remind patients and visitors of the smoke-free policy if they consider them to be in breach of the policy by smoking in the organisation’s premises including the grounds. The Trust do not want anyone to feel that they need to engage in difficult or challenging situations and should not approach individuals (whether staff or patients) to ask them to stop smoking unless they are confident and feel that it is safe to do so.

The reality is that staff may not feel confident enough to challenge very often. We will ask those security staff currently employed and the Community Support

Officers who visit our sites, to assist us in enforcing the policy. We have explored employing additional security staff to assist, but the cost is prohibitive.

5.3 We will have set out our intent as a Trust and will do all we reasonably can to enforce. We have to rely on the goodwill of patients and the public to comply and peer pressure to avoid smoking in an environment which is all about keeping people healthy.

6. Support To Stop Smoking

6.1 Appendix 1 of the Policy sets out the extensive support available to help patients, staff or carers stop smoking. We are already proactive with all patients around helping them stop if they are smokers. We will launch a further campaign in the build up to January 2020, as part of our communications plan (see section 7) and will engage with Public Health to do so. This will include highly visible campaigns in hospital entrances, close to where people currently smoke.

7. Communications

7.1 We recognise the challenges around the implementation of this policy and the reputational risks involved. We can learn from other Trusts who have followed a similar path. The Policy already includes at Appendices 2 and 3 sections on what this means for patients and staff, based around FAQs.

7.2 A full communication plan is included at Appendix C.

Appendix A

United Lincolnshire Hospitals NHS Trust

Smoke Free Policy

Version:	8.0
New or Replacement:	Replacement
Policy number:	
Document author(s):	Stephen Kelly, OH
Contributor(s):	
Approved by:	
Date approved:	
Document status (RAG):	Green
Review date:	As and when required

Policy is:	**Trust-wide**

Version History Log

Version	Date Published	Details of key changes
6.0		
5.0		
4.0		
3.0	June 2018	Formatting and inclusion of policy group comments
2.0	October 2019	Full review, inclusion of current legislation
1.0	2006	Archived

Contents

1. Summary

1.1 United Lincolnshire Hospitals NHS Trust (ULHT) as a healthcare provider and major employer in Lincolnshire will set an example to other organisations, promote public health and create an environment that minimises the health risks to members of the public, patients and staff who access or provide our services.

1.2 ULHT endorses the principle that whilst smoking is a matter of personal choice and that not all smokers will wish to cease smoking, where an individual smokes is of public concern. ULHT acknowledges that breathing other people's smoke is both a public health hazard and a welfare issue. Therefore, the Smoke Free policy has been adopted.

1.3 The organisation is carrying out its duty of care as an employer and complying with current Health and Safety legislation; this policy has been created in line with the requirements of, but not limited to NICE Guidance - Smoking cessation in secondary care: acute, maternity and mental health services - November 2013; Health Act 2006, which prohibited smoking in public places from 1 July 2007; Health & Safety at Work etc Act 1974 Section 2 (2) (e) - to provide a working environment that is safe and without risk to health; The Management of Health and Safety at Work Regulations 1999 - to assess risks to health, safety and welfare in the workplace; The arrangements for the Health and Safety at Work - Pregnant Workers Directive (92/85/EEC), to protect employees that are pregnant, have recently given birth or who are breastfeeding.

1.4 As well as its duty to protect the health of employees, patients and visitors, ULHT also has a duty to safeguard its property. Therefore this policy is also intended to minimise the risk of fire caused by smoking in unauthorised areas.

1.5 ULHT will actively encourage, promote and support smoking cessation amongst employees, patients, visitors and members of the general public. It is recognised that some employees may experience difficulty in complying with this policy. Any employee who is considering stopping smoking can access information and support through the Trust's Occupational Health Service. This may take a variety of forms including: the provision of information and guidance; counselling; in-house smoking cessation programmes and referral to Stop Smoking Services.

2. Introduction

2.1 Purpose

2.1.1 To exercise the organisation's statutory role in promoting and maintaining the health of employees, patients, visitors and members of the general public and to extend its health philosophy to the work environment which it manages.

2.2 Context

2.2.1 The organisation is carrying out its duty of care as an employer and complying with current Health and Safety legislation.

2.3 Objectives

2.3.1 To ensure that all staff, patients and visitors including contractors clearly understand their obligations. To protect all employees, patients, visitors and members of the general public who access any site or enter any establishment or enclosed space owned or used by the organisation for any undertaking whatsoever, from exposure to second hand smoke. (To include any site or establishment currently sublet, rented or leased from ULHT, to other government/NHS organisations). To be an exemplary employer, as well as an exemplary public organisation, in protecting people from the health risks of passive smoking. To encourage a healthier workforce that recognises the benefits of a smoke free environment. To ensure legal compliance.

2.4 Scope

2.4.1 This policy applies to all Trust employees, patients, visitors, members of the general public and third party users of the site.

2.5 Compliance

2.5.1 This policy complies with the legislation, standards, guidelines, codes of conduct, and any other relevant document listed in the Referenced Documents' section.

3. Roles and Responsibilities

The policy has the support of the Trust Board, Staff and Health & Safety representatives. Its successful application is dependent upon the full support of all staff. It also requires acceptance by patients, visitors and the wider community.

3.1 Managers' Responsibilities

3.1.1 All members of staff who have managerial or supervisory responsibility will ensure staff who report to them understand and comply with this policy; Fully support staff who bring this policy to the attention of any person in breach of it by reinforcing the smoke free message and by intervening in situations that become difficult for the staff member to handle.

3.1.2 Fully support any members of staff who wish to cease smoking by referral for stop smoking assistance, providing adequate cover when staff attend such sessions so that the Trust's work, and especially clinical care, can continue uninterrupted; Monitor policy application in their ward, department or associated work area(s); Ensure their department is adhering to the policy.

3.2 Staff Responsibilities

3.2.1 All staff are to be familiar with this policy in order to contribute towards its application; To politely remind patients and visitors of the smoke-free policy if they consider them to be in breach of the policy by smoking in the organisation's premises including the grounds. The Trust do not want anyone to feel that they need to engage in difficult or challenging situations and should not approach individuals (whether staff or patients) to ask them to stop smoking unless they are confident and feel that it is safe to do so.

3.2.2 To recognise that smoke lingers on breath and clothes and that patients and other staff may find this offensive; To offer routine brief advice to smokers regarding support to quit. All staff to be aware that they may face disciplinary action should they be found transgressing this policy.

3.2.3 The first step in treating tobacco dependence is to identify current tobacco users. Ask every patient if they currently smoke tobacco. Record smoking status in Current Physical Health Assessment. All in patients will be Screened for smoking status and this this will be recorded in the patient records, clearly and consistently.

3.2.4 All eligible patients will be given very brief advice and an offer of support to comply with the Trust's Smoke free Policy and the NICE guidelines for smoking cessation in secondary care smokers will need to abstain from smoking whilst in Trust buildings and grounds during an inpatient admission.

3.2.5 Making an attempt to permanently stop smoking is an opportunity not an obligation.

3.2.6 Every smoker should be offered Medication/NRT to manage their tobacco dependence in a reasonable time on arrival to an inpatient unit. This should be followed up by the offer of tobacco dependence treatment support from the stop smoking service.

3.2.7 Offering support to quit or manage tobacco withdrawal symptoms during a period of temporary abstinence, rather than asking a smoker how interested are they in stopping or telling a person they should stop, leads to more people making a quit attempt.

3.2.8 The most effective method of quitting or managing tobacco withdrawal symptoms during a period of temporary abstinence, is with combination NRT (i.e. a patch and oral

product) and behavioural support. Advising the smoker that stopping smoking is one of the best things they can do for their health and wellbeing is recommended by the Department of Health. Please see **Appendix 1.**

3.2.9 Patients who insist on leaving the ward areas to smoke will be advised that it will be noted in the patient record that they have been advised and will need to leave the hospital site completely before smoking.

3.2.10 Remind the patient of the smoke free policy and make sure they have been offered NRT. If they still insist on leaving, then they must accept full responsibility for doing this and this must be documented in the patient records. Also record that you have offered NRT and advised the patient of the policy.

3.3 **Human Resources**

3.3.1 Human Resources will provide advice and assistance on the implementation of the policy; Advise on the appropriateness and support of the Trust's disciplinary procedure; Ensure job advertisements include reference to the smoke free policy, indicating adherence to it is contractual; Ensure appropriate reference to the smoke free policy is made during Induction training. The trust will require all new staff to undertake the NCSCT online very brief advice training http://elearning.ncsct.co.uk/vba-stage_1

3.3.2 The Trust will Require relevant staff to undertake the NCSCT online practitioner levels 1 & 2 training, followed by additional training for staff whose role will include supporting people who want to stop smoking. http://elearning.ncsct.co.uk/practitioner_training-registration

3.4 **Occupational Health Service**

3.4.1 The Occupational Health Service will provide advice on smoking cessation support available and provide literature for staff who wish to stop smoking; Review and provide additional support for staff who are undertaking smoking cessation programmes when required; Actively promote the benefits of not smoking.

3.5 **Staff Side Organisation**

3.5.1 The Staff Side Organisation will advise their members of their rights and responsibilities with regard to the policy.

4. Definitions

4.1 Smoking in enclosed, or substantially enclosed, public places has been banned since July 2007 (section 7, Heath Act 2006 and associated regulations). The ban includes manufactured and hand rolled cigarettes, pipes (including shisha and hookah water pipes), cigars and herbal cigarettes. The definition of smoking under the Act refers to tobacco and other substances in a lit form which are capable of being smoked.

5. What is our Policy?

5.1 There will be no smoking in any buildings, grounds, rented, leased, sub-let or used by ULHT. Smoking inside cars whilst parked on Trust property is prohibited. Smoking will not be permitted within ULHT pool cars and vehicles.

5.2 Smoke free means that smoking, is not permitted anywhere within hospital buildings or grounds.

5.3 The use of E-Cigarettes or Vaporises will only be permitted in external areas in the Trust grounds. We would ask that you consider other people and do not use them in

close proximity to other people

5.4 The use of E-Cigarettes or Vaporises is not permitted inside any building or structure on the Trust sites.

5.5 The charging of any E-Cigarettes or Vaporises devices is prohibited in the Trust

5.6 This policy applies to all staff, patients, visitors, contractors and other person(s) who access any Trust site or enter any building that is owned, or used by the organisation for any purpose whatsoever.

6. Delivering the Policy

6.1 Our expectation is to promote and develop a culture across the Trust, Trust property and sites that smoking is unacceptable and that this is respected by patients, visitors, staff and contractors.

6.2 We aim to achieve a smoke free Trust by a change in culture and behaviours. This culture change will be achieved if we stay committed to a Smoke free Trust becoming a reality and respond to situations when this does not happen, and we see a breach as an opportunity rather than a failure of the policy.

6.3 Tobacco sales are not permitted on any NHS establishment. Advertising or promotion of tobacco products or companies is not permitted on any NHS establishment or in any or its publications. It is illegal to purchase tobacco products (cigarettes, tobacco, cigars) under the age of 18 years

6.4 E-Cigarettes or Vaporises devices may be purchased at the retail outlets on Trust sites It is at the discretion of the retailer to offer these devices for sale.

6.5 All main entrances to NHS sites and buildings on site are to be clearly signed to indicate that smoking is prohibited in both buildings and grounds. All pool vehicles are to display a no smoking sign within the vehicle.

6.6 The use of CCTV will take place and may be used to support compliance in conjunction with datix entries to record any incidents.

6.7 Elective patients and outpatients will be informed of the policy prior to attending their hospital appointment. Support through nursing staff and smoking cessation specialists will be provided if this is requested. Non elective/emergency admission patients will be advised of the policy upon admission.

6.8 The Disciplinary policy will be invoked as appropriate where members of staff contravene the policy.

6.9 The Trust do not want anyone to feel that they need to engage in difficult or challenging situations and should not approach individuals (whether staff or patients) to ask them to stop smoking unless they are confident and feel that it is safe to do so.

6.10 Should any ULHT staff member have a complaint made against them for politely pointing out the policy to anyone who is smoking, they will have the Trust's full support for taking such action, which will be in compliance with this policy.

7. E-Cigarettes or Vaporises

7.1 The use of E-Cigarettes or Vaporises, is not permitted in Trust buildings and premises, E-Cigarettes or Vaporises will only be permitted in external areas in the Trust grounds. We would ask that you consider other people and do not use them in close proximity to other people

7.2 E-cigarettes or Vaporises are battery-powered products that release a visible vapour that contains liquid nicotine that is inhaled by the user. Currently, e-cigarettes/Vaporises fall outside the scope of smoke-free legislation.

7.3 There is evidence that e-cigarettes/Vaporises may help some smokers to give up, but there is a lack of evidence on the health risks that they pose to the individual using them and those in close proximity. In relation to the risk to the user, there is a lack of quality control because the manufacture and sale of e-cigarettes/Vaporises is not tightly regulated and e-cigarettes/Vaporises contain nicotine, which is addictive. In relation to the risk to third parties, the trust believes that work colleagues could be exposed to e-cigarette vapours.

7.4 The Trust is also concerned that the use of e-cigarettes/Vaporises might undermine existing restrictions on smoking in workplaces, particularly in a healthcare setting, by misleading people to believe it is acceptable to smoke.

7.5 The Trust fully recognises the significance to the individual of substituting normal tobacco products for e-cigarettes /Vaporises as a commitment towards stopping smoking.

7.6 These devices are not yet regulated and therefore cannot be recommended or dispensed by healthcare professionals. Staff will be able to offer support and access to regulated treatments to help individuals quit smoking.

7.7 In addition, e-cigarettes/Vaporises present a known fire-risk recent events have highlighted potential dangers such as the chargers and integral batteries being fire hazards especially in health care settings where there may be oxygen enriched atmospheres.

8. Implementation, Monitoring and Review

8.1 The policy will be subject to review through the Trust's Procedural process for documents to be reviewed by the Author prior to the Policy Approval Group every two years if appropriate in response to exceptional circumstances or relevant changes in legislation or guidance.

8.2 Various strategies will be used to raise awareness of this policy and responsibilities under this policy.

- Manager Briefings
- Information on Newslinc
- HR News for Managers
- HR Policies on the intranet page
- Signage via facilities
- Elective patients and outpatients invite letters informing individuals of ULHT's policy.
- Conflict resolution training.

Monitoring Compliance

Minimum requirement to be monitored –monitoring against standards set out in policy	**Process for monitoring** **e.g. audit**	**Responsible individuals/ group/ committee**	**Frequency of monitoring/ audit/ reporting**	**Responsible individuals/ group/ committee for review of results and determining actions required**

Appendix 1 - Support for Smokers

STEP 1: Identification of smokers

The first step in treating tobacco dependence is to identify current tobacco users.

Ask every patient if they currently smoke tobacco. **Record** smoking status in Current Physical Health Assessment.

The identification and recording of each patient's smoking status needs to be completed regularly, i.e. on admission and discharge from hospital.

STEP 2: Advise and offer support

To comply with the Trust's Smoke free Policy and the NICE guidelines for smoking cessation in secondary care smokers will need to abstain from smoking whilst in Trust buildings and grounds during an inpatient admission.

Making an attempt to permanently stop smoking is an opportunity not an obligation. During an inpatient admission a smoker has **three** options

OPTION 1: to temporarily abstain from smoking whilst in buildings and in the grounds, ***with*** pharmacological and/or psychological support

OPTION 2: to temporarily abstain from smoking whilst in buildings and in the grounds, ***without*** pharmacological and/or psychological support

OPTION 3: to use the opportunity to make a sustained quit attempt, with pharmacological and/or psychological support

Regardless of which option the patient chooses, **every smoker** should be **offered NRT** to manage their tobacco dependence **within a reasonable time on** arrival to an inpatient unit. This should be followed up by the offer of tobacco dependence treatment support from stop smoking advisory service.

Offering support to quit or manage tobacco withdrawal symptoms during a period of temporary abstinence, rather than asking a smoker how interested are they in stopping or telling a person they should stop, leads to more people making a quit attempt.

The most effective method of quitting or managing tobacco withdrawal symptoms during a period of temporary abstinence, is with combination NRT (i.e. a patch and oral product) and behavioural support. Advising the smoker that stopping smoking is one of the best things they can do for their health and wellbeing is recommended by the Department of Health.

Record in the Current Physical Health Assessment /Patient Record.

1. That you have advised the smoker that stopping smoking is one of the best things they can do for their health and wellbeing
2. If the smoker wants NRT for temporary abstinence
3. If they want to see a tobacco dependence treatment advisor during their admission

STEP 3: Act on smoker's response

For smokers choosing **Option 1**: to temporarily abstain from smoking whilst in buildings and in the grounds, ***with*** pharmacological and/or psychological support, **follow treatment pathway 1** below.

<table>
<tr><td colspan="2">PATHWAY 1: Inpatient Tobacco Dependence Treatment</td></tr>
<tr><td colspan="2">Does the patient want NRT support for temporary abstinence?</td></tr>
<tr><td colspan="2">Yes</td></tr>
<tr><td colspan="2">Assess Level of nicotine dependence, i.e. how many cigarettes a day do you usually smoke? How soon after you wake up do you have your first cigarette of the day?
Past use of NRT
● Patient choice of NRT product
● Known allergies to NRT products
● Current medical conditions</td></tr>
<tr><td colspan="2">Choose 1 product for light smokers or a combination of products for moderate to heavy smokers based on outcome of assessment</td></tr>
<tr><td>Light smoker: Smokes
1-10 cigarettes a day</td><td>Moderate smoker: Smokes
11-20 cigarettes a day</td></tr>
<tr><td>Nicotine replacement therapy advised,
See Pace Guidance attached
For NRT prescribing</td><td>Nicotine replacement therapy advised,
See Pace Guidance attached
For NRT prescribing</td></tr>
</table>

For smokers choosing **OPTION 2**: to temporarily abstain from smoking whilst in buildings and in the grounds, ***without*** pharmacological and/or psychological support, **follow treatment pathway 2** below

Provide education & raise awareness of tobacco dependence & treatment

Daily assessment of nicotine withdrawal symptoms and the impact these may have on mental health symptoms and wellbeing

Daily assessment of any cigarette use. Consider how this may impact on therapeutic care

Manage any occurrence of smoking in buildings and grounds according to therapeutic management of smoking incidents

Repeat education and the offer of support regularly. Switch to pathways 1 or 3 if patient agrees to support

If the patient has tried NRT and has used it correctly (at the correct dose for the correct length of time), unsuccessfully for temporary abstinence previously, advise on use of electronic cigarettes (see appendix 4)

Record, care plan and review

For smokers choosing **OPTION 3:** to use the opportunity to make a sustained quit attempt, with pharmacological and/or psychological support, follow treatment pathway 3 below

<table>
<tr><td colspan="2">PATHWAY 3: Inpatient Tobacco Dependence Treatment</td></tr>
<tr><td colspan="2">Yes</td></tr>
<tr><td colspan="2">Assess Level of nicotine dependence, i.e. how many cigarettes a day do you usually smoke? How soon after you wake up do you have your first cigarette of the day?
Past use of NRT
● Patient choice of NRT product
● Known allergies to NRT products
● Current medical conditions</td></tr>
<tr><td colspan="2">Choose products based on patient preference, level of dependence, past use of NRT, nicotine withdrawal symptoms and cravings and patient preference</td></tr>
<tr><td>Light smoker Smokes 1-10 cigarettes a day</td><td>Moderate smoker: Smokes 11-20 cigarettes a day Heavy smoker:
Smokes more than 20 cigarettes a day Or smokes within 30 mins of waking</td></tr>
<tr><td>Nicotine replacement therapy advised, See Pace Guidance attached For NRT prescribing</td><td>Nicotine replacement therapy advised See Pace Guidance attached For NRT prescribing</td></tr>
</table>

Appendix 2 – ULHT Patients

ULHT Patients What does this mean for you Questions and Answers

Introduction

Welcome to United Lincolnshire Hospitals NHS Trust a smoke free organisation.

Being smoke free means that patients, carers, staff and other visitors will not be allowed to smoke on any ULHT premises. This includes our buildings and grounds, as well as vehicles within those grounds. Anyone wishing to smoke will need to leave Trust premises.

Support will be provided for patients in our care to help them either abstains from smoking during their stay or to try and stop smoking permanently

Why smoke free?

The purpose of the smoke free policy is to protect and improve the health and wellbeing of all employees, visitors, contractors but most importantly you the patient.

Completely smoke free

Hospitals and grounds create a clean, pleasant environment for people trying to stop smoking and reduces triggers that cause many smokers to relapse. Smoking increases a patient's risk of complications and often delays their recovery.

If smoking occurs at entrances and windows, the smoke will drift in through the doors and windows and pose a further hazard to the health and wellbeing of inpatients.

Stop Smoking support for patients

If you have a planned intervention in hospital, stopping smoking weeks or even months before your procedure will really help your recovery. Time in hospital is a great time to stop smoking and research tells us that hospitalised patients are more successful at stopping than any other smokers.

Our staff are here to help and support you throughout both your hospital stay and when you go home. On admission, all patients, who smoke, will be prescribed Nicotine Replacement Therapy (NRT) and with their consent will be referred to our Smoke free Service.

What will happen if I don't comply?

Patients will be given every support to comply with the smoke free policy and prescribed NRT products to ease withdrawal symptoms during their stay in hospital.

Anyone smoking on site will be asked to stop smoking and extinguish their cigarette.

All staff are expected to remind patients and their visitors of the smoke free policy.

How will you ensure that people don't smoke on ULHT premises?

Prior to planned admissions to hospital, patients will be advised that ULHT is smoke free and consequently smoking is not permitted in the hospital or grounds. An individual's smoking status will be logged in there clinical records so they will be offered support to either temporarily refrain from smoking or to attempt to quit. This support will include nicotine replacement therapy (NRT) alongside behavioural and psychological. Patients and carers will be asked not to bring tobacco, cigarettes, lighters or matches with them to hospital.

For unplanned admissions, patients will not be allowed to keep tobacco, cigarettes, lighters or matches with them. If the patient arrives with a carer or relative, they will be asked to take the prohibited items home. If the patient is unaccompanied, our staff will store the items for them until they are discharged.

The level of support provided to patients who are abstaining from smoking will be constantly monitored as part of that individual's package of care.

We want to develop a culture where smoking is viewed as unacceptable across our sites, and for this to be respected. In situations where an individual is breaching the smoke-free policy, that person may be approached by a member of staff who will remind them of our smoke-free status and signpost them to the appropriate smoking cessation support.

Can ULHT legally enforce being smoke free? What about my human rights?

In July 2007, the government introduced legislation in England banning smoking in workplaces and enclosed public spaces, and ULHT's decision to go smoke-free is covered by that legislation. In addition, National Institute for Health and Care Excellence (NICE 2013) guidance recommends that smoking is banned on hospital sites.

After Rampton Hospital in Nottinghamshire went smoke-free, the argument about infringement of a service user's human rights was legally tested in the Court of Appeal in 2008. The court ruled that a hospital is not the same as a home environment and should support the promotion of health and wellbeing. Patients can therefore legally be prevented from smoking for health and security reasons.

What support will there be for patients who smoke?

Denying a smoker a nicotine substitute is not acceptable so clearly it is very important that the appropriate support is in place to enable smokers to abstain from smoking while on our premises.

Department of Health guidance recommends a combination of intensive behavioural and psychological support alongside medication to minimise nicotine withdrawal symptoms and help with cravings.

Following assessment, smokers will be offered nicotine replacement therapy (NRT) and behavioural support. Those who wish to use the opportunity of a hospital stay to try and give up smoking will be referred to a trained stop smoking advisor.

What about electronic cigarettes?

At present electronic cigarettes and all forms of vaping are not regulated and therefore we cannot recommend their use. Patients should not use E cigarette's and Vape chargers should not be used as they constitute a fire risk.

E-Cigarettes or Vaporises will only be permitted in external areas in the Trust grounds. We would ask that you consider other people and do not use them in close proximity to other people

Appendix 3 – ULHT Staff

ULHT Staff What does this mean for you

Questions and Answers

What about patients who need to smoke?

Nothing harmful will happen to someone if they don't smoke. They may experience withdrawal symptoms due to lack of nicotine, but this can be easily managed with nicotine replacement therapy (NRT). Patients in the Emergency department and Inpatients should be offered NRT during their stay and a referral to the stop smoking service. Outpatients can be directed to the Lloyds pharmacy where they can purchase NRT.

What if the patient asks to leave the ward to smoke?

Remind the patient of the smoke free policy and make sure they have been offered NRT. If they still insist on leaving, then they must accept full responsibility for doing this and this must be documented in the patient records. Also record that you have offered NRT and advised the patient of the policy.

What if a patient or visitor gets really aggressive when I ask them not to smoke?

If someone gets really aggressive or violent, the standard NHS procedures for aggressive behaviour should be invoked. A 'zero tolerance' policy applies in the NHS in all other aspects of treatment and smoking is not an exception. Security should be contacted on extension 3333 if staff feel in any danger.

What if people just carry on smoking?

We anticipate that not everyone will stop smoking when we ask them to and that there are limits to what we can do. Politely provide people with information about the smoke free policy, point to the signage .

What if a patient asks, "where can I go to smoke?"

It is important to reiterate they cannot smoke anywhere on the site. It is important that we don't tell them where they can smoke as this would condone smoking.
What should I advise patients to do, if they are craving a cigarette?
Find out if they have been offered NRT and if not, advise them to ask the nurse to get it prescribed. NRT can be used by smokers for temporary abstinence as well as for people wanting to quit for good.

What about electronic cigarettes?

At present electronic cigarettes and all forms of vaping are not regulated and therefore we cannot recommend their use.

E-Cigarettes or Vaporises will only be permitted in external areas in the Trust grounds. We would ask that you consider other people and do not use them in close proximity to other people.

E cigarette's and Vape chargers should not be used as they constitute a fire risk.

How should people be approached if they continue to smoke?

Anyone seen smoking on site should be politely asked not to smoke. Staff are expected to remind people of the smoke free policy whilst avoiding putting themselves at risk. A suggested script might be: " Excuse me can I remind you that this is a smoke free site and you can't smoke here".

Approaching a group of smokers - " I'm sorry folks, would it be ok for you not to smoke until you are off the hospital grounds?"

Inpatients - " Hello, my name is…….I'm wondering if anyone on the ward has offered you things like nicotine patches to help with your smoking? I am afraid you cannot smoke here. You can just ask the nurse for nicotine replacement when you get back to the ward".

If they are close to signage it is easy to point to it to reinforce the message. Business cards with information about where to get support will be made available to all staff to hand out.

In the event visitors refuse to extinguish their cigarettes, please contact security on 3333

What about at night- especially in A&E and Emergency Admissions Areas

Nicotine Replacement Therapy will be available as stock in A&E. Patients can be offered this (as long as there are no clinical contraindications), especially if they are becoming agitated from missing their cigarettes. (Agitation is a common sign of nicotine withdrawal)

What if someone has just had bad news/bereaved and is smoking?

If someone is obviously distressed and smoking, a sensitive approach should be taken. " Hello, my name is…..I am sorry you are having a difficult time. Would it be ok for you not to smoke in the hospital?"

Who is going to enforce all of this?

This is everyone's responsibility. For this to succeed everyone needs to be prepared to remind smokers of our policy. Business cards will be made available on wards and main reception areas for you to have in your pocket- so as a minimum you could hand these out to smokers.

Staff are expected to remind people of the smoke free policy and only approach people if they feel comfortable to do so and avoiding putting themselves at risk.

Appendix 4 – Management of ULHT Staff

Management of ULHT Staff/Employees

Will staff smoking breaks be allowed?

Staff will be encouraged to take their official breaks. As smoking will not be permitted on the grounds, we would encourage smokers to take their break and use nicotine replacement therapy like the inhalator to help cope with cravings.

What about staff who want to smoke at night- we are worried about their safety if they go off site?.

It is important that night staff take their official breaks. We would encourage staff who smoke to first consider using alternatives, like the nicotine replacement therapy inhalator instead of tobacco during their shift.

There is a clear disciplinary procedure for staff who do not follow hospital regulations and contractual obligations. This will apply to all levels of staff.

So where can I go to smoke?

As a member of staff you cannot smoke in uniform or with a hospital ID badge whether on or off duty. You should not smoke at hospital entrance and exits. Trust employees are not entitled to take breaks during working hours for the purpose of smoking. If you wish to smoke in your official break you will need to leave the premises and change out of uniform. We would encourage you to walk whilst smoking to avoid groups of smokers congregating in residential areas.

What if staff just carry on smoking?

Politely provide staff with information about the smoke free policy, point to the signage .If staff carry on smoking this is a disciplinary matter which should be escalated to their manager.

There is a clear disciplinary procedure for staff who do not follow hospital regulations and contractual obligations. This will apply to all levels of staff

Appendix 5 – GUIDANCE ON THE PRESCRIBING OF SMOKING CESSATION THERAPY

Greater East Midlands Commissioning Support Unit in association with Lincolnshire Clinical Commissioning Groups, Lincolnshire Community Health Services, United Lincolnshire Hospitals Trust and Lincolnshire Partnership Foundation Trust

Lincolnshire Prescribing and Clinical Effectiveness Bulletin

Volume 8; Number 17 **October 2014**

GUIDANCE ON THE PRESCRIBING OF SMOKING CESSATION THERAPY

- **Smoking cessation services are most effective if patients are offered a combination of be avioural support and pharmacotherapy.**
- **To ensure the most effective use of NHS resources, patients requiring pharmacotherapy to support smoking cessation should be referred into a smoking cessation service (i.e. Phoenix Smoking Cessation Service).**
- **Nicotine Replacement Therapy (NRT), varenicline or bupropion should only be prescribed as part of a smoking cessation programme where a smoker makes a commitment to stop smoking and sets a stop date.**
- **Initial therapy should only be prescribed to last until two weeks after the stop date; at this point the patient needs to be reviewed to ensure that the quit attempt is still ongoing.**
- **Individuals should only receive a maximum of 12 weeks pharmacotherapy related to any one quit attempt. If further supplies ar required to prevent the occurrence of craving, individuals should be advised to purchase these themselves. There may be a minority of patients on varenicline that require an additional 12 week course to reduce the risk of relapse.**
- **A gap of 3 months from the last appointment (12 weeks) should be maintained between repeated quit attempts for the majority of s okers. This will ensu e that individuals are sufficiently motivated prior to setting another quit date and will avoid the risk f continuous repeat prescribing of NRT where success may be severely limited. In exceptional circumstances, particularly where the quit attempt is interrupted by a traumatic event, the indiv dual may reset their quit date and continue with pharmacotherapy for an extended period.**
- **Nicotine replacement therapies (NRT) should not be prescribed for individuals who wish to reduce the amount they smoke but have not agreed to stop smoking, as this level of support is not currently commissioned in Lincolnshire**
- **A successful quit attempt is dependent upon the ind vidual being sufficiently motivated and compliant with therapy. To maximize ngagement, patient choice should be taken into account, subject to contraindications and potential for adverse reactions. National guidance does not recommend one form of pharmacotherapy in preference to another; local figures suggest that higher quit rates are obtained with varenicline.**
- **Despite the evidence that varenicline is associated with superior long-term quit rates, the wide range of adverse effects, cautions and contra-indications associated with this form of pharmacotherapy mean that it can only be initiated following full cons deration of risks and benefits by the patient's GP. Varenicline tablets 500microgram and 1mg are on the *Lincolnshire Joint Formulary*; designation GREEN.**
- **Evidence suggests that bupropion therapy does not achieve quit**

rates as high as those achieved by NRT or varenicline. Nonetheless, the product retains a third line role and may be particularly useful in ex-smokers relapsing after a prolonged period who have previously used this product to support a successful quit attempt. Bupropion sustained release tablets 150mg (*Zyban*)

remain on the *Lincolnshire Joint Formulary* as a third line choice; designation GREEN.

- **Neither bupropion nor varenicline should be used concurrently with nicotine replacement therapies.**
- **The majority of people requiring NRT as part of a smoking cessation programme should be prescribed a long-acting transdermal patch in combination with an immediate release, short-acting product to counteract cravings. Where short-acting NRT products are prescribed as monotherapy, the maximum dose for each product is as stated in the *BNF* and product SPC. When a short-acting NRT product is used in combination with a long-acting nicotine transdermal patch, the maximum dose of the short acting product should be reduced to half the stated maximum dose. Combination NRT prescribing should never involve more than two formulations, one long-acting and one short-acting.**
- **Transdermal nicotine patches are an effective way of delivering background continuous nicotine replacement therapy. For the majority of patients, a 16 hour patch is preferred with the starting dose based on the individual's previous smoking habit. A 24 hour patch is indicated for those smokers usually requiring their first cigarette within a few minutes of waking and for shift workers with unpredictable work patterns. The available patches are comparably priced. Due to the preference for a 16 hour patch, the *Nicorette Invisipatch* (all strengths) is approved for inclusion in the *Lincolnshire Joint Formulary* designation GREEN. The *NiQuitin* range of patches (all strengths) offer 24 hour cover and are also approved for *Formulary* inclusion; designation GREEN. *Nicotinell* patches are classed as non-formulary and should not be prescribed.**
- **If nicotine chewing gums are prescribed, mint flavours are often more palatable and are better tolerated by most people. *Nicorette* icy white flavour gum is advocated as the first line product of choice and is approved for inclusion in the *Lincolnshire Joint Formulary*; designation GREEN.**
- ***NiQuitin Lozenge* 2mg and 4mg and *NiQuitin Minis Lozenges* 1.5mg and 4mg are advocated first line where a short-acting lozenge is indicated. Both formulations are approved for inclusion in the *Lincolnshire Joint Formulary* and designated GREEN. *NiQuitin* orodispersible film 2.5mg has already been evaluated by PACEF and designated RED-RED. It is not approved for use through the *Joint Formulary* and should not be prescribed. Due to current supply problems with *NiQuitin Minis*, *Nicorette Cools* 2mg and 4mg are also designated GREEN and included in the *Lincolnshire Joint Formulary*.**
- **Nicotine oral sprays, nasal sprays and inhalators are relatively high cost in comparison with other formulations of NRT. *Nicorette QuickMist* oromucosal spray and *Nicorette Inhalator* are approved for use through the *Lincolnshire Joint Formulary* and are designated GREEN; they should only be prescribed for those who have previously failed to quit using other forms of NRT. *Nicorette Nasal Spray* is not approved for inclusion in the *Joint Formulary* and should not be prescribed.**
- **Electronic cigarettes are currently not classed as medicines and therefore do not have to comply with the same regulatory standards as licensed nicotine replacement therapies. There are reports that the quality and nicotine content of these products varies widely between brands. There is only limited evidence of effectiveness in supporting a smoking cessation attempt, although some patients are being supported to stop smoking using electronic cigarettes through the Phoenix service. However, in most cases, where the person wants to stop smoking, evidence based pharmacotherapy using licensed NRT products, varenicline or bupropion is preferred.**

FORMULARY OF SMOKING CESSATION PRODUCTS

Drug	Indication(s)	Traffic Light and Joint Formulary Status
First line: *Short-acting nicotine formulations*		
Nicotine chewing gum (*Nicorette Gum*) icy white flavour 2mg and 4mg	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary.*
Nicotine lozenge (*NiQuitin Lozenge*) 2mg and 4mg	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary.*
Nicotine lozenge (*NiQuitin Minis Lozenges*) 1.5mg and 4mg	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary.*
Nicotine lozenge (Nicorette Cools) 2mg and 4mg	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary* due to current supply problems with *NiQuitin Minis*..
First line: *Long-acting transdermal nicotine formulations*		
Nicotine transdermal patch 10mg, 15mg and 25mg(16 hours) (*Nicorette Invisipatch)*	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice of long-acting therapy. For the majority of patients, a 16 hour patch is preferred with the starting dose based on the individual's previous smoking habit. Included in the *Lincolnshire Joint Formulary*
Nicotine transdermal patch 7mg, 14mg, 21mg (24 hours) (*NiQuitin*)	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible first line choice. A 24 hour patch is indicated for those smokers usually requiring their first cigarette within a few minutes of waking and for shift workers with unpredictable work patterns. Included in the *Lincolnshire Joint Formulary*
Second line: *Short-acting nicotine formulations*		
Nicotine inhalation cartridge plus mouthpiece (*Nicorette Inhalator*) 15mg	Nicotine replacement as an aid to smoking cessation or reduction.	GREEN Possible second line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary.*
Nicotine oromucosal spray (*Nicorette QuickMist*) 1mg per dose	Nicotine replacement as an aid to smoking cessation	GREEN Possible second line choice of short-acting therapy. Included in the *Lincolnshire Joint Formulary.*
Others		
Bupropion 150mg sustained release tablets (*Zyban*)	Aid to smoking cessation	GREEN 3rd line choice Included in the *Lincolnshire Joint Formulary*
Varenicline 500microgram/1mg tablets (*Champix)*	Smoking cessation	GREEN Possible first line choice. Included in the *Lincolnshire Joint Formulary*

Products not listed on this Formulary are not recommended for use and should not be prescribed.

Introduction

General guidance

National Institute for Clinical Excellence (NICE) *Quality Standard 43 - Smoking cessation: supporting people to stop smoking* (August 2013)

NICE emphasize the importance of:

(1) healthcare practitioners proactively asking patients if they smoke and offering identified smokers advice on how to stop.
(2) offering smokers who wish to stop a referral to an evidence-based smoking cessation service.
(3) ensuring that people being supported to stop by an evidence-based smoking cessation service are offered both behavioural support and pharmacotherapy in combination as this approach has the highest likelihood of success.
(4) ensuring that people being supported to stop smoking are offered a full course of pharmacotherapy.
(5) ensuring that people being supported to stop smoking set a quit date and are assessed for carbon monoxide levels 4 weeks after that date.

Guidance on the use of nicotine replacement therapy to reduce but not stop smoking

NICE Public Health Guidance 45 - *Tobacco: harm-reduction approaches to smoking* (June 2013)

This PHG acknowledges that people:

- may not be able (or may not want) to stop smoking in one step.
- may want to stop smoking without necessarily giving up nicotine.
- may not be ready to stop smoking, but may want to reduce the amount they smoke.

PACEF Recommendations

(1)Smoking cessation services are most effective if patients are offered a combination of behavioural support and pharmacotherapy. This was backed up by local figures published by Lincolnshire Community Health Services in May 2014.
(2)To ensure the most effective use of NHS resources, patients requiring pharmacotherapy to support smoking cessation should be referred into a smoking cessation service.
(3) Lincolnshire County Council has confirmed that NICE PHG 45 is currently not commissioned within Lincolnshire. As a result of this,

Guidance on the appropriate interval between treatment episodes

NICE Public Health Guidance 10 - *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities* (February 2008)

NICE recommendations state that:

- Following an unsuccessful quit attempt using NRT, varenicline or bupropion, a subsequent quit attempt should not be supported within 6 months unless special circumstances have hampered the person's initial attempt to stop smoking, when it may be reasonable to try again sooner.
- It may take many attempts before a person can successfully quit smoking and encouragement needs to be maintained throughout.

Department of Health - *Local Stop Smoking Services - Key updates to the 2011/12 service delivery and monitoring guidance for 2012/13*

This is a good practice guide for the provision of smoking cessation services and provides some guidance on the recommended interval between treatment episodes:

- When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking adviser should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, attend one session of a structured multi-session intervention, consent to treatment and set a quit date with a stop-smoking adviser.

PACEF Recommendations

(4) Following discussion between representatives from the Phoenix Smoking Cessation Service and Lincolnshire Public Health it is recommended that a gap of 3 months from the last appointment (12 weeks) should be maintained between repeated quit attempts for the majority of smokers. This will ensure that individuals are sufficiently motivated prior to setting another quit date and will avoid the risk of continuous repeat prescribing of NRT where success may be severely limited.

Pharmacotherapy

NICE Public Health Guidance 10 - *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities* (February 2008)

The main recommendations relating to the use of pharmacotherapy are as follows:

- Offer NRT, varenicline or bupropion, as appropriate, to people who are planning to stop smoking.
- Before prescribing a treatment take into account the person's intention and motivation to quit and how likely it is they will follow the course of treatment. Consideration should be given to which treatments the individual prefers, whether they have attempted to stop before (and how), and if there are medical reasons why they should not be prescribed particular pharmacotherapies.
- Offer advice, encouragement and support, including referral to the NHS Stop Smoking Service, to help people in their attempt to quit.
- NRT, varenicline or bupropion should normally be prescribed as part of an abstinent-contingent treatment, in which the smoker makes a commitment to

stop smoking on or before a particular date (target stop date). The prescription of NRT, varenicline or bupropion should be sufficient to last only until 2 weeks after the target stop date. Normally, this will be after 2 weeks of NRT therapy, and 3–4 weeks for varenicline and bupropion, to allow for the different methods of administration and mode of action. Subsequent prescriptions should be given only to people who have demonstrated, on re- assessment that their quit attempt is continuing.

PACEF Recommendation

(5)A successful quit attempt is dependent upon the individual being sufficiently motivated and compliant with therapy. To maximize engagement, patient choice should be taken into account, subject to contraindications and potential for adverse reactions. National guidance does not recommend one form of pharmacotherapy in

Duration of treatment

The recommended duration of treatment for each form of pharmacotherapy is tabulated below:

	Maximum length of treatment
Nicotine Replacement Therapy	12 weeks
Bupropion (*Zyban*)	7 to 9 weeks
Varenicline (*Champix*)	12 weeks (but can be repeated in abstinent individuals to reduce risk of relapse).

PACEF Recommendation

(6)In accordance with guidance from Phoenix Smoking Cessation Service and Lincolnshire Public Health, it is recommended that individuals should only receive a maximum of 12 weeks pharmacotherapy related to any one quit attempt. If further supplies are required to prevent the occurrence of craving, individuals should be advised to purchase these themselves. There may be a minority of patients on varenicline that require an additional 12 week course to reduce the risk of relapse.

Choice of therapy

The table below illustrates that NRT (in a variety of formulations) and varenicline are widely prescribed in all four Lincolnshire Clinical Commissioning Groups (CCGs): in comparison, bupropion is prescribed very infrequently. NRT is most commonly prescribed in a patch formulation:

Product	**LECCG Items**	**LWCCG Items**	**SLCCG Items**	**SWLCCG Items**
Bupropion 150mg SR tablets (*Zyban*)	21	26	13	22
Varenicline 500microgram/1mg tablets (*Champix)*	1,575	1,009	731	591
NRT				
NRT patches	1281	1094	583	474
NRT chewing gum	164	129	111	71
NRT lozenges/tablets/strips	364	270	154	107

NRT sprays	289	222	101	82
Nicorette inhalator	512	377	220	185

Figures derived from CCG prescribing data for the 4th quarter of 2013/14

Varenicline (*Champix*)

Varenicline is a selective nicotine receptor partial agonist used as an aid for smoking cessation. Clinical evidence published as part of NICE Technology Appraisal 123 supports claims that varenicline is more effective than NRT in terms of long term quit rates. Local data from the LCHS smoking cessation report published in May 2014 also supports this conclusion.

Varenicline (*Champix*) is only licensed for use in adults aged over 18. Treatment should usually be initiated 1-2 weeks prior to the target stop date, with an initial dose of 500mcg once daily for three days increasing to 500mcg twice daily for 4 days; the usual maintenance dose is 1mg twice daily for 11 weeks, leading to 12 weeks treatment in total. The maintenance dose can be reduced to 1mg twice daily if not tolerated. Sometimes, Phoenix recommends tapering of varenicline dosage towards the end of the 12 weeks. As stated above, the 12 week course can be repeated in abstinent individuals to reduce the risk of relapse, although this goes beyond the 12 week programme of support that Phoenix is commissioned to provide.

Varenicline is associated with a wide range of adverse effects, most commonly gastrointestinal disturbances, appetite changes, dry mouth, taste disturbance, headache, drowsiness, dizziness, sleep disorders and abnormal dreams. It is contraindicated in pregnancy and when breast feeding. In 2008, the MHRA issued a safety alert highlighting a potential association between varenicline therapy and increased risk of suicidal thoughts and behaviour. Patients should be advised to stop treatment and contact their doctor immediately if they develop suicidal thoughts, agitation or depressed mood. Those with a history of psychiatric illness should be monitored closely while taking varenicline. Varenicline should also be used with caution in those with a history of cardiovascular disease and in those with a predisposition to seizures.

Decision making around the appropriateness of initiation of varenicline in an individual patient requires access to the individual patient record. As a result of this, the final decision as to whether varenicline treatment is clinically appropriate remains the responsibility of the clinician that prescribes the therapy.

PACEF Recommendation

(7)Despite the evidence that varenicline is associated with superior quit rates, the wide range of adverse effects, cautions and contra-indications associated with this form of pharmacotherapy mean that it can only be initiated following full consideration of risks and benefits by the patient's GP. Varenicline tablets 500microgram and 1mg remain on the *Lincolnshire Joint Formulary*; designation GREEN.

Bupropion hydrochloride (*Zyban*)

Bupropion (*Zyban*) has previously been used as an antidepressant. Its mode of action in smoking cessation is not clear and may involve an effect on noradrenaline and dopamine neurotransmission.

Bupropion (*Zyban*) is only licensed for use in adults aged over 18; it should only be used in those smoking at least 15 cigarettes a day and weighing at least 45kg.

The dose of bupropion is 150mg initially once daily for 6 days then twice daily for a period of 7 to 9 weeks, commencing treatment 1 to 2 weeks before target stop date.

Bupropion is associated with a number of adverse effects including: dry mouth, gastrointestinal disturbances, taste disturbance, agitation, anxiety, dizziness, depression, headache, impaired concentration, insomnia, tremor, fever, pruritus, rash and sweating. It is contraindicated in those with severe hepatic cirrhosis, CNS tumour, history of seizures, eating disorders or bipolar disorder. It should be used with caution in the elderly and in those with a predisposition to seizures, those on concomitant drug therapy which lowers the seizure threshold, those with a history of alcohol abuse and those with a history of head trauma or diabetes.

PACEF Recommendation

(8)Evidence suggests that bupropion therapy does not achieve quit rates as high as those achieved by NRT or varenicline. Nonetheless, the product retains a third line role and may be particularly useful in ex-smokers relapsing after a prolonged period who have previously used this product to support a successful quit attempt. Bupropion sustained release tablets 150mg (*Zyban*) remain on the *Lincolnshire Joint Formulary* as a third line choice; designation GREEN.

Nicotine Replacement Therapy

There are several different types of formulation available:

- Patches – controlled release patches delivering a continuous dose of background nicotine over a 16 to 24 hour period.
- Oral products - chewing gum, lozenges, sublingual tablets, oral film strips, oral or nasal sprays – designed to provide a short-acting, additional dose of nicotine to relieve intense craving.
- Inhalator devices – provide an inhaled dose of nicotine; the device mimics the delivery system of a cigarette or e-cigarette.

Selection of NRT

NICE Public Health Guidance 10 - *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities* (February 2008)

- Consider offering a combination of a long-acting nicotine patch with a shorter acting form of NRT (e.g. gum, inhalator, lozenge or nasal spray) to people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past.
- Explain the risks and benefits of using NRT to young people aged from 12 to 17, women who are pregnant or breastfeeding and those with unstable cardiovascular disorders.
- To maximise the benefits of NRT, people should be strongly encouraged to use behavioural support in conjunction with pharmacotherapy as part of their quit attempt.
- NRT, varenicline and bupropion should not be used in combination.

PACEF Recommendation

(9)The majority of people requiring NRT as part of a smoking

combination with an immediate release, short-acting product to counteract cravings. Where short-acting NRT products are prescribed as monotherapy, the maximum dose for each product is as stated in the *BNF* and product SPC. When a short-acting NRT product is used in combination with a long-acting nicotine transdermal patch, the maximum dose of the short acting product should be reduced to half the stated maximum dose. Combination NRT prescribing should never involve more than two formulations, one long-acting and one short-acting.

Transdermal patches

There are a variety of patches licensed for use over 16 or 24 hours. The 24 hour patch is more suitable for:

- Heavily dependent smokers usually requiring their first cigarette within a few minutes of waking.
- Shift workers, particularly those with unpredictable work patterns.

The 16 hour patch is more suitable for:

- Those who crave their first cigarette at least 1 hour after waking.
- Patches licensed for use over 24 hours can be used for patients requiring 16 hour cover if the person is advised to remove them at bedtime.

A common adverse effect of nicotine is sleep disturbance and, for the majority of people, the 16 hour patch is the most appropriate. Local prescribing data indicates that the 16 hour patches are the most frequently prescribed.

The strength of the patch prescribed is usually dependent upon the person's past smoking habit, with the strength of the patch reduced over time. Patches should be applied daily, normally in the morning, to a clean dry, non-hairy area of skin on the hip, trunk or upper arm. Patch sites need to be rotated to avoid skin irritation. Patches should not be applied to broken or inflamed skin and are unsuitable for those with skin disorders. Local experience suggests that *Niquitin* clear patches may preferred in people who suffer from skin problems. Where transdermal patches are used within this context, the patch should only be applied to areas of skin not affected by the skin disorder.

Patches need to be disposed of correctly (i.e. by folding in half) to prevent children and/or pets being accidentally exposed to nicotine.

As illustrated by the table below, patches are comparably priced:

Cost comparison: *Nicotine transdermal patches*

Patch	Strength	Cost (£ per 7 patches)
Nicorette Invisipatch	10mg/16hrs	£9.97
	15mg/16hrs	£9.97
	25mg/16hrs	£9.97 or £16.35 for 14
Nicotinell	7mg/24 hrs	£9.11
	14mg/24hrs	£9.40
	21mg/24hrs	£9.97 or £24.51 for 21
Niquitin	7mg/24 hrs	£9.97
	14mg/24hrs	£9.97
	21mg/24hrs	£9.97 or £18.79 for 14

Cost per course: *Nicotine transdermal patches*

Patch	Number cigarettes/day	Dose regimen	Cost per quit attempt
Nicorette Invisipatch (16 hour patch)	>10/day	25mg daily for 8 weeks then 15mg daily for 2 weeks then 10mg daily for 2 weeks (12 weeks)	£119.64
	<10/day	15mg daily for 8 weeks then 10mg daily for 4 weeks (12 weeks)	£119.64
	Smoking reduction	25mg daily until smoking <10 cigarettes a day then 15mg daily for 8 weeks then 10mg daily for 4 weeks	£119.64 +
Nicotinell (24 hour patch)	>20/day	21mg/24hrs daily for 3-4 weeks then 14mg/24 hours for 3-4 weeks then 7mg/24 hours for 3-4 weeks. (maximum duration 3 months)	£113.92 (based on 4 weeks use per strength patch)
	<20/day	14mg/24 hrs for 3-4 weeks then 7mg/24 hours for 3-4 weeks. (maximum duration 3 months)	£74.04 (based on 4 weeks use per strength patch)
NiQuitin (24 hour patch)	>10/day	21mg/24hrs daily for 6 weeks then 14mg/24 hours for 2 weeks then 7mg/24 hours for 2 weeks. (maximum duration 10 weeks)	£99.70
	<10/day	14mg/24hrs daily for 6 weeks then 7mg/24 hours for 2 weeks (maximum duration 8 weeks)	£79.76

Short-acting nicotine replacement products

There are a variety of nicotine containing formulations designed to provide a small dose of nicotine to help relieve intense cravings. The quickest acting formulation is the nasal spray, followed by the oral spray. Lozenges release nicotine faster than chewing gum and seem to be a more acceptable formulation for many patients. Choice of adjunct therapy is largely guided by client preference and is influenced by past smoking habits.

All short-acting nicotine replacement products can be used as monotherapy, although national guidance, supported by local data, suggests that higher quit rates are obtained if short-acting products are used in combination with longer-acting

transdermal nicotine patches. If used in combination with a patch, the maximum

recommended dose for each product is half of the maximum recommended dose if used as monotherapy.

Oral products

Examples: chewing gum, lozenges, sublingual tablets, oral film strips, oral or nasal sprays.

Oral products should be used with caution in those with oesophagitis, gastritis or peptic ulcers because, if swallowed, nicotine can aggravate these conditions. Acidic beverages, such as coffee or fruit juice, may decrease absorption through the buccal mucosa and should be avoided for 15 minutes before the intake of oral nicotine replacement therapy.

Chewing Gums

- The recommended dose is one 2mg gum to be chewed when the urge to smoke occurs. The gum should be chewed until the taste becomes strong, and then rested between the cheek and gum; when the taste starts to fade, chew again and repeat the process. One piece of gum used in this way should last for approximately 30 minutes.
- If used as monotherapy, the recommended dose for those smoking fewer than 20 cigarettes per day is 2mg. For those smoking over 20 cigarettes a day, requiring more than 15 pieces of 2mg gum, the 4mg strength should be used; care should be taken not to exceed the maximum dose.
- Prescribing data indicates that chewing gum is not as popular as it used to be, although it is still the short-acting product of choice for some individuals.
- There is some variation in price between the different brands and flavours, although generally the larger pack sizes are the most cost effective options. Smaller pack sizes should be prescribed initially to avoid unnecessary wastage if treatment needs to be changed in the middle of the course.
- Nicotine chewing gum has a very bitter taste that seems most effectively masked by mint flavours, particularly when used in the 2mg strength.
- If used in combination with nicotine patches, the 2mg strength should be used in preference to the 4mg strength. Highly dependent smokers may need the 4mg gum in combination with a nicotine patch
- Chewing gum may not be suitable for denture wearers as it can stick to and damage dentures.

Cost comparison: *Nicotine chewing gums*

Product	**Strength**	**Maximum dose if used as monotherapy (halved if used in conjunction with nicotine patches)**	**Price/pack size**
Nicorette gum	2mg	15 gums/day	Original, freshmint, mint & fresh fruit (mint & fresh fruit 105 pack size only) £3.25 (30), £9.27 (105) £14.82 (210) Icy white £3.42 (20) £9.37 (105)
	4mg	15 gums/day	Original, freshmint, mint & fresh fruit (mint & fresh fruit 105 pack size only) £3.99(30), £11.30 (105), £18.24

			(210) Icy white £11.48 (105)
Nicotinell gum	2mg	25 gums/day	Mint , fruit £1.45 (12), £2.67 (24), £8.26 (96) Icemint £6.69 (72) Liquorice £2.67 (24), £8.26 (96)
	4mg	15 gums/day	Mint, rruit £1.57 (12), £3.30 (24), £10.26 (96) Icemint £8.29 (72) Liquorice £3.30 (24), £10.26 (96)
Niquitin gum	2mg & 4mg	15 gums/day	Mint £1.71 (12), £3.25 (24), £9.97 (96)

Product	**Max daily dose**	**Cost /day**
Chewing gums		
***Nicorette* gum**		
original & fresh mint	**15 x 2mg**	**£1.06**
mint & fresh fruit	**15 x 2mg**	**£1.32**
original & fresh mint	**15 x 4mg**	**£1.30**
mint & fresh fruit	**15 x 4mg**	**£1.61**
Nicotinell		
mint ,fruit .liquorice	25 x 2mg If using 15/day	£2.15 £1.29
ice mint	25 x 2mg If using 15/day	£2.32 £1.39
mint, fruit. liquorice	15 x 4mg	£1.60
ice mint	15 x 4mg	£1.73
NiQuitin		
mint	15 x 2mg or 15 x 40mg	£1.56

PACEF Recommendation:

(11) If nicotine chewing gums are prescribed, mint flavours seem to be more palatable and better tolerated by most people. As a result of this, and in the absence of any clear difference in price between the major brands and flavours, *Nicorette* icy white flavour gum is advocated as the first line product of choice and is approved for inclusion in the *Lincolnshire Joint Formulary*; designation GREEN.

Lozenges and microtablets

Based on current prescribing trends lozenges are a popular formulation of oral short-acting nicotine. One lozenge should be used every 1 to 2 hours when the urge to smoke occurs. The lozenge should be allowed to dissolve in the mouth and periodically moved from one side of the mouth to the other; each lozenge should last for 10 to 30 minutes. The mini-lozenge is currently the most popular formulation as it is much smaller than alternatives, although slightly more expensive. Due to variation in pack size, it is difficult to compare the cost of different products. Generally, it is more cost effective to prescribe in larger packs, particularly where the prescriber can be confident of patient preference. If used in combination with nicotine patches, 1.5mg or 2mg strengths should be used in preference to the 4mg.

Oral dispersible films (NiQuitin Strips)

There is currently only one oral dispersible film holding a UK marketing authorisation, *NiQuitin Strips*. PACEF evaluated the product in January 2014 and did not consider the available evidence sufficient to support inclusion in the *Lincolnshire Joint Formulary.* As a result of this, nicotine 2.5mg orodispersible film (*NiQuitin Strips Mint*) is designated RED-RED and should not be prescribed.

Cost comparison: *Nicotine lozenges, microtablets and oral dispersible films*

Product	Strength	Maximum dose	Price/pack size
Lozenges/micro tablets			
Nicorette Cools (lozenges)	2mg	15 lozenges/day	Mint £3.18 (20), £11.48(80)
	4mg	15 lozenges/day	Mint £11.48 (80)
Nicorette Microtab (sublingual)	2mg	40tabs/day	£4.83 (30),£13.12 (100)
Nicotinell Lozenge	1mg	30 mg/day (30 loz)	Mint £1.71 (12), £4.27 (36), £9.12 (96)
	2mg	30mg/day(15 loz)	Mint £1.99 (12), £4.95 (36), £10.60(96)
NiQuitin Lozenge	2mg & 4 mg	15 lozenges/day	Original & mint £5.12 (36) £9.97 (72)
NiQuitin Minis Lozenge	1.5mg & 4mg	15 lozenges/day	Mint & Cherry £3.18 (20), £8.93 (60)
NiQuitin Strips orodispersible film	2.5mg	15 films /day	£3.51 (15),£10.85 (60)

Cost per day of treatment: *Nicotine lozenges, microtablets and oral dispersible films*

Product	Max daily dose	Cost /day
Lozenges/micro tabs		
Nicorette		
lozenges	15 x 2mg or 15 x 4mg	£2.15
Microtabs	40 x 2mg	£2.25
Nicotinell		
Lozenge	30 x 1mg	£2.85
Lozenge	**15 x 2mg**	**£1.66**
NiQuitin		
Lozenge	**15 x 2mg, 15 x 4mg**	**£2.08**
Minis Lozenge	15 x 1.5mg, 15 x 4mg	£2.23
Orodispersible film	15 x 2.5mg	£3.15

PACEF Recommendation

(12) *NiQuitin Lozenge* 2mg and 4mg and *NiQuitin Minis Lozenges* 1.5mg and 4mg are advocated first line where a short-acting lozenge is indicated. Both formulations are approved for inclusion in the *Lincolnshire Joint Formulary* and designated GREEN*. NiQuitin* orodispersible film 2.5mg has already been evaluated by PACEF and designated RED-RED. It is not approved for use through the *Joint Formulary* and should not be prescribed. Due to current supply problems with *NiQuitin Minis*, *Nicorette Cools* 2mg and 4mg are also designated GREEN and included in the *Lincolnshire Joint Formulary*.

Oral sprays, nasal sprays and inhalators

Nicotine oral spray (*Nicorette QuickMist*): patients can use one or two sprays into the mouth when the urge to smoke occurs or to prevent cravings. The spray should be released into the mouth, holding the spray as close to the mouth as possible and avoiding the lips. The patient should not inhale whist spraying and avoid swallowing for a few seconds after use. Patient experience suggests that some patients have difficulty with this technique and can experience a gagging sensation. Directing the spray to the side of the mouth can help to avoid this. Oral sprays should be used with caution in those with oesophagitis, gastritis or peptic ulcers because, if swallowed, nicotine can aggravate these conditions.

Nicotine inhalation cartridges (*Nicorette Inhalator*): the cartridges can be used when the urge to smoke occurs or to prevent cravings. The cartridge is inserted into the device and air is drawn in through the mouth piece with each use of the device lasting for approximately 5 minutes. The amount of nicotine from 1 puff of the cartridge is less than that from a cigarette and it is likely to be necessary for the person to inhale more frequently than when smoking. A single 15mg cartridge lasts for approximately 40 minutes of intense use. Care should be taken with the inhalation cartridges in those with obstructive lung disease, chronic throat disease or bronchospastic disease. The *Nicorette Inhalator* is the only option that directly mimics the physical activity of smoking. Anecdotal reports indicate that many patients continue to use the inhalator as a habit substitute even after the cartridge is empty.

Nicotine nasal spray (*Nicorette Nasal Spray*): one spray can be used in each nostril when the urge to smoke occurs up to a frequency of twice an hour. If lower doses are required the spray can be applied to just one nostril. The nasal spray can cause worsening of bronchial asthma and is associated with sneezing and local irritation.

Cost comparison: *oral sprays, nasal sprays and inhalators*

Product	Strength	Maximum dose	Cost
Nicorette Nasal Spray	500mcg/dose	1 spray into each nostril each nostril twice an hour maximum 64 spray/day	£13.40 (10ml – 200 doses)
Nicorette QuickMist oromucosal spray	1mg/dose	Maximum 4 sprays an hour, 64 sprays/day.	1x 13.2ml £12.12 2X13.2ml £19.14
Nicorette Inhalator inhaler plus cartridge	15mg	6 cartridges/day	4 x £4.14 20 x £14.03 36 x £23.33

PACEF Recommendation

(13) Nicotine oral sprays, nasal sprays and inhalators are relatively high cost in comparison with other formulations of NRT. *Nicorette QuickMist* oromucosal spray and *Nicorette Inhalator* are approved for use through the *Lincolnshire Joint Formulary* and are designated GREEN; they should only be prescribed for those who have previously failed to quit using other forms of NRT. *Nicorette Nasal Spray* is not approved for inclusion in the *Joint Formulary* and should not be prescribed.

Electronic cigarettes

Electronic cigarettes (or e-cigarettes) are battery powered devices that deliver on inhalation a vaporised liquid nicotine solution. Each device is comprised of a battery, atomiser and cartridge containing water, propylene glycol or glycerine, varying amounts of nicotine and flavourings such as tobacco, whisky, bubble-gum or fruit. When the user inhales, a sensor detects the airflow and heats the liquid nicotine filled cartridge to produce the vapour. This has led to the team "vaping" being used to describe the use of e-cigarettes.

Electronic cigarettes mimic a real cigarette in design, often having a 'lit' end to resemble a lit cigarette and emit a 'smoke like' vapour when the user exhales. Despite this resemblance, they do not contain tobacco, don't burn and therefore do not produce tobacco smoke.

Studies undertaken to date suggest that electronic cigarettes are less harmful than smoking conventional cigarettes. The British Medical Association (BMA) advises that "while e-cigarettes are unregulated and their safety cannot be assured, they are likely to be a lower risk than continuing to smoke." However, as yet there has been no research to assess the long term health effects of using electronic cigarettes.

At present these products are unlicensed and unregulated; there may be vast differences between brands. In particular, some brands have been found to be of poor quality and ineffective at delivering the nicotine vapour; this means the user could inhale too much or too little nicotine. While cartridges are available in a range of different nicotine strengths; some studies have found that the actual nicotine level does not correspond to that advertised. This may lead to users inhaling more or less nicotine than expected. There have also been some incidents reported in the media where e-cigarette batteries have exploded or started fires.

The MHRA announced in June 2013 a government intention to regulate electronic cigarettes and other nicotine containing products (NCPs) as medicines. There is an expectation that the first NCPs will be regulated as early as 2014.

PACEF Recommendation

(14) Electronic cigarettes are currently not classed as medicines and therefore do not have to comply with the same regulatory standards as licensed nicotine replacement therapies. There are reports that the quality and nicotine content of these products varies widely between brands. There is only limited evidence of effectiveness in supporting a smoking cessation attempt, although some patients are being supported to stop smoking using electronic cigarettes through the Phoenix service. In most cases where the person wants to stop smoking, evidence based pharmacotherapy using licensed NRT products, varenicline or bupropion is preferred.

Acknowledgements

Many thanks to:
Tracey Matthewman, Amanda Richardson, Georgina Barclay, and Carol Johnson from the Phoenix Stop Smoking Service, Lincolnshire Community Health Services. and Phil Garner and Ros Watson from Lincolnshire County Council for their help in the compilation of this *Bulletin.*

Prepared by:

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Stephen Gibson
Head of Prescribing and Medicines Optimisation
GEMCSU

October 2014

References

1. National Institute for Clinical Excellence (NICE) Quality Standard 43 - *Smoking cessation: supporting people to stop smoking* (August 2013)
2. NICE Public Health Guidance 45 - *Tobacco: harm-reduction approaches to smoking* (June 2013).
3. NICE Public Health Guidance 10 - *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities* (February 2008).
4. Phoenix Pharmacotherapy Protocol May 2011. To be reviewed June 2014.
5. NHS Nottingham Health Community, *Smoking Cessation Algorithm*.
6. *Guidelines for the prescribing and administration of smoking cessation pharmacotherapy on inpatient wards*.
7. *Standard Treatment programme – one to one smoking cessation programme*. Andy McEwan. 2011. NHS centre for Smoking Cessation and Training.
8. Lincolnshire Stop Smoking Services, *Service Delivery and monitoring guidance 2011/12.*
9. *MIMS* (June to August 2014.
10. National Centre for Smoking Cessation and Training, *Electronic cigarettes* (2014)

United Lincolnshire Hospitals NHS Trust

Equality Analysis: Initial Assessment Form

Title: Smoke Free Policy

Describe the function to which the Equality Analysis Initial Assessment applies:		
☐ Service delivery	☐ Service improvement	☐ Service change
Policy	√ Strategy	☐ Procedure/Guidance
☐ Board paper	☐ Committee / Forum paper	☐ Business case
☐ Other (please specify) ……		

Is this assessment for a new or existing function?	**New**
Name and designation of function Lead professional:	**Stephen Kelly**
Business Unit / Clinical Directorate:	**HR & OD**

What are the intended outcomes of this function? (*Please include outline of function*

objectives and aims): *United Lincolnshire Hospitals NHS Trust (ULHT) as a healthcare provider and major employer in Lincolnshire will set an example to other organisations, promote public health and create an environment that minimises the health risks to members of the public, patients and staff who access or provide our services by providing a smoke free Trust environment.*

Who will be affected? Please describe in what manner they will be affected?

Patients / Service Users:	**Staff:**	**Wider Community:**
Patients will not be permitted to smoke on Trust permitted.	Employees will not be permitted to smoke on Trust premises.	Visitors contractors and members of the public will not be permitted to smoke on Trust premises

What impact is the function expected to have on people identifying with any of the protected characteristics (below), as articulated in the Equality Act 2010? (Please tick as appropriate)

	Positive	Neutral	Negative	**Please state the reason for your response and the evidence used in your assessment.**
Disability	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation.
Sex	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Race	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Age	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Gender Reassignment	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Sexual Orientation	Yes			ULHT will actively encourage Health and wellbeing in promoting and

				supporting smoking cessation
Religion or Belief	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Pregnancy & Maternity	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Marriage & Civil Partnership	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation
Carers	Yes			ULHT will actively encourage Health and wellbeing in promoting and supporting smoking cessation

If the answer to the above question is a predicted negative impact for one or more of the protected characteristic groups, a full Equality Analysis must be completed. (The template is located on the Intranet)

Name of person/s who carried out the Equality Analysis Initial Assessment:	**Stephen Kelly**
Date assessment completed:	**6th of November 2017**
Name of function owner:	
Date assessment signed off by function owner:	
Proposed review date (please place in your diary)	

As we have a duty to publicise the results of all Equality Analyses, please forward a copy of this completed document to tim.couchman@ulh.nhs.uk.

Referenced Documents

References

The Health Act 2006, Department of Health

NICE Guideline on Quitting Smoking in Pregnancy and following Childbirth. (PH 26), June 2010

NICE Guideline on Smoking cessation in Secondary care: acute, maternity and mental health services. (PH 48), November 2013

British Thoracic Society Smoking Cessation information https://www.brit-thoracic.org.uk/clinical-information/smoking-cessation/

Smoking Kills - A White Paper on Tobacco https://www.gov.uk/government/publications/a-white-paper-on-tobacco

Healthy Lives, Healthy People https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

WHO Framework on Tobacco Control Report on Electronic Nicotine Delivery Systems – July 2014. http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_10-en.pdf

Schraufnagel *et al* (2014) Electronic cigarettes: A position statement of the Forum of International Respiratory Societies. AJRCCM. 190(6): 611-618.

United Lincolnshire Hospitals NHS Trust

Signature Sheet

Names of people consulted about this policy:

Name	Job title	Department

Names of committees which have approved the policy	Approved on
Trust Health and Safety Committee	
Staff Engagement Group (SEG)	

Appendix B

ULHT Smoke Free consultation survey feedback –

From Wednesday 13 March to end-July 2019, ULHT engaged members of the public and staff on the proposal to make the Trust 100% smokefree across all sites.

As part of this work, an online survey was produced which has been heavily promoted on the Trust website, across social media channels and at a number of staff and public events. This was to gain feedback and suggestions as to whether people thought a blanket ban was a good idea and what the main challenges might be if any new policy came into effect.

In total, 801 people responded to the survey (151 hardcopy and 650 online) with the following results received.

N.B not all respondents answered all the questions and some answers revealed multiple themes/examples, all of which are reflected here.

1. Do you believe ULHT should become completely Smokefree?

Yes – 453 (56%)

No – 347 (44%)

2. How can we ensure that adherence to a new Smokefree policy is effectively 'policed'?

The strongest theme here was the suggestion that any new policy needs to be effectively monitored or policed, either by specific staff or via CCTV or similar surveillance.

The second most common theme was the feeling that adherence will not be possible.

Areas monitored/policed – 198
Not possible – 172
Unsure – 79
Have smoking shelters - 61
Fines – 58
Education/training – 51
Signage - 50
Challenge people – 42
Disciplinary action – 14
Pre-recorded message playing out – 11
People should be able to make up their own minds – 9
Smoking cessation help - 9
Persuasion - 9
Posters - 6
Refuse treatment – 5

Alarms - 4

3. How do we manage situations where patients and visitors may wish to smoke because they have had bad news or are distressed?

The vast majority of respondents to this question suggested that patients and visitors should be directed to a designated ‘on site’ smoking shelter/area.

Other popular suggestions included, asking them/encouraging them to leave the site, the offer of smoking cessation support or a blanket zero tolerance approach, i.e. adherence to smokefree policy should always be observed.

Signpost to smoking shelter/designated area – 307
Ask them to leave the site – 119
Offer support/smoking cessation – 94
Should be allowed to – 68
Zero tolerance - 53
Unsure – 49
Unmanageable – 32
Get staff to communicate new policy to patients – 28
Clear signage – 6
Education on harmful effects - 1

4. What about 'vaping’? Should the same rule apply to vaping or should we have designated vaping areas?

Permitted in hospital grounds? – 117 (15%)

Permitted in designated areas? – 388 (49%)

Not allowed anywhere? – 281 (36%)

5. What should we do about staff who wish to smoke on their breaks?

Similar to the responses to question three, most people here suggested that staff on their breaks should make use of a designated ‘on site’ smoking shelter/area.

Asking them to go ‘off site’ and ‘sticking firmly to new policy’ were the next most popular responses.

Provide smoking shelter/designated area – 249
Ask them to go off-site - 163
Need to stick to new policy – 136
Let them – 113
Offer support/smoking cessation – 51
Make them change out of uniform - 37

Unsure – 15
Give longer/flexible breaks to allow them to go off site – 6
Vaping only – 5
Smoke after work – 3
They should know better – 2
Dock wages - 1
Dismiss them – 1

6. What support should we be offering for patients admitted to our hospitals to help them stop smoking?

Here, the most popular suggestions was offering bespoke smoking cessation or counselling/support to patients, with the prescribing of patches, gums and other treatments following closely behind.

Another popular suggestion was giving patients admitted, advice on the new policy and the health benefits associated with 'giving up'.

Smoking cessation/support groups – 278
Patches – 169
Advice - 133
Chewing gum - 40
Leaflets – 30
Vaping – 20
Trained staff - 15
Medication – 11
Hypnotherapy – 5
Withdraw treatment – 3
Stop Smoking Champions – 2
Poster campaign – 1
Information on reception – 1
Information on discharge – 1

7. How can we ensure that everyone knows about the proposed new Smokefree policy?

This question provoked the highest number of different responses with the two clear winners suggesting adequate signage and posters would ensure widespread promotion of any new policy.

Utilising local media, social media, a robust advertising campaign and online tools followed closely behind.

Signage – 232
Posters – 200
Media – 169
Social media – 111
Advertising campaign – 76

Online info – 66
Leaflets – 40
Patient letters – 36
Email - 22
Info on payslips – 19
Word of mouth – 11
Screensavers – 7
TV screens in waiting rooms – 5
Training – 4
Make people sign the policy – 4
Advise on staff induction – 4
Roadshows – 3
Newsletters – 2
Letters to all staff – 1
Videos – 1
Threats – 1
Badges for staff – 1

8. What will be positive about a move to become a Smokefree Trust?

The clear winner was here was that making ULHT completely smokefree will result in better health for all.

The second most popular response was the welcome thought of no longer having to pass through clouds of smoke at our hospital entrances.

Cleaner environments/less litter and cleaner air followed closely behind.

Better health – 232
No more smoke in hospital entrance – 118
Cleaner environment/less litter – 96
Cleaner air – 53
Positive hospital image – 24
Less cost to the NHS – 9

Appendix C

ULHT smokefree communications and engagement implementation plan 2020

1. Introduction

To enable ULHT to provide a safe environment that promotes health and reduces harm from exposure to second-hand smoke, the decision to turn all of our hospital sites completely smokefree has been made by Board. This means that smoking will no longer be permitted on any of our sites including all buildings, grounds and vehicles with effect from Monday 6 January 2020.

As an NHS organisation, we have a duty to protect and care for the health and wellbeing of our patients, staff and visitors. Many of the people who access our services are particularly vulnerable to the harmful effects of second hand smoke, such as pregnant women, babies, children and those with medical conditions.

2. Objectives

We recognise that smoking is a personal choice and we do not discriminate against those who choose to do so. We are a health-promoting organisation and are committed to protecting and improving the health and wellbeing of all employees, patients and visitors.

Smoking is the leading cause of premature death in the UK. Exposure to second-hand smoke can also cause disease and premature death among non-smokers and even brief exposure can cause immediate harm. Many of the people who use our services such as pregnant women, babies and children and people with medical conditions are particularly vulnerable to the harmful effects of exposure to tobacco smoke. **As an NHS organisation, we have a duty to protect and care for the health and wellbeing of all our patients. Being completely smokefree reflects our commitment and responsibility for improving health and wellbeing.**

Our decision to go smokefree is also in line with The Health Act (2006) and The National Institute for Health and Care Excellence (NICE) 2013 guidelines which state that all hospital sites should ideally be 100% smokefree.

Throughout 2019 we undertook an extensive consultation and engagement exercise with our patients, public and staff, which began on national No Smoking Day (Tuesday 13 March). The consultation ran for four months, ending on Wednesday 31 July 2019. The consultation exercise comprised of a survey (online and hardcopy) which was widely publicised across social media and our website and internally for staff, in addition to 'drop-in' smokefree roadshows across all four hospital sites (w/c Monday 8 July), attended by ULHT OH, comms and public health colleagues.

During the consultation, 801 people completed the survey which included the following questions:

- Do you believe ULHT should become completely smokefree?
- How can we ensure that adherence to the policy is effectively 'policed'?

- How do we manage situations where patients and visitors may wish to smoke because they have had bad news/ are distressed?
- How do we manage the issue of vaping vs. smoking?
- What will be positive about this move to become a smokefree Trust?
- How do we manage the issue of staff wishing to smoke on their breaks?
- How can we ensure that everyone knows the new policy?
- What support can we offer people to help them stop smoking?

56% of respondents answered 'yes' to the first question, 'do you believe ULHT should become completely smokefree?' - with 44% of overall respondents disagreeing.

We know that many people are giving up smoking by switching to e-Cigarettes and as they do not expose others to second hand smoke and offer a less harmful alternative to smoking, their use will **still be permitted within the grounds of our sites**, under the new policy.

There is no given right to smoke and no obligation to permit people to smoke. Becoming smokefree is part of our duty to improve and the protect the health and wellbeing of our staff, patients and wider communities and this includes ensuring we uphold their right to be protected from second hand smoke.

We want staff to be ambassadors for good health and promote and smokefree policy, therefore all patients who attend our sites will be asked if they smoke. Patients who are admitted either as an emergency or planned admission, will be offered nicotine replacement therapy (NRT) in the form of patches and inhalator and will be offered a referral for ongoing support. Patients who insist on leaving the ward areas to smoke will not be obstructed but will be advised of the smokefree policy and asked not to smoke within the hospital grounds.

The Department of Health recommends that you are four times more likely to quit smoking if you use a combination of Nicotine Replacement Therapy (NRT) and support from a trained stop smoking adviser.

3. Key audiences

- Primary audiences – All staff, public, patients and carers, members and the media.

- Secondary audiences – MPs, Healthwatch Lincolnshire, patient and third sector groups, local politicians including district and county councillors, health scrutiny committee and health and wellbeing board chairs, commissioners (CCGs, NHS England and county council), partner organisations (councils, EMAS, LCHS, LPFT, STP, Lincolnshire Police, fire and rescue, universities), regulators (NHS Improvement, CQC), neighbouring trusts, councils or CCGs and GPs.

4. Key messages

From January 2020, there will be no smoking, including e-Cigarettes and vapes in any buildings or grounds, rented, leased, sub-let or used by ULHT, apart from some clearly identified designated external areas for e-Cigarettes and vapes.	**Staff will be asked to politely remind patients and visitors of the new smoke-free policy and ask them to stop smoking in the hospital grounds if they do so, only if they feel confidents and it is safe to do so.**	**It is everyone's responsibility to enforce smoke-free. Everyone needs to be prepared to remind smokers of our policy.**
NICE guidelines (2013) and The Health Act (2006), state all hospitals should be 100% smoke-free.	The Trust does not want anyone to feel they need to engage in difficult or challenging situations and not approach or challenge individuals if they do not feel confident to do so.	The challenges around implementing the policy are recognised and we have consulted with staff and members of the public since March 2019 around the implications of the policy and the way in which we implement it.
To enable ULHT to provide a safe environment that promotes health and reduces harm from exposure to second-hand smoke, all of our sites will go completely smoke-free from 2020.	All eligible patients accessing our services will be given advice and an offer of support to help stop smoking.	We have listened to members of the public and our consultation exercise revealed that people agree with us turning ULHT completely smokefree.
As an NHS organisation, we have a duty to protect and care for the health and wellbeing of all our patients. Being completely smoke-free reflects our commitment and responsibility to do this.	Making an attempt to permanently stop smoking is an opportunity not an obligation.	Look out for the new signage around our hospitals from January 2020 – 'ULHT smokefree'.

5. Plan

From the week after Board makes its final decision, a comprehensive communications campaign will begin across all available channels, to 'warm people up' to the implementation of ULHT smokefree in January 2020.

This campaign will focus on the benefits of becoming smokefree, whilst also acknowledging the challenges this will bring, in addition to the ways in which we will support patients (and staff) to stop smoking whilst in our hospitals.

Local media and stakeholders will be informed and encouraged to share the messaging – with all social media channels maximised, a poster campaign launched and videos utilised.

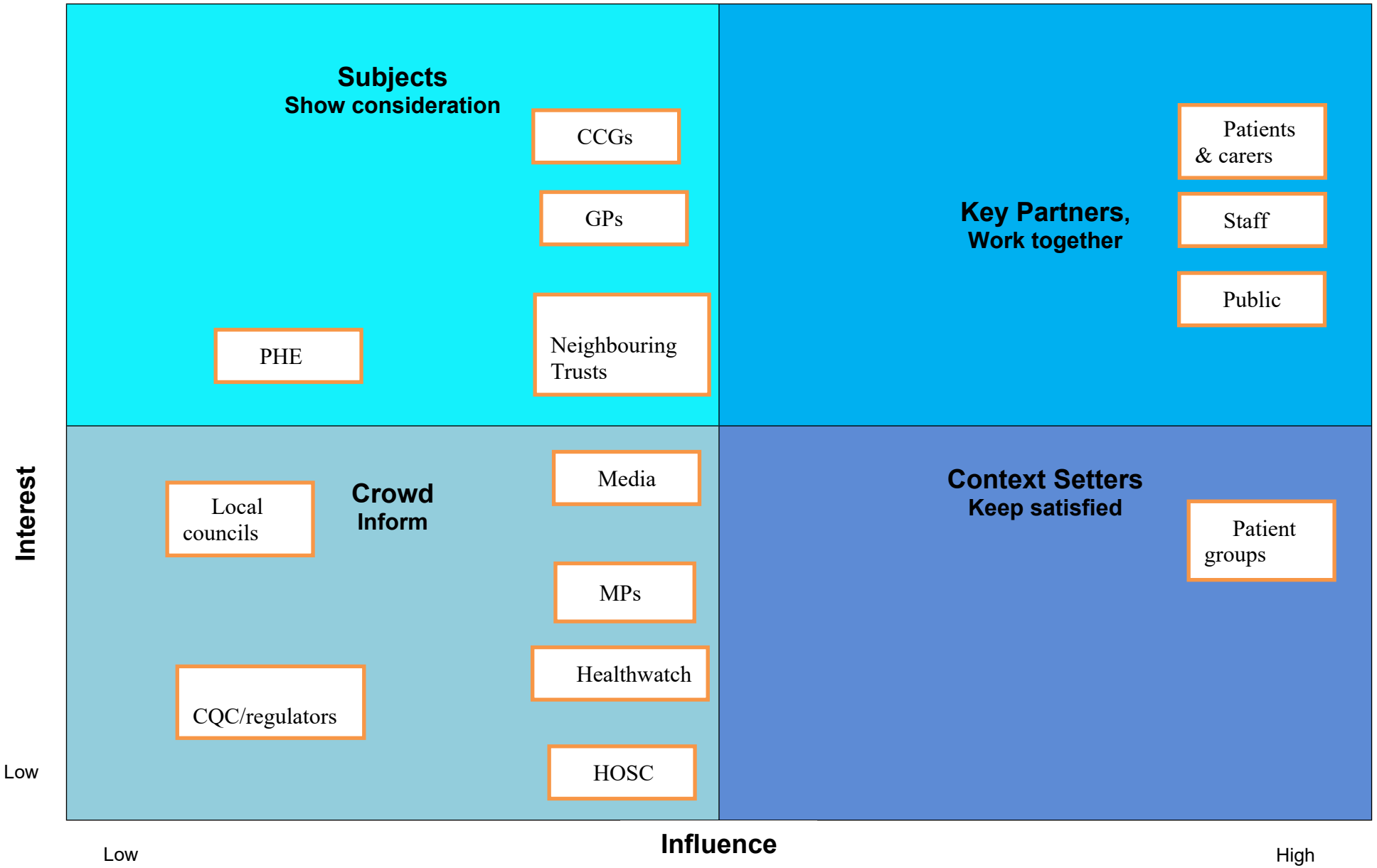
Learning from other NHS Trusts who have adopted a smokefree policy will also be considered and included in the developing communications plan.

Audience	Format or method	Message	Channel/ outlet	Timing	Lead	Progress
Staff/patients /public	Intranet and website update	Smokefree area of the intranet/website created/updated to announce policy change, inc. FAQs from policy.	Intranet and website pages	w/c Mon 7 October	BW/LB	
Staff/patients /public	Round-up message /Team Brief item/social media message	Above key messages communicated.	Weekly round-up/Team Brief and social media messaging	w/c Mon 7 October	BW	
Staff	Weekly round-up/intranet/ social media	What does our policy say? Policy on page and link to.	Weekly round-up and social media messaging	w/c Mon 21 October	BW	
Patients/public/staff/stakeholders	Press release/ website	Key messages above and support to be offered to patients	Local media	w/c 4 November	BW	
Patients/public/staff	Social media messaging	Promotion of smokefree ULHT – in line with NICE guidelines and PHE – signpost to cessation help	Trust social media accounts	w/c 11 Mon Nov and w/c 18 Nov	BW	
Patients/public/staff	Video	Why are we going smokefree – challenges we'll face/right thing to do	Trust website and social media outlets	w/c Mon 25 Nov	BW/LB /MR	
Patients/public/staff	Posters	ULHT smoke free is coming	Posters across all ULHT sites	w/c Mon 2 Dec	BW	
Staff	Round-up and Team Brief message	ULHT smoke free is coming next month – key messages repeated and support to be offered to patients	Weekly round-up/Team Brief	w/c Mon 2 Dec	BW	
Patients/public/staff	Social media messaging	Have you seen the signage around our hospitals? 'ULHT will be smokefree'	Trust social media outlets	w/c Mon 16 Dec	BW	
Staff	Round-up and Team Brief message	We are ULHT smokefree. Help us implement the new policy, let us know about the challenges	Weekly round-up/Team Brief	w/c Mon 6 Jan 2020	BW	

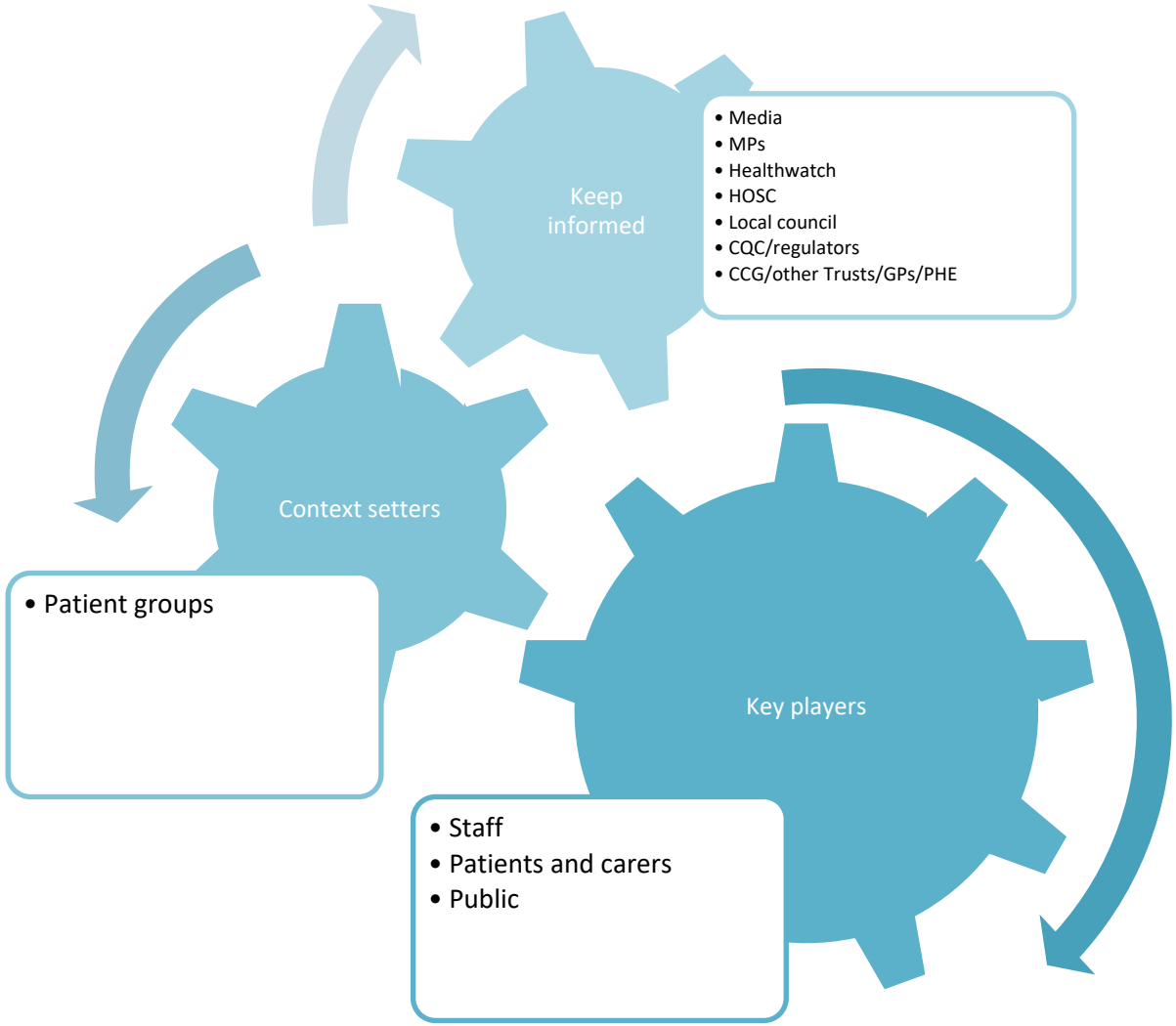
Comms plan for weeks following implementation to be formulated in due course.

Although most of the above deals with proactive communications there is recognition that adopting a completely smokefree policy may pose a reputational risk for the organisation, particularly among certain groups of patients and staff.
This will be managed and monitored on a day-to-day basis by the communications team who will deal with any reactive media issues.

Appendix 1 – stakeholder interest and power grid



Appendix B communicating



To:	**Trust Board**
From:	Dr. Neill Hepburn, Medical Director
Date:	October 1st 2019
Title:	Medical vacancies that are leading to a potential risk to the continuity of service in the area of 1) medicine at Grantham, and 2) Stroke services Trust wide. .

Authors:

- Dr. Neill Hepburn, Medical Director
- Deborah Pook, Divisional Managing Director
- Damian Carter, General Manager
- Lisa Vickers, Deputy General Manager
- Julie Pipes, Deputy Director for Clinical Strategy & Transformation

Purpose of the Report:

To raise awareness of the impact of medical vacancies in 1) Medicine services at Grantham Hospital and in 2) the Stroke services Trust wide, and medical vacancies at the Grantham & District Hospital, which now present a risk to the continuity of these services, and if left unaddressed could give rise to patient safety issues.

To provide assurance to the Trust Board that these risks are being taken seriously and that options are being considered and appraised for mitigating the potential risk to service continuity.

The Report is provided to the Executive Team for:

Decision		Discussion	
Assurance	✓	Information	✓

Summary/Key Points

This report is for discussion and information. It provides a high-level overview of the actions that are being taken to mitigate the risk to service continuity at Grantham Hospital, and for stroke services Trust wide.

Recommendations:

The Trust Board are asked to

- Note the content of this report
- Note actions are being taken urgently to mitigate the potential risk to the continuity of services covered within this papers, which could give rise to patient safety issues

1. Background

1.1 Medicine services at Grantham & District Hospital

Grantham and District Hospital provides inpatient and outpatient services for both medical and surgical patients, including a full range of diagnostic services. It offers an Accident and Emergency Department that has restricted criteria, for patients who are in need of urgent care.

The medicine services provided at Grantham include; acute general medicine, gastroenterology, cardiology, care of the elderly patient, and respiratory medicine.

The medicine rota at Grantham Hospital is made up of physicians from respiratory, gastroenterology, acute medicine and care of the elderly specialities.

The restricted criteria for the Accident and Emergency Care means that some patients will not be taken to the Grantham Hospital by the ambulance service because they require specialist services that are not available on the Grantham Hospital site. For example:

Ambulances / GP's <u>SHOULD NOT</u> bring / send the following patient groups to Grantham and District Hospital A&E department, and Emergency Assessment Unit:

- Fast Positive Stroke
- STEMI, Chest pain with dynamic or high risk ECG changes
- Bradycardias which may require pacing, broad complex tachycardia / VT
- ST MI
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain.
- A male under 30 years of age with testicular pain.
- A patient with suspected AAA or ischaemic limb needs admission to the on-call Vascular Unit (Pilgrim Hospital)

- All Obstetric and Gynaecological patients
- Head injury – Glasgow Coma Score **< 14**
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies (e.g. acute glaucoma, Trauma)
- Severe ENT emergencies

Patients with Major Injuries

- All major trauma involving head, cervical spine, chest, abdominal or pelvic injuries.
- All suspected and actual spinal trauma and patients with abnormal spinal neurological examination

- Multiple peripheral injuries involving more than one long bone fracture above the knee or elbow.
- Head injuries with a Glasgow Coma Score **< 14**
- All gunshot wounds.
- All penetrating injuries above the knee or elbow.
- Scalds and burns covering >15% body surface area.
- Burns to face, neck, eyes, ears or genitalia.
- Electrical burns, significant inhalation injuries or significant chemical burns.

Patients with Significant Mechanism of Injury who need Admission or Assessment

- Ejection from vehicle.
- Death in same passenger compartment.
- Roll over RTA.
- High speed /impact RTA (speed > 30mph, major vehicle deformity, passenger. compartment intrusion, extraction time > 20 mins).
- Motorcyclist RTA > 20mph or run over.
- Pedestrian thrown, run over or > 5 mph impact.
- Falls > 3m.

Paediatric Exclusions

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital A&E department, and Emergency Assessment Unit:

- Children requiring Paediatric assessment / Review
- Children with severe Breathing difficulties
- Children with severe asthma
- Children with Severe Bronchiolitis
- Children with biphases stridor
- Children with Severe Croup
- Children with DKA
- Children with Status epilepsy
- Children who have self-harmed
- Children requiring Mental health assessment

Inpatient bed facilities

There are 68 funded medical inpatient beds at the Grantham Hospital; these beds are for patients with medical problems. In addition, there are 23 funded beds used for elective surgical procedures.

1.2 Stroke services

Stroke services are provided at the Lincoln County Hospital and the Pilgrim Hospital, Boston. Both hospital sites offer hyper-acute stroke services (first 72 hours of care following diagnosis of a stroke), and acute stroke services (care following the first 72 hours to the point of discharge home or to rehabilitation services).

There are around 1200 diagnosed strokes in Lincolnshire each year.

We currently have 28 funded stroke beds at both Lincoln and Pilgrim, 56 beds.

There is a joint programme of work involving the whole health & care system of Lincolnshire to reduce the existing length of stay in hospital for patients diagnosed with a stroke. At the current time, and on average, a patient diagnosed with a stroke will stay in hospital for around 15 days, but the national guidelines for improving clinical outcomes for stroke patients suggest that this is too long to be in an acute hospital, and the stroke patient should be discharged sooner to commence a robust community led rehabilitation service.

2. The medical workforce issues for these services

The issue that is now becoming critical for both of these services relates to the shortage of clinical and nursing staff to sustain the services.

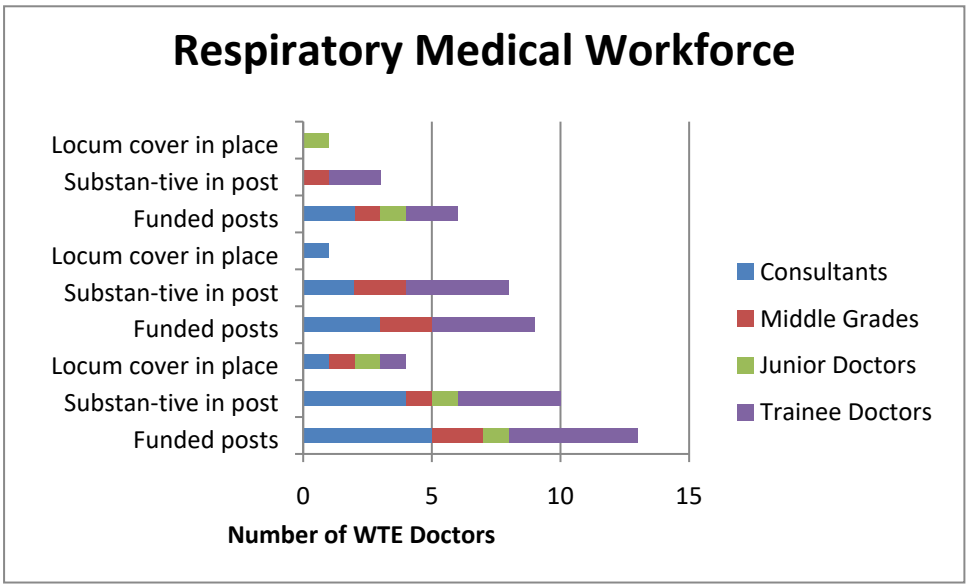
2.1 Medicine at Grantham

There are no concerns or risks to sustaining the elective surgical procedures performed at the Grantham Hospital. The problem is confined to the medical services only. Medicine and Surgery have different clinical skills, and it is “medical” doctors who provide medicine services, and “surgical doctors” who provide surgical services.

At Grantham Hospital, there are twelve funded Consultant medical posts, but at the current time, only five of these are filled with substantive doctors, and this will reduce to four from March/April 2020, when the Cardiologist currently in post takes retirement.

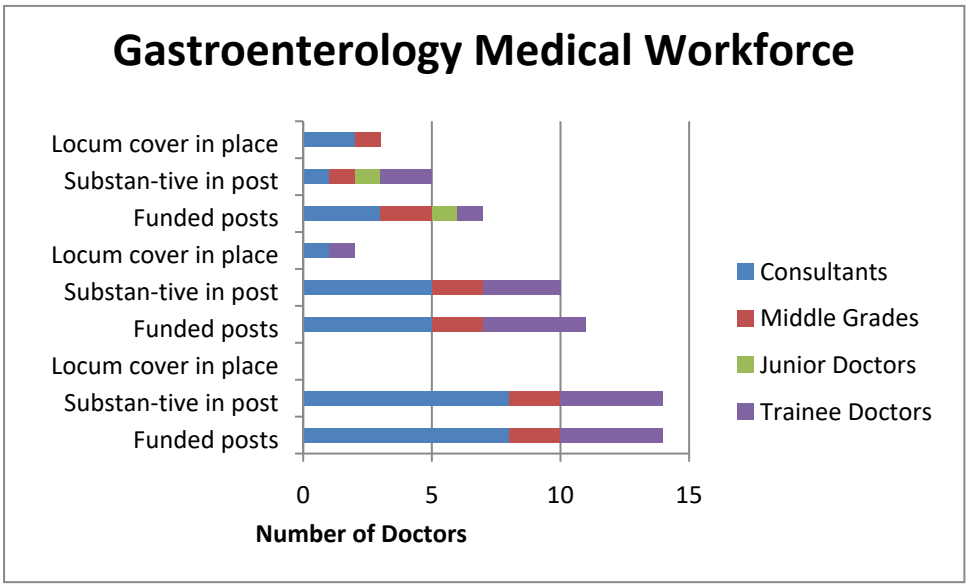
The charts below show the breakdown of the medical workforce at all of the ULHT Hospital sites, and highlight the gaps in the medical workforce Trust wide.

Respiratory Medicine



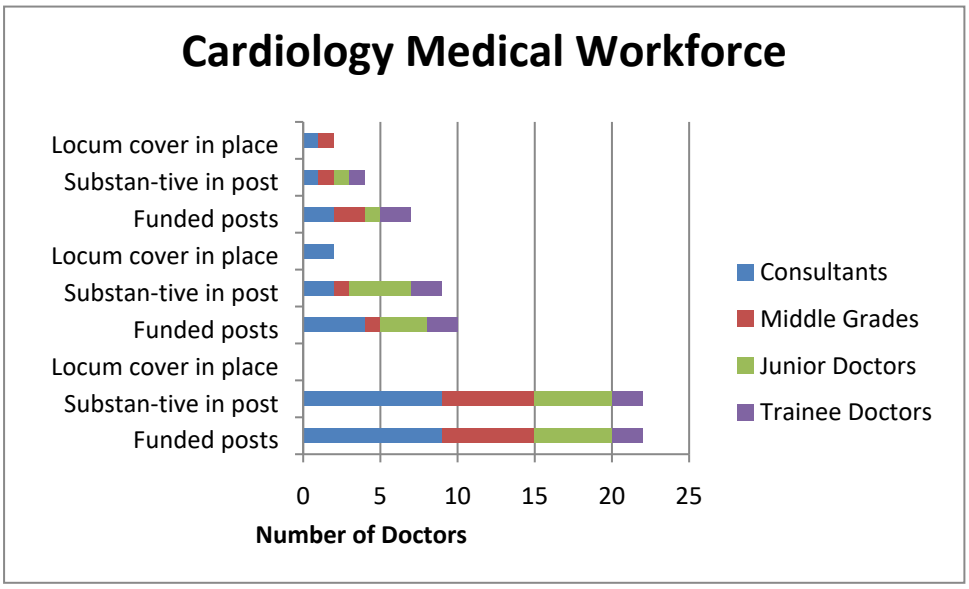
RESPIRATORY	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	5	4	1	3	2	1	2	0	0
Middle Grades	2	1	1	2	2	0	1	1	0
Junior Doctors	1	1	1	0	0	0	1	0	1
Trainee Doctors	5	4	1	4	4	0	2	2	0

Gastroenterology



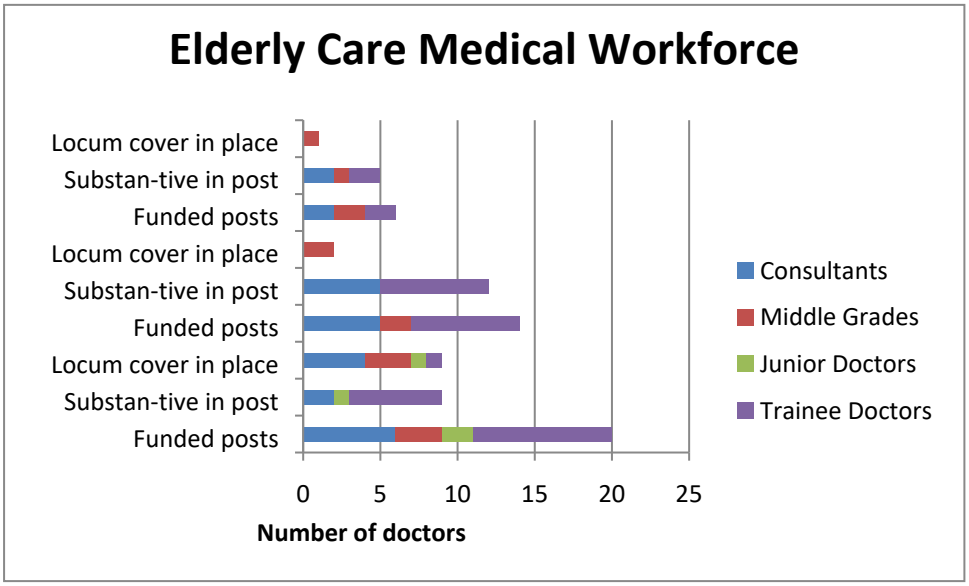
GASTROENTEROLOGY	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	8	8	0	5	5	1	3	1	2
Middle Grades	2	2	0	2	2	0	2	1	1
Junior Doctors	0	0	0	0	0	0	1	1	0
Trainee Doctors	4	4	0	4	3	1	1	2	0

Cardiology



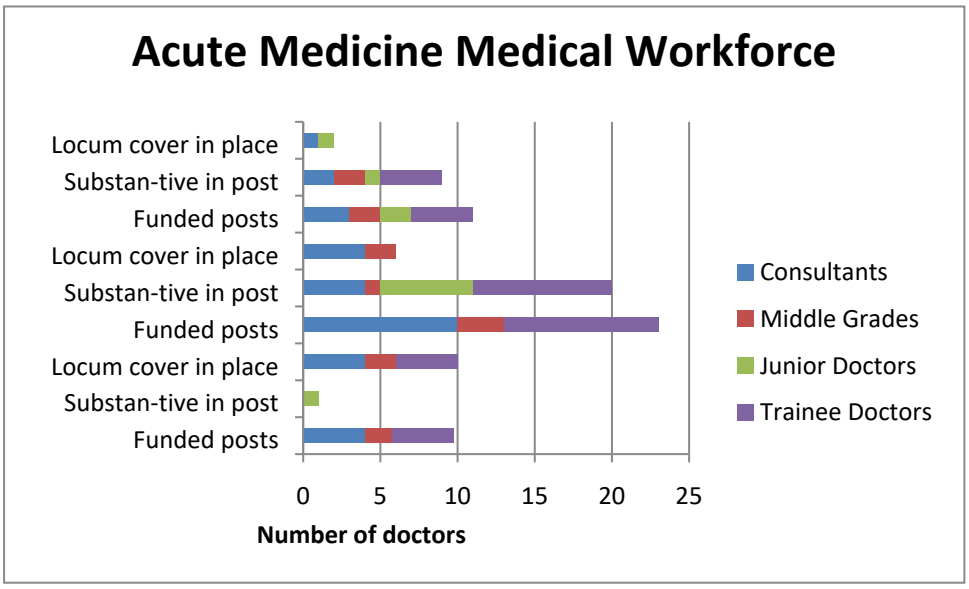
CARDIOLOGY	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	9	9	0	4	2	2	2	1	1
Middle Grades	6	6	0	1	1	0	2	1	1
Junior Doctors	5	5	0	3	4	0	1	1	0
Trainee Doctors	2	2	0	2	2	0	2	1	0

Elderly Care



ELDERLY CARE	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	6	2	4	5	5	0	2	2	0
Middle Grades	3	0	3	2	0	2	2	1	1
Junior Doctors	2	1	1	0	0	0	0	0	0
Trainee Doctors	9	6	1	7	7	0	2	2	0

Acute Medicine



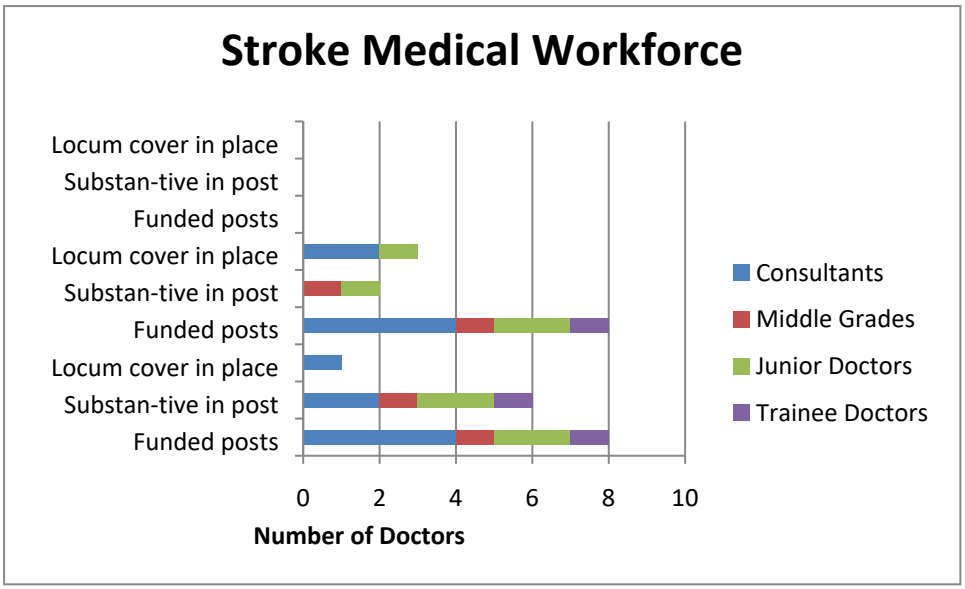
ACUTE MEDICINE	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	4	0	4	10	4	4	3	2	1
Middle Grades	1.76	0	2	3	1	2	2	2	0
Junior Doctors	0	1	0	0	6	0	2	1	1
Trainee Doctors	4	0	4	10	9	0	4	4	0

2.2 Stroke services Trust wide

There are eight funded Consultant Stroke Physician posts for ULHT, four at the Lincoln Hospital site and four at the Pilgrim Hospital, Boston site. There are currently only two substantive consultants in post, and both are based at the Lincoln Hospital site. Of the remaining vacant six consultant posts, Locum and/or Agency Consultants cover only 50%.

The workforce vacancy issues relating to the stroke services are not limited to the shortage of Doctors; they also include a shortage of nurses at both of the hospital sites.

The tables below show the medical and nursing workforce position for stroke services Trust wide.



STROKE SERVICES	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place	Funded posts	Substan-tive in post	Locum cover in place
Consultants	4	2	1	4	0	2	0	0	0
Middle Grades	1	1	0	1	1	0	0	0	0
Junior Doctors	2	2	0	2	1	1	0	0	0
Trainee Doctors	1	1	0	1	0	0	0	0	0

Stroke Nursing Staff

	Lincoln County Hospital			Pilgrim Hospital			Grantham Hospital		
	Funded posts	Substan-tive in post		Funded posts	Substan-tive in post		Funded posts	Substan-tive in post	
Band 8	0	0		0	0		0	0	
Band 7	1	1		1	1		0	0	
Band 6	5.8	2		2.6	5		0	0	
Band 5	22.1	14.34		24.84	7.87		0	0	
Band 4	0	0		2	1		0	0	
Band 3	1	2		0	2		0	0	
Band 2	14.32	11.79		14.46	10.8		0	0	
Band 1	0	0		0	0		0	0	

3. Why is there a risk to the continuity of these services

Medicine at Grantham

This major gap in medical staffing presents challenges for sustaining the delivery of clinical services, because there are not enough medical staff to provide a 24/7 rota. Therefore, this presents a potential risk to sustaining service continuity, which could lead to a potential risk to patient safety.

The on call rota is a rota for providing medical cover overnight for sick patients who need to be seen by a consultant. Currently, including the Locum Doctors covering the vacancies at Grantham, the ratio of the medical on call rota is a 1 in 7, this mean that each Consultant is on call every 7th night. However, the 7th place on the rota is currently vacant as we try to recruit to this post. This in turn, means that the Consultants are working a 1 in 6 on call rota at the present time.

There is a heavy reliance on Locum and Agency medical staff to cover vacant posts and therefore to sustain the medical rota; this in itself presents a risk, as Locum and Agency Staff can leave at short notice.

This is why the sustainability of these medicine services at Grantham is at risk.

The Cardiologist does not form part of the on call rota, because the Cardiology rota is run from the Lincoln Hospital site, where the Heart Centre is located. Patients requiring urgent Cardiac Care overnight are transferred to the Heart Centre for specialist cardiac care.

Stroke services Trust wide

There are eight funded consultant posts for the stroke service Trust wide, and only two of these posts are substantively filled. Both substantive consultants are based at Lincoln Hospital.

Recruitment has been ongoing for a number of years without success, and active recruitment is still in progress. Therefore, an alternative service model option needs to be considered. This was part of the recent Acute Services Review and options from this review are forming part of the Healthy Conversation 2019 engagement process, which continues.

4. Recruiting to the vacant posts

Medicine at Grantham

Recruiting to the vacant medical posts has been in progress now for a significant amount of time, but without success. It is also becoming harder to source NHS Locum and Agency Doctors to provide cover for the gaps. However, recruitment attempts are continuing, and our Human Resources Department is working on a targeted overseas recruitment programme, in addition to seeking out suitable candidates from within the UK.

The Division of Medicine has a plan for every vacant medical post in the Trust, supported by the Human Resources Department and recruitment is underway.

5. Mitigating the risks to clinical and patient safety

The Medical Division is already mitigating the risks but this is potentially unsustainable.

The Division of Medicine are working to develop options for consideration by the Trust Board to further mitigate the risks.

The Division is hosting a ULHT internal risk summit for the Grantham Medicine services on Wednesday 25th September to consider these. If the output from this internal risk summit suggests that a further external risk summit is required, this will be convened and it will include input from our Commissioning colleagues, and colleagues in both primary and community care across Lincolnshire, together with colleagues from neighbouring organisations outside of the county of Lincolnshire.

A risk summit to consider mitigating options for Stroke services is being arranged as a matter of urgency.

6. Summary and next steps

This paper is bringing to the attention of the Trust Board a potential risk to sustainability of medical services at Grantham Hospital, and to Stroke services Trust wide, brought about by the significant gaps in medical staffing demonstrated in this paper.

An internal risk summit to consider mitigating options for medicine at Grantham is taking place on 25th September, and the output of this risk summit will be shared with the Trust Board, together with the next steps to ensure clinical sustainability at the Grantham Hospital.

A risk summit is being arranged to consider the mitigating options for the Stroke service.

To:	Trust Board
From:	Julie Pipes Jeff Ashby Neill Hepburn
Date:	01/10/19
Healthcare Standard	N.A

Title:	Update on the Medical School

Author/Responsible Director: Julie Pipes / Jeff Ashby / Dr Neill Hepburn

Purpose of the report: For Discussion, Assurance and Information

The report is provided to Trust Board for:

Decision		Discussion	X
Assurance	X	Information	X

Summary / Key points:

The Medical School represents a challenge and an opportunity that is unlikely to be seen again in our lifetime. It is therefore vital that the Trust's aims are achieved.

This paper focuses on:

1. Construction of the buildings.

    - A business case will be brought to Trust Board for approval.
    - Timeline:
        - **24/9/2019** – OBC (Outline Business Case) goes to CRIG (Capital Revenue Investment Group) for discussion
        - **30/09/2019** – Options appraisal
        - **29/10/2019** – OBC goes to CRIG for final approval
        - **November 2019** – OBC goes to ET for approval
        - **03/12/2019** – OBC goes to Trust Board for approval
        - **December 2019 to July 2020** – Procurement process
        - **August/September 2020** – Building starts
        - **August 2021 –** Building completed

2. Appointment and training of teaching staff:

- Dual-appointed Educational academics (Professors) will be required for the Medical School. These will initially be University of Nottingham posts.
- They will provide 50% clinical activity and 50% educational activity.
- This should entice a high caliber of doctors into ULHT.
- Additional educational training has been sourced.

3. The structure of ULHT's Education Department:

- A fundamental change in structure is required in order to achieve the changes that are necessary in undergraduate medical education, and also our approach to postgraduate medical education and continuing professional education.
- This would involve a Professor of Undergraduate Medical Education, a Deputy Director of Postgraduate Medical Education and a Medical Education Business Manager.

Recommendations:

To be assured of the Trust's processes and progress in relation to the Medical School.

To await the Business Case for the building component which will be escalated to Board on 3 December 2019.

Strategic risk register N.A	**Performance KPIs year to date** N.A
Resource implications (eg Financial, HR): Financial, HR	
Assurance implications: N.A	
Patient and Public Involvement (PPI) implications: Yes	
Equality impact: N.A	
Information exempt from disclosure: N.A	
Requirement for further review?: N.A	

Overview

On 16 September 2019, Lincoln welcomed its first ninety students to the Medical School. Lincoln was selected as one of five locations to open new medical schools. This was the first time in twelve years that new medical schools have been established. This represents a significant opportunity for the Trust and the health economy.

> *I'm pleased to see the first cohort of local medical students arriving. The Lincoln Medical School is an exciting development that will provide a massive boost for the Lincolnshire NHS workforce for the future. These students will train in our hospitals and we hope will go forward to work in our local NHS and care for the people of Lincolnshire.*
>
> Andrew Morgan, CEO

This paper will focus on:

1. Construction of the buildings.
2. Appointment and training of teaching staff.
3. The structure of ULHT's Education Department.

A number of initiatives are already in place to build relationships and develop mutual confidence with our colleagues at the University of Lincoln (UoL) and the University of Nottingham (UoN). Over the last four months, the following meetings have taken place:

- 24th May – School at Lincoln Project Board, UoN.
- 3rd June – Secondary Care Plenary Teaching, UoL.
- 27th June – Human and Physical Resources Workstream, UoN.
- 2nd July – School at Lincoln Project Board, UoN.
- 3rd July – Clinical Experience Workstream, UoL.
- 26th July – School at Lincoln Project Board, UoN.
- 29th July – Clinical Delivery meeting with the MD and University Deans
- 11th Sept – LMS Course Management Committee, UoL.

In addition, a number of smaller meetings have taken place internally and externally regarding the curriculum and clinical academic appointments.

It is apparent that higher-level involvement is also necessary. A regular meeting is therefore being arranged that will include the Deans from the University, certain members of ULHT's Board and the project managers working on development of the Medical School.

Construction of The Buildings

A collaborative bid in 2018 to the Higher Education Funding Council England and Health Education England HEE from the University of Lincoln and University of Nottingham for a new Medical School hub to be situated primarily on the University of Lincoln Campus, has been successful. The funding that has been allocated for a new medical school hub is £1.5m, and United Lincolnshire Hospitals NHS Trust has added £300k, making the total amount of funding available for this project; £1.8m.

As a result, United Lincolnshire Hospitals NHS Trust, hereby known as the Trust, as part of its signed memorandum to support the bid application, is expected to reconfigure and expand its current undergraduate and postgraduate departments at Lincoln County Hospital and Pilgrim Hospital Boston to become fully functioning Medical Schools of excellence.

The scheme focuses on two of the Trust's acute sites. At Lincoln County Hospital, the scheme will deliver a new consolidated undergraduate and postgraduate facility to enhance the provision of education to medical students and relevant support staff. The facility will be used for teaching, and study purposes.

At Pilgrim Hospital Boston, the scheme will enhance the existing Education Block to accommodate the increased volume and activity of medical students and relevant support staff, again to support with healthcare teaching and studying provisions.

Grantham Hospital, as the third site, has no changes being proposed to either the education facilities or estate within this case as the current provision has been deemed satisfactory for the size of the site and the complement of trainees that attend the site currently and in the future.

As such, the purpose of the Outline Business Case (OBC) is to put forward the; strategic, economic, financial and management case behind enhancing current postgraduate and undergraduate departments at both Lincoln County Hospital and Pilgrim Hospital Boston to support the students from the new University of Lincoln Medical School.

1.1 Medical Education Strategy

1.1.1 Background

The development of the existing medical education facilities occurred after the Trust put forward a bid to work with the University of Derby in the year 2006. It was proposed back in 2006 that the Trust would work with the University of Derby's graduate entry medical school program. The result of the bidding process was such that Derby Hospitals NHS Trust was successful in securing the funding to support the University of Derby's medical school program.

However, not all was lost, because the work that the Trust did to submit the initial bid was fully utilised when the University of Nottingham's medical school called for extra

medical placements for their student body. The extra placements were placed with ULHT.

The medical education facilities provide the infrastructure for the education of medical and dental personnel, postgraduate doctors and undergraduate medical students.

The Trust currently provides Undergraduate and Postgraduate medical education facilities at all three hospital of its hospital sites. The extent of facilities differs a little by site.

The majority of the medical students using the Trusts medical education facilities come from the University of Nottingham. However, there is also an agreement in place with Leicester University to offer specific blocks of medical education and training to their medical students.

ULHT's medical education facilities also provide the infrastructure to support the Boston and Lincoln areas, General Practice Training Scheme and the work of the GP Tutor in relation to continuing medical education of general practitioners in South Lincolnshire.

The facilities are also utilised by Trust/career grade doctors and consultants for continuing professional development.

1.1.2 Regional strategy for Medical Education

Regionally, the Trust actively engages with the system priorities of the local sustainability and transformation partnership (Lincolnshire STP). There is a shared vision for Lincolnshire to move to an integrated care system by 2020/21. Providing more locally-based medical schools will continue to add to the infrastructure that is already in place to lead the system towards shared clinical and financial accountability.

One of the four priorities for the Lincolnshire STP is 'system working' with common purpose, standards and outcomes for the benefit of the Lincolnshire population. The phrase 'system working' extends beyond healthcare providers and looks to exploit opportunities through collaborative working with other public sector organisations such as this (the University of Lincoln) as part of agendas such as the One Public Estate.

Workforce, including 'out of hospital service delivery' is another key priority for the region in an attempt to move a greater amount of care and resources from the organisations acute hospitals to networks of integrated neighbourhood teams in order to provide 'care closer to home'. As a number of the undergraduate and medical academics will be undertaking their clinical placements in GP Practices and other community based healthcare premises, the investment into the two Medical Education facilities will support this regional strategy.

Nationally Health Education England's (HEE) Quality Framework, published for 2017/18 identifies 6 standards of quality to ensure effective education of medical learners. These standards cover:

1. Learning Environment and Culture (addenda 1.1 through 1.6).

2. Educational Governance and Leadership (addenda 2.1 through 2.5).
3. Supporting and Empowering Learners (addenda 3.1 through 3.5).
4. Supporting and Empowering Educators (addenda 4.1 through 4.4).
5. Delivering Curricula and Assessments (addenda 5.1 through 5.3).
6. Developing a Sustainable Workforce (addenda 6.1 through 6.4).

Each standard's addenda details the key criteria and expectations HEE has regarding the provision of high quality learning environments. It is proposed that the changes to the Trust's educational facilities, as well as increased budgetary oversight of educational monies (through the creation of an education division within the trust) would be a key factor in ensuring that the Trust has the educational structures capable of delivering a high quality learning environment that is guided effectively by its own divisional structure.

Concentrated resources allow for better monitoring and governance processes, promoting excellence where found and acting on areas of concern where identified. Support for learners would improve, both in terms of state of the art teaching and training facilities, that are future proofed for increased student numbers, as well as a more focused and dedicated use of monies allowing the educational division to provide opportunities based on equality and diversity principles and ensure effective pastoral care structures are in place to best support learners.

Educators would also be better supported through the improved links with the Universities. Joint academic appointments would play a key part in this, having the knowledge of both university and hospital processes and helping shape the content of the curricula assessments and programs offered by hospital placements.

1.1.3 The future strategy for Medical Education at ULHT

The vision for Medical Education in Lincolnshire is to expand the training facilities in order to support the students going through the new University of Lincoln Medical school. In addition, the strategy includes combining the current undergraduate and postgraduate facilities at Lincoln County Hospital into one overall education facility. At the Pilgrim site, the undergraduate and postgraduate facilities are already combined in a standalone building. There is no suggestion of relocating the facility at the Pilgrim site, but, it will require some refurbishment.

The strategy includes updating the estate facilities , and equipment so that the all sites have the capacity to deliver excellent medical education in state of the art facilities. This includes:

- Clinical skills suites equipped to mimic a ward environment to allow for training in a controlled and familiar setting, realistic to the environment in which students will be actually working
- Dedicated medical/clinical education suites with the capacity and equipment necessary to support the growth of the medical student intake from the University of Lincoln and maintain our provision for Leicester and Nottingham
- Continuity in the provision of education for ULHT's Doctors.

- An adequate space for larger scale events –for example the ULHTs Grand Round or hosting of external exams for the region, which would help to improve links with educational partners and improve the Trust's reputation in regards to education.
- Provision of Joint Academic/Clinical posts, bringing in highly skilled consultant staff, who split their time between completing clinical activity for ULHT and providing education to medical students at the University.

The longer term strategy and vision for medical education at the Trust involves giving autonomy and making medical education a core business of the Trust.

In summary, the longer term strategy for medical education is to create a Medical Education clinical business unit, sitting in the Medical Directorate that will have autonomy and control over their own budget, bringing closer and succinct control over medical education.

1.2 Existing Arrangements

1.2.1 The current service offered by the Medical Education Team

Lincoln County Hospital

The site has two separate facilities on site, one for the undergraduates and one for postgraduates. The two facilities are far from being co-located at the Lincoln site. The undergraduate facility is located in the West Wing of the hospital, and the post graduate facility is located in the main clinical hub area of the hospital, on the lower ground floor.

The Undergraduate facility

The undergraduate facility is a purpose built construction, in an area that had previously been one of the old "nightingale wards". It was completed in 2006 as part of the offering to support Nottingham University medical students.

The facility current comprises of :

- 3 x Teaching rooms (tabled) – capacity of 25, 15 and 10.
- 1 x Clinical Skills room (3 people max)
- 1 x Study room
- 1 x Faculty office
- 1 x Administration office
- 1 x Common room
- 1 x Kitchen
- Male, female and disabled WC's

The Postgraduate facility

The postgraduate facility in comparison is not a purpose built facility/conversion. The Trust has used pre-existing teaching facilities on site in which to fit the postgraduate facility.

Current provision is as follows:

- 3 x Teaching rooms – capacity of 50, 40 and 15.
- 1 x Clinical Skills Laboratory – actually owned and equipped by Dentistry teaching but agreement in place to use outside of the 16 sessions per annum that Dentistry uses the room.
- 1 x Computer room (3 Desktop workstations)
- 1 x Reception/Meeting room
- 1 x Deanery office
- 3 x Administration offices

The Postgraduate facility also has to share their teaching space with the Resuscitation training team, and encompasses a store room that is used by the hospital shop on site for stock storage. The Postgraduate facility also use an additional administration office space that is not part of their facility.

There is no dedicated lecture theatre at the Lincoln Hospital site for Medical Education either undergraduate or post graduate.

Pilgrim Hospital Boston

The Postgraduate facility (incorporates the Medical students also)

A fully converted, standalone building at the Pilgrim Hospital provides a Postgraduate Medical and Dental Education Centre. Included in the current provision is as follows:

- 1 x Lecture theatre (seats 90)*
- 1 x Courtyard room (seats 30)*
- 1 x room, known as the McKenzie suite (seats 40)*
- 1 x Seminar room (seats 26)*
- 1 x Lecture hall (seats 50)*
- 1 x Clinical Skills Laboratory
- 1 x Computer room (10 Desktop workstations)

*all highlighted rooms have presentation facilities.

Teleconferencing is available in Lincoln, Grantham and Boston. The video conferencing equipment in the Lincoln undergraduate and postgraduate facilities, and at the Boston education facility is now out of warrantee. It is no longer covered by a maintenance contract. There is an IT project underway to look at teleconference equipment across the Trust, and further cost will be involved, but the cost of this will be in a separate business case. It is not included within the scope of this outline business case.

Grantham and District Hospital

The Stonebridge suite at Grantham and District Hospital provides both Undergraduate and Postgraduate facilities at the Grantham site. Grantham is the smallest hospital site within the Trust, and therefore requires fewer facilities to support medical education. The current provision is as follows:

- 1 x Lecture hall (seats 40)
- 1 x Videoconference enabled meeting room (seats 12)
- 1 x common area
- 1 x Administration office
- 1 x Coffee room

It should be noted that any future changes to medical education provision will not look to change the estate used at Grantham hospital, as the estate provided is more than adequate.

Case for Change

The Trust itself is facing a significant challenge with regard to recruiting and retaining medical staff, predominantly; consultants, middle grade and junior medical staff. At times, Consultants are required to support the middle grade doctors by acting down into middle grade rotas. This is physically unsustainable for the consultants, and financially unsustainable for the organisation.

The shortage of key healthcare staff in the past year has caused concern with the likes of Health Education England, who considered withdrawing their provision of Junior Doctors from Paediatric Wards at Pilgrim Hospital Boston due to concerns around patient safety and the safe supervision of Junior Doctors. Discussions are also taking place around the training support for junior doctors at Grantham, and these too are at risk of being withdrawn

As the universities of Lincoln and Nottingham have secured funding for an initial 80 first year undergraduate places in September 2019 with a further 80 per intake in subsequent years, this will ensure clinical placements take place at the Trust's acute sites and it is hoped that the scheme will attract senior clinical academics, whom will support with the clinical curriculum development and delivery and oversee the education of the students. This will enhance the medical education in general across all grades of doctors and other healthcare undergraduates, leading to service improvements and delivering better care.

We have an increase in the number of students that will be accessing and using the medical education facilities at our hospital sites. The students enrolling at the University of Lincoln medical school in September, 80 in total, will start to train on the hospital sites with effect from February 2022. The Medical School will take 80 new students each year, so the number coming through the medical education facilities at the Trust will increase year on year.

The current medical education facility at the Lincoln Hospital site is not large enough to accommodate the numbers coming through. The facility at Pilgrim is large enough, but requires some modifications.

(Undergrad = medical students)
(Post Grad = trainee doctors)

Number of medical students

Since initial investment in the medical education centres across the Trust back in the year 2006, there has been a small increase in student numbers. Internal figures from 2008 show 464 medical students received training within the Trust (200 from Nottingham and 264 from Leicester), whereas in 2019, a total of 496 medical students will receive Trust support (356 from Nottingham and 140 from Leicester).

In order to understand the impact on the medical education accommodation and facilities, we need to understand the impact of the new medical school opening at Lincoln University, with the first cohort of 80 students starting in September 2019. The increase in medical student numbers that will need access to the Trusts Medical Education facilities is summarised in the table below

The table below shows a summary of the medical student numbers per year starting from this year. This demonstrates the increase in student numbers, and the number of student weeks per year.

The increase in medical students from this current year (2019) to 2022 when the first of the new cohort at Lincoln University medical school will access the Trust medical education facility is 66%, with a further increase of 39% in 2024.

Year	Number of Students Doing a block at any one time	Total number of students doing each block over the year	Number of Students Weeks
2019	146	496	3564
2022	242	592	5420
2024	336	988	7348

In addition to the above, ULHT has around 169 trainee doctors on their sites at any given time who also need access to training facilities covered by postgraduate department.

The important thing to note is that a significant amount of additional students, 39% increase to current numbers, will access our education centres from February 2022. The current facilities will not accommodate this increase in student numbers.

As the universities of Lincoln and Nottingham have secured funding for an initial 80 first year undergraduate places in September 2019 with a further 80 per intake in subsequent years, this will ensure clinical placements take place at the Trust's acute

sites and it is hoped that the scheme will attract newly trained junior doctors to work for the trust long term.

The development of senior clinical academics; consultants who split their time between lecturing at University and clinical sessions within the Trust, is also being planned. These posts are very attractive to senior clinicians and will help with their recruitment. These posts which support the clinical curriculum development and delivery and oversee the education of the students, will enhance the medical education in general across all grades of doctors and other healthcare undergraduates, leading to service improvements and delivering better care.

Options explored in the Business Case for additional medical training facilities at ULHT

Option 1:

- Do nothing.

Option 2:

- Expansion of the existing Post Graduate Centre at the Lincoln site
- Refurbishment of the Education Centre at the Pilgrim site
- Circa £2.3m

Option 3:

- Expansion of the existing Undergraduate Centre, by taking the existing finance department area, and the nightingale ward located directly below the finance department
- Refurbishment of the Education Centre at the Pilgrim site
- Circa £2.3m

Option 4:

- Expansion of the existing Undergraduate Centre by taking the existing finance department area, and erecting an extension to the existing finance department
- Refurbishment of the Education Centre at the Pilgrim site
- Circa £2.3m

Option 5:

- A New Building located on the Lincoln site that would also accommodate; the Research & Development function, and office accommodation for the administrative staff based at the Lincoln site.
- Refurbishment of the Education Centre at the Pilgrim site
- Circa >£10m

Timescale to completion and start of building works

- 24/9/2019 – OBC goes to CRIG (Capital Revenue Investment Group) for discussion
- 30/09/2019 – Options appraisal
- 29/10/2019 – OBC goes to CRIG for final approval
- November 2019 – OBC goes to ET for approval
- 03/12/2019 – OBC goes to Trust Board for approval
- December 2019 to July 2020 – Procurement process
- August/September 2020 – Building starts
- Building completed August 2021

Appointment and Training of Teaching Staff

A fundamental change for ULHT is the requirement for joint academic appointments. These will initially be between ULHT and the University of Nottingham. This will likely evolve over time.

A number of professorial and senior appointments will be necessary. This should be a recruitment draw for high caliber individuals which will ultimately lead to improving the quality of medical staff at ULHT. The academics that ULHT will be appointing will be Educational Academics, rather than Research Academics. The original plan was to appoint two professors (one in Medicine, one in Surgery).

The plan has developed since its inception, with a current expectation of five professors or associate professors. Their time will be split evenly between clinical and educational commitments. This 50:50 model is new to ULHT and the University of Nottingham (at Lincoln) are sharing some examples of similar job descriptions for adapting.

The Medical School will not be receive funding for clinical teaching until October 2021, when the students arrive. Therefore the arrangement is for ULHT to pump prime the staffing requirements using the agency premium. There is the opportunity of receiving some funding through HEEM and this is being explored by the University.

In addition to recruiting high caliber of medical staff, it is acknowledged ULHT need to develop the education skills of our current staff. An online course: “Developing Expert Educators for Healthcare Professions” is being provided for relevant staff. This is an online course, runs in affiliation with the University of Nottingham, which provides teaching in:

- Motivation.
- Learning strategies.
- Reflection.
- Design of teaching, cognitive load theory and effective instruction.
- Validity and reliability.
- Assessment methods.
- Feedback.
- Curriculum statements.
- Constructive alignment.
- Educational governance.
- Impact.
- Psychological safety and group dynamics.

Certification costs £52 and can be funded from the doctors' own study leave budget. Full details can be found at: https://www.futurelearn.com/courses/from-philosophy-to-practice.

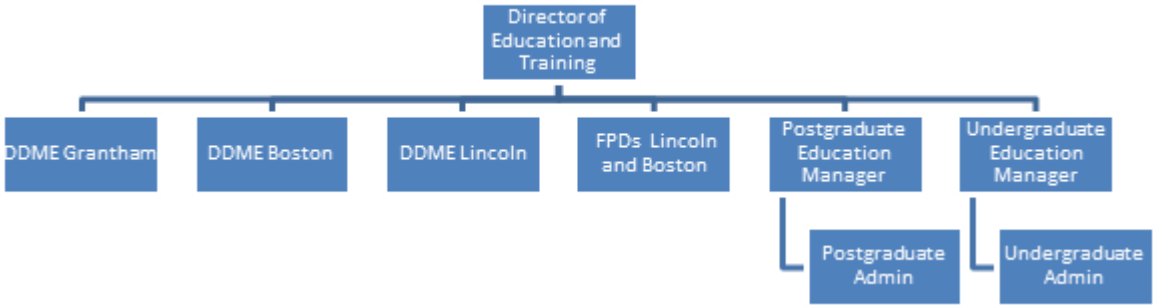
Additionally, the Trust have appointed teaching fellows who will have responsibility for educating the students. As part of this, the fellows are studying for an MMedSci in Medial Education with the University of Nottingham. More information can be found at: https://www.nottingham.ac.uk/pgstudy/course/taught/medical-education-mmedsci.

The Structure of ULHT's Education Department

When ULHT's Education Department was designed, there was no indication that the Lincoln Medical School would be developed. There is therefore a need to update the current structure needs to be changed.

The current structure for medical education has evolved over time and has responsibility for:

1. Undergraduate teaching (medical students).
2. Postgraduate training (foundation years, core training, specialist training).
3. Continuing Professional Development.



Issues and Opportunities:

The main issues and opportunities are:

1. The new medical school represents a step change in medical student teaching with an associated requirement for facilities (teaching rooms, lecture facilities, work spaces, I.T, etc.), staff training, programme development, delivery and monitoring.
2. The overseas recruitment of doctors to whom we have promised a structured CESR programme to gain entry to the specialist register (and our plans to develop our 'middle grade' doctors) represents a further step change.
3. There are ongoing concerns around the welfare and experience of junior doctors nationally and these issues exist within ULHT.
4. Concerns have been raised by HEEM and the universities regarding responsiveness to the issues, our 'grip' on training in ULHT and the development of the Medical School.

The current structure was not designed to deliver the changes required. The ultimate aim is to combine professional education and training for all professional groups into a single directorate. This was the direction of travel when the current Director of Medical Education (DME) was appointed. However, that is an aspiration which has been achieved in a only a small number of Trusts, such as Doncaster and Bassetlaw NHS Foundation Trust.

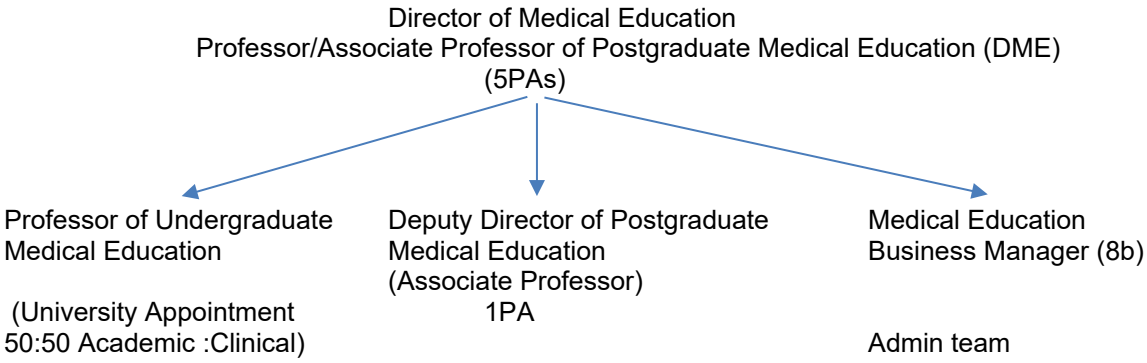
The Medical School represents an additional challenge. However, it also represents an opportunity as it holds the potential of enticing individuals with the potential to drive this change forward.

Planned Restructure

To create two (50:50) posts linked to the Universities of Lincoln/Nottingham:

- Clinical Professor/Associate Professor of Undergraduate Medical Education (University Appointment)
- Clinical Professor/Associate Professor of Postgraduate Medical Education (ULHT appointment)

This will be supported by an 8b Medical Education Manager:



The funding for the ULHT appointment and the Business Manager is from the existing budget. The funding for the University post will need to come from Agency overspend from the Divisions initially until students arrive to commence clinical studies in Sept 2022.

Agenda Item 14.3

LINCOLNSHIRE CO-ORDINATING BOARD

DATE OF MEETING		AGENDA ITEM	

TITLE OF REPORT	Healthy Conversation 2019 update report: 12 September 2019
STATUS OF REPORT	For information
LEAD AND JOB TITLE	Sarah Furley, STP Programme Director
AUTHOR AND JOB TITLE	Steph King, Strategic Engagement Lead
APPENDICES	Appendix A: Healthy Conversation Engagement Event Poster Distribution Appendix B: Wave 3: Healthy Conversation

PURPOSE OF REPORT
This report provides a summary of the feedback from the Healthy Conversation 2019 campaign to NHS provider trust boards, commissioning governing bodies, partners and stakeholders. It details the campaign activity-to-date, feedback and results to inform the development of Lincolnshire's Long Term Plan and system programmes, as well as the next steps to be taken with further engagement.

RECOMMENDATIONS
The report is noted.

BACKGROUND
On 5 March 2019, the NHS across Lincolnshire launched its Healthy Conversation 2019. It is an open engagement exercise which will shape how the NHS in Lincolnshire takes health care forward in the years ahead. It is a chance for everyone to learn more about the NHS's current thinking on the future of NHS services and is a way to get meaningful feedback from our patients, their representatives, the public,

NHS partners and staff about what future services may look like. Healthy Conversation 2019 has continued throughout the year, with a wide range of engagement events and discussions across the county. The nearly 7 months of engagement is due to come to a close on 31st October 2019 which will enable all feedback received to be considered in a timely manner to inform the Lincolnshire's Long Term Plan alongside the Healthwatch engagement results.

ANALYSIS OF KEY AREAS

The report outlines the communications and engagement activities undertaken and the feedback received from the open engagement events; paper and online forms and queries; workshops and community group meetings.

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family
- NHS111 and its effectiveness
- EMAS and response times
- Issues of overburden on Lincoln County Hospital

RESOURCES

These activities have been undertaken by the Healthy Conversation 2019 communications and engagement team and supported by leads across all organisations.

PATIENT AND PUBLIC / STAKEHOLDER INVOLVEMENT

Healthy Conversation 2019 is an open engagement exercise which will shape how the NHS in Lincolnshire takes health care forward in the years ahead and has involved a wide range of patients, the public, staff and stakeholders in a variety of engagement activities.

FINANCIAL IMPACT

None

ANALYSIS OF RISKS AND ISSUES

Risks are monitored within the Communications and Engagement Programme

www.lincolnshire.nhs.uk

Healthy Conversation 2019 update report
12 September 2019

This report provides a summary of the feedback from the Healthy Conversation 2019 campaign to NHS provider trust boards, commissioning governing bodies, partners and stakeholders. It details the campaign activity-to-date, feedback and results to inform the development of Lincolnshire's Long Term Plan and system programmes, as well as the next steps to be taken with further engagement.

Contents:

1. Background:

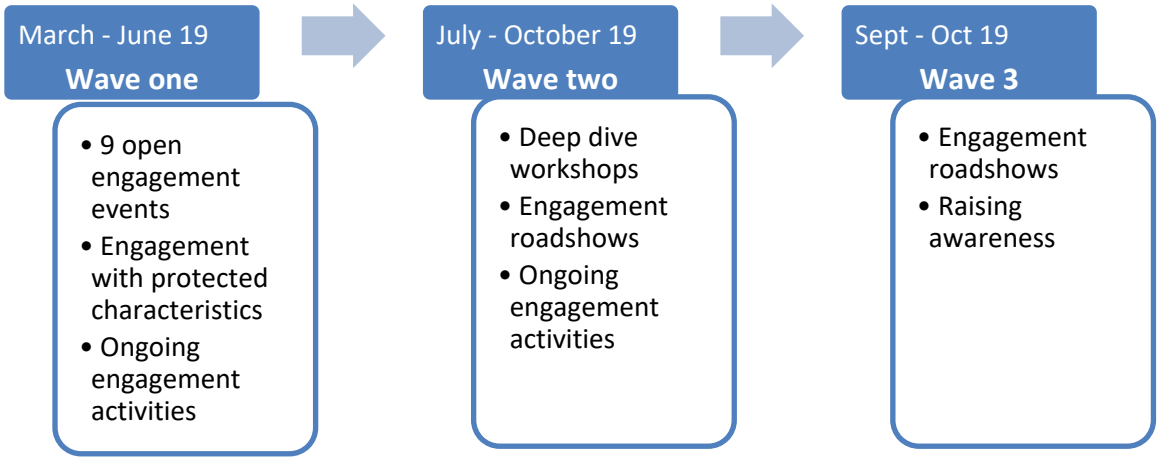
On 5 March 2019, the NHS across Lincolnshire launched its Healthy Conversation 2019. It is an open engagement exercise which will shape how the NHS in Lincolnshire takes health care forward in the years ahead. It is a chance for everyone to learn more about the NHS's current thinking on the future of NHS services and is a way to get meaningful feedback from our patients, their representatives, the public, NHS partners and staff about what future services may look like. Healthy Conversation 2019 has continued throughout the year, with a wide range of engagement events and discussions across the county. The nearly 7 months of engagement is due to come to a close on 31st October 2019 which will enable all feedback received to be considered in a timely manner to inform the Lincolnshire's Long Term Plan alongside the Healthwatch engagement results.

The key overarching Healthy Conversation 2019 campaign messages have been:

- Lincolnshire's NHS needs to continue to transform to improve quality, attract staff and be fit for the future
- The way we all use the NHS needs to change too
- We need to make this change together – get involved

2. Activity undertaken:

The various waves of communications and engagement have incorporated a number of activities to give as many people as possible the opportunity to get involved and share their views in a way that suits them:

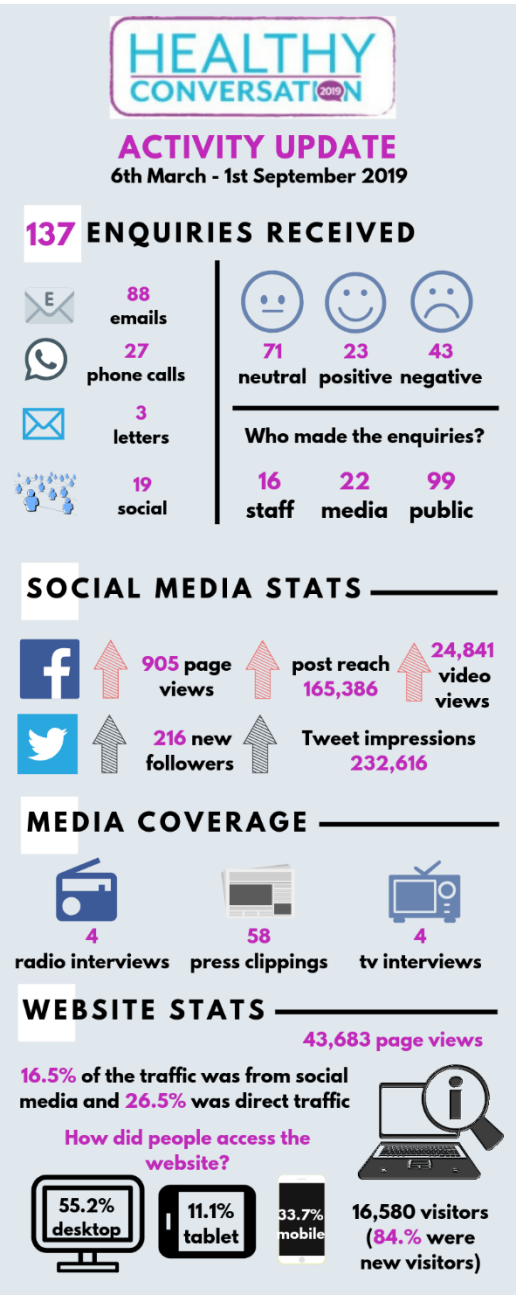


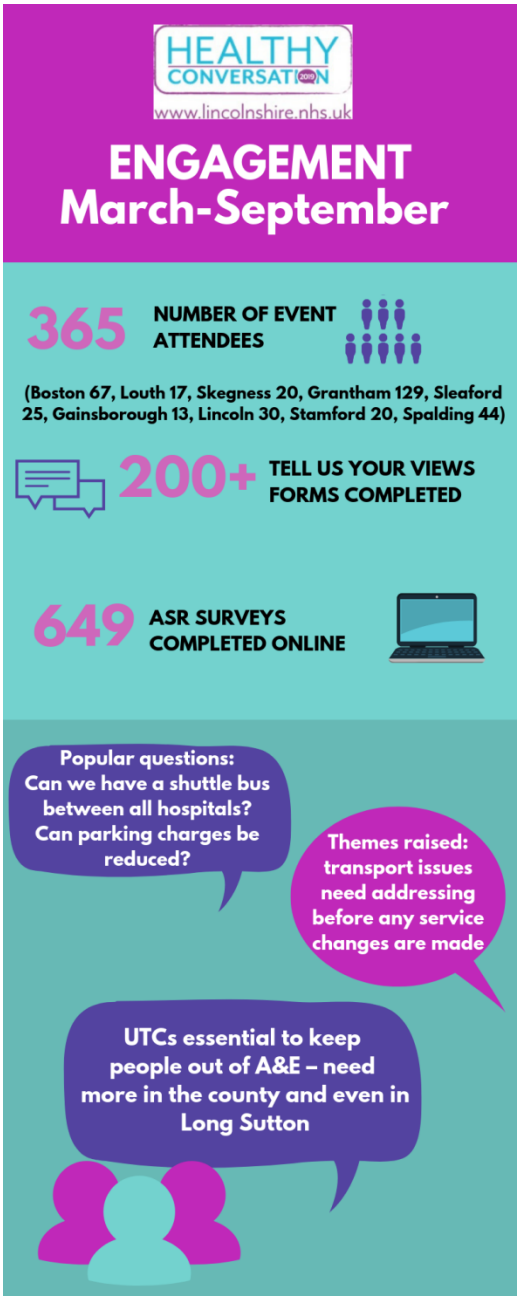
Overview of engagement to date:

Engagement activity	Reach
Acute Service Review (ASR) survey *(closed 31st August 2019)* (also translated into Romanian, Polish, Russian, Latvian, Lithuanian, and Portuguese)	649 responses
General feedback forms	200+ responses
9 Healthy Conversation open events in Boston, Louth, Skegness, Grantham, Sleaford, Gainsborough, Lincoln, Stamford and Spalding	365 attendees
People's Partnership engagement with protected characteristics	130 responses
Roadshows	Grantham shopping centre, Boston market place and Tesco
Distribution of leaflets and posters (see appendix A)	All NHS organisations and staff, GP practices, libraries, pharmacies, colleges etc
Locality workshops	Grantham: 19 June 2019 Boston: 27 June 2019
Community meetings (e.g. Health Improvement Partnership, Toddler Group, Blind Society meetings etc)	139 attendees at meetings with a reach of over 7000 members.
Ongoing direct contact with the HC2019 team via telephone, email and letter	

This has been supported by widespread media and social media activity as well as direct calls and emails to the team. Although the volume of media coverage has dropped, the amount of social media activity continues to grow with to date an audience reach for posts of over 165,000 and over 43,000 website views since the launch of the campaign in March.

The infographics below summarise communications and engagement activity throughout the campaign.





Appendix A highlights the distribution of posters to local outlets and stakeholders to raise awareness of the engagement exercise as well as the numerous opportunities to get involved; promote the engagement events; press releases to key media contacts and channels utilised to promote the workshops.

3. Engagement feedback overview:

The Acute Services Review survey was closed on 31st August 2019 following six months of engagement. These results are currently being analysed and will be reported into the Lincolnshire NHS system to ensure it informs the next stage of the acute services review programme. In addition, the engagement undertaken by The People's Partnership to hear the views of Lincolnshire's communities with protected characteristics and those who would otherwise not be readily represented will also be considered in this process as well as informing our Equality Impact Assessments. Once complete, both of the reports, their outcomes and next steps will be circulated and published on our website.

The following sections of the report highlight the summarised HC2019 feedback received from the 9 engagement events; paper and online forms; locality workshops and meetings with various community groups.

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects.

3.1 Feedback from open engagement events:

Since the campaign launch, we have held 9 Healthy Conversation 2019 events, advertised locally, for the public to attend drop in sessions between 2-7pm in the locations in the table below. These events have been attended by 365 people and the core themes that were raised (through direct verbal feedback, formal forms and the surveys analysed to date) were:

Date	Location	Key Locality Themes	No. of attendees
13/03	Boston	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	67
14/03	Louth	• Threat of hospital closure (this was an initial concern that alleviated once responded to)	17
19/03	Skegness	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	20
20/03	Grantham	• Concern that A&E is being 'downgraded' • Urgent Treatment Centres and what they are	129
20/05	Sleaford	• Lack of GP access • Lack of coordination following discharge from hospital	25
21/05	Gainsborough	• Lack of GP access • Financial difficulties when having to travel to visit family	13
22/05	Lincoln	• Financial difficulties for family members having to travel to hospital • Professionals should be able see each other's notes to make it more streamlined for patient	30

12/06	Stamford	• Ensure links with North West Anglian NHS Trust for services in Stamford • Grantham A&E closure overnight	20
13/06	Spalding	• UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton	44

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family
- NHS111 and its effectiveness
- EMAS and response times
- Issues of overburden on Lincoln County Hospital

3.2 Feedback from paper and online forms and queries:

We have received over 200 completed HC2019 feedback forms on various elements of the campaign via social media, telephone, email and forms at events and on our website. The detailed feedback has been circulated to programme Senior Responsible Officers and a summary of the key themes and suggestions for each of the services is provided below:

Acute Medical Services

Key themes:

- Capacity issues at Lincoln hospital – delays in being seen
- Length of time to get to hospital

Suggestions include:

- Airlift to specialist hospitals outside of Lincolnshire if case is too complex

Breast services

Key themes:

- Poor infrastructure and road networks causing access difficulties for patients and families who need to get to Lincoln.
- Lack of confidence in Lincoln Hospital having sufficient capacity
- Favour of keeping services at Pilgrim

No suggestions were given.

Diabetes, Self-Care and Prevention Services

Key themes:

- Variation in standard of diabetes care between GP Practices
- No infrastructure to support the communities, especially in Mablethorpe

Suggestions included:

- Focus on education and generational change
- Clinic appointments needed outside of working hours to reduce time needed off work
- Regular blood tests for everyone to alert people to problems before they arise

General Surgery Services

Key themes:

- Lack of confidence that staff will be able to deal with more complex issues
- Team is mainly built up of agency staff meaning service is not sustainable
- Journey will be too long for people in severe pain to travel
- Lack of signage around Grantham hospital

Suggestions include:

- To hold follow up clinics and monitoring in local hospitals

Haematology and Oncology Services

Key themes:

- Capacity/ issues of over burden on Lincoln hospital – overcrowded and poorly staffed, not enough beds
- Costly travel and parking that could cause hardship for both patients and their families when having to visit on such a regular basis
- Frequent cancellations and delays to appointments

Suggestions include:

- To have follow up appointments locally

Mental Health Services

Key themes:

- Really good care and support especially with autism
- Impossible to get appointment with CAMHS
- Lack of awareness on how to care for people with dementia and the care plans put in place by social services
- Additional community based services, enabling patients to stay at home with family

Suggestions included:

- More information required for parents about what services are available, especially online
- Improve links (transition) from children to adult services
- Improve flexibility of CBT appointments for those who work
- More information is required about what support is available in times of a mental health crisis – A+E seems too often to be the only option
- Share updates on mental health patients with the police so they have an understanding on how to deal with the individual

Primary Care Services

Key themes:

- Interface between GPs and other services – so patients do not have to tell their story multiple times
- Lack of availability for appointments

Suggestions included:

- Charge patients if they (do not attend) DNAs booked GP appointments
- Communicate all options for appointments as patients don't always need to see a GP
- Suggestion that 1 'carer' cares for all of the people in one area; this would give more caring time and cut down on travel

Stroke Services

Key themes:

- 'Golden Hour' not achievable from some parts of the county
- Consideration of population need by locality before determining locations of service
- No mention of step down / rehabilitation
- Ambulance response times are poor – assurance needed
- Capacity issues – overburden on Lincoln hospital
- Loss of service at Pilgrim hospital

Suggestions included:

- Scope how to link mental health support and stroke community rehabilitation
- Transport issues need addressing before any services is relocated

Technology and Innovation

Key themes:

- Welcome e-consultations to avoid concerns regarding transport/reducing the NHS' carbon footprint
- Refreshing to hear; innovative thinking, digital is the future
- Due to cyber-attacks, how safe is the 'digital system'?
- Many people do not have access to the internet and will need alternative options
- Areas of poor broadband and poor mobile phone signal
- Shouldn't need to keep re-telling your story/medical history

Suggestions included:

- Patients holding their own records and notes like in France
- Other communications needed such as face to face and local newspapers

Travel and Transport

Key themes:

- Issue isn't the hospitals but travelling to them – poor road networks and lack of public transport
- Early appointments not achievable when using public transport
- Costly travelling across the county to hospitals further away
- Hardship to patients and families by having to take additional time off work to travel further
- Can't always rely on family and friends
- Community transport sometimes unreliable
- Unable to get back from hospitals if taken by ambulance

Suggestions included:

- Inter-site transport - provision of shuttle between hospitals or accommodation for family to stay
- Development of a driver volunteer scheme
- Direct trains between Boston, Skegness and Lincoln
- Routes and times clearly displayed at all bus stops
- Introduction of a travel helpline

Urgent and Emergency Care Services

Key themes:

Grantham

- Grantham is on major road and rail links and needs an A&E open 24/7
- New housing developments with increasing local population
- Travelling time is not within the 'golden hour' from parts of the county, especially for those without their own transport
- Poor road networks and lack of public transport, especially in rural villages
- Ambulance availability and response times concerns
- Capacity issues – overburden on Lincoln hospital
- Inability to get back from hospitals if taken by ambulance
- Lack of transport to attend another A&E during the night
- NHS 111 and its effectiveness

Suggestions included:

- If people call NHS 111, Grantham Hospital needs to be the first option
- Educate the public on how not to abuse the NHS
- Patients need to be clearly informed about the UTCs capabilities and limitations
- Free shuttle bus or volunteer transport to hospitals from main train and bus stations and between hospitals

Stamford (proposal)

- Great service in Stamford Hospital, would like an extended service
- Support for UTC in Stamford to reduce need to travel elsewhere for emergency care
- UTC will reduce the pressure on surrounding hospital

Suggestions included:

- Increase in population anticipated therefore need extended access to urgent care 7 days a week
- Hospital could provide additional outpatient and emergency clinics

Women's and Children's Services

Key themes:

- Lack of transport if service is moved Lincoln
- Length of time taken to get to Lincoln in an emergency is too long
- Loss of services at Boston and the desire to retains women's and children's at Pilgrim

Suggestions included:

- The need for an easier way to access community Paediatrics before children's educations are affected
- To send out clearer communication about the situations concerning women's and children's services at Pilgrim hospital

3.3 Feedback from workshops:

Locality workshops were held in Grantham on 19th June and Boston on 27th June which members of the public were invited to register to attend. Clinicians and staff were involved in discussions with the public about the key themes (ASR focused) emerging from the earlier engagement. A summary of the feedback received is outlined below. The full feedback report is currently being collated and will be reported alongside the full ASR engagement findings.

Grantham service change:

- Clarity about definitions of A&Es and Urgent Treatment Centres (including access times) is required to ensure correct usage and consistency across Lincolnshire
- Case studies required for how patients could access the UTC with various conditions/emergencies
- Increased promotion of the NHS111 service is required including how this would work alongside an UTC in Grantham
- Recognition that the future is about treating people in their local communities in their own homes and communities but if needed, ensuring that they are treated in the right place at the right time and this may mean in a more specialist hospital and sometimes outside of Lincolnshire
- Confusion about availability of staff to stabilise patients who require transfer and who will employ staff in the UTC
- Other – improved use of Emerald Suite; support for centre of excellence for planned care; reduce the need to attend second out-patient appointments if not needed or can be undertaken digitally; access to mental health single point of access within UTC; desire for new hospital in Grantham; need for organisations to work closer together.

Grantham travel and transport:

- Financial burden for those having to travel to other hospital sites, including car parking
- Concern about travel times to other hospitals and the 'golden hour'
- Population growth requires more services rather than less
- Need to reduce the need for transport – use of other technologies, discharge lounges, patient hotels, first responders able to treat patients in own home rather than transfer to hospital

- Improve transport links – work with the County Council, volunteer schemes, road networks and public transport links
- Vulnerable patients particularly affected such as those on low income, with chronic conditions and the elderly
- Concerns about EMAS capacity to transport patients further and need to improve promotion of the work they are doing to treat patients at home and improve access to the most appropriate urgent care services
- Importance of patients being seen in the right place at the right time to improve outcomes even if that means travelling further for better care.

Boston stroke services and travel and transport:

- Concern over longer treatment time for strokes if need to travel to Lincoln Hospital but recognition that patients need to go to the right place at the right time
- Improvements needed in discharge and treatment once back at home
- Prevention essential e.g., smoking cessation, tackling obesity
- Concerns over lack of staff and high vacancy rates
- Long travel times from some areas of Lincolnshire and possible detrimental impact on coastal holiday trade
- Concern about capacity of EMAS
- Concerns about the future of Pilgrim Hospital if services removed
- Increased funding required in Lincolnshire as a rural area

Boston women's and children's services; travel and transport:

- Ongoing uncertainty about services could have discouraged women from choosing to give birth at Pilgrim, reducing the services
- Recognition that some very premature babies will need to go to other specialist units
- Concerns about the need to transfer some paediatric patients to other hospitals
- Possible limitation of visits and support from friends and family
- Clarity and reassurance about suitable staffing available

3.4 Feedback from community group meetings:

Throughout HC2019, we have also attended a range of community groups and meetings to raise awareness of HC2019, promote opportunities for involvement and gather feedback about their experiences and any issues or concerns.

The feedback is summarised below:

GPs and primary care:

- Preference for email or text reminders for appointments rather than letters which can be delayed and the appointment is missed resulting in believing the patient Did Not Attend.
- Still experiencing difficulties getting appointments and would like to be told when booking an appointment if it is with a nurse rather than a doctor to manage expectations.
- Some concerns that health visitors are not contacting all new parents and some may be missed.

Workforce:

- It would be good to upskill and increase staff recruitment by being 'attached' to a training hospital
- Staff not well looked after as an employee, for example having to supply their own refreshments including tea bags; "how do we expect to fill our vacancies when we are not looking after the ones we've got!"

Technology:

- Welcomed the use of technology such as care portal as not having the correct notes in front of the doctor or consultant was very frustrating for some of this group.
- Not sure about using the phone for 'facetime' but liked the idea of having a hub to go to (for example at a GP practice) where people can be supported to log onto e-consultations etc. It was also felt that the elderly would embrace this as it means less travel and less costs.

Supporting engagement with hard to reach groups:

- Suggestions provided on how to support deaf / blind people to attend health events such as providing transport and translation into braille etc.
- People with sight or hearing loss struggle with access to services, access to GP appointments, optometrist appointments and dentist appointments and travel to appointments. Often no interpretation service is offered and patients have to sit with a doctor and write notes between them.
- Making a doctor's appointment is usually via phoning the practice- not everyone has access to the online services so it would be useful to introduce text for deaf patients.
- An example was provided of an elderly couple who have sight difficulties and needed to travel by train for a hospital appointment which lasted 10 minutes but they were out of the house for 9 hours.
- One query was raised about how someone will books appointments etc. once they go deaf as they already have an amplifier and still struggles to hear.

Travel and transport

- Travel was a concern for the majority of the group in south Lincolnshire for both GP and hospital visits. Their nearest hospital is Grantham, but a lot of the time they are sent to either Boston or Lincoln for appointments/treatment. This can be extremely difficult for those who do not drive as there is only 1 bus into Lincoln or they have to pay for a taxi.
- Alternative suggestions include volunteer driver schemes and patients only have to pay for the mileage.
- Frustration with Thames Ambulance Service Limited (TASL) which is now no longer accepting a patient who has been using it previously for 6 years.
- Some people are often not given a choice of which hospital they would like to go to for treatment and the majority agreed they would travel out of county if it meant receiving treatment quicker.
- In Peterborough they run a service where paramedics, Occupational Therapists and nurses visit the frail and elderly if ill or had a fall – this team prevents that patient going into hospital and keeps them in their own home.

4. Next steps:

A full overview of the planned activities for wave 3 of the HC2019 campaign until 31st October is provided at Appendix B. Our next steps include:

- The locality roadshows will continue across Lincolnshire to raise awareness of the campaign as well as attendance at local community groups and meetings and focus upon the continued outreach to groups who may ordinarily not feel able to become involved in the process
- Further locality workshops are being arranged for 9th October in Grantham and 10th October in Boston to continue the deep dive into emerging issues
- Extensive analysis of the HC2019 engagement results received to date and communication of the HC2019 outcomes and themes, outcome of the Lincolnshire Long Term Plan and recruiting for a Lincolnshire Citizen's Panel.

Appendix A

Healthy Conversation Engagement Event Poster Distribution

Promotion of the engagement events began in March with poster distribution to local outlets and to a number of stakeholders (sees Table A). Press releases to key media contacts (see Table B) were also regularly issued to promote the events.

The communications and engagement team have been busy circulating the posters locally by visiting local businesses across the county including supermarkets, libraries, pharmacies and colleges etc. (Appendix A). Posters and dates of the engagement events were also sent to the communications teams in ULHT, LCHS and LPFT for further distribution via their internal post, newsletters to staff, websites and social media platforms. Further to this, they were also circulated for example to patient councils, staff and GP practices across the 4 CCGs.

Press releases and dates for the June workshops were also circulated in the locality in which they were held including being sent to local and regional media outlets such as Lincs FM, BBC Look North and the Grantham Journal. Again, these were also distributed via the CCGs to staff, patient councils and stakeholder lists as well as being promoted across social media platforms (Table C).

Tables:

A. Healthy Conversation 2019 engagement event poster distribution

Outlets and Channels of Distribution	
ULHT	**Lincoln:**
ULHT Comms	Lincoln County Hospital
Website	GP Surgeries
Lead clinicians	University of Lincoln
Internal post	BGU
Social media platforms	Lincoln College

LCHS	Lincoln BIG
LCHS Comms	Lincoln Library
Newsletter to all staff	LPAC
Posted on Intranet	Health Centre (University of Lincoln)
Website	Isaac Newton Building
Internal post list	Minerva Building
Social media platforms	Sarah Swift Building
LPFT	Art Bridge
LPFT Comms	University of Lincoln GP surgery
Newsletter to all staff	High Street Dentist
Posted on Intranet	ASDA
Internal post list (62 locations)	Tesco (Wragby Road)
Social media platforms	Tesco (Canwick Road)
Lincs West:	Tesco Express
Patient Council members	Morrisons
GP Practices	Sainsbury's
South West Lincs	Matalan
Patient Council	Marks and Spencer
PPGs and Practice managers	Waitrose
Staff (inc. execs and clinicians)	Lincoln Drill Hall
Parish Councils (reach 156)	Co-Op
Virtual patient panel (reach 127)	**Gainsborough:**
Stakeholder database (see list below – reach 93)	John Coupland Community Hospital
East Midlands Academic Health Science network	GP Surgeries
GP Practices	Village halls
South Lincs	Gainsborough college
Patient Council	DW Fitness
All staff (inc. execs and clinicians)	Bungham and Young Opticians
Practice managers/PPGs	Age UK
GP Practices	Holland and Barratt
Lincs East	Connexions community hub
Patient Council (PPG/Practice managers)	Walters Opticians
Staff (inc. lay members etc)	Sense
View point and readers panel	Eco Scooters
GB members/GB clinicians	Gainsborough Library
GP Practices	West Lindsey Council
Other	Job Centre
Healthwatch	Coop Pharmacy
LIVES	Market Place Dental
STP Stakeholder Board	Superdrug
Campaign Groups	Boots Pharmacy
Staff representatives/Trade unions	Wilko
Parish Councils	Tesco
District Councils	Home Start Family and Voluntary Centre
Local MPs	**Sleaford:**
Regulators	GP Surgeries
Health Scrutiny Committee	Heckington Co-op pharmacy
Health Education England	Sleaford library
Lincs Police and Crime Commissioner	The Source

Visit Lincoln	Great Hale Village Hall
Siemens	Newsagent
Co-op	Various local outlets and community groups (see list below)
RAF	**Stamford:**
Lindum	GP Surgeries
East Midlands trains	Stamford Library
Stagecoach	Stamford performing Arts Centre
	Theatre Lounge Stamford
	Waitrose

An example of a CCG's Stakeholder database (Grantham/Sleaford area)

Adults Supporting Adults - Sleaford	Kesteven Morris
Allington Playing Field Fundraisers	Kesteven Rideability
Allington toddler group	Library - Ruskington
Alzheimers Carers Lunch Group - Grantham	Library - Sleaford
Ancaster Day Centre	Lincolnshire CVS - Health Trainers
Arthritis Care	Lincolnshire Dementia Family Support Service
Barrowby Baby and Toddler Group	Lincolnshire Traveller Initiative
Beat	Lincolnshire Visual Impairment Services
Belton Lane Children's Centre	Lincs Home Improvement Agency (LHIA)
Billinghay Children's Centre	Little Acorns Toddler Group
British Red Cross - Grantham	Multiple Sclerosis Society Support Group
Bump 2 Baby Antenatal Classes	New Life Church Ministries
C.A.P.A.A.S. (Children and Parents Asperger Autistic Support).	North Kesteven Voluntary Centre
CANadda	PALS
Caythorpe & Ancaster Children's Centre	Parkinsons UK - Grantham Branch
Celebration Active Care Club	Positive Health
Chamber of commerce	Royal Air Forces Association
Churches Together in Grantham and District	Royal British Legion - Sleaford & District Branch
Claypole Village Hall	Ruskington Youth Centre
Community Lincs	Salvation Army
Dementia Companion Service	Salvation Army
Disability Lincs Ltd	Senior Community Development Officer
Dyslexia Lincolnshire	Shareing the Care
Ethnic Minority & Traveller Education Team	Sleaford & District Citizens Advice Bureau
Evergreen Sleaford	Sleaford & District Lions
Gay Outdoor Club	Sleaford & District Round Table
Grantham & District Talking Newspaper for the Blind	Sleaford and District Lions Club
Grantham and South West Family & Carer Support Service	Sleaford Carer Support Group
Grantham Area Community Transport Scheme	Sleaford Children's Centre

Grantham Autistic Information Network (GAIN)	Sleaford Dementia Café
Grantham College	Sleaford Probus Club
Grantham Dementia Café	Sleaford Rotary Club
Grantham Hard of Hearing Club	Sleaford Youth Centre
Grantham Jubilee Church Life Centre	South Witham Childrens Centre
Grantham Peer Support Group - Alzheimer's Society	The Nettles Volunteer Group
Grantham Poverty Concern	The Pottery Painting Cafe
Grantham Rotary Club	Toy Box
Grantham Senior Citizens Club Ltd	Trust House
Grantham Stroke Club	United Together
Grantham Volunteer Centre	Vitality
Grantham Writers	Walking for Health SK
Grantham Youth Centre	
Guillan Barre Syndrome Support Group	
Headway Lincolnshire	
Health Trainers - North Kesteven	
Healthwatch	
Heckington Area Voluntary Car Scheme	
Heckington Children's Centre	
Home Start Grantham	
Ingoldsby Baby and Toddler group	
Involving Lincs	
Just Lincolnshire	

B. Local media distribution

Organisation	
BBC Look North	Langworth Local
BBC Radio Lincolnshire	Sheepwash Times
BBC East Midlands Today	Chamber Matters
Lincs FM	Lincolnshire in Focus
ITV Calendar	Fiskerton News
Grantham Journal	Village Venture
Lincolnshire Echo	Nettleham News
Sleaford/Boston/Wolds & East Coast Target	Mollys Guide
Sleaford Standard	Lincolnshire Life
Boston Standard	Lincolnshire Pride
Skegness Standard	Foss Focus
Louth Leader	The Lime Light
Horncastle News	Signpost (Owmby parishes)
Market Rasen Mail	Inside Lincs
Lincs. Free Press/Spalding Guardian	Your Local Lincs Magazine 22,850
The Lincolnite/Lincolnshire Reporter	Gainsborough Life

Spalding Voice	Bourne Marketplace
Grimsby Evening Telegraph	Discovering Bourne
Stamford Mercury	
Bourne Local	
Gainsborough Standard	
Grantham Matters	
Gravity FM	
Stamford Living	
Bailgate Independent	
Lincs Scene	

C. Healthy Conversation 2019 Workshop Press Release Distribution

Boston Workshop Distribution
LECCG Patient Council
LECCG Viewpoint/reader panel
LECCG Staff
LECCG Stakeholder database inc. hard to reach groups
LECCG PPG
Boston Standard
Lincolnshire Live
Radio Lincolnshire
Lincs FM
BBC Look North
BBC East Midlands
ITV Calendar
Facebook – across CCG and Trust pages
Twitter
Instagram
Healthy Conversation Website
LPFT Comms
ULHT Comms

Grantham Workshop Distribution
Grantham Journal
Grantham Matters
Radio Lincolnshire
Lincs FM
BBC Look North
BBC East Midlands
ITV Calendar
Sleaford Standard
Facebook – across CCG and Trust Pages
Twitter
Instagram
Healthy Conversation Website
LPFT Comms
ULHT Comms
SLCCG Governing Body Members
SLCCG Lay Members

SLCCG Staff
SLCCG Officers

Appendix B

Wave 3: Healthy Conversation 2019

	Who or where	Date (if known)	Action
Workshops	Grantham	9th Oct	Attend
	Boston	10th Oct	Attend
Annual Public Meetings	Healthwatch	3rd Sept	Attend
	LCHS	5th Sept	Sending leaflets and display boards
	ULHT	17th Sept	Sending leaflets and display boards
	LPFT	19th Sept	Attend
	SWLCCG	19th Sept	Attend
	SLCCG	19th Sept	Attend
	LECCG	26th Sept	Attend
	LWCCG	27th Sept	Sending leaflets and display boards
Events	New College Stamford Fresher's Fair	10th Sept	Attend
	STP Digital Connected Care	2nd Oct	Attend
	Safeguarding Conference	16th Oct	Attend
Markets and Supermarkets	ASDA, Lincoln	4th Sept	Attend
	The Waterside, Lincoln	5th Sept	
	Hildred's Centre, Skegness	23rd Sept	
	Louth Market	23rd Oct	
	Alford Market	18th Oct	
	Market Rasen Market	Any Tues/Fri	
	Gainsborough Market	1st Oct	
	Horncastle Market	10th Oct	
	Mablethorpe Market	17th Oct	
	Bourne Market	Any Thurs	
	Stamford	Any Fri	
	Long Sutton Market	11th/18th/25th TBC	

	Sleaford	TBC	
General	LECCG Listening clinics	On-going	Leaflets/posters via engagement lead
	GP Practices (Countywide)		Refresh email
	Community Venues inc. village halls		Send posters
	Parish councils		Leaflets/posters via engagement leads
	PPGs		Leaflets/posters via engagement leads
Staff (all providers and CCGs)	Staff venues inc. Trust HQs, Hospitals and Community Hospitals	On-going	Send/refresh leaflets and posters
	Weekly comms		Email leaflets/posters
	Intranet		Email leaflets/posters
	Team briefings		Email info
	Screen savers		Email info
	Chief Execs emails		Email info
Voluntary Engagement Team	Age UK Lincoln and S Lincs	On-going	Email leaflets and posters for wider distribution
	Action for Children		
	Active Lincolnshire		
	Age UK Lindsey		
	Lincs and Notts Air Ambulance		
	Alzheimers UK		
	Butterfly Hospice		
	Children's Links		
	Community Lincs		
	Development Plus		
	Every-one		
	Framework Housing		
	Healthwatch		
	LACE Housing		
	Lincolnshire CVS		
	Lincolnshire Home Indepence Agency		
	Lincolnshire Rural Stress Network		
	Lincolnshire Voluntary Centre Services		
	Linkage		
	LIVES		
	South Kesteven Blind Society		
	St Barnabas Hospice		
	Walnut Care		
	YMCA		
	Healthwatch		
	Involving Lincs		
Additional Community Groups	Children Centres (countywide)		Email leaflets and poster
	Pregnancy and maternity support groups		Email leaflets and posters Via Better Births
	Covering a range of languages e.g. Romanian, Lithuanian, Polish,		Leaflets and posters via LCHS community health

	Russian, Bulgarian and Latvian.		officers
	Lincs Sensory Service (Countywide)		Email info, leaflet and posters for wider distribution
	Blind Society (2000 members)		Email info, leaflet and posters for distribution, converted into brail by Blind Society
	Other support/community groups inc. disability, sexual orientation, gender reassignment and carers and wellbeing.		Email leaflets and poster for wider distribution via engagement lead
	Various others inc. LECCG carers wellbeing group		Leaflets via engagement lead
Stakeholders	Local MPs		Email briefing
	HOSC		
	HWB		
	NEDs and Lay members		
	Health Partners inc. HEE, AHSN, Health Watch etc.		
	Regulators		
District Councils	City of Lincoln Council		Email leaflets and posters via comms leads
	Boston Borough Council		
	East Lindsey District Council Horncastle, and Louth)		
	West Lindsey District Council		
	North Kesteven District Council		
	South Kesteven District Council		
	South Holland District Council		
Local Influencers	Visit Lincoln		Email briefing/ posters via comms leads
	University of Lincoln		
	Lincoln College		
	Fire		
	Lincs Police and Crime Commissioners		
	Large private employers – Siemens, Co-Op RAF, Stagecoach, East Midlands Trains		

To:	Trust Board
From:	Paul Matthew, Director of Finance & Digital
Date:	1st October 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for August 2019

Author/Responsible Director: Paul Matthew, Director of Finance & Digital

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

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

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

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

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

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

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

Patient and Public Involvement (PPI) implications None

Equality impact None

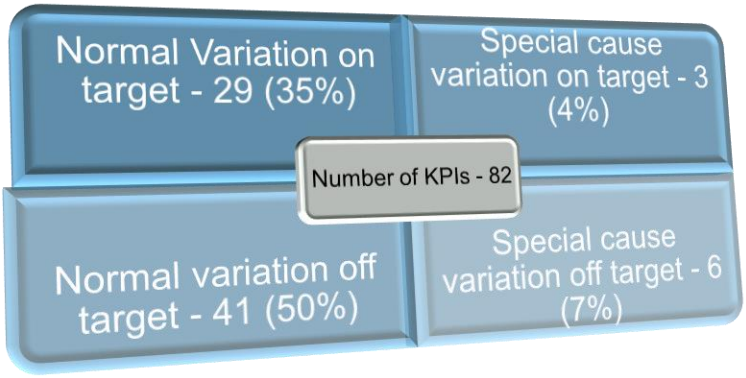
Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
September 2019

EXECUTIVE SUMMARY



Quality

HSMR (June 2018-May 2019) is 89.18 and is below expected limits, the lowest reported HSMR for the Trust.
SHMI (April 2018-March 2018) is 109.91 and is in band 2 within expected limits.
Dashboards are now developed for each Division.

Incident reporting rates so far for 2019 remain consistent with levels reported in 2018 (no significant increase or reduction), with an average of 1149 patient incidents reported per month. The number of Medication incidents reported in August was consistent with the monthly average and the Trust's Medicines Safety Officer (MSO) reviews and quality assures all medication category incidents each month in order to prepare a report for the Medicines Optimisation & Safety Group (MOpS).

A higher than average number of patient behaviour incidents were reported in August (86); a higher than average number of Blood/Plasma incidents were reported in August (45); this appears to be due to the reporting of failure to use iPods to complete bedside transfusion safety checks; both areas are under further review by the Patient Safety Group.

The Trust declared 8 Serious Incidents in August 2019, which is the lowest number for any month in 2019 so far (and compared with an average of 18 per month in 2018). There were 32 Serious Incidents open at the end of August and no Serious Incidents have been overdue their deadline to the CCG in the last six months. One Never Event was declared in August 2019 – administration of medication by the wrong route, at Lincoln Emergency Department.

Duty of Candour (in person notification) compliance in July 2019 was 96% (1 non-compliant incident) with written notification at 88% (3 non-compliant incidents). Additional guidance has been added to the Datix system to support managers in accurately recording Duty of Candour compliance: these changes went live at the end of July 2019 and compliance will continue to be monitored through the Risk & Incident Team. As of the end of August 2019 the percentage of eligible staff who have completed their mandatory Core Plus Duty of Candour training was at 93.3%.

Operational Performance

Zero waiting indicators in urgent care services have seen some improvements in August against previous months although has not met trajectory or standard. The A&E 4 hour standard improved although has not returned to previous June peak improvement. Ambulance handovers waiting >59 minutes improved back to average levels for the last 12 months, and did not show improvement to trajectory.

Ambulance conveyances increased again in August for the 3rd month far above trajectory and set a new recorded maximum experienced. There were a number of positive improvements within the urgent care programme in length of stay for emergency patients which continued below mean and was favourable against trajectory, as well as streaming at Lincoln hospital, which for the second month set a new record peak.
Unfortunately despite these achievements the benefits were more than offset by other factors including high bed occupancy, and demands on ED from increase ambulance conveyances.

August saw the next series of workshops for Lincoln Big Change reconfiguration scheme that sits alongside the 5 other urgent care improvement streams covering all aspects of the urgent care pathway. The first move within the reconfiguration programme commence in early September 2019.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have grown by 282 pathways from previous month, which is a reduced level of growth compared to previous months but is not in line with trajectory or improvement plans. No single specialty area disproportionately contributed to this growth in waiting list, although three specialties Gastroenterology, General Surgery and Maxillofacial have seen the largest growth of nearly 500 addition to waiting lists.

Overall performance against the RTT incomplete 18 week standard improved negligibly in July at 83.2% of patient pathways waiting less than 18 weeks for treatment. This was a 0.04% improvement from June.
In July there was 1 patient waiting for more than 52 weeks for their treatment. This exceeds the 0 tolerance trajectory disappointingly reflects the risk carried regarding data quality and training on RTT and patient pathway monitoring, as the patient pathway had been incorrectly recorded. The patient was treated subsequently in August 2019.

Building on the external support provided by pathway management specialists the Trust has started its improvement project on data quality and pathway management. This scheme will support the sustained performance of RTT 18 week standard, and will help alleviate errors in pathway management that contribute to 52 week wait patient pathways. In addition to internal improvement activities the Trust is requesting continued support from the NHSi Intensive Support Team who have provided access to training and specialist advice in recent months. Improvement plans have started that incorporate analysis from previous month, particularly focussing on areas where vacancy management is likely to impacting on pathway management.

In July the Trust achieved three out of the nine cancer standards, nationally only three of the standards were met.
Zero waiting indicators in Cancer Services showed our 62 Day Cancer performance in July dipped in relation to our performance in June, and was below the national percentage which was 77.6%. Regionally, our performance places us in between UHL who achieved 76.3% and NUH who achieved 70.3%.

Although this performance is below the Trust trajectory, on a positive note our 104+ backlog has reduced to 12 patients as of 12/09/2019, with the plan to reduce this number by the end of September.
The Trust continues to be in the top 15 of the largest providers of cancer treatments in the UK with July showing that the Trust has moved up from 20th to 14th largest number of treatments.

The 14 day standard (2ww Suspect) has continued to improve in July with August starting to show four tumour sites hitting the national standard of 93%.

Finance

YTD financial performance is £26,368k deficit, or £3,212k adverse to the planned £23,156k deficit.

Income is £657k adverse to plan YTD. Excluding the £965k adverse movement to plan in relation to pass through, income is £308k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £2,641k, delivery of which is yet to be validated, and is a risk to the Trust. The income position also includes PSF and FRF of £3,368k for July and August, which is at risk if the Trust does not deliver its financial plan in the second quarter.

Expenditure is £2,718k adverse to plan YTD: pay is £4,861k adverse to plan and non-pay is £2,143k favourable to plan.

The £4,861k adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £1,586k favourable to plan, bank pay is £1,444k adverse to plan and agency pay is £5,005k adverse to plan. The pay position is driven by lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing. Staffing pressures are most acute in the Medicine Division.

The pay position includes £417k (in line with plan) in relation to a 1% Medical & Dental pay award, which has now been agreed nationally at 2.5% back-dated to April. If there is no central funding for the costs of the award over and above 1%, the risk to the Trust in 2019/20 is £1,500k, of which £625k would apply YTD.

Excluding the £965k favourable variance in relation to pass through, non-pay is £1,178k favourable to plan. However, the non-pay position includes £1,493k of non-recurrent technical savings delivery, without which non-pay would be £315k adverse to plan. Likewise, the pay position includes £1,021k of non-recurrent technical FEP, without which Pay would be £5,882k adverse to plan.

Overall, FEP savings of £5,895k have been delivered YTD, or £979k less than savings of £6,874k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, FEP savings delivery is £3,510k adverse to plan YTD.

The most likely unmitigated forecast is a deficit of £79.2m excluding PSF, FRF and MRET or £8,826k adverse to plan. This forecast is inclusive of £20.2m of FEP savings or £5.4m less than planned.

Workforce

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

Total agency run rate for month five increased to a new high with significant month to month increase for nurse agency driven by increased demand and a broadly flat level of Medical agency spend. Detailed analysis of July increases suggests three main causes, level of substantive vacancies, rostering practice and a disproportionate effect from the school holiday period on both supply and price.

The overall vacancy rate improved again (-0.3%) in August with continued recruitment improvement, however the impact of this improvement continues to be reduced due to continued high turnover amongst key professional staff groups. Overall turnover also improved marginally in August.

Sickness absence (rolling twelve months) increased slightly (+0.1%) to 4.9% 2018 and the Non – Medical Appraisal Rate remained stable consolidating the improvement reported in July.

The number of unresolved employee relations cases reduced again in August to now 50 from 63 in May.

Paul Matthew
Director of Finance & Digital
September 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostrum Difficile (post 3 days)	Safe	Our Patients	Michelle Rhodes	5	5	3		17	P		
	MRSA bacteraemia (post 3 days)	Safe	Our Patients	Michelle Rhodes	0	0	0		0	P		
	MSSA	Safe	Our Patients	Michelle Rhodes	2	0	2		5	P		
	ECOLI	Safe	Our Patients	Michelle Rhodes	8	4	5		18	P		
	Number of Never Events	Safe	Our Patients	Neil Hepburn	0	0	0	1	3	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	New Harm Free Care %	Safe	Our Patients	Michelle Rhodes	98%	98.90%	99.20%		98.85%	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Pressure Ulcers Category 4	Safe	Our Patients	Michelle Rhodes	0	0	0	4	4	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Michelle Rhodes	80%	74.70%	84.10%		80.53%	P		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Michelle Rhodes	80%	74.70%	79.10%		77.03%	F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Michelle Rhodes	50%	63.10%	52.90%		57.55%	P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Michelle Rhodes	100%	95.70%	98.90%		98.35%	F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Michelle Rhodes	90%	65.60%	65.50%		65.10%	F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Michelle Rhodes	17%	12.10%	3.70%		9.18%	P		
	SHMI (Latest Data Apr18 - Mar19)	Effective	Our Patients	Neill Hepburn	100	110.67	109.91		110.59	F		
	HSMR (Latest Data Jun18 - May19)	Effective	Our Patients	Neill Hepburn	100	89.29	89.18		89.66	P	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis Bundle compliance in A&E	Caring	Our Patients	Michelle Rhodes	90%	78.30%	85.00%		82.90%	F		
	IVAB within 1 hour for sepsis in A&E	Caring	Our Patients	Michelle Rhodes	90%	86.90%	88.00%		89.10%	F		
	Sepsis screening compliance in inpatients	Caring	Our Patients	Michelle Rhodes	90%	80.00%	93.30%		87.48%	P	A	
	IVAB within 1 hour for sepsis in inpatients	Caring	Our Patients	Michelle Rhodes	90%	70.50%	70.30%		70.63%	F		
	Serious Incidents reported (unvalidated)	Safe	Our Patients	Neill Hepburn	0	11	14	9	61	F	B	Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Catheter & New UTIs	Safe	Our Patients	Michelle Rhodes	1	0			0			
	Falls (with Harm)	Safe	Our Patients	Michelle Rhodes	0.19	0.03	0.13	0.06	0.12	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Medication errors	Safe	Our Patients	Neill Hepburn	0	218	287	206	1099	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Medication errors (mod, severe or death)	Safe	Our Patients	Neill Hepburn	0	2	4	1	11	F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	VTE Risk Assessment	Safe	Our Patients	Michelle Rhodes	95%	96.57%	97.53%	97.16%	96.92%	P		
	Dementia Screening	Caring	Our Patients	Michelle Rhodes	90%	96.92%	94.14%		94.47%	P		
	Dementia risk assessment	Caring	Our Patients	Michelle Rhodes	90%	98.95%	99.44%		99.17%	P		
	Dementia referral for Specialist treatment	Caring	Our Patients	Michelle Rhodes	90%	100%	100.00%		98.22%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	91.98%	92.16%	91.16%	91.90%	F		
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	15.43%	15.22%	14.94%	14.72%	F		
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.81%	4.82%	4.87%	4.80%	F		
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	12.18%	11.79%	11.88%	10.73%	F		
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	72.74%	76.00%	76.00%	74.03%	F		
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-6009	-5126	-2808	-5136	-22956	P		
	Income	Well-Led	Our Services	Paul Matthew	36935	39838	43614	41112	206307	P		
	Expenditure	Well-Led	Our Services	Paul Matthew	-42944	-44964	-46422	-46248	-229263	F		
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	2838	1342	1557	940	5895	F		
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	4031	2875	3135	1751	10558	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-1905	-3640	-4027	-4147	-19455	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	30.78%	27.72%		29.23%	P	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	97%	89.30%	89.83%		90.13%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	19%	21.37%	25.42%		23.85%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	82.19%	79.33%		80.32%	F		
	Friends & Family Test Maternity (Reponse Rate)	Caring	Our Patients	Martin Rayson	23%	15.64%	23.71%		16.43%	P		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Martin Rayson	97%	98.36%	100.00%		99.6%	P		
	Friends & Family Test Outpatients (Reponse Rate)	Caring	Our Patients	Martin Rayson	14%	11.51%	11.49%		10.42%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	93.27%	93.82%		93.48%	F		
	Mixed Sex Accommodation	Caring	Our Patients	Michelle Rhodes	0	0	0		0	P		Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	50	64		244	P		Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Martin Rayson		416	499		1875	F		Timeliness, Completeness, Validation, Process
	eDD sent within 24 hours	Effective	Our Patients	Neill Hepburn	99%	94.00%	94.50%	93.00%	91.34%	F		
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	2.95%	5.16%	3.77%	3.15%	F		
	Duty of Candour compliance - Verbal	Responsive	Our Patients	Neill Hepburn	100%	95.00%	96.00%		96.00%	F	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Neill Hepburn	100%	83.00%	82.00%		85.25%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	77.0%	72.44%	67.05%	69.24%	68.66%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	79.5%	78.96%	69.49%	75.27%	78.60%	F		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	0	1		4	F		
	18 week incompletes	Responsive	Our Services	Mark Brassington	84%	83.16%	83.20%		83.75%	F		
	Waiting List Size	Responsive	Our Services	Mark Brassington	36,718	40,171	40,457		40,171	F	H	
	62 day classic	Responsive	Our Services	Mark Brassington	80%	79.08%	73.42%		73.83%	F		
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	79.80%	85.70%		81.83%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	94.59%	85.52%		84.90%	F		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	97.10%	96.50%		97.19%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	98.59%	100.00%		98.87%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	96.77%	95.00%		94.19%	P		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	94.38%	92.31%		94.75%	F		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	90.16%	82.10%		91.09%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Jun-19	Jul-19	Aug-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	86.73%	81.69%		84.09%	F		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	99.0%	97.09%	94.53%		96.09%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	0.8%	2.04%	3.30%		2.19%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	1.71%	1.88%		5.60%	P		
	#NOF 24	Responsive	Our Services	Mark Brassington	70%	63.49%	63.10%		63.73%	F		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	90%	87.30%	86.90%		90.24%	F		
	#NOF 36 hrs	Responsive	Our Services	Mark Brassington		80.95%	82.14%		83.47%	F		
	EMAS Conveyances to ULHT	Responsive	Our Services	Mark Brassington	4743	4823	5231	5347	5062	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	47	494	809	563	599	F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	20	18	13	77	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	2.34	3.08	2.52	2.65	P		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.40	4.19	4.33	4.35	P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	3.33%	3.03%		2.84%	P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	8565	9111	10705	8913	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Mark Brassington	47.3%	34.6%	34.8%	35.1%	35.52%	F		
	% discharged within 24hrs of PDD	Effective	Our Services	Mark Brassington		58.6%	59.1%	61.4%	58.04%			

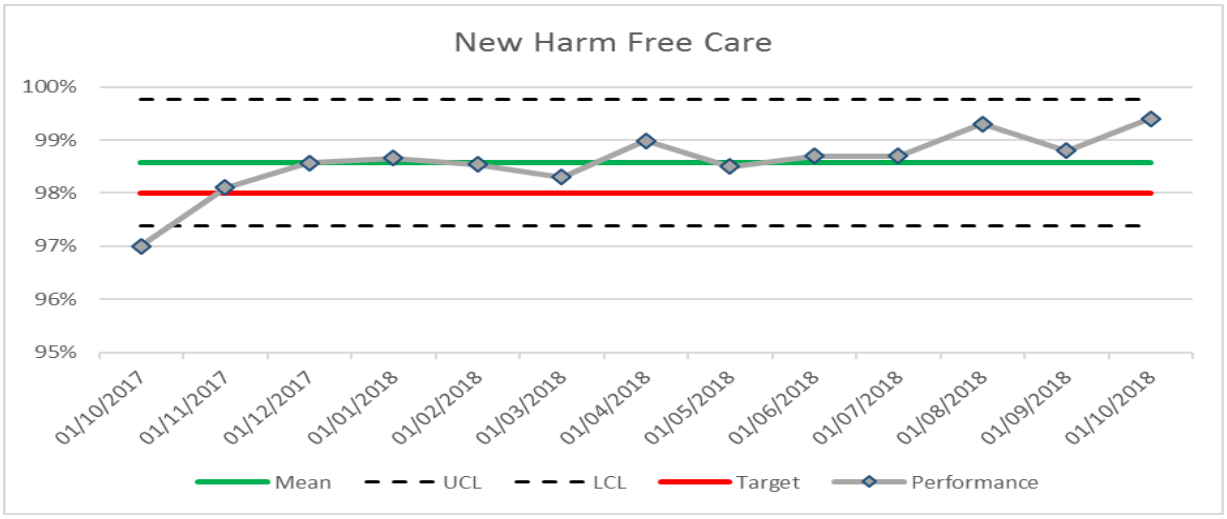
STATISTICAL PROCESS CONTROL CHARTS

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



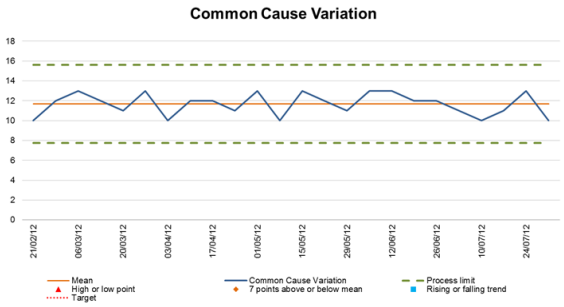
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

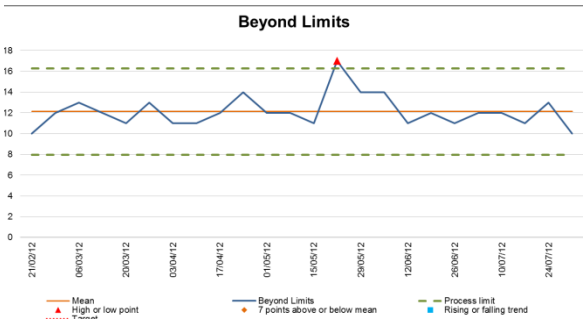
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation

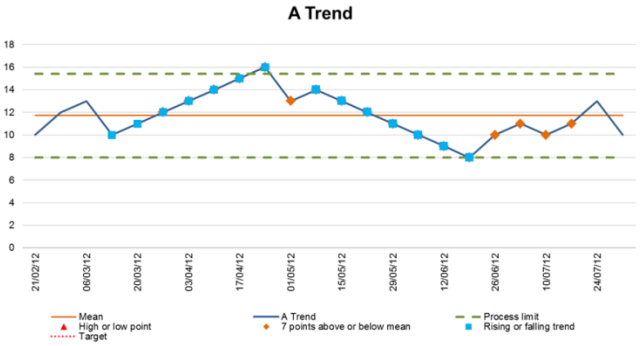


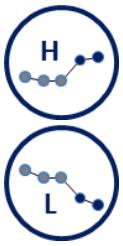
Extreme Values



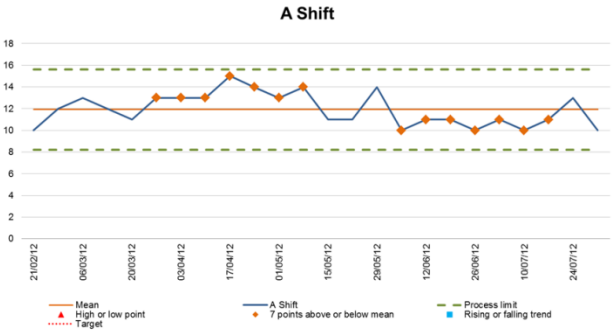
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

Where the target has been met or exceeded for at least 3 of the most recent data points in a row, or sitting is a string of 7 of the most recent data points, at least 5 out of the 7 data points have met or exceeded the target.

Where a target has been missed consistently

Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE - MORTALITY

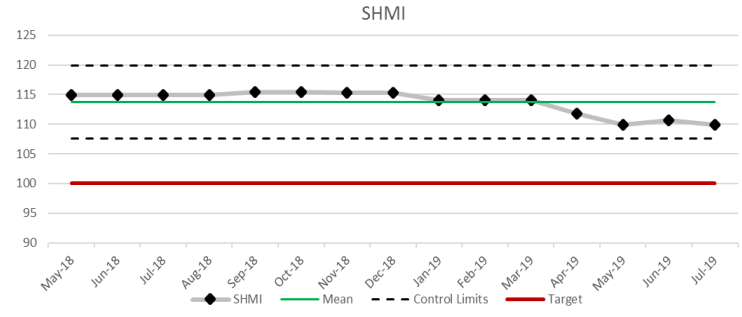
Executive Lead: Neill Hepburn

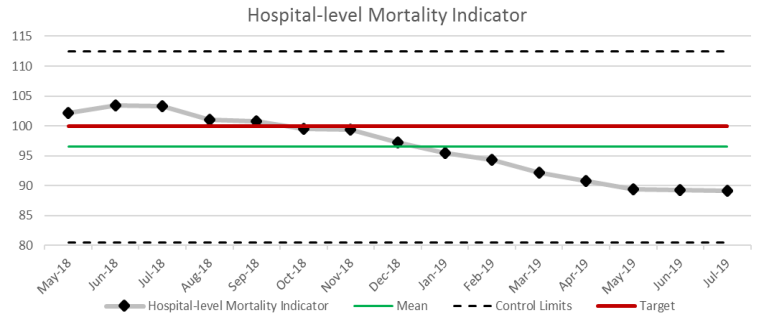
CQC Domain: Safe

2021 Objective: Our Patients

SHMI

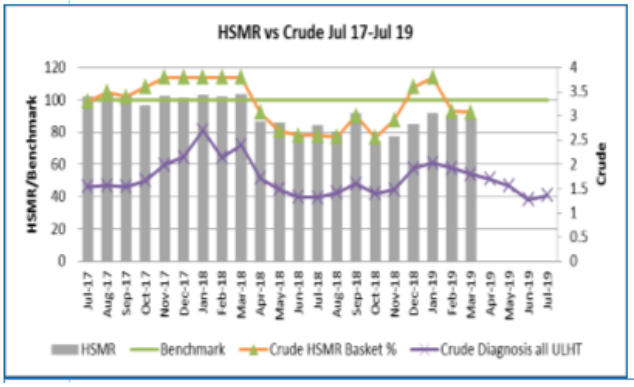
HSMR

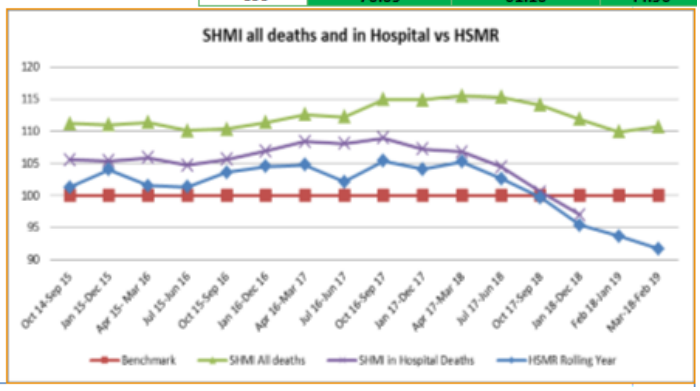




Trust/ Site	ULHT HSMR Jun 18-May 19 12 month	ULHT HSMR Apr 19-May 19 FYTD	ULHT HSMR May 19	ULHT SHMI Apr 18-Mar 19	Trust Crude Mortality Internal source Sep 18-Aug 19
Trust	89.18	90.74	89.96	109.91	1.63%
LCH	101.84	111.64	112.32	113.01	1.70%
PHB	83.53	75.39	72.86	113.33	1.81%
GDH	50.60	54.40	48.65	80.82	0.69%

Division	ULHT HSMR Jun 18-May 19 12 month	ULHT HSMR Apr 19-May 19 FYTD	ULHT HSMR May 19
Medicine	83.98	88.38	88.97
Surgery	127.26	116.32	118.95
F/H	143.26	122.59	0.00
CSS	70.09	61.10	44.96





Performance Overview

Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 89.18 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits. HSMR has now been reported by divisions, where HSMR is high but not alerting is due to small numbers and high confidence intervals.

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is a Quality and Safety Improvement Programme (QSIP) to address the improvements required. 'Other Perinatal Conditions' a paper has been produced and was presented at QSG and Trust Board in March 19. A mortality process is currently being written for Family Health. A meeting is to be held for an update on the QSIP programme with Family Health and Clinical Governance on the 2nd September 2019.

There are no site alerts currently; COPD previous alert is currently having an action plan developed from the National Audit Results-due to be presented at Patient Safety Group.

Summary-level Hospital Mortality Index-SHMI

ULHT are in Band 2 within expected limits with a score of 109.91, which shows a slight decrease from the previous reporting period. SHMI includes both death in-hospital and within 30 days of discharge. The data is reflective up to March 2019.

Alerts: Septicemia is an outlier for SHMI, this was not an outlier in HSMR at this time.

Mortality Strategy Reduction Key Actions:

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

- Surgical Division is currently an outlier, driven by Critical Care. Surgical Mortality reviews have previously not raised any significant concerns in care. The Trust has a low depth of coding for elective spells. An in-depth review is currently underway– 84 sets of notes have been delivered to the Lead for dissemination and a mortality proforma agreed. The results will be collated by Clinical Governance and upon the results and action plan agreed by Lead. It has been established from the review that the inclusion of ICU within the divisional dashboard is what is driving the division to be an outlier. ICU are monitored by ICNARC data which shows that Critical Care is not an outlier for mortality. Included within the left hand side of the report are the Divisional Dashboards including and excluding Critical Care. Although the patients passed away on ICU these patients could have been admitted through other specialties and therefore the expected mortality is calculated from the input of other specialties. **PSG to advise on Dr Foster Outcome Dashboard, to include Critical Care but gain assurance from ICNARC data.**
- In-depth Dr Foster reviews ongoing for Acute MI and Lower Respiratory Disease due to previous alerts. COPD and bronchiectasis improvement plan is currently being developed which will be presented at Patient Safety Group for approval. A meeting was held for an update on the Perinatal Action Plan with Clinical Governance 2nd September 2019. Actions with Maternity Medway are being ratified. Since April 2019 Other Perinatal conditions are not alerting.
- The Community have various work streams they are undertaking to ensure out of hospital patients receive appropriate end of life care which include; End of life audits in care homes, end of life training, multidisciplinary approach to advance care planning and anticipatory prescribing and Project Echo.
- Lincolnshire health and care community have launched; Home First Prioritisation. An initiative aimed to focus on frail and over 75's out of hospital and close to there homes. Neighbourhood team have work streams in; advanced care planning in care homes, Complex Case Managers, Short term overnight carer intervention, practice Care Coordinator and Triage Practitioner. The Collaborative have asked the CCG if KPI's are being developed for these. It has been confirmed that the Mortality Summit will be reinstated.
- The CCG have developed Enhanced Health in Care Home work programme in line with National care elements.
- Patient Experience briefing has been disseminated for the Importance of following the ReSPECT process, this can be found in the left hand side of this document. The community highlighted cases where the ReSPECT process had not been followed by the Trust. The experience briefing gives training and resources for the ReSPECT process.

Crude Mortality

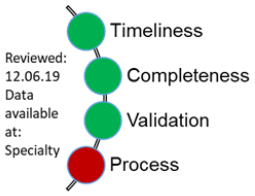
The crude mortality has increased in August 19 to 1.46%. In rolling year September 18-August 19 crude has increased slightly to 1.63%.

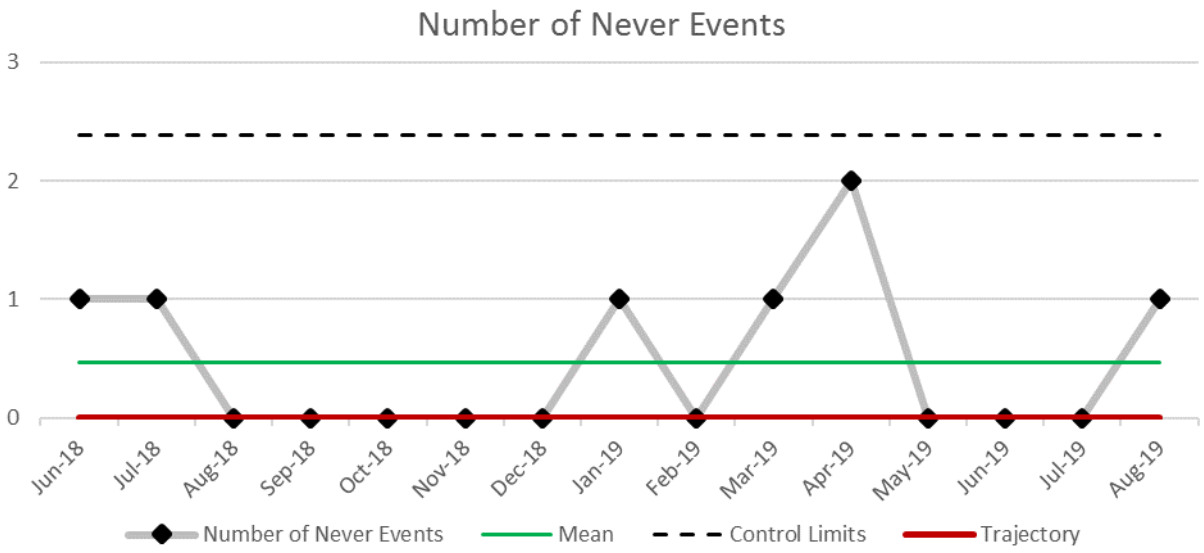
HARM FREE CARE – NEVER EVENTS

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- 3 Never Events have been declared as Serious Incidents by the Trust this financial year to the end of August 2019.
- 2 of these Never Events were declared in April.
- 1 Never Event was declared as a Serious Incident in August 2019; this was a wrong route administration of medication at Lincoln County S&E.
- A theme has been identified in relation to wrong site surgery incidents occurring primarily outside of the theatre environment.

Actions being taken to address any issues:

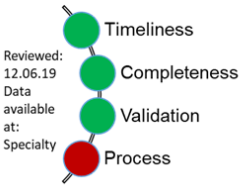
- Analysis is being undertaken of all wrong site surgery incidents reported in the last 2 years.
- The application and monitoring of compliance with local safety standards for invasive procedures (LocSSIPs) being reviewed.
- A Never Event Summit with the CCGs has been set up for September 2019, to review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

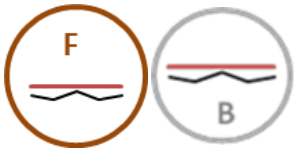
HARM FREE CARE – SERIOUS INCIDENTS

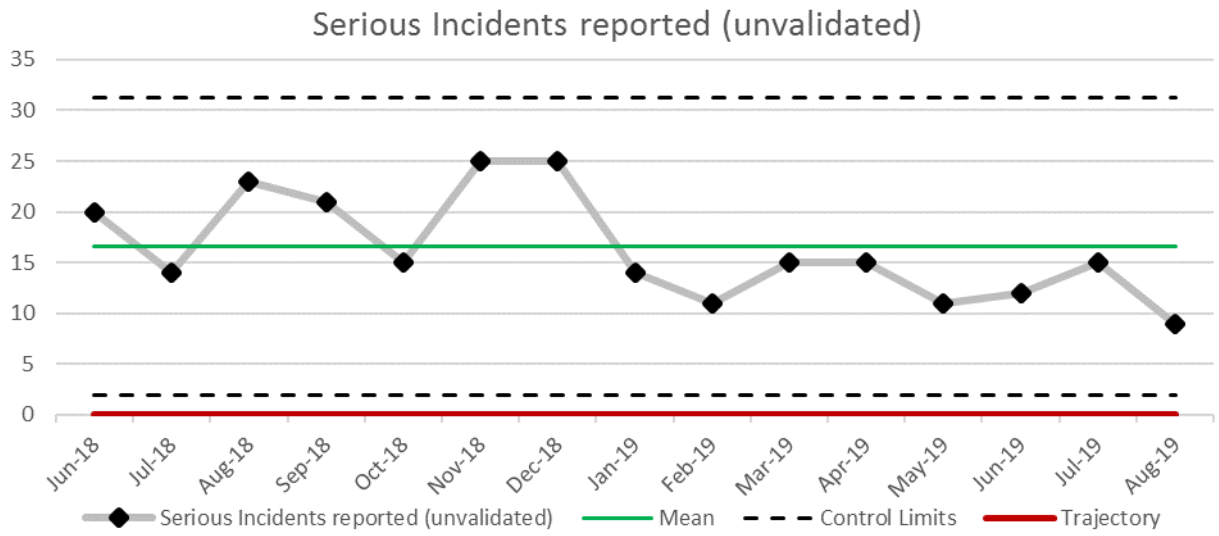
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes

- The Trust declared 9 Serious Incidents in August 2019.
- This is lower than the average of 12 per month for this financial year to date, and significantly lower than the average of 18 per month in 2018/19 and 24 per month in 2017/18.
- 62 Serious Incidents have been declared this financial year to date.
- 33% of Serious Incidents declared by the Trust in this financial year to date occurred within Urgent & Emergency Care; 26% occurred within Specialty Medicine.

Actions in place to recover:

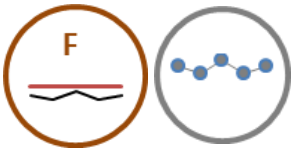
- Medicine Division has reviewed recent incident reports for A&E and reported to the Patient Safety Group; themes were identified in relation to diagnostic processes and the response to deteriorating patients, and improvement plans have been developed to address the underlying issues.

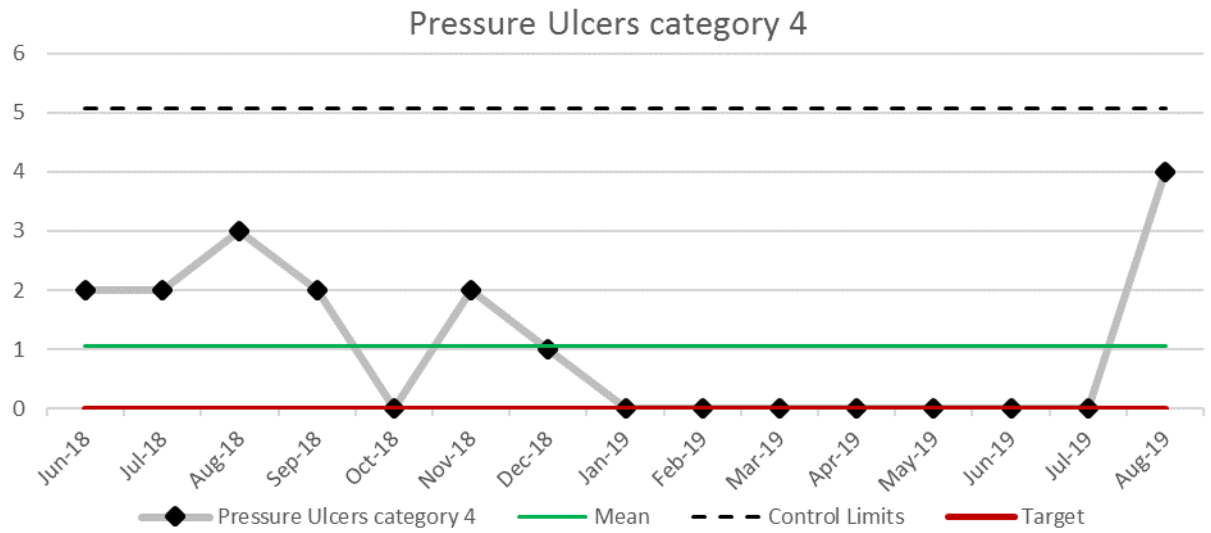
HARM FREE CARE – PRESSURE ULCERS CATEGORY 4

Executive Lead: Michelle Rhodes

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

It is clear that the new categorisation system has led to a significant change in the level of reported Category 4 pressure ulcers. The case spike seen in July is as a direct result of this new system. These pressure ulcers were first recorded as 'Unstageable' and were only re-categorised as Category 4 once the wounds had been successfully debrided. The system is now consistent with the national pressure ulcer management programme and the organisation is still below expected trajectory as part of the reduction plan.

Actions in place to recover:

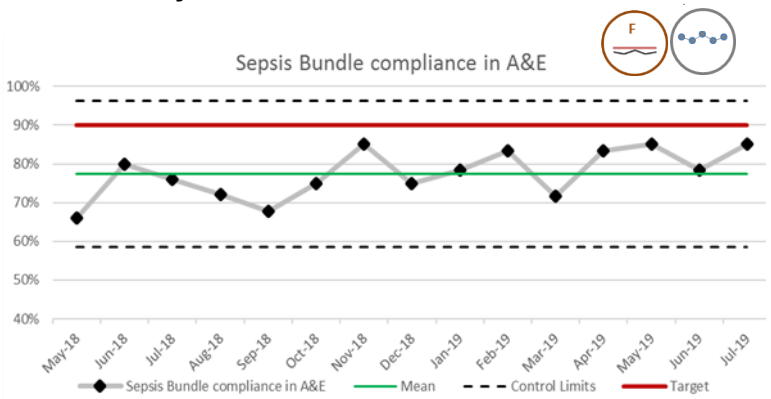
Each case will be subject to a review via the pressure ulcer scrutiny panel where robust challenge around practice and lapses in care in particular is presented. There is also a trust wide action plan in progress with a 30% pressure ulcer reduction trajectory for each category.

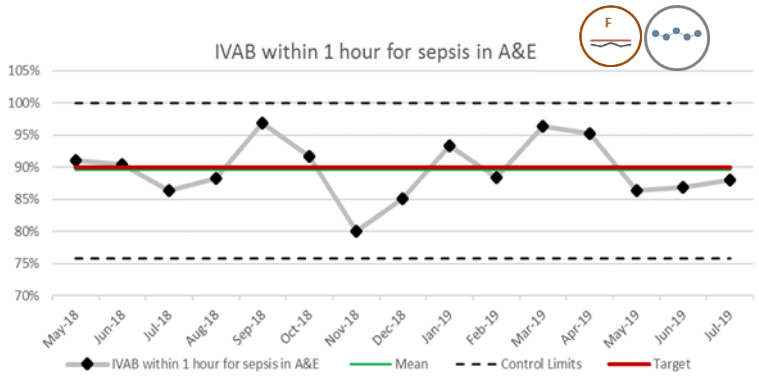
HARM FREE CARE - SEPSIS

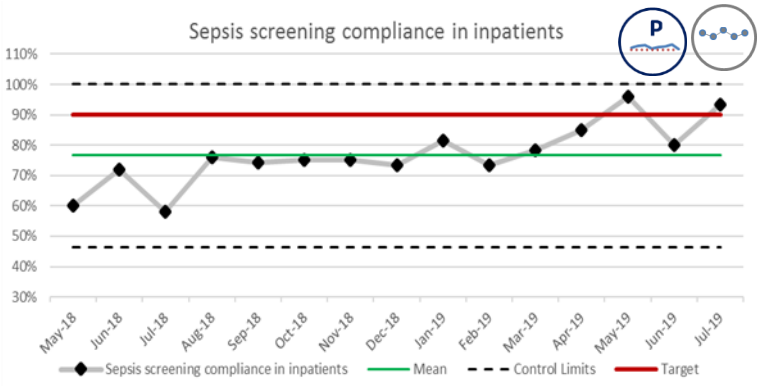
Executive Lead: Michelle Rhodes

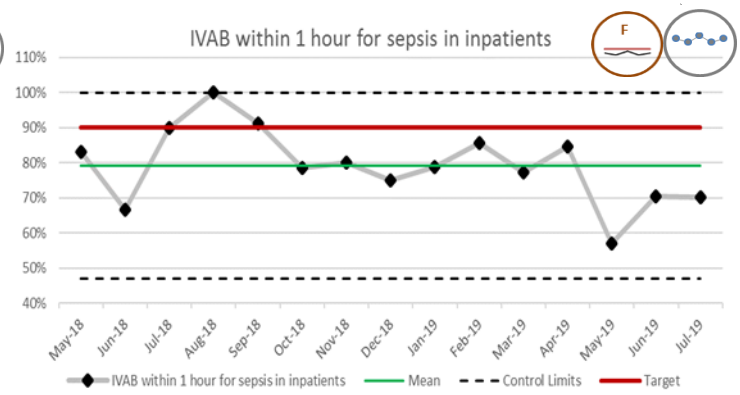
CQC Domain: Safe

2021 Objective: Our Patients









Sepsis screening

The themes that have been seen are similar to other months in that the nursing staff are still not selecting the non- infection option to show that the screen has been considered the cause of the raised NEWS score, further adhoc training has been given to the clinical areas and this theme is hoped to reduce in coming months following the train the trainer role out in September.

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

Delivery of IV antibiotics within 60 minutes

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

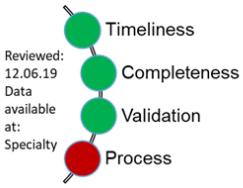
The policies for all aspects of sepsis are now out for agreement and final sign off this is hoped that this will strengthen the clinical pathways and support decision making particularly around paediatrics.

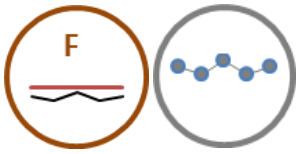
HARM FREE CARE – MEDICATION ERRORS

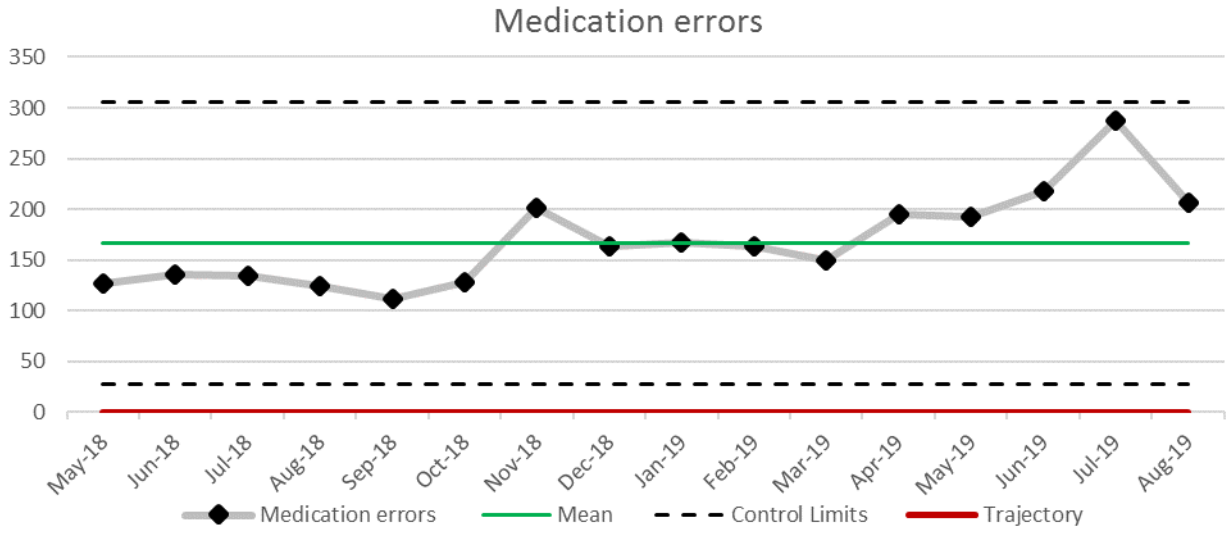
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes -

This data report is inclusive of all medication related incidents that were reported from 1st August 2019 to 31st August 2019. In August there were 206 medication related incidents reported via Datix.

For August the medication incident reporting rate for the Trust per 1000 bed days was 6.54. The rate is expressed as total number of medication incidents reported divided by the number of bed days in the Trust, multiplied by 1000 bed days.

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

Harm Rate

- There were no Never Events ONE never events relating to medication incidents reported during the reporting period.
- There were no Deaths relating to medication incidents reported during the reporting period.
- There were no Severe Harm events relating to medication incidents reported during the reporting period.
- There was 1 incident rated as Moderate Harm.

Of the 206 medication incidents reported, 13.5% were rated as causing some level of harm (calculated as medication incidents reported as causing harm or death/all medication errors x 100 – (28/206x100).
The national average of medication incidents reported as causing harm or death is 10.6% and the peer average is 14%.

Action plan to reduce harm and reduce omitted and delayed medicines

Within the Quality and Safety Improvement Plan - QS08 Medicines Management are improvement goals that ULHT will work towards to improve overall quality and safety around medicines across the organisation.
The key milestone that is relevant to this report is 'Reducing harm through the culture of safety and learning from medication related adverse events'.

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

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

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

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

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

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

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

Further actions to be taken

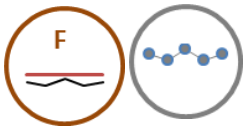
- In addition to these actions within the Quality and Safety Improvement Plan we have updated the Prescribing and Medicines Optimisation and Safety webpages and made them more engaging and user friendly. Within the new design we have a page dedicated to sharing learning from medication incidents and informing staff of themes and trends. There are also strategies to help combat medication related incidents.
- We have created a Facebook account to link in with the ULHT Together account and share information via that forum. This will then help to us to capture as many of ULHT staff as possible and ensure that learning reaches as far as possible.
- A specialist forum is to be set up. This forum will give opportunity to discuss medication incidents, look at the themes and trends, and allow staff to share good practice and ideas from different areas. Medicine Management Link Nurse and junior grade doctors will be given the opportunity to attend.
- To address the prescribing issues in the outpatient department individual prescribers are now being identified and are being informed directly about the error made.
- The speciality pharmacists are linking into the speciality governance meetings and are sharing their bespoke reports. From these reports actions can be discussed to support reducing harm from medication incidents.
- The four Divisions are asked to support the actions required to improve prescribing within their area and to address key issues highlighted within this report to reduce harm from medication incidents.

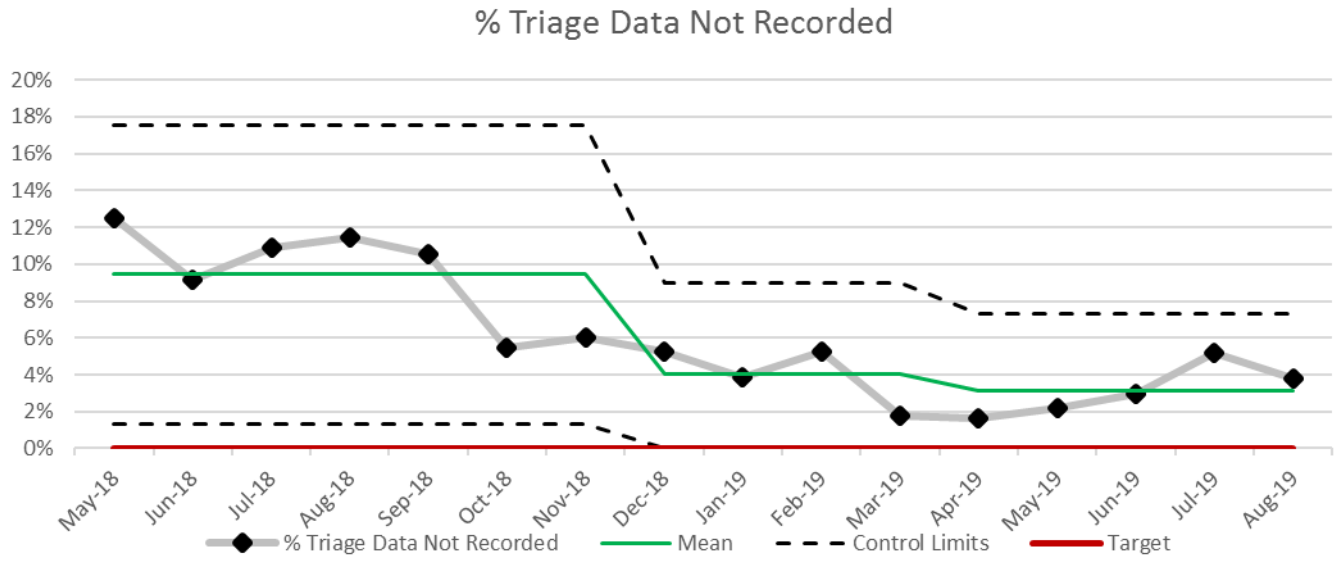
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Mark Brassington

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

An improving position was demonstrated in August by 2.38%.

Achievement against this metric is still dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.

Higher levels of agency usage and temporary non-substantive staff have an impact on being able to consistently achieve higher levels of performance against this target. It is monitored by the CBU and performance is fed back to clinical teams.

Actions in place to recover:

The UEC Improvement Programme, continue with analysis of individual performance and productivity to highlight individual compliance and this is being addressed with staff members on an individual basis.

Triage time is a key performance indicator and continues to be monitored and challenged at all operational delivery levels 3 x daily through the Capacity and Performance Meetings and within the UEC programme.

Alternative systems have been developed at PHB where agency usage is at its highest and the impact on triage is at the greatest. The use of a triage coordinator role ensures that this important process is delivered consistently.

A new printing device has been installed where this was identified as a bottleneck within the process and a photocopier geographically isolated was increasing process time.

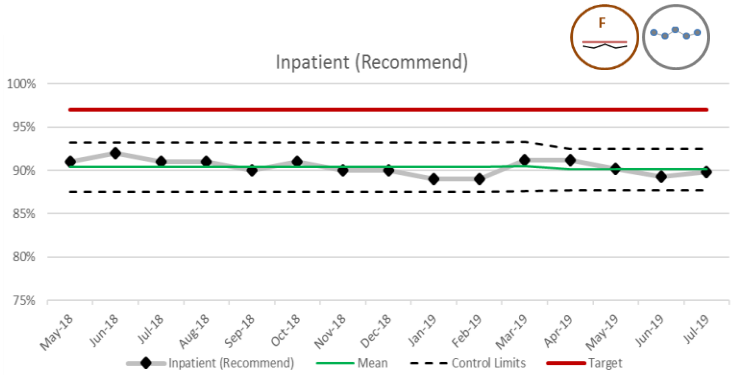
Additional support from divisional managerial teams is in place each day to ensure that all staff are accurately recording at that triage times remains a key focus of departmental leadership.

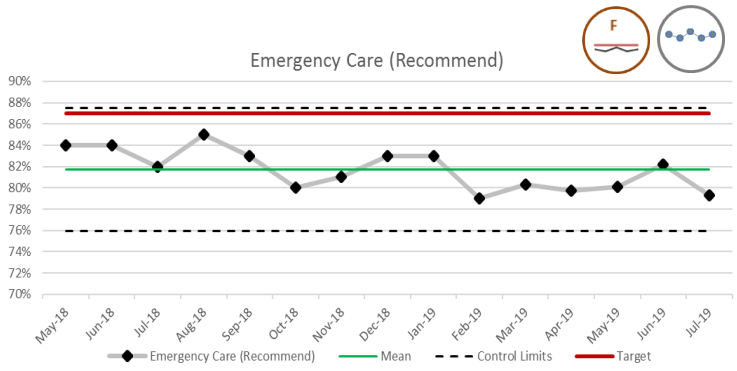
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

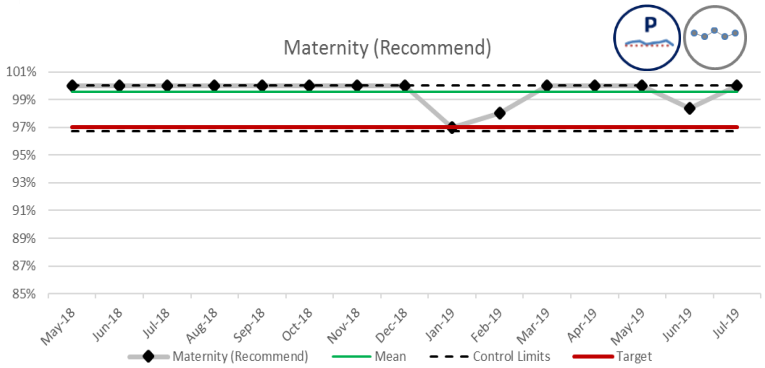
Executive Lead: Martin Rayson

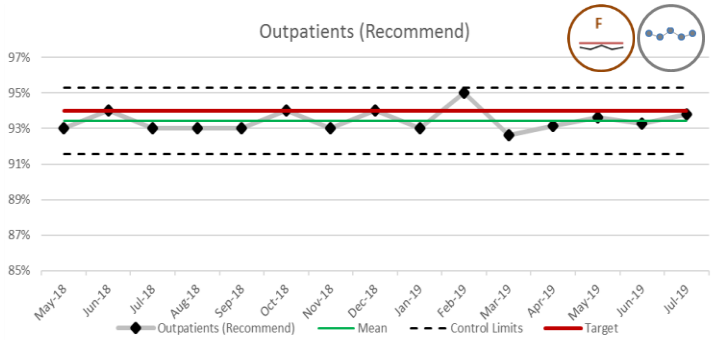
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Emergency care has seen a decrease of 3% to 79% of patients who recommend and also an increase in the number of patients who would not recommend by to 25%,
- Inpatients and outpatients percentage FFT recommends have stayed fairly consistent between April and July.
- Overall 91% of patients would recommend and 5% of patients would not recommend. This was based on 8,168 ratings and 6,347 comments with 74% of comments received being positive, 6% neutral and 20% negative. Top 3 positive themes from FFT comments were clinical treatment, admission and discharge.

Actions in place to recover:

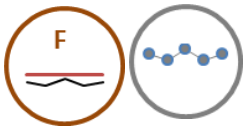
- FAB Experience Champions have been contacted to check progress and support required.
- Heat map produced showing gaps shared with divisions seeking ‘recruitment’ and identifying where support needed.
- FABChange19 action plan in place which includes promoting champions role and patient experience improvements.
- Communication training under review and new proposal to come to PX group in November.
- Meeting scheduled with CSS on utilising patient feedback in improvements to appointment delays.
- Patient and Carer Experience 5 year plan awaiting sign off once Quality Strategy approved.

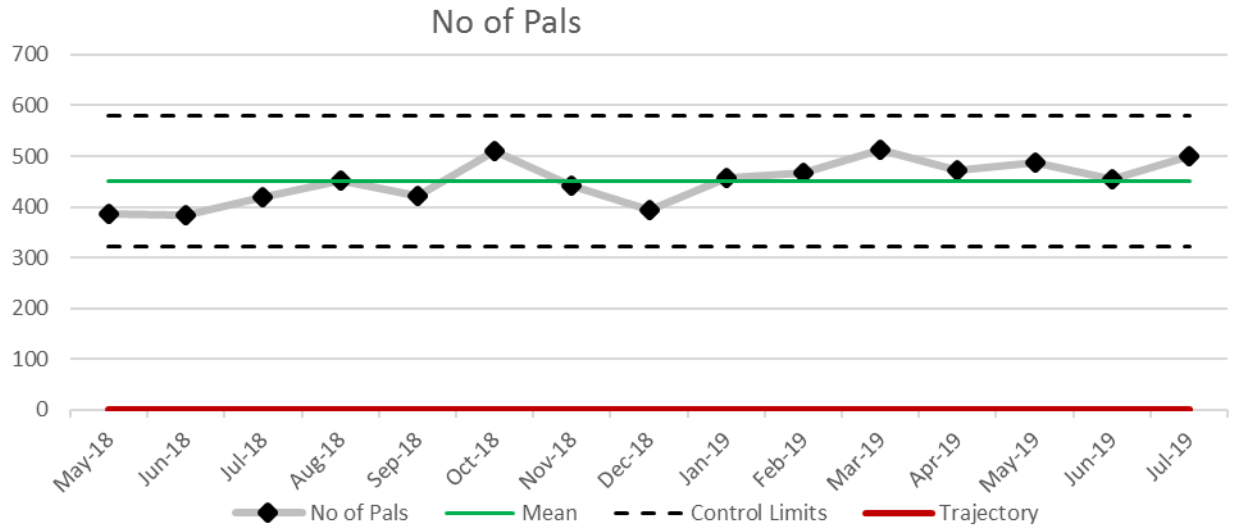
VALUING PATIENTS TIME – PALS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients





Challenges/Successes

- The top 3 themes for PALS for July were: Communication with Patients/relatives & carers, Appointment Cancellations and Car Parking
- 499 concerns were taken to PALS during. 270 for Lincoln and Louth, 45 for Grantham, 179 for Pilgrim and the remainder for community hospitals. 14 PALS concerns were escalated to formal complaints
- The divisional split for PALS concerns received were:

Clinical Support Services	186
Medicine	140
Surgery	81
Estates & Facilities	62
Family health	17
Corporate	6

- 2,215 counting compliments were recorded and the overall total currently stands at 87,859
- Counting Compliments against complaints ratio – 35:1

Actions in place to recover:

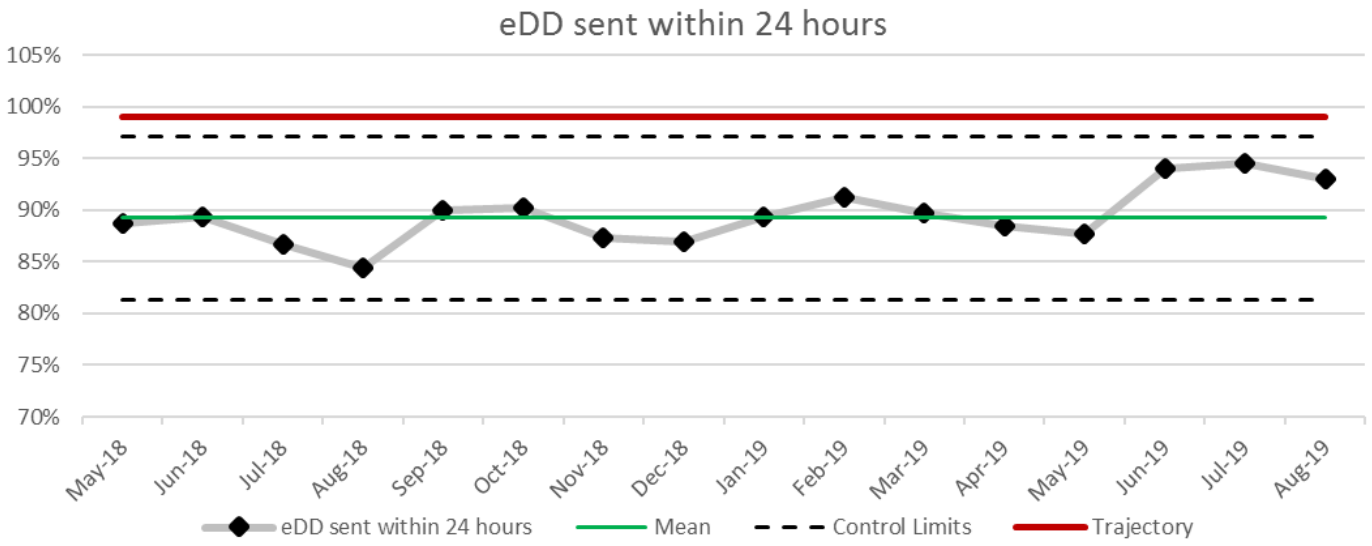
- FAB Experience Champions have been contacted to check progress and support required.
- Heat map produced showing gaps shared with divisions seeking 'recruitment' and identifying where support needed.
- FABChange19 action plan in place which includes promoting champions role and patient experience improvements.
- Communication training under review and new proposal to come to PX group in November.
- Meeting scheduled with CSS on utilising patient feedback in improvements to appointment delays.
- Patient and Carer Experience 5 year plan awaiting sign off once Quality Strategy approved.

VALUING PATIENTS TIME – ELECTRONIC DISCHARGE DOCUMENTS

Executive Lead: Neil Hepburn

CQC Domain: Caring

2021 Objective: Our Patients



eDD performance for August 2019 was 93% for sending within 24 hours. The target is 99% within 24 hours. Divisional reports are being circulated to highlight the wards / departments that are outliers.

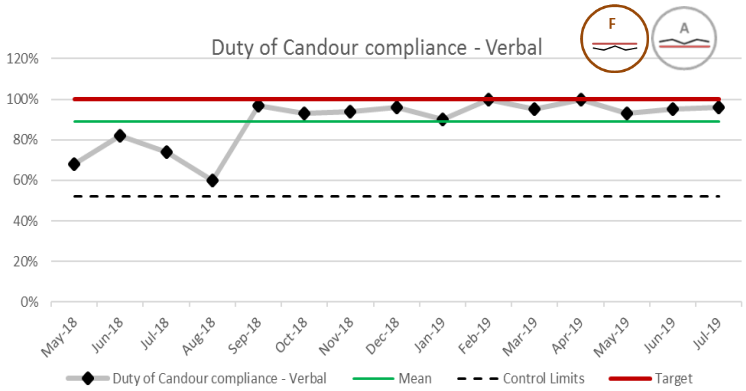
The eDD dashboard has been circulated to all staff. Paediatric wards have been highlighted as an outlier and the chair of the eDD group has sent a letter to the Divisional leads highlighting this issue and requesting an action plan for improvement.

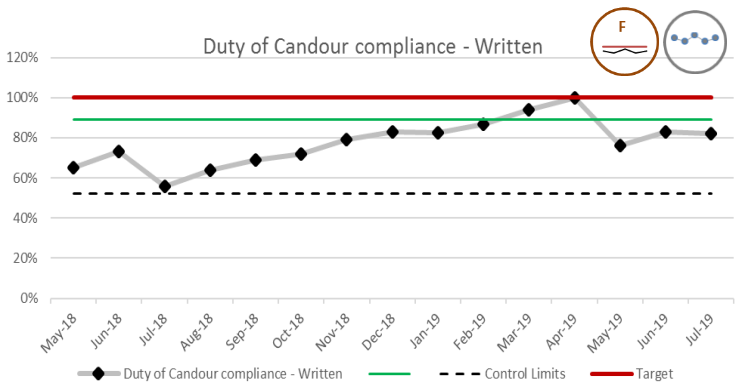
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges / successes

- Duty of Candour (in person notification) compliance in July 2019 was 96% (1 non-compliant incident)
- This was the 11th month in a row with a compliance level of 90% or more
- Written follow-up compliance in July 2019 was 88% (3 non-compliant incidents)

Actions in place to recover

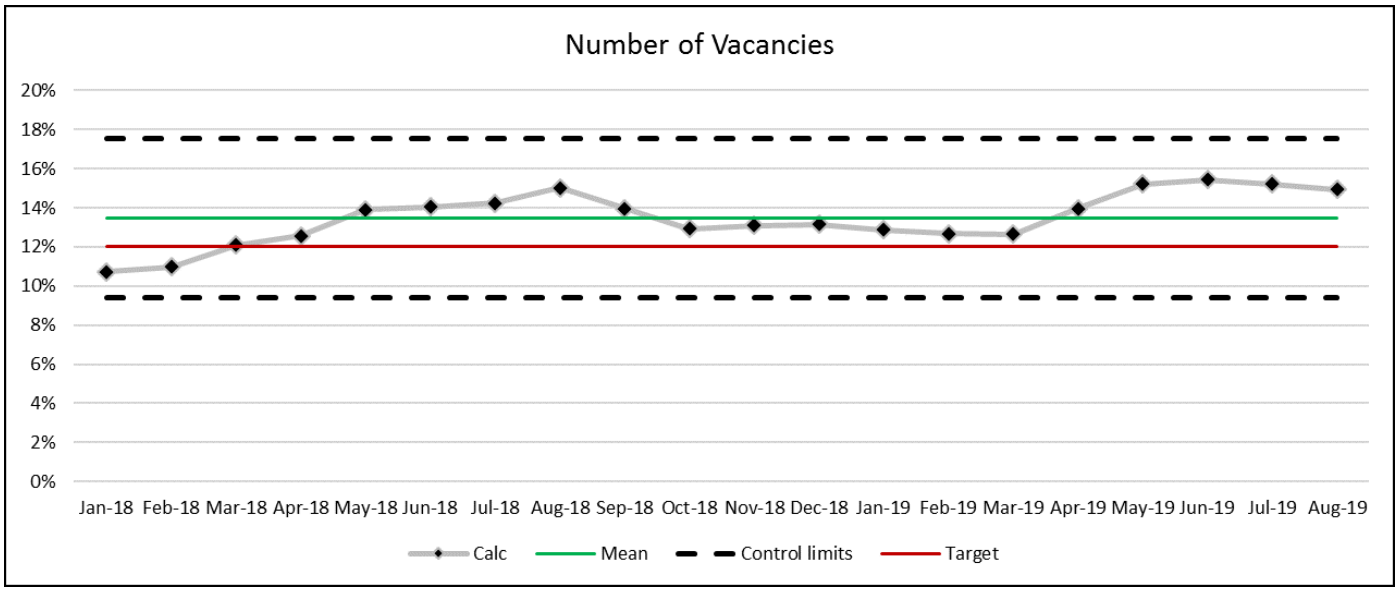
- Additional guidance has been added to the Datix system to support managers in accurately recording Duty of Candour compliance; these changes went live at the end of July
- A suite of dashboard reports has also now been created to provide divisional and Clinical Governance managers with live status information for all notifiable incidents

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People

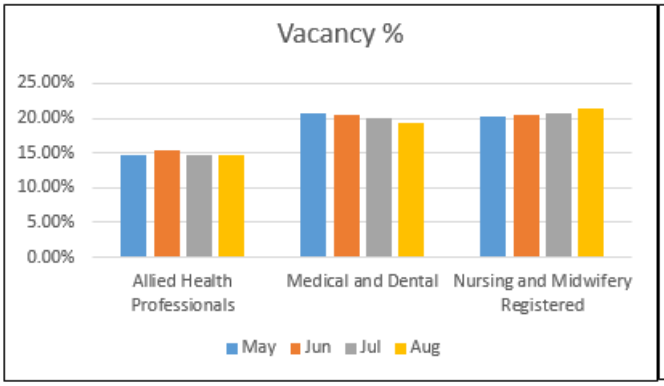


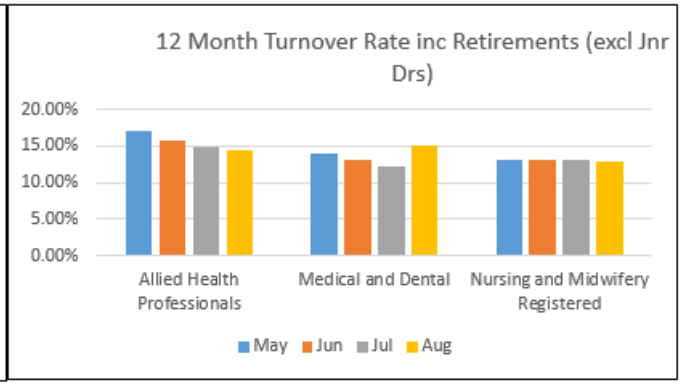
Challenges/Successes

The overall Trust Vacancy Rate decreased slightly from 15.2% in July to 14.9% in August.

Weekly recruitment and exit tracking continues. There was a total of 12.4 fte of consultant and Speciality Doctors starts in July and 8.2 fte of new registered nurses. The number of doctors in training with the Trust increased by 20 fte upon the August rotation.

Whilst overall Turnover reduced marginally again in August, with improvement in AHP rates, nursing remained broadly flat and medical staff increased, the rates remain above national and regional benchmarks slowing the improvement in vacancy rate from recruitment.





Staff Group	May	Jun	Jul	Aug
Allied Health Professionals	14.80%	15.48%	14.61%	14.60%
Medical and Dental	20.80%	20.45%	20.04%	19.38%
Nursing and Midwifery Registered	20.19%	20.46%	20.80%	21.37%

Staff Group	May	Jun	Jul	Aug
Allied Health Professionals	16.99%	15.73%	14.84%	14.53%
Medical and Dental	14.09%	13.21%	12.16%	15.10%
Nursing and Midwifery Registered	13.21%	13.19%	13.05%	12.99%

Vacancy rate for medical staffing is overstated due to additional DiT Starts in August not processed at reporting point.

A bespoke nursing recruitment campaign in partnership with TMP launching the new employer brand is planned for w/c 23rd September and one for AHPs w/c 16th September.

The Trust is also engaging with the National NHSE/I retention team to support continued work and focus on this, with a visit planned by the NHSI national team, to review progress on 25th September.

Medical Vacancy Rate

The vacancy rate continues to improve, staff in post at the end of August increased by 6.36 FTE.

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

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

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

Further details of "hot spot" Medical Vacancy Rates are provided in the following table:

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Radiology Consultants	7.9	47%
	Pilgrim Clin Haematology IP	3.0	75%
	Lincoln Clin Haematology IP	2.1	22%
Family Health	Lincoln Paediatrics IP	7.0	24%
	Pilgrim Paediatrics IP	3.7	19%
	Pilgrim Breast Surgery IP	2.0	47%
Medicine	Lincoln Elderly Care IP	12.2	50%
	Lincoln Acute Medicine	5.8	59%
	A&E Attenders Lincoln	12.7	33%
	A&E Attenders Pilgrim	7	20%
Surgery	Lincoln ENT IP	4.7	44%
	Pilgrim Urology IP	4.0	44%
	Lincoln Ophthalmology IP	4.6	33%

Nursing Vacancy Rate

Further details of "hot spot" Nurse Vacancy rates are provided in the following table:

Division	Team	Vacancy FTE	Vacancy %
CSS	Clinical Support Pan Trust Mgmt	4.0	67%
	Rheumatology Nursing	3.7	62%
	Dermatology Outpatients	3.8	52%
	Ward 7A Chemo Suite	5.6	35%
Medicine	Pilgrim AMSS	18.2	53%
	Pilgrim Stroke Unit	14.6	51%
	A&E Pilgrim	31.1	51%
	Ward 6A	11.7	51%
	Ward 7B	10.1	44%
	Ward 1	8.2	43%
Surgery	Bevan Ward	9.9	67%
	Ward 5B	10.8	46%
	Ward 9A	9.3	43%
	Ward 2	9.9	45%
	Lincoln Main Theatres	15.8	24%
Family Health	Ward 4A	14.2	43%
	Rainforest Ward	13.5	42%

AHPs Vacancy Rate

Resourcing are focusing on a recruitment campaign to target AHP's planned for third week in September.
Pilgrim Occupational Therapy reduced their vacancies by10% [2.0 FTE].
Details of notable AHP Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	12.4	39%
	Pilgrim Occupational Therapy	5.1	25%

Actions in place to recover

Medical and Dental

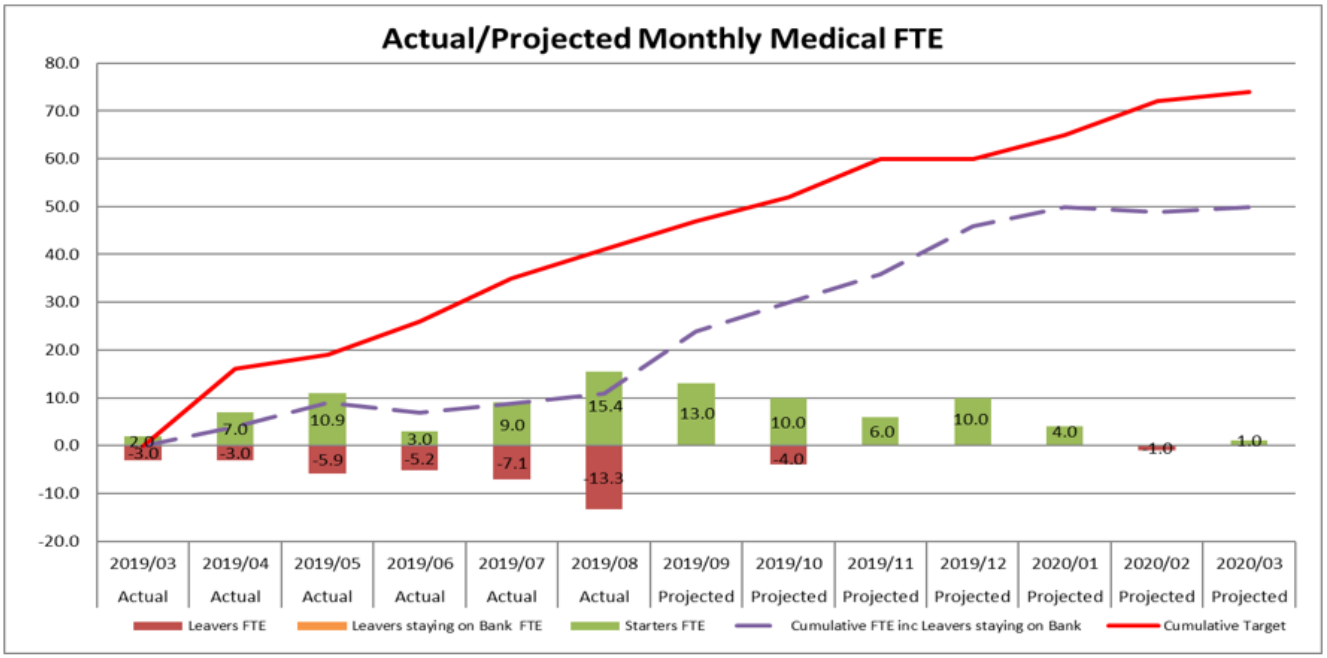
Continued strong pipeline into Q3.

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

New international strategic partner has been appointed.

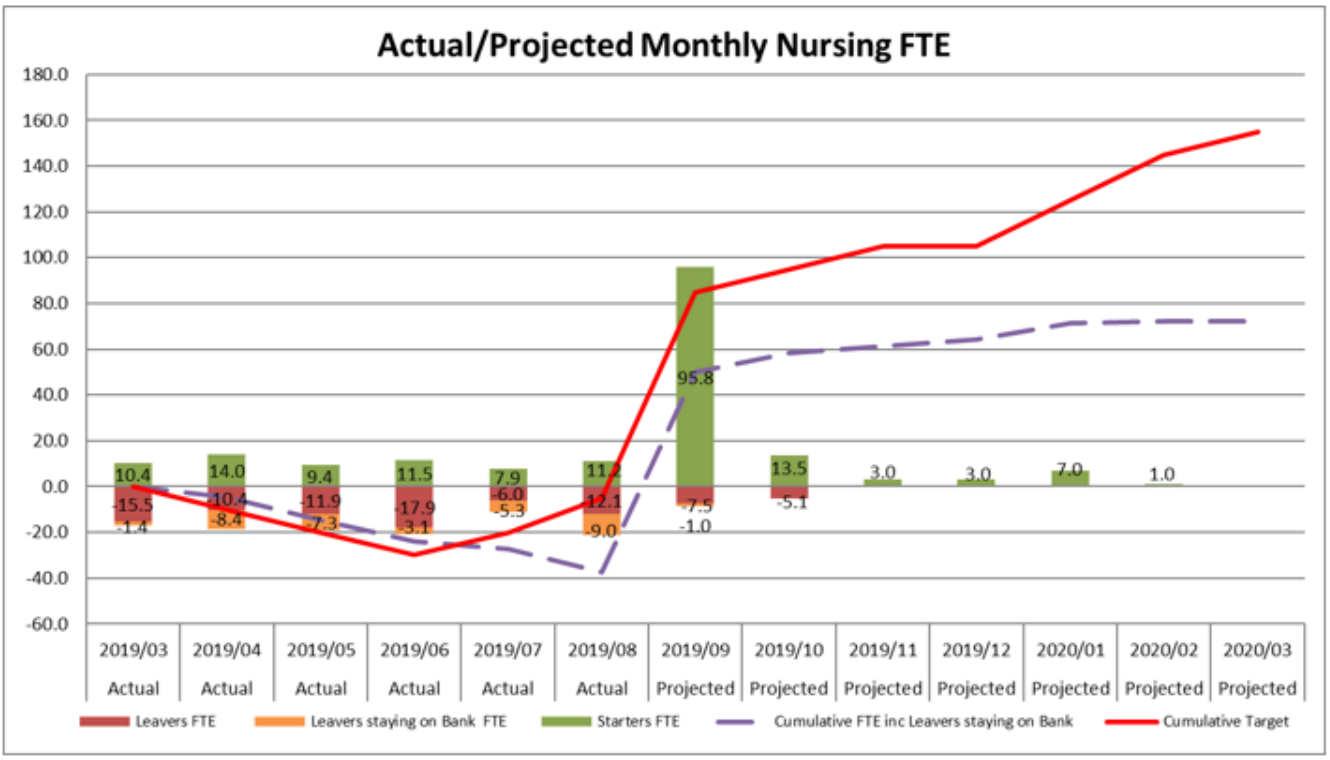
Increased focus on medical engagement to reduce turnover.

August Rotation for junior doctors, as projected had a positive effective on medical vacancy rate.



Graph as at 2 September 2019

Nursing – Subject to late submission of EF3 (Notice to terminate contract) nursing numbers to July just off plan but with strong projected NQN programme for September.



Graph as at 2 September 19

NQN Nursing programme remains on track.

International strategic partner agencies in procurement stage.

Information on high vacancy areas and wards using block nursing agency will be used to inform TMP supported domestic campaigns planned for third week in September

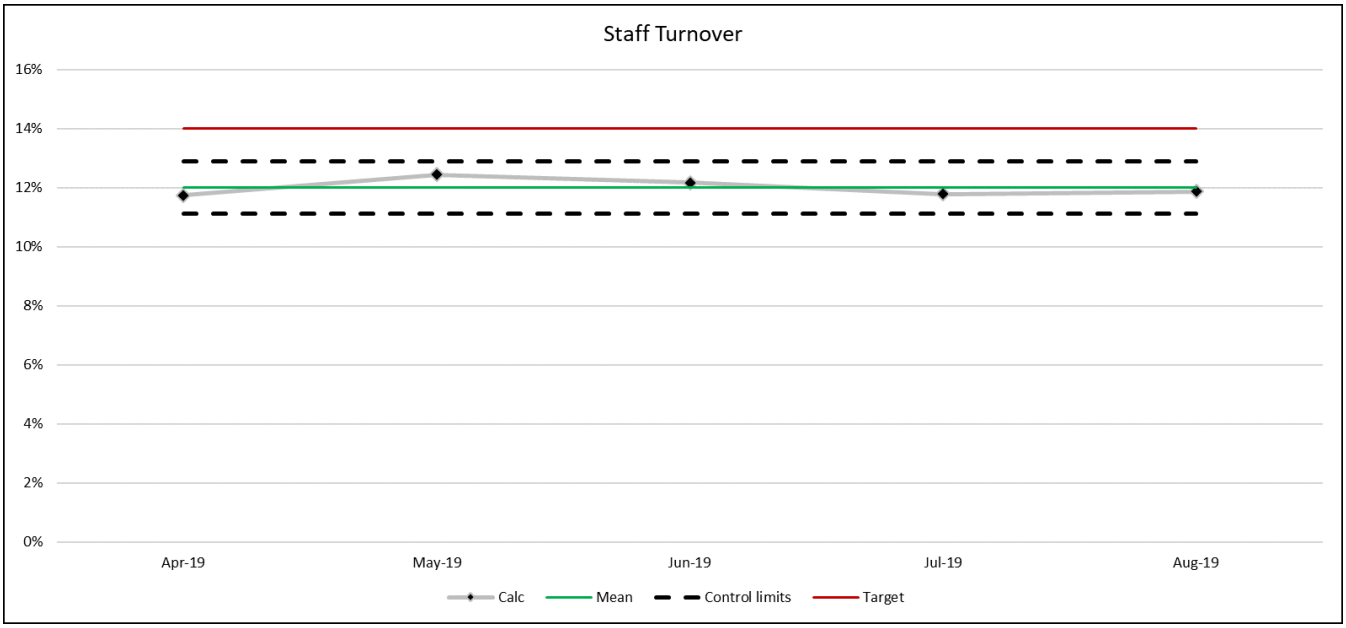
AHP recruitment campaign planned for third week in September

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

- **Exit interviews:** The exit interview process is providing us with some useful data. We intend to focus particular attention on why people leave the Trust after a short time period
- **Flexible Retirement - Retire and Return:** The Retire and Return scheme is an initiative that looks at retiring staff and roles that they can come back to – the new role could be in the same ward/clinic or could be a completely different area. The process was designed and implemented in **April 2019** and sits within the nursing Clinical Education team. A tracker is used to monitor progress as well as report impact on periodic turnover data.
- **Itchy Feet Interviews:** 26 people have had interviews since June and those 26 people continue to be employed by the Trust.

Actions in place to recover

The Bus Station engagement event will take place across sites during the week of the week of 16th September. During this week, the Bus will be stationed at each of the four hospital sites from 10 AM until 4 PM.

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

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

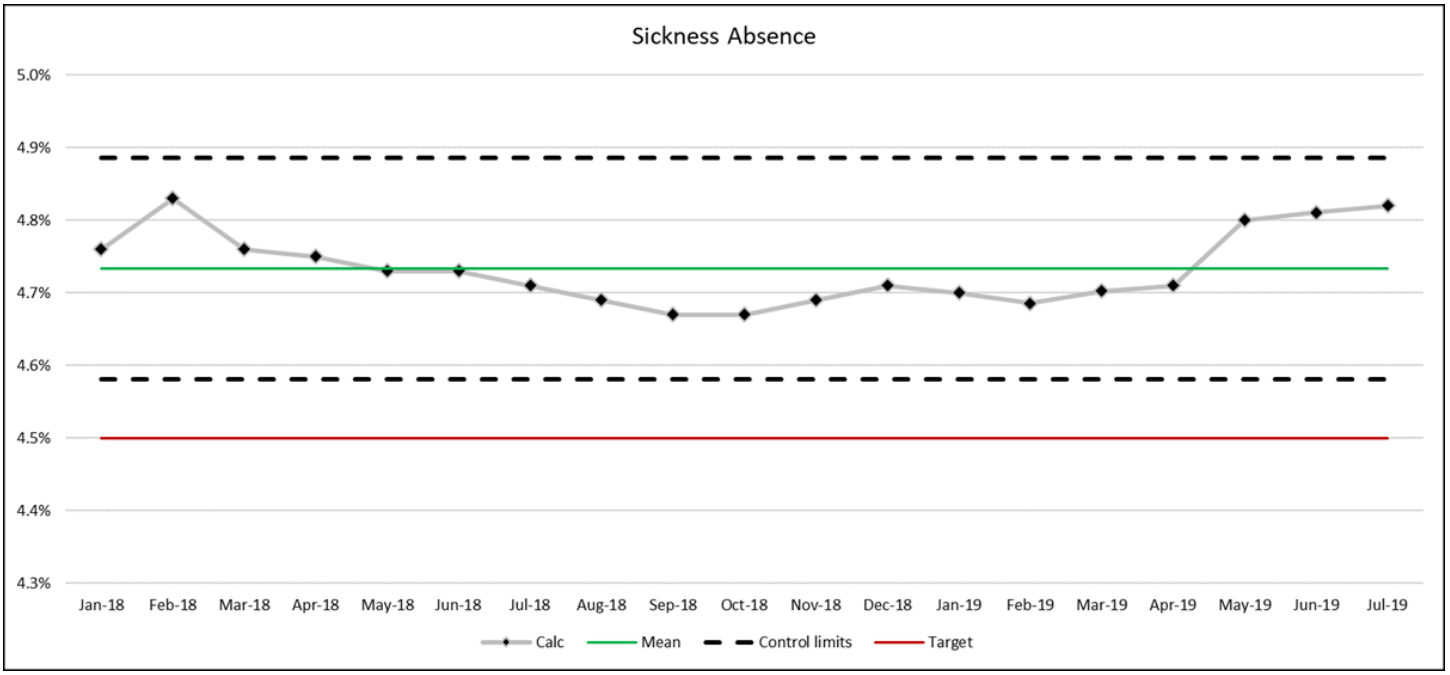
The Legacy Nurse initiative addresses the needs of both newly qualified nurses as well as those at the end of their career considering retirement. We aim to create a mentorship program through which newly qualified nurses can opt to be mentored by more experienced nurses. An established process will review and monitor progress of the mentoring relationship to ensure its success. The initiative has been designed and will be put in place for the new cohort of newly qualified nurses joining us in September 2019.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People

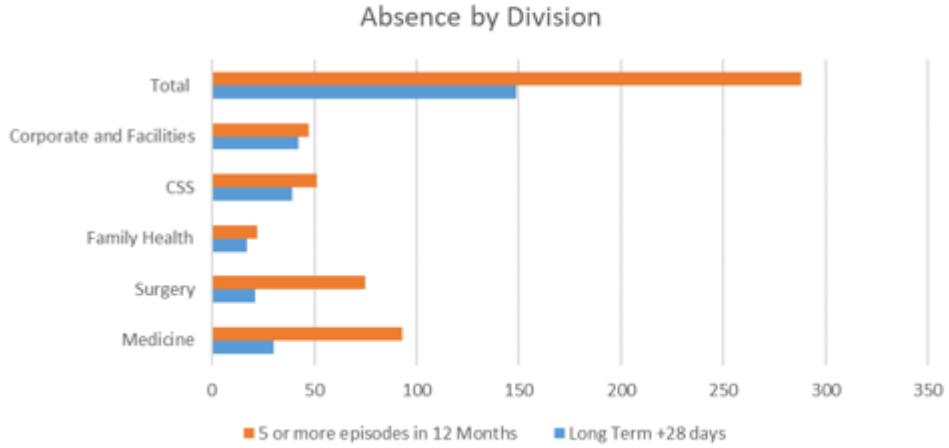


Challenges/Successes

The rolling 12 month average has increased to 4.9%. We are concerned about the growth in sickness in the period May to August, when sickness traditionally declines. We have a longer-term plan to address absence, linked to the use of the Empactis system. In the short-term, it is the combination of HR, OH and managers working together that will put us in the best place to reverse the current upward trend.

The tables below shows the monthly sickness cases that are being managed, by Division:

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate and Facilities	Total
Long Term +28 days	30	21	17	39	42	149
5 or more episodes in 12 Months	93	75	22	51	47	288



Absence data is reported to the Divisions on a monthly basis by the ER Advisors, this highlights areas of focus and concerns.
The ER Advisors are working with the Divisions and SHRBP's to work on trajectories for future sickness reporting.

The work is having an impact. The table below shows the reduction in cases by Division

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate and Facilities
Long Term +28 days	-6	-7	0	5	-23
5 or more episodes in 12 Months	-4	12	1	0	-18

Actions in place to recover

Full review of all training packages to support managers with the attendance management training.

Full review of all existing attendance management template letters.

Sanctions outside of hearings being introduced to support the decrease in stress levels and possible consequential absence of staff in applicable cases.

Review of all special leave taken to ensure attendance is being managed correctly.

Vacancies that are currently on hold are being monitored to support permanent redeployment opportunities becoming available at the earliest opportunity to support staff returning to work.

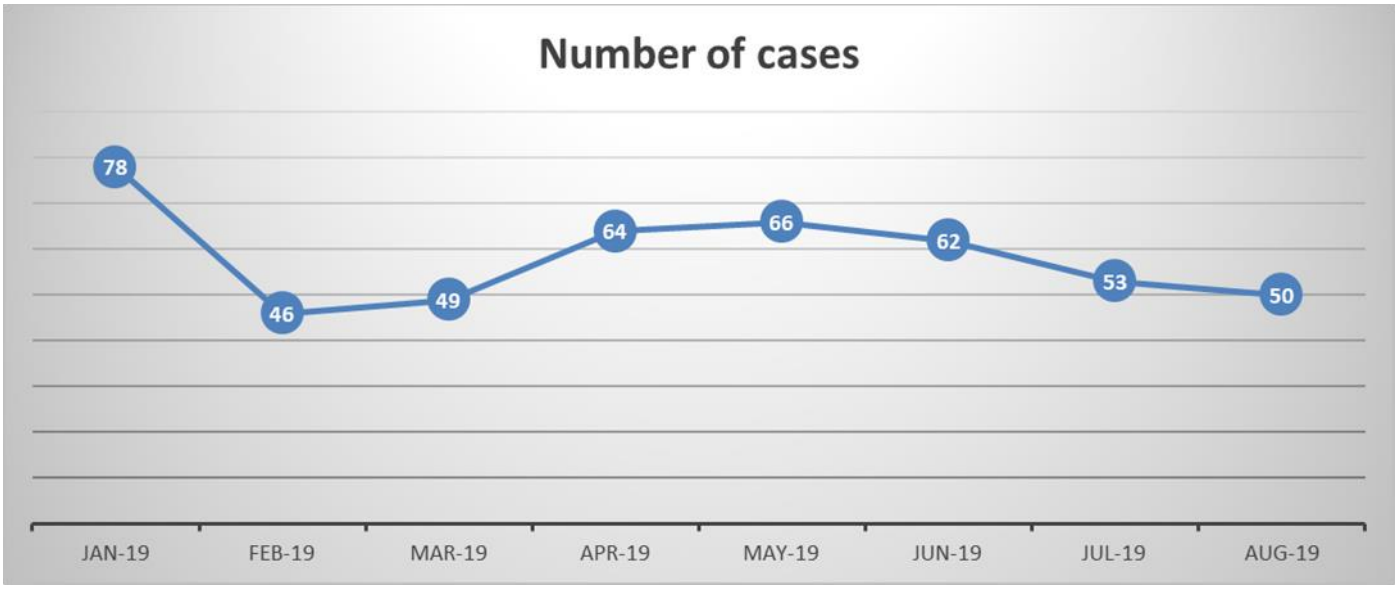
Continued work to support the implementation of the Empactis Attendance Platform.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People

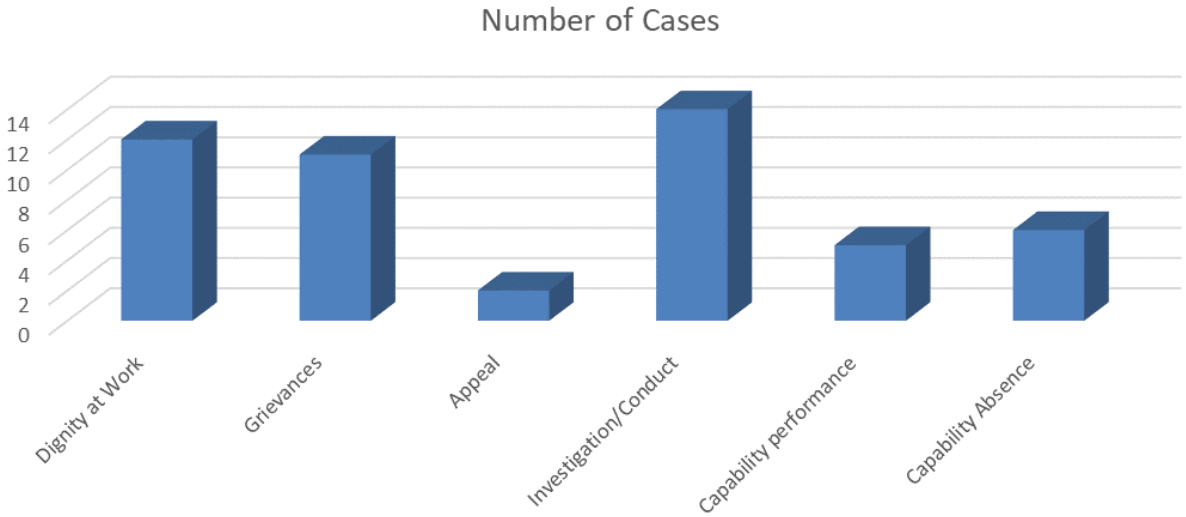


There are 50 open cases in August compared with 53 cases in July, representing a 6% decrease.

Number of cases by category

Dignity @ Work has decreased by 2 cases from last month, with a Conduct cases & Performance capability remaining the same however, Sickness capability has increased by 4.

We remain concerned about the number of performance capability cases. This is still a lot lower than we might expect, in a challenged Trust with Circa 7,800 staff.



Actions in place to recover

The ER team has reviewed the template letters for disciplinary and grievance and once these have been sense checked they will be published on the Intranet.

We will support the commissioning managers to engage with investigation officers to adhere to the time scales to produce the report in a timely manner
and this can now be monitored through the investigation log.

We will be working through the Autumn to review our key workforce policies against the “Just Culture” framework.

Actions completed

We have carried out one sanction outside of a formal hearing.

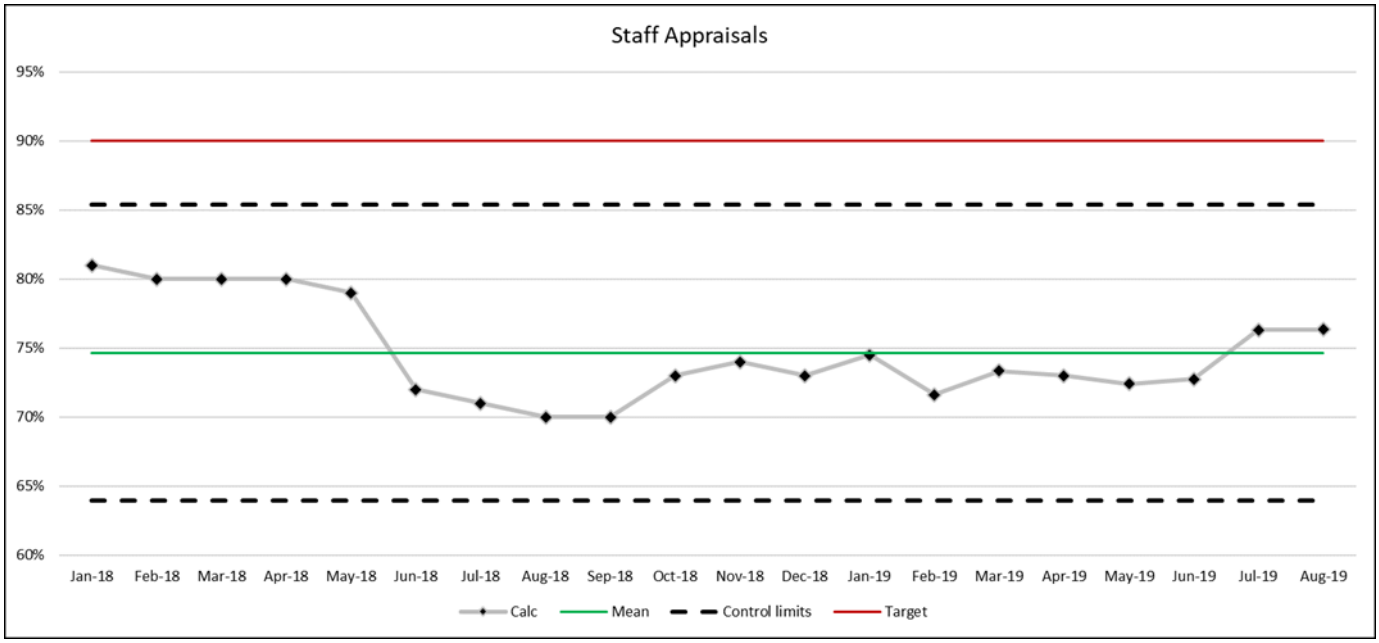
Carried out feedback sessions to commissioning managers after hearing on lessons learned for hearing panels.

MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

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

Actions in place to recover

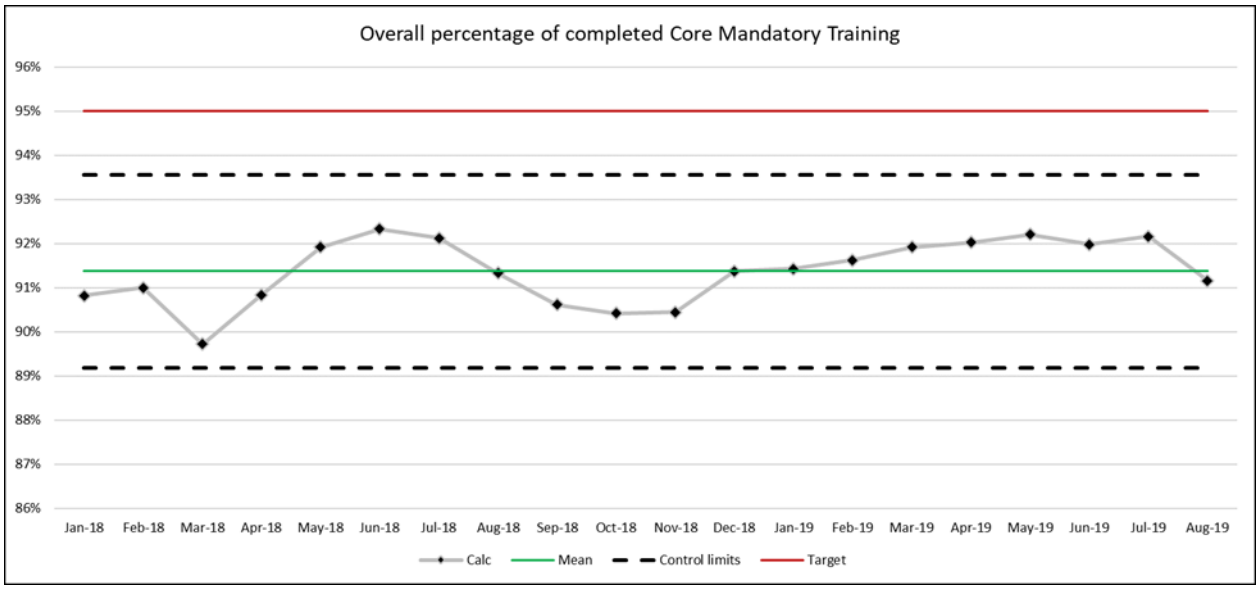
- Revised appraisal paperwork launched in July and widely circulated
- Appraisee and appraiser training widely available across all sites
- SHRBPs working with Divisional teams to improve position

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Core learning is showing a consistent pattern of over 90% compliance.

Data from Lincolnshire Partnership Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS) show that their compliance rates are in the same overall range.

Actions in place to recover

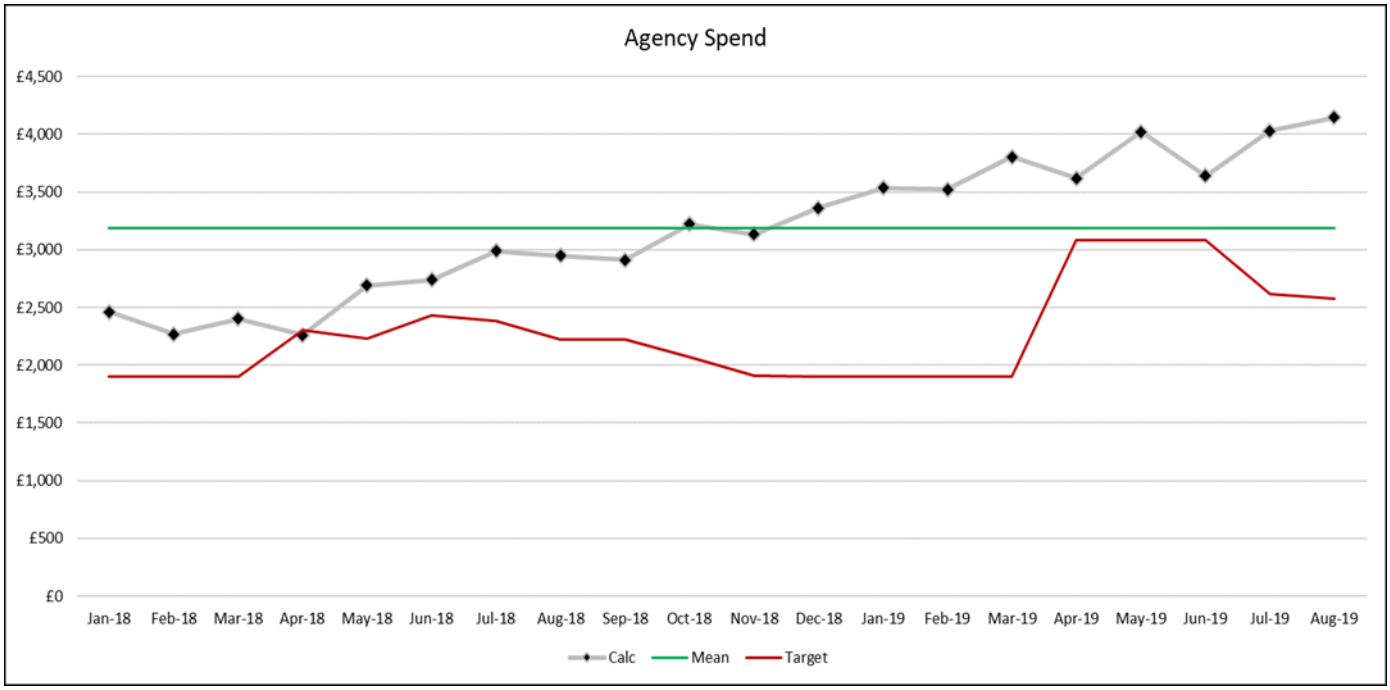
The target set for Core Learning will be reviewed as long-term sickness/absence and maternity leave may be affecting the feasibility of increasing compliance further.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



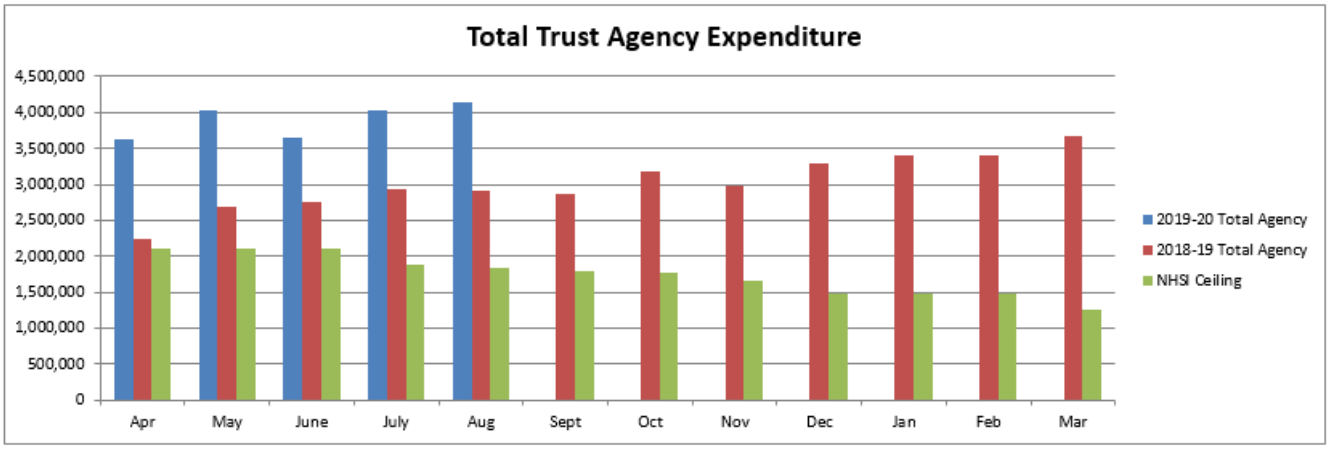
Challenges/Successes

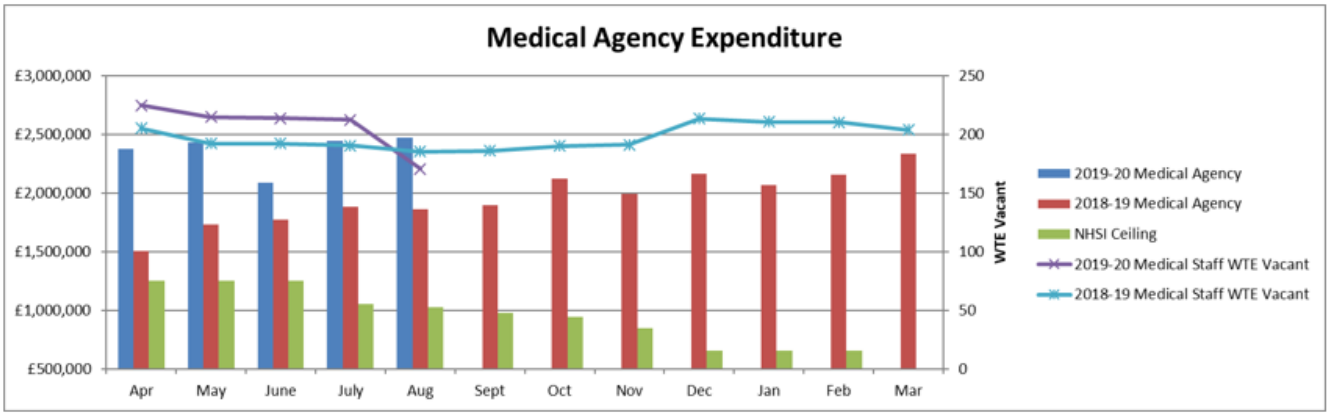
In August (M05), Year to Date (YTD) planned pay costs deteriorated to 3.2% adverse to plan [an underlying position of 3.7% adverse to plan excluding releases] and 73.3% (+0.4%) of income, which is 2.6% higher than plan. The adverse variance to plan for both bank and agency increased YTD with a corresponding decrease in the savings for substantive staff.

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

The monthly run rate for total Agency spend increased from Month 4 to Month 5 to £4.15M and exceeds that planned by 35% and a new monthly high.

Despite good progress against delivery plan of the medical central agency team (see below for details), Medical Agency pay costs increased marginally following the increase in July from June. Nursing Agency costs rose steeply again in August, a third consecutive month of rises. Further progress with the introduction of framework agencies at lower prices continues and price per nurse agency shift reduced so total cost is volume driven and continues to be out of step with vacancy rate changes. Detailed analysis of July increases suggests three main causes, level of substantive vacancies (marginal increase for nurses and a significant reduction for medical staff in the month of August), rostering practice and a disproportionate effect from the school holiday period.



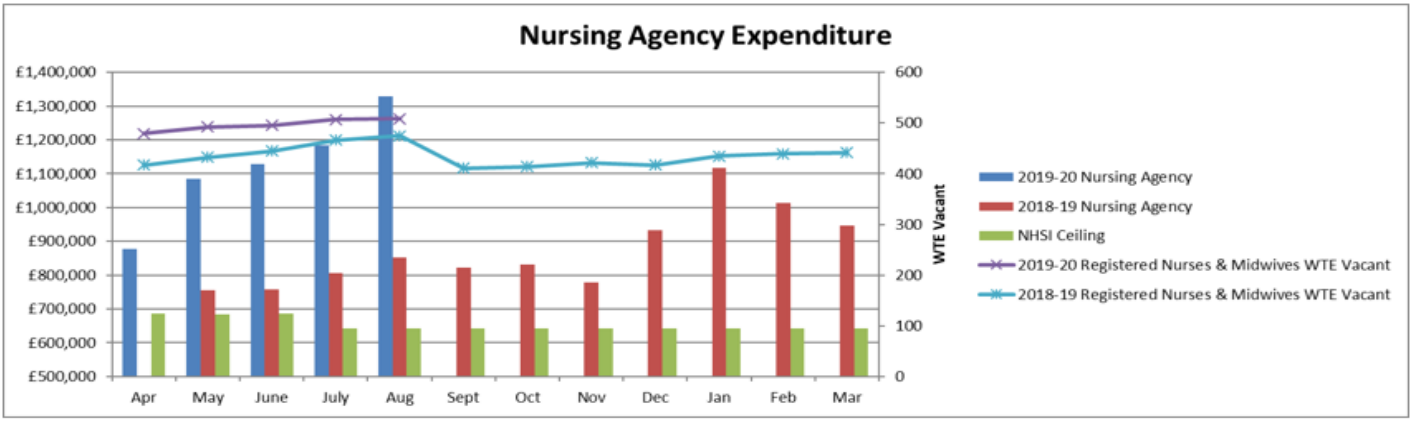


Medical agency costs increased marginally in August but against a back drop of an improvement in vacancy rate, £ per vacant fte increased from £11,487 to £14,484. Reduction in volume in shifts 3892 from 4458 was offset by price increases due to seasonality. The volume and cost per hour increased at Consultant level by £1.63 (with an additional Oncology Consultant, which are a very difficult to fill premium rate specialty) and speciality doctors / DIT up by £1.37 and £1.45 respectively.

Positive work on commissions control continued in August with a further £11,632 savings. In the last 12 months combined savings of £146K against commissions Holt tendered as part of the contract showing additional rates control.

A further £6,317 has been saved on breaks, above and beyond break policy for the month of July. This takes the total for the last 12 months to £88,303.

DE savings for the month of August were at £385,800 taking the last 12 months total to £4.17M. The DE efficiency was at 92.6% (+0.2%) with only 215 (--47) shifts being VAT applicable. AHP DE savings are at a total of £40,340 with £12,200 being saved in August



The agency costs of Nursing increased for the fourth consecutive month in August.

Patterns of fill rate and by staff type continue as reported previously.

LINCOLN Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Contracted staff Percentage	76%	71%	71%	73%	72%	69%	67%	66%
Total temp percentage	20%	24%	23%	22%	22%	25%	26%	27%
Bank percentage	11%	13%	14%	12%	11%	12%	12%	12%
Agency percentage	9%	11%	9%	10%	11%	14%	14%	15%
Total bank requests	540	657	665	606	640	711	749	781
Percentage bank fill	80%	76%	73%	76%	73%	75%	73%	70%
Total percentage staffing against required	96%	95%	94%	95%	94%	94%	94%	92%
Total percentage staffing without agency	87%	84%	85%	85%	83%	81%	79%	77%

BOSTON Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Contracted staff Percentage	58%	57%	59%	59%	58%	58%	60%	57%
Total temp percentage	38%	37%	38%	36%	38%	38%	38%	39%
Bank percentage	11%	11%	12%	12%	11%	10%	10%	11%
Agency percentage	27%	27%	26%	24%	27%	28%	28%	28%
Total bank requests	679	704	664	667	686	685	665	712
Percentage bank fill	83%	81%	88%	83%	85%	87%	89%	85%
Total percentage staffing against required	96%	95%	97%	96%	96%	97%	97%	96%
Total percentage staffing without agency	69%	68%	71%	71%	69%	68%	69%	68%

Scientific and AHP agency continued to reduce to £148K in August down from £176 in June.
Other Agency costs reduced in August from £250K in July to £196K per month and is largely from investment in transformation and FEP programmes.

Actions in place to recover

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

Continued targeted removal of Medical Umbrella companies.

Pay was the subject of the August Board Development Session and a Nurse Agency and Medicine Division Pay Summits took place w/c 12th August to bring together all key stakeholders to re-affirm current action and identify further interventions that may be necessary to bring levels the level of demand under control. These include:

- Continued introduction of tier 3.5 framework agencies to further reduce reliance on off frame work agency use;
- Enhanced nursing bank rate pilot, focused on high cost agency areas – September 19;
- Full review of rostering practice for Nursing including payments of breaks and management of annual leave – September 2019 and
- Longer term temporary nursing staffing plans to be developed to avoid higher premiums of shorter lead time requests.
- Planned commitment to remove Thornbury supply in the next rostering period (October 7th).

Robust Division Medical Agency review meetings chaired by The Chief Operating Officer have been taking place w/c 7th September to review medical agency staffing line by line by speciality, by site and by consultant, specialty doctor and Trainees. Detailed actions for each division to reduce spend have been identified.

The Trust medical vacancy rate for August improved significant (42fte) and should provide for a significant reduction in September. September rates for medical staff are expected to reduce.

The Trust is exploring a technology solution (Patchwork) to increase medical bank working which has interoperability with Allocate.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Summary 2019/20

2019/20	Current Month			Year to Date			Plan		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Income	41,645	41,111	(534)	206,963	206,306	(657)	501,616	480,437	(21,179)
Expenditure	(44,530)	(46,246)	(1,716)	(226,544)	(229,261)	(2,717)	(533,922)	(543,553)	(9,631)
EBITDA	(2,885)	(5,135)	(2,250)	(19,581)	(22,955)	(3,374)	(32,306)	(63,117)	(30,811)
Net Finance costs	(756)	(758)	(2)	(3,580)	(3,509)	71	(9,106)	(8,815)	291
Surplus/(Deficit)	(3,641)	(5,893)	(2,252)	(23,161)	(26,464)	(3,303)	(41,412)	(71,931)	(30,519)
Technical adjustments	1	19	18	5	96	91	14	230	216
Surplus/(Deficit)	(3,640)	(5,874)	(2,234)	(23,156)	(26,368)	(3,212)	(41,398)	(71,701)	(30,303)
EBITDA % Income	-6.9%	-12.5%	-5.6%	-9.5%	-11.1%	-1.7%	-6.4%	-13.1%	-6.7%
FEPs	1,770	940	(830)	6,874	5,895	(979)	25,610	20,200	(5,410)

Income is £657k adverse to plan YTD. Excluding the £965k adverse movement to plan in relation to Passthrough, Income is £308k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £2,641k, delivery of which is yet to be validated, and is a risk to the Trust. The income position also includes PSF and FRF of £3,368k for July and August, which is at risk if the Trust does not deliver its financial plan in the second quarter.

Expenditure is £2,718k adverse to plan YTD: Pay is £4,861k adverse to plan and Non Pay is £2,143k favourable to plan.

The £4,861k adverse Pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive Pay is £1,586k favourable to plan, Bank Pay is £1,444k adverse to plan and Agency Pay is £5,005k adverse to plan. The Pay position is driven by lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing. Staffing pressures are most acute in the Medicine Division.

The pay position includes £417k (in line with plan) in relation to a 1% Medical & Dental pay award, which has now been agreed nationally at 2.5% back-dated to April, and if there is no central funding for the costs of the award over and above 1% the risk to the Trust in 2019/20 is £1,500k of which £625k would apply YTD.

Excluding the £965k favourable variance in relation to Passthrough, Non Pay is £1,178k favourable to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £315k adverse to plan. Likewise, the Pay position includes £1,021k of non-recurrent technical FEP, without which Pay would be £5,882k adverse to plan.

Overall, FEP savings of £5,895k have been delivered YTD or £979k less than savings of £6,874k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, FEP savings delivery is £3,510k adverse to plan YTD.

The most likely unmitigated forecast is a deficit of £79.2m excluding PSF, FRF and MRET or £8,826k adverse to plan. This forecast is inclusive of £20.2m of FEP savings or £5.4m less than planned.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Run Rate 2019/20

2019/20	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	In Month Plan M5	In Month Actuals M5	In Month Variance M5	Year to date Plan M5	Year to date Actuals M5	Year to date Variance M5	Full Year Plan Full Year	Full Year Most Likely Forecast Full Year	Full Year Required Mitigation Full Year
Income														
Clinical income	31,788	33,208	31,840	34,422	32,741	32,690	32,741	50	163,439	163,999	560	389,070	392,147	3,077
Pass through income	4,101	4,068	3,793	4,455	3,745	4,224	3,745	(478)	21,127	20,162	(965)	50,710	48,390	(2,321)
Total Patient related income	**35,889**	**37,276**	**35,633**	**38,877**	**36,486**	**36,914**	**36,486**	**(428)**	**184,566**	**184,161**	**(405)**	**439,780**	**440,536**	**756**
PSF, FRF and MRET funding	1,568	1,568	1,569	1,989	1,989	1,989	1,989	0	8,683	8,683	0	28,928	7,450	(21,478)
Other Income	2,764	2,678	2,636	2,748	2,636	2,742	2,636	(106)	13,714	13,462	(252)	32,908	32,450	(458)
Total Other operating income	**4,332**	**4,246**	**4,205**	**4,737**	**4,625**	**4,731**	**4,625**	**(106)**	**22,397**	**22,145**	**(252)**	**61,836**	**39,900**	**(21,936)**
Total Income	**40,221**	**41,522**	**39,838**	**43,614**	**41,111**	**41,645**	**41,111**	**(534)**	**206,963**	**206,306**	**(657)**	**501,616**	**480,437**	**(21,179)**
Expenditure														
Pay	(30,868)	(29,254)	(29,808)	(30,551)	(30,758)	(28,697)	(30,758)	(2,061)	(146,379)	(151,239)	(4,860)	(342,620)	(355,203)	(12,583)
Pass through non pay	(4,101)	(4,068)	(3,793)	(4,455)	(3,745)	(4,224)	(3,745)	478	(21,127)	(20,162)	965	(50,710)	(48,390)	2,321
Other Non pay	(11,369)	(11,969)	(11,363)	(11,416)	(11,741)	(11,609)	(11,743)	(133)	(59,038)	(57,860)	1,178	(140,592)	(139,961)	631
Total Expenditure	**(46,338)**	**(45,291)**	**(44,964)**	**(46,422)**	**(46,244)**	**(44,530)**	**(46,246)**	**(1,716)**	**(226,544)**	**(229,261)**	**(2,717)**	**(533,922)**	**(543,553)**	**(9,631)**
Interest receivable	16	12	11	12	10	3	10	7	15	61	46	36	146	110
Finance costs	(659)	(701)	(709)	(747)	(771)	(759)	(771)	(12)	(3,595)	(3,587)	8	(9,142)	(9,252)	(110)
Profit on disposal of assets	0	10	2	2	3	0	3	3	0	17	17	0	291	291
I&E - Deficit	**(6,760)**	**(4,448)**	**(5,822)**	**(3,541)**	**(5,891)**	**(3,641)**	**(5,893)**	**(2,252)**	**(23,161)**	**(26,464)**	**(3,303)**	**(41,412)**	**(71,931)**	**(30,519)**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	19	20	19	19	19	1	19	18	5	96	91	14	230	216
Adjusted Surplus/(Deficit)	**(6,741)**	**(4,428)**	**(5,803)**	**(3,522)**	**(5,872)**	**(3,640)**	**(5,874)**	**(2,234)**	**(23,156)**	**(26,368)**	**(3,212)**	**(41,398)**	**(71,701)**	**(30,303)**
Adjusted Surplus/(Deficit) ex PSF, FRF & MRET	**(8,309)**	**(5,996)**	**(7,372)**	**(5,511)**	**(7,861)**	**(5,629)**	**(7,863)**	**(2,234)**	**(31,839)**	**(35,051)**	**(3,212)**	**(70,326)**	**(79,151)**	**(8,825)**
Adjustments to derive underlying deficit														
FSM Loan Interest	643	689	698	735	761							9,106	9,106	(0)
External Support	558	558	558	75	75							1,900	1,900	0
Prior Year Income & Challenges	0	0	0	0	0							0	0	0
Profit on Disposals	0	0	0	0	0							(250)	(250)	0
Technical Adjustments	(94)	(1,140)	(347)	(950)	0							(500)	(2,531)	(2,031)
Income timing adjustment	0	0	0	0	0							0	0	0
Underlying Surplus/(Deficit)	**(5,633)**	**(4,321)**	**(4,894)**	**(3,662)**	**(5,036)**							**(31,142)**	**(63,476)**	**(32,334)**

As at the end of August, the Trust position is a deficit of £26,369k or £3,213k adverse to plan, including an adverse movement to plan of £2,235k in August.

The adverse movement to plan both YTD and in August is driven by the adverse movement to plan in relation to Pay: Pay moved adversely to plan in Auust by £2,062k and YTD has moved adverselyt to plan by £4,861k.

The unmitigated most likely forecast is a deficit of £79,152k or £8,826k adverse to plan. Including PSF, FRF and MRET, the forecast is £30,304k adverse to plan because failure to achieve the financial plan in the second, third and final quarter of 2019/20 would result in the loss of £21,478k of PSF and FRF funding. Actions are therefore required to mitigate the £8,826k adverse movement to plan in order to achieve the PSF and FRF funding.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income & Activity 2019/20

2019/20 Clinical Income Summary: YTD Month 5

	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20			2018/19	2019/20			2018/19	2019/20		
	Aug Activity Actual	Aug Activity Plan	Aug Activity Actual	Aug Activity Variance	Aug £k Actual	Aug £k Plan	Aug £k Actual	Aug £k Variance	Aug Activity Actual	Aug Activity Plan	Aug Activity Actual	Aug Activity Variance	Aug £k Actual	Aug £k Plan	Aug £k Actual	Aug £k Variance
Activity:																
Accident & Emergency	12,429	12,197	12,632	435	1,819	2,073	2,175	102	63,771	60,192	62,641	2,449	9,222	10,230	10,723	493
Daycases	5,460	5,373	5,227	(146)	2,775	2,864	2,825	(39)	27,475	27,119	27,293	174	14,162	14,454	14,886	432
Elective Spells	726	771	767	(4)	1,899	2,128	2,183	55	3,834	3,892	3,713	(179)	9,746	10,739	10,717	(22)
Non Elective Spells	5,969	6,137	6,222	85	10,488	11,464	12,508	1,044	29,404	30,264	31,454	1,190	51,982	56,515	64,847	8,332
Elective Excess Bed Days	178	117	36	(81)	47	32	9	(23)	641	586	468	(118)	161	159	127	(32)
Non Elective Excess Bed Days	1,438	1,645	1,462	(183)	342	431	224	(207)	7,926	8,223	6,022	(2,201)	1,912	2,155	1,461	(693)
Outpatient Firsts	24,444	24,538	22,059	(2,479)	3,226	3,516	3,095	(421)	124,108	123,847	120,978	(2,869)	16,456	17,744	17,247	(497)
Outpatient Follow Ups	31,432	31,841	29,013	(2,828)	2,669	2,953	2,604	(349)	161,922	160,720	156,817	(3,904)	13,713	14,908	14,364	(543)
Outpatient Non Face To Face	2,037	2,090	2,144	54	45	137	131	(5)	10,630	10,483	12,539	2,056	232	685	799	115
Outpatient Advice & Guidance	0	279	445	166	0	8	11	3	0	1,396	2,308	912	0	42	57	15
Critical Care	1,549	1,630	1,618	(12)	1,362	1,551	1,607	55	7,751	8,152	7,290	(862)	6,059	7,757	6,868	(889)
Maternity	974	1,028	946	(82)	802	895	876	(19)	5,044	5,138	4,773	(365)	4,236	4,475	4,429	(46)
Non PbR		78,674			3,707	3,069	3,221	152					18,990	15,416	15,794	378
Block	0	0	0	0	0	237	237	0	0	0	0	0	0	1,187	1,187	0
Shadow Monitoring	0	1,395	1,186	(209)	0	0	0	0	0	6,975	6,934	(41)	0	0	0	0
Repatriation						483	483	0						2,383	2,383	0
Backlog						54	54	0						258	258	0
Work in Progress:						0	300	300						0	(101)	(101)
Sub total without passthrough					**29,181**	**31,896**	**32,542**	**647**					**146,872**	**159,107**	**166,047**	**6,940**
CQUIN					593	366	370	4					3,000	1,828	1,917	89
Fines						0	(59)	(59)						0	(346)	(346)
Fines Reinvested						0	18	18						0	130	130
Bring Lincolnshire CCG Contract to Plan						0	(568)	(568)						0	(7,050)	(7,050)
APA (calculated at quarterly billing)						0	(105)	(105)						0	810	810
Prior Year						0		0						0		0
Maternity Prepayment						0		0						0		0
Total (Non Passthrough)						**32,262**	**32,198**	**(64)**						**160,935**	**161,508**	**573**
Passthrough					4,292	4,223.7	3,734.4	- 489.3					20,440	21,127.2	20,162	(965)
Total (Inc Passthrough)						**36,485.7**	**35,932.5**	**- 553.2**						**182,062.0**	**181,670**	**(392)**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Headline
Contract income year to date of £181.7m is £0.4m (0.22%) adverse to plan. Excluding £1.0m adverse variance on pass-through, contract income year to date is £0.6m favourable to plan.

Key variances by POD below excluding pass-through
• Non Elective Spells are favourable to plan by £8,332k (14.7%) – Medicine accounts for £7,520k of the over-performance. Activity is above plan by 1,190 (3.9%) and the Trust has seen 2,050 more patients for the same time period in 2018/19.
• Outpatients are £911k adverse to plan - Medicine and Surgery account for 82% of the adverse movement to plan. Activity is 3,804 adverse to plan in 2019/20
• Critical Care is £889k adverse to plan – with this variance driven by Adult Critical Care. Activity is 862 adverse to plan in 2019/20 and 461 down on the same time period in 2018/19.
• A&E attendances are £493k favourable to plan. Activity in 2019/20 is above planned levels by 2,449 attendances, however this is 1,130 less than the same time period in 2018/19.

Key variances by Commissioner
• Lincolnshire CCGs are £810k favourable to plan. This is driven by the NEL APA adjustment.
• Non Lincolnshire commissioners are £237k adverse to plan driven by:
  o Fines of £216.3k, predominantly due to 2ww breast symptomatic and suspect cancer.
  o Screening is £125.5k adverse to plan, of which bowel scope is £201k, diabetic retinopathy is £63k, offset by a favourable variance of £138k in Breast Screening.

Risks
• Lincolnshire CCGs are querying the level of NEL financial over-performance for both volume (activity) and price (casemix). Specifically these queries are in relation to Frailty Unit, Discharge (from A&E) and Paediatric Assessment Unit.
• Delivery of the backlog and repatriation activity levels. The Trust assumes £2.3m backlog and £5.7m repatriation. Backlog is presentationally split; where there are plans these are split at specialty/POD for 2019/20 with £0.6m unidentified at present. No plans have been identified and agreed with commissioners for repatriation. The current risk around repatriation and unidentified backlog is £3.6m in the year-to-date position.
• A&E over performance – the plan assumed a greater impact in relation to primary care streaming and commissioner demand management schemes than is currently being delivered.
• PLCV challenges – It has been identified that prior approval is not being received for all procedures currently and there is a risk in the year-to-date position of c£0.3m, in particular tonsillectomy's and hernias. This is not transacted through the current contract arrangements.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - Activity 2019/20

	Activity Units					In Month				Year to date			
Activity	**Actual M1**	**Actual M2**	**Actual M3**	**Actual M4**	**Actual M5**	Plan M5	Actuals M5	Variance	% Variance	Plan M5	Actuals Variance	Variance	% Variance
Accident & Emergency	11,989	12,740	12,017	13,263	12,632	12,197	12,632	435	3.6%	60,192	62,641	2,449	4.1%
Daycases	5,307	5,786	5,260	5,713	5,227	5,373	5,227	-146	-2.7%	27,119	27,293	174	0.6%
Elective Spells	681	784	683	798	767	771	767	-4	-0.5%	3,892	3,713	-179	-4.6%
Non Elective Spells	6,045	6,477	6,023	6,687	6,222	6,137	6,222	85	1.4%	30,264	31,454	1,190	3.9%
Elective Excess Bed Days	67	110	87	168	36	117	36	-81	-69.3%	586	468	-118	-20.1%
Non Elective Excess Bed Days	1,002	1,220	1,171	1,167	1,462	1,645	1,462	-183	-11.1%	8,223	6,022	-2,201	-26.8%
Outpatient Firsts	24,311	24,634	23,298	26,676	22,059	24,538	22,059	-2,479	-10.1%	123,847	120,978	-2,869	-2.3%
Outpatient Follow Ups	31,382	32,082	29,772	34,567	29,013	31,841	29,013	-2,828	-8.9%	160,720	156,817	-3,904	-2.4%
Outpatient Non Face To Face	2,726	2,686	2,413	2,570	2,144	2,090	2,144	54	2.6%	10,483	12,539	2,056	19.6%
Outpatient Advice & Guidance	373	437	524	529	445	279	445	166	59.3%	1,396	2,308	912	65.4%

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

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

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

Non Elective activity is 3.9% up against plan YTD in relation to activity and 15% in relation to income. This Non Elective over performance is mainly within the Medicine Division and further details are being shared with the Division.

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

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - £ 2019/20

	(£k)					In Month			Year to date		
Income	**Actual M1**	**Actual M2**	**Actual M3**	**Actual M4**	**Actual M5**	Plan M5	Actuals M5	Variance	Plan M5	Actuals M5	Variance
Accident & Emergency	2,039.2	2,167.5	2,060.4	2,281.0	2,174.6	2,072.9	2,174.6	101.7	10,230.0	10,722.7	492.7
Daycases	2,897.9	3,144.1	2,902.1	3,116.6	2,825.3	2,863.9	2,825.3	(38.6)	14,454.0	14,885.9	432.0
Elective Spells	1,963.1	2,295.1	2,081.7	2,194.5	2,182.9	2,128.1	2,182.9	54.9	10,739.3	10,717.3	(22.0)
Non Elective Spells	12,688.6	13,551.1	12,452.9	13,646.8	12,507.8	11,463.7	12,507.8	1,044.1	56,515.2	64,847.2	8,332.0
Elective Excess Bed Days	17.4	28.8	24.9	47.0	9.2	31.8	9.2	(22.5)	158.9	127.3	(31.7)
Non Elective Excess Bed Days	273.8	326.2	317.7	319.3	224.3	431.0	224.3	(206.6)	2,154.8	1,461.4	(693.4)
Outpatient Firsts	3,477.6	3,509.3	3,349.6	3,816.1	3,094.5	3,515.9	3,094.5	(421.3)	17,744.2	17,247.1	(497.1)
Outpatient Follow Ups	2,874.4	2,950.2	2,769.8	3,165.9	2,604.1	2,953.4	2,604.1	(349.4)	14,907.6	14,364.4	(543.2)
Outpatient Non Face To Face	172.1	167.9	163.3	164.6	131.4	136.6	131.4	(5.2)	684.7	799.5	114.8
Outpatient Advice & Guidance	9.5	10.8	13.0	12.8	11.1	8.5	11.1	2.6	42.5	57.2	14.7
Critical Care	1,380.6	1,166.6	1,608.1	1,106.2	1,606.8	1,551.5	1,606.8	55.4	7,757.3	6,868.5	(888.9)
Maternity	897.9	829.4	901.0	925.0	875.5	895.0	875.5	(19.5)	4,474.9	4,428.9	(46.0)
Non PbR	3,011.8	3,316.4	2,915.0	3,329.8	3,220.9	3,069.2	3,220.9	151.7	15,416.4	15,793.9	377.5
Block	237.4	237.4	237.4	237.4	237.4	237.4	237.4	0.0	1,186.8	1,186.8	0.0
Repatriation	467.2	482.8	467.2	482.8	482.8	482.8	482.8	0.0	2,382.8	2,382.8	0.0
Backlog	47.8	54.1	47.8	54.1	54.1	54.1	54.1	0.0	257.8	257.8	0.0
Work in Progress	(219.6)	(391.6)	570.6	(360.4)	299.5	0.0	299.5	299.5	0.0	(101.4)	(101.4)
Sub total without passthrough	32,236.8	33,846.2	32,882.5	34,539.5	32,542.3	31,895.6	32,542.3	646.7	159,107.3	166,047.3	6,940.0
CQUIN	375.0	395.2	373.0	403.5	370.1	366.4	370.1	3.7	1,827.5	1,916.8	89.3
Fines	(19.9)	(21.8)	(185.7)	(59.6)	(59.4)	0.0	(59.4)	(59.4)	0.0	(346.3)	(346.3)
Fines Reinvested	16.1	0.0	0.0	0.0	0.0	0.0	17.8	17.8	0.0	130.0	130.0
Bring Lincolnshire CCG Contract to Plan	(1,618.8)	(1,346.5)	(1,871.6)	(1,644.7)	(567.9)	0.0	(567.9)	(567.9)	0.0	(7,049.6)	(7,049.6)
APA (calculated at quarterly billing)	123.5	206.4	53.8	530.9	(104.8)	0.0	(104.8)	(104.8)	0.0	809.9	809.9
Total (Non Passthrough)	**31,112.7**	**33,079.6**	**31,251.9**	**33,769.6**	**32,180.3**	**32,262.0**	**32,198.1**	(63.9)	**160,934.8**	**161,508.1**	**573.3**
Passthrough	4,101.2	4,174.2	3,957.9	4,194.5	3,734.4	4,223.7	3,734.4	(489.3)	21,127.2	20,162.3	(964.9)
Total (Inc Passthrough)	**35,214.0**	**37,253.8**	**35,209.9**	**37,964.1**	**35,914.7**	**36,485.7**	**35,932.5**	**(553.2)**	**182,062.0**	**181,670.4**	**(391.6)**

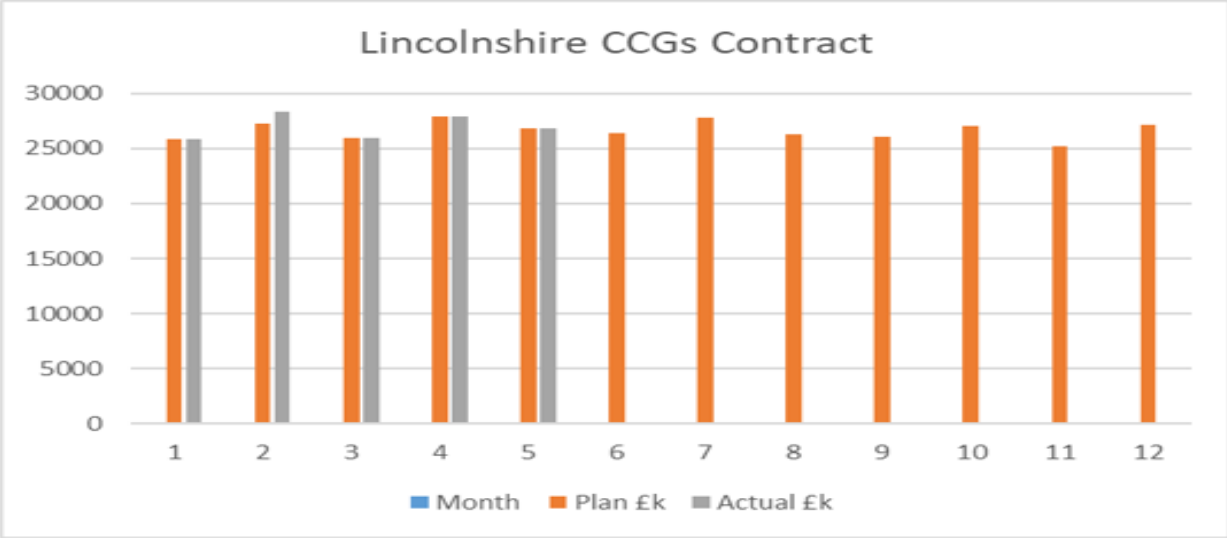
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

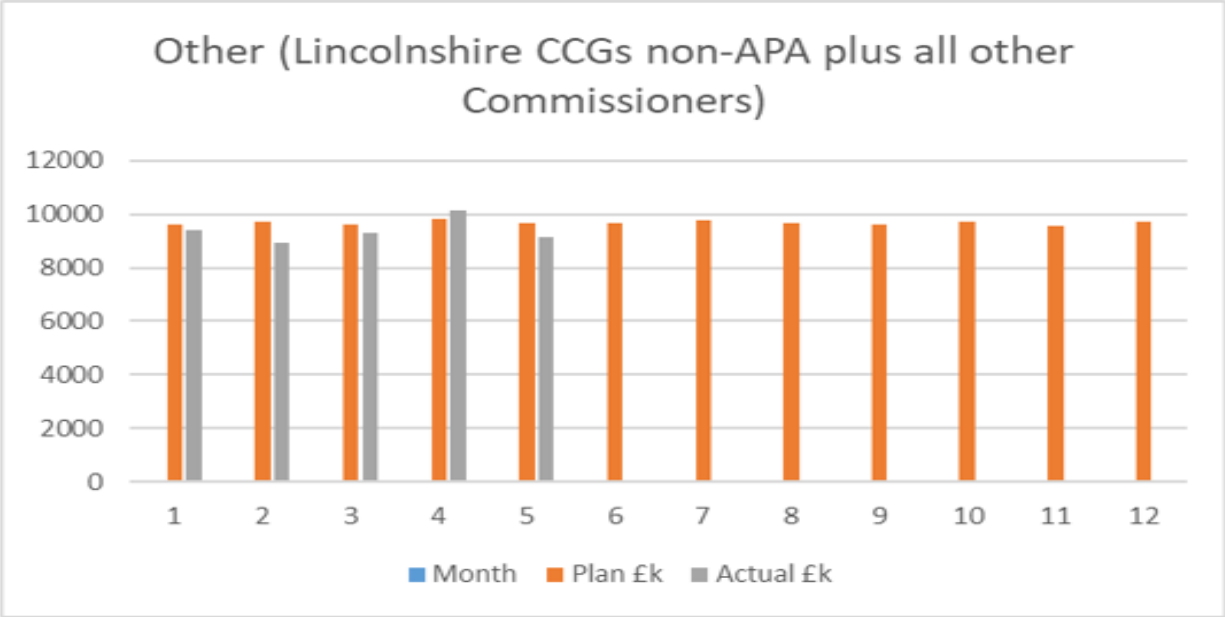
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income 2019/20 - Lincolnshire CCGs and 'Other' performance





SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Pay Summary 2019/20

2019/20 Pay Summary: YTD Month 5

	By Month					Pay: In-Month				Pay: Year-To-Date			
Staff Groups	**Actual M1 £k**	**Actual M2 £k**	**Actual M3 £k**	**Actual M4 £k**	**Actual M5 £k**	**2018/19 Aug £k Actual**	**2019/20 Aug £k Plan**	**2019/20 Aug £k Actual**	**2019/20 Aug £k Variance**	**2018/19 Apr - Aug £k Actual**	**2019/20 Aug £k Plan**	**2019/20 Aug £k Actual**	**2019/20 Aug £k Variance**
Substantive:													
Registered Nursing, Midwifery and Health visiting staff	7,614	6,880	7,094	7,082	7,158	7,092	7,190	7,158	32	34,647	36,116	35,829	287
Health Care Scientists and Scientific, Therapeutic and Technical staff	2,868	2,672	2,712	2,739	2,737	2,607	2,602	2,737	(135)	12,586	13,098	13,727	(629)
Support to clinical staff	5,127	4,787	4,886	4,895	4,869	5,092	4,780	4,869	(89)	23,065	24,095	24,564	(469)
Medical and Dental Staff	6,435	6,092	6,566	6,855	6,871	6,554	6,793	6,871	(78)	32,694	34,354	32,819	1,535
Non-Medical - Non-Clinical Staff	2,872	2,671	2,713	2,730	2,872	2,691	2,911	2,872	39	12,734	14,655	13,858	797
Apprentice levy	119	113	115	86	113	113	107	113	(6)	528	535	546	(11)
Capitalised staff	- 14	- 14	- 17	- 16	- 15	(171)	0	(15)	15	(245)	0	(76)	76
Total Substantive costs	**25,022**	**23,201**	**24,069**	**24,372**	**24,605**	**23,978**	**24,383**	**24,605**	**(222)**	**116,009**	**122,853**	**121,267**	**1,586**
Bank:													
Registered Nursing, Midwifery and Health visiting staff	508	495	520	496	506	461	471	506	(35)	2,399	2,357	2,525	(168)
Health Care Scientists and Scientific, Therapeutic and Technical staff	39	44	47	48	44	40	44	44	0	215	221	223	(2)
Support to clinical staff	379	371	395	404	466	497	371	466	(95)	1,923	1,857	2,014	(157)
Medical and Dental Staff	1,073	893	880	1,004	796	930	675	796	(121)	4,182	3,757	4,646	(889)
Non-Medical - Non-Clinical Staff	226	233	256	199	199	236	177	199	(22)	934	885	1,113	(228)
Total Bank costs	**2,225**	**2,036**	**2,098**	**2,150**	**2,012**	**2,164**	**1,738**	**2,012**	**(274)**	**9,653**	**9,077**	**10,521**	**(1,444)**
Agency:													
Registered Nursing, Midwifery and Health visiting staff	877	1,082	1,127	1,185	1,329	851	876	1,329	(453)	3,654	4,554	5,599	(1,045)
Health Care Scientists and Scientific, Therapeutic and Technical staff	147	177	176	155	149	145	131	149	(18)	768	676	804	(128)
Support to clinical staff	1	3	2	-	-	1	17	0	17	13	64	6	58
Medical and Dental Staff	2,379	2,431	2,091	2,442	2,473	1,863	1,406	2,473	(1,067)	8,747	7,975	11,816	(3,841)
Non-Medical - Non-Clinical Staff	216	327	245	245	196	88	146	196	(50)	448	1,180	1,229	(49)
Total Agency costs	**3,621**	**4,020**	**3,640**	**4,027**	**4,147**	**2,948**	**2,576**	**4,147**	**(1,571)**	**13,630**	**14,449**	**19,454**	**(5,005)**
Total Pay	**30,867**	**29,256**	**29,807**	**30,549**	**30,763**	**29,090**	**28,697**	**30,763**	**(2,066)**	**139,292**	**146,379**	**151,243**	**(4,864)**

Pay year to date is £4,864k adverse to plan including an adverse movement to plan of £2,066k in August, despite the release of £1,021k of non-recurrent technical savings in prior months.

The adverse movement to plan in Pay includes two key movements: £1,586k favourable movement against substantive staffing and £6,449k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £1,556k favourable to plan, this includes £993k of one-off technical benefit. Excluding the impact the one-off cost of £920k in April of the Agenda for Change pay award and the one-off technical benefits of £993k, Substantive Pay was broadly flat in the first quarter at £24.0m per month, but increased to £24.3m and £24.4m in the last two months.

The above table shows that:

1) The adverse movement to plan on temporary staffing comprises of an adverse movement to plan of £1,444k on Bank Pay and £5,005k on Agency Pay.
2) Medical & Dental Pay accounts for £3,196k (66%) and Nursing & Midwifery accounts for £927k (19%) of the overall adverse movement to plan.

Whilst year to date Agency Pay has averaged £3.9m per month, Agency Pay has increased by £0.5m from £3.6m in April to £4.1m in August. The Medicine Division account for 58% of all Agency Pay. Whilst the Medicine Division's use of Medical and Nursing Agency spend will be in part due to need to respond to safety concerns and the growth in Non-Elective activity, the scale of expenditure and the generally upward trend in expenditure is of great concern given the impact it will have upon the Trust's ability to deliver the control total. Enhanced support is to be provided to Medicine in order to agree and deliver plans to improve the Division's performance.

SUSTAINABLE SERVICES – NON PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Non Pay Summary 2019/20

2019/20 Non Pay Summary: YTD Month 5

	By Month					Non Pay: In-Month				Non Pay: Year-To-Date		
Non Pay	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	2018/19 August £k Actual	2019/20 August £k Plan	2019/20 August £k Actual	2019/20 August £k Variance	2019/20 August £k Plan	2019/20 August £k Actual	2019/20 August £k Variance
Ambulance Services	125	195	149	166	169	221	170	168	2	849	804	45
Clinical Supplies & Services	4,756	5,345	4,883	5,702	5,112	5,178	5,181	5,115	66	25,906	25,798	108
Drugs	275	392	246	(446)	278	555	441	278	164	2,198	745	1,453
Drugs Pass through	4,101	4,068	3,793	4,455	3,745	4,180	4,224	3,745	478	21,127	20,162	965
Establishment Expenditure	505	643	458	674	561	560	528	567	(39)	2,640	2,841	(201)
General Supplies & Services	1,047	817	977	889	661	1,145	489	662	(173)	3,444	4,391	(947)
Other	286	242	370	184	293	255	325	279	46	1,628	1,375	253
Premises & Fixed Plant	1,549	1,511	1,464	1,429	1,842	1,432	1,634	1,843	(209)	8,168	7,795	373
Clinical Negligence	1,741	1,741	1,740	1,741	1,741	1,774	1,741	1,741	0	8,705	8,704	1
Capital charges	1,085	1,083	1,076	1,077	1,084	950	1,100	1,085	15	5,500	5,405	95
Total Non Pay	**15,470**	**16,037**	**15,156**	**15,871**	**15,486**	**16,250**	**15,833**	**15,483**	**350**	**80,165**	**78,020**	**2,145**

Non Pay expenditure of £78,020k is £2,145k (2.8%) favourable to plan.

Excluding £965k favourable variance on Pass-through, Non Pay is £1,180k favourable to plan. The release of technical Non-Pay flexibility of £1,493k - including £651k released in M4 in relation to Drugs - has also also significantly contributed to the favourable Non-Pay position.

Excluding both Passthrough and Technical FEP savings, Non Pay year to date is £0.3m adverse to plan. Variation to plan, though, is to be expected given the overall underlying contract income position is £0.6m favourable to plan.

SUSTAINABLE SERVICES – FINANCIAL EFFICIENCY PROGRAMME SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

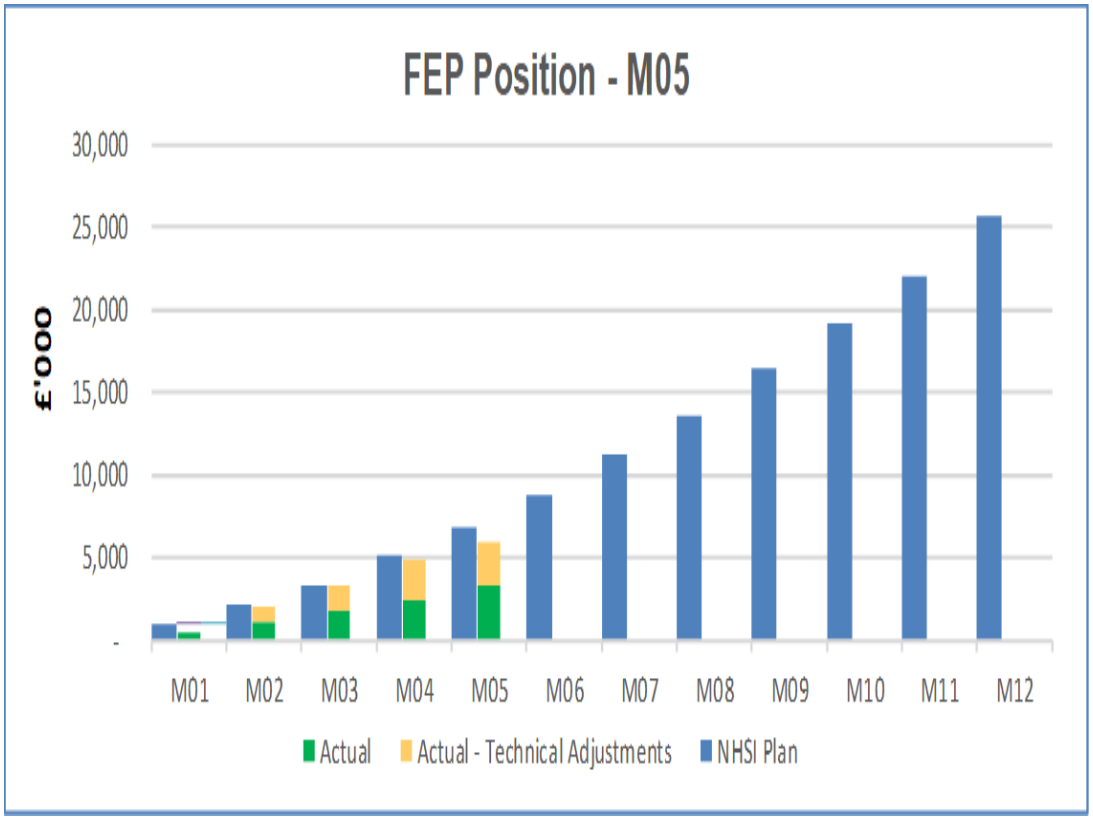
M05

	In Month			YTD			
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	RAG
FEP	1,770	940	(830)	6,874	5,895	(979)	

Finance Position

YTD ACTUAL	£k	FORECAST	£k
Recurrent	3,364	Recurrent	22,829
Non Recurrent	2,531	Non Recurrent	2,781
TOTAL	**5,895**	**TOTAL**	**25,610**

Financial Commentary - Month 05 Position



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

FEP savings delivery of £940k is reported in August; compared to planned FEP savings delivery of £1,770k, savings delivery in August is £830k adverse to plan.

YTD FEP savings delivery of £5,895k to the end of August is £979k adverse to planned FEP savings delivery of £6,874k.

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

The delivery of non-recurrent Technical FEP savings have mitigated some of the continued underperformance in relation to Theatres, Outpatients, Procurement, Workforce programmes and some of the Divisional Transactional schemes. In relation to Theatres, it is noted that whilst four specialties within the Theatres Productivity Programme have delivered above their FEP targets, this Productivity Programme has not delivered the anticipated overall increase in activity.

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

The Year to date and forecast balance sheets are broadly in line with plan with the following main exceptions:

- Property plant and equipment: the 2019/20 plan was constructed prior to the results of the 31 March 2019 revaluation being completed. This resulted in an increase in asset valuation of circa £32m; the offset to this can be seen within the revaluation and Income & Expenditure Reserves.

- Borrowings: the split between debt due to be repaid within and after one year was incorrect at plan. In total however this is accurate.

The forecast balance sheet assumes that the control total of £41.5m is achieved and the full PSF / FRF are awarded.

	Year end		Year to date			Monthly Actual 2019/20				Forecast Outurn	
	31 March 2019		31 August 2019			30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31 March 2020	
	Actual	Plan	Actual	Plan	Variance	Actual	Actual	Actual	Actual	Actual	Plan
	Month 12					Month 1	Month 2	Month 3	Month 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets											
Intangible assets	6,341	5,488	5,625	4,859	766	6,195	6,048	5,907	5,766	4,639	4,637
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	27,654	22,495	27,481	27,190	291	27,619	27,585	27,550	27,515	27,238	26,954
Property, plant and equipment: other	181,095	213,599	187,134	208,656	(21,522)	181,031	182,083	184,058	186,292	201,948	224,849
Trade and other receivables: due from non-NHS/DHSC group bodies	1,560	1,828	1,586	1,600	(14)	1,529	1,551	1,537	1,558	1,600	1,600
Total non-current assets	**216,650**	**243,410**	**221,826**	**242,305**	**(20,479)**	**216,374**	**217,267**	**219,052**	**221,131**	**235,425**	**258,040**
Current assets											
Inventories	7,440	6,799	7,961	7,350	611	7,593	7,521	7,317	7,449	7,350	7,350
Trade and other receivables: due from NHS and DHSC group bodies	15,203	17,664	20,023	21,368	(1,345)	15,563	18,820	16,170	19,002	26,845	26,845
Trade and other receivables: Due from non-NHS/DHSC group bodies	6,833	4,848	17,839	7,964	9,875	11,306	12,479	15,803	16,544	7,912	7,912
Assets held for sale and assets in disposal groups	660	0	660	660	0	660	660	660	660	0	510
Cash and cash equivalents: GBS/NLF	7,376	6,143	1,818	990	828	3,251	2,248	1,206	1,645	5,447	4,214
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	10
Total current assets	**37,522**	**35,464**	**48,311**	**38,342**	**9,969**	**38,383**	**41,738**	**41,166**	**45,310**	**47,564**	**46,841**
Current liabilities											
Trade and other payables: capital	(10,791)	(4,723)	(7,581)	(3,869)	(3,712)	(8,748)	(7,764)	(7,990)	(8,790)	(4,332)	(4,466)
Trade and other payables: non-capital	(40,622)	(38,039)	(47,352)	(39,416)	(7,936)	(46,383)	(47,773)	(47,043)	(47,082)	(41,163)	(41,096)
Borrowings	(114,339)	(77,359)	(106,008)	(40,281)	(65,727)	(118,596)	(124,423)	(124,423)	(106,008)	(197,439)	(197,289)
Provisions	(608)	(735)	(608)	(565)	(43)	(608)	(608)	(608)	(608)	(565)	(565)
Other liabilities: deferred income	(2,869)	(2,707)	(1,487)	(1,200)	(287)	(1,106)	(1,088)	(1,110)	(1,634)	(1,200)	(1,200)
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	(503)
Total current liabilities	**(169,732)**	**(124,066)**	**(163,539)**	**(85,834)**	**(77,705)**	**(175,944)**	**(182,159)**	**(181,677)**	**(164,625)**	**(245,202)**	**(245,119)**
Net Current liabilities	**(132,210)**	**(88,602)**	**(115,228)**	**(47,492)**	**(67,736)**	**(137,561)**	**(140,421)**	**(140,511)**	**(119,315)**	**(197,638)**	**(198,278)**
Total assets less current liabilities	**84,440**	**154,808**	**106,598**	**194,813**	**(88,215)**	**78,813**	**76,846**	**78,541**	**101,816**	**37,787**	**59,762**
Non-current liabilities											
Borrowings	(188,196)	(228,888)	(237,202)	(299,857)	62,655	(189,662)	(191,890)	(199,326)	(226,484)	(178,309)	(178,440)
Provisions	(2,863)	(2,911)	(2,689)	(2,932)	243	(2,865)	(2,865)	(2,989)	(2,689)	(2,825)	(2,782)
Other liabilities: other	(13,081)	(13,081)	(12,872)	(12,871)	(1)	(13,040)	(12,998)	(12,956)	(12,914)	(12,578)	(12,578)
Total non-current liabilities	**(204,140)**	**(244,880)**	**(252,763)**	**(315,660)**	**62,897**	**(205,567)**	**(207,753)**	**(215,271)**	**(242,087)**	**(193,712)**	**(193,800)**
Total net assets employed	**(119,700)**	**(90,072)**	**(146,165)**	**(120,847)**	**(25,318)**	**(126,754)**	**(130,907)**	**(136,730)**	**(140,271)**	**(155,925)**	**(134,038)**
Financed by											
Public dividend capital	260,042	257,563	260,042	260,258	(216)	260,042	260,042	260,042	260,042	265,319	265,318
Revaluation reserve	32,159	34,455	31,782	35,371	(3,589)	32,089	32,008	31,933	31,858	31,255	34,951
Other reserves	190	190	190	190	0	190	190	190	190	190	190
Income and expenditure reserve	(412,091)	(382,280)	(438,179)	(416,666)	(21,513)	(419,075)	(423,147)	(428,895)	(432,361)	(452,687)	(434,497)
Total taxpayers' and others' equity	**(119,700)**	**(90,072)**	**(146,165)**	**(120,847)**	**(25,318)**	**(126,754)**	**(130,907)**	**(136,730)**	**(140,271)**	**(155,923)**	**(134,038)**

BORROWINGS	Year end		Year to date			Monthly Actual 2019/20				Forecast Outurn	
Current	31 March 2019		31 August 2019			30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31 March 2020	
Borrowings: DHSC capital loans	1,889	2,429	2,570	2,562	8	1,828	1,828	1,828	2,570	2,753	2,636
Borrowings: DHSC working capital / revenue support loans	112,450	74,930	101,304	35,508	65,796	114,694	120,938	120,859	101,935	191,520	191,521
Accrued interest on DHSC loans	**0**	0	2,134	2,211	(77)	2,074	1,657	1,736	1,503	2,703	2,670
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	0	463	462
Accrued interest on other (non-DHSC) loans	0	0	0	0	0	0	0	0	0	0	0
Total current borrowings	**114,339**	**77,359**	**106,009**	**40,281**	**65,728**	**118,596**	**124,423**	**124,423**	**106,008**	**197,439**	**197,289**
Non-current											
Borrowings: DHSC capital loans	24,283	33,343	(28,026)	28,125	(56,151)	24,344	25,005	25,005	25,863	32,629	32,746
Borrowings: DHSC working capital / revenue support loans	163,913	195,545	(209,177)	271,732	(480,909)	165,318	166,885	174,321	200,621	142,674	142,687
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	0	3,006	3,007
Total non-current borrowings	**188,196**	**228,888**	**(237,203)**	**299,857**	**(537,060)**	**189,662**	**191,890**	**199,326**	**226,484**	**178,309**	**178,440**

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Paul Matthew

Cash Report 2019/20 Month 5

CQC Domain: Well-Led

2021 Objective: Our Services

	Monthly Actual			Year to date			Year End Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k	£k	£k	£k
Cash balance	1,000	1,828	828	1,000	1,828	828	(101)	5,458	5,559

	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k	£k	£k	£k
Operating Surplus	(2,885)	(5,135)	(2,250)	(19,581)	(22,955)	(3,374)	(32,306)	(32,597)	(291)
Depreciation	1,100	1,084	(16)	5,500	5,405	(95)	13,200	13,200	0
Other Non Cash I&E Items	(18)	0	18	(90)	0	90	(214)	(120)	94
Movement in Working Capital	(3,678)	(2,776)	902	(9,779)	(11,235)	(1,456)	(13,680)	(14,303)	(623)
Provisions	0	0	0	69	(183)	(252)	(81)	(81)	0
Cashflow from Operations	**(5,481)**	**(6,827)**	(1,346)	**(23,881)**	**(28,968)**	(5,087)	**(33,081)**	**(33,901)**	(820)
Interest received	3	10	7	15	61	46	36	146	110
Capital Expenditure	(1,774)	(2,960)	(1,186)	(15,544)	(13,767)	1,777	(38,312)	(38,276)	36
Cash receipt from asset sales	0	3	3	0	19	19	150	679	529
Cash from / (used in) investing activities	**(1,771)**	**(2,947)**	**(1,176)**	**(15,529)**	**(13,687)**	**1,842**	**(38,126)**	**(37,451)**	**675**
PDC Received	108	0	(108)	216	0	(216)	5,276	5,277	1
PDC Repaid	0	0	0	0	0	0	0	0	0
Dividends Paid	0	0	0	0	0	0	0	0	0
Interest on Loans, PFI and leases	(464)	(140)	324	(3,315)	(3,407)	(92)	(8,486)	(8,327)	159
Capital element of leases	0	0	0	0	0	0	0	0	0
Drawdown on debt - Revenue	5,325	7,925	2,600	32,841	36,081	3,240	59,809	59,795	(14)
Drawdown on debt - Capital	3,200	3,155	(45)	5,760	5,416	(344)	15,400	15,400	0
Repayment of debt	(917)	(993)	(76)	(1,245)	(993)	252	(2,721)	(2,721)	0
Cashflow from financing	**7,252**	**9,947**	**2,695**	**34,257**	**37,097**	**2,840**	**69,278**	**69,424**	**146**
Net Cash Inflow / (Outflow)	**0**	**173**	**173**	**(5,153)**	**(5,558)**	**(405)**	**(1,929)**	**(1,928)**	**1**
Opening cash balance	1,000	1,655	655	6,153	7,386	1,233	1,828	7,386	5,558
Closing Cash balance	**1,000**	**1,828**	**828**	**1,000**	**1,828**	**828**	**(101)**	**5,458**	**5,559**

SUSTAINABLE SERVICES – CASH REPORT continued

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

The cash balance at 31 August 2019 was £1.8m. This includes revenue and capital cash loans drawn in April 2019 - August 2019 of £36.1m / £5.4m respectively.
The Trust has reduced the level of capital creditors from £10.8m to £7.6m.
Despite the current deficit, the impact on the ability to pay suppliers has to date been limited due to the high levels of capital creditors.

Timing differences between income / expenditure being recorded within revenue and the receipt / payment of cash, alongside the year to date deficit and reduction in capital creditors indicate that the Trust will experience severe cashflow issues without further intervention or support between Oct - Dec 2019. To mitigate against these, the Trust is in discussion with CCGs to make payment in October to support the year to date deficit. In addition the Trust will be submitting a business case to access an exceptional working capital loan of £7.3min November.

Total revenue and capital borrowings (excluding accrued interest) at 31 August were £343m. As a consequence of this borrowing costs are anticipated to be £9.1m in I&E terms , and in cash terms £8.3m.

The cash balance of £1.8m at 31 August reflects a number of factors, of which the most significant are:
- the reduction in capital creditors from the year end high of £10.8m to £8.8m;
- the operating deficit against plan
- Drawdown of Capital and Revenue loans being higher than plan.

The Trust was awarded a £26.6m single currency interim capital support facility agreement in relation to the Fire Safety Capital scheme in 2018/19 of this, £9.6m was deferred into 2019/20. The Fire Safety Loan spanned three financial years with a further £2.1m agreed for 2019/20. The final drawing against this facility will be made in September.
Revenue loans totalling of £36.1m have been drawn in the year to August 2019. This is against the backdrop of a cumulative I&E deficit to August of £26.5m.
Capital cash is supporting the overall cash position by circa £6.8m at August 2019.

The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £4.3m in March 2020

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

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Capital Report 2019/20 Month 5

Funding available 2019/20

The Trust has capital resources of c£32m for 2019/20 including ring-fenced funding e.g. Fire, Medical School and LED Lighting.
The Trust has very limited discretionary capital resources available, totalling c£9.0m - the discretionary capital available has been reduced due to the requirement to pay the fire loan. This leaves limited resources available to prioritise against Medical Device replacement, IT infrastructure and replacement, Estates Backlog and Service and Digital Developments.

The M5 spend incurred amounts to c£10.6m against a planned spend of c£8.4m, details below:
Facilities; Minimal spend in M5 of £289k. Majority of spend incurred links to Anti-barricading improvements (£185k), 2nd IT room at Pilgrim (£24k), Lincoln Heating where CQC had raised an issue following an incident with a patient (£22k). Pilgrim Kitchen Floor (£17k) and Endoscopy (£13k). Added to this spend are starting costs of £5k and £5k for Water Access/Water Tanks and Mental Health respectively.
Fire; Expenditure on fire related schemes continues to progress at pace. Costs incurred at the end of August amounted to c£9.1m (spend in month was c£1.5m). Fire Works package 1 at LCH is £3.0m, package 2 is £1.6m, Emergency Lighting at LCH is £0.5m. Package 1 at Pilgrim amounts to £1.4m.
Medical Devices; Radiology Ultrasound machine purchase of £66k, alongside Theatre Tables (£177k), Surgical Diathermy (£114k) and Theatre lights (£35k) - total year-to-date spend of £392k.
IT; E-Health-record costs of £207k together with Wifi spend linked to HSLI deferred monies amounting to £63k has been incurred at the end of M5 along with £104k of PC replacement, £104k on NSX Cyber Security and £65k for Windows 7 to 10.

Updated Phased Plan profile

A revised capital programme has been agreed following the national requirement to deliver within an STP control total. Subsequently, following the Prime Minister's increased funding support across the country, NHSI have stated that all providers revert back to the original plans submitted however Lincolnshire have requested a preference to continue as an STP. Due to on-going discussions with NHSI as to how to enact this, the revised plan will be reported from M6 onwards although managers are aware of their individial allocations and alterations already.

Year to date

	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	**8,363**	**10,557**	**-2,194**

Year End Forecast

	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	**31,818**	**31,818**	**0**

Year to date

	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	538	392	**146**
Estates - Fire	4,700	9,141	**-4,441**
ICT	495	545	**-50**
Estates - Backlog	500	289	**211**
Service developments	2,130	190	**1,940**
Total	**8,363**	**10,557**	**-2,194**

Year End Forecast

	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	936	936	**0**
Estates - Fire	13,700	13,700	**0**
ICT	2,408	2,408	**0**
Estates - Backlog	3,789	3,789	**0**
Service developments	10,985	10,985	**0**
Total	**31,818**	**31,818**	**0**

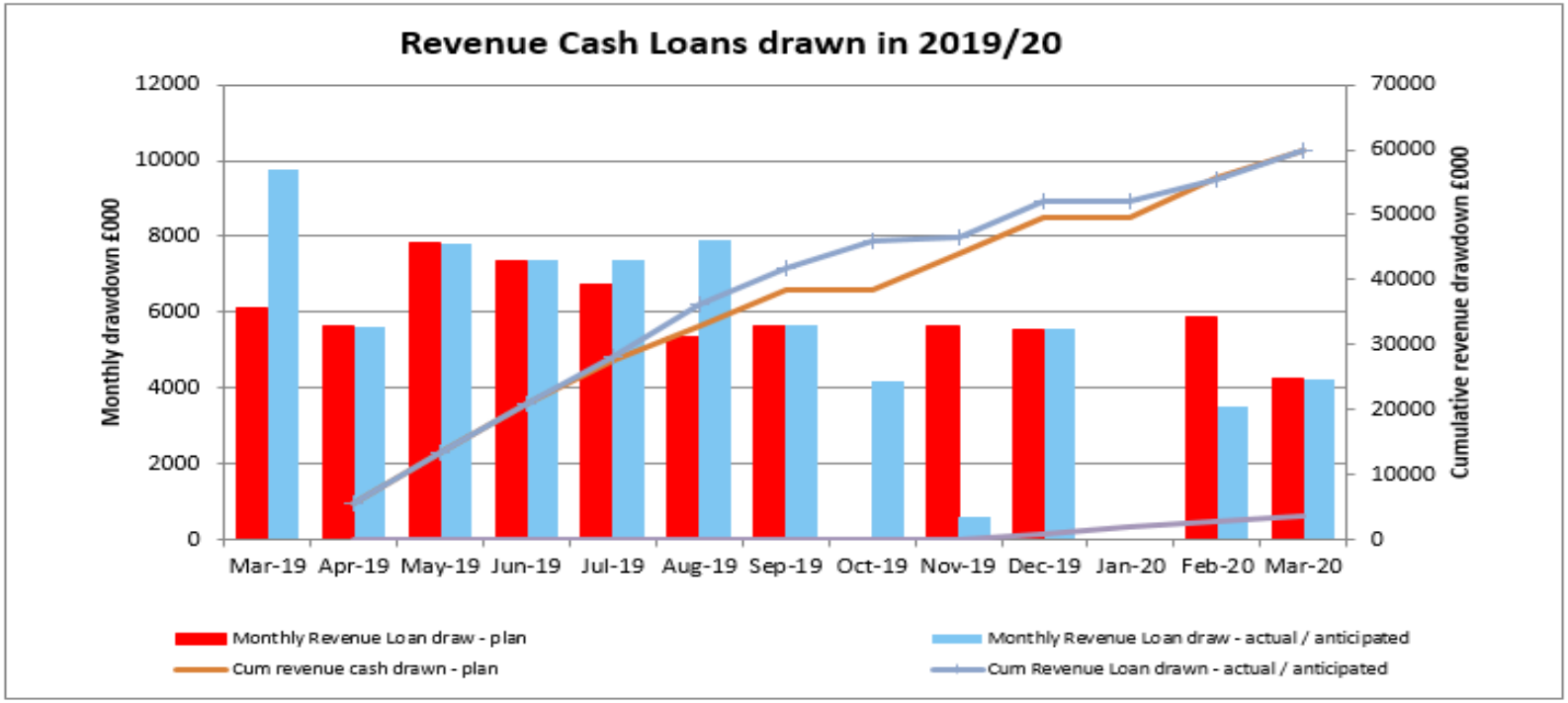
SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Revenue and Capital Borrowing



Revenue Borrowing

The Trust has drawn cash loans of £41.4m during the five months to August 2019, this is split £36.1m revenue support and £5.4m capital. This includes £9.6m deficit support relating to 2018/19.
The forecast deficit for 2019-20 is £41.4m in line with the financial plan. Revenue borrowings are planned to be £59.8m (Deficit support 19/20: £41.4m, 18/19: £9.6m and PSF / FRF: £8.8m).

The impact upon the Trust to pay creditors has to date largely been mitigated by capital cash, available due to the high level of capital creditors brought forward from 2018/19.

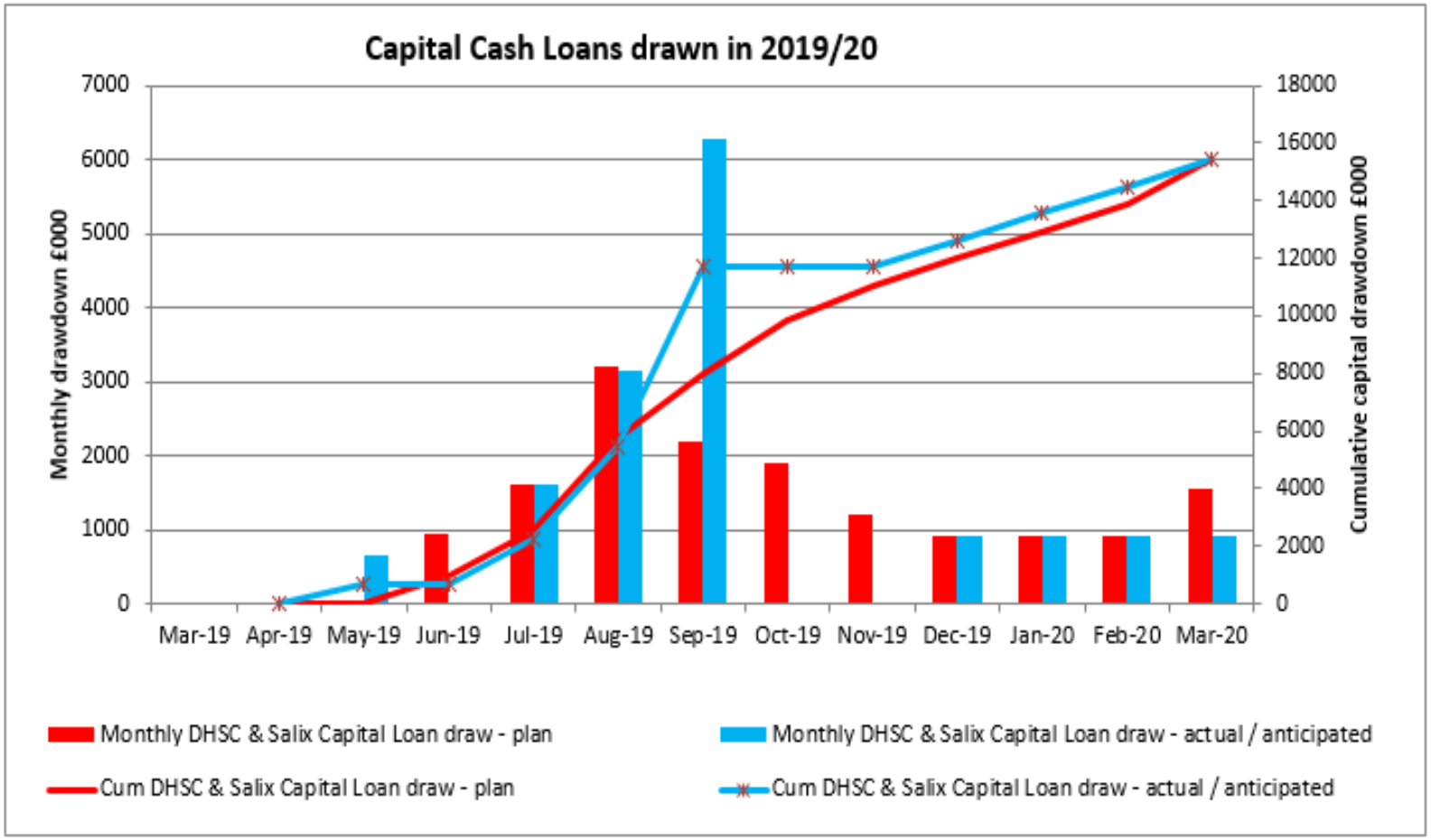
In accordance with Trust Standing Financial Instructions and in line with the draft 2019/20 financial plan, the Board is requested to approve revenue borrowing of £0.590m in November 2019.
Borrowing rates for new loans are 3.5%.

SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Capital Borrowing

A series of capital loans totalling £28.7m were agreed with DHSC in relation to the Fire Safety Capital scheme. Against this £17m was drawn prior to 2019/20. The balance of £11.7m has subsequently been drawn over the first 5 months of 2019/20.

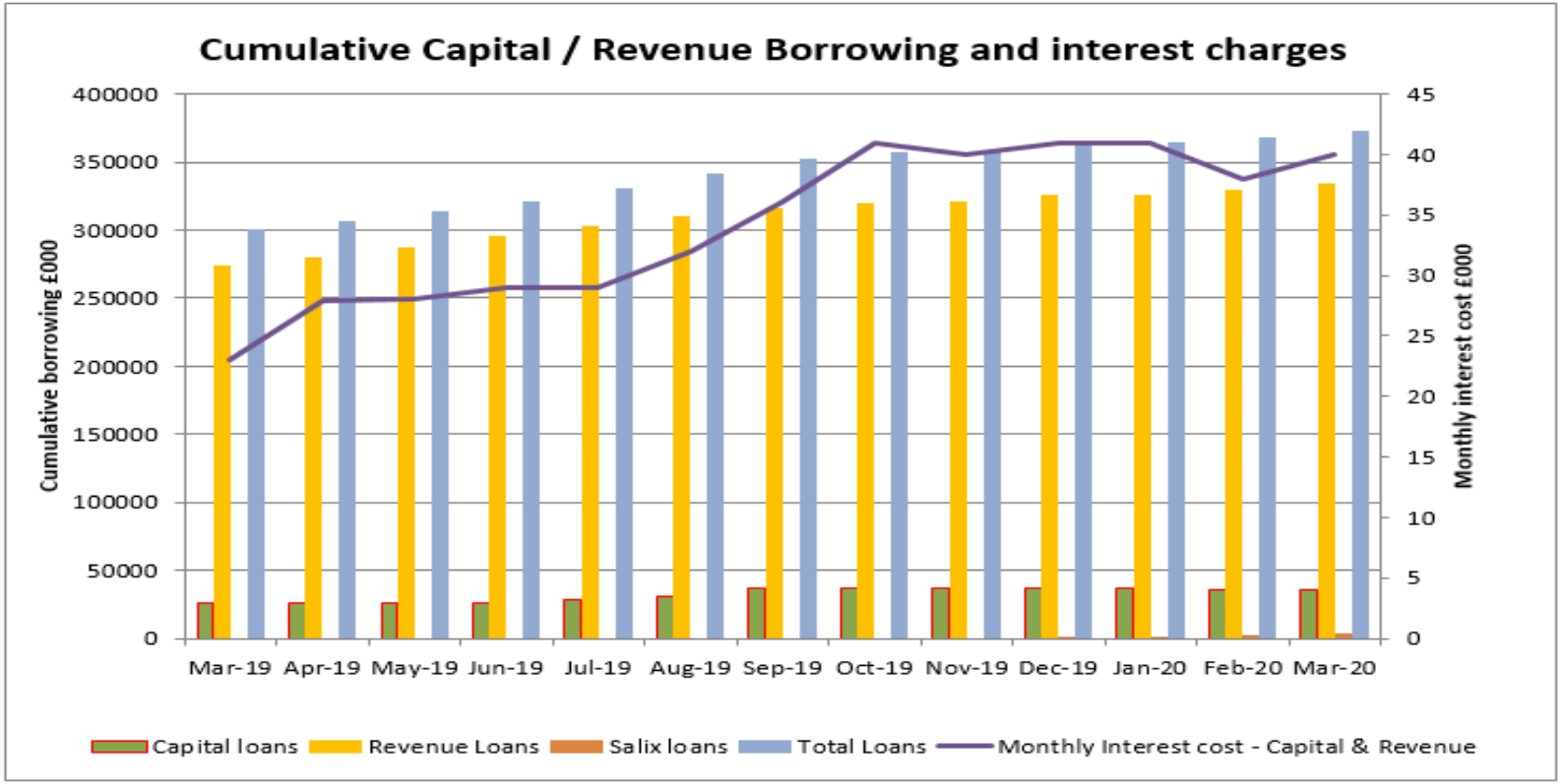
A further loan of £3.0m funded through the SALIX Energy Efficiency Loan Scheme is expected to be drawn from December 2019.

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowings and Interest

At 31 August 2019 total 'repayable' borrowings (excluding accrued interest) were £341m, capital (£30.6m) and revenue (£310.4m).

Existing loans are held at a variety of interest rates, Capital 1.1% (£9.1m) & 1.37% (£21.5m), Revenue 1.5% (£155.3m), 3.5% (£111.7m) & 6.0% (£43.4m).

In 2018/19 a revenue loan of £35.6m due to be repaid in November 2018 was extended by DHSC, no revised repayment date or interest rate has been advised. For the purposes of the above analysis the interest charge has been assumed at 3.5%.

A further £74.9m of revenue loans are due to be repaid between November 2019 - March 2020. No details regarding extensions have been received to date.

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

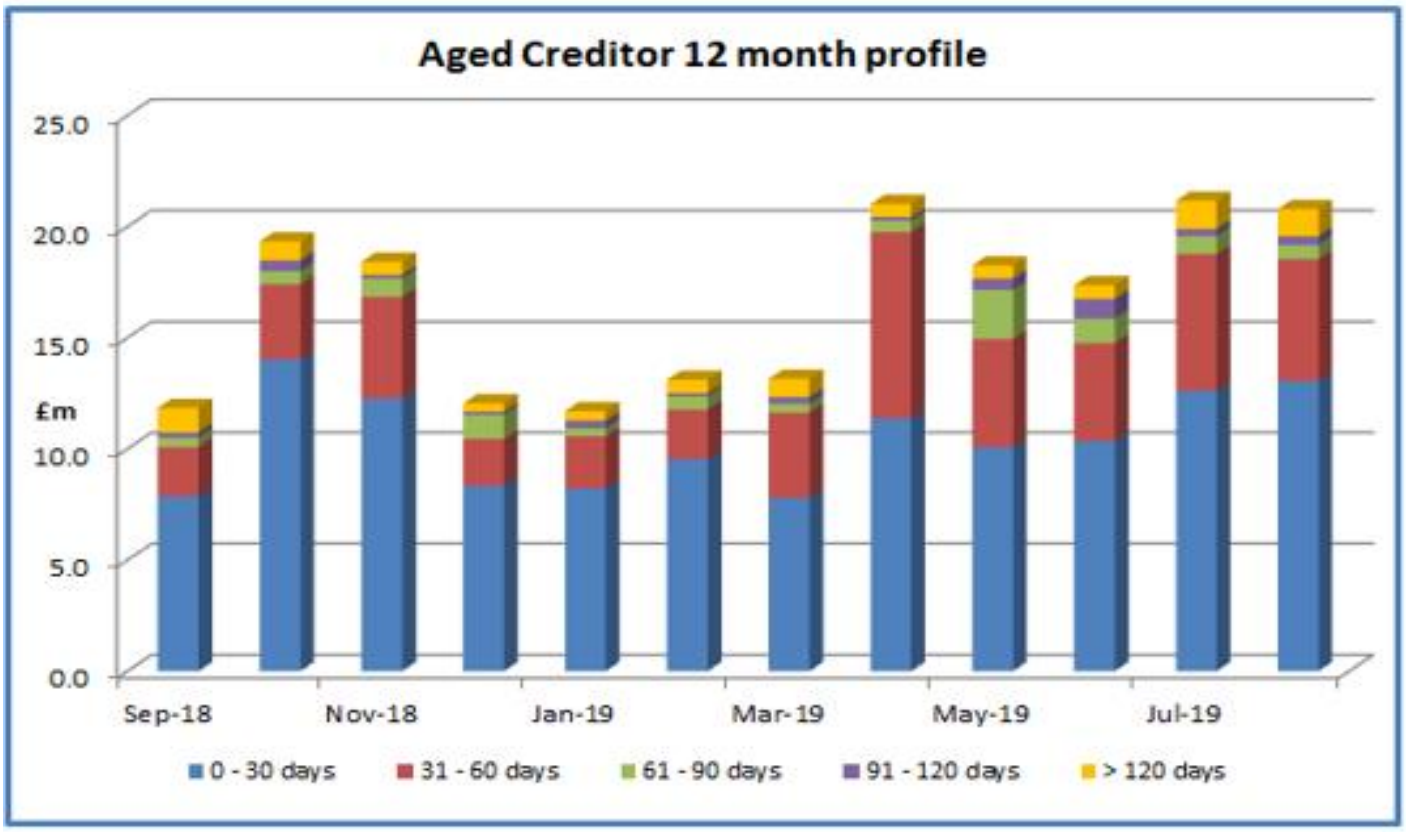
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

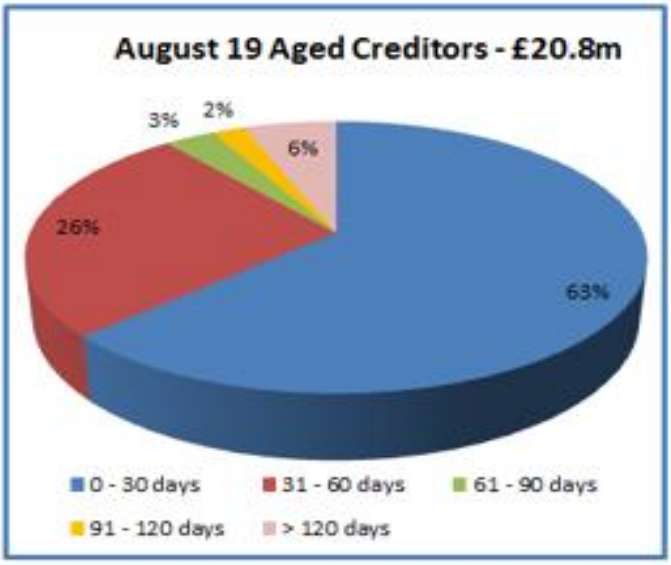
2021 Objective: Our Services

Creditor Payments



Creditors

Total Creditors were £20.8m at 30 August 2019, of which; £7.7m were over 30 days (£1.6m > 90 days). Focusing further upon those invoices over 30 days £2.5m (56%) relates to just ten suppliers.



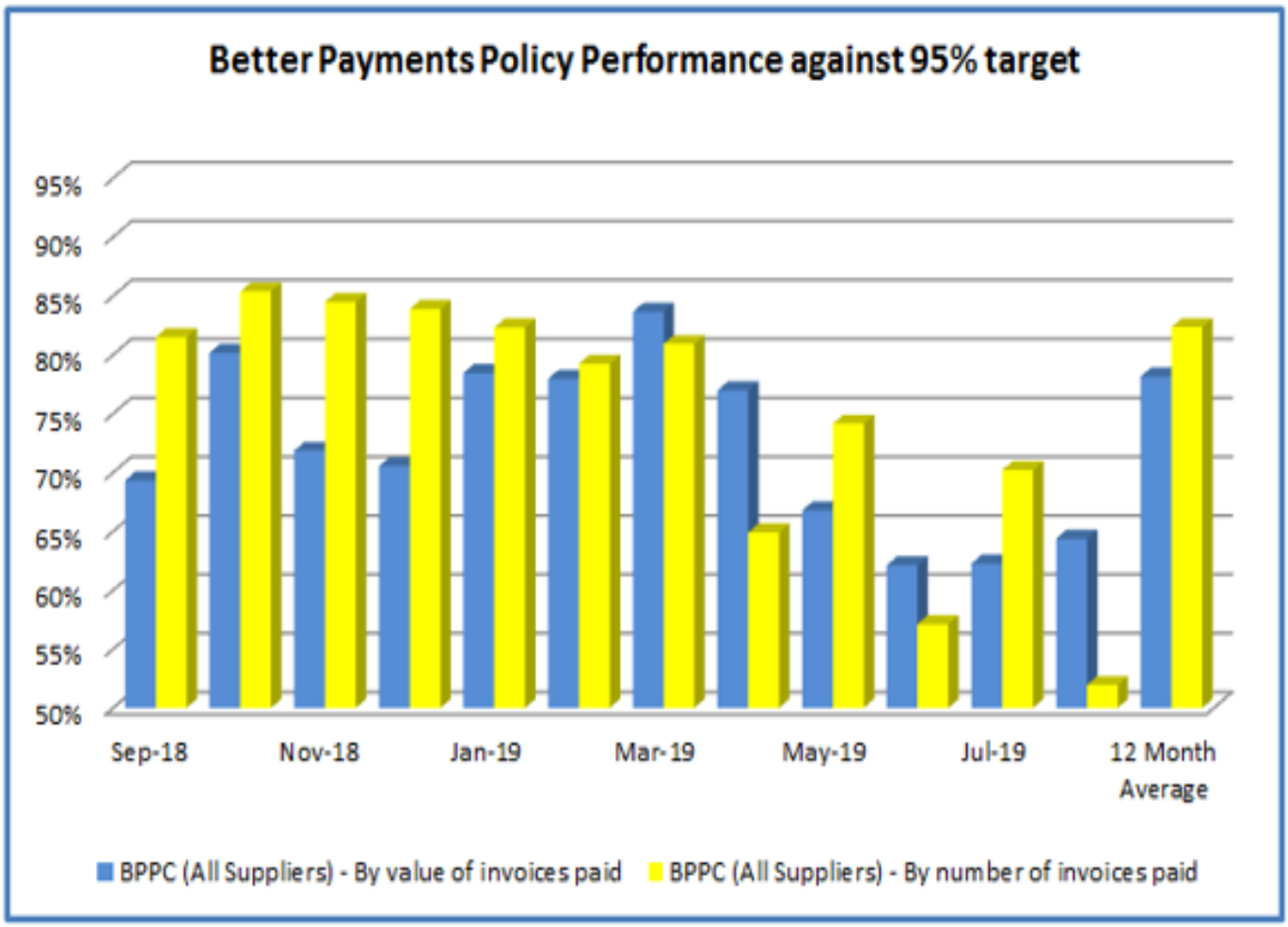
SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Performance against the Better Payments Target



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

Year to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	933	17,543	49,358	81,402
Total bills paid within target	560	15,748	31,232	49,339
% of bills paid within target YTD	60.02%	89.77%	63.28%	60.61%
% of bills paid within August 2019	65.66%	91.71%	51.59%	60.27%

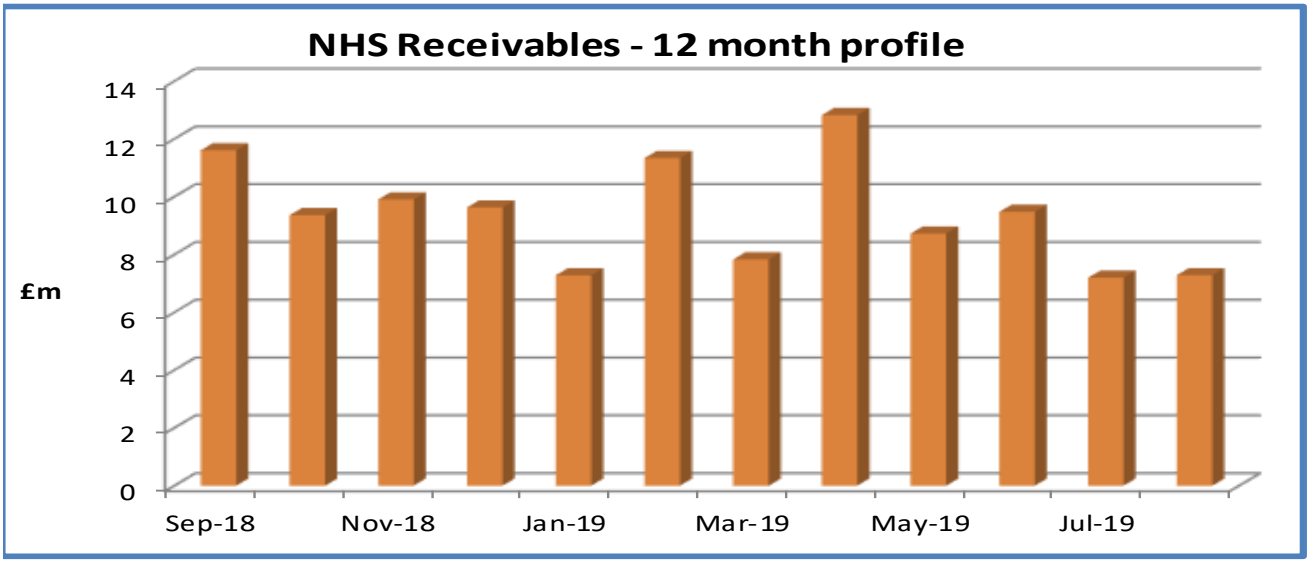
SUSTAINABLE SERVICES – NHS RECEIVABLES

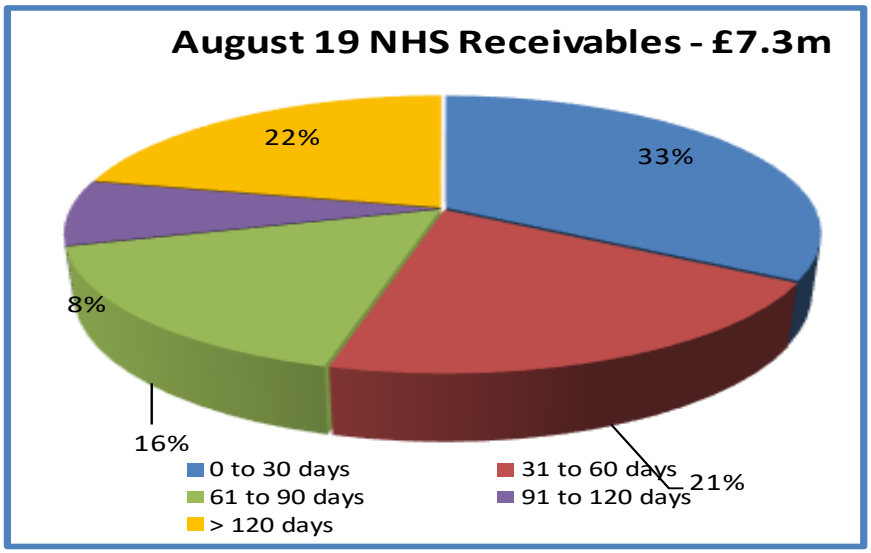
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Receivables





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

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

Totals shown in £000	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	1,442	381	325	200	322	2,670	522
CCGs - Other	442	(3)	102	93	177	811	270
Trusts - Lincolnshire	131	476	15	10	130	762	140
Trusts - Other	246	267	418	29	784	1,744	813
Other NHS	179	395	349	223	165	1,311	388
Total	**2,440**	**1,516**	**1,209**	**555**	**1,578**	**7,298**	**2,133**

The level of aged debt > 90 days has increased from £1.5m in March 19 to £2.1m at 31 August. The largest element currently over 90 days relates to NHS Trusts where queries are unresolved with

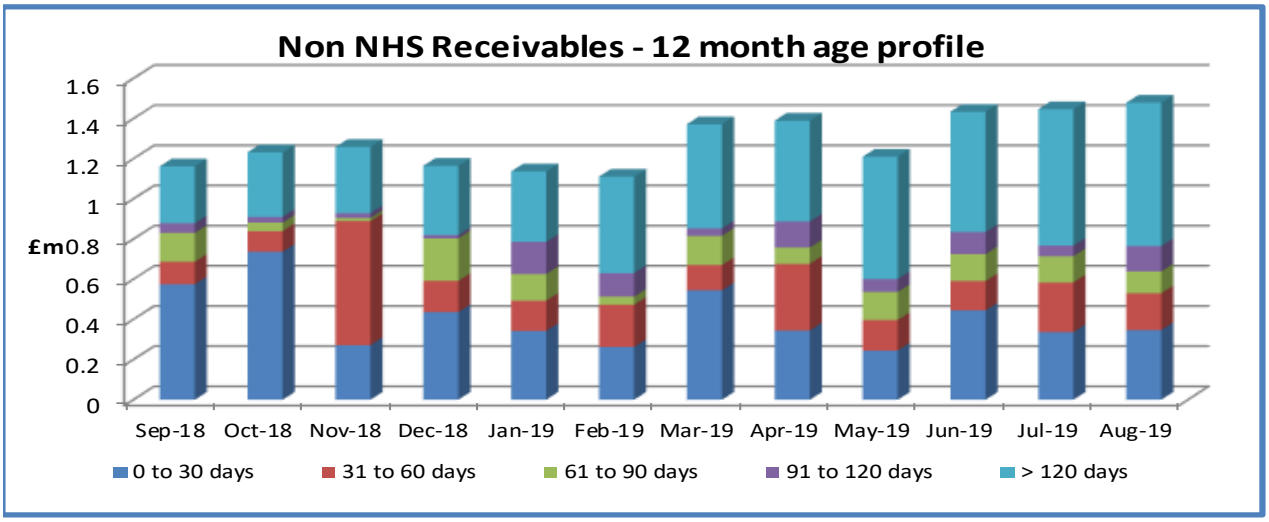
SUSTAINABLE SERVICES – NON NHS RECEIVABLES

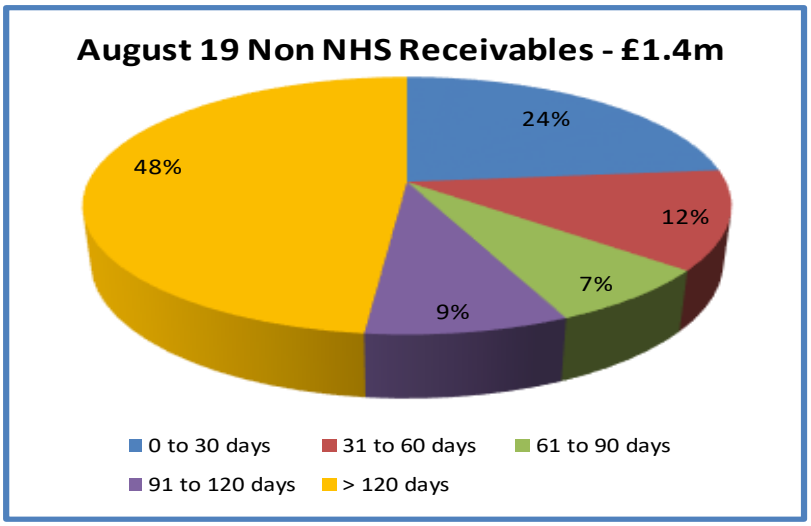
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Non-NHS Receivables





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

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

	Totals outstanding debt £'000						
Description	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
Overseas Visitors	16	40	0	5	161	223	166
Debt Collection - Overseas	0	0	0	0	123	123	123
NHS Non English	31	11	0	5	15	62	20
Misc	250	128	95	113	321	906	433
Salary Overpayments	50	5	12	3	35	106	38
Private Patients	0	0	0	0	0	-	0
Debt Collection - General	0	0	0	0	34	34	34
Agreed Installment Plans	0	0	0	0	26	26	26
Grand Total	347	183	108	126	714	1,479	840

The balance over 90 days (£0.8m) comprises relatively high volume (320) low value invoices.
Of this total £0.2m is being actively managed by the Trust Debt collection agency.

SUSTAINABLE SERVICES – FINANCIAL DASHBOARD

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

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

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

In Month Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	41,522	39,838	43,614	41,112							
Operating Expenditure	-46,332	-45,297	-44,964	-46,422	-46,248							
Efficiency	510	1,546	1,342	1,557	940							
Agency	-3,621	-4,019	-3,640	-4,027	-4,147							
Capital	839	1,958	2,875	3,135	1,751							
Operating Surplus/Deficit	-6,111	-3,775	-5,126	-2,808	-5,136							

Cumulative Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	81,743	121,581	165,195	206,307							
Operating Expenditure	-46,332	-91,629	-136,593	-183,015	-229,263							
Efficiency	510	2,056	3,398	4,955	5,895							
Agency	-3,621	-7,640	-11,280	-15,307	-19,454							
Capital	839	2,797	5,672	8,806	10,557							
Operating Surplus/Deficit	-6,111	-9,886	-15,012	-17,820	-22,956							

In Month Variance (-) adverse	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-264	-553	801	-533							
Operating Expenditure	84	204	539	-1,828	-1,718							
Efficiency	-532	375	162	-154	-830							
Agency	-535	-933	-554	-1,412	-1,571							
Capital	-23	-641	-1,702	-760	931							
Operating Surplus/Deficit	-23	-60	-14	-1,027	-2,251							

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-371	-924	-123	-656							
Operating Expenditure	84	288	827	-1,001	-2,719							
Efficiency	-532	-157	5	-149	-979							
Agency	-535	-1,468	-2,022	-3,434	-5,005							
Capital	-23	-664	-2,366	-3,125	-2,194							
Operating Surplus/Deficit	-23	-83	-97	-1,124	-3,375							

In Month Variance (-) adverse %	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.63%	-1.37%	1.87%	-1.28%							
Operating Expenditure	0.18%	0.45%	1.18%	-4.10%	-3.86%							
Efficiency	-51.06%	32.02%	13.73%	-9.00%	-46.89%							
Agency	-17.34%	-30.23%	-17.96%	-54.00%	-60.99%							
Capital	-2.82%	-48.63%	-145.11%	-31.98%	34.72%							
Operating Surplus/Deficit	-0.38%	-1.62%	-0.27%	-57.66%	-78.02%							

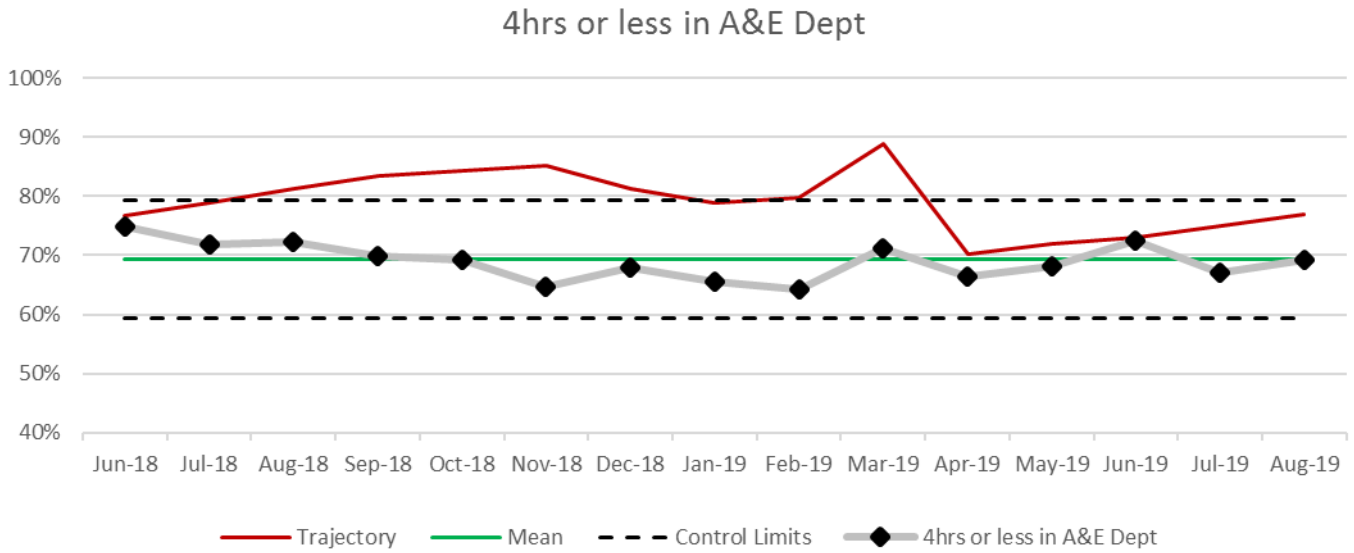
Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.45%	-0.75%	-0.07%	-0.32%							
Operating Expenditure	0.18%	0.31%	0.60%	-0.55%	-1.20%							
Efficiency	-51.06%	-7.09%	0.15%	-2.92%	-14.24%							
Agency	-17.34%	-23.78%	-21.84%	-28.93%	-34.64%							
Capital	-2.82%	-31.11%	-71.55%	-55.01%	-26.23%							
Operating Surplus/Deficit	-0.38%	-0.85%	-0.65%	-6.73%	-17.24%							

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- A&E overall outturn for August, Type 1 and primary care streaming delivered 69.24% against a trajectory of 77%, a variance of -7.7% and was a 2.19% performance improvement on July's performance of 67.05%.
- The system has set a target of 20% of all ED attendances at LCH and PBH to be primary care streamed. For August, PBH delivered 21.1% a 0.5% performance improvement compared with July. LCH delivered 19.6%, a 1.6% performance improvement compared with July.
- A&E attendances have reduced from July peaks however, Type 1&3 numbers represent an 11% increase above previous years activity. Non-elective demand has experience an increase above July's already high levels.
- Nursing and Medical staffing levels for inpatient wards and the emergency department continue to be an area of concern. The fragility of medical staffing will improve towards the end of Q3 2019/20 beginning of Q4 2019/20 as we start to see newly appointed doctors come into post. Recruitment plans against start dates are monitored weekly.
- The weekly long stay meetings at LCH and PHB continue to deliver within trajectory with performance in August for LCH at 70 against a trajectory of 102, PBH performance at 41 against a trajectory of 48 and GDH performance at 11 against a performance of 5.
- Total ULHT bed occupancy for August was 89.99% compared with 90.79% in July. LCH and PBH continue to experience the greatest operational occupancy and flow pressures.

Actions in place to recover:

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

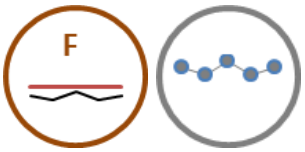
- Reduction of ambulance conveyances through alternative pathways targeting out of area first and increased use of the Clinical Assessment Service;
- Increasing the numbers of patients seen through primary care streaming; protecting the minors stream and focussing on delivering 4 hours through this stream;
- Long stay Tuesday and Wednesday at LCH and PHB to further reduce stranded patient numbers;
- Criteria led discharge;
- Increasing the numbers of patients who are seen and treated through a Same Day Emergency Care (SDEC) pathway;
- Red to Green has been rolled out across the organisation and delays are being actively managed. Board Rounds are also under scrutiny with increased focus around the SAFER patient bundle.

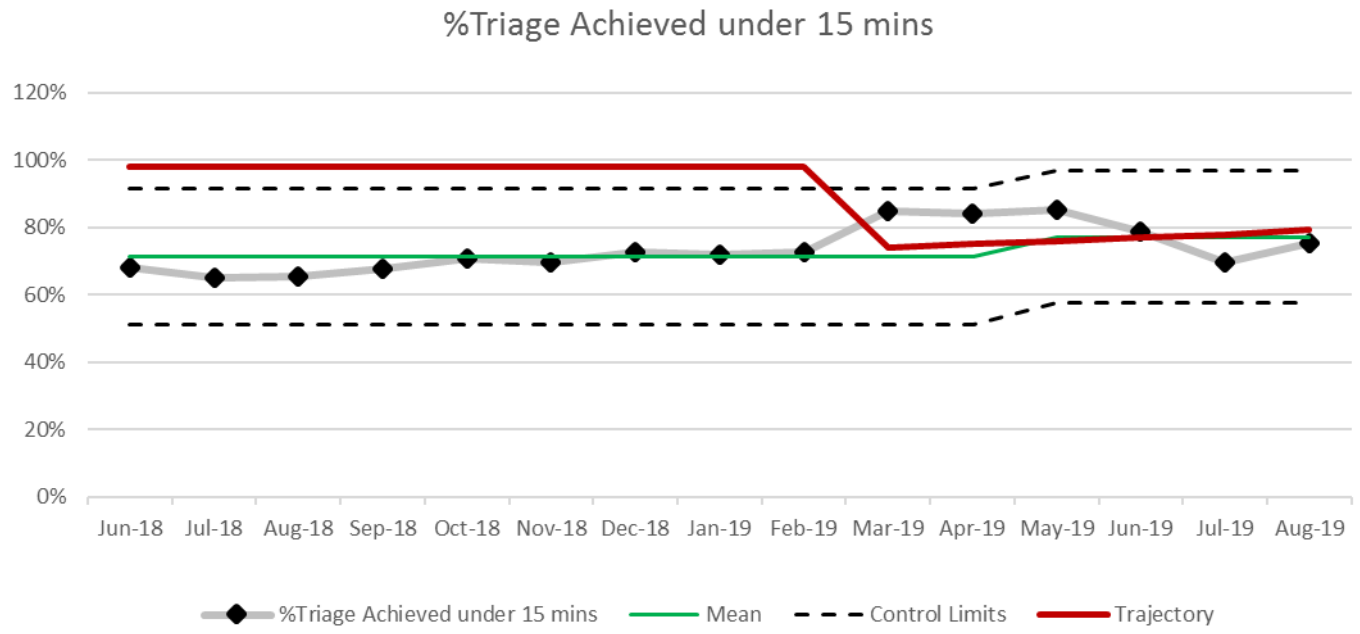
ZERO WAITING – TRIAGE ACHIEVED UNDER 15 MINUTES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- Performance across the three hospital sites demonstrated an improvement, achieving an overall improvement of 5.78%. All 3 sites improved against this metric.
- The performance trajectory for August was 79.50% and achieved was 75.27%
- Only GDH achieved this (80.43%). LCH outturn for July 68.11% (89.70% June), PHB outturn 66.14 (73.30& June)
- In addition to delayed or non-recording of the actual time of triage, some aspects of care are being delivered in triage that could be delivered outside of this activity, for example, taking bloods, cannulation. Good practice triage processes have been re-launched with the teams and are being monitored by the CBU.

Actions in place to recover:

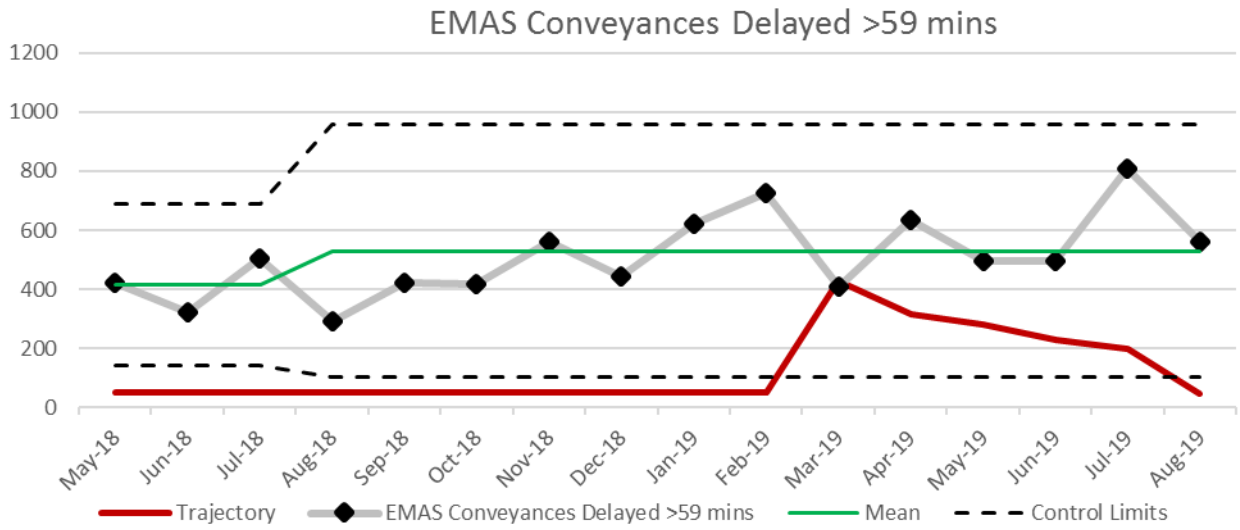
- These 2 elements are reviewed and challenged within the newly formatted Capacity and Flow meetings three time daily.
- Further work has taken place with LCH and PHB, ensuring that the 2nd triage stream is in place at LCH and protecting the triage health care support worker role within triage.
- Good practice triage processes are being monitored by the CBU and feedback is given to teams and individuals where necessary.

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Handover delays >59 mins experienced a significant improvement in August but still missed the agreed trajectory. 563 exceeding 59 mins compared with 805 in July. The improvement was most noted at LCH. PBH have seen an improvement in handover delays >59 mins however they saw 103 more ambulances in August than in July which will have impacted their ability to deliver a greater improvement of this metric. The trajectory for August was 47, which exceeded the trajectory by 516.

- Same Day Emergency Care (SDEC) pathways have been implemented in AEC and SAU at LCH. Gains are being realised in terms of ambulance handover times but not consistently.

Actions in place to recover

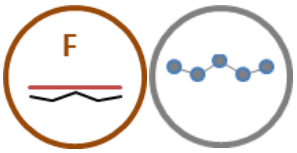
- New pathways at PHB rolled out to enable GP direct admissions bypassing ED.
- Rapid Access and Treatment (RAT) models are being reviewed at both LCH and PHB hospital sites in particular the staffing models for RAT, competency and processing of patients. An example of this would be at PHB where an additional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

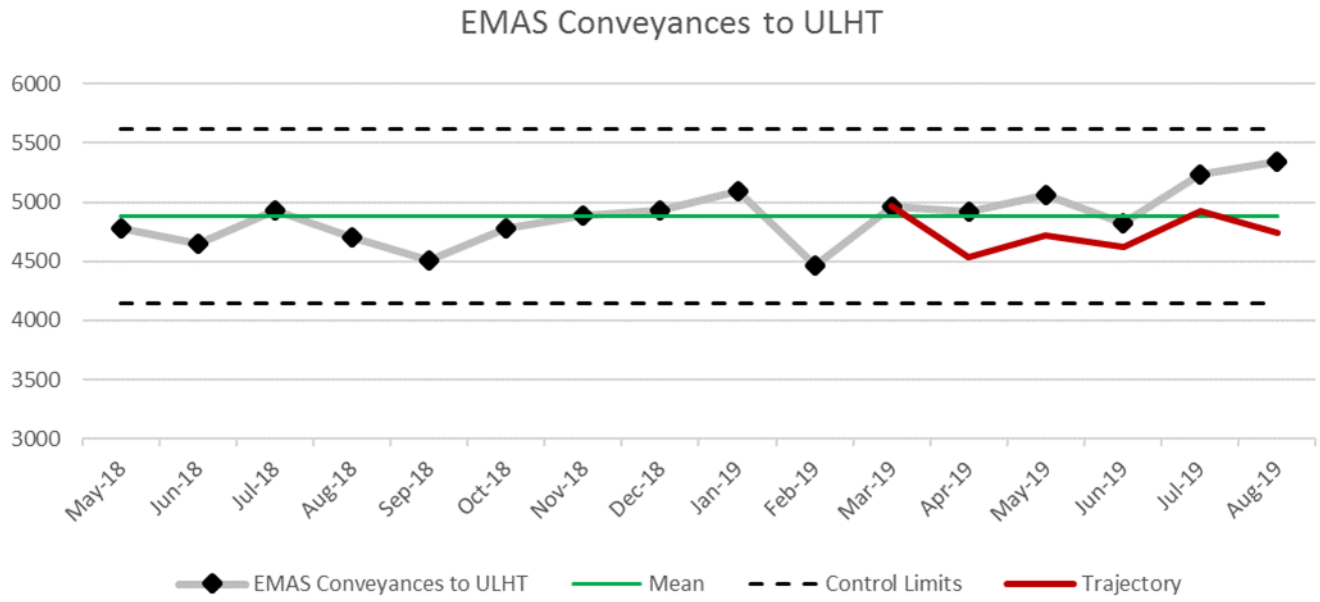
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- There was an increase overall in ambulance conveyance through August (5347) with 408 ambulances greater than in June (4823).
- This represents a 5.89% increase against plan (4923) and a 13.8% increase from the August 2018.
- At hospital site level, LCH received the same number of ambulance conveyances as July; PBH received 103 more ambulances than July and GDH received 13 more ambulances than July.
- Alternative pathways to avoid conveyance have still not been realised to deliver the percentage reduction anticipated.
- There are 38 pathways currently under review for conveyance.

Actions in place to recover

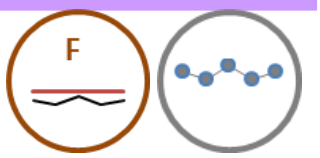
- This is a key metric within the Capacity and performance meeting held x 3 daily and has individual accountability to ensure delivery.
- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This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

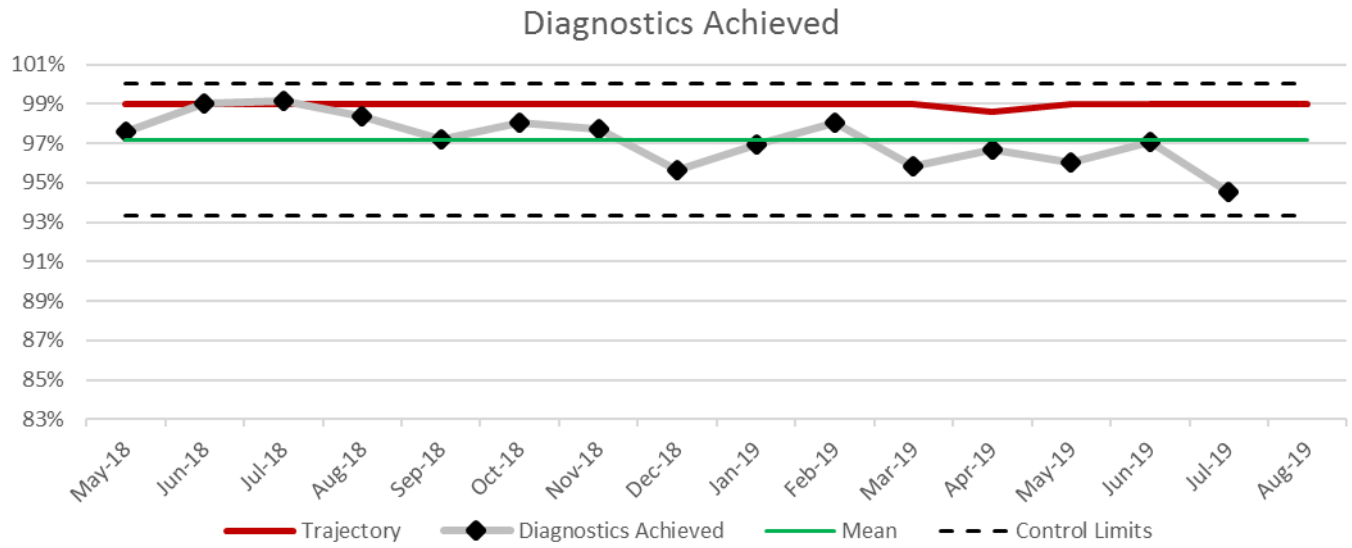
ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance has deteriorated from 96.71% in April, 96.03% May, 97.09% June to 94.53% in July 2019. Trajectory is not being met and a recovery trajectory is being developed to return to national standard.

Performance is challenged by staff retirement and sickness in Neurophysiology and Urodynamics where small teams have lost a large amount of capacity. This is most noticable within the urodynnamics service at Boston where the single member of staff carrying out these examination has been of sick and then retired leaving no servive. Neurophysiology has been carriying a vacancy which caused a 25% drop in capacity and this has been seen in an increase in month end breaches.

Cardiac have a high number of breaches with over 200 for August this has asrisen from unplanned sickness and booking errors within choice and access. CT Cardiac capacity is also an issue although additional capacity has been provided and long term options are being investigated, and such should be short lived as an outlier for waiting times.

Endoscopy are not forcasting any month end breaches and this is a real success as month end breaches within the unit have been maintained at very low levels over the last few months.

CT has recovered to low numbers of breaches and this is expected to coninute.

Actions in place to recover

Neurophysiology

Additional capacity started in June 2019 aims to reduce backlog by August 2019. This has been challinging as neuropysiology staff member has been supporting Boston urodynamics without the support there would be no service at all.

Complex Echocardiograms

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

MRI GA

Close working between CT and Anaesthetic department has commenced to align capacity with demand and this is expected to be the last month to see significant breaches for MRI with General Anaeasthetic.

Echo-Cardiology

An agreement has been reached for specific rates to encourage the increase in capacity to mitigate sickness, absence and increase obaove baseline where possible. The business teams are reviewing slot utilisation and anticipate improved September performance onwards with a foreacst of October achievement.

Urodynamics

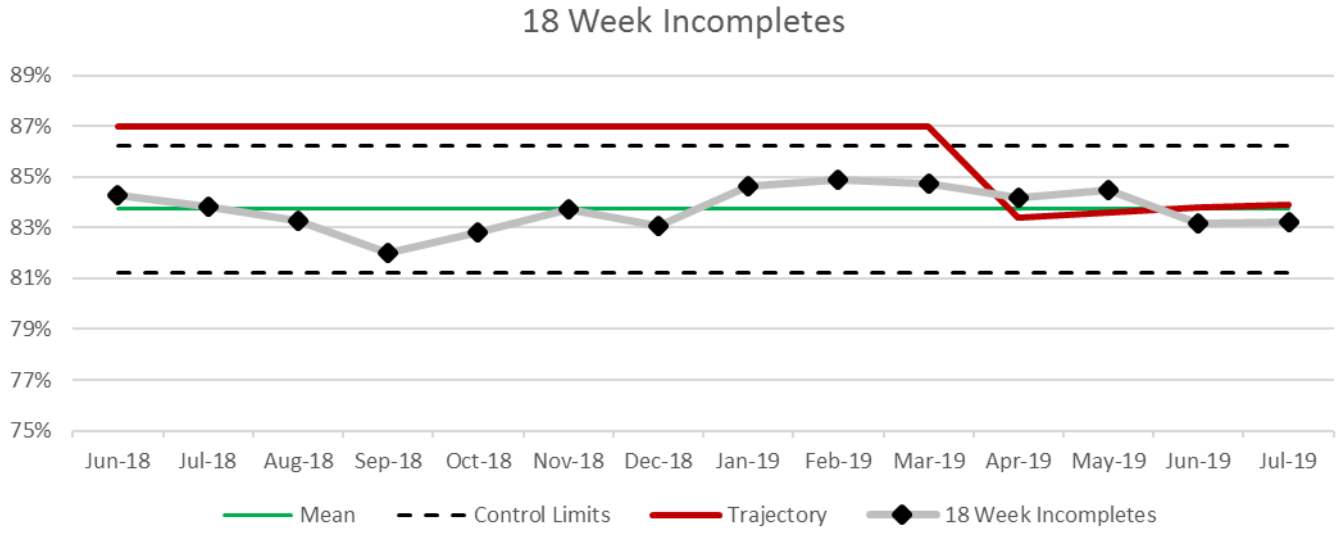
To recover the urodynamics at Boston as there is no current staff to undertake the servive and surrounding trusts and organisation are unable to give support. Initial contingency will redirect demand to Lincoln until a medium term solution can be found. Initially this should mitigate the demand vs capacity gap, however there is still a requirement for longer term strategy.

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

July saw RTT performance of 83.20%, a slight but positive increase of 0.04% on June.

Specialities with the lowest performance against the RTT standard continue to be; Neurology (42.84%), General Medicine (66.11%) and Maxillo-Facial Surgery (71.31%) Each have recovery plans in place that are demonstrating small but positive improvements.

Although Neurology performance remains weak significant improvements in consultant to consultant referrals has seen a 50% reduction and for the first time since the service reopened over 18 week waiting list size is reducing.

Actions in place to recover:

Additional capacity in ENT has delivered an improvement in July of 0.33% from June.

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

Validation software has been procured to ensure standardisation of process across Trust. Although full rollout will not be completed until March 2020.

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

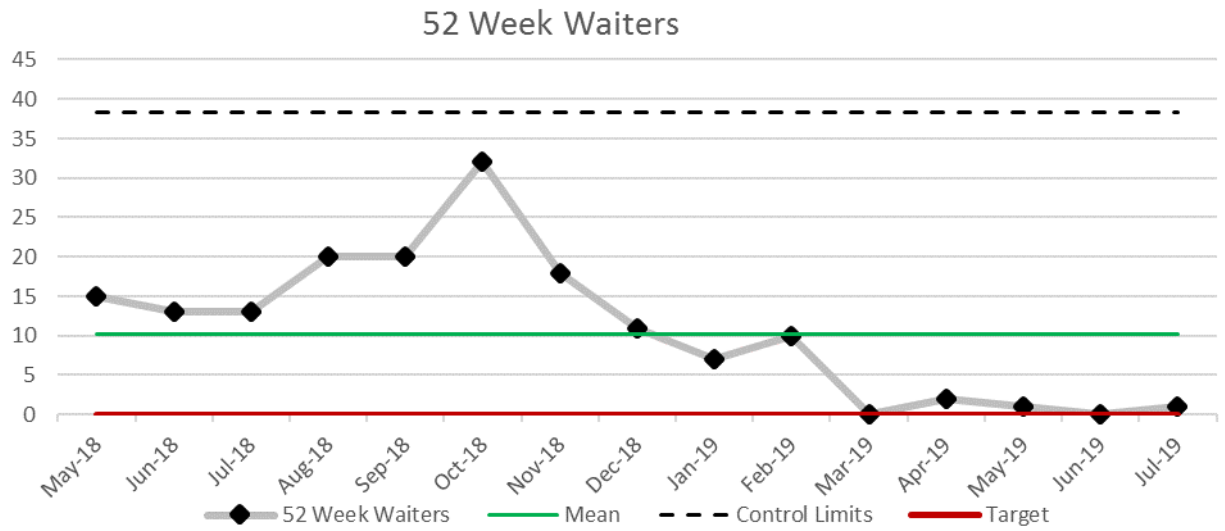
The targeted specialty specific recovery plan is being extended in Neurology. This is a significant shared priority with CCGs which includes an external provider taking via IPT, a cohort of patients between 25 – 40 weeks waiting. The introduction of GP with Special Interest (GPwSI) clinics is awaiting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

ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

July 52 week performance – 1 patient was waiting longer than 52 weeks at the end of July. The patient was treated and clock stopped at the beginning of August.

- This is a detrimental position from June where there was 0 confirmed.
- The end of July position was reported as 1 incomplete 52 week waiter.

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

Validation and administrative error remains a key risk to the delivery of 52 week standard and was the route cause of the July 52 week breach.

Although training controls are now in place for new staff and rollout out to existing users is ongoing, there is a ongoing risk of data quality from the last 52+ weeks which cannot be 100% mitigated until 2020.

June to July showed a decrease of 17 patients waiting over 40 weeks, with Neurology showing the biggest reduction of 17.

The Trust are also planning to reduce overall waiting times to 26 weeks. With monitoring/challenge of this target being tracked through the RTT Recovery and Delivery meeting.

Actions in place to recover:

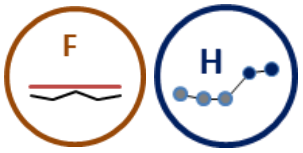
- Continued operation of weekly oversight via RTT PTL meeting and senior review of over 40 week patients.
- Recovery plans are showing positive results in Neurology. As at 31 July 8 patients have been transferred and accepted by the BMI for their care, with a further 280 awaiting review. There has also been a 50% reduction in consultant to consultant referrals.
- OMF has backlogs in dental extractions and skin. A mid-grade doctor left the Trust in July, however the division are looking at replacing this doctor. Plans are being discussed to transfer the backlog out if possible to alternative providers
- Validation tracking software has been procured and will be rolled out, first wave of the roll out is expected to be complete during September.
- An in house RTT training programme has also been developed with competency and compliance monitoring to ensure that administrative errors reduce. This commenced 29 July and is anticipated to complete by 31 October 2019.

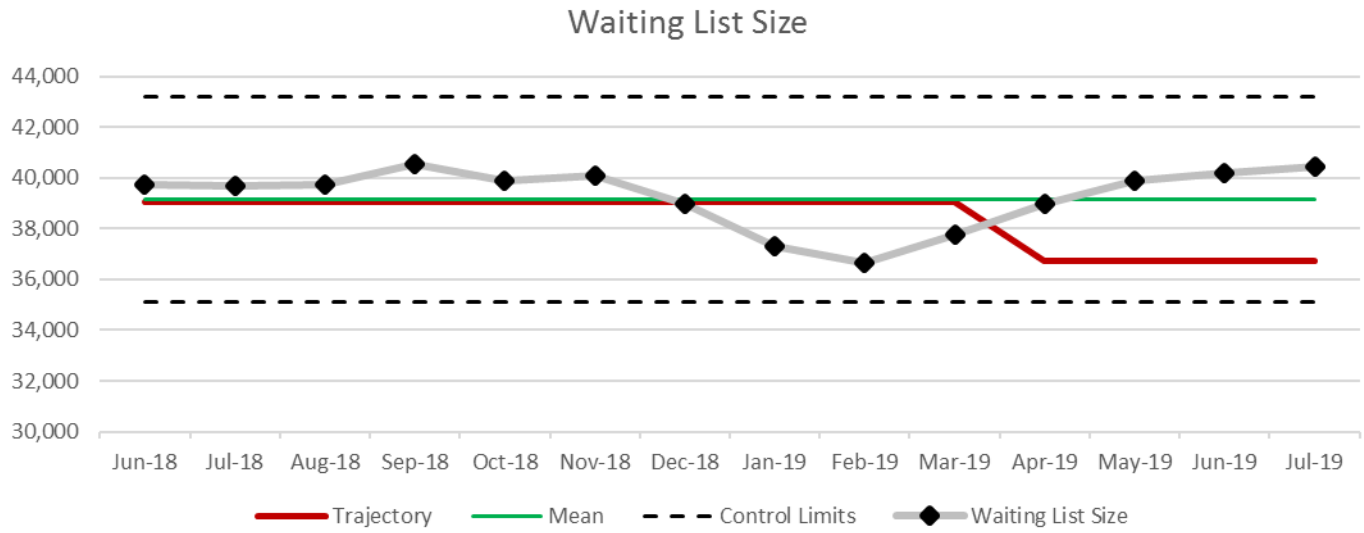
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size continued to deteriorate, with July waiting list increasing by 286 to 40,457, however growth has slowed from previous month.

The incompletes position for July 19 is now in the same region as it was in 2018. There have now been 6 consecutive months of negative effect (more new pathways than removed), with July having 1046 fewer clock stops than average. However, the gap between new and removed pathways has closed in both June and July 2019. The incompletes position continues to grow, but at a slower rate.

The top three specialties showing an increase in total incomplete waiting list size from June are:

- Gastroenterology - 251
- General Surgery - 166
- MaxFax - 78

Actions in place to recover

Continued analysis of incomplete waiting list to determine reason for growth. In depth analysis of cause and contributory factors such as clock starts, stops and data entry; each service now has a tailored recover plan that reflects one of three main causes:

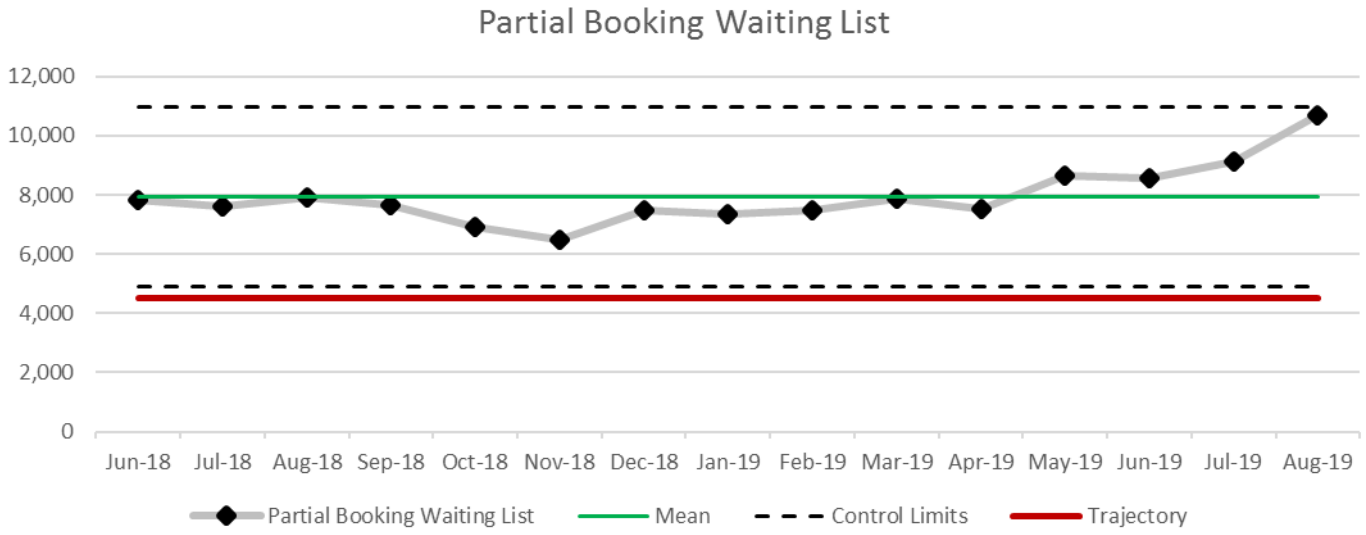
- Growth in referrals – with strategies to reduce this either internally through reduction in consultant to consultant, or externally working with CCG and the planned care improvement programme
- Mismatch of demand and capacity, or short term reduction in capacity through lack of workforce – with appropriate alternatives to attempting locums or existing models of staffing services which may have failed previous. For example the use of virtual clinics, nurse led clinics or non face to face and telephone clinics in key areas.
- Lack of appropriate validation and completion of administrative activities to remove from waiting list – with a targeted release of vacancy hold where staffing is insufficient to complete all tasks, alongside targeted improvement in processes and the flexible use of teams across sites.

ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Backlog recovery plans are being revisited as original plans have not had the desired effect.

Overall Outpatient Capacity has reduced up to and including M5.

We have seen an increase to the number of short notice clinic cancellations that has reduced core capacity and we have seen a reduction in adhoc additional payment sessions that have been put on to support Outpatient Capacity. This is a likely correlation to the national pension tax issue that is having an impact on senior medical staff.

Other challenges for the PBWL backlog recovery plans are

- the availability of locums,
- the extra costs incurred,
- providing nursing and space for the extra capacity requested in the right areas,
- balancing priorities due to focus on 2WW patients in Trust
- Reduction in attendances overall up to M5

Actions in place to recover:

All Divisions are in the process of reviewing why original plans were not successful (as above) and factoring in mitigation into recovery plans.

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

The Outpatient 642 process to be re-introduced to challenge all short notice cancellations and support adhoc sessions required.

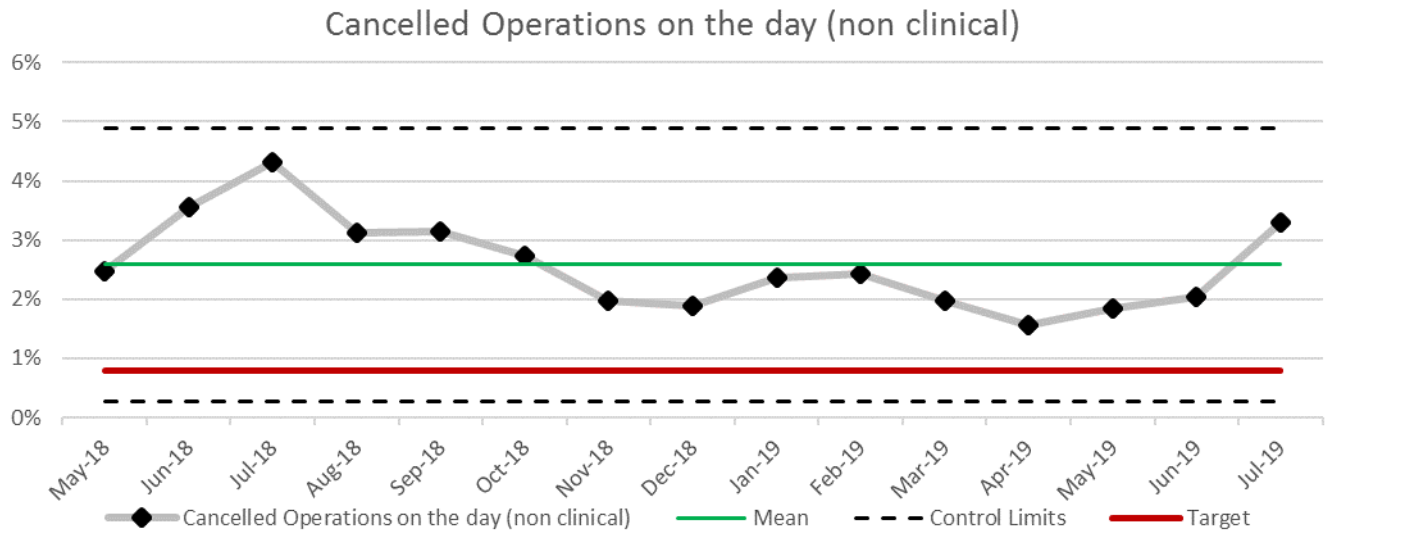
The Divisions will be accountable to the action plans, the main themes are Validation, Alternative patient pathways, Outsourcing and Locums

ZERO WAITING – CANCELLED OPS ON THE DAY (NON CLINICAL)

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services

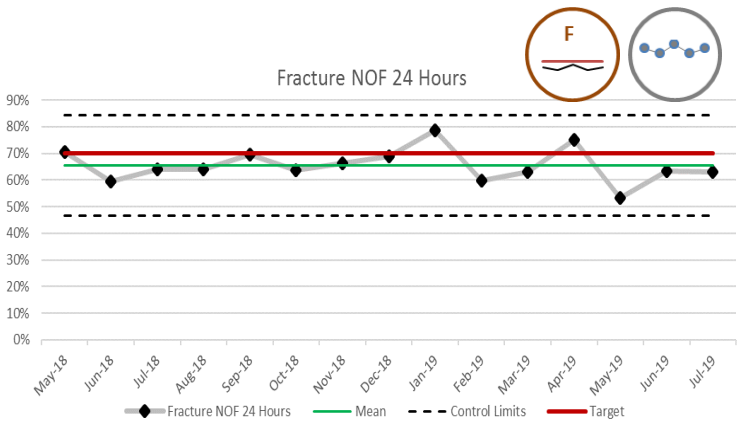


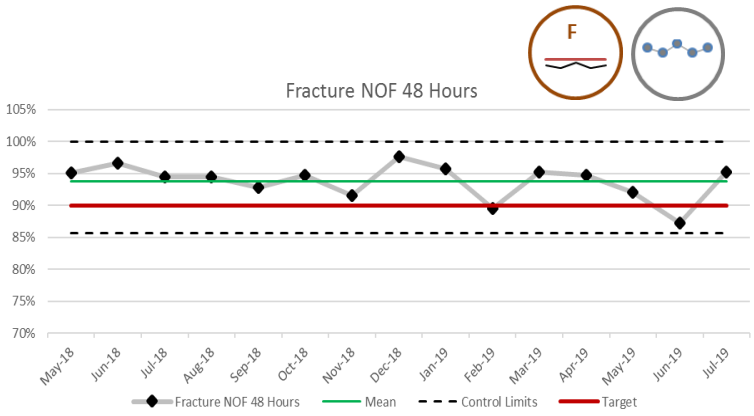
ZERO WAITING – FRACTURE NECK OF FEMUR BPT

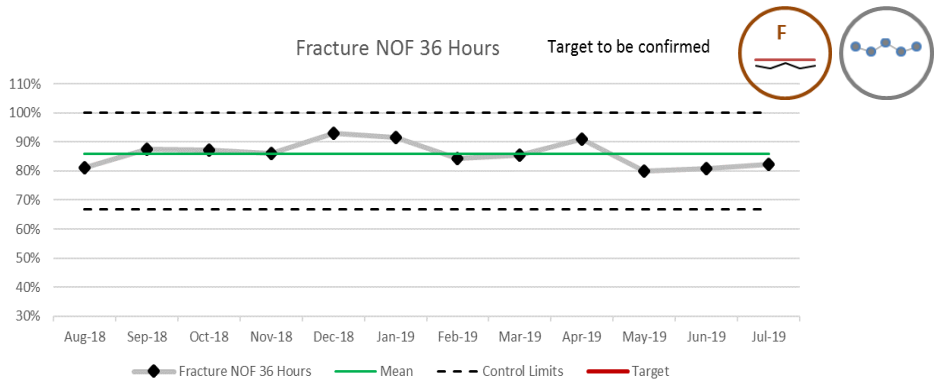
Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services







Challenges/Successes

Performance for time to theatre within 36 hours and 48 hours continues to fluctuate.
Performance has been challenged by lack of consistency in process so when the #NOF lead is on leave at PHB, there is a lack of focus on #NOF performance. There is no #NOF lead at LCH.
Issues relating to flooding at LCH and air flow exchanges at PHB contributed to a reduction in available trauma sessions in June and July.
Trauma coordinator vacancies at both LCH and PHB have meant a lack of daily focus on ensuring #NOF's are prioritised on the trauma theatre list
Patients have breached both targets due to fitness for surgery which has caused a delay in them being added to the trauma list
In July 19, trauma sees an increase in paediatric trauma, most of these patients are prioritised over #NOF patients, due to their age
X-ray availability issues i.e. only one C Arm available between both Orthopaedic elective and Trauma theatre, this causes delays on the list which means patients are often cancelled/delayed due to lack of theatre time
There seems to be a discrepancy in the recording of #NOF and what is reported i.e. patients treated conservatively for #NOF should not be excluded from the time to theatre reported performance
Inefficiencies in trauma theatres leads to delays in treatment and patients being cancelled from the end of the lists.

Actions in Place to Recover

LCH

- #NOF lead to be recruited **update 9/9/19** job plan with the royal college for approval
- #NOF theatres to be allocated in place of specialty trauma lists **update 9/9/19** theatres to be adapted from OCT 19 (this will not impact elective capacity)

PHB

- Current #NOF lead to become Trustwide #NOF lead so best practice at PHB is shared across the sites **update 9/9/19** lead to commence trustwide responsibilities once LCH #NOF lead is recruited
- Sustainable processes to be put in place as current performance improvement relies on #NOF lead (people rather than process) **update 9/9/19** #NOF lead, Clinical Lead and Deputy GM to meet 17/9/19 to discuss and come up with an improvement plan

Trustwide

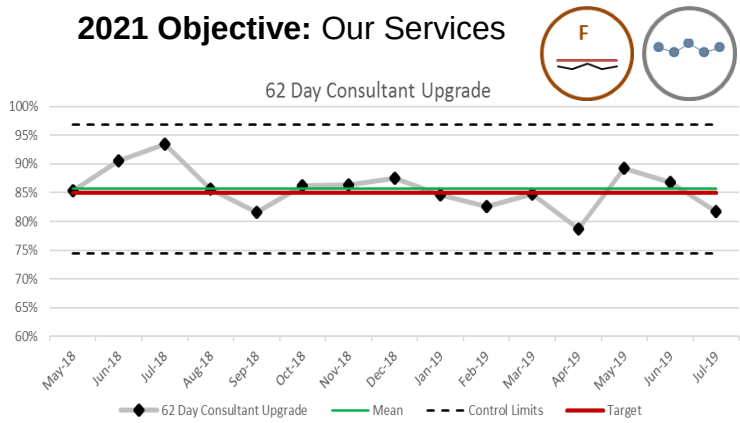
- Audit to be carried out on June and July #NOF patients to understand breach themes and create an action plan to reduce breaches **update 9/9/19** #NOF lead at PHB to undertake audit w/c 9/9/19
- Discussion to be held with the GIRFT team to understand the target for time to theatre within 36 hours. This is cannot be 100% and cannot be due to the nature of the patients, some will not be fit for surgery and others will not require surgery **update 9/9/19** Deputy General Manager to contact GIRFT national team for advice
- Review of NHFD data and reporting of performance **update 9/9/19** Orthopaedics Clinical Lead, #NOF lead, Deputy General Manager and Head Of Information to review
- Orthopaedic Consultants and Anaesthetic Consultants to discuss how to optimise patients and ensure early investigations so to reduce the wait time in being ready for surgery **update 9/9/19** Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
- Anaesthetic trauma lead to take responsibility for ensuring anaesthetists are supported to reduce cancellation of patients and protocols are put in place **update 9/9/19** Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
- Review the possibility of anaesthetists specialising in trauma with the aim of reducing anaesthetic time, therefore, increasing the efficiency of the trauma theatre lists **update 9/9/19** Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
- Orthopaedic ACP's to be trained in how to optimise #NOF patients for surgery, currently undertaken by F2's which is not a permanent workforce **update 9/9/19** #NOF lead, Clinical Lead, Lead Nurse and Deputy GM to meet 17/9/19 to discuss and plan how this role will work for the ACP's
- Optimise 'golden patient' night before to ensure theatre starts on time the next day **update 9/9/19** this has been started and is ongoing
- There is currently no review of trauma/emergency theatre efficiency. Efficiency of trauma theatre to be reviewed and performance target to be set **update 9/9/19** efficiency to be reviewed by TACC Business Manager September 2019
- Review of Consultant on-call rota with the aim of a team of 2 Consultants undertaking the on-call and trauma commitments for a full week. This will decrease the possibility of patients not being fully optimised due to daily change of trauma surgeon **update 9/9/19** meeting held with Consultants 4/9/19 to discuss proposal and final decision to be agreed on 4/10/19
- Discussion to be held with Diagnostic Services about x-ray support in theatre **update 9/9/19** TACC Business Manager and Deputy General Manager to discuss with Radiology Manager in September 2019

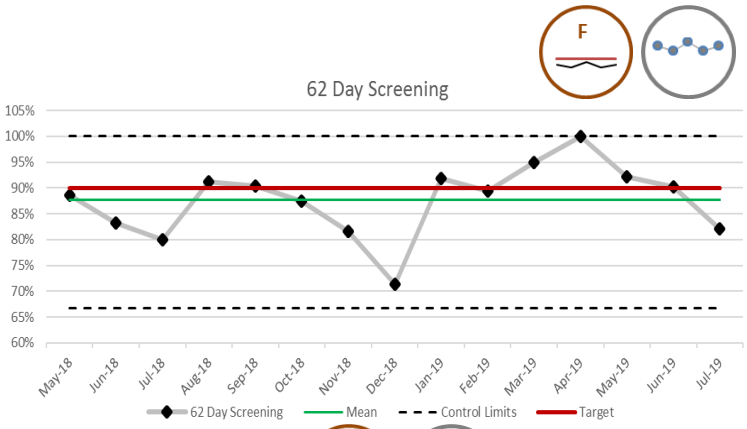
ZERO WAITING – CANCER 62 DAY

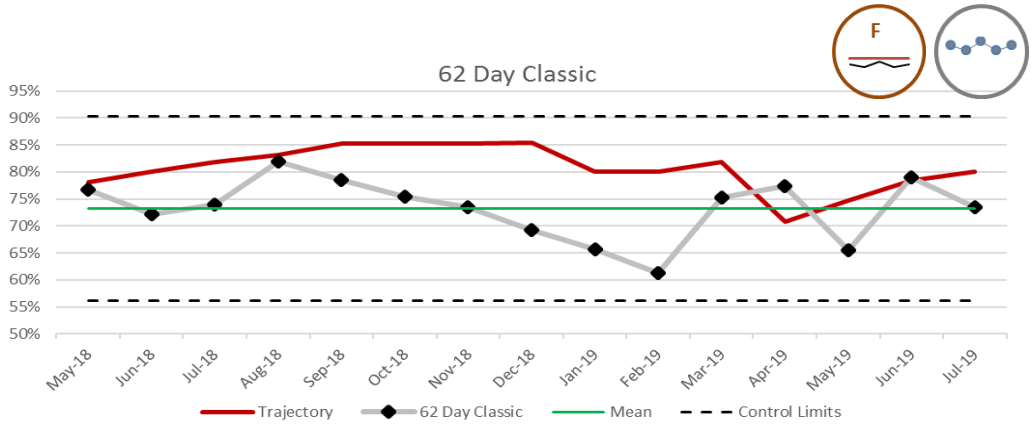
Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services







The 62 Day Classic standard under-performed against the trajectory of 80%, with only Lung and Urology performing against their agreed trajectories though Breast and Skin finished close to their targets.

Early indications are that our August 62 Day Classic performance will not be as successful as July, with anticipated performance being circa 73% (trajectory 83%).

The number of Trust patients waiting over 62 & 104 days has now been steadily decreasing with the increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).

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

There are a number of service challenges common to all tumour sites, which will require Trust-wide actions to support the divisions:

- Faster Diagnosis Standard (FDS) +62 Day patients (diagnosed & undiagnosed) – ULHT continues to be challenged by the implementation of the FDS. The greatest challenge in collecting the data has been ensuring adequate recording suitable for audit (essentially in the patient notes or a letter to the patient) as well as gaining clinical engagement in completing and documenting to a satisfactory standard (clarity of letters stating cancer is no longer a concern).
- Colorectal – From April 2019 this tumour site has had difficulty in achieving its 62 Day performance. Colorectal did not meet their agreed trajectory in April, May and June for number of treatments or breaches contained within the treated volume. In July they met their trajectory for number of treatments but exceeded the number of breaches.

- Gynaecology – Through April, May and June 2019, this tumour site has had difficulty in achieving the 14 Day standard with these delays at the start of the pathway impacting on their 62 Day performance as well. Gynaecology did not meet their agreed trajectory in June for number of treatments or breaches contained within the treated volume and in July, though their breaches were within trajectory the number of treatments was below.

- Pathology – Path Links have been unable to recruit sufficient staff to cover their core service demand. Local operational relations with the Path Links team are positive but the organisational relationships are less so and impacted by the absence of a signed contract, with clear KPIs, escalation and penalties. Path Links are hosted by NLAG and ULHT representatives are seeking active contract negotiations. NHSI are also to engage in discussions about regional provision of pathology services, including the Path Links service – an input that should assist ULHT in better engaging NLAG. We routinely review cancer patient turn-around times for pathology.

- Tertiary Diagnostics and Treatments - A number of tumour sites are continuing to experience delays in securing timely diagnostics and/or treatments from the tertiary cancer centres (predominately Nottingham).

- Oncology – This service is continuing to have clinic capacity difficulties for numerous tumour sites and should be considered to have significant fragility. Recent recruitment success in starting a new Medical Oncologist meant that the ULHT Oncology service would have been be staffed to establishment however another Oncologist is now due to leave in October and adds ongoing instability.

- Implementation of NHSI Elective Care Essentials – Cancer guidance – Work is ongoing to benchmark ULHT against the NHSI best practice for Cancer Centres and the corporate management of the cancer standards. This includes adopting recommended monitoring processes, terms of reference, role clarity within the Cancer Centre and the Divisions to reduce duplication of work and to embed joint working to deliver a patient pathway that cuts across Divisions (including CSS).

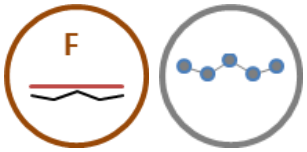
- MDT Organisation – There are a number of tumour sites which are operating hospital site specific MDTs. The rationale for the continuation of such arrangements needs to be reviewed in the context of national guidance for MDTs, the ULHT commitment to Trust-wide working and the pressures in supporting services to attend or support MDTs (particular pressures in pathology and oncology). Recognising the commitment in MDTs to site working, the direction of wider reviews is likely to need direction from the Medical Director/Trust Cancer Lead.

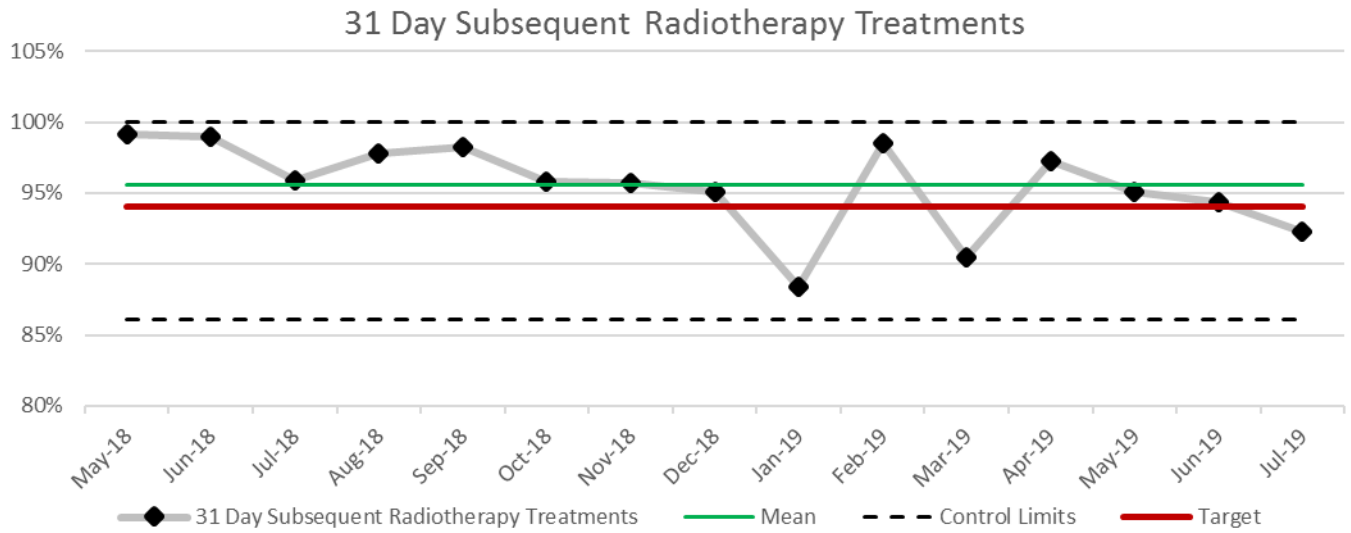
ZERO WAITING – CANCER 31 DAY

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





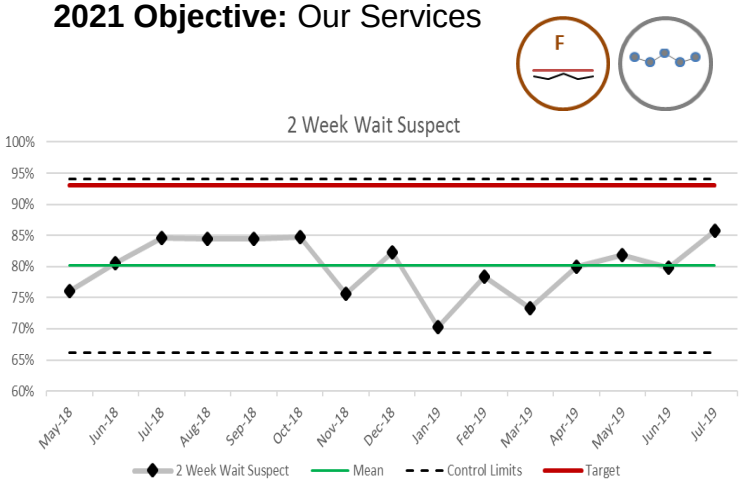
31 Day standards – The Trust achieved three of the four 31 Day standards in July, failing the Subsequent Radiotherapy due to a surge in patient numbers, together with one of the LINAC machines breaking down .

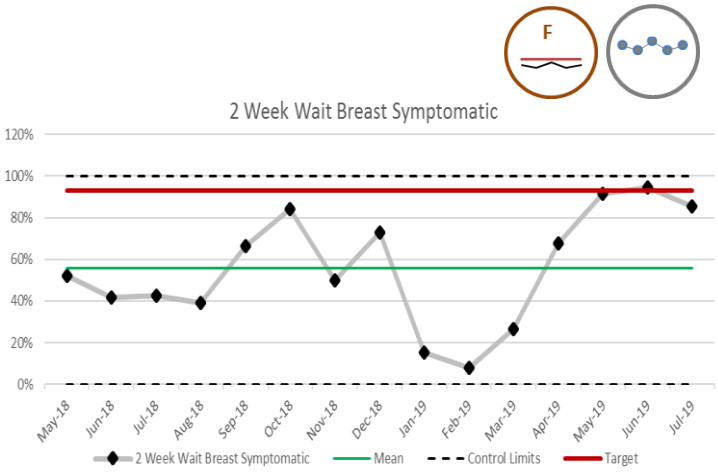
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Two tumour sites met the 14 Day standard in July: Lung and Upper GI, with Breast, Brain, Urology, Head & Neck and Sarcoma all being above 90%

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

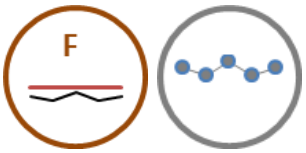
7 Day internal target = 60% 14 Day national standard = 93%	Total	< 7 Day Prfrmnce %	< 14 Day Prfrmnce %
Brain/CNS	15	33.3	100.0
Breast	195	2.1	55.9
Breast Symptomatic	93	3.2	62.4
Colorectal	517	36.6	87.4
Gynaecology	185	28.1	90.3
Haematology	13	46.2	100.0
Head & Neck	241	48.1	92.5
Lung	50	64.0	98.0
Sarcoma	23	39.1	91.3
Skin	467	3.2	52.0
Upper GI	166	68.7	97.0
Urology	212	43.4	90.6
Totals (excl Breast Sympto)	2084	30.4	78.9

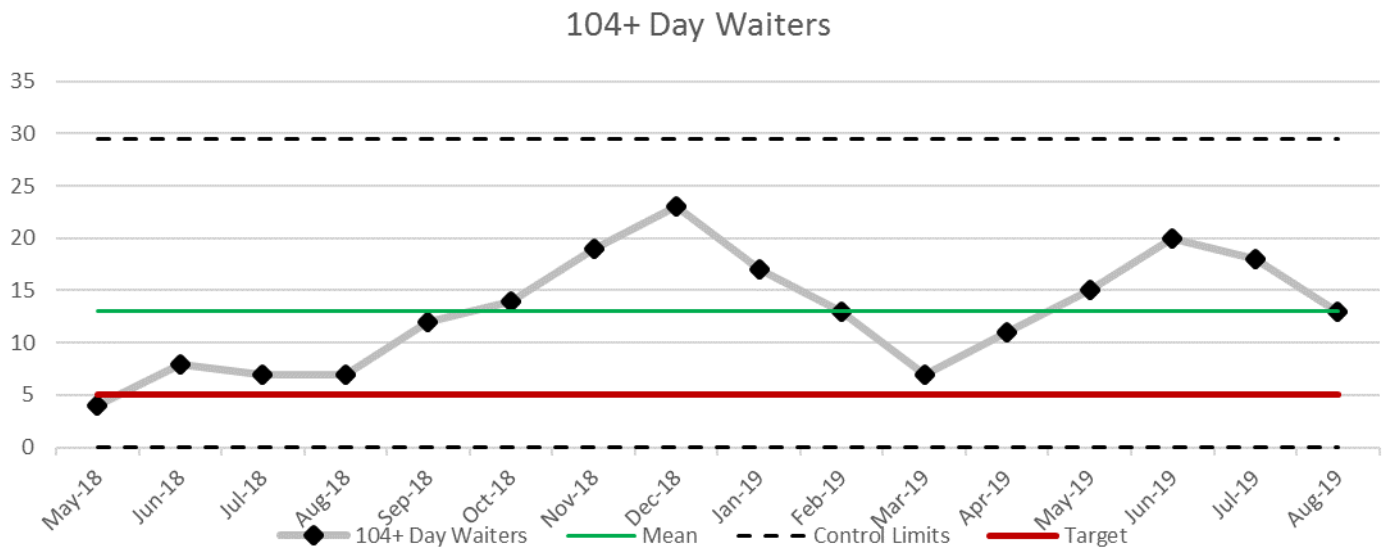
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





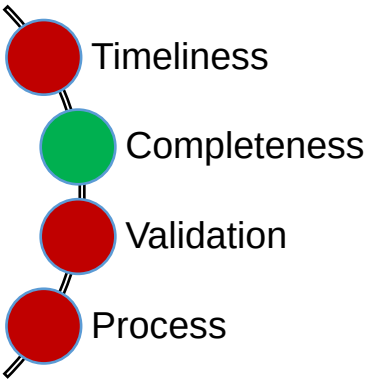
The number of Trust patients waiting over 62 & 104 days has now been steadily decreasing with the increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).

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

The 104+ patients are first to be discussed during the twice weekly Trust-wide Cancer Call, chaired by the CSS Divisional Managing Director.

APPENDIX A – KITEMARK

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



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

United Lincolnshire Hospitals NHS Trust

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

Title:	**Corporate Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Manager

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

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

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- The highest rated corporate risks remain the same as last month: financial sustainability; workforce capacity, capability and morale; and the vulnerability of aseptic pharmacy services;
- 42% of corporate risks are currently rated Very high or High risk (down from 47% last month)
- A review of corporate Estates & Facilities risks has resulted in several risk scores being reduced and operational risks reallocated where appropriate
- There has been no material change to any of the High risks on operational (business unit) risk registers since last month

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required.

Strategic Risk Register Corporate risks that are considered to be of strategic significance are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risk in accordance with the Risk Management Policy is reported regularly to the Audit Committee.

Assurance Implications This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.
Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.
Information exempt from Disclosure – No
Requirement for further review? No

1. Purpose of the Report

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

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

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

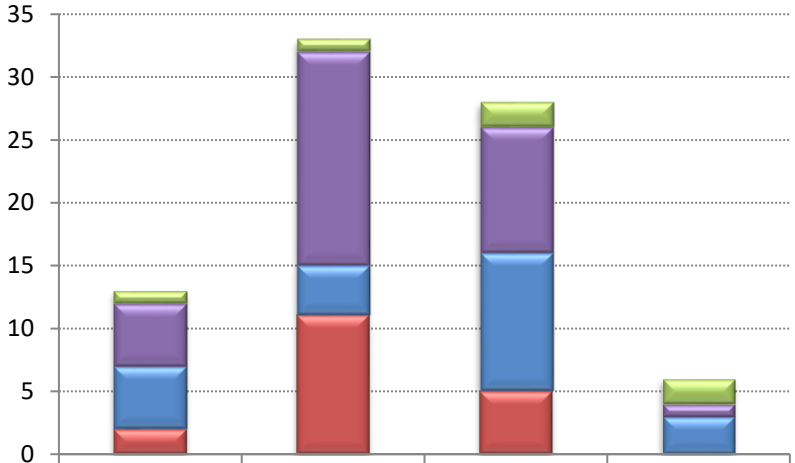
3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation.

4. Summary of Key Points

Corporate Risk Profile

4.1 **Chart 1** shows the number of corporate risks by current (residual) risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	1	2	2
Reputation / compliance	5	17	10	1
Service disruption	5	4	11	3
Harm (physical or psychological)	2	11	5	0

4.2 A report showing details of all corporate risks recorded on the Corporate Risk Register with a current (residual) risk rating of High or Very high (a score of 12 or more), along with planned mitigating actions is included as **Appendix I**.

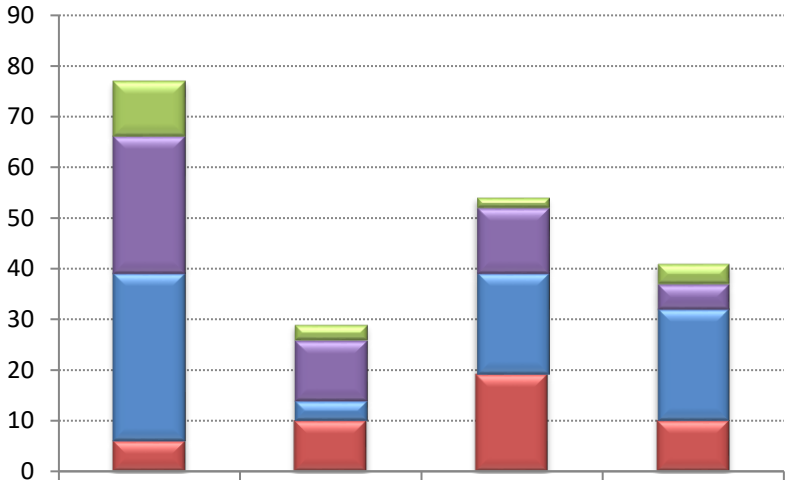
4.3 43% of corporate risks are currently rated as Very high or High (down from 47% last month)

4.4 A comprehensive review of corporate Estate & Facilities risks has been undertaken, resulting in the following changes:

- The risk of critical failure of the electrical infrastructure has reduced in risk score from 16 to 12 on review (still rated High risk)
- The risk of critical failure of the mechanical infrastructure has reduced in risk score from 16 to 8 (now rated Moderate risk)
- The risk of a major fire safety incident has reduced in risk score from 12 to 8 (now rated Moderate risk)
- The risk of failure to deliver the estates strategy has also reduced in risk score from 12 to 8 (now rated Moderate risk)
- Operational estates risks previously recorded within the Corporate Risk Register have been realigned to the appropriate business unit risk register

Operational Risk Profile

4.5 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk
Finances	11	3	2	4
Reputation / compliance	27	12	13	5
Service disruption	33	4	20	22
Harm (physical or psychological)	6	10	19	10

4.6 20% of operational risks are currently rated as High, with no material change since last month. A summary of those operational risks with a current rating of High risk is included as **Appendix II**.

Risk management process

4.7 Each corporate risk has an Executive lead, with overall responsibility for its management; and a Risk lead responsible for reviewing and updating the risk register. The majority are also assigned to a lead management group for regular scrutiny. All are aligned with the appropriate assurance committee of the Trust Board.

4.8 Risks are defined according to the type of consequence that would be experienced should they materialise, with a severity scale of 1 to 5 using the following definitions:

- Harm (physical or psychological) – this may be to patients (as a result of issues with care); to members of staff, or to visitors (arising from health & safety issues) and covers a range from minor injuries through to multiple fatalities
- Service disruption – which ranges from the implementation of local business continuity plans up to critical and major incidents
- Reputation / compliance – which covers the potential for individual complaints up to a fundamental loss of confidence amongst commissioners; regulators; and the government (many risks of this nature relate to compliance with national standards, regulations and contractual obligations)
- Finances – which is based on the budgetary impact, from minimal cost increases to jeopardising financial sustainability

4.9 Within each corporate risk register entry there may be several risk factors associated with identified gaps in the risk control framework. These are individually assessed and prioritised by way of a 'Component risk rating', which is shown on the attached report.

4.10 The Risk Scoring Guide, which is used to assess all risks recorded on the Trust's corporate an operational risk registers, is attached for reference as **Appendix III**.

4.11 Operational risk registers are also in place for every Clinical Business Unit (CBU) and corporate department. The provision of management information to divisional and business unit management teams is still being developed. Once in place this will facilitate more regular and routine review of operational risks and improve the level of analysis that can be done to identify areas of significant concern. Oversight of risk management at divisional level is already included with the Performance Review Meeting (PRM) process.

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4383	**Substantial unplanned expenditure or financial penalties (corporate)** If the Trust incurs substantial unplanned expenditure or financial penalties within the current financial year; Caused by issues with budget planning, budgetary controls, compliance with standards or unforeseen events; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Annual budget setting process. Capital investment planning process. Capital investment programme delivery & monitoring arrangements. Monthly financial management & monitoring arrangements. Contract governance and monitoring arrangements. Directorate performance & accountability framework. Key financial controls. Financial management information.	Very high risk (20)	Financial Turnaround Group	Moderate risk	31/10/2019	Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost.	Very high risk (20-25)	Finance	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	31/03/2020	
										Interest rate may increase if the Trust deviates adversely from plan in the financial year. Non-delivery of plan would also mean the Trust won't have access to FRF; PSF; and MRET (valued at £29m).	Very high risk (20-25)	Finance	Delivery of the Financial Recovery Programme; maintaining grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed.	31/12/2018	
4382	**Delivery of the Financial Recovery Programme (corporate)** If the Trust becomes unable to delivery key elements of the Financial Recovery Plan within the current financial year; Caused by issues with the design or implementation of planned cost reduction initiatives; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Financial recovery planning process. Financial Recovery Plan governance & monitoring arrangements. Directorate performance & accountability framework. Financial management information. Financial Special Measures (since September 2017). Financial Turnaround Group (FTG) oversight. Programme Management Office & dedicated Programme Manager.	Very high risk (20)	Financial Turnaround Group	Moderate risk	31/10/2019	Identified schemes for 2019/20 cover the level of efficiency required (£25.6m). If assumptions are inaccurate; or if there are capacity & capability issues with delivery; it may result in failure to deliver these schemes.	Very high risk (20-25)	Finance	Finance PMO team working with divisions to manage planned schemes and identify mitigating schemes. Additional external resource to be brought in to support delivery.	31/03/2020	
4175	**Management of emergency demand (corporate)** If the volume of emergency demand significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	ULHT operational demand management policies & procedures. Operational performance management framework & regular reporting / monitoring at divisional and corporate levels. Monthly performance report to Trust Board. Urgent and Emergency Care Board (UECB) delivery plan. Lincolnshire Sustainability & Transformation Partnership (STP) and Plan. Horizon scanning processes.	Very high risk (20)		Moderate risk	30/09/2019	• Comprehensive and effective triage • Improve time to RAT • Reduce ambulance handover delay • Improve time to 1st assessment • Effective GP Streaming • Improve non-admitted pathway compliance • Delivery of an ambulatory care model • Implementation of frailty model • Reconfiguration • Redesign the site management and bed meeting model • SAFER implementation • Effective discharge by 1000 • Reduce number of stranded and super stranded patients • Implementation of Red to Green • Implementation of Full Capacity Protocol (FCP) • Implementation of criteria led discharge	Very high risk (20-25)	Operations	Urgent and Emergency Care Programme work streams: QS04 Pilgrim EC1A Lincoln EC1B Grantham EC2 Assessment Function EC3 Site Function EC4 Inpatient Ward Function EC5 Discharge and Partnerships	31/03/2020	Project updates for each of the five work streams are brought to Recovery Steering Group meetings which take place fortnightly. The recovery steering group has now been extended to include partners, stakeholders and regulators.
4083	**Workforce engagement, morale & productivity (corporate)** If the Trust were to lose the engagement of a substantial proportion of its workforce; Caused by issues with low morale, lack of job satisfaction or uncertainty about the future; It could result in a substantial, widespread and prolonged reduction in productivity across multiple services affecting a large number of patients and staff.	Rayson, Martin	Reputation / compliance	Very high risk	Staff Charter & Personal Responsibility Framework Staff engagement strategies & plans. Internal communications platforms (intranet; bulletins; forums). Staff survey process and response planning. People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring. Core learning programmes. Leadership development and succession planning processes. Management of change policies, guidelines, support and training. Partnership agreement with staff side representatives. Occupational health & wellbeing arrangements for staff.	Very high risk (20)		Low risk	30/11/2019	Impact of the cost reduction programme & organisational change on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.	Very high risk (20-25)	Human Resources	Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. The actions proposed provide the mitigation, but we have to recognise that this remains a tough environment in which to drive up morale. Staff survey predated launch of 2021, but there is a need to tackle vacancy gaps as well.	31/03/2020	Actions have been taken since the 2018 staff survey results against some the biggest themes emerging. Each Division has been asked to work to address the issues identified in their survey results. The Engagement Bus will be visiting each site in September. This will be accompanied by a "you said, we did" campaign. The next staff survey will be open in October 2019 and results will be available in early 2020. Review once the next set of staff survey results are available.
										Relationships with staff side representatives are challenged by the scale of organisational change required and the extent to which staff side wish to protect the status quo. There are disagreements amongst staff side representatives and not all meetings have taken place as scheduled.	Moderate risk (8-10)	Human Resources	Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. It is based on the Sandwell model and seeks to ensure proper debate, without giving staff side the capacity to prevent us moving beyond the status quo. Intention is to write to staff side to propose a further partnership meeting. Formal consultation around the new recognition agreement will begin shortly.	31/03/2020	Vote of no confidence in the Board by staff side in November 2018. Outstanding issues have been resolved, except there is a need for a facilitated discussion on future partnership working. The review of the recognition agreement has been on hold. We will resurrect this and elements of this will be controversial.
4362	**Workforce capacity & capability (recruitment, retention & skills)** If there is a significant reduction in workforce capacity or capability across the Trust; Caused by issues with the recruitment and retention of sufficient numbers of staff with the required skills and experience; It could result in sustained disruption to the quality and continuity of multiple services across directorates and may lead to extended, unplanned closure of one or more services which has a major impact on the wider healthcare system.	Rayson, Martin	Service disruption	Very high risk	Overall ULHT People Strategy & Workforce Operational Plan. Workforce planning processes & workforce information management. Medical staff recruitment framework & associated policies, training & guidance. Medical staff appraisals / validation processes. National audit & benchmarking data on the medical workforce. Nursing staff recruitment framework & associated policies, training & guidance. Allied Healthcare Professionals (AHPs) staff recruitment framework & associated policies, training & guidance. Non-clinical staff recruitment framework & associated policies, training & guidance. Bank, locum & agency staffing arrangements. Rota management systems & processes. People management policies, training & guidance. Core learning programme & training provision. Leadership development programme.	Very high risk (20)		Moderate risk	30/11/2019	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	Very high risk (20-25)	Human Resources	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	31/03/2020	Nursing offer in place. Strategy for recruiting nurses in place, involving international and national recruitment, alongside maximising NQNs and trainee nurse associates. Review again at end of financial year.
										High vacancy rates for consultants & middle grade doctors throughout the Trust.	Very high risk (20-25)	Human Resources	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	31/03/2020	Plan for every medical post in place. Good progress on recruitment (to plan) in QTR 1 and good pipeline in QTR 2. Working with two agency partners. Review again at end of financial year.
										A significant proportion of the current clinical workforce are approaching the age at which they could retire, which may increase skills gaps and vacancy rates.	High risk (12-16)	Human Resources	Workforce plans to identify the potential risk due to the age profile in more detail, by year and service area; People Strategy includes mitigating actions; using HEE funding to bring additional capacity into OD in order to make progress on this project.	31/12/2019	Retention plan in place - aiming for 1-2% reduction in attrition in 2019/20. Review again at end of calendar year.
										The Trust is dependent on Deanery positions to cover staffing gaps with medical trainees; shortages in the medical recruitment team will impact on the next rotation if not resolved.	High risk (12-16)	Human Resources	Education Director action plan to address the issues raised.	31/12/2019	Higher number of junior doctors in August rotation. Actions to improve juniors experience identified. Review again at end of calendar year.

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										NHSI propose the introduction of 2 further measures to reduce agency spend in non-clinical areas: - a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts (to use of on-framework agencies only) - A restriction on the use of admin and estates agency workers to bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	High risk (12-16)	Human Resources	Review of proposals and potential impact, to identify any required action.	31/12/2019	Action plan in place to reduce agency spend. Central medical agency team operating and impact is being felt. However agency spend is not reducing as expected. Further action being taken, particularly around nursing agency spend. Review again at end of calendar year.
4405	**Critical infrastructure failure disrupting aseptic pharmacy services (corporate)** If there is a critical failure of the infrastructure that supports aseptic pharmacy services within the Trust; Caused by issues with the age and condition of the facilities and the impact of managing increasing levels of demand; It could result in unplanned suspension of services which would have a significant and prolonged impact on a large number of patients, services, and other service providers.	Hepburn, Dr Neill	Service disruption	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Estates & Facilities Planned Preventative Maintenance programme & responsive repairs process. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates). Business continuity plans for ASU require patients to be treated outside of the Trust in the event of service disruption.	Very high risk (20)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	The Pilgrim ASU facility is18 years old, is operating at capacity and the availability of external supplies is both erratic and inconsistent. In addition, cancer care in the Trust is increasing by 10% annually and demand for aseptic preparations is predicted to outstrip current levels of availability by the end of 2020.	Very high risk (20-25)	Pharmacy	Development of a sustainable infrastructure plan for aseptic pharmacy services.	31/12/2020	Full Business Case being prepared for Trust Board in October 2019, containing proposals for a new aseptic unit; preferred option is a joint venture partnership through the STP.
										Repeated incidents of water leaks into one of the PHB aseptic rooms (tray washing room) from an upstairs toilet. If this happens and water reaches the main clean room it could result in closure of the aseptic unit for recommissioning and therefore inability to provide an aseptic service for the Trust for several months.	Very high risk (20-25)	Pharmacy	With Estates, to identify the reasons for the ongoing leaks and provide a permanent resolution to the problem; if a permanent resolution is not possible, to explore a way to identify the leaks at an early stage to minimise the risks (detection alarms are in other areas of the aseptic unit, so can this be applied to all other areas). To arrange cultures and chemical assay of the water. To request an assessment from Bernie Sanders, East Midlands Regional Quality Assurance to advise on continuation of production.	31/10/2019	Temporary closure of the aseptic unit at PHB - implementing BCP until assurance is received that the contamination is safely managed.
3520	**Compliance with fire safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with fire safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance (PPM) / testing. Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processes.	High risk (16)	Fire Safety Group	Low risk	31/10/2019	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards. The Maternity Wing has a partially compliant alarm system in need of upgrading to current standards (Any works to the Fire alarm system within the Maternity Wing are constrained by the presence of asbestos. This applies to maintenance works and any upgrade works). Detection Zones plans are also referenced as a reason for the inadequate Fire Detection System under Article 13(1) (a) & 13 (2) of the Fire Enforcement noticed served 14th June 2017.	High risk (12-16)	Estates	The Fire Alarm System at LCH is maintained by a specialist contractor and directly employed labour force. The system in some areas has been upgraded as part of services developments e.g. HDU & ICU and as part of previously funded upgrade. Programme of refurbishment and re-provision on a phased basis to install a 'loop' for the site and linking in modern equipment is underway.	31/12/2019	Phases 1, 2 and 3 complete. Phases 4 is underway and as part of these works; and to improve auditability and compliance with DDA, additional sounders and beakers are being installed. Phase 5 (Mat Wing) The Fire Alarm systems on 1st and 6th floor have been replaced, works are currently on-going to replace the Fire Alarm system within all lift lobby areas and within the 3rd floor ward area.
										Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection of patient and staff areas in accordance with statutory standards. See Fire Strategy surveys for areas affected. As referenced under article 8 in the Fire Enforcement Notices. Numerous sets of fire doors in poor condition due to wear and tear and damage where the fire resisting qualities have been reduced or negated. Under article 17(1).	High risk (12-16)	Estates	Fire Strategy Plans and surveys identify where compartmentation is required. Fire compartmentation works costs are detailed within the capital plan. Fire Doors will be addressed as part of the Fire Action Plan from the enforcement notices received for Lincoln and Pilgrim. Fire Doors requiring replacement to be replaced with new certified fire doors. PPM inspections and ad hoc repairs to fire doors in response to serious damage, etc.	31/12/2019	The work packages for the remedial works are taking place subject to availability of sufficient capital funding.
										Adherence to fire safety policy, procedures, strategic approach to active and passive fire safety measures and evacuation strategy. Adherence to Fire Safety training arrangements which include recording, analysis of training needs, personal development systems in place for all staff inclusive of permanent, temporary, agency and or bank staff.	High risk (12-16)	Estates	Specific actions in relation to fire safety training & evacuation: 1. staff identified and managers informed to ensure staff attend 2. Evacuation drills to be implemented and tested. 3. New Fire safety training packages being introduced. 4. persons requiring PEEP and procedures tested during evacuation drills. 5. discussions with HR to identify an appropriate procedure to identify and inform staff outside of compliance dates, with managers cc into correspondence to ensure urgent attendance. 6. Fire safety trainer to discuss with ESR team about information required for PDR and H & S team for reporting against core modules to ensure compliance.	31/03/2020	New mandatory staff fire safety awareness module introduced.
4384	**Substantial unplanned income reduction or missed opportunities (corporate)** If the Trust experiences a substantial unplanned reduction in its income or missed opportunities to generate income within the current financial year; Caused by issues with financial planning, an unexpected reduction in demand or loss of market share; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Contract governance and monitoring arrangements. Annual budget setting & monthly management process. Monthly financial management & monitoring arrangements. Key financial controls. Financial management information.	High risk (16)	Financial Turnaround Group	Moderate risk	31/10/2019	Clinical coding & data quality issues impacting on income.	High risk (12-16)	Information Services	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	31/03/2020	
										Operational ownership of income at directorate level.	High risk (12-16)	Finance	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	31/10/2019	
										Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	High risk (12-16)	Finance	Agreed contractually that the impact of income reduction for these schemes will be on a net neutral basis for the Trust; monitored and managed through the Finance & Contracting Group.	31/03/2020	
										Activity levels increase above the plan where the Trust remains under tolerance, no additional income is received; where above tolerance only a percentage of tariff is received.	High risk (12-16)	Finance	Internal control via PRM process for monitoring and agreeing any necessary actions to manage demand; & via Finance & Contracting Group for the system to manage demand.	31/03/2020	

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										Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	High risk (12-16)	Finance	System to develop robust plans and internal productivity gains to ensure there is sufficient capacity to deliver the activity; where the planned level of activity can't be achieved to secure income, the associated costs will need to be removed.	31/03/2020	

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3688	**Quality of the hospital environment (corporate)** If the Trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the Trust and may lead to commissioner or regulatory intervention.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Patient Experience Committee. NHS Premises Assurance Model (PAM) Patient-led Assessment of the Care Environment (PLACE) survey & response plans. Robust defect reporting system which prioritises critical issues within available resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.	High risk (16)	Patient Experience Group	Moderate risk	31/10/2019	Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	High risk (12-16)	Estates	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	31/12/2019	Funding and resource to be allocated.
										Floor Coverings across the Trust - Many areas are 45 years old, looks tired and is damaged in areas. Frequently fails environment and PLACE audits. Sub Floor is also damaged in some cases. High risk areas include Maternity at Lincoln, Tower Block at Grantham, Theatre Corridors at Pilgrim.	High risk (12-16)	Estates	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	31/12/2019	
										LCH & GDH: Lack of resources to carry out external decoration. High level areas in the East Wing are difficult and costly to access due to requirement to erect scaffolding. Deterioration of paint finish to wooden windows and door fascias and soffits leaving timber exposed to weather. Will lead to deterioration of timber window frames and their failure with associated costs. Physical appearance very poor. Fails annually on PLACE scores.	Moderate risk (8-10)	Estates	Repairs to external decoration at LCH & GDH undertaken based on available labour, accessibility. Monitor the situation and carry out ad hoc repairs where situation dictates. Funding required for a rolling programme of external decoration, window replacement and facias.	31/12/2019	
										LCH: Patient bed space curtain track systems within patient areas are obsolete; sufficient hooks to hang the curtains satisfactorily are not available; not all curtain tracking is ligature safe; inadequately hung curtains can affect patient dignity as reported on PLACE.	Moderate risk (8-10)	Estates	Existing curtain hooks at LCH are "spaced out" to increased distances to allow curtains to hang. Funding required to replace the obsolete curtain rail systems.	31/12/2019	
3951	**Compliance with regulations & standards for aseptic pharmacy services (corporate)** If the Trust is found by a regulator to be systemically non-compliance with regulations & standards for aseptic pharmacy services; Caused by fundamental issues with the design or application of local policies and procedures, or the quality of the facility; It could result in regulatory intervention that forces immediate closure of the facility and suspension of services, impacting on a large number of patients, services and other service providers.	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (16)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	Pilgrim Hospital ASU does not comply with national and EU standards: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	31/12/2020	Business Case in development, to be presented to Trust Board in October 2019.
										Aseptic preparation services must have adequate resources to ensure compliance with the defined national standards as described in Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic preparation time has increased due to changes in aseptic services standards (addition of an extra disinfection stage and use of a sporicidal agent with an increased contact disinfection time).	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a service that complies with QAAPS standards. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
4497	**Contamination of aseptic products (corporate)** If the products supplied by the Trust's aseptic pharmacy services were to become contaminated; Caused by issues with hygiene standards at the production facility, or user error; It could result in significant harm and potentially the death of multiple patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS) regulatory stndards. Aseptic pharmacy lead. QAAPS states that aseptic capacity should not exceed 80%. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (15)	Medicines Optimisation & Safety Group	Low risk	31/10/2019	Due to the current state of the infrastructure in Lincoln, and the potential risk of contamination, the Lincoln Pharmacy ASU is not fit for purpose.	High risk (12-16)	Pharmacy	Closure of the Lincoln Pharmacy ASU to avoid the risk.	28/02/2018	Lincoln Pharmacy ASU has been closed.
										Most aseptic processes are operator dependant. This means that when overcapacity there is an increased risk of calculation errors or producing contaminated products. Whilst air pressure monitoring will highlight the risk of contamination it does not give information on the actual risk. Microbial plates take 2 weeks to provide results, therefore any potentially contaminated products cannot be identified until after they have been issued and administered to patients. This is because the aseptic unit operates under Section 10 exemption from the Medicines Act and is not licensed. There is therefore no batch manufacturing and no associated quality control of batch manufactured products which would otherwise enable microbiological and chemical stability testing to take place.	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a safe service and achieve capacity levels of under 80%. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity. Frequent activation of BCP paces additional workload strain on staff, which further increases the associated risks. This is only sustainable for a short period of time.
										The current condition of the aseptic facility at Pilgrim Hospital is inadequate, which increases the risk of contamination: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Implementation of a sustainable and fit for purpose aseptic services facility at Pilgrim Hospital.	31/12/2019	Business Case in development, to be presented to Trust Board in October 2019.

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4300	**Availability of medical devices & equipment (corporate)** If the Trust's is unable to maintain the availability of essential medical devices and equipment; Caused by issues with capital and / or revenue planning, procurement and delivery processes or the availability of sufficient funding and resources; It could result in widespread disruption to clinical services across one or more divisions, reducing productivity and impacting on the experience of multiple patients.	Hepburn, Dr Neill	Service disruption	Very high risk	Capital and revenue planning processes. Procurement, delivery and contract management processes. Medical Device Group operational oversight. Medical device & equipment inventory. Clinical Engineering Services and Estates & Facilities equipment maintenance programmes & repairs capability. Business continuity / contingency plans for reduced availability of devices & equipment. CAS Alerts processes for managing device safety issues. Datix incident reporting & management processes for incidents.	High risk (12)	Patient Safety Group	Low risk	30/09/2019	Trust-wide issues with the availability of suitable equipment (e.g. beds / trolleys; wheelchairs; weighing scales; blood pressure cuffs) and appropriate policies, procedures & pathways supported by training for the safe care of bariatric patients.	High risk (12-16)	Corporate Nursing	To review and update where necessary policies, procedures and relevant pathways to improve the safety of care for bariatric patients across existing policy areas, including: moving & handling policy; Theatres - procedures on trolleys / tables; observation policy (e.g. right size cuff to take blood pressure); A&E; outpatients.	31/12/2019	Working group set up, involving corporate nursing, health & safety & risk, to identify required improvements.
										Lack of a centralised database for all medical devices; some records are held locally.	High risk (12-16)	Clinical Engineering	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	30/11/2019	MDSG has agreed on MEMS as the centralised medical equipment management database. Divisional engagement is underway.
										Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control.	High risk (12-16)	Clinical Engineering	Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT.	31/12/2019	BC developed and approved in principle by CRIG
4041	**Safe and responsive delivery of Non-Invasive Ventilation (NIV)** If there are delays in the identification or treatment of patients requiring or receiving Non-Invasive Ventilation (NIV) within the Trust; Caused by issues with staffing capacity or capability, equipment availability, bed availability, the design or application of systems and processes; It could result in severe, permanent harm or the death one or more patients.	Rhodes, Michelle	Harm (physical or psychological)	Very high risk	Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting. Governance arrangements within Medicine Division. National & local audits of compliance with best practice guidelines. NIV Quality & Safety Improvement Group established with membership from Respiratory teams from all 3 sites. Carlton-Coleby Ward (LCH) is established for 4 NIV beds, with 6 NIV machines (4 installed 2009; 1 in 2011; 1 in 2018). Ward 7B (PHB) is established for 2 NIV beds, with 4 NIV machines (2 installed in 2007; 1 in 2017; 1 in 2018). Additional NIV machine available in Clinical Engineering if needed. Acute Care Unit at GDH is established for 3 NIV beds. Escalation process in place. Authorisation to increase staffing capacity through the use of Bank, overtime and agency. Oxygen saturation monitoring in place and cardiac monitoring can be accessed via the Outreach Team if any concerns re potential arrhythmia. Trust-wide staff competencies for NIV. Safecare Live system used to record patient acuity. 1x NIV-skilled nurse per shift in all areas where NIV is provided.	High risk (12)	Patient Safety Group	Low risk	30/09/2019	1. Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. 2. NIV may be the ceiling of care which would deem a patient not suitable for admission to an ICU bed; if a patient were then admitted to ICU it may be unsuitable for the patient and would be in breach of Critical Care Network agreed policies. 3. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. 4. Recruitment of nurses with required skills to vacancies on Ward 7B (PHB). 5. Inconsistent adherence to the NIV Care Pathway.	High risk (12-16)	Respiratory Medicine	1. SOP to be developed for commencement of NIV in Emergency Departments. 2. Escalation Process for Ward Based NIV Capacity developed. 3. Capacity & demand being reviewed with the aim of increasing established, trained staff levels. 4. On-going competency training in place for all nurses. 5. NIV to review audit results and agree appropriate action.	31/03/2020	Action plan kept under regular review by he NIV Group, which meets quarterly. Next meeting September 2019.
4081	**Quality of patient experience (corporate)** If multiple patients across a range of the Trust's services have a poor quality experience; Caused by issues with workforce culture or significant process inefficiencies and delays; It could result in widespread dissatisfaction and a high volume of complaints that leads to a loss of public, commissioner and regulator confidence.	Rayson, Martin	Reputation / compliance	Very high risk	Patient Experience Strategy and Workplan; Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments); Patient Experience training (leadership development programmes).	High risk (12)	Patient Experience Group	Low risk	31/08/2019	Staff engagement & ownership of patient experience feedback, staff morale and staff shortages; lack of pride or hope in working at ULHT translated as low energy and passion; communication features highly as a negative indicator within feedback; staff lacking awareness of the 'impact of self'; staff do not feel valued; workload and demand gives little time to provide the care to the standard aspired to leaving staff disappointed and dissatisfied.	High risk (12-16)	Human Resources	Deliver against Patient Experience workplan; provide service and divisional level patient experience reports that are useful, timely and meaningful, secure a FAB Experience champion in every directorate; promote & spread Academy of FAB NHS Stuff to highlight FAB patient experience quality projects and achievements - spreading celebration and enthusiasm to rebuild motivation and hope and passion; determine links between staff and patient experience and drill down to team level to support improvements and interventions; provide data that delivers confidence that this is what staff and patients are saying about their experience within that service - and then support that service to design and deliver improvements.	30/09/2019	
4142	**Safe delivery of patient care (corporate)** If there are multiple patient incidents throughout the Trust; Caused by fundamental issues with the safe and consistent application of clinical policies, procedures, guidelines or pathways; It could result in significant harm caused to a large number of patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG) & sub-groups: - Harm Reduction Group - Radiation Protection Group - Deteriorating Patient Group - Medical Devices Group - Hospital Transfusion Group - Nutrition Group Divisional Clinical Cabinets & CBU / specialty governance arrangements. Clinical staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes (including Safety Thermometer). Quality Matron team and specialist nurses (Tissue Viability; Frailty; Sepsis).	High risk (12)	Patient Safety Group	Low risk	30/11/2019	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	High risk (12-16)	Corporate Nursing	Design & introduce refined policies and processes for the identification of & response to deteriorating patients.	30/09/2019	Regular progress reporting through Quality & Safety Implementation Group (QSIG).
										Inconsistent levels of compliance with the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs), particularly outside of the operating theatre environment, which increases the likelihood of a Never Event occurring.	Moderate risk (8-10)	Quality & Compliance	Conduct an initial review of compliance with LocSSIPs to identify areas for improvement.	31/10/2019	
										Development of the WebV system for handover has been delayed due to lack of dedicated project manager; potential adoption of the Nervecentre system is not possible until 2021. Presently there is no Trustwide handover IT system in place.	High risk (12-16)	Information & Communications Technology	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	31/03/2020	Associate Director of ICT to be invited to PSG in August to discuss project management options.
										Inconsistent application of clinical pathways and guidelines for pneumonia, leading to increased mortality risk.	Moderate risk (8-10)		Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	31/03/2020	Business case in development for audit function.
4145	**Compliance with safeguarding regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS	Rhodes, Michelle	Reputation / compliance	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team.	High risk (12)	Safeguarding Group	Low risk	30/11/2019	Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.	Moderate risk (8-10)	Safeguarding	Increase visibility of the Safeguarding team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored.	30/11/2019	Lead professional for MCA reports that although MCA audits continue to show areas of concern they are showing a significant increase in knowledge and compliance. This is supported by CCG and CQC feedback. There remains some cases where there is clear evidence of lack of compliance with policy for example SI investigation. Monitoring will continue through audit and review of incidents, complaints and concerns. On this basis risk reduced to moderate.

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
	Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.				Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.					Not yet consistently achieving 90% compliance with safeguarding training requirements.	Moderate risk (8-10)	Safeguarding	Confirm that safeguarding training completion continues to be included in performance framework with compliance reviewed and managers held to account through operational performance management reviews; individual accountability to be managed through appraisal process.	30/11/2019	9/8/19 Training compliance is consistently not achieving the 90% trajectory. Monitoring and reporting of this will continue through Safeguarding Group.
										Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.	High risk (12-16)	Safeguarding	Areas for more efficient working to be identified and improvements implemented; progress work to develop an integrated Safeguarding model for Lincolnshire that will deliver optimum benefits for Safeguarding across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority.	30/11/2019	Different models of working being explored. 9/8/19 -Additional temporary support is in place to support work required from the team. Will require a sustainable plan to meet the recommendations with in the Intercollegiate staffing guidance.
4146	**Effectiveness of safeguarding practice (corporate)** If there is a significant, widespread deterioration in the effectiveness of safeguarding practice across the Trust; Caused by fundamental issues with the design or application of local policies and protocols; It could result in multiple incidents of significant, avoidable harm affecting vulnerable people in the care of one or more directorates.	Rhodes, Michelle	Harm (physical or psychological)	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Mandatory safeguarding training (role-based) as part of Core Learning. Safeguarding Committee & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing. Learning Disability Mortality Review process (LeDeR). Safeguarding Statements of Intent (covering access to services by children, young people & adults as well as modern slavery & human trafficking).	High risk (12)	Safeguarding Group	Low risk	30/11/2019	Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration.	High risk (12-16)	Safeguarding	Develop & roll out clinical holding training for identified staff Trust-wide. Introduce debrief process. Identify trends and themes through incidents reported on Datix. Monitor training compliance rates. Introduce audit of 5 security incidents per month from September 2018. Review of chemical sedation pathway.	30/11/2019	9/8/19 Clinical Holding Level 4 training (2 day) compliance at 69% from staff identified as requiring training as virtue of their role would be responders to urgent assistance calls. In addition staff from other roles such as portering/security ,safeguarding and training have attended. 67% of identified staff have attended the level one day training. Further training dates are available and training needs analysis being refreshed to reflect staff changes and to establish if any further courses require commissioning. Outstanding staff will be monitored on an individual basis to prioritise booking and completion. Learning events/debrief process provide scrutiny(in place of audit of 5 security incidents per month).Safeguarding team are alerted to datix incidents from security or involving vulnerable patients. Monthly chemical sedation audits continue to be undertaken by Safeguarding team and show improvements in compliance.Process in place for clinical areas to escalate to Matron when chemical restraint has been used to allow for review of episode of care. Rapid Tranquilisation policy has been reviewed and incorporates new pathways to support staff. Currently in consultation process prior to submission to CESG. Local training package on use of chemical restraint in development by Safeguarding Lead, delivery will be supported by the Clinical Education team.
										The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.	High risk (12-16)	Safeguarding	Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group to scope extent of issues and to progress pathway development.	30/11/2019	Draft pathway developed and under consultation. 9/8/19 Plan for key stakeholders to meet to agree pathway prior to submission to CESG for approval.
										There is no mandatory, core learning or core learning plus formal training programme provision within the Trust for: 1. Mental Health - awareness; responsibilities in relation to administering the Mental Health Act, ligature risk 2. Learning disability - awareness, care in hospital and reasonable adjustments 3. Autism - - awareness, care in hospital and reasonable adjustments	Moderate risk (8-10)	Safeguarding	1. Liaise with training and development department to resubmit applications for core learning. 2. Liaise with clinical education department to determine numbers and reach of HEE funded programme. 3. Refresh training needs analysis to incorporate Autism developments. 4. Ensure reflected within MHLD&A Strategy and associated work-plan.	30/11/2019	Mental Health Awareness Core learning training developed and available from 1st July 2019. As of 25th July 2019 49.66% of required staff had completed it. Compliance and impact will be monitored through MHLDA group. Update reports received by Safeguarding Group.
4156	**Safe management of medicines (corporate)** If there are multiple, widespread failings in the safe management of medicines across the Trust; Caused by issues with the design or application of medicines safety policies and procedures; It could result in multiple incidents of significant, avoidable harm to patients in the care of one or more directorates.	Costello, Colin	Harm (physical or psychological)	Very high risk	Medicine safety policies & procedures. Medicine management governance arrangements (including audit & performance monitoring). Medicine safety training & education programmes. Pharmacy support and advice service. Pharmacy facilities & specialist equipment. Incident reporting and investigation systems & processes (Datix).	High risk (12)	Medicines Optimisation & Safety Group	Low risk	30/09/2019	The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.	High risk (12-16)	Pharmacy	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	31/03/2020	
										Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.	High risk (12-16)	Pharmacy	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	31/03/2019	
										The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.	High risk (12-16)	Pharmacy	Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency - ward monitoring of temperatures & escalation of issues.	31/12/2019	
										Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	Very high risk (20-25)	Pharmacy	Temperatures of refrigerated medicinal products to be monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased.	31/03/2019	

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Moderate risk (8-10)	Pharmacy	Risk regarding unsecure storage and stock accountability of medical gas cylinders at all sites to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	30/06/2019	

Appendix I - Very high High Corporate Risks (September 2019)

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4157	**Compliance with medicines management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Costello, Colin	Reputation / compliance	Very high risk	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Mandatory medicines management training as part of Core Learning for clinical staff. Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.	High risk (12)	Medicines Optimisation & Safety Group	Low risk	30/09/2019	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	High risk (12-16)	Pharmacy	Planned introduction of an auditable electronic prescribing system across the Trust.	31/03/2020	
										Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	High risk (12-16)	Pharmacy	The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	30/06/2019	
										Administration of medication by pharmacy technicians including oral, intravenous, NG and PEG - legislation, governance and training issues. The Medicines Regulations 2012 specified that parenteral products can be legally administered by persons acting under the instruction of a legally valid appropriate prescriber (as shown in Regulation 214). Pharmacy technicians could also adopt this role in clinical areas in the Trust. However, his practice has not been approved and accepted by the Trust and is not embedded into the Medicines Management policy.	High risk (12-16)	Pharmacy	To define the process for administration of medicines by pharmacy technicians and their supervision and training. To embed the process in the Medicines Management Policy.	30/09/2019	
										There is not full assurance that the new pharmacy technician roles and practices are acceptable in terms of professionally registered practice and that professional codes of practice are being correctly adhered to.	High risk (12-16)	Pharmacy	To establish the professional supervision and development of the new roles. To take advice from the General Pharmaceutical Council (GPhC) and NHSI to ensure the new roles are covered by the relevant professional codes of practice.	30/09/2019	
4476	**Compliance with clinical effectiveness regulations & standards (corporate)** If the Trust is found to be systemically non-compliance with regulations and standards for clinical effectiveness; Caused by fundamental issues with the systems and processes used for managing clinical audits, policies, guidelines and best practice; It could result in a significant loss of confidence amongst a large number of patients as well as commissioners, regulators and the general public which may lead to regulatory action and sanctions.	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Clinical governance arrangements in place at corporate level: Quality & Safety Oversight Group (QSOG) / Clinical Effectiveness Group. Clinical policies, guidelines and best practice management processes. National clinical audit programme management processes. Local clinical audit programme management processes.	High risk (12)	Clinical Effectiveness Group	Low risk	30/11/2019	Infrastructure is in place for divisional management of clinical policies; guidelines; best practice and clinical audit. Issues with time allocation within job plans for divisional leads to deliver against requirements.	High risk (12-16)	Quality & Compliance	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	31/03/2020	Report template in development.
										Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	Moderate risk (8-10)	Quality & Compliance	Integration of routine oversight of clinical effectiveness as part of the divisional Performance Review Meeting (PRM) process through the introduction of appropriate KPIs.	31/03/2020	
										Insufficient staffing resources within the established Clinical Effectiveness central support team.	High risk (12-16)	Quality & Compliance	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	31/12/2019	
3720	**Critical failure of the electrical infrastructure (corporate)** If the Trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.	Boocock, Paul	Service disruption	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (12)	Electrical Safety Group	Low risk	31/10/2019	Potential for Mechanical & Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	High risk (12-16)	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	31/12/2019	Estimated cost £50k +vat.
										Mechanical & electrical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity	High risk (12-16)	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	31/12/2019	
										Potential for failure of Electrical Infrastructure at GDH resulting in service interruption, fire and closure of clinical services. The site has an aging electrical infrastructure and some of the switchgear is obsolete and in need of replacing. It does not comply with current IET wiring regulations (BS7671).	High risk (12-16)	Estates	Capital investment required to upgrade electrical infrastructure at GDH.	31/12/2019	Capital funding applied for.
4423	**Working in partnership with the wider system (corporate)** If the Trust fails to work effectively in partnership with the wider system, including other healthcare providers and commissioners; Caused by issues with the planning process, the availability of sufficient resources or the effectiveness of partnership governance arrangements; It could result in significant disruption to the provision and sustainability of multiple services that has a long term impact on the experience and quality of care for a large number of patients.	Turner, Kevin	Service disruption	Very high risk	Sustainability & Transformation Partnership (STP), including ULHT; LCHS' LPFT; & others. STP partnership governance arrangements. STP planning & delivery mechanisms. Lincolnshire Coordinating Board (including chairs of each partner organisation).	High risk (12)		Low risk	30/09/2019	Failure to work effectively in partnership may result in some ULHT services having demand that exceeds capacity; failure to work with other providers and CCGs may also result in the viability of ULHT services being jeopardised. Failure to progress on taking forward the Acute Services Review may result in some existing fragile services failing, or some services becoming fragile.	High risk (12-16)	Strategy & Change	Re-assessment of strategic risk and development of appropriate mitigations.	31/03/2020	Continued engagement with the STP delivery process through established governance arrangements.

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4179	**Major cyber security attack (corporate)** If the Trust is subject to a major cyber security attack that breaches its network defences; Caused by the exploitation of an existing vulnerability or the emergence of a new type of threat; It could result in loss prolonged, widespread loss of access to ICT systems throughout the Trust which disrupts multiple services and affects a large number of patients and staff.	Humber, Michael	Service disruption	Very high risk	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital (CareCerts) ICT hardware & software upgrade programme. NHS Data Security Protection Requirements (DSPR). Corporate and local business continuity plans for loss of access to ICT systems. Mandatory major incident training for all staff (part of Core Learning). Installation of Site based Firewalls with full Traffic inspection enabled.	High risk (12)	Information Governance Group	Low risk	10/10/2019	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Moderate risk (8-10)	Information & Communications Technology	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	12/09/2019	The DPST was updated nationally to include the requirements of Cyber Essentials and other national requirement's. The Trust is working towards meeting this for march 2020 return.
										Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.	High risk (12-16)	Information & Communications Technology	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	11/09/2019	For financial year 19/20 no Trust capital has currently been provided to any Business as Usual schemes. Affecting the ability to continue in delivery schemes Move forward with in plan schemes Delays will affect the strategy as attack vectors and methods are constantly evolving
										Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Moderate risk (8-10)	Information & Communications Technology	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	11/09/2019	The BCP and Disaster plan has been updated A test of the plan is scheduled for the 31st July 2019, to desktop test the current plan.
4437	**Critical failure of the water supply (corporate)** If there is a critical failure of the water supply to one or more of the Trust's hospital sites; Caused by the age and condition of water pipes, or a major incident which damages the infrastructure; It could result in significant, prolonged disruption to multiple services throughout the site, impacting on the experience and care of a large number of patients and the productivity of a large number of staff.	Boocock, Paul	Service disruption	Very high risk	Estates Investment & Environment Group oversight. Water Safety Group operational governance. Capital & revenue prioritisation & investment procedures. Planned Preventative Maintenance (PPM) programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Appointed Authorising Engineer (Water). Emergency & business continuity plans for infrastructure failure / evacuation / relocation.	High risk (12)		Low risk	31/10/2019	Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	High risk (12-16)	Estates	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	31/12/2019	Scheme of work and design currently being produced.
4467	**Impact of a 'no deal' EU Exit scenario (corporate)** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust.	Turner, Kevin	Service disruption	Very high risk	Dep Ch Exec appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables - medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT EU Exit Planning Group: - local risk assessment, covering: potential demand increase; supply of medicines, medical devices & clinical consumables; supply of non-clinical goods & services; EU workforce; reciprocal healthcare; research & clinical trials; data sharing & security.	High risk (12)		Low risk	31/10/2019	The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	High risk (12-16)	Pharmacy	Completion of all required actions in respect of medicines and vaccines, as detailed in the national EU Exit guidance. Specific instruction not to stockpile medicines or to prescribe extra medicines.	31/12/2019	Current Pharmacy stock holding of around 27 days. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. Options to manage the impact of the current recruitment freeze on staffing capacity in Pharmacy procurement to be considered.
										The supply of medical devices & clinical consumables may be disrupted in the event of a 'no deal' EU Exit. Some parts for diagnostic machines used in Radiology & Cardiology (Cath Lab imaging systems; MRI compatible monitors – two out of support monitors, two MRIs) are obtained from Germany, which may lead to delays in fulfilling orders. There are BC plans in place, including back-up machines and some spare parts held, but not all possibilities can be covered. Availability of single-use consumable accessories for medical devices that are used constantly across the trust is also of concern.	Moderate risk (8-10)	Finance	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments. Concern that we do not have assurance about plans to manage the traffic impact of Immingham being opened up to increase port capacity – to be escalated through SCG to the Dept of Transport/Highways Agency.
										The supply of non-clinical goods and services may be disrupted in the event of a 'no deal' EU Exit. There are some concerns regarding the supply of food, as 30% comes from the EU and import delays would affect perishable goods.	Low risk (4-6)	Finance	Completion of all required actions in respect of non-clinical goods and services, as detailed in the national EU Exit guidance. The DHSC has issued updated guidance on supply of food, advising a common sense approach in the event of short-term shortages.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments.
										The supply of workforce may be disrupted in the event of a 'no deal' EU Exit. Concern emerging that under a 'no deal' scenario a DBS check for a European national maybe subject to a long delay.	Moderate risk (8-10)	Human Resources	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	31/12/2019	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Awaiting further guidance regarding professional registration. Agencies may also be reliant on EU workforce - risk assessment requested from Holt. HR to liaise with agencies providing medical staff to assess any risks throughout the EU Exit period. To consider the possibility of cancelling annual leave during the EU Exit period if planned staffing levels are not sufficiently robust.
										Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	31/12/2019	Need to understand the scale of risk, to ascertain how many patients would suddenly have to pay if reciprocal arrangements cease and who would not qualify; to pull together resource plan to meet the requirements to charge EU citizens following UK Exit.
										Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Research and Development	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	31/12/2019	All sponsors are UK-based and actively working to ensure continuity of drug supply. ULHT is not a sponsor for any of the 38 current trials. Some trial drugs come from the EU. Current trials to be risk assessed against threat from a 'no deal' scenario.
										Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	Moderate risk (8-10)	Information & Communications Technology	Completion of all required actions in respect of data sharing, processing & access, as detailed in the national EU Exit guidance. Instruction to follow advice from The Department for Digital, Culture, Media and Sport and the ICO and to complete the annual Data Security and Protection Toolkit assessment as early as possible.	31/12/2019	Local risk assessment carried out did not identify any significant data sharing implications. Latest guidance to be reviewed and potential impact re-assessed.
										Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	31/12/2019	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time). Consideration to be given to the potential that prices for some goods (e.g. food) may increase post-Brexit.

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Moderate risk (8-10)	Communications & Engagement	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	31/12/2019	Communication of common message regarding clinicians not writing longer prescriptions and patients' storage of medicines at home. Communications plan in progress to inform affected staff of settlement scheme and professional registration requirements. Use of traditional and social media channels, in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).
										The date of the UK's exit from the EU has been moved to 31st October 2019. Existing contingency plans may or may not be sufficient to mitigate potential impacts on the workforce; supply of medicines and medical devices; and the availability of information.	Low risk (4-6)	Emergency Planning	To review existing business continuity plans and update where necessary, in line with national and local guidance. Trust response to be coordinated through re-establishment of an executive-led task & finish group.	31/10/2019	Currently awaiting further details from the Dept of Health regarding potential impacts and any required changes to existing business continuity plans.
4385	**Compliance with financial regulations, standards & contractual obligations (corporate)** If the Trust is found to be systemically non-compliant with financial regulations & standards & or is unable to meet its contractual payment obligations; Caused by issues with the design or application of financial and contract management policies and procedures, or the availability of sufficient cash to meet payment obligations; It could result in regulatory action and sanctions or legal action which damages the reputation of the Trust amongst key stakeholders and may lead to sustained adverse local and / or social media coverage.	Matthew, Paul	Reputation / compliance	Very high risk	Financial governance & compliance monitoring arrangements. Trust Board approval of borrowing. Scheme of delegation & authority limits. Financial management policies, procedures, systems & training. Working capital strategy; prioritisation of payroll & critical supplier payments and escalation through Trust Board to NHSI. Cash forecasting and reconciliation processes. Contingency fund balance. Self-assessment & management processes for statutory & regulatory requirements. Annual internal audit plan. External audit annual report.	High risk (12)	Financial Turnaround Group	Low risk	31/10/2019	The Trust has a financial deficit and is therefore not able to meet its statutory obligation to break even.	High risk (12-16)	Finance	In Financial Special Measures; agreed Financial Recovery Plan to return the Trust to a sustainable footing ove ther medium term.	31/03/2024	
3689	**Compliance with asbestos management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with asbestos management regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Trust Asbestos Core Working Group. Asbestos Awareness training for managers and operatives (Estates staff and contractors). Specialist contractor appointed to advise Trust on specific Asbestos management issues across sites. Site Survey data available on Micad. Third Party Contractor induction for both capital schemes and day to day maintenance. Annual Facefit training for specialist PPE equipment. Occupational Health reviews, lung function test. Specialist surveys prior to making any physical change to built-in environment. Air monitoring of specific areas to give assurance that controls in place are adequate. Risk Prioritised Estates Capital Programme. Restricted access where known asbestos containing materials (ACMs) exist (permit to work system).	High risk (12)	Asbestos Management Group	Low risk	31/10/2019	Asbestos Policy is overdue for review.	High risk (12-16)	Estates	Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.	31/10/2019	
										Asbestos Management Plan still to be fully developed.	High risk (12-16)	Estates	Complete development & begin implementation of Asbestos Management Plan.	31/10/2019	
										Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	High risk (12-16)	Estates	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	31/10/2019	
										Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Moderate risk (8-10)	Estates	Agree Appointed Person & structure for Asbestos management.	31/10/2019	
										Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	High risk (12-16)	Estates	Review of asbestos contractors appointment & verification of training.	31/10/2019	
										No Access areas still to be surveyed for asbestos.	Moderate risk (8-10)	Estates	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	31/10/2019	
										Potentially inaccurate survey data due to restricted access to areas.	Moderate risk (8-10)	Estates	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	31/10/2019	
3690	**Compliance with water safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with water safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Trust Water Safety Group. Oversight by Infection Prevention & Control Committee (monthly report submitted by the AE). Water safety policies, procedures & training. Duty Holder, Responsible person, Site Deputy responsible persons and competent persons in place. Appointed Authorising Engineer (Water). Chlorine Dioxide Injection water treatment. Planned maintenance regime in place including written scheme of works. Site based Risk Assessments informing the Water Safety Group Management process. Water sampling, temperature monitoring and flushing undertaken; remedial actions taken in response to positive samples.	High risk (12)	Water Safety Group	Low risk	31/10/2019	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Moderate risk (8-10)	Estates	Legionella monitoring carried out by direct labour as far as possible with competing priorities. Action required: appoint additional staff or contractor in lieu of staff to carry out work. Further actions required (subject to funding): water systems drawings are required for all sites (CAD); review and issue a Trustwide tender document for the monitoring work; to appoint a responsible person; to form a Trustwide Legionella group to consist of Facilities, Infection Prevention and Control Consultant and Nurses (sub group of Infection Prevention and Control Committee?)	31/12/2019	
										13 waste disposal units do not incorporate a 'Type A Air Gap' on the water supply inlet and therefore as they are classed as 'CAT 5 Fluid' they do not comply with the 'Water Regulations' which is a statutory regulation.	High risk (12-16)	Estates	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'. The non-compliant units to be replaced with those which comply with the Water Regulations.	31/12/2019	Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.
										Lack of compliance with ACOP L8 and HTM standards in respect of water schematics for the hot and cold water systems could impact on the Trust's ability to demonstrate compliance with statutory standards and potentially place service users at risk of poor water safety.	High risk (12-16)	Estates	Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	31/10/2019	Funding required for replacement TMVs, sinks and hand basins. Schematics produced by surveyors have not been quality assessed and have not been stitched into Estates and Facilities master CAD models. Some funding has been identified from Facilities CIP.
										Although routine checks are undertaken , the water tanks at LCH do not comply with the Water Regulations	Moderate risk (8-10)	Estates	Bid for Capital funding to replace non-compliant water tanks made May 2016.	31/12/2019	
										Trustwide Water Systems - Chlorine Dioxide Dosing System. Scotmas inform that some of the monitors are now obsolete and require replacing. BMS is now linked to Lincoln.	Moderate risk (8-10)	Estates	Specification has been out to tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	31/10/2019	In December 2017 Scotmas were the only supplier to bid on this tender.

Appendix I - Very high High Corporate Risks (September 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										The Trust may not comply with drinking water guidelines and HTM04-01 at Pilgrim Hospital, because of Chlorine Dioxide dosing impurities due to lack of available maintenance.	Moderate risk (8-10)	Estates	Automatic monitors in place. It is being constantly monitored and completion of new water main which will be 2018/19. Capital investment required to mitigate this risk.	31/12/2019	Delayed completion of new water main which is required before we can gain access to complete the work required.
										The Water Safety Statutory Improvement Programme (directed by site risk assessments) may not complete on time; on going upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Moderate risk (8-10)	Estates	Stringent Water sampling and flushing programs in place. Funding required.	31/12/2019	
4176	**Management of demand for planned care (corporate)** If demand for planned care (elective, outpatient and diagnostic services) significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	Divisional capacity management processes. Corporate assurance processes including weekly PTL & fortnightly recovery & delivery meetings. Specialty recovery plans. System-wide planned care group driving reduced referrals into secondary care. Annual capacity & demand planning process. Productive services work-streams including: outpatients; theatres; endoscopy.	High risk (12)		Low risk	31/10/2019	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	High risk (12-16)	Operations	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. Capital plan for estate development, space utilisation and medical equipment.	31/03/2020	Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP).
4368	**Management of demand for outpatient appointments (corporate)** If the Trust's Outpatient Services are unable consistently to manage the level of demand for appointments; Caused by issues with the design or application of demand management systems and processes; It could result in a significant reduction in the quality and continuity of outpatient services across multiple directorates and failure to achieve NHS constitutional standards, affecting a large number of patients.	Rinaldi, Dr Ciro	Service disruption	Very high risk	Governance & performance management arrangements. Outpatient Improvement Group. Clinical policies, guidelines and pathways. Staff recruitment, induction & training policies & programmes. Access management policies, guidelines & staff training. Medway patient administration system. Self-assessment & performance management processes for national requirements. Patient Tracking List (PTL) validation & management processes. Approval policy for clinic cancellation with less than 6 weeks notice (Deputy Director level). Weekly PTL meetings. Incident reporting and management systems and processes (Datix).	High risk (12)	PRM	Low risk	30/11/2019	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients.	High risk (12-16)	Operations	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	31/12/2019	Requested further information from performance team to understand discussions at PTL meetings. Information are producing an extra report for all 40week+ patients regardless of RTT status for validation, also further DQ checks have been completed on specific cohorts of patients to improve DQ.
										Capacity to record e-outcomes onto Medway in a timely manner; Consultants not taking ownership of completing e-outcomes. May lead to Missing Outcomes not being completed & consequent delayed treatment.	Moderate risk (8-10)	Operations	Short term solution to offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes.	31/12/2019	Missing Outcomes transposing of outcomes is currently about 10 days behind on LCH site. Overtime being offered to reduce timeframes. All other sites being completed within 2 working days. Increase in number of outcomes not being completed by clinicians, this is being highlighted to DMD's for action. Business case for API links agreed by CRIG, delays in implementation occurring due to upgrades by 3rd parties need to happen first. Further update due 01/10/2019.
										Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	High risk (12-16)	Operations	Clinical Directorates to provide trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans at speciality level. C&A manually drawing down referrals from ASI list.	30/11/2019	CBU Recovery plans submitted to the performance team and they are tracking performance against trajectory. Performance being monitored at Delivering Productive Services Group.
										Overdue new appointments may be incorrectly added / unvalidated on the Open Referrals worklist . The New Booking team identify 'other' new patient referrals added to the Open Referral worklist by other parties in BU's. As the New Booking Team did not make the entry they are unable to validate the referral.	High risk (12-16)	Operations	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	31/12/2019	The Trust is fully compliant with the NHSI requirement to be receiving GP requests to first consultant led appointment by eRS. It is those referrals that do not fit the specific criteria of the NHSI scheme that could lead to un-validated patients on the open referral worklist. Further work required with information support and the booking team to ensure all patients are identified and validated.
4082	**Workforce planning process (corporate)** If there is a fundamental failure in the Trust's workforce planning process; Caused by issues with the design or application of the process, the availability of accurate workforce information or the capability to utilise it; It could result in significant, prolonged disruption to multiple services across directorates and potential unplanned closure of one or more services.	Rayson, Martin	Service disruption	Very high risk	Workforce strategy & improvement plans. Workforce planning processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements.	High risk (12)		Moderate risk	30/11/2019	Capacity within the business to support the process and recognition of its priority is an inhibiting factor, which is less within the direct control of HR.	Very high risk (20-25)	Human Resources	KPMG are providing additional capacity and capability. Created temporary team to take forward work aligned to CSR. Business partners to be appointed. Skill-building planned at STP level, where we also have continued support from WSP. Escalation to FRG if necessary.	31/03/2020	Greater capacity has been created in the HR team (business partners and enhanced workforce information function) to support workforce planning. New business planning process being put in place for 20/21 and workforce planning will be an integral part of that. The Clinical Services Review process is in place and includes a workforce planning element. Workforce planning is also taking place at a system level. Further review at the end of the business planning process.
3503	**Sustainable paediatric services at Pilgrim Hospital, Boston (Children & YP CBU)** If the Trust is unable to maintain the full range of paediatric services at Pilgrim Hospital, Boston; Caused by issues with the recruitment or retention of sufficient numbers of staff with the required skills and experience; it could result in extended, unplanned closure of the service or significant elements of it, impacting on the care and experience of a large number of patients and on the provision of interdependent services across the region.	Joachim, Suganthi	Service disruption	Very high risk	Workforce planning systems & processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.	High risk (12)	Family Health Clinical Cabinet	Low risk	30/09/2019	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	High risk (12-16)	Paediatric Medicine	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	30/03/2020	
										Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	High risk (12-16)	Paediatric Medicine	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	31/03/2020	
										Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown).	High risk (12-16)	Paediatric Medicine	Development of sustainable long-term model for paediatrics at PHB, through the STP.	31/03/2020	

Appendix II - High Operational Risk Summary (September 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	16	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	16	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	16	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	16	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	16	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	15	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	15	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	15	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	15	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	15	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	15	High risk
4330	Workforce capacity & capability (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4115	Workforce capacity & capability (TACC & Pain CBU)	Surgery	Service disruption	12	High risk
4120	Delayed patient discharge or transfer of care (TACC & Pain CBU)	Surgery	Harm (physical or psychological)	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4190	Safety & effectiveness of patient care (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4191	Availability of essential equipment (Surgery CBU)	Surgery	Service disruption	12	High risk
4195	Delayed patient discharge or transfer of care (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4214	Workforce capacity & capability (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4262	Availability of essential equipment & supplies (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk

Appendix II - High Operational Risk Summary (September 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4329	Safety & effectiveness of patient care (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4373	Availability of essential information (Outpatient Services)	Clinical Support Services	Service disruption	12	High risk
4408	Safety & effectiveness of patient care (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4409	Health, safety & security of staff, patients and visitors (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4410	Compliance with regulations & standards (Children & Young Persons CBU)	Family Health	Reputation / compliance	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4456	Exceeding annual budget (Women's Health & Breast Services CBU)	Family Health	Finances	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk

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Risk Management Policy Appendix I: Risk Scoring Guide

To be used when assessing risks that are recorded on the Trust risk register (Datix).

	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting a small number of patients, staff or visitors within a single location.	Low level of harm affecting a large number of patients, staff or visitors within a single location.	Significant but not permanent harm affecting multiple patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

Item 16.2

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	1st October 2019
Essential Standards:	

Title:	Board Assurance Framework (BAF) 2019/20

Author/Responsible Director: Karen Willey, Deputy Trust Secretary/Jayne Warner, Trust Secretary

Purpose of the Report:

To present the 2019/20 Board Assurance Framework

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/Key Points:

The 2019/20 BAF has been presented to the Board Committees during September. There were no material changes to the content of the framework and as such none of the assurance ratings have been amended by the Committees during their considerations in September.

Direction of Travel of Assurance Ratings:

RAG Rating	August 2019	September 2019	Direction
Red	6	6	→
Amber	1	1	→
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise/identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2019/20 - September 2019

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Unreliable or inaccurate data Steps not delivered within the Trust Mortality Reduction Strategy Partnership working across health care system Coding incomplete/inaccurate Case mix numbers presenting for admission	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Dr Foster - investigations into Dr Foster alerts SHMI and HSMR National Benchmarking Reports Integrated Performance Report Speciality Governance National surveys and audit - secondary control National Audit Data - HQIP ReSPECT Care Plan Quality Account Priority 3 Incident Reviews	Speciality governance process Partnership working across health care system ReSPECT care plans not adhered to or in place No established process for cross system reviews Inability to control/manage emergency demand	Trust Operating Model role out Performance review mechanisms of staff	Speciality assurance against governance guide National audit reports Audit of speciality governance Mortality Reduction Plan Quality review of medical workforce Quality review of nursing workforce Regular reporting on learning from deaths. Independent Reviews of alerting diagnosis Updates on coroner cases and preventing future deaths	System wide partnership reports - variable community buy in ReSPECT roll out not clear	Masterclass for coding Organisational Development Patient Safety Committee Clinical Effectiveness Committee Drugs and therapeutic Committee 7 day Services Mortality review group Formal report from public health workshops to be requested ReSpect update and coding update requested within next mortality report July 2019	Quality Governance Committee	A
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy Patient Experience Plan Inclusion Strategy QSOG reports Quality Account priorities 1 ,2 & 4 Hygiene Code	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Quality Strategy not approved Metric not finalised Sharing and learning not at desired level	Bi weekly meetings Harm Free care Steering Group QSIP Programme Patient experience annual plan as part of Quality Strategy Meeting to finalise metrics Infection Prevention and Control Group	Integrated Performance Report Patient Experience Dashboard and codesign of pathways with patients Quality and Safety Improvement Plan Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain as gap for time being QSOG still in development New Trust Operating Model still embedding. Patient Experience and links to Quality Strategy and how articulated in BAF	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
							Internal Audit: Data quality of KPIs - Q4 Compliance with legislation - Q2			Infection Prevention Control exception report Equality and Diversity Patient report Inclusion strategy				
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	Systems unable to capture and report data Unreliable, incomplete or inaccurate data Insufficient clinic capacity resulting in overbooking Inappropriate clinic configuration providing duplicate appointment times Patients arriving late for their clinic appointment Poor engagement	Corporate risk ID 4368 - Outpatient demand (High)	CQC Responsive	Specialty Governance Data Quality Group Outpatient Improvement Programme Delivering Productive Services Group Internal Audit: Data quality - Q1	Data Quality Group New reporting metric Insufficient outpatient capacity to meet current demand across a number of specialties Consistency of Specialty Governance process	Data Quality workstream Performance Review Meetings Outpatient improvement programme System approach to managing planned care demand Governance team supporting embed of specialty governance port TOM implementation	Monthly Delivering Productive Services report PRM FPEC	Data quality assurance IPR	Development of data quality process prior to reporting Report from system SRO	Finance, Performance and Estates Committee	R
SO2	Providing efficient and financially sustainable services													
2a	Have 'zero waits' to access our services	% patients discharged within 24 hours of PDD	Chief Operating Officer	Systems unable to capture and report data Unreliable or inaccurate data Poor engagement with setting PDD Internal systems not efficient to support timely discharge	Corporate risk ID 4176 - Planned care demand (High)	CQC Effective	Urgent and Emergency Care Improvement Programme - workstream 4, Ward Processes and 5, Discharge and Partnerships Daily review and overview by operational services Delivering Productive Services Group	Specialty Governance Data Quality Issues New reporting metric	Data Quality workstream PRM Roll out of the TOM in line with the governance framework	Monthly Delivering Productive Services report Urgent and Emergency Care Improvement Programme update IPR	Reporting shows legitimate amendments made to dates of predicted discharge generate an artificially positive position at times.	Additional reports showing where dates have been amended are being produced, to complement the indicator and show where further improvement is required.	Finance, Performance and Estates Committee	R
2b	Ensure that our services are sustainable on a long-term basis i.e. here to stay	Delivery of Financial Plan £70.3m deficit	Director of Finance and Procurement	Efficiency schemes do not cover extent of savings required - £25.6m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure or financial penalties Failure to secure all income linked to coding or data quality issues Failure to secure contract income through backlog and repatriation schemes and inability to remove cost Activity exceeds contracted levels over and above repatriation and fails to secure all income due from commissioners	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very high)	CQC Well Led CQC Use of Resources	Financial Turnaround Group (FTG) oversight of FRP Vacancy control process Centralised agency team Financial Strategy and Annual Financial Plan Performance Management Framework Delivery of output of Clinical Service Review programme System wide savings plan Internal Audit: Finance efficiency programme - Q2 Performance Management and reporting - Q3 Education Funding - Q1	Reliance on temporary staff to maintain services, at increased cost Operational ownership and delivery of efficiency schemes, workforce reduction in particular Clinical coding & data quality issues Operational ownership of income at directorate level Lack of control over local demand reduction initiatives	Recruitment & retention initiatives to reduce reliance on temporary staff Income improvement plan for each directorate Engagement with commissioners through system wide contract management framework Improved reporting in to divisions System savings plan and delivery group Performance review process refresh through new operating model	Monthly Finance Report to Trust Board including capital and contracting FSM meetings with NHSI Scrutiny and challenge through Finance, Performance and Estates Committee Internal Performance Review Meetings Internal Audit work reports IPR System Wide NHSE&I Performance and Escalation Meeting			Finance, Performance and Estates Committee	R

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
		% of services rated as 'delivering' *Note: 2019/20 is baseline year. % not in place, working through baseline in draft, scrutiny and road testing criteria and application, scheme of delivery and devolution* *Baseline analysis of how to manage classification of service performance - 3 levels*	Director of Finance and Procurement	Lack of capacity to establish a robust programme of work Lack of focus and attention - not nationally required, externally driven - alternative pressures	None	CQC Use of Resources	TOM Operational Group TMG Delivery Proposal taken and agreed at TMG to set baseline 6 month shadow running Internal Audit: TOM Governance - Q4	Aligned to revision to national standards 20/21 Report on milestone plan Triumvirate Plan Signed off proposal at TMG	Tracking national developments Developing shadow running of national standards as they become clear Trust Operating Model Operational Group Debate on metrics across the CBUs/Divisions Project management plan with milestones being met	FPEC Updates TMG Updates	Process not in place currently, no plan and milestones	TOM Implementation to develop and agree service rating scheme for formal agreement at TMG	Finance, Performance and Estates Committee	
SO3	**Providing services by staff who demonstrate our values and behaviours**													
3a	Have a modern and progressive workforce	Vacancy fill rate	Director of HR&OD	Inability to recruit and retain a suitably skilled workforce to meet demand resulting in unplanned and indefinite closure of multiple services across the Trust Failing to reduce high vacancy rates of consultants, doctors and registered nurses Reliance on deanery positions to cover staffing gaps Significant proportion of workforce approaching retirement age Inadequate workforce planning process	Corporate risk ID 4362 - Workforce capacity & capability (Very high) Corporate risk ID 4082 - Workforce planning (High)		People Strategy and Annual Workforce Plan Recruitment and retention strategies People management policies & procedures Vacancy controls Agency cost reduction plan Access to workforce business intelligence Core learning & leadership development programmes Internal Audit: Temporary Staffing Recruitment - Q3	Impact of Brexit on staff from EU countries Capacity within the business to support the process Shortage of sufficient numbers of staff in key areas, impacting on vulnerable services and potential risk to maintain safe services Talent management + succession planning arrangements Age profile of the clinical workforce Accuracy of all workforce information	Focus on nursing & medical staff engagement & development to reduce attrition Review approach to recruitment to deliver at greater pace and scale Communication & engagement with EU staff & their managers Development of sustainable service model + new roles Talent Academy to develop new entry and development pathways NHSI Retention Project Review of age profile & People Strategy to mitigate impact	People Strategy Additional resourcing support Staff survey results Data on effective application of people management policies Absence management arrangements in Trust GMC Surveys Data quality work	Medical capacity planning Delivery of People Strategy Workforce planning	Reviewing progress with Trust Management Group Completion of more detailed action plans Agreement of revised People Strategy and workforce plans	Workforce, OD and Transformation Committee	**R**
3b	Work as one team	Recommend as a place to work in staff survey 46% (↑ of 5%) Recommend as a place to receive care in staff survey 53% (↑ of 5%)	Director of HR&OD	A fundamental loss of workforce engagement which could result in a culture of low morale and motivation that impacts on the quality & safety of services throughout the Trust and permanently damages its reputation	Corporate risk ID 4083 - Workforce engagem ent (High)		Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: -Engagement of staff in 5-Year Strategy -Opportunities for staff voice to be heard -Work on staff charter and values -Leadership and management development Staff charter and vision and values People management policies, systems, processes & training Management of organisational change policies & procedures Inclusion strategy Quality Account Priority 2 Internal Audit: Policy compliance - Q2 Mandatory training - Q2	Consistent quality of local leadership and management Staff engagement and belief in 5-year strategy as means of bringing improvement 2018 Staff Survey suggest gap between individuals and Trust around belief that patient care is most important	Localised divisional action plans in response to staff survey results Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose Leadership and management development programmes Revamp of communications around 5-year strategy and direction of travel Trust-wide response to staff survey results to inform revised People Strategy	CQC report Workforce Committee KPIs including vacancy rates, appraisals, turnover, core learning, agency usage Pulse survey Staff Survey Quarterly FTSU Guardian report to Board Staffside representative feedback Report on application of people policies - Sickness absence, disciplines, grievances TB FTSU Self Assessment IA Review Public Sector Equality Duty	Guardians of Safe Working Divisional management teams, completing engagement work with staff Bullying and harassment scores are a concern, particularly for BAME staff Lack of evidence of improvement in scores around quality and consistency of leadership	Development of alternative to deliver Guardians of Safe Working responsibilities FTSU champions Review Divisional management teams through PRMs Project underway to understand causes of scores on bullying and harassment - initial survey and focus groups to gather intelligence - actions to follow Review of approach to leadership development, with additional actions to follow e.g. coaching, 360 appraisal and middle manager forum	Workforce, OD and Transformation Committee	**R**

United Lincolnshire Hospitals NHS Trust

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO4	**Providing seamless integrated care with our partners**													
4a	Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration	% reduction in face to face contacts in Outpatients 5% (Responsibility for the metric delivery sits with the Chief Operating Officer)	Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable Poor system working No single system plan	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive CQC Well Led	1st line Activity monitoring Activity plan Contract Improvement project System plan delivery System Performance Report to SET STP/SET/LCB infrastructure ASR Single system plan ICC development programme 2nd line: ICS Development 3rd line: NHS ICS Maturity Index Internal Audit: STP Governance - Q2	ASR - capital limitation System delivery method not yet mature	ASR being refreshed for resubmission System wide SROs appointed and delivery framework being established	LCB Oversight SET CEO Updates at Board Healthy Conversation		Being developed for going live in July 2019	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

The Trust Board has assigned each strategic objective of the 2021 Strategy to a lead assurance committee. Outcomes under each strategic objective are aligned to a lead committee or reserved for review by the Trust Board.

The process for routine review and update of the BAF is as follows:

- The corporate risk register is maintained by the lead executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from committees
- The lead assurance committee (or Trust Board, where applicable) reviews the management of risks to each required outcome(as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by executive leads
- The lead committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each committee will receive regular reports from specialist groups, executive leads and other sources which provide management information and analysis of relevant key risks, to enable the committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to committees should first have been reviewed and approved by the executive lead.

When deciding on the assurance rating for each outcome the following key should be used:

Effective controls may not be in place and/or appropriate assurances are not available to the Board

Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Agenda Item

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner Trust Secretary
Date:	1st October 2019
Essential Standards:	

Title:	NHSI Board Observations and Action Plan

Author/Responsible Director: Jayne Warner, Trust Secretary

Purpose of the Report:
To share the NHSI Board observations and agree actions with Trust Board.

The Report is provided to the Trust Board for:

Decision		Discussion	
Assurance	X	Information	X

Summary/Key Points:

NHSI carried out an observation of the July Board meeting and provided feedback. An action plan has been developed and this will be reviewed at a future Board meeting to ensure all actions have been addressed

Recommendations:

- The Board are asked to note the NHSI observations and agree actions to address.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR) N/A

Assurance Implications

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review?

Board and sub-committee observation template

Trust	United Hospitals Lincolnshire NHS Trust (ULHT)
Date	2nd July 2019
Observers	Janet Driver (Senior Clinical Manager) and Pete Burdett (Senior Delivery and Improvement Lead)
Meeting observed	Public Board and Private Board

What worked well

General
Meet and greet of public and staff by the exec and non-exec teams was a welcome segway into the meeting.
The meeting commenced on time.

Public Questions – Were taken in line with Trust on line instructions.

Certificates of achievement – awarded by chair to ward sister. Positive reinforcement of quality importance through the Trust.

Chair – made good links to strategic objectives of the Trust and to work that is outstanding for the Trust. Gave good challenge to drive work forward and instructed non-execs to oversee progress.

CEO - New CEO will provide written reports in future which will bring a positive change to the CEO reporting process to Board. Good introduction of his leadership style (2nd day in post).

Horizon scanning – LTP implementation and Primary care networks and system finance etc with good explanation to public about what these mean and what they mean for the Trust and system. Good links to NHSE/I.
Opportunity given to Board members to question CEO.
Non-exec questioning putting quality and safety first. – robust answer from CEO linking quality and other priorities firmly placing patients first.
Good link to strategic plan by chair in response to question.
Question from health watch member – clear answer from CEO with his vision for integration in partnership with other health and social care colleagues.

Patient story
Good introduction by chair of the value and need for Board to be in touch with staff. Good summary linking the presentation content to Trust vision and values.
Non-exec link to smoking cessation. Good evidence of knowledge of challenges around the pathway and impact on women.
Good management of the questions by the chair. Thanks, summary and offer of the Boards help.

Break built into agenda to allow the execs to manage any press/distressed patient or to praise staff following the patient story is a positive.

Prompt bring back to meeting.

QSOG - Paper taken as read. Highlights provided. Link to BAF agenda items. Need to move to outcomes-based report noted. Good summary by the chair and link to the new CQC findings and the need for the Trust to get a better report on the improvement plan given the repetitive nature of issues.

Letters from CQC- Each point raised by CQC highlighted with the Board position on each point highlighted and areas that the Board now need to focus on if the information was new. Finished with positive points raised by the CQC letters.

Good Non-exec challenge to Board about concerns that had previously received assurance around and reference to model hospital data and Trust position against those stats.

Good management of questioning process by Chair.

CEO highlighted to the team on use of initials that he is not familiar with. See areas to improve.

Chair allocated actions to the execs following the discussion.

Finance Assurance and risk reports- Good summary and evidence of actions but pace and momentum also highlighted as an issue.
2 key areas to escalate to Board.
Links to other strategic committee work made.
Links to assessment of risk by extension of fire work – detailed response and reassurance given by exec.

Good chair summary

People Strategy - Summary of content of the strategy by Chair. Note that it is a refresh using national and local evidence and feedback.
Taken as read.
Performance measures highlighted.
Good challenge in the non-exec discussions regarding what is different this time, lack of transformation of workforce and of plans to deliver the strategy. Deputy Director of HR outlined that a detailed workforce plan had been submitted as part of the planning process, but the board had not received it.
Chair rephrase of question to make clear.
Good reflections from chair and CEO at the end of discussions.

Chair summary –Takeaway message reflected.

Continuous quality improvement strategy - Link to strategic objectives made.
Summary given.
NED request to link the work to Board stories.

Size of the document was critised and challenged by Non-Execs and this was accepted by the Exec Team
Good challenge around the upscale of QI raised.
Chair – summary and celebration of progress.
CEO – Reflection that there needs to be a system QI approach.

Integrated Board report – Exec summary highlights given.
Chair bringing in other execs to comment on their areas of responsibility.
CEO reflection on need to highlight positive stories in Trust.

Risk register report - Key new risk discussed with explanation of mitigation.
NED commentary on out of date risks on the RR and narrative around risks.
Chair reflected slow movement of risks on the risk register.
Agreed action by chair and reflection of the executive ownership of the risks.

BAF - Chair discussion of scorings and reason for score and assurance received against each risk.

Challenge to scores made and change to score given.

Board strategic priorities – Good evidence of scrutiny at PRMs using True North Methodology.

Board forward planner - Recognition that safeguarding report was not presented which was a deviation from planner.

Private Board

Timely reconvene

Actions- Good management of discussion by Chair to ensure discussion is held at relevant point in meeting.

CEO report – CQC Section 31 and section 29a discussed.

Good NED data challenge between board papers and CQC and reflection that there needs to get single truth.

NED link to future engagement event for paediatrics and risks that the letters pose. Captured action for use of comms in that meeting.

Positive reflection that executives need to drive the response and work.

Patient safety incident report - Paper highlights given.
Chair of committee asked if the Board need more detail. Good demonstration of evolving safety and reporting culture.

NED challenge to NED re work in the risk and quality meetings.

Finance - Report presented.
Agreed to take each section of finance at a time to allow questioning. Good clear explanations.

Some good challenge from the Chair and the Non- executives.

Chair refocus of 'patients' waiting not targets or finance. Positive reminder to the meeting of need to keep the patient at the forefront of minds.

Link to model hospital and need to transform workforce.

Request from NEDS for greater detail.

System working for 19-20 - Progress report highlight provided.
Good evidence of system change and progress.
Questions addressed through the chair.
Need to build relationship and assurance mechanisms with system partners.
Link to non-delivery of trust programs.

Meeting - Closed on time

Reflections of meeting

- NED challenge about content of private board vs public board.
- NED challenge re Grantham site
- Directors should be available to present their own documents.
- Use of electronic system for board reports
- Public question felt sterile – happy to change (see areas for improvement)

What didn't work well

Public questions -The meeting commented that the public questions section of the meeting felt 'sterile' which a good reflection of how this section of the meeting was felt from the audience

- Some answers appeared to be read out from a briefing paper from the Executive which did not feel engaging nor heartfelt.
- Whilst the public questions were taken in line with the Trusts directions on the website, the ability for the public to raise their questions and to respond to the executive's answers felt very limiting.

The Trust may like to consider how to soften this section of the meeting.

Use of names and acronyms – During both the public and the closed Board meetings there was a high use of acronyms and people's names i.e. Reference to Dale

Defensiveness or reluctance to accept challenge – In a few sections of the meetings, when discussing CQC findings, members of the executive reflected on the reasons that the CQC found concerns in the paediatric pathways. These reflections included lack of organisational memory and new divisional teams not being able to describe the pathways.

These comments felt defensive and appeared to give an impression that the executives did not consider that the CQC found real concerns. The executive should consider how these comments are heard and interpreted by the public.

Action log - Feedback on progress of actions taken during meeting. The Chair may like to consider items which are completed to be brought together prior to the meeting. Not all of the actions were clear for the public to follow, e.g. 919/19 review of 15 steps. Some actions were outlined to have been completed but no detail provided.

Workforce Strategy – The strategy received a great deal of negative feedback during the meeting and was not accepted, leaving a need for pace to set the strategy. Given the amount of feedback the Chair should consider if the strategy should have come to Board for ratification. There is a need to strengthen the governance systems prior to presentation at Board.

Planning –It was clear that the Board had not received the workforce plan submission. All planning submissions should be scrutinised and approved by the Board.

Patient safety incident report – The need for staff to understand significance of incidents and regrading them was made and a link made to CQC commentary however there were no actions agreed on how this would be taken forward.

Integrated Performance Report - The scrutiny of the delivery of the Trust main KPI's was not as strong or detailed as expected, given the continued non-achievement of constitutional standards.

Length of the Agenda – Due to the length of the agenda there was not enough time available towards the end of the public section of the meeting to allow for detailed discussion to take place on each of the agenda items.

<u>What needs to be improved</u>

Overall both meetings were run effectively with papers taken as read and good highlight reports given. There was a good balance of challenge and praise throughout the meetings and participation for all.

The Chair was effective in the management of the meetings and all questions where managed through the Chair.

Effective summarisation of discussions was made at the end of each topic.

The Board should consider the 'what didn't work well' section for improvements.

	Recommendation	Trust Proposed Action	Completion Date	Lead
1	Public Questions felt sterile how to soften	Review of arrangements in place in other outstanding and challenged Trusts to identify any elements of best practise which could be introduced. Paper with recommendations to go to Board	Nov 2019	Chair/ Trust Secretary
2	Answers to questions read out from briefing paper not engaging or heartfelt	Execs to consider their delivery of responses to questions and where they are present make response more directly to member of public	Immediate	Exec Directors
3	No ability for the public to respond to the responses given to their questions	Trust to review published arrangements for questions and consider the right to reply on responses to public questions. Noting • Questioner not always present • Time limit currently in place. Some meetings volume of questions has been much greater.	Nov 2019	Chair/ Trust Secretary
4	Use of people's names and acronyms	Board Members to keep this in mind during verbal delivery of papers Trust Secretary to complete sweep of papers and minutes to ensure all acronyms are fully explained.	Immediate	Board Members/ Trust Secretary
5	Defensive response or reluctance to accept challenge	Board Development?		Exec Directors
6	Consider action log items which are completed to be brought together prior to the meeting	Query?		Trust Secretary
7	Greater clarity of action for the public to follow	Trust Secretary to review all existing actions to ensure enough clarity on meaning. Greater detail provided for future actions	Immediate	Trust Secretary
8	Greater detail where actions are marked as completed	Trust Secretary to ensure greater detail provided for all completed actions	Immediate	Trust Secretary

9	Issues relating to workforce Strategy – should strategy have come to Board need to strengthen governance systems prior to Board presentation	Workforce strategy had previously been agreed by the Workforce, OD and Transformation Committee. Actions to be taken to strengthen assurances received at Committee. Chair to attend meetings going forward. Continue to review all board agenda items prior to inclusion to ensure Exec Team oversight and appropriate Committee review.	Immediate	Chair/ Trust Secretary
10	All planning submissions should be scrutinised and approved by the Board	Planning Submissions to be identified by all Exec leads and advised to Trust Secretary for inclusion within Board Forward Planner and Committee schedules	Nov 2019	Exec Dir/ Trust Secretary
11	Patient safety incidents no action agreed about how to ensure staff understood the significance and grading of them	One off item where an action not captured. Chair to continue to monitor discussions to ensure actions captured where challenges are raised.	Immediate	Chair
12	Scrutiny of delivery of main KPI's not as strong or detailed as expected given non achievement of constitutional standards	This should be picked up through FPEC upward report. Does the FOEC report need developing to emphasise this more? Consider whether need separate escalation report?	Nov 2019	Chair/ COO
13	Length of agenda to allow time for discussions on all items	Continuous review of items included on agenda to allow management of time	Immediate	Chair/ Trust Secretary

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER

[2019/20]

	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020									X		
BAF Sign off for 2019/20	X									X	
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
NHSI Board Observation Actions						X			X		
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											

Finance, Performance and Estates Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Financial Plan and Budgets										X	
Clinical Strategy Update					X					X	
Operational Plan Update					X		X		X		
Emergency Planning Annual Self Assessment					X						
SO 3 Providing Services by Staff Who Demonstrate our Values and Behaviours											
Workforce, OD and Transformation Committee Assurance and Risk Report	X			X		X			X		X
Staff Survey Results											X
Freedom to Speak Up Report	X			X			X			X	
Report from Guardian of Safe Working		X			X					X	
Equality and Diversity Strategy		X									
5 Year Strategy	X			X			X		X		X
SO 4 Providing Seamless Integrated Care with our Partners											

Agenda Item 19

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Anna Richards
Date:	1st October 2019

Title:	Innovation Report

Author/Responsible Director: Anna Richards, Associate Director Communications and Engagement/ Andrew Morgan Chief Executive

Purpose of the Report:

To update the Trust Board on innovative work within the Trust.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	√

Summary/Key Points:

First day case hip replacement carried out at Grantham hospital

Patients needing planned hip replacements at a Lincolnshire hospital can now be operated on and return home the same day, thanks to an innovative new way of working.

The ground breaking procedure is part of United Lincolnshire Hospitals NHS Trust's (ULHT) trailblazing trauma and orthopaedic 'hot and cold' site trial – with emergency/unplanned (hot) orthopaedic surgery carried out on one hospital site and elective/planned (cold) orthopaedic surgery on another.

As part of the trial, the first day case hip replacement has recently taken place at Grantham and District Hospital, with the patient being admitted at 7.30am for surgery and then discharged home just over 12 hours later.

Day case surgery of this kind is dramatically reducing the overall length of stay for patients at Grantham, resulting in improved efficiency, better use of hospital resources and most importantly, better patient experience.

Carried out by Consultant Surgeon Mr Rohit Rambani, the hip replacement

procedure took just over half an hour to carry out, with the patient back on the ward soon after for assessment by the physiotherapy team and supported home with an appropriate care package by early evening.

It is hoped that more day case hip replacement procedures can take place over the next few months as the orthopaedic trial continues to go from strength to strength.

Launched a year ago, the trial was initiated by the Getting It Right First Time (GIRFT), national clinical improvement programme, which works with NHS trusts to tackle unwarranted variation in the way services are delivered.

In addition to reduced lengths of hospital stay, other benefits to separating emergency and planned procedures in this way include improved infection rates and less pressure on emergency beds.

Chloe Scruton, Deputy General Manager for Trauma and Orthopaedic Surgery at ULHT said: “We are very proud of the success of the hot and cold site reconfiguration. We had clear expectations of the benefits we wanted to achieve from the trial and are delighted with the positive results we’ve had to date.

“We continue to push the boundaries, striving towards becoming a centre of excellence for orthopaedic surgery.

“One of our many successes is the reduction in length of stay for total hip replacements by 2.5 days and we have been able to push ourselves even further now, to achieve our first day case hip replacement, providing an excellent patient experience.

“None of this could have been achieved without the fantastic ’can do’ approach demonstrated by all of our Trust wide orthopaedic team members.”

This first day case hip procedure at Grantham follows similar operations launched at Pilgrim hospital last year, where some ankle replacement surgery can now be carried out as day cases.

Recommendations:

For Trust Board to note the Innovation report.

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