Bundle Trust Board Meeting in Public Session 3 December 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 09:20 - Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 09:35 - Minutes of the meeting held on 5 November 2019
Chair
Item 3 Public Board Minutes November 2019 v2.docx

6 09:40 - Matters arising from the previous meeting/action log
Chair
Item 6 Public Action log November 2019.docx

7 09:50 - Chief Executive Horizon Scan Including STP
Chief Executive
Item 7 Chief Executive's Report.doc

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

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

9 10:40 - BREAK

10 Strategic Objectives

11 Providing consistently safe, responsive, high quality care SO1

11.1 10:55 - Assurance and Risk Report Quality Governance Committee
Liz Libiszewski
Item 11.1 QGC Upward report November 2019 v1.doc

11.2 11:10 - Patient Safety Report
Medical Director
Item 11.2 Patient Safety Incidents Report - November 2019.docx
Item 11.2 Appendix I - Patient Safety Incidents Dashboard - November 2019.pdf

11.3 11:20 - Ward Accreditation
Director of Nursing
Item 11.3 Ward Accreditation board update Dec 19.docx.doc
Item 11.3 Ward Accreditation board update Dec 19.docx

12 Providing efficient and financially sustainable services SO2

12.1 11:30 - Assurance and Risk Report Finance, Performance and Estates Committee
Gill Ponder
Item 12.1 FPEC Upward Report November 2019 v1.doc

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

13.1 11:45 - Assurance and Risk Report Workforce and OD Committee
Geoff Hayward
Item 13.1 WODT - Upward Report -November 2019 v1.doc

14 Providing seamless integrated care with our partners SO4

15 Performance
Director of Finance and Digital

15.1 12:00 - Integrated Performance Report

Item 15.1 Integrated Performance Report - Trust Board Final.pdf

16 Risk and Assurance

16.1 12:10 - Risk Management Report

Item 16.1 Corporate Risk Report - November 2019.docx

Item 16.1 Appendix I - Very high & High Corporate risks - November 2019.pdf

Item 16.1 Appendix II - Very high & High Operational risks - November 2019.pdf

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

16.2 12:20 - Board Assurance Framework 2019/20

Trust Secretary

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

Item 16.2 BAF 19-20 v26.11.19.xlsx

17 Strategy and Policy

18 12:30 - Board Forward Planner

Trust Secretary
For Information

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

19 12:35 - ULH Innovation

Assistant Director Communications
For Information

Item 19 Innovation report - December.doc

20 12:40 - Any Other Notified Items of Urgent Business

21 The next meeting will be held on Tuesday 4 February 2020 - There is no Board meeting in January

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 5th November, 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
Miss Victoria Bagshaw, Director of Nursing
Mr Paul Matthew, Director of Finance and Digital
Mr Geoff Hayward, Non-Executive Director
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Chief Operating Officer

Non-Voting Members:
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
Ms Cathy Geddes, Improvement Director, NHS Improvement
Ms Michelle Harris, Deputy Director of Operations – Item 13.3
Ms Saumya Hebbar, Organisational Development Lead – Item 20

1646/19	**Item 1 Introduction** The Chair welcomed members of staff and public to the meeting and introductions were made.
1647/19	**Item 2 Public Questions** **Q1 from Alison Marriott** **When will the Pilgrim neonatal unit be officially allowed to keep babies from 32 weeks gestation please? And is this dependent on Lincoln County neonatal unit being able to care for babies from 27 weeks gestation? (If so why?)** The Medical Director responded: Discussions would be held at a future Board however it was planned that Pilgrim would be able to allow admissions at 32 weeks gestations, this would be supported by the Commissioners. The Family Division continued to work with consultant to ensure that this would be done safely. The Medical Director advised that the changes at Pilgrim Hospital were not dependent on the neonatal unit at Lincoln County Hospital.

Q2 from Jody Clarke

Looking at the latest CQC results and for us in Grantham, it's upsetting to see that our "Good" rated services are inaccessible to us overnight and the only other 2 "in county" are still struggling to provide safe care, regardless of 2 years of special measures. Making us feel that our only option for safe care, is to go out of county, which doesn't help your financial situation.

So my question is, with the focus being mainly on Lincoln and Boston, what efforts have been made to improve the "areas of concern" for Grantham? (See below)

"There was not a robust system in place for checking availability of life saving equipment.

We found staff had not checked resuscitation equipment in line with trust policy. Several single-use items in the paediatric resuscitation trolley were out of date.

There were not sufficient numbers of children's nurses in the department and four out a possible 20 (20%) adult nurses had completed paediatric competencies.

There were insufficient numbers of nurses and doctors trained in paediatric resuscitation.

Nurses and doctors told us the department was not big enough for the number of patients now accessing the department. We saw doctors bringing patients into the department to cubicles, which were already in use. There was no dedicated receiving area for patients arriving by ambulance.

Staff allocated ambulance stretchers to the corridor until a cubicle was available. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.

Patients could not always access the right care at the right time due to the department's overnight closure, especially those with urgent care needs.

There was a mixed morale amongst staff in the department, some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight. Some said they liked it as staffing levels had improved during the day. Consultants said morale was low; they felt they were unable to provide the service they wanted to the local population of Grantham."

The Director of Nursing responded:

Grantham Urgent and Emergency Care department was not inspected during the latest inspection at the Trust, the areas of concern referred to relate to the previous report received by the Trust.

The Trust have in place a comprehensive programme led by the Chief Operating Officer and Grantham would form part of this. The Trust have in place a robust accreditation programme and progress continues to be made against the programme. Within the programme specific lines of questioning were developed to address the concerns raised in the CQC report.

Q3 from Liz Wilson

	When the Board closed Grantham A&E "temporarily "overnight in August 2016, it indicated that once it reached the required number of doctors – 22 – to run the service safely, it would re-open . What is the current position regarding the number of doctors, and if the required number has been reached, why has the A&E not been re-opened 24/7? The Medical Director responded: The current numbers of staff within the Emergency Department at Grantham include 2 Locum Doctors and 6 Junior Doctors, 3 of who are Locums. The number of Doctors at the site remains low however the establishment had been increased to respond to the level of demand. The Trust remains reliant on a number of Locum Doctors within the service although there had been some recent success in overseas recruitment. The long term plan for Grantham continues to be discussed through Healthy Conversations and the public were encouraged to use the process to provide feedback and influence the outcomes.
1648/19	**Item 3 Apologies for Absence** There were no apologies for absence
1649/19	**Item 4 Declarations of Interest** There were no declarations of interest that had not previously been declared
1650/19	**Item 5 Minutes of the meeting held on 1st October 2019 for accuracy** The minutes were agreed as a true and accurate record subject to the following amendments: Mrs Libiszewski was recorded as present in the minutes but had given apologies to the October meeting, note apologies. The Director of Nursing should be recorded as Miss, not Mrs. 1492/19 – Should read – The Committee received an update on the level of carbon savings not being met in respect of the energy performance contract 1498/19 – Should read - The Chief Operating Officer advised that the A&E Clock Stops had been a specific issue following the introduction of GP Streaming. A number of patients had not been recorded on the clock stop for the point of access at GP streaming but rather on their return to A&E. 1521/19 – Should read – The Committee noted that the plans had been risk rated but the challenge remained that this had not been fully completed. 1538/19 – Should read – These gave the opportunity to suggest improvements e.g. to address the concerning national data recently in relation to maternal deaths for black mothers.
1651/19	**Item 6 Matters arising from the previous meeting/action log** 827/19 – Assurance in respect of Health & Safety actions reported to Finance, Procurement and Estates Committee (FPEC) - Assurances included within FPEC upward report at item 13.1, complete

	884/19 – National urgent care pathway changes – No national update had been published item deferred to 3 December 2019 1016/19 – Care Quality Commission (CQC) Feedback letters June 2019 – Revision to Quality and Safety Improvement Programme. The Chief Executive advised that this was underway and would be discussed at Item 9 on the agenda - Complete 1186/19 – Quality Governance Committee (QGC) Assurance report - Proposal to increase frequency of window cleaning considered at CRIG in October, required additional information. Update at December QGC meeting. 1317/19 – Board Assurance Framework - As an interim measure Board agreed the Lincolnshire Commissioning Board system report would be circulated to Board members as an addition to the minutes. Circulated 22 Oct 2019, complete 1443/19 – Matters arising/action log - Circulated 22 Oct, complete 1503/19 – Workforce, Organisational Development & Transformation Assurance Report – Agenda item, complete 1545/19 – Equality, Diversity and Inclusion (EDI) Annual Report – Referred to System Executive Team for discussion in November. Also picked up at NHSE/I review meetings, complete 1573/19 – Smoke Free ULHT – Communications plan reviewed, complete 1638/19 – Board Assurance Framework –Update of narrative - Complete
1652/19	**Item 7 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board detailing both system and Trust specific issues. **System Issues**
1653/19	The Chief Executive advised that an additional item for inclusion in the report was the recently announced general election. Purdah guidance was awaited by the organisation but would cover the period from the dissolution of parliament through to the forming of the new government. The Trust approach would be that public discussions would take place in line with nationally agreed approaches for public bodies during the purdah period. This could have an impact on the discussions that could be held by the Board during the December meeting.
1654/19	The Trust continue to fulfil its responsibility towards the EU Exit following the extension of the exit deadline.
1655/19	The Trust and wider system continues to be under scrutiny regarding Accident and Emergency performance with fortnightly meetings being held with the National Clinical Director. The Trust had improved against the national league table for performance however scrutiny continues due to ambulance handover performance. The Chief Executive advised that as the Chair of the Urgent and Emergency Care Board there was a system wide focus to find solutions. The Long Term Plan continued in the draft phase however the anticipated publication date of December would not be possible due to purdah, this would alter timescales.

1656/19	Work continued with colleagues at the County Council and within the voluntary sector on the development of the Integrated Care System. The Development Plan required preparing and a joint working executive group had been established in order to progress the work.
1657/19	Development of the Count Councils Corporate Plan was underway with NHS Partners being asked for views on the plan, these would be fed through the System Executive Team and Lincolnshire Coordinating Board.
1658/19	NHS England/Improvement had now approved in principle the establishment of a single Clinical Commissioning Group for Lincolnshire which should be in existence from 1 April.
	Trust Specific issues
1659/19	The year to date financial position at month 6 was that the Trust continued to have significant underlying financial performance issues. A large amount of work would be required over the remaining 5 months of the year in order to achieve a year end position which was close to the planned yearend total.
1660/19	The Board welcomed Cathy Geddes, Improvement Director who had joined the Trust to provide support whilst providing assurance back to NHS Improvement that the Trust were making the required changes and improvements to address the issues highlighted in the CQC report.
1661/19	The interviews for the Director of Finance and Digital were due to take place on 14 November with the Director of Nursing interviews scheduled for mid-December.
1662/19	The Trust had been informed that it would be possible to bid for capital funding to replace imaging equipment. Work was underway to identify if the Trust had any equipment suitable for replacement and would work with NHS England/Improvement to access the capital funding.
1663/19	Efforts continued to create an improved and more productive working relationship with Staffside colleagues with a view to updating the recognition agreement that was in place. There was a need for a clear consultation and negotiation process to be agreed. It would be important to have a constructive relationship in place as the involvement of Staffside in improvement actions would be essential for the organisation to recover performance.
1664/19	Discussions recently held with Staffside had resulted in changes being made to staff parking charges, from April 2020 these would be reduced by half. It was clear that the funding received through the charges would be visibly used to improve the parking conditions. Conversations had commenced regarding 'Big Conversations' specifically in relation to a new travel plan for the Trust, parking was to be considered as part of this alongside addressing green travel issues.
1665/19	The Staff Survey was live and staff were being encouraged to complete the survey, the Trust rely on feedback in order to make improvements.
1666/19	The Trust had become a menopause friendly employer and the Chief Executive gave an opening speech at the conference launch, this was a positive move for the organisation.
1667/19	The Trust had become the first in the county to be accredited by The Academy of Fabulous Stuff.

1668/19	The Director of Human Resources and Organisational Development advised the Board that there had been 29% completion of the staff survey to date, compared to the same time last year which had seen 24% completion. The Trust remained below the national average currently but work continued with Communications to promote the survey. Facilities were also being made available to staff to support the completion of the survey.
1669/19	Dr Gibson raised the issue of the Big Conversations and asked if it would be possible to feed back to the Council the difficulty of travelling across Lincolnshire. It was confirmed that this was one of the big factors being discussed regarding travel and the ability to access transport.
1670/19	Discussions were being held with Councils about how NHS systems align with County Council plans, work was underway to build and improve communication with the Council.
1671/19	The Trust Board: • **Received the report**
	Item 8 Patient/Staff story
1672/19	Deborah Birch, Consultant Nurse for Frailty attended the Board to present her staff story.
1673/19	Ms Birch attended a patient at Accident and Emergency in April, the patient was an 85 year old gentleman with dementia. The patient had absconded from his care home the previous day and police had brought him to the A&E department due to potential injuries from landing on concrete.
1674/19	During his attendance at A&E the patient decided to leave, the staff were not about to stop him from going however Ms Birch accompanied the patient to ensure no harm came to him.
1675/19	The police were alerted to the fact that the patient had left however he was not deemed a high priority as he had a healthcare professional with him. He had also been removed from the A&E system this resulted in the patient being lost in the system. Ms Birch managed to escort the patient back to the hospital after a number of hours.
1676/19	Ms Birch had undertaken her duty of care to the patient but felt that there had been no duty of care from the organisation to herself. The requirement under the duty of care policy states that once a patient leaves the premises they become the responsibility of the police. In this instance this was not the case as Ms Birch was with the patient who then became a low priority to the police.
1677/19	As a result of the incident the Trust policy was now under review. The police had also acknowledged the learning from the case.
1678/19	The Chair thanks Ms Birch for her professionalism and personal resilience in the situation. The Chair acknowledged that the organisation had failed in their duty of care to Ms Birch and this was not acceptable. Staff stories were presented to the Board in order to learn from experiences. It was clear that following the incident learning was being undertaken on a multi professional basis.
1679/19	Whilst the policy was under review the Board requested assurance that staff who went off site during their shift were tracked. **Action: Chief Operating Officer, 3 December 2019**

1680/19	The Director of Nursing thanked Ms Birch for sharing her experience and noted the need for better alignmentbetween agencies. A wider piece of work would be conducted to offer the opportunity for staff to share stories with each other and to take learning from them. This would need to be addressed from a multi-professional view point.
1681/19	Mrs Libiszewski stated that if the care system had worked the patient would not have needed to present to A&E in the first instance. There was a need to learn across the system in order to prevent inappropriate access to services.
1682/19	The Chief Executive would raise the issue with the Urgent Care Board to determine how learning for the experience could influence service development to avoid unnecessary admissions to A&E.
1683/19	The Board discussed the culture of staff and the experience of Ms Birch on her return in to the organisation following the incident. It was acknowledged that this was not a unique example of how staff treat each other and was not the culture that the Trust were aspiring to. However it did reflect the pressure on staff and the need to work on this as an underpinning element of the organisation being kind to each other.
1684/19	The Trust Board: • **Received the staff story**
	Item 9 Care Quality Commission Report Publication
1685/19	The Chair stated that the report had identified areas of concern that the Trust had been working on for some time including workforce, culture and significant governance issues. Disappointment was expressed that there had not been the expected impact of actions from the improvement journey in response to previous reports from the Care Quality Commission (CQC).
1686/19	The Chief Executive reflected on the report presented to the Board and provided a brief summary of the content. The overall rating for the Trust was Requires Improvement with all domains rated as requires improvement with the exception of Caring which was rated as Good.
1687/19	The Use of Resource report for the Trust was rated as inadequate overall resulting in the Trust remaining in special measures. Activity with the media and stakeholders was undertaken to ensure that the outcome of the reports was communicated appropriately.
1688/9	The Board accepted the findings of the report and committed to the work being undertaken to ensure improvements were made. The Board recognised that actions that had been taken previously had not had the desired outcome and a different approach would be needed to improve the position and performance and ensure improvements become embedded.
1689/19	The Board were pleased with the rating for the caring domain as this acknowledged the commitment of staff to patient care. A number of outstanding areas of practice were identified within the report specifically around medicine, critical care and maternity services.
1690/19	The report contains a number of “must do” and “should do” actions and demonstrates that three services were rated as inadequate. The Board were clear that this was not an acceptable position and improvement would be supported by the Improvement Director. The Trust would move to a single integrated improvement plan that would be reported to the

	Board. The focus would be on delivery of the actions and embedding change in to the organisation. A large part of the change would be in relation to behaviour, culture, and values.
1691/19	The Director of Nursing stated that there was a need to move from improvement in silos to normal governance processes that allowed a continuous improvement journey to be embedded to move the organisation forward. Ownership would need to be through the Trust Operating Model structure with a focus on both the must and should do's identified within the reports. Clear monitoring would be required to ensure the Board had sight of the actions being taken and the impact.
1692/19	Elements of the report would support the development of the Quality and Safety Improvement Plan which would be aligned to the quality strategy and aspirations. This would be aligned to the Board Assurance Committees and sub groups with systematic reporting.
1693/19	This would be driven at a divisional level to ensure that there would be the ability to deliver at a frontline level. The requirement for leadership would need to be recognised, Executive Leads and Senior Responsible Officers for the programmes of work had been identified.
1694/19	Reports would be presented to the Quality Governance Committee and reported to the Board. This would address the areas of improvement required whilst holding discussions about the quality of care in the organisation.
1695/19	Mrs Libiszewski advised the Board that the new approach was about the alignment in to governance arrangements but that the Board would need to take responsibility. There would be a need to change and shift the organisations to a joined up approach.
1696/19	Mrs Libiszewski commented that greater clarity was needed on what the direction of the organisation would be and questioned if there was a need for a single strategy that demonstrated what the Board expected to see and moved away from a number of enabling strategies. There was a need for a shift of emphasis to outcome focused rather than process focused.
1697/19	The Chair agreed that there was a need to simplify and become less bureaucratic with a focus on outcomes and identify the role of the Board and individuals in order to achieve this. Pride and ownership of improvements was needed. Time for the Board to focus on the improvements would be required in line with planning cycles.
1698/19	The Chief Executive concurred that there was a need to simplify the visions and values of the organisations due to the large number of them in place. There would need to be a different approach and learning from other organisations with the ability to tell a simple story to staff and engage them.
1699/19	The Board agreed to use the development session scheduled in November to hold planning conversations and develop the work described by the Improvement Director. There was agreement that in order to progress there was a requirement to engage with staff in a way that enthused them in order for them to work with the Board to see improvements.
1700/19	The Director of Finance and Digital acknowledged that there was always a focus on the finances of the organisations however this was a wider issue that required integration. If the quality was in place the finances would follow.
1701/19	The Chair surmised that the Board were clear about the organisations ambition including the improvement in the CQC ratings and a fundamental review of how services were provided in an organisation that focused on quality improvement.

1702/19	The Board know the direction of travel and the right actions were being taken to improve quality and safety, the framework requires streamlining to ensure this was understood and manageable, with a process through which it could be expedited. The Trust Board: • **Note the CQC report** • **Agreed to the new approach of delivery for the improvement plan**
	10 BREAK
	Item 11 STRATEGIC OBJECTIVES
	Item 12 Providing consistently safe, responsive, high quality care SO1
	Item 12.1 Assurance and Risk Report Quality Governance Committee
1703/19	The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurance received by the Committee at the October meeting.
1704/19	All divisions had been present at the Quality and Safety Oversight Group meeting and had focused on the divisions presenting any issues. The Committee had not yet delegated any reporting to the group so there was an element of double running however this was to ensure that assurance could be provided.
1705/19	There continued to be a reduction in falls and pressure ulcers. Concern was raised by the Committee regarding Medicines Optimisation due to data not correlating with the dashboard, further work was requested to resolve the concerns.
1706/19	A number of medicines issues were discussed at the meeting including the NHS Improvement observation feedback and internal audit report regarding medicines management. An update had been provided to the Committee however this had not provided the expected level of assurance.
1707/19	The Committee received the Lincoln reconfiguration quality impact assessment and noted that staff and patient impact had not been included. The embedding of patient experience and co-production had not been evidenced in the documentation however this did not mean that it was not taking place.
1708/19	An update was received on the work with East Midlands Ambulance Service and the shift of caring for patients and escalation approach for ambulance handover. The process was considered however the quality impact assessment had not been received, this was requested by the Committee.
1709/19	The Committee noted that the risks within the risk register had not been updated and requested that this was received and an update brought back to the Committee.
1710/19	The concerns regarding moving and handling were discussed, the Committee does not lead on health and safety however had been concerned about actions being taken by the Trust from a case 2 years ago. A copy of the report submitted to the Finance, Performance and Estates Committee was reviewed, this created an overlap of the Committees however this had been reviewed in order to ensure there was a true grasp on the issue.
1711/19	The Committee discussed the CQC reports and the initial proposal developed by the Director of Nursing.

1712/19	The Board Assurance Framework continued to be rated amber, the rating would however be reconsidered following the Board discussion and a review of the CQC report.
1713/19	Mrs Ponder confirmed that the Finance, Performance and Estates Committee continued to seek updates regarding training for the moving and handling case. The Committee were satisfied that the recommendations had been addressed however concerns remained regarding the extent to which managers in the organisation followed up the training to exercise their own responsibility for the training of staff using equipment.
1714/19	The Board agreed that the Finance, Performance and Estates Committee would continue to lead on the issue with support from the Director of Nursing.
1715/19	To ensure that the Board were fully sighted on the Lincoln reconfiguration this would be presented back to the Board in December with patient experience reflected. **Action: Chief Operating Officer, 3 December 2019** The Trust Board: • **Received the update**
	Item 13 Providing efficient and financially sustainable services SO2
	Item 13.1 Assurance and Risk Report Finance, Performance and Estates Committee
1716/19	The Chair of the Finance, Performance and Estates Committee, Mrs Ponder, provided the assurance received by the Committee at the October meeting.
1717/19	The Committee were not assured in respect of the Trusts financial position, this had been reported in line with plan however the underlying cost issues, particularly in relation to pay, were a source of concern and risk to delivery of the year end control total.
1718/19	The Committee were alerted to the risk of repatriation activity built in to the financial plan of £5.7m, bed capacity issues were driving down non-elective care, these presented a risk of delivery.
1719/19	The Financial Efficiency Programme had not progressed to delivery, presenting a source of concern. The forecast worst case scenario of £87.7m was presented to the Committee, this figure was unmitigated.
1720/19	Contradictions had been seen in the papers regarding the achievement of the CQUINs, the concerns of the Committee were registered against the £250k non-delivery. Assurance was given during the meeting that all the CQUINs had been confirmed as on track however this was contradicted by a further report that advised of non-delivery.
1721/19	The Committee discussed additional borrowing, there was no capital borrowing during December however the Committee recommended for approval by the Board revenue borrowing of £5.553m.
1722/19	The Committee requested that the Executive Team provide assurance on the Financial Efficiency Plan and the delivery of the control total due to concerns about delivery.
1723/19	Discussions were held regarding reference costs and the completion of job plans. Costs would need to be brought back in line with similar organisations.

1724/19	The Committee received the Financial Strategy, due to be discussed later by the Board, this was presented as a high level narrative paper. It was notes that the strategy required review in light of the CQC use of resources report having been published. The Committee noted that it felt as though the acute services review had been omitted and required inclusion.
1725/19	Discussion had been held regarding 2020/21 planning, the Committee were assured of the process in place but noted concern of the alignment of timescales to the system. The planning process was approved subject to system alignment.
1726/19	The Committee were not assured by the Estates updated with regard to manual handling, the confined space report was received and progress noted against the Health and Safety Executive (HSE) notice. There was evidence of compliance in most areas submitted to the HSE however further evidence regarding rescue training was required.
1727/19	Concern was raised by the Committee regarding the potential cost pressure of £1.5m in relation to security management of lockdown of the fire doors, this would need to be absorbed within future maintenance plans. Fire safety improvement was reported as on track.
1728/19	There had been some improvement shown within critical mechanical infrastructure but a lack of funding had resulted in non-compliance in some areas. The financial view had been that there was a need to invest £12m each year to be fully compliant with all statutory obligations, the reality was the ability to invest circa £4m. The Committee requested that there was a review of all red risks regarding the critical mechanical infrastructure.
1729/19	Progress Housing was noted with previously agreed actions was underway.
1730/19	The Committee received a lack of assurance regarding the Pilgrim Urgent Care Programme and the expansion of the A&E unit. A paper had been received by the Committee to fund upfront consultancy fees for design work. There had however been no clear process for accessing funding from NHS England. The Committee requested clarification of access to funding for all aspects of the delivery of the programme.
1731/19	The winter plan was received by the Committee and it was noted that additional beds would not be opened, nor additional capacity created. The plan had been discussed both regionally and nationally and the approach had been supported. The plan was to maintain 92% bed occupancy. Further work would be completed to include the local council plans once available.
1732/19	The urgent care improvement programme update had shown that the Trust were the 7th most improved organisation in the country with an achievement of 7% improvement, this however had not achieved trajectory. There had been some 52 week breaches and as such the Committee had requested an update on how these would be brought back on track.
1733/19	Cancer services had delivered 3 of the 9 standards in August which was comparable nationally. There had been a reduction in 62 day performance however there had been an improvement in 62 and 104 days backlog. Further information had been requested regarding the improvement programme.
1734/19	The Committee dashboard had provided assurance and there had been a deep dive in to the risk of quality of hospital environment, a PLACE Care Environment steering group was being developed to support the required improvements.
1735/19	A number of updates were identified on the Board Assurance Framework and the assurance ratings were confirmed. The Data diagnostics internal audit was received and regular updates on the actions requested.

1736/19	The Committee referred Time to Hire to the Workforce, Organisational Development and Transformation Committee requesting that the Committee continued to monitor the impact of actions on improving the filling of substantive vacancies.
1737/19	It had been noted that there had been no material change to the corporate or high risks in the operational risk register.
1738/19	The Board commented on the critical mechanical infrastructure noting that there was a need to understand the plan and risks and prioritisation regarding the backlog.
1739/19	The Board also noted the additional cost associated with fire lockdown and this was believed to have been included. It was confirmed that the fire door installation and lockdown would be completed however there was an additional maintenance cost in order to maintain compliance. This had also been the result of lockdown being included within the fireworks after the commencement of the programme of work.
1740/19	Concern was raised that the timescale for completion of the doors and implementation of lockdown would not be met. Confirmation was provided that the timescales reported to the Board were accurate and would be delivered. In order to ensure lockdown could be delivered on each site additional door furniture was required. Timescales for delivery remain on track and the Trust would deliver in line with timescales for emergency planning processes.
1741/19	Mrs Libiszewski asked if work had been undertaken from the previous years PLACE assessment due to the convening of the new group.
1742/19	The Director of Nursing stated that there had been concerns about this being reported to the Finance, Performance and Estates Committee as work had been completed at the Quality Governance Committee. However work had been undertaken and a report would be received by the Infection Prevention and Control Group. This would subsequently be reported to the Quality Governance Committee. This would provide an initial position, some work had been agreed through the Quality Governance Committee which had gone ahead.
1743/19	It was explained that the Finance, Performance and Estates Committee had sight of the work due to the risks being aligned to estates and assurance was required on the high risk.
1744/19	Mrs Dunnett raised concern regarding the £4.4m variance on the capital programme and requested assurance that the variance was in fact due to the bringing forward of the programme and not variations to the contract.
1745/19	The Director of Finance and Digital advised that this was in relation to the phasing of the plan for the fire doors and was taken at a point in time but phased over the year. There was a need to ensure the money was bought forward to spend, hence the valid variance.
1746/19	In order to ensure that the Board were clearly sighted on the £45.9m spend agreed through the business case a review would be presented back to the assurance Committees of the spend based on the business case. **Action – Director of Estates and Facilities/Director of Finance and Digital, 3 December 2019**
1747/19	The Director of Finance and Digital discussed the borrowing for December. The Board had the previous month approved November draw down of £7.3m exceptional capital, the request for the December borrowing was explicitly asking for £5.5m draw down in line with plan.

1748/19	The Chair raised concerns that the CQUIN delivery was not as expected. The Director of Finance and Digital identified that there had been difficulties for a number of reasons including the move to an aligned incentive contract.
1749/19	The Chief Executive advised that it was the understanding in the system that the key Board members of the Clinical Commissioning Group were not looking to less than 100% of the CQUIN, as such the assurances provided were correct. Clarity of the position for delivery was required. **Action – Medical Director, 3 December 2019**
1750/19	The managed equipment service was being scoped although there were no clear timescales for delivery, however there was a clear direction of travel. The Board would require a view of this to understand if this was something that could be taken forward due to the requirement for capital.
1751/19	The work required was technically complex and would be reported to the Finance, Performance and Estates Committee.
1752/19	The Chief Operating Officer provided clarity regarding the monies awarded for the build at Pilgrim. This had been awarded on the basis of a strategic outline business case that had previously been submitted. An element of fees had been envisaged, in line with the business case, circa 15% of the cost. The Trust must follow the Procure 22 route and work with a design company in order to progress. In order to release the monies for the design company NHS Improvement needed to be approached, this would ensure the correct process was followed. The Trust Board: • **Received the update**
	Item 13.2 EU Exit
1753/19	The Chief Operating Officer presented the report to the Board noting that planning continued and the risks remained as previously reported.
1754/19	Radioisotopes required further work to be undertaken and there was nothing further to report. Planning would continue working towards the newly agreed exit date. The Trust Board: • **Received the report**
	Item 13.3 Winter Plan
1755/19	The Deputy Director of Operations joined the meeting for this item. The Chief Operating Officer presented the Winter Plan noting that the system was entering the Winter in the most challenged state. This was being driven by the constraint previously discussed, workforce and capacity of services within the county and capacity outside of the organisation including EMAS, community and primary care.
1756/19	The plan presented to the Board recognised the constraints of the system with a range of actions being taken that are within the control of the Trust and would be deliverable. The plan

	articulates the gap in relation to beds, some challenges have been mitigated from previous years due to the Pilgrim reconfiguration.
1757/19	The Trust did not plan to open additional beds during the winter as there were issues being faced with staffing of the current bed base, both for medical and nursing staff. Work had been undertaken in order for community colleagues to support the Trusts staff.
1758/19	The plan detailed 6 schemes which would increase capacity whilst also considering how available capacity could be better utilised.
1759/19	The schemes in the plan would, it was hoped, provide the ability to mitigate the bed capacity however this would be dependent on the demand on the services. The Trust would continue to deliver as had been done in previous winters that had had a positive impact on managing the winter period. Work would be undertaken with local authority colleagues in order to manage processes.
1760/19	The Chief Operating Officer stated that it would be a challenging winter however it was believed that the package of schemes within the plan were deliverable and the risks would be managed.
1761/19	The Deputy Director of Operations advised the Board that the winter plan was part of a system wide plan with integrated governance and a number of challenge and confirm actions in place, including weekly calls. The plan was supported by partners and regulators who, through the weekly calls were able to hold the Trust to account on the schemes, this was a significant difference within the plan for the year.
1762/19	The Chair was pleased to see that the plan had been developed from that of previous years and that following the patient pathways was a logical approach. There remained challenge around the assumptions as these did not always reflect activity and assurance would be required on the assumptions made. The capacity gaps that would always be faced would need to be responded to dynamically.
1763/19	The Chief Executive stated that at a recent CEO and Chairs event attendees were reminded what the priorities should be for winter services, the plan set forward by the Trust had actions against each of the areas highlighted by NHS England/Improvement for the winter efforts.
1764/19	The Board discussed the change of behaviours that staff exhibited during pressured times and how there was a need to ensure a culture was created for how people should behave under stress.
1765/19	Mrs Dunnett questioned scheme 29, the shift of routine elective activity on mass to two sites in order to release capacity, and if this had been planned with regard to operational performance and patient experience.
1766/19	The Chief Operating Officer advised that this had been factored in and had been done for a number of years. This would improve operational performance and had been factored in financially. Communication regarding patient movement between the sites was embedded in to process.
1767/19	The Director of Finance and Digital stated that there needed to be an awareness of the delivery of the plan, anything that needed to be completed outside of the plan would impact on the Trusts finances.

1768/19 1769/19 1770/19	Concern was raised about how staff health and wellbeing had been factored in to the plan, assurance would be required that workforce had been considered as a key element of the plan. The Chief Operating Officer advised that further work would be required to ensure workforce was fully included within the plan and more thought would be required in relation to support for staff. The Director of Human Resources and Organisational Development offered to support the wider discussion. Mrs Libiszewski stated that it had been expected that the plan would contain more specifics in relation to the management of paediatric patients, it was not clear through the plan if paediatric patients would be managed in the same way as adult patients. The schemes within the plan were adult focused and looked externally.
1771/19	The Chief Operating Officer advised that the schemes and actions were underway and that the comments made regarding paediatrics would be included within the plan for clarity.
1772/19	It was also identified that the Trust were outside of the national average for elderly patients and there was a focus required here as well. Consideration should be given to patients over the age of 80 waiting more than 4 hours in A&E. The Trust were making improvements within the frailty team that could be offered through winter, this had not been available in previous years, as such the Trust would be achieving the expectation and requirement for frailty.
1773/19	The Chair questioned the governance processes monitoring the winter plan and if all staff who were identified as gold, silver and bronze were trained and able to deliver.
1774/19	It was confirmed that the governance process was managed through a fortnightly meeting chaired by the Director of Operations. The meeting applied check and challenge to the plan and reported in to the monthly resilience group meeting. This also fed the system resilience meeting and urgent and emergency care delivery group. There was also regulator check and challenge in place.
1775/19	All staff involved in on-call for bronze, silver and gold were trained and signed off, where support would be required to individuals this had been identified. Clear delegated levels of authority had been communicated to staff.
1776/19	The current status of the full capacity protocol was confirmed as being in place and staff alerted to it. The rapid ambulance handover was now in place however concern was raised over how often this would be required to be put in place due to the demand levels on the system. If enacted too frequently an alternative response would be required.
1777/19	The Board questioned how the impact of the plan would be monitored by the Board. It was agreed that updates would be provided monthly through the Finance, Performance and Estates Committee and then to Board.
1778/19	**Action: Chief Operating Officer 3 December 2019** The Trust Board: • **Received the report** • **Endorsed the Winter Plan**

	Item 14 Providing services by staff who demonstrate our values and behaviours SO3
1779/19	**Item 14.1 Assurance and Risk Report Workforce, Organisational Development and Transformation Committee**
1780/19	The Workforce, Organisational Development and Transformation Committee assurance and risk report was presented to the Board for information following the verbal update provided at the October Board meeting.
1781/19	The Board held a discussion about the recruitment within both the medical and nursing workforce noting that there had been a focused effort on recruitment. If all recruits in the medical pipeline come through then all but 2 vacancies would be filled within the emergency department by the Spring.
1782/19	A national campaign to recruit nurses had recently commenced alongside a campaign for Allied Health Professionals. It was hoped that these would also have an impact on recruitment. Currently the turnover rate remains higher than desired however this was reducing. The Trust Board: • **Noted the written report**
1783/19	**Item 14.2 Flu Vaccination Self-assessment** The Director of Nursing presented the report to the Board noting the requirement from NHS England/Improvement that the Board were sighted on the self-assessment.
1784/19	1600 front line staff had been vaccinated to date however due to the intermittent supply of vaccinations there had been some delay with the vaccination programme. The remaining vaccines were due for delivery.
1785/19	Specific focus had been given to high risk areas that had previously had a low uptake, it was too early in the programme to see if this had resulted in the desired impact.
1786/19	The Trust was the 5th highest in the country for vaccinations in 2018/19 and a stretch target of 90% had been set for the current year, there was a clear expectation set with the team to exceed the target.
1787/19	Mrs Ponder raised concerns about the use of social media to advertise drop in sessions for vaccinations as not all staff would be using the platforms.
1788/19	The Director of Nursing advised that social media was being utilised in additional to traditional communication methods. The Trust Board: • **Received the report** • **Endorsed the self-assessment**
1789/19	**Item 14.3 Freedom to Speak up Quarterly Report** The Freedom to Speak Up Guardian presented the report to the Board.
1790/19	It was noted that the Trust were not well placed on the index report that had been published by the National Guardian's Office which collated specific responses within the staff survey

	along with an organisation's CQC ratings. There had been 7 issues reported by staff for the last quarter. This was lower than previous quarters. A number of issues had been identified from national case study reviews which had been published nationally these would be reviewed with a gap analysis presented to the Workforce, Organisational Development and Transformation Committee. The gap analysis would identify if there was any learning to be considered in the Trust.
1791/19	There were now 13 Freedom to Speak Up Champions in the Trust operating across all sites. Training for the champions had been identified locally and it was hoped that this could be conducted in the near future. Evidence of the success of champions had been seen in other Trust's through the Freedom to Speak Up Regional Network and this work would continue to be pushed forward.
1792/19	Communication to staff regarding Freedom to Speak Up had been stepped up during Freedom to Speak Up Month in October and would continue to ensure staff were aware of the service, it had been identified in the CQC report that staff remained unaware of how to access the service.
1793/19	Consideration would be given to the Workforce Race Equality Standards team in order to provide additional support with speaking up as this had also seen positive results in other Trusts. It was also clear through the report that this was a Board function and not just the responsibility of the Guardian. As such a Board Development session would be considered within the planner for 2020. **Action: Trust Secretary, 3 December 2019** The Trust Board: • **Received the report**
1794/19	**Item 14.4 Feedback from Hearing Lincolnshire's Hidden Voices – Race Equality Conference** The Chair presented the feedback to the Board from the Race Equality Conference, this had been hosted by the Trust and chaired by the Trust Chair with attendance from all Executives.
1795/19	The paper provided highlights from the day and the event demonstrated the national position and emotion from staff members of the experiences that had been faced.
1796/19	The Chair made a personal commitment to Trust staff to ensure that improvements were made and action plans were being developed. The update to the Board was to ensure early sight of the outcome of the conference, feedback and need to develop further actions.
1797/19	The Chief Executive advised that following the conference the Trust had now received from the National Team the Model Employer Aspirational Targets for the proportion of BME staff in leadership roles. This would be reported through the Workforce, Organisational Development and Transformation Committee however it was clear that the Trust had work to do in relation to BME staff in senior levels at the Trust.
1798/19	The Chief Operating Officer advised that as the new executive sponsor of the BME Network there was significant support required to the network for them to come forward in a confident way to seize the opportunity of how this would be managed within the organisation. Support would be sought from the Workforce Race Equality Standards team.

1799/19	Mrs Libiszewski raised the need for this to be linked through to the CQC report and ensure that there was an overarching view rather than this being picked up separately.
1800/19	The Chair confirmed that this would be reported through the Workforce, Organisational Development and Transformation Committee. The Trust Board: • **Received the report**
	Item 15 Providing seamless integrated care with our partners SO4
1801/19	No items
	Item 16 Performance
1802/19	**Integrated Performance Report** The Director of Finance and Digital presented the report to the Board.
1803/19	The Chair identified that the challenges of the report have been heard through the Committee upward reports and Executive colleagues were invited to raise any areas to note.
1804/19	The Director of Nursing drew attention to Sepsis as discussion had been held regarding a clear line of sight on the detail to the Board. Work had been completed to do this and specific work had been completed on the alignment of data due to the conditions placed on the Trust by the Care Quality Commission. The work undertaken to address the issues raised in Accident and Emergency had demonstrated an impact on the wider organisation.
1805/19	The Director of Human Resources and Organisational Development identified that the Friends and Family Test had been conducted in the summer and demonstrated a half way marker for staff engagement. Recommending the Trust as a place of treatment had scored 66%, this was a positive improvement against the 47% recorded in the previous staff survey. Recommending the Trust as a place to work was reported at 56% and again was positive against the previous staff survey. It was noted that the Friends and Family Test usually reported higher that the staff survey however demonstrated movement in a positive direction.
1806/19	The Chief Operating Officer noted that ongoing issue regarding availability of staff due to the pension issues, this had resulted in additional capacity being provided predominantly on an ad hoc basis to improve pressures on waiting lists.
1807/19	The Chair and Chief Executive recognised that other Trusts were also experiencing issues with the ability to deliver services due to the pension issues being faced. NHS Providers had on behalf of providers written to the Prime Minister stating that urgent actions was needed due to the potential detrimental effect on patient care.
1808/19	Dr Gibson noted his concern about some missing September data and that the partial booking waiting list performance was demonstrating a decline over the past 12 months.
1809/19	The Chief Operating Officer advised that this decline related back to staff availability due to pensions and this was where additional ad hoc clinics had been targeted. Work was underway to try and reduce the partial booking waiting list.

1810/19	Mrs Libiszewski stated that there were a number of parameters which were not being achieved in relation to waiting times and raised concern that these issues were not being fed through to the Quality Governance Committee as part of the harm review process.
1811/19	The Chief Operating Officers advised that there were 2 cases that should have been reported and work would be undertaken to ensure the process of reporting was working correctly. This required linking in to the governance process in order to report to the Committee. **Action: Chief Operating Officer, 3 December 2019** The Trust Board: • **Received the report**
	Item 17 Risk and Assurance
1812/19	**Item 17.1 Risk Management Report** The Risk report was presented to the Board noting that there had been a new risk included whilst current risks were progressively being updated and reviewed.
1813/19	Aseptic risk remained the top risk for the organisation and the temporary unit was due to be commissioned in December.
1814/19	Concern was raised that the Committees had fed back that risks appeared out of date. These would be reviewed on a monthly basis with the Executives to ensure that assurance was reported to the Committees and subsequently Board. The process would be put in place to ensure updates were undertaken. **Action:Medical Director 3 December 2019** The Trust Board: • **Received the report** • **Accepted the top risks within the register**
1815/19	**Item 17.2 BAF 2019/20** The Board Assurance Framework was presented to the Board as an update, this had been reviewed and updated through the Board Committees.
1816/19	There were no change to the ratings however the objective in relation to high quality care would need to be reviewed. The Quality Governance Committee were asked to consider the objective and make the appropriate recommendations to the Board regarding the assurance ratings.
1817/19	The pension issue previously discussed would require inclusion against Objective 1b due to the impact being seen on services. The Trust Board: • **Received the Board Assurance Framework** • **Noted the progress**
1818/19	**Item 17.3 Assurance and Risk Report Audit**

1819/19	The Chair of the Audit Committee, Mrs Dunnett, provided the assurance received by the Committee at the October meeting. The Board were advised that assurance had been provided to the Committee that the programme of internal audit would be completed at the end of 2019/20. The new provider had highlighted to the Committee that there was no clear escalation in place regarding challenges if issues were faced. The escalation process was revisited by the Committee.
1820/19	The had been a request to move some audits to the later part of the year, the Committee were clear that the programme had to be completed in year. Where significant areas had been identified for audit, the Committee were keen to ensure that these commenced in the quarter originally identified.
1821/19	There had been some contingency built in to the plan and it had been identified that further work with Medicines and Pharmacy could use this however consideration would be given by Executive colleagues about this.
1822/19	The Board were advised of the outstanding recommendation from 2018/19 audits, particularly with regard to job planning, this also triangulated with other job planning concerns raised by Board members.
1823/19	The Committee were assured with regard to the Counter Fraud service however due to the proactive approach being taken with regards to awareness, communications and training there had been an increase in reports through to the service. The remit for counter fraud sits with the Director of Finance and Digital who will consider if sufficient capacity was in place to respond to the issues being raised.
1824/19	External audit had commenced work and were starting to progress on the 2019/20 programme. The Committee were assured on the implementation of the ISA260 actions.
1825/19	The Committee were also assured that work was on track for the production of the quality account and completion of the audit.
1826/19	The Board were advised that PriceWaterhouse Cooper, the external auditors were seeing a number of changes internally which would result in a different organisational structure. This would not affect the teams working with the Trust. These changes would also be seen with other providers in the future.
1827/19	Mrs Dunnett advised of the governance discussions that were held including policy management, this had not moved as quickly as hoped, particularly in relation to control over clinical and non-clinical policies. The Committee were seeking an update on the position and wished to be advised if there was any areas where the Trust were being exposed to risk, grip and control on policies was required.
1828/19	The Committee had discussed the scheme of delegation to ensure that there was clarity of the accountability of divisions and operating procedures in relation to these.
1829/19	NHS Improvement undertakings were considered by the Committee, regular reports were received and this was reviewed further for assurance on the evidence of the delivery of the undertakings. The Executive Directors were asked to further consider.
1830/19	The Committee remained unassured regarding the Sustainability and Transformation Partnership governance and the risks as related to the Trust. The Boar were advised of pan STP internal audit that was being conducted, this would be presented back to the Committee when completed.

1831/19	The Board were advised that the Committee were escalating job planning concerns, this required moving at pace with the appropriate focus. This had been flagged by the Committee to the Workforce, Organisational Development and Transformation Committee who had a clear view on the issues. This had also been raised with the Finance, Performance and Estates Committee to ensure they were sighted.
1832/19	The Chair highlighted the need for the Director of Nursing and Medical Director to discuss the job planning process in place to ensure these were completed, further emphasis was required on the process.
1833/19	The Medical Director advised that the process was correct however the difficulty was within the Clinical Divisions due to capacity and the time to implement, there was dedicated time given to consistency panels. The savings identified from job planning would not be realised by the Trust and this had also been an issue within other organisations. This was aligned to the pension issues and Doctors wanting to move to part time working hours.
1834/19	The Board were advised that the issue had been discussed by the Trust Management Group to identify what action was required and what had been working well.
1835/19	The Trust Secretary recognised the position in relation to policy management that had been raised identifying that work was underway to align policies to the development of SharePoint. This would support the progression of management of policies as the current system was not fit for purpose.
1836/19	The Chair asked if the level of risk attached to outstanding policies was known. The Trust secretary advised that manual review of policies was a continual process and at the request of the Audit Committee had been added to the corporate risk register.
1837/19	Clarity about the process would be required whilst the development of SharePoint was underway, the system would not resolve the issues immediately however would provide the ability to report against the current position. The Director of Finance and Digital and Trust Secretary were asked to progress the implementation of policies on to the SharePoint system and ensure current processes in the interim were clear. **Action – Director of Finance and Digital/Trust Secretary – 3 December 2019**
1838/19	The Director of Finance and Digital acknowledged the significant piece of work that was required in relation to the NHS undertakings,. The Trust Board: • **Received the report**
	Item 18 Strategy and Policy
1839/19	**Item 18.1 Finance Strategy** The Director of Finance and Digital presented the strategy to the Board noting that this had been received by the Finance, Performance and Estates Committee. The comments received from the Committee had been reflected in the version received by the Board.
1840/19	Mrs Libiszewski noted that the strategy was concise but that it did not reference being part of one of the 8 organisational strategies. There was a need to ensure alignment and provide detail on how this supported the delivery of other strategies

1841/19	It was noted that the strategy contained a number of acronyms which did not support the strategy being a public document.
1842/19	The Board endorsed the strategy recognising it as a high level strategic document and noted the need to develop the detail of delivery in to a wider organisational plan. The Trust Board: • **Endorsed the strategy**
1843/19	**Item 19 Board Forward Planner** For information
1844/19	**Item 20 ULH Innovation** The Director of Human Resources and Organisational Development introduced the item stating that there had been a need to better engage with staff about what was available to them through the health and well being programme. There were a number of opportunities available to staff and the bus was an alternative way of giving the message to and accessing more staff.
1845/19	Saumya Hebbar, Organisational Development Lead attended the Board to discuss the project. The project had been devised by staff from cohort 3 of NHS Improvements training programme for improvement plans, Ms Hebbar had been asked to implement the project of focus which had been staff retention.
1846/19	A number of ideas had been considered to support staff retention including self-rostering and flexible working, case studies were created in order to discuss with staff what options were available to them.
1847/19	Work was undertaken with Staffside and Communications in order to ensure staff were able to receive the messages. It was acknowledged that staff would be at different stages of their careers. A review of staffing data had shown that 30% of staff were due to retire in the next 5 years, as such initiatives to consider what could be done to bring back retirees back in to the organisation.
1848/19	Initiatives that had been rolled out did not appear to be reaching all staff and so alternative methods of communication were considered and the idea of the bus evolved. There idea was identified at the end of June giving 2 months for this to be implemented.
1849/19	A number of teams came together including occupational health, physiotherapy, clinical education and teams that provided developmental services to staff. 700 staff were directly engaged and wider engagement took place through word of mouth and feedback from attendees to the bus.
1850/19	Feedback from the Director of Nursing had been the difficulty to release staff and the next development of the bus would be to bring this in to wards and departments. It was recognised that the release of staff to events was a common difficulty and there would need to be creative thinking and innovation to resolve this. The Trust Board: • **Received the report**

1851/19	**Item 21 Any Other Notified Items of Urgent Business** None
	The next meeting will be held on Tuesday 3 December 2019, Boardroom, Lincoln County Hospital, Lincoln

Voting Members	**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**	**1 Oct 2019**	**5 Nov 2019**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	X	X	X	X
Geoff Hayward	X	A	A	A	X	A	X	X	X	A	X	X
Gill Ponder	X	X	X	X	A	X	X	X	X	A	X	X
Jan Sobieraj	X	X	X	X	X	X	X					
Neill Hepburn	X	X	X	X	X	X	X	X	X	A	X	X
Michelle Rhodes	X	A	X	X	A	X	X	A	A	X		
Kevin Turner	X	X	X	X	X	X	X	X	A			
Sarah Dunnett	X	X	X	X	X	X	X	X	A	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	A	X
Alan Lockwood	X	X	X	A								
Paul Matthew	X	X	X	X	X	X	X	X	A	X	X	X
Andrew Morgan								X	X	A	X	X
Victoria Bagshaw											X	X
Mark Brassington											X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
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~~ 05/11/2019	Assurances included within FPEC upward report at item 13.1 Complete
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	~~30/09/2019~~ ~~5/11/2019~~ 3/12/2019	National update not available as at 5 Nov 2019 Board meeting.
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~~ 3/12/2019	Agenda Item 11.2
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~~ 04/02/2020	Strategy being considered against CQC findings. To January W&OD Comm. Return to Board 4 Feb 2020.
6 August 2019	1186/19	QGC Assurance report	Review of window cleaning impact on cleanliness audit	Boocock, Paul	~~03/09/2019~~ Revised date of 3/12/2019	Proposal to increase frequency of window cleaning considered at CRIG in October, required additional info. Update at December meeting.

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	As an interim measure Board agreed the LCB system report would be circulated to Board members as an addition to the minutes. Circulated 22 Oct 2019 Complete
1 October 2019	1443/19	Matters arising/action log	LCB system report to be circulated with minutes to Board members	Warner, Jayne	05/11/2019	Circulated 22 Oct - Complete
1 October 2019	1462/19	Patient/Staff Story	The Deputy Chief Nurse would provide a future update to the Board on the focused work of the pathways to ensure lessons were learnt.	Negus, Jennie	03/12/2019	
1 October 2019	1545/19	Equality, Diversity and Inclusion (EDI) Annual Report	Pursue support from STP for system wide approach to EDI.	Morgan, Andrew	05/11/2019	Referred to SET for discussion Nov. Also picked up at NHSE/I review meetings. Complete
1 October 2019	1573/19	Smoke Free ULHT	Review of communications plan to ensure clarity of implementation	Rayson, Martin	05/11/2019	Comms plan reviewed. Complete
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	07/04/2020	
1 October 2019	1596/19	Medical School update	Medical School business case to be presented to the Board	Hepburn, Neill	03/12/2019	Agenda item private Board. Complete
1 October 2019	1638/19	BAF	Review and update of narrative	Willey, Karen/Executive Team	05/11/2019	Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

1 October 2019	1641/19	NHS Improvement Board Observations and actions	Updated action plan to be presented to the Board	Warner, Jayne	~~03/12/2019~~ 4/12/2019	See action below. Audit Committee to review in January meeting
1 October 2019	1642/19	NHS Improvement Board Observations and actions	Audit Committee to receive reports and action plans	Warner, Jayne	14/10/2019	Audit Committee agreed to review progress at January 2020 meeting
5 November 2019	1679/19	Patient/Staff story	Assurance required by the Board that whilst the Trust policy was under review that staff who go off site during their shift were tracked	Brassington, Mark	3/12/2019	
5 November 2019	1715/19	Assurance and Risk Report Quality Governance Committee	Board requested full sight of Lincoln reconfiguration including patient experience	Brassington, Mark	3/12/2019	Agenda item private board
5 November 2019	1747/19	Assurance and Risk Report Finance, Performance and Estates Committee	Business case review of fire works to be completed and reported back to Finance, Performance and Estates Committee detailing spend	Boocock, Paul/ Matthew, Paul	3/12/2019	
5 November 2019	1749/19	Assurance and Risk Report Finance, Performance and Estates Committee	Clarity to be provided to the Board on the position of CQUIN delivery	Hepburn, Neill	3/12/2019	
5 November 2019	1778/19	Winter Plan	Updates would be provided monthly through the Finance, Performance and Estates Committee and then to Board	Brassington Mark	3/12/2019	Agenda Item private board
5 November 2019	1793/19	Freedom to Speak Up	Board development session to be scheduled to support development in 2020	Warner, Jayne	3/12/2019	Included in 2020 planner
5 November 2019	1811/19	Integrated Performance Report	Ensure reporting process to QGC functioning effectively in relation harm reviews required for patients outside of waiting times	Brassington, Mark	3/12/2019	
5 November 2019	1814/19	Risk Report	Risks to be reviewed on monthly basis to ensure updates were made.	Medical Director	3/12/2019	Risks to be shared with Execs on

						monthly basis with BAF to ensure updates captured.
5 November 2019	1837/19	Assurance and Risk Report Audit	Progress implementation of policies on to the SharePoint system, ensure current processes in place were clear	Matthew, Paul/ Warner, Jayne	3/12/2019	First stage transfer of key corporate policies will be complete by 31/12/2019

Agenda Item:

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	3 December 2019
Healthcare standard	

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 is 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 (eg Financial, HR)	
Assurance implications	
Patient and Public Involvement (PPI) implications	
Equality impact	
Information exempt from disclosure	
Requirement for further review?	

Agenda Item:

System Issues

a) A System Review meeting was held with NHSE/I on 20th November. The key areas requiring continued focus were agreed as being the delivery of financial control totals; urgent and emergency care; waiting times; cancer waits; mental health out of area treatments; the learning disability Transforming Care Partnership.

b) Through the Joint Working Executive Group (JWEG) work is continuing around the transition to an Integrated Care System (ICS). External support via Tricordant has been secured and there is a workshop for JWEG on 5th and 6th December. The work on developing an ICS is not taking precedence over the operational issues identified at point 1 above.

c) The Trust has responded to the CQC following the publication of the CQC inspection report outcome that was reported to the Board in October. This response summarises the action the Trust will be taking to comply with Regulations and is set out using the template provided by the CQC. There is a Quality Summit on 10th December involving all parts of the system to review the CQC report and the action being taken by the Trust. This summit will include discussions about how the system will support any improvements that need to be made.

d) The draft Lincolnshire Long Term Plan 2019-2024 has been submitted to NHSE/I. This will now go through the agreed regional assurance processes. Publication through Trust Boards will be dependent on the timescales relating to the purdah period for the general election. At the moment the precise publication dates are not known.

e) A very successful and well attended Lincolnshire Health Awards event was held on the 19th November. The winners have received media coverage as well as being celebrated in their own organisations, including ULHT.

f) The Urgent and Emergency Care Delivery Board met on 19th November. As usual the focus was on pre-hospital care, care within the acute sector and discharges. The Board focused in particular on CAMHS services; ambulance handover times; weekend discharges; Lincolnshire County Council winter schemes; Urgent Treatment Centres; having appropriate systems for knowing the pressures and escalation levels in general practice.

g) SET has agreed that further work is needed on assessing the capacity and capability required for tackling system wide areas of work.

Trust specific issues

a) At M7 the Trust is reporting a deficit of £30.711m. This is £1.937m adverse to the planned deficit of £28.774m. The underlying position is a deficit of £14.060m. This underlying position takes into account transitional relief,

accruals for backlog waiting list work and repatriation, technical adjustments. The control total for the year remains a deficit of £70.3m excluding any PSF etc. As reported at point 1 in the System issues above, there is a clear expectation that the Trust takes urgent action to get the financial position under control in order to achieve the control total.

b) Work is progressing to identify the priorities for the Trust's Integrated Improvement Plan. This will bring together all of the actions that are being taken to improve the Trust rather than having separate work streams. It will be informed by a review of the Trust's five year strategy which the Board is undertaking in order to simplify the key messages and clarify the key objectives and priorities. In support of this Integrated Improvement Plan, further work is being done with the national Intensive Support Directorate to identify the resources that are available to assist the Trust in its Improvement work.

c) Following an external recruitment process supported by the NHS Leadership Academy, I am pleased to report that Paul Matthew has been appointed as the Trust's substantive Director of Finance and Digital. Paul has taken up this role with immediate effect.

d) Work is underway to improve the communication and joint working between ULHT clinicians and GPs. By getting clinicians together more frequently, it is anticipated that solutions will be found to problems that get in the way of good patient care.

e) The National Staff Survey closes on 29th November. This is a key way of ensuring that the views of staff are known and there has been considerable work to support staff to complete the survey. An up to date completion figure will be provided at the Board meeting. Similarly, there is a lot of work going on to ensure that front line staff are vaccinated against the flu. Again, the latest uptake figure will be provided at the Board meeting.

f) The Trust is continuing to comply with the election purdah guidance prior to the general election on 12th December. By necessity this has entailed the Trust taking a lower media profile than would normally be the case. This compliance with the purdah guidance is not preventing the Trust from conducting normal operational business.

NHS
United Lincolnshire Hospitals
NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19th November 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> The October meeting had been attended by all Divisions with a full agenda that had concentrated on the divisions presenting their issues. The group had been unable to discuss the expert groups in detail and as such discussions would be held to further develop the structure of the meeting to ensure full delivery of the agenda. <u>Source of Assurance: CAUTI Q2 –</u> The Committee received the Q2 report noting that improvements in the reporting system were required in order to ensure the calculation of UTIs and CAUTIs were accurate. The position for the Trust was positive and there was a continued focus on removing catheters as quickly as possible to reduce the risk of infection. <u>Source of Assurance: VTE Q1 –</u> Performance of the Trust was consistently above the national average of 95%. A Coagulation Nurse Champion had been appointed to the Trust with a remit to improve education of staff and discharge process for patients, the role was working well. The learning from serious incidents was being shared and actions implemented from these. The early themes appeared to be about the ability to follow policy. As such the policy would be reviewed to ensure this was suitable. <u>Lack of Assurance: Safeguarding –</u> The Committee were advised that attendance by the divisions at the meetings had been poor and the information presented to the Committee within the report had been based on the work of specialist teams and not the engagement with the

	divisions. A root and branch review of the meeting would be conducted to ensure the correct focus. The safeguarding risks on the risk register were noted as currently being accurate however a review of the meeting may identify further risks. The Trust had recently being sighted as an area of good practice from the Royal Court of Justice in respect of forward looking work. <u>Source of Assurance: Quality Impact Assessment –</u> The Committee were advised that the process was currently being managed through the PRM's and the 2021 team, it was noted that this felt disconnected from the governance team. There was a need to ensure that this was more joined up. Work was being undertaken in the system to ensure that the Trusts QIAs supported and reflected the work of the system. The Committee were unclear about the level of ownership of the QIAs and were advised that work was being conducted to move the position of ownership forward through alignment with the QSIR methodology. <u>Source of Assurance: Clinical Audit –</u> The National Audit Data placed the Trust as an outlier for the National Bowel Cancer Audit Project (NBOCAP) based on data collected between 1st April 2013 and 31st March 2018, this had not previously been recognised as an issue for the Trust. Action has already been undertaken to address the issues raised including individual case reviews. The Committee were advised that the Trust were an outlier for children being reviewed within 12 hours, this had been identified as a documentation issues and reviews were being completed. Clinical Effectiveness Review meeting was in operation and functioning better which has resulted in audits and data being reviewed. This would enable the Trust to be better sighted at an earlier stage of potential issues arising from audits. The Committee were advised that audit was a rolling programme and some data now being reported was historical, as the programme progresses this should move the Trust away from being an outlier. <u>Source of Assurance: NICE and Best Practice Report –</u> The Committee received the updated position of the Trust noting that there had been some improvement. The move away from a site to a divisional process would support further improvement. <u>Source of Assurance: Quality Priorities and Quality Account –</u> The outturn of the priorities for the current had demonstrated that 13 out of 27 were on track to deliver. The Committee were not assured of delivery and were unclear if the actions identified would have the required impact.

	The Committee requested that efforts continued to improve the current years position. The Committee received and approved the proposed timescale for the production of the 2019/20 Quality Account. Source of Assurance: Lessons Learnt Q2 – The Committee were advised that the report continued to develop and that the move to Datix for the legal team would support the development of the report. The underlying issue within the Trust remained the maturity of governance at the divisional and business unit level. Source of Assurance: Equality and Diversity Q1 & Q2 – The Committee were advised that the Trust were now being rated as developing due to the work required to deliver the quality objectives within the year. The Committee were assured that work was progressing and leadership within the organisation was supporting the improvements. Source of Assurance: 15 Steps – The Committee received a proposal to broaden the 15 Steps programme to Board to Ward engagement. Refinement of the proposals was requested prior to a further discussion by the Board. Lack of Assurance: Children's and Young Peoples report – The Committee were not assured by the report received as this had not detailed information regarding the operation and safety of the model of care or a clear structured response to the findings of the CQC. The Committee requested that the paper be developed to demonstrate the position in the context of the improvement plan and what actions were being taken as a result of the CQC findings. Source of Assurance: Patient and PALS report – The Committee received the Q2 data in respect of patient experience and were advised of the top risks. Patient experience was not deteriorating however there had been no improvemnt in the position. Plans were underway to develop customer care and the patient experience action plan was progressing and being monitored by the Patient Experience Group. The Committee requested details through the patient experience group upward report of the outcome of the national survey programme. Source of Assurance: Complaints report – The Committee received the Q2 complaints report noting the data presented. Source of Assurance: Risk Report – The Committee received the risk register noting that there had been no change.

	Assurance in respect of other areas:- Quality Governance Performance report – The Committee received the dashboard noting that some data remained un-populated, however this had improved since the previous month. The Committee held discussions against the various performance indicators noting the SHMI and HSMR continued to report positively. It was noted that there had been an increase in category 2 pressure ulcers however the Committee were advised that this was due to the timing of data validation and not an increase in pressure ulcers. Completed SI Reports for Never Events – The Committee were advised that there were currently 6 Never Events reported in the current financial year. Actions were being taken Trust wide in response to Never Events and learning being shared more widely across the organisation. The Improvement Director and Medical Director are looking to secure an external reviewer to support the Trust. Quality and Safety Improvement Plan/CQC Report – The Committee received the update to the existing plan noting that it was hoped the next iteration seen by the Committee would be the newly developed plan. The Committee were assured that work had commenced on the must and should do actions identified within the CQC report and updates had been provided against the specific areas of action being undertaken. The Committee received the progress reported relating to the section 29a and 31 letters from the CQC noting that there was a lack of assurance in relation to the data received as this was not in a well presented format. This would be presented to the Private Board however work would be undertaken to ensure the data presented was in an accessible format and provided assurance. Ward Accreditation, Lancaster – The Committee received the action plan for Lancaster Ward which had been requested following the receipt of the ward accreditation report the previous month. Seven Day Services Board Assessment Framework – The Committee received the assessment framework noting that the organisation required improvement in documenting reviews of patients. The reviews were being undertaken however these were not being recorded in a timely fashion. A plan is in place to ensure the required improvements were made. The Committee signed off the information presented in the report noting that this was factually accurate but not the position that the Trust expected.
Issues where assurance remains outstanding for escalation to the	

Board	
Items referred to other Committees for Assurance	
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 revised the rating up to red based on the current lack of progress identified in the CQC report and the current level of never events. The rating was now red.
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

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

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

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

Title:	**Patient Safety Incidents 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:

- Trends in the volume and type of patient safety incidents reported
- Trends in the volume and type of Serious Incidents (SIs) declared
- Performance in managing Serious Incident (SI) investigations
- Performance in managing reported incidents
- Compliance with the statutory Duty of Candour

The Report is provided to the Committee for:

Decision		Discussion	⚑
Assurance	⚑	Information	

Summary/Key Points:

- The Patient Safety Group reviews the Patient Safety Incidents Dashboard every month and identifies areas of concern for further analysis and action where necessary; a copy of the most recent report is attached as **Appendix I**. Key points to note are as follows:
  - Patient incident reporting rates have remained consistent through the financial year to date
  - 'Patient accidents / falls' remains the highest volume incident category in 2019/20
  - There were 16 Serious Incidents declared in October, of which 11 actually occurred during the month
  - 1 Never Event was declared in October (a 'Wrong site surgery' in Urology theatres)
  - All Serious Incident investigations have been completed within their deadline so far in 2019/10
  - 27 significant harm incidents were reported in October, of which 21 actually occurred in the month
  - Compliance with the Duty of Candour was 100% in September
  - 6 Divisional Investigations were closed in September; 2 new DIs were requested
  - The number of open patient safety incidents reduced by 576 in September

Recommendations:

- That the Trust Board considers the content of the report and identifies any further action required

Strategic Risk Register Patient safety risks that are currently identified as strategic risks are included in the Board Assurance Framework (BAF).	**Performance KPIs year to date** This report details the Trust's performance with regard to the timely completion of incident investigations and compliance with the statutory Duty of Candour.
Resource Implications (e.g. Financial, HR): In order to support improvements in the incident management process the Trust has invested in the further development of the existing Datix system, to include the introduction of management dashboards and web-based versions of the Complaints and Claims modules.	
Assurance Implications The content of this report will enable the committee to review the effectiveness of existing strategies and policies relating to patient safety, in accordance with regulatory requirements and expectations.	
Patient and Public Involvement (PPI) Implications An essential aspect of the incident management process is the delivery where appropriate of an apology when something has gone wrong with a person's care and, in the case of a Serious Incident the sharing of the final report with affected patients or their representatives.	
Equality Impact The policies and processes associated with incident management have been assessed for equality impact and no outstanding issues have been identified.	
Information exempt from Disclosure – No	
Requirement for further review? No	

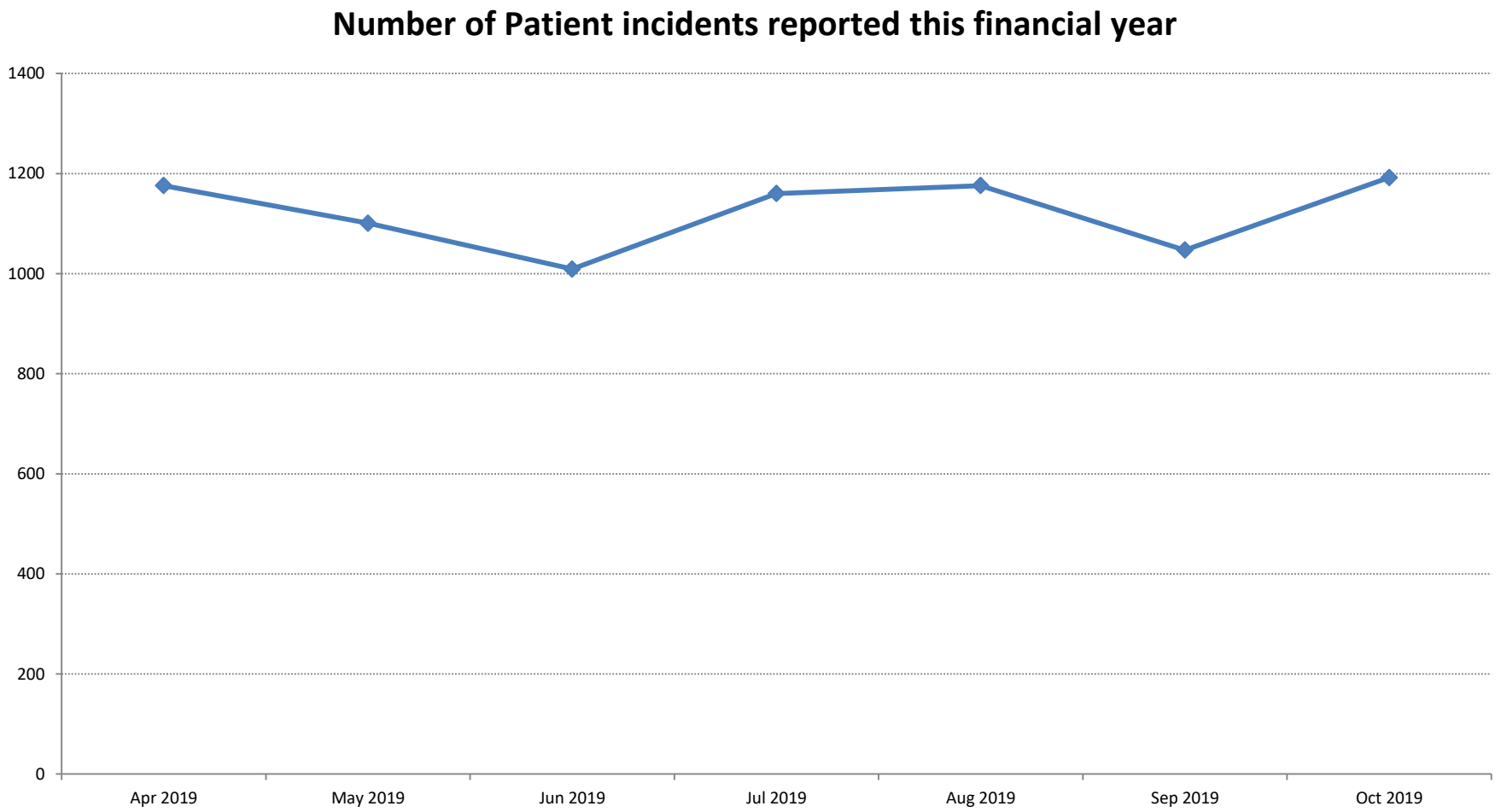
Patient Safety Incidents Dashboard

November 2019

Author: Paul White, Risk Management Lead

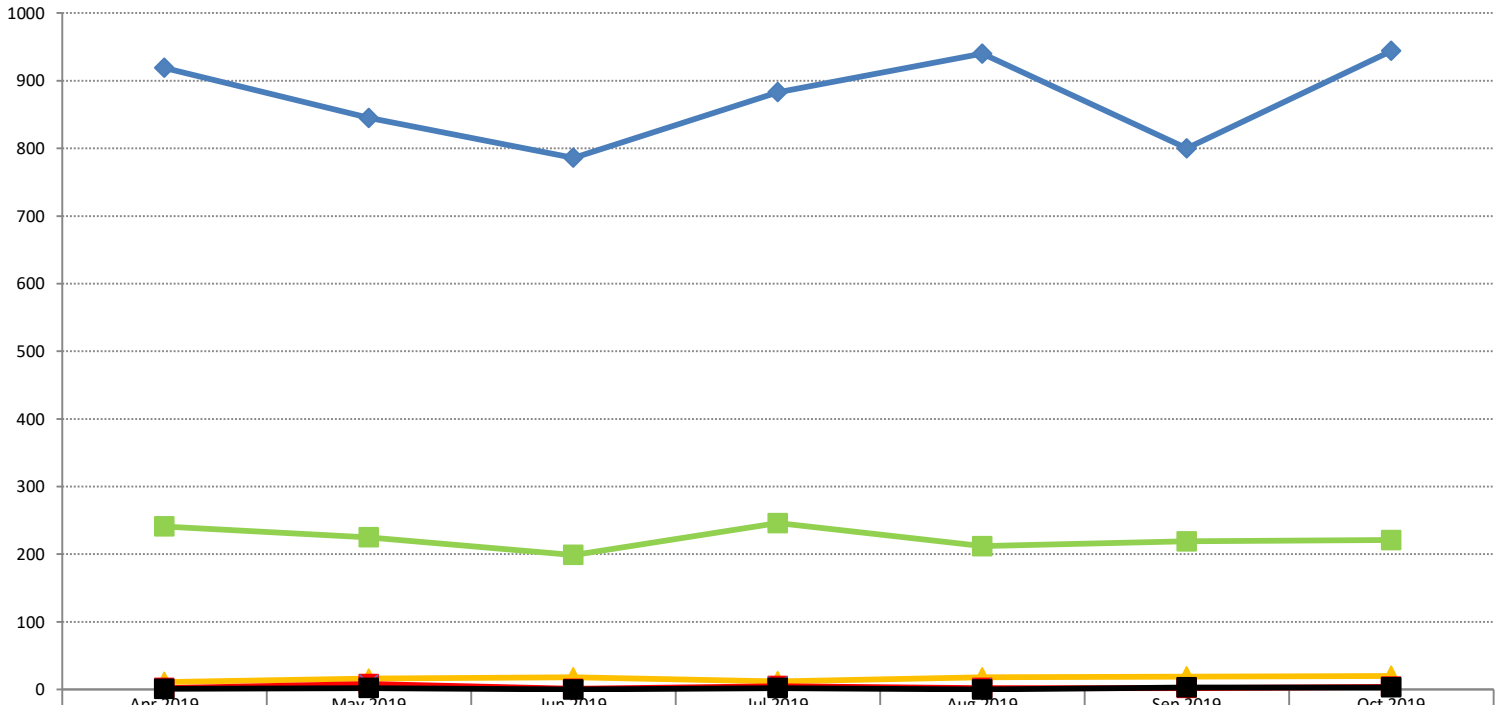
Contents

1a. Patient incidents



1b. Patient incidents

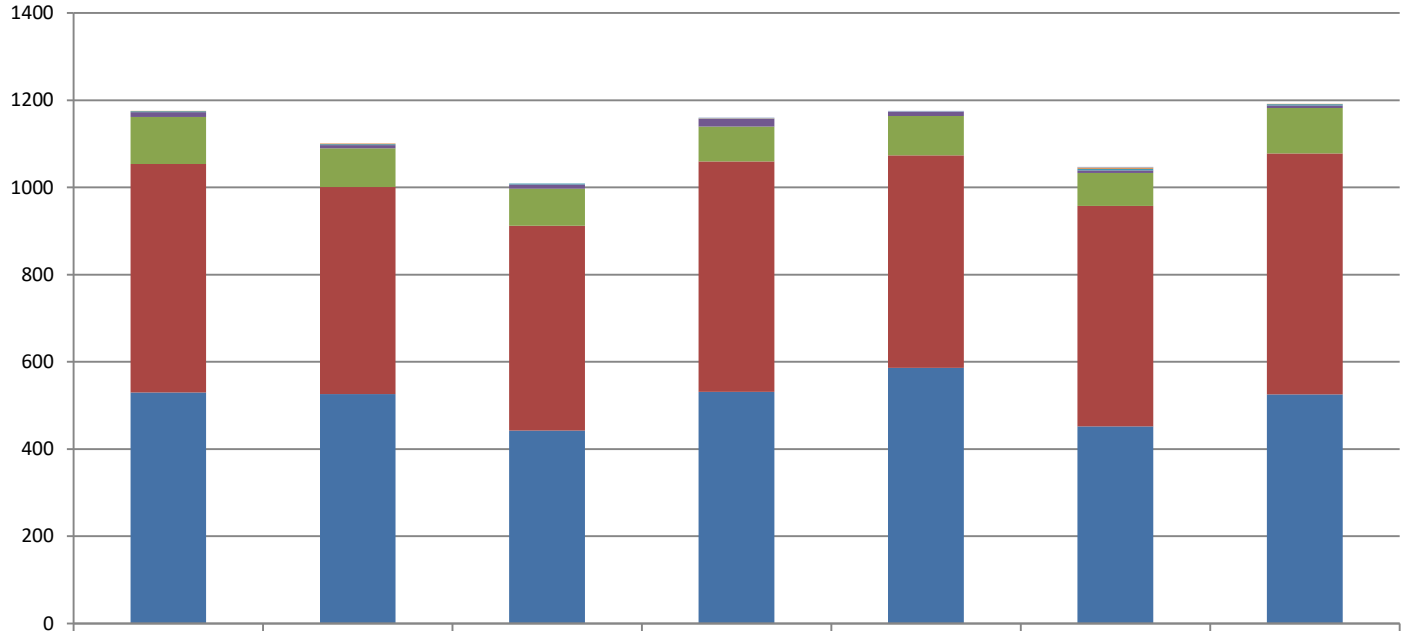
Patient incidents reported this financial year (by severity)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
1 - No harm	919	845	786	883	940	800	944
2 - Low Harm	241	225	199	246	212	219	221
3 - Moderate Harm	11	16	18	12	18	19	20
4 - Severe Harm	2	8	1	5	2	2	4
5 - Death	1	2	0	2	0	3	3

1c. Patient incidents

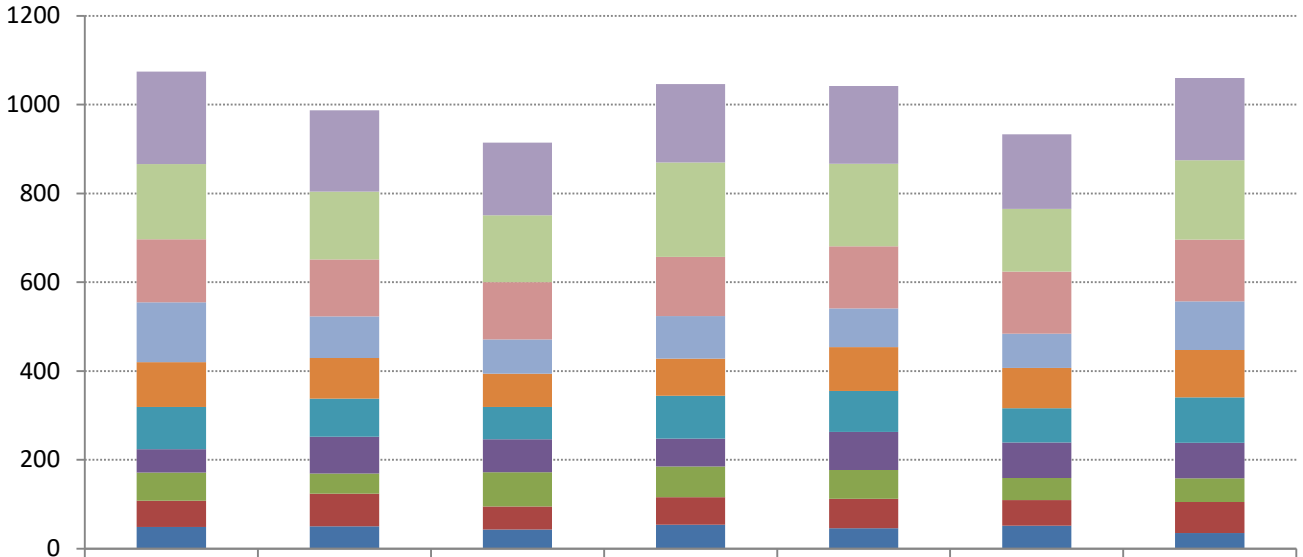
Patient incidents reported this financial year (by hospital)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	YTD TOTALS
John Coupland Hospital	0	0	0	1	2	1	0	4
Skegness Hospital	1	2	0	1	0	3	1	8
Spalding Hospitals	2	2	2	1	0	4	3	14
County Hospital, Louth	11	7	10	17	10	6	6	67
Grantham & District Hospital	108	89	85	80	90	75	104	631
Lincoln County Hospital	524	475	470	529	488	506	553	3545
Pilgrim Hospital, Boston	530	526	442	531	586	452	525	3592

1d. Patient incidents

Patient incidents reported this financial year (top 10 categories)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	YTD TOTALS
Patient Accidents/Falls	208	183	163	176	175	168	185	1258
Medication/Biologics/Fluids	169	153	151	213	186	141	179	1192
Diagnostic Processes/Procedures	142	128	129	133	140	140	139	951
Administrative Processes	135	94	77	96	87	77	110	676
Documentation	101	91	75	84	99	91	106	647
Pressure Ulcers	95	86	73	96	92	77	103	622
Behaviour	53	83	74	63	86	80	80	519
Maternity Care	63	45	77	69	65	50	53	440
Communication	59	74	52	62	66	57	70	422
Therapeutic Processes/Procedures	49	50	43	54	46	52	35	329

1e. Patient incidents

Analysis

- 1192 patient incidents were reported in October, which is consistent with the monthly average for 2019/20 so far
- 'Patient accidents / falls' remains the highest volume incident category in 2019/20; 185 incidents were reported under this category in October, the highest number in any month since April
- The average number of patient falls with significant harm reported each month so far in 2019/20 is 3.85; there were 5 in reported September and 5 in October
- The number of 'Administrative Processes' and 'Documentation' incidents reported in October were noticeably higher than they have been in recent months
- There were 32 incidents related to the 'Discharge' process or documentation reported in October; 28 incidents related to 'Access & admission' or 'Referrals'; 20 incidents related to the management of 'Paper medical records'
- 103 'Pressure Ulcers' incidents were reported in October, the highest number in a single month since February; of these, there was 1 graded as Moderate harm (Category 3) and all others were Low or No harm

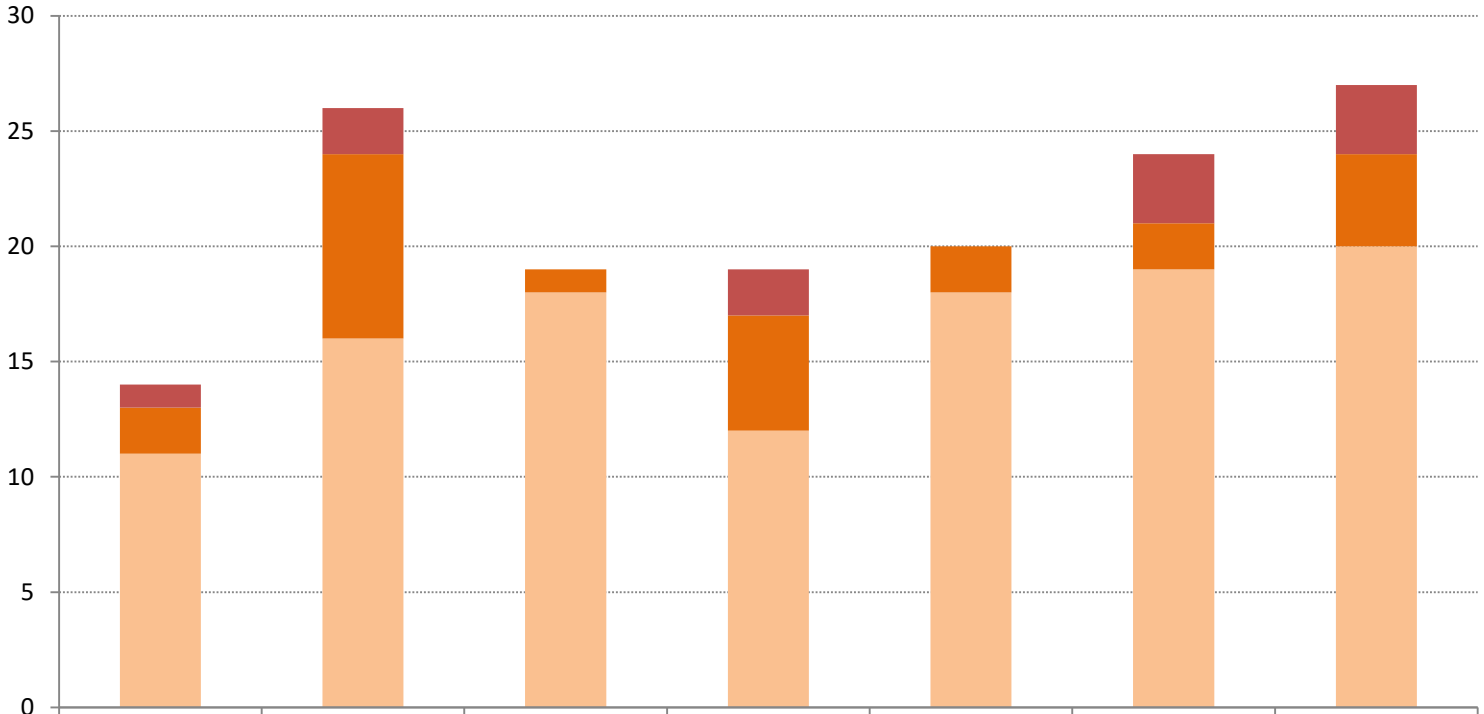
1f. Patient incidents

Analysis

- The relatively high number of patient behaviour incidents has been identified within Medicine Division as being due to reporting practice at Pilgrim Hospital, with the majority of incidents occurring within A&E; security staff have now received additional guidance on what should and should not be reported as an incident on Datix
- The Trust had been highlighted by the NHSI National Reporting & Learning System (NRLS) as potentially under-reporting patient incidents between October 2018 and March 2019; analysis of NRLS data alongside Trust data from Datix has identified a technical issue with the export of incidents in January and February 2019 as the reason for this; the issue has now been corrected and all incidents reported to NRLS; Trust data has continued to show a consistent level of incident reporting throughout the last 2 financial years

2a. Significant harm incidents

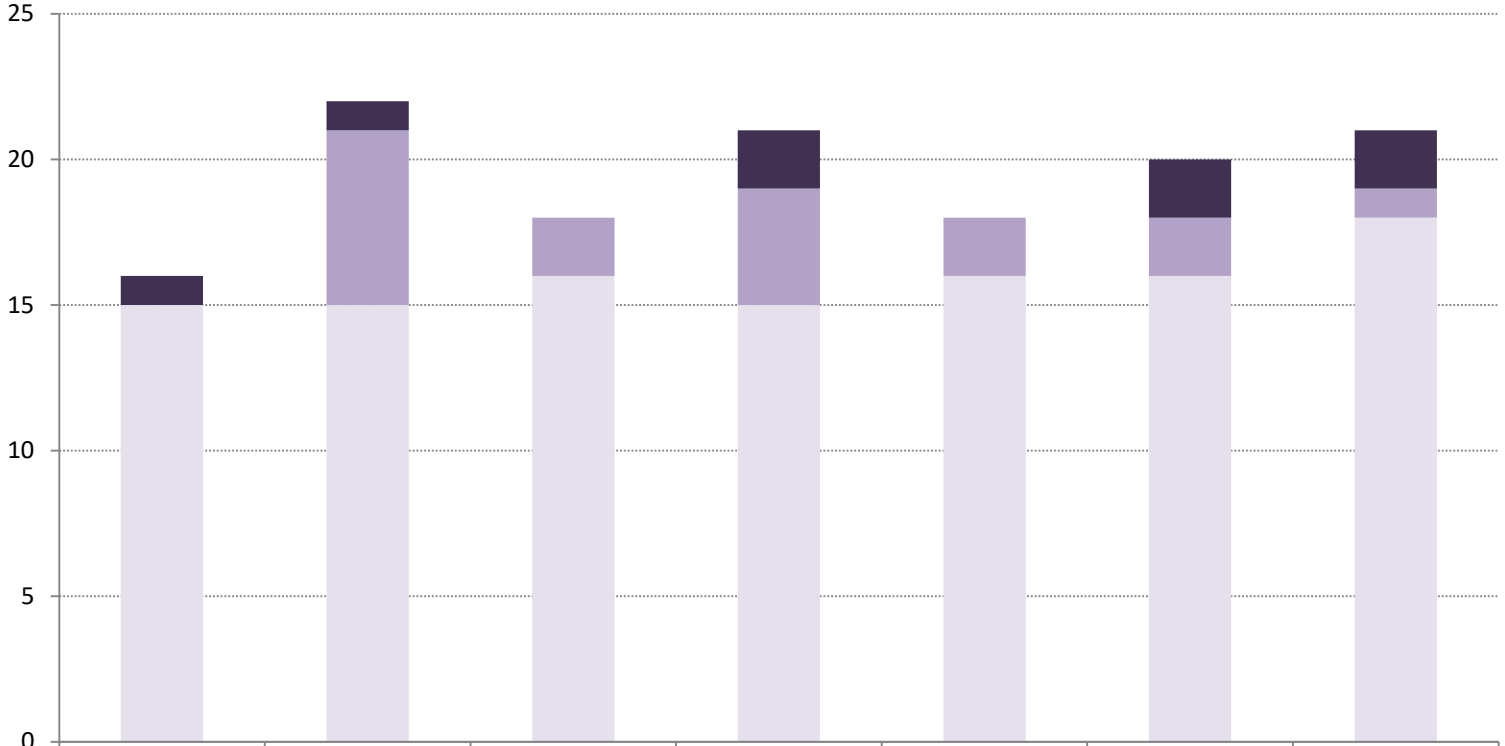
Significant harm incidents this financial year (by reported date)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
5 - Death	1	2	0	2	0	3	3
4 - Severe Harm	2	8	1	5	2	2	4
3 - Moderate Harm	11	16	18	12	18	19	20

2b. Significant harm incidents

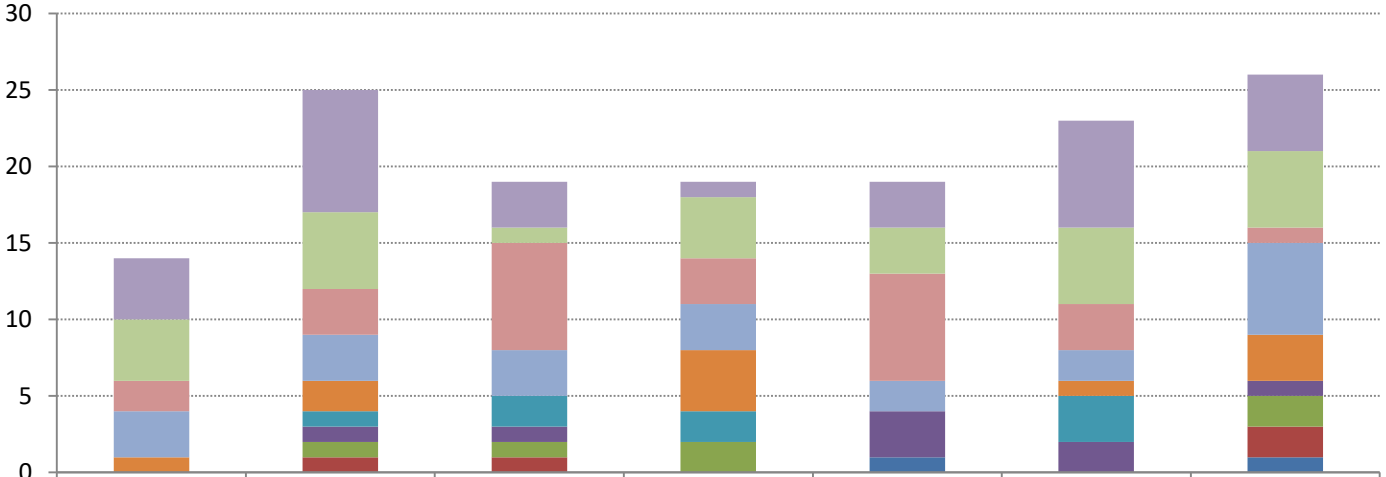
Significant harm incidents this financial year (by incident date)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
5 - Death	1	1	0	2	0	2	2
4 - Severe Harm	0	6	2	4	2	2	1
3 - Moderate Harm	15	15	16	15	16	16	18

2c. Significant harm incidents

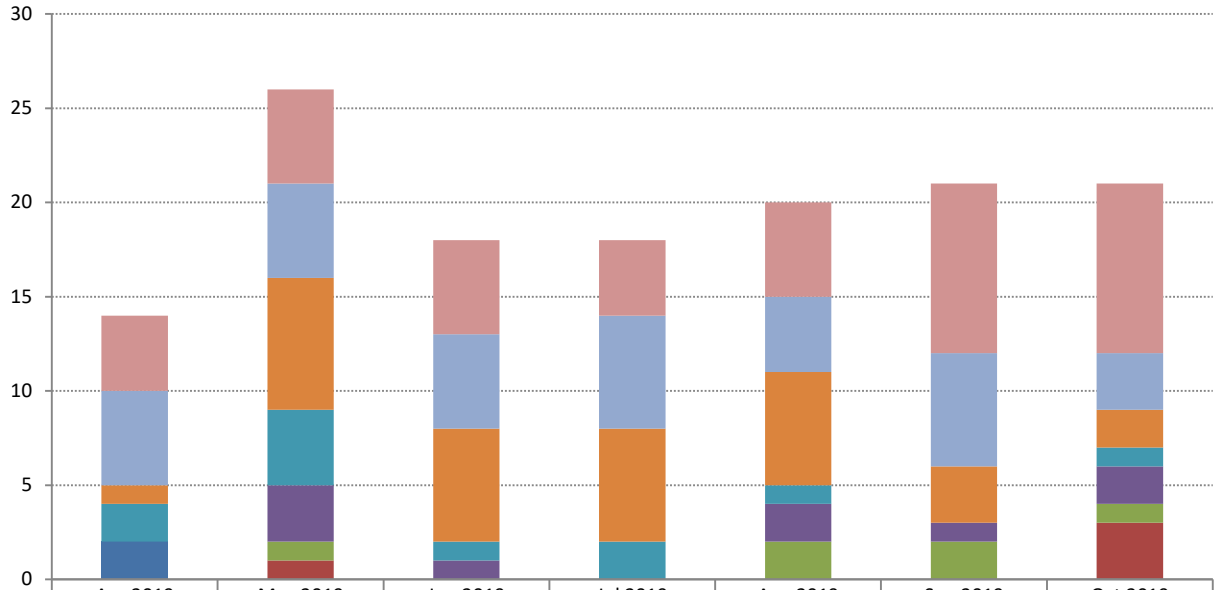
Significant harm incidents reported this financial year (by top 10 categories)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
Diagnostic Processes/Procedures	4	8	3	1	3	7	5
Patient Accidents/Falls	4	5	1	4	3	5	5
Pressure Ulcers	2	3	7	3	7	3	1
Therapeutic Processes/Procedures	3	3	3	3	2	2	6
Unexpected Deaths or Severe Harm	1	2	0	4	0	1	3
Medication/Biologics/Fluids	0	1	2	2	0	3	0
Maternity Care	0	1	1	0	3	2	1
Administrative Processes	0	1	1	2	0	0	2
Infection Control Incident	0	1	1	0	0	0	2
Blood/Plasma Products	0	0	0	0	1	0	1

2d. Significant harm incidents

Significant harm incidents reported this financial year (by location type)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
Wards @ Lincoln	4	5	5	4	5	9	9
A&E and Assessment units (IAC, AMSS, SAU, EAU, etc.)	5	5	5	6	4	6	3
Wards @ Pilgrim	1	7	6	6	6	3	2
Outpatient Department/Services OPD/Clinic Area	2	4	1	2	1	0	1
Operating Theatre	0	3	1	0	2	1	2
Women and Children	0	1	0	0	2	2	1
Other	0	1	0	0	0	0	3
Wards @ Grantham	2	0	0	0	0	0	0

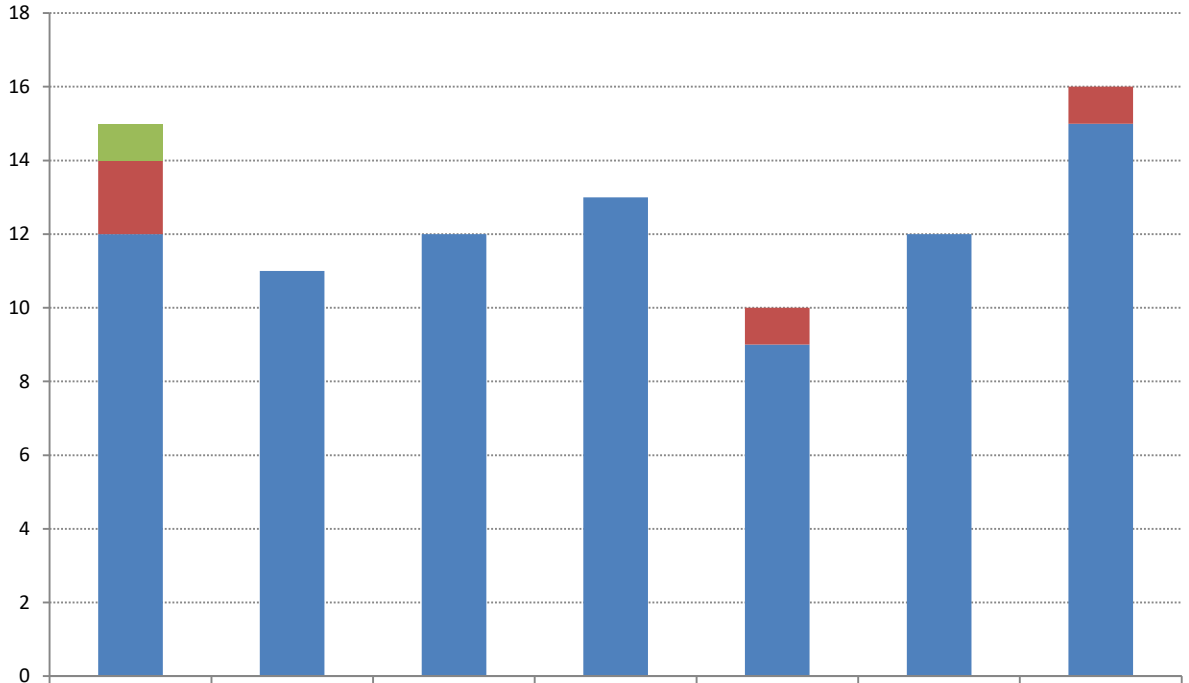
2e. Significant harm incidents

Analysis

- There were 27 significant harm incidents (those resulting in Moderate harm; Severe harm; or Death) reported in October, which is consistent with the average for 2019 so far (these figures are subject to change as a number of these incidents are currently undergoing the Rapid Review process)
- Of these 27 incidents, 21 actually occurred in September (as some incidents are reported retrospectively)
- The most frequent reported incident category for significant harm incidents remains 'Diagnostic processes'; in the last 2 months the number of Patient Falls incidents resulting in significant harm has been higher than the average so far this financial year
- 30% of all significant harm events so far this financial year have been reported on wards at Lincoln County Hospital; 22% at Pilgrim Hospital, Boston and 25% at A&E or assessment units across the Trust

3a. Serious Incidents

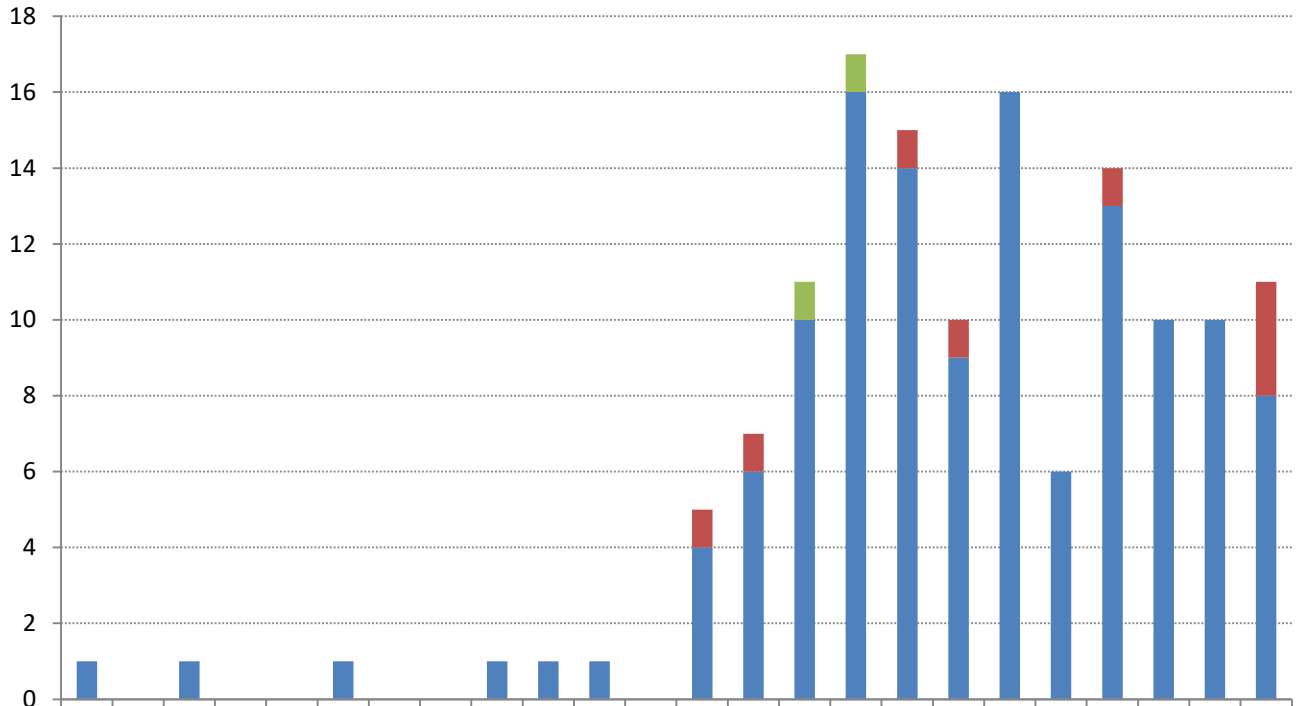
Patient Serious Incidents reported on StEIS this financial year (by date declared)



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
Independent Serious Incident investigation (StEIS)	1	0	0	0	0	0	0
Never Event Serious Incident (StEIS)	2	0	0	0	1	0	1
Serious Incident (StEIS)	12	11	12	13	9	12	15

3b. Serious Incidents

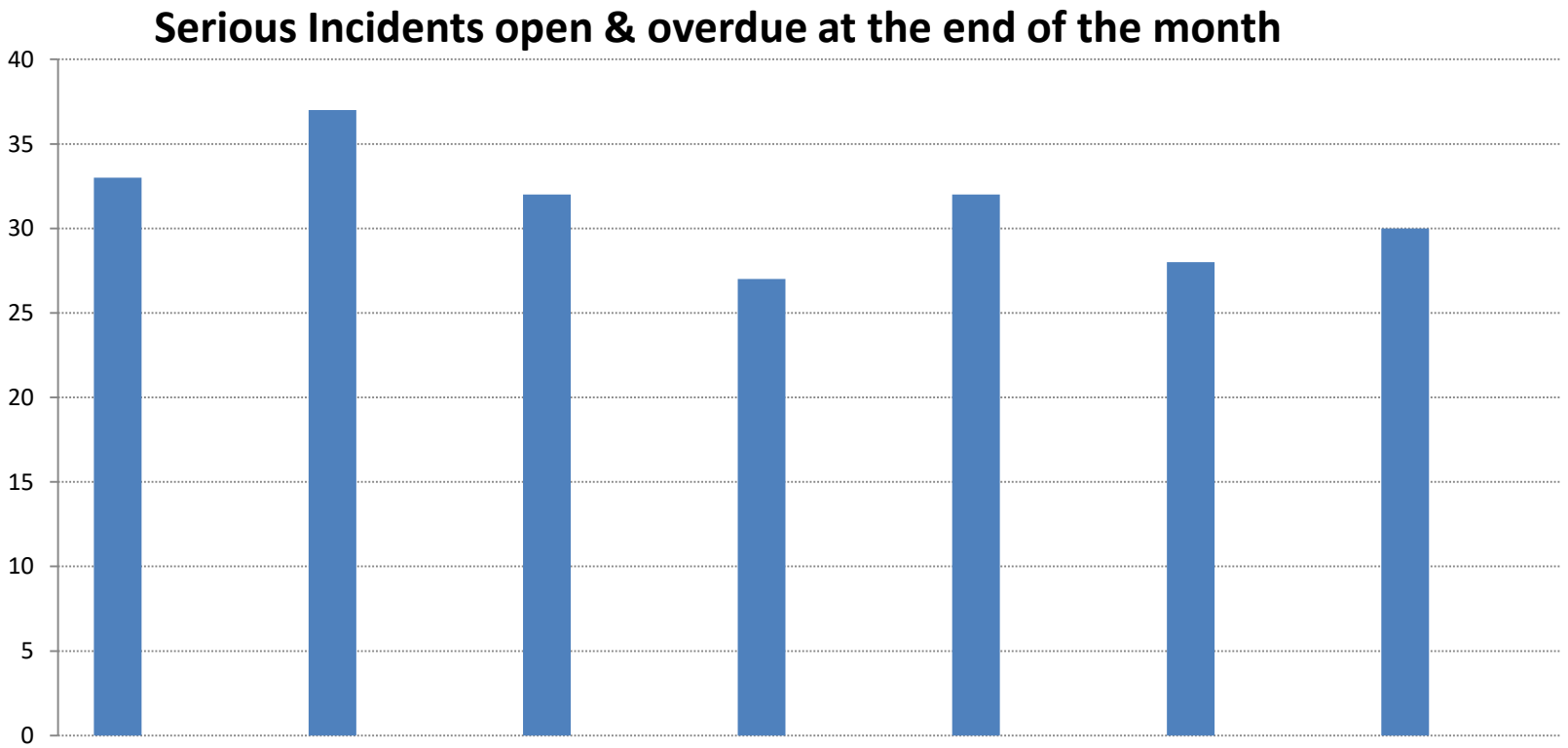
Serious Incidents declared this year (by incident date)



	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
Independent Serious Incident investigation (StEIS)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Never Event Serious Incident (StEIS)	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1	0	0	1	0	0	3
Serious Incident (StEIS)	1	0	1	0	0	1	0	0	1	1	1	0	4	6	10	16	14	9	16	6	13	10	10	8

** Plus one incident which occurred in October 2015*

3c. Serious Incidents



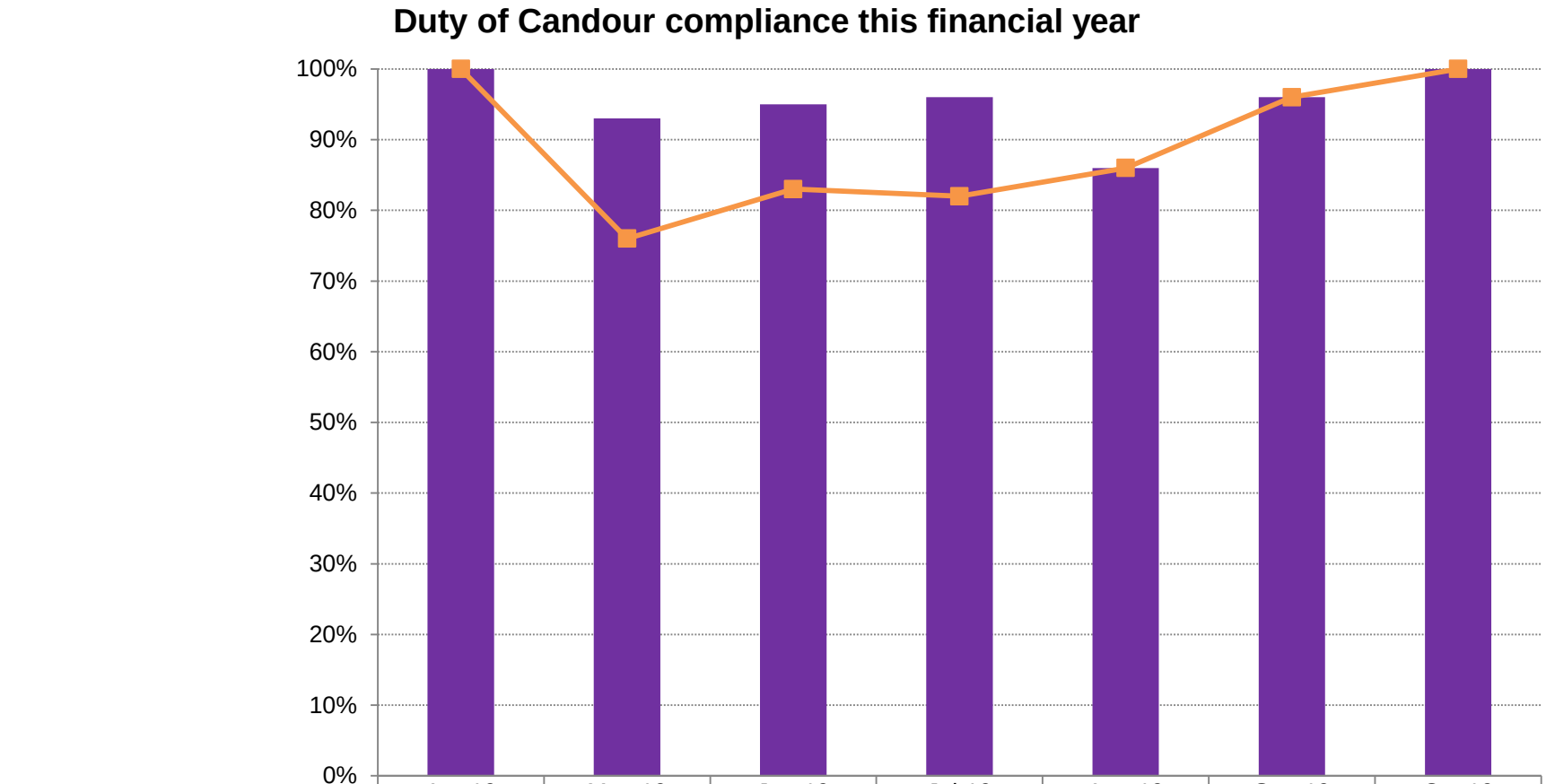
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Total SIs	33	37	32	27	32	28	30
Overdue	0	0	0	0	0	0	0
%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

3d. Serious Incidents

Analysis

- The Trust declared 16 Serious Incidents in October 2019, which is above the average of 13 for 2019 and the highest number in a single month so far this year (the average in 2018 was 18 per month)
- Of those 16, there were 11 which actually occurred in October (the other 5 were declared retrospectively)
- 1 of the Serious Incidents declared in October was a Never Event (Wrong site surgery at Lincoln County Hospital)
- 4 Never Events have been declared this financial year so far
- There were 30 Serious Incident investigations open at the end of October
- No SIs have been overdue their deadline to the CCG so far this financial year

4a. Duty of Candour



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
% DoC Notification in person	100%	93%	95%	96%	86%	96%	100%
% DoC Written follow-up	100%	76%	83%	82%	86%	96%	100%

4b. Duty of Candour

Analysis

- Duty of Candour (in person notification) compliance in October 2019 was 100%
- Written follow-up compliance in October 2019 was also 100%
- This represents the best overall compliance rate achieved by the Trust since April 2019
- Further changes have been made to the Datix system to support managers in accurately recording Duty of Candour compliance; these changes went live at the start of November
- 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

United Lincolnshire Hospitals NHS Trust

To:	Public Trust Board
From:	Victoria Bagshaw, Director of Nursing
Date:	3 December 2019
Essential Standards:	

Title:	Ward Accreditation

Author/Responsible Director: Victoria Bagshaw, Director of Nursing

Purpose of the Report:

To update the Board on the development of how Ward Accreditation is reported and the next iteration of the programme.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	✓

Summary/Key Points:

This paper details the work that has been undertaken to further triangulate patient experience information, particularly with reference to the SUPERB data, with Ward Accreditation to give a more comprehensive picture of care being delivered on wards and the experiences of patients and their loved ones.

The Trust's Ward Accreditation process has matured and become established within ULHT as the mechanism through which quality of patient care and experience is pulled together and monitored. Ward Accreditation continues to evolve to promote continuous quality improvement across our ward environments and the paper includes details of version three of the programme, which stretches wards further to improve care against the Trust's priorities including, for example, deteriorating patients and medicines management. Continued rollout of the programme in 2020 remains a priority but needs to be balanced against ensuring delivery of the existing programmes and supporting teams and areas that are not achieving expected improvements. The new areas proposed for 2020 include theatres, paediatric wards, day case areas and ICU.

Ward Accreditation has recently been identified by the national nursing team as one of the national exemplar programmes and the Director of Nursing and ULHT team are currently supporting other Trusts to develop their accreditation programmes and

the national nursing team to develop supportive resources.	
Recommendations: To note the continued maturity of the Ward Accreditation programme and external recognition of positive impact from this work programme on quality of patient care and culture of engagement and leadership by frontline nursing and clinical teams.	
Strategic Risk Register	**Performance KPIs year to date** Improvement against all 13 accreditation standards
Resource Implications (eg Financial, HR) nil	
Assurance Implications improved assurance through detailed analysis of improvements in patient care outcomes and experience, adherences to regulatory standards	
Patient and Public Involvement (PPI) Implications improvement in patient experience	
Equality Impact no	
Information exempt from Disclosure no	
Requirement for further review? On request from Trust Board, reported regularly to Quality Governance Committee	

NHS
United Lincolnshire Hospitals
NHS Trust

Ward Accreditation at United Lincolnshire Hospitals

1. Introduction

The Trust's Ward Accreditation process has matured and become established within United Lincolnshire Hospitals Trust (ULHT), as the mechanism through which quality of patient care and experience is pulled together and monitored. Externally ULHT has been recognised as having implemented a successful ward accreditation programme and has been invited by the CNO office to become a ward accreditation exemplar site. As an exemplar site, ULHT will be included within the national Collective Leadership programme resources. Ward Accreditation continues to evolve to promote continuous quality improvement across ward environments. Version three of the programme will be launched on 1st January 2020; this stretches wards further to improve care against the Trust's priorities. The existing programme contains a process to ensure that in addition to improvements in the physical aspects of care delivery and patient outcomes, patient experience is triangulated. Recent work between the Quality Matron Team and Patient Experience Team has commenced to develop a more compressive understanding of patient experience through the alignment of the SUPERB metrics with the Accreditation tools.

2. ULHT as an exemplar organization.

Central to the Chief Nursing Officer for England's (CNO) vision is ensuring the nursing and midwifery collective voice is heard across all sectors so that the professions' contribution is valued and listened to in all decision-making conversations. There is a national CNO Shared Governance: Collective Leadership Programme, which is made up of three components.

i. Local Accreditation
ii. Nursing and Midwifery Excellence
iii. Shared Decision Making

ULHT has been recognised as having implemented a successful ward accreditation programme and has been invited by the CNO office to become a ward accreditation exemplar site. As an exemplar site, ULHT will be included within the national Collective Leadership programme resources. To support this programme dedicated NHS webpages have been developed to share frameworks, tools, resources and case studies from organisations that have successfully embedded programmes with demonstrable positive outcomes.

One aspect of becoming an exemplar site has involved working with a film production crew to develop a video resource, which includes Ward Sisters and the Quality Matron team sharing their experiences of ward accreditation supporting improvements in patient care and staff experience. This will be shortly available within the national resources.

Recently ULHT Director of Nursing was asked to join other exemplar sites and share ULHT's work at a National Local Accreditation Masterclass. The sharing of ULHT's

journey received extremely positive feedback and we have received requests by a number of other organisations to visit and learn more about our work.

3. Improvements to the Accreditation Programme planned for 2020

The yearly update of the ward accreditation metrics has been completed to incorporate the latest national guidance and areas of local 'stretch' that have been agreed with Divisions. In the 2020 iteration, the principal development is that the deteriorating patient and medicines safety standards, now have the same weighting as Infection Prevention & Control. Therefore, if a ward is graded 'red' in any of these domains the ward is allocated an overall red accreditation score. The rationale for this is that these three standards are all equally fundamental, and any insufficiency whereby a ward fails to achieve in these areas, gives an indication of the potential negative impact on patient safety in the clinical area. It is expected that this 'stretch' will be a challenge for some areas to continue to achieve their GREEN status.

2020 will see the first applications for 'Gold' ward status. Wards are eligible to apply for their 'Gold' accreditation status once they have received three consecutive Green accreditations, including containing no red standards from their latest accreditation result. The status reflects 'value –added' rather than continuous compliance with standards.

There is continued progression to develop accreditation tools for Day case areas, Theatres, Critical Care, and Paediatrics. For the critical care areas, the tool is almost complete with an expectation to pilot early 2020. The new tool for day case areas is ready to trial with pilots expected in the next 8 weeks and roll out fully in early 2020. The Quality Matron team are working with the paediatric teams to finalise the accreditation tool for trial early in the new financial year. Work on a theatre accreditation tool has commenced and the aim is to pilot in the summer of 2020.

4. Further improvements to patient experience information

Patient's experiences of care is currently captured within the accreditation process through various methods. Prior to accreditation the team will review all the FFT, complaints and compliments that a ward or department has received since the last accreditation. Key lines of enquiry are developed for further exploration during the accreditation. Whilst on the ward or department the accreditation team will observe care to ensure it is delivered with respect and dignity, and that communication occurs in a meaningful and compassionate manner. The team will also talk with patients and their loved ones about their specific experience of care, and with staff to understand what their perceptions of patient experiences are and how they use the information to improve the quality of care.

Work has commenced towards aligning Ward Accreditation metrics and the Patient Experience data metrics held and displayed within the SUPERB dashboard. ICT are developing an alternative data storage solution to enable accreditation to move from a paper to an electronic platform. Once this work has been completed, the expectation

is that the two data sets can be linked at source and compared effectively with various Patient Experience data sources. Currently this triangulation occurs but is difficult and across multiple formats and platforms.

A single centralised repository is currently under development and will incorporate all actions assigned to each ward, regardless of the source of those actions. This work started as a more streamlined and manageable way of maintaining an action plan following a Ward Accreditation visit. However, it is apparent that the same approach could be scaled up to include all actions from all plans. This unified action plan will facilitate oversight on progress across all action plans both at ward level, but also at higher levels as appropriate. An early prototype of this unified action plan is currently being tested within two wards and is undergoing further review and development. The Director of Nursing is in discussion with the CCG about the use of the single action plan with CCG's to give greater assurance and reduce duplication.

5. Conclusion

Trust Board are asked to note the continued maturity and expansion of the Ward Accreditation programme to drive a culture of continuous improvement and align more closely the experience of patients. Also to note the external recognition by the national nursing team of the positive impact from this work programme on quality of patient care and culture of engagement and leadership by frontline nursing and clinical teams.

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 November 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 including Financial Efficiency Programme Reason for lack of Assurance: The Committee were advised that at Month 7 the Trust was reporting a £1.9m adverse variance to plan with a year to date deficit of £30.7m, inclusive of Provider Sustainability Fund (PSF) monies. The Committee were advised that the assumptions on the income made at Month 6 remained in the position with support from the Clinical Commissioning Groups being cash backed. However £1.9m non-recurrent support was not cash back by the CCGs and requires formal agreement. The system remain committed to ensuring the Trust maximises PSF monies and as such is operating based on the position that the Trust will recover to £70.3m at year end. Without support the year to date position is £11.4m adverse to plan which requires recovery to achieve the £70.3m Control Total deficit. Income was reported £1.3m favourable to plan mainly due to increased levels of Non-Elective Activity however has incurred £300k in fines relating to Breast 2 Week Wait standard. Outpatient activity was adverse to plan and recovery actions being taken to recover the activity to the planned level or adjust capacity as required. Pay remained the key financial pressure for the Trust with the Month 7 position being £10.4m adverse to plan. The core driver of the adverse variance remained the sustained above plan level of agency spend. Non-pay, with the removal of pass through drugs, reported £23k favourable to plan. There were a number of areas that required attention

	in order to ensure non-pay costs are contained within budget over the remainder of the year, particularly within estates and IT. The Committee were advised that the Cost Improvement Programme remained significantly behind plan. Meetings were scheduled to take place between the Director of Finance and Digital, Chief Executive and programme SROs in order to discuss issues and ensure they were held to account. The current risk adjusted position sat at £19m but was likely to reduce by circa £4m. Action to identify and implement further mitigation was taking place. There had been no formal request for borrowing during January, in line with plan due to the receipt of PSF monies. However the Director of Finance and Digital requested delegated authority from the Committee to request borrowing of £4m, if required. The Committee agreed to delegated authority for the Chair, Chief Executive and Director of Finance and Digital subject to Board approval. The Committee raised concerns about how well sighted it was regarding CQUIN and the current risk of medicines optimisation at £200k. There did not appear to be a plan in place to recover the CQUIN financial position by the year end and mitigating actions had not been received by the Committee. Action requested by the Committee: The Medical Director would be invited to the December meeting in order to discuss the mitigation of the CQUIN delivery.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Fire Update Reason for lack of Assurance: The Committee received the update noting that this was not an assurance report but simply provided the current position, not detailed against the plan. Concern was noted due to the drift of the timescales for completion of the programme however the Committee acknowledged that the extension had been granted by Lincolnshire Fire and Rescue. The Trust were on track for delivery at the end of May 2021. The Committee were verbally updated that all fire doors had been installed at Pilgrim and Lincoln, with the exception of one external metal door at Lincoln. All doors had been delivered on site to Grantham and were awaiting installation due to additional electrical work that was required prior to installation. Advisors had been brought in to the Trust to support the development of lockdown plans and the development of the lockdown policy.

	Actions requested by the Committee: The Committee requested an assurance report against the programme plan at future meetings.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Reinforced Autoclaved Aerated Concrete The Committee were advised that the Trust had received a notice from NHS England/Improvement with regard to Reinforced Autoclaved Aerated Concrete (RAAC) and the concerns regarding structural safety. A site survey had been undertaken that had identified one non-patient area on the Grantham site. It had been unclear as to the quantity of RAAC due to this being in a sealed asbestos area. The Board would be advised of the return made by the Trust and further work was underway to commission specialised structural engineers to conduct inspections across all affected sites.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: ICO Report (Subject Access Requests and Freedom of Information) Reason for lack of Assurance: The Committee were advised that the Trust had not been meeting the target of 90% compliance for completion of Subject Access Requests within the statutory timeframe. The increased number of requests had been as a result of the change in legislation which removed the charge to the individual associated with making a request. The Committee were advised that the main issues were staffing, clinician sign off, redaction not being completed and time for staff to complete the copying of records. The Information Commissioners Office had received a number of complaints which had resulted in a data return submission and subsequent submission of an action plan on 15th November. There was a risk to the organisation that an enforcement notice could be received from the ICO, this could cause a reputational issue for the Trust. Non achievement of the enforcement notice, if issued, could result in a fine. The Information Governance Group had considered the action plan to improve compliance to the statutory timeframe and the plan would be monitored through the group and progress upwardly reported to the Committee.
	Lack of assurance in respect of SO1 Providing Consistently Safe,

	Responsive, High Quality Care Issue: 4 Hour Performance Reason for lack of assurance: The Committee were advised that there continued to be a reduction in 4 hour performance that had been driven by increased demand and bed occupancy. There had been an 13% increase in emergency admissions against plan which had driven additional bed demand of circa 80 beds. Delayed transfers of care had also seen an increase due to the number of patients requiring support at point of discharge. The Committee were advised of a number of actions being taken including long length of stay, ready steady flow and adoption of wards by Directors and Deputy Directors. System schemes would be implemented during December which would focus on supporting patients out of the acute setting. The system had experienced additional demand earlier than expected and the start date of the schemes to reduce demand. Improvement was expected to be seen during winter with the schemes in place however this would only be achieved if there was no further increase in volume of demand. The Committee were advised that the improvement plan was on track with actions being delivered against the plan with further actions to be put in place. The rapid handover protocol was in place to support the community risk and release ambulance crews to attend. Action requested by the Committee: The Committee requested that an update be reported to the February Board to include the strategy to manage urgent care.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Lincoln Reconfiguration The Committee were advised that there had been significant progress on the Lincoln reconfiguration and had reported ahead of the expected position. Work was being undertaken with community colleagues in order to support the flow of patients both in hospital and in the community. GP streaming would be relocated in order to expand the service to become an Urgent Treatment Centre with Ambulatory care relocating to primary streaming during December. Greetwell Ward had been identified as a swing ward and for the duration of the winter period, from 23rd December, would become a medical ward,

	support was currently being put in place to support this change. The creation of short stay wards would impact on the turnaround of patients. The main risks associated with the reconfiguration had been identified as staffing and a potential increase in cost as short stay wards were more labour intensive. As such there would be a change to staffing establishments. Further discussions were held regarding areas that may have capacity for additional beds, however remedial estates work would impact on capital spend. A decision would be required to determine if there was sufficient benefit to open additional beds or if the costs should be taken out with no additional beds opened.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Cancer Constitutional Standards Reason for lack of assurance: The Committee were advised that the Trust continued to achieve 3 of the 9 cancer standards during September and that a step change had not been made. The cancer action plan submitted to the Committee had been identified as no longer being fit for purpose and was being reviewed and developed using a dashboard developed in partnership with KPMG. The developments would allow a clear view to track milestone achievement against the constitutional standards. It would be possible to use the information as a forecasting tool in order to ensure corrective action could be undertaken as required. Action requested by the Committee: The Committee requested that future reports on performance against the cancer standards provide assurance on the actions being taken and their impact on improving performance
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: EU Exit The Committee received a verbal update noting that regional reporting had been stood down nationally due to the delay of the EU Exit date. There were no new risks to advise the Committee of however planning continued locally.
	<u>Assurance in respect of other areas:</u>

	<u>Committee Dashboard:</u> The Committee received the dashboard, noting that a number of areas had deteriorated. The Committee identified the need for the additional metrics to be included within future reports and again requested that the data be provided against all measures on the dashboard. <u>Board Assurance Framework:</u> The Committee undertook a review of the content of the Board Assurance Framework identifying a number of updates and confirming the assurance ratings. The assurance ratings would remain RED.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	
Committee Review of corporate risk register	The Committee received the corporate risk register and noted that there had been no material change to the corporate risk profile or very high and high risks.
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 discussions.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

Voting Members	D	J	F	M	A	M	J	J	A	S	O	N
Gill Ponder, Non-Exec Director	X	X	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	A	X	X	A	X	A	X	A
Deputy Chief Executive	X	X	X	A	A	A	X	X	X			
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	D	X
Chief Operating Officer	A	X	D	X	X	X	X	D	D	X	D	X
Director of Estates and Facilities	D	X	D	A	X	D	X	X	D	X	X	D

X in attendance A apologies given D deputy attended

Report to:	Trust Board
Title of report:	Workforce, OD and Transformation Committee Assurance Report to Board
Date of meeting:	13th November 2019
Chairperson:	Geoff Hayward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme.
Assurances received by the Committee	**Lack of Assurance in regard to Workforce KPI Report** **SO Ref: SO3a** **Reason for lack of assurance**: The Committee received the key performance indicators noting that there had been some improvement of the Friends and Family test. The national FFT had increased from 47% - 66% in respect of the Trust being recommended as a place for treatments and an increased from 41% to 56% as a place recommended to work. Further work was required to continue to see improvement in the scores however this had demonstrated positive movement. The Committee noted that despite the improvements within the FFT in general all other targets were being missed and as such the Committee could were not assured. There were some assurances given regarding medical and nursing agency as the initiatives had shown improving progress in some areas. For example the new ED rota and reduced tier 6 usage. However, further consistent evidence over a longer period would be required to gain full assurance.
	Assurance in regard to Workforce Planning **SO Ref: SO3a** **Source of Assurance:** the Committee were assured that work had begun regarding workforce planning and a detailed review had been received by the Committee. There were some concerns raised by the committee about the alignment of the Trusts workforce plan to the system assumptions. This was being addressed.

	Lack of Assurance in regard to Financial Efficiency Programme **SO Ref: SO3a** **Reason for lack of assurance:** The Committee received assurances that work was still being progressed on the plans for recruitment and agency price and were advised that these areas were on target to achieve the latest risk adjusted value. The Committee were not assured on the delivery of the medical capacity and E—roster and activity management plans. There had been risk adjusted to £250k.
	Assurance in regard to Summer 2018 Friends and Family Test **SO Ref: SO3b** **Source of Assurance:** The Committee received the latest scores in relation to the Friends and Family Test, this had demonstrated improvements in the areas of recommending as a place to work and to receive treatment. Work was underway to address the issues raised through the results and themes identified to support actions required. The Directors and Deputy Directors had already 'adopted' a ward to help form relationships on the wards and increase visibility with staff.
	Lack of Assurance in regard to Bullying and Harassment Concerns **SO Ref: SO3b** **Reason for lack of Assurance**: The Committee were not assured that the changes to be made would be effective at the right pace. The work undertaken had confirmed the themes, including, senior leadership, policies and procedures and culture. The Organisational Development Team would be launching a 'building respectful teams' challenge from early 2020 with a target of reaching 60% of the organisation by March 2020. A number of actions were in hand to progress including the freedom to speak up champions and well being support from occupational health.

	Assurance in regard to Equality, Diversity and Inclusion Group and Annual Plan **SO Ref: SO3b** **Source of Assurance**: The Committee received the update from the Equality, Diversity and Inclusion Group and the annual plan. The Committee were assured of the progress via the ratings given to the Trust by the Clinical Commissioning Group and Care Quality Commission. Work would be required to continue progressing however plans were in place to achieve.
	Assurance in regard to WRES Aspirational Goals – Representation at senior levels **SO Ref: SO3b** **Source of Assurance:** The Committee received the report regarding the aspirational goals of representation at senior levels. There remained a challenge regarding representative leadership and goals would require defining along side a review on how to progress. This would be developed in to the overall approach to talent management and an update would be presented back to the Committee in January to advise of the action to be taken.
	Lack of Assurance in regard to Freedom to Speak Up Guardian **SO Ref: SO3b** **Reason for lack of assurance:** The Committee received the latest Freedom to Speak up report noting that awareness of the service remained low and this had been reflected in the CQC report. Most referrals to the service had contained elements described as bullying. 12 Freedom to Speak Up Champions had been identified across the Trust and regional training had been requested a date for this was still awaited. The Committee received the action plans in response to the two most recent NGO case studies. The Committee would monitor identified actions in line with the regular updates in the committee annual work programme.
	Assurance in regard respect of other areas: **Continuous Quality Improvement Programme** The Committee were assured there was a training programme in place and that 4 cohorts (200+ staff) had been through the programme with more staff coming through. The Committee were not assured that there was a clear identification of the areas of improvement to be followed by the staff to be able to assess, from evidence, the effectiveness of the training being put into use.

	Board Assurance Framework The Board Assurance Framework was presented to the Committee who agreed that the current assurance ratings remain however requested a review of the gaps be undertaken by the Committee Chair, Director of Human Resources and Organisational Development and Deputy Trust Secretary. **Risk Register** The Committee noted the risks and identified that the recruitment efforts were not having an effect as 12 of the 13 clinical business units were showing workforce capability and capacity as a high risk. This was particularly within medicine, cancer, pharmacy, therapies and rehabilitation. **NHS Improvement Observation Feedback** The Committee reviewed the feedback from the observations made by NHS Improvement and considered the proposed action plan. The Committee endorsed the action plan and requested monthly review **Improving Partnership Working with Trade Unions** The Committee held a discussion about the partnership working with Staffside
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	No areas identified
Committee Review of corporate risk register	None
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	No further areas identified.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**
Geoff Hayward (Chair)	No meeting	X	No meeting	X	No meeting	X	No meeting	X	No meeting	X	X	X
Sarah Dunnett		X		X		X		X		X	X	X
Alan Lockwood		A		A								
Non-Voting Members												
Martin Rayson		X		X		X		X		X	X	X
Matthew Dolling		A				A		A		A	A	A
Debrah Bates		X		X		A						
Simon Evans						X		A		X	X	X
Victoria Bagshaw										X	X	X

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

Title:	Integrated Performance Report for October 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 October 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
November 2019

EXECUTIVE SUMMARY

Quality

The Trust implemented a modified hand hygiene compliance tool in April 2019 and anticipated a drop in compliance as a result. The new audit tool suggests that all professions are equally at an inconsistent standard, as a result of this the IP&C team are now undertaking more focused work through core learning and bespoke training to address the compliance issues.

There was one reported case of MRSA Bacteraemia in October, which is currently under investigation. Preliminary investigation has highlighted a number of lapses in care relating to peripheral IV cannula management. Actions already in place to share the learning from the incident.

There have been three falls resulting in moderate harm for October, all incidents have been through the Rapid Review process and one declared as a Serious Incident. All three falls will be reviewed by the Falls Scrutiny Panel and lessons learned will be shared back to the individual clinical teams and more widely through the Falls Ambassadors.

October's data for Pressure Ulcers would appear that there has been a significant increase in the number of reported Category two's from September. Discussion with the Tissue Viability team would suggest that the data for September is not correct. The Risk and Incident team have been asked to undertake a review of September's data for validation purposes.

There has been one declared Never Event for October due to Wrong Site Surgery in Urology Theatres at Lincoln. This is currently under investigation. There are now four Never Events declared for 19/20 financial year. Of the 16 declared Serious Incidents in October 12 of those reported occurred in previous months.

Medicines incidents reported as causing harm has reduced for October to 8.4% and is within the agreed target. Work continues through the QSIP action plan to reduce harm and reduce omitted and delayed medicines.

The Trust currently has two Patient Safety Alerts that are now both overdue one from February and one from October 2019. Both have been escalated through the Patient Safety Group and feedback is expected in November 19.

SHMI (May 2018-April 2019) is 109.82 and is in band 2 within expected limits. Clinical Governance are currently triangulating data from deaths within 30 days, readmissions and care home admissions to develop a work plan to reduce the SHIMI ratio.

There are still a number of NICE Technology Appraisals outstanding for the Trust. A lead Pharmacist for each speciality has been allocated to work with the lead Clinician to complete all outstanding baseline assessments. There are a number of historical baseline assessments dating back to 2000, improvement trajectories have been set and are being monitored through the Clinical Effectiveness Group.

eDD performance has improved for October with a rate of 93.8% of eDD's being sent within 24 hours. 48-hour performance is also the highest at 94.5%, which is also a 3.5% improvement over the last year.

Sepsis data for October shows that compliance with the bundle for adults both in ED and inpatients has declined. Areas on the league table that are under 90% are receiving further input from the Sepsis Practitioners. Compliance for IV antibiotics in children both in ED and inpatients remains below the target of 90%. Harm reviews continue to be undertaken by the Sepsis Practitioners and at present, no harm has been reported.

The trend in increasing rate of Induction of Labour has been discussed at length in Speciality Governance. The increase in the induction rate mirrors a National Trend. A clinical working party has been formed to look at the Induction of Labour decision process in place across ULHT with a view to reviewing each case put forward for Induction.

National birth rate is falling, this general trend is reflected in the birth figures for ULHT. Women have choice in where to birth and 15-17% of women booked for antenatal care at ULHT will choose to birth at a neighbouring unit, largely due to proximity/geographical area. The plan for increasing choice within ULHT with the plan for a Midwifery Led

Unit will fulfil the current gap in midwifery led hospital based services. The early successes of the continuity of carer module will potentially change the choice for some of these families.

Operational Performance

Zero waiting indicators showed substantial deterioration across many areas. September 4 hour standard performance dropped sharply from Septembers peak and failed to meet trajectory and standard. In context demands on urgent care services continue to exceed expected contractual levels in adult emergency care as and operate at significantly higher than 2018/19 levels. Ambulance handovers waiting >59 minutes also reflected the signs of initial winter demand with a substantial increase in breaches of the target, although there was a reduction in the longest handover delays >120minute. As per emergency demand, ambulance conveyances increased again above expected levels.
October showed the first signs of winter pressures with combinations of increased demand across A&E attendances, emergency admissions and ambulance conveyances. Analysis of the impact of October has been considered across the wider system with an expectation that lessons learnt are incorporated into winter plan actions.

October saw the first stages of moves for the Lincoln Big Change reconfiguration scheme that sits alongside the 5 other urgent care improvement streams covering all aspects of the urgent care pathway. November is still on track for the next stage of delivery of Same Day Emergency Care, with a December date for ward assignments and the implementation of the swing ward.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have increased again slightly which is not in line with trajectory or improvement plans. Risk of failure to deliver trajectory is high with the large volume of pathways that must be treated being a key concern together with ongoing administration validation issues. Work with the Intensive Support Team and CCGs in relation to validation processes are promising and future reports will incorporate recovery trajectories to recover the years position.

Overall performance against the RTT incomplete 18 week standard deteriorated in September at 82.64% of patient pathways waiting less than 18 weeks for treatment. This was a 0.57% decrease from August.
In September 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. Aforementioned work with the intensive support team on validation and management of pathway processes is expected to help reduce risk of data quality issues impacting on long wait patient pathways.

The planned care improvements on data quality and pathway management continue with a focus on intensive training in October. 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.

In September the Trust achieved three out of the nine cancer standards, nationally only two of the standards were met.

Zero waiting indicators in Cancer Services showed our 62 Day Cancer performance in September (72.9%) improved in relation to our performance in August, although this was below the national percentage which was 76.9%. Regionally our performance places us below all the other trusts, with UHL achieving 74.4% and NUH who achieved 78.1%.

It was recognised that the Trust's Cancer Action Plan was no longer fit for purpose due to it not including a measurement of expected impact nor outcome, level of risk to achieving outcome and no formal sign off of completed tasks. This has now been redesigned through the new Cancer Improvement Managers and they are supporting the Divisions in its application.

The Trust continues to be in the top 15 of the largest providers of cancer treatments in the UK with September showing that the Trust remaining as 14th largest for number of treatments.

Our 62+ backlog had begun to show improvement (dropping to 78 on 4/11/19) though has increased again (100 as of 13/11/19), remaining well above the target of 40. A trajectory to regain this by the New Year was completed, with the Divisions adding the narrative on how this will be accomplished and identifying risks to achievement, with Director sign-off and shared with NHSI. This is now monitored and managed by both our internal Cancer Delivery & Recovery meeting and the external NHSI Cancer Improvement Meeting.

The 104+ backlog is reliant on the work to reduce the 62+ backlog, thereby limiting the number of patients approaching this higher level. The main themes currently contributing to patients reaching day 104 are capacity (OPA, theatres, pathology, diagnostics), admin (delay in letters or tests not requested promptly), patient fitness and patient choice to delay appointments and tertiary diagnostics and treatments. This last cohort are being reviewed and taken forward by one of the new Cancer Improvement Managers in discussions with the tertiary trusts.

The 14 day standard (2ww Suspect) that deteriorated in August has remained at a similar poor level in September (79.8%) but showing an improvement in October, back to our July level, with six tumour sites above the national standard of 93%. To better support the Divisions in managing this standard a new dashboard has been rolled out giving them sight of the patients waiting to be booked, available capacity for the next 6 weeks, tumour site referral trends for the past 18 weeks and in-month performance to-date.

Finance

YTD financial performance is £30,709k deficit, or £1,935k adverse to the planned £28,774k deficit.

Income is £7,295k favourable to plan YTD. Excluding the £616k adverse movement to plan in relation to Passthrough, Income is £6,679k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £3,692k, delivery of which is yet to be validated and is a risk to the Trust. The income position also includes £5,900k of transitional support.

Expenditure is £9,394k adverse to plan YTD: pay is £9,315k adverse to plan and non-pay is £79k adverse to plan.

The YTD pay position includes £1,021k of non-recurrent technical FEP, without which Pay would be £10,339k adverse to plan. The adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £501k favourable to plan, bank pay is £1,968k adverse to plan and agency pay is £7,850k 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.

Excluding the £616k favourable variance in relation to Passthrough, Non Pay is £695k adverse to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £2,183k adverse to plan. Some variation to plan would be expected given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure. This includes higher than planned expenditure in a number of areas e.g. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and additional building & engineering costs in Estates. Non Pay expenditure is being reviewed to ensure that any expenditure which may be capitalised is treated accordingly and that Non Pay expenditure in general is minimised.

Overall, CIP savings of £7,977k have been delivered YTD or £3,219k less than savings of £11,196k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, CIP savings delivery is £5,750k 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 October, which continues to be driven by continued higher than planned agency costs exceeding substantive staff savings, with the actual savings on substantive pay costs again reducing further in October.

The monthly run rate for total agency spend increased (+£345K) from Month 6 to Month 7 to £4.04M, with increase in both medical and nurse agency cost.

Overall Vacancy Rate improved to a six month low despite a broadly flat Turnover rate. Importantly improvement in vacancy rate of medical, nursing and AHP continue and evidences improvement in recruitment activity. Nursing vacancy rate is significantly reduced this month due to the commencement of our newly qualified nurses and establishment changes to account for qualified nursing associates as part of ward skill mixing which are all the subject of robust QIA.

Absence rate improved marginally but remains above the target, assurance is provided around continued management of persistent short-term absence and longer-term cases.

Staff appraisal rate dipped slightly.

Core learning continues above 90% and whilst below target is consistent with local provider rates.

Second Quarter Friends and Family Test (FFT) survey results show promising improvement on engagement metrics.

The number of unresolved employee relations cases remained broadly static maintaining the improved position since August.

Paul Matthew
Director of Finance & Digital
November 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostridioides difficile position	Safe	Our Patients	Director of Nursing	9	6	9	9	40		P		
	MRSA bacteraemia	Safe	Our Patients	Director of Nursing	0	0	0	1	1		F		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Our Patients	Director of Nursing	TBC	0.03	0.21	0.07	0.07				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Our Patients	Director of Nursing	TBC	0	0.21	0.01	0.22				
	Never Events	Safe	Our Patients	Medical Director	0	1	0	1	4		F		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Our Patients	Director of Nursing	99%	98.80%	99.40%	99.00%	98.94%		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Our Patients	Director of Nursing	4.3	2	1	1	21		P		
	Pressure Ulcers category 4	Safe	Our Patients	Director of Nursing	1.3	4	0	0	4		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Our Patients	Director of Nursing	19/20 will be used as a benchmark	5	2	3	15				
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Director of Nursing	80%	86.40%	85.30%		82.30%		P		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Director of Nursing	80%	73.20%	87.30%		78.10%		P		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Director of Nursing	50%	46.30%	53.20%		54.95%		P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Director of Nursing	100%	97.60%	96.10%		97.85%		F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Director of Nursing	90%	59.80%	69.30%		64.92%		F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Director of Nursing	17%	7.40%	10.70%		9.13%		P		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Our Patients	Medical Director	100	109.91	109.82	109.43	110.27		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Our Patients	Medical Director	100	89.18	91.85	91.37	90.92		P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis screening (bundle) compliance for inpatients (adult)	Caring	Our Patients	Director of Nursing	90%	96.00%	94.00%	84.00%	88.29%		F	A	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	100.00%	100.00%	100.00%	95.71%		P		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	95.20%	87.50%	100.00%	82.83%		P		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	50.00%	100.00%	75.00%	56.43%		F		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	98.00%	100.00%	82.00%	88.86%		F	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Our Patients	Director of Nursing	90%	40.00%	90.00%	100.00%	72.86%		P		
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	95.80%	97.10%	100.00%	96.42%		P	A	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Our Patients	Director of Nursing	90%	N/A	N/A	50.00%	30.00%		F		
	Rate of stillbirth per 1000 births	Safe	Our Patients	Director of Nursing	4.2%	2.93%	2.95%	2.95%	3.00%		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Our Patients	Medical Director	14	9	12	16	88		F	B	Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Our Patients	Director of Nursing	1	0	1	0	1		P		
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Our Patients	Director of Nursing	0.19	0.06	0.17	0.13	0.13		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Our Patients	Medical Director	4	6.54	5.46	6.46	6.78		F	A	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Our Patients	Medical Director	10%	13.50%	13.20%	8.40%	10.70%		P		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Our Patients	Medical Director	TBC	Data Unavailable	11	Data Unavailable	8.13				
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Our Patients	Medical Director	0	1	1	2	8		F		
	National Clinical audit participation rate	Effective	Our Patients	Medical Director	98%	91.11%	91.11%	91.11%	93.53%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Our Patients	Medical Director	90%	Not Collected	61.00%	Not Collected	61.00%		F		
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Our Patients	Medical Director	90%	Not Collected	83.00%	Not Collected	83.00%		F		
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Our Patients	Medical Director	95%	97.16%	96.98%	97.60%	97.03%		P		
	eDD issued	Effective	Our Patients	Medical Director	95%	93.0%	93.60%	93.80%	92.02%		F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Director of HR & OD	95%	91.16%	90.26%	90.52%	91.47%		F		
	Number of Vacancies	Well-Led	Our People	Director of HR & OD	12%	14.94%	15.30%	14.57%	14.78%		F	H	
	Sickness Absence	Well-Led	Our People	Director of HR & OD	4.5%	4.87%	4.87%	4.85%	4.82%		F	H	
	Staff Turnover	Well-Led	Our People	Director of HR & OD	6%	11.88%	10.92%	11.38%	10.85%		F		
	Staff Appraisals	Well-Led	Our People	Director of HR & OD	90%	76.00%	75.85%	73.93%	74.27%		F		
True North	KPI	CQC Domain	2021 Objective	Responsible Director	£'000	£'000	£'000	£'000	£'000	£'000			
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Director of Finance & Digital	-£887	-£5,136	£31	-£2,157	-£25,082	-£23,671	F	H	
	Income	Well-Led	Our Services	Director of Finance & Digital	£43,394	£41,112	£47,349	£44,230	£297,886	£291,595	P	A	
	Expenditure	Well-Led	Our Services	Director of Finance & Digital	-£44,281	-£46,248	-£47,318	-£46,387	-£322,968	-£315,266	F		
	Efficiency Delivery	Well-Led	Our Services	Director of Finance & Digital	£2,453	£940	£992	£1,090	£7,977	£11,196	F		
	Capital Delivery Program	Well-Led	Our Services	Director of Finance & Digital	£4,015	£1,751	£1,669	£1,971	£14,197	£15,255	F		
	Agency Spend	Well-Led	Our Services	Director of Finance & Digital	-£2,385	-£4,147	-£3,699	-£4,045	-£27,199	-£19,348	F	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Director of HR & OD	26%	28.09%	27.39%		28.73%		P	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Director of HR & OD	97%	86.82%	88.54%		89.31%		F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Director of HR & OD	19%	26.23%	26.43%		24.68%		P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Director of HR & OD	87%	81.95%	82.84%		81.01%		F		
	Friends & Family Test Maternity (Response Rate)	Caring	Our Patients	Director of HR & OD	23%	12.72%	15.43%		15.65%		F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Director of HR & OD	97%	96.08%	100.00%		99.1%		P		
	Friends & Family Test Outpatients (Response Rate)	Caring	Our Patients	Director of HR & OD	14%	11.16%	11.58%		10.74%		F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Director of HR & OD	94%	92.42%	93.27%		93.27%		F		
	Mixed Sex Accommodation breaches	Caring	Our Patients	Director of Nursing	0	0	0	0	0		P		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Our Patients	Chief Operating Officer	0%	3.77%	1.76%	1.59%	2.73%		F		
	Duty of Candour compliance - Verbal	Safe	Our Patients	Medical Director	100%	86.00%	96.00%	100.00%	95.14%		P	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Medical Director	100%	86.00%	96.00%	100.00%	89.00%		P	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Chief Operating Officer	80.0%	69.24%	73.07%	64.22%	68.66%	75.16%	F		
	12+ Trolley waits	Responsive	Our Services	Chief Operating Officer	0	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Chief Operating Officer	82.5%	75.27%	82.39%	79.77%	79.31%	78.43%	F		
	52 Week Waiters	Responsive	Our Services	Chief Operating Officer	0	3	1		8	0	F		
	18 week incompletes	Responsive	Our Services	Chief Operating Officer	84%	82.64%	82.27%		83.32%	83.77%	F		
	Waiting List Size	Responsive	Our Services	Chief Operating Officer	38,191	39,853	40,697				F	H	
	62 day classic	Responsive	Our Services	Chief Operating Officer	83%	65.60%	72.86%		72.30%	78.91%	F		
	2 week wait suspect	Responsive	Our Services	Chief Operating Officer	93%	78.70%	79.83%		80.98%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Chief Operating Officer	93%	62.37%	36.49%		73.08%	93.00%	F		
	31 day first treatment	Responsive	Our Services	Chief Operating Officer	96%	96.08%	97.23%		97.01%	96.00%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Chief Operating Officer	98%	98.25%	98.61%		98.72%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Chief Operating Officer	94%	96.15%	87.80%		93.45%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Chief Operating Officer	94%	88.31%	97.03%		94.06%	94.00%	P		
	62 day screening	Responsive	Our Services	Chief Operating Officer	90%	86.57%	64.52%		85.91%	90.00%	F	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Aug-19	Sep-19	Oct-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Chief Operating Officer	85%	80.13%	83.33%		83.30%	85.00%	F		
	diagnostics achieved	Responsive	Our Services	Chief Operating Officer	97.0%	94.15%	96.59%	97.65%	96.11%	98.23%	P		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Chief Operating Officer	0.8%	2.10%	1.84%	1.98%	2.09%		F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Chief Operating Officer	5%	6.35%	0.00%	3.94%	4.67%		P		
	#NOF 48 hrs	Responsive	Our Services	Chief Operating Officer	90%	90.36%	91.43%	90.48%	90.46%		P		
	#NOF 36 hrs	Responsive	Our Services	Chief Operating Officer	TBC	81.93%	82.86%	83.33%	83.14%				
	EMAS Conveyances to ULHT	Responsive	Our Services	Chief Operating Officer	4,760	5,347	5,049	5,267	5,100		F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Chief Operating Officer	0	563	516	929	634		F		
	104+ Day Waiters	Responsive	Our Services	Chief Operating Officer	5	13	14	16	107		F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Chief Operating Officer	2.80	2.52	2.57	2.72	2.65		P		
	Average LoS - Non Elective	Effective	Our Services	Chief Operating Officer	4.50	4.33	4.36	4.20	4.33		P		
	Delayed Transfers of Care	Effective	Our Services	Chief Operating Officer	3.5%	3.32%	3.38%		3.01%		P		
	Partial Booking Waiting List	Effective	Our Services	Chief Operating Officer	4,524	10,705	10,504	11,071	9,449		F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Chief Operating Officer	50.5%	35.1%	33.7%	35.1%	35.20%		F	A	
	% discharged within 24hrs of PDD	Effective	Our Services	Chief Operating Officer	45.0%	59.0%	44.5%	46.5%	54.06%		P		

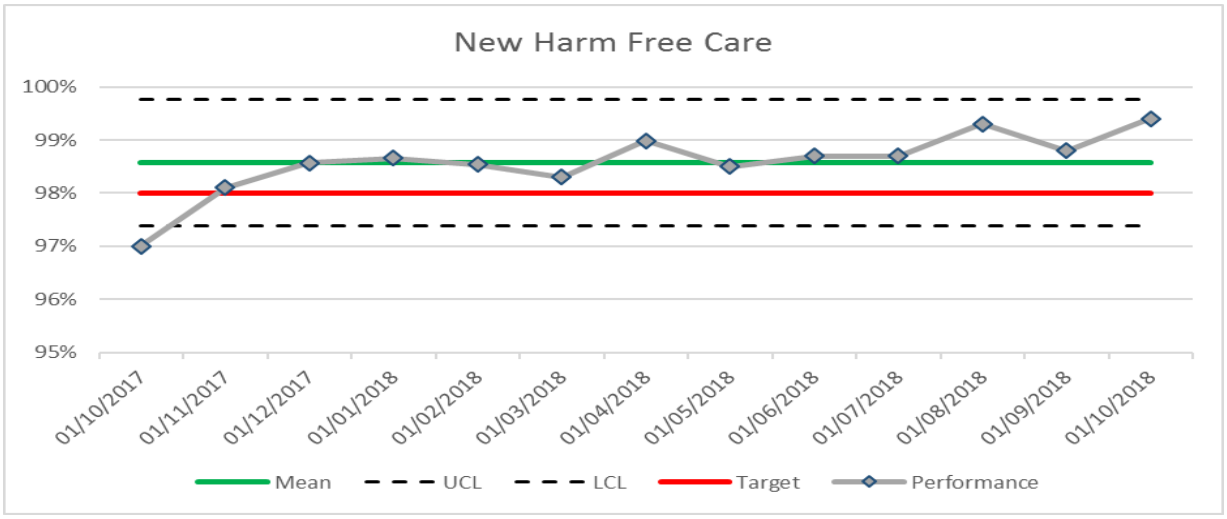
STATISTICAL PROCESS CONTROL CHARTS

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:



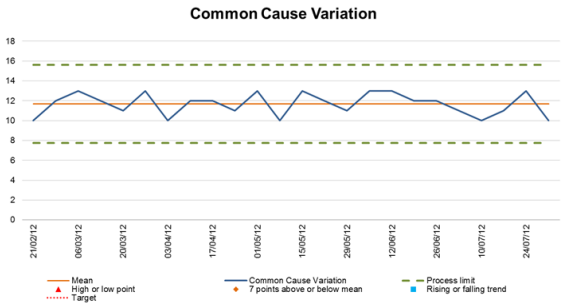
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

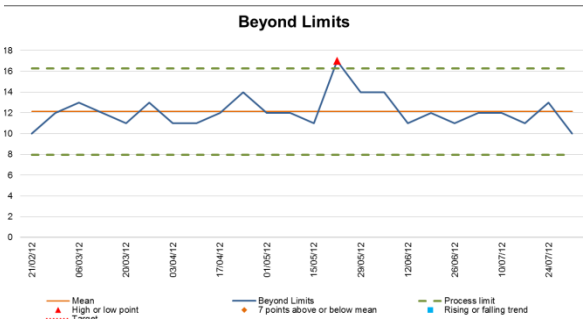
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

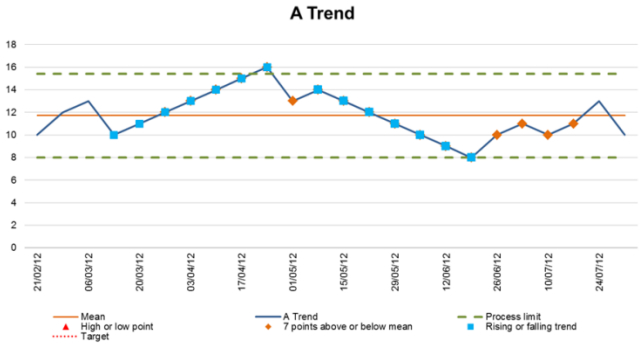


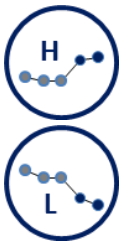
Extreme Values



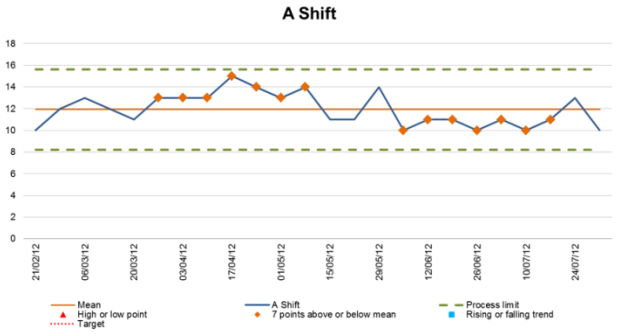
There is no Icon for this scenario.

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

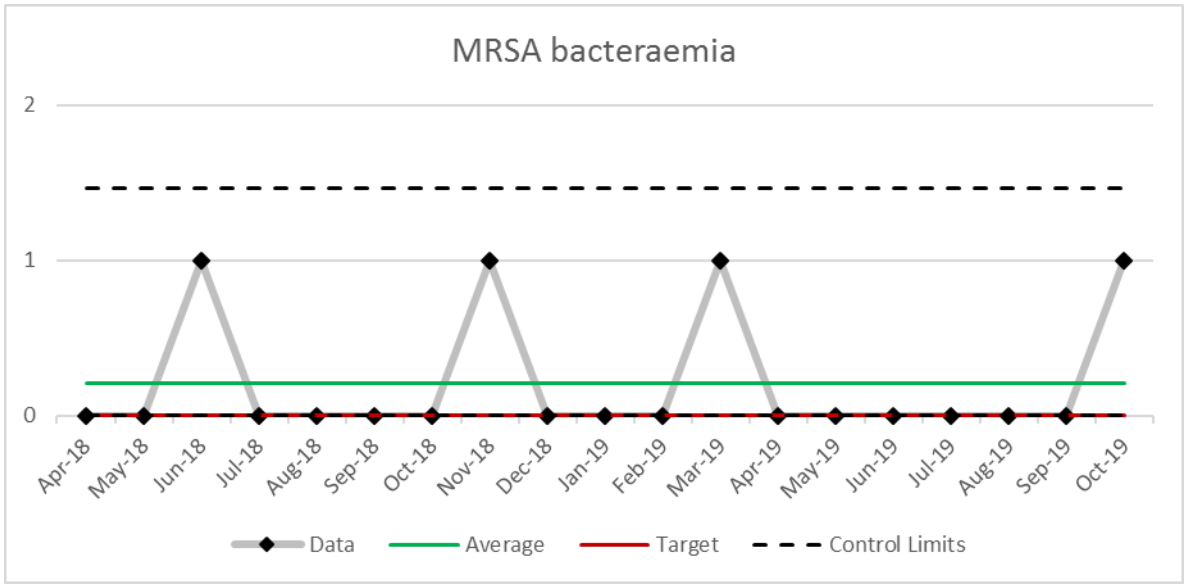
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE – INFECTION CONTROL

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

MRSA bacteraemia post infection review found that there were lapses in care relating to the peripheral IV cannula management. There were several gaps in the visual infusion phlebitis (VIP) scores and it was identified that the cannula had been in situ for six days (ideally should not be in longer than 72hrs unless clinically justified). No other significant factors could be identified that could be considered the cause of the bacteraemia.

Discussions were had with the Patient regarding the Duty of Candour and he declined a written response stating that he was satisfied with the verbal explanation by the Ward manager.

Actions in place to recover

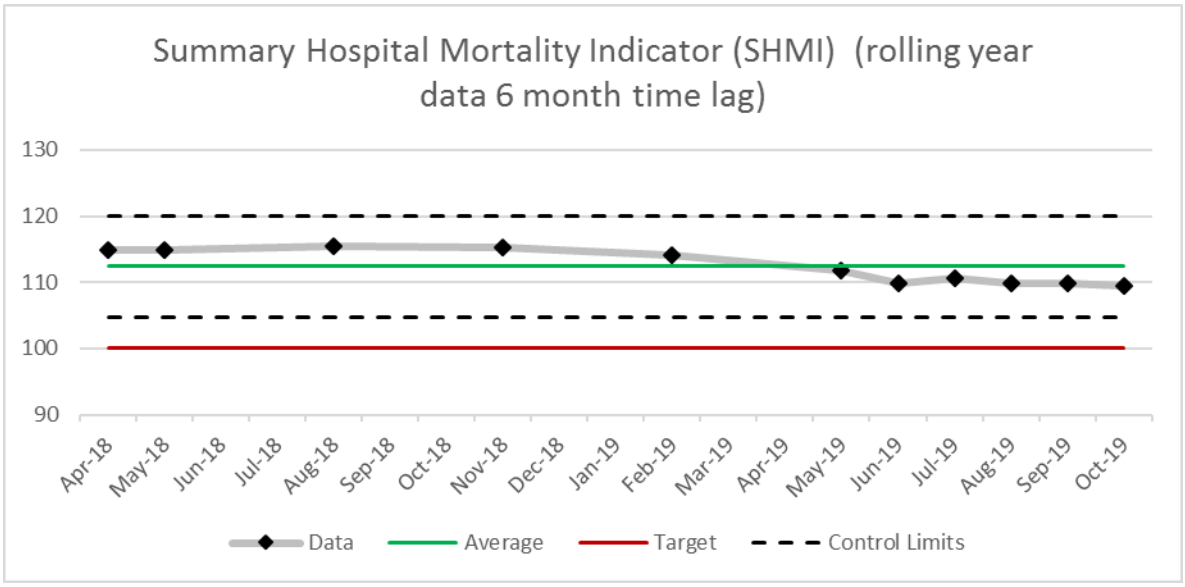
Daily ward huddles to highlight the importance of VIP scores and good peripheral IV cannula management. Ward manager increasing scrutiny of daily tasks by clinical staff to ensure missed areas are picked up and challenged.

HARM FREE CARE - MORTALITY

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients



Performance Overview

Summary-level Hospital Mortality Indicator-SHMI

ULHT are in Band 2 within expected limits with a score of 109.43, 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 May 2019. SHMI out of hospital deaths data has been updated within Dr Foster

Alerts: There are no in hospital diagnosis groups currently alerting at Trust or site level. Out of hospital diagnoses are alerting for Fluid and electrolyte disorders, Pneumonia and Sepsis. Out of hospital diagnoses are based upon hospital episode coding.

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:

- In-depth Dr Foster reviews ongoing for division of Surgery, Acute MI and Lower Respiratory Disease due to previous alerts.
- COPD and bronchiectasis action plan has been developed.
- Divisional Reports can be found in the left hand panel of this report. For Surgery HSMR reporting for the month of July this is not alerting due to small numbers and high confidence intervals.
- Other perinatal conditions is no longer alerting at Trust or Site level; actions have been put in place to ensure that maternity medway is capturing all comorbidities and conditions.
- Family Health mortality process has been developed and is being ratified at the next specialty governance in November 2019.
- 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 their 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 CCG have developed Enhanced Health in Care Home work programme in line with National care elements.
- LeDeR (Learning disabilities) steering group was held in October 2019 and a theme emerging from LeDeR reviews is the compliance of completion of the learning disability annual health check completed by GP's it was agreed that an improvement plan would be developed. Full LeDeR steering group update is included.
- Patient Safety briefing has been disseminated for new legislation published by the ministry of justice for notifying a death to the coroner.
- The mortality review assurance group (MoRAG) have asked to highlight an on-going theme within MoRAG reviews—fluid balance management. Mortality with identified issues of Fluid Balance Management is being monitored through the quality schedule and compliance is monitored through the safety quality dashboard and is consistently scoring below 95% with low compliance for metrics fluid input and output recorded correctly and running balance not recorded.
- Clinical governance are currently triangulating data from deaths within 30 days, readmissions and care home admissions to develop a work plan to reduce the SHMI ratio.

Crude Mortality

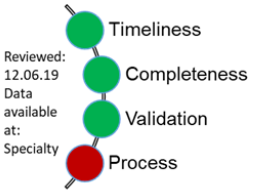
The crude mortality has increased in October 2019 to 1.45%. In rolling year November 2018-October 2019 crude has decreased slightly to 1.63%.

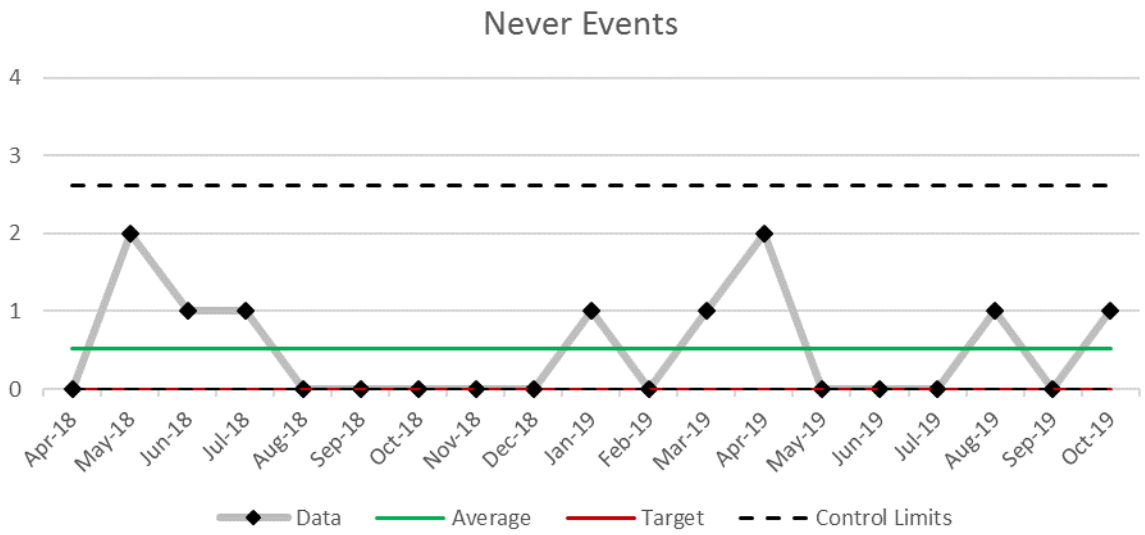
HARM FREE CARE – NEVER EVENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- 1 of the Serious Incidents declared in October was a Never Event (Wrong site surgery – Urology / Lincoln Theatres)
- 4 Never Events have been declared this financial year so far; 6 in total in 2019

Actions in place to recover

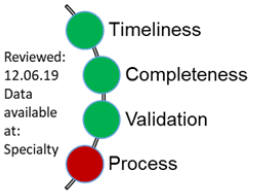
- A Never Event Summit with the CCGs took place in September 2019, to review learning and actions arising from incidents reported this year
- The next Summit is being planned for Quarter 4

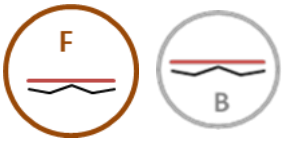
HARM FREE CARE – SERIOUS INCIDENTS

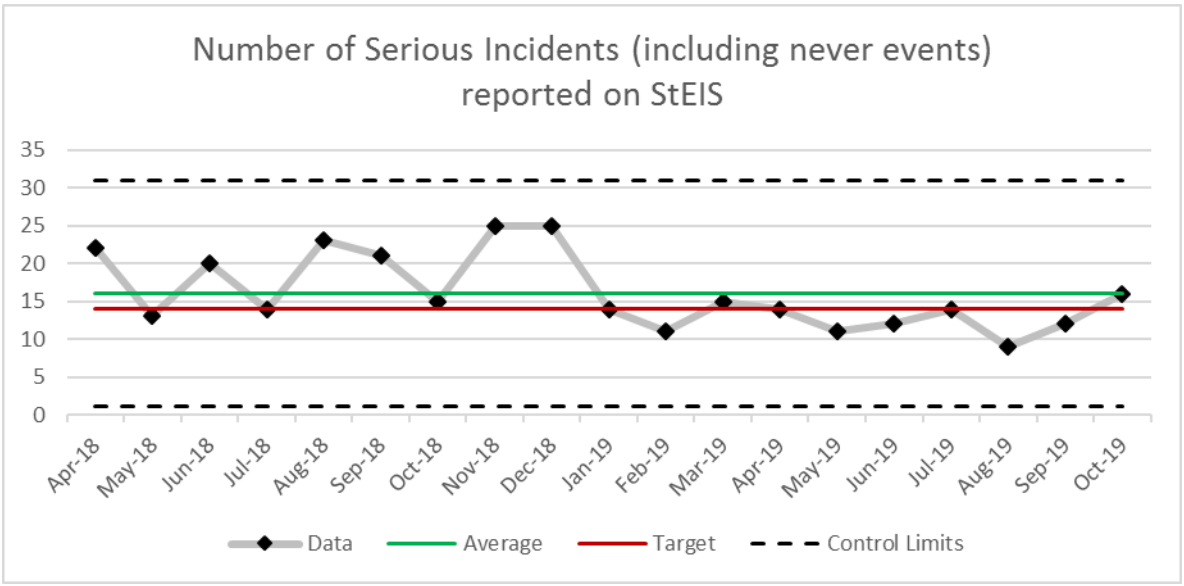
Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes

- The Trust declared 16 Serious Incidents in October 2019, which is above the average of 13 for 2019 and the highest number in a single month so far this year (the average in 2018 was 18 per month)
- 1 incident previously declared as a Serious Incident in July 2019 has now been down-graded with agreement from the CCG
- There were 30 Serious Incident investigations open at the end of October

Actions in place to recover

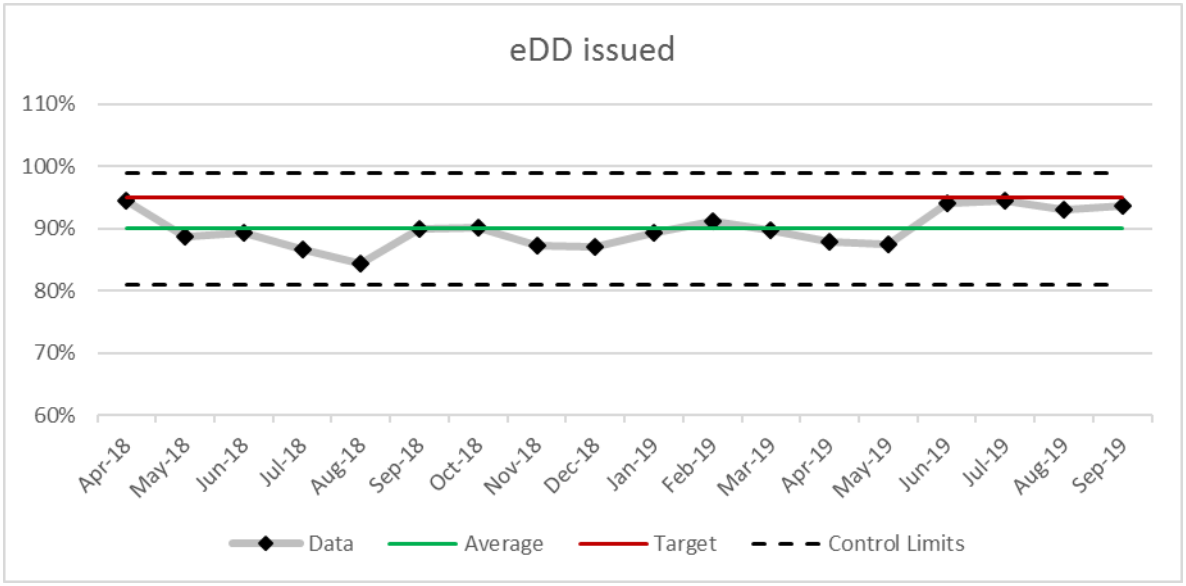
- No SIs have been overdue past their deadline to the CCG in the last 8 months
- Incident investigation training and a range of guidance materials are being developed

HARM FREE CARE – eDD ISSUED

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients



Challenges/Successes

93.8% of eDDs were sent within 24 hours, which is the best performance ever reported for the Trust and a 3.5% improvement over the last 12 months.

48 hour performance is also the highest ever at 94.5%, which is also a 3.5% improvement over the last year.

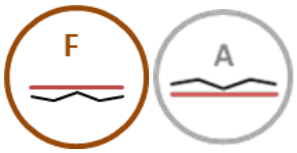
5 day performance was 95.5% which whilst being the best ever performance, is still short of the 99% target Grantham's 24 hour performance is 96.9%, Lincoln 93.8% and Pilgrim 94.5%.

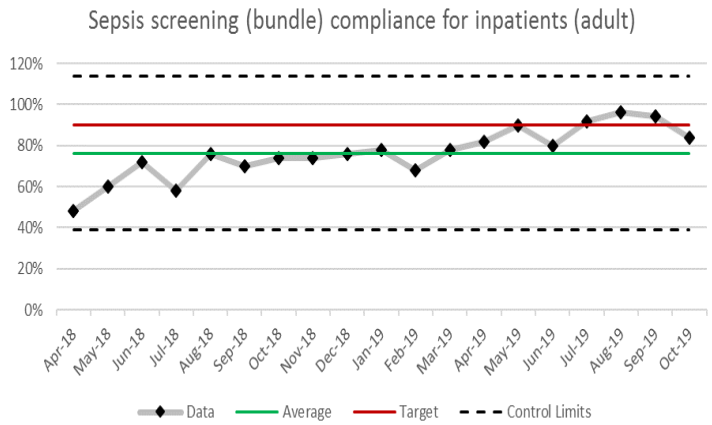
HARM FREE CARE – SEPSIS SCREENING

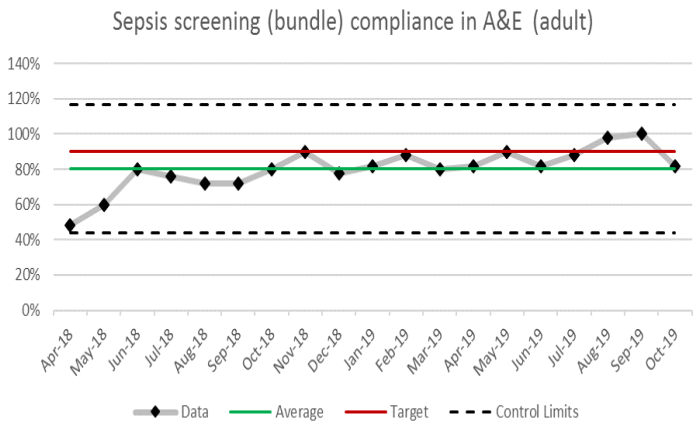
Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients







The data for this report is gained from a sample of patients totalling 50 inpatients and 50 A & E patients.

The A&E departments are under daily scrutiny in order to prevent harm and submit weekly data to the CQC. Over the course of October the three A&E departments across the trust have received 92.35% when using 100% of the data available.

The Inpatients areas achieved 84% for October which equates to 42 of 50 patients across the 3 sites (Pilgrim 80% 16/20, Lincoln 90% 18/20, Grantham 80% 8/10).

The areas on the league table that are under 90% are receiving further input from sepsis practitioners with encouragement to the ward managers to take ownership of sepsis within their ward area.

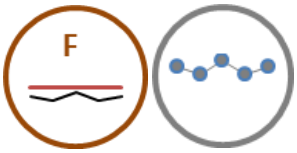
Areas achieving under 80%- the staff are all having refresher training provided by sepsis practitioners and cascaded through the wards senior team.

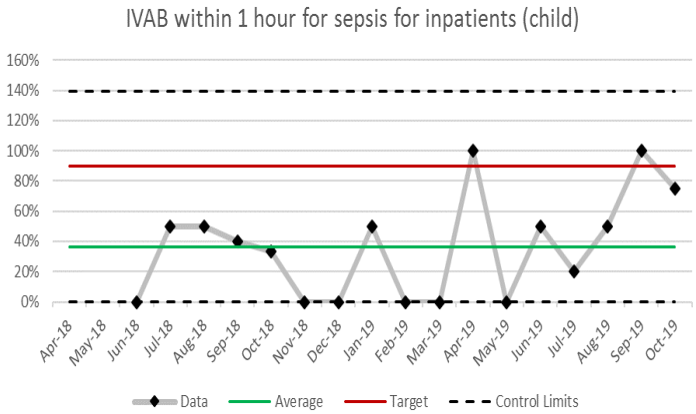
HARM FREE CARE – SEPSIS INTRAVENOUS ANTIBIOTICS

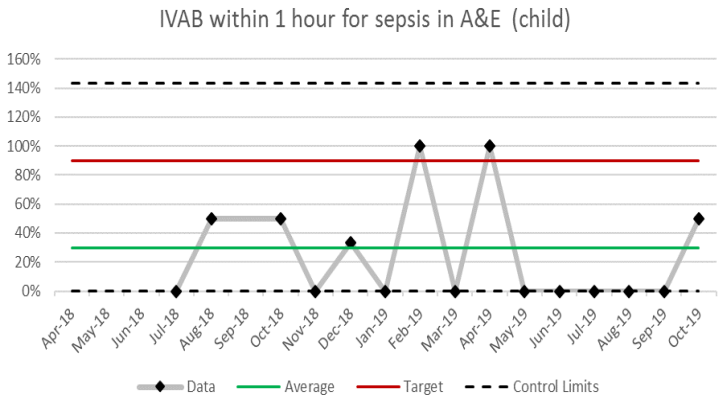
Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients







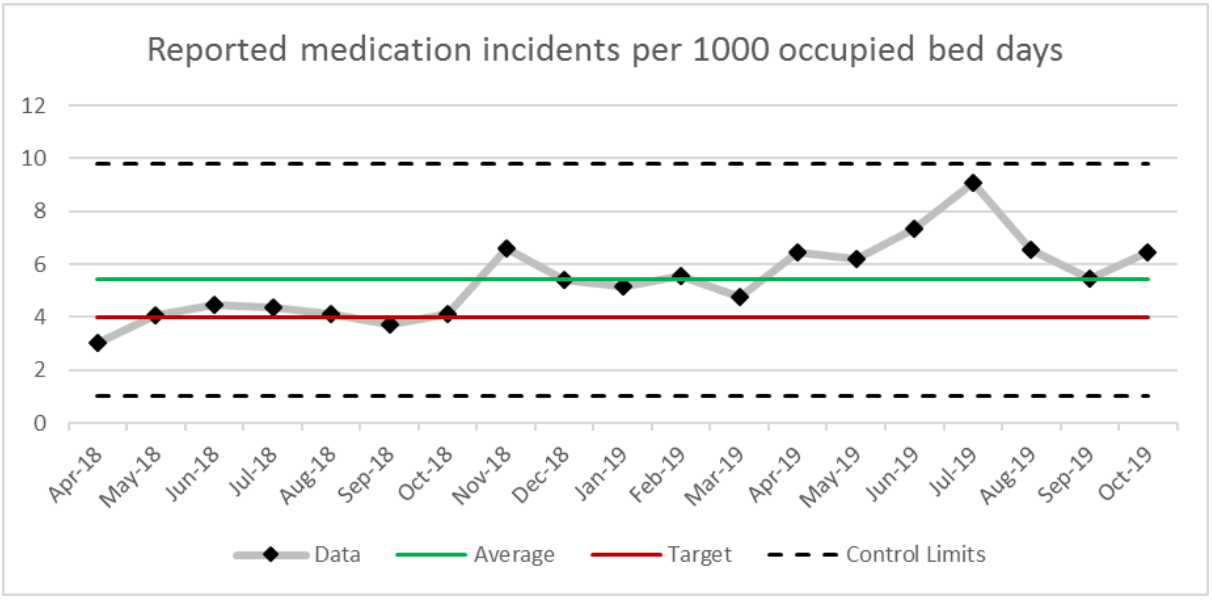
During October the results remain falling short of the 90% target, the results were based on 2 patients within the sample, 1 patients treatment was completed within 1 hour and the other patients screen was left in progress on the Web v system. Following further validation of this patients notes it can be seen that all patients actions were completed within the hour target however had not been documented on the web v system- no harm had be caused to the patient and the patient was treated appropriately.

HARM FREE CARE – MEDICATION INCIDENTS

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes –

In October there were 202 medication related incidents reported via Datix.

For October the medication incident reporting rate for the Trust per 1000 bed days was 6.46. 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.

Of the 202 medication incidents reported:

- 0% were rated as either Moderate Harm, Severe Harm or Death (calculated as medication incidents reported as causing Moderate Harm, Severe Harm or death x 100 – (0/202x100).

- 8.4% were rated as causing some level of harm (calculated as medication incidents reported as causing some level of harm or death x 100 – (17/202x100).

- 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

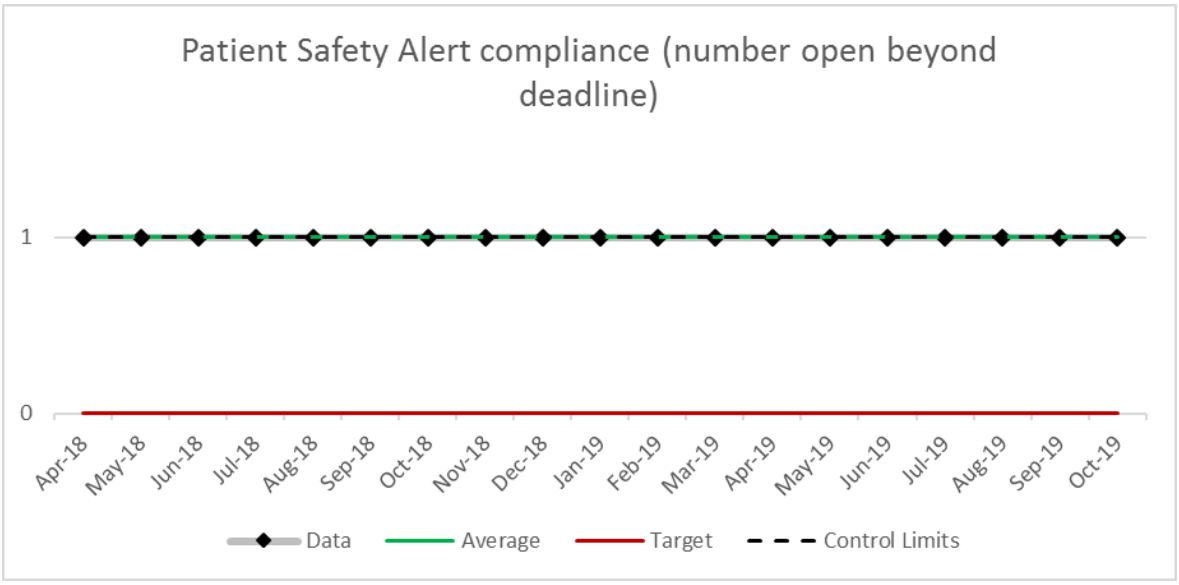
- In addition to these actions within the Quality and Safety Improvement Plan we have updated the Prescribing and Medicines Optimisation and Safety webpages and made them more engaging and user friendly. Within the new design we have a page dedicated to sharing learning from medication incidents and 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.
-

HARM FREE CARE – SAFETY REPORTING

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

- Anti-Barricade Devices: risk of in effectivity in certain circumstances (EFA/2017/002). DEADLINE 19th February 2018.
- Breathing circuit swivel elbow recall due to risk of cracks forming before or during use (MDA/2019/032). DEADLINE 31ST October 2019.

Actions in place to recover:

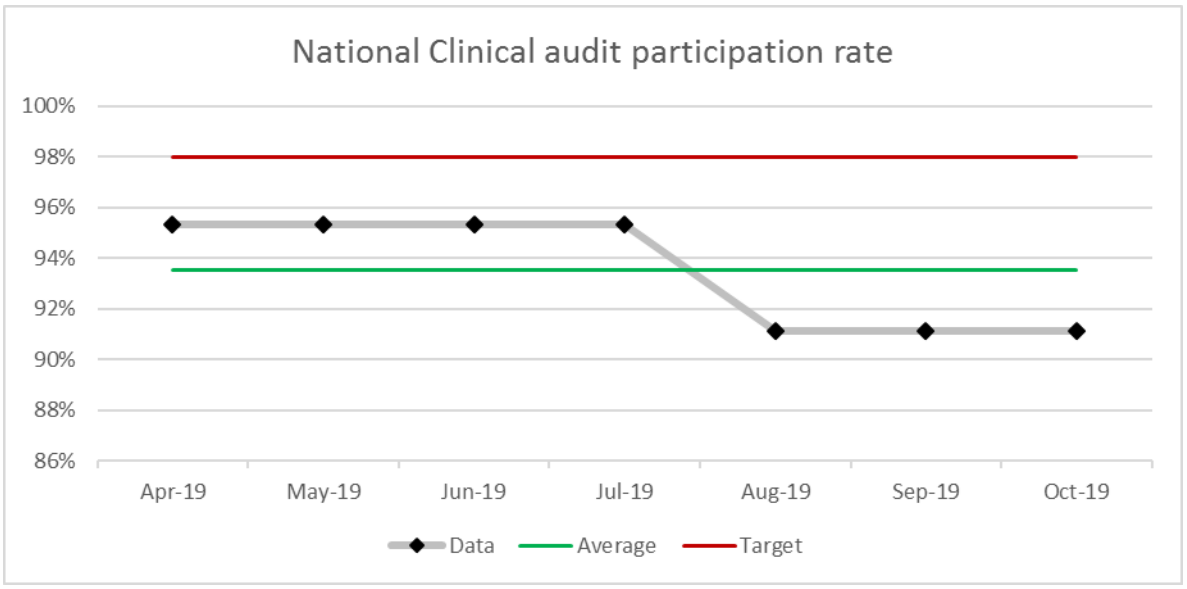
- EFA/2017/002 - Surveys carried out in 2018. Tenders for work sent out and a contractor has been appointed to complete the works. Further assessments to take place to ensure all faulty doors have been identified and are included in works programme. Estates & Facilities to provide confirmation of completion to Patient Safety Group.
- Communicated with all relevant departments. Awaiting on small number of departments to confirm action has been taken.

HARM FREE CARE – NATIONAL CLINICAL AUDIT

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients



The % participation rate is lower than expected for August through to October 2019 due to the following;

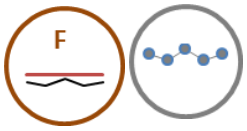
- Royal College Emergency Medicine (RCEM) for Level 1 ED (Pilgrim and Lincoln) Audits - late payment of the fee to access the audits
  1. Cognitive Impairment Older People
  2. Care of Children Emergency Department
  3. Mental Health Care in the Emergency Department
- Escalated to General Manager payment now authorised audits have commenced November 2019 with retrospective data collection
- The National Ophthalmology Audit has been a challenge to secure funding to support the technology required by the Clinicians to complete this audit, business case was not approved escalated to General Manager and Clinical Lead, work is underway to review resources to implement the audit
- The overall % participation rate will improve November 2019.

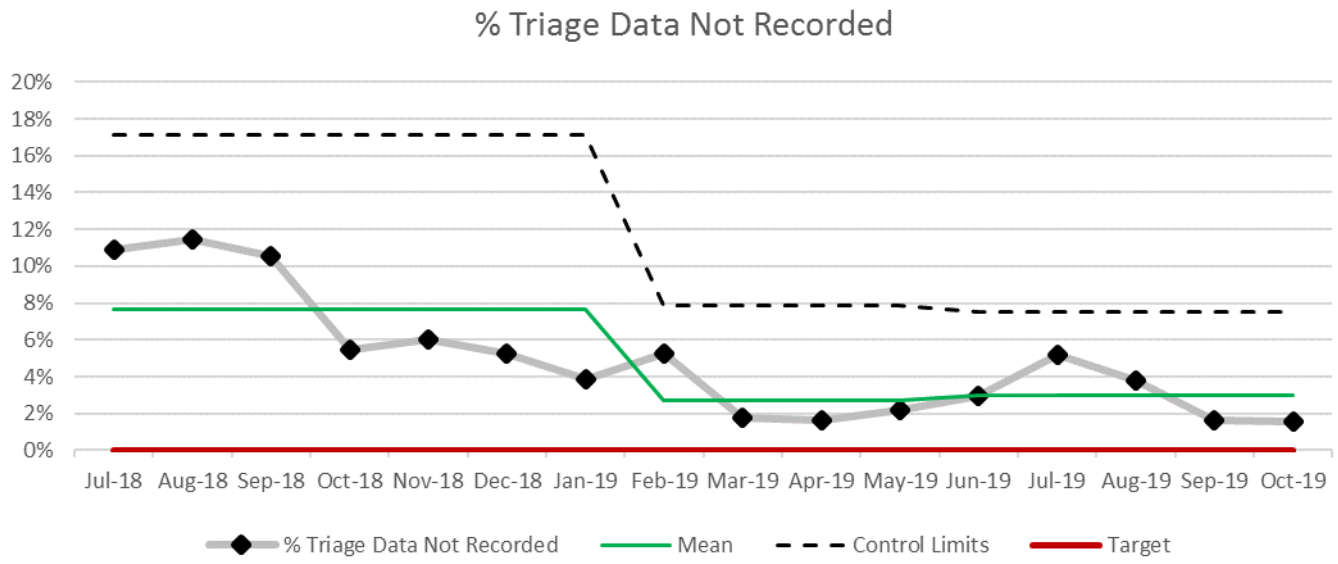
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

An improving position was demonstrated in October by 0.06%. Now reporting 1.59%

Achievement against this metric remains 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 continue to have an impact on being able to consistently achieve higher levels of performance against this target but steady improvement is being seen

The use of a triage coordinator role ensures that this important process is delivered consistently and a greater compliance has been demonstrated and sustained.

Changes in leadership approach within the divisional managerial teams ensures all staff are accurately recording triage times. These changes will be crucial to maintaining focus on this.

Actions in place to recover:

Since the appointment of Urgent and Emergency Care Lead Nurse (Secondment) compliance is increasing and being maintained

The CBU feeds back performance to the clinical teams and non-adherence to process is addressed on an individual basis.

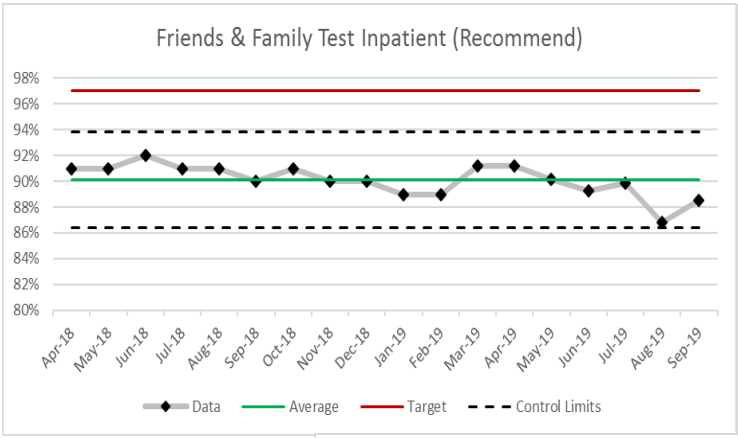
Triage time is a key performance indicator in regards to patient safety and will continue to be monitored and challenged at all operational delivery levels 3 x daily through the Capacity and Performance Meetings and within the UEC programme.

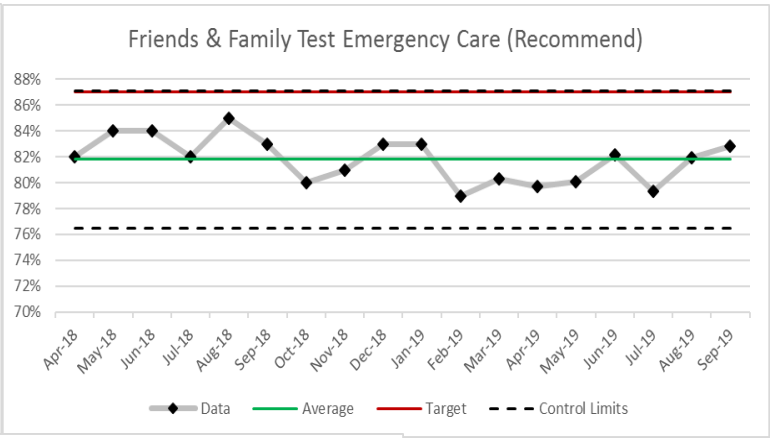
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

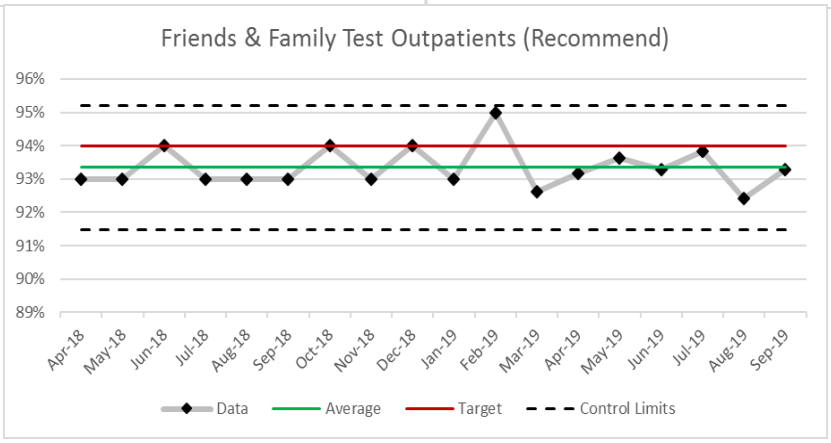
Executive Lead: Director of HR & OD

CQC Domain: Caring

2021 Objective: Our Patients







Challenges/Successes

- Inpatients has seen a 1% decrease in % FFT recommends and a 1% increase in % non recommends in September
- Other FFT streams have remained static over since April 2019
- Overall 91% of patients would recommend and 4% of patients would not recommend. This was based on 7,526 ratings and 5,750 comments with 76% of comments received being positive, 6% neutral and 18% negative. Top 3 positive themes from FFT comments were Staff attitude, waiting times and implementation of care

Actions in place to recover:

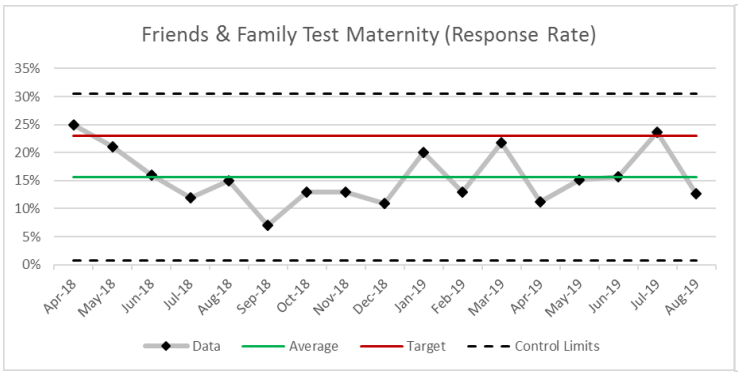
- Meetings scheduled during October with divisional clinical leads to secure patient experience engagement and actions
- FABChange19 programme of activities finalised to showcase and promote FAB Experience champion roles
- Patient and Carer Experience 5 year plan signed off at Patient Experience Group. However requires Quality Strategy to be approved before being formally launched. In the meantime, work is being progressed.
- Communication First training under review and new proposal to come to PX group in November that will include alignment with staff charter and behaviours. Plan is to focus on attitude, compassion & empathy in communication.
    - 3rd annual Patient Experience Conference is planned for December 2019 with the focus being on empathy, civility, compassion and communication

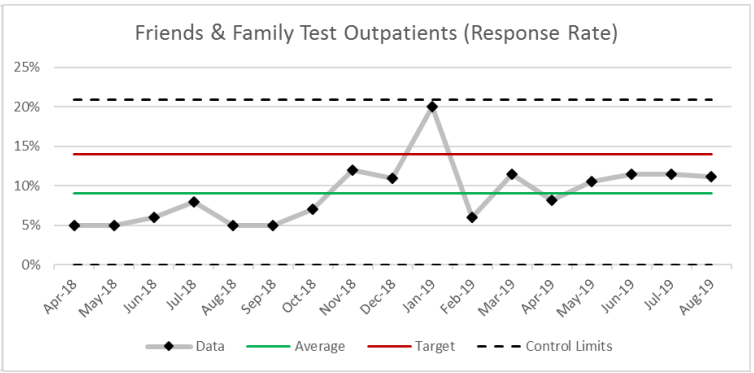
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

Executive Lead: Director of HR & OD

CQC Domain: Caring

2021 Objective: Our Patients



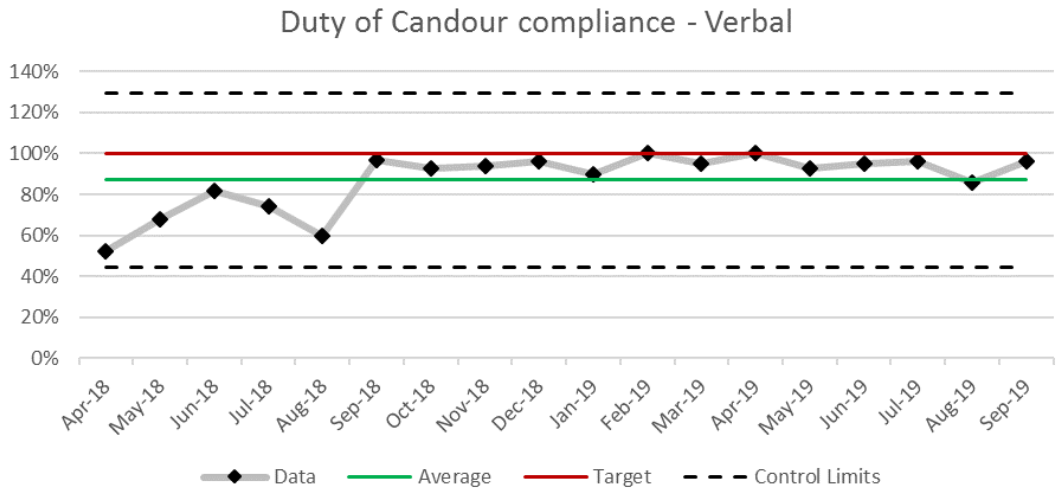


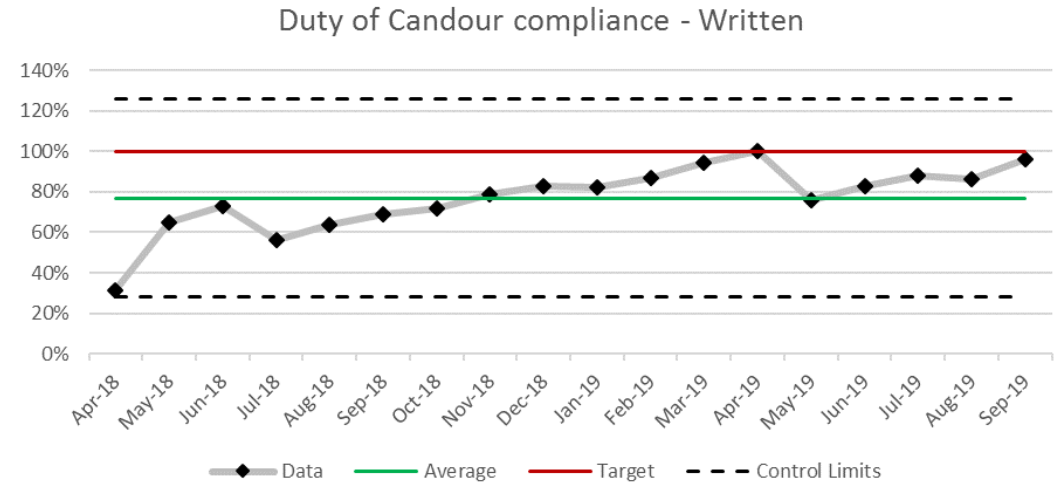
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Medical Director

CQC Domain: Safe/Responsive

2021 Objective: Our Patients





Challenges/Successes

- Duty of Candour (in person notification) compliance in September 2019 was 96% (1 non-compliant incident)
- Written follow-up compliance in September 2019 was also 96% (1 non-compliant incidents)

Actions in place to recover:

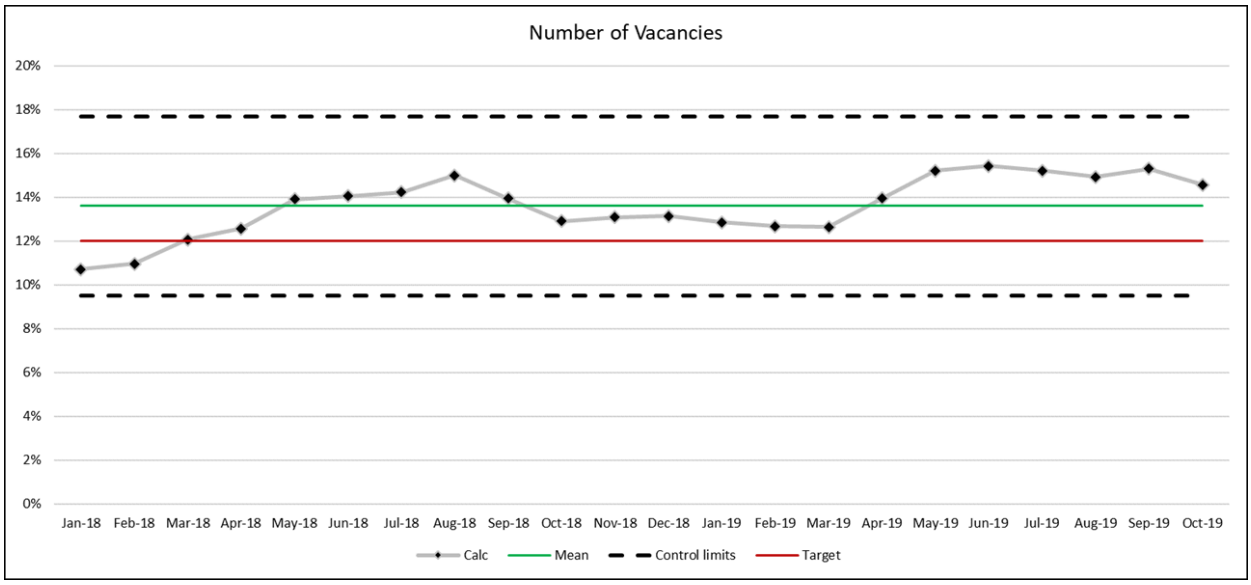
- Additional guidance has been added to the Datix system to support managers in accurately recording Duty of Candour compliance; these changes went live at the end of July
- A suite of dashboard reports has also now been created to provide divisional and Clinical Governance managers with live status information for all notifiable incidents
- Completion rate for the new Duty of Candour e-learning package that was launched in January 2019 is currently 94.14%
- A review of compliance over the last 6 months was presented to the Patient Safety Group in October; as a result, additional support is now being provided to divisions throughout each month.

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Director of HR & OD

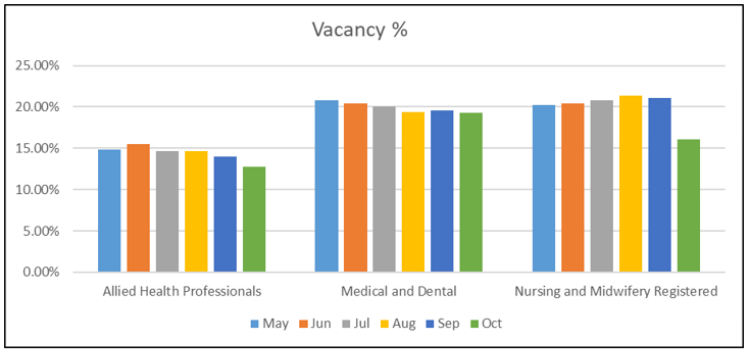
CQC Domain: Well-Led

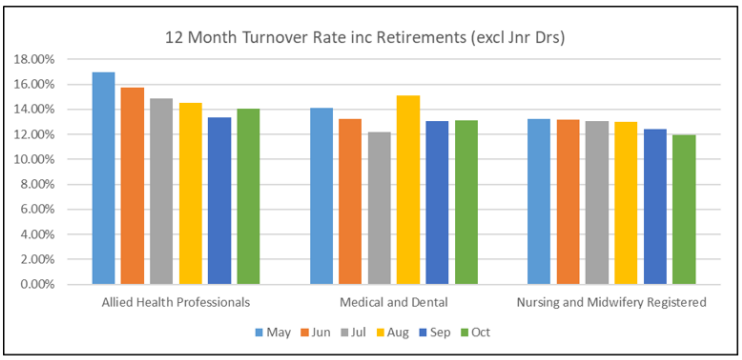
2021 Objective: Our People



Challenges/Successes

Overall vacancy rate improved to a six month low in October to 14.6% (- 0.3%) despite a broadly flat Turnover rate. Importantly improvement in vacancy rate of medical, nursing and AHP staff continued and evidences improvement in recruitment activity. Nursing vacancy rate is significantly reduced this month due to the commencement of our newly qualified nurses and establishment changes to account for qualified nursing associates as part of ward skill mixing, which are all the subject of robust QIA.





Staff Group	May	Jun	Jul	Aug	Sep	Oct
Allied Health Professionals	14.80%	15.48%	14.61%	14.60%	13.94%	12.76%
Medical and Dental	20.80%	20.45%	20.04%	19.38%	19.60%	19.24%
Nursing and Midwifery Registered	20.19%	20.46%	20.80%	21.37%	21.04%	16.06%

12 Month Turnover Rate

Staff Group	May	Jun	Jul	Aug	Sep	Oct
Allied Health Professionals	16.99%	15.73%	14.84%	14.53%	13.36%	14.02%
Medical and Dental	14.09%	13.21%	12.16%	15.10%	13.07%	13.11%
Nursing and Midwifery Registered	13.21%	13.19%	13.05%	12.99%	12.43%	11.96%

Medical Vacancy Rate

Plan for every post is being used and continues to be further developed, as a tool to deliver recruitment strategy and agency reduction. There are examples of how it is being used across the Divisions. For example, Family Health strategy is to recruit Locum Consultants as soon as vacancy occurs with AAC panel dates planned in the following 12 months. There have been improvements in several areas with the following teams showing reductions: Lincoln Clinical Haematology, Pilgrim Paediatrics and A&E Lincoln. Family Health have Consultants in the pipeline for Paediatrics following a recent AAC process and recruitment is in progress for 3 Obs & Gyn posts.

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	6.7	40%
	Lincoln Clinical Oncology IP	6.0	33%
	Pilgrim Clinical Haematology IP	3.0	75%
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	4.8	49%
	A&E Attenders Lincoln	10.7	28%
	Grantham Cardiology IP	4.0	57%
Surgery	Lincoln ENT IP	4.7	44%
	Pilgrim Urology IP	4.0	44%
	Lincoln Max Facial Surgery IP	6.6	48%

We are looking to introduce early risk summits, where workforce gaps are contributing to service fragility, to ensure we are doing everything practical to recruit or redesign the workforce.

Nursing Vacancy Rate

The nursing vacancy rate significantly reduced to 16.1%, but high vacancy rates remain on a number or wards and higher risk clinical areas. 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	6.0	86%
	Macmillan Specialist Nursing	2.0	45%
	Ward 7A Chemo Suite	3.1	21%
Medicine	Pilgrim AMSS	13.2	41%
	Pilgrim Stroke Unit	12.6	48%
	A&E Pilgrim	29.6	50%
	Ward 6A	8.9	32%
	Ward 1	5.2	42%
Surgery	Bevan Ward	8.6	68%
	Ward 5B	5.8	29%
	Ward 9A	6.5	34%
	Ward 2	9.9	45%
	Lincoln Main Theatres	10.5	16%
Family Health	Ward 4A	12.2	37%
	Bardney Ward	15.0	35%
	Rainforest Ward	12.5	39%

AHPs Vacancy Rate

Despite improved vacancy and turnover rates for AHPs overall, there are notable AHP Vacancy rates in particular areas, as shown in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	11.5	36%
	Pilgrim Occupational Therapy	3.4	18%
	Lincoln Physiotherapy	7.35	16%

Actions in place to recover

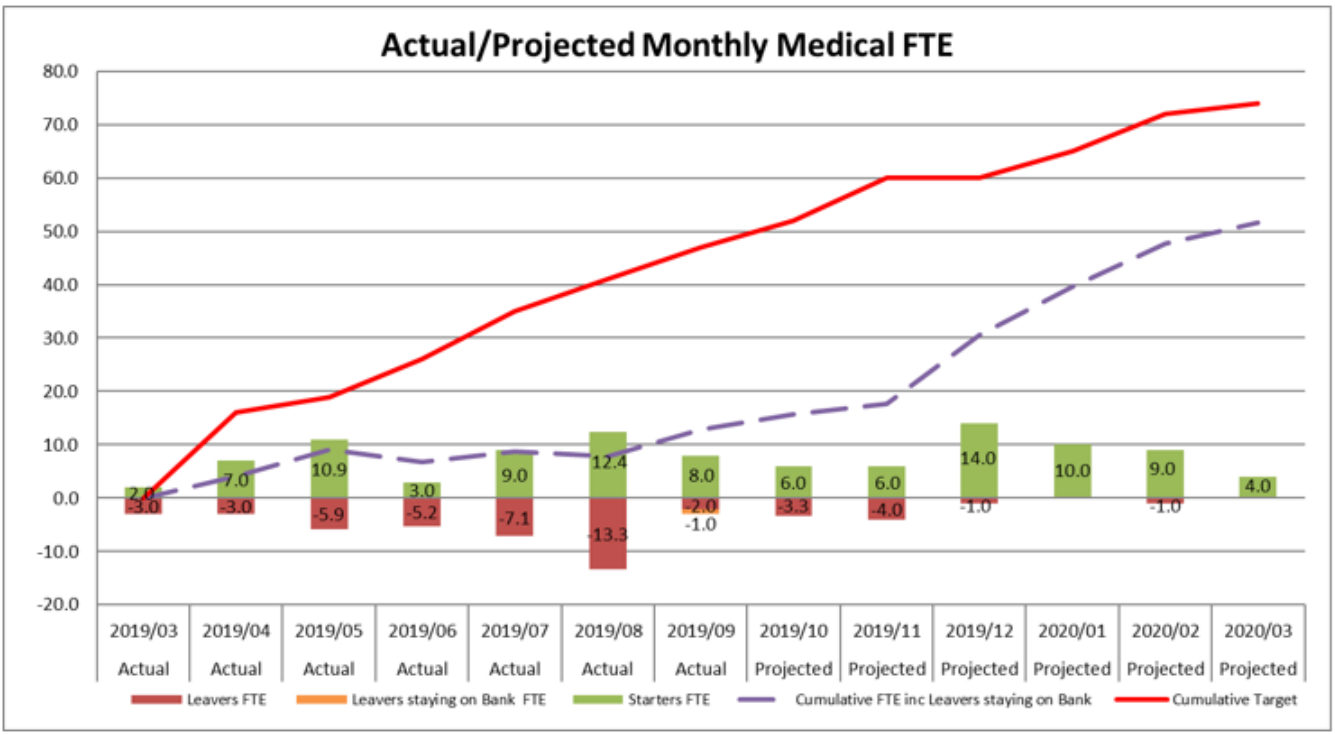
Medical and Dental

Continued strong pipeline into Q3.

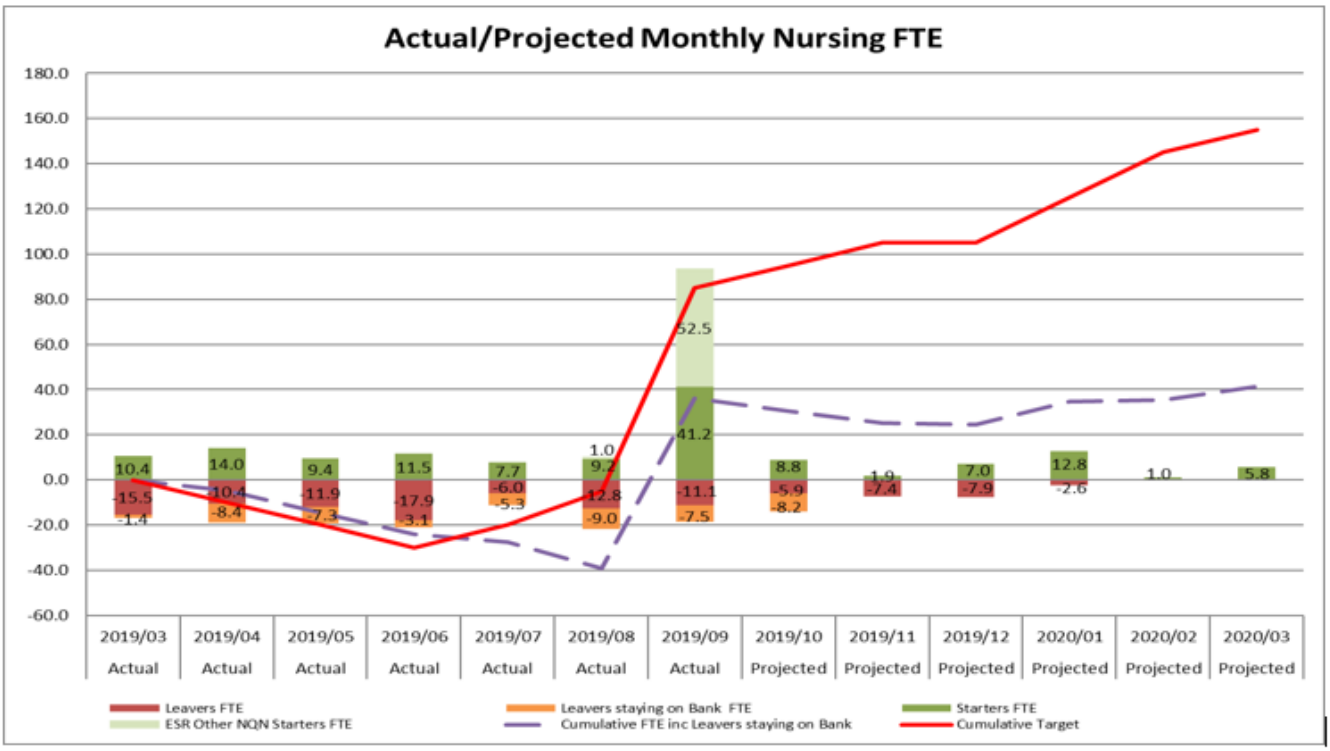
Divisions are increasingly adopting the 'plan for ever post' approach to all vacant post and there is greater triangulation with associated agency costs.

New international strategic partner contract approved and will now be mobilised with initial focus on all fragile services.

Increased focus on medical engagement to reduce turnover.



Nursing



NQN recruitment to plan.

International strategic partner to commence programme.

TMP supported domestic campaign in progress.

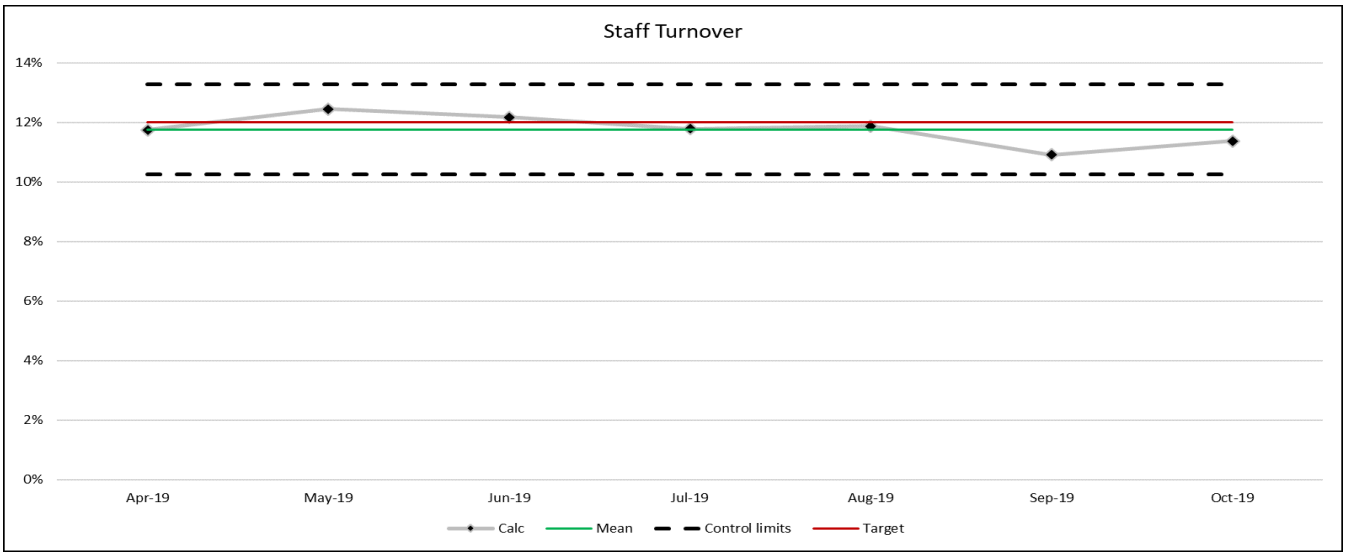
HEE Global Learners programme being explored in detail

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

- We are slowly starting to see a downward trend in the turnover of nurses across the last 6 months.
- The completion rate for the leavers questionnaire is a continuing struggle.
- Exit data is highlighting 'flexible working' as a reason for leaving. This is a change from the previous 6 months (Reason with the highest percentage was Retire and Return)

Actions in place to recover

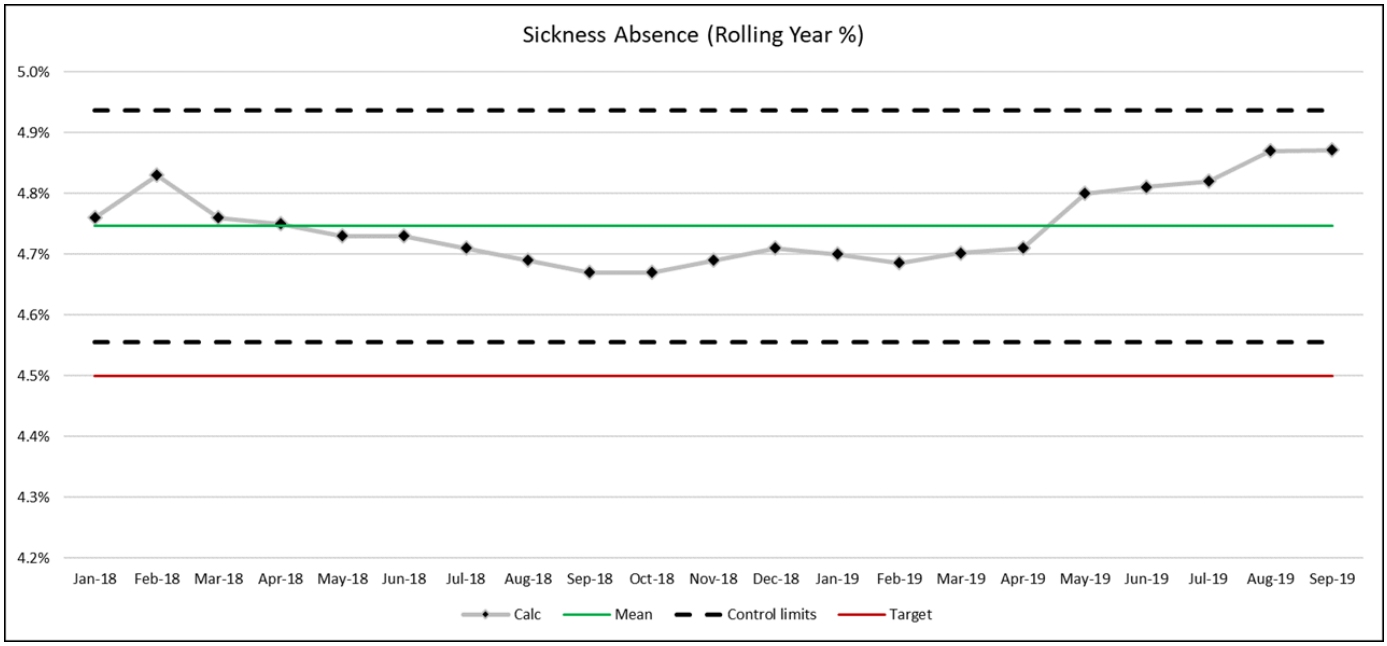
Work is ongoing on improving the response rate of exit surveys
Legacy Nurse initiative has been introduced as a mechanism of providing Buddy's to Newly qualified nurses.
Flexible working - There is also some action underway on enhancing staff awareness about flexible working opportunities available within the Trust. A paper has been submitted to Workforce and OD Board on the next set of actions to be put in place to address people leaving citing lack of flexible working as a reason.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People

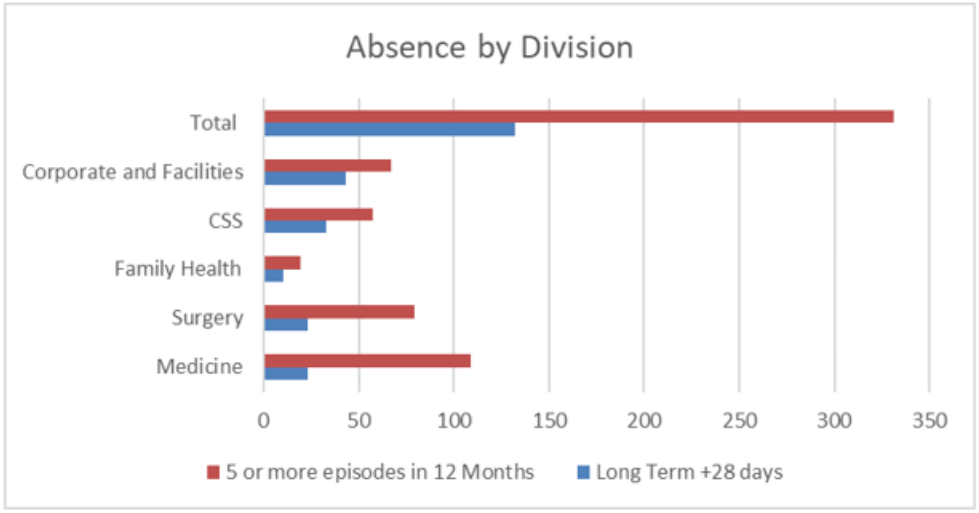


Challenges/Successes

For the 12 month rolling period absence has reduced slightly to 4.8%.

The information below is in real time, i.e. as at 31 October 2019.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	23	23	10	33	43	132
5 or more episodes in 12 Months	109	79	19	57	67	331



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 table below shows the reduction/ increase in cases by Division

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate and Facilities	Total
Long Term +28 days	-13	-5	-14	-1	-22	-55
5 or more episodes in 12 Months	+12	+12	0	+6	+2	32

Long term cases have decreased by 55 cases this month and short term increased by 32 cases. The reduction in long-term cases is very positive, as this has been a focus of the team. Continued improving picture in Family Health.

Actions in place to recover

ER Advisors to formulate Sickness action plans within their Divisions. Focus on short term absence now within the Divisions

Communication to be released in November regarding return to work interviews to relaunch the process and ensure managers are clear on their responsibility in the process.
A review of hotspot areas in Divisions to ensure managers are adhering to the managing attendance process. External audit is underway.

Interviews for replacement ER advisor to take place next week.

New HR Ops team leader appointed to lead on the role out of Empactis Attendance Platform (supported by dedicated project manager).

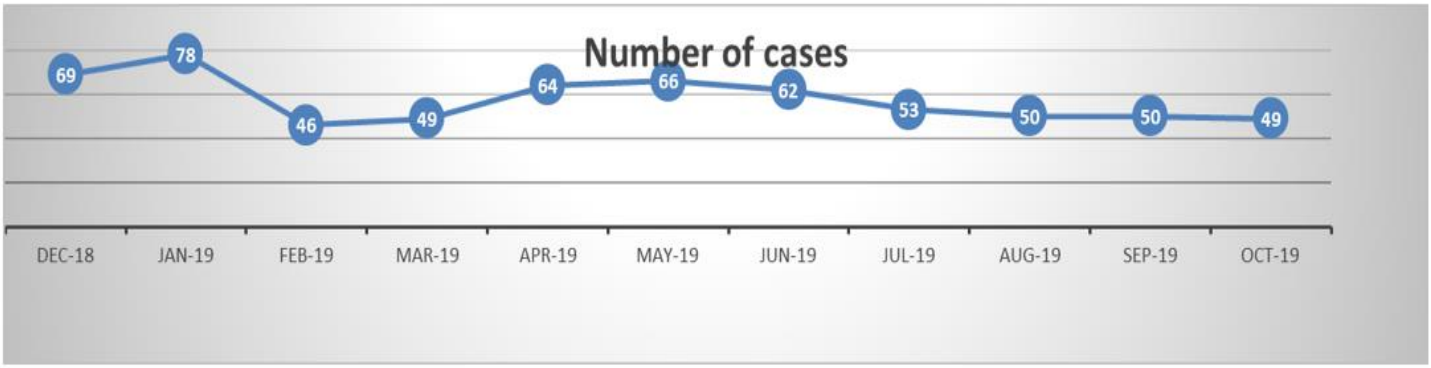
Estates and Facilities holding steady, with improvement plan still in place, supported by SHRBP. Planned interventions include training for Line Managers.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Employee Relations Cases:

There are 49 open cases in October compared with 50 cases in September.

There are currently 7 cases proceeding to hearings for November covering:

- Appeals x 0
- Grievance x 3
- Disciplinary x 2
- Capability Ill Health x 2

In October we have had 5 hearings cancelled 4x Grievance and 1x disciplinary.

Actions in place to recover

A review of GDPR processes for disciplinary cases to be undertaken, in terms of patient confidentiality and redaction of appropriate information within disciplinary packs

The volume of SAR requests impact on the ER activity owing to the time taken by the HR Team in responding, as does the collation of paperwork for Employment Tribunal cases and again we have seen an increase in the last six months.

A review of timescales into formal processes is to be undertaken over the next month.

A review of the MHPS policy for medics is being undertaken

ER team are working with the policy leads on the review of the Dignity @ Work Policy

OD lead is presenting findings of the Bullying and Harassment review at the next SLF.

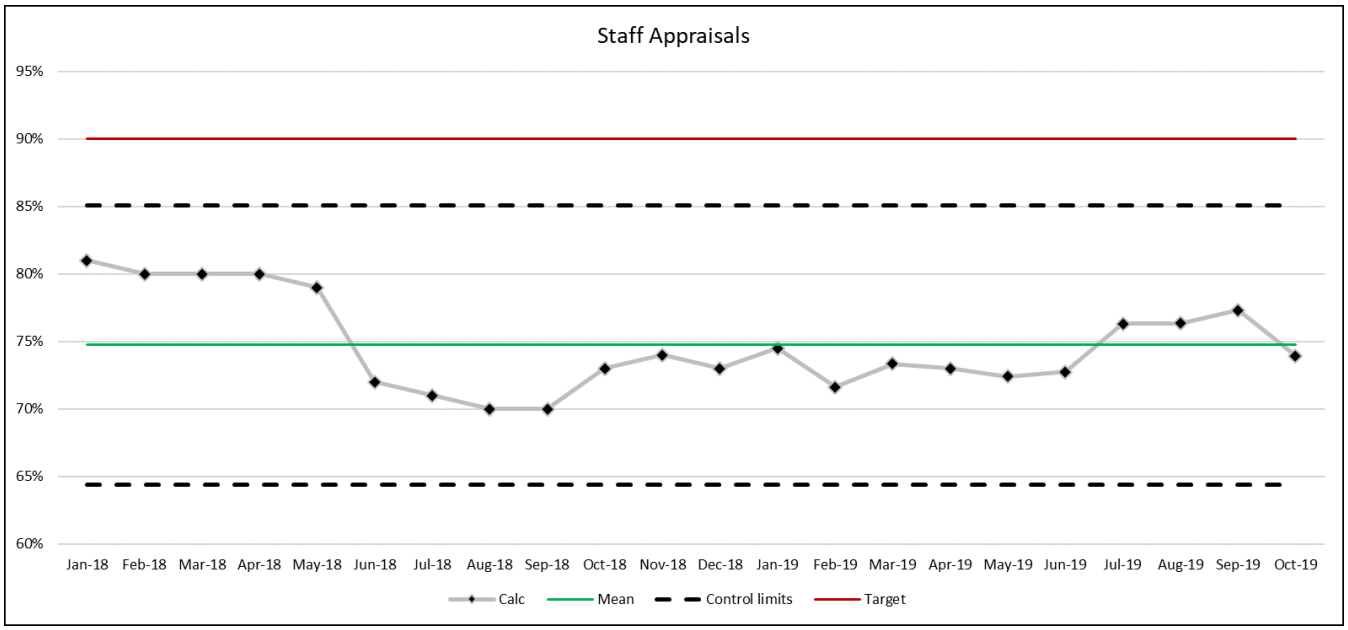
A group has been set up to review and support the Junior Doctor experience.

MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Overall appraisal rate dipped slightly in October.

Actions in place to recover

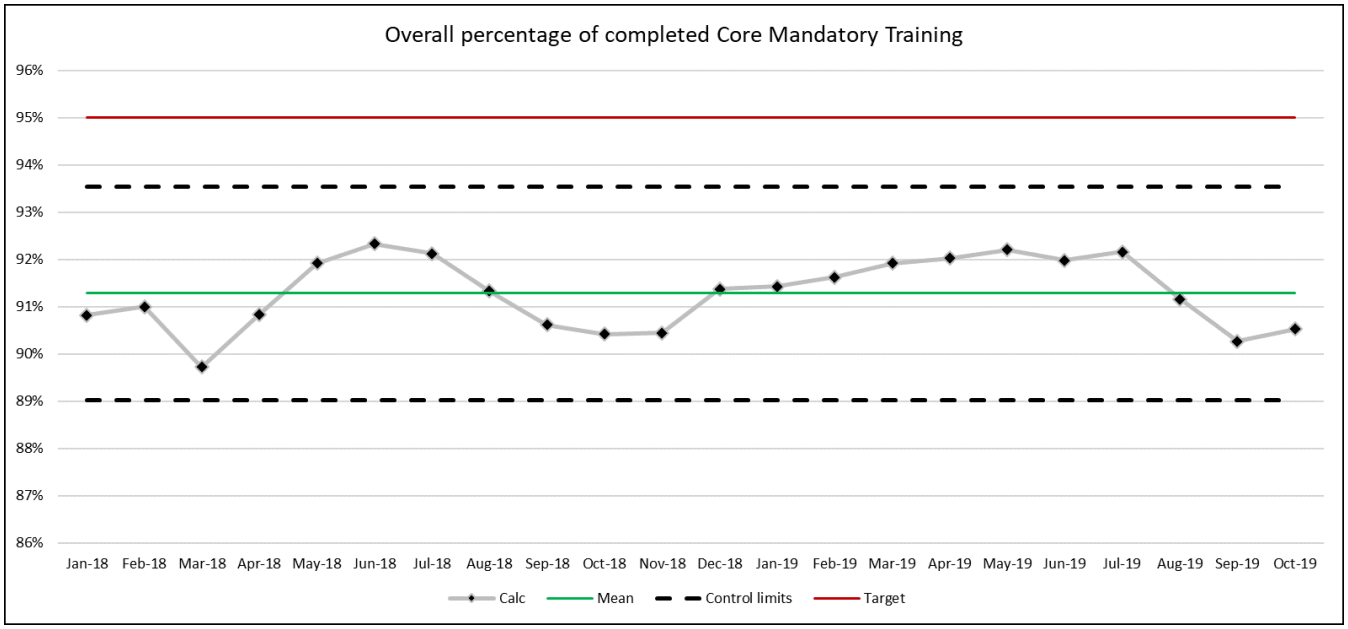
- Appraisee and appraiser training widely available across all sites
- SHRBPs working with Divisional teams to improve position. In surgery monthly reports are sent to managers showing appraisals overdue and appraisals which will expire in the following month. Rolling programme to ensure completion levels continue to improve are maintained.
- Estates and Facilities – position continues to improve following targeted work in this area, supported by SHRBP
- Family Health seeking to improve their position. Reports issued to Managers showing both appraisals overdue and due. More detailed actions being developed to improve the position supported by SHRBP

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Compliance rate for 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.

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.

Actions in place to recover

Discussions are ongoing within the STP to consider the possible benefits of sharing approaches to Core Learning with other Trusts in the Lincolnshire Healthcare community and the potential of this to increase Core Learning compliance even further. In addition, HR Business Partners and specialist trainers such as those in the Resuscitation Department are working actively with senior managers to continue to improve compliance.

In Surgery monthly reports are sent to managers and clinical leads showing where core training has expired, work is ongoing to improve the current position.

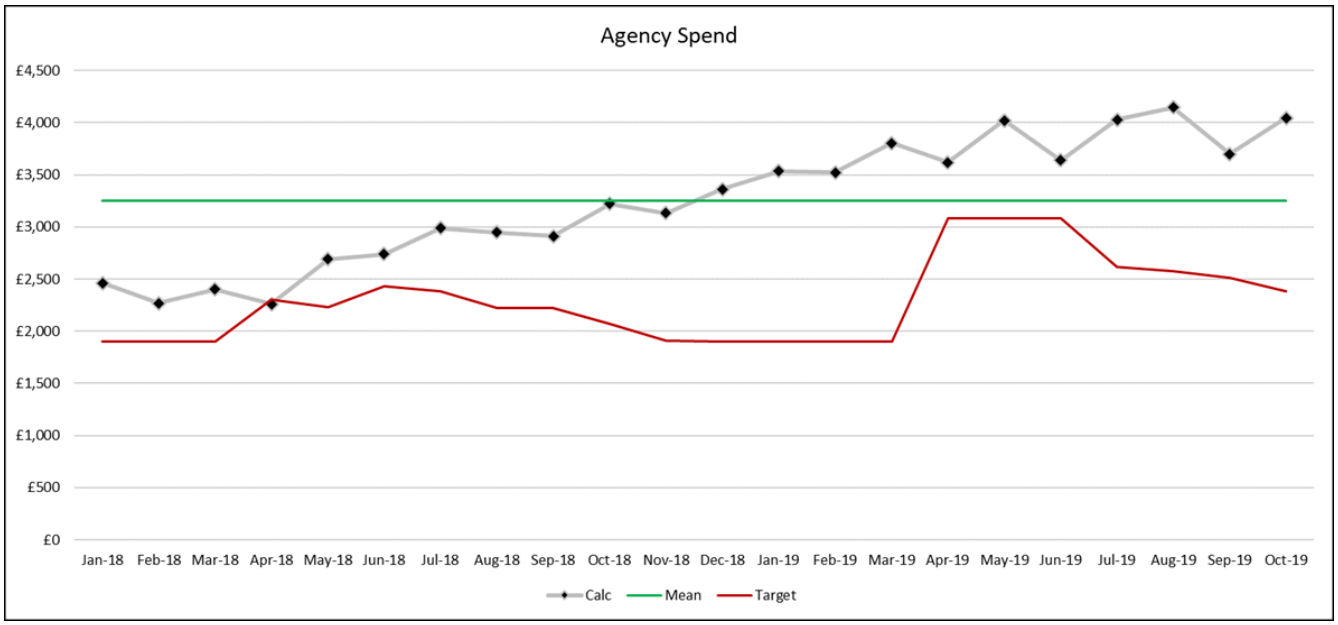
Family Health remains good overall; focused activity around completion of all Safeguarding training.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

2021 Objective: Our People

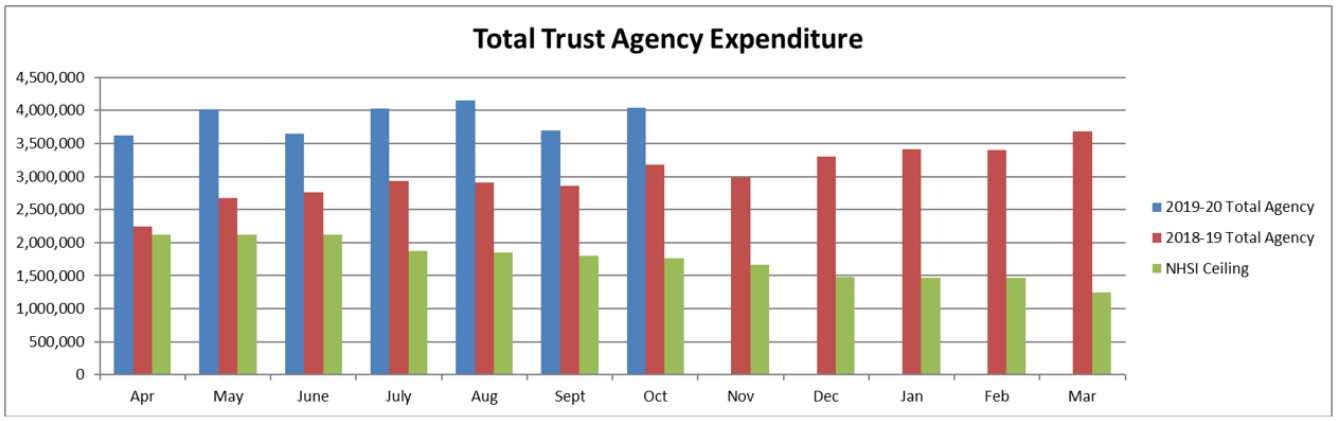


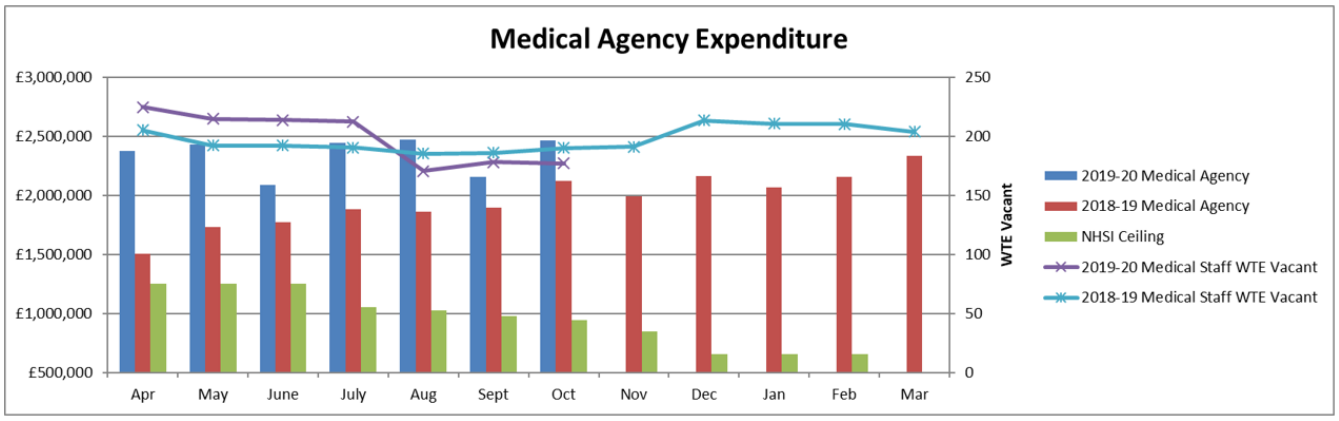
Challenges/Successes

In October (M07), Year to Date (YTD) planned pay costs further deteriorated to 4.6% adverse to plan [an underlying position of 5.1% adverse to plan excluding releases] but a further improved 71.4% (-0.4%) of income, although 1.8% higher than plan. Income YTD actual against YTD plan increased further. 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, higher than planned activity and under delivery of workforce FEP.

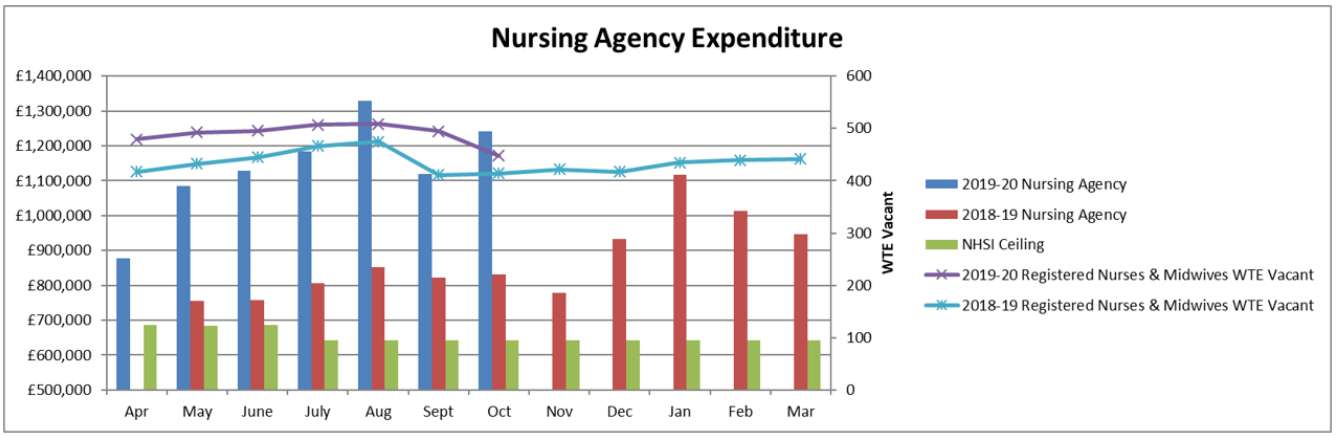
The monthly run rate for total agency spend increased (+£345K) from Month 6 to Month 7 to £4.04M, with monthly reductions built into plan, agency spend now exceeds that planned by 40.6% (+4.6%).





Overall temporary medical staffing costs increased marginally in October but medical Agency pay costs increased significantly (+ £307K) with a corresponding reduction in Bank staffing. A £2 per hour rate increase was observed at Consultant level due to mix of speciality.

Nursing Agency Costs



Nursing Agency costs increased (+£137 K, 11%) in October despite Tier 6 (off – framework) reductions. Nurse agency costs are disproportionately impacted upon by school half-term holidays due to elevated vacancy rates. Nurse vacancy rate improvement as a consequence of NQN starts should be reflected in November spend due to initial work plans for this group of newly qualifying staff.

Reductions in hourly rate were offset by an increase in volume with fill rates increasing at both Lincoln and Boston.

LINCOLN Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Contracted staff Percentage	76%	71%	71%	73%	72%	69%	67%	66%	66%	68%
Total temp percentage	20%	24%	23%	22%	22%	25%	26%	27%	29%	29%
Bank percentage	11%	13%	14%	12%	11%	12%	12%	12%	12%	11%
Agency percentage	9%	11%	9%	10%	11%	14%	14%	15%	17%	18%
Total bank requests	540	657	665	606	640	711	749	781	762	732
Percentage bank fill	80%	76%	73%	76%	73%	75%	73%	70%	78%	88%
Total percentage staffing against required	96%	95%	94%	95%	94%	94%	94%	92%	95%	97%
Total percentage staffing without agency	87%	84%	85%	85%	83%	81%	79%	77%	78%	79%
BOSTON Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Contracted staff Percentage	58%	57%	59%	59%	58%	58%	60%	57%	59%	56%
Total temp percentage	38%	37%	38%	36%	38%	38%	38%	39%	37%	41%
Bank percentage	11%	11%	12%	12%	11%	10%	10%	11%	10%	10%
Agency percentage	27%	27%	26%	24%	27%	28%	28%	28%	27%	32%
Total bank requests	679	704	664	667	686	685	665	712	678	730
Percentage bank fill	83%	81%	88%	83%	85%	87%	89%	85%	83%	90%
Total percentage staffing against required	96%	95%	97%	96%	96%	97%	97%	96%	96%	97%
Total percentage staffing without agency	69%	68%	71%	71%	69%	68%	69%	68%	69%	66%

Scientific, AHP and other agency costs decreased by £84K in October.
Other Agency are 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).

Medical Agency

- Continued targeted removal of Medical Umbrella companies (three remain post end of October).
- Detailed line by line review of September to October movements and November projections
- Continued focus on total planned and actual medical resourcing.
- Continued Divisional Medical Agency Review Meetings and follow up actions.
- Further improvements to triangulation with vacancies and divisional 'plans for every post'
- The Trust will join the South Yorkshire Collaborative Medical Staffing Bank and launch the associated Bank App.
- Review of divisional processes to optimise bank staffing.
- Review of rotas in ED and Acute medicine.

Nursing

- 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
- Full review of rostering practice for Nursing including payments of breaks and management of annual leave
- Continued 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
- Planned rate reduction of high volume Tier 4 supplier (18th October) will be reflected in November spend.
- STT and Other

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Summary 2019/20

2019/20	Current Month			Year to Date			Plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	43,394	45,235	1,841	291,595	298,890	7,295	501,616	480,437	(21,179)
Expenditure	(44,281)	(48,080)	(3,799)	(315,266)	(324,660)	(9,394)	(533,922)	(543,553)	(9,631)
EBITDA	(887)	(2,845)	(1,958)	(23,671)	(25,770)	(2,099)	(32,306)	(63,117)	(30,811)
Net Finance costs	(782)	(804)	(22)	(5,111)	(5,073)	38	(9,106)	(8,815)	291
Surplus/(Deficit)	(1,669)	(3,649)	(1,980)	(28,782)	(30,843)	(2,061)	(41,412)	(71,931)	(30,519)
Technical adjustments	1	19	18	8	134	126	14	230	216
Surplus/(Deficit)	(1,668)	(3,630)	(1,962)	(28,774)	(30,709)	(1,935)	(41,398)	(71,701)	(30,303)
EBITDA % Income	(2.0%)	(6.3%)	(4.2%)	(8.1%)	(8.6%)	(0.5%)	(6.4%)	(13.1%)	(6.7%)
CIPs	2,453	1,090	(1,363)	11,196	7,977	(3,219)	25,610	20,200	(5,410)

YTD financial performance is £30,709k deficit, or £1,935k adverse to the planned £28,774k deficit.Income is £7,295k favourable to plan YTD.

Excluding the £616k adverse movement to plan in relation to Passthrough, Income is £6,679k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £3,692k, delivery of which is yet to be validated and is a risk to the Trust. The income position also includes £5,900k of transitional support.

Expenditure is £9,394k adverse to plan YTD: pay is £9,315k adverse to plan and non-pay is £79k adverse to plan. The YTD pay position includes £1,021k of non-recurrent technical FEP, without which Pay would be £10,339k adverse to plan. The adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £501k favourable to plan, bank pay is £1,968k adverse to plan and agency pay is £7,850k 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.

Excluding the £616k favourable variance in relation to Passthrough, Non Pay is £695k adverse to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £2,183k adverse to plan. Some variation to plan would be expected given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure. This includes higher than planned expenditure in a number of areas e.g. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and additional building & engineering costs in Estates. Non Pay expenditure is being reviewed to ensure that any expenditure which may be capitalised is treated accordingly and that Non Pay expenditure in general is minimised.

Overall, CIP savings of £7,977k have been delivered YTD or £3,219k less than savings of £11,196k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, CIP savings delivery is £5,750k 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: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Run Rate 2019/20

2019/20	By Month / Quarter			In Month			Year to date			Full Year		
	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual M7 £'000	Plan October £'000	Actuals October £'000	Variance October £'000	Plan October £'000	Actuals October £'000	Variance October £'000	Plan Full Year £'000	Unmitigated Most Likely Forecast Full Year £'000	Required Mitigation Full Year £'000
Income												
Clinical income	96,836	105,372	34,897	33,576	34,897	1,321	229,298	237,105	7,806	389,070	392,147	3,077
Pass through income	11,962	12,428	4,586	4,241	4,586	345	29,592	28,976	(616)	50,710	48,390	(2,321)
Total Patient related income	**108,798**	**117,799**	**39,483**	**37,817**	**39,483**	**1,666**	**258,890**	**266,080**	**7,190**	**439,780**	**440,536**	**756**
PSF, FRF and MRET funding	4,705	5,968	2,832	2,832	2,832	0	13,505	13,505	0	28,928	7,450	(21,478)
Other Income	8,078	8,307	2,920	2,745	2,920	175	19,200	19,305	105	32,908	32,450	(458)
Total Other operating income	**12,783**	**14,275**	**5,752**	**5,577**	**5,752**	**175**	**32,705**	**32,810**	**105**	**61,836**	**39,900**	**(21,936)**
Total Income	**121,581**	**132,074**	**45,235**	**43,394**	**45,235**	**1,841**	**291,595**	**298,890**	**7,295**	**501,616**	**480,437**	**(21,179)**
Expenditure												
Pay	(89,930)	(92,308)	(30,507)	(28,444)	(30,507)	(2,063)	(203,430)	(212,745)	(9,315)	(342,620)	(355,203)	(12,583)
Pass through non pay	(11,962)	(12,428)	(4,586)	(4,241)	(4,586)	(345)	(29,592)	(28,976)	616	(50,710)	(48,390)	2,321
Other Non pay	(34,701)	(35,252)	(12,987)	(11,596)	(12,987)	(1,391)	(82,244)	(82,940)	(695)	(140,592)	(139,961)	631
Total Expenditure	**(136,593)**	**(139,987)**	**(48,080)**	**(44,281)**	**(48,080)**	**(3,799)**	**(315,266)**	**(324,660)**	**(9,394)**	**(533,922)**	**(543,553)**	**(9,631)**
Interest receivable	39	31	11	3	11	8	21	81	60	36	146	110
Finance costs	(2,069)	(2,290)	(815)	(785)	(815)	(30)	(5,132)	(5,174)	(42)	(9,142)	(9,252)	(110)
Profit on disposal of assets	12	8	0	0	0	0	0	20	20	0	291	291
I&E - Deficit	**(17,030)**	**(10,164)**	**(3,649)**	**(1,669)**	**(3,649)**	**(1,980)**	**(28,782)**	**(30,843)**	**(2,061)**	**(41,412)**	**(71,931)**	**(30,519)**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	58	57	19	1	19	18	8	134	126	14	230	216
Adjusted Surplus/(Deficit)	**(16,972)**	**(10,107)**	**(3,630)**	**(1,668)**	**(3,630)**	**(1,962)**	**(28,774)**	**(30,709)**	**(1,935)**	**(41,398)**	**(71,701)**	**(30,303)**
Adjusted Surplus/(Deficit) ex PSF, FRF & MRET	**(21,677)**	**(16,075)**	**(6,462)**	**(4,500)**	**(6,462)**	**(1,962)**	**(42,279)**	**(44,214)**	**(1,935)**	**(70,326)**	**(79,151)**	**(8,825)**
Total Trust (including passthrough)												
Adjustments to derive underlying deficit												
FSM Loan Interest	2,030	2,259	804		804			5,093		9,106	9,106	(0)
External Support	1,216	533	104		104			1,852		1,900	1,900	0
Profit on Disposals	(12)	(8)	0		0			(20)		(250)	(250)	0
Technical Adjustments	(1,581)	(950)	0		0			(2,531)		(500)	(2,531)	(2,031)
Transitional Support	0	(5,900)	0		0			(5,900)		0	(5,900)	(5,900)
Underlying Surplus/(Deficit)	**(15,319)**	**(14,174)**	**(2,722)**		**(2,722)**			**(32,215)**		**(31,142)**	**(69,376)**	**(38,234)**

As at the end of October, the Trust position is a deficit of £30,711k or £1,537k adverse to plan, including an adverse movement to plan of £3,632k in October.

The adverse movement to plan YTD in Expenditure of £9,394k has only partly been offset by a favourable movement in Income of £7,295k which includes transitional support of £5,900k.

The unmitigated most likely forecast is a deficit of £79,151k or £8,825k adverse to plan; actions are required to mitigate the £8,825k adverse movement to plan in order to avoid the loss of PSF and FRF funding.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Obiective: Our Services

NHS Patient Care Income & Activity 2019/20

2019/20 Clinical Income Summary: YTD Month 07

	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19 Actual October Activity	2019/20 Plan October Activity	2019/20 Actual October Activity	Variance October Activity	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000	2018/19 Actual October Activity	2019/20 Plan October Activity	2019/20 Actual October Activity	Variance October Activity	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000
Activity:																
Accident & Emergency	12,318	12,197	12,576	379	1,789	2,073	2,202	129	88,123	84,189	87,771	3,582	12,764	14,309	15,099	790
Daycases	5,795	5,880	5,648	(232)	3,032	3,133	2,988	(145)	38,177	38,373	38,026	(347)	19,781	20,451	20,584	133
Elective Spells	783	843	761	(82)	2,040	2,326	2,337	10	5,291	5,506	5,189	(317)	13,463	15,193	15,238	44
Non Elective Spells	6,076	6,110	6,631	521	11,125	11,399	13,863	2,465	41,235	42,326	44,201	1,875	73,004	79,038	91,787	12,749
Elective Excess Bed Days	139	117	65	(52)	33	32	17	(15)	906	820	707	(113)	224	223	189	(33)
Non Elective Excess Bed Days	1,470	1,645	1,721	76	360	431	287	(144)	11,150	11,513	8,562	(2,951)	2,687	3,017	2,126	(891)
Outpatient Firsts	26,635	26,848	25,231	(1,616)	3,566	3,846	3,579	(267)	174,074	175,233	170,882	(4,350)	23,180	25,106	24,424	(682)
Outpatient Follow Ups	34,436	34,870	34,011	(860)	2,924	3,234	3,112	(122)	226,258	227,432	221,628	(5,804)	19,187	21,095	20,466	(630)
Outpatient Non Face To Face	2,306	2,156	2,456	300	50	140	154	14	14,754	14,729	18,284	3,555	323	961	1,174	213
Outpatient Virtual	0	0	61	61	0	0	1	1	0	0	42	42	0	0	2	2
Outpatient Advice & Guidance	0	279	461	182	0	8	11	3	0	1,954	3,227	1,273	0	59	80	20
Critical Care	1,995	1,630	1,338	(293)	1,678	1,551	1,206	(345)	10,910	9,782	8,838	(944)	8,601	10,860	9,399	(1,461)
Maternity	1,075	1,028	947	(81)	933	895	882	(13)	7,127	6,165	5,700	(465)	5,966	6,265	6,171	(94)
Non PbR				0	4,261	3,094	3,236	142				0	26,974	21,609	22,043	434
Block	0	0	0	0	0	237	237	(0)	0	0	0	0	0	1,658	1,658	(0)
Shadow Monitoring	0	1,395	1,556	161	0	0	0	0	0	8,370	8,341	(29)	0	0	0	0
Repatriation						483	483	0						3,333	3,333	0
Backlog						54	54	0						360	360	0
Work in Progress:						0	(195)	(195)						0	(818)	(818)
Sub total without passthrough					**31,793**	**32,936**	**34,454**	**1,518**					**206,153**	**223,537**	**233,314**	**9,777**
CQUIN					647	379	402	22					4,210	2,568	2,703	135
Fines						0	(74)	(74)						0	(516)	(516)
Fines Reinvested						0	30	30						0	213	213
Bring Lincolnshire CCG Contract to Plan						0	(1,676)	(1,676)						0	(10,002)	(10,002)
APA (calculated at quarterly billing)						0	458	458						0	1,312	1,312
Prior Year								0								0
Maternity Prepayment								0								0
Total (Non Passthrough)					**32,439**	**33,315**	**33,595**	**279**					**210,364**	**226,105**	**227,023**	**918**
Non-recurrent Transitional Support						0	0	0						0	5,900	5,900
Total (Non Passthrough including transitional support)					**32,439**	**33,315**	**33,595**	**279**					**210,364**	**226,105**	**232,923**	**6,818**
Passthrough					4,658	4,241	4,414	173					28,312	29,592	28,976	(616)
Total (Inc Passthrough)					**37,097**	**37,556**	**38,009**	**452**					**238,676**	**255,697**	**261,899**	**6,202**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Headline
Contract income year to date of £262m is £6m (2.4%) favourable to plan. Excluding £1.0m adverse variance on pass-through, contract income year to date is £7m favourable to plan.

Key variances by POD below excluding pass-through
• Non Elective Spells are favourable to plan by £13m (16.1%) – Medicine accounts for £11m of the over-performance. Activity is above plan by 1,875 (4.4%) and the Trust has seen 2,966 more patients for the same time period in 2018/19.
• Outpatients are £1.1m adverse to plan - Medicine and Surgery account for 91% of the adverse movement to plan. Activity is 5,223 adverse to plan in 2019/20
• Critical Care is £1.5m adverse to plan – with this variance driven by Adult Critical Care. Activity is 1,518 adverse to plan in 2019/20 and 1,016 down on the same time period in 2018/19.
• A&E attendances are £0.8m favourable to plan. Activity in 2019/20 is above planned levels by 3,582 attendances, however this is 352 less than the same time period in 2018/19.

Key variances by Commissioner
• Lincolnshire CCGs are £1.3m favourable to plan excluding the £5.9m non-recurrent transitional support funding. This is driven by the NEL APA adjustment.
• Non Lincolnshire commissioners are £1m adverse to plan driven by:
  o Fines of £303k, predominantly due to 2ww breast symptomatic and suspect cancer.
  o Screening is £435k adverse to plan, of which bowel scope is £372k, diabetic retinopathy is £180k, offset by a favourable variance of £117k 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 £3.7m 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£0.5m, 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: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - Activity 2019/20

Activity	Activity Units: By Month / Quarter			In Month				Year to date			
	Actual Qtr 1	Actual Qtr 2	Actual M7	Plan October Activity	Actual October Activity	Variance October Activity	% Variance	Plan October Activity	Actual October Activity	Variance October Activity	% Variance
Accident & Emergency	36,746	38,449	12,576	12,197	12,576	379	3.1%	84,189	87,771	3,582	4.3%
Daycases	16,353	16,025	5,648	5,880	5,648	(232)	(4.0%)	38,373	38,026	(347)	(0.9%)
Elective Spells	2,148	2,280	761	843	761	(82)	(9.7%)	5,506	5,189	(317)	(5.8%)
Non Elective Spells	18,545	19,025	6,631	6,110	6,631	521	8.5%	42,326	44,201	1,875	4.4%
Elective Excess Bed Days	264	378	65	117	65	(52)	(44.6%)	820	707	(113)	(13.8%)
Non Elective Excess Bed Days	3,393	3,448	1,721	1,645	1,721	76	4.6%	11,513	8,562	(2,951)	(25.6%)
Outpatient Firsts	72,243	73,408	25,231	26,848	25,231	(1,616)	(6.0%)	175,233	170,882	(4,350)	(2.5%)
Outpatient Follow Ups	93,236	94,381	34,011	34,870	34,011	(860)	(2.5%)	227,432	221,628	(5,804)	(2.6%)
Outpatient Non Face To Face	7,825	8,003	2,456	2,156	2,456	300	13.9%	14,729	18,284	3,555	24.1%
Outpatient Virtual	-	42	61	-	61	61		-	42	42	
Outpatient Advice & Guidance	1,334	1,432	461	279	461	182	65.2%	1,954	3,227	1,273	65.2%

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

Whilst A&E activity is lower for the first seven 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. Those discussions are continuing around Discharge Lounge, PAU and Frailty activity.

Non Elective activity is 4.4% up against plan YTD in relation to activity and c16.1% 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: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - £ 2019/20

	By Month / Quarter			In Month			Year to date		
	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual M7 £'000	Plan October £'000	Actual October £'000	Variance October £'000	Plan October £'000	Actual October £'000	Variance October £'000
Accident & Emergency	6,267	6,629	2,202	2,073	2,202	129	14,309	15,099	790
Daycases	8,944	8,652	2,988	3,133	2,988	(145)	20,451	20,584	133
Elective Spells	6,340	6,561	2,337	2,326	2,337	10	15,193	15,238	44
Non Elective Spells	38,693	39,231	13,863	11,399	13,863	2,465	79,038	91,787	12,749
Elective Excess Bed Days	71	101	17	32	17	(15)	223	189	(33)
Non Elective Excess Bed Days	918	921	287	431	287	(144)	3,017	2,126	(891)
Outpatient Firsts	10,337	10,509	3,579	3,846	3,579	(267)	25,106	24,424	(682)
Outpatient Follow Ups	8,603	8,750	3,112	3,234	3,112	(122)	21,095	20,466	(630)
Outpatient Non Face To Face	504	517	154	140	154	14	961	1,174	213
Outpatient Virtual	0	1	1	0	1	1	0	2	2
Outpatient Advice & Guidance	33	35	11	8	11	3	59	80	20
Critical Care	4,155	4,038	1,206	1,551	1,206	(345)	10,860	9,399	(1,461)
Maternity	2,628	2,661	882	895	882	(13)	6,265	6,171	(94)
Non PbR	9,242	9,565	3,236	3,094	3,236	142	21,609	22,043	434
Block	711	711	237	237	237	(0)	1,658	1,658	(0)
Repatriation	1,417	1,433	483	483	483	0	3,333	3,333	0
Backlog	150	156	54	54	54	0	360	360	0
Work in Progress	(41)	(582)	(195)	0	(195)	(195)	0	(818)	(818)
Sub total without passthrough	**98,972**	**99,889**	**34,454**	**32,936**	**34,454**	**1,518**	**223,537**	**233,314**	**9,777**
CQUIN	1,144	1,157	402	379	402	22	2,568	2,703	135
Fines	(227)	(215)	(74)	0	(74)	(74)	0	(516)	(516)
Fines Reinvested	94	88	30	0	30	30	0	213	213
Bring Lincolnshire CCG Contract to Plan	(4,849)	(3,477)	(1,676)	0	(1,676)	(1,676)	0	(10,002)	(10,002)
APA (calculated at quarterly billing)	384	470	458	0	458	458	0	1,312	1,312
Total (Non Passthrough)	**95,518**	**97,911**	**33,595**	**33,315**	**33,595**	279	**226,105**	**227,023**	**918**
Non-recurrent Transitional Support	0	5,900	0	0	0	0	0	5,900	5,900
Total (Non Passthrough)	**95,518**	**103,811**	**33,595**	**33,315**	**33,595**	279	**226,105**	**232,923**	**6,818**
Passthrough	12,230	12,332	4,414	4,241	4,414	173	29,592	28,976	(616)
Total (Inc Passthrough)	**107,748**	**116,143**	**38,009**	**37,556**	**38,009**	**452**	**255,697**	**261,899**	**6,202**

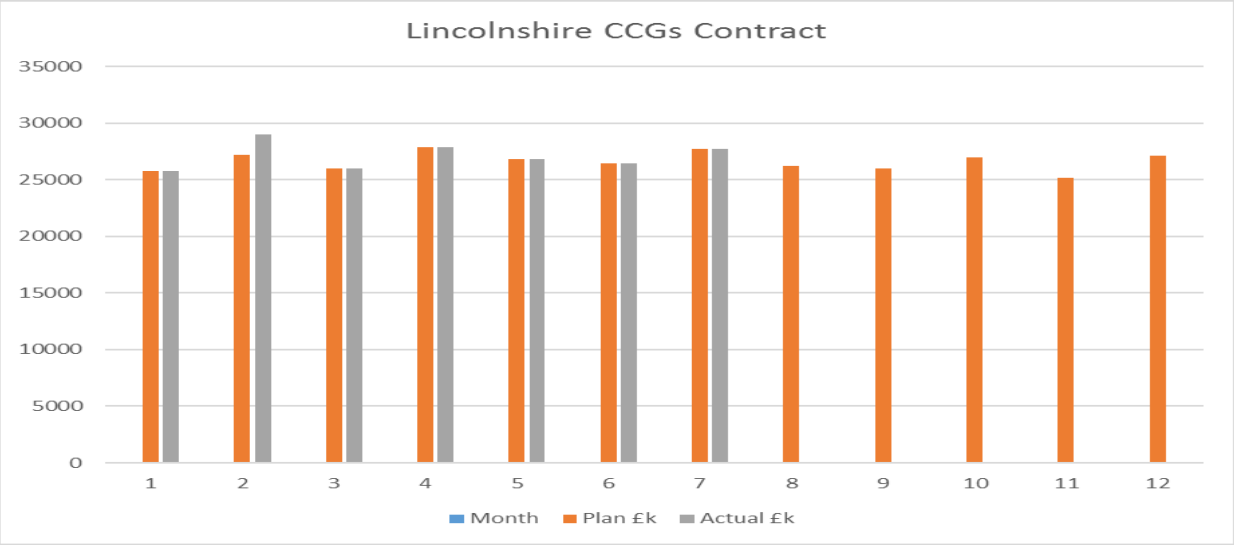
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

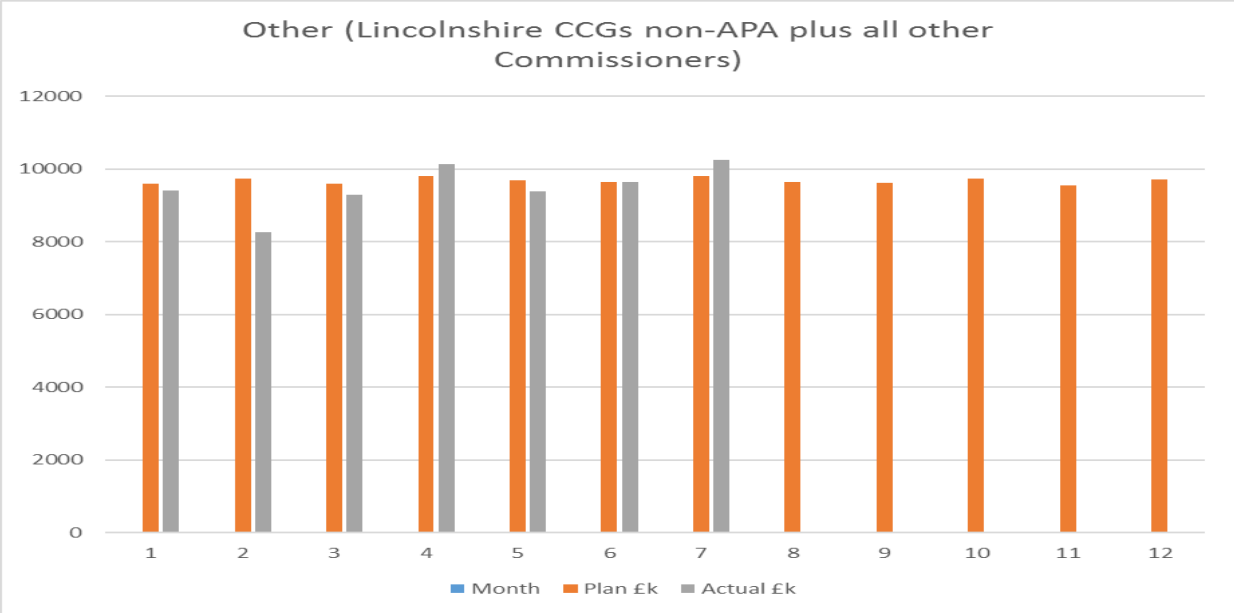
Executive Lead: Director of Finance & Digital

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: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Pay Summary 2019/20

2019/20 Pay Summary: YTD Month 07	By Month / Quarter			Pay: In-Month				Pay: Year-To-Date			
Staff Groups	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual M7 £'000	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000
Substantive:											
Registered Nursing, Midwifery and Health visiting staff	21,589	21,389	7,079	7,028	7,190	7,079	111	48,677	50,496	50,057	439
Health Care Scientists and Scientific, Therapeutic and Technical staff	8,251	8,242	2,802	2,532	2,602	2,802	(200)	17,661	18,302	19,295	(993)
Support to clinical staff	14,800	14,881	4,958	4,594	4,780	4,958	(178)	32,270	33,655	34,639	(984)
Medical and Dental Staff	19,093	20,956	6,838	6,290	6,777	6,838	(61)	45,503	47,915	46,888	1,027
Non-Medical - Non-Clinical Staff	8,256	8,720	2,868	2,622	2,911	2,868	43	17,932	20,477	19,844	633
Apprentice levy	347	316	114	106	107	114	(7)	741	748	777	(29)
Capitalised staff	(45)	(261)	(102)	(54)	0	(102)	102	(379)	0	(408)	408
Total Substantive costs	**72,291**	**74,243**	**24,558**	**23,118**	**24,367**	**24,558**	**(191)**	**162,405**	**171,593**	**171,092**	**501**
Bank:											
Registered Nursing, Midwifery and Health visiting staff	1,523	1,526	531	423	471	531	(60)	3,288	3,301	3,580	(279)
Health Care Scientists and Scientific, Therapeutic and Technical staff	131	136	51	48	44	51	(7)	302	312	318	(6)
Support to clinical staff	1,144	1,272	362	340	371	362	9	2,641	2,601	2,777	(176)
Medical and Dental Staff	2,846	2,758	785	824	629	785	(156)	5,822	5,036	6,389	(1,353)
Non-Medical - Non-Clinical Staff	715	501	177	298	177	177	0	1,514	1,239	1,393	(154)
Total Bank costs	**6,358**	**6,194**	**1,906**	**1,934**	**1,692**	**1,906**	**(214)**	**13,566**	**12,489**	**14,457**	**(1,968)**
Agency:											
Registered Nursing, Midwifery and Health visiting staff	3,086	3,631	1,242	830	876	1,242	(366)	5,304	6,306	7,959	(1,653)
Health Care Scientists and Scientific, Therapeutic and Technical staff	500	484	111	109	131	111	20	944	938	1,096	(158)
Support to clinical staff	6	0	0	1	17	0	17	15	98	7	91
Medical and Dental Staff	6,901	7,075	2,467	2,123	1,290	2,467	(1,177)	12,770	10,609	16,443	(5,834)
Non-Medical - Non-Clinical Staff	787	682	224	159	71	224	(153)	730	1,397	1,694	(297)
Total Agency costs	**11,281**	**11,873**	**4,045**	**3,221**	**2,385**	**4,045**	**(1,660)**	**19,764**	**19,348**	**27,198**	**(7,850)**
Total Pay	**89,930**	**92,310**	**30,508**	**28,274**	**28,444**	**30,508**	**(2,064)**	**195,735**	**203,430**	**212,748**	**(9,318)**

Pay year to date is £9,318k adverse to plan (despite the release of £1,021k of non-recurrent technical savings in prior months) including an adverse movement to plan of £2,064k in October.

The adverse movement to plan in Pay includes two key movements: £501k favourable movement against substantive staffing and £9,819k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £501k favourable to plan, this includes £993k of one-off technical benefit and £467k YTD in relation to higher than planned cost of the Medical & Dental pay award - the impact of Medical & Dental pay award on the Trust's I&E position was halved by additional external funding the Trust received. The underlying substantive pay position was c£1m higher in Q2 than in Q1, but has not moved materially in October relative to Q2.

The above table also shows that:

1) The movement from plan is as a result of both the planned spend reducing (which reflects the increasing CIP savings profile) and actual spend increasing.
2) The majority of the movement from plan relates to temporary staffing in general and Agency Pay in particular.
3) Medical & Dental Pay accounts for £6,160k (66%) and Nursing & Midwifery accounts for £1,493k (16%) of the overall adverse movement to plan.

Actual Agency Pay has averaged £3.9m per month YTD compared to an average planned Agency Pay spend of £2.8m per month YTD, and in October was £4.0m. Whilst the higher than planned spend on Agency Pay is in part due to need to respond to safety concerns and the growth in Non-Elective activity, the scale of expenditure and trend in expenditure over a longer period is of great concern given the impact it will have upon the Trust's ability to deliver the control total. Enhanced support is being provided to Medicine in order to agree and deliver plans to improve the Division's performance.

SUSTAINABLE SERVICES – NON PAY SUMMARY

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Non Pay Summary 2019/20

2019/20 Non Pay Summary: YTD Month 07

	By Month / Quarter			Non Pay: In-Month				Non Pay: Year-To-Date			
Non Pay	Actual Qtr 1 £'000	Actual Qtr 2 £'000	Actual M7 £'000	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000	2018/19 Actual October £'000	2019/20 Plan October £'000	2019/20 Actual October £'000	Variance October £'000
Ambulance Services	469	500	133	169	170	133	37	843	1,188	1,102	86
Clinical Supplies & Services	14,984	15,991	5,567	5,199	5,182	5,567	(385)	35,346	36,270	36,542	(272)
Drugs	913	279	1,018	650	426	1,018	(592)	3,634	3,064	2,210	855
Pass through	11,962	12,428	4,586	4,373	4,241	4,586	(345)	27,958	29,592	28,976	616
Establishment Expenditure	1,606	2,054	540	544	528	540	(12)	3,844	3,696	4,200	(504)
General Supplies & Services	2,841	2,335	776	1,245	489	776	(287)	7,363	4,422	5,952	(1,530)
Other	898	712	314	(181)	326	314	12	1,050	2,282	1,924	358
Premises & Fixed Plant	4,524	4,918	1,817	1,735	1,634	1,817	(183)	9,775	11,435	11,259	176
Clinical Negligence	5,222	5,223	1,740	1,770	1,741	1,740	1	12,417	12,187	12,185	2
Capital charges	3,244	3,242	1,075	(2,300)	1,100	1,075	25	3,476	7,700	7,561	139
Total Non Pay	**46,663**	**47,681**	**17,566**	**13,204**	**15,837**	**17,566**	**(1,729)**	**105,706**	**111,836**	**111,910**	**(74)**

Non Pay expenditure of £111,910k is £74k adverse to plan.

Excluding £616k favourable variance on Pass-through, Non Pay is £690k adverse to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £2,183k adverse to plan.

Some variation to plan would be expected in Non Pay given the slower than planned savings delivery and higher than planned levels of Non Elective volumes. The majority of the movement to plan, though, is in relation to the level of non-clinical expenditure i.e. the spend is higher in relation to Establishment Expenditure, General Supplies and Services and Premises and Fixed Plant. This includes higher than planned expenditure in a number of areas i.e. ongoing support costs in relation to FSM, dual running for Community COIN (for which there is an offset within Income) and (more recently) additional building & engineering costs in Estates.

SUSTAINABLE SERVICES – COST IMPROVEMENT PROGRAMME (CIP) SUMMARY

Executive Lead:

Director of Finance & Digital

CQC Domain:

Well-Led

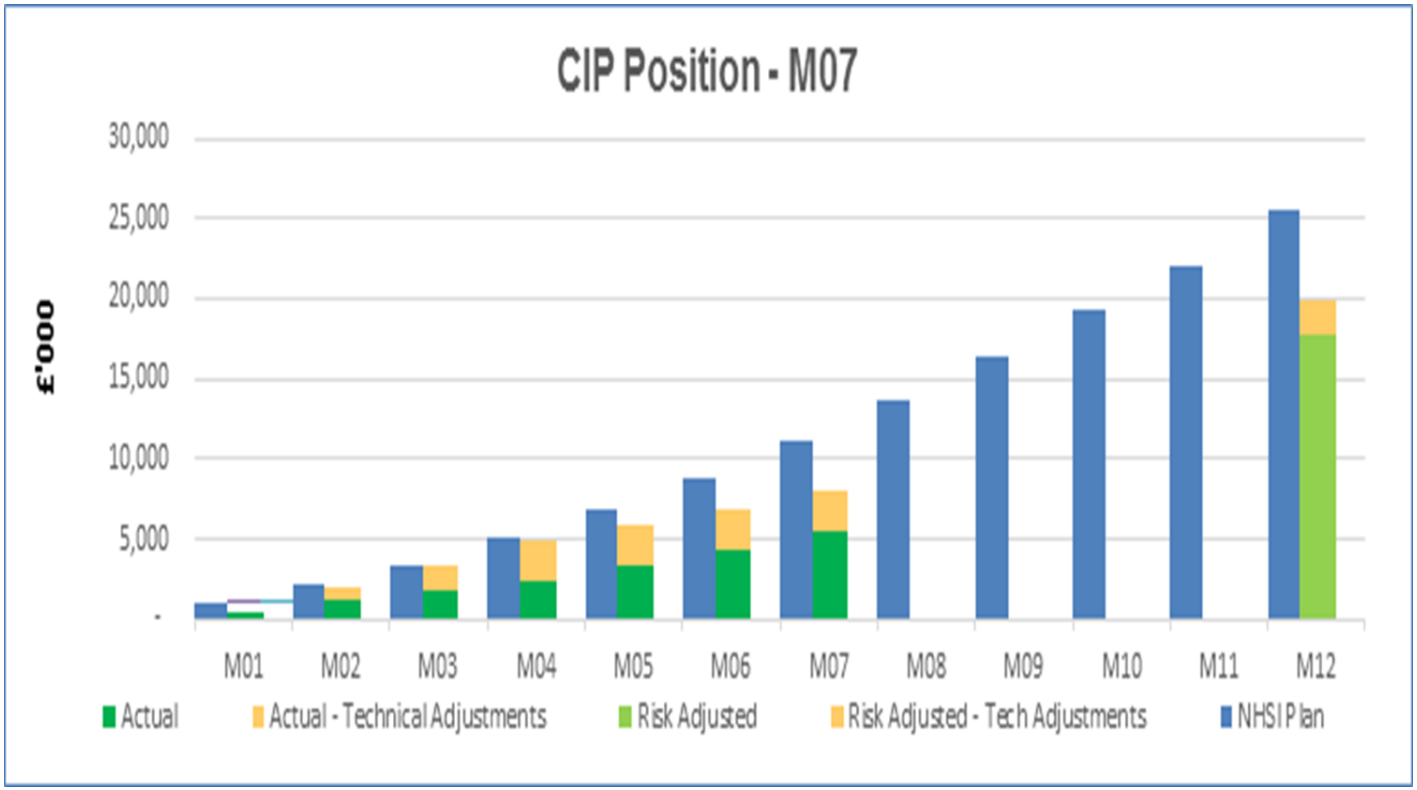
2021 Objective:

Our Services

M07	In Month: 2019/20			YTD: 2019/20			
	Plan October £'000	Actual October £'000	Variance October £'000	Plan October £'000	Actual October £'000	Variance October £'000	RAG
CIP	2,453	1,090	(1,363)	11,196	7,977	(3,219)	

Finance Position

YTD ACTUAL	£'000	FORECAST	£'000
Recurrent	5,446	Recurrent	17,419
Non Recurrent	2,531	Non Recurrent	2,781
TOTAL	**7,977**	**TOTAL**	**20,200**



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.

CIP savings delivery of £1,090k is reported in October; compared to planned CIP savings delivery of £2,453k, savings delivery in October is £1,363k adverse to plan including £250k in relation to thesale of Grantham Hospital which has not taken place in October as planned.

YTD CIP savings delivery of £7,977k to the end of October is £3,219k (28.8%) adverse to planned CIP savings delivery of £11,196k.

However, the YTD CIP position is supported by delivery of £2,531k of non-recurrent Technical CIP savings. This non-recurrent CIP savings delivery comprises of £1,022k of Technical Savings in relation to Pay, £1,493k in relation to Non Pay and £16k in relation to Income. Excluding Technical CIP delivery, the YTD CIP position is £5,750k (51.4%) adverse to plan.

The delivery of non-recurrent Technical CIP savings have mitigated some of the continued underperformance in relation to Theatres, Outpatients, Procurement, Workforce programmes and Divisional Transactional schemes.

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

	Year end		Year to date			Monthly Actual 2019/20			Forecast Outturn		
	Plan	Actual	Plan	Actual	Variance	Actual	Actual	Actual	Actual	Plan	Variance
	31 March 2019		31 October 2019			Qtr 1	Qtr 2	31-Oct	31 March 2020		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets											
Intangible assets	5,488	6,341	4,795	5,343	(548)	5,907	5,484	5,343	4,639	4,637	2
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	22,495	27,654	27,122	27,411	(289)	27,550	27,446	27,411	27,238	26,954	284
Property, plant and equipment: other	213,599	181,095	213,202	188,970	24,232	184,058	187,899	188,970	202,512	224,849	(22,337)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,828	1,560	1,600	1,528	72	1,537	1,561	1,528	1,600	1,600	0
Total non-current assets	**243,410**	**216,650**	**246,719**	**223,252**	**23,467**	**219,052**	**222,390**	**223,252**	**235,989**	**258,040**	**(22,051)**
Current assets											
Inventories	6,799	7,440	7,350	7,418	(68)	7,317	7,484	7,418	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	17,664	15,203	20,527	33,531	(13,004)	16,170	25,931	33,531	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	4,848	6,833	7,949	10,157	(2,208)	15,803	15,671	10,157	7,912	7,912	0
Assets held for sale and assets in disposal groups	0	660	510	660	(150)	660	660	660	660	510	150
Cash and cash equivalents: GBS/NLF	6,143	7,376	990	2,876	(1,886)	1,206	3,423	2,876	5,345	4,214	1,131
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	0
Total current assets	**35,464**	**37,522**	**37,336**	**54,652**	**(17,316)**	**41,166**	**53,179**	**54,652**	**48,122**	**46,841**	**1,281**
Current liabilities											
Trade and other payables: capital	(4,723)	(10,791)	(5,154)	(6,583)	1,429	(7,990)	(6,831)	(6,583)	(9,742)	(4,466)	(5,276)
Trade and other payables: non-capital	(38,039)	(40,622)	(35,046)	(43,645)	8,599	(47,043)	(41,788)	(43,645)	(35,456)	(41,096)	5,640
Borrowings	(77,359)	(114,339)	(57,003)	(164,596)	107,593	(124,423)	(122,404)	(164,596)	(196,607)	(197,289)	682
Provisions	(735)	(608)	(565)	(663)	98	(608)	(608)	(663)	(663)	(565)	(98)
Other liabilities: deferred income	(2,707)	(2,869)	(1,200)	(1,919)	719	(1,110)	(1,871)	(1,919)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	0
Total current liabilities	**(124,066)**	**(169,732)**	**(99,471)**	**(217,909)**	**118,438**	**(181,677)**	**(174,005)**	**(217,909)**	**(244,171)**	**(245,119)**	**948**
Net Current liabilities	**(88,602)**	**(132,210)**	**(62,135)**	**(163,257)**	**101,122**	**(140,511)**	**(120,826)**	**(163,257)**	**(196,049)**	**(198,278)**	**2,229**
Total assets less current liabilities	**154,808**	**84,440**	**184,584**	**59,995**	**124,589**	**78,541**	**101,564**	**59,995**	**39,940**	**59,762**	**(19,822)**
Non-current liabilities											
Borrowings	(228,888)	(188,196)	(294,700)	(195,101)	(99,599)	(199,326)	(232,940)	(195,101)	(179,777)	(178,440)	(1,337)
Provisions	(2,911)	(2,863)	(2,882)	(2,651)	(231)	(2,989)	(2,689)	(2,651)	(2,532)	(2,782)	250
Other liabilities: other	(13,081)	(13,081)	(12,787)	(12,788)	1	(12,956)	(12,830)	(12,788)	(12,578)	(12,578)	0
Total non-current liabilities	**(244,880)**	**(204,140)**	**(310,369)**	**(210,540)**	**(99,829)**	**(215,271)**	**(248,459)**	**(210,540)**	**(194,887)**	**(193,800)**	**(1,087)**
Total net assets employed	**(90,072)**	**(119,700)**	**(125,785)**	**(150,545)**	**24,760**	**(136,730)**	**(146,895)**	**(150,545)**	**(154,947)**	**(134,038)**	**(20,909)**
Financed by											
Public dividend capital	257,563	260,042	260,941	260,042	899	260,042	260,042	260,042	266,293	265,318	975
Revaluation reserve	34,455	32,159	35,251	31,632	3,619	31,933	31,707	31,632	31,255	34,951	(3,696)
Other reserves	190	190	190	190	0	190	190	190	190	190	0
Income and expenditure reserve	(382,280)	(412,091)	(422,167)	(442,409)	20,242	(428,895)	(438,834)	(442,409)	(452,685)	(434,497)	(18,188)
Total taxpayers' and others' equity	**(90,072)**	**(119,700)**	**(125,785)**	**(150,545)**	**24,760**	**(136,730)**	**(146,895)**	**(150,545)**	**(154,947)**	**(134,038)**	**(20,909)**

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.

- Trade / NHS Receivables: the levels at 30 October are significantly increased against plan (£13m) due to high levels of NHS Accrued income. versus plan. The balance of £33.5m broadly breaks down into outstanding invoices awaiting payment (£6.9m), PSF / FRF monies awaited (£7.6m) NHS Prepayments (£2.7m), NHS Accrued Contract Income (£13.2m) and Other NHS Accrued Income (£3.1m).

- Trade Payables - these are currently operating at levels above plan reflecting the level of cash resources available.

The forecast balance sheet assumes that the control total of £41.5m is achieved and the full PSF / FRF are awarded.

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Cash Report 2019/20 Month 07

Year to date:
The cash balance of £2.9m at 31 October 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 £6.6m;
- the operating deficit (£30.7m) against plan
- Drawdown of Capital and Revenue loans being higher than plan
- Working Capital being flexed as necessary to manage payments in line with income receipt and borrowings

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. Capital cash is supporting the overall cash position by circa £11.6m at October 2019.

Borrowing:
Revenue and capital cash loans drawn between April - October 2019 equate to £45.9m / £11.7m respectively; taking the total revenue and capital borrowings (excluding accrued interest) at 30 October to £357.1m. As a consequence borrowing costs for 2019/20 are anticipated to be £9.2m in I&E terms, and in cash terms £8.8m.
Revenue borrowings to date are higher than plan due to the later than anticipated receipt of PSF / FRF monies for Q2. The financial plan assumed receipt during October.
Total borrowings since February 2018 against the Fire Safety Capital Scheme are £38.2m. The original business case agreed with NHSI set external support at £39.9m. NHSI have requested the business case be refreshed before signing off the final £1.7m.
Close monitoring of the cash position must continue to ensure sufficient borrowing is put in place where required.

Forecast:
The cash forecast is broadly in line with plan. The capital creditors are forecast to increase to £9.8m by March 2020 which allows the Trust to continue to meet revenue creditor obligations.

The cash forecast assumes capital borrowing of £11.7m and revenue borrowing in 2019/20 at £60.6m (£41.4m: 2019/20 deficit support; plus £9.6m 2018/19 deficit support, £0.8m working capital support and £8.8m PSF and FRF).

SUSTAINABLE SERVICES – CASH REPORT continued

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

	In Month Actual October			Year to date October			Year End Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating Surplus	(2,885)	(2,846)	39	(23,671)	(25,772)	(2,101)	(32,306)	(32,443)	(137)
Depreciation	1,100	1,075	(25)	7,700	7,561	(139)	13,200	13,200	0
Other Non Cash I&E Items	(18)	0	18	(125)	0	125	(214)	(120)	94
Movement in Working Capital	(3,678)	(124)	3,554	(13,344)	(19,818)	(6,474)	(13,680)	(20,010)	(6,330)
Provisions	0	17	17	19	(166)	(185)	(81)	(276)	(195)
Cashflow from Operations	**(5,481)**	**(1,878)**	3,603	**(29,421)**	**(38,195)**	(8,774)	**(33,081)**	**(39,649)**	(6,568)
Interest received	3	11	8	21	81	60	36	140	104
Capital Expenditure	(1,774)	(2,218)	(444)	(20,853)	(18,405)	2,448	(38,312)	(33,430)	4,882
Cash receipt from asset sales	0	0	0	150	22	(128)	150	22	(128)
Cash from / (used in) investing activities	**(1,771)**	**(2,207)**	**(436)**	**(20,682)**	**(18,302)**	**2,380**	**(38,126)**	**(33,268)**	**4,858**
PDC Received	108	0	(108)	899	0	(899)	5,276	6,251	975
Interest on Loans, PFI and leases	(464)	(650)	(186)	(4,522)	(4,616)	(94)	(8,486)	(8,789)	(303)
Drawdown on debt - Revenue	5,325	4,188	(1,137)	38,478	45,906	7,428	59,809	60,598	789
Drawdown on debt - Capital	3,200	0	(3,200)	11,340	11,700	360	15,400	15,400	0
Repayment of debt	(917)	0	917	(1,245)	(993)	252	(2,721)	(2,574)	147
Cashflow from financing	**7,252**	**3,538**	**(3,714)**	**44,950**	**51,997**	**7,047**	**69,278**	**70,886**	**1,608**
Net Cash Inflow / (Outflow)	**0**	**(547)**	**(547)**	**(5,153)**	**(4,500)**	**653**	**(1,929)**	**(2,031)**	**(102)**
Opening cash balance	1,000	3,433	2,433	6,153	7,386	1,233	6,153	7,386	1,233
Closing Cash balance	**1,000**	**2,886**	**1,886**	**1,000**	**2,886**	**1,886**	**4,224**	**5,355**	**1,131**

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

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£9m - 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 year-to-date spend incurred amounts to c£14m against a planned spend of c£15m however planned spend linked to the replacement of the CHP (via Salix loan) was due to commence which and hasn't yet, details below:

Facilities; Minimal spend at M6 of £395k. Majority of spend incurred links to Anti-barricading improvements, £185k. 2nd IT room at Pilgrim, £27k. Lincoln Heating where CQC had raised an issue following an incident with a patient, £22k. Pilgrim Kitchen Floor, £27k. Corridor Flooring, £21k. Endoscopy, £14k. Regular meetings are taking place to ensure planned spend levels are accurate, and risks identified early - currently the roof improvement scheme is incurring significantly higher costs than was planned and the allocation has risen from £13k to £140k as part of the re-prioritisation work and the current forcast is closer to £222k but not finalised. A revised forecast for all schemes has recently been completed for further review.

Fire; Expenditure on fire related schemes continues to progress at pace. Costs incurred at the end of October amounted to c£12m (spend in month was c£1.6m). Fire Works package 1 at LCH is £3.4m, package 2 is £2.0m, Emergency Lighting at LCH is £0.6m. Package 1 at Pilgrim amounts to £1.6m. Work continues with the QS to ensure robust mechanisms are in place for capturing financial information and projections. Cash flow forecasts are also being managed.

Medical Devices; Spend year-to-date is £0.6m. The equipment replaced this year has been; Radiology Ultrasound machine £66k, Theatre Tables £177k, Surgical Diathermy £114k, Theatre lights £123k, YAG Laser £42k, Field Analyser £38k and Ultrasound Scanner £22k. Due to the levels of emergency equipment replacement required there has been further reprioritisation of allocations involving Divisions - this has removed the £100k allocation for phaco-emulsifiers and enabled the Field Analyser, YAG Laser and Ultrasound for LCH A&E to be purchased instead.

IT; Spend to date of £0.9m. Key spend areas are as follows - E-Health-record costs of £297k, Windows 7 to 10 £131k, E-prescribing £140k, Cyber Security £104k, PC replacement £98k, Wifi spend linked to HSLI deferred monies amounting to £63k and Digital Dictation £103k. Forecasts of each are currently being progressed as there may be potential in 2 key schemes for slippage or actual reduction in spend anticipated, those being E-prescribing and Robot.

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.

External Funding update

Work continues to progress regarding the £21.3k allocated for Pilgrim A&E and UTC. Business case being updated currently involving key stakeholders across Lincolnshire to ensure robust plans are assessed and options appraised.

SUSTAINABLE SERVICES – CAPITAL REPORT continued

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**14,957**	**14,197**	760

Year End Forecast	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**32,381**	**32,381**	**0**

Year to date	Plan	Actual	Variance
	£'000	**£'000**	**£'000**
Medical Equipment replacement	1,007	585	422
Estates - Fire	7,200	12,010	(4,810)
ICT	1,151	971	180
Estates - Backlog	1,188	395	794
Service developments	4,411	236	4,175
Total	**14,957**	**14,197**	760

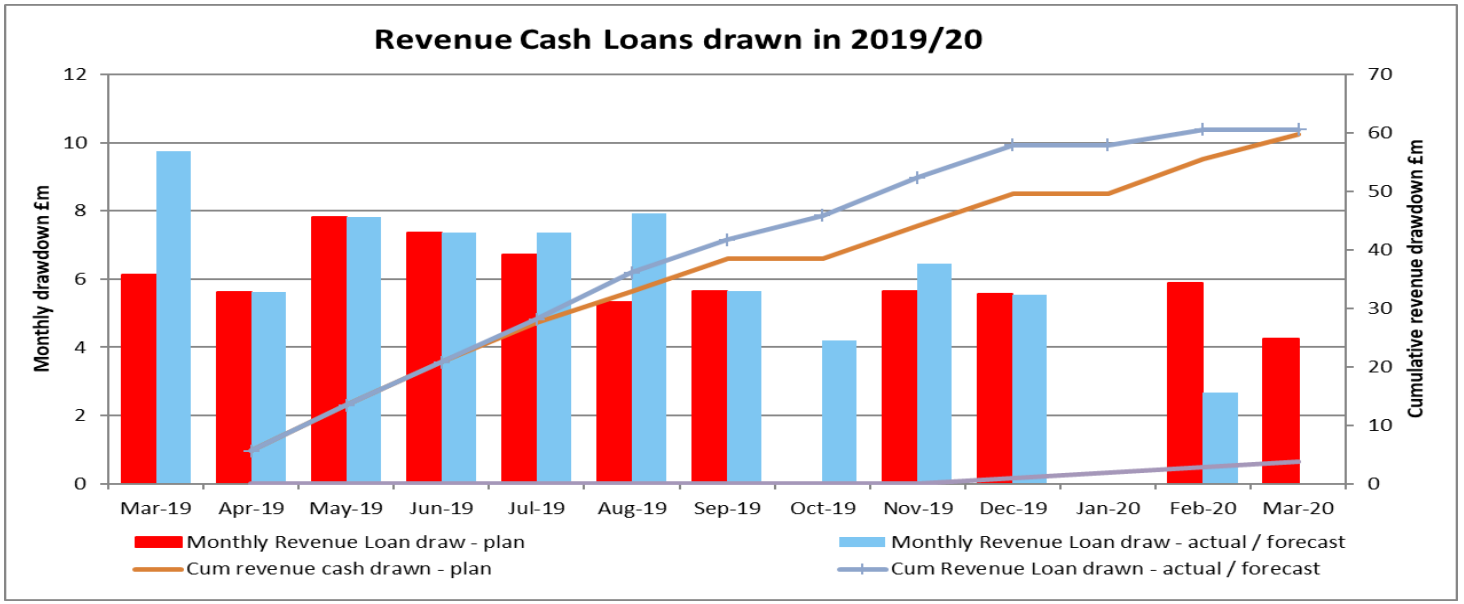
Year End Forecast	Plan	Actual	Variance
	£'000	**£'000**	**£'000**
Medical Equipment replacement	1,697	1,697	**0**
Estates - Fire	13,470	13,470	**0**
ICT	4,344	4,344	**0**
Estates - Backlog	2,852	2,852	**0**
Service developments	10,018	10,018	**0**
Total	**32,381**	**32,381**	**0**

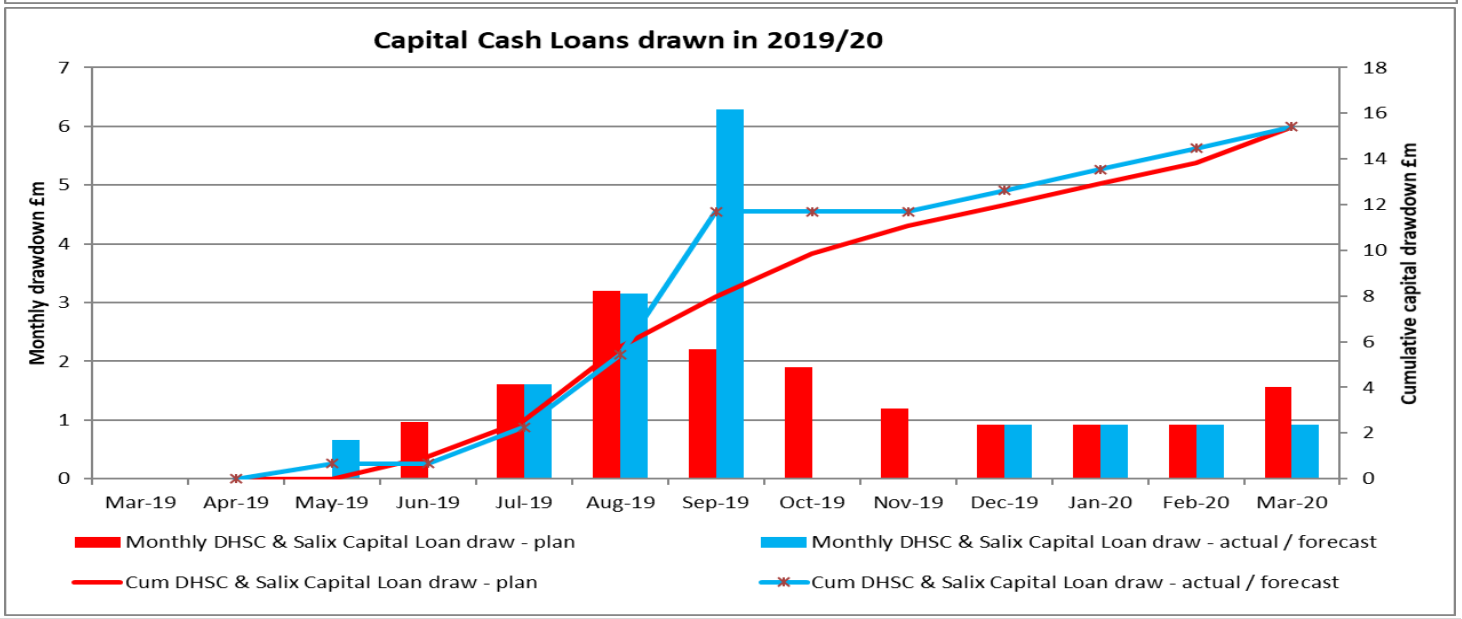
SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Borrowing
The Trust has drawn cash loans of £57.6m during the seven months to October 2019, this is split £45.9m revenue support and £11.7m capital. This includes £9.6m deficit support relating to 2018/19.

Revenue
The forecast deficit for 2019-20 is £41.4m in line with the financial plan. Revenue borrowings are planned to be £60.6m (Deficit support 19/20: £41.4m, 18/19: £9.6m, working capital support £0.8m and PSF / FRF: £8.8m).
The impact of I&E pressures upon the Trust ability to pay suppliers has to date been largely mitigated by capital cash, available due to the high level of capital creditors brought forward from 2018/19. A significant proportion of these are expected to be cleared during November / December which will partially crystalise the underlying revenue working capital pressures. This is offset in part by the fact that a significant portion of the capital programme will not be completed until the final months of 2019/20 with cash payments of £9.8m not expected until the new financial year.
The Trust borrowing agreed by NHSI for November was £6.5m which is within the limits authorised by the Trust Board (£7.3m) December borrowing yet to be formally agreed by NHSI is set at £5.6m, in line with Board approval provided in October.

Receipt of Q2 PSF / FRF monies of £5.1m is expected in January 2020. As a consequence no new borrowing is likely to be required in January. The Finance Team will however continue to manage outgoings to ensure sufficient cash is held to meet all urgent requirements.
To mitigate against any unexpected adverse impacts upon cash and uncertainty around the timing and level of cash support from CCGs, the Board is requested to delegate authority to the Director of Finance to submit a further working capital loan request of up to £4.0m should the position deteriorate unexpectedly over the next two months.

The cash position remains intrinsically linked to the revenue position which in turn is dependent upon delivery of the cost improvement programme and containment of expenditure within control totals

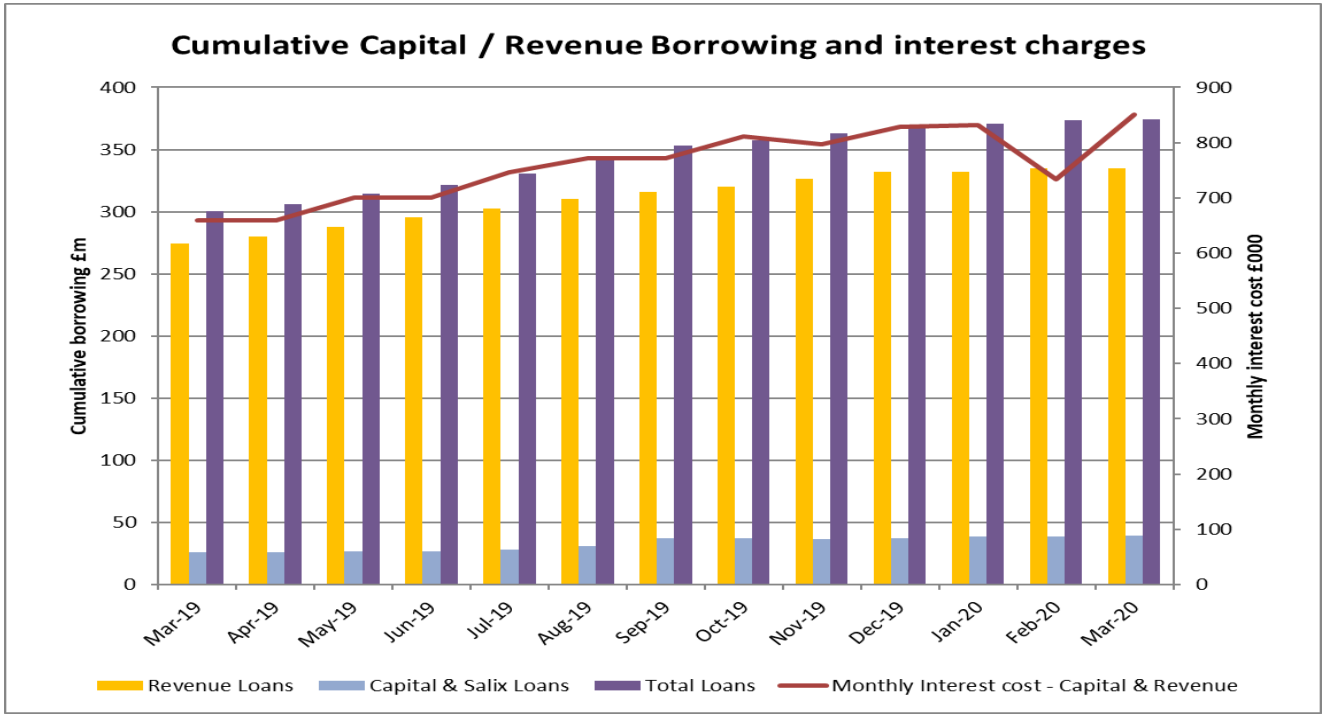
Capital Borrowing
A series of capital loans totalling £38.2m were agreed with DHSC in relation to the Fire Safety Capital scheme. Against this £26.5m was drawn prior to 2019/20 and a further £11.7m subsequently drawn in 2019/20. The balance of £1.7m is subject to a refresh of the original business case and once approved will be drawn in 2020/21.
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: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowings and Interest
At 31 October 2019 total 'repayable' borrowings (excluding accrued interest) were £357.2m, capital (£36.9m) and revenue (£320.3m).
Existing loans are held at a variety of interest rates, Capital 1.1% (£8.9m) & 1.37% (£28.0m), Revenue 1.5% (£155.3m), 3.5% (£121.6m) & 6.0% (£43.4m).

In early November the Trust received notification from DHSC that a series of loans with original repayment dates between November 2018 and March 2019 have been extended into 2020/21. The original interest rates remain unchanged.

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

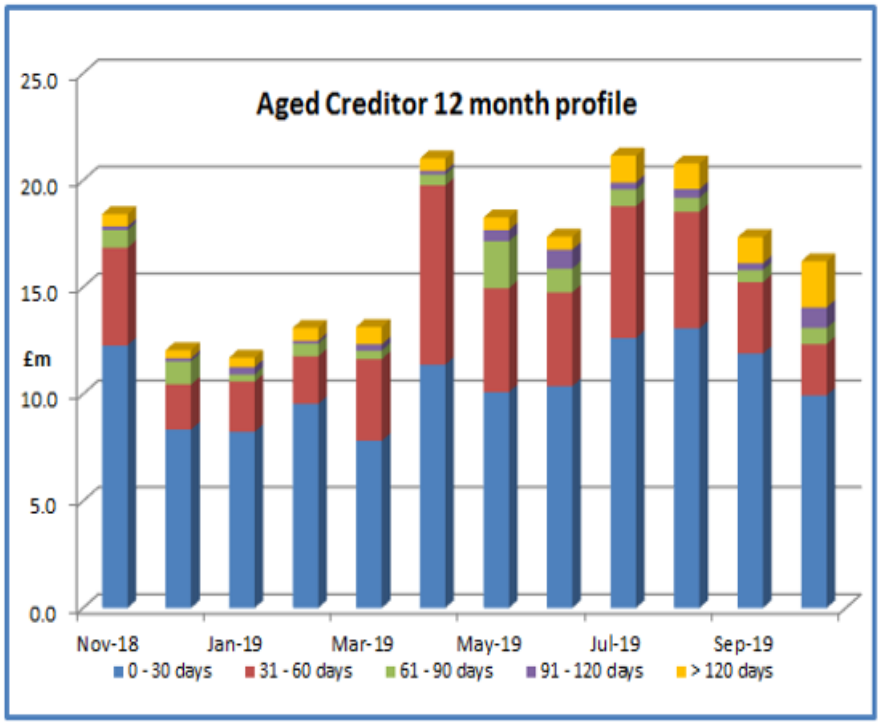
Associated interest costs for 2019/20 are £9.2m (Revenue £8.8m / Capital £0.4m).
Changes in accounting standards from 2018/19 have meant that any accrued interest (October 19 - £2.5m) is now reported as part of overall borrowings on the Statement of Financial Position.

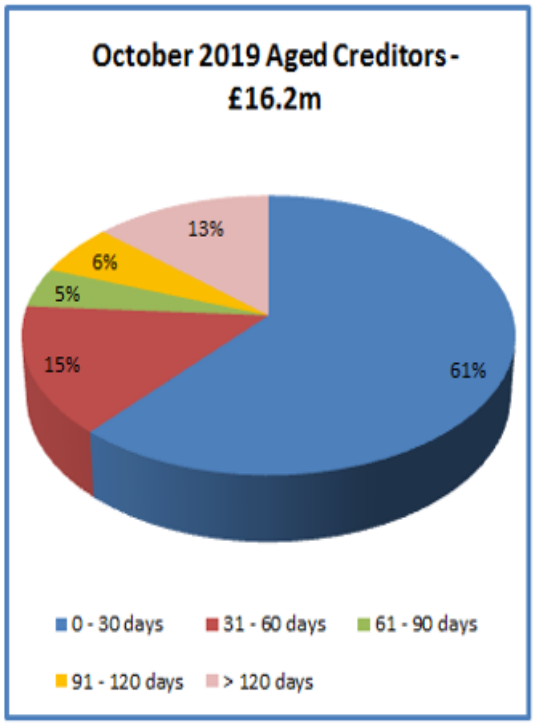
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors
Total Creditors were £16.2m at 31 October 2019, of which; £6.2m were over 30 days (£3.1m > 90 days).
Focusing further upon those invoices over 30 days; £1.7m had been authorised and was ready to pay at 31 October, a further £3.0m (65%) relates to ten suppliers where there are specific queries and which the payments team are working to resolve with the supplier and purchasing departments. The remaining £1.5m is spread across 336 suppliers and circa 1070 invoices.

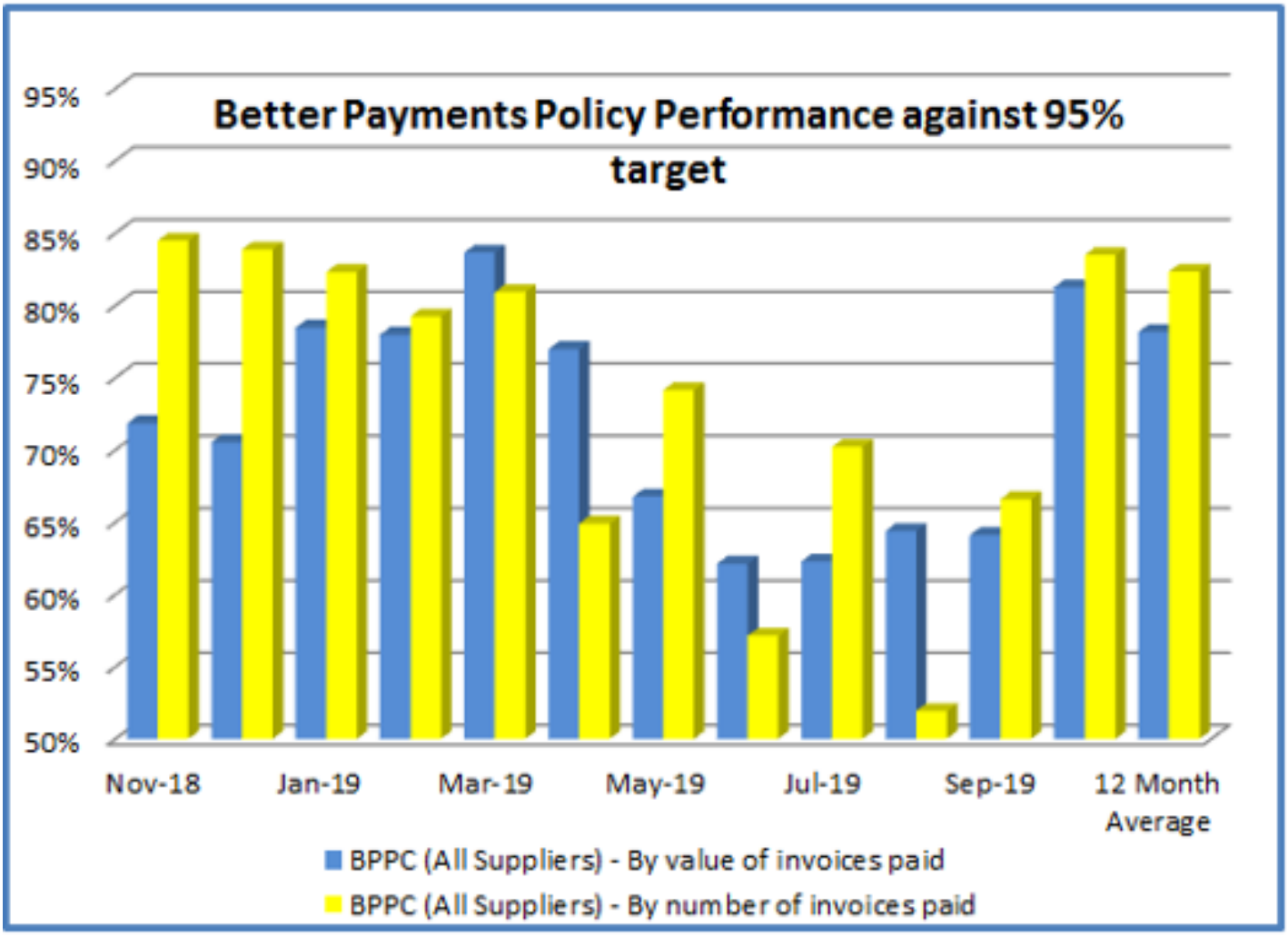
Performance
Performance against BPPC has declined from 2018/19 levels, principally due to the cash position of the Trust. It has been necessary to carefully manage outgoings often at the expense of BPPC to ensure sufficient reserves have been maintained to cover month end payroll costs and other potential unforeseen 'urgent' payments. The BPPC and Creditor profiles covering the previous 12 months illustrate the increase in Creditors and decline in BPPC since April.

SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services



BPPC

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 October 2019 performance are shown in the following table.

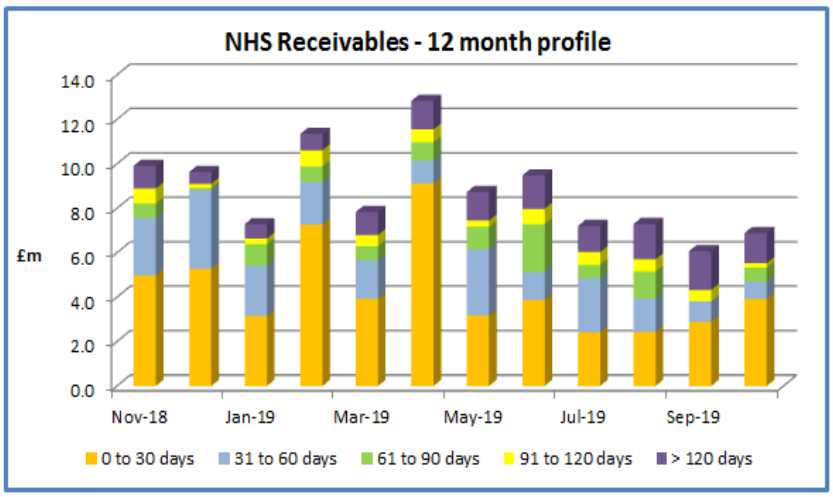
	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	1605	27,843	81,613	113,190
Total bills paid within target	929	22,749	55,904	72,169
% of bills paid within target YTD	**57.88%**	**81.70%**	**68.50%**	**63.76%**
% of bills paid within October 2019	**63.30%**	**69.52%**	**83.81%**	**86.65%**

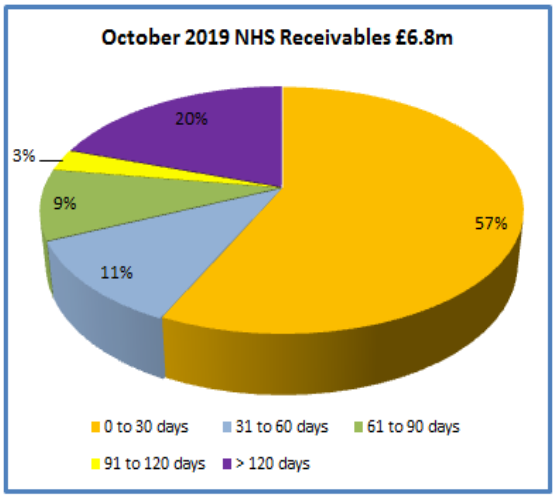
SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





	Totals outstanding debt £'000						
	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	2,014	107	120	47	242	2,530	289
CCGs - Other	423	230	93	19	244	1,009	263
Trusts - Lincolnshire	220	142	5	27	50	444	77
Trusts - Other	631	297	267	17	568	1,780	585
Other NHS	1,550	0	146	(831)	254	1,119	(577)
Total	**4,838**	**776**	**631**	**-721**	**1,358**	6,882	**637**

The tables above show the level of Non-NHS debt over the last 12 months alongside the aged split at 31 October 2019.
Overall levels of debt are at the lowest point for over 12 months. Much of this can be attributed to the 'without prejuduce' agreement between ULHT and the four Lincolnshire CCGs, LPFT and LCHS to make invoice payments 'on account' to assist ULH cash liquidity.

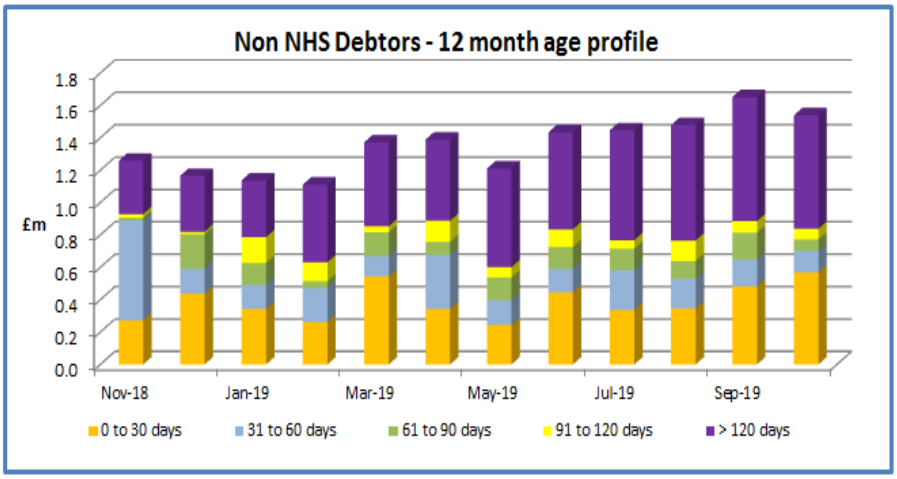
The principal area of concern at present is the level of debt outstanding with Nottingham University Hospitals (£1.3m) and, the majority of which is over 30 days this balance has however been escalated.

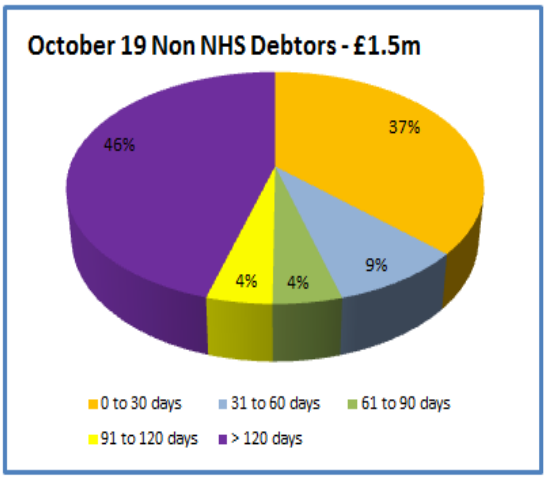
SUSTAINABLE SERVICES – NON NHS RECEIVABLES

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services





	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	15	13	14	39	148	**229**	187
Debt Collection - Overseas	0	0	0	0	127	**127**	127
NHS Non English	3	43	20	0	6	**72**	6
Misc	507	72	9	19	323	**930**	342
Salary Overpayments	40	0	10	7	31	**88**	38
Private Patients	0	0	0	0	0	-	0
Debt Collection - General	0	0	0	0	32	**32**	32
Agreed Installment Plans	3	6	16	1	36	**62**	36
Grand Total	**569**	**134**	**69**	**66**	**702**	**1,539**	**768**

The tables above show the level of Non-NHS debt over the last 12 months alongside the aged split at 31 October 2019.

The current debt is the highest it has been in the last year and is driven predominently by 3 factors:

1. Overseas Debt - currently £0.2m over 90 days. (previously £0.3m) Write offs were reviewed and processed during October, however a risk share arrangement is in place with CCGs, so the Trust is guaranteed 50% of this income.
2. A dispute has arisen with one of the retailers on Trust Sites. This is being addressed through legal channels but accounts for £0.2m.
3. A further £0.3m is in dispute with St Barnabas and has been escalated to the contracting team to seek resolution / payment.

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

SUSTAINABLE SERVICES – EXTERNAL FINANCIAL LIMIT & CAPITAL RESOURCE LIMITS

Executive Lead: Director of Finance & Digital

CQC Domain: Well-Led

2021 Objective: Our Services

Position as at 31 October 2019

External Financing Limit Target (EFL)	**Forecast £000s**
Anticipated EFL at Plan	**79,693**
Opening EFL allocated to Trust	
April 19 Plan movement in cash balances	**1,929**
Capital element of Finance leases - repayments	**0**
Initial EFL	**1,929**
Confirmed / actioned adjustments	
PDC drawn 18/19 carried forward	102
2018/19 additional deficit financing	9,552
Interim revenue support loan: deficit financing	28,774
PSF temporary loan financing	7,580
Fire safety - Loan	11,700
Fire safety loan repayments	(993)
PDC received: LED Lighting	1,439
PDC received: E- Health Records	977
Current Notified EFL	**61,060**
Anticipated adjustments	
Interim revenue support loan: deficit financing	12,624
PSF temporary loan financing	1,265
Working Capital Loan	805
Fire safety loan repayments	(1,350)
Salix Loan Financing	3,700
Salix Loan repayment	(231)
PDC received: Medical School	1,500
PDC received: LED Lighting	1,361
PDC received: E- Health Records	0
PDC received: STP support LCHS / LPT	974
Anticipated EFL	**81,708**

Performance against Capital Resource Limit (CRL) Target	**Forecast £000s**
Anticipated CRL at Plan	**31,155**
Opening CRL allocated to Trust	
Depreciation	**13,200**
Fire safety loan repayments	**(2,490)**
Salix Loan repayment	**(231)**
Initial CRL	**10,479**
Confirmed / actioned adjustments	
PDC drawn 18/19 carried forward	102
Fire safety - Loan	11,700
Fire safety loan repayments	
PDC received: LED Lighting	1,439
PDC received: E- Health Records	977
Current Notified CRL	**24,697**
Anticipated adjustments	
Fire safety loan repayments	147
Salix Loan Financing	3,700
Salix Loan repayment	0
PDC received: Medical School	1,500
PDC received: LED Lighting	1,361
PDC received: E- Health Records	0
PDC received: STP support LCHS / LPT	974
Current Anticipated CRL	**32,379**
Forecast Capital expenditure	**32,501**
Less Capital funded via Charitable Donations	**(120)**
Less Net book value of disposed assets	**(2)**
Charge against CRL	**32,379**
(Over) / Under shoot against CRL target	**0**

EFL

The Trust External Financing limit is set by the DHSC.
This is a cash limit on net external financing and it is one of the controls used by the DHSC to keep cash expenditure of the NHS as a whole within the level agreed by Parliament in the public expenditure control totals.
Trusts must not exceed the EFL target, which effectively determines how much more (or less) cash a Trust can spend over that which it generated from its activities.
This target translates in simple terms to the Trust holding a minimum cash balance at year end of £5.4m.

CRL

The Trust is allocated a CRL target based upon its planned internally generated resources - depreciation and asset sale proceeds plus agreed net additional developments funded by loans / PDC.

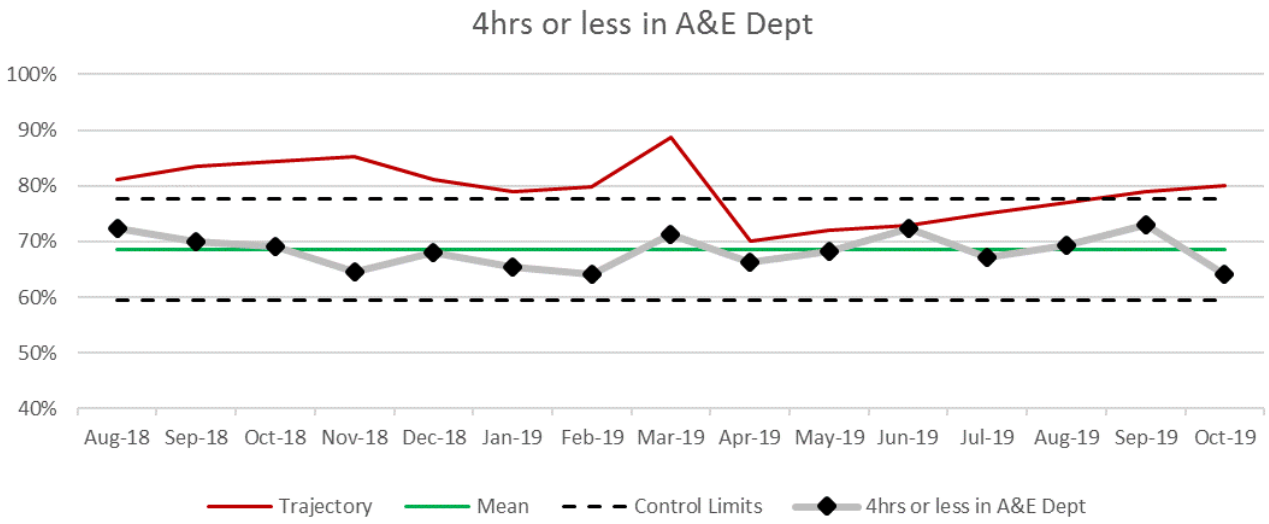
Trusts are not permitted to exceed the CRL.

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- A&E overall outturn for October, Type 1 and primary care streaming delivered 64.3% against a trajectory of 80%, a variance of 15.7% and was a 8.78% performance deterioration on September performance of 73.07%.
- The system has set a target of 20% of all ED attendances at LCH and PHB to be primary care streamed. For , PBH delivered 20.2% a 0.9% performance deterioration compared with August. LCH delivered 19.3%, a -0.3% performance deterioration compared with August.
- A&E attendances in October were 15,162, compared to 13,974 in October 2018 - Type 1 & 3 numbers and represent a 7.84% increase. Non-elective demand has experienced an increase of 153 (3468 October vs 3315 September).
- Adult inpatient demand in October was 13% above 2018/19 levels and 11% above contract plan.
- Nursing and Medical staffing levels for inpatient wards and the emergency department continue to be an area of concern. We are now beginning to benefit from new consultants taking up post. Recruitment plans against start dates are monitored weekly.
- The weekly long stay meetings at LCH and PHB continue to progress toward meeting the agreed monthly trajectories. October saw 101 patients >21 days against trajectory of 97. Pilgrim continue to be below their trajectory.
- Total ULHT bed occupancy for October was 94.48% compared with 88.70% in September. LCH and PHB 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:

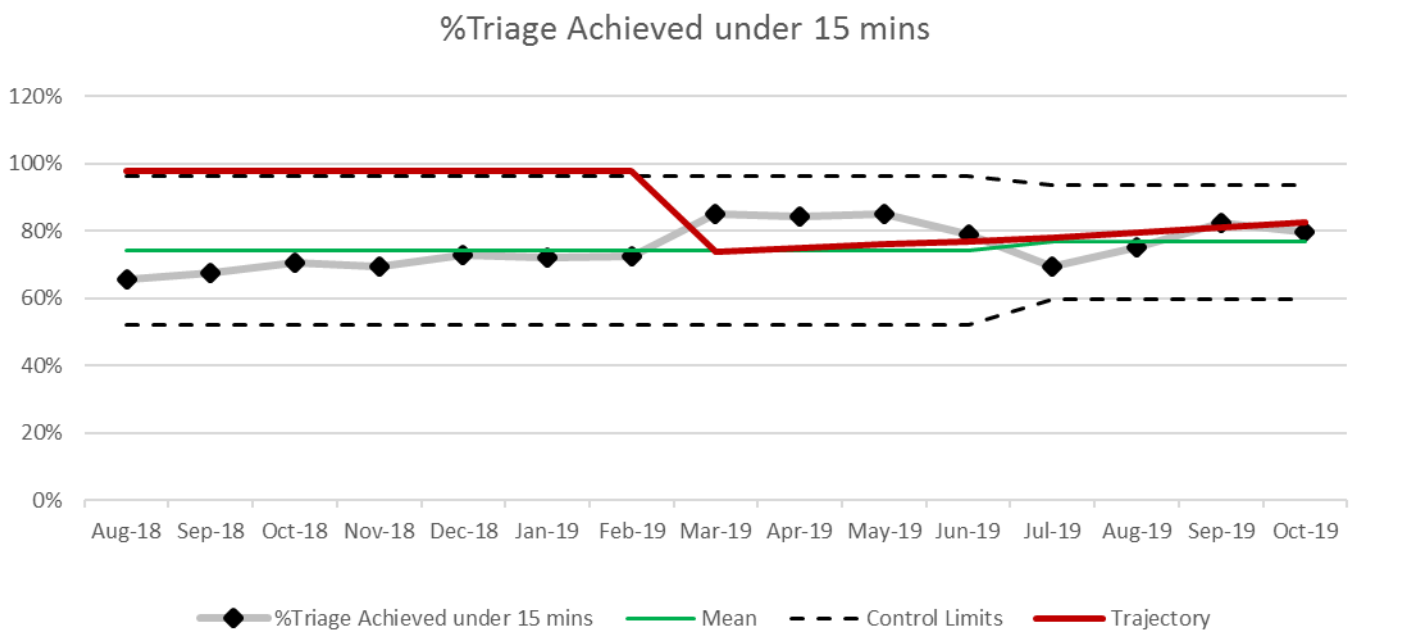
- Reduction of ambulance conveyances through alternative pathways targeting out of area first and increased use of the Clinical Assessment Service;
- Increasing the numbers of patients seen through primary care streaming; protecting the minors stream and focussing on delivering 4 hours through this stream;
- Long stay Tuesday and Wednesday at LCH and PHB to further reduce stranded patient numbers;
- 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. #ReadySteadyFlow was launched on 4th November
- The Adopt a Ward initiative went live 4th November which ensures senior leader presence and visibility to help unblock delays to discharges

ZERO WAITING – %TRIAGE ACHIEVED UNDER 15 mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Performance across the three hospital sites demonstrated a deterioration in performance against the standard with an overall decline of 2.71%.
- The performance trajectory for October was 82.50% and achieved was 79.77%
- The key theme remains delayed or non-recording of the actual time of triage.
- The use of a triage coordinator role ensures that this important process is delivered consistently and a greater compliance has been demonstrated and sustained.

Actions in place to recover:

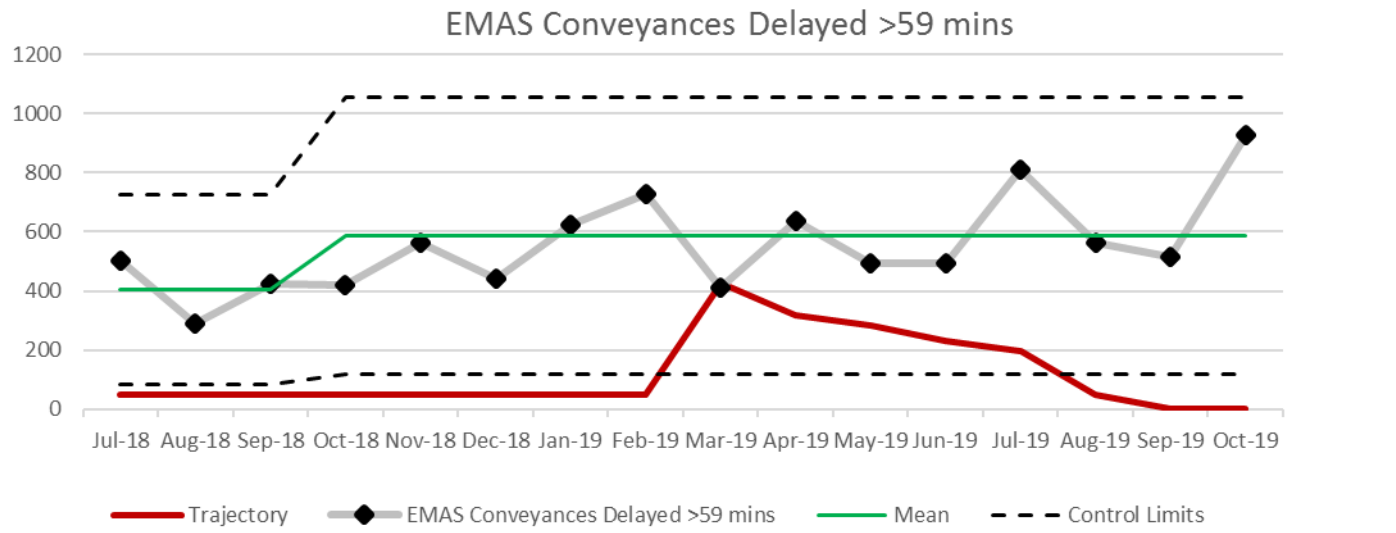
- Further work has taken place with LCH and PHB, ensuring that the 2nd triage stream is in place at LCH and protecting the triage health care support worker role within triage
- Triage time is a key performance indicator in regards to patient safety and will continue to be monitored and challenged at all operational delivery levels 3 x daily through the Capacity and Performance Meetings and within the UEC programme.
- A report is now available at individual patient level to identify where the standard has not been met and why.

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Handover delays >59 mins experienced a deterioration in October, 929 compared to 516 in September. LCH saw the largest increase in >59 mins handovers, 649 in October against 296 in September. The trajectory for >59 mins handover delays in October was 0 although >2hrs delays reduced compared to September figures.
- Funding has been approved for 3 x Band 8a HALO (Hospital Ambulance Liaison Officer) roles. These are to be piloted at LCH as this is the site reporting the longest handover delays.
- Twice Daily System Partner calls are now in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive. All ambulance handover delays >30mins are reported into the Capacity and Flow meetings as well as the twice daily system calls.
- 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

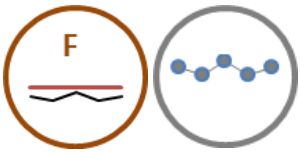
- New pathways at PHB rolled out to enable GP direct admissions bypassing ED but this is not consistently adhered to.
- Rapid Access and Treatment (RAT) models have been reviewed at both LCH and PHB hospital sites in particular the staffing models for RAT, competency and processing of patients
- This 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 and report to the Deputy Director of Operations, Urgent Care
- A closer working relation now exists with the DOM and Daytime Silver and jointly support appropriate conveyance and handover delays.
- Pre Hospital Practitioner Roles are now in place 24/7 on both PHB and LCH sites supporting additional capacity to handover ambulance crews.
- Daily system calls remain in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.
- The Rapid Handover Protocol has now been agreed jointly between ULHT and EMAS and will be implemented in November

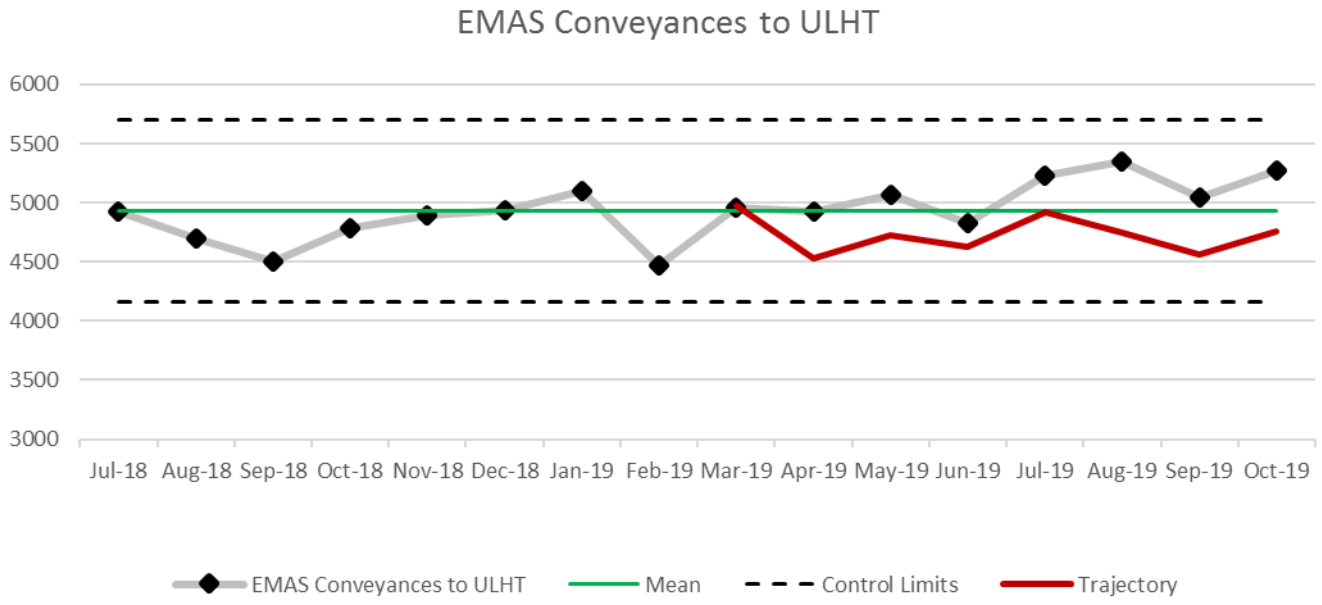
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- Overall EMAS conveyances in October went up by 218, compared with September. However, October was over plan by 507. During October both PHB and LCH experienced an increase in demand and multiple crew attendance in the evening and overnight. GDH also saw an increase in daily conveyance, particularly on a Monday and Friday.
- Improvement work with system partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory is under more scrutiny in light of the implementation of the Rapid Handover Protocol. The number of conveyances to the Trust is discussed daily on the Lincolnshire System Call and is also monitored through the Ambulance Handover Group which is chaired by NHSi.
- Non conveyances rates, as well as monitoring of alternative pathway usage is also reported.

Actions in place to recover

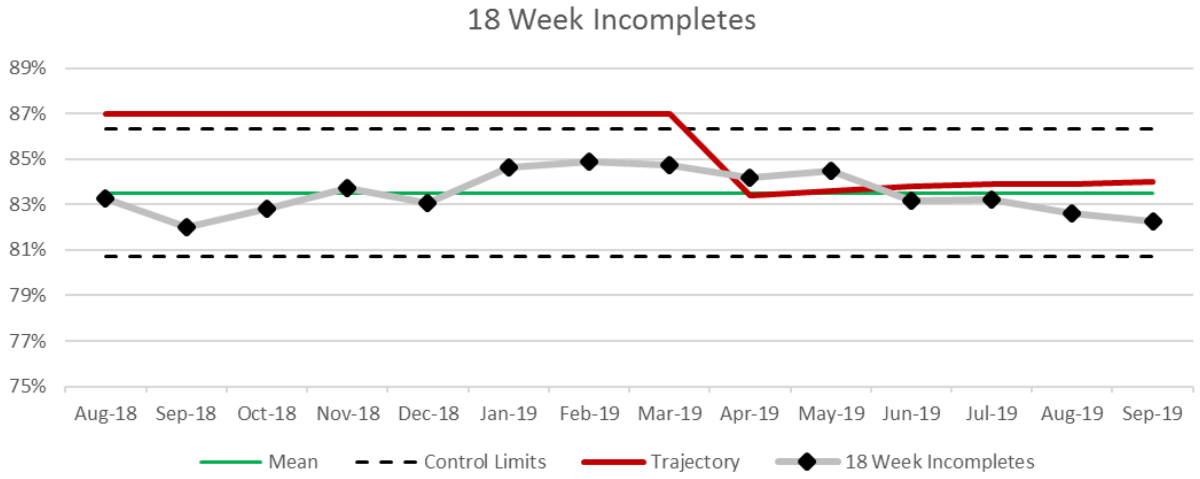
- This is a key metric within the Capacity and performance meetings held x 3 daily and has individual accountability to ensure delivery. This is overseen by the Deputy Director of Operations, Urgent Care.
- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily and the monthly Ambulance handover delay meeting chaired by NHSi
- 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. This is co-ordinated by the Deputy Director of Operations, Urgent Care and the Duty DOM
- Conveyance numbers continue to be monitored through the Ambulance Handover Group which is chaired by NHSi
- Appropriate conveyance monitoring is 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 - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

September saw RTT performance of 82.27%, a decrease of 0.37% on August.

Neurology (56.78%) is the worst performing specialty but is showing improvement from 46.15% last month (+10.63%)

General Medicine (71.70%) has improved from 61.02% last month (+10.68%)

Each have recovery plans in place all but Maxillo-Facial Surgery are demonstrating small but positive improvements.

The five specialties with the highest number of 18 week breaches at the end of the month were:

- General Surgery - 820 (increased by 125)
- Maxillo-Facial Surgery - 800 (increased by 30)
- Ent - 777 (increased by 33)
- Gastroenterology - 578 (increased by 47)
- Neurology - 574 (reduced by 104)

Although Neurology performance remains weak, significant improvements have been made and over 18 week waiting list size is reducing.

Actions in place to recover:

Continued focus in ENT has kept performance stable into September.

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 by end of December 2019.

A cohort of Maxillo-Facial patients have started to be outsourced to an external provider.

Rollout of training on ClearPTL validation software, has commenced. Staff identified by the divisions will be targeted first. Training will be ongoing to support the divisions. As at 13th November however, only 10.4% of staff trained are inputting data in ClearPTL. This will be addressed with the divisions.

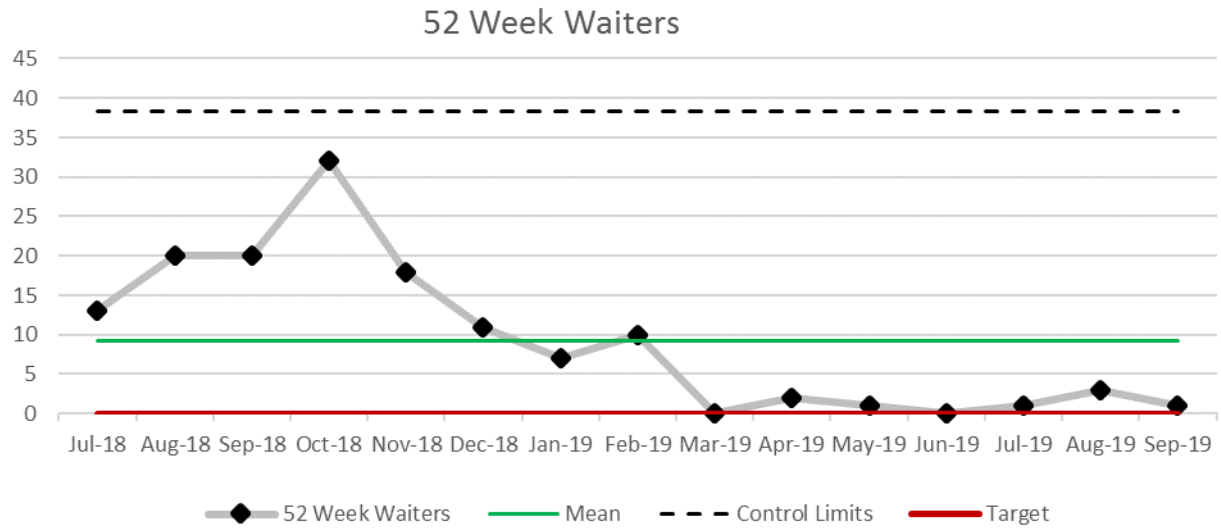
The targeted specialty specific recovery plan in Neurology is a significant shared priority with CCGs. The GP with Special Interest (GPwSI) clinics are now up and running. Work continues on revised pathways out of hospital and suspension of referral access are being reviewed.

ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

September 52 week performance – 1 patient was waiting longer than 52 weeks at the end of September. This is a better position than August when 3 were confirmed, although the 0 tolerance trajectory was not met.

RCAs are completed for all patients who breach 52 weeks waiting, together with harm reviews. The harm reviews are reviewed and completed by clinical teams.

In order to prevent deterioration in 52 week wait patient numbers, all patients are escalated at 45 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 has been the main source for all of previous 3 months breaches.

Although training controls are now in place for new staff and rollout out to existing users is ongoing, there is an ongoing risk of data quality, which cannot be 100% mitigated.

Actions in place to recover:

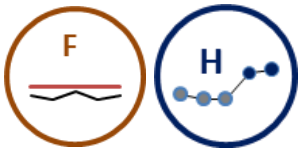
- Continued operation of weekly oversight via RTT PTL meeting and senior review of over 45 week patients.
- OMF has backlogs in dental extractions and skin. A mid-grade doctor left the Trust in July, however the division now have an agency doctor whilst recruiting a substantive replacement.
- Validation tracking software (ClearPTL) has been procured which will be rolled out and training delivered.
- The first wave of the roll out was completed 31st October. Of the 107 staff identified as requiring training, 89.72% (96, due to staff availability) have been trained. The remaining have training dates booked in November.
- 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.An annual e-learning refresher course is to be developed.
- An initial meeting has taken place with the IST regarding a Data and Information review with the Trust. A date of 26th November has been arranged for a visit from the IST, with, the Director of Operations, Operations Manager, Surgery DMD, and Head of Information Services.

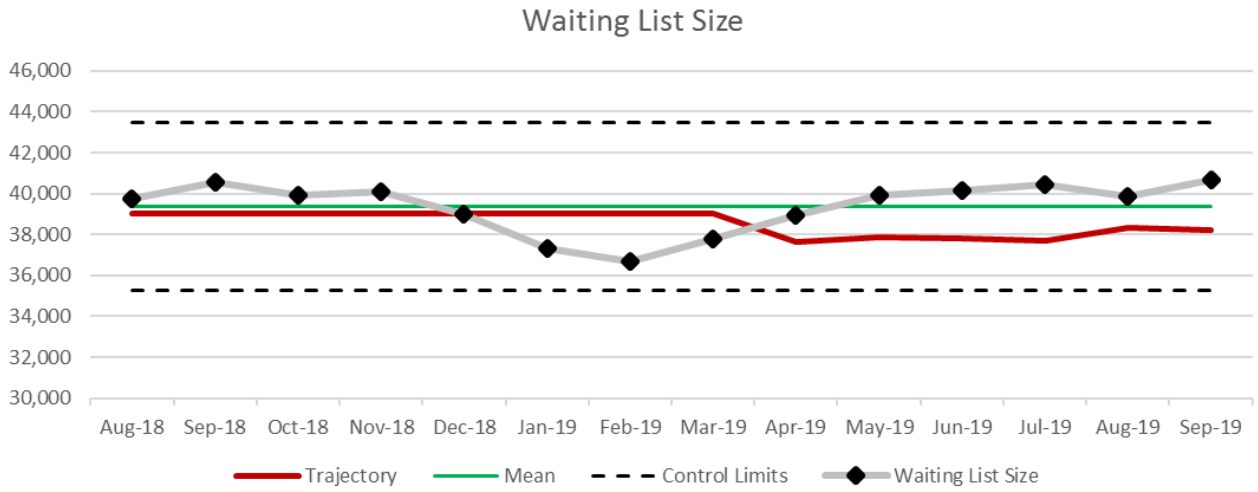
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size has deteriorated from August, with September total waiting list increasing by 844 to 40,697.The incompletes position for September is now approx. 1,665 more than it was in March 2018 (39,032).

The top five specialties showing an increase in total incomplete waiting list size from August are:

- Ophthalmology +250
- General Surgery +214
- Gynaecology +117
- Gastroenterology +96
- Dermatology +76

These specialties combined total 753 and represent 89% of the total increase from August 2019 to September 2019.

Actions in place to recover

In depth analysis of cause and contributory factors such as clock starts, stops and data entry; each service now has a tailored recovery 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 external, 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. Same as last month Provision of additional support is being looked at by the CCG.
- August to September showed a decrease of 83 patients waiting over 40 weeks, with Neurology (40) showing the largest decrease.

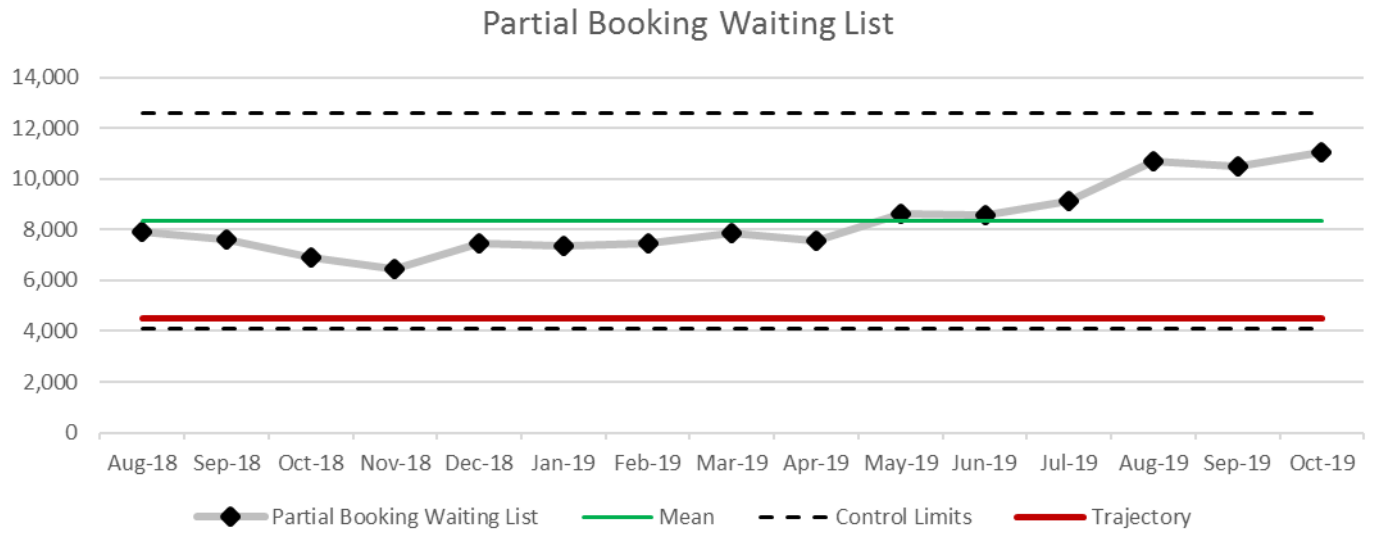
- The Trust are also planning to reduce overall waiting times to 26 weeks. With monitoring/challenge of this target being tracked through the RTT Recovery and Delivery meeting. The table below shows progress up to 30th September, with a reduction of 86 patients from August. The largest decrease of 111, being in Neurology.

ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Backlog recovery plans have been submitted and are currently being reviewed as per agreed contract delivery.

More emphasis has been placed on validating patients on the PBWL, especially those patients that are significantly overdue. This is both from an administration and clinical perspective.

The Trust is currently conducting a deep dive into outpatient capacity and utilisation. This includes the reduction in capacity over the first 7 months and ways to maximise our existing capacity and improve utilisation.

Overall Outpatient Capacity and attendances have reduced YTD.

Continued challenges for the PBWL backlog recovery plans are

- the availability of locums,
- the extra costs incurred to provide extra capacity,
- 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 M7

Actions in place to recover:

Backlog recovery plans submitted and are being discussed alongside our 2019/20 contract to check delivery and impact across all Divisions.

Updates reviewed at delivering productive services group to ensure delivery.

The Outpatient 642 process has been introduced but has not had the desired effect. The process to be revisited with Divisional Managing Directors, to ensure an effective process in place.

Outpatients will provide support for the Divisions to redesign, offering alternative patient pathways to reduce the number of patients on the PBWL.

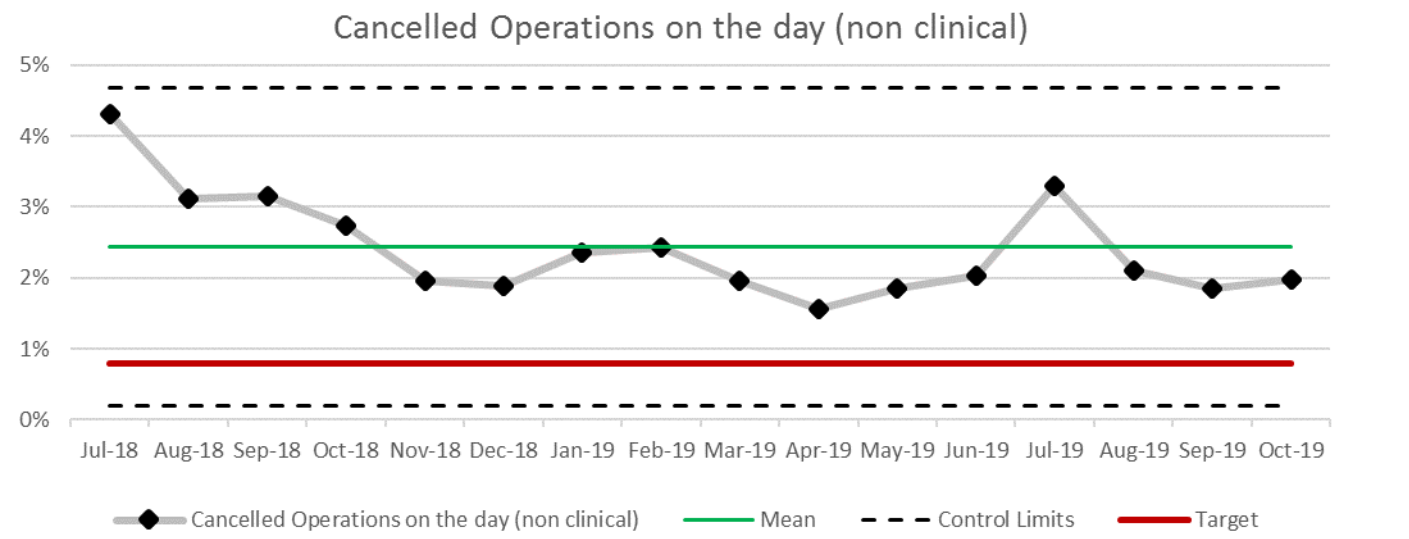
The Divisions will be accountable to the action plans, the main themes are Validation, Alternative patient pathways, Outsourcing and Locums.

ZERO WAITING – CANCELLED OPS ON THE DAY (NON CLINICAL)

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Against a national target of 0.8% we are demonstrating a downward trend from 3.30% in July 19 to 1.98% in October 19.

Improvement and sustainability of this metric is dependent on multiple factors, therefore the Trust Wide theatre services has been identified as an area for improvement via the Quality and Safety Programme of improvements. An ongoing challenge continues to be the high vacancy factors within our theatre departments.

A programme of work was developed in 2017/2018 to optimise theatre efficiency and improve patient experience. To continue building and strengthening this work two Listening into Action workshops involving key stakeholders were held mid 2019. Cancellations on the day for non-clinical reasons is a work stream identified through this process.

Actions in place to recover:

The project aims to reduce the cancellations on the day for non-clinical reasons by 30%. This will be achieved through the following actions:

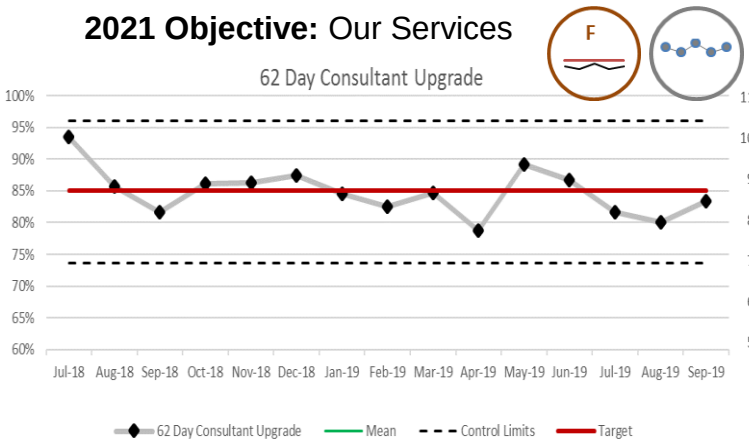
- Engagement with the wider teams to support reduction in on the day cancellations for non-clinical reasons.
- A robust escalation process has been embedded in all theatre suites across the trust.
- A new role has been implemented in all theatre departments to co-ordinate theatre equipment to ensure correct equipment and kit is identified prior to the day of surgery.
- Implementation of long term staffing strategy with the recruitment of 6 apprentice ODP posts Trustwide.
- To address establishment and recruitment constraints.
- To address training and skill mix constraints.
- To re-define the identification of the “golden” patient on every theatre list to ensure all lists start on time with no list order changes.
- To implement an evening team to reduce cancellations due to lack of theatre time (Grantham)
- To address leadership and managerial support for all theatre service managers.

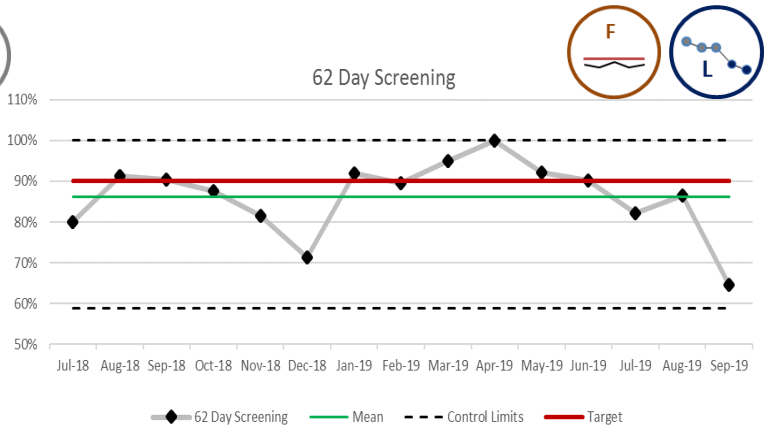
ZERO WAITING – CANCER 62 DAY

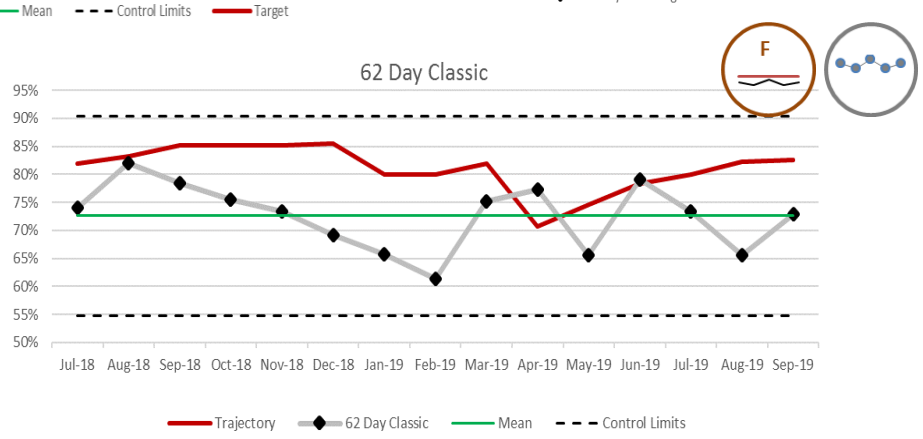
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services







The 62 Day Classic standard under-performed against the trajectory of 82.5%, with only Breast and Skin performing against their agreed trajectory though Urology finished close to their target.

Early indications are that our October 62 Day Classic performance will be less successful than September, with anticipated performance being circa 70% (trajectory 83.8%).

The number of Trust patients waiting over 104 days had been gradually increasing since the end of September though had a drop at the beginning of November to be within one patient of the target of '10 or fewer'. The number of Trust patients waiting over 62 days has been gradually decreasing over the same period, meeting the trajectory agreed with NHSI for the first three weeks but failed it for the fourth, w/e 8 Nov, by 7 patients.

A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing 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.

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) – The size of this issue is very much reduced with the number stabilising below 10 and, as the figure is a snapshot, a number will have only become apparent the day of the report. The figure will continue to be monitored through the daily report but is no longer considered to be a significant issue for the Trust.

- 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, August and September they have met their trajectory for number of treatments but significantly exceeded the number of breaches.

- Gynaecology – Through April to September 2019, this tumour site has not achieved the 14 Day standard and these delays at the start of the pathway impacting on their 62 Day performance as well. Gynaecology did not meet their agreed trajectory July to September for number of treatments or breaches contained within the treated volume.

- Pathology – Path Links have been unable to recruit sufficient staff to cover their core service demand, particularly visible on Gynaecology and Urology pathways where between 0 to 10% of samples are being reported within 7 days. A number of locum posts are due to commence over the coming months but this will still leave gaps in tumour site coverage, especially over the holiday period. 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 - Tumour sites are continuing to experience delays in securing timely diagnostics and/or treatments from the tertiary cancer centres (predominately Nottingham) and this is now being supported by the East Midlands Cancer Alliance funded Cancer Improvement Manager.

- Oncology – This service is continuing to have clinic capacity difficulties for numerous tumour sites due to consultant vacancy (and maternity leave) and skill mix issues. The service should therefore still be considered to have significant fragility as we are unable to source enough backfill for vacant and absence posts, due to a national shortage of consultant oncologists. Our capacity difficulties are also compounded by increased activity above contracted plan, of around 200 new referrals per month.
  At present we have 12 consultants in post, of these 2 are agency and 1 on maternity leave; thus making 11 posts out of 13 recruited to either substantively or fixed term locums.

  We have recently recruited to the 13th Clinical Oncologist post from overseas who commenced at the beginning of November 2019 and is undergoing further training in prostate brachytherapy at present. They are also undertaking the chemotherapy training in January 2020, subject to enrolment and placement at Nottingham University. Once this is completed then we will be able to go out to AAC to recruit substantively. In addition, we have recruited a further 2 Clinical Oncologist who are awaiting GMC registration, a medical oncologist has been offered a post (starting from June 2020) and we have a clinical oncologist to interview at an AAC panel at the end of November 2019. Subject to all candidates getting registration and accepting posts, this would take establishment to 14 consultants (5 medical and 9 clinical). The 14th consultant would be funded through reallocation of PA's across the consultant workforce.

  At present we have 2 agency consultants working with the team to provide tumour site cover and it envisaged these will be required until the recruitment process is completed.
  We are reviewing our demand activity against our funded capacity to release and convert follow up capacity to new appointment capacity in order to meet the rising referral demand. Until the recruitment process in place and no staff leave in the meantime, our ability to meet the demand faces month on month pressure to provide timely appointments and deal with the backlog. We will therefore continue to risk stratify patients who fall into the backlog to mitigate clinical risk.

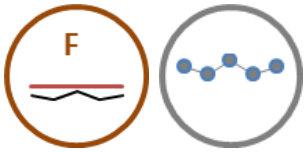
- MDT Organisation – There are a number of tumour sites which are operating hospital site specific MDTs. The rationale for the continuation of such arrangements needs to be reviewed in the context of national guidance for MDTs, the ULHT commitment to Trust-wide working and the pressures in supporting services to attend or support MDTs (particular pressures in pathology, radiology 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.

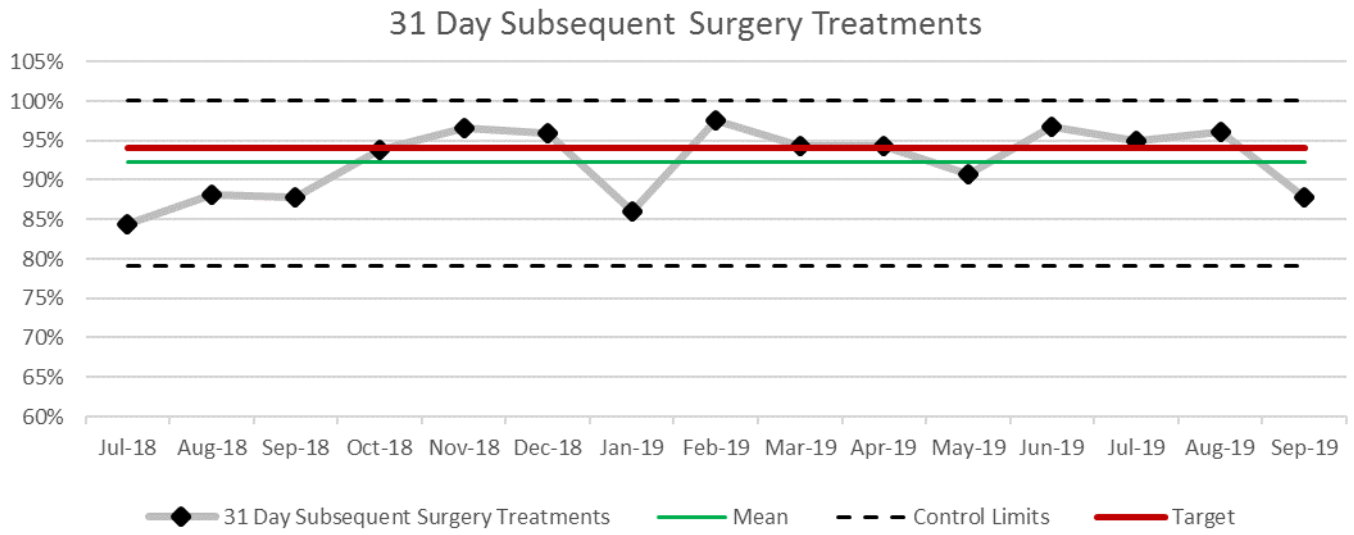
ZERO WAITING – CANCER 31 DAY

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





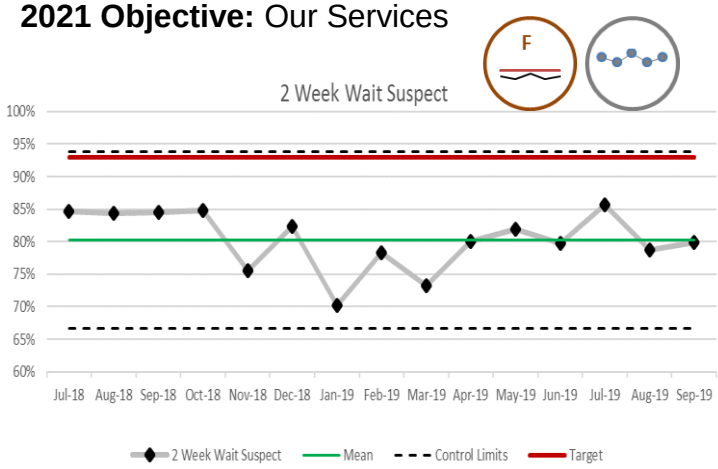
31 Day standards - The Trust achieved three of the four 31 Day standards in September, failing the Subsequent Surgery due to theatre capacity (colorectal and plastics)

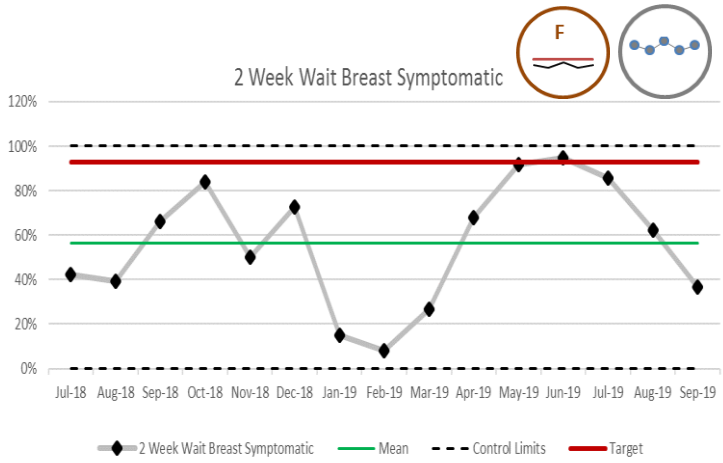
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Four tumour sites met the 14 Day standard in September (Brain, Head & Neck, Lung and Upper GI).

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, with the exception of Gynaecology, 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, working collaboratively with Access, Booking and Choice with a new dashboard for 2ww First Appointments has been rolled out to the Divisions. October's forecast tumour site performance is as below:

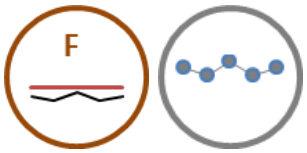
7 Day internal target = 60% 14 Day national standard = 93%	Total	< 7 Day Prfmnce %	< 14 Day Prfmnce %
Brain/CNS	18	22.2	94.4
Breast	275	4.4	45.5
Breast Symptomatic	172	1.7	40.7
Colorectal	571	56.7	87.9
Gynaecology	221	28.1	89.1
Haematology	12	41.7	83.3
Head & Neck	273	53.9	94.1
Lung	70	64.3	97.1
Sarcoma	14	78.6	100.0
Skin	477	14.7	83.7
Upper GI	194	49.5	93.3
Urology	262	43.1	94.7
Totals (excl Breast Sympto)	2387	37.2	*84.5*

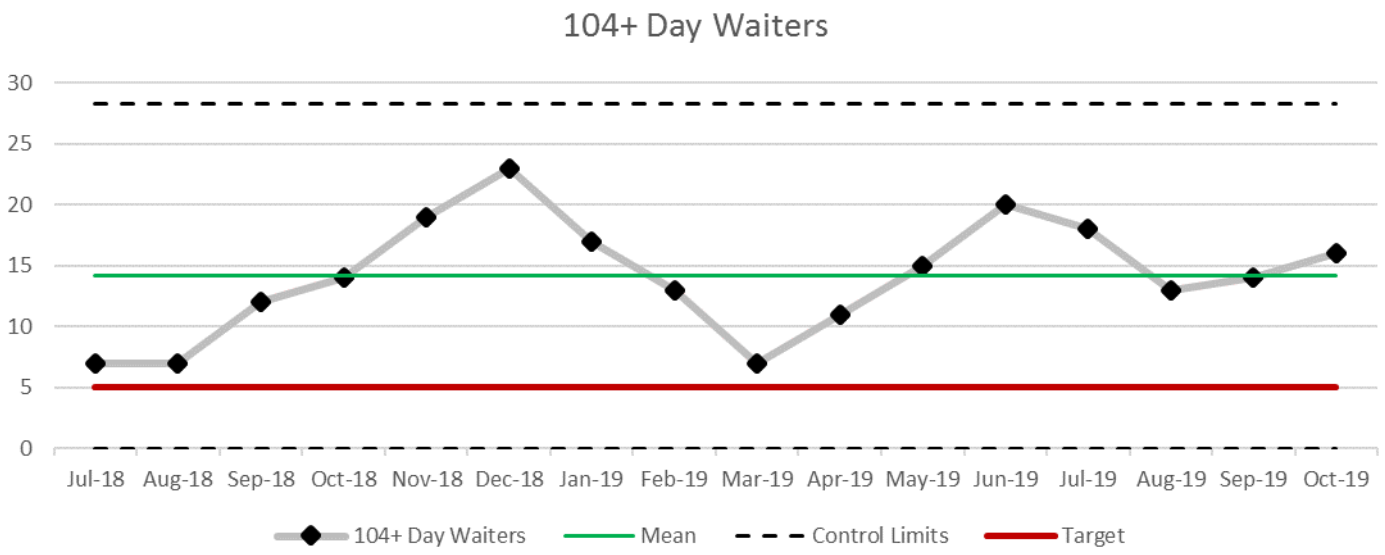
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services

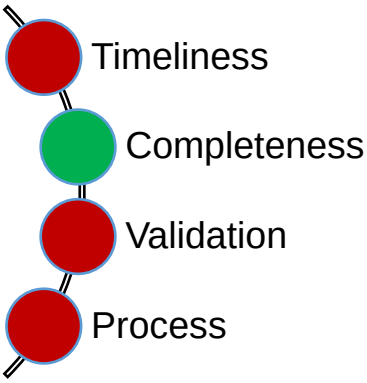




The number of Trust patients waiting over 104 days had been gradually increasing since the end of September though had a drop at the beginning of November to be within one patient of the target of '10 or fewer'. The number of Trust patients waiting over 62 days has been gradually decreasing over the same period, meeting the trajectory agreed with NHSI for the first three weeks but failed it for the fourth, w/e 8 Nov, by 7 patients. A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing 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

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	December 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:

- Of the 77 risks entered on the Corporate Risk Register 35 (45%) have a current rating of Very high or High risk
- The highest rated corporate risks remain the same as reported last month: financial sustainability; workforce capacity, capability and morale; emergency demand; and the vulnerability of aseptic pharmacy services
- 2 operational risks have recently increased in rating to Very high (20), both in Diagnostics CBU and both concerning the age and condition of a substantial amount of diagnostic equipment

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.

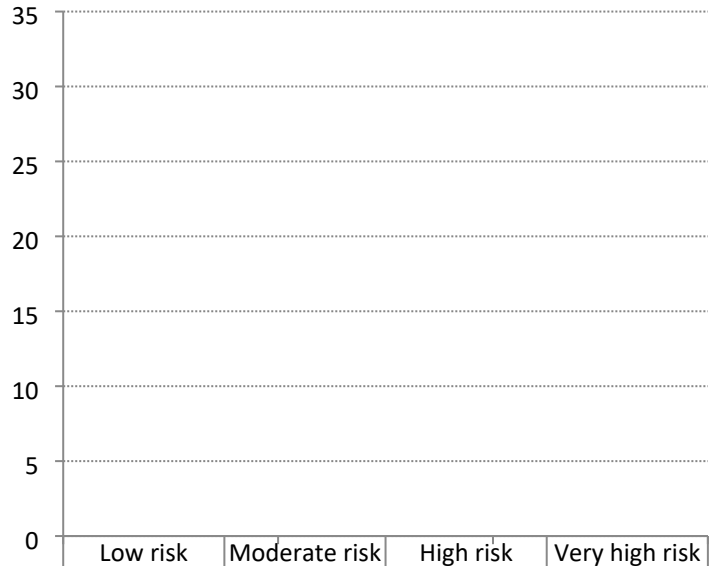
3. Reasons for Recommendations

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 risk type and current (residual) risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	0	2	2
Reputation / compliance	5	16	11	1
Service disruption	4	5	11	3
Harm (physical or psychological)	2	9	5	0

4.2 **Table 1** shows a summary of the full Corporate Risk Register:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4382	Delivery of the Financial Recovery Programme (corporate)	Corporate	Finances	20	Very high risk
4383	Substantial unplanned expenditure or financial penalties (corporate)	Corporate	Finances	20	Very high risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services (corporate)	Clinical Support Services	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity (corporate)	Corporate	Reputation / compliance	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Corporate	Service disruption	20	Very high risk
4175	Management of emergency demand (corporate)	Corporate	Service disruption	20	Very high risk
3688	Quality of the hospital environment (corporate)	Corporate	Reputation / compliance	16	High risk
3520	Compliance with fire safety regulations & standards (corporate)	Corporate	Reputation / compliance	16	High risk
3951	Compliance with regulations & standards for aseptic pharmacy services (corporate)	Clinical Support Services	Reputation / compliance	16	High risk
4156	Safe management of medicines (corporate)	Clinical Support Services	Harm (physical or psychological)	16	High risk
4384	Substantial unplanned income reduction or missed opportunities (corporate)	Corporate	Finances	16	High risk
4497	Contamination of aseptic products (corporate)	Clinical Support Services	Harm (physical or psychological)	15	High risk
3689	Compliance with asbestos management regulations & standards (corporate)	Corporate	Reputation / compliance	12	High risk
3690	Compliance with water safety regulations & standards (corporate)	Corporate	Reputation / compliance	12	High risk
3720	Critical failure of the electrical infrastructure (corporate)	Corporate	Service disruption	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston (Children & YP CBU)	Family Health	Service disruption	12	High risk
3722	Energy performance and sustainability (corporate)	Corporate	Finances	12	High risk
4041	Safe and responsive delivery of Non-Invasive Ventilation (NIV)	Medicine	Harm (physical or psychological)	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4081	Quality of patient experience (corporate)	Corporate	Reputation / compliance	12	High risk
4082	Workforce planning process (corporate)	Corporate	Service disruption	12	High risk
4142	Safe delivery of patient care (corporate)	Corporate	Harm (physical or psychological)	12	High risk
4145	Compliance with safeguarding regulations & standards (corporate)	Corporate	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice (corporate)	Corporate	Harm (physical or psychological)	12	High risk
4157	Compliance with medicines management regulations & standards (corporate)	Clinical Support Services	Reputation / compliance	12	High risk
4176	Management of demand for planned care (corporate)	Corporate	Service disruption	12	High risk
4300	Availability of medical devices & equipment (corporate)	Corporate	Service disruption	12	High risk
4179	Major cyber security attack (corporate)	Corporate	Service disruption	12	High risk
4385	Compliance with financial regulations, standards & contractual obligations (corporate)	Corporate	Reputation / compliance	12	High risk
4368	Management of demand for outpatient appointments (corporate)	Clinical Support Services	Service disruption	12	High risk
4406	Critical failure of the medicines supply chain (corporate)	Clinical Support Services	Service disruption	12	High risk
4423	Working in partnership with the wider system (corporate)	Corporate	Service disruption	12	High risk
4437	Critical failure of the water supply (corporate)	Corporate	Service disruption	12	High risk
4476	Compliance with clinical effectiveness regulations & standards (corporate)	Corporate	Reputation / compliance	12	High risk
4467	Impact of a 'no deal' EU Exit scenario (corporate)	Corporate	Service disruption	12	High risk
4154	Participation in important clinical research projects (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4177	Critical ICT infrastructure failure (corporate)	Corporate	Service disruption	8	Moderate risk
4363	Compliance with HR regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4180	Reduction in data quality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4181	Significant breach of confidentiality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4144	Uncontrolled outbreak of serious infectious disease (corporate)	Corporate	Service disruption	8	Moderate risk
4138	Patient mortality rates (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4043	Compliance with patient safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4044	Compliance with information governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4003	Major security incident (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
3687	Delivery of an Estates Strategy aligned to clinical services (corporate)	Corporate	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure (corporate)	Corporate	Service disruption	8	Moderate risk
4389	Compliance with corporate governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4401	Safety of the hospital environment (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4402	Compliance with regulations and standards for mechanical infrastructure (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4403	Compliance with electrical safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4404	Major fire safety incident (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4483	Safe use of radiation (corporate)	Clinical Support Services	Harm (physical or psychological)	8	Moderate risk
4486	Clinical outcomes for patients (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4502	Compliance with regulations & standards for medical device management (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4514	Hospital @ Night management (corporate)	Corporate	Service disruption	8	Moderate risk
4469	Compliance with blood safety & quality regulations & standards (corporate)	Clinical Support Services	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products (corporate)	Clinical Support Services	Harm (physical or psychological)	4	Low risk
4438	Severe weather or climatic event (corporate)	Corporate	Service disruption	4	Low risk
4439	Industrial action (corporate)	Corporate	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards (corporate)	Clinical Support Services	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service (corporate)	Corporate	Service disruption	4	Low risk
4387	Critical supply chain failure (corporate)	Corporate	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4277	Adverse media or social media coverage (corporate)	Corporate	Reputation / compliance	4	Low risk
4061	Financial loss due to fraud (corporate)	Corporate	Finances	4	Low risk

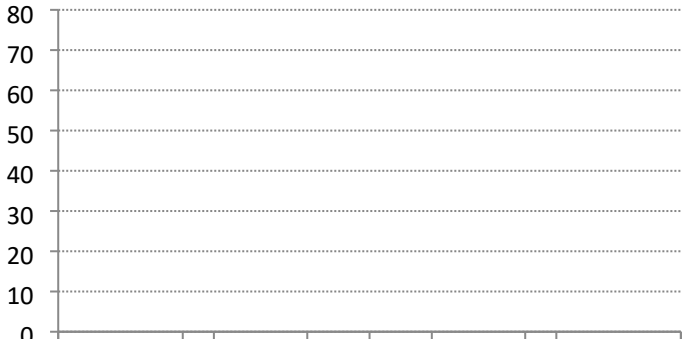
ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4155	Safety of research project participants (corporate)	Corporate	Harm (physical or psychological)	4	Low risk

4.3 45% of corporate risks are currently rated as Very high or High. The risk associated with the safe use of radiation has been reviewed by the Clinical Lead for CSS Division and increased in rating from Low to Moderate risk, based on evidence that the risk of harm is increased because the Trust's CT scanners are not able to apply the latest dosage reduction techniques. However, all 4 CT scanners used by the Trust are operating within acceptable safety parameters.

4.4 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**.

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	Very high risk
Finances	10	4	2	4	0
Reputation / compliance	27	8	18	5	0
Service disruption	30	4	22	23	1
Harm (physical or psychological)	6	8	16	12	1

4.6 Of the 201 risks recorded on divisional business unit risk registers, 46 (21%) are currently rated as Very high or High, compared with 20% last month. 2 of these have recently increased in rating to Very high risk (both are within Diagnostics CBU, with the increased risk attributed to the age and condition of a substantial amount of medical equipment that is in need of replacement). Those risks are:

- Availability of essential equipment
- Safety & effectiveness of patient care

4.7 A summary of those operational risks with a current rating of Very high or High risk is included as **Appendix II**.

Risk management process

4.8 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.

4.9 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

4.10 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.

4.11 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**.

4.12 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 progressing, along with additional support and training provided by the central Risk Team within Clinical Governance, in order to 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.

Updates to the existing process from December 2019

4.13 From December 2019 onwards, prior to the routine review of corporate risks by each lead assurance committee the lead executive will be asked to review, alongside their respective objectives in the Board Assurance Framework (BAF) all corporate risks within their areas of accountability. The date of that review will be recorded within the risk register on Datix and reported to the assurance committee and Trust Board, along with an assurance rating drawn from the following options:

- Not assured – insufficient evidence available
- Not assured – inadequate risk management plan
- Not assured – insufficient progress with risk management plan
- Assured – appropriate risk management plan in progress
- Assured – managed within risk appetite

Appendix I - Very high High Corporate risks (December 2019)

ID	Title & description	Executive / Divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Action risk rating	Action due date	Action progress
4175	**Management of emergency demand (corporate)** If the volume of emergency demand significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, 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)	Finance, Performance & Estates Committee	Moderate risk	31/01/2020	• 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	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	Very high risk (20-25)	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.
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)	Finance, Performance & Estates Committee	Moderate risk	31/01/2020	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.	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.	Very high risk (20-25)	31/03/2020	
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)	Finance, Performance & Estates Committee	Moderate risk	31/01/2020	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.	Finance	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	Very high risk (20-25)	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).	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.	Very high risk (20-25)	31/03/2020	
										As advised by NHS Digital this risk has been added to the corporate risk register as there is a considered risk that the Trust is at risk of being removed from the National Windows 10 licensing arrangement with a potential liability of up to £1.5m. NHSDigital will make a final decision in March 2020 depending on the overall state of the NHS estate in England. The recent announcement by Microsoft that they will continue to provide extended support for Windows 7 until January 2021 does not provide any reason to delay your migration to Windows 10. Currently licensed organisations have been granted free licensing on the basis of agreeing to fully utilise the Windows 10 licences provided. As per Clause 2.11 of your Service Agreement, licences may be revoked if they are not fully utilised. This decision will be taken in March 2020, the annual review point at which we must decide which organisations continue to be part of the national agreement with Microsoft. Any organisation who has licences revoked will also cease to qualify for the free extended support for Windows 7, since this free extended support is only available by being part of the NHS national agreement. Therefore by delaying Windows 10 local organisations will not only risk losing the free Windows 10 licences but will also need to pay for their own extended support for their Windows 7 estate. The cost of replacing free National licences and purchasing extended support is currently £205 per user (inc. VAT) x all users in your estate - £1m for an NHS organisation with 5,000 users. Please ensure that you calculate and include this risk on	Information & Communications Technology	The Trust to continue to work closely with NHS Digital keeping them appraised of our situation. The ICT Department has a plan to continue the rollout of Windows 10 upgrading the devices that can be upgraded and by rolling out the correct version to the VDI environment, this will continue to increase the numbers of devices that are using the national licensing agreement. The ICT Department working with finance continue to explore ways and means of accessing external capital resource and this continues to be top priority pending any capital allocation to ICT in 19/20 and beyond.	Moderate risk (8-10)	31/03/2020	Risk has been discussed within ICT and with Paul Matthew, it has also been escalated as a system issue to the STP via IMTEG. Current capital position is unhelpful and unsupportive of a resolution. ICT working with Finance colleagues to explore options and review potential for emergency capital bids.
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	Hepburn, 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	Very high risk (20)	Quality Governance Committee	Low risk	31/01/2020	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.	Pharmacy	Development of a sustainable infrastructure plan for aseptic pharmacy services.	Very high risk (20-25)	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.

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ID	Title & description	Executive / Divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Action risk rating	Action due date	Action progress
	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.				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.					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.	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.	Very high risk (20-25)	31/01/2020	Temporary closure of the aseptic unit at PHB - implementing BCP until assurance is received that the contamination is safely managed.
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)	Workforce, Organisational Development & Transformation Committee	Low risk	28/02/2020	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.	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.	Very high risk (20-25)	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.	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.	Moderate risk (8-10)	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)	Workforce, Organisational Development & Transformation Committee	Moderate risk	28/02/2020	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	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.	Very high risk (20-25)	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.	Human Resources	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	Very high risk (20-25)	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.	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.	High risk (12-16)	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.	Human Resources	Education Director action plan to address the issues raised.	High risk (12-16)	31/12/2019	Higher number of junior doctors in August rotation. Actions to improve juniors experience identified. Review again at end of calendar year.
										NHSI propose the introduction of 2 further measures to reduce agency spend in non-clinical areas: - a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts (to use of on-framework agencies only) - A restriction on the use of admin and estates agency workers to bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	Human Resources	Review of proposals and potential impact, to identify any required action.	High risk (12-16)	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.

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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, 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)	Quality Governance Committee	Low risk	31/01/2020	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.	Pharmacy	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	High risk (12-16)	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).	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.	High risk (12-16)	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.
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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	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. Following the installation of the additional fire compartmentation within the east wing roof voids and corridors a review of the fire alarm system is required to ensure compliance.	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.	High risk (12-16)	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.	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.	High risk (12-16)	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. 1. Staff failing to attend Fire Safety Training in accordance with policy, procedures and Training needs analysis. 2. No testing of emergency procedures via evacuation drills. 3. Fire safety training to be provided in accordance with role, seniority or professional discipline within the fire emergency plan. 4. Undertaking and Recording of Personal Emergency Evacuation Plans for Less able bodied and disabled staff. 5. Staff being allowed to continue within role against HTM guidance that states: 'should not be permitted to continue their duties with a gap in their record of training longer than twice the interval identified in the training needs analysis' which is two years within ULH. 6. Non identification of staff by managers to attend core modules when undertaking annual PDR.	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.	High risk (12-16)	31/03/2020	New mandatory staff fire safety awareness module introduced.
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	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	High risk (16)	Finance, Performance & Estates Committee	Moderate risk	31/01/2020	Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	Estates	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	High risk (12-16)	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.	Estates	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	High risk (12-16)	31/12/2019	

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	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.				resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.					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.	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.	Moderate risk (8-10)	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; [redacted] inadequately hung curtains can affect patient dignity as reported on PLACE.	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.	Moderate risk (8-10)	31/12/2019	
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)	Finance, Performance & Estates Committee	Moderate risk	31/01/2020	Clinical coding & data quality issues impacting on income.	Information Services	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	High risk (12-16)	31/03/2020	
										Operational ownership of income at directorate level.	Finance	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	High risk (12-16)	31/01/2020	
										Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	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.	High risk (12-16)	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.	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.	High risk (12-16)	31/03/2020	
										Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	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.	High risk (12-16)	31/03/2020	
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, 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)	Quality Governance Committee	Low risk	31/01/2020	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.	Pharmacy	Closure of the Lincoln Pharmacy ASU to avoid the risk.	High risk (12-16)	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.	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.	High risk (12-16)	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.	Pharmacy	Implementation of a sustainable and fit for purpose aseptic services facility at Pilgrim Hospital.	High risk (12-16)	31/12/2019	Business Case in development, to be presented to Trust Board in October 2019.
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.	Hepburn, Neill	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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	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.		Re-assessment of strategic risk and development of appropriate mitigations.	High risk (12-16)	31/03/2020	Continued engagement with the STP delivery process through established governance arrangements.

Appendix I - Very high High Corporate risks (December 2019)

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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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	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.	Estates	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	High risk (12-16)	31/12/2019	Scheme of work and design currently being produced.
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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	The Trust has a financial deficit and is therefore not able to meet its statutory obligation to break even.	Finance	In Financial Special Measures; agreed Financial Recovery Plan to return the Trust to a sustainable footing ove ther medium term.	High risk (12-16)	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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	Asbestos Policy is overdue for review.	Estates	Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.	High risk (12-16)	31/01/2020	
										Asbestos Management Plan still to be fully developed.	Estates	Complete development & begin implementation of Asbestos Management Plan.	High risk (12-16)	31/01/2020	
										Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	Estates	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	High risk (12-16)	31/01/2020	
										Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Estates	Agree Appointed Person & structure for Asbestos management.	Moderate risk (8-10)	31/01/2020	
										Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	Estates	Review of asbestos contractors appointment & verification of training.	High risk (12-16)	31/01/2020	
										No Access areas still to be surveyed for asbestos.	Estates	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	Moderate risk (8-10)	31/01/2020	
										Potentially inaccurate survey data due to restricted access to areas.	Estates	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	Moderate risk (8-10)	31/01/2020	
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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Estates	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?)	Moderate risk (8-10)	31/12/2019	Legionella monitoring carried out by direct labour as far as possible with competing priorities.
										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.	Estates	The non-compliant units to be replaced with those which comply with the Water Regulations. Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.	High risk (12-16)	31/12/2019	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'.
										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.	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.	High risk (12-16)	31/01/2020	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	Estates	Replacement of non-compliant water tanks at LCH.	Moderate risk (8-10)	31/12/2019	Capital funding required.
										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.	Estates	Specification tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	Moderate risk (8-10)	31/01/2020	In December 2017 Scotmas were the only supplier to bid on this tender.

Appendix I - Very high High Corporate risks (December 2019)

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										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.	Estates	Completion of new water main. Automatic monitors in place. Capital investment required to mitigate this risk.	Moderate risk (8-10)	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; ongoing upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Estates	Completion of the Water Safety Statutory Improvement Programme. Stringent Water sampling and flushing programs in place.	Moderate risk (8-10)	31/12/2019	Funding required to complete the programme.
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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	Potential for Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	High risk (12-16)	31/12/2019	Estimated cost £50k +vat.
										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.	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	High risk (12-16)	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). Area affected are:- Tower Block. Rayrole room. Main Switchgear fed from Transformer no 3 (back of Theatres). Main Switchroom outside of ward 6 including Ward 6 Distribution boards. Various Distribution are obsolete and we unable to obtain spare parts for. A&E Endoscopy X-ray Department Theatres Tower Block Out-Patients Medical Physic Pharmacy Rehabilitation	Estates	Capital investment required to upgrade electrical infrastructure at GDH.	High risk (12-16)	31/12/2019	Capital funding applied for.
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, 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)	Finance, Performance & Estates Committee	Low risk	31/01/2020	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).	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.	High risk (12-16)	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.	Brassington, Mark	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)	Finance, Performance & Estates Committee	Low risk	28/02/2020	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.	Operations	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	High risk (12-16)	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.	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.	Moderate risk (8-10)	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
										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.	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.	High risk (12-16)	28/02/2020	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.	Operations	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	High risk (12-16)	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

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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.	Brassington, Mark	Service disruption	Very high risk	COO 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)	Finance, Performance & Estates Committee	Low risk	28/02/2020	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)	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. MoU in place to support transfer of medicines between providers if needed.
										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)	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)	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)	31/12/2019	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Concern that DBS check for a European national maybe subject to a long delay. Memorandum of Understanding has been agreed for staff sharing within Lincolnshire.
										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)	31/12/2019	Concern over staffing capacity to deal with a potential increase in overseas visitor screening and billing/payment processing.
										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)	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)	31/12/2019	Local risk assessment carried out did not identify any significant data sharing implications.
										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)	31/12/2019	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time).
										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)	31/12/2019	Use of traditional and social media channels to provide up to date information to staff and patients; managed in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).
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.	Matthew, Paul	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)	Finance, Performance & Estates Committee	Low risk	31/12/2019	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Information & Communications Technology	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	Moderate risk (8-10)	31/03/2020	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.	Information & Communications Technology	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	High risk (12-16)	31/03/2020	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

Appendix I - Very high High Corporate risks (December 2019)

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										Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	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.	Moderate risk (8-10)	31/12/2019	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.
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, 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)	Quality Governance Committee	Low risk	31/12/2019	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.	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.	High risk (12-16)	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.	Clinical Engineering	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	High risk (12-16)	28/02/2020	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.	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.	High risk (12-16)	31/12/2019	BC developed and approved in principle by CRIG
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)	Quality Governance Committee	Low risk	31/12/2019	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.	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.	High risk (12-16)	31/03/2020	
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.	High risk (12)	Quality Governance Committee	Low risk	28/02/2020	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	Corporate Nursing	Design & introduce refined policies and processes for the identification of & response to deteriorating patients.	High risk (12-16)	31/03/2020	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.	Quality & Compliance	Conduct an initial review of compliance with LocSSIPs to identify areas for improvement.	Moderate risk (8-10)	31/01/2020	
										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.	Information & Communications Technology	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	High risk (12-16)	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.		Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	Moderate risk (8-10)	31/03/2020	Business case in development for audit function.
4145	**Compliance with safeguarding regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Bagshaw, Victoria	Reputation / compliance	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	High risk (12)	Quality Governance Committee	Low risk	28/02/2020	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.	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.	Moderate risk (8-10)	28/02/2020	Lead professional for MCA reports that although MCA audits continue to show areas of concern they are showing a significant increase in knowledge and compliance. This is supported by CCG and CQC feedback. There remains some cases where there is clear evidence of lack of compliance with policy for example SI investigation. Monitoring will continue through audit and review of incidents, complaints and concerns. On this basis risk reduced to moderate.
										Not yet consistently achieving 90% compliance with safeguarding training requirements.	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.	Moderate risk (8-10)	28/02/2020	9/8/19 Training compliance is consistently not achieving the 90% trajectory. Monitoring and reporting of this will continue through Safeguarding Group.

Appendix I - Very high High Corporate risks (December 2019)

ID	Title & description	Executive / Divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Action risk rating	Action due date	Action progress
										Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.	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.	High risk (12-16)	28/02/2020	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.	Bagshaw, Victoria	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)	Quality Governance Committee	Low risk	28/02/2020	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.	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.	High risk (12-16)	28/02/2020	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.
										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.	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.	High risk (12-16)	28/02/2020	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	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.	Moderate risk (8-10)	28/02/2020	Mental Health Awareness Core learning training developed and available from 1st July 2019. As of 25th July 2019 49.66% of required staff had completed it. Compliance and impact will be monitored through MHLDA group. Update reports received by Safeguarding Group.
										Children and young people (under 18) may be admitted to an adult inpatient ward, where there is a lack of specialist paediatric care and equipment available, such as paediatric resus trolleys. The current mechanism for real time alerting to safeguarding if staff fail to follow the current policy & do not complete the necessary risk assessment is not reliable (either ad hoc or retrospectively through incident reporting); this impairs the ability to respond in a timely manner to the needs of children & young people to ensure they receive appropriate care from appropriately trained staff in the right environment. Only areas that regularly care for children receive Level 3 child safeguarding training (others received L2). It is also not clear if an emergency call for a child on an adult ward would be responded to by paediatrics on-call. Paediatrics are not routinely involved in bed management meetings in order to be made aware of outliers.	Safeguarding	To review and update the existing policy for admission of 14-18 year olds to adult inpatient areas, so that anyone under 16 must be admitted to a paediatric ward (unless they strongly object, fully aware of the risks). Those aged 16-17 to be given the choice, once made fully aware of the risks. Risk assessment to be reviewed. Potential for enhancements to patient administration systems to be considered to reinforce policy. Engagement of paediatrics with bed management meetings to be introduced.	High risk (12-16)	31/03/2020	Action plan to be reassigned to appropriate lead once in post.
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.	Hepburn, Neill	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)	Quality Governance Committee	Low risk	28/02/2020	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.	Pharmacy	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	High risk (12-16)	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.	Pharmacy	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	High risk (12-16)	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.	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.	High risk (12-16)	31/12/2019	

Appendix I - Very high High Corporate risks (December 2019)

ID	Title & description	Executive / Divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Action risk rating	Action due date	Action progress
										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.	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.	Very high risk (20-25)	31/03/2019	
										Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	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.	Moderate risk (8-10)	30/06/2019	
4157	**Compliance with medicines management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Hepburn, Neill	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)	Finance, Performance & Estates Committee	Low risk	28/02/2020	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	Pharmacy	Planned introduction of an auditable electronic prescribing system across the Trust.	High risk (12-16)	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.	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.	High risk (12-16)	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.	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.	High risk (12-16)	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.	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.	High risk (12-16)	30/09/2019	
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.	Bagshaw, Victoria	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	High risk (12)	Quality Governance Committee	Low risk	31/12/2019	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.	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.	High risk (12-16)	31/03/2020	Action plan kept under regular review by the NIV Group, which meets quarterly. Next meeting September 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	Hepburn, 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)	Quality Governance Committee	Low risk	28/02/2020	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.	Quality & Compliance	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	High risk (12-16)	31/03/2020	Report template in development.
										Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	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.	Moderate risk (8-10)	31/03/2020	
										Insufficient staffing resources within the established Clinical Effectiveness central support team.	Quality & Compliance	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	High risk (12-16)	31/12/2019	

Appendix I - Very high High Corporate risks (December 2019)

ID	Title & description	Executive / Divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Action risk rating	Action due date	Action progress
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)	Workforce, Organisational Development & Transformation Committee	Moderate risk	28/02/2020	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.	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.	Very high risk (20-25)	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.

Appendixc II - Very high High Operational Risks (November 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4434	Safety & effectiveness of patient care (Diagnostics CBU)	Clinical Support Services	Harm (physical or psychological)	20	Very high risk
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	20	Very high risk
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 CBU)	Surgery	Service disruption	12	High risk
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4120	Delayed patient discharge or transfer of care (TACC 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
4301	Delayed patient diagnosis or treatment (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	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
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
4416	Delayed patient diagnosis or treatment (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk

Appendixc II - Very high High Operational Risks (November 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
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
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
4429	Availability of essential information (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4433	Compliance with regulations & standards (Diagnostics CBU)	Clinical Support Services	Reputation / compliance	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)

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	3rd December 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 November. Updates had been made to the BAF resulting in objective 1a being down rated from Amber to Red.

This change to the assurance rating had been due to a number of reasons including the latest CQC findings demonstrating that there had not been sufficient progress.

Objective 3a had been discussed in detail at the Workforce, Organisational Development and Transformation Committee and it was agreed a review of the objective would be undertaken by the Committee Chair and Director of Human Resources and Organisational Development. The updated objective would be presented to the December Committee.

Direction of Travel of Assurance Ratings:

RAG Rating	October 2019	November 2019	Direction

Red	6	7	↑
Amber	1	0	↓
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 - October 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	Coding incomplete/inaccurate Non delivery of the Trust Mortality Reduction Strategy Not working in Partnership across the health care system Inability to control/manage emergency demand	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Dr Foster - investigations into Dr Foster alerts HSMR and SHMI National Benchmarking Reports National audits - secondary control ReSPECT Quality Account Priority 3 Learning from deaths and patient safety incidents	Consistent delivery of ReSPECT Inability to control/manage emergency demand System wide partnership working: - preventing admission - provision of appropriate and timely discharge - reviewing deaths	Comprehensive ReSPECT roll out programme, system wide multi-professional education and audit Urgent Care Board Lincolnshire Mortality Learning Network	Triangulation of lessons learned, incidents, coroners, claims and complaints National audit reports Mortality Reduction Plan Regular reporting on learning from deaths. Reviews of alerting diagnosis/conditions, including independent reviews IPR Routine quarterly focussed assurance reports to Quality Governance Committee	System wide partnership reports	System wide mortality group System Improvement Board	Quality Governance Committee	R
		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 Lack of ability to rely on divisional governance Metric not finalised Sharing and learning not at	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	Sharing and learning not at desired level		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	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	Data Quality Group 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 post TOM implementation	Monthly Productive Services Group FPEC	Impact of actions being taken via PRM and prodcutive services group not visible	Ensure reported through performance report to incorporate necessary narrative and impact from productive services group	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	Data Quality workstream PRMs probing gaps in speciality control and assigning actions to close Roll out of the TOM in line with the governance framework	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.	A new process is in place that prohibits changes to PDD for all but clinical reasons. Plan changes are being monitored and this gap is expected to be fully mitigated by December 2019	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 Digital	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	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	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	Impact of recruitment and reduction in temporary staff Structures and systems in place however the Trust have a lack of control over expenditure Model Hospital Benchmarking CQC Use if resources	Report on recruitment and temporary staffin impact PRM Meeting outcomes, dashboard to be developed to be presented to Finance, Performance and Estates Committee Delivery of Financial Efficiency plans	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
				levels over and above repatriation and fails to secure all income due from commissioners			Education Funding - Q1							

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 Digital	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 <u>Internal Audit:</u> 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 <u>Internal Audit:</u> 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 engagement (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 <u>Internal Audit:</u> 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**

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	System wide partnership reports not routinely shared	System SRO to share reports. Allocation of responsibility and resource to ULHT individual for delivery of workstream	Finance, Performance and Estates Committee	R

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

The Trust Board has assigned each strategic objective of the 2021 Strategy to a lead assurance committee. Outcomes under each strategic objective are aligned to a lead committee or reserved for review by the Trust Board.

The process for routine review and update of the BAF is as follows:

- The corporate risk register is maintained by the lead executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from committees
- The lead assurance committee (or Trust Board, where applicable) reviews the management of risks to each required outcome(as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by executive leads
- The lead committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each committee will receive regular reports from specialist groups, executive leads and other sources which provide management information and analysis of relevant key risks, to enable the committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to committees should first have been reviewed and approved by the executive lead.

When deciding on the assurance rating for each outcome the following key should be used:

Effective controls may not be in place and/or appropriate assurances are not available to the Board

Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

United Lincolnshire Hospitals NHS Trust

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											

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Anna Richards
Date:	Tuesday 3 December

Title:	Innovation Report

Author/Responsible Director: Anna Richards, Associate Director of Communications and Engagement/ Andrew Morgan, Chief Executive

Purpose of the Report: To update the Trust Board on innovative working across the Trust

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	X

Summary/Key Points:

A state-of-the-art robot is dispensing medication to hospital patients in Lincolnshire. The Robotic pharmacy, which brings hospital patients their medication faster and safer, has been built at Lincoln County Hospital, with a smaller dispensing cabinet at Pilgrim Hospital, Boston.

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?	

Robotic pharmacy brings hospital patients their medication faster and safer

A state-of-the-art robot is dispensing medication to hospital patients in Lincolnshire.

The robot has been built at Lincoln County Hospital, with a smaller dispensing cabinet system coming soon to Pilgrim Hospital, Boston.

The robot takes in deliveries of medicines, scans their barcodes and places them in an available storage space. When a medicine is needed the robot collects it from the location it is stored in and places it in a bin ready for the pharmacy team to check and label, before it is taken to be given to a patient. As stock is used the robot will automatically re-order more supplies.

The £286,000 investment by United Lincolnshire Hospitals NHS Trust in the robot, cabinets and training will help reduce dispensing errors, reduce turnaround time, free up staff time, help with faster patient discharges, reduce stock holding, improve security and make sure the shelves are restocked promptly. The robot is expected to result in more than £3 million of efficiency savings over the next five years.

ULHT Senior Project Manager in Digital Transformation, Kelly Wymer, said: “This is all about providing the best possible care to our patients and supporting our staff across the Trust. Robotic dispensing systems are known to provide safer and more efficient dispensing. It will release pharmacy time from back office and administrative tasks so it can be better spent on face-to-face patient care.

“The robot also manages stock rotation – reducing the risk of medication wastage by ensuring medication with the shortest expiry date is always used first. We have invested in the biggest and best robot that we could fit in the space available and it is great to see it in action and making such a difference already.”

The custom built robot at Lincoln has taken a team of 11 people three weeks to build. It holds 24,000 packets of medication and can work around the clock dispensing medication. The robot arm can travel at 30 kilometres per hour, with the ability to dispense an item every 10-20 seconds.

A smaller cabinet has also been installed at Pilgrim Hospital, Boston, so staff can access emergency medicine supplies at any hour of the day. This will automatically be restocked in the same way as the robot at Lincoln.