Bundle Trust Board Meeting in Public Session 4 June 2019

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

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.

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

2 Public Questions
Chair

3 09:45 - Apologies for Absence
Chair

4 Declarations of Interest
Chair

To Note - verbal

5 09:50 - Minutes of the meeting held on 7th May 2019
Chair

To approve

Item 5 Public Board Minutes MAY 2019 v2.docx

6 Matters arising from the previous meeting/action log
Chair

To consider

Item 6 Public TB Action Log June 2019 290419.doc

7 10:00 - Chief Executive Horizon Scan Including STP
Chief Executive

To consider - verbal

8 10:15 - Patient/Staff Story
Director of Human Resources and Organisational Development

To consider

Verbal

9 10:30 - ULH Five Year Strategy
To approve

Director of HR/OD

Item 9 Trust Strategy for Trust Board vs1.docx

Item 9 Final five year strategy May vs2.docx

10 Strategic Objectives

11 11:00 - Providing consistently safe, responsive, high quality care SO1

11.1 Assurance and Risk Report - Quality Governance Committee
To consider

QGC Chair

Item 11.1 QGC Upward report May 2019.doc

11.2 Clinical Strategy
To approve

Medical Director

Item 11.2 Trust Board June 2019 Clinical Strategy front page.docx

Item 11.2 Refreshed Clinical Strategy 030519 v5.pdf

12 11:20 - Providing efficient and financially sustainable services SO2

12.1 Assurance and Risk Report FPE Committee

To consider

FPEC Chair

Item 12.1 FPEC Upward Report May 19 v2.doc

12.2 Digital Strategy

To consider

Deputy CEO

Item 12.2 1906 TB - Digital Strategy - Front cover final.doc

Item 12.2 1906 TB - Integrated Digital Care Strategy 2021 v0_06.docx

13 11:50 - Providing services by staff who demonstrate our values and behaviours SO3

13.1 Guardian of Safe Working Report

To consider

Medical Director

Item 13.1 Board Report - GoSW June 2019.doc

13.2 Assurance and Risk Report W&OD Committee

To consider

WFOD Chair

Item 13.2 WODT Upward Report - May 2019 v2.docx

14 12:00 - Providing seamless integrated care with our partners SO4

No items

15 12:15 - Performance

15.1 Integrated Performance Report

To consider

Exec Directors

Item 15.1 Integrated Performance Report - Trust Board.pdf

16 12:30 - Risk and Assurance

16.1 Risk Management Report

To approve

Medical Director

Item 16.1 Trust Board - Corporate Risk Report - June 2019.docx

Item 16.1 Appendix I - High & Very High corporate risks - June 2019.pdf

16.2 BAF 2019/20

To approve

Trust Secretary

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

Item 16.2 BAF 19-20 v27.05.19.xlsx

16.3 Audit Committee Report

To consider

Audit Chair

Item 16.3 Audit Upward Report May 19.docx

16.4 Annual Self Certification NHS Provider Licence Conditions

Trust Secretary

To approve

Item 16.4 Self Certification - NHS Provider Conditions Front Cover.docx

Item 16.4 Self-certification_template_FT4.xlsm

17 13:00 - Strategy and Policy

17.1 Health Conversation 2019 Summary

Deputy CEO

For information

Item 17.1 Health Conversation Front Sheet.doc

Item 17.1 Healthy Conversation Report for Trust Board.docx

17.2 Board Forward Planner

For information

Trust Secretary

Item 17.2 Public TB Board Forward Planner 2019 v 1.doc

17.3 ULH Innovation

Assistant Director Comms

For information

Item 17.3 Transforming the experience for patients needing partial knee replacements V2.docx

17.4 Board Visibility

To consider

Assistant Director Comms

Item 17.4 Board visibility.docx

18 13:10 - Any Other Notified Items of Urgent Business

19 The next meeting will be held on Tuesday 2nd July 2019

Agenda Item 5

Minutes of the Public Trust Board Meeting

Held on 7th May, 2019

Lincoln County Hospital, Lincoln

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mrs Sarah Dunnett, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Dr Neill Hepburn, Medical Director
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Interim Director of Finance and Procurement
Mr Jan Sobieraj, Chief Executive
Mr Kevin Turner, Deputy Chief Executive
Mrs Michelle Rhodes, Director of Nursing
Mrs Gill Ponder, Non-Executive Director
Mr John Bains, Healthwatch

Non-Voting Members:
Mr Martin Rayson, Director of Human Resources and Organisational Development
Mr Mark Brassington, Chief Operating Officer
Mr Paul Boocock, Director of Estates and Facilities

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)

Apologies:
Mr Geoff Hayward, Non-Executive Director

566/19 **Item 1 Introduction**

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

567/19 **Item 2 Public Questions**

Q1 Jody Clark – As we approach 1000 days of overnight closure at Grantham A&E (on 13th May 2019) and it will be some considerable time until we see a resolution. Would you please give some assurances to our community that Grantham and District Hospital remains a priority to the United Lincolnshire hospitals trust?

The Medical Director responded:
The 2021 Strategy is on the agenda of the May Board meeting and outlines the future of each of the main sites for United Lincolnshire Hospitals Trust. This includes the Trust's view for the future of Grantham Hospital and what the Trust aims to achieve. The clear message being that Grantham Hospital continues to play an important part in the future of the Trust.

Q2 Sue McQuinn – Could the board please define under what circumstances transport is arranged and paid for by the Trust when patients are discharged from emergency departments? Sometimes taxis are paid for by the Trust when patients from Grantham are discharged from Lincoln Hospital A&E. Sometimes patients are left in the middle of the night with a £60/£70 bill to get themselves home. There seems to be no consistency. At the meeting held at St Wulfram's Church, shortly after the overnight closure of Grantham A&E, board members promised to look at the question of transport costs being incurred as a result of the closure. That was 2016. In 2019, what are the criteria being used and how are patients informed of what is available?

The Chief Operating Officer responded:
All patient transport is provided based on standard criteria regardless of the healthcare accessed that is agreed between commissioners and transport providers. Following the Grantham closure the criteria was reviewed however the terms were not changed. On occasion clinical need may result in staff working outside of the set criteria, this is determined by the clinicians within the Emergency Department based on clinical need of the patient. The majority of patients follow the criteria set by the commissioners.

Q3 Alison Marriott – Please could the public have an update on the paediatric and maternity situation at Pilgrim Hospital Boston, to include an update on progress towards lowering the neonatal unit's gestation age admission criteria to 32 weeks (including likely effective date, milestones to be achieved and date when it will be announced publicly).

Also to include a detailed update on progress with recruitment to children's ward/PAU (number of doctors, nurses and other roles vacant, adverts placed, numbers recruited and details of other recruitment strategies).

The Medical Director responded:
A detailed review of the interim service model was presented at the April Trust Board meeting which addressed the issues raised. The Trust Board agreed that service delivery would move to business as usual and report through the Trust's Quality Governance Committee on a quarterly basis, the next report would be presented to the Committee in July. Work is underway with the whole health community to develop the service model and these discussions include gestational age. Currently a definitive solution has not been agreed and as such no detailed plan is in place.

Q4 Liz Wilson – At its last meeting, the Board received a paper with regard to the Orthopaedic trial at Grantham and District Hospital, which, according to the minutes "demonstrated that the expected impact has been realised, there is positive support from both patients and the public with an increase in the number of operations. The flow of patients at Grantham and Louth had increased but there is a requirement to improve reporting on surgical site. The Board were aware of the challenges, these have been identified in the feedback however there had been a positive impact on the patients seen and staff had been supportive."
From this, it would seem that the trial is progressing well, with few glitches.
However, the experience of many patients does not seem to accord with this view, with comments and information received from members of the public that:

- ***a) Fracture and referral clinics are cancelled at short or no notice***
- ***b) Patient referred to see orthopaedic Consultant urgently in January, has had appointment cancelled three times, and when phoning-in in case of cancellation has been told that whole clinic has been cancelled.***
- ***c) That consultants on call for all three sites are failing to contribute to the proper operation of services there – for example, failing to provide cover for the clinics mentioned in a)***
- ***d) That post-operative care is left to junior/middle grade doctors, which puts at risk any patients who may suffer post-operative complications – this is at odds with the National Guidelines, which require that post-operative care should be given by Consultant grade doctors***
- ***e) That there is little or no experience of Consultants conducting ward rounds***
- ***f) That neck of femur is not being dealt with in the way the Board says it is***

Please can the Board provide an accurate and complete version of how the whole of this trial is working, as patient experience is significantly different from that reported to the Board, and specifically, please provide data on:

- ***i) Numbers of patients treated and nature of treatment***
- ***ii) Numbers of clinics cancelled and why***
- ***iii) Auditable evidence that Consultants respond to treatment requests across all three sites***
- ***iv) Evidence that the Trust's operational model for this trial is, and can prove itself to be, being run to meet National guidance.***

Given that the trial is expected to continue until 31st March 2020, can the Board indicate when they intend to undertake the necessary public consultation about this significant and permanent change in service provision?

The Chief Operating Officer responded:
A number of papers had been presented to the Board regarding the trial, the papers provided detail about the move from site based ways of working to a single team. The challenges included some disruption in the way outpatient services were provided. The full challenges had previously been shared with the Board.

The number of patients treated had previously been provided, one or two clinics were cancelled each week due to the availability of workforce and also the complexity of delivering the service. A request to extend the trial to 2020 would enable retention of consultants in order to deliver an improved service. Further resolution of consultant retention would be addressed through the job planning process and action plans.

The model had been designed in line with national guidance with each patient having a named consultant, care is provided by the consultant and a team, as such not every interaction would result in the patient being seen by the named consultant.

The Trust are not responsible for undertaking consultation and discussions regarding the future of the service would be held as part of Healthy Conversations 2019.

Q5 Marie Therese Biddles – Why will Grantham residents have to ring 111 to access the proposed UTC overnight ?
Why can't we have a walk in UTC?

The Medical Director responded:
As a result of the Acute Services Review a proposal has been developed and this is the responsibility of the Clinical Commissioning Group to conduct a public consultation, no decision has been made at this stage. The proposed service design would ensure patients attend the right place first time. The Medical Director encouraged individuals to share their views as part of the Healthy Conversations.

Q6 Councillor Ray Wootten – On several occasions I have raised with the board the complaints that I have received from staff on bullying and victimisation. I congratulate you on trying to tackle this issue however, feedback from staff state that they have no confidence in the complaint process and, by creating a 'champion' unless, they are independent from the trust, this will not improve this situation.
How are you going to encourage staff to have the confidence to come forward.

The Director of Human Resources and Organisational Development responded:
The report from the Freedom to Speak up Guardian due to be discussed on the agenda sets out the steps to increase options for the Trusts staff to report concerns. The Trust will be

establishing champions to support the Guardian, staff have been engaged in the work to nominate staff for the role who they would have confidence in.

There is national recognition that a network of champions has worked well in other Trusts and it is recognised that there are occasions where staff to do not wish to speak to someone within the Trust. However in order to tackle issues raised the Trust does need to be made aware of them. The Trust are aware that there continues to be a perception as highlighted in the staff survey about staff not feeling confident to speak up and the Trust continue to work hard to resolve this.

Q7 Councillor Ian Selby – Last month I asked a question regarding a petition to parliament that all Hospital Trust Board positions become an elected position and elected by the people they serve. Before I decide to initiate the petition, I may be persuaded not to pursue the petition if I felt that the Health Trust Boards were more accountable and listening to the people. Therefore, just as South Kesteven District Council allow members of the public when asking public questions at full council meetings to ask a supplementary question, would ULHT also allow members of the public to ask a supplementary question at your meetings?

The Chair responded:
NHS Trust Boards are enshrined in national legislation one of the reasons that Non-Executive Directors are appointed is due to the full range of experience they bring to advocate for patients, this is the same across all NHS Trusts. Whilst members of the Trust Board are keen to ensure proper dialogue with all patients and the public, for a range of reasons the Trust Board meeting is not the place to hold the conversations. There are plenty of opportunities for the Trust Board to meet with the public to hold discussion and all patients and public are encourage to have the proper conversations through the Healthy Conversations 2019 public engagement events.

Q8 Councillor Linda Wootten – On the 13th of May it will be a thousand days since the overnight closure of Grantham 's A&E. At the time of closure you stated there was insufficient middle grade doctors so therefore, can you inform me how many middle grade doctors you have now recruited, since that closure and, when do you expect Grantham's A&E to reopen overnight? as you had previously eluded to.

The Medical Director responded:
The number of middle grade doctors remains similar however there has been an increase from seven to eight middle grade doctors. The Accident and Emergency teams had been brought together across the Trust, the total establishment required for the Trust is 44 doctors, eight of which are required at Grantham. The Trust currently employs 15 substantive doctors and staffing in the emergency departments remains an issue.

The future of Grantham was previously responded to, a consultation is underway through the commissioners. Again people are encouraged to respond in detail through the consultation process.

Following the response to the public questions the Chair advised that further discussion could be held at the Healthy Conversation public engagement events either collectively or one on one. Each event runs for 5 hours and the next round of meetings are set and publicised.

568/19 **Item 3 Apologies for Absence**

Apologies were received from Mr Hayward, Non-Executive Director

569/19 **Item 4 Declarations of Interest**

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

570/19 **Item 5 Minutes of the meeting held on 2nd April 2019 for accuracy**

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

398/19 – Should read – Engagement is positive with 8000 views of the Healthy Conversations video, there is some difficulty with the engagement process due to purdah and public services not being able to conduct consultations during this period however, a summary of findings this far will be published in June and presented to the Board.

447/19 – Should read – Capacity issues were discussed and it was confirmed that this is considered across the whole system and where possible patients are repatriated to their closest hospital. The Trust was looking into the requirement for weekend working and senior presence and criteria based discharge.

492/19 – Should read – The Board need to ensure there is an understanding of the sources of information and consider where the findings of the PLACE report would fit in to the Trusts statutory and mandatory requirements relating to estates works.

510/19 – Should read – The Chief Operating Officer confirmed that the control over the gender pay gap that the Trust has could relate to the allocation of Clinical Excellence Awards and the allocation may be different between gender.

532/19 – Agenda item should read – 2018/19 Operational Plan

546/19 – Should read – Aseptic pharmacy continues to be noted as an emerging risk. Partial recruitment to the aseptic business case is underway and should help to reduce the risk.
556/19 – Should read – The external audit annual engagement letter had been agreed.

561/19 – Should read – The single appointment of Grant Thornton across the three providers had been made and it is hoped this would provide a fresh view of the organisation with an opportunity to review the board assurance framework and direct internal audit work appropriately.

571/19 **Item 6 Matters arising from the previous meeting/action log**

350/19 Risk register update – It was confirmed that Estates review dates had been updated with the Risk Manager. Item complete.

387/19 Written feedback had been provided to the public question – Item complete

438/19 Paediatric patients – Discussions continue with commissioner to ensure that the service provided is appropriate

439/19 Enhanced exception reporting in relation to paediatrics – Discussion held at April Quality Governance Committee Item complete

483/19 Corporate records issue – Discussion held with Associate Director of Clinical Governance, systems had been put in place and records were being held in line with Trust process, Item complete

492/19 PLACE outcomes – The minute was clarified, PLACE scores and actions are being picked up within the Estates Strategy Item complete

507/19 Guardians of Safe Working – Assurance to be sought at Workforce, Organisational Development and Transformation Committee 15th May, report to be presented to Board following the committee meeting

523/19 2021 Strategy, agenda item 9. Item complete

540/19 2018/19 Operational Plan, agenda item 11.4. Item complete

550/19 Risk appetite documentation, private Board meeting agenda. Item complete

563/19 Forward Planner – Review undertaken, Item complete

572/19 **Item 7 Chief Executive Horizon Scan including STP**

The Chief Executive provided an update to the Board.

573/19 NHS Providers had released a report looking at the state of acute hospitals, the report contained a large amounts of information including the average planned financial savings percentage for acute trusts(3.6%) for the forth coming year, the Trust are aiming to achieve 6% putting in perspective the scale of what the Trust is aiming to achieve. At the time of release of the report almost half of Trusts were not meeting control totals.

574/19 The Board were advised there were a number of legislative changes expected to affect the NHS. The 9 proposed changes to affect the NHS include Collaborating and Competition, Procurement, NHS Payments system, Integrated Care Trusts, Mergers and Acquisitions, Capital Spending, Provider and Commissioner joint working, Shared duties, Formality for NHS England and NHS Improvement.

575/19 The capital spending legislation would restrict the ability of foundation trusts to retain large amounts of money in accounts and the amount spent on their Trust. This would enable funding to become available to other organisations to support capital works.

576/19 The Chief Executive highlighted that further Healthy Conversations engagement events were scheduled to take place across the county, the events were being held as drop in sessions between 2pm – 7pm at the following venues:

Monday 20 May, New Life Centre, Sleaford, NG34 7JP
Tuesday 21 May, United Reformed Church, Gainsborough, DN21 2JR
Wednesday 22 May, Lincoln City Football Club, Lincoln, LN5 8LD
Wednesday 21 June, The Theatre Lounge, Stamford, PE9 1PJ
Thursday 13 June, United Reformed Church, PE11 1QD

577/19 Engagement remains positive with 20,000 page views of the website, 10,000 new visitors to the website and an increase to 8,500 views of the video, purdah does not appear to have resulted in a decrease in the number of enquiries or questions being asked.

578/19 The Board were advised that timescales for formal consultation following Healthy Conversations had not been set, the plans being discussed were dependent on capital funds being available. If there were opportunities to move forward without capital funds being required this would be considered and timescales discussed.

579/19 The Trust had held its annual staff awards with a large number of staff attending, this is a positive event for staff, family and friends, there were over 600 nominations across all sites and

professions with nominations coming in from both staff and public. The Trust are planning on conducting the event again in 2020.

580/19 **Item 8 Patient/Staff story**

The Director of Nursing advised the Board that the Trust were celebrating the International Day of the Midwife, Nurse and ODP during the week with activity around the Trust and introduced Charge Nurse Donohoe, Deputy Charge Nurse Limb and Trainee Nurse Associate, Racheal Lear from Ward 9A at Pilgrim Hospital.

581/19 Charge Nurse Donohoe shared the story of the leadership developments on ward 9A. The ward provides orthopaedic trauma care. There had been a series of short term leaders on the ward and the lack of leadership resulted in a number of red ratings for ward accreditation.

582/19 When Charge Nurse Donohoe commenced in post leadership stabilised, however in October 2018 the ward experienced a high number of pressure ulcers resulting in harm. Pressure ulcer scrutiny panels were held for 3 consecutive months and this was a difficult time for the staff.

583/19 Plans were put in place to identify issues and ensure improvements would be made, there had been clear direction from Charge Nurse Donohoe that there would not be a repeat of the pressure ulcer incidents and that patients could expect to receive harm free care from the ward.

584/19 The team worked closely with the Tissue Viability team who provided training to staff and put in place a new turning regime and altered care plan to suit the needs of the department. Improvements were slowly seen and collaborative working with other Band 7's in the Trust had been undertaken in order to gain insight of how to make improvements and call upon colleagues for support.

585/19 Following the changes to the ward and increased leadership the team have seen improvements in morale, engagement and communication, self-rostering, safety culture and an overall improvement in the reputation of the ward across the hospital. The team consistently achieve 100% on the Friends and Family Test, low sickness absence rates, 93% achievement in core learning and top performance around falls.

586/19 Charge Nurse Donohoe advised the Board that the ward had achieved 169 days free of pressure ulcers and hoped to continue to achieve 200 days. The overall aim of the ward would be to achieve a green ward accreditation, in order to do this consistency must be maintained along with staff morale.

587/19 The Chair praised the team for taking responsibility for the issues faced and the improvements made.

588/19 Mrs Dunnett commented that the ward accreditation had clearly had an impact on staff as there was a desire to achieve a good rating. The Director of Nursing stated that the Trust would be used as an example of good practice for the implementation of ward accreditation.

589/19 The Director of Human Resources and Organisational Development sought feedback regarding self-rostering and the challenges faced by the team. Charge Nurse Donohoe indicated that the most frequent issue had been staff choosing to work the same weekends and nights however the team would be flexible and move shifts accordingly.

590/19 The Director of Nursing confirmed that teams had been encouraged to take up self-rostering and the issues in relation to uptake were due to the set of operating procedures put in place by

the Trust, this had made it difficult for teams to achieve. Large vacancy rates also impact on the ability for teams to self-roster.

591/19 Mrs Libiszewski thanked the team for discussing the Friends and Family test and the proactive approach being taken to achieve 100% and asked the trainee nurse associate what her experience had been on the ward.

592/19 The trainee nurse associate identified that she had only been on the ward for 2 weeks and was the first ward she had worked on. The staff are supportive and helpful allowing for a hands on experience. The trainee nurse associate indicated that she hoped to return to the hospital following completion of her training in order to undertake her nurse training.

293/19 The Chief Executive added his congratulations to the presentation and work achieved on the ward and asked the Staff Nurse in attendance what his experience had been like. He advised the Board that 16 months with no clear manager had been difficult especially with the pressure ulcer scrutiny panel. The ward accreditation had provided a clear direction of travel for the team and an increase in staff morale.

594/19 Overall the ward had achieved improved patient experience by reducing the amount of falls resulting in harm, catheters are removed in a timely manner and the ethos of doing no harm to patients has greatly improved. Communication with staff had improved and safety huddles across the team were now in place on a regular basis.

The Trust Board:

- **Received the staff story**

595/19 **Item 9 Five Year Strategy**

The Director of Human Resources and Organisational Development presented the Five Year Strategy to the Board.

596/19 True North work had provided the Board with clear priorities for the development of the strategy and had revised the priorities and overall vision for the Trust, the strategy finalises clear priorities for the Trust. Moving forward, once the strategy is signed off a key next step would be engaging staff. It would be possible to raise staff morale through great leadership but staff were also looking for clarity regarding the future of the Trust, the 2021 Strategy articulates this future.

597/19 The communications plan is being relaunched in order to deliver the strategy and organisational objectives there is a need to ensure active plans are in place and alignment with operational plans.

598/19 Mrs Dunnett asked if regulators were supportive of the plans and direction of travel for the Trust. The Chief Executive confirmed that in principle support is being given by the regulators however there were some difficulties.

599/19 Dr Gibson enquired about the inclusion of the establishment of the paediatric and stroke services as these were not specifically identified. It was confirmed that these were included within the strategy..

600/19 Concerns were raised regarding the use of number of beds in the strategy, the Trust are commissioned to deliver a service and bed numbers may provide a misconception, the board suggested consideration be given to removing bed numbers, instead referring to the service as a whole. An observation regarding the language was made if the strategy was aimed at mobilising staff there should be stronger and more motivating language.

601/19 The word workforce appears frequently throughout the document and Dr Gibson identified that this felt more aspirational than definitive, there would need to be a way in which the Board are able to monitor the workforce changes and transformation in order to maintain sight.

602/19 The Chair confirmed that there would need to be a clear process for monitoring and tracking progress to ensure Board received assurance on the monitoring of activity set out in the strategy.

603/19 In order to ensure the delivery of the strategy there would be a requirement to align to the Board Assurance Framework, Operational Plan and ensure that language used throughout is consistent.

604/19 Board members were asked to provide feedback on the strategy to the Director of Human Resources and Organisational Development. The Strategy would be updated and re-presented to the June Board.

ACTION: All Board members, 27 May 2019

605/19 The Trust Board:

- **Approved the strategy subject to the revisions discussed**
- **Requested sight of the updated strategy at the June Trust Board**

606/19 **Item 10.1 Assurance and Risk Report Quality Governance Committee**

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

607/19 The Board were asked to note the continued progress against the quality indicators, the quality and safety improvement plan and further work in relation to considering how reporting is conducted in light of the position statement and the inspection due in the near future.

608/19 Verbal updates continued to be received from the Quality and Safety Oversight Group, the Committee had asked for further rigour in reporting and momentum in the governance process.

609/19 Verbal updates had been received in relation to the QIAs, written updates had been requested

610/19 The Committee noted disappointment with some of the risk register entries where timescales had slipped in terms of the review, the Board noted that this was also evident across the wider register. This had been highlighted to the Risk Manager and consideration should be given to the risk ratings and the understanding of initial and residual risks.

611/19 The Committee had been advised at their meeting of a 6th Never Event in the 2018/19 financial year, work had been undertaken to determine if a Never Event had occurred at the start of the year and this had been confirmed. The Medical Director was working to identify any themes from Never Events, particularly in relation to wrong site surgery and non-theatre Never Events.

612/19 The quality priorities had been reviewed by the Committee who advised they would need to align to True North and the quality strategy. The priorities were not agreed by the Committee as they were not sufficiently aligned and patient experience and staff priorities had not been included. The priorities would be considered when the Board met in private to ensure the Quality Account would be delivered on time.

613/19

Development of an action plan in response to an audit of governance functions in the Trust had been completed Dr Gibson had provided his thoughts and these would be fed to the Audit Committee, significant work had been undertaken by the Committee in response to the report.

614/19

Further work would be required regarding internal audit reports, specifically in relation to medicine reconciliation which required executive oversight.

615/19

The Board were advised that NHS Improvement had notified their intention to observe the next meeting of the Committee.

616/19

The Committee wished to raise one issue with the Board in relation to the risk register and the consideration of inclusion of residual risk. The Medical Director agreed to address this with the Risk Manager

ACTION: Medical Director 4 June 2019

617/19 **Item 11.1 Assurance and Risk Report FPE Committee**

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

618/19 The key points highlighted by the Committee were that the Trust was reporting a year end deficit of £88.2m against the £89.4m revised plan. There had been 6 months of consistent delivery against the plan which demonstrated the improved financial grip and control.£16.2m of efficiency savings had been delivered against a plan of £15.1m of which 80% of were recurrent. Capital funding had also been achieved with an underspend of £5k.

619/19 The Committee were asked to support revenue borrowing of £7.376m for June 2019, support had been given and this was escalated to Board for approval, a request had been made for monthly borrowing figures to be reported to the Committee.

620/19 Contracting discussions were held by the Committee and further discussion would be held at the private Board meeting.

621/19 The Committee had noted that the long term plan would now be progressed allowing the finance strategy to be presented to the Board in September 2019.

622/19 The Committee had agreed the reference cost process to support the submission on 2nd August.

623/19 Positive performance had been seen in relation to planned care, the waiting list reduction target was exceeded by 3,000 patients with the Trust being only one of a few organisations to achieve this.

624/19 The Trust had also achieved zero 52 week waits by the end of March 2019.. As a result of this the 18 week wait position had remained the same.

625/19 Breast 2 week waits remained challenging however the Trust were achieving treatment within 62 days, a planned improvement trajectory would be presented to the May Committee.

Urgent Care March performance remained below trajectory, the Committee had asked for individual improvement trajectories for each of the 5 improvement work streams at the May
626/19 Committee meeting.

627/19 Extension dates had been granted for fire enforcement works due to contract performance and contractual issues, the Committee were assured that Lincolnshire Fire and Rescue remain satisfied with progress.

628/19 The Committee had requested evidence of management compliance with health and safety, this would be included in the Performance Review Meetings and as part of the management structures for the Trust Operating Model.

629/19 NHS England had confirmed substantial compliance for the Trust in relation to emergency planning however lock down had not yet been achieved due to the remainder of the fire doors requiring installation.

630/19 The Committee received the Digital Strategy and this would be presented to the Board for approval.

631/19 The risk register was reviewed and the Committee had noted that a number of risks were overdue and required updating.

632/19 The Chair of the Committee noted the progress that had been made and the increased level of assurance reported by the Committee.

633/19 Mrs Libiszewski asked if the CQUINs were based on 100% achievement and if this was an achievable aspiration. It was confirmed that the CQUINS for 2019/20 would be substantially different to previous years, the plan has been built on 100% achievement however due to the reduced number they could be resourced appropriately to ensure achievement.

634/19 The Chair noted the achievement against the waiting lists and the progress to increasing patient experience, thanks were given to those involved in achieving the improved position.

635/19 **Item 11.2 Capital Plan 2019/20**

The Interim Director of Finance and Procurement presented the capital plan to the Board.

636/19 The plan was the proposed capital spend for the Trust through 2019/20, the Trust have a capital resource of c£33m including remaining fire compliance monies, medical school and national allocation for LED lighting.

637/19 The Trust have control of £8.6m and a risk based approach had been taken to assess the capital and align to risk in order to drive service improvement. The Board were advised that the NHS Improvement prioritisation scoring matrix had been used to identify the priority schemes.

638/19 The Interim Director of Finance and Procurement highlighted the spend of £2.2m in relation to asbestos works being carried out, the asbestos risk is from previous years and will reduce the total available in capital spending. The £2.2m spend does not remove the Health and Safety Executive Notice however would move the Trust significantly closer to closing this down.

639/19 Discussion was held in relation to managing risks that would not be covered by capital and also the involvement of the divisions in these decisions. Confirmation was given that the plan had been presented to Trust Management Group for discussion but had not been through a full consultation process in detail. Divisions would continue to submit business cases for areas where they require work to be completed. Moving forward there would be greater involvement at divisional level to ensure understanding at a clinical level and ownership challenges.

640/19 Mrs Ponder made the Board aware of the need to consider statutory and non-statutory risks, the Trust would continue to be exposed to a number of risks following the completion of works. Capital spend would not be enough to cover all of the statutory risks identified. In order to ensure that the Trust is aware of this there would be a requirement to build a knowledge base of the backlogs.

641/19 Mrs Libiszewski raised concerns regarding the asbestos enforcement notice, and the possible lack of awareness by the Board of other enforcement notices, this does not appear on the risk register.

642/19 The Director of Estates and Facilities advised that the enforcement notice regarding asbestos had been issued in 2015. Tackling both asbestos and fire works at the same time would be more efficient for the Trust due to the access required. Discussions had been held through governance routes previously however a refresh would be timely and reported through Finance, Performance and Estates Committee.

ACTION: Director of Estates and Facilities, 4th June 2019

643/19 Confirmation was given that the Trust had enforcement notices in relation to fire and asbestos only, however consideration would be given to periodic reporting to include all enforcement, regulatory, health and safety and coroner notices. The Board agreed this could be reported to Board through the Audit Committee.

ACTION: Trust Secretary, 15th July 2019

644/19 Clarification was provided to the Board in relation to those schemes identified as 'could be stopped', should there be a requirement to stop work to prioritise alternative schemes those identified as 'could be stopped' would be.

645/19 The Interim Director of Finance and Procurement confirmed that discussions would be held with Trust Management Group regarding implementation and mitigation of risks. External opportunities for capital would continue to be explored with NHS Improvement being approached regarding funding for fluoroscopy at Lincoln and Pilgrim.

646/19 The Trust Board:

- **Approved the capital plan for 2019/20**

647/19 **Item 11.3 Annual Plan 2019/20**

The Interim Director of Finance and Procurement presented the plan and advised that previous comments on the draft document had been included.

648/19 Some alignment improvements as with the Five Year Strategy would be required for the annual plan, and as such the Interim Director of Finance and Procurement sought approval for the annual plan subject to the alignments being made.

649/19 The key deliverables and metrics set out in the plan would be presented to the Board in June through the operational delivery plan where relevant owners and milestones would be included and would provide a 5 year strategy that will be pulled together in line with the Board Assurance Framework.

650/19 Comments in relation to the annual plan are to be provided to the Interim Director of Finance and Procurement.

ACTION – All Board members, 28th May 2019

651/19 The Trust Board:

- **Approved the plan subject to further work as described**

652/19 **Item 11.4 Year End update on operational plan 2018/19**

The Interim Director of Finance and Procurement presented the year end position on the operational plan.

653/19 A number of red items remain in the plan with some outside of the control of the Trust . The reported reds are in relation to cancer, 4 hour wait, estates issues, ongoing delivery issues with job planning and the 2019/20 delivery programme.

654/19 Discussions were held regarding the content of the plan particularly in relation to the workforce areas. It was acknowledged that the Trust are behind on the workforce plans for 2019/20 and this is monitored through the Workforce, Organisational Development and Transformation Committee. The Board were reminded that job plans and delivery for 2019/20 is a refresh of previous work and not newly initiated.

655/19 The agency cost reduction plan was identified as being reported green however the Trust had spent more than planned. The Director of Human Resources and Organisational Development clarified that although costs were not met the plan had been delivered.

656/19 Moving forward to 2019/20 the tracking document would need to provide clarity regarding achievement against actions or outcomes and what would be RAG rated.

657/19 Work is in progress to hand over any relevant areas to the divisions to run as business as usual and as the 2019/20 plan is built those areas in the plan required to be passed to business as usual will be identified.

The Trust Board:

- **Received the report and noted the year end position**

658/19 **Item 12.1 FTSU Quarterly Report**

The Freedom to Speak up Guardian presented the quarterly update to the Board.

659/19 The key points to note include the 2018/19 figures demonstrating more contacts with the guardian than in the previous year. Work continues to raise awareness with the Trust implementing plans to move to a network of champions.

660/19 A survey was conducted with staff to determine how they would like a network to be structured and which staff would be preferred champions. Representatives from each of the staff groups would be on each site. Nominations for the champion roles had been opened up to staff and the process continues to identify the champions, this will be an add on role to existing roles.

661/19 The champion role had worked successfully in other Trusts and ensures accessibility to staff. There had not been a large number of nominations however conversations had been held with staff who had shown an interest. Further communication work may be required to ensure a suitable level of uptake.

662/19 Mrs Dunnett enquired as to how the ‘so what’ questions was answered when concerns had been raised. The Freedom to Speak up Guardian advised that work was ongoing to examine how feedback was given and also obtained from staff involved in the process. The Trust was implementing an idea from another Trust where a letter from the Chief Executive to thank the

staff member for raising the issue along with feedback to the Board to identify the issues and actions taken.

663/19 Mrs Ponder queried figures in relation to bullying and harassment which appeared contradictory. Confirmation was provided that the first set of figures were issues raised directly with the guardian and the second were issues raised through alternate routes.

664/19 The Freedom to Speak up Guardian advised the Board that a comparison of speak up numbers with other organisations was not necessarily a measure of the impact of speaking up no clear comparison could be drawn from numbers alone. The Trsut recognised that it still had work to do to create a Trust where all staff would have the confidence to speak up.

665/19 The Board considered future reporting and whether case studies could be considered and communications would be utilised to support those staff who have reservations about coming forward. By demonstrating the outcomes for those who have reported issues this may encourage others to raise concerns. Staff survey result could be considered to identify if over time an improvement had been made with staff feeling able to raise concerns.

The Trust Board:

- **Received the report**

666/19 **Item 13.1 Urgent and Emergency Care Improvement Programme**

The Chief Operating Officer presented the paper.

667/19 The report detailed the position of the trajectory and planning assumptions set for 2019/20. The report outlines the current position in relation to the original assumptions. Levels of activity and demand had not remained within expected limits across the sites.

668/19 Monthly reporting of the trajectory for 4 hour performance, ambulance handovers and trajectories against performance were being received by the Finance, Performance and Estates Committee. Assumptions had been received and these underpin the trajectory and remain similar to previous years.

Recruitment continues to be delivered against agreed timescales in emergency departments.

669/19 Work would be undertaken to ensure that the data presented is more accessible and provides assurance, tracking will be presented by site and organisation to provide a position against key metrics identified for improvement.

670/19 Concern was raised regarding the ability to deliver the assumptions due to the current position in relation to transformation, workforce and whether the work programmes had been agreed across the system.

671/19 The Chief Operating Office confirmed that developments are continuing and the Trust would need to work differently to deliver the urgent and emergency care programme deliverables. Conversations continue to be held and updates will be provided to the Finance, Performance and Estates Committee.

672/19 The Chair confirmed that a single system plan had been put in place however this had not been considered by the Board, this would require sight at the Board to ensure understanding of what the whole system had committed to. Clarity had been sought regarding how Boards will be engaged as part of the single system plan, a response was awaited.

673/19 The Deputy Chief Executive confirmed that there had been a new system programme infrastructure agreed for 2019 for the Lincolnshire Wide System that attempted to rationalise, strengthen and clarify the number of Board and groups. As part of the process the Deputy Chief Executive confirmed he had been appointed as the Senior Responsible Officer of the system wide delivery for urgent and emergency care and as part of the role would write to the other Senior Responsible Officers to develop a single plan on a page that would allow performance reporting to be made against that plan.

674/19 Reporting arrangements were discussed and it was agreed reporting would take place through the Finance, Performance and Estates Committee.

The Trust Board:

- **Received the report**

675/19 **Item 14.1 Integrated Performance Report**

The Interim Director of Finance and Procurement presented the report to the Board and advised that further work was to be completed on the report.

676/19 The executive summary indicated the continued improvement of notifications in person and written follows ups in relation to duty of candour. HSMR remained within expected limits.

677/19 The Trust had achieved zero 52 week waits in March 2019, this was a big achievement and the trajectory for waiting lists was achieved at the end of March, the Trust continue to strive to improve this in 2019/20.

678/19 62 day cancer compliance had declined and was reported at 61.3% for February, this is reflected nationally. Issues with pathology continue with work underway with the current provider and other providers to resolve the performance issues.

679/19 Financially the Trust has reported a deficit of £88.2m which is £1.2m ahead of revised plan, this achievement was recognised by NHS Improvement. The Trust have delivered against plan for 6 months and over achieved on the financial efficiencies programme.

680/19 Agency expenditure continues to be high at £37.1m set against a spend of £21m last year, this demonstrates the level of pressure staffing is under.

681/19 An improvement in the medical vacancy rates was seen in March however due to annual leave being taken medical agency costs increased. In order to ensure this is avoided in the future greater control of leave must be in place.

682/19 The Trust need to achieve £15m of workforce savings moving forward.

683/19 Wider discussions were held regarding the report including the good progress that is being made and the need to set realistic stretch targets to be able to demonstrate the level of performance being achieved.

684/19 The Trust Board will move to the new reporting format in June 2019 and kite marks would be populated in time for this report, there was acknowledgement of the large number of metrics being reported. There was a need for the Committees to review the number of KPIs that are reported to them with a view to confirming if these were all required. The report must become more succinct in relation to data collection to ensure focused reporting to the Board.

ACTION: All Board Committees, 7th June 2019

685/19 Concerns were raised in relation to the metrics which appear to show that the Trust is failing and also those where the Trust would not be able to achieve. Discussion was held about the need to be clear when navigating through the performance data, there would be a need for the Trust to be able to provide clarity against what would be deliverable. Where delivery would not be possible the Trust must be clear through the performance report.

686/19 The Chair reiterated that the data reported should ensure that Board are able to discharge responsibilities without data being collected when there is no requirement for it.

687/19 The Director of Nursing identified that the national quality guidance within the workforce section would need to include CHPD reporting.

The Trust Board:

- **Received the report**

688/19 **Item 15.1 Risk Management Report**

The Medical Director presented the report to the Board.

689/19 The corporate risk register contained 2 very high risks in relation to finance and 3 in relation to service disruption, specifically demand, workforce and estate.

690/19 The operational and divisional high risks are similar and the register was as described, a review of dates and names would be required to update the risks.

691/19 The Chair indicated that it would be useful to meet with the Risk Manager and Divisions to discuss how risk is managed. Mrs Dunnett asked how this would fit with the role of the Audit and Risk Committee and this could be included in the work programme. It was agreed that a session with the Divisions and Risk Manager would be arranged.

692/19 The Trust Board:

- **Received the report**

Mr Bains, Healthwatch representative left the meeting

693/19 **Item 15.2 BAF 2019/20**

The Trust Secretary presented the 2019/20 Board Assurance Framework.

694/19 The document had been populated utilising the Trust objectives and further identification of controls has taken place, further refinement is required however progress is being made.

695/19 The Chair identified that a lot of progress had been made in the last year however there was a requirement to align the long term strategy, framework and 2021 strategy to ensure the Board are able to assure delivery of the strategic objectives.

696/19 Further work would also be required to align both clinical and internal audit plans and to ensure that internal audit actions in relation to the Board Assurance Framework have been completed.

ACTION: Trust Secretary, 4th June 2019

697/19 A discussion was held in relation to the inclusion of the metrics and if the judgement made for achievement of the objectives was based on the single metric within the Board Assurance Framework or the wider knowledge of the Committees.

698/19 Confirmation was provided that achievement would be consider by looking at the wider view of the overall objective not the metric in isolation.

The Trust Board:

- **Approved the framework subject to further developments by the committees and alignment with wider plans and audits**

699/19 **Item 15.3 Audit Committee Report**

The Chair of the Audit Committee, Mrs Dunnett, provided the assurance received by the Committee at the April meeting.

700/19 Key points noted were that the external auditors were progressing the final accounts work. This remained on track against timetable.

701/19 Internal audit had completed the 2018/19 programme and the Committee had received the final reports from the auditors. 360 Assurance were exiting as the Trusts internal auditors and reported overall limited assurance, this was expected by the Committee and Board. All internal audit reports would be sent on to the relevant committees for review. The Committee noted that the Trust had completed the internal audit programme within the year.

702/19 The Board were advised that Grant Thornton were appointed as the new internal auditors from 1st April and work had commenced on the internal audit programme for 2019/20. A risk based approach to planning the forthcoming programme would be undertaken with Executive Directors and senior management.

703/19 The Counter Fraud Specialist progress report was received and an operational plan for 2019/20 was agreed by the Committee. Concerns regarding the stretched resource were identified, the Interim Director of Finance and Procurement would ensure this remains under review.

704/19 The Committee received the Standing Orders and Standing Financial Instructions, further work was to be completed prior to submitting to the July Committee for approval.

705/19 The draft annual report was received and the Committee noted the improved position to previous years.

706/19 Areas highlighted to seek further assurance include overpayments of staff, gifts and hospitality policy, clinical and non-clinical policies, ongoing work is being undertaken. Progress housing issue, being scrutinised by Finance, Performance and Estates Committee. Concerns regarding procurement and estates which should be included within the internal audit plan for the coming year.

707/19 **Item 15.4 Annual Self Certification NHS Provider Licence Conditions**

The Trust Secretary presented the annual self-certification declaration.

708/19 NHS Improvement require all NHS Trusts to complete an annual declaration that is published on the Trusts website. The declaration requires the Trust to self-certify against condition G6, *The provider has taken all precautions necessary to comply with the licence, NHS Acts and Constitution* and condition FT4, *The provider has complied with required governance arrangements.*

709/19 Where the Trust are submitting 'not confirmed' reasons as to why must be provided.

710/19 The declaration for Condition G6 for 2018/19 was that the Trust could not confirm.

711/19 The Chief Executive and Chair confirmed that the submission would be consistent to the previous year and an explanatory note had been included.

The Trust Board:

- **Approved the submission of the self-certification for condition G6**

712/19 **Item 15.5 Fit and Proper Person Annual Report to Board**

The Trust Secretary presented the paper to the Board and advised that the annual review had been completed to ensure that all Board members continued to meet the requirement of the Fit and Proper Person Test. There had been changes to the Board over the past year. A further national review of the fit and proper person requirements is awaited and will result in changes to the process.

713/19 The report presented to the Board provides confirmation that each Board member satisfies the fit and proper persons requirements.

The Trust Board:

- **Approved the report**

714/19 **Item 16.1 Board Forward Planner**

For information

715/19 The content of the forward planner would be updated once the Board Assurance Framework had been updated

The Trust Board:

- **Noted the content of the update**

716/19 **Item 16.2 ULH Innovation**

For information

717/19 The Board were advised of the positive impact on patients of the new digital communications system. Since the introduction of the system a reduction in the number of people who do not attend appointments had been seen.

The Trust Board:

- **Noted the content of the update**

718/19 **Item 17 Any Other Notified Items of Urgent Business**

None

719/19 The next meeting will be held on Tuesday 4 June 2019, Boardroom, Lincoln County Hospital

Voting Members	25 May 2018	29 June 2018	27 July 2018	31 Aug 2018	28 Sept 2018	26 Oct 2018	30 Nov 2018	7 Jan 2019	5 Feb 2019	5 Mar 2019	2 Apr 2019	7 May 2019

Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	A	X	A	A	X	X	X	X	X	X
Geoff Hayward	X	X	X	A	A	X	X	A	A	A	X	A
Gill Ponder	X	X	X	X	X	X	X	X	X	X	A	X
Jan Sobieraj	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	X	X	X	X	X	X	X	X	X	X	X	X
Karen Brown	X	X	X	X	A	X						
Michelle Rhodes	X	X	A	X	X	X	X	A	X	X	A	X
Kevin Turner	A	A	A	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	A	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X
Alan Lockwood		X	X	X	X	X	X	X	X	A		
Paul Matthew							X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Trust Board date	Minute ref	Action agreed	Add to TB planner	Lead Director	Completion date	Date cleared
30 November 2018	1077/18	Board should hear a staff story from a Nurse Associate in the Spring.		Director of HR & OD	~~2 April 2019~~ 7 May/ 4 June 2019	Agenda Item Complete
30 November 2018	1084/18	It was agreed that the action plan to support the Board FTSU self assessment would be monitored through the WOD Committee and Board updates on FTSU.		Trust Secretary	2 April 2019 Amend to 7 May 2019	Report received at W&OD meeting. Complete
5 March 2019	350/19	Review due dates for estates risks on register		Dir Estates and Facilities	~~2 April 2019~~ 7 May 2019	Complete – May 2019
2 April 2019	387/19	Written feedback to be provided in response to public question 5		Medical Director	7 May 2019	Complete – May 2019
2 April 2019	398/19	Healthy Conversation consultation summary to be presented to the Board		Chief Executive	4 June 2019	Agenda Item. Complete
2 April 2019	438/19	Understanding of where Paediatric patients are being received from to support discussions with commissioners		Medical Director	7 May 2019	Reviewed as appropriate. Complete
2 April 2019	439/19	Enhanced exception report to be developed to ensure sufficient information reported to Board in respect of Paediatrics.		Medical Director/Mrs Libiszewski	7 May 2019	Complete – May 2019
2 April 2019	483/19	Review to ensure that processes were being following in respect of corporate records		Trust Secretary	7 May 2019	Complete – May 2019
2 April 2019	492/19	Understand sources of information and consider where the PLACE outcomes fit with the Trusts current position		Chief Executive/Deputy Chief Executive	7 May 2019	Complete – May 2019
2 April	507/19	Guardians of safe working report to be presented		Medical Director	7 May 2019	Agenda Item

2019		to Board				Complete
2 April 2019	523/19	2021 Strategy to be presented to Board		Director of HR & OD	7 May 2019 / 4 June 2019	Complete – May 2019
2 April 2019	540/19	2018/19 Annual Plan to be updated and presented back to Board		Interim Director of Finance & Procurement	7 May 2019	Complete – May 2019
2 April 2019	550/19	Develop risk appetite documentation		Trust Secretary	7 May 2019	Complete – May 2019
2 April 2019	563/19	Forward planner to be reviewed in line with the Trusts 2019/20 strategic objectives		Trust Secretary	7 May 2019	Complete – May 2019
7 May 2019	604/19	Board members to provide feedback on the Five Year Strategy to the Director of HR/OD. The Strategy to then be re-presented to the Board in June		All Board members	4 June 2019	Agenda Item. Complete
7 May 2019	616/19	Medical Director to discuss with the Risk Manager regarding consideration to include the residual risk within the Risk Register		Medical Director	4 June 2019	
7 May 2019	642/19	Discussions to take place regarding the asbestos and fire works taking place at the same time. Report to go through the Finance, Performance and Estates Committee		Director of Estates and Facilities	4 June 2019	
7 May 2019	643/19	Consideration be given to periodic reporting to include all enforcement, regulatory, health & safety and coroner notices. It was agreed this would be reported through the Audit Committee		Trust Secretary	15 July 2019	
7 May 2019	650/19	Comments to be provided to the Interim Director of Finance and Procurement in relation to the annual plan		All Board members	28 May 2019	Complete
7 May 2019	684/19	Committees to review the number of KPIs that are reported to them with a view to confirming they are required.		All Board members	4 June 2019	Considered by Committees at May meetings.
7 May 2019	696/19	Further work required to align both the clinical and		Trust Secretary	4 June 2019	IA Plan agreed

		internal audit plans to the BAF.				by Audit Committee and cross ref'd to BAF. Clinical Audit Plan work still to be completed.

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Kevin Turner, Deputy Chief Executive Martin Rayson, Director of HR and OD
Date:	5th June 2019

Title:	**Our Five Year Strategy: Our journey to excellence**

Author: Karen Sleigh, Head of 2021 Change Programme

Purpose of the Report:

The purpose of this report is to provide the Trust Board with our five-year strategy which has been built on the 2021 vision, which is recognised as a key milestone in our journey to excellence.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	✓	Information	✓

Summary/Key Points:

- Producing our final five-year strategy that brings together our vision, ambitions, objectives and priorities to be delivered on our journey to excellence.

Recommendations

The Board are asked to:

- Note the final five-year strategy for the Trust, with 2021 being a key milestone.

Strategic Risk Register The five-year strategy sets out the vision for striving for excellence in Rural Healthcare being delivered through clear ambitions that have been supported by the strategic priority setting, which provides the objectives to be monitored for the risk of delivery through the Board Assurance Framework (BAF).	**Performance KPIs year to date** The Trusts Performance Framework outlines the performance of the Trust to deliver KPIs to achieve our five-year strategy.

Assurance Implications
This paper forms part of the governance assurance of the Trust for the implementation of our five-year strategy.

Patient and Public Involvement (PPI) Implications
There will be further communication and engagement to provide updates to our staff, patients and the public to communicate the delivery of our strategy.

Equality Impact
An Equality Impact Assessment has been conducted as part of our engagement processes.

Information exempt from Disclosure – No

Requirement for further review? Yes

1. Purpose of the Report

1.1 The purpose of this report is to present to the Trust Board our final five-year strategy, which highlights 2021 as a key milestone.

2. Recommendations

2.1 That the Trust Board notes the five-year strategy, with 2021 being a key milestone.

Summary of Key Points

Background

3.1 The 2021 Strategy Route Map was launched at the end of 2017. The launch was promoted through a wide variety of communication and engagement activities, which included a poster campaign around all ULHT sites, supported by Big Conversations and the Executive and Non-Executive "Walkabouts", staff briefings and Senior Leadership Forum presentations. These events identified that staff recognise 2021 as a brand for setting the future direction of the Trust.

3.2 From the end of 2018 we have been refining our strategic planning, focusing on re-setting our purpose and vision, our strategic objectives to deliver our ambitions, together with identifying strategic and tactical priorities. This has set the strategic framework for our five-year strategy.

Developing our Strategy for publication

3.3 Our five-year strategy has been built on consultation and engagement foundations, with staff, volunteers, patients, carers and our key stakeholders to set out clear ambitions for the Trust. Whilst the 2021 brand has traction within the Trust, we need to set out our longer-term strategic intent, recognising that 2021 is a milestone in our journey to excellence.

3.4 This strategy sets out our intended journey towards excellence, with 2021 being a key milestone. It sets out our intention to put our patient's right at the centre of everything we do. We want to clearly outline the changes we need to make, together with our wider health and care system, to improve the quality of care that we provide and help our staff to come on this journey with us.

3.5 We will be moving away from reactive, hospital-based treatment where we can, towards proactive healthcare for the people of Lincolnshire. We intend to deliver continuously improving value for money high quality services delivered by skilled and passionate staff across the whole Trust.

3.6 Our five year strategy sets out our purpose and vision:

Our purpose

"We are here to deliver the most effective, safe and personal care to every patient through our team of safe, skilled, compassionate, dedicated and valued staff."

Our vision

"We will provide excellent specialist care to the people of Lincolnshire, and collaborate with our local partners to prevent or reduce the need for people to be dependent upon our services."

3.7 To ensure the delivery of our vision, we have shaped our ambitions with our staff, volunteers, patients and key stakeholders. Through our new approach to strategic planning this year, we have identified an additional ambition to reflect our health and care system partners, and the delivery of our future care system.

3.8 We want to be aspirational, celebrate the talented staff that we have, and be recognised for being a learning organisation where we encourage innovation and continuous improvement. To demonstrate how we will deliver our vision, we have set the following four ambitions:

- **Our Patients:** Providing consistently safe, responsive, high quality care.
- **Our Services:** Providing efficient, effective and financially sustainable services.
- **Our People:** Providing services by staff who demonstrate our values and behaviours.
- **Our Partners:** Providing seamless integrated care with our partners.

3.9 Our values have been designed by our staff, volunteers and patients and they are underpinned by our staff charter and our personal responsibility framework, which set out the expected behaviours of our staff. Our values are:

- **Patient-centred:** Putting patients at the heart of everything that we do, listening and responding to their needs and wishes.
- **Safety:** Following ULHT and your own professional guidelines. Speaking up to make sure patients and staff are safe from harm.
- **Excellence:** Striving to be the best that we can be. Innovating and learning from others.
- **Compassion:** Caring for patients and their loved ones in ways we would want for our friends and family.
- **Respect:** Behaving and using language that demonstrates respect and courtesy of others. Zero tolerance to bullying, inequality, prejudice or discrimination.

3.10 Our vision has high quality patient-centred care at the heart of everything we do. We want to build a reputation for being a learning organisation supported by Centres of Excellence. We want to encourage our staff and patients to develop ideas for improving the way we deliver our services, ensuring that we are valuing our patient's time.

3.11 We have taken a different approach to identifying our priorities and agreed on our most important improvements we have to make. We have set some longer-term, very ambitious, objectives, which will be the focus of our improvement energies. To deliver our ambitions, we have set the following seven objectives:

- **Deliver harm free care.**

- **Value our patients' time.**
- Have **'zero waits'** to access our services.
- Ensure that our services are **sustainable** on a long-term basis i.e. here to stay.
- Have a **modern and progressive workforce.**
- Work as **one team.**
- Make sure that the care given to our patients is seamless between ULHT and other service providers through better **service integration.**

3.12 To support the delivery of our ambitions and objectives, we have also set strategic and tactical priorities. We have 8 strategic priorities:

- Learning and safety culture
- Estates and facilities
- Financial recovery plan
- Digitalisation
- Future workforce
- One team
- Quality Improvement Programme
- Partnership working – Integrated Community Care (ICC) in Lincolnshire

3.13 There have also been key developments over the last year to design and deliver our new Trust Operating Model (TOM). The TOM 'go live' date was set early in the programme as the 1st April 2019. This has been a complex, inclusive programme, which has aimed to:

- Move to a new operating model to reduce the tensions that pull service areas into meeting day-to-day activity, at the expense of delivering and driving the transformational changes needed to meet our 2021 vision.
- Strengthen roles and review team structures, which has led to the restructuring of the x15 Clinical Directorates into x4 Divisions, with triumvirate models, supported by x13 Clinical Business Units and 40 Clinical Services has directly affected just over 100 posts.
- Reconfirm governance new ways of working arrangements.
- Develop staff to address cultural issues.

3.14 Whilst the redesign of our clinical services is dependent upon the wider health and care transformation, through our Sustainability and Transformation Partnership,

reshaping our operating model is our response to facilitating teams deliver the day-to-day activity whilst driving the transformational changes needed to meet our vision.

3.15 We have been continuing to deliver improvements through our five transformational change Improvement Programmes, which have been overseen by our 2021 Programme Board. Together with finalising and refreshing our key enabling strategies to align our strategic intentions across the Trust.

3.16 All these contributions have been aligned to the development of our five-year strategy, which is attached at **Appendix A**.

3.17 It is important to note that our Patient Representatives have played an important part in writing the five-year strategy.

Communication Plan

3.18 There has been a refreshed communications approach to support the re-launch of the five-year strategy and share our vision for ULHT with our staff and public, together with celebrating what we have achieved so far.

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Our journey to excellence

ULHTs five year strategy

2019 - 2024

Contents

Foreword

Jan Sobieraj, Chief Executive

Welcome to this five-year strategy, which sets out our intentions to strive for excellence in all that we do. I would like to take this opportunity to thank everyone for their involvement in shaping this strategy for the Trust, and for their continued hard work, which is so valuable to our patients.

I want us to be recognised for being a learning and improving organisation, which will be supported by our new Medical School and being a National Centre for Rural Health and Care. Developing this strategy has involved:

- Asking our staff, patients and key stakeholders what and how things need to change to deliver our ambitions to strive for and consistently deliver excellent patient care.
- Bringing together local plans that are shaping integrated health care system working.
- Identifying opportunities to make better use of our existing resources and facilities.
- Prioritising our focus on improving the quality of our services for our patients.

This strategy outlines a range of improvements, which will allow us to achieve our vision and ambitions:

- **Our patients** - providing consistently safe, responsive, high quality care.
- **Our services** - providing efficient, effective and financially sustainable services.
- **Our people** - providing services by staff who demonstrate our values and behaviours.
- **Our system / partners** - providing seamless integrated care with our partners.

Our patients, their carers and families are at the heart of everything we do. Our relationship with them is very important to us, and we will continue to act on their advice and experiences to ensure that they play a key role in working with us to plan and improve the way we deliver our services. Together, we can strive for excellent patient care and experience.

Elaine Baylis, Chair

We want our patients to receive consistent, high quality care across all of our hospitals.

We will be working closely with our health and care system partners to bring together new ways of working that will lead to the redesigning of some of our clinical services. This strategy sets out our journey to excellence, so that we can all be part of achieving our vision.

Our improvement programmes outline how we will deliver excellence through affordable and sustainable transformational change. These improvements will support our operational model by building capacity and capability. We will be developing centres of excellence at each of our sites through delivering our clinical strategy.

We want to support our staff to be innovative and deliver improvements. We know that to achieve this we must give our staff the skills and opportunities they need to learn and grow and this will be supported through our improvement faculty.

Our values underpin everything we do, which will be brought to life through demonstrating the behaviours set out in our staff charter. We want our staff to feel part of one team no matter which area or site they work in.

We will be focusing on making changes on the ground, and the benefits that these will bring to our patients through improving the quality of our services with staff who are proud to work for the Trust.

Part one: Shaping our future

1. Our five-year strategy

This five-year strategy sets out our journey to excellence. We want to be recognised for providing consistently high quality patient-centred care. We will focus on valuing our patient's time and work alongside our staff and patients to develop ideas for continually improving the effectiveness and efficiencyiy of how we deliver our services. We want to build a reputation for being a learning and improving organisation, which has centres of excellence in some key clinical areas.

1.1 Outlining our journey

This strategy sets out our journey towards excellence, with 2021 being a key milestone. We will put our patients right at the centre of everything we do. We want to clearly outline the changes we need to make, together with our wider health and care system, to continuously improve the quality and safety of the care we provide. This strategy sets out our intentions which we will support our staff to come on this journey with us, to build a reputation for being a Trust that we are all proud of.

We will be moving away from reactive, hospital-based treatment where we can, towards proactive healthcare for the people of Lincolnshire. We intend to deliver value for money services that are continuously improving by skilled and motivated staff working together as one team across the whole Trust.

1.2 Who we are

United Lincolnshire Hospitals NHS Trust (ULHT) provides a comprehensive range of hospital-based services to the people of Lincolnshire from four main sites:

- Pilgrim Hospital, Boston
- Grantham and District Hospital
- Lincoln County Hospital

- County Hospital, Louth (part of Lincolnshire Community Health Services NHS Trust)

There are also three additional hospitals where we provide some services:

- John Coupland Hospital, Gainsborough
- Skegness and District Hospital
- Johnson Community Hospital, Spalding

In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients, over 140,000 inpatients and deliver over 5,000 babies. We provide a broad range of clinical services including planned care, specialist stroke, vascular and cardiac services, community population screening and emergency care.

1.3 How we organise ourselves

We face significant challenges from providing consistent quality of care, demonstrating value for money and workforce planning:

- Our most recent CQC inspection report moved our rating from ‘inadequate’ to ‘requires improvement’. However, we are currently in both quality and financial special measures.

- We have one of the largest financial deficits in the English NHS having ended the 2018/19 financial year with a deficit of £88.2 million. We have agreed a £70.3m deficit for 2019/20 financial year, which includes an agreed delivery of a £25m financial efficiency programme (FEP).

- We struggle to recruit to some of our specialist job roles across the organisation, which leads to an over-reliance on expensive agency staff.

- Safety issues have resulted in high-cost renovation of our estates and whilst this has led to improvement, it does restrict our spending in other areas.

We have moved to a new operating model from April 2019, which has reshaped our clinical directorates and moved to four

divisions. The key aim of this operational model has been to reduce the tensions that pull services into meeting day-to-day activity, at the expense of delivering and driving transformational change to meeting our longer-term vision.

The following table provides an overview of our organisational divisions and clinical services:

Division	Clinical business units	Clinical services	
Family Health	Women's health and breast services	• Breast • Obstetrics	• Gynaecology
	Children and young person's	• Paediatrics	• Neonatology
Clinical Support	Diagnostics	• Endoscopy • Respiratory physiology • Neurophysiology • Audiology • Radiology	• Nuclear medicine • Clinical engineering • Radiation protection and radiation physics • Screening services
	Therapies and rehabilitation	• Rehabilitation medicine • Occupational therapy • Speech and language therapies	• Dietetics • Physiotherapy
	Pharmacy	• Pharmacy	
	Outpatients	• Access, booking and choice • Health records	• Outpatients
	Cancer	• Haematology • Oncology/radiotherapy palliative care	
Surgery	Surgery	• General surgery • Vascular	• Urology • Head and neck
	Trauma and orthopaedics and ophthalmology	• Orthopaedics • Ophthalmology	• Orthoptics
	Theatres and critical care	• Theatres • Critical care	
Medicine	Urgent and emergency care	• A&E • Acute medicine	
	Cardiovascular	• Cardiology (including cardiac physiology) • Stroke • Endocrinology	• Diabetes • Renal
	Speciality medicine	• Dermatology • Rheumatology • Neurology	• Gastroenterology • Respiratory • Health care of the older person

Supporting this operating model are clear ways of working, which set out our approach to decision making through clear governance, quality, performance, financial and workforce management. This is further supported by our organisational development approaches to building capacity and capability in our staff to deliver improvements. We want to move to a more devolved structure, so that the responsibility for decision-making is closer to where the issues are in divisions.

1.4 The national, regional and local context

The context within which we deliver services includes:

- Lincolnshire is the second largest county in England and currently ranks 18th in terms of the overall population. However, it has a very low population density of just 155 people per square kilometre.
- As a rural county with an extensive coastline, the population is subject to seasonal fluctuations caused by holidaymakers. This puts further stress on services that are in places already stretched.
- Our population is currently increasing faster than the rest of the East Midlands or the national average, and is predicted to grow by 16% within the next 20 years.
- There is a declining younger population and a growing older population, which not only changes the needs of our patients but also the frequency of medical consultation required.
- Public transport in Lincolnshire can be restrictive on people's ability to attend our major hospitals, which is why we are currently working with our partner organisations to develop more localised centres of access where possible.
- The infant mortality rate in Lincolnshire is 3.2 deaths per 1,000 live births, which is lower than both the East Midlands and English averages.
- There are some areas of Lincolnshire that are ranked amongst the most deprived in the country, and others that are ranked amongst the least deprived.

We provide a wide range of services at different sites across Lincolnshire, but also in neighbouring counties. Our services form part of the wider health and care system in Lincolnshire, which is under pressure, requiring us to play a key role in making our services more sustainable and reduce the demand on our acute services, through more community-based services.

The following are key local influences for changing the way we will provide health and care services across Lincolnshire:

- Lincolnshire Sustainability and Transformation Partnership
- The Acute Service Review
- The four Lincolnshire Clinical Commissioning Groups

National strategy and policy directives also apply to the whole health and care system in Lincolnshire which include:

- NHS Long Term Plan – setting out the next 10 years for the NHS
- Carter Review - reducing waste through improving standardisation
- CQC strategy - developing a single view of quality
- NHS Improvement Use of Resources – assessments aimed at helping patients, providers and regulators understand how effectively trusts are using their resources
- National Information Board (NIB) report – progress on improving healthcare using data and technology

2. One team

Our patients are at the heart of everything we do. We want to be an organisation that is recognised for living our values which will be demonstrated through everything we say and do. We want to build on our pride to be such a valuable part of the health and care system of Lincolnshire, working together as one team to provide consistently safe quality care.

2.1 Our values

As a Trust, we want to be recognised for providing consistently safe high quality care for our patients across all our services and sites. We are committed to listening and learning from staff and public feedback to continually improve our services and this will be demonstrated through the positive patient experience of the care they receive.

We want to be able to demonstrate that we are living our values. Our staff, volunteers and patients have developed these. They will shape our behaviours, which are clearly outlined in our staff charter and our personal responsibility framework. Our values are:

- **Patient-centred** - putting patients at the heart of everything that we do, listening and responding to their needs and wishes.
- **Safety** - following ULHT and your own professional guidelines. Speaking up to make sure patients and staff are safe from harm.
- **Excellence** - striving to be the best that we can be. Innovating and learning from others.
- **Compassion** - caring for patients and their loved ones in ways we would want for our friends and family
- **Respect** - behaving and using language that demonstrates respect and courtesy of others. Zero tolerance to bullying, inequality, prejudice or discrimination.

Our values will form part of our recruitment, our staff appraisals and our organisational development across the Trust. Consistently demonstrating that we are living our values will also show that we are ‘one team’ with a shared focus, delivering services that our communities and we are proud of.

3. Our vision and ambitions

We have developed our ambitions through extensive consultation, with our staff, volunteers and patients. As part of our planning process, we have developed our purpose and vision statements, together with our objectives, strategic and tactical priorities to help us deliver our ambitions.

3.1 Our purpose

We are here to deliver the most effective, safe and personal care to every patient through our team of safe, skilled, compassionate, dedicated and valued staff.

3.2 Our vision

We will provide excellent specialist care to the people of Lincolnshire, and collaborate with our local partners to prevent or reduce the need for people to be dependent upon our services.

3.3 Our ambitions

To ensure the delivery of our vision, we have shaped our ambitions with our staff, volunteers, patients and key stakeholders. We want to be aspirational, celebrate the talented staff that we have, and be recognised for learning and improving together.

To demonstrate how we will deliver our vision, we have set the following four ambitions:

- **Our patients** - providing consistently safe, responsive, high quality care.
- **Our services** - providing efficient, effective and financially sustainable services.
- **Our people** - providing services by staff who demonstrate our values and behaviours.
- **Our partners** - providing seamless integrated care with our partners.

3.4 Our objectives

We have identified our objectives to deliver our ambitions. These objectives will be delivered through our annual and operational plans and will be the focus of our improvement energies. The following are our seven objectives:

- Harm free care
- Valuing Patients time
- Zero waiting
- Sustainable services
- Modern and progressive workforce
- One team
- Service integration

These objectives reflect our collective desire to be excellent in rural healthcare. We will set a number of milestones and delivery plans with our Divisions and Directorates as part of our annual planning cycle. These objectives will be measured by the following metrics:

Objective	Measure	Baseline 2018/19	Metric 2019/20	Metric 2023/24
Harm free care	Mortality – HSMR	Within control limits	Within control limits	Within control limits
	Avoidable harm – safety thermometer	98.5%	99%	99%
Valuing patient's time	% patients seen at appointment time (within 15 minutes of appointment time)	33%	40%	75%
Zero waiting	Patients discharged within 24 hours of predicted discharge date	40%	45%	75%
Sustainable services	Delivery of financial plan		£70.3m deficit	Break even
	% of clinical services rated as 'delivering' or 'excellent'		Baseline year	
Modern and progressive workforce	Vacancy fill rate (all staff)	14.3%	12%	9%
One team	Recommended as a place to work (NHS Staff Survey)	41%	46%	63%
	Recommended as a place to receive care	47%	53%	72%
Service integration	% reduction in face-to-face contacts in outpatients		5%	33%

3.5 Our strategic priorities

To support the delivery of our objectives we have set the following eight priorities:

Learning and safety culture
Our vision is for all of our staff to be safety-conscious with a positive approach to systems, structures and processes. This means that we will develop an open and transparent culture, providing safe and positive environments to raise concerns. We aspire to be able to provide evidence of learning, sharing the lessons learned and changing practice as a result, which ultimately will result in the reduction or elimination of harm-causing events.

Estates
Our vision is for our estate to become safe and functional, enabling us to deliver modern healthcare and improved outcomes for our patients. We aim to:

- Develop a five-year plan to upgrade the overall condition of our estate, and reducing further deterioration.
- Produce an organisation-approved estates strategy, capturing clinical and service developments in accordance with the Trust's emerging clinical strategy and acute services review.
- Create energy infrastructure plans to upgrade the Trust's supply plant and equipment. Investment has already been secured to ensure improvements, through successful bids for Department of Health and Social Care grants and using interest free loans.
- Explore the feasibility of delivering 'new environments' (an estate that conforms to Health Buildings Notes). This includes joint venture/collaborative working with both private and public sector organisations.
- Rationalise our estate and generate capital from the sale of surplus land and assets, as well as improving the utilisation of space and prioritising clinical services.

Financial recovery plan
Our vision is to become self-sufficient in delivering change across the organisation, which in turn supports delivery of our savings programmes. Our goals are to:

- Deliver the 19/20 financial plan and the control total, which would allow the Trust to access the provider sustainability fund (PSF) and financial recovery fund (FRF) of £28.9m, reducing the 2019/20 deficit to £41.4m.

- Develop a detailed five-year financial recovery plan as part of the long-term financial strategy aligned with the NHS 10 Year Plan that enables the Trust to return to a financially sustainable position by the end of the 2023/24 financial year.

- Understand the structural deficit and work with the system and regulators to find a solution.

- Review fragile and unsustainable services.

- Significantly reduce unwarranted variation between our sites.

- Create business cases to support required capital investment work, along with system partners and NHS Improvement, to help us access available funds.

Digitalisation
Digitalisation will help us deliver our objectives by:

- Enabling harm-free care though the introduction of e-prescribing.

- Valuing patients' time by providing improvements to scheduling through a systems such as hybrid mail and TheatreMan.

- Ensuring zero waiting for patients by enabling more efficient processes and workflow.

- Providing sustainable services by ensuring immediate access to the right information so that the right decisions can be made (removing inefficient and potentially harmful paper-based processes).

- Being a modern and progressive workforce by providing 21st Century digitalised services in line with other organisations within the NHS.

- Becoming one team by enabling standardisation of systems and processes across the organisation as well as the smooth/safe transfer of care across organisational boundaries.

- Fully supporting service integration using system-wide initiatives such as HSCN, Care Portal and VPN.

Future workforce
The vision is to have a workforce that is affordable and working in new ways. This workforce would need to have a new and modern skill mix in order to deliver excellent patient care, and be motivated to perform at its best whilst delivering the Trust's values.

The Trust has agreed a new workforce plan, which demonstrates how the shape and cost of the workforce will change over the course of the next five years. This is driven, in the first year, by the need to reduce workforce costs, aligned to our overall savings programme. Over the next five years, we want to see realignment to new clinical pathways (with more care delivered in the community) and the introduction of new roles into the organisation. All this should be accompanied by work to maximise the productivity of the staff that we have.

One team
We want to break down barriers that prevent teams across our sites from operating as one team, by putting the patient at the centre of everything we do. We need to build a sense of hope and common purpose through engagement with the Trust's vision and values. We will build engagement with our staff through focusing on the four key drivers of engagement:

- Strategic narrative – the vision brand, ambitions, objectives and priorities
- Employee voice
- Effective leadership at all levels
- Organisational integrity – values and staff charter

Quality improvement programme
Our vision is to develop a culture of improvement and learning. We want to embrace and embed our quality improvement approach as part of delivering our transformational change in the organisation to deliver our vision. We want to build a culture of improvement and innovation that we can share across our services to deliver continuous quality improvement (CQI). Our goals are to:

- Develop expertise throughout the Trust on the use of and application of science for improvement (SOI) tools and techniques to deliver improvements to our patient's care. This will support the delivery of our vision and identified transformational

change programmes, together with supporting our staff at all levels in the Trust to deliver improvements that will improve patient care.

- Launching our CQI Faculty, being able to deliver in-house Quality Improvement (QI) programmes and NHS Improvement Accredited Quality Service Improvement and Redesign (QSIR) Practitioner programmes to support individuals and teams to deliver new and existing programmes, projects and initiatives successfully. Offering training, support, coaching and shared learning.

- Provide bespoke quality improvement programmes to individuals and teams to address improvement initiatives.

- Celebrating our successful delivery of improvements through sharing with the FAB Academy, and promoting improvements across the Trust.

Partnership Working – Integrated Community Care (ICC) in Lincolnshire
Our vision is to co-design our care pathways with Lincolnshire residents and the Lincolnshire health and care workforce, which will be our long-term view of what could be achieved in Lincolnshire:

- Our default is care, which will be delivered in the community unless there is a clinical need or economic case for it to be delivered in an acute hospital setting.

- The frame for delivery will be fixed points at neighbourhood levels across the system.

- Place will be used flexibly to ensure service provision makes sense.

- A framework of flexibility will be developed to ensure arrangements are in place to accommodate Primary Care Networks that do not align to neighbourhoods.

3.6 Why is this important?

The following section sets out some of the key issues that we have addressed through the delivery of this five-year strategy:

- We need to involve our patients in their own health care to enable them to have trust and confidence in the care that we provide.
- It is important that staff learn to see our services through the eyes of their patients and carers, who do not necessarily recognise organisational boundaries, to make improvements.
- We want to build a culture of quality and safety, where all patients and their carers are treated with respect and compassion.
- We want to be open and transparent with our patients, providing care shaped around their individual needs.
- We want all visitors to our hospitals to have a positive experience, where they feel that they have been given the right information and have been involved in making decisions about their care, support and recovery.
- To develop a financially sustainable Trust we must build a reputation for providing quality services, where there are no variations between sites and services.
- We will need to demonstrate improvement if we are to meet national and local targets and therefore access further funding/income. This will increase the viability of essential services and reduce any threat of closure due to unsustainable funding.
- There is a need to produce a balanced budget through the close monitoring of actual spending against budget for each of our services.
- Our people are our greatest asset and we want the Trust to be a place where they are proud to work, and which is recognised publicly.
- We want to celebrate the commitment and professionalism of our people.
- We want to support the development of talent, innovation and leadership in the delivery of our vision.
- We want to support our people to develop a ‘one Trust’ culture that reflects our values and behaviours outlined in the staff charter.

- We want to demonstrate that as an employer we reflect the communities that we serve by our approach to inclusion and engagement.

- We want to attract and retain talented people.

- We want to continue to deliver our people strategy to develop flexible ways of working that allows people to maintain a healthy work-life balance and nurtures opportunities for career development.

- To build the capacity and capability to deliver the 2021 strategy, we need to be in a position to be able to change.

- To create an efficient and effective health care system across Lincolnshire, we will need to work collaboratively with our health care partners.

- The health care system in Lincolnshire and nationally is evolving, moving many services away from hospitals to become more community based. ULHT will need to demonstrate good management of the demand on resources if it is to become financially sustainable and respond to the need for acute hospital provision.

Our five-year strategy sets out how we will monitor the delivery of our ambitions and the strategic priorities. Our Delivery Plan is outlined in **Appendix 1**.

Part two: Striving for excellence

4. Our hospital site visions

We have been working on our hospital site visions, so that everyone is clear on the direction we are taking to redesign the way we deliver our services. Our clinical strategy sets out the detail of our clinical redesign, which also aligns to the Acute Services Review (ASR), part of the Lincolnshire Sustainability and Transformation Partnership (STP). All changes will form part of our public consultation.

4.1 Pilgrim Hospital, Boston

"A modern district general hospital with a focus on emergency care and specialist surgery"

We want to make Pilgrim hospital a centre of excellence for complex elective (planned) surgery. Including the use of new and innovative state-of-the-art technology, which includes robotic surgery.

In addition, Pilgrim is only one of four hospitals in the country to be utilising an Integrated Assessment Centre (IAC), which is helping to transform its urgent and emergency care services.

Non-elective care:

- Urgent treatment centre:
    - Integrated workforce model (Acute/GP/community) and ambulatory care
    - ULHT A&E consultant input
- Emergency department
- Paediatric assessment unit
- Acute medicine inpatient and outpatient services.
- Trauma and orthopaedics.
- Emergency surgery – all specialities

Elective specialised services:

- Elective inpatient and same day case surgery (cancer and non-cancer) for:
  - General surgery, ENT, urology, head and neck, ophthalmology, gynaecology, breast, orthopaedics (patients needing ITU or not well enough for Grantham)
- Consultant-led obstetrics, neonatal and gynaecology service
- Midwifery-led unit
- Consultant-led paediatric assessment and outpatient service
- Lincolnshire vascular service

Elective care:

- Diagnostics, including endoscopy, radiology imaging, interventional radiology, cardiology advanced diagnostics
- Lincolnshire digestive diseases service (gastroenterology)
- Medical specialities (rheumatology, endocrinology, neurology), diabetes (inpatient), dermatology (inpatient)
- Day case chemotherapy service
- Day case medical unit
- Therapies (occupational therapy, physiotherapy, dietetics)
- Outpatient clinics for multiple specialties

4.2 Grantham and District Hospital

"A local urgent care and surgical centre"

Our innovative integrated workforce model for Grantham will, transform it into a 24/7 urgent treatment centre. Including acute, GP, community and ambulatory care. Up to 56 medical beds will also be available, meaning that the vast majority of patients seen at Grantham will continue to be treated there.

Day case and inpatient surgical activity will also continue for: orthopaedics, general surgery, urology, gynaecology, ophthalmology, ear, nose and throat (ENT) and a range of diagnostic services.

Non-elective care:

- Urgent treatment centre with:
  - Integrated workforce model (acute/GP/community) and ambulatory care
  - ULHT A&E consultant input
  - ULHT consultant medical physician support to ambulatory care

Medicine:

- Medical inpatient beds (up to 56 beds)
- The vast majority of patients currently seen and treated at Grantham will continue to be seen and treated there

Surgery:

- Day case surgical activity for orthopaedics, general surgery, urology, gynaecology, ophthalmology, ENT and others

Elective and diagnostics:

- Diagnostics, including endoscopy, radiology imaging, cardiology advanced diagnostics
- Therapies (occupational therapy, physiotherapy, dietetics)
- Outpatient clinics for multiple specialties
- Mobile chemotherapy service
- All inpatient orthopaedic elective surgery at Grantham (except patients needing ITU and patients not fit for Grantham)
- Single trust wide rota for orthopaedics

4.3 Lincoln County Hospital

"A modern district general hospital with a focus on emergency care and cancer"

We want Lincoln to remain our biggest emergency department. To provide consolidated hyper-acute and acute-stroke services and cardiac care in highly regarded, state-of-the-art Lincolnshire Heart Centre. To provide all one-stop diagnostic and surgical treatment for breast services, elective and same day case surgery, ENT, urology, head and neck, ophthalmology, gynaecology, breast and orthopaedics.

Non-elective care:

- Urgent treatment centre:
  - Integrated workforce model (acute/GP/community) and ambulatory care
  - ULHT A&E consultant input
- Emergency department – ULHT led
- ITU/critical care level 3
- Consolidated hyper-acute and stroke services for Lincolnshire
- Lincolnshire Heart Centre
- Acute medicine inpatient and outpatient services
- Trauma and orthopaedics
- Emergency surgery - all specialities
- Paediatric consolidated inpatient (emergency and elective) service for Lincolnshire

Elective specialised services:

- Lincolnshire (consolidated) breast service (all one-stop diagnostic and surgical treatment)
- Consultant-led obstetrics and gynaecology service
- Midwifery-led unit
- Consultant-led paediatric and neonatal service
- Paediatric inpatient surgery
- ITU/critical care level 3
- Lincolnshire inpatient haematology and oncology centre for (non-elective and elective including chemotherapy)
- Lincolnshire Heart Centre
- Lincolnshire radiotherapy centre
- Lincolnshire specialised rehabilitation medicine level 2a (complex brain, trauma and neurological patients (elective and non-elective)

Elective care:

- Elective inpatient and same day case surgery (cancer and non-cancer) for general surgery, ENT, urology, head and neck, ophthalmology, gynaecology, breast, orthopaedics (patients needing ITU or not well enough for Grantham)
- Lincolnshire digestive diseases service (gastroenterology)
- Medical specialities (rheumatology, endocrinology, neurology, diabetes (inpatient), dermatology (inpatient)

- Day case chemotherapy service
- Day case medical unit
- Therapies (occupational therapy, physiotherapy, dietetics)
- Outpatient clinics for multiple specialties
- Diagnostics including endoscopy, radiology imaging, interventional radiology, cardiology advanced diagnostics

4.4 County Hospital, Louth

“A centre for day case surgery and diagnostics”

County Hospital, Louth is not a ULHT hospital, however, Louth hospital remains an integral part of our plans for the future and will continue to provide vital ULHT services including day case surgery for urology, ophthalmology and gynaecology. Outpatient clinics and diagnostic services will also be provided for selected specialities.

- Outpatient clinics for selected specialities
- Day case surgery:
  - Urology
  - Ophthalmology
  - Gynaecology
- Diagnostics

4.5 Other sites

It is expected that a range of ambulatory services, predominantly outpatient services, will also be provided at locations around the county to make them more accessible to local communities. The activity assumptions included in the STP state that by 2022:

- Outpatient activity at ULHT will reduce by 21%.

- Presentations to the emergency departments will reduce by 27.5%.

- Non-elective care will reduce by 12%.
- Elective activity will reduce by 10%.
- Some activity is anticipated to stop, due to care in the community being stepped up.

Some activity will be delivered differently, including care at sites other than our hospitals and the urgent care centres that stand at the front of our emergency departments.

5. Thinking as a healthcare system

We are embracing working together as a system at both a local and national level. There is clear recognition that if whole system change does not happen, it will be detrimental to patient care and the health of the population.

5.1 Lincolnshire's health and social care challenge

Lincolnshire's STP plan clearly outlines the financial and performance reasons for why health and care services need to change, as well as the views of our population which have been gathered over the past few years through active engagement. The case for change shows that:

- Key NHS standards are not being met.
- 2,000 planned operations are cancelled every year.
- In 2018/19, the Lincolnshire healthcare system spent £110m more than it received in funding.
- Too much money is spent on treating people in hospital, rather than on prevention and early intervention to support people in the community and prevent acute care needs.
- The current 'do nothing' scenario for Lincolnshire health and social care organisations is predicted to generate a £182m deficit by 2021 (providers and commissioners). Within the acute sector, there is a predicted 13% growth requirement.

5.2 Achieving clinical and financial sustainability

Sustainability is only achievable at scale, across the whole health and care system, not at individual service levels. Over the last year, local senior leadership forums such as the Lincolnshire Coordinating Board (LCB), the Joint (shadow) Commissioning Committee, and the System Executive Team (SET) have all agreed to a system-wide approach to service change.

Consequently, the Lincolnshire STP plan has been developed, which sets out five system themes that are planned to support £136 million in financial savings across the county focussing on clinical redesign, capacity optimisation, operational efficiency, workforce productivity and redesign and right care/commissioning priorities.

Overall, there is a critical focus on a shift to support patient pathways that are more preventative and community-based. These changes, and governance surrounding shared decision-making and accountability will be managed through the LCB, Joint Commissioning Committee, and SET. The ambition is to reduce hospital activity through moving more care into the community.

5.3 Lincolnshire Acute Services Review (ASR)

Our commissioners spend the biggest part of their budgets on acute care, and the majority of acute activity within Lincolnshire is delivered by ULHT. The viability and long-term sustainability of services within ULHT is therefore critical to the wider long-term sustainability of Lincolnshire's NHS.

The configuration of acute services within Lincolnshire must be clinically, operationally and financially sustainable to deliver safe, efficient, effective and high quality services to the local population. The ASR is a review of acute services across the county, which has been undertaken as part of the wider STP plan.

The ASR has focused on eight clinical services, considered to have the strongest and compelling case for change:

- Breast services
- Haematology and oncology
- Stroke services
- General surgery
- Trauma and orthopaedics
- Obstetrics, paediatrics and neonatology
- Urgent and emergency care
- Medical services

It has been acknowledged that the current STP plan is not ambitious enough to address quality, staffing and financial challenges across the system. The ASR has focused on making sure acute hospital provision across Lincolnshire is adequate to address both

the growing demand across the county and the need to achieve the ambitions of the STP plan. The review has considered current and projected future needs for hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care. The aim has been to make a set of recommendations on the optimal configuration of acute services across Lincolnshire. Any significant changes to services as a result will be fully consulted upon in public and could take a number of years to become a reality.

The ASR has brought together commissioners and providers across the county to answer the question posed by the Lincolnshire Coordinating Board:

> **"What is the optimum configuration of ULHT services (and the role of neighbouring acute trusts), in order to achieve a thriving acute hospital service in Lincolnshire (and for the population as a whole) achieving clinical and financial sustainability across the Lincolnshire NHS health economy?"**

This work gathered specialty-specific information from across ULHT to establish the case for change and evaluate potential alternatives. In parallel, there has been the development of a whole system model to assess the impact of different options on activity, finance and patient access.

There are a number of challenges across the local health and care economy that have been addressed and considered as part of this review:

- Patient pathways across Lincolnshire are very hospital dependent, putting pressure on all acute provision across the county.
- There is clinical variation across providers, including across sites within providers, impacting on patient care and outcomes.
- There are significant workforce challenges both current and future, including low staff morale, low productivity, staff shortages and impending future skills shortages.
- Inefficiencies exist as there is duplication in services even across sites within providers, some services are sub-optimally sized and/or distributed over a large geographical footprint.

5.4 The Integrated Community Care (ICC) Programme

Lincolnshire NHS' Integrated Community Care (ICC) programme of work has been introduced to the public through the Healthy Conversation 2019 campaign. The default methodology is that care will be delivered in the community unless there is a clinical need or economic case for it to be delivered in an acute hospital.

The supporting detail will be developed through a co-production phase we are soon to embark on with staff, the public, our patients and their representatives from across the county. The objective of this phase is to create a future model of care that sustainably improves patient safety, experience and outcomes.

6. Being finanically stable

6.1 Overview

The Trust was placed into financial special measures by the regulator NHS Improvement (NHSI) in September 2017. As part of this agreement, we initially appointed and worked with a turn-around director, lately a financial advisor. In addition, the Trust has engaged external specialist services to provide support and expertise to enable sustainable financial improvement.

In 2018/19 the Trust did not accept the total deficit it had been asked to meet for the year (control total). The Trust submitted a planned deficit for 2018/19 of £74.7 million highlighting approximately £13 million of risk to delivery of the plan. Working with the financial advisor, the Trust reforecast the 2018/19 outturn and developed a financial recovery plan (FRP) over an 18-month period, incorporating the final six months of 2018/19 and the entirety of 2019/20. This remodelling projected:

- A 2018/19 year-end position of £89.4 million deficit, inclusive of delivery of a £15.1 million financial efficiency programme (FEP). The Trust delivered a deficit of £88.2 million at year-end.

- A 2019/20 year-end position of £75.2 deficit, inclusive of delivery of a £25 million FEP.

In January 2019, the Trust received notice that it will be expected to meet a deficit of £70.3 million for 2019/20, which it has agreed to do albeit with some risks to delivery. Allowing for adjustments, this will require the Trust to reduce its planned expenditure in 2019/20 by approximately £1.5 million. Delivery of this total would allow the Trust to access approximately £29 million of additional funding through a combination of PSF, FRF and MRET monies, improving the reported outturn income and expenditure position to approximately £41 million deficit.

6.2 Financial efficiency programme

Acknowledging the magnitude of the FEP challenge in 2019/20 and beyond, the Trust has appointed a head of finance programme management office and a support officer. Upon entering financial special measures, the Trust set up the Financial Turnaround Group (FTG) that continues to meet fortnightly. It is attended by a multidisciplinary group, including the new divisional leads appointed through the Trust Operating Model (TOM). FEP delivery is underpinned by key programmes of work, covering:

- Workforce
- Productivity
- Procurement
- Operational

The FEP process, from saving/income generation idea to delivery, is supported by a full quality impact assessment (QIA) and milestone monitoring process, with leads identified and held accountable for delivery.

The Trust is working with system partners to maximise Lincolnshire-wide opportunities, including streamlining patient pathways and bringing activity back to Lincolnshire's hospitals where possible.

6.3 Long-term financial plan

2018/19 should be viewed as the base year and 2019/20 as year one of the long-term plan to deliver financial sustainability at ULHT.

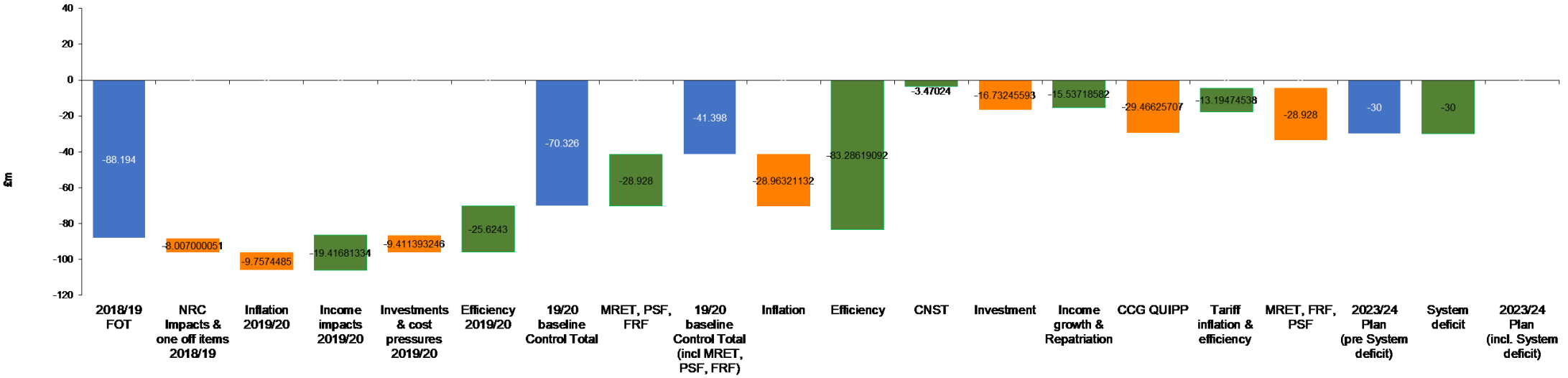
The long-term financial plan (LTFP) will map out the requirements needed to address a range of issues that affect the current financial position, including:

- **Staffing:** high level of agency staff and difficulty in attracting well qualified permanent staff.
- **Multiple sites:** three major hospitals that are at some distance from each other.
- **The estate:** different states of repair and the original structures limit the capability of some of our buildings to be used for modern patient care.
- **Lack of digitisation:** many documents are still paper-based and so restrict access at multiple sites when a patient moves from one consultant to another.
- **System deficit:** the Trust needs to clearly define the additional costs by specialty of providing services in Lincolnshire.
- **FSM:** exiting the FSM and therefore removing the interest and external support costs.
- **Operational efficiency:** the Trust needs to continuously deliver a year-on-year FEP of a minimum of £19 million to maintain its financial position and allow investment in services.

The following graphic contains the five-year key assumptions that support the Trust achieving a breakeven position. There are a significant number of key assumptions that underpin the delivery incorporating inflation, investment and agency staffing reductions as examples. As part of the LTFM, there are also risks identified that would need mitigation in order to achieve the targets set i.e. fines and penalties.

The table shows:

- Key building blocks that cannot be changes or controlled (blue)
- Our spend (orange)
- Improvements or cost reductions to be made (green)



6.4 Capital

The Trust has very limited internally-generated capital resources to invest in its sites and services. Due to the ageing nature of the estate and equipment the majority, if not all, of this is directed at statutory compliance and replacement.

Due to the fire enforcement notices served at the Pilgrim and Lincoln sites in 2017, the Trust was required to borrow approximately £40 million of capital from the Department of Health, and paying it back has further reduced the capital funds at the Trust's disposal.

We have an ambitious digital strategy, and as part of the Lincolnshire STP we are considering opportunities to configure acute services in the county. Both will require capital investment.

The Trust is working with Lincolnshire healthcare partners and NHS Improvement to review opportunities to maximise the availability of capital funding. This will be key to the Trust modernising its services and improving its financial position.

Part three: Delivering excellence

7. Our improvement programmes

We have been making progress with the changes we need to make through our improvement programmes. Each of these programmes are led by an executive team member, and directly contributes to the delivery of our five-year strategy.

7.1 Improvement programme focus

We have five improvement programmes which are delivering our transformational changes, they are:

Our vision	Our improvement programmes	Our outcomes
We will provide excellent specialist care to the people of Lincolnshire, and collaborate with our local partners to prevent or reduce the need for people to be dependent upon our services	Improving quality and safety	We will focus on having the right numbers of staff, preventing infections, developing a culture of safety
	Saving money and improving our environment	We will be smarter, saving money and modernising our buildings
	Redesigning our clinical services	We will make sure patients will get the right care, first time
	Delivering productive services	We will deliver great patient experiences by improving our systems and processes
	Developing the workforce to meet our future needs	We will retain and recruit more staff. Staff will be trained, healthy and supported

8. Improving quality and safety improvement programme

We are seeking to develop a culture of safety within our Trust, so that everybody who attends our hospitals can enjoy a positive care experience. We have a comprehensive quality improvement plan which delivers improvements in safety and quality across the Trust.

Why is it important?

- We want our patients to have the best outcomes possible, cared for in areas with safe staffing levels and good quality-infection control practices.
- We want to continue involving our whole community in improving our services.
- We want to continue working collaboratively with our partner organisations to ensure that we meet the needs of all members of our community.

What we will do:

- Listen to staff, so that through their experiences they can help us shape a better service.
- Engage a team to review all negative comments on patient surveys.
- Encourage staff to help us meet the outstanding markers for safety outlined in the CQC inspection toolkit.
- Share positive experiences from within our Trust.
- Encourage staff to bring forward ideas that will improve standards without impacting negatively on our finances.

The outcomes we hope to achieve:

- High quality services have fewer incidents, and when they do happen we will share our learning to reduce future events.
- High quality services will be reflected in positive responses to patient surveys.
- We will improve the response times to patients experiencing difficulties in the hospital through high quality training.
- We will encourage staff to become involved in the development of standards and change programmes, so that they feel listened to and valued. This will be revealed in appraisals and staff surveys.
- Training needs identified by staff in the appraisal programme will result in appropriate development.
- Staff can access training to help them deliver the outstanding level of care we want to give to our patients.
- We will have, from staff, a clear picture of how our limited resources are used.
- We will work together to prioritise the use of our limited resources to make best use of them.
- Our response to the additional needs of patients with mental health conditions will be both swift and compassionate, thanks to improved communication between ULHT and partner organisations. This will be revealed by positive responses to the Trust Friends and Family Test.
- Processes for the escalation of issues and risks will be clear.
- We will ensure opportunities for development for all staff.

9. Saving money and improving our environment improvement programme

We are seeking to become more efficient and effective in the use of our resources so that we are able to deliver consistently high quality patient care. We are also seeking to develop our estate to support our services and provide a safe working environment for all our staff.

Why is it important?

- We must achieve our agreed financial total for 2019/20 (financial control total) if we are to access additional funding that will enable us to provide sustainable services.
- We must adapt to the changing needs of our communities.
- Our estates must be maintained safely, as described in CQC inspection standards.

What we will do

- Establish a long-term financial strategy, which sets out revenue and capital requirements linked to all improvement programmes and the STP plans, enabling us to achieve financial targets.
- Develop a procurement strategy that will maximise opportunities for efficiency.
- Develop a long-term financial model to forecast requirements and enable us to build financially-sustainable clinical services.
- Put in place a year-on-year financial efficiency programme to support and improve patient care as well as deliver savings.
- Use tools such as the Model Hospital and Patient Level Costing to benchmark efficiency opportunities.

- Establish a programme of governance and monitoring that will ensure continual review.
- Reduce the risks presented by our aging estate, thereby meeting legal and statutory compliance requirements whilst maintaining continuity of service.
- Modernise our estate, as part of our clinical strategy, helping us to improve patient experience and outcomes.
- Strive to maximise efficient use of our estate in accordance with both the Lord Carter and Naylor reports.
- Establish a programme of targeted estates projects, aligned with the sustainable management programme, that will helped us to reduce wasted energy and consumables.
- Maintain high standards of cleaning and nutrition to enhance patient comfort.

The outcomes we hope to achieve:

- All services will achieve financial balance, enabling ULHT to become a financially viable and sustainable organisation.
- Revenue and capital investments will be aligned with strategically planned organisational priorities.
- There will be an estates strategy that is linked to the clinical strategy.
- The sustainability performance, infrastructure safety and resilience of the estate will have improved.
- Patient and staff perception of the estate will have improved through the thoughtful management of development projects.
- Improved infection control metrics will have increased patient satisfaction on PLACE.

10. Redesigning our clinical services improvement programme

We are seeking to change our clinical services to align with the aspirations of the STP plans, and thereby improve efficiency and patient satisfaction. This programme will cover planned care, urgent and emergency care, women's and children's services, clinical support services and cancer pathways.

Why is it important?

- Working in partnership to achieve a significant change in the delivery of our hospital services, in order to keep people out of hospital and closer to home for longer.
- Working on redesigning our services to meet the future needs of our patients, ensuring that they are sustainable and deliver improved quality.

What we will do:

- Implement the ULHT clinical strategy (following consultation where needed, as a part of the STP).
- Implement actions identified as necessary/desirable by the clinical service review programme.
- Implement Getting It Right First Time (GIRFT) action plans.

The outcomes we hope to achieve:

- Improved clinical pathways, reducing the time taken from diagnosis to treatment, thereby enhancing patient experience.
- Services of the same type will be of the same standard wherever they are provided by ULHT.

- ULHT will match nationally-expected standards and key performance indicators.
- Significant improvements to the financial position of ULHT.

11. Delivering productive services improvement programme

We are seeking to be the healthcare provider of choice for our communities. We want to provide high quality, safe and sustainable services, which are designed to meet the changing needs of our patients. It is intended that this programme will help us to sustain and deliver acute services across Lincolnshire.

Why is it important?

- The Trust aspires to receive a CQC rating of 'good' for outpatients and 'outstanding' for theatres.
- To become a financially viable organisation, ULHT will need to become more efficient, optimising the use of both resources and staff.
- We need to streamline our processes for the benefit of our patients and to minimise boundaries between services.
- Improving our operational capacity will reduce the number of cancelled operations and reduce the number of patients that we are unable to discharge.

What we will do:

- Establish reviews of four key workstreams - acute care, cancer and planned care, diagnostics and portfolio review, with a view to improving standards and patient experiences.
- Undertake tactical/performance reviews with a focus on achieving operational and financial efficiency:
  - Theatre optimisation
  - Outpatient optimisation
- Develop a faster referral/booking response.

- Promote earlier diagnosis.

- Support the delivery of care in the right setting and reduce inequalities of access to services.

- Secure and maintain consistent compliance with national standards on key services including A&E, cancer, frail elderly, diabetes, maternity, paediatrics and mental health.

The outcomes we hope to achieve:

Capacity (outpatients)
- Reduction in follow-up appointments
- Stratified follow-up management
- Reduced backlog recovery trajectories
- Conversion of day case procedures to outpatient procedures
- Primary/community outreach service delivery

Capacity (elective theatre)
- Improved theatre utilisation
- Conversion of inpatient to day case procedures
- Improved primary/community outreach service delivery

Capacity (diagnostic)
- Increase diagnostic testing and reporting capacity
- Standardise care pathways to reduce variation
- Optimise the diagnostic capacity in primary care

Capacity and demand
- Improve planning for resilience at peak A&E times

Referral management
- Deliver the use of e-referrals and e-bookings

- Issue explicit referral guidance and an accurate directory of services.

Patient experience

- Reduce patient waiting times
- Improve the quality of the service given to patients
- Prevent avoidable hospital admissions/appointments
- Reduce the length of any hospital stay
- Reduce the number of cancellations experienced by patients

12. Developing the workforce to meet future needs

The overall scope of this improvement programme is to ensure that we have the right number of people in the right places with the right skill mix, attitudes and behaviours, being motivated to perform to the best of their abilities (at a price that we can afford) and engaged on patient safety.

Why is it important?

Delivering our vision through our people strategy has two strands:

- **Workforce and skills** - the need to change the shape of the workforce, together with stabilising numbers so that there is less reliance on agency and temporary staff, thereby increasing the productivity of existing teams.

- **Organisational development** - the need to engage our workforce around a future vision and a set of values that will define our culture.

Our workforce is made up of four groups of people, who are each important in their own way:

- Our permanent staff, including trainees, all of whom help to shape and support the vision of ULHT.

- Our temporary staff, who include agency workers who fill in for unpredicted staff absence and Bank staff who are more aware of ULHT routines and practices.

- Our volunteers, who freely give of their own time to support the work of ULHT.

- Our carers who support the wellbeing, both physical and mental, of our patients.

To deliver our vision, we need to significantly change the way we organise and deliver our services. This will involve us managing the budget whilst developing a workforce who will be equipped with the skills and resources to meet the expectations of our patients.

What we will do:

- Work with our teams of people to involve them in shaping our services for the future.
- Strengthen the sense of 'one team', 'one workforce', 'one Trust' - embracing all staff on all sites where we operate.
- Enable everybody to have a voice that will be acknowledged, and making sure staff feel that their contribution is valued.
- Recognise the strengths of individuals and help them to fulfil their potential through the appraisal process.
- Through continued professional development (CPD), ensure that all staff are aware of and exercise best practice standards in patient safety.
- Involve the workforce in developing the vision for the future and share it with all staff to increase confidence in the journey that we are making.
- Involve staff in reviewing the progress of the work programmes and adjusting them as appropriate.
- Involve all staff in achieving the objectives set out in the STP, through appraisal and break-out groups.
- Involve our staff in making more effective and efficient use of skills and capabilities of our people. For some, this will involve from acute to community care.
- Engage in a technology training programme and review the use of technology.
- Train staff in prevention and the treatment of the whole person.
- Support our staff to own and deliver improvements through our continuous quality improvement approach.

The outcomes we hope to achieve:

- A marked change in the shape of the workforce that supports the Trust's vision and STP vision.
- That staff are all engaged in a positive future vision in which they can have confidence.
- Safety training in place to ensure that staff in all areas of the organisation are compliant with national standards, with no areas of inconsistency.
- There is a culture of safety in all parts of ULHT.
- The values in the staff charter will be fully embedded in the culture of ULHT.
- Rebalanced workforce mix so that there are less agency/temporary staff, thereby helping us to achieve financial sustainability.
- Improved people management so that we are able to become a more productive workforce.
- There is a system in place for holding people to account for their work.
- There will be compassionate, inclusive leadership at all levels across ULHT.
- Staff will feel confident that their voice will be heard when they raise concerns.
- ULHT will be seen as equitable and fair in the way that we treat all of our people, thereby promoting the value of diversity.
- Staff feel empowered to innovate and make improvements.

13. Our supporting strategies

We have been ensuring that we link the delivery of our vision through all of our supporting strategies. These have been termed our suite of enabling strategies. Aligning our vision and ambitions through our enabling strategies will demonstrate delivery of our five-year strategy.

13.1 Our enabling strategies

Quality strategy
This strategy sets out our approach to ensuring that we deliver high quality care for the patients who use our services. It sets out how we will be putting patients at the heart of improving standards of care and safety. The ultimate aim of the quality strategy is to enable us to deliver the highest quality of healthcare in the country. Patients will be encouraged to become partners in their own care and should expect to find an ever-developing service, which is designed alongside them and meets their specific healthcare needs.

Clinical strategy
This strategy sets out the clinical transformation required for us to lead the development of integrated care closer to home. It outlines our move to consolidate specialist care on fewer sites where it improves outcomes and safety, and the advancement of improvements through service reviews and GIRFT improvements. We have been reviewing a range of options, working alongside clinical colleagues and key partners across our STP, where we are working in collaboration to provide services that achieve our site visions.

People strategy
This strategy has been refreshed to align to the Trust's revised strategic direction. A key focus has been to include workforce productivity, planning and development to ensure that we have the 'right number of people, in the right places, with the right skill mix, attitudes and behaviours, motivated and managed to perform at their best (at a price that we can afford) and engaged on high value care'.

It explores who we will continue to explore opportunities to innovate around recruitment. We also recognise that we want our staff to have a positive experience of working for the Trust, feeling supported by their managers to develop their potential and make

improvements to patient care. We will continue to improve our leadership and talent management work to support development at all levels, together with supporting managers across the Trust to manage more effectively. It also outlines how we will use workforce systems to streamline ways of working and capacity.

Inclusion strategy
Our vision is for inclusion to be a 'golden thread' running through all that we do and say in providing high quality patient-centred care for our population. This strategy sets out the objectives and outcomes for patients/service users, local communities, staff and our organisation. By delivering the objectives, we as a Trust will be able to evidence improvements in the compliance and performance with both our statutory and mandatory duties, together with demonstrating how a rich diverse workforce will promote our equality, diversity and inclusion agenda.

Financial strategy
This strategy sets out how we intend to achieve planned savings and more efficient ways of working that will enable us to move to a sustainable financial position. This will then allow us to invest in the development of our staff, services and estate.
Through the development of new models of care and the reduction in the demand for acute services across the health and care system, we aim to achieve a more financially sustainable position that will enable us achieve financial balance.

Digital strategy
This strategy will deliver the clinical systems, technology, information, resources and processes required to help us transform our clinical services and deliver the highest quality patient care. It outlines how we will provide secure online access in real time to accurate information for the right person in the right place, via a single portal that will be available on a choice of different devices to meet clinical needs. Using data and technology, we will transform outcomes for our patients as we move closer to becoming a paperless organisation. By digitising the records of our patients, they will be available whenever and wherever needed. In addition to this, an e-prescribing system will be implemented for both inpatients and outpatients across all sites, supporting the delivery of drugs on discharge and providing the relevant information to GPs.

Delivering high quality care will require accurate data to be at the heart of our transformation, enabling us to identify where new care is needed, what care is working well and what care needs to be improved. This will allow patients, clinicians and commissioners to compare the quality and efficiency of care in different parts of the organisation.

Estates strategy
This strategy recognises remodelling buildings and infrastructure will be paramount as services change. We will be working with architects and healthcare planners to take account of diverse stakeholders, new treatments and medical advances using evidence-based strategies, practical guidance, good practice and new tools for improving the design of healthcare space and layout. Building on the work that we have carried out so far, this will result in a sustainable estates strategy development control plan and programme delivery plans across all sites.

Research strategy
We recognise that the best quality care and outcomes can be achieved in an environment that inspires research and innovation. The ULHT ambition for research is to ensure that we feature nationally and internationally on the research landscape and to deliver clinical research, which provides benefit to patient care and contributes to learning in regard to the provision of healthcare within a rural setting.

13.2 Supporting change

The Trust has been developing our change methodology to support our improvements, which will be delivered through our CQI Faculty. We have also been developing our Continuous Quality Improvement Strategy, which sets out our journey to support the systematic implementation of improvement tools and techniques across our programmes, projects, initiatives and improvement ideas across the whole organisation.

Building on existing good practice, we will be supporting new and existing programmes to deliver improvement, tailored for all levels of the Trust. This will mean supporting staff, volunteers and our patients to contribute to driving improvements.

14. How we organise ourselves

We have developed new ways of working to strengthen our operating model and provide support and guidance throughout the organisation on how decisions are made, building transparency and trust and devolving responsibility for decision making closer to the service issues.

14.1 Governance guide

This guide outlines how we are run and make decisions within ULHT. This outlines how we are assured that we are achieving what we expect of ourselves, by:

- Ensuring accountability for the delivery of our required standards (clinical, workforce, financial, performance or legal).
- Identifying, sharing and ensuring the delivery of best practice.
- Identifying and managing risks and the quality of care.
- Ensuring that the Trust's culture - 'the way we do things around here' - supports effective engagement on the Trust's priorities.
- Driving continuous improvement in the quality of patient care.
- Investigating and taking action on sub-standard performance.

Governing the delivery of our five year strategy
We have refreshed our meeting arrangements to support decision-making in the new ways of working. We will ensure that there is openness and transparency on the delivery of our ambitions and priorities. There will be the strategic monitoring, reviewing and escalation through the Trust Management Group, reporting through to the Trust Board.

Delivery of the ambitions and the targets set will be monitored through integrated business planning and divisional performance management reviews. The Board Assurance Framework will capture the risks to delivery of the strategic ambitions and performance for the Trust Board.

Each of the improvement programmes has a transformation group to manage, monitor and identify risks and issues to the delivery of its objectives. These report through to the Trust Management Group on a monthly basis.

The five-year plan will be monitored and reported to the Trust Board as part of our strategic planning, with any areas of concern or off target being escalated through our governance structures.

Appendix 1: Our Delivery Plan

Our five year strategy at a glance	
Our purpose	We are here to deliver the most effective, safe and personal care for every one of our patients, through our team of safe, skilled, compassionate, dedicated and valued staff
Our vision	We will provide excellent specialist care to the people of Lincolnshire, and collaborate with our local partners to prevent or reduce the need for people to be dependent upon our services

Delivering our objectives							
Our ambitions	**Our patients**		**Our services**		**Our people**		**Our system partners**
Our objectives	**Harm free care**	**Valuing patients' time**	**Zero waiting**	**Sustainable services**	**Modern and progressive workforce**	**One team**	**Service integration**
Our measures	**Mortality (HSMR)** Metric 2023/23 – within control limits **Avoidable harm** Safety thermometer Metric 2023/24: 99%	**% patients seen at appointment time (within 15 minutes of appointment time** Metric 2023/24: 75%	**Patients discharged within 24 hours of predicted discharge date** Metric 2023/24: 75%	**Delivery of financial plan** Metrics 2023/24: break even **% of clinical services rated as 'delivering' or 'excellent'**	**Vacancy fill rate (all staff)** Metric 2023/24: 9%	**Recommended as place to work (NHS Staff Survey)** Metric 2023/24: 63% **Recommended as a place to receive care** Metric 2023/24: 72%	**% reduction in face-to-face contacts in outpatients** Metric 2023/24: 33%

Delivering our priorities				
	Our patients	**Our services**	**Our people**	**Our system partners**
Our 2021 priorities	• Learning and safety culture	• Estates • Financial recovery plan • Digitalisation	• Future workforce • One team • Quality Improvement Programme	• Partnership working (ICP) – governance and strategy definition in line with the STP and LTP
Our tactical priorities for 2019	• Learning from experience • Patient experience	• GIRFT • Theatres • Urgent and emergency care (Q&E, SDEC) • 62 day cancer • Data quality	• TOM • Recruitment	• Pathway redesign
Delivering our improvement programmes				
Our 2021 improvement programme	• Quality and safety	• Saving money and improving our environment • Delivering productive services	• Developing the workforce to meet future needs	• Redesigning our clinical services

If you require any further information, please contact the 2021 Programme Hub: 2021.Strategy@ulh.nhs.uk

NHS
United Lincolnshire Hospitals
NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	22nd May 2019
Chairperson:	Elizabeth 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 fee care: reduction in pressure ulcers, falls and infection rates - Mortality <u>Source of assurance: Risk Report including Risk Register –</u> The Committee received the risk register and noted the change to the format to aid the flow of reading. Emergent risks had been removed and consideration of detail reported in the risk register would be reviewed to ensure appropriate content. The Committee endorsed the approach taken in the review of the risk register and were informed of the education of staff being undertaken through the TOM masterclasses. <u>Actions Requested by the Committee:</u> A summary of the key points and changes to the risk register to be advised to Finance, Performance and Estates Committee <u>Source of assurance: Incident Management - including SI and Never Events –</u> The Committee received the report and noted that there was a need to report the 'so what' questions to identify actions taken as a result of incidents and never events. The reported received presented the data in an improved format with the requirement to add in a learning section to the report <u>Actions Requested by the Committee:</u> Learning from incidents and never events to be added to the report <u>Source of assurance: Still Birth Deep Dive Report –</u> The Committee received deep dive reports in to the three still births that had been requested. The Committee were advised that there was no evidence to suggest that the Trust had not acted appropriately in the cases.

	Assurance in respect of SO 1a Issue: Delivering harm fee care: reduction in pressure ulcers, falls and infection rates – Harm Free Care Source of Assurance: Quality and Safety Improvement Plan – The Trust remains amber across the 12 programmes with top level risks being staff leaving the organisation, data quality and hospital at night. The main concern highlighted to the committee was the work in relation to pharmacy not being delivered. The Committee were advised that work would be undertaken to ensure the metrics form part of the performance report. Source of Assurance: Quality and Safety Oversight Group – Positive progress had been made by the divisions with a willingness to take issues forward. The report received by the Committee was helpful to demonstrate the impact that is being had however the Committee agreed to continue receiving reports until the divisions were fully functioning. Actions Requested by the Committee: The Committee would need to consider what reporting would be required going forward Source of Assurance: QIA – The Committee were assured that the QIA process was now in place and functioning has improved due to QIAs being rejected if not appropriate. Further work would be required across the organisation to understand QIAs. The Committee discussed the need to ensure that an update on approved QIAs were received in order to see the impact and close the reporting loop. Actions Requested by the Committee: Confirm that the Workforce, Organisational Development and Transformation Committee receive relevant QIAs Source of Assurance: Harm Review – The Committee received the report and identified that further work is required, the Director of Nursing offered support to the Associate Director Clinical Governance to further develop this work. Further consideration is required to determine the ownership of the policy and process which will require formalising through the appropriate group. Source of Assurance: Infection Prevention Control – The Committee receive the annual report, C Difficile report and upward report. The Committee were advised that for part of the year there had been no decontamination lead within the organisation. Disappointment was expressed regarding PLACE reviews and had previously been reviewed in detail by the Committee. The aim is to use these as a driver in the estates work and strategy. The Committee approved the annual report The C Difficile and upward reports were received by the Committee positive achievements across the domain were noted

	Source of Assurance: Medicines Optimisation – The Committee received an update from the Chief Pharmacist who advised that following the Aseptic Facility business case to the Board in October a number of appointments had been made and further recruitment was underway. Assurance could not be given that learning is shared across the business units however performance review meetings will include learning from medicines issues. Actions Requested by the Committee: Future reports to demonstrate current position of actions from the internal audit report and consideration to the rating of the aseptic risk on the risk register
	Assurance in respect of other areas:- Quality Account – The Committee received the Quality account and the draft report from the external auditors was shared. Some data was awaited for inclusion in the account and this would be included prior to the publication date of 30 June. The Committee noted the feedback from Health Watch and their support to the Trusts priorities for 2019/20. The Committee acknowledged the effort made in the production of the document. Patient Experience – National Inpatient Survey The survey results received are disappointing for the Trust and appear to show a significant decrease following last years improvements. Concerns were highlighted regarding Doctors and their communication to patients. The Committee advised local ownership of the data to drive improvement and identified the significant focus that is likely to be had by the Care Quality Commission during their inspection process. Action requested by the Committee: The Committee request sight of the focused actions following the result publication Clinical Audit annual report The Clinical Audit plan was approved by the Committee noting that further developments may be required if gaps are identified when aligned to the Board Assurance Framework NICE/Best Practice Report The Committee received the NICE/Best Practice Report, the Committee raised concerns regarding the capacity to ensure delivery however the divisional structure should aid this. There is a requirement to ensure NICE and Best Practice is captured within the Board Assurance Framework. Quality Strategy The Committee received the Quality Strategy acknowledging the alignment with True North however it was felt that this had weakened the

	strategy. There is a requirement to ensure patient experience is included within the strategy, the Committee did not approve the strategy Action requested by the Committee: The Director of Nursing to work with the Medical Director to review and further develop the strategy. External Reports – Internal Audit Report, Governance Review Plan The updated governance review plan was received by the Committee, this will be reviewed on a quarterly basis by the Committee to ensure completion of actions Policies for approval: Managing allegations of abuse made against persons who work with children and young people The Committee approved the policy Incident Management Policy The Committee approved the policy
Issues where assurance remains outstanding for escalation to the Board	The Harm Review process was received by the Committee and further work is required, ownership of the policy/process requires identification Significant decline in National Inpatient Survey results, data to be presented to the June Private Board
Items referred to other Committees for Assurance	The Committed wish to seek assurance from the Finance, Performance and Estates Committee to review the findings of the external audit report for the Quality Account in relation to the Quality data. The Committee also wish to seek assurance on robust education and SOP processes in place.
Committee Review of corporate risk register	The Committee had received a Quality Governance Corporate Risk Register, the review of the register had resulted in improved reporting
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee were not assured in respect of any of the strategic risk areas which aligned to it.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

Voting Members	J	J	A	S	O	N	D	J	F	M	A	M

Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director	X	X	X	A	X	X	X	X	X	X	A	X
Alan Lockwood Int Non-Executive Director	A	X	X	X	X	X	A	X	A	A		
Michelle Rhodes Director of Nursing	X	X	D	X	X	X	X	X	X	X	X	X
Neill Hepburn Medical Director	X	D	X	X	D	X	X	X	X	X	X	D

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Dr. Neill Hepburn
Date:	June 2019

Title:	**Our Clinical Strategy**

Author: Julie Pipes, Assistant Director of Strategy and Change

Purpose of the Report:

The purpose of this report is to provide the Trust Board with a refreshed clinical strategy, one of the enabling strategies that will contribute to the delivery of the 2021 vision for ULHT.

The Report is provided to the Board for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- The clinical strategy is aligned to the output of the Acute Services Review commissioned by the Lincolnshire Clinical Commissioning Groups, for the nine services addressed within the scope of the ASR
- The full extent of the ULHT clinical strategy covers all clinical services provided by ULHT
- The Trust Board are asked to note that this strategy is a high level strategy
- The clinical strategy is a working document and more detail will evolve at a clinical speciality level now that the Trust Operating Model has been implemented.
- This high level strategy will be further developed into detailed strategies for each clinical speciality within each Division that can be taken forward to implementation and delivery as part of a structured clinical transformation programme overseen by the Clinical Strategy Transformation Group
- The detailed strategies for each clinical speciality will reflect the milestones set out in the NHS 10 year plan published in January 2017

Recommendations

The Board is asked to:

- Note the clinical strategy for the Trust, and that delivery of the full strategy is dependent on the timescales for completing consultation with the public on the outcome of the Acute Services Review, although there are elements that we can proceed with implementing
- Note that a programme for developing the detailed strategies at clinical speciality level will be shared with the board together with the supporting governance framework to ensure alignment & consistency with interdependent services/specialties

Strategic Risk Register The 2021 Strategy sets out the vision for striving for excellence in Rural Healthcare being delivered through clear ambitions that have been supported by the strategic priority setting, which provides the	**Performance KPIs year to date** The Trusts Performance Framework outlines the performance of the Trust to deliver KPIs to achieve our clinical vision.

objectives to be monitored for the risk of delivery through the Board Assurance Framework.	
Assurance Implications This paper forms part of the governance assurance of the Trust for the implementation of our clinical strategy	
Patient and Public Involvement (PPI) Implications There will be further communication and engagement to provide updates to our staff, patients and the public to communicate the delivery of our clinical strategy.	
Equality Impact There will be an EQIA (Equality Impact Assessment) conducted as part of the consultation and engagement processes, this will be aligned to the EQIA currently being undertaken for the output of the System Wide STP led Acute Services review	
Information exempt from Disclosure – No	
Requirement for further review? Yes	

1. Purpose of the report

The purpose of this report is to present the ULHT clinical strategy to the Trust Board.

2. Summary of key points

2.1 Background

The clinical strategy is one of the Trusts enabling strategies for delivery of the overall Trust vision and 2021 strategy.

The clinical strategy has been developing since 2014. In the autumn of 2017, the Lincolnshire Clinical Commissioning Groups commissioned an Acute Services Review, which focussed on nine clinical service areas, these being;

- Stroke services
- Breast services
- General Surgery
- Haematology
- Oncology
- Trauma and Orthopaedics
- Acute Medicine at Grantham
- Paediatrics & Neonatology
- Obstetrics and Gynaecology

The output of this review and the ULHT clinical strategy are aligned for these nine service areas.

The output of the ASR, which informs part of the ULHT clinical strategy, is currently going through the NHSE approval gateway process. This process is a system led piece of work that will lead to a consultation period with the public once NHSE has given their approval to the Pre-consultation business case. It is hoped that consultation with the public will start later in 2019.

2.2 Integrated care models of care

Development of the clinical strategy has considered and included the longer term vision for health care as set out in the NHS long term plan that was published in January 2019, which is to deliver care in the acute hospital only where necessary to do so. The ULHT clinical strategy and the wider Lincolnshire system health and care plan, is to move clinical activity away from the acute hospital where safe to do so, and to provide this closer to the patient in the community. The future vision involves multiple organisations coming together to jointly provide care pathways in the most appropriate setting, with integrated workforce teams that are "seamless" to the patient receiving care

3. Vision for our hospital sites and services

3.1 Grantham and District Hospital

"Local urgent care and surgical centre"

Our innovative **integrated workforce model for Grantham will:**

- Transform it into a 24/7 urgent treatment centre
- Including acute/GP/community and ambulatory care

Up to 56 medical beds will also be available

- Meaning the vast majority of patients seen at Grantham will continue to be treated there

Day case and inpatient surgical activity will also continue for:

- Orthopaedics, general surgery, urology, gynaecology, ophthalmology, and ENT

Diagnostic services will also continue

3.2 Pilgrim Hospital

"A modern district general hospital with a focus on emergency care and specialist surgery"

We want to make Pilgrim hospital;

- A centre of excellence for complex elective (planned) surgery
- Including the use of new and state of the art technology

In addition;

- Pilgrim is only one of four hospitals in the country to be utilising **an integrated assessment centre (IAC)** - helping to transform its urgent and emergency care services.

3.3 Lincoln County Hospital

"A modern district general hospital with a focus on emergency care and cancer"

We want Lincoln:

- To remain our biggest emergency department
- To provide
  - Consolidated hyper-acute and stroke services
  - Cardiac care in the highly regarded, state-of-the-art Lincolnshire Heart Centre.
  - All one-stop diagnostic and surgical treatment for breast services
  - Elective and day case surgery, ENT, urology, head and neck, ophthalmology, gynaecology, breast and orthopaedics.

4. Summary & next steps

This clinical strategy is aligned to the output of the Acute Services Review, but it is only a high level clinical strategy.

Next steps will include the development of detailed clinical strategies for each clinical service/speciality within each Division, now that the TOM has been implemented. The detailed speciality level strategies will reflect the milestones for each clinical service as set out in the NHS 10 year plan published in January 2019.

The detailed strategies at speciality level will be developed so that they can be taken forward to implementation and delivery. This will form a structured clinical transformation programme that will be overseen by the Clinical Transformation Steering Group, and supported by the Clinical Strategy Team.

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

Draft Clinical Strategy and Delivery Plan

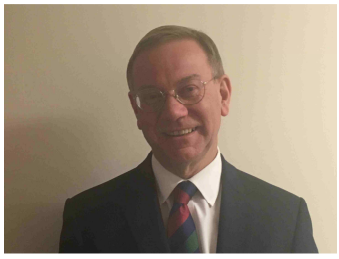
2019-2024

Medical Directorate

Assistant Director of Strategy and Change
Julie Pipes

Prepared April 2019

Foreword



Dr. Neill Hepburn
Medical Director

I am delighted to introduce a refresh of the United Lincolnshire NHS Hospital Trust's (ULHT) Clinical Services Strategy.

This document sets out the vision for clinical services, and the vision for our hospital sites over the next five years at United Lincolnshire Hospitals; it provides the broad strategic direction and reflects the output from the Lincolnshire Acute Services Review undertaken during 2018/19. It identifies the case for change as compelling and demonstrates that "Do-nothing" is not an option. The strategy goes on to describe the nature of the services we will be providing and the type of organisation we aspire to be, to ensure we realise the vision we have set for the organisation and the populations we serve.

United Lincolnshire Hospitals Trust (ULHT) needs a clinical strategy to outline the direction of travel of its services. It has been developed now to ensure that the organisation is clear about its role in providing secondary healthcare in the future.

After some challenging times ULHT is on a journey of improvement with patient safety and improving the patient experience being our highest priorities and this is reflected in everything we do. However ULHT is part of a broader healthcare system and our changing external environment and expectations of our partners need to be addressed in this strategy.

The wider NHS is experiencing unprecedented change. It is becoming a system that is highly regulated by external bodies such as the Care Quality Commission (CQC) and NHS England & Improvement. National standards are set and some of these will be mandatory with the further development of NICE Quality Standards. Specialised care is becoming more complex within an environment where increasing demand and public expectations mean that care will be delivered closer to the individuals' own home, with an integrated workforce.. "Integration" meaning that the workforce from ULHT, Lincolnshire Community Health Services, Lincolnshire Partnership Foundation Trust and Primary Care will come together to provide care as integrated teams to support patients closer to home, and avoid unhelpful admissions to acute hospitals. All these changes are required within a constrained financial resource.

Developing this strategy has identified the following key points:

- Services are not clinically sustainable in the current configuration
- Services are not affordable in the current configuration
- Do nothing is not an option

- Services need to be better integrated and co-ordinated to deliver an improved patient experience and outcome closer to home
- Care needs to be consultant led 24/7
- There is a balance to strike between the need to concentrate scarce specialist resources and ensure local access
- In-hospital services need to be fully utilised to achieve maximum economies of scale
- Telemedicine technologies need to be used to the maximum in Lincolnshire to minimise the problems associated with rurality.

The main thrust of our clinical strategy is to retain services locally where safe to do so, and to consolidate services to ensure safety and sustainability where necessary, and appropriate. We have looked at how our services can become more efficient and how the impact of transforming our services, together with improving efficiency can improve both clinical safety and our financial position.

We have worked alongside our health and care partners in Lincolnshire to ensure our clinical strategy is aligned with their strategic direction for the county wide health and care services.

The clinical strategy we have developed is balancing sustainability whilst developing our services for the future, paving the way to implement the NHS long term plan published in January 2019, giving our patients access to the most modern treatments available.

We believe that this clinical strategy will provide both clinical sustainability and our patients with access to these modern treatments. However, the strategy on its own will not go far enough to bring financial sustainability, this now needs to be considered in the wider context of the Lincolnshire health and care economy, and we need to work with our partners across Lincolnshire to identify how further financial savings can be made to complete the journey.

Contents

The Strategic Case

1. Introduction

What does our strategy describe?
Our Clinical Services Strategy (CSS) describes a vision that shapes our clinical services over the next five years. It has been developed in consultation with our clinical teams, using a validated methodology that led to strategic objective development for the individual clinical services that we currently provide. Our strategy has been influenced by changes in the external landscape, and takes account of national drivers for change, as well as transformation plans across the local and regional health and social care communities.

We have set out a programme of work that will ensure we develop a portfolio of high-quality services that are both clinically and financially sustainable, deliver excellent care and an exceptional experience for our patients.

A strategy for the residents of Lincolnshire
We are looking to develop innovative models of care, which will fully integrate partnership care pathways across primary and acute health and care systems, that can be delivered through a five-year place based planning Sustainability Transformation Plan (STP). We will develop our research, innovation and education services, which will be transformed by the new medical school at the University of Lincoln, which opens in 2019. The aim of our strategy is to improve patients' access to services locally, improve the quality of our services whilst meeting challenging financial constraints across the health and care system in Lincolnshire.

Promoting good health and well-being is everyone's business including ours. One in twenty people still smoke; more than half the population drinks too much alcohol and is overweight. The clinical services we provide should not only focus on treating ill-health, but through this strategy, have the opportunity to work in partnership with our colleagues in primary care and community services, to promote better lifestyle choices, to educate our patients, and support them to achieve improved health as part of their regular care and treatment.

How will we achieve and deliver the goals within our strategy?
This will be achieved by challenging and changing the traditional ways in which we have previously delivered clinical services. This means breaking down barriers and creating new integrated models of care, as well as alternative ways of bringing services to our patients.

The ambition within our strategy is challenging. It is our ambition for the Trust is to become a national Centre for Rural Health and Care, through health and care reform working in collaboration with our wider health and care partners and stakeholders. These include Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services (LCHS) and the Lincolnshire STP Delivery Unit, together with stakeholders in the wider community, including local businesses, regional developments, universities and schools.

2. About our Hospital Trust

- **Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.**
- **Transport networks are underdeveloped resulting in transport times of around 1 hour between the respective hospital sites.**
- **Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.**
- **We provide acute hospital care, to around 757,000 residents of Lincolnshire.**
- **Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037.**
- **These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.**
- **In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.**

ULHT is one of the largest acute trusts in the country. We provide services from three acute hospitals in Lincolnshire:

Lincoln County Hospital

This district general hospital serves the city of Lincoln and the North Lincolnshire area. It provides all major specialties and a 24-hour major accident and emergency service. Founded over two hundred years ago, the majority of the hospital has been rebuilt over the past twenty years. Major developments over recent years include a new heart centre for the county at Lincoln County Hospital, with two new cardiac catheter laboratories and a short-stay unit, the addition of a 4th Linear accelerator machine with extensive expansion of the Oncology / Radiotherapy service.

Pilgrim Hospital Boston

This district general hospital was opened in 1976 to replace a number of small hospitals. It serves South and South East Lincolnshire with a 24-hour major Accident and Emergency Department and all main specialties. Lincolnshire Partnership NHS Trust manages the Adult Psychiatry Department on the same site. The hospital is constantly being upgraded, and this has included a £3.4 million new intensive care unit, a 2.5 million endoscopy unit and £1.2 million MRI scanner, and new clinical unit to the value of £9m currently being used to deliver Obstetrics and Gynaecology services

Grantham & District Hospital

This mainly acute hospital originates from 1874 and serves Grantham and the local area. It has substantial recent additions and improvements including a new state-of-the-art CT scanner. It provides consultant led medical and some surgical specialties, a 24-hour accident and emergency services limited to a limited specific criteria of emergencies. Emergency cases relating to; suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions are not taken by the ambulance service to Grantham hospital, these types of emergency are directed straight to either Lincoln or Pilgrim hospital where these specialised services are located.

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GP clusters. These include:

- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital

We deliver services across the following clinical specialities:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory Physiology
Breast Services	Diabetic Medicine	Hepatobiliary and Pancreatic Surgery	Oral and Maxillofacial Surgery	Rheumatology
Cardiology	Diagnostic Services	Maternity and Obstetrics	Orthodontics	
Chemotherapy	Dietetics	Medical Physics		Specialist Rehabilitation Medicine
Children's Community Services	Ear, nose and Throat	Medical Oncology	Palliative Care	Therapies
Clinical Immunology	Endocrinology	Neonatology	Pharmacy	Trauma and Orthopaedics
Clinical Oncology	Gastroenterology	Nephrology	Radiotherapy	Urology
Colorectal Surgery	General Medicine	Neurology	Rehab Medicine	Vascular Surgery
Community Paediatrics	General Surgery	Neurophysiology	Research and Development	
Critical Care	Gynaecology	Nuclear Medicine	Respiratory Medicine	

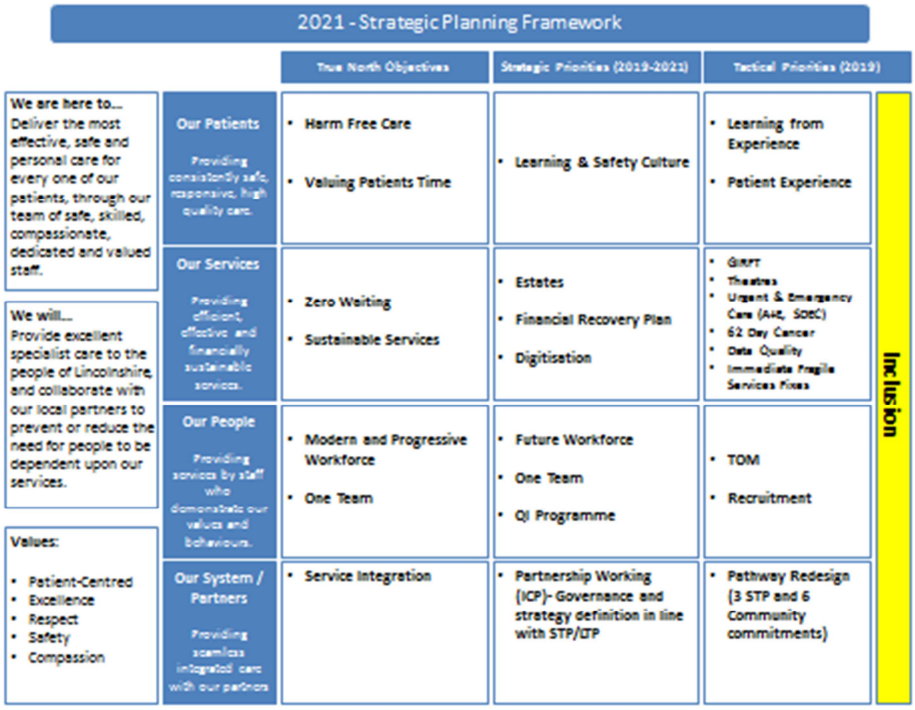
Whilst ULHT is the leading provider of elective care across all four CCGs in Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford NHS Foundation Trust achieve a significant share of elective care in Lincolnshire East and South Lincolnshire respectively. It is of note that South Lincolnshire CCG commissioners have more than 70% of its elective care from hospitals outside Lincolnshire.

3. Our Purpose and Our Vision – *The ULHT Approach*

We have worked with KPMG to develop our key strategic and tactical priorities on which the ULHT will need to focus.

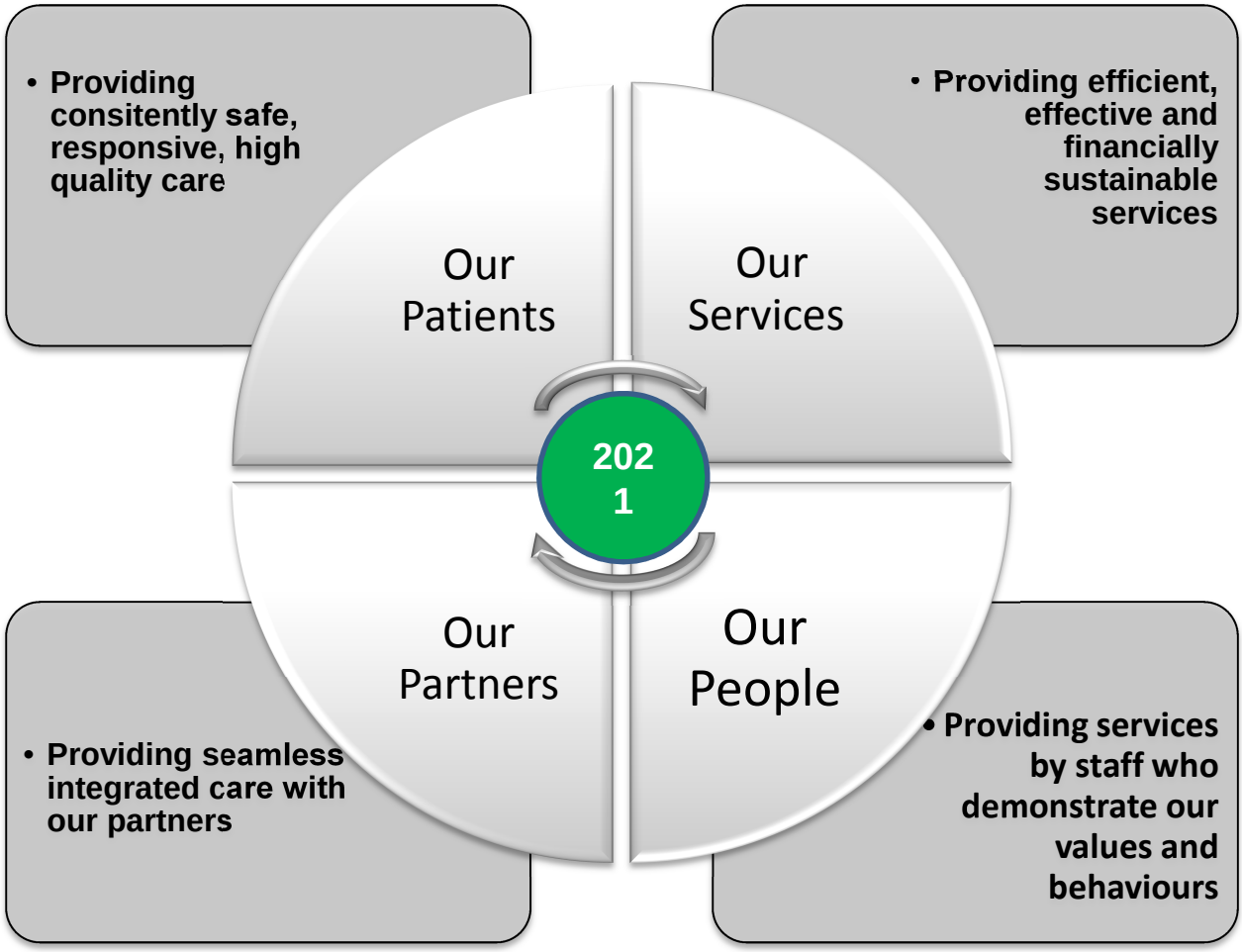
The four strategic pillars on which the Trust's Framework is based are shown in the diagram below.

These strategic pillars form the basis of the Organisation's strategic planning framework detailed in the diagram below.



Trust Strategic Priorities

The Trust Board has set out **seven** strategic objectives, which will act as the focus for our improvement efforts for years to come, drawn from our **four** agreed ambitions of:



Our agreed objectives are:

- For **our patients** ambition:
    - **Deliver harm free care.**
    - **Value our patients' time.**
- For **our services** ambition:
    - Have **'zero waits'** to access our services.
    - Ensure that our services are **sustainable** on a long-term basis i.e. here to stay.
- For **our people** ambition:
    - Have a **modern and progressive workforce.**
    - Work as **one team.**

- For **our partners** (other health and care providers) in Lincolnshire ambition, our objective is to:
    - Make sure that the care given to our patients is seamless between ULHT and other service providers through better **service integration.**

The Executive Team has been exploring a range of measures, and associated metrics. After collective review, the Executive Team has identified a total of 10 measures covering the seven objectives:

Objective	Measure	Metric 19/20	Metric 23/24
Harm Free Care	Mortality - HSMR	Within control limits	Within control limits
	Avoidable Harm –Safety Thermometer	99%	99%
Valuing Patients Time	% patients seen at appointment time (within 15 mins of appointment time)	***note 1***	
Zero Waiting	% patients discharged within 24 hours of PDD	***note 2***	
Sustainable Services	Delivery of Financial Plan	£70.3m Deficit	Break-even ***(note 3)***
	% of services rated as 'delivering'	***note 4***	
Modern and Progressive Workforce	Vacancy fill rate	***note 5***	
One Team	Recommend as a place to work (staff survey)	46% (↑ of 5%)	63%
	Recommend as a place to receive care	53% (↑ of 5%)	72%
Service Integration	% reduction in face to face contacts in Outpatients	5%	33%

Notes:

1. Baseline position and metrics to be finalised, but potentially an improvement of 20% of the gap between current positon and the YE21 target in YE19
2. Method of data reporting being developed and tested, and baseline position and metrics to be finalised at the time of writing this document
3. This assumes a wider system solution to the estimated £30m structural deficit
4. 'Shadow' form in 19/20 as the rating system is developed and embedded
5. To be finalised at the time of writing this document

Once complete, the measures and metrics will be embedded into 19/20 operational plan, the 19/20 BAF and the 2021 strategy.

4. The Strategic Environment

There are several drivers for change – local, regional, and national, that provide the impetus to "do something different".

6.1 The NHS Long Term Plan

Our National Health Service was founded in 1948 in place of fear - the fear that many people had of being unable to afford care for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war. At its best our National Health Service is the practical expression of a shared commitment by the British people: over the past seven decades, there when we need it, at the most profound moments in our lives. But as medicine advances, health needs change, and society develops, the Health Service continually has to move forward. This Long Term Plan shows how we will do so. So that looking forward to the NHS' 80th Birthday, in a decade's time, we have a service that is fit for the future

The NHS published their long term plan on January 7th 2019. The opening statement in the plan highlights the pride in the NHS enduring success, and in the shared commitment it represents. There is a national concern about funding, staffing, increasing inequalities and pressures from a growing and ageing population. However, there is also optimism about the possibilities for continuing medical advance and better outcomes of care.

The latest NHS long term plan sets out to:

- Keep all that is good about the health service and its place in our national life
- Tackle the pressures that our staff are facing
- Making the additional funding that will be made available go as far as possible
- Accelerate the redesign of patient care to future-proof the NHS for the decade ahead

The NHS long term plan is divided into seven chapters each focussing on the following themes:

- **Chapter One: A new service model for the 21st Century**
  This chapter focusses on setting out the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the time in the optimal care setting. Over the next five years, every patient will have the right to online 'digital' GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments, saving patients 30 million trips to hospital, and saving the NHS over £1 billion per year in new expenditure averted. GP practices typically covering 30-50,000 people will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GP's, community health and social care staff to provide fast support for people in their own homes as an alternative to hospitalisation.

- **Chapter Two: More NHS action on prevention and health inequalities**
  Wider action on prevention will help people to stay healthy and also moderate demand on the NHS services. The plan sets out specific action to cut smoking in pregnancy, and by people with long term mental health problems; ensure people with learning disability and/or autism get better support; provide outreach services to people with experiencing homelessness; help people with severe mental illness find and keep a job, and improve uptake of screening and early cancer diagnosis for people who currently miss out.

- **Chapter Three: Further progress on care quality and outcomes**
  For all major conditions, results for patients are now measurably better than a decade ago. Childbirth is the safest it has ever been, cancer survival is at an all-time high, deaths from cardiovascular disease have halved since 1990, and male suicide is at a 31-year low. But for the biggest killers and disablers of our population, we still have unmet need, unexplained local variation, and undoubted opportunities for further medical advance. These facts, together with patients' and the public's views on priorities, mean that the Plan goes further on the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multi-morbidity and healthy ageing including dementia. But it also extends its focus to children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.

  Some improvements in these areas are necessarily framed as 10 year goals, given the timelines needed to expand capacity and grow the workforce. So by 2028 the Plan commits to dramatically improving cancer survival, partly by increasing the proportion of cancers diagnosed early, from a half to three quarters. Other gains can happen sooner, such as halving maternity-related deaths by 2025. The Plan also allocates sufficient funds on a phased basis over the next five years to increase the number of planned operations and cut long waits. It makes a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ring fenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people. The Plan also recognises the critical importance of research and innovation to drive future medical advance, with the NHS committing to play its full part in the benefits these bring both to patients and the UK economy.

  To enable these changes to the service model, to prevention, and to major clinical improvements, the Long Term Plan sets out how they will be backed by action on workforce, technology, innovation and efficiency, as well as the NHS' overall 'system architecture'.

- **Chapter Four: NHS staff will get the backing they need**
  The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. But our staff are feeling the strain. That's partly because over the past decade workforce growth has not kept up with the increasing demands on the NHS. And it's partly because the NHS hasn't been a sufficiently flexible and responsive employer, especially in the light of changing staff expectations for their working lives and careers. However there are practical opportunities to put this right. University places for entry into nursing and medicine are oversubscribed, education and training places are being expanded, and many of those leaving the NHS would remain if employers can reduce workload pressures and offer improved flexibility and professional development. This Long Term Plan therefore sets out a number of specific workforce actions which will be overseen by NHS Improvement that can have a positive impact now. It also sets out wider reforms which will be finalised in 2019 when the workforce education and training budget for HEE is set by government. These will be included in the comprehensive NHS workforce implementation plan published later this year, overseen by the new cross-sector national workforce group, and underpinned by a new compact between frontline NHS leaders and the national NHS leadership bodies.

  In the meantime the Long Term Plan sets out action to expand the number of nursing and other undergraduate places, ensuring that well-qualified candidates are not turned away as happens now. Funding is being guaranteed for an expansion of clinical placements of up to 25% from 2019/20 and up to 50% from 2020/21. New routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support, are all being backed, together with a new post-qualification employment guarantee. International recruitment will be significantly expanded over the next three years,

and the workforce implementation plan will also set out new incentives for shortage specialties and hard-to-recruit to geographies.
To support current staff, more flexible rostering will become mandatory across all trusts, funding for continuing professional development will increase each year, and action will be taken to support diversity and a culture of respect and fair treatment. New roles and inter-disciplinary credentialing programmes will enable more workforce flexibility across an individual's NHS career and between individual staff groups. The new primary care networks will provide flexible options for GPs and wider primary care teams. Staff and patients alike will benefit from a doubling of the number of volunteers also helping across the NHS.

- **Chapter Five: Digitally-enabled care will go mainstream across the NHS**
  These investments enable many of the wider service changes set out in this Long Term Plan. Over the next ten years they will result in an NHS where digital access to services is widespread. Where patients and their carers can better manage their health and condition. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today. Where predictive techniques support local Integrated Care Systems to plan and optimise care for their populations. And where secure linked clinical, genomic and other data support new medical breakthroughs and consistent quality of care. Chapter Five identifies costed building blocks and milestones for these developments.

- **Chapter Six: Taxpayers' investment will be used to maximum effect**
  In ensuring the affordability of the phased commitments in this Long Term Plan we have taken account of the current financial pressures across the NHS, which are a first call on extra funds. We have also been realistic about inevitable continuing demand growth from our growing and aging population, increasing concern about areas of longstanding unmet need, and the expanding frontiers of medical science and innovation. In the modelling underpinning this Long Term Plan we have therefore not locked-in an assumption that its increased investment in community and primary care will necessarily reduce the need for hospital beds. Instead, taking a prudent approach, we have provided for hospital funding as if trends over the past three years continue. But in practice we expect that if local areas implement the Long Term Plan effectively, they will benefit from a financial and hospital capacity 'dividend'.

  In order to deliver for taxpayers, the NHS will continue to drive efficiencies - all of which are then available to local areas to reinvest in frontline care. The Plan lays out major reforms to the NHS' financial architecture, payment systems and incentives. It establishes a new Financial Recovery Fund and 'turnaround' process, so that on a phased basis over the next five years not only the NHS as a whole, but also the trust sector, local systems and individual organisations progressively return to financial balance. And it shows how we will save taxpayers a further £700 million in reduced administrative costs across providers and commissioners both nationally and locally.

- **Chapter Seven: Next Steps**
  We will build on the open and consultative process used to develop this Plan and strengthen the ability of patients, professionals and the public to contribute by establishing the new NHS Assembly in early 2019. 2019/20 will be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation for their populations, taking account of the Clinical Standards Review and the national implementation framework being published in the spring, as well as their differential local starting points in securing the major national improvements set out in this Long Term Plan. These will be brought together in a detailed national implementation programme by the autumn so that we can also properly take account of Government Spending Review decisions on workforce education and training budgets, social care, councils' public health services and NHS capital investment.

Parliament and the Government have both asked the NHS to make consensus proposals for how primary legislation might be adjusted to better support delivery of the agreed changes set out in this LTP. This Plan does not require changes to the law in order to be implemented. But our view is that amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to: create publicly-accountable integrated care locally; to streamline the national administrative structures of the NHS; and remove the overly rigid competition and procurement regime applied to the NHS.

In the meantime, within the current legal framework, the NHS and our partners will be moving to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

Reference: Section 6.1 above has been taken directly from the NHS Long Term Plan published on 7th January 2019.

6.1 The community we serve is changing

Lincolnshire has one of the fastest growing populations in England and is projected to rise to 838,200 by the year 2033. Greater life expectancy and increase co-morbidity will substantially raise the demand for healthcare. If we "stand still" we will soon be unable to meet all the needs of increasing numbers of patients, many of whom have complex healthcare needs. Our desire to provide local, high quality, sustainable healthcare to every citizen that uses our services has been the main driver underpinning our strategy.

The following information helps to illustrate the critical challenges and factors for change we face now, and which our clinical services need to respond to.

A growing elderly population

Latest statistics show that the proportion of residents in Lincolnshire over the age of 75 is predicted to increase by 101% between 2012 and 2037.

Rising demand for healthcare

Demand for hospital care has risen, especially for patients aged over 65 years. These patient, are often the most vulnerable in society and have complex co-morbidities the older they get. The elderly patients are at high risk of hospital-associated harms. Hospital is often not the best place for these people, especially on a long-term basis. The needs of the aging population are social, physical and mental, and not well met by the configuration of our current services. Integrating care with other health and social providers will help to ensure these citizens get the right care, in the right place and at the right time.

6.2 National policy drivers

Smaller district general hospitals can thrive but the way services are provided to local patients must change to guarantee quality care. The impact of sub-specialisation, recruitment, rising demand, technological developments and the economic outlook will have a particular effect on smaller organisations. It is essential that United Lincolnshire Hospitals NHS Trust identifies new models of care for patients, for example re-designing services to improve the integration of care community

services and with other providers in Lincolnshire to deliver care locally where possible, using new technology and building networks with other providers and major centres, and making sure the right balance is struck in local communities between redesigning services and making sure patients are treated near to where they live.

6.2.1 The 5-year forward view

In October 2014, Simon Stevens, Chief Executive of NHS England, published the 5-year forward view. This clearly articulates the challenge facing the NHS in terms of rising demand and the economic pressures. The document also points the way for some new models of care, aimed at meeting this challenge, whilst delivering better services that are sustainable and affordable. These new models include:

- Multi-speciality community providers, integrated out of hospital care organisations made up GP's, nurses, community health services, hospital specialists and others
- Primary and acute care systems, combining general practice and hospital services to provide integrated acute and primary care
- Urgent and emergency care networks, promoting links between specialist and general hospitals as well as more integrated services locally with improved triage enabling patients to navigate the system successfully
- Viable smaller hospital, different models of partnership and organisational form that help retain hospital services locally, but in a sustainable way

Considerable emphasis is placed on the prevention of ill health, and how all health organisations can contribute to this to a much greater degree.

Since the 5-year forward view, the Lincolnshire Health system has been working to develop integrated service provision, but more work is needed on this, and at a greater pace. .

6.2.2 The Keogh urgent and emergency care review

This two-phase report published by the Medical Director for England, Sir Bruce Keogh, sets out a vision for urgent and emergency care and describes the following approach to services:

"Those with urgent but non-life threatening needs receiving care outside of hospital, as close to their home as possible, and those with serious or life threatening emergencies should be treated in centres with the best expertise and facilities."

The latter includes a vision of urgent care centres, emergency care centres, and specialist emergency centres providing tiered care, according to clearly defined pathways and within emergency care networks. Developing our role within the East Midlands and Trauma network, and delivering the emerging role for integrated urgent and emergency care in Lincolnshire, including the creation of Urgent Care Centres, will help us to adopt this approach.

NHS England has asked that Urgent Care Centres are developed, up and running by December 2019. The Lincolnshire health and care system has designed the model for the Urgent Treatment Centres in Lincolnshire of which the plan is to have five, three of which will be located on the ULHT Hospital sites. Lincoln and Pilgrim will have Urgent Treatment Centres located in front of the Emergency Departments, and Grantham will have its own Urgent Treatment Centre. These will be led by Primary care and Community Health Services staff, leaving ULHT A&E Doctors to run the Emergency Departments.

6.2.3 Seven day services

NHS services – open seven days a week – aims to ensure all patients have consistently good quality of care, regardless of what day of the week it is, the programme for delivering seven day services across England is initially focusing on urgent and emergency care services, and the diagnostic services that support them. The delivery of seven day services: notably the ambition that by March 2017, 25% of the population will have access to acute hospital services that comply with four priority clinical standards every day, and that 20% of the population will have enhanced access to primary care. Articulated are the three challenges with regard to implementing seven day working: reducing excess deaths at the weekend; improving access to out of hours care; and increasing capacity within primary care to improve access to services at weekends and in the evenings.

The full ten evidence-based clinical standards for seven days services are as follows:

- **Patient experienc**e – seven day a week involvement of patients and carers in decision making
- **Time to first consultant review** – all emergency patients seen by a suitable consultant within a maximum of 14 hours
- **Multi-disciplinary team (MDT) review** – within 14 hours, integrated management plan with estimated discharge date in place within 24 hours
- **Shift handovers** – by competent senior decision maker & standardised across seven days
- **Diagnostics** – inpatient seven-day access to diagnostic services. Consultant-directed diagnostic tests and their reporting within one hour for critical patients; within 12 hours for urgent patients; and within 24 hours for non-urgent patients
- **Intervention/Key services-** 24 hour access, seven days a week to consultant directed interventions, either on site or through formally agreed networked arrangements
- **Mental Health** – assessment by psychiatric liaison 24 hours a day, seven days a week; within 1 hour for emergency care needs and within 14 hours for urgent care needs
- **On-going review** – all patients on high dependency areas including EMU/CDU, must be seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours , seven days a week
- **Transfer to Community, primary care and social care** – all support services, must be available seven days a week
- **Quality improvement** – all those involved in the delivery of acute care must participate in the review of patient improvement

6.2.4 The Dalton Review

Sir David Dalton, Chief Executive of Salford Royal Hospital NHS Foundation Trust was commissioned by the Secretary of State for Health to undertake a review of how different

organisational forms could accelerate service transformation – to meet the challenge of improving both the quality and sustainability of clinical services.

The outcome of the review was published in December 2014 and describes a spectrum of potential relationships ranging from the relatively informal, such as strategic clinical networks, through to more formal contractual relationships between organisations; and finally consolidated organisation forms such as multi-site hospital chains. The review proposes greater the degree of consolidation the greater efficiency gains to be made.

In developing our clinical services strategy, we recognise the potential to work much closely with other partner organisations in order to develop more sustainable models of clinical care, which at the same time, help to preserve local access where it is clinically appropriate to do so.

6.2.5 GIRFT "Getting it Right First Time"

Professor Tim Briggs in his report ***"Getting it Right First Time"*** highlights the problem relating to Orthopaedic care, whilst acknowledging with the population living longer, the increased demand for joint replacement. Briggs summarises the problem and solution as follows:

The Problem

The annual budget for musculoskeletal disease is £10 billion. The new health reforms, aimed at commissioning, empower General Practitioners and the National Commissioning Board with £80 billion of health care spending. With a projected NHS savings requirement of £20 billion by 2015, against a background of an ageing population with an increasing requirement for orthopaedic treatment, there must be an attempt to address provision of care, which accounts for 80% of the total cost.

The Solution

Briggs identifies the solution to the problem as follows:

- By developing clinical pathways that begin in primary care, but that involve a seamless transition across the secondary care sector, will ensure best value, high quality outcomes for patients.

- High quality clinical leadership and the focused partnership of the British Orthopaedic Association, its specialist societies, frontline hospital specialists, together with GPs in Commissioning Consortia, is the way forward to provide the population with access to high quality care at the right time whilst ensuring the best use of taxpayers' money.

- Appropriate nationally developed guidelines for referral and subsequent treatment are essential to contain cost and ensure patients receive the appropriate and effective treatment. A lead GP for musculoskeletal disease in each practice, linked to the local orthopaedic provider, would streamline referrals and ensure patients are seen for treatment by the right specialist at the right place at the right time.

- Instead of orthopaedic departments and clinicians acting, alone they will form part of a network of hospitals and treatment centres forming Specialist Orthopaedic Units with an appropriate critical mass, with ring-fenced elective beds, and working to quality assurance standards, which will include measures of outcome. This will generate standardised protocols for prostheses and treatment pathways across the NHS benefiting patients, thereby improving outcomes and reducing complications. Protocols will be based on either their own accrued evidence or from the published literature or registries. All providers of orthopaedic care to NHS patients will be required to work to these nationally agreed standards.

- The cost of orthopaedic implants, with the same functional outcome, varies considerably between trusts with significant cost implications for The NHS. By negotiating as a network/specialist, orthopaedic unit implant prices will be reduced. Using implants that demonstrate survival rates of at least 90% at ten years should be the "gold standard". Offering patients more expensive implants with little or no added benefit denies other patients orthopaedic care.

- The development and introduction of new technologies, implants and procedures into the NHS is important for the whole population who can gain significant benefits. Initially, however, early clinical trials should take place in "accredited" Specialist Units with a proven track record of translational research, taking on a leading role in their evaluation. Once appropriate data has been accrued demonstrating the added benefit to patients it can be cascaded down into the wider NHS.

- Specialist services, such as revision hip and knee arthroplasty, should only be done in specialist units with an appropriate critical mass, or as part of a specialist network, all aspects of which should be subject to regular performance review.

Following on from the work with Orthopaedics, the "GIRFT" programme has now been extended to all clinical specialties, and also to cross cutting themes including; Strategic clinical design, Litigation, Patient Safety, Clinical Coding, Procurement & Technology, Surgical Site Infection, and Medicines Optimisation.

6.2.6 The Carter Report

On11th June 2015 (later updated on 5th February 2016), the NHS published the report written Lord Carter following the request for him to carry out an efficiency review by the Minister of Health at that time Jeremy Hunt, as part of his aim to make the NHS the safest and most efficient healthcare system in the world. The efficiency expert had spent 18 months visiting hospitals across the country and reviewing productivity to ensure the NHS gets the best value from its >£100 billion annual budget and help the NHS to implement a 7-day service.

The report identified significant and unwarranted variation in costs and practice which, if addressed, could save the NHS £5bn.

Of these savings up to £2bn comes from the workforce budget, through:

- Better use of clinical staff
- Reducing agency spend and absenteeism
- Adopting good people management practices.

Model hospital

The report looked at good practice in the NHS and elsewhere and developed the concept of a "*Model Hospital*". Based on data from successful organisations, it has identified nine practices that are the key elements in developing a successful organisation. Implementing the practices of the model hospital would, the report claims, achieve the £5bn in savings.

Values-based	Developing a values-based behavioural framework, agreeing at the

behavioural framework	outset the trust's underpinning values
Patient-centred organisation	Moving towards a patient-centred organisation design – ensuring structure, workflow and resource allocation is designed around the patient through each stage of their hospital journey.
Structural improvements	Adopting basic structural improvements – ensuring adherence to best practice management spans and layers, consistency of roles, and defining clearly individual accountabilities and decision rights
Leadership Strategy	Developing a board-sponsored leadership strategy, based on business need and a clear set of expectations, and encompassing all leaders from board to front line
Operational management process	Implementing a comprehensive operational management process that drives operational performance, cost reduction, increased efficiency and continuous improvement
Dashboards	Adopting the model hospital dashboards with metrics that provide a balanced view of patient, people and financial performance
Individual performance management system	Introducing an individual performance management system for appraising both task and behavioural performance for every individual in the trust, including a range of feedback mechanisms and linking this to consequences including reward, development, career progression
Engagement	Building engagement across all occupational groups – harnessing the ideas and viewpoints of everyone in the trust, paying particular

	attention to clinical engagement and the role of the clinical leader
Colleague opinion survey	Repurposing the colleague opinion survey – reflecting more appropriately targeted questions and surveying sections of the workforce on a rolling monthly or bi-monthly basis to deliver a more timely pulse of people's views, and using the outcomes as a key metric in all managers' performance appraisals.

6.3 Strategic partnerships

In order to respond to the national policy direction to improve the quality of care whilst ensuring that services are sustainable, the Trust recognises the importance of partnership working. Our 4th strategic pillar focusses specifically on this, seeking to ***"build on existing partnerships and create new ones to deliver better care around patient needs***"

The Trust has developed a number of formal partnership arrangements both locally within the county of Lincolnshire and with other providers outside of Lincolnshire. These include:

- A partnership with Leicester Hospitals NHS Trust for provision of
  - Urology services
  - Robotic surgery
  - Vascular services
- A partnership with Nottingham University Hospitals for provision of:
  - Maxillo-facial surgery services
  - Major Trauma services (aligned to the trauma network)
- A partnership with Sheffield to support delivery of Neurology services in Lincolnshire

7 The STP (Sustainability Transformation Plan)

Lincolnshire's health and social care challenge

Lincolnshire's Sustainability and Transformation Partnership (STP) plan clearly outlines the residents' views and the financial and performance imperatives for why health and care services need to change:

- Key NHS standards are not being met
- 2,000 planned operations are cancelled every year
- In 2018/19, it is forecast that the system will spend £110m more than it has in funding.
- Too much money is spent on treating people in hospital, rather than on prevention and early intervention to support people in the community and prevent acute care needs. The current 'do nothing' scenario for Lincolnshire health and social care organisations is predicted to generate a £182m deficit by 2021 (providers and commissioners); within the acute sector, there is a predicted 13% growth requirement.

Achieving clinical and financial sustainability

System thinking at a national and local level is rapidly developing. There is recognition that if whole system change does not happen, it will be detrimental to patient care and the health of the population. Sustainability is only achievable at scale, across the system, not at service level. In the last 12 months, local senior leadership forums such as the Lincolnshire Co-ordinating Board (LCB), the Joint (shadow) Commissioning Committee, and the System Executive Team (SET) have all agreed to a system-wide approach to the problem.

Consequently, the Lincolnshire STP plan has been developed, which sets out five system themes that are planned to support £136m savings across the county, spanning across:

- Clinical redesign
- Capacity optimisation
- Operational efficiency
- Workforce productivity and redesign;
- Right Care/commissioning priorities.

Overall, there is a critical focus on a 'shift left', to support patient pathways that are more preventative and community based. These changes and governance surrounding shared decision-making and accountability will be managed through the LCB, Joint Commissioning Committee, and SET. The ambition is to reduce hospital activity through moving more care into the community as follows by 2022:

- Outpatient activity at ULHT will reduce by 21%.
- Presentations to the emergency departments will reduce by 27.5%.
- Non-elective will reduce by 12%.
- Elective activity will reduce by 10%.

Acute Services Review

The configuration of acute services within Lincolnshire must be clinically, operationally and financially sustainable and underpin the safe, efficient and effective delivery of quality services to the local population. A review of acute services across the county has been undertaken during 2018 within the context of the wider STP plan which aims to improve population health management, improve prevention and redesign community and primary care services.

It is acknowledged that the current STP plan is not ambitious enough to address quality, staffing and financial challenges across the system at sufficient pace. The acute services review (ASR) has focused on ensuring acute hospital provision across Lincolnshire is adequate to address both the growing demand across the county and the need to deliver the ambitions, and financial savings, set out in the STP plan. The review has considered current and projected future needs for hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care in line with the STP. Its aim has been to make a set of recommendations on the optimal configuration of acute hospital services across the Lincolnshire County to maximise clinical, quality, operational and financial sustainability to 2023.

Throughout 2018, commissioners and providers across the county came together to answer the question posed by the Lincolnshire Co-ordinating Board:

What is the optimum configuration of ULHT services (and the role of neighbouring acute trusts), in order to achieve a thriving acute hospital service in Lincolnshire (and for the population as a whole) achieving clinical and financial sustainability across the Lincolnshire NHS health economy?

This work, which is referred to locally as the Acute Services Review (ASR), gathered specialty specific information from across ULHT to establish the case for change and evaluate potential alternatives. The output from the ASR was shared with the East Midlands Clinical Senate in the autumn of 2018. In parallel KPMG developed a whole system model to assess the impact of different options on activity, finance and patient access. Public engagement events have and continue to take place to inform the future configuration of acute hospital services. A pre-consultation business case has been written and shared with NHS England, their response to the proposals is expected during the spring of 2019, and thereafter a consultation with the Public of Lincolnshire will begin, to consult on the changes to clinical services being proposed as a result of the ASR.

There are a number of challenges across the local health and care economy that have been addressed and considered as part of this review:

- Patient pathways across Lincolnshire are very hospital dependent, putting pressure on all acute provision across the county
- There is clinical variation across providers, including across sites within providers, impacting on patient care and outcomes
- There are significant workforce challenges both current and future e.g. low staff morale, low productivity, staff shortages, and impending future skills shortages
- Inefficiencies exist as there is duplication in services even across sites within providers -some services are sub-optimally sized and/or distributed over a large geographical footprint

ASR Phase 1

Approach

- Service review for each specialty within Lincolnshire using key drivers for change: quality, workforce, performance, accessibility and affordability
- Understanding of the future needs of the Lincolnshire population
- A proposed future state configuration for each specialty across the county
- Recommendations on the optimum configuration of services and the respective role of acute trusts serving Lincolnshire.

This work involved:

- Extensive engagement across ULHT and the wider health and care system
- Analysis of current performance data
- Population/activity modelling and impact analysis

Outcomes

- A base case in which configuration is not changed revealed that across Lincolnshire, bed requirements, activity, travel times and the financial deficit would all increase over the next five years.

- Eight specialty areas were identified as having a strong case for change and became the areas upon which reconfiguration scenarios were concentrated:
  - Breast
  - Trauma & Orthopaedics
  - General Surgery
  - Stroke
  - Acute Medicine
  - Women's and Children's
  - Urgent and emergency care pathways
  - Haematology & Oncology
- Using a set of agreed design principles, key leaders across Lincolnshire's health and care economy came to a professional opinion consensus regarding a preferred reconfiguration option for the future. This option aims to produce:
  - Improved financial position
  - Minimal impact on activity
  - Decreased bed requirements
  - Enhanced access, quality, sustainability and deliverability
  - Promotion of a 'one trust' team approach
  - Successful recruitment and retention of talent.

ASR Phase 2

The East Midlands Clinical Senate and NHS England agreed that there is a strong case for change in relation to some services and determined a best solution in terms of a future option for configuration of services. The system reached a consensus on the proposed solution and clinical reconfiguration for the eight services contained within the scope of the ASR.

Public engagement events have and continue to take place to inform the future configuration of acute hospital services. Detailed activity modelling has been completed for the proposed solution. A pre-consultation business case has been written and shared with NHS England, their feedback has led to more work being undertaken and it is hoped that the case will be approved by the end of June 2019. Thereafter a consultation with the Public of Lincolnshire will begin, to consult on the changes to clinical services being proposed as a result of the ASR.

ASR Phase 3

Following completion of the consultation with the public, the output of the consultation will be used to inform the "Decision Making Business Case", which is required to conclude the consultation process. Upon completion and approval of the Decision Making Business Case, the process will then move back into ULHT for delivery and implementation of the agreed new clinical service delivery models. It is hoped that this phase will begin in Quarter 4 of 2019/20.

➡ The ASR is a key strategic driver and the outputs will heavily inform the evolution of the Trust's 2021 Improvement Programme

The "Out of Hospital Services" Review

- The Development of "Out of Hospital Services Lincolnshire" has, for a number of years, been planning to achieve a significant change in the delivery of out of hospital care across the County and both the development of the initial STP Delivery Plan and the recent modelling work to support the ASR has added a real momentum to the Out of Hospital programme.

- Over the last two years there has been a real push to ensure delivery of key Programmes that will result in real change to community based services as set out in both the original STP Delivery Plan and the more recently developed Single System Plan, the main one being the development of Integrated Neighbourhood Working across the County.

- Lincolnshire's overarching aim for its Out of Hospital programme is to deliver pro-active, place based care, that will support people in local communities to remain well, independent at home, for as long as possible.

- Despite the work to date, in recent months it has been recognised that if Lincolnshire is to achieve the required shift of care from the acute hospital into a community setting then a more detailed and robust approach is required to truly achieve the shift of emphasis that has been aspired to. To this end the out of hospital work is moving into a robust programme of work, now re-named '***Integrated Community Care Programme'*** and although the detail is still emerging, it will incorporate a range of key work streams including Integrated Neighbourhood Working, community based urgent care, and Long Term Conditions – initially focusing on Diabetes.

- To support the further development of an integrated care system for Lincolnshire the following is underway:
    - A detailed analysis to provide a robust 'demand and capacity' model to inform the level of community services required to deliver the original modelling assumptions contained within the STP. It will also read across to the analytics undertaken for the ASR, to provide an understanding of the expected community impact as a result of the ASR implementation.
    - Working with key system leaders to determine what the 'vision' for an Integrated Care System in Lincolnshire would be and what actions would be necessary to realise it.
    - Work with three of the current Neighbourhood areas to support them to establish a systematic approach to population health management which can then be rolled out to all 12 Neighbourhood areas.

Summarising the essence of the Lincolnshire STP

The table below summarises the essence of the STP and demonstrates how it will be delivered.

System impact: supporting delivery of the Lincolnshire STP

Facilitating integration	• Working with established partners: across acute health care, community health, primary care, mental health and palliative care services to support the development of place-based services using integrated service delivery models

Moving care from acute hospitals to the community	• Neighbourhood Teams - Supporting the neighbourhood team model of care by providing in reach services for frailty, long term conditions management for diabetes, respiratory, heart failure, neurological conditions and stroke alongside the development of cross-organisational working to support the health and care needs of populations • Urgent Care - Developing a network of Urgent Care Treatment Centres as an accessible and more appropriate alternative to A&E that are staffed with an integrated staffing model drawing on skills from both primary and secondary care • Planned Care - Leading the 100 day NHSE transformation programme for Ophthalmology: Our ambition is that no patient goes outside of Lincolnshire to have their cataract operation. We will do this by ensuring referrals into secondary care are appropriate and as a result we will reduce the new referrals in to secondary care by 10% and improve our conversion rate from 60% to 90%. - In Dermatology**,** also through the NHS 100 day transformation programme and working in partnership with community primary care services for patients from a specific neighbourhood (East Lindsey tbc), the aim is to decrease median wait times between referral and treatment from 8 weeks to 6 weeks. - For Diabetes, and the final element of the NHSE 100 day transformation programme, again working with primary and community services colleagues, by the end of the 100 days the referral rate into specialist care will reduce by 50% for patients in 3 GP practices South West Lincolnshire CCG.
System Efficiency	• Introducing technology into acute care services across the Trust, including; telehealth, telemedicine and self-care apps to transform the way people engage in and control their own healthcare. • Using telemedicine to facilitate the introduction of one medical rota for stroke medicine across the Trust's hospital sites • Taking forward and implementing the recommendations from the national GIRFT (Getting it Right First Time) programme. Services currently in the programme for the Trust include; Trauma & Orthopaedics, Ophthalmology, General Surgery, Gynaecology, Vascular services and Urology. • Right-Care: positioning Trust services to be better placed to realise Right-Care – Commissioning for Value opportunities to improve outcomes & efficiencies, specifically with regards to reducing non-elective admissions.
Making it happen	• Supporting the development and implementation of: - Innovative contractual solutions (e.g. alliance, lead provider) which focus on system value, outcomes & accountability for STP delivery - The Single System Plan, which includes single system efficiency and investment plans and aligned incentives across providers

8 The Clinical Strategy for ULHT

The ULHT clinical strategy is an organisation led strategy for the clinical services that are provided by ULHT, but it is important to highlight that our clinical strategy has not been developed in isolation of the system led Acute Services Review, and Out of Hospital Integrated Community Care programmes of work. These programmes of work are closely aligned.

The ASR focussed on eight services as listed in section 7 and the out of hospital integrated community care programme of work is currently focussing on three areas, these being

- Enhanced Stroke rehabilitation
- Frailty
- Diabetes.

The ULHT clinical strategy also includes strategies for all other services provided by ULHT that are not included within the scope of the ASR and Integrated community care programme.

The case of need for change is compelling. The precise configuration of hospital services will be confirmed following consultation with the Lincolnshire population on the options proposed in the Acute Services Review. However, at this stage, our broad vision for services is to attain both clinical and financially sustainability through:

- Local access being maintained for outpatient and diagnostic and therapy services,
- Consolidation of some services based on clinical sustainability, safety and affordability but available to all
- Maximum use of Grantham and Louth for elective work, thereby ensuring their future viability
- Fewer hospital beds with sufficient protected elective beds to consistently meet patients' expectations for waiting times and timely access.
- Increased focus on Pilgrim and Lincoln for a broad range of emergency services where it is safe and viable to do so, but with a concentration of very specialised urgent care on fewer sites
- Rapid access to urgent care in the right place when needed with a tiered emergency and urgent care service that is staffed on a sustainable basis, with the development of urgent care models which are less dependent upon scarce skills
- Development and expansion of workforce skills to enable specialist care to be delivered in the community
- Development of different roles, where historically it has been difficult to recruit by the use of skill mix and training our own staff, where appropriate.

8.1 How we developed our clinical services strategy

Development of the clinical strategy started in July 2014 with the establishment of the Clinical Strategy Implementation Group chaired by the Medical Director.

It was recognised at that point in time that the driving factors for change focussed initially on four service areas, these being Women & Children's services from a clinical sustainability perspective, Urgent and Emergency Care services from both a clinical and financial sustainability perspective, Breast services from a clinical sustainability perspective and Orthopaedic services from a demand and capacity perspective.

Clinical project teams led by independent specialists were established for these four services to develop the future clinical strategy for these services, led by:

- Women and Children's services chaired by Dr.Shirine Boardman (Consultant Acute Physician)
- Emergency Care services chaired by Dr Neill Hepburn (Consultant Dermatologist)
- Orthopaedic Services chaired by Mr. Mohit Gupta (Consultant Ophthalmologist)
- Breast Services chaired by Dr. Gurdip Samra (Consultant Anaesthetist)

A number of staff engagement sessions were held in 2014 and in 2015 across each of our hospital sites to share the development of the clinical strategy and the emerging options, and to provide an opportunity for clinical and non-clinical staff at each of the hospital sites to input to the developmental work.

Each step in the developmental process was fully recorded and documented including the staff engagement sessions.

These clinical project teams developed the clinical service model options that have subsequently been approved at Trust Board level, and these align with the later work of the Acute Service Review. The options went through a non-financial options appraisal process, and were shared with the wider clinical teams.

Following on from the work completed by the above clinical teams, further work has been completed with the remaining clinical specialities and the newly formed Divisions to understand their longer-term strategic direction; this is detailed in the following sections.

9 The case for change

There are a number of challenges facing the NHS as a whole and within ULHT as an organisation

- **Why we need to change?**
- **We need to ensure we are giving our patients the best possible patient experience**
- **We need to ensure that we are delivering our services to the required clinical standards consistently**
- **We need to meet national waiting time standards consistently**
- **We need to find new ways to recruit and retain staff in all disciplines**
- **We need to ensure that our nursing workforce meets the safer staffing requirements**
- **We need to be able to attract specific medical posts in some specialties**
- **Our estate needs to be fit for healthcare in the 21st century**
- **We need to change how our services are delivered to make them affordable and sustainable**

The health needs of the people of Lincolnshire are changing; demands on our health services are increasing; the way we have organised our hospitals and primary care in the past will not meet the needs of the future

The population of Lincolnshire is facing major changes in its health and care needs and these are placing ever-greater demands on services provided by ULHT. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia.

Providing suitable care will mean providing more proactive services in the community and spending proportionately more on those services in local communities and less on hospitals. It is up to ULHT, in partnership with their CCG colleagues, county council, social care and other providers of care in Lincolnshire to focus on tackling these challenges, through an integrated care approach.

People needing hospital care must be sure of receiving the best possible services, and much progress has been made at ULHT – for example, in centralising heart attack care and major arterial surgery, but more of this is needed to improve the quality of and access to care.

For a number of clinical specialities, ULHT does not have the market share of activity for Lincolnshire that one would expect. The key point to note here is that market share for ULHT is declining further and the reasons for this include;

- GP referral patterns
- Quality of care
- Hospital reputation
- Inability to access appointment on the Choose and Book system
- Capacity not meeting the demand for services
- The environment is old and the physical condition of the buildings & facilities needs to improve, backlog maintenance is estimated to be £52m

The table below summarises the case for change at a speciality level as most recently identified in 2018 during the Acute Services Review Programme of work

1. Strong case for change	2. No case for change or will respond to changes in specialties activity	3. Some case for change but not currently prioritised
Breast: Lack of consistent model of care across sites and compliance with clinical guidelines, lack of breast radiologists and wider workforce issues.	**Clinical Support Services (Radiology, Nuclear Medicine, Audiology & Endoscopy, Therapies, Pharmacy)**: responds to changes in other specialities	**Care of the elderly**: operational sustainability challenges, not enough consultants. Strong co-dependency with Acute Medicine.
Trauma & Orthopaedics: currently unsustainable service with significant workforce and financial challenges.	**TACC: Anaesthetics & Pain Management, ICU & Critical Care**: responds to changes in other specialities	**OMF & Orthodontics**: heavily reliant on temporary workforce
General Surgery: workforce challenges limiting ability to provide adequate cover across the geography; not meeting performance targets.	**Gastroenterology**: no case for change other than to move towards the national model of a community led Diabetes service	**ENT**: high use of agency
Stroke: Clinical standards and performance standards not being met, and significant workforce	**Palliative care**: no case for change	**Ophthalmology**: shortage of staff nationally

gaps against clinical guidelines staffing levels.		
Acute Medicine including Respiratory, Cardiac Services: significant workforce challenges impacting on ability to deliver safe, quality service. Operationally unsustainable in current form.	**Diabetes and endocrinology**: no significant case for change	**Vascular**: recently consolidated services at Pilgrim, independent clinical review is expected to recommend that arterial work ceases to be provided in Lincolnshire with a transfer to a specialist centre.
Women's & Children are including Obstetrics, Gynaecology, Neonatology and Paediatrics: Significant staff shortages impacting capacity and ability to meet national standards on staffing. Quality challenges in Obs& Gynae and viability of current birthing units configuration in question.		**Interventional radiology**: a case for consolidation of vascular interventional radiology
Urgent & Emergency Care pathways: significant workforce issues impacting coverage. 4 hour target and financial challenges.		**Nephrology**: Uncertainty about appropriate level of inpatient services provided
Haematology& Oncology: heavy reliance on agency staff and lack of compliance with standards.		**Urology**: currently ongoing detailed piece of work to review Trust provision.
		Neurology: mainly outpatient activity, not a driving factor in reconfiguration

9.1 Clinical Sustainability

9.1.1 Fragile Services

Following on from the case for change identified as part of the Acute Services Review and summarised in the previous section, we have a growing number of clinical services that are not clinically sustainable in their current form, some are identified in the previous section.

Nine essential ULHT Clinical Services have struggled to be sustainable over the past 5 years with no obvious solution in the short to medium term (up to 3 years). Services are becoming increasingly unstable and more challenging to sustain with temporary solutions, which has the consequence of partial or complete service failure. As a result of these fragile services, patients experience long waiting times for a clinic appointment which impacts on our RTT and Cancer waiting time performance, delays in receiving treatment, clinical staff are over-stretched and at risk of burning out, and if services fail completely, then patients could die. In addition, there is a high financial cost attached in an attempt to sustain clinical care. All nine services struggling to sustain their service delivery are "*Commissioner Required Services"* and therefore, essential to Lincolnshire. Our

neighbouring out of county providers do not have capacity to take the patients from these delicate services at ULHT. The services currently on the Trusts risk register due to their fragile status are:

- Accident & Emergency
- Neurology
- Paediatrics & Neonatology
- Head and Neck (ENT/OMF)
- Acute Medicine
- Stroke Services
- Breast
- Haematology
- Oncology

9.1.2 Delivery of constitutional standards

Planned surgical procedures have been cancelled on a regular basis for a variety of reasons including medical emergencies and bed capacity. Therefore, our ability to meet the 28-day constitutional standard to re-schedule these patients has proved to be challenging resulting in financial penalties.

Patients needing treatment for cancer are often delayed due to a shortage of beds, and again this results in cancellation of surgery, and on occasion, chemotherapy and radiotherapy, although these two treatment modalities are generally delivered in an outpatient setting. Again, this is not good for the patient from the perspective of having life-saving treatment delayed, or palliative care for symptom management delayed, and leads to psychological stress for some patients. For the organisation, it results in failed performance against the constitutional standards for cancer, and subsequent financial penalties imposed by the Clinical Commissioning Groups.

9.1.3 The changing population profile

Lincolnshire has a rapidly expanding and ageing population resulting in an increased number of patients living with long term conditions, multiple co-morbidities and in general, expecting more from their health and care providers

9.1.4 Workforce recruitment and retention

One of the major challenges to health care services in Lincolnshire is recruitment and retention of medical and nursing staff; this is the key contributing factor to our clinical services becoming fragile.

9.1.5 Financial Affordability

The Trust is in Financial Special Measures and has submitted an 18 month Financial Recovery Plan (FRP) to NHSI that is inclusive of the 2019/20 financial year. The FRP and its underpinning assumptions were accepted by NHSI, inclusive of a forecast outturn for 2018/19 of £89.4m deficit with an improvement trajectory in 2019/20 to a £75.2m deficit.

Subsequently the Trust has been formally notified of its 2019/20 control total of £70.3m deficit before the application of PSF, FRF and MRET funding that are predicated on acceptance of and delivery of the £70.3m.

9.1.6 Quality

In addition the Trust is in Quality Special Measures and in 2018 the Trust was re-inspected by the CQC and received an improvement in their rating to 'Requires Improvement'. It is the Trust's ambition to improve that rating further to 'Good' and a Quality Improvement Plan is being implemented to that end.

9.2 Are our services clinically safe?

To answer this in one word, YES, our clinical services are clinically safe at the current time, ***but the cost of mitigating the risks to our clinical services is not sustainable in the medium to longer term***.

Is Doing Nothing an option?

If we do nothing then things will start to go wrong, patient safety will become a risk in areas identified earlier in this document, and our financial position, already a sizeable deficit, will deteriorate further. Although we strive, every day to deliver safe, clinically effective and financially sustainable services we know that the measures we have put in place can only be temporary.

Nationally there is a drive to reduce the dependency on hospitals; people want care closer to their own home that is responsive and timely. As services transfer into the community if we do not change within the hospital, it will increase our clinical and financial pressures.

The population is ageing; the good news is that life expectancy is improving and so people are living longer. For the NHS this increases the pressure on services because older people are more likely to develop long-term health conditions such as diabetes, heart disease, breathing difficulties and dementia. By 2033, all age groups are projected to grow with the largest increase in the group aged 75 and over. This age group is projected to more than double in size (109% between 2008 and 2033).

The population has different life expectancies. Lincolnshire varies in economic terms from place to place, and health varies with wealth; the poorer you are, the more likely you are to suffer ill health. There are areas of deprivation across Lincolnshire, but more evident on the East Coast.

In addition, we would still have our expensive old buildings that require increasing levels of maintenance just to be able to use them. If we do not maintain the buildings, we will not be able to use them.

Finally our problems with attracting and retaining high quality healthcare staff to Lincolnshire hospitals would continue if we do nothing. If we cannot attract the workforce required to deliver services, this means that we will struggle to deliver the best care, safe care, and as such, we would have to consider closing services.

Whilst our services are mostly providing good standards of care now, they cannot do this for much longer, and the impact of this on our patients and staff will only increase.

The Clinical Services Strategy 2019 to 2024

We have developed the vision for each of our hospital sites, so that everyone is clear on the direction that we are taking to redesign the way we deliver our services. Our Clinical Strategy sets out the detail of our clinical redesign.

The Trust has implemented a new Trust Operating Model which has restructured the Trust's services to operate across all sites via a Four Division structure: Surgery, Medicine, Women's Health and Clinical Support Services.

Our Divisions and the services that sit within each of them

Women's Health	Clinical Support Services	Surgery	Medicine
Breast	Radiology	General Surgery	A&E
Obstetrics & Gynaecology	Pathology	Vascular	Acute Medicine
Paediatrics	Audiology	Urology	Stroke
Neonatology	Medical Physics	Head & Neck	Endocrinology
	Rehabilitation Medicine	Trauma & Orthopaedics	Diabetes
	Occupational Therapy	Ophthalmology	Renal
	Speech & Language Therapy	Theatres	Cardiology
	Dietetics	Critical Care	Rheumatology
	Physiotherapy		Neurology
	Pharmacy		Gastroenterology
	Outpatients		Respiratory
	Haematology		Health Care of the Older Person
	Oncology		Dermatology
	Radiotherapy		
	Palliative Care		
	Chemotherapy		

10 Hospital site plans

10.1 What does the future clinical strategy mean for our hospital sites in the future?

The tables below show our proposed changes in service configuration at each of our hospital sites, and the additional services that would be delivered at each of the sites, together with the consequential impact on services that would not in future be delivered at each of the hospital sites.

Pilgrim Hospital

Will provide emergency and planned medical and surgical services, and will also become a Centre of Excellence for complex elective surgery. It is also proposed to sustain the delivery of specialised vascular services at the Pilgrim Hospital.

In summary the following services will be provided at the Pilgrim Hospital

Specialised services at Pilgrim Hospital

These are generally provided at fewer hospital sites in order to optimise the skill required and the quantity of technical equipment needed. The following list of specialist services will be available at Pilgrim Hospital, Boston and will be provided for both planned care and emergencies:

- Vascular services.
- Consultant led Obstetric service.
- Co-located midwifery led birthing unit.
- Consultant led Neonatal.

In addition to the specialised services, the table below sets out the full vision for the Pilgrim Hospital in the future.

Pilgrim Hospital Vision for the future	Consequence:
• 24/7 emergency department fronted by an Urgent Care Centre. • Short Stay Paediatric Assessment Unit • Vascular services • Consultant led Obstetric Service • 24/7 Co-located midwifery led birthing unit • 24/7 Consultant led Neonatology service • Complex inpatient elective surgery for General and Colorectal surgery, Urology, Gynaecology, Ophthalmology and Orthodontics. • Trauma and Orthopaedic services. • Day case surgery unit. • A full range of medicine services including: General medicine, Respiratory medicine, Gastroenterology medicine and Emergency medicine. • Care of the elderly, Frailty service. • Multi-speciality outpatient clinics. • Provision of medical specialities including: Neurology, Rheumatology, Dermatology, Diabetes and Endocrinology services. • Full range of diagnostic and clinical support services. • Day case Chemotherapy service	The following services will not be delivered at Pilgrim Hospital: • Stroke: Hyper Acute and Acute stroke services • Breast Diagnostic, Day Case and Inpatient Surgery • Inpatient Haematology & Oncology services

Lincoln County Hospital

Will provide emergency and planned medical and surgical services across the site, including specialised services, and “Centres of Excellence” for Cardiac Care, (Lincolnshire Heart Centre,

Stroke services, Breast diagnostic and surgical services, and inpatient Haematology and Oncology services.

Specialised services at Lincoln

These are generally provided at fewer hospital sites in order to optimise the skill required and the quantity of technical equipment needed. The following is the list of specialist services that will be available at Lincoln Hospital and will be provided for both planned care and emergencies:

- Consolidated Hyper Acute and Acute Stroke services.
- Cardiac Centre
- Consultant led Obstetric service.
- Co-located midwifery led birthing unit.
- Neonatal level 2
- Renal and Acute Kidney Injury service.
- Specialised rehabilitation medicine level 2a (Complex Patient Rehabilitation.). Inpatient Oncology and Haematology patients, including chemotherapy / radiotherapy treatments that need to be administered as an inpatient rather than day/outpatient.
- Oncology and Radiotherapy Centre providing for outpatients and day care patients.

In addition to the specialised services, the table below sets out the full vision for the Lincoln Hospital in the future

Lincoln Hospital vision for the future	Consequence
• 24/7 emergency department fronted by an Urgent Care Centre supported by GP streaming. • 24/7 Paediatric Emergency Department. • Hyper Acute and Acute Stroke services • Cardiac Centre • Consultant led Obstetric Service • Co-located midwifery led birthing unit • Neonatal level 2 • Renal and Acute Kidney Injury service • Specialised Rehabilitation Medicine level 2a • Oncology and Radiotherapy centre providing for outpatients and day care patients • Complex inpatient elective surgery for General and Colorectal surgery, Urology, Ear, Nose and Throat, Oral, Maxillo-Facial, Gynaecology, Ophthalmology and Orthodontics. • Trauma and Orthopaedic services. • Day case surgery procedures. • A full range of medicine services including: General medicine, Respiratory medicine,	• Some complex inpatient surgery will transfer to Pilgrim • Some - day case activity will move to Grantham

Gastroenterology medicine and Emergency medicine. • Care of the elderly, Frailty service, and Day-case and Inpatient Chemotherapy service. • Radiotherapy services. • Multi-speciality outpatient clinics. • Provision of medical specialities including; Neurology, Dermatology, Diabetes and Endocrinology services. • Full range of diagnostic and clinical support services. • A Centre of Excellence for Breast Cancer diagnostic and surgical treatment services.	

Grantham Hospital

Will provide care for a range of clinical conditions and become the Centre of Excellence for Planned Care in Lincolnshire. Grantham will deliver urgent care through the Urgent Treatment Centre and the Ambulatory Care Centre.

Grantham Hospital vision for the future	Consequence:
• Urgent Care and Ambulatory Care. • Short stay, low complex inpatient planned surgery for a range of specialities including; General Surgery, Orthopaedics, Gynaecology, ENT and Urology. • Day Case Surgical Unit. • Medical beds. • Full range of Diagnostic and Clinical support services. • Mobile Chemotherapy service. • Palliative care, St Barnabas Hospice. • Multi-speciality outpatient clinics. • Children's Ambulatory Care facility	• Only a very small number of patients currently treated at Grantham will need to be treated at either Lincoln or Pilgrim Hospital

10.2 Louth Hospital

This is not a ULHT hospital; however, ULHT currently provides services for a number of clinical specialities at this venue and will continue to do so. Activities provided by ULHT at Louth will include:

- Increased day case activity providing more access for local residents and to the Lincolnshire wide population.

- Increased use of operating theatres.
- Continue to run Outpatient clinics and Outpatient procedures.

10.3 Other venues

It is expected that a range of ambulatory services, predominantly outpatient services, will also be provided at locations around the county to make them more accessible to local communities. The activity assumptions included in the STP by 2022:

- Outpatient activity at ULHT will reduce by 21%.
- Presentations to the emergency departments will reduce by 27.5%.
- Non-elective will reduce by 12%.
- Elective activity will reduce by 10%.
- Some activity is anticipated to stop, due to care in the community being stepped up.

Some activity will be delivered differently, adopted and "integrated care" approach including care in venues other than our hospitals, and in the Urgent Care Centres that form the front of our Emergency Departments.

11 Divisional Clinical Strategies

11.1 Division of Surgery

11.1.1 Trauma and Orthopaedics

Grantham Hospital will become a centre of excellence for planned and day case orthopaedic surgery. Lincoln and Pilgrim Hospitals will provide some day case surgery and planned surgery for patients with more complex needs.

Outpatient services will remain at Lincoln, Pilgrim and Grantham hospital.

Benefits of this model include:

- Protected capacity for elective surgical procedures
- Reduction in the number of cancelled procedures
- Reduction in waiting time for treatment
- Better results for patients with lower rates of readmission after surgery
- Reduced length of stay in hospital
- Reduced risk of infection and injuries
- Trauma patients seen more quickly by more specialised clinicians
- Improved job satisfaction, and moral for our staff
- Increased productivity through theatres
- Opportunities to repatriate patient activity currently going to other providers

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11.1.2 General Surgery and Urology

The strategy for general surgery and Urology is to consolidate most elective care and make Grantham Hospital a centre of excellence for elective short stay and day case surgery. Lincoln and Pilgrim Hospitals will provide some day case and elective care for patients who require complex surgery and those patients with complex needs.

Outpatients will remain at all three hospitals. The benefits of this direction include:

- Protected capacity for elective surgical procedures
- Reduction in the number of cancelled procedures
- Reduction in waiting time for treatment
- Better results for patients with lower rates of readmission after surgery
- Reduced length of stay in hospital
- Reduced risk of infection and injuries
- Improved job satisfaction, and moral for our staff
- Increased productivity through theatres
- Opportunities to repatriate patient activity currently going to other providers

The partnership with Leicester around Robotic surgery for Urology will continue, and more activity from Leicester will be undertaken at the Grantham Hospital as part of this partnership.

The provision of Robotic surgery at ULHT will be further explored as part of the development of the strategic outline case.

11.1.3 Head and Neck

Little change is proposed to the Head and Neck services (Ophthalmology, ENT, and Oral Maxillo Facial), with outpatients continuing at all hospital sites. Consolidation of some elective surgery at the Grantham and Louth Hospital sites may develop in order to deliver the same benefits as identified for general surgery and urology.

Hospital Dentistry plans to cease new patient consultation clinics at Pilgrim Hospital in July 2019. Following this, the intention is to cease all orthodontic clinics at Pilgrim from 1st October 2019. The service will then be concentrated at Lincoln and Grantham with fortnightly outreach clinics at Louth. A review of the service provision at Gainsborough is underway, and this may cease if it is not financially sustainable.

11.1.4 Vascular surgery

Vascular surgery is one of those services classified as “specialised services” commissioned by the NHSE Specialised Commissioning Team. The latest planning guidance for 2019/2020 is directing each region of the country to establish “***Specialised Services Planning Network Boards”*** to ensure that specialised services are in the future, considered in a more systematic way, with integration of specialised services within local health and care systems, and with better engagement from Specialised Commissioners both into acute trusts collectively and ultimately into the STPs/ICSs. NHS England & Improvement is encouraging all providers to move from competition to collaboration for these services.

ULHT has been working with the Specialised Commissioning Team towards retaining “hub” status for vascular services in Lincolnshire. The service does not meet two of the current service criteria from the service specification as follows:

- The number of AAA procedures performed per annum should be 60, and ULHT perform between 30 and 40
- The number of Interventional Radiologists in post is 3.0 wte, and the specification requires 6.0 wte

These two areas need to be addressed. Discussions are in progress about repatriating some patients who currently travel to Peterborough for Vascular services. The patient pathway to

Peterborough is not optimum, as patients travel to Peterborough for their first outpatient appointment, but then have to go to Cambridge for surgery. If referred into the Pilgrim site, the patients could have their outpatient and treatment at the same hospital site.

ULHT has successfully partnered with Leicester Hospitals NHS Trust to train and perform EVAR (Endovascular Aneurysm Repair).

The Strategic direction for vascular services is to retain the full "hub" status at the Pilgrim Hospital, working with the Specialised Services Planning Network Board to sustain this. The Trust recognises that we should look to move Vascular services to the Lincoln site to be co-located with the consolidated stroke and cardiac services, however, the capital investment to achieve this would be significant. This case may be revisited in the future, but current strategic direction is to maintain this specialised service at the Pilgrim site.

11.1.5 Day Case Surgical Units

It is proposed that Day-case surgical units are established on the Lincoln and Grantham sites. Pilgrim already has a Day-case unit.

11.1.6 Theatres

The impact of the strategy for surgical services discussed thus far in this section is such that additional theatre capacity will be required at the Grantham Hospital site. Initial modelling of activity changes indicate that two additional theatres will be required at the Grantham Hospital site to support the movement of the elective activity described above, together with repatriation of activity planned for the future, and to sustain the anticipated growth of activity in the future. Although this may be offset by moving towards a 6-day operating week, even with this, the existing four theatres will not be sufficient to support the movement of activity and repatriation of activity from other providers within Lincolnshire and from across the borders.

The additional theatre capacity required at the Grantham Hospital site will require either capital investment to build the theatres, or revenue investment to have "mobile" Vanguard theatre facilities.

Part of the strategic outline case will need to identify where theatre capacity on the Lincoln and Pilgrim sites can be reduced if activity is moved from these sites to Grantham. The option of "mothballing" some of theatre capacity at Lincoln and Pilgrim will be explored to cover the running costs of additional theatre capacity at Grantham.

11.1.7 Critical Care

No strategic change is planned to the Critical Care service, therefore the Acute Care Unit (level 1) care will continue at the Grantham site, and Critical Care Unit (level 3) at both Pilgrim and Lincoln Hospital sites.

11.2 Medicine

11.2.1 Urgent & Emergency Care

National Definition of Emergency and Urgent Care

i.e. time critical and not time critical care

"Patients should not be expected to choose correctly between the two options, it is the function of the system to direct the patient to the correct level of care"
NHS England 2014

The strategy for Urgent and Emergency care services is to:

- Maintain A&E /Emergency Department services at both Lincoln and Pilgrim Hospitals, and to add an Urgent Treatment Centre at both sites
- Remove the A&E branding at the Grantham Hospital and establish an Urgent Treatment Centre

Paediatric Emergency Department
The strategy also includes establishing a separate Paediatric Emergency Department at both the Lincoln and the Pilgrim sites, which will share a reception area with the adult emergency department, but will be separated from the adult emergency department treatment areas.

Resus facilities
The resus area at both Lincoln and Pilgrim need to be extended, with a revision of how the footprint will look for the Emergency Departments after the Urgent Treatment Centres become operational, as these will take a significant volume of patients out of the Emergency Departments.

Urgent Treatment Centres
There is a national service specification for Urgent Treatment Centres, and this is what will be used to guide the implementation of Urgent Treatment Centres at all of the ULHT Hospital sites.

A new Urgent Treatment Centre will be introduced at the Grantham Hospital to provide 24 hour, 7 day a week access to urgent care services locally. It is expected that the doors will be open for walk in patients 16 hours per day, in line with the national NHS service specification for Urgent Treatment Centres. This means that the vast majority of local patients who need care quickly will be supported in Grantham as they are now. To ensure the local population receive the right urgent and emergency care, overnight access to this Urgent Treatment Centre at Grantham will be supported by NHS111 to ensure patients are sent to the right place, first time. NHS 111 will serve as the entry point to the Urgent Treatment Centre during the overnight period.

The Urgent Treatment Centre at Grantham will still be able to receive patients by ambulance. Refinements to the current access criteria will ensure that critically injured and ill patients will be cared for at the their nearest A&E emergency department; treated safely and quickly by staff who have the right training and experience to give the best outcome.

The Urgent Treatment Centres located on the ULHT Hospital sites will be provided by the Community Health services rather than ULHT, but with ULHT hospital clinicians providing specialist

advice where this is required for patients. This is the true definition of providing Integrated Care in order to get the best outcome for patients.

11.2.2 Acute Medicine

Across the county there are not enough Consultants to deliver the medicine services in our three hospitals, and a number of our medicine specialities are now on the Trust risk register because they have become fragile and are at risk of not being clinically sustainable. The challenge is recruiting into the vacant posts, a challenge that is a national one and not confined to Lincolnshire.

We need to get patients to the right specialities quickly, matching patient need to the appropriate expertise. The current medicine services at Grantham Hospital deal with a restricted range of cases, patients with lower acuity than those treated at Lincoln & Pilgrim hospitals, and receive fewer patients than at Lincoln and Pilgrim Hospitals.

The strategy for acute medicine is to see it continue in its current form at the Pilgrim and Lincoln Hospital sites, providing the full range of ULHT Consultant led acute medicine services.

Integrated services for Grantham

The strategy for Grantham is to bring a change in the way medicine is delivered at the Grantham Hospital site, one that is clearly supported by the new NHS long term plan (published January 2019). Grantham Hospital will adopt a new model whereby they are joined to local primary and community services and managed as part of the local enhanced neighbourhood team. The new model will be led by Community Health Services, not by ULHT, but with ULHT hospital doctors and the hospital services being part of an integrated service. In practice, the medical beds will be managed by the Community Health services; they will not be included in the ULHT bed stock. ULHT Clinicians will continue to provide medical outpatient services at Grantham Hospital, and can be called upon to in-reach to the inpatient wards to provide consultation and advice.

This new model for Grantham is aimed at keeping people at home for as long as possible and when hospital care is required, delivering that in Grantham and supporting patients to get back home safely, as quickly as possible.

Initial modelling of the new medical model has demonstrated that only a small number of patients currently seen and treated on the Grantham site will need to be admitted to hospitals with more specialist services.

The integrated service model will also deliver more ambulatory care, including diagnosis, observation, consultation, treatment, and intervention and rehabilitation services. This ambulatory care model will also be adopted at Pilgrim and Lincoln Hospitals.

The benefits of the new strategy:

- Will see community and hospital teams working as one integrated team to prevent hospital admissions, providing coordinated care when hospital is required, and where possible reduce the length of times patients stay in hospital, working to the principle of care closer to home.
- The majority of patients currently treated at Grantham will continue to be treated at Grantham Hospital
- The most acutely ill patients will get the right specialist care, first time

"Emergency Floor" for Lincoln and Pilgrim Hospitals

The current ambulatory service areas at both Lincoln and Pilgrim Hospitals are often used for escalation (emergency admissions). The future strategy will see the ambulatory service being co-located with a combined surgical and medical assessment unit, emergency department and urgent

treatment centre, thus providing an “emergency floor” or otherwise known as an “emergency village” approach that will improve the flow of patients through the emergency care and assessment pathway. This will facilitate both medical and surgical patients for assessment so that the patients get to the right place first time and where possible are discharged from the assessment facility to return as an outpatient, or for a planned procedure or treatment.

11.2.3 Stroke services

The current model for stroke services at ULHT is such that both hyper-acute (Day 0 to 3 on the pathway), and acute stroke services (Day 3 + on the pathway) are provided at both Lincoln and at Pilgrim Hospitals. There is also stroke rehabilitation provided in the community by the community health service.

The stroke service at both Lincoln and at Pilgrim Hospitals is challenged by a shortage of both Stroke Consultants and nursing staff. There are currently only 2.0 wte substantive stroke consultants in post out of a funded establishment of 9.0 wte. The gaps in the workforce are patched with Locum consultants and Associate Specialists. This shortage of clinical staff makes it very difficult for the ULHT stroke service to meet and sustain the performance required in the national stroke audit (SSNAP), and is currently not achieving the best practice tariff for the care they provide. The stroke service is on the Trusts official list of fragile services.

Clinical evidence is clear that concentrating services in a specialist unit will reduce the number of deaths from stroke, improve rehabilitation, will get patients home more quickly, and will increase our ability to attract and recruit staff into the service. There is clear evidence that concentrating such expertise saves lives, the Lincolnshire Heart Centre is a good example of this.

The future strategy for ULHT stroke services is to adopt a centre of excellence approach, providing hyper-acute and acute stroke care from the Lincoln Hospital site only, thus consolidating the resources and the services at the Lincoln Hospital. This will provide the most robust model to meet national care standards for patients, and to attract, recruit and retain staff.

The future strategy also includes enhancing slow stream rehabilitation in the community across Lincolnshire, to reduce the length of stay for stroke patients in hospital from the current average of 14 days, down to 7 days in line with national best practice. This will reduce the overall number of beds needed in the hospital for stroke patients. It will allow the increase of hyper-acute stroke beds on the stroke unit to care for patients from the onset of their stroke for the first 72 hours of the pathway before stepping down into the acute stroke bed. The number of acute stroke beds will decrease significantly as the patient will be discharged on average at day 7 of their stroke pathway into the enhanced slow stream community rehabilitation service.

11.2.4 Diabetes and Endocrinology

There is a Lincolnshire system intention to move 90% of diabetes activity from the acute hospital, to a model that is delivered in the community. This is aligned to the national best practice model for diabetes. This will require the residual in-hospital service for complex diabetes patients to be reconfigured.

The ULHT Consultant Diabetologists form a third of the current acute medical rota across ULHT, and this will need to be sustained as we design the community model for diabetes, and the residual inpatient service at the acute hospital sites.

Endocrinology will be reviewed but is likely to remain a hospital based service delivery model, with some skill mix change.

11.2.5 HCOP (Health Care of the Older Person)

The strategy for health care of the older person has seen the total redesign of the clinical pathway introducing a ***"front door"*** frailty service, and the creation of a "***DTOC" ward (***Delayed transfers of care).

The strategy is challenging, due to the ever increasing number of patients, the co-dependencies with community services and a shortage of doctors to sustain the front door frailty service.

11.2.6 Cardiology

The Lincolnshire Heart Centre based at the Lincoln Hospital has a very good reputation nationally for its excellent clinical outcomes. The strategy for Cardiology is to further develop the service, introducing a complex Echo suite at Lincoln Hospital, and a third Cath Lab during the next five years.

There are currently six beds at the Grantham Hospital allocated to Cardiology, and the strategy is to close these and consolidate the six beds to the Lincoln Hospital site.

Cardiology outpatients and diagnostic services will continue at the Grantham Hospital.

11.2.7 Renal Services

The future direction for the renal medicine service is to establish an inpatient Kidney Dialysis facility on Burton ward; this will facilitate the repatriation of Lincolnshire patients who currently travel to Leicester for inpatient Dialysis.

11.2.8 Rheumatology, Neurology, Gastroenterology, Respiratory and Dermatology

Little change is proposed to the strategic model for these services, although we will see the community services working more closely with the hospital teams, providing an integrated care model for Rheumatology, Neurology, Respiratory and Dermatology, as some of the clinical pathways for these services can be successfully delivered in the community supported by an integrated workforce model.

11.3 Women and Children's Health

11.3.1 Breast Services

We are currently not able to sustain delivery of breast services (one-stop diagnostic, surgical treatment and follow up) on our three hospital sites. This is due to the challenges in recruiting clinical staff, predominantly Breast Radiologists. A number of actions have been completed to help with the issue including skill mix change, but the challenge still remains that we cannot sustain a three site service with the current workforce.

As a result of the workforce challenges, we are not able to deliver breast services as efficiently as we would like to, and this has been further reflected in the Trusts performance against the breast 2-week wait cancer performance standard, which we are failing to achieve by a very large margin.

This means that patients with suspected breast cancer are waiting longer for an appointment than they should, they are waiting longer to be diagnosed and this could impact on their eventual clinical outcome. The care and treatment we deliver is good, but the waiting time is too long to receive it.

The strategic vision for Breast services is to consolidate the breast services on the Lincoln Hospital site. Lincoln Hospital is the ideal site for consolidation because Sherwood Forest Hospitals NHS Trust has set up a new one-stop breast diagnostic service at the Newark Hospital. Patients needing treatment from this service will be referred to Newark's "sister" hospital; Kings Mill Hospital. Therefore patients in the South West of the county (Grantham and borders), would also have easy access to the Newark Hospital service. This is one of the reasons why it is favourable to consolidate the breast service at the Lincoln Hospital site, and "right size" the breast services in Lincolnshire.

Locating the Breast service at Lincoln Hospital will allow the Trust to create a "Centre of Excellence", maximising the utilisation of breast radiology resource, which is challenging to recruit and to retain.

This new model of care would mean that all follow up outpatient's appointments and routine breast mammography screening services would continue to be available across the county as they are now. It is the first appointments, the one-stop triple assessment diagnostic pathway, and the surgical treatments would be provided at the centre of excellence located at the Lincoln Hospital site.

This new strategy of creating a centre of excellence will:

- Reduce waiting times for patients to be seen in the one-stop diagnostic triple assessment clinic
- Standardise models of care so that all patients access the same high quality service
- Improve ability to deliver the national best practice guidelines, with all diagnostic tests being done at the first outpatient appointment, and the first outpatient appointment being within 14 days of referral by the GP
- Improve recruitment and retention of staff as staff are attracted to working in specialist environments, centres of excellence

The option for introducing a new treatment for breast cancer will be reviewed; the treatment is "Intra-Operative Radiotherapy". This is where radiotherapy is given during a surgical procedure. Results of national trials are awaited to inform the future direction of this for Lincolnshire.

The Breast services currently at Lincoln are moving into a new location from May 2019, this will release the fourth floor of the Maternity Wing at Lincoln. The new location for the breast service will also allow for further extension to be made to accommodate the consolidation of the breast service.

11.3.2 Obstetrics, Gynaecology, Paediatrics and Neonatology

We have significant staffing issues particularly at the Pilgrim Hospital site relating to Paediatric middle grade posts. Currently there is 1.0 wte substantive middle grades out of a funded establishment of 6.0 wte. This is further challenged by the difficulty in obtaining temporary agency and /or locum medical staff to cover the gaps.

In addition, a shortage of consultants also makes it more difficult to support the junior doctors, with their training requirements.

This shortage of medical staff has led to a heavy reliance on agency staff, which adds financial pressure to the Trusts delicate financial position, and also leaves the Obstetrics and Paediatric services in a very fragile state.

The link between Paediatrics and Obstetrics

At this point, we need to highlight the link between Paediatric and Obstetric services. In addition to providing Paediatric services, the Paediatric medical team also provide the Neonatology service, which is a fundamental requirement for a Consultant led Obstetric service. As babies are not always born at the time they should be and some are unfortunately not born well, and need the intervention and care from the Neonatology specialist team.

Across ULHT we want to continue to provide both Paediatric and Neonatology services and in order to sustain both Paediatric and Neonatology services at both Lincoln and Pilgrim hospitals, we introduced temporary changes on the grounds of safety with effect from August 2018. These changes are:

- Closure of the paediatric in-patient beds and the opening of a short stay Paediatric assessment unit at the Pilgrim site. The assessment unit is open for 12 hours per day, and any child needing to be admitted to a hospital bed is transferred to the Lincoln site
- Any babies born pre 34 weeks gestation at Pilgrim are transferred to the Lincoln Neonatology service where there are more staff and equipment to handle the special needs of these premature infants

Future strategy for obstetrics, paediatrics and neonatology

Pilgrim Hospital

- Continue with a consultant led obstetric service with the addition of a co-located midwifery led unit
- Continue with a specialist care baby unit with Neonatology specialists, caring for babies born from 32 weeks gestation
- Establish a short stay paediatric assessment unit for children needing up to 23 hours of care
- Provision of paediatric day case surgery

Lincoln Hospital

- Continue with a consultant led obstetric service with the addition of a co-located midwifery led unit
- Continue with a neonatal unit caring for babies born from 27 weeks gestation
- Continue with a short stay paediatric assessment unit
- Continue with paediatric in-patient beds
- Continue with paediatric day case surgery and inpatient surgery

Many of the issues in the Paediatric & Neonatal services are workforce related, and we therefore need to develop a non-medical workforce solution to replace Doctors with Advanced Nurse Practitioners.

Future strategy for Gynaecology

The gynaecology service will remain the same as it is now on the Lincoln, Pilgrim and Grantham hospital sites.

How does this differ from what we have currently and how can we deliver this?

This is very similar to the clinical models that are in place today, the difference will be in the way the new strategy will be delivered, which will be through one clinical team working across the two hospital sites, and supported by robust community pathways.

11.4 Clinical Support Services

11.4.1 Haematology and Oncology Services

Haematology and Oncology services have also been added to the Trusts list of fragile services, due to the current medical staffing vacancies and difficulties in recruiting and retaining medical staff. We also know that the number of people diagnosed with cancer is increasing and the number of patients being seen in the haematology and oncology services is increasing.

As a result of the staffing challenges, and the increased demand for activity, patients are waiting too long to be seen, and we are not achieving the performance against the national standards.

The future strategy for our haematology and oncology services is to consolidate the inpatient services at the Lincoln Hospital. All other services will remain the same; this means that haematology and oncology outpatient and day case activity (except Radiotherapy, which will continue on the Lincoln site) will continue to be provided locally at all three hospital sites, creating no additional travel for patients for these most frequent appointments. The provision of outpatient and day case oncology appointments at Grantham will increase over what is provided at the current time.

This new strategy will optimise the efficiency of the medical and nursing staff. In practice, this means:

- That both planned and emergency admissions for oncology and haematology will be to the Lincoln Hospital.
- Inpatient chemotherapy and Radiotherapy treatment will be provided at the Lincoln Hospital
- Day case Radiotherapy treatment will continue to be provided at the Lincoln Hospital
- Day case Chemotherapy treatment will continue to be provided at all hospital sites
- Outpatient activity will continue to be provided at all hospital sites

The benefits of this new strategy include:

- People with the worry of a cancer diagnosis will see a specialist and receive treatment much sooner
- Improving our ability to attract and retain staff and maximise the efficiency of our consultants
- Reducing our reliance on high cost agency staff
- Providing services that will be fit for the future and meet the needs of the anticipated growing number of people with cancer

Additional developments in Haematology and Oncology

Acute Oncology Services

The following developments are also being planned for the Haematology & Oncology service:

Enhancing the Acute Oncology service at Pilgrim and at Lincoln Hospitals. For Pilgrim, this will ensure that patients are assessed fully and treated where possible to avoid un-necessary transfer to the Lincoln Hospital site, following consolidation of the inpatient services.

The Acute Oncology services will be supported delivered by a specialty doctor, and Acute Oncology Clinical Nurse Specialist and a Consultant on call.

Expanding the estate

The patient activity in Oncology and Haematology has increased significantly over recent years and the services have outgrown their facilities to deliver outpatients and day case chemotherapy services. Therefore, the plans include extending the chemotherapy suite at Pilgrim Hospital, and extending the outpatient and day-case chemotherapy facility at Lincoln Hospital.

Rapid Diagnostic centres for cancer providing diagnosis by Day 28 in the patient pathway

New 'one stop shops' designed to speed-up cancer diagnosis and help save lives are being rolled out across the country.

Rapid diagnostic and assessment centres are being piloted in ten areas as part of NHS England's drive to catch cancer early and speed up diagnosis for people with cancer.

Each of the centres will operate in a different way to ensure they meet the needs of their local communities. However, all have the same purpose – to diagnose cancers early in people who do not have 'alarm symptoms' for a specific type of cancer.

People with vague, non-specific symptoms, such as unexplained weight loss, appetite loss or abdominal pain are often referred multiple times for different tests for different cancers, but these new centres will help end this cycle.

If a GP or other healthcare professional suspect cancer, they will now be able to refer to a one stop shop where all the necessary investigations can be done under one roof.

Some patients will receive a definitive diagnosis or all clear on the same day; while others will need to undergo further assessment, but can generally expect a diagnosis within two weeks of their first appointment.

These new centres are part of NHS's plan to meet the new faster diagnosis standard, where patients with suspected cancer should receive a diagnosis or the all clear within 28-days.

Those diagnosed with cancer can be referred on to specialists, while those with benign conditions receive appropriate treatment and tailored advice about prevention.

The concept for a multidisciplinary diagnostic centre originated in Denmark, and was developed in response to the issue of patients presenting with vague symptoms being referred for multiple tests, when they required an urgent diagnosis.

We will be exploring how one-stop rapid diagnostic services can be delivered at ULHT hospital sites in order to achieve performance against the new cancer standard being introduced; *Diagnosis by Day 28 in the pathway*.

11.4.2 Radiology and Endoscopy

No change to the current service model planned.

11.4.3 Therapy Services

Continue with the current service strategies for Therapies, and working more closely with Community colleagues to provide integrated models of care.

11.4.4 Pharmacy & Medicine Optimisation Services

Key Objectives and Targets

- Restructuring of aseptic services, based on the national aseptic review, with a view to moving from two aseptic compounding units to one centralised ULHT aseptic compounding unit.
- Proposal to develop a Joint Venture Partnership to deliver Pharmacy Aseptic Services.
- Increasing the number of pharmacy cancer services and aseptic staff to nationally benchmarked levels to address unsafe capacity of over 80%.
- Implementation of ePMA.
- Implementation of automated supply and distribution services.
- Implementation of the Falsified Medicines Directive (FMD).
- Development of Divisional Medicines Optimisation and Safety work-programmes.
- Increase the number of pharmacist prescribers to undertake prescribing around medicines reconciliation on admission and discharge.
- Increase clinical pharmacy technician time by developing ward-based clinical pharmacy technicians.
- Increase Pharmacy Support Worker clinical time to enable PSWs to undertake ward-based activities.
- Expanding pharmacy technician apprenticeships.
- Implement Pharmacy 7-day services.
- Development of Pharmacy discharge teams.
- Implementation of over-labelled packs.
- Implementation of pilots for ED Pharmacists.
- Implementation of Medicines Optimisation (MOCH) in Nursing Homes pilots.
- Develop satellite dispensaries at PHB and LCH.
- Develop a Transfer of Care Around Medicines Programme (TCAM).
- Focus on improving recruitment and retention.
- Review pharmaceutical supply chain shortages.
- Implement OPAT.
- Refurbishment of the Pharmacy Departments at LCH, PHB, GDH and Louth Hospital.
- Trust-wide electronic web-based ward and clinical area fridge monitoring (Tutella).
- Development of a set of Pharmacy and Medicines Optimisation KPIs based on NHSI standards and Model Hospital KPIs.
- Development of the STP Prescribing and Pharmacy Work-Programme.

12 Clinical Strategy – overarching priorities

12.1 Transferring activity from the hospital to a community delivery model

12.2 Repatriation of market share

The future recovery of the financial deficit in ULHT is partially dependent on repatriation of activity from our competitors both in the NHS and in the private sector. ULHT currently captures

approximately 50% overall market share in Lincolnshire, this means that 50% of Lincolnshire residents are either travelling out of Lincolnshire for health care, or, they are being treated by private providers in Lincolnshire.

One of the top priorities in the ULHT Clinical Strategy is to win back market share, to increase the viability and sustainability of our clinical services.

To be successful in winning back market share, we need to:

- Work hard to improve our reputation and branding in the county and out of the county
- Ensure we have the capacity in place to deliver the addition market share
- Deliver good quality services, with good accessibility and good clinical outcomes

Our strategic objective is to win back at least 30% of our competitor's market share.

The activity that is likely to be repatriated will be suitable for Grantham Hospital, and work is underway to confirm the theatre capacity that will be required to support repatriation.

12.3 Building up the reputation of our organisation and services

We provide good quality services in many areas of our organisation, and we need to communicate our "good news" stories out to the community in order to build up our reputation with the outside world. If we are to repatriate activity into ULHT, we will need to have a solid reputation for good quality, sound delivery, and good clinical outcomes.

We will work hard with our GP colleagues in Primary Care, to encourage them to change their referral approach and behaviour, and refer patients back into ULHT.

For the GP's to refer patients into ULHT, not only will we need to provide good quality, sound delivery and good clinical outcomes, but our services need to be accessible via the electronic booking systems, and we need excellent communication back to the GP when the patient has completed their treatment pathway with ULHT.

We will need to establish a communication strategy that sells our services everywhere; this will assist in repatriation of activity and in recruiting staff into Lincolnshire.

12.4 Seven day services

The organisation has completed a gap analysis to understand what would be needed to comply with the clinical standards set out by the NHS Services Seven Days a Week Forum

The recommendations from the internal review will be used to identify investment required to comply with the required standards.

Priority will be allocated to the first four of the 10 standards (the immediate priority set by NHS England) set for seven day services as follows:

- **Standard 2: Time to first consultant review** – all emergency patients seen by a suitable consultant within a maximum of 14 hours
- **Standard 3: Multi-disciplinary team (MDT) review** – within 14 hours, integrated management plan with estimated discharge date in place within 24 hours

- **Standard 5: Diagnostics** – inpatient seven-day access to diagnostic services. Consultant-directed diagnostic tests and their reporting within one hour for critical patients; within 12 hours for urgent patients; and within 24 hours for non-urgent patients
- **Standard 8 On-going review** – all patients on high dependency areas including EMU/CDU, must be seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours , seven days a week

12.5 Telemedicine and increased use of Technology

The strategic direction is to maximise the use of telemedicine in all specialties, for example the introduction of remote consultations, such as virtual fracture clinics, and to support clinical services across all hospital sites. For example, a paediatric patient in the paediatric assessment unit at the Pilgrim Hospital may benefit from a telemedicine consultation with the on-call paediatric consultant at the Lincoln site, and this could, prevent an un-necessary inter-hospital transfer for the patient and their family.

The STP technology-working group has introduced a portal in Lincolnshire that will facilitate the access to patient information in all care settings for the clinicians. For the first time, acute care clinicians will be able to access the patient medical records in primary care and vice-versa.

The use of new technology will assist with delivery of healthcare in the remote areas of Lincolnshire, and will reduce the amount of un-necessary travelling for our patients.

12.5 Capital funding

The clinical strategy will not be delivered without capital funding. The Trust cannot generate sufficient capital to deliver the strategy and therefore via the STP/Acute Service Review, a programme of work is underway to identify the funding sources for the capital needed.

12.6 Acute Services Review & the NHSE Gateway process of approval

The output from the Acute Services review has been shared with NHSE who met with the ULHT Executives and the STP Executive Director, John Turner on the 5th December 2018 to discuss their initial thoughts.

This has led to more work being undertaken and the Pre-Consultation business case being reviewed and amended. NHSE has stipulated to the Lincolnshire Health & Care system, that Consultation with the public on the proposed changes cannot commence until capital funding sources have been identified. This therefore impacts on the delivery plan for the output from the Acute Services Review, together with our Clinical Strategy, which is aligned to the output from the Acute Services Review.

This therefore limits what we are able to deliver from our clinical strategy, but we can continue to deliver the elements that do not require consultation with the public.

The delivery plan in section 13 below provides an estimate of the timescales for the NHSE gateway process and consultation with the public on the output from the Acute Services Review.

13. Delivery Plan for the output of the ASR – major transformation

Timescales

The Acute Services Review is at the stage of finalising the pre-consultation business, and it is hoped that this will be finalised and approved through local provider and commissioning boards by the end of May 2019. Approval from NHSE is then sought and it is hoped that this may be achieved by the end of June. If we are able to identify capital funding sources, the STP will then be in a position to start the consultation process with the public. Therefore, very high level indicative timescales for implementation of the Acute Services Review and Clinical Strategy are as follows:

Very Estimated start/implementation Date	Scheme	Comments
Sept/Oct 2019	Consultation on the ASR starts with the public	Subject to identifying capital funding source
Feb 2020	Completion of Decision Making Business Case	
April 2020	Hand over implementation phase to ULHT (for completion of Strategic Outline Case, Outline Business Cases & Full Business Cases and then implementation	
April 2020	Co-located midwifery led units opened	Business cases being prepared in 2019, is not reliant on public consultation
May 2019	Move as much surgical activity to Grantham as current theatre capacity will permit	Undertake on a pilot basis
Jan 2021	Additional theatre capacity in place at Grantham	(Capital or revenue options)
Jan 2021	Move more surgical activity to Grantham aligned to the ASR Planned activity movement for General surgery, Urology & Orthopaedics	Plus other specialities e.g. ENT, Ophthalmology
July 2021	Consolidation of breast services at Lincoln Hospital	
Sept 2021	Consolidation of stroke services at Lincoln Hospital	
April 2022	Consolidation of Haematology & Oncology	

A number of the services in the table above are on the Trust risk register as being very fragile, and, therefore action may be required before the estimated timescales in the table above to ensure patient safety and sustainability of the service.

Governance and oversight of delivery by Clinical Transformation Steering Group

The delivery of the ASR/Clinical strategy will be undertaken by the Divisions, coordinated & supported by the Clinical Strategy & Transformation team within the Medical Directorate. The delivery and implementation will be overseen by the Clinical Transformation Steering Group, chaired by the Medical Director, which reports into the Trust Management Board.

14. Conclusion

The ULHT clinical strategy has been developed alongside the Acute Services review and the two programmes of work are fully aligned. The Clinical Strategy has focussed on restructuring the clinical models for service delivery to sustain the services across ULHT. .

One of the main cases for change throughout the strategy is linked to workforce, and especially the challenges in recruiting and retaining medical and nursing staff across a number of specialities. For some specialities, the strategic direction is to consolidate the services to one hospital site, which will optimise the use of the medical resource where medical resource is critical to service delivery. However, opportunities exist in some clinical specialties to change the "skill mix" within the workforce, and this requires restructuring the workforce to include more nurse led activities, and advanced nurse practitioner roles.

New technology will be critical to delivery of the clinical strategy, in addressing the challenges associated with the rurality of our county through the introduction of telehealth, giving clinicians the resource and technology to provide clinical expertise at a distance.

Background papers and referencing documents

This paper has referred to the following guidance and supporting information:

- NHS Five year Forward View
- The Dalton Review; "Examining new options & opportunities for providers of NHS care, (Sir David Dalton, December 2014)
- Delivering the Five Year Forward View: NHS Planning Guidance 2016/17 to 2020
- The Mandate from the Department of Health to NHS England published 17th December
- Transforming Urgent and Emergency Care Services in England (Sir Bruce Keogh, and Professor Keith Willets)
- Achieving World-Class Cancer Outcomes: A Cancer Strategy for the NHS 2015-2020 published 19th July 2015
- Independent report for the DOH by Lord Carter: Review of Operational Productivity in NHS providers: Interim report June 2015
- Details on the Government's Sustainability and Transformation Fund published on 16th December 2016
- The "Right Care Programme"
- "Getting it right first time", (Professor Timothy Briggs 2012)
- "Productivity in NHS hospitals" (Lord Carter, 2015)
- NHS Long Term Plan January 2019
- NHS Rapid Diagnosis for cancer April 2019

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 May 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	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Financial Performance Source of assurance: The Committee received the Integrated Performance and Finance reports and noted that the Trust was reporting a deficit of £6.7m, which was £16k favourable against the planned deficit. However, this was mainly due to operating expenses being £696k below plan, as the paybill was £613k over plan and income was £128k under plan. The Finance team were analysing the reasons for these significant variances. Divisional budgets were being discussed at Performance Review Meetings in May. Agency spend had reduced by £200k, but still remained over budget. Further work was taking place on the 4 proposed CQUINS for 2019/20, but as these had still not been signed off, therefore the CQUIN actions will need to be delivered in months 3-12. The capital plan had been agreed at £31.3m, with £500k unallocated for in-year contingency. Spend on Fire Compliance Works was being reviewed between Procurement, Finance and Estates and an application had been made to Lincolnshire Fire and Rescue for an extension to the enforcement notice deadlines where contractors were unable to complete all the work required within the timescales. A phased capital plan would be brought to the Committee in June. The Committee were asked to support revenue borrowing of £6.717m and £1.6m capital borrowing, in line with the initial plan for 2019/20. The borrowing trajectory for revenue had been included in the IPR and a trajectory for capital borrowing would be produced in June. The Committee gave support to the borrowing and recommended Board

	approval.
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception report from Financial Turnaround Group Source of assurance: The Committee received the report and noted the drive to ensure full delivery of the £25.6m plan. A risk adjusted plan had been produced, which reduced the value of the plan to £21.5m. At Month 1, the Trust was behind plan by £421k and there are further risks to the plan from the 4 standards required to reduce the maternity CNST premium and deliver the required output from job planning. If these savings could not be delivered, additional efficiency schemes would be needed to make up the shortfall.
	Lack of Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Health and Safety Assurance Reports, including Manual Handling and Managers Fulfilling Legal Responsibilities for Health and Safety Source of Assurance: The Committee received a suite of papers in respect of Health and Safety. Key points noted were: • Health and safety declaration within ESR was being introduced for both staff and managers, confirming that safety checks were being completed and training had been received. It was anticipated this would be in place by the end of May. • Manual handling strategy did not provide context or scale, or confirm recommendations from the learning from previous incidents had been fully implemented. Assurance was not provided to the Committee that appropriate numbers of staff had been trained, or that other actions arising from the recommendations from a specific case had been fully implemented. Actions requested by the Committee: The Committee requested further assurance from the Health and Safety Group to provide clarity on actions taken, those in progress and planned timescales, to enable the Committee to discharge its responsibilities to the Board.
	Lack of Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent and Emergency Care Source of assurance: • April 4 hour performance was 66.51% (Type 1+ streaming) against a trajectory of 72.4% • EMAS handover times remained challenging with 635 ambulances

	waiting over 59 minutes • 'Super-stranded' patient numbers reduced closer to plan at 101 against an ambition of 94 A detailed 4 hour improvement plan was in place, with a trajectory that had been approved by NHSI, but that would not achieve the constitutional standard this year. An improvement plan was also in place to reduce ambulance handover delays over 59 minutes to zero by August 2019, but there remained risk to this plan due to conveyance numbers and flow through the A&E department due to bed availability and overall attendance numbers. The Committee received detailed reports and were assured that robust plans were in place to improve the Trust's 4 hour and ambulance handover performance.
	Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Cancer Performance Source of assurance: The Committee received the update and noted that in March the Trust delivered 75.2%, which was above trajectory. The Trust is the 14th largest cancer provider in the country but does not necessarily have the level of resource to reflect this. Significant issues remained across the cancer pathway due to historical under investment. In 18/19, 4 of the 9 cancer standards were achieved with 13.5% more patients treated last year, despite receiving 9% more referrals, which was twice the national level of growth in demand for services. The main challenges were the time taken to diagnose, as once diagnosed patients were treated within 31 days. The Trust's trajectory for 2019/20 had been approved by NHSI and the Trust had exceeded trajectory in April, but May was at risk due to patient backlogs. The Committee were assured that plans were in place to improve performance and were pleased to receive improvement trajectories by specialty to enable future assurance to be obtained at that level. A system cancer oversight group will also been established, chaired by the Chief Operating Officer of Lincolnshire West CCG.
	Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Planned Care Source of Assurance: The Chief Operating Officer provided a verbal update to the Committee on planned care performance, as the data had

	not been available when the IPR was produced. After achieving the waiting list size target and zero waits over 52 weeks at the end of March, the Trust remained confident that this level of performance could be maintained at each month end. This would enable the current trajectory performance of 84% to be maintained throughout 2019/20
	Assurance in respect of other areas: Terms of Reference The Committee reviewed the draft of the revised Terms of Reference for the Committee and proposed a number of amendments. Board Assurance Framework The Committee reviewed the BAF and populated the assurance gaps, how they were being managed and assigned an assurance rating to each strategic risk assigned to the Committee. The Committee requested that identified controls on the BAF were aligned to primary, secondary or tertiary controls, in accordance with the 3 Lines of Defence. No assurance could be gained against strategic objectives SO.1b, SO.2a or SO.4a, as the relevant metrics and reports were still under construction. Digital Board Source of assurance: The Committee received the report from the Digital Board and noted that the lack of available capital was delaying ongoing ICT projects including those in maternity, digital dictation, voice recognition and upgrade to Windows 7. Available capital had been allocated to e-Prescribing and Robotic Pharmacy. Due to restricted capital available, e-Prescribing was a multi-year programme, but was being rolled out to the highest risk areas first. Action requested by the Committee: As public wifi was now available, the Committee requested that staff were reminded that this should not be used for work related purposes. Information Governance Group Source of lack of assurance: The Committee received the report and noted that the Trust had 6 non-compliant areas on the Data Security and Protection Toolkit. These mainly related to contracting/Procurement and training. As a result, the Trust had been classified as 'standards not fully met, but improvement plan agreed'. The IG Group had escalated the health records destruction policy to the Committee, as there was no medical records destruction clause in the contract with the current provider, Restore, who had taken over the existing supplier. Procurement were negotiating a destruction clause and the Clinical Records Group had been asked to conclude the production of

	the Health Records Destruction Policy. The Committee were also advised that there appeared to be an issue with ensuring that bank staff access to systems was removed when they left the Trust. Work was underway to establish the scale of the issue. Their access to the Trust network was removed when they left. <u>Internal Audit Reports</u> 5 internal audit reports were received by the Committee for information, 3 of which were afforded significant assurance. 1 had limited assurance and the other was for information. Recommendations were being implemented and these would be checked as part of Internal Audit's follow ups to audits undertaken, the results of which were reported to the Audit Committee.
Issues where assurance remains outstanding for escalation to the Board	The Committee wish to raise with the Board the following points: • The Trust are 2 months behind agreeing CQUINS which may affect delivery of the plans. • Concerns about the progress being made with the delivery of the FEP and the impact of the risk adjustment to the value of the plan, both of which were likely to require further schemes to be identified and delivered
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the corporate risk register and noted the updates made. The Committee discussed the review of the corporate risk register and the fact that many of the risks were routinely reviewed as part of the reports submitted to the Committee each month. The Committee decided to identify those that were not reviewed as part of the work plan and to carry out a more in depth review of 1 risk area each month, to ensure that the Committee could be assured that all risks on the register were being updated regularly and risks mitigated to an acceptable level, in line with the Board's risk appetite.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	Lack of appropriate metrics and reports prevented the Committee from gaining assurance against strategic objectives SO.1b, SO.2a or SO.4a. Development of the necessary data and reports was required. The Committee were advised that some of this information would be available by the end of June, but that would be too late for next month's meeting.
Areas identified to visit in dept walk rounds	None

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

Attendance Summary for rolling 12 month period

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Deputy CEO
Date:	3 June 2019
Healthcare standard	

Title:	Digital Care Strategy

Author/Responsible Director: Kevin Turner, Deputy Chief Executive

Purpose of the Report: Seeking Trust Board support for, and approval of, the Digital Care Strategy

The Report is provided to Trust Board for:

Decision	X	Discussion	X
Assurance		Information	

Summary/Key Points:

Attached is the Integrated Digital Care Strategy that for simplicity is referred to as the Digital Strategy.

The draft strategy has been reviewed by the 2021 Programme Board (October 2018 and April 2019) and FPEC (April 2019) with changes made to the strategy accordingly.

This Digital Strategy will deliver the digitalisation (including clinical systems, technology, information, resources and processes) required to underpin the transformation of the Trust's clinical services as part of the 2021 vision in order to further deliver excellence in rural healthcare.

Recommendations:

The Trust Board are asked to review the strategy and approve it.

Strategy Impact **Agreed as a key strategic priority for the Trust**	**Performance KPIs year to date** **The strategy will enhance the Trust's digital maturity index rating over the life of the strategy.**
Resource Implications (e.g. Financial, HR) – contained within the strategy, and progress is subject to capital resourcing	
Assurance Implications: To be reviewed by FPEC	
Patient and Public Involvement (PPI) Implications – Strategy has been developed through the 2021 Programme Group which includes patient representation. Significant PPI required when implementing patient facing systems	
Equality Impact: to be considered in individual business cases	
Information exempt from Disclosure: commercial aspects remain confidential	
Requirement for further review? Yes, through strategy refresh.	

Agenda Item 12.2

United Lincolnshire Hospitals NHS Trust

Integrated Digital Care Strategy

Version 0.06

Digital Care for Excellence in Rural Healthcare

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0.05	10/04/2019	Update following 2021 Board
0.06	24/05/2019	Update following FPEC

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1 Vision for Digital Care

This Integrated Digital Care Strategy will deliver the digitalisation (including clinical systems, technology, information, resources and processes) required to underpin the transformation of the Trust's clinical services as part of the 2021 vision in order to further deliver excellence in rural healthcare.

2021 Vision

The 2021 Strategy sets out the direction of travel for the Trust to achieve our vision of Excellence in Rural Healthcare.

We want to:

- Improve our quality and performance of care in line with national standards
- Reflect wider NHS national agendas for new ways of working
- Treat fewer patients in our hospitals, being more efficient and effective
- Develop new and innovative models of care
- Attract more Lincolnshire patients to choose ULHT for their planned care
- Consolidate services onto specific sites and develop centres of excellence
- Becoming a national, if not an international, centre for rural healthcare
- Change and shape of our workforce in line with the new models of care
- Work in partnership to sell Lincolnshire as an excellent place to live and work

It will provide the step change required to transform the Trust's digital clinical capabilities to provide secure on-line access to real time and accurate information to the right person in the right place. Using advanced data and technology it will transform outcomes for our patients. Digital healthcare technologies (including digital medicine, artificial intelligence (AI) and pharmacy and surgical robotics) are a new and fundamental means of addressing the big healthcare challenges of the 21st century, particularly the increase in the demand for healthcare as people live longer and with more long-term conditions.

This strategy is a key enabling strategy to facilitate the achievement of our ambitions and priorities for 2021 as well as our new Trust Operating Model to optimise new ways of working.

We will become a paper-lite organisation with patient records being digitised to ensure that they are available whenever and wherever they are needed, including external stakeholders such as patients themselves, GPs, and Social Services. The vast majority of our clinical systems will be integrated ensuring the efficient and effecting flow of information and care delivery. Information will be recorded once electronically, at first contact, and shared securely between those providing the patient's care to reduce data duplication, enable proactive patient monitoring and support better multidimensional 'whole person' decisions. All clinical information will be available in real time through a single 'portal' and will be available on a choice of different devices to meet clinical need.

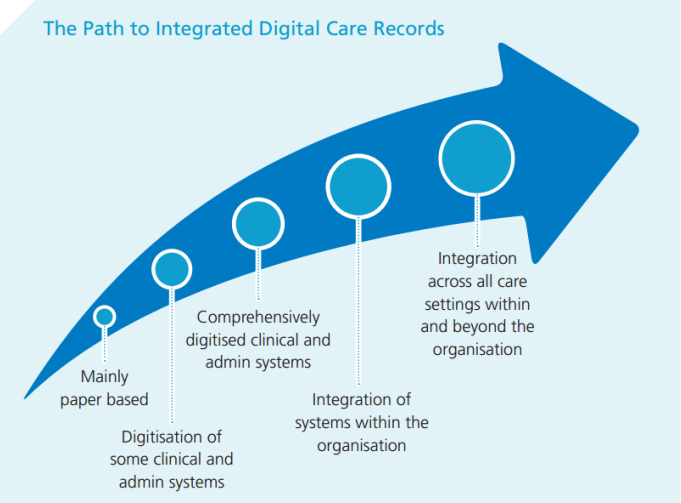
2 What is an Integrated Digital Care Organisation?

Essentially it is an organisation that has joined up electronic clinical systems supporting paper-lite clinical business processes across health and social care.

Patients are at the heart of this strategy with the Electronic Health Record (e-HR or e-Health Record) being the main enabler to ensure that clinical information is readily available when and where it is needed:

- They enable the flow of high quality, comprehensive and up to date information between healthcare professionals across health and social care, and to and from patients that leads to greater patient involvement.
- They improve the quality of care, streamline clinical processes and provide a better patient experience.
- They remove the need for paper entry, duplication and storage that also reduces costs in the long-term.

The e-Health Record is fundamental to this endeavour but so too are the additional clinical and business systems, technology, infrastructure, information, resources, processes, security, etc. that all need to be in place to enable the Integrated Digital Care Organisation to function safely.



Source: The Integrated Digital Care Fund: Achieving Integrated Health and Care Records

The Integrated Digital Care Organisation is in line with the Government's 'Digital by Default' Strategy that will revolutionise public services by utilising the technology and the internet that is already transforming society as more of us bank, shop and socialise online. Embracing this philosophy in healthcare will lead to better health, better care and better value by enabling people to do things quicker, safer and more efficiently. It is essential to our move towards increased joint working across health and social care, with services wrapped around the user.

3 What does being an Integrated Digital Care Organisation mean to you?

Building on our current SystemC Medway Patient Administration and A&E system, the development of the Integrated Digital Care Organisation will support our focus on improving patient care and will help us achieve our 2021 ambitions by improving functionality, ensuring the right information is in the right place at the right time, helping to deliver news ways of working, enabling our workforce by giving them the right tools and improving capability and capacity through digitisation.

2021 Ambitions	
	**Our patients:** • Will receive consistently compassionate, safe high quality care • Will be listened to and be involved in shaping their care around their needs • Will be involved in shaping services around lessons learned from their care • Will want to choose us for their care and be champions in our communities
	**Our services:** • Will work in partnership to develop integrated models of care • Will involve communities in shaping our services • Will develop centres of excellence across all our hospitals • Will value patients time and get things right first time
	**Our people:** • Will be proud to work at ULHT • Will feel valued, motivated and adaptive to change • Will challenge convention and improve the way we do things • Will strive for continuous learning and development being supported to be innovative
	**Our System / Partners:** • Will provide seamless integrated care with our partners • Will make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration – through pathway redesign across partner organisations

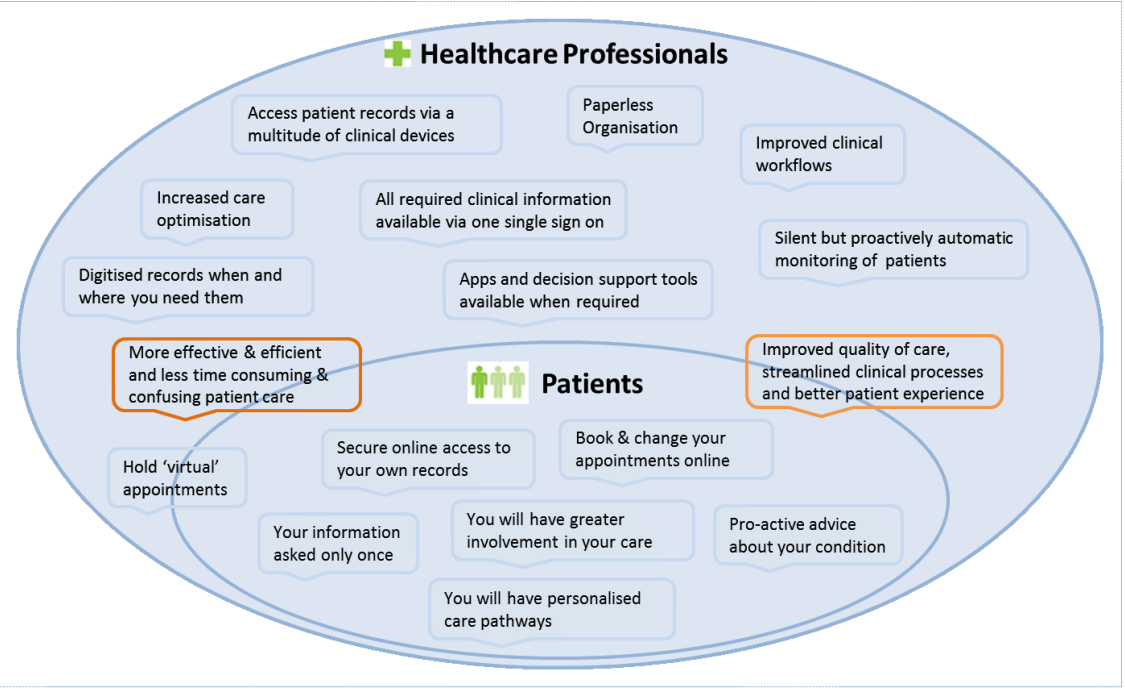
It will dramatically transform clinical care and organisational efficiency by:

- Capturing, storing, and retrieving clinical information in real time at the point of care.
- Integrating ICT, medical and communication technologies to 'join up' care along patient pathways rather than organisational or geographic boundaries.
- Optimising processes using electronic notes, forms and workflows to become paper-lite.

We will make safe digital record-keeping commonplace across our organisation.

Access to accurate, timely and comprehensive information will transform the quality and efficiency of the healthcare we provide through improved clinical workflows, increased care optimisation and greater patient involvement. It will provide the ability to capture and synthesise 'insights' about our patients' health status, for example, by joining up and interpreting observations, vital signs monitoring and diagnostic testing.

As a patient or a clinician your experience of care delivery over the next few years will be truly transformed.



Integrated Digital Care Organisation
What it means to patients and healthcare professionals

3.1 As a patient

You will have secure access to your own patient record in similar ways as you do to your online bank account. You will no longer need to repeat yourself a multitude of times as your care provider will have ready access to your information, literally in the palm of their hand. Your journey with us will be more expedient, more efficient, less time consuming and less confusing. You will be able to see where you are on your personalised care pathway and know what to expect next. You will be able to book and change your appointments online, hold 'virtual' appointments with our health professionals and received pro-active advice about your condition, particularly if it is a long term condition. With your permission, and when it will be of benefit to you, we

will share your information with other external professionals such as your GP and social services.

3.2 As a clinician

Your patients' records will be digitised ensuring that they are available to you when and where you need them. No longer will you have missing notes or have to spend time sorting through disorganised paper records. All the clinical information you need will be available to you in real time through a single 'portal' so you no longer have to sign on to a multitude of different clinical systems. You will be able to access the clinical information you need via the array of devices available to you from bedside interactive screens dedicated to an individual patient, to ward based electronic whiteboards and further to a choice of personal handheld devices. Apps and decision support tools will be readily available to you to aid your clinical care. Apps will proactively but silently monitor your patients and only 'wake up' when necessary to ensure that you are immediately made aware of what's important, such as at the very first signs of a patient deteriorating. All the time your patients' information will be kept safe and secure.

4 Design principles of the strategy

The six simple design principles that underpin this strategy and should apply to all of our strategic decision making are:

✓ **Easy**

Systems at the point of care should be **as easy to use as those we use in our personal lives** and do many of the same things such as drawing, handwriting and click and select options that maximise speed.

✓ **Flexible**

Staff and patients should be able to use **any appropriate device, including their own,** confidently and securely, and systems should be available, accessible, reliable, and fit for the task they are doing.

✓ **Connected** 

Users should be able to **easily contact their colleagues, talk to them as if we were face to face, and exchange information with them** at the point of care wherever that is, and wherever they are.

✓ **Supportive** 

Users should be able to find **all of the information they need to have about a patient in a clear and easy way in one click at the point of care** and have confidence that it is up to date and complete.

✓ **Reliable** 

Users should be confident that if something goes wrong with any technology they need to do their job, it will be **fixed quickly and ideally even before they are aware that there is a problem.**

✓ **Coordinating** 

Systems should **help coordinate teams and resources effectively, efficiently and safely so that users can deliver the best possible care to our patients.**

Professor Robert Wachter's report to the National Advisory Group on Health Information Technology in England entitled 'Making *IT* Work: Harnessing the Power of Health Information Technology to Improve Care in England' produced findings around 10 core principles that are important for digitalisation:

- ***Digitise for the correct reasons.***
  - It is not always appropriate to introduce technology in every arena therefore giving careful consideration to how we approach technology change is vital. The aim of introducing technology is to improve the delivery of patient care, not turn a clinician's focus away from the patient and towards a computer.
  - Engaging with clinicians will help us to make the right choices.
- ***It better to get digitisation right than do it quickly.***
  - The urgency to digitise can prompt organisations to run before they can walk. This leads to failed efforts and therefore a pragmatic, staged approach that allows organisations of differing capability to implement the process at the most appropriate pace.
  - To do this we need to properly employ our governance model and make sure we critically assess our investments to maximise the benefits.
- ***Return on Investment from digitisation is not just financial.***
  - The financial rewards of digitisation can take a long time to emerge ("10 years or more"). However 'Return on Investment' should be viewed in ways other than solely monetary value.
  - We need to build non-financial benefits into our business cases.
- ***When it comes to centralisation, the NHS should learn, but not over-learn, the lessons of the National Programme for IT (NPfIT).***

  - The failure of NPfIT has left many cautious of new technology initiatives. Taking a combinatorial approach of local and regional control, plus elements of appropriate centralisation should be applied to any new strategy.
  - We need to recognise the ways in which the Trust benefitted from NPfIT and build on it.
- ***Interoperability should be built in from the start.***
  - As data sharing becomes more important and prevalent, the need for interoperability increases accordingly. It is proposed that there should be comprehensive national standards for interoperability.
  - Interoperability both within and without the Trust is fundamental to development of our e-Health Record.
- ***While privacy is very important, so too is data sharing.***
  - Concerns for data security have previously overshadowed data sharing, but ensuring effective data security and sharing would be extremely beneficial to patient care and research.
  - Sharing data with our wider healthcare economy to enable better patient care is vital in our new environment and the delivery the STP and Local Delivery Roadmap. We will need a fully developed cyber security strategy to augment this in Lincolnshire.
- ***Health IT systems must embrace user-centred design.***
  - It's important not to lose sight of how the user interacts with the system and how this affects their ways of working. All too often, the implementation of new systems fail because the business change element is overlooked.
  - We have often struggled with systems that have poor user interfaces but excellent functionality – improving this will help the adoption of technology within the Trust.
- ***Going live with a health IT system is the beginning, not the end.***
  - Making any change in the healthcare sector is fraught with difficulties and doesn't always consider the cultural shift that needs to accompany it to make the change successful. Implementing systems is just the start of the journey. It takes time for systems to embed in organisations when ways of working are changed as a result – therefore there needs to be tolerance towards the decrease in activities that follow change.
  - As a Trust we are good at planning and funding the implementation of new technologies but we are not so good at returning to them later to optimise them further.
- ***A successful Digital Strategy must be multifaceted, and requires workforce development.***
  - To make sure a digital strategy is successful it is important to resource it fully, with ICT specialists and strong leadership and clinical / non-clinical informaticists. Presently there is a deficit, which must be remedied.
  - Although we have clinicians working within technology projects (e.g. clinical leads for projects) and the Digital Hospital Group,

these numbers need to increase to create greater clinical representation in the ICT arena.

- ***Health IT entails both technical and adaptive change.***
  - Change is hard and this is felt particularly in the healthcare sector. It requires adaption by front line workers, whilst being supported by strong leadership. To enable successful change there needs to be on-going and robust engagement with users.
  - This is a lesson we learned from the Medway programme. We are committed to maintaining and improving our engagement with the wider Trust.

Further, we need to keep in mind that the technology is often the easy part of the strategy; it's more about people and ways of working:

> "The experience of industry after industry has demonstrated that just installing computers without altering the work does not allow the systems and its people to reach their potential; in fact, technology can sometimes get in the way. Getting it right requires a new approach; one that may appear paradoxical yet is ultimately obvious: digitising effectively is not simply about the technology, it is mostly about the people…"
>
> Wachter, R. (2016) "Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England"

5 Clinical Business Units ownership

The Digital Strategy is a key enabling strategy for the 2021 programme. It must be clinically and business led and so must be resourced appropriately and owned, designed and delivered by the Clinical Business Units supported by ICT.

Improvement must be embedded as a cultural norm across the whole organisation to sustain improvements and so all staff must engage in the Digital Strategy programme. Sufficient time needs to be provided to develop the new skills required to optimise the new technology for both the ICT teams and the Clinical & Business staff in the usage of the new technologies.

Clinical Business Units will ensure that their future digital modernisation plans are embedded within the Digital Strategy through the continued engagement with ICT and via the Digital Hospital Group (see 'Strategy governance').

6 Future patient pathways

The Integrated Digital Care Strategy will ensure that in the future all appropriate patient information will be available to any member of staff with the required access wherever and whenever they need it to support patient care.

The Integrated Digital Care Strategy will transform patient pathways and will support our staff to achieve safety and excellence in patient care.

New appointments will be made via the Electronic Referral System (e-Referral Service or e-RS) allowing the GP to assist the patient in selecting their healthcare setting of choice. Patients will receive appointment letters directly to their mobile phone – greatly improving their 'experience' as they will be able to confirm, cancel or arrange to rebook their appointment with just one click. Once confirmed, the appointment will be added directly into their digital calendar, helping to reduce the risk of forgetting their appointment. Those patients who call or text about their appointments will initially interact with an Artificial Intelligence 'chat box' that will confirm their identify and allow them to review, query and amend their appointments without them having to speak directly to a member of staff, unless of course they would like to.

Clinics could be virtual or in person, either way when the patient arrives at the clinic the notes will be available to the clinician so the risk of non-availability and illegible notes will be eliminated. Clinical decision making will be greatly improved as all noting from previous episodes of care and correspondence will be instantly accessible.

The clinician will be able to add notes directly to the patient's electronic record with clinical letters being dictated through voice recognition directly to the record. This will only need to be checked for accuracy by the secretary before being sent out to the GP / patient. The outcome will be processed in the consultation room in real time so the risk of lost outcomes and missing procedure codes will be eradicated ensuring that all income is claimed.

All diagnostic tests will be requested using the same order communications system with the results being delivered straight in to the patient's electronic record ensuring that no result is lost and no test needs to be redone. Further, Artificial Intelligence technologies will be used to speed the diagnostic process such as reading CT and other images, analysing pathology tests, etc. Medications will be available through e-Prescribing, ensuring that patients receive safe prescriptions at the correct time with minimal error. Drug audit and stock control will be much easier and automated.

When a patient is admitted to a ward their wrist band will be scanned to ensure that the clinician knows exactly who they are dealing with avoiding wasted clinical time repeatedly recording patient demographic information. Up to date and accurate ward information including electronically captured patient observations will be available on an electronic 'whiteboard' that will be fed information in real time from the e-Health Record. Live bed states will be available to the Opps Centres and community to help with patient flow and prevent 'stranded' patients. They will even be accessed by the catering department to help forecast actual meal requirements reducing food waste. 'Visual hospital' care alerts and other patient based activities will be obvious to the ward team. Care will be supported by pathways and care plans reducing clinical documentation time and ensuring consistently high quality

care. Requests for other support services (e.g. physio, portering, etc.) will be scheduled allowing those teams to actively plan and manage their demand requirements.

The trust will continue to make use of RFID tracked equipment (where an electronic tag is attached to our valuable clinical equipment that connects to our network and automatically updates in real time the location of our 'assets'). This will mean that our clinical staff will spend less time trying to locate specialist equipment such as infusion pumps and specialist mattresses. The trust currently has to pay to hire these pieces of equipment when they cannot be located.

The patients' notes will be available wherever and whenever they are needed and can be seen by multiple users across multiple locations at the same time. Staff will have increased access to patient records through the use of mobile devices including iPads and Smartphones, and even their own devices. All such equipment will be held on an inventory to ensure security and prevent loss of such equipment.

All patient observation readings will be fed directly into the patient record via automated monitoring devices or portable hand held devices. The system will calculate the individual NEWS, PEWS etc. scores to identify deteriorating patients and will automatically and instantly escalate appropriately. When a patient goes to theatre baseline observations and medication information will be instantly at hand. Our new modern theatre system including advanced scheduling and anaesthetic and theatre notes will ensure the patient's safety. Specialist equipment can be pre-scheduled to ensure that it will be available for an operation to reduce cancelations and wasted theatre time. Medical and nursing notes will be available wherever needed with no risk to information loss or misplacement.

On discharge the letter will be generated from a template with the information automatically collated from the information already held within the e-Health Record. The clinician will simply need to select and sign it and then the letter will be transmitted directly into the patient's GP system where it will be available instantly. A view only click through into the acute record will be available if further information is required.

Throughout this process the patient experience of our services will be enhanced through efficiency and effectiveness. No longer will they be required to provide demographic information multiple times during the same visit. They will be reassured that clinicians are making decisions based on accurate information about them and will ultimately have access to this information themselves.

7 Electronic Health Record – the heart of the strategy

Creating an Integrated Digital Care Organisation will require fundamental changes to our clinical systems, infrastructure (including building the resilience required), processes and staffing. In order to achieve it we will need to commit to significant investment and change over the life of this strategy.

At the heart of the Integrated Digital Care Organisation is the Electronic Health Record (e-HR or e-Health Record) that ensures that clinical information is readily available when and where it is needed.

Building on our current SystemC Medway Patient Administration and A&E system, our e-Health Record will become the foundation upon which the Integrated Digital Care Organisation will be developed. It will provide the strategic platform to integrate patient records across the Trust and enable data sharing with external stakeholders such as Patients, GPs, and Social Services.

The e-Health Record will be a set of integrated modules that over time will build to cover an increasing number of clinical aspects of care such as observations and charting, nurse handover, theatres, bed management, etc.

e-Health Records focus on the total health of the patient – going beyond standard clinical data collected in the provider organisation to present a broader view on a patient's care. They reach out beyond the health organisation that originally collected and compiled the information. They share information with other health care providers, such as GPs and Social Services, and can be accessed by all people involved in the patients care – including the patients themselves.

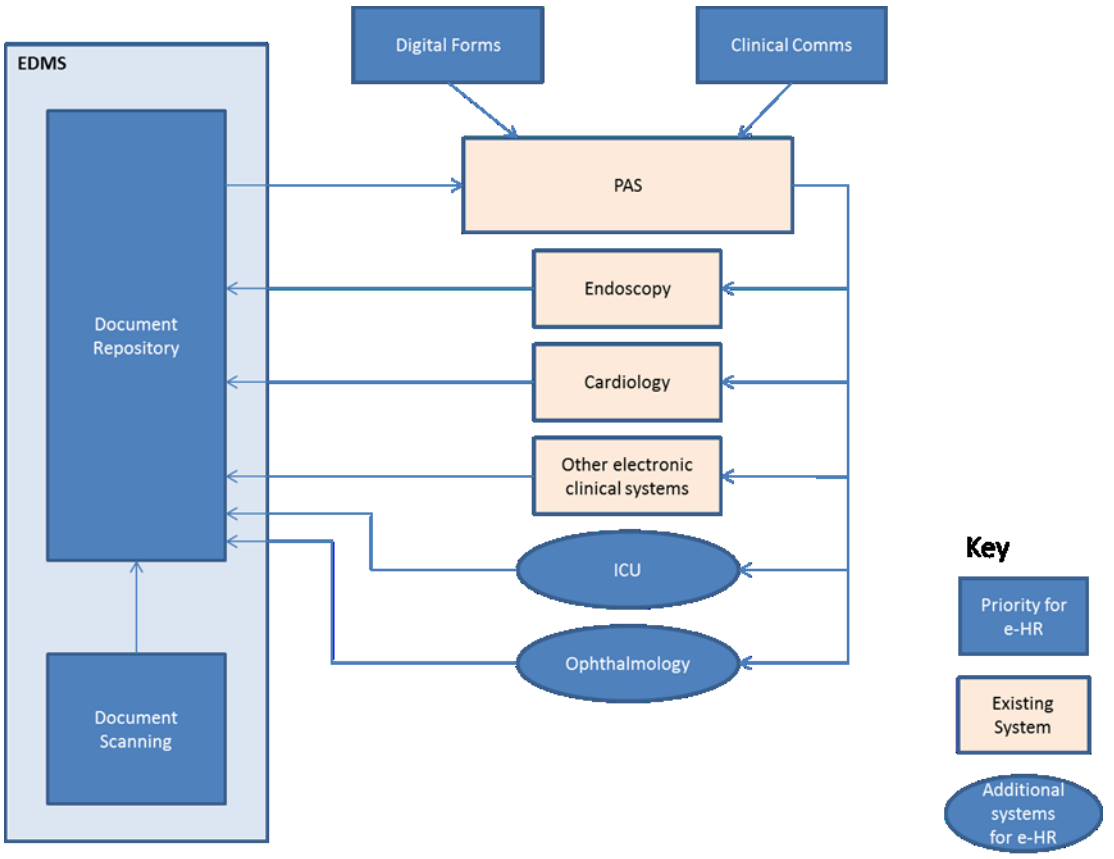
Health care is a team effort, and shared information supports that effort. Because the information in the e-Health Record is shared in a secure way, it becomes more powerful – helping to transform patient outcomes:

- They enable the flow of high quality, comprehensive and up to date information between healthcare professionals across health and social care, and to and from patients that leads to greater patient involvement.
- They improve the quality of care, streamline clinical processes and provide a better patient experience.
- They remove the need for paper entry, duplication and storage that also reduces costs in the long-term.

The e-Health Record includes an number or essential core components:

- An ***Electronic Document Management System*** (EDMS) – to capture, store and view digital copies of our existing paper notes.
    - This involves two aspects:
        - A Document Scanning function to scan our paper notes.
        - A Document Repository to manage and view the digital copies of our paper notes.

- ***Digital Forms*** – to capture, store and view the required new information (including our future patients' notes) electrically rather than on paper.
    - This includes Clinical Noting, e-Forms and e-Consent systems.
- ***Clinical Comms*** – an integrated communication and collaboration platform to facilitate faster and safer care co-ordination between clinical teams.
    - This Includes secure messaging, handover task management and hospital at night referrals and alerts.



The interoperability between the Trust's current systems and the e-Health Record essential core components

7.1 Electronic Document Management System (EDMS)

The Electronic Document Management System (EDMS) will provide a single repository for the capture, storage, retrieval and exchange of all unstructured documents. In order to become paper-lite some of our paper documents will need to be scanned into the EDMS to make them available digitally. This will include medical casenotes, nursing documentation, referral letters, clinic outcomes, corporate forms, etc.

All digital clinical documents stored in the EDMS will be made available in patient context to the e-Health Record.

7.2 Digital Forms

Digital (or electronic) forms are a key component of moving towards a paper-lite working environment. They are essential for the transformation from paper based processes to electronic forms and workflows.

Unlike paper, electronic forms are not susceptible to loss and are legible. Paper forms once completed need to be filed away whereas electronic forms are filed immediately they are saved ensuring that all information and history notes are available at the time of the consultation with the patient – so no lost documents. Further, many current paper forms are pre-printed so there is a printing cost which will be eliminated once the digitalisation takes place.

E-consent forms can be automatically generated during the consultation with the relevant information given directly there and then or emailed to the patient. This ensures that they receive all the required information in order for them to make informed and consensual decisions about their treatment – preventing potential litigation claims which have cost the trust £357,000 over the last 5 years with another 6 claims still outstanding.

7.3 Clinical Communications

This is an integrated communication and collaboration platform to facilitate faster and safer care co-ordination between clinical teams and includes secure messaging, handover task management and hospital at night referrals and alerts.

It will ensure that a set of priority patient information is available in one location to support clinicians through the care process both within the Trust and the wider community. Relevant actionable information will be available using one single tool and it will provide a wide range of functions to support clinical collaboration on individual patients' care.

8 Fundamental components to support the strategy

The e-Health Record is the foundation of the strategy. However, there are other essential aspects that are required to make the Integrated Digital Care Organisation work effectively and efficiently. Without investment in these supporting components the Integrated Digital Care Organisation will be at risk of not being fully achieved.

The supporting components required to ensure the Integrated Digital Care Organisation is successful are:

- Clinical Portal
- Digital Imaging

- Increased Points of Access
- Telehealth / Telemedicine
- ICT Infrastructure
- Resources
- Cyber Protection
- Clinical Information, Clinical Decision Support and Artificial Intelligence
- Improved Processes

8.1 Clinical Portal

Utilising an easy-to-use but secure web-based interface that is accessible anywhere, anytime our Clinical Portal will provide a single unified view of patient information not only from across our organisation, but also from our partners from health and social care (such as GPs and social services). It will also allow patients to securely access their own records.

The Clinical Portal will pull together our e-Health Record and other legacy (non e-Health Record) clinical IT systems in order to present a comprehensive clinically rich patient record. These non e-Health Record systems provide specialised clinical data that needs to be made available in clinical context (including PACS, pathology, cardiology, theatres, etc.). These legacy systems will eventually need to be upgraded or replaced and so may become part of the e-Health Record.

The Clinical Portal will deliver ‘single sign-on’ solution so that clinicians only need to log on once to access the information from the multitude of separate clinical IT systems. It will also enable the sharing of information with our wider health community by joining up our electronic clinical systems to support paper-lite clinical business processes across health and social care.

We already have the Clinical Portal technology, purchased via the STP, and it is currently being deployed. It already interfaces with our larger main systems such as PAS, PACS, pathology, etc.

8.2 Digital Imaging

We need to provide the infrastructure to store and retrieve all patient digital images, not only from Radiology and the Picture Archiving and Communication System (PACS) but also Cardiology, Endoscopy, Ophthalmology, EEGs, Medical Photography, etc. They need to be made available in the context of the patient.

We already have a storage facility that is currently being used for PACS. This is a Vendor Neutral Archive (VNA) that uses an internationally approved technical standard to support image and report sharing between organisations. The VNA will need to be expanded to encompass all the other modalities into a totally integrated solution.

Using AI-based technologies, automated image interpretation in the areas will lead to faster diagnosis.

8.3 Increased Points of Access

There is currently insufficient ICT equipment in clinical areas resulting in clinicians having to 'queue' for access to systems. The Integrated Digital Care Organisation would be seriously undermined should this situation continue with clinicians not having the devices to access the integrated and comprehensive digital patient information when and where they need it.

We will need to ensure that there are sufficient numbers of various types of devices that support specific care settings, such as bedside interactive screens dedicated to an individual patient, ward based electronic whiteboards, handheld mobile devices and even our own personal devices. We need to facilitate a fully mobile workforce supported by easy to use mobile technologies. Our aim is for every clinician to have their own personal clinical device.

8.4 Digital Medicine (Telehealth / Telemedicine)

Although Telehealth is maturing, the initial results from the Whole System Demonstrator (the world's largest randomised control trial of Telehealth) showed that the correct use of this kind of technology can deliver significant benefits to the NHS and social care services including:

- 45% reduction in mortality rates
- 15% reduction in A&E visits
- 20% reduction in A&E admissions
- 14% reduction in elective admissions
- 8% reduction in tariff cost

Further in 2012, the Department of Health launched the 3 million lives Telehealth campaign indicating that "at least three million people with long term conditions and/or social care needs could benefit from using Telehealth".

Digital medicine is already changing the way people interact with healthcare. Telemedicine services include telephone triage such as 111 and the ability to have video appointments. Smartphone apps help patients self-manage and order repeat prescriptions. Remote monitoring is changing the way care is delivered. Almost 90% of the population regularly use the internet and the health and care system needs to work with patients to co-create applications of digital technologies which meet their needs.

We need to investigate and invest in Telehealth solutions, such as deploying remote medical devices (including home-based equipment that can send us details of the vital statistics of 'at-risk' patients) and other technologies that enable us to hold secure 'virtual' consultations with our patients and other health professionals.

Through rolling out home-based monitoring devices and smartphone apps at scale, patients will be supported to understand their condition and how best to manage it at home. For the more vulnerable, discrete remote monitoring systems will support independent living – giving peace of mind to patients, families and professionals. This includes everything from monitoring falls risk through gait assessment, tracking location for people with dementia, and sensors on televisions (monitoring for sensory problems), kettles and fridges (mobility, nutrition) and even curtains (mobility, air quality).

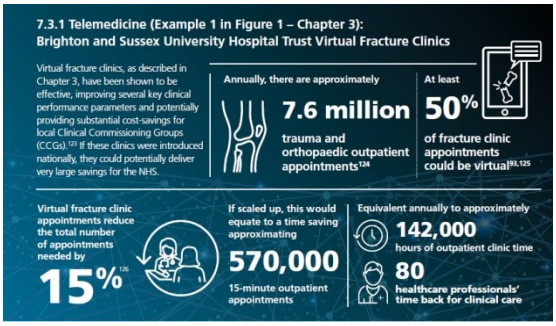
Telehealth solutions will enable health and social care organisations across Lincolnshire to share data and plan, in partnership and with patients, the best way to deliver care to people with long term conditions based on their needs and wants. This will be achieved by integrating patient focused technology with strategic decision support technology.

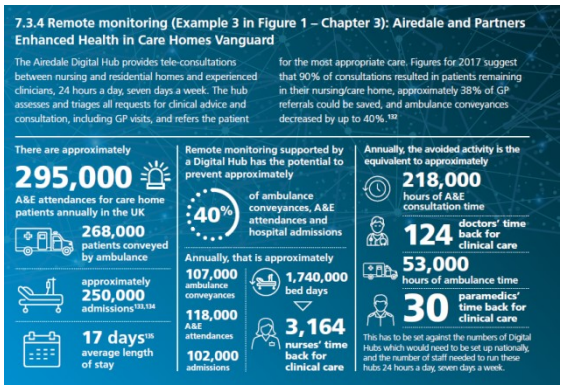
Patient focused technologies in the home will be used to facilitate self-management of long term conditions including hypertension, respiratory illness and diabetes, and also to allow peer support for mental health conditions.

Monitoring technologies may include discrete remote monitoring systems, based on sensors, to support independent living and provide peace of mind to patients, families and professionals.

We currently have three Telehealth business cases in train:

- Stroke (using e-consultations) – to support a trust wide on call rota.
- Gastro (using screening forms) – to develop a screening tool to reduce the number of unnecessary diagnostic procedures.
- Renal (using remote monitoring) – to monitor adolescents for organ rejection post-transplant.





The Topol Review (2019) "Preparing the healthcare workforce to deliver the digital future"

8.5 ICT Infrastructure

The Integrated Digital Care Organisation will only be possible if we ensure that our ICT infrastructure is fast, resilient, robust, standardised, optimised and integrated so that patient information can be shared securely across our organisation and with key stakeholders.

We need a robust, reliable and flexible infrastructure that facilitates rather than impedes benefits delivery through technology. And this needs to be backed by a responsive and efficient 24/7/365 ICT service.

8.6 Resources

Delivering the strategy will require significant change management resources to facilitate the organisation wide service re-design and adoption of new ways of working; technical resources to develop, test, implement and support the implementation; as well as leadership with the capability to direct the agenda.

We need to invest in our workforce to develop specialist skills, including the assessment and commissioning of digital technologies. With all new technologies, it is essential to identify future champions early and create the capability and networks to enable collaborative learning. Accredited continuous professional development (CPD) and flexible on-going training and career opportunities are essential and important to delivering this long term change. We need to work more closely with Universities, Colleges and wider networks to develop this capability and attract and deliver future talent and resource.

Further, as we move towards more digitally delivered clinical services we need to ensure that we have a responsive 24/7/365 ICT support service that gives rapid results, is effective to use and anticipates and fixes problems before they become apparent to users. Providing an effective and efficient ICT support service will be fundamental to the smooth running of our digitised clinical services.

A self-service portal with built in Artificial Intelligence will save time for our clinical and other staff and not detract from patient care activities as well as freeing up our Service Desk staff to deal with other non-standard problems.

Responding rapidly to ICT problems reported by our clinical staff around the Trust will improve the operational effectiveness of the Trust. Further, improving the service provided by the ICT support service will help the adoption of new technology as our clinicians will feel better supported and confident in the digital solutions from the start.

8.7 Cyber Protection

Healthcare is rapidly becoming more digital, the benefits of which are evident already in that significant progress is being made in the quality of patient care which is resulting in more people surviving serious and life threatening illnesses or injuries. To become a fully digital NHS we need to be aware of our responsibilities and the potential threats to the integrity of our data and technology.

The benefits of moving towards an electronic NHS are significant. However, doing this safely in a way that patient data is secure and the provision of care is not interrupted is becoming increasingly complicated (the WannaCry incident clearly showed this). The threats posed by cybercriminals means that we must address any vulnerabilities we may have. Commercial products, such as Facebook, PayPal and WhatsApp have all recently experienced breaches in their security resulting in the theft of client personal data and in some cases individuals have been defrauded out of thousands of pounds. In a healthcare setting, the effects resulting from a cyber-attack can be devastating.

Of particular concern is the significant rise in attempts to extort NHS organisations through the use of ransomware – malicious software that can block user access to the information held within systems and will only be released upon payment. The infection can come from anywhere, sometimes even a trusted source, and therefore we need to be extra vigilant.

Increasing the volume of information relating to patients and their care stored electronically, and the growing number of mobile devices connected to the network increases the availability of information and improves patient care. However, it also increases the number of areas in which we are vulnerable to attack. To make sure we maintain the confidentiality, integrity and accessibility of our data and continue to introduce connected mobile technologies that respond appropriately to the Caldicott Report and meet Care Quality Commission (CQC) inspection standards there are key activities we must undertake:

- Clearly identify vulnerabilities and develop comprehensive strategies to remediate through education, bolstering of the Trust's network infrastructure, effective maintenance of software and systems roadmaps.
- All take responsibility for the security of electronic information stored and shared within the Trust and our colleagues in the wider health economy.

Our work to comply with the national programmes around Cyber Essentials Plus, the new Data Security and Protection Toolkit, NHS Digital CareCERTS (Care Computing Emergency Response Team Service that went fully live January 2016), etc. are helping us to drive forward with regards to cyber security.

However, the responsibility to protect our patient data, whilst being able to share it appropriately has become a greater task due to the cyber threats which increase in sophistication exponentially and can be extremely costly. We need to be able to maintain a sufficient level of protection around our data. Key reports on cyber security in the NHS from the CQC and the National Data Guardian, Dame Fiona Caldicott, have found that there are challenges that must be factored into our future activities. We need to make sure we have the appropriate cyber specialists, leadership and capacity but presently there is a deficit, which must be remedied.

8.8 Clinical Information, Clinical Decision Support and Artificial Intelligence

Accessing multiple applications simultaneously causes problems and often prevents a holistic view of a patient's record. A lack of availability of a patient's information in one place can be a limiting factor for our clinical teams. Making sure that we get the clinical information we need in one place in order to provide the best care and make the right clinical decisions is paramount. The shortage of doctors and nurses means that we need to help them in every way we can in their decision making.

We need to employ new systems that assist in clinical decision making. Building guidelines and care pathways that are powered by clinical decision support technologies into our clinical support functions would be really beneficial. Having the ability to edit these and maintain the most up to date information will support best practice. It will also be critical as workforce pressures – for example in nursing – increase to be able to support nurses with things like clinical observations, guidelines, care pathways, etc.

Further, advances in Cognitive Analytics and Decision Support should be exploited. For example, Watson is a system that is at the forefront of cognitive computing. It employs human ways of analysing problems and has the ability to learn. It is able to evaluate information outside of the standard computing structured rules. By taking data from multiple sources, Watson can help MDTs by collating patient information and assessing this against other information. For example, when a new medical study shows a new drug has proved effective treatment for a specific cancer, Watson can analyse this data alongside the patient's record and provide a recommendation to the Oncologist on which to make a better, evidence based decision. Watson is being used by many industries today for anything from travel to catering. Within a healthcare setting Watson and other such technologies will improve patient care by helping doctors in their decision making.

Employing Artificial Intelligence technologies will help greatly in terms of quality of service and capacity. For example, they can be used to speed the diagnostic process such as reading CT and other images, analysing pathology tests, etc. They can be used to help ensure patients receive best

evidence based treatments or medications for their personal circumstances and comorbidities and reduce the number of clinical errors (e.g. prescribing). Further, they can be used to interact directly with patients and staff on routine but frequently occurring interactions such as around appointment booking, ICT support services, etc.

8.9 Improved Processes

Just installing new technology without changing the way we work will not enable the systems and people to reach their potential. As mentioned earlier it can sometimes get in the way.

We need to look at what we do and how we do them. We need to improve our processes and ways of working in order to drive out efficiencies and improvements. For example, many of our processes are paper and human effort heavy. Just think about the process for ordering equipment, even ICT equipment, or how we manage the documents and actions for Trust governance meetings. Using technologies such as SharePoint could dramatically improve this process by streamlining and automating where possible to free up staff time to do the more added value tasks they are employed to do.

9 Benefits

9.1 Benefits the strategy will deliver

The Integrated Digital Care Strategy will deliver a number of benefits including:

Patient:

- Improved safety: clinicians will have quicker and simplified access to the full care record during acute or emergency situations. The information available will include medical history, problems, clinical teams managing their care, current and historic medications orders and requests. Where all relevant information is shown together risk of harm is reduced.
- Positive impact on length of stay (LOS) due to real time review and action leading to reduced non added value patient waits.
- Improved quality of care: treatment plans will be more tailored as clinicians would be able to communicate across departments more easily.
- A reduction in the need for a patient to repeat information to multiple providers or undergo repeated or unnecessary tests.

- Improved patient experience, e.g. significant improvement in the speed of accessing key information such as test results.

Clinical:

- Improved decision support information (real time actionable intelligence).
- Reduced risk of clinical errors, e.g. mis-prescribing incidents.
- Reduction in unnecessary admissions and procedures as health care professionals would be able to spot and avoid escalations.
- Contextualised data would support diagnosis and patient management as well as discharge from secondary to community care.

Efficiency:

- Reduced administrative costs through quicker sourcing of patient information.
- Reduced waste such as duplicate tests (50% reductions have been achieved by other hospitals using this technology).
- Better management of the flow and scheduling of patients in and out of the Trust.

Developing a framework for partnership working:

- Many of our patients have shared care delivered by a number of providers. This strategy will ensure that accurate clinical information can be shared easily and quickly between these organisations to ensure – for the benefit of our patients – that this partnership working is as efficient and effective as possible.
- More complete patient information will be available via the wider Community Clinical Portal.
- Access to patient information (notes, prescriptions and other information) will be available 24/7 and not just within the hospital environment, but our partner organisations (with the appropriate safeguards in place), which will support better decision making around patient care across the STP.
- Electronic discharge documents will be more timely, providing the information to the GPs quicker. Clinical information from out-patient clinics and inpatient stays will be available and received by the GPs / health community sooner.
- Length of stay will be reduced and, with the more rapid access to discharge information by other providers, our patients will be able to return home or to the community in a more timely manner, supporting more streamlined flow of patients in to and out of our hospitals (e.g. fewer stranded patients).
- Sharing our patients' information with the wider system will help create a shared view between health and care professions working in people's homes to optimise the care that patients receive, reducing the number of admissions to hospital and enabling our patients to receive the

treatment they need at or closer to home. Community colleagues (including neighbourhood teams) will have access to more patient information, improving the quality of home visits as well as reducing wasted visits when the patient is under the care of other providers.

9.2 Benefits delivered so far (or in progress)

Below lists some of the quality, safety and financial benefits of the elements of the Integrated Digital Care Strategy that have been delivered or are now beginning to be realised as the implemented systems start to mature. Some attempts to quantified the benefits has been undertaken but they should be read with caution as these will need to be verified in due course as the post project implementation reviews are carried out.

Benefits from the implementation of eCOBs (electronic Clinical Observations) and eWhiteboards:

- Patients added to the electronic whiteboard ensures that patient information is immediately available and visible. The information moves with the patient when transferred between wards. The time saving from the manual board is 12 seconds per patient (we have 168k inpatients per year so this has the potential to save 560 hours per year).
- Taking and recording of observations electronically is much safer for the patient as there is no risk of errors as there can be in manual calculations.
- The recording of observations using electronic devices is much quicker than recording on paper which gives the nursing staff more time to care. Time saved is 2 minutes if taken on the iPad and 3 minutes 10 seconds if done on the iPod. This is the time saved per set of observations (if we make the assumption that half of our patients have six hourly observations with an average of 2.5 minutes saving per observation we have a potential saving of 3,500 hours per year).
- The system alerts staff when observations are due / overdue ensuring that patients are monitored in a timely manner.
- Good quality nursing handover tool which ensures all the information on a given patient is stored and can be handed over to the next nurse so the same level of care can be administered.
- The electronic Sepsis tool triggers for those patients who are at risk of Sepsis. This ensures that the nursing staff carry out the Sepsis bundle immediately and the Outreach Team are alerted at the same time should they need to respond.
- Time saved for the Outreach Team as they can now carry out virtual reviews on their patients so they have an understanding of the patient's condition and can decide if they need a ward visit (the time saved is approximately three hours per day / 21 hours per week across the Trust).

- Outreach Team receive an email when a patient scores a NEWs of 5 or more, again a virtual review can be carried out before attending the patients bed side if required.
- Time saved for the Dietetics Team. As each team member does not have allocated wards they can use the 'hospital view' to see where the referrals to them are coming from and where the patients are located so that they can plan their attendance accordingly and most efficiently (estimated at 2.5 hours per week for Lincoln, 2 hours for Pilgrim and 30 mins for Grantham so 5 hours saved per week across the sites).
- The learning disability nurses (who are external to the Trust) can now see where their patients are in the hospital. Before they had no visibility of their patients and had to rely on the wards advising them where their patients were – this rarely happened.
- Ward managers and matrons have a more efficient management tool via the WebV dashboard to ensure the highest quality of care is given to their patients.
- Financial savings on the purchasing and printing of the NEWs, MEWs and PEWs (to follow) Charts as well as the Sepsis bundle. This totals £23.2k per year.
- Plan for Every Patient is now incorporated within the WebV board. This saves nursing staff time so gives further time to care for the patient (savings are approximately one hour per ward per day so taking 47 wards could be as much as 47 hours per day across the Trust).
- Cost saving on the removal of the Cayder Boards which equated to £11.3k per year.
- Theatres are carrying out the last set of obs on eCOBS in recovery so when the patient returns to the ward the nursing staff have a full picture of the patients wellbeing since having their procedure.
- Staff at Louth can view patients episodes if the patient has been cared for by ULHT or NLG. This eliminates the need to telephone the hospital or confirm details with the patients or expecting the patient to remember information leading to improved quality of care.

Benefits from the implementation of TheatreMan:

- Meets the latest NHS interfacing standards enabling data to be shared in real time with other systems and across key stakeholders.
- Inability to proceed unless specified alerts are checked and mandatory fields completed ensuring all appropriate information is captured and improved data quality.
- Provides a visual timeline to enable real time tracking of the patient's pathway / journey through theatres.
- Records critical milestones along the patient pathway e.g. anaesthetic start / finish time, knife to skin, time to recovery, time to ward, etc. that can be used for improving efficiency (by reviewing the timing and any delays) and audit.
- Can create a matrix of information that will report performance data in a clear and concise format.
- Is a Trust wide system of 'live' data.

- Is now future proof i.e. fits in with ULHT plans for future development.
- Reports session utilisation.
- Has the ability to improve staff management through integrating with staff scheduling systems.
- Flags under or over booked lists.
- Supports the delivery of the national standards for treatment waiting times.

Benefits from the implementation of Medway Maternity:

- Introduces a maternity electronic patient record that supports better patient care by ensuring that the right staff have access to the right information at the right time in the right place – this was hindered before with the manual paper records.
- Ability to retrieve data and statistics immediately to inform the Directorate and Trust Board of Trends and Targets (limited to bookings, deliveries & post-natal discharge in Phase 1).
- Produces reports to show activity per site and on a Trust wide basis allowing correct funding to be claimed (could be as much as £600k per year after Phase 2 / August 2018 due to the current loss of income for incorrect activity billing such as only billing for a simple birth when in fact it was a complex one, activity completed but not billed, etc.).
- Easier and quicker to provide data for Health Care Commission, NHSLA, RCOG, RCM from the Trust as a whole that previously achieved via many hours of collecting the data manually.
- Show trends to improve patient care, reduce litigation as the trends etc. will be highlighted earlier and therefore can be acted upon quicker.
- Ensures standardisation of data collection (limited to bookings, deliveries & post-natal discharge in Phase 1) across all sites.
- Reports are more flexible supporting clinical and business needs (limited to bookings, deliveries & post-natal discharge in Phase 1).
- Can produce data to aid audit.
- Can produce forms and documents for patient notes directly.
- Quality of care will improve as it will free midwives' time to deliver services to their patients (more time to care).

Benefits from the implementation of Medway PAS & Upgrade (major upgrade in October 2017):

- McKesson PAS contract expiry – mitigated risk with new Medway PAS system and full support and maintenance contract.
- Concurrent number of users cap with McKesson PAS removed with Medway PAS.
- A&E coding – real time recording now happening.
- RTT recording – pathways removed at original Medway Go-Live will now be updated with the upgrade and re-introduced.
- Increased speed / performance of the system.
- Merge & de-merge of health records easier.

- Provides better and safer patient care by improving access to patient information.
- Upgrade introduced recording of ECDS for A&E.

10 Delivering the strategy

This is a key enabling strategy for our 2021 vision and is essential for the achievement of our ambitions and helping us to strive towards excellence. Delivery of this strategy will require robust programme management, robust governance, appropriate investment and appropriate resources.

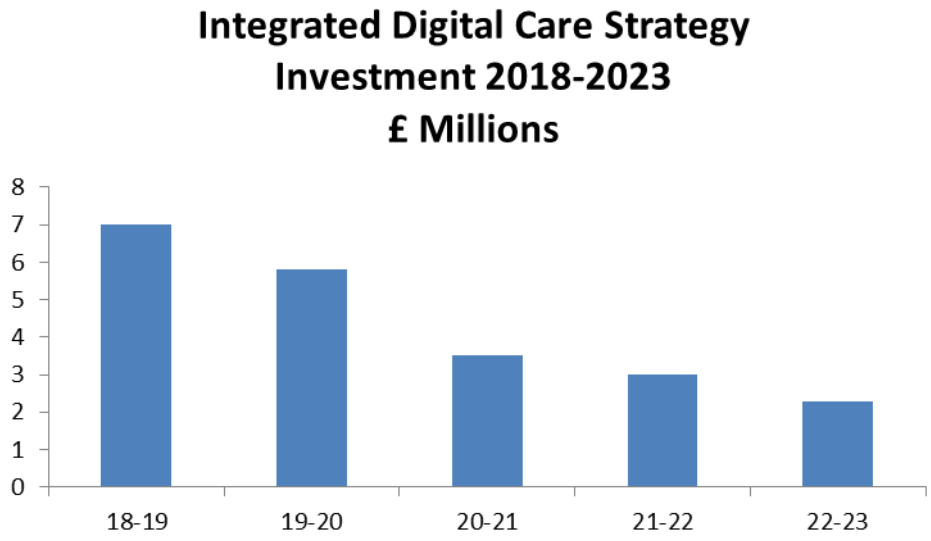
Transforming the Trust into an Integrated Digital Care Organisation will require significant process and working practices changes.

None of this will be possible without the significantly commitment, understanding and ambition of our clinical and other leaders.

10.1 Potential savings and investment required

It is expected that once completed the Integrated Digital Care Strategy will deliver £15m per annum cash savings – £5m cashable immediately with £10m time and capacity released that may become cashable at some point during the life of the strategy. These savings may be cautious and will need to be refined during individual business case development.

Below illustrates the indicative investment required over five years totalling over £20 million. It should be noted that not all costs are currently known and some are estimates (so are subject to refinement during full business case development, procurement, etc.).



Indicative investment required to deliver the strategy

10.2 High level programme delivery plan

Appendix A is the high level indicative programme delivery plan. It is estimated that up to 30 additional staff will be required at any one time to deliver the strategy and this number will vary throughout the duration of the programme.

10.3 Strategy governance

Delivery of the Integrated Digital Care Strategy is overseen by the Digital Hospital Group and managed via regular reports to the appropriate Trust Governance bodies such as the Finance, Procurement and Estates Committee, etc. This is reflected in Appendix B.

A detailed implementation plan and capital investment plan will be developed annually to reflect any changes in priorities over subsequent years and to ensure alignment with the Trust's Strategy.

All major aspects of the strategy will be managed using the PRINCE2 project management methodology.

10.4 Commitment of our leaders

The implementation of this strategy depends significantly on the commitment, understanding and ambition of our leaders. Addressing current and emergent challenges will require interoperable and flexible systems and locally championed innovation. The Trust Board should take responsibility for effective knowledge management to support this innovation and change.

> "Digital medicine will require leadership with the capability to direct the agenda, which should include a Board-level member, as well as new senior roles with responsibility for advising boards on digital technologies. The NHS must build skills in data provenance, curation and governance, enhance the understanding of ethical considerations and strengthen the necessary skills to carry out critical appraisal."
>
> The Topol Review (2019) "Preparing the healthcare workforce to deliver the digital future"

11 Conclusion

11.1 Why do we need this strategy?

Better use of data and technology has the power to improve health, give our clinicians and patients more control over the care we deliver, and transform the quality and reduce the cost of our health and care services.

In other parts of our lives, we have become accustomed to the benefits of technology: in the way we book our travel and holidays, manage our bank accounts and utility bills, buy groceries, and connect and communicate with our friends and family. Digital technologies are changing the way we do things, improving the accountability of services and reducing their cost. It puts people first, giving us more control and more transparency.

The health and care system faces unprecedented financial constraint at a time of rising demand for its services. One of the greatest opportunities available to us is the potential to safely harness the power of modern technology to meet the challenges of improving health and providing better, safer and sustainable care for all. Technology can help transform the cost of our services and help us meet the efficiency, as well as quality, challenges we face.

Addressing current and emergent challenges requires interoperable and flexible systems and locally championed innovation. By effectively harnessing technology to help reshape care delivery we will drive down variations in quality and cost-effectiveness while improving safety.

11.2 Consequence of not implementing the strategy

While developments in clinical technology have had a revolutionary impact on healthcare over the last 30 years, the same cannot be said for the use of technology and data to improve heath and the way health and social care services are delivered.

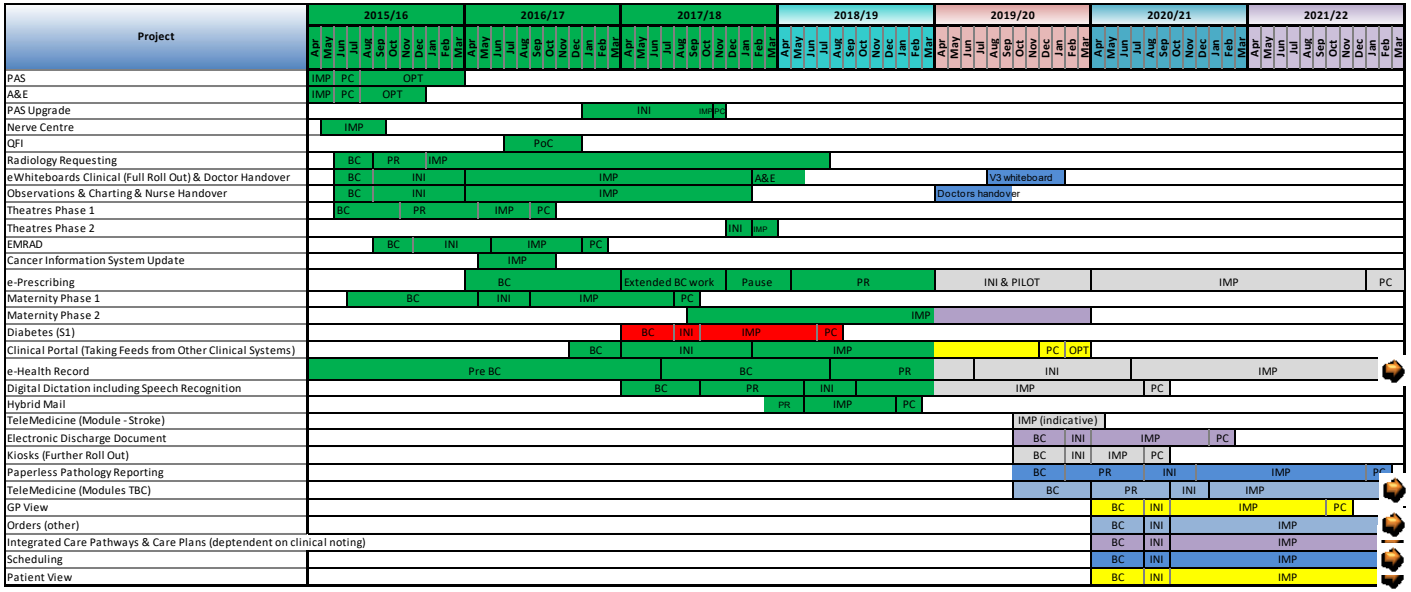
The failure to use information and technology properly means that our patients can experience unnecessary levels of preventable ill health, can suffer harm when it could be avoided and could live in greater pain and distress than they need to.

This strategy is fundamental to the transformation of our clinical services. If we do not deliver it we will not reap the benefits of modern technologies and of a paper-lite integrated organisation. Our systems will remain predominantly paper based and of poor quality, patient information will continue to be duplicated and recorded in over 60 disparate clinical IT systems and stored in over 100 different places across multiple sites. Important patient information will continue to be elusive when and where it is needed. Patient care and safety will continue to be compromised.

If we do not implement the Integrated Digital Care Strategy the experience of our patients would remain much as it was before the mobile phone and the internet became commonplace.

Appendix A – Indicative high level programme delivery plan

It should be noted that not all costs are currently known. They are still being developed with many being estimates and so are subject to change during full business case development, procurement, etc.



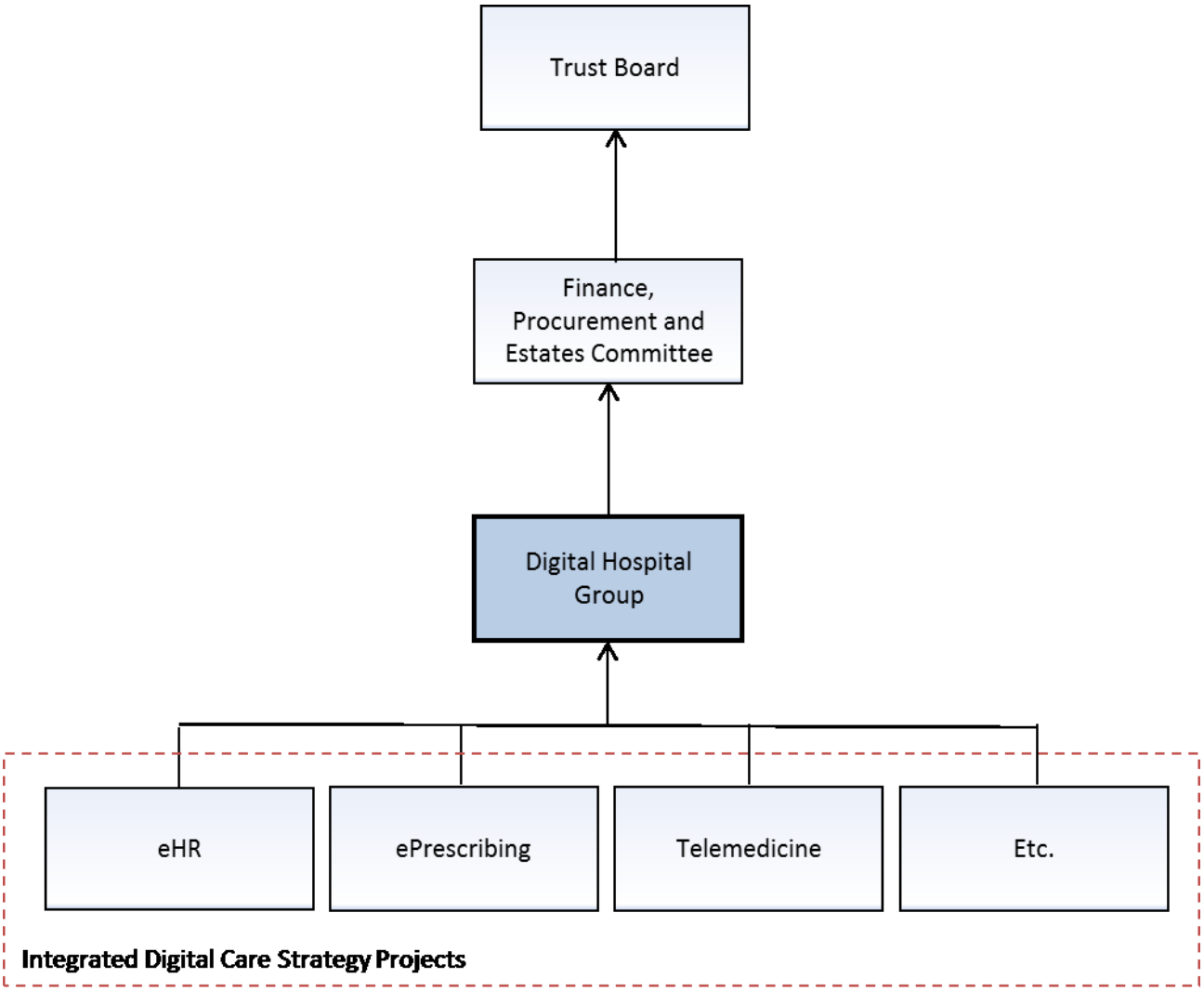
STATUS/STAGE
BC - BUSINESS CASE
PR - PROCUREMENT
INI - INITIATION
IMP - IMPLEMENTATION
OPT - OPTIMISATION
PC - PROJECT CLOSURE
PoC - PROOF OF CONCEPT

PLAN COLOUR KEY
Medway Module
Other Programme Work
WebV (or other solution)
Portal
Complete

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total 5 Year Costs
	Excludes Capital Charges, inlcudes annual maintenance and support						
PAS	£358,034	£366,798	£392,592	£392,592	£392,592	£392,592	**£2,295,200**
A&E	N/A	N/A	N/A	N/A	N/A		**£0**
PAS Upgrade	£70,000						**£70,000**
Nerve Centre							**£0**
QFI							**£0**
Radiology Requesting							**£0**
eWhiteboards Clinical (Full Roll Out) & Doctor Handover	£224,000	£71,508	£21,508	£21,508	£21,508	£21,508	**£381,540**
Observations & Charting & Nurse Handover							**£0**
Theatres Phase 1	£28,500	£28,500	£28,500	£28,500	£28,500	£28,500	**£171,000**
Theatres Phase 2	£50,000						**£50,000**
EMRAD							**£0**
Cancer Information System Update							**£0**
e-Prescribing		£1,857,304	£911,602	£152,298	£152,298	£152,298	**£3,225,800**
Maternity Phase 1	£252,277	£41,292	£41,292	£41,292	£41,292	£41,292	**£458,737**
Maternity Phase 2	£67,109	£115,746	£119,733				**£302,588**
Diabetes (S1)		£7,500	£7,500	£7,500	£7,500	£7,500	**£37,500**
Clinical Portal (Taking Feeds from Other Clinical Systems)		TBC	TBC	TBC	TBC	TBC	**£0**
e-Health Record		£4,031,563	£3,822,702	£2,836,252	£2,310,934	£1,581,934	**£14,583,385**
Digital Dictation including Speech Recognition	£134,249	£507,855	£446,495	£43,435	£43,435	£43,435	**£1,218,904**
Hybrid Mail		£16,643					**£16,643**
TeleMedicine (Module - Stroke)			TBC				**£0**
Electronic Discharge Document			TBC				**£0**
Kiosks (Further Roll Out)			TBC				**£0**
Paperless Pathology Reporting			TBC				**£0**
TeleMedicine (Modules TBC)			TBC				**£0**
GP View				TBC			**£0**
Orders (other)				TBC			**£0**
Integrated Care Pathways & Care Plans (deptendent on clinical noting)				TBC			**£0**
Scheduling				TBC			**£0**
Patient View				TBC			**£0**
	£1,184,169	**£7,044,708**	**£5,791,924**	**£3,523,377**	**£2,998,059**	**£2,269,059**	**£22,811,297**

Appendix B – Digital Strategy delivery governance

The delivery of the Integrated Digital Care Strategy will be overseen by the Digital Hospital Group.



United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Guardian of Safe Working
Date:	04/06/19
Healthcare Standard:	N/A

Title:	Annual Board Report on Safe Working Hours: Doctors and Dentists in Training

Author/Responsible Director: Dr M Chablani / Dr Neill Hepburn

Purpose of the report: For discussion, assurance and information

The report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Information	X

Summary / Key points:

Purpose of report:

- Provide the Board with assurance that patients are receiving safe, high quality care.
- Provide the Board with assurance that junior doctors are working within the Terms and Conditions of the 2016 contract.

Context:

- This report covers the period from 1st April 2018 - 31st March 2019.
- Data relating to temporary staffing has been unavailable due to vacancies in the Temporary Medical Staffing Team. These vacancies have since been filled.
- This report was taken to the Workforce and Organisational Development Assurance Committee. The Committee remains unassured.

Improvements and Actions:

- Fewer Exception Reports being generated in Medicine.
- Educational Supervisors are actioning Exception Reports faster.
- Non-issuance of usernames and passwords for Exception Reporting has been resolved.
- Engagement by the Educational Supervisors has improved and a command and control system for acting on Exception Reports has been implemented.
- Plans for better management of medical outliers is in discussion.
- The Guardian role is fully remunerated with plans to change how the role is delivered.
- There is better attendance at the Junior Doctors' Forums.
- Issues with the Allocate system are largely resolved. Two developments are outstanding (the ability to see where fines are applicable and the ability of the payroll to pick up the Exception Reports eligible for payment directly from the system).
- The Guardian has circulated an Excel spreadsheet to all trainees to allow them to monitor their rota and ascertain any fines that may be applicable.

Current Guardian arrangements:

- One Guardian has stepped down.
- One Guardian is in situ.
- Administrative support remains the same.
- This is an interim arrangement.

Proposal:

- A proposal was taken to CRIG to move towards a model that included a Guardian (1 PA) and a Coordinator (0.6 WTE of band 5).
- This was placed on the 'long list' and is being taken again, with modifications, to the next meeting on 5th June 2019.
- Financial impact:
  - Revenue investment of £6,080 in 2019/20.
  - Full year effect of £9,210 for pay cost impacts.
  - Non-recurrent investment required in 2019/20 of £1,000 for the purchase of a desktop PC, desk and chair.
- Benefits:
  - A more resilient, less vulnerable system.
  - A clear message to our junior doctors that the Trust is investing in their welfare.
  - Potential savings can come from three areas. Improved recruitment, improved retention and reduced sickness. It is not possible to quantify the effect on the recruitment and retention.
  - The Trust spent £203,179 on temporary staffing to cover junior doctors in 2018/19. Assuming that 19% of this absence is due to Anxiety / Stress, then there is a potential to save £38,604 without even considering the likely positive impact on absences for other reasons.

Recommendations:

Guardian recommendations:

1. Better coordination between the Educational Department and the Guardian regarding issues which are common to both.
2. Timely action on the Exception Reports by Educational Supervisors.
3. Smoother resolutions to payment of Exception Reports to junior doctors.

Proposal recommendations:

- To support the change in how the role is delivered.

Strategic risk register N/A	**Performance KPIs year to date** N/A

Resource implications (eg Financial, HR): HR, Financial

Assurance implications:

The board requires annual assurance in line with national guidelines.

Patient and Public Involvement (PPI) implications: N/A

Equality impact: None identified

Information exempt from disclosure: N/A

Requirement for further review?: N/A

Introduction

High Level Data for ULHT

Number of doctors / dentists in training (total):	Please refer to section (e)
Amount of time available in job plan for guardian to do role:	0.75 PA/week
Admin support provided to the guardian (if any):	0.1 WTE
Amount of job-planned time for educational supervisors:	0.25 PA/week per trainee

a) Exception Reports

April – June 2018:

Exception reports by specialty			
Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	0	0	0
Anaesthetics	0	0	0
General Medicine	11	11	0
General Surgery	0	0	0
Psychiatry	0	0	0
Trauma & orthopaedics	0	0	0
Total	**11**	**11**	**0**

Exception reports by grade			
Grade	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
FY1	7	7	0
FY2	0	0	0
CT	4	4	0
ST	0	0	0
Total	**11**	**11**	**0**

United Lincolnshire Hospitals NHS Trust

July – September 2018

Exception reports by specialty			
Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	0	0	0
Anaesthetics	0	0	0
General Medicine	15	12	3
General Surgery	0	0	0
Psychiatry	0	0	0
Haematology*	2	0	2
Total	**17**	**12**	**5**

*Haematology – Exception Reports pertained to education.

Exception reports by grade			
Grade	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	8	7	1
F2	0	0	0
CT1-2 / ST1-2	8	5	3
ST3+	1	0	1
Total	**17**	**12**	**5**

October – December 2018

Exception reports by specialty			
Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	0	0	0
Anaesthetics	0	0	0
General Medicine	10	10	0
General Surgery	2	2	0
Psychiatry	0	0	0
Total	**12**	**12**	**0**

Exception reports by grade			
Grade	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	9	9	0
F2	0	0	0
CT1-2 / ST1-2	0	0	0
ST3+	3	3	0
Total	**12**	**12**	**0**

January – March 2019

Exception reports by grade			
Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	0	0	0
Anaesthetics	0	0	0
General Medicine	4	4	0
General Surgery*	6	4	2
Psychiatry	0	0	0
Haematology	0	0	0
Trauma & Orthopaedics**	2	1	1
Total	**12**	**9**	**3**

* Please note that on logging into Allocate there are five Exception reports which show as being open under General Surgery but three of them have actually been closed but show as open on the system because of a system fault or the way they have been recorded. The Guardian has however instructed payment for the outstanding Exception Reports.

** Please that the outstanding Exception Report categorised under Trauma & Orthopaedics relates to an HR/Payroll issue whereby the trainee had not been paid correctly for working weekends. Hence this should not be seen as an Exception Report.

Exception reports by grade			
Grade	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	5	2	3
F2	0	0	0
CT1-2 / ST1-2	0	0	0
ST3+	7	7	0
Total	**12**	**9**	**3**

The following table is not applicable as all the doctors in training are on the new contract:

Hours Monitoring Exercises (for Doctors on 2002 TCS only)					
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
A&E					
Anaesthetics					
General Medicine					
General Surgery					
Psychiatry					
Etc.					

b) Work Schedule Reviews

Work Schedule Reviews by Grade	
F1	0
F2	0
CT1-2 / ST1-2	0
ST3+	0

Work Schedule Reviews by Department	
A&E	0
Anaesthetics	0
General Medicine	0
General Surgery	0
Psychiatry	0
Haematology	0

c) Locum Bookings

i) Internal Bank

April 2018

By Grade:

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	111.00	875	£54,556
Consultant Non Res on Call	4.00	60	£3,900
Associate Specialist	4.00	13	£676
Middle Grade	41.00	326	£16,835
GPVTS	1.00	8	£263
StR (ST3-8)	79.00	686	£45,383
Core Trainee/ST1&2 (formally SHO)	33.00	312	£8,523
FY 2	12.00	125	£2,590
FY 1	31.00	173	£5,110
Grand Total	**316.00**	**2575**	**£137,836**

By Specialty:

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	57.00	383	£18,999
Anaesthetics	24.00	227	£14,092
Breast Surgery	8.00	41	£1,911
Care of the Elderly	2.00	8	£488
Emergency Medicine	61.00	543	£38,222
Endocrinology and Diabetes	3.00	16	£1,040
ENT	7.00	28	£1,619
General Surgery	36.00	397	£15,922
Intensive Care	13.00	123	£6,585
Obstetrics and Gynaecology	18.00	132	£4,674
Ophthalmology	1.00	4	£260
Orthopaedic and Trauma Surgery	7.00	42	£2,158
Paediatrics	40.00	368	£19,528
Pain Medicine	3.00	15	£975
Respiratory Medicine	10.00	78	£2,040
Rheumatology	7.00	61	£3,088
Stroke Medicine	2.00	45	£2,779
Urology	12.00	42	£2,240
Vascular Surgery	5.00	25	£1,220
Grand Total	**316.00**	**2575**	**£137,836**

By Reason:

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	5.00	42	£3,429
Capacity Pressures	76.00	568	£39,667
Compassionate/Special leave	20.00	164	£10,569
Extra Cover	91.00	677	£34,111
Sick	6.00	35	£2,028
Vacancy	117.00	1086	£47,707
Waiting list initiative	1.00	5	£325
Grand Total	**316.00**	**2575**	**£137,836**

May 2018

By Grade:

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	624.00	4817	£298,222
Consultant Non Res on Call	39.00	442	£28,730
Consultant 2nd on call	1.00	4	£228
Associate Specialist	30.00	134	£6,552
Middle Grade	230.00	2136	£107,716
GPVTS	22.00	129	£4,253
StR (ST3-8)	407.00	3650	£231,085
Core Trainee/ST1&2 (formally SHO)	142.00	1237	£28,549
FY 2	291.00	2562	£53,034
FY 1	71.00	453	£12,022
Nurse	1.00	4	£0
Grand Total	**1858.00**	**15567**	**£770,390**

United Lincolnshire Hospitals NHS Trust

By Specialty:

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	239.00	1769	£75,070
Ambulatory Paediatrics	9.00	81	£5,265
Anaesthetics	115.00	998	£60,224
Breast Surgery	30.00	179	£10,946
Cardiology	6.00	37	£1,430
Care of the Elderly	7.00	42	£1,400
Chest Medicine	2.00	8	£565
Community Paediatrics	1.00	7	£0
Diabetes	4.00	15	£975
Emergency Medicine	315.00	2746	£202,108
Endocrine Surgery	1.00	6	£390
Endocrinology and Diabetes	14.00	63	£3,598
Endoscopy - Surgical	4.00	35	£2,286
ENT	111.00	933	£31,627
Gastroenterology	4.00	20	£895
General Surgery	197.00	1647	£57,572
Gynaecology	6.00	33	£2,067
Intensive Care	52.00	478	£24,245
Medical Outliers	1.00	1	£18
Neurology	1.00	12	£780
Obstetrics and Gynaecology	123.00	908	£45,827
Oncology	3.00	10	£634
Ophthalmology	17.00	136	£6,362
Oral and Maxillofacial Surgery	1.00	9	£442
Orthogeriatrics	2.00	2	£98
Orthopaedic and Trauma Surgery	89.00	902	£41,499
Paed Sla	20.00	231	£12,609
Paediatric A&E	2.00	24	£1,248
Paediatrics	104.00	956	£48,610
Paediatrics and Neonates	95.00	884	£38,584
Pain Medicine	9.00	60	£3,900
Respiratory Medicine	188.00	1519	£49,920
Rheumatology	1.00	4	£260
Stroke Medicine	27.00	307	£14,455
Urology	44.00	430	£21,433
Vascular Surgery	14.00	79	£3,051
Grand Total	**1858.00**	**15567**	**£770,390**

By Reason:

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	52.00	455	£36,079
Capacity Pressures	373.00	2810	£197,654
Compassionate/Special leave	11.00	169	£9,428
Exempt from On Call	7.00	64	£4,128
Extra Cover	431.00	3221	£157,808
Induction	1.00	3	£255
Maternity/Pregnancy leave	1.00	5	£158
Paternity Leave	7.00	59	£1,530
Restricted Duties	3.00	36	£0
Seasonal Pressures	2.00	22	£0
Sick	168.00	1248	£85,121
Study Leave	7.00	78	£4,404
Vacancy	783.00	7322	£268,984
Waiting list initiative	12.00	78	£4,843
Grand Total	**1858.00**	**15567**	**£770,390**

June 2018

By Grade:

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	476.00	3693	£193,069
Consultant Non Res on Call	44.00	558	£26,119
Associate Specialist	17.00	100	£1,274
Middle Grade	192.00	1722	£117,606
GPVTS	5.00	28	£963
StR (ST3-8)	407.00	3706	£184,823
Core Trainee/ST1&2 (formally SHO)	516.00	4656	£143,680
FY 2	118.00	1117	£16,288
FY 1	56.00	450	£11,331
Grand Total	**1831.00**	**16029**	**£695,152**

By Specialty:

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	200.00	1693	£55,089
Ambulatory Paediatrics	4.00	46	£1,430
Anaesthetics	25.00	271	£15,955
Breast Surgery	8.00	45	£2,815
Cardiology	8.00	63	£2,899
Care of the Elderly	208.00	1704	£56,827
Chest Medicine	3.00	14	£650
Community Paediatrics	30.00	227	£7,817
Diabetes	1.00	4	£228
Emergency Medicine	380.00	3337	£194,103
Endocrinology and Diabetes	42.00	354	£26,081
ENT	44.00	493	£8,079
Gastroenterology	53.00	409	£10,309
General Medicine	22.00	161	£1,756
General Surgery	96.00	840	£27,173
Gynaecology	1.00	4	£0
Haematology	67.00	552	£36,231
Intensive Care	20.00	200	£10,374
Medical Outliers	17.00	120	£4,848
Neurology	21.00	160	£15,214
Obstetrics and Gynaecology	81.00	770	£38,019
Ophthalmology	7.00	52	£1,360
Oral and Maxillofacial Surgery	2.00	17	£995
Orthopaedic and Trauma Surgery	137.00	1435	£58,370
Paed Sla	4.00	36	£2,308
Paediatrics	55.00	557	£24,210
Paediatrics and Neonates	138.00	1223	£32,964
Pain Medicine	3.00	25	£1,625
Respiratory Medicine	58.00	437	£23,632
Rheumatology	2.00	15	£0
Stroke Medicine	13.00	91	£520
Urology	47.00	394	£30,094
Vascular Surgery	34.00	284	£3,179
Grand Total	**1831.00**	**16029**	**£695,152**

By Reason:

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
A&E double up	2.00	15	£0
Annual Leave	14.00	123	£8,571
Capacity Pressures	98.00	670	£45,169
Compassionate/Special leave	7.00	81	£1,883
Exempt from On Call	1.00	10	£618
Extra Cover	162.00	1223	£54,364
Paternity Leave	1.00	5	£0
Restricted Duties	2.00	24	£0
Seasonal Pressures	1.00	14	£0
Sick	40.00	302	£16,100
Study Leave	22.00	207	£15,815
Vacancy	1478.00	13333	£551,008
Waiting list initiative	3.00	25	£1,625
Grand Total	**1831.00**	**16029**	**£695,152**

July 2018

By Grade:

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	783.00	6091	£370,282
Consultant Non Res on Call	42.00	489	£31,785
Consultant 2nd on call	1.00	4	£228
Associate Specialist	36.00	158	£7,826
Middle Grade	278.00	2605	£131,662
GPVTS	34.00	205	£6,913
StR (ST3-8)	483.00	4362	£270,504
Core Trainee/ST1&2 (formally SHO)	172.00	1507	£31,603
FY 2	306.00	2660	£56,289
FY 1	92.00	632	£16,340
Nurse	1.00	4	£0
Grand Total	**2228.00**	**18716**	**£923,430**

By Specialty:

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	315.00	2363	£101,358
Ambulatory Paediatrics	9.00	81	£5,265
Anaesthetics	131.00	1103	£66,087
Breast Surgery	42.00	268	£16,491
Cardiology	7.00	41	£1,690
Care of the Elderly	15.00	99	£2,536
Chest Medicine	7.00	34	£1,903
Community Paediatrics	3.00	20	£878
Diabetes	4.00	15	£975
Emergency Medicine	354.00	3102	£230,938
Endocrine Surgery	1.00	6	£390
Endocrinology and Diabetes	21.00	99	£5,921
Endoscopy - Surgical	4.00	35	£2,286
ENT	115.00	952	£32,686
Gastroenterology	5.00	26	£1,285
General Medicine	1.00	8	£0
General Surgery	223.00	1836	£64,777
Gynaecology	6.00	33	£2,067
Intensive Care	83.00	816	£43,024
Medical Outliers	9.00	36	£1,878
Neurology	1.00	12	£780
Obstetrics and Gynaecology	139.00	1057	£49,694
Oncology	3.00	10	£634
Ophthalmology	18.00	138	£6,466
Oral and Maxillofacial Surgery	2.00	17	£995
Orthogeriatrics	2.00	2	£98
Orthopaedic and Trauma Surgery	98.00	991	£45,659
Paed Sla	20.00	231	£12,609
Paediatric A&E	2.00	24	£1,248
Paediatrics	162.00	1580	£81,350
Paediatrics and Neonates	98.00	920	£38,584
Pain Medicine	11.00	75	£4,875
Respiratory Medicine	193.00	1543	£51,659
Rheumatology	24.00	168	£650
Stroke Medicine	28.00	310	£14,545
Urology	55.00	557	£28,102
Vascular Surgery	17.00	114	£3,051
Grand Total	**2228.00**	**18716**	**£923,430**

By Reason:

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	59.00	521	£41,646
Capacity Pressures	468.00	3513	£245,210
Compassionate/Special leave	12.00	175	£9,850
Exempt from On Call	7.00	64	£4,128
Extra Cover	503.00	3784	£185,141
Induction	1.00	3	£255
Maternity/Pregnancy leave	1.00	5	£158
Paternity Leave	7.00	59	£1,530
Restricted Duties	3.00	36	£0
Seasonal Pressures	2.00	22	£0
Sick	179.00	1309	£88,782
Study Leave	9.00	97	£5,639
Vacancy	962.00	9029	£334,656
Waiting list initiative	15.00	102	£6,435
Grand Total	**2228.00**	**18716**	**£923,430**

United Lincolnshire Hospitals NHS Trust

August 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
GPVTS	2.00	12	£420
StR (ST3-8)	147.00	1351	£79,320
Core Trainee/ST1&2 (formally SHO)	54.00	422	£10,325
FY 2	3.00	29	£0
FY 1	7.00	37	£885
Grand Total	**213.00**	**1850**	**£90,950**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	29.00	222	£3,342
Anaesthetics	9.00	104	£4,974
Cardiology	2.00	18	£0
Community Paediatrics	3.00	21	£1,092
Emergency Medicine	121.00	1082	£68,371
General Surgery	1.00	7	£195
Intensive Care	1.00	3	£130
Medical Outliers	3.00	9	£60
Obstetrics and Gynaecology	5.00	56	£494
Paediatrics	14.00	147	£5,892
Respiratory Medicine	2.00	9	£293
Stroke Medicine	23.00	175	£6,108
Grand Total	**213.00**	**1850**	**£90,950**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	33.00	293	£18,697
Capacity Pressures	52.00	472	£29,375
Extra Cover	26.00	196	£13,753
Sick	6.00	50	£1,610
Vacancy	96.00	840	£27,515
Grand Total	**213.00**	**1850**	**£90,950**

United Lincolnshire Hospitals NHS Trust

September 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	259.00	2534	£112,170
Core Trainee/ST1&2 (formally SHO)	142.00	1111	£24,256
Dental Core Training	4.00	41	£980
FY 2	22.00	189	£6,615
FY 1	20.00	192	£3,690
Grand Total	**447.00**	**4066**	**£147,711**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	38.00	344	£9,337
Anaesthetics	9.00	53	£2,175
Care of the Elderly	3.00	27	£0
Community Paediatrics	2.00	16	£832
Emergency Medicine	233.00	2053	£77,886
ENT	3.00	24	£0
General Medicine	37.00	320	£6,248
General Surgery	15.00	153	£5,668
Intensive Care	3.00	29	£1,482
Medical Outliers	3.00	8	£198
Obstetrics and Gynaecology	6.00	67	£3,390
Oral and Maxillofacial Surgery	4.00	41	£980
Orthopaedic and Trauma Surgery	44.00	500	£25,847
Paediatrics	17.00	165	£5,599
Paediatrics and Neonates	9.00	103	£2,106
Stroke Medicine	20.00	160	£5,600
Vascular Surgery	1.00	7	£364
Grand Total	**447.00**	**4066**	**£147,711**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	5.00	44	£2,068
Capacity Pressures	153.00	1450	£79,107
Extra Cover	35.00	303	£18,235
Induction	1.00	13	£676
Seasonal Pressures	3.00	24	£800
Sick	35.00	303	£8,033
Vacancy	215.00	1930	£38,793
Grand Total	**447.00**	**4066**	**£147,711**

United Lincolnshire Hospitals NHS Trust

October 2018

By Grade:

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	252.00	2531	£124,669
Dental Core Training	4.00	88	£3,080
FY 2	31.00	146	£4,830
FY 1	34.00	256	£6,945
Core Trainee	110.00	963	£8,330
Grand Total	**431.00**	**3983**	**£147,854**

By Specialty:

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	37.00	233	£7,706
Anaesthetics	7.00	59	£3,008
Cardiology	1.00	8	£416
Community Paediatrics	3.00	21	£1,092
Emergency Medicine	253.00	2242	£88,838
General Medicine	1.00	8	£0
General Surgery	18.00	137	£2,695
Intensive Care	1.00	2	£104
Obstetrics and Gynaecology	1.00	13	£0
Oral and Maxillofacial Surgery	4.00	88	£3,080
Orthopaedic and Trauma Surgery	60.00	722	£36,516
Paediatrics	17.00	193	£2,337
Paediatrics and Neonates	11.00	136	£1,950
Stroke Medicine	15.00	120	£0
Vascular Surgery	2.00	4	£113
Grand Total	**431.00**	**3983**	**£147,854**

By Reason:

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	22.00	276	£10,513
Capacity Pressures	138.00	1389	£81,974
Extra Cover	43.00	333	£22,709
Seasonal Pressures	2.00	16	£480
Sick	21.00	155	£3,613
Study Leave	2.00	17	£723
Vacancy	203.00	1798	£27,844
Grand Total	**431.00**	**3983**	**£147,854**

United Lincolnshire Hospitals NHS Trust

November 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	316.00	3067	£126,780
Dental Core Training	1.00	24	£840
FY 2	32.00	203	£7,105
FY 1	15.00	110	£3,300
Core Trainee	121.00	1080	£16,993
Grand Total	**485.00**	**4484**	**£155,017**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	35.00	271	£6,158
Anaesthetics	4.00	33	£1,690
Care of the Elderly	4.00	50	£0
Community Paediatrics	8.00	34	£1,742
Emergency Medicine	295.00	2639	£94,708
General Medicine	10.00	109	£1,950
General Surgery	26.00	245	£4,754
Intensive Care	4.00	10	£520
Medical Outliers	2.00	5	£165
Neonatal Medicine	1.00	13	£0
Obstetrics and Gynaecology	10.00	107	£4,744
Oral and Maxillofacial Surgery	2.00	34	£1,360
Orthopaedic and Trauma Surgery	58.00	679	£31,658
Paediatrics	25.00	246	£5,570
Paediatrics and Neonates	1.00	12	£0
Grand Total	**485.00**	**4484**	**£155,017**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	17.00	160	£10,298
Capacity Pressures	133.00	1304	£73,165
Extra Cover	69.00	573	£33,170
Seasonal Pressures	4.00	25	£875
Sick	21.00	159	£5,692
Study Leave	8.00	71	£1,575
Vacancy	233.00	2194	£30,244
Grand Total	**485.00**	**4484**	**£155,017**

December 2018

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

January 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

February 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

March 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

ii) Agency

April 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	141.00	1178	£126,621
Consultant Non Res on Call	19.00	267	£14,888
Middle Grade	4.00	44	£0
StR (ST3-8)	139.00	1299	£94,174
Core Trainee/ST1&2 (formally SHO)	191.00	1808	£103,639
FY 1	62.00	586	£18,486
Grand Total	**556.00**	**5181**	**£357,808**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	44.00	402	£26,613
Cardiology	21.00	158	£17,868
Care of the Elderly	66.00	559	£26,311
Community Paediatrics	12.00	96	£10,589
Emergency Medicine	108.00	991	£72,018
ENT	1.00	8	£171
Gastroenterology	21.00	170	£18,439
General Medicine	2.00	19	£2,317
General Surgery	60.00	605	£32,509
Haematology	51.00	443	£37,368
Obstetrics and Gynaecology	32.00	344	£20,733
Orthopaedic and Trauma Surgery	44.00	494	£24,360
Paediatrics	26.00	337	£28,978
Paediatrics and Neonates	20.00	165	£8,836
Respiratory Medicine	33.00	279	£25,895
Vascular Surgery	15.00	113	£4,803
Grand Total	**556.00**	**5181**	**£357,808**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Extra Cover	3.00	27	£3,028
Study Leave	1.00	8	£171
Vacancy	552.00	5147	£354,610
Grand Total	**556.00**	**5181**	**£357,808**

United Lincolnshire Hospitals NHS Trust

May 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	691.00	5337	£551,461
Consultant Non Res on Call	62.00	793	£37,968
Middle Grade	430.00	3837	£271,711
StR (ST3-8)	727.00	6628	£486,241
Core Trainee/ST1&2 (formally SHO)	916.00	8268	£481,943
FY 2	106.00	855	£34,284
FY 1	49.00	410	£13,898
Grand Total	**2981.00**	**26128**	**£1,877,506**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	167.00	1402	£101,178
Cardiology	95.00	746	£80,014
Care of the Elderly	349.00	2989	£177,462
Community Paediatrics	15.00	116	£12,807
Emergency Medicine	925.00	8126	£594,866
Endocrinology and Diabetes	91.00	797	£46,617
ENT	25.00	189	£10,107
Gastroenterology	88.00	742	£79,741
General Medicine	24.00	189	£18,581
General Surgery	63.00	637	£37,239
Haematology	278.00	2273	£172,317
Neurology	64.00	489	£54,259
Obstetrics and Gynaecology	211.00	2194	£127,916
Oncology	11.00	87	£7,482
Orthopaedic and Trauma Surgery	230.00	2296	£139,951
Paediatrics	13.00	176	£10,986
Paediatrics and Neonates	109.00	932	£68,140
Respiratory Medicine	109.00	855	£77,415
Urology	87.00	690	£54,915
Vascular Surgery	27.00	205	£5,513
Grand Total	**2981.00**	**26128**	**£1,877,506**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Exempt from On Call	4.00	48	£3,695
Extra Cover	136.00	1065	£63,832
Maternity/Pregnancy leave	7.00	81	£3,961
Sick	5.00	56	£3,953
Study Leave	83.00	726	£61,564
Vacancy	2746.00	24152	£1,740,501
Grand Total	**2981.00**	**26128**	**£1,877,506**

June 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	1554.00	12308	£577,190
Consultant Non Res on Call	95.00	924	£29,168
Consultant 2nd on call	1.00	4	£228
Associate Specialist	31.00	176	£4,446
Middle Grade	411.00	3754	£184,131
GPVTS	20.00	124	£3,938
StR (ST3-8)	977.00	8972	£449,908
Core Trainee/ST1&2 (formally SHO)	1130.00	10304	£340,407
FY 2	369.00	3010	£57,445
FY 1	96.00	773	£18,931
Grand Total	**4684.00**	**40347**	**£1,665,791**

United Lincolnshire Hospitals NHS Trust

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	506.00	4141	£117,598
Ambulatory Paediatrics	7.00	60	£3,120
Anaesthetics	62.00	445	£25,763
Breast Surgery	18.00	108	£6,500
Cardiology	133.00	1052	£89,099
Care of the Elderly	333.00	2729	£117,481
Chest Medicine	3.00	16	£960
Community Paediatrics	85.00	634	£15,628
Diabetes	3.00	12	£748
Emergency Medicine	962.00	8849	£424,174
Endocrinology and Diabetes	124.00	972	£25,308
Endoscopy - Surgical	4.00	35	£2,286
ENT	156.00	1166	£33,409
Gastroenterology	87.00	681	£44,107
General Medicine	70.00	533	£10,936
General Surgery	300.00	3034	£73,419
Gynaecology	4.00	21	£1,287
Haematology	153.00	1247	£92,993
Intensive Care	44.00	463	£23,407
Medical Outliers	38.00	280	£5,115
Neurology	53.00	409	£38,975
Obstetrics and Gynaecology	200.00	1846	£74,575
Oncology	1.00	4	£228
Ophthalmology	12.00	90	£4,122
Orthopaedic and Trauma Surgery	316.00	3114	£139,371
Paed Sla	10.00	105	£2,730
Paediatric A&E	2.00	24	£1,248
Paediatrics	165.00	1616	£76,322
Paediatrics and Neonates	231.00	1851	£44,880
Pain Medicine	6.00	40	£2,600
Respiratory Medicine	348.00	2685	£105,352
Rheumatology	23.00	164	£390
Stroke Medicine	48.00	441	£8,345
Urology	74.00	723	£46,961
Vascular Surgery	103.00	760	£6,355
Grand Total	**4684.00**	**40347**	**£1,665,791**

United Lincolnshire Hospitals NHS Trust

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	32.00	297	£20,880
Capacity Pressures	242.00	1858	£108,446
Compassionate/Special leave	20.00	244	£6,083
Exempt from On Call	12.00	113	£2,535
Extra Cover	368.00	2854	£129,020
Maternity/Pregnancy leave	2.00	10	£0
Paternity Leave	7.00	59	£1,530
Restricted Duties	3.00	36	£0
Sick	112.00	858	£57,189
Study Leave	21.00	186	£14,418
Vacancy	3859.00	33789	£1,322,799
Waiting list initiative	6.00	45	£2,893
Grand Total	**4684.00**	**40347**	**£1,665,791**

NHS
United Lincolnshire Hospitals
NHS Trust

July 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
Consultant	945.00	7404	£766,874
Consultant Non Res on Call	90.00	1157	£54,637
Middle Grade	430.00	3837	£271,711
StR (ST3-8)	1019.00	9439	£698,652
Core Trainee/ST1&2 (formally SHO)	1218.00	11160	£648,073
FY 2	119.00	952	£39,741
FY 1	113.00	1096	£34,007
Grand Total	**3934.00**	**35045**	**£2,513,696**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	212.00	1882	£137,539
Cardiology	137.00	1097	£110,011
Care of the Elderly	452.00	3924	£242,878
Community Paediatrics	27.00	204	£22,567
Emergency Medicine	1116.00	9822	£719,187
Endocrinology and Diabetes	100.00	865	£54,731
ENT	40.00	307	£19,192
Gastroenterology	109.00	924	£99,428
General Medicine	30.00	235	£24,077
General Surgery	165.00	1497	£81,615
Haematology	345.00	2803	£207,350
Medical Outliers	11.00	85	£8,163
Neurology	64.00	489	£54,259
Obstetrics and Gynaecology	245.00	2547	£151,855
Oncology	11.00	87	£7,482
Orthopaedic and Trauma Surgery	352.00	3740	£209,826
Paediatrics	48.00	595	£45,082
Paediatrics and Neonates	158.00	1358	£106,035
Respiratory Medicine	135.00	1056	£99,856
Stroke Medicine	2.00	15	£747
Urology	137.00	1227	£101,745
Vascular Surgery	38.00	287	£10,071
Grand Total	**3934.00**	**35045**	**£2,513,696**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Capacity Pressures	2.00	15	£900
Exempt from On Call	4.00	48	£3,695
Extra Cover	166.00	1293	£80,877
Maternity/Pregnancy leave	7.00	81	£3,961
Sick	27.00	276	£27,823
Study Leave	95.00	844	£71,618
Vacancy	3633.00	32489	£2,324,822
Grand Total	**3934.00**	**35045**	**£2,513,696**

United Lincolnshire Hospitals NHS Trust

August 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	292.00	2828	£223,041
Core Trainee/ST1&2 (formally SHO)	307.00	2831	£151,947
FY 2	4.00	33	£1,913
FY 1	26.00	257	£8,398
Grand Total	**629.00**	**5949**	**£385,299**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	24.00	228	£10,449
Care of the Elderly	36.00	344	£26,836
Emergency Medicine	121.00	1136	£89,456
ENT	45.00	351	£23,323
General Medicine	14.00	110	£5,314
General Surgery	47.00	443	£18,846
Haematology	46.00	354	£21,900
Obstetrics and Gynaecology	70.00	668	£37,215
Orthopaedic and Trauma Surgery	68.00	710	£38,125
Paediatrics	26.00	267	£18,078
Paediatrics and Neonates	99.00	1037	£72,787
Stroke Medicine	9.00	74	£4,440
Urology	23.00	219	£17,992
Vascular Surgery	1.00	9	£538
Grand Total	**629.00**	**5949**	**£385,299**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
A&E double up	1.00	11	£654
Annual Leave	26.00	242	£19,775
Capacity Pressures	4.00	39	£3,325
Study Leave	24.00	237	£18,950
Vacancy	574.00	5421	£342,596
Grand Total	**629.00**	**5949**	**£385,299**

September 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	781.00	7153	£577,423
Core Trainee/ST1&2 (formally SHO)	915.00	8311	£475,125
FY 2	61.00	574	£31,575
FY 1	14.00	120	£4,252
Grand Total	**1771.00**	**16158**	**£1,088,375**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	77.00	740	£48,151
Care of the Elderly	153.00	1382	£92,099
Community Paediatrics	20.00	160	£13,598
Emergency Medicine	319.00	2919	£211,932
ENT	97.00	886	£60,868
Gastroenterology	97.00	919	£59,023
General Medicine	153.00	1343	£85,134
General Surgery	119.00	1164	£78,593
Haematology	60.00	480	£31,624
Neonatal Medicine	1.00	6	£339
Obstetrics and Gynaecology	100.00	871	£55,359
Oncology	26.00	220	£18,341
Ophthalmology	20.00	160	£13,704
Orthopaedic and Trauma Surgery	220.00	2033	£118,030
Paediatrics	29.00	311	£23,642
Paediatrics and Neonates	110.00	1122	£80,559
Rehabilitation Medicine	20.00	160	£9,582
Respiratory Medicine	34.00	290	£20,987
Stroke Medicine	44.00	400	£23,910
Urology	72.00	595	£42,898
Grand Total	**1771.00**	**16158**	**£1,088,375**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	3.00	25	£1,967
Capacity Pressures	4.00	38	£3,304
Extra Cover	9.00	76	£5,017
Sick	12.00	102	£5,891
Study Leave	26.00	225	£18,247
Vacancy	1717.00	15692	£1,053,950
Grand Total	**1771.00**	**16158**	**£1,088,375**

October 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	816.00	7395	£602,361
FY 2	62.00	587	£31,735
FY 1	22.00	176	£6,514
Core Trainee	1078.00	9395	£541,125
Grand Total	**1978.00**	**17552**	**£1,181,734**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	114.00	967	£54,005
Care of the Elderly	181.00	1563	£101,732
Community Paediatrics	20.00	160	£13,598
Emergency Medicine	362.00	3387	£249,721
ENT	103.00	959	£66,266
Gastroenterology	113.00	987	£62,313
General Medicine	168.00	1481	£94,133
General Surgery	121.00	1146	£80,160
Haematology	69.00	552	£36,368
Medical Outliers	3.00	24	£1,426
Obstetrics and Gynaecology	117.00	960	£57,000
Oncology	25.00	202	£16,841
Ophthalmology	23.00	184	£15,760
Orthopaedic and Trauma Surgery	212.00	1890	£113,467
Paediatrics	22.00	217	£17,038
Paediatrics and Neonates	138.00	1325	£92,461
Rehabilitation Medicine	23.00	184	£11,020
Respiratory Medicine	49.00	394	£28,362
Stroke Medicine	41.00	361	£21,587
Urology	74.00	613	£48,477
Grand Total	**1978.00**	**17552**	**£1,181,734**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	13.00	122	£8,247
Capacity Pressures	21.00	209	£17,369
Extra Cover	7.00	57	£3,372
Sick	8.00	98	£5,722
Study Leave	24.00	193	£15,522
Vacancy	1905.00	16874	£1,131,502
Grand Total	**1978.00**	**17552**	**£1,181,734**

United Lincolnshire Hospitals NHS Trust

November 2018

By Grade

Grade	Number of shifts	Number of hours	Sum of Estimated Cost
StR (ST3-8)	861.00	7794	£635,838
FY 2	43.00	404	£20,671
Core Trainee	1095.00	9565	£551,943
Grand Total	**1999.00**	**17763**	**£1,208,452**

By Specialty

Specialty	Number of shifts	Number of hours	Sum of Estimated Cost
Acute Medicine	140.00	1214	£76,258
Care of the Elderly	135.00	1211	£81,336
Community Paediatrics	22.00	176	£14,958
Emergency Medicine	422.00	3856	£287,552
ENT	95.00	890	£59,773
Gastroenterology	109.00	982	£63,136
General Medicine	148.00	1327	£87,182
General Surgery	113.00	1066	£70,056
Haematology	67.00	536	£35,257
Medical Outliers	5.00	40	£2,377
Neonatal Medicine	20.00	174	£10,202
Obstetrics and Gynaecology	115.00	945	£56,255
Oncology	26.00	225	£18,717
Ophthalmology	22.00	176	£15,074
Orthopaedic and Trauma Surgery	191.00	1709	£103,021
Paediatrics	22.00	235	£18,371
Paediatrics and Neonates	136.00	1275	£88,033
Rehabilitation Medicine	22.00	176	£10,541
Respiratory Medicine	45.00	376	£26,278
Stroke Medicine	44.00	370	£20,279
Urology	100.00	806	£63,796
Grand Total	**1999.00**	**17763**	**£1,208,452**

By Reason

Reason	Number of shifts	Number of hours	Sum of Estimated Cost
Annual Leave	2.00	21	£1,435
Capacity Pressures	25.00	243	£20,276
Sick	1.00	8	£472
Study Leave	29.00	271	£21,056
Vacancy	1942.00	17220	£1,165,213
Grand Total	**1999.00**	**17763**	**£1,208,452**

December 2018

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

January 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

February 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

March 2019

By Grade

Data not available at the time of preparation of this report.

By Specialty

Data not available at the time of preparation of this report.

By Reason

Data not available at the time of preparation of this report.

d) Locum Work Carried out by Trainees

Information to complete this table is currently unavailable.

Locum Trainee by Trainee						
Specialty	**Grade**	**Number of shifts worked**	**Number of hours worked**	**Number of hours rostered per week**	**Actual hours worked per week**	**Opted out of WTR?**
A&E						
Anaesthetics						
General Medicine						
General Surgery						
Psychiatry						
Etc.						
Total						

e) Vacancies

*Headcount refers to the exact number of junior doctors in post
*FTE refers to full-time equivalent
*Vacancies are based off FTE rather than headcount as different doctors work different hours.

April 2018

Specialty	Headcount	In post FTE	Vacant FTE
AE Boston	7	7	1
Anaesthetics Boston	15	15	0
Breast Surgery Boston			1
Cardiology Boston	2	2	2
Diabetes Boston	5	5	0
Elderly Care Boston	9	9	-3
ENT Boston	3	3	0
Gastroenterology Boston	3	3	2
General Medicine Boston	8	8	-6
General Surgery Boston	11	11	2
Haematology Pan Trust	1	1	0
Obs & Gynae Boston	11	11	0
Ophthalmology Boston	1	1	1
Orthopaedics Boston	7	7	5
Paediatrics Boston	6	6	1
PGME	9	9	-9
Radiologist Services	2	1.6	0.4
Respiratory medicine	5	5	1
Stroke Boston	1	1	3
Urology Boston	3	3	0
Vascular Surgery			3

May 2018

Specialty	Headcount	In post FTE	Vacant FTE
AE Boston	7	7	1
Anaesthetics Boston	13	13	2
Breast Surgery Boston			1
Cardiology Boston	2	2	2
Diabetes Boston	4	4	1
Elderly Care Boston	9	9	-3
ENT Boston	3	3	0
Gastroenterology Boston	3	3	2
General Medicine Boston	9	9	-7
General Surgery Boston	11	11	2
Haematology Pan Trust	1	1	0
Obs & Gynae Boston	11	11	0
Ophthalmology Boston	1	1	1
Orthopaedics Boston	7	7	5
Paediatrics Boston	6	6	1
PGME	9	9	-9
Radiologist Services	3	2.6	0.6
Respiratory Medicine	5	5	1
Stroke Boston	1	1	3
Urology Boston	3	3	0
Vascular Surgery			3

June 2018

Specialty	Headcount	In post FTE	Vacant FTE
AE Boston	7	7	1
Anaesthetics Boston	13	13	2
Breast Surgery Boston			1
Cardiology Boston	4	4	0
Diabetes Boston	6	6	-1
Elderly Care Boston	6	6	0
ENT Boston	3	3	0
Gastroenterology Boston	5	5	0
General Medicine Boston	4	4	-2
General Surgery Boston	11	11	2
Haematology Pan Trust	1	1	0
Obs & Gynae Boston	11	11	0
Ophthalmology Boston	1	1	1
Orthopaedics Boston	6	6	6
Paediatrics Boston	9	9	-9
PGME	3	2.6	-0.6
Radiologist Services	3	3	1
Respiratory medicine	6	6	0
Stroke Boston	7	7	0
Urology Boston	3	3	0
Vascular Surgery			3

July 2018

Specialty	Headcount	In post FTE	Vacancy FTE
AE Boston	7	7.00	1.00
Anaesthetics Boston	13	13.00	2.00
Breast Surgery Boston	0	0.00	1.00
Cardiology Boston	3	3.00	1.00
Cardiology Lincoln	1	1.00	-1.00
Diabetes Boston	6	6.00	-1.00
Elderly Care Boston	6	6.00	0.00
ENT Boston	3	3.00	0.00
Gastroenterology Boston	5	5.00	0.00
General Medicine Boston	4	4.00	-2.00
General Surgery Boston	13	13.00	1.00
Haematology Pan Trust	1	1.00	0.00
Obs & Gynae Boston	11	11.00	0.00
Ophthalmology Boston	1	1.00	1.00
Orthopaedics Boston	6	6.00	5.00
Paediatrics Boston	6	6.00	1.00
PGME	9	9.00	-9.00
Radiologist Services	3	2.60	-0.60
Stroke Boston	3	3.00	1.00
Thoracic Med Boston	6	6.00	0.00
Urology Boston	3	3.00	0.00
Vascular Surgery	0	0.00	3.00

August 2018

Specialty	Headcount	In post FTE	Vacancy FTE
AE Boston	6	6.00	2.00
Anaesthetics Boston	13	12.99	2.01
Breast Surgery Boston	1	1.00	0.00
Cardiology Boston	4	4.00	0.00
Diabetes Boston	3	3.00	2.00
Elderly Care Boston	6	6.00	0.00
ENT Boston	2	2.00	1.00
Gastroenterology Boston	4	4.00	1.00
General Medicine Boston	5	5.00	-3.00
General Surgery Boston	13	13.00	1.00
Haematology Pan Trust	1	1.00	0.00
Obs & Gynae Boston	9	9.00	2.00
Ophthalmology Boston	2	2.00	0.00
Orthopaedics Boston	7	7.00	4.00
Paediatrics Boston	3	3.00	4.00
PGME	9	9.00	-9.00
Radiologist Services	3	2.76	-0.76
Stroke Boston	1	1.00	3.00
Thoracic Med Boston	5	5.00	1.00
Urology Boston	2	2.00	1.00
Vascular Surgery	0	0.00	3.00

September 2018

Specialty	Headcount	In post FTE	Vacancy FTE
AE Boston	6	6.00	2.00
Anaesthetics Boston	13	12.99	2.01
Breast Surgery Boston	1	1.00	0.00
Cardiology Boston	4	4.00	0.00
Diabetes Boston	3	3.00	2.00
Elderly Care Boston	6	6.00	0.00
ENT Boston	2	2.00	1.00
Gastroenterology Boston	4	4.00	1.00
General Medicine Boston	5	5.00	-3.00
General Surgery Boston	14	14.00	0.00
Haematology Pan Trust	1	1.00	0.00
Obs & Gynae Boston	9	9.00	2.00
Ophthalmology Boston	2	2.00	0.00
Orthopaedics Boston	8	8.00	3.00
Paediatrics Boston	3	3.00	4.00
PGME	9	9.00	-9.00
Radiologist Services	3	2.76	-0.76
Stroke Boston	1	1.00	3.00
Thoracic Med Boston	5	5.00	1.00
Urology Boston	2	2.00	1.00
Vascular Surgery	0	0.00	3.00

October 2018

Specialty	Headcount	Inpost FTE	Establishment FTE	Vacancy FTE
AE Boston	6	6.00	8.00	2.00
Anaesthetics Boston	13	12.99	15.00	2.01
Breast Surgery Boston	1	1.00	1.00	0.00
Cardiology Boston	4	4.00	4.00	0.00
Diabetes Boston	3	3.00	5.00	2.00
Elderly Care Boston	6	6.00	6.00	0.00
ENT Boston	2	2.00	3.00	1.00
Gastroenterology Boston	5	5.00	5.00	0.00
General Medicine Boston	5	5.00	5.20	0.20
General Surgery Boston	16	16.00	14.00	-2.00
Haematology Pan Trust	1	1.00	1.00	0.00
Obs & Gynae Boston	9	9.00	11.00	2.00
Ophthalmology Boston	2	2.00	2.00	0.00
Orthopaedics Boston	8	8.00	11.00	3.00
Paediatrics Boston	3	3.00	7.00	4.00
PGME	9	9.00	0.00	-9.00
Radiologist Services	2	1.80	2.00	0.20
Stroke Boston	1	1.00	4.00	3.00
Thoracic Med Boston	5	5.00	6.00	1.00
Urology Boston	2	2.00	3.00	1.00
Vascular Surgery	0	0.00	3.00	3.00

November 2018

Specialty	Headcount	Inpost FTE	Establishment FTE	Vacancy FTE
AE Boston	5	5.00	8.00	3.00
Anaesthetics Boston	12	11.99	15.00	3.01
Breast Surgery Boston	1	1.00	1.00	0.00
Cardiology Boston	4	4.00	4.00	0.00
Diabetes Boston	3	3.00	5.00	2.00
Elderly Care Boston	5	5.00	6.00	1.00
ENT Boston	2	2.00	3.00	1.00
Gastroenterology Boston	5	5.00	5.00	0.00
General Medicine Boston	6	6.00	5.20	-0.80
General Surgery Boston	16	16.00	14.00	-2.00
Haematology Pan Trust	1	1.00	1.00	0.00
Obs & Gynae Boston	9	9.00	11.00	2.00
Ophthalmology Boston	2	2.00	2.00	0.00
Orthopaedics Boston	8	8.00	11.00	3.00
Paediatrics Boston	3	3.00	7.00	4.00
PGME	9	9.00	0.00	-9.00
Radiologist Services	1	0.90	2.00	1.10
Stroke Boston	2	2.00	4.00	2.00
Thoracic Med Boston	5	5.00	6.00	1.00
Urology Boston	2	2.00	3.00	1.00
Vascular Surgery	0	0.00	3.00	3.00

December 2018

Specialty	Headcount	In post FTE	Establishment FTE	Vacancy FTE
AE Boston	5	5.00	8.00	3.00
Anaesthetics Boston	13	12.99	15.00	2.01
Breast Surgery Boston	1	1.00	1.00	0.00
Cardiology Boston	3	3.00	4.00	1.00
Diabetes Boston	1	1.00	5.00	4.00
Elderly Care Boston	7	7.00	6.00	-1.00
ENT Boston	2	2.00	3.00	1.00
Gastroenterology Boston	4	4.00	5.00	1.00
Gen Surgery Boston	16	16.00	14.00	-2.00
General Medicine Boston	6	6.00	5.20	-0.80
Gynae Boston	8	8.00	11.00	3.00
Haematology Boston	2	2.00	1.00	-1.00
Ophthalmology Boston	2	2.00	2.00	0.00
Orthopaedics Boston	8	8.00	11.00	3.00
Paediatrics Boston	3	3.00	7.00	4.00
PGME	9	9.00	0.00	-9.00
Radiologist Servs Bost	1	0.90	2.00	1.10
Stroke Boston	1	1.00	4.00	3.00
Thoracic Med Boston	5	5.00	6.00	1.00
Urology Boston	2	2.00	3.00	1.00
Vascular Surgery	0	0.00	3.00	3.00

January 2019

Specialty	Headcount	Inpost FTE	Establishment FTE	Vacancy FTE
AE Boston	6	6.00	8.00	2.00
Anaesthetics Boston	13	13.00	15.00	2.00
Breast Surgery Boston	0	0.00	1.00	1.00
Cardiology Boston	3	3.00	4.00	1.00
Diabetes Boston	3	3.00	5.00	2.00
Elderly Care Boston	6	6.00	6.00	0.00
ENT Boston	3	3.00	3.00	0.00
Gastroenterology Boston	4	4.00	5.00	1.00
Gen Surgery Boston	19	18.99	14.00	-4.99
General Medicine Boston	6	6.00	5.20	-0.80
Gynae Boston	10	10.00	11.00	1.00
Haematology Boston	1	1.00	1.00	0.00
Ophthalmology Boston	1	1.00	2.00	1.00
Orthopaedics Boston	7	7.00	11.00	4.00
Paediatrics Boston	2	2.00	7.00	5.00
PGME	7	7.00	0.00	-7.00
Radiologist Servs Bost	1	0.90	2.00	1.10
Stroke Boston	1	1.00	4.00	3.00
Thoracic Med Boston	4	4.00	6.00	2.00
Urology Boston	2	2.00	3.00	1.00
Vascular Surgery	0	0.00	3.00	3.00

February 2019

Specialty	Headcount	Inpost FTE	Establishment FTE	Vacancy FTE
AE Boston	6	6.00	8.00	2.00
Anaesthetics Boston	15	15.00	15.00	0.00
Breast Surgery Boston	0	0.00	1.00	1.00
Cardiology Boston	3	3.00	4.00	1.00
Diabetes Boston	4	4.00	5.00	1.00
Elderly Care Boston	6	6.00	6.00	0.00
ENT Boston	3	3.00	3.00	0.00
Gastroenterology Boston	4	4.00	5.00	1.00
Gen Surgery Boston	18	17.99	14.00	-3.99
General Medicine Boston	5	5.00	5.20	0.20
Gynae Boston	10	10.00	11.00	1.00
Haematology Boston	1	1.00	1.00	0.00
Ophthalmology Boston	1	1.00	2.00	1.00
Orthopaedics Boston	8	8.00	11.00	3.00
Paediatrics Boston	1	1.00	7.00	6.00
PGME	7	7.00	0.00	-7.00
Radiologist Servs Bost	3	2.90	2.00	-0.90
Stroke Boston	2	2.00	4.00	2.00
Thoracic Med Boston	4	4.00	6.00	2.00
Urology Boston	2	2.00	3.00	1.00
Vascular Surgery	0	0.00	3.00	3.00

March 2019

Data not available at the time of preparation of this report.

f) Fines

Fines by Department		
Department	**Number of Fines Levied**	**Value of Fines Levied**
Acute medicine	0	£0
Anaesthetics	0	£0
General Medicine	0	£0
General Surgery	0	£0
Psychiatry	0	£0
Haematology	0	£0
Total	0	£0

Fines (Cumulative)			
Balance at End of Last Quarter	**Fines this Quarter**	**Disbursements this Quarter**	**Balance at End of this Quarter**
£0	£0	£0	£0

First Quarter (April – June 2018)

Issues arising:

1. Not all trainees and their Educational Supervisors have usernames and passwords to access the Exception Reporting process. This has previously been highlighted in the previous reports and has also been escalated to HR.

2. Cooperation and engagement from some of the Educational Supervisors continues to be of concern.

3. All the Exception Reports in this period pertain to General Medicine. The common themes have been lack of manpower, delays in starting ward rounds and in seeing the medical outliers.

4. The Guardian was not being remunerated for his role.

Actions Taken to Resolve Issues:

1. The issue pertaining to non-issuance of passwords and usernames is now resolved due to regular attendance of HR and allocation of passwords at induction.

2. Better cooperation is now being seen after continued perseverance by the Guardian to emphasise the issue at the MAC, Educational committee meetings and by one to one conversation with the educational supervisors.

3. The Guardian met with the Clinical Director for Medicine to highlight and explore solutions to address some of these issues.

4. The matter of remuneration for the Guardian was resolved after meeting with the Medical Director and the Guardian was back-paid for his role in August 2018.

Second Quarter (July – September 2018)

Issues arising:

1. Cooperation and engagement from some of the Educational Supervisors continued to be of concern. None of the Exception Reports were actioned within the stipulated seven days.

2. The majority of the Exception Reports in this period pertain to General Medicine. The common themes were lack of manpower on the respiratory ward. One of the Exception Reports had highlighted this an immediate safety concern.

3. Lack of attendance at the junior doctor forums was an issue.

4. The new Allocate system made it difficult to differentiate the Exception Reports according to site. Also, the Exception Reports could not be closed by the Educational Supervisor or the Guardian unless the trainee signed off the Exception Report in the system.

5. There was a resistance to put in, and act upon Exception Reports. This required a cultural change and there seemed to be a culture of dissuading the trainees from submitting Exception Reports.

Actions Taken to Resolve Issues:

1. Please refer to Point 1 in the first quarter.

2. The medical rota continued to be a problem. The Guardian had a meeting with the respiratory physicians who said that the problem could not be solved unless additional manpower is provided.

   N.B. In the final quarter (January – March 2019), no issues were highlighted around the medical rota so this may represent an improvement.

3. To address the decreased attendance at the junior doctors' forum the Guardian has started "Guardian's Surgeries" which are drop in sessions for the trainees and the Educational Supervisors to come and see the Guardian.

4. The issues relating to Allocate have been raised with the company and they assured us that they will work on a solution.

   N.B. A meeting has since been held with Allocate and the matters relating to identification of the site have been resolved.

5. The Guardian had undertaken a survey to understand the barriers to Exception Reporting, and is trying to promote the Exception Reporting culture by conducting "Guardian Surgeries."

Third quarter (October – December 2018):

Issues arising:

1. Four of the Exception Reports were actioned outside the stipulated seven day period and required the Guardian to write to the Educational Supervisors to action them.

2. The Exception Reports pertain to General Medicine (3), ACU (3) and General Surgery (2). The majority of the Exception Reports highlighted issues around inability to handover to the on-call team because of the timing of transfer to the ward (i.e. around 17.00 hours) and the excessive burden on an already "thin" on-call team. The ward being occupied with medical/surgical outliers, who still needed reviewing, added to the problem. Ongoing staff shortages were noted in the general medicine rota.

3. Lack of attendance at the junior doctor forums continued to be an issue.

4. A delay in payments of the extra hours to the junior doctors.

Actions Taken to Resolve Issues:

1. Please refer to Point 1 in the first quarter – this matter is now much improved. Frequent email reminders were sent to Educational Supervisors to act on Exception Reports in a timely manner. In addition, a letter proposed and devised by the Guardian, to be sent to Educational Supervisors, warning them that if they continued not to engage then they will be relinquished of their duties as Educational Supervisor. This letter was to be co-signed by the Medical Director, the two Guardians and the Deputy Director of Medical Education.

2. Please refer to Point 2 in the second quarter (July – September 2018).

   N.B. In the final quarter (January – March 2019) were highlighted around the medical rota.

3. The response to "Guardian Surgery" has been lukewarm from the trainees, again indicating a lack of engagement/motivation. The Guardian continues to offer "Guardian Surgery" to encourage junior doctor participation.

   N.B. In the final quarter, there has been better attendance at the junior doctors' forum because of one-to-one encouragement of the trainees by the Guardian, and also by the efforts of Deputy Director of Medical Education to encourage the respective departments to send their junior doctors to this forum.

4. The Guardian had ensured that all Exception Reports have been acted upon, and those requiring payment are to be paid out by January 2019.

   N.B. An email has been sent to the Payroll Department to check that the junior doctors have been paid for any Exception Reports up to 31st March 2019.

Fourth quarter (January – March 2019):

Issues arising:

1. There were concerns raised about the continuity of care received by patients who are medical outliers by the junior doctors in the junior doctor forum, and one of the Exception Reports alludes to that in detail.

2. Three of the Exception Reports for this period are outstanding. The Guardian has written to the Educational Supervisor but to no avail. Four of the Exception Reports were actioned outside the stipulated seven day period and required the Guardian to write to the Educational Supervisors to action them.

3. There are still some software related issues with Allocate, for instance the payments to the trainees for Exception Reports still have to be physically collated and signed by the Guardian, rather than picked up automatically from the Allocate system by the Payroll Department because of use of different software.

4. The Exception Reports pertain to General Surgery (6), General Medicine (7) and Trauma & Orthopaedics (2). The majority of the Exception Reports highlighted issues around overrunning clinics or handover. However, it is to be noted that seven of the Exception Reports were submitted by the same doctor, who has been advised regarding better time management by the Educational Supervisor.

Actions Taken to Resolve Issues:

1. This matter was discussed by the Guardian with the Medical Director. There are proposals to improve the flow through AMSS, thereby minimising the number of medical outliers. This seems to be working well at the moment. There is a further proposal to look at having a dedicated team looking after medical outliers comprising of a Consultant and a junior trainee/ACCP, with the ACCP route being the preferable option.

2. The letter alluded to in the previous report about getting Exception Reports resolved within the stipulated timeframe of one week has been sent to the Educational Supervisors. Failure of the Educational Supervisor to resolve the Exception Reports immediately will result in them losing their Educational Supervisor status.

3. The Guardian has ensured that all Exception Reports have been acted upon, and those requiring payment are to be paid out up until 31st March 2019. The Guardian will have further meetings with Allocate, HR and the Payroll Department to establish if the payments to the junior doctors can be streamlined so that they can be picked up and paid without any intervention by the Guardian.

Summary

The Guardian has seen significant improvements and has resolved a number of issues which arose over the year, namely:

1. Non-issuance of usernames and passwords for Exception Reporting.

2. Better engagement by the Educational Supervisors, and devising a command and control system for acting on Exception Reports.

3. Suggesting plans for better management of medical outliers (this plan would need implementation and testing during the surge periods). The Guardian has already requested the Medical Director to look into this and delegate appropriately.

4. The Guardian role is now fully remunerated and there are plans to relook at the role of the Guardian at Trust-wide level, with more administrative support.

5. There is better engagement and attendance at the junior doctors' forum.

6. Issues with the Allocate system are largely resolved, except from the ability to see where fines are applicable, and also the ability of the payroll to pick up the Exception Reports eligible for payment directly from the system. The Guardian has circulated an Excel spreadsheet devised by one of the junior doctors who worked in the Trust to all trainees to allow them to monitor their rota and ascertain any fines that might be applicable.

Areas for improvement

1. Better coordination between the Educational Department and the Guardian regarding issues which are common to both.

2. Timely action on the Exception Reports by Educational Supervisors.

3. Smoother resolutions to payment of Exception Reports to junior doctors.

The Guardian foresees that these matters should be resolved once more administrative support is available.

Report to:	Trust Board
Title of report:	Workforce, OD and Transformation Committee Assurance Report to Board
Date of meeting:	15th May 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 bi monthly and takes scheduled reports according to an established work programme.
Assurances received by the Committee	**Assurance in regard to Terms of Reference** **Source of Assurance**: The Committee debated the content of the Terms of Reference and were assured that work is in hand to refocus around the Trust Operating Model. **Actions requested by the Committee:** Final Terms of Reference to be presented to the Committee
	Assurance in regard to Revised People Strategy **Source of Assurance**: The Committee were assured that the revised strategy is providing a clear direction and that it has been reviewed and prepared for presentation to the Board. **Actions requested by the Committee:** The Committee sought further assurance regarding capacity to deliver the intended outcomes. The Business Delivery Plan for Human Resources and Organisational Development will be presented to the Committee.
	Assurance in regard to Workforce KPI Report **Source of Assurance**: The Committee received the KPI report and felt that the data was better presented, there were clear assurances provided and an improving position was demonstrated **Actions requested by the Committee:** The Committee sought further assurance on the alignment of the KPIs with other corporate documents to facilitate triangulation and requested that this be reviewed
	Lack of assurance in regard to Workforce Financial Recovery Plans **SO Ref: SO3a** **Source of Assurance:** The Committee received the report and raised concerns regarding the medical capacity and activity management milestones report. Assurance could not be given due to the completion

	timescales and delivery of savings. The Committee noted that a number of milestones were overdue **Actions requested by the Committee:** Referred to Finance, Performance and Investment Committee
	Assurance in regard to Revised approach to managing sickness absence **SO Ref: SO3a** **Source of Assurance:** The Committee noted the continuous improvement of processes for control and support of recruitment and sickness areas, progress should be demonstrated over the year
	Assurance in regard to 2021 Marketing and Relaunch **SO Ref: SO3b** **Source of Assurance**: The Committee were assured by the communications plan in place however there would be a need for support to deliver the messages. Social media would be developed over the coming weeks once the plan is agreed with patient case studies being utilised due to their impact
	Lack of Assurance in regard to Revised approach to Leadership Development **SO Ref: SO3b** **Source of Assurance**: The Committee noted the work being undertaken and the training schemes that have been put in place however concerns remain. The Committee felt that full achievement of the objectives would be difficult due to evidence of partial interest from managers. Full support would be required by senior management to drive this forward.
	Lack of Assurance in regard to Assurance Report from Trust Operating Model Group **SO Ref: SO3b** **Source of Assurance:** The Committee were advised that the group remains in place however would evolve to a transitional group. Concern was raised due to remaining vacancies within the structures.
	Assurance in regard to Assurance Report from Equality, Diversity and Inclusion Group **SO Ref: SO3b** **Source of Assurance:** The Committee received a verbal update from the Equality, Diversity and Inclusion group and were assured of the position to meet statutory requirements and reporting. The Committee noted the development of emerging staff networks and acknowledged that networks were beginning to self-manage programmes of work

	Assurance in regard to Assurance Report from Guardian of Safe Working Practice **SO Ref: SO3b** **Source of Assurance:** The Committee received the partial (1 site) report and welcomed the continued improvements. An interim solution had been identified and is in place whilst the final organisational solution is identified. The Committee noted that progress would need to be made quickly to maintain progress. **Actions requested by the Committee:** The Committee requested consideration of a report to Board even if this provided incomplete information
	Assurance in regard to Assurance Report Freedom to Speak Up Guardian **SO Ref: SO3b** **Source of Assurance:** The Committee were assured that work was in hand to review the process to encourage staff to use the facility as uptake remains low. The Committee were advised that national benchmarking and comparisons would not be available due to the nature of freedom to speak up.
	Assurance in regard to Assurance Report from 2021 Programme Group **SO Ref: SO3b** **Source of Assurance:** The content and format of the report provided a good level of the detail to gain assurance and discussions were held regarding consideration of content of future reports to committees. The Committee felt that the detail contained within the report was duplicate information previously reported within the meeting however the format and content could be utilised to streamline reporting.
	Lack of Assurance in regard to QSIR Programme Update **SO Ref: SO3b** **Source of Assurance:** The Committee received the draft continuous Quality Improvement Strategy and noted concerns regarding the successful implementation at pace without full management backing and involvement at all levels. The Committee noted that staff would require release to undertake training which continues to be an issue due to the inability to release staff due to staffing pressures **Actions requested by the Committee:** The Committee suggested a Board Development Session to support implementation would be beneficial
	Assurance in regard to Board Assurance Framework **SO Ref: SO3b** **Source of Assurance:** The Board Assurance Framework was presented to the Committee and discussion regarding alignment of the current details

	was requested. Identification of upward reporting was clearly detailed in the control column **Actions requested by the Committee:** Alignment of details within the framework to ensure read across
Issues where assurance remains outstanding for escalation to the Board	Management leadership and support from the Board required for: 1. Leadership training due to lack of interest 2. TOM remaining vacancies put this at risk 3. QSIR full support and backing Guardians of safe working interim report
Items referred to other Committees for Assurance	Medical capacity and activity management milestone report referred to Finance, Performance and Estates Committee to identify the impact due to the delay in completion
Committee Review of corporate risk register	No areas identified
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	None
Areas identified to visit in ward walk rounds	No further areas identified.

Attendance Summary for rolling 12 month period

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

To:	Trust Board
From:	Paul Matthew, Acting Director of Finance & Procurement
Date:	4th June 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for April 2019

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

Purpose of the report:
To update the Board on the performance of the Trust for the period 30th April 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

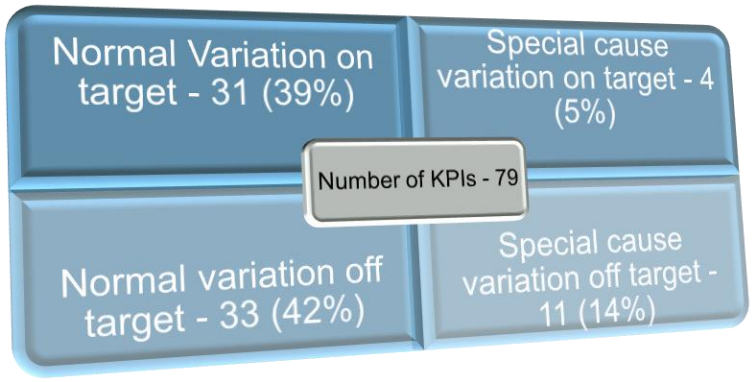
Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
April 2019

EXECUTIVE SUMMARY



Quality

The Trust is reviewing the complaints process to ensure timely and quality responses are sent to the complainants. The Trust has rolled out the streamlined eDD platform and a standardised process is being implemented across the Trust.

Duty of Candour compliance is continuing to improve across both notifications in person and written follow ups.

The Trust HSMR is below expected limits at 92 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits.

Operational Performance

RTT performance of 84.87%. The main focus in March 2019 was to achieve the zero tolerance target for 52 week waiters in March 2019, which it achieved. This is a huge achievement for the Trust.

The CCG funded external waiting list validation team have completed their contract with the Trust and validated 25,311 patients with approximately 14% having clock stops added. The Trust has achieved the Trajectory for Waiting lists that was set for March 2019.

Our 62 Day Classic performance declined rapidly over the winter months with February performance being a low point at 61.3%. March has shown a significant recovery at 75.2% and put us back on track for our recovery trajectory, with early indications for April figures to maintain a similar level to March.

The DM01 position is constantly being reviewed and the Lead for Diagnostics is working with outlier departments to improve.

Finance

The Trust's financial plan for 2019/20 is a deficit of £41.4m. The planned deficit includes £28.9m of PSF, FRF and MRET funding, and a Financial Efficiency Programme (FEP) of £25.6m.

The Month 1 financial position is a deficit of £6.7m or £16k favourable to the planned deficit of £6.8m.

The key movements to note are as follows:

- Income is £0.1m below plan.
- Operating Expenditure overall is £0.1 below plan.

Within the Operating Expenditure position, Pay is £0.6m higher than planned and Non Pay is 0.7m lower than planned.

The following is noted in relation to the Pay position:

- April includes a one off cost of £0.9m in relation to the Agenda for Change pay award; this payment was recognized in the profiled Pay plan for 2019/20, and as such this expense has not contributed to the adverse movement to plan in Pay in April
- Within the Pay position, Expenditure on Substantive Staffing is £0.3m lower than planned and expenditure on Temporary Staffing is £0.9m higher than planned.
- Expenditure on Temporary Staffing includes expenditure on Agency Staffing of £3.6m or £0.5m higher than planned.

The Non Pay under spend of £0.7m can be attributed to lower than planned expenditure in relation to clinical Non Pay - the under spend to plan being mainly in relation to Ambulance Services, Clinical Supplies and Services and Drugs - and the reason for lower than planned Non Pay expenditure is being investigated.

The financial plan for 2019/20 includes a Financial Efficiency Programme (FEP) to deliver £25.61m of savings. The plan assumed savings delivery of £1,042k in April; actual savings delivery in April is being validated.

Workforce

Overall the Trust Vacancy Rate increased slightly from 12.6% to 12.7%. Marginal improvement in medical vacancy rate was off-set by increases in Nursing (which was in line with workforce planning assumptions) and AHP rates.

The overall sickness rate for the Trust has been stable at 4.7% since October 2018. Gastrointestinal problems and cold, cough, flu remain the two top reasons for sickness in March across all areas.

Recruitment Improvement is one of the main Workforce FEP schemes for 2019/20 which is to address the fundamental balance of substantive to temporary staffing and the root cause of many of the challenges faced by the Trust. Improvement to both medical and nursing substantive numbers is projected for quarters one and two of 2019/20. Weekly tracking of all starters and leavers is now the norm.

Paul Matthew
Interim Director of Finance & Procurement
April 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostrum Difficile (post 3 days)	Safe	Our Patients	Michelle Rhodes	5	0	5	5	5	P		Reviewed: 1st April 2018 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	MRSA bacteraemia (post 3 days)	Safe	Our Patients	Michelle Rhodes	0	0	1	0	0	P		
	MSSA	Safe	Our Patients	Michelle Rhodes	2	1	0	1	1	P		
	ECOLI	Safe	Our Patients	Michelle Rhodes	8	3	0	3	3	P	B	
	Number of Never Events	Safe	Our Patients	Michelle Rhodes	0	0	1	2	2	F		
	New Harm Free Care %	Safe	Our Patients	Michelle Rhodes	98%	99.10%	99.20%		98.85%	P		
	Pressure Ulcers 3/4	Safe	Our Patients	Michelle Rhodes	0	4	3		85	F		
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Michelle Rhodes	80%	80.30%	88.00%		81.24%	P		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Michelle Rhodes	80%	79.50%	79.50%		76.41%	F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Michelle Rhodes	50%	47.10%	58.60%		53.32%	P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Michelle Rhodes	100%	95.30%	98.90%		97.01%	F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Michelle Rhodes	90%	56.50%	69.00%		62.45%	F	B	
	Stroke - Patient death in Stroke	Caring	Our Patients	Michelle Rhodes	17%	9.20%	8.40%		10.39%	P		
	SHMI	Effective	Our Patients	Neill Hepburn	100	114.05	114.05		114.62	F	A	
	Hospital-level Mortality Indicator	Effective	Our Patients	Neill Hepburn	100	94	92		99.19	P	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis Bundle compliance in A&E	Caring	Our Patients	Michelle Rhodes	90%	83.30%	71.60%		75.16%	F		
	IVAB within 1 hour for sepsis in A&E	Caring	Our Patients	Michelle Rhodes	90%	88.40%	96.40%		90.63%	P		
	Sepsis screening compliance in inpatients	Caring	Our Patients	Michelle Rhodes	90%	73.30%	78.30%		70.39%	F		
	IVAB within 1 hour for sepsis in inpatients	Caring	Our Patients	Michelle Rhodes	90%	85.70%	77.20%		83.85%	F	B	
	Serious Incidents reported (unvalidated)	Safe	Our Patients	Neill Hepburn	0	12	16	12	12	F		
	Catheter & New UTIs	Safe	Our Patients	Michelle Rhodes	1	0	1		10	P		
	Falls	Safe	Our Patients	Michelle Rhodes	3.9	6.0			5.7			
	Medication errors	Safe	Our Patients	Neill Hepburn	0	164	150	195	195	F		
	Medication errors (mod, severe or death)	Safe	Our Patients	Neill Hepburn	0	25	23	20	20	F		
	VTE Risk Assessment	Safe	Our Patients	Michelle Rhodes	95%	96.61%	96.46%	96.15%	96.15%	P		
	Dementia Screening	Caring	Our Patients	Michelle Rhodes	90%	92.9%	93.10%		91.62%	P		
	Dementia risk assessment	Caring	Our Patients	Michelle Rhodes	90%	98.40%	98.60%		98.92%	P		
	Dementia referral for Specialist treatment	Caring	Our Patients	Michelle Rhodes	90%	81.82%	100.00%		88.62%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	92.23%	92.52%	92.62%	92.62%	F		
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	12.68%	12.65%	12.78%	12.78%	F	B	
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.69%	4.70%	4.71%	4.71%	F	B	
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	5.63%	5.45%	5.34%	5.34%	P	L	
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	71.63%	73.35%	72.99%	72.99%	F		
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-6009	-8512	-23202	-6112	-6112	F		
	Income	Well-Led	Our Services	Paul Matthew	36935	36714	41313	40221	40221	P		
	Expenditure	Well-Led	Our Services	Paul Matthew	-42944	-45226	-64515	-46333	-46333	F	B	
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	2838	2370	2480	1042	1042	F	H	
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	4031	1958	11159	839	839	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-1905	-3522	-3802	-3460	-3460	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	32.00%	32.16%		24.26%	P	H	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	96%	89.00%	91.20%		90.52%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	14%	13.00%	22.77%		21.90%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	79.00%	21.72%		77.31%	F		
	Friends & Family Test Maternity (Reponse Rate)	Caring	Our Patients	Martin Rayson	23%	13.00%	21.72%		14.89%	F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Martin Rayson	97%	98.00%	100.00%		99.42%	P		
	Friends & Family Test Outpatients (Reponse Rate)	Caring	Our Patients	Martin Rayson	14%	6.00%	11.44%		8.45%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	95.00%	92.62%		93.39%	F		
	Mixed Sex Accommodation	Caring	Our Patients	Michelle Rhodes	0	0	0		4	P		
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	66	70		661	P		
	No of Pals	Caring	Our Patients	Martin Rayson		468	229		4963	F		
	eDD	Effective	Our Patients	Neill Hepburn	95%	91.23%	89.72%		89.05%	F		
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	5.28%	2.20%	1.66%	1.66%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	70.1%	60.72%	68.55%	66.36%	66.36%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	0	1	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	75%	72.68%	84.54%	84.20%	84.20%	F		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	10	0		171			
	18 week incompletes	Responsive	Our Services	Mark Brassington	87%	84.87%	84.73%		83.69%	F		
	Waiting List Size	Responsive	Our Services	Mark Brassington	39032	36657	36718		38962	P		
	62 day classic	Responsive	Our Services	Mark Brassington	86%	61.34%	75.24%		73.48%	F	L	
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	78.31%	73.29%		79.34%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	8.02%	26.51%		41.89%	F		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	96.92%	96.96%		97.35%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	98.94%	97.30%		99.08%	F		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	97.62%	94.29%		89.45%	P		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	98.55%	90.48%		95.83%	F		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	89.47%	95.00%		86.73%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Feb-19	Mar-19	Apr-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	82.58%	84.75%		86.10%	F		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	98.6%	98.06%	95.86%	96.53%	96.53%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	1%	2.43%	1.96%	1.56%	1.56%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	5.56%	15.13%	16.30%	16.30%	F		
	#NOF 24	Responsive	Our Services	Mark Brassington	70%	59.65%	62.90%		65.41%	F		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	95%	89.47%	95.16%		94.24%	P		
	EMAS Conveyances to ULHT	Responsive	Our Services	Mark Brassington	4530	4466	4960	4920	4920	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	317	726	410	635	635	F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	13	7	11	11	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	2.98	2.62	2.80	2.80	P		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.80	4.66	4.44	4.44	P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	3.80%	3.45%		4.27%	P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	7479	7872	7540	7540	F		

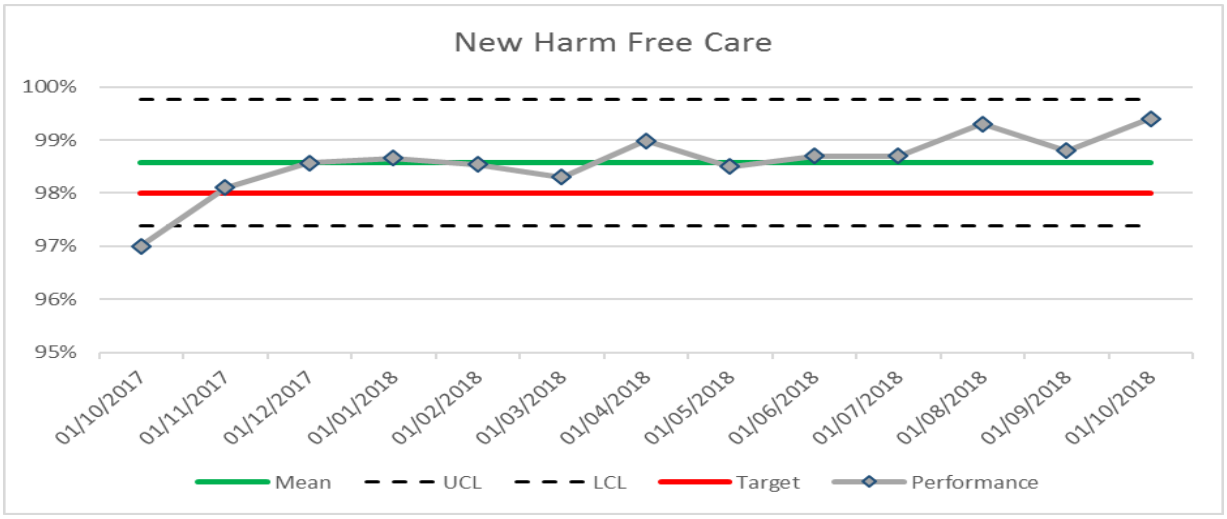
STATISTICAL PROCESS CONTROL CHARTS

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



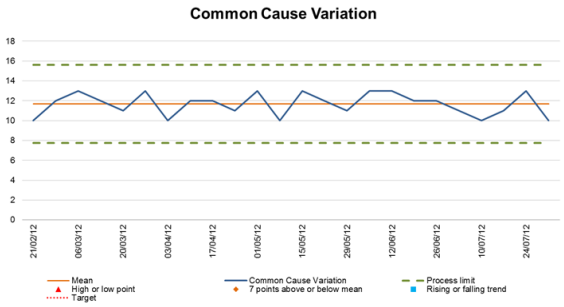
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

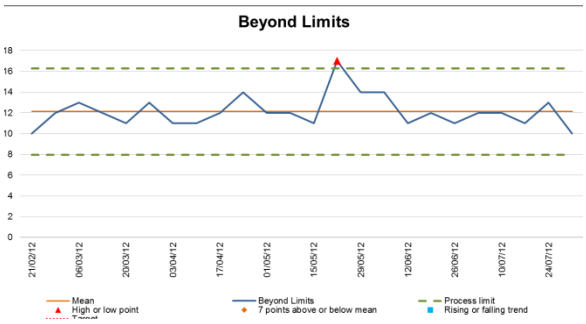
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation

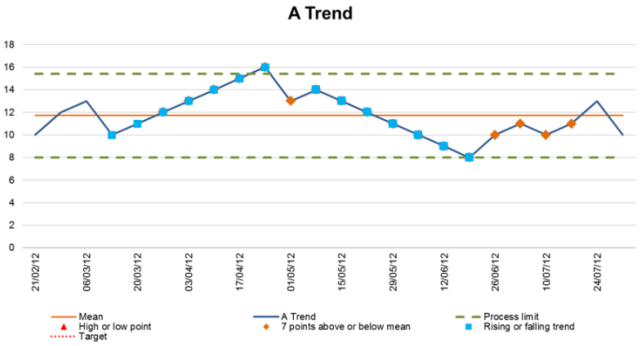


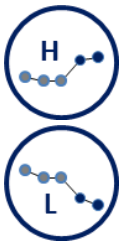
Extreme Values



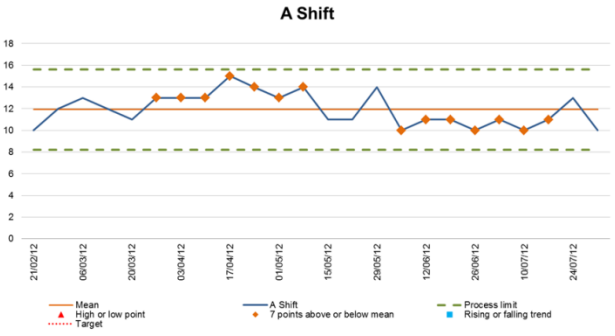
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

HARM FREE CARE - MORTALITY

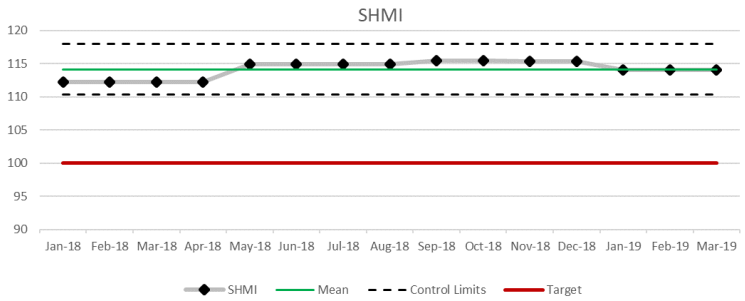
Executive Lead: Neill Hepburn

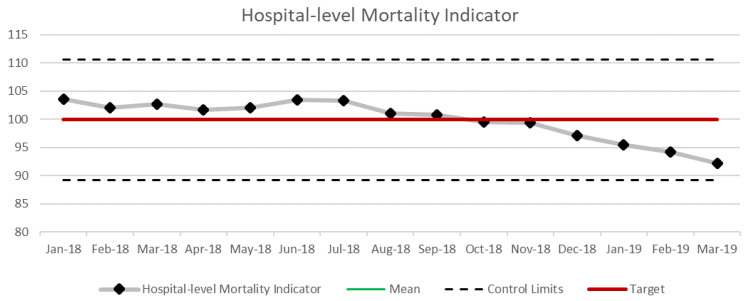
CQC Domain: Safe

2021 Objective: Our Patients

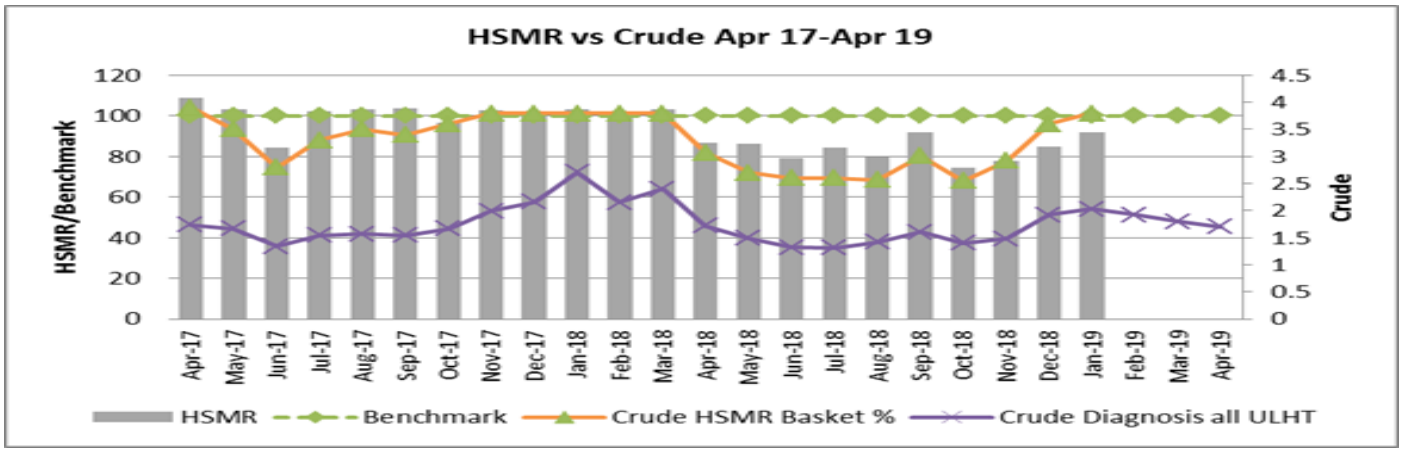
SHMI

HSMR





Trust/Site	ULHT HSMR Feb 18-Jan 19 12 month	ULHT HSMR Apr 18-Jan 19 FYTD	ULHT HSMR Jan 19	ULHT SHMI Oct 17-Sep 18	Trust Crude Mortality Internal source May 18-Apr 19
Trust	92.18	88.22	91.75	114.05	1.62%
LCH	102.55	98.57	106.91	116.53	1.69%
PHB	89.16	85.06	85.47	118.36	1.83%
GDH	53.65	50.36	44.70	85.82	0.57%



Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 92.18 this is the lowest recorded Trusts HSMR. All sites are within expected limits.

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is a Quality and Safety Improvement Programme to address the improvements required. COPD and Bronchiectasis is alerting for the Lincoln site for the second month.

Summary-level Hospital Mortality Index-SHMI

ULHT remain within Band 1 outside of expected limits with a score of 114.05, which shows a reduction from the previous reporting period. Driven by Lincoln and Pilgrim sites. Pilgrim is not alerting within HSMR, however has the highest SHMI. SHMI includes both death in-hospital and within 30 days of discharge. In Hospital deaths SHMI is currently at 100.53, which is within expected limits. The data is reflective up to September 2018.

Alerts—ongoing: Septicemia (except in labour), Pneumonia, Chronic obstructive pulmonary disease and bronchiectasis, Acute bronchitis

Alerts—New: Deficiency and other anaemia, Superficial injury, contusion, Other lower respiratory disease, Diverticulosis

and diverticulitis, Short gestation, low birth weight, and fetal growth retardation, Phlebitis, thrombophlebitis and thromboembolism. The only In-hospital alert is Septicemia, this is in line with HSMR for the time period.

In-depth reviews are underway for Sepsis deaths. The Trust are partaking in the National audits for COPD (BTS), pneumonia and COPD care bundle compliance audits have been undertaken and a work programme developed to increase compliance.

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:

- Other Perinatal Conditions has undertaken an in-depth review which demonstrates issues with documentation. A plan has been implemented to address these issues
- Divisional Mortality Dr Foster Outcome reports will be produced in line with the Trust's Operating Model from April 2019.
- Thematic case note review from cases escalated to mortality surveillance groups for admissions from Care Homes to Acute Care. Discussions are starting with Wye Valley who have established a programme of work.
- 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 Collaborative have asked the CCG if KPI's are being developed for these, feedback will be given at the next Lincolnshire Mortality Collaborative on the 31st May 2019.
- In-depth reviews for Liver Disease and Biliary Tract Disease external review concluded on the 15th April 2019. A preliminary report has been sent to CQC and the external reviewer will submit the full report by the 12th May. No concerns of care were highlighted by the external reviewer.
- The Importance of Clinical Coding was held on the 27th March 2019; there were 16 attendees of which 10 were Consultants. A survey monkey has been distributed to the participants of the day, to ask opinions on how to drive the teaching forward and the focus of future workshops and delivering the agenda in the Trust. A meeting to discuss the future workshops and how to deliver is yet to be held.

Crude Mortality

The crude mortality has decreased in April 19 to 1.70%. In rolling year May 18-April 19 crude has remained the same 1.62%. A reduction in crude and an increase in Dr Foster expected mortality is the driving force behind the reduction in HSMR and hopefully this reduction will be replicated in SHMI.

Mortality Reviews– Deaths in Scope

Deaths reported to Feb-19 to allow for 4 week deadline completion of initial mortality review.

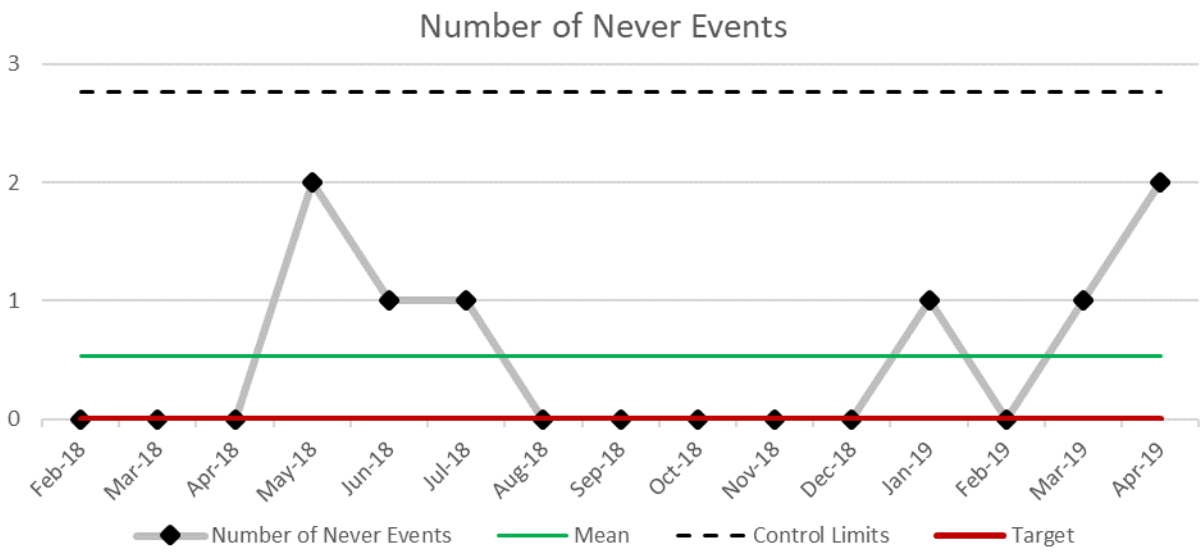
Measure	Description	Month Feb 19	YTD Apr 18-Feb 19	Narrative
Deaths in Scope	• Total Deaths in scope • Number inpatient deaths • Number of A&E Deaths	179 156 23	2002 1730 272	All deaths as reported, in Month and rolling year.
ME Screening	• ME Deaths Screened • % of referrals to Specialty	53 11%	201 15%	Medical Examiner post commenced in October 2018. As the Medical Examiner is not running a 5 day service as yet. A percentage of cases not screened by the Medical Examiner will still be reviewed in the first instance by the Specialty. MEscreening equates to 4 months of that reported.
Await Completion	• To be reviewed by Specialty • Total allocated Specialty • % of total with Specialty • % of total awaiting allocation	70%/126 69 54.8% 44.4%	89%/1801 595 33% 20.1%	Cases allocated or referred by the ME to Specialty for completion. The total awaiting allocation are those notes that are in department or awaiting notes to send for review. % taken from reviewed by Specialty.
Reviews completed	Completed Reviews/Screens • Specialty Reviews completed • % Specialty Review compliance • Complete ME & Specialty (%/N)	53 42% 59%/106	1005 55.8% 60%/1206	Total Specialty Reviews completed by consultants and review compliance from those referred for specialty review. And total of ME Screened and Specialty review completed
Grading	Completed Specialty Reviews • Grade 0 (N/%) • Grade 1 (N/%) • Grade 2 (N/%) • Grade 3 (N/%) • Not Graded (N/%)	47/88% 2/3% 1/1% 0/0% 3/5%	825/86% 73/7% 25/2% 0/0% 82/8%	The number of deaths and percentage of mortality specialty reviews completed by Grade. Grade 0-No Suboptimal Care Grade 1– Suboptimal Care—no change to outcome Grade 2– Suboptimal Care-Might have changed outcome Grade 3-Suboptimal Care-Possibly avoidable Not Graded by Consultant upon review
Escalated Reviews	Completed Specialty Reviews • Reviews identified For MoRAG / Collaborative • % of deaths identified • % of reviews completed	12 11% 8%	122 10% 78%	All cases identified for review escalation from mortality review to MoRAG or the Lincolnshire Mortality Collaborative and reviews completed compliance. There is a backlog of cases with the collaborative. Reviewers are reviewing cases but only presenting to the meeting where issues have been identified
Learning Disability	• Total Deaths in scope • Submitted to LeDeR • % reviews completed	1 0 0%	22 21 95%	These include all Learning Disability deaths as identified by the information support team using code FB19 as advised by the NHS Quality Board. Lincolnshire only became part of review process in October 17.
Severe MH	• Total Deaths in scope • Number Reviews completed • % review compliance	6 2 33%	23 14 60%	Severe Mental Health Codes,/Diagnosis as advised by NHSI they advise to include schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

HARM FREE CARE – NEVER EVENTS

Executive Lead: Michelle Rhodes

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

- 4 Never Events have been declared by the Trust so far in 2019.
- 2 of these Never Events were declared in April 2019.
- The 2 Never Events declared in April (both of which were at Lincoln County Hospital) were:
  - a wrong site surgery in Maxillofacial Surgery Outpatients / Dermatology; and
  - a retained foreign object post-procedure in Theatres / Gynaecology.
- A theme is emerging in relation to wrong site surgery incidents occurring primarily outside of the theatre environment.

Actions in place to recover:

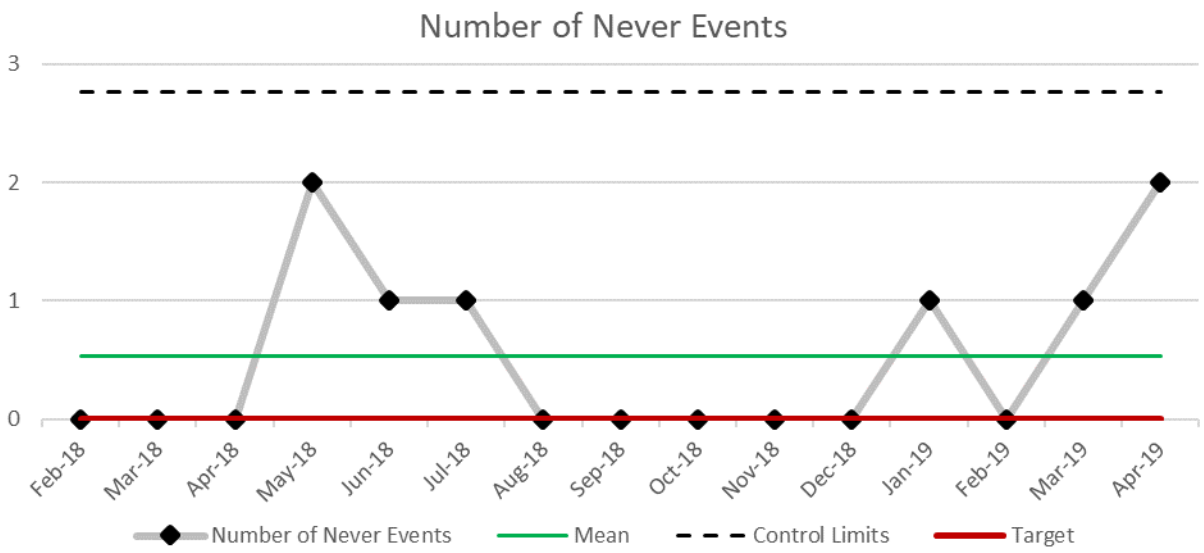
- Analysis is being undertaken of all wrong site surgery incidents reported in the last 2 years.
- The application and monitoring of compliance with local safety standards for invasive procedures (LocSSIPs) is to be reviewed and strengthened.
- A Never Event Summit with the CCGs is being set up for September 2019, to review learning and actions arising from recent incidents.

HARM FREE CARE – SERIOUS INCIDENTS

Executive Lead: Michelle Rhodes

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

- The Trust declared 14 patient Serious Incidents in April 2019
- This is consistent with the monthly average in 2019 so far, but lower that the average of 18 per month in 2018
- One organisational Serious Incident was also declared in April, which concerns the temporary loss of ICT at Pilgrim Hospital
- Pressure ulcer incidents account for the highest proportion of Serious Incidents declared so far in 2019 (23.1% of the total), although this compares favourably with 40% of the total in 2018
- Accident & Emergency at Lincoln County Hospital have declared 9 Serious Incidents in 2019 so far; no other location in the Trust has declared more than 2

Actions in place to recover:

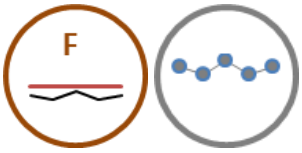
- The Patient Safety Group has commissioned a reviewed of incidents reported within A&E departments on all sites, to identify common themes and causes
- There are processes in place to ensure timely completion of effective Serious Incident investigations; there were 33 Serious Incident investigations open at the end of April 2019; none of these were overdue their deadline date

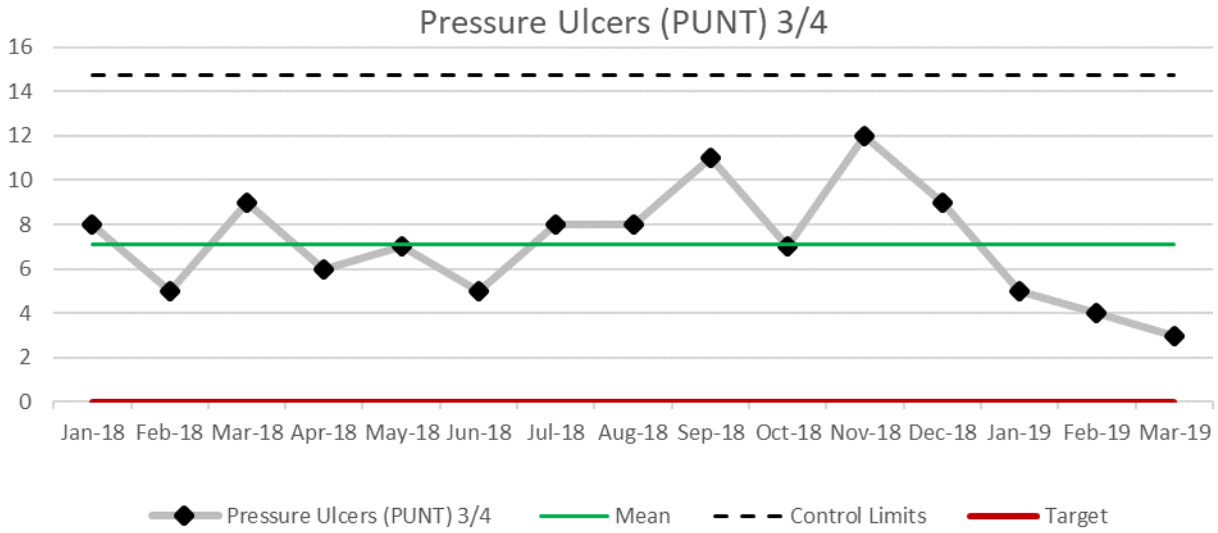
HARM FREE CARE - PRESSURE ULCERS

Executive Lead: Michelle Rhodes

CQC Domain: Safe

2021 Objective: Our Patients





Pressure Ulcers Category 2, 3 and 4 Post admission

In April 2019 there were zero Category 3 or 4 pressure ulcers reported in ULHT. This shows a significant improvement on the previous year and work will now focus on management of unstageable pressure ulcers. Where possible, the Tissue Viability team will validate the category 2 pressure ulcers and more attention is needed to improve skin assessments during admission.

Below is the table for Category 2 pressure ulcers.

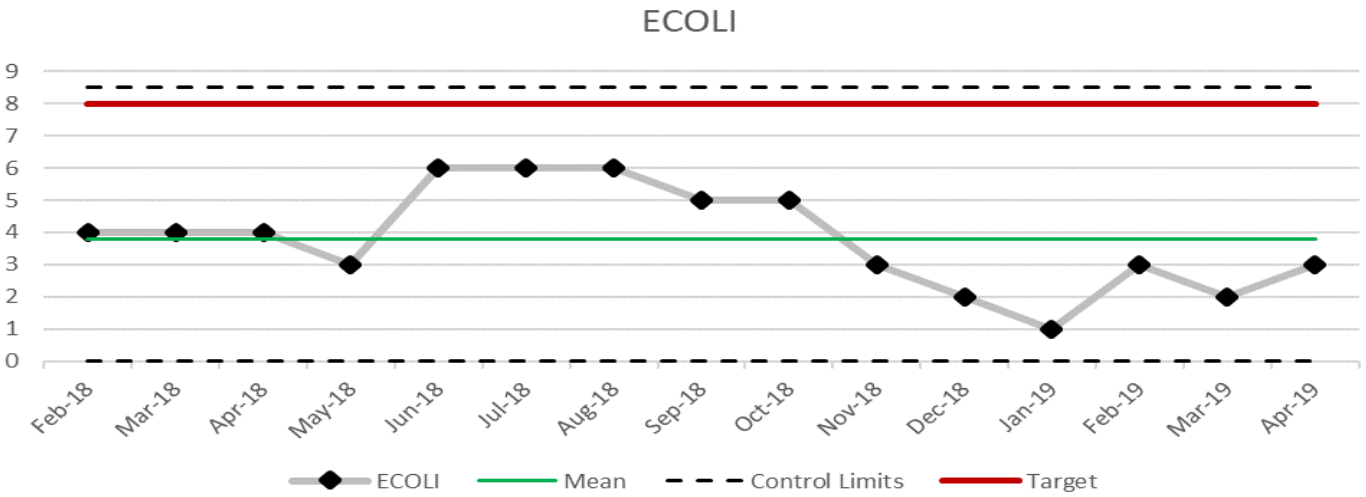
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LCH	9											
PH	16											
GDH	1											
Total	26											
Cumulative	26											

HARM FREE CARE – INFECTION PREVENTION - ECOLI

Executive Lead: Michelle Rhodes

CQC Domain: Safe

2021 Objective: Our Patients



E.coli bacteraemia (post 2 days)

The following table of E.coli bacteraemia cases demonstrate data collected as part of the mandatory HCAI reporting to PHE. The tables demonstrate the number of trust-attributed cases of E.coli bacteraemia for 2019/20. No thresholds for these organisms are currently in place for acute hospital trusts. Action planning to reduce E.coli bacteraemia rates is being led by the CCG through the Whole Health Economy IP&C group work with the ambition of reducing Gram negative bloodstream infections by 50% by 2021.

A whole health economy action plan has been produced with tasks linked to respective organisations. ULHT is a key member of the whole health economy and will deliver on all agreed actions. The CCG's have approved the countywide action plan through their respective governing bodies. This will encompass the work being undertaken at whole health economy level.

Below are the tables and charts to illustrate the numbers of Gram negative bloodstream infections seen in 2019/20.

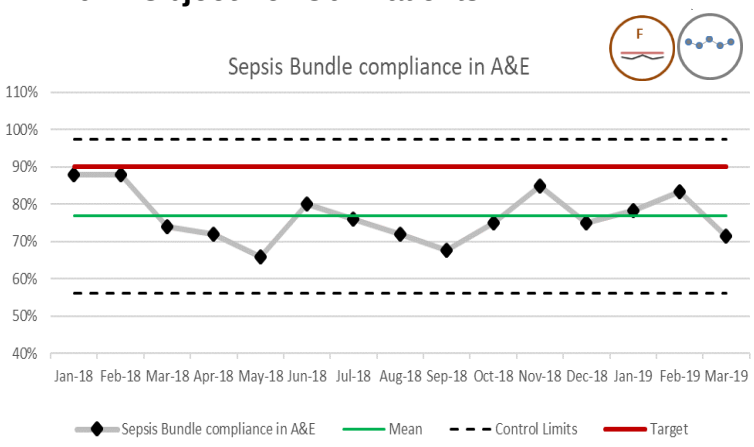
E.coli Bacteraemia					
Month	**Pilgrim**	**Lincoln**	**Grantham**	**Louth**	**Total**
April	**0**	**2**	**0**	**0**	**2**
May					
June					
Total					

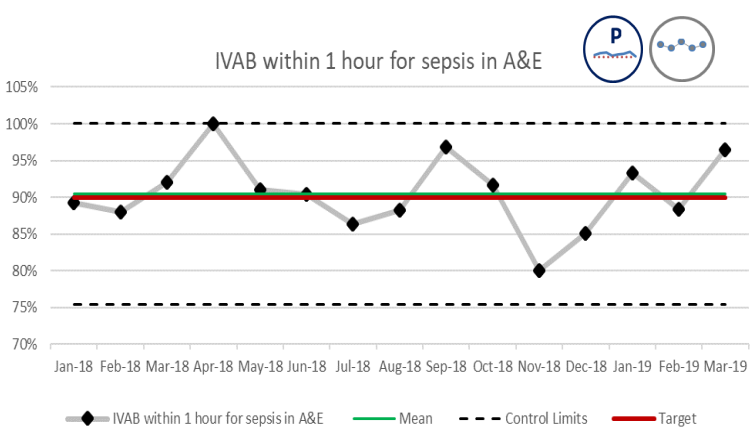
HARM FREE CARE - SEPSIS

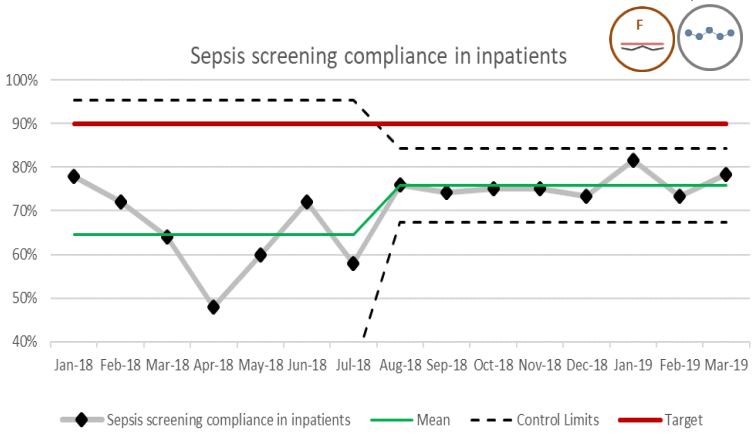
Executive Lead: Michelle Rhodes

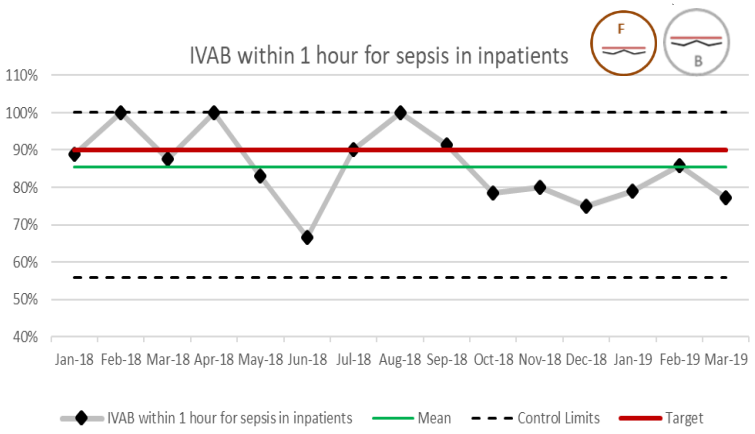
CQC Domain: Safe

2021 Objective: Our Patients









Sepsis screening

The month on month figures for screening within inpatients shows a slight improvement although the overall picture is static. The figures for A&E show a deterioration for the last month which is mainly attributable to Pilgrim site.

The Sepsis Practitioners have been conducting deep dive reviews to reveal themes and there have been concerns over agency nurses and how well they have been prepared. A short survey has been sent to all of the agencies for the nurses to complete and this should highlight where teaching and additional support can be targeted.

The Sepsis Trust have now sent out the materials required for the Sepsis Practitioners to roll out Train the Trainer so that each area can assume responsibility for rolling out training to all staff including Bank and Agency.

Best practice has been identified from visits to Manchester Hospitals and this is being utilised to inform data collection and has fed into the Quality Priorities for 2019/2020.

Delivery of IV antibiotics within 60 minutes

The performance of A&E continues to meet the standard and the month on month figures show an improvement in the latest figures. Inpatients continue to lag and the month on month figures are worse in the current data.

Thematic analysis suggests a link to senior clinicians being less available on the wards at certain times and this leads to more uncertainty in decision making.

The Sepsis Practitioners are attending the clinical governance meetings and engagement with medical staff has improved.

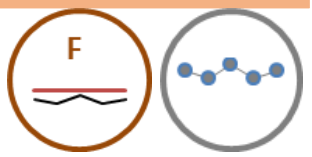
Paediatrics are a current focus and the policy is being written with their support and will include an unsure option allowing for a period of observation and harvesting of results before the antibiotics are given.

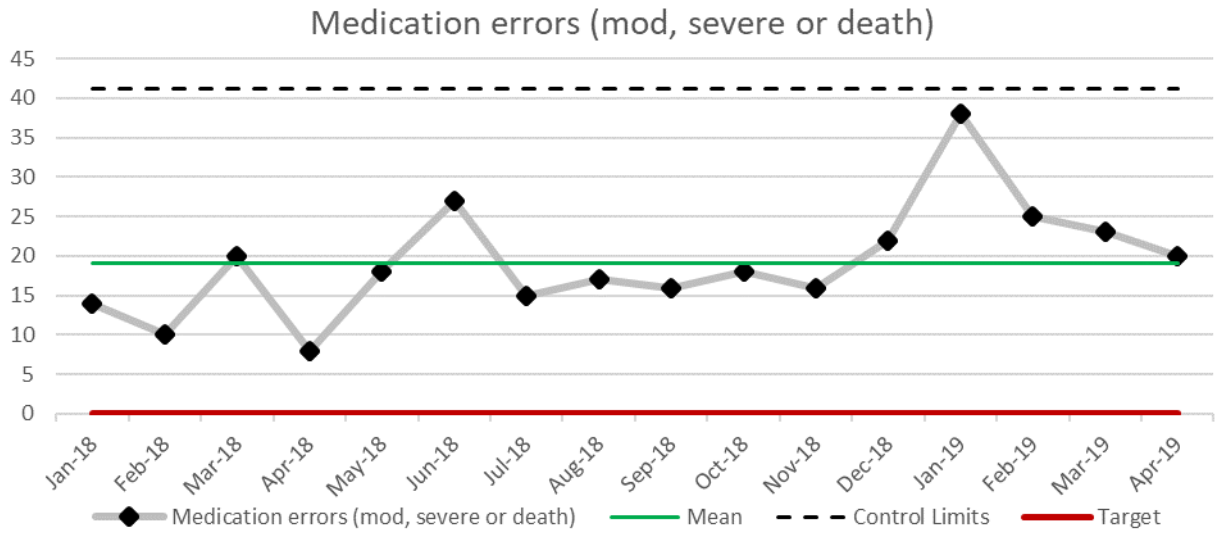
HARM FREE CARE – MEDICATION ERRORS

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

For April the medication incident reporting rate for the Trust per 1000 bed days was 6.44. The rate is expressed as total number of medication incidents reported divided by the number of bed days in the Trust, multiplied by 1000 bed days. The national average as displayed by Model Hospital (from data taken from NRLS, National Reporting and Learning Service) is 4.0 and the peer average is 3.4 – this figure was last updated in November 2018.

There were no never events relating to medication incidents reported during the reporting period. There were no Deaths relating to medication incidents reported during the reporting period.

Of the 195 medication incidents reported, 10.2% (calculated as medication incidents reported as causing harm or death/all medication errors x 100 – (20/195x100) were rated as causing some level of harm. The national average of medication incidents reported as causing harm or death is 10.6%.

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

Actions in place to recover

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’.

This is supported by the following points:

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 will look to update the Prescribing and Medicines Optimisation and Safety webpages to make them more engaging and user friendly. Within the new design we will have a page dedicated to sharing learning from medication incidents and informing staff of themes and trends.

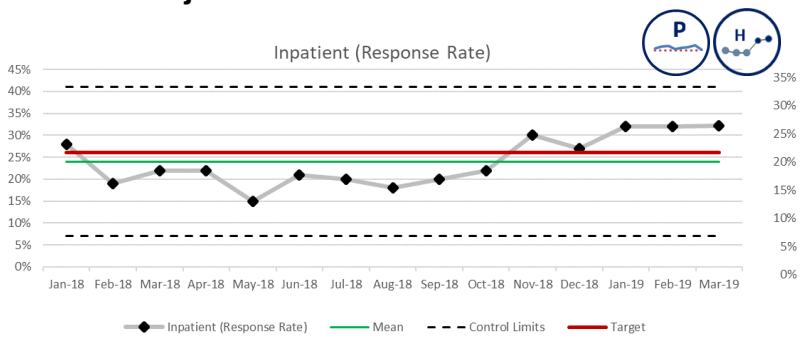
We plan to develop a secure Twitter page to share medication related information and also create a Facebook account to link in with the ULHT Together account and share information via that forum. This will then help to us to capture as many of ULHT staff as possible and ensure that learning reaches as far as possible.

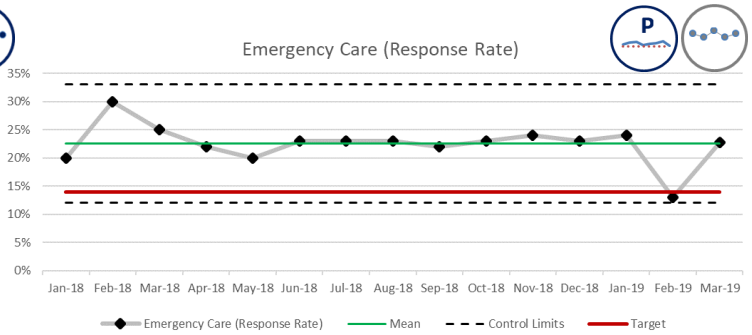
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

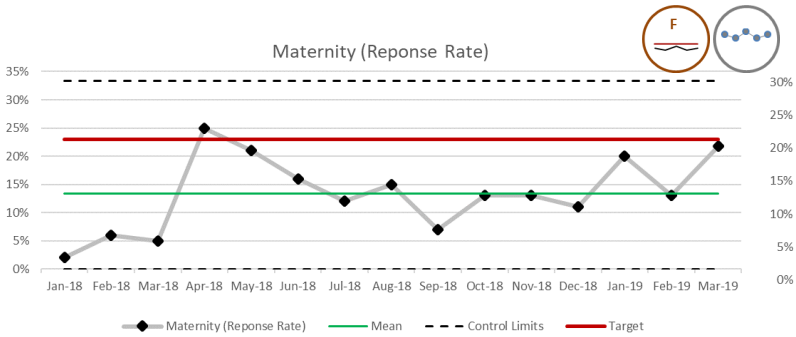
Executive Lead: Martin Rayson

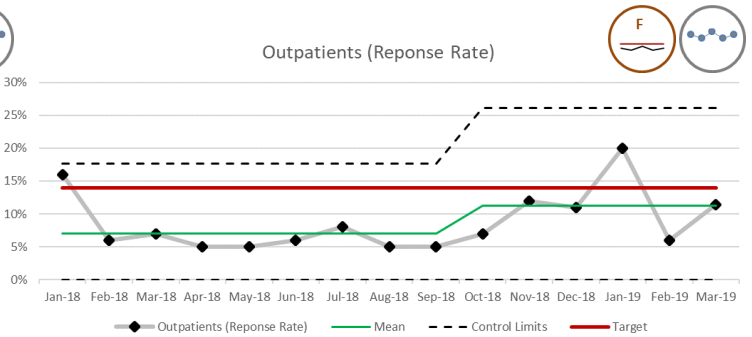
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

Slight improvement across emergency care, inpatients and outpatients for percentage FFT recommends in March. 90% of patients would recommend which remained static against data for February.

Actions in place to recover:

Patient Experience paper to be presented to Trust Management Group regarding performance management, engagement and ownership of all patient experience metrics and initiatives by the divisions.

FAB Experience Champions recruitment initiative was launched in March. The patient experience team will liaise and support teams with their patient experience data and provide guidance when emerging themes are identified via FFT, PALS, Care opinion etc.

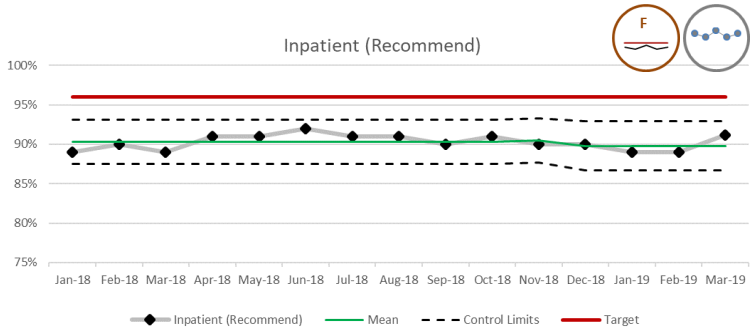
The SUPERB dashboard went live in March and many different teams, departments and areas have begun to make good use of it and have also assisted in some further developments (both currently being implemented and planned for the future). Future developments include SPC-charts where appropriate as they become more standard across higher-level reporting in the Trust, add in further data sources to the mix (Care Opinion data and National Patient Experience surveys etc) and bring in an element of 'Sentiment Analysis' of feedback received.

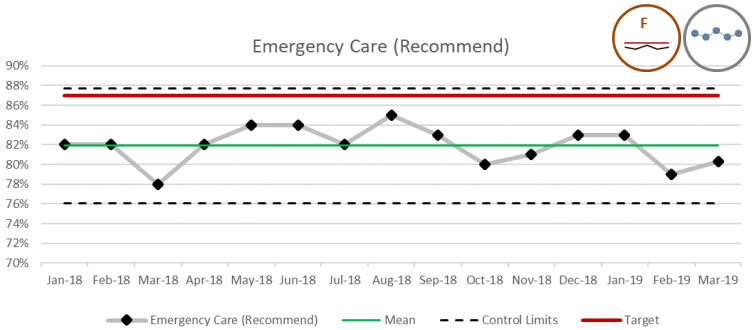
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

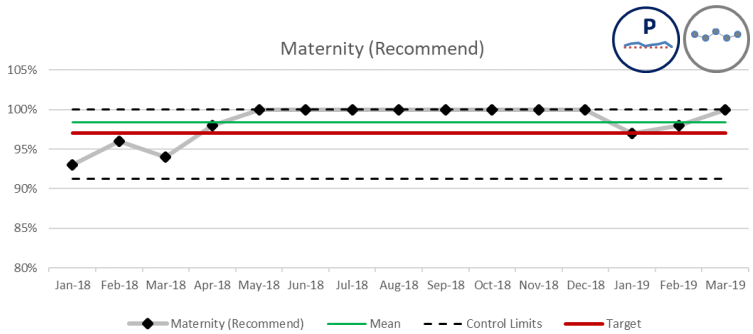
Executive Lead: Martin Rayson

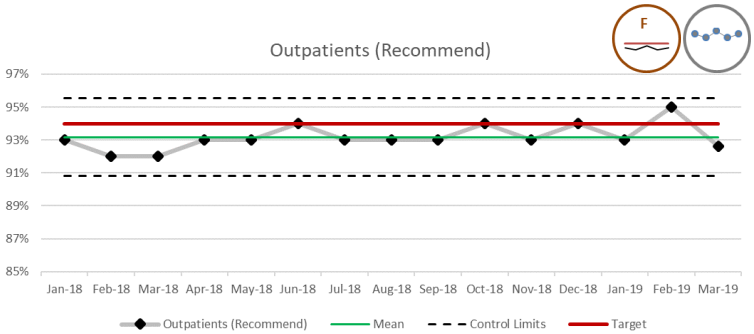
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

Comparison against the % response rates for Q4 show the trust is above the national average across all nationally reportable streams

- ED - Trust 18%, National 12%
- OP - Trust 9%, National 7%
- IP (DC) - Trust 25%, National 24%

Actions in place to recover:

Patient Experience paper to be presented to Trust Management Group regarding performance management, engagement and ownership of all patient experience metrics and initiatives by the divisions.

FAB Experience Champions recruitment initiative was launched in March. The patient experience team will liaise and support teams with their patient experience data and provide guidance when emerging themes are identified via FFT, PALS, Care opinion etc.

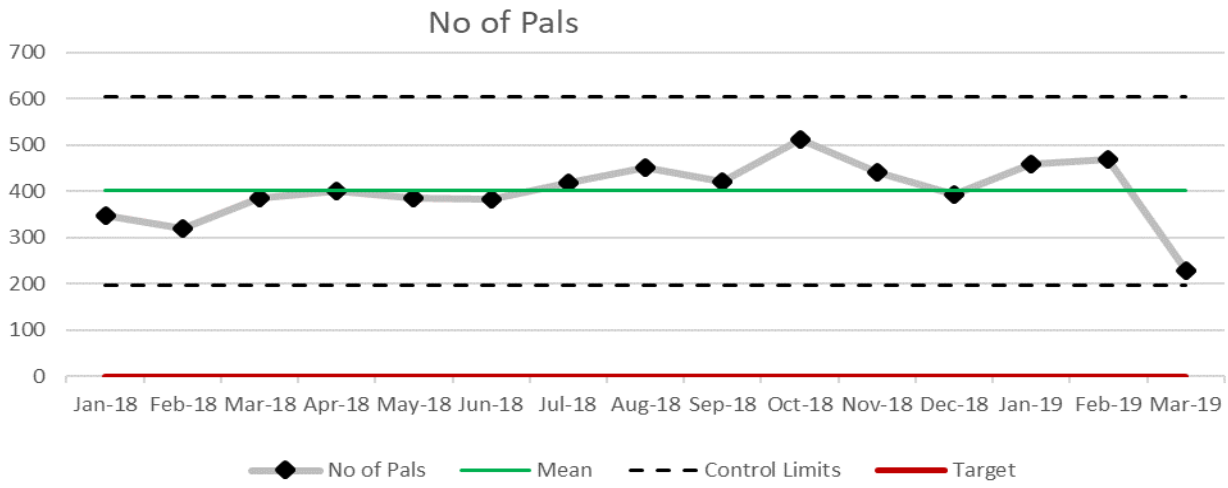
The SUPERB dashboard went live in March and many different teams, departments and areas have begun to make good use of it and have also assisted in some further developments (both currently being implemented and planned for the future). Future developments include SPC-charts where appropriate as they become more standard across higher-level reporting in the Trust, add in further data sources to the mix (Care Opinion data and National Patient Experience surveys etc) and bring in an element of 'Sentiment Analysis' of feedback received.

VALUING PATIENTS TIME – PALS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients



Challenges/Successes

The top 3 themes for PALS for March were: Appointments, Communication and Facilities (Car Parking)

PALS concerns dropped slightly in March. 231 concerns were taken to PALS during December. 126 for Lincoln and Louth, 21 for Grantham, 75 for Pilgrim and the remainder for community hospitals.

Using SUPERB dashboard, the divisional split for PALS concerns received were:

- Clinical Support Services 44
- Medicine 43
- Surgery 51
- Estates & Facilities 26
- Family health 15

Counting Compliments against complaints ration – 31:1

Actions in place to recover:

Patient Experience paper to be presented to Trust Management Group regarding performance management, engagement and ownership of all patient experience metrics and initiatives by the divisions.

FAB Experience Champions recruitment initiative was launched in March. The patient experience team will liaise and support teams with their patient experience data and provide guidance when emerging themes are identified via FFT, PALS, Care opinion etc.

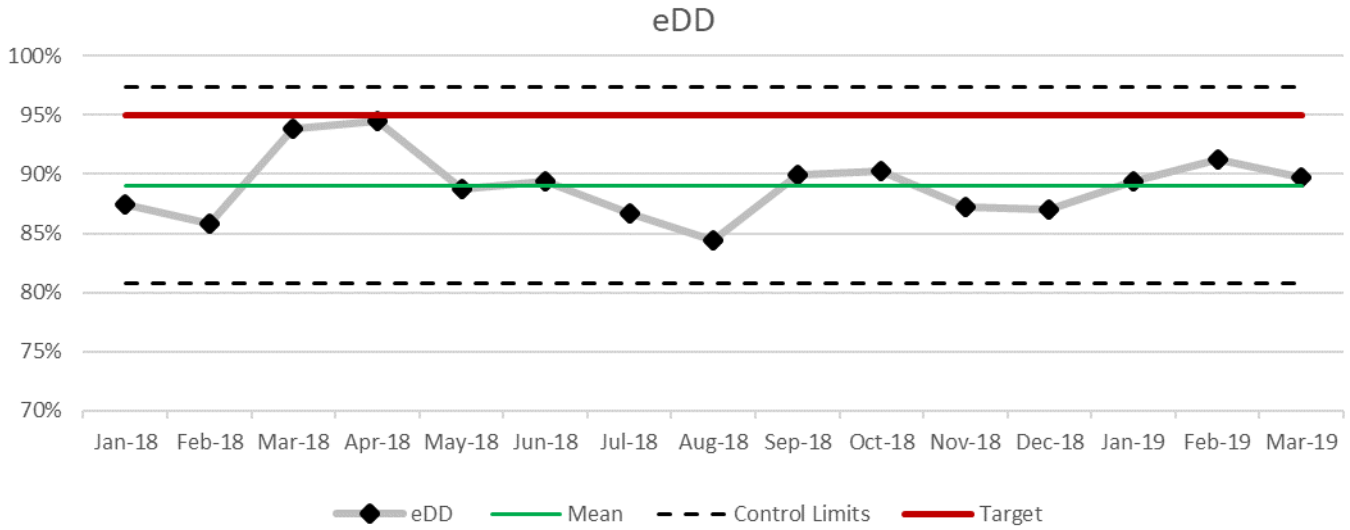
The SUPERB dashboard went live in March and many different teams, departments and areas have begun to make good use of it and have also assisted in some further developments (both currently being implemented and planned for the future). Future developments include SPC-charts where appropriate as they become more standard across higher-level reporting in the Trust, add in further data sources to the mix (Care Opinion data and National Patient Experience surveys etc) and bring in an element of 'Sentiment Analysis' of feedback received.

VALUING PATIENTS TIME – ELECTRONIC DISCHARGE DOCUMENTS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients



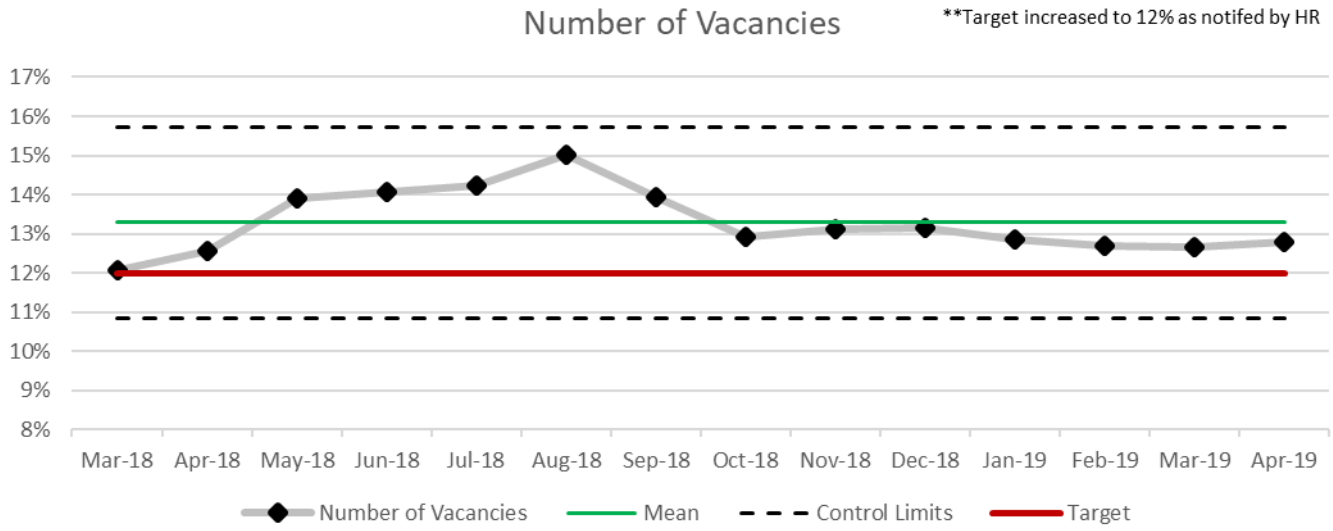
The Trust is not achieving the standard of all eDDs being sent within 24 hours. The Trust launched the streamlined eDD on the 21st February 2019 to improve the quality and reduce the time taken to write an eDD. In conjunction with the streamlined eDD the Trust developed an escalation process to ensure eDDs are completed prior to a patients discharge. Currently an eDD dashboard is being developed to give real time status for completion of eDDs.

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

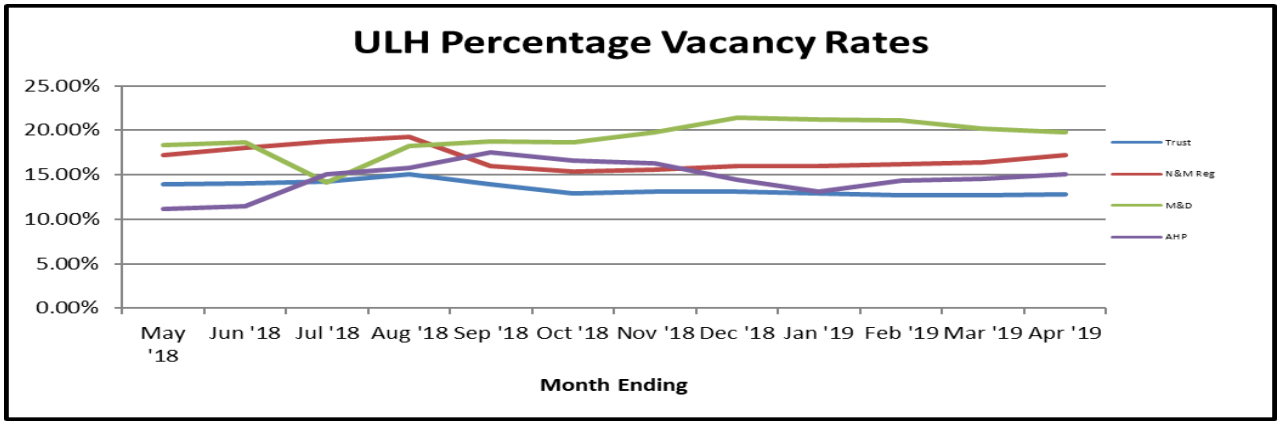
Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People



Overall the Trust Vacancy Rate increased slightly from 12.6% to 12.7%. Marginal improvement in medical vacancy rate was off-set by increases in Nursing (which was in line with workforce planning assumptions) and AHP rates.



Challenges/Successes

Medical Vacancy Rate improved in April to 19.8% from 20.2%. Further detail of higher Medical Vacancy Rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Lincoln Radiology Consultants	6.7	49%
	Pilgrim Clinical Haematology IP	2.0	50%
Family Health	Lincoln Paediatrics IP	8.7	30%
	Pilgrim Paediatrics IP	3.7	19%
Medicine	A&E Attenders Pilgrim	18.0	51%
	Grantham Elderly Care IP	3.0	50%
	Grantham Gastroenterology IP	3.2	46%
	A&E Attenders Lincoln	16.2	42%
Surgery	Lincoln ENT IP	4.7	44%
	Lincoln Ophthalmology IP	5.3	30%

There are significant numbers of A and E medical staff in process. Five substantive consultants started in April.

Nursing Vacancy Rate increased in April to 17.2% from 16.4%, with slightly more leavers than starters (although half have been retained on the nursing bank). The rate also increased due reduced contractual hours of substantive nursing staff. Further detail of higher Nurse Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Medicine	Ward 7B Respiratory	13.0	56%
	Pilgrim AMSS	18.6	55%
	Pilgrim AE Acute Care Pract Team	5.4	54%
	Ward 6A	11.7	50%
	Pilgrim Stroke Unit	12.8	45%
	Ward 8A	9.5	44%
	A&E Pilgrim	21.8	44%
Surgery	Bevan Ward	8.5	58%
	Ward 5B	11.8	51%
	Ward 9A	9.3	43%
	Grantham Ward 2	9.3	42%
Family Health	Rainforest Ward	14.5	45%
	Ward 4A	12.5	38%

AHPs Vacancy Rate increased in April by 0.5% to 15.1%, with slightly more leavers than starters. Further detail of the highest AHP Vacancy rates are provided in the following table. Further increase in vacancy rate is projected until end of May.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	9.4	30%
	Pilgrim Radiology	6.2	25%

Actions in place to recover

Weekly recruitment and exit tracking is now taking place. Robust tracking of planned new starts is in place and earlier sight of forecast leavers is allowing for earlier dialogue around replacement recruitment.

TMP have completed the first phase of their work around employer brand development and will start to inform some of our recruitment activity. It is planned for their work to be tested with a number of staff focus groups.

Medical and Dental – There are 23 fte of new starts (Consultant and SAS) forecast for the first quarter and 37.3 fte for the second quarter of 2019/20 with 26 new starts in A&E across Lincoln and Pilgrim. Emergency Department recruitment is being tracked closely with two weekly reporting at ET. Divisions are increasingly adopting the 'plan for ever post' approach to all vacant post and there is greater triangulation with associated agency costs. Recruitment to the resourcing partner team is now complete. Selection of 2 strategic international recruitment partner agencies has been completed. Agreement to run a pilot programme with Paragona has been reached. Work to validate the DiT establishment has commenced.

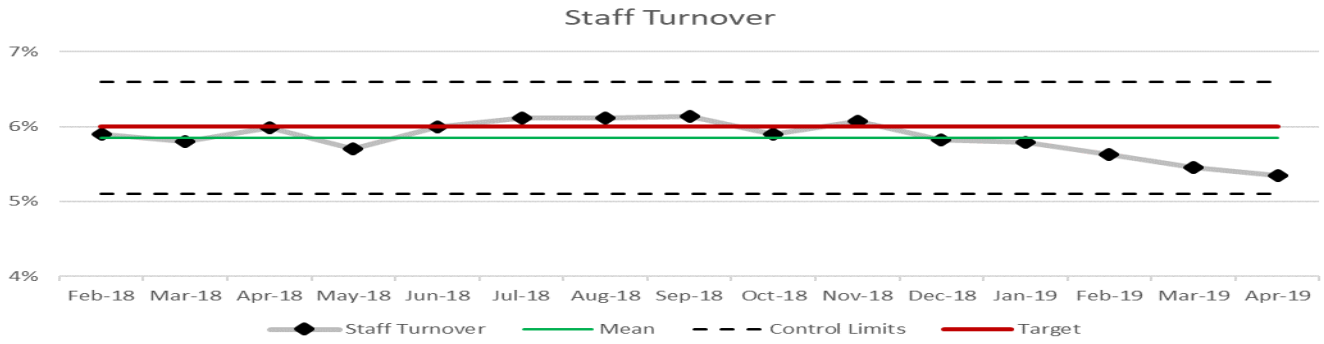
Nursing – The Nursing Workforce and Agency Reduction meeting which takes place bi-weekly and forms part of the workforce governance structure has been reviewed to ensure improved engagement at a senior divisional nursing level. Weekly tracking of projected starters and early progression of nursing staff giving notice is now in place. Information on high vacancy areas and wards using block nursing agency will be used to inform a domestic campaign planned for April and May. All routes to employment are being evaluated including RtP, HEE Earn, Learn and Return, Domestic and International. Two international strategic partner agencies have been provisionally selected and a Business Case for International Nursing is being prepared for Executive Review w/c 20th May. NQN Nursing programme is on track. Subject to late submission of EF3 (Notice to terminate contract) nursing numbers for April and Quarter one are slightly ahead of the 19/20

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Analytical Insights:

The 317.6 FTE represents 396 staff.

Row Labels	Sum of FTE	Count of Employee Number
357 Clinical Support Services - L3 2018	112.92	137.00
357 Corporate - L3 2018	25.57	30.00
357 Director of Estates & Facil - L3 2018	19.67	30.00
357 Medicine - L3 2018	64.42	80.00
357 Surgery - L3 2018	63.91	80.00
357 Family Health - L3 2018	31.10	39.00
Grand Total	**317.58**	**396.00**

The top 3 reason for leaving (exc retirements) are:

Voluntary Resignation - Other/Not Known	56%
Voluntary Resignation – Relocation	17%
Voluntary Resignation – Promotion	10%

Actions in place to recover

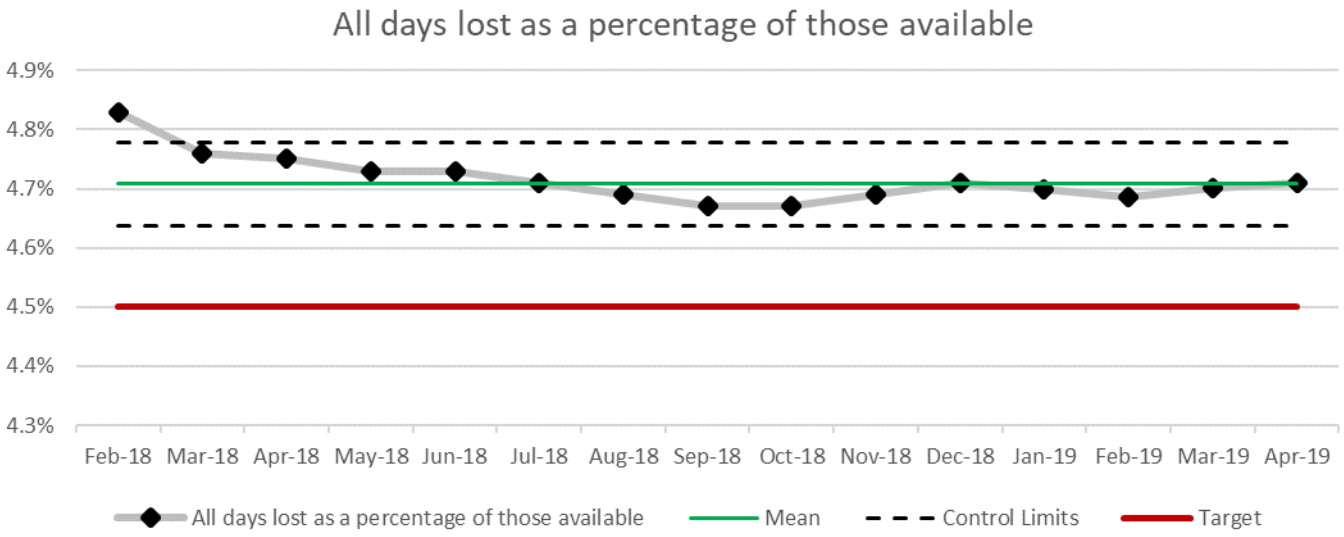
- Self-rostering pilot in progress. A few wards have stopped doing it with the new TOM structure coming into place. The rosters go live the week of 17th of June.
- Process for Retire and Return designed and implemented.
- Currently modifying Retirement workshops to include more information on Retire and Return
- Legacy Nurse role currently under discussion
- Videos being developed on different flexible working options and the current policy also being re-worded
- Internal transfer policy created and taken to the Policy Development group in April
- Itchy Feet conversations launched. Communication plan being designed to ensure staff are aware about this scheme.
- Launch of career pathways campaign – starts May 2019 and goes on till October 2019
- Analysis of Q1 Leavers' data to be produced May 2019
- Education Strategy due for completion end May 2019

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People

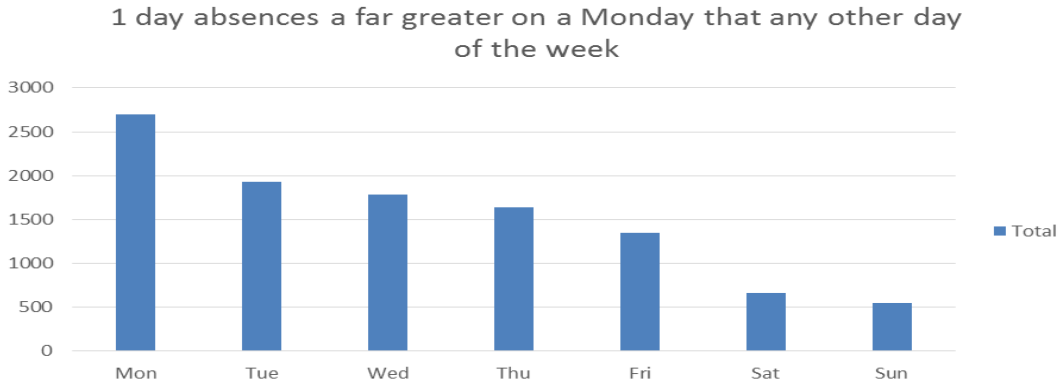


Analytical Insights:

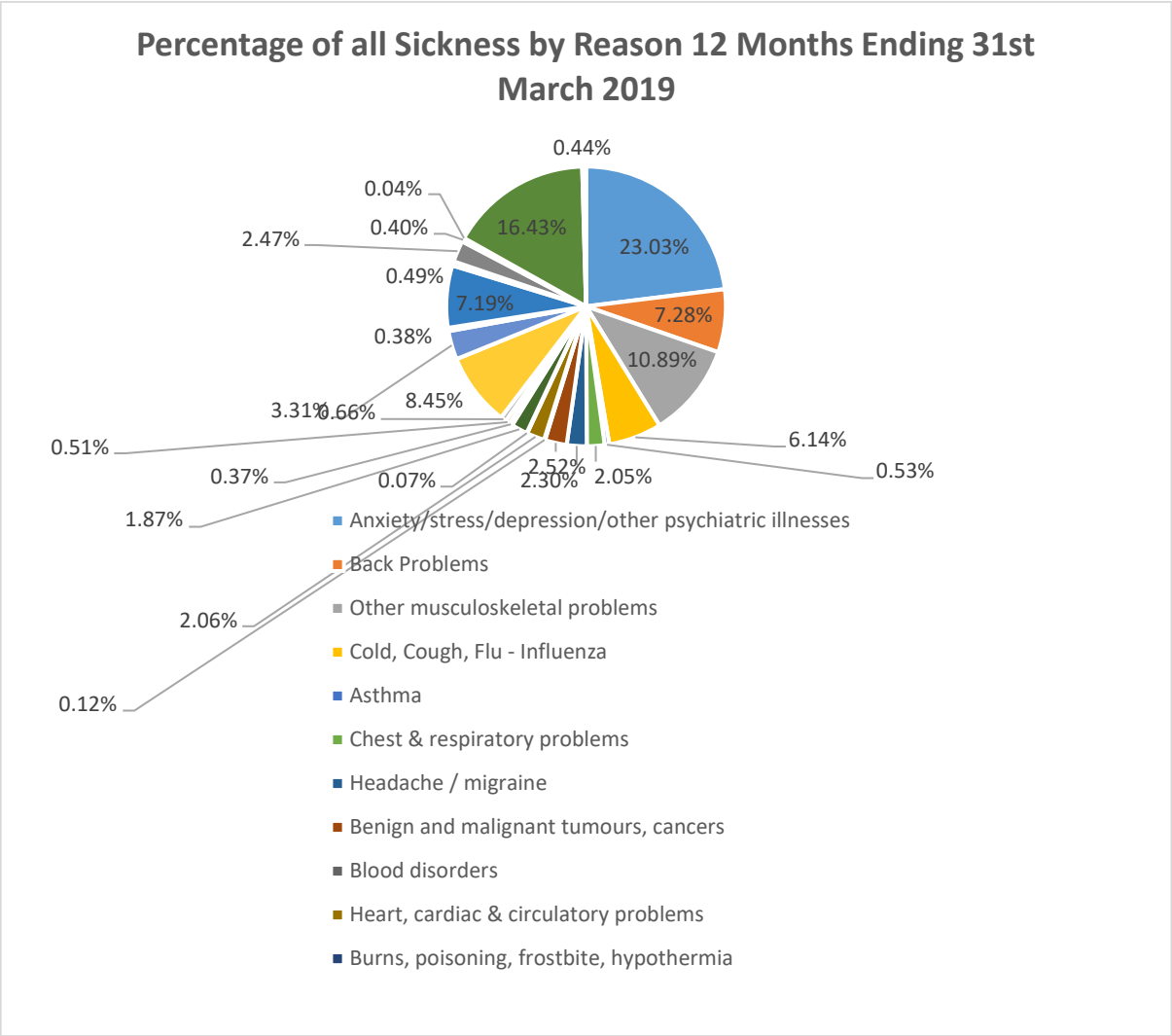
The overall sickness rate for the Trust has been stable at 4.7% since October 2018. Gastrointestinal problems and cold, cough, flu remain the two top reasons for sickness in March across all areas.

ULHT remains 0.2% above our target of 4.5%. There is variation between Divisions.
According to the national statistics on all Acute hospitals, ULHT are reporting to be the 7th highest nationally out of 35 other organisations (12 month period up to December 2018).

90% of absences are uncertified and recorded as under 7 days and the average length of absence is 3.5 days. The table below shows the particular day on which sickness is taken.

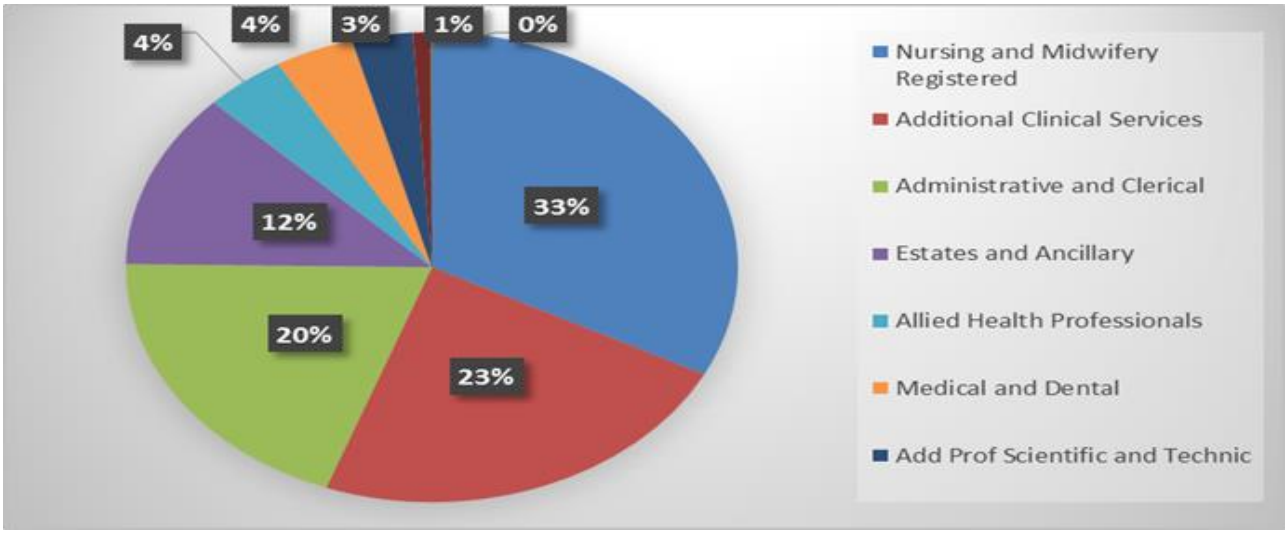


The reasons for absence are recorded and presented (last 12 months). There continues to be a significant number recorded as “other”, these have been highlighted to Divisions. This information is now reported within the Divisions as set out in the new TOM reporting.



Stress/ Anxiety and depression and MSK are causes for the majority of absence. Other known cause is the next largest area.

Sickness by Staff Group



Assurances:

Regular/monthly 'Case Reviews' with input from Occupational Health in 'difficult to manage' situations are undertaken.
ER are supporting managers to arrange immediate follow-up meetings following OH appointments to review reports, with greater emphasis on ensuring timely case reviews where it is identified that further support is impracticable. Consideration and earlier discussions around early retirement on the grounds of capability due to ill health is considered with ER supporting the application process.

The ER team are currently supporting managers to look at a number of opportunities to support staff to be able to return to work as soon as practicable in some capacity, even if they are not able to fulfil the requirements of their substantive role completely, by considering adjustments to roles/duties. Redeployment options are also being considered earlier in the process to support earlier returns particularly where there are underlying disabilities.

To target the percentage of return to work interviews and report into Divisions to highlight non-compliance.

The ER Team to focus on short term absences, in particular to identify any trends.

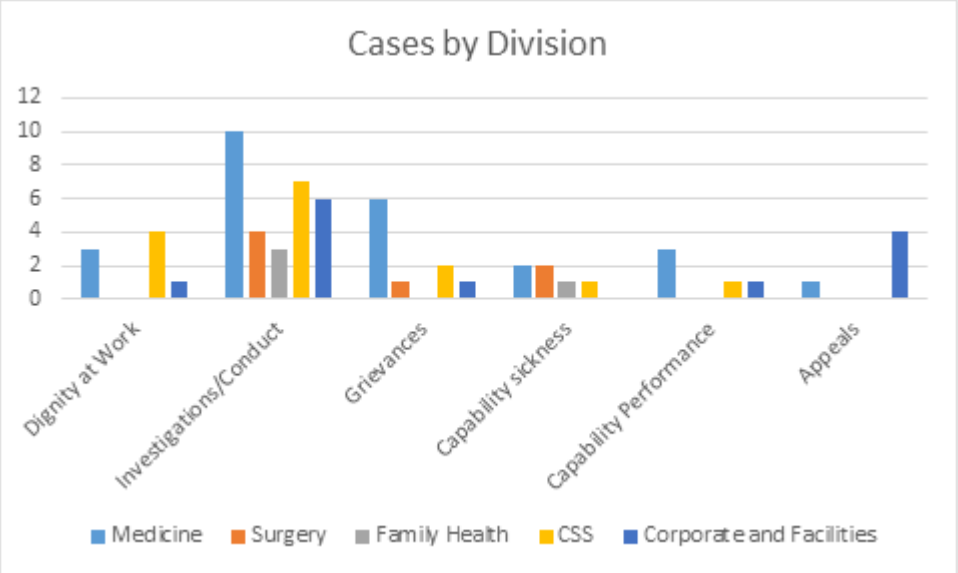
SHRBPs work closely with ER advisors to ensure plans are in place for all long term and short term frequent absences are in place and to ensure areas of concern are escalated as necessary.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

There are 64 open cases for April compared with 49 cases for March, this is a 23% increase in activity. The majority of cases are in the Medicine Division with 25 cases. The Division has seen a significant increase for April by 8 additional cases, this is a 32% increase in activity. There is still a significant drift in the amount of Performance capability cases live, compared to what would be expected for a challenging Trust with Circa 7,800 staff.

Two of the Employment tribunals are ongoing over a number of years. One is around pay and therefore should be settled before reaching the hearing. Out of the other 4 ET Claims all have above 50% prospect of being successfully defended.

We currently have 3 suspensions (none are medical staffing). HR strongly advise against suspensions and look at redeployment options in suspensions.

There are currently 17 active cases logged through the Medial LDMG, all these cases are not formal be managed through MHPS process.

Actions in place to recover

The ER Managers are having weekly case conferences with the ER Advisors to ensure and update cases and identify any problems with cases being completed.

ER team ensuring higher standards and quality of investigations and completion of documentation to reduce the amount of unsuccessful outcomes.

The HR Operations team arranging hearings in a timely manner.

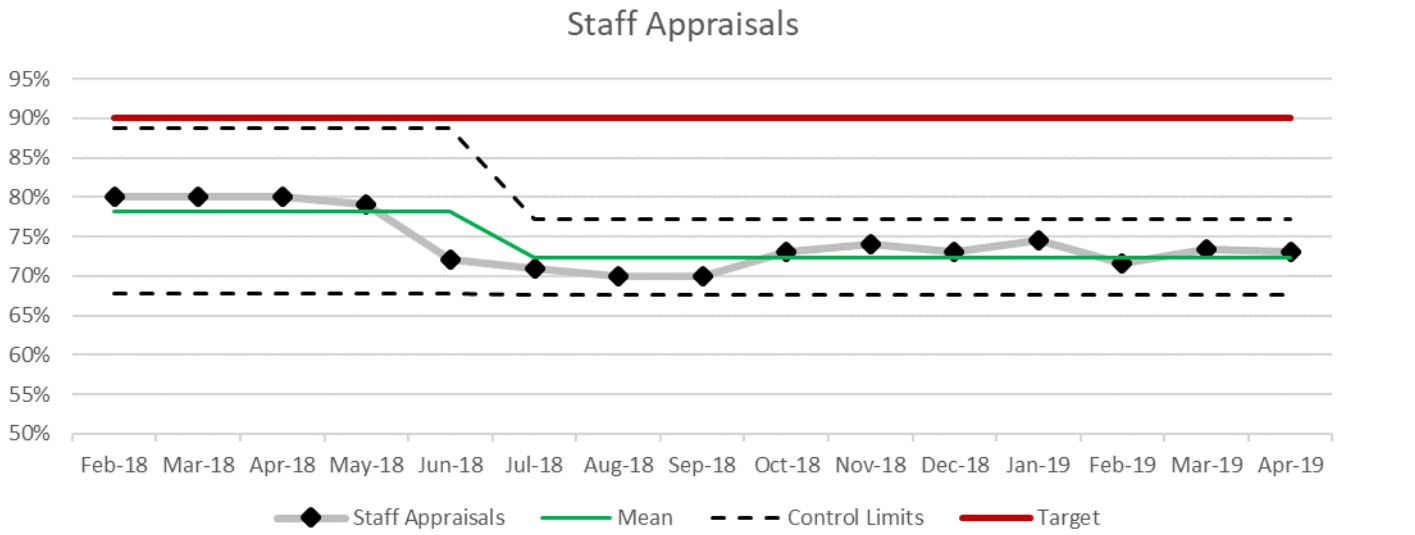
Divisional reporting will now support better ownership of cases.

MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

The 3 lowest percentage of non-medical appraisal completions recorded are –

- Surgery Division Management 18.60%
- Family Health Division Management 37.50%
- Chief Operating Officer 38.64%

Actions in place to recover

Following feedback, the current appraisal paperwork is being re-drafted and tested with managers with a view to re-launching in June 2019

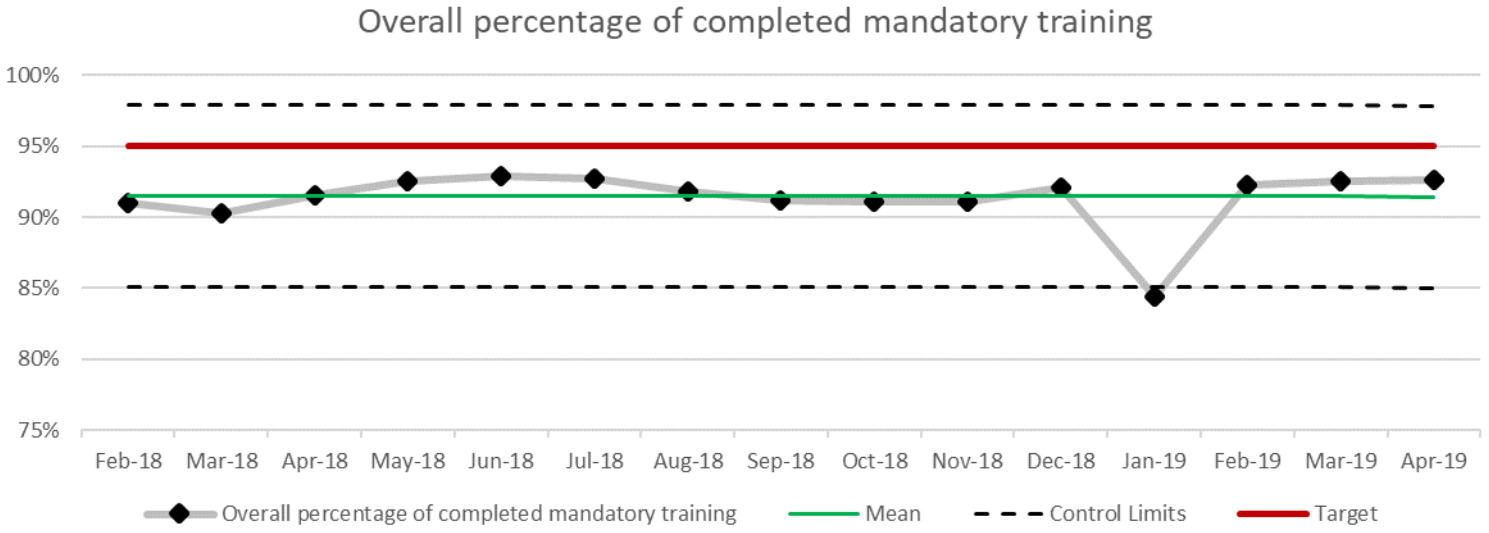
SHRBP's to identify areas with poor completion rates, in many cases working with new managers, to ensure that they are equipped to challenge and support where existing practice is poor.

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Overall compliance has increased slightly by 0.1% to 92%. This is now only 0.31% below the highest percentage the Trust has achieved. Looking at the individual topics, after seeing a fall last month for safeguarding, this shows the biggest increase this month of 1.48%. 7 topics however have fallen with Infection prevention the highest at -0.78%. Fire Safety has also fallen by -0.61%. The table below shows compliance by Division for those topics that have not reached 95%. Compliance below 90% has been highlighted red. The Division with the lowest compliance per topic is still Medicine with 7 topics below 90%, followed by Estates & Facilities and Surgery.

Assignment Count	Division	Equality, Diversity and Human Rights - 3 Years	Fire Local Procedures - 1 Year	Fire Safety - 1 Year	Fraud Awareness - 3 years	Infection Control - 1 Year	Information Governance - 1 Year	Major Incidents - 1 Year	Resuscitation [BLS] - 1 Year	Safeguarding Adults Level 1 - 3 Years	Safeguarding Children Level 1 - 3 Years
1916	Clinical Support Services	95.72%	96.56%	92.64%	95.93%	91.54%	90.34%	92.48%	86.90%	92.85%	92.80%
622	Corporate	95.50%	94.86%	93.41%	94.53%	93.41%	90.68%	92.60%	88.75%	92.60%	92.60%
890	Director of Estates & Facil	91.35%	94.04%	91.57%	91.46%	86.07%	80.11%	86.18%	83.60%	89.55%	89.55%
1508	Medicine	94.03%	91.18%	88.13%	92.04%	88.33%	82.76%	86.87%	82.03%	88.79%	88.66%
1540	Surgery	94.55%	94.55%	89.81%	94.48%	89.29%	87.99%	90.97%	83.18%	90.84%	90.84%
751	Family Health	95.07%	95.34%	92.94%	95.34%	91.88%	90.15%	93.61%	86.68%	91.34%	91.21%
7227	Trust	94.49%	94.42%	91.06%	94.08%	89.91%	87.01%	90.34%	84.82%	90.99%	90.94%

Corporate includes Chief Executive, Chief Operating Officer, Deputy Chief Executive, Director of HR & OD, Director of Nursing and Medical Director

Actions in place to recover

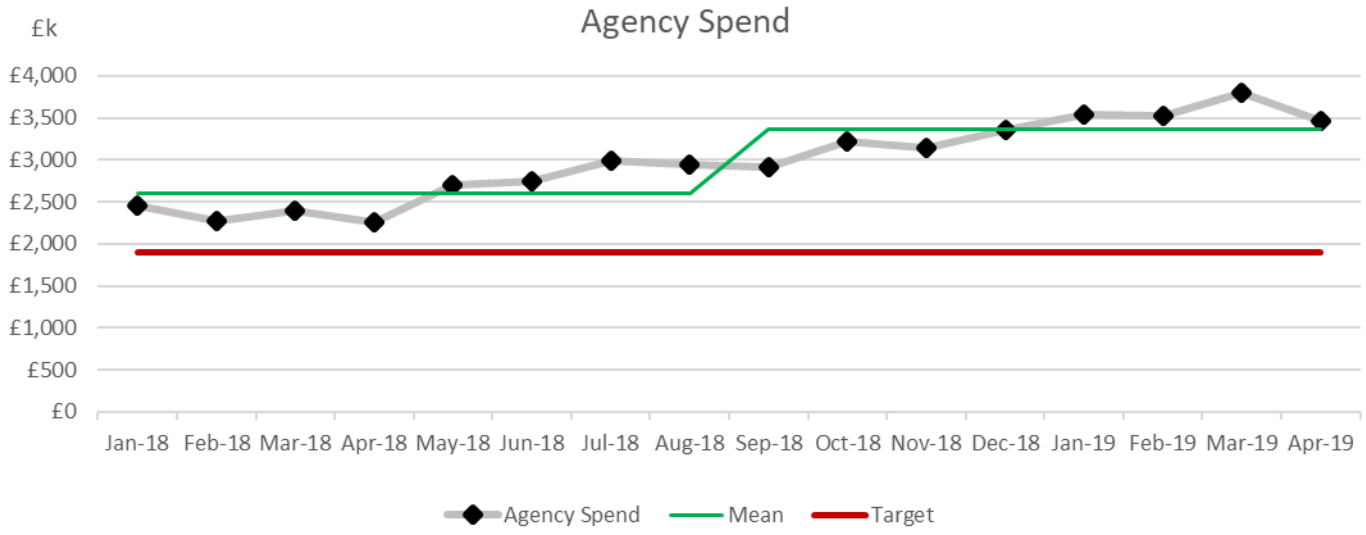
- Strategic HR Business Partners to support identification & escalation of service areas with poor compliance rates.
- Considering incentivising teams to complete 100% core learning – paper due to ET.
- Core Learning Panel to consider use of external e-learning which is generally more problematic than in-house designed programs.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



There was a review on agency spend to align all the different systems to ensure the accuracy of Agency reporting which was held mid-May, which should start to take effect immediately.

HR are working with all the Divisions to enforce the importance of Agency spend and looking at ways of reducing this.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Current Month			Year to Date			Forecast		
	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k
Income	40,328	40,221	(107)	40,328	40,221	(107)	501,616	501,616	0
Expenditure	(45,316)	(45,247)	69	(45,316)	(45,247)	69	(520,722)	(520,722)	0
EBITDA	(4,988)	(5,026)	(38)	(4,988)	(5,026)	(38)	(19,106)	(19,106)	0
Depn/Interest	(1,764)	(1,728)	36	(1,764)	(1,728)	36	(22,306)	(22,306)	0
Surplus/(Deficit)	(6,752)	(6,754)	(2)	(6,752)	(6,754)	(2)	(41,412)	(41,412)	0
Technical adjustments	1	19	18	1	19	18	14	14	0
Surplus/(Deficit)	(6,751)	(6,735)	16	(6,751)	(6,735)	16	(41,398)	(41,398)	0
EBITDA % Income	-12.4%	-12.5%	-0.1%	-12.4%	-12.5%	-0.1%	-3.8%	-3.8%	0.0%
FEPs	1,042	1,042	(1,042)	1,042	1,042	(1,042)	25,610	25,610	0

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

Overall YTD financial performance is £6.735m deficit, or £16k favourable to the planned £6.751m deficit.

EBITDA for the year to date is £5.026m deficit (-12.5% of Income).

Whilst Income from NHS Patient Care is assumed at plan, income overall is £107k below plan YTD; the income position assumes £1.568m in relation to PSF, FRF & MRET.

Expenditure is £69k below plan YTD, but this comprises of an adverse Pay movement to plan of £614k and a favourable Non Pay movement to plan of £683k.

Pay expenditure is £298k lower than planned against substantive staffing and £899k higher than planned expenditure on temporary staffing; the adverse movement in temporary staffing includes an adverse movement to plan of £535k in relation to expenditure on Agency staffing.

The above tables assumes FEP delivery is in line with plan; actual FEP delivery in April is being validated.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Run Rate 2019/20

2019/20	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	In Month			Full Year		
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Plan M1	Actuals M1	Variance M1	Plan Full Year	Forecast Full Year	Variance Full Year
Income																		
NHS Clinical Income	31,253	32,961	31,582	33,557	32,408	32,001	33,294	31,646	31,404	32,481	30,469	32,630	31,520	31,253	(267)	385,686	385,686	0
Non NHS Clinical Income	421	282	282	283	282	282	282	281	282	282	284	361	282	421	139	3,384	3,384	0
Pass through income	4,215	4,232	4,215	4,241	4,224	4,224	4,241	4,224	4,215	4,232	4,215	4,232	4,215	4,215	0	50,710	50,710	0
Total Patient related income	**35,889**	**37,475**	**36,079**	**38,081**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**37,223**	**36,017**	**35,889**	**(128)**	**439,780**	**439,780**	**0**
PSF, FRF and MRET funding	1,568	1,568	1,569	1,989	1,989	1,990	2,832	2,832	2,831	3,252	3,252	3,256	1,568	1,568	0	28,928	28,928	0
Other Income	2,764	2,743	2,743	2,743	2,742	2,741	2,745	2,743	2,741	2,744	2,742	2,797	2,743	2,764	21	32,908	32,908	0
Total Other operating income	**4,332**	**4,311**	**4,312**	**4,732**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,053**	**4,311**	**4,332**	**21**	**61,836**	**61,836**	**0**
Total Income	**40,221**	**41,786**	**40,391**	**42,813**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**43,276**	**40,328**	**40,221**	**(107)**	**501,616**	**501,616**	**0**
Expenditure																		
Pay	(30,868)	(29,333)	(29,338)	(28,757)	(28,697)	(28,607)	(28,444)	(28,253)	(27,859)	(27,847)	(27,848)	(26,769)	(30,254)	(30,868)	(614)	(342,620)	(342,620)	0
Pass through non pay	(4,215)	(4,232)	(4,215)	(4,241)	(4,224)	(4,224)	(4,241)	(4,224)	(4,215)	(4,232)	(4,215)	(4,232)	(4,215)	(4,215)	(0)	(50,710)	(50,710)	0
Other Non pay	(10,164)	(10,836)	(10,850)	(10,496)	(10,509)	(10,510)	(10,496)	(10,507)	(10,519)	(10,603)	(10,614)	(11,288)	(10,847)	(10,164)	683	(127,392)	(127,392)	0
Total Expenditure	**(45,247)**	**(44,401)**	**(44,403)**	**(43,494)**	**(43,430)**	**(43,341)**	**(43,181)**	**(42,984)**	**(42,593)**	**(42,682)**	**(42,677)**	**(42,289)**	**(45,316)**	**(45,247)**	**69**	**(520,722)**	**(520,722)**	**0**
Finance & Depreciation costs	(1,728)	(1,804)	(1,810)	(1,846)	(1,856)	(1,849)	(1,882)	(1,867)	(1,908)	(1,912)	(1,867)	(1,977)	(1,764)	(1,728)	36	(22,306)	(22,306)	0
I&E - Deficit	**(6,754)**	**(4,419)**	**(5,822)**	**(2,527)**	**(3,641)**	**(3,952)**	**(1,669)**	**(6,965)**	**(3,028)**	**(1,603)**	**(3,582)**	**(990)**	**(6,752)**	**(6,754)**	**(2)**	**(41,412)**	**(41,412)**	**0**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	19	1	1	1	1	2	1	1	1	1	2	(17)	1	19	18	14	14	0
Adjusted Surplus/(Deficit)	**(6,735)**	**(4,418)**	**(5,821)**	**(2,526)**	**(3,640)**	**(3,950)**	**(1,668)**	**(6,959)**	**(3,027)**	**(1,602)**	**(3,580)**	**(1,007)**	**(6,751)**	**(6,735)**	**16**	**(41,398)**	**(41,398)**	**0**
Adjustments to derive underlying deficit																		
FSM Loan Interest	643	704	710	746	756	749	782	767	808	812	767	841				9,106	9,106	0
External Support	558	558	558	75	75	75	0	0	0	0	0	0				1,900	1,900	0
Prior Year Income & Challenges	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0
Profit on Disposals	0	0	0	0	0	0	(250)	0	0	0	0	0				(250)	(250)	0
Accruals Adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0
Income timing adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0
Underlying Surplus/(Deficit)	**(5,534)**	**(3,156)**	**(4,553)**	**(1,705)**	**(2,809)**	**(3,126)**	**(1,136)**	**(6,192)**	**(2,219)**	**(790)**	**(2,813)**	**(166)**				**(30,642)**	**(30,642)**	**0**

The Trust's financial plan is a deficit of £41.4m, and as at the end of April the Trust position is a deficit of £6.7m or £16k favourable to plan.

The run rate in future months is based upon plan and the table above shows that the planned run rate in future months is markedly better than in April - the planned run rate from May to March averages £3.1m per month.

The Pay position in April includes payment of a one off cost of £0.9m in relation to the Agenda for Change pay award; this one off payment was assumed in the planned expenditure profile and such that it has not contributed to the adverse movement to plan in Pay of £0.6m in April.

FEP delivery in April is being validated. To achieve the planned deficit, the Trust requires to deliver Financial Efficiency savings of £25.6m.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Clinical Income Summary: YTD Month 1

	Activity: In-Month				Income: In-Month			
	2018/19	2019/20			2018/19	2019/20		
Total Trust	Apr Actual	Apr Activity Plan	Apr Activity Actual	Apr Activity Variance	Apr £k Actual	Apr £k Plan	Apr £k Actual	Apr £k Variance
Accident & Emergency	12,231	11,209	11,209	0	1,741,684	2,005,793	2,005,793	0
Accident & Emergency Streaming	1,060	0	0	0	67,726	0	0	0
Daycases	5,422	5,074	5,074	0	2,757,399	2,692,134	2,692,134	0
Elective Spells	727	719	719	0	1,860,822	1,981,405	1,981,405	0
Elective Spells WIP	0	0	0	0	0	0	0	0
Non Elective Spells	5,678	5,894	5,894	0	10,120,085	10,987,692	10,987,692	0
Non Elective Spells WIP	0	0	0	0	0	0	0	0
Non Elective Excess Bed Days	1,677	1,645	1,645	0	391,316	430,968	430,968	0
Non Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0
Elective Excess Bed Days	79	117	117	0	22,741	31,753	31,753	0
Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0
Outpatient Firsts	23,352	23,093	23,093	0	3,090,096	3,298,038	3,298,038	0
Outpatient Follow Ups	31,733	30,292	30,292	0	2,689,502	2,809,884	2,809,884	0
Critical Care	771	1,630	1,630	0	1,331,970	1,551,464	1,551,464	0
Critical Care WIP	0	0	0	0	0	0	0	0
Maternity	1,032	1,028	1,028	0	845,117	894,986	894,986	0
Audiology	1,633	1,474	1,474	0	117,096	108,558	108,558	0
Block	0	0	0	0	853,267	769,932	769,932	0
Chemotherapy	2,945	3,148	3,148	0	372,602	372,877	372,877	0
Radiology	16,857	17,040	17,040	0	962,858	952,480	952,480	0
Gainshare & Admin Fee	0	39,786	39,786	0	73,688	76,828	76,828	0
Paediatric Cystic Fibrosis	31	30	30	0	13,166	13,440	13,440	0
Radiotherapy	1,998	2,236	2,236	0	380,821	433,529	433,529	0
Screening	7,785	6,940	6,940	0	463,594	448,134	448,134	0
Specialised Rehab	554	535	535	0	231,303	258,708	258,708	0
Specialised Rehab WIP	0	0	0	0	0	0	0	0
Therapies	5,521	5,573	5,573	0	201,538	210,699	210,699	0
Other - non PbR etc	0	5,146	5,146	0	163,837	333,789	333,789	0
Activity sub total	**121,086**	**162,608**	**162,608**	**0**	**28,752,228**	**30,663,091**	**30,663,091**	**0**
Readmissions					(243,862)	(304,058)	(304,058)	0
MRET					(279,583)	(305,017)	(305,017)	0
System Resilience					192,121	199,018	199,018	0
CQUIN					588,926	353,608	353,608	0
Fines					(106,606)	0	0	0
Fines Reinvested					0			
AIV Challenges					0			
PLCV Challenges					0			
Other					0	560,294	560,294	0
Prior Year - Invoiced					0			
Prior Year - Fines and Challenges					0			
Maternity Prepayment					0			
Total Cost/Volume PODs (Non Passthrough)	**121,086**	**162,608**	**162,608**	**0**	**28,903,224**	**31,166,936**	**31,166,936**	**0**
Passthrough		5,854	5,854	0	3,827,224	4,215,176	4,215,176	0
Total (Inc Passthrough)	**121,086**	**168,462**	**168,462**	**0**	**32,730,448**	**35,382,112**	**35,382,112**	**0**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Activity Units												
Activity	**Plan M1**	**Plan M2**	**Plan M3**	**Plan M4**	**Plan M5**	**Plan M6**	**Plan M7**	**Plan M8**	**Plan M9**	**Plan M10**	**Plan M11**	**Plan M12**	**Full Year Plan**
Accident & Emergency	11,209	11,585	11,209	11,585	11,585	11,209	11,585	11,209	11,585	11,585	10,832	11,585	136,763
Accident & Emergency Streaming	0	0	0	0	0	0	0	0	0	0	0	0	0
Daycases	5,074	5,582	5,074	5,835	5,328	5,328	5,835	5,328	5,074	5,582	5,074	5,582	64,695
Elective Spells	719	791	719	827	755	755	827	755	719	791	719	791	9,166
Elective Spells WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Spells	5,894	6,100	5,979	6,153	6,137	5,952	6,110	5,867	6,012	5,995	5,587	6,034	71,820
Non E;ective Spells WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Excess Bed Days	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	19,736
Non Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Excess Bed Days	117	117	117	117	117	117	117	117	117	117	117	117	1,406
Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Firsts	23,093	25,402	23,093	26,557	24,247	24,247	26,557	24,247	23,093	25,402	23,093	25,402	294,433
Outpatient Follow Ups	30,292	33,321	30,292	34,836	31,806	31,806	34,836	31,806	30,292	33,321	30,292	33,321	386,221
Critical Care	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	19,565
Critical Care WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	12,330
Audiology	1,474	1,622	1,474	1,695	1,548	1,548	1,695	1,548	1,474	1,622	1,474	1,622	18,796
Block	0	0	0	0	0	0	0	0	0	0	0	0	0
Chemotherapy	3,148	3,148	3,148	3,148	3,148	3,148	3,148	3,148	3,148	3,148	3,148	3,148	37,771
Radiology	17,040	17,040	17,040	17,040	17,040	17,040	17,040	17,040	17,040	17,040	17,040	17,040	204,478
Gainshare & Admin Fee	39,786	39,786	39,786	39,786	39,786	39,786	39,786	39,786	39,786	39,786	39,786	39,786	477,437
Paediatric Cystic Fibrosis	30	30	30	30	30	30	30	30	30	30	30	30	355
Radiotherapy	2,236	2,236	2,236	2,236	2,236	2,236	2,236	2,236	2,236	2,236	2,236	2,236	26,831
Screening	6,940	7,190	6,940	7,315	7,065	7,065	7,315	7,065	6,940	7,190	6,940	7,190	85,157
Specialised Rehab	535	535	535	535	535	535	535	535	535	535	535	535	6,424
Specialised Rehab WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Therapies	5,573	6,130	5,573	6,409	5,852	5,852	6,409	5,852	5,573	6,130	5,573	6,130	71,054
Other - non PbR etc	5,146	5,251	5,146	5,304	5,199	5,199	5,304	5,199	5,146	5,251	5,146	5,251	62,542
Total Cost/Volume PODs (Non Passthrough)	**162,608**	**170,169**	**162,693**	**173,711**	**166,717**	**166,155**	**173,667**	**166,070**	**163,102**	**170,063**	**161,924**	**170,103**	**2,006,982**
Passthrough	5,854	6,438	5,854	6,730	6,146	6,146	6,730	6,146	5,854	6,438	5,854	6,438	74,628
Board Report Position	**168,462**	**176,607**	**168,546**	**180,441**	**172,863**	**172,301**	**180,398**	**172,216**	**168,956**	**176,501**	**167,778**	**176,541**	**2,081,610**

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

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Plan (£k)												
Income	Plan M1	Plan M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Full Year Plan
Accident & Emergency	2,005,793	2,073,116	2,005,793	2,073,116	2,073,116	2,005,793	2,073,116	2,005,793	2,073,116	2,073,116	1,938,470	2,073,116	24,473,451
Accident & Emergency Streaming	0	0	0	0	0	0	0	0	0	0	0	0	0
Daycases	2,692,134	2,961,309	2,692,134	3,095,897	2,826,722	2,826,722	3,095,897	2,826,722	2,692,134	2,961,309	2,692,134	2,961,309	34,324,425
Elective Spells	1,981,405	2,179,452	1,981,405	2,278,475	2,080,428	2,080,428	2,278,475	2,080,428	1,981,405	2,179,452	1,981,405	2,179,452	25,262,211
Elective Spells WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Spells	10,987,692	11,376,174	11,186,373	11,501,402	11,463,818	11,124,607	11,398,723	10,923,422	11,168,292	11,128,240	10,360,476	11,220,902	133,840,121
Non Elective Spells WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Excess Bed Days	430,968	430,968	430,968	430,968	430,968	430,968	430,968	430,968	430,968	430,968	430,968	430,968	5,171,615
Non Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Excess Bed Days	31,753	31,814	31,753	31,845	31,783	31,783	31,845	31,783	31,753	31,814	31,753	31,814	381,493
Elective Excess Bed Days WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Firsts	3,298,038	3,627,842	3,298,038	3,792,744	3,462,940	3,462,940	3,792,744	3,462,940	3,298,038	3,627,842	3,298,038	3,627,842	42,049,988
Outpatient Follow Ups	2,809,884	3,090,872	2,809,884	3,231,366	2,950,378	2,950,378	3,231,366	2,950,378	2,809,884	3,090,872	2,809,884	3,090,872	35,826,019
Critical Care	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	1,551,464	18,617,565
Critical Care WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity	894,986	894,986	894,986	894,986	894,986	894,986	894,986	894,986	894,986	894,986	894,986	894,986	10,739,834
Audiology	108,558	119,414	108,558	124,842	113,986	113,986	124,842	113,986	108,558	119,414	108,558	119,414	1,384,115
Block	769,932	769,932	769,932	769,932	769,932	769,932	769,932	769,932	769,932	769,932	769,932	769,932	9,239,183
Chemotherapy	372,877	372,877	372,877	372,877	372,877	372,877	372,877	372,877	372,877	372,877	372,877	372,877	4,474,527
Radiology	952,480	952,480	952,480	952,480	952,480	952,480	952,480	952,480	952,480	952,480	952,480	952,480	11,429,761
Gainshare & Admin Fee	76,828	76,828	76,828	76,828	76,828	76,828	76,828	76,828	76,828	76,828	76,828	76,828	921,940
Paediatric Cystic Fibrosis	13,440	13,440	13,440	13,440	13,440	13,440	13,440	13,440	13,440	13,440	13,440	13,440	161,274
Radiotherapy	433,529	433,529	433,529	433,529	433,529	433,529	433,529	433,529	433,529	433,529	433,529	433,529	5,202,344
Screening	448,134	462,040	448,134	468,993	455,087	455,087	468,993	455,087	448,134	462,040	448,134	462,040	5,481,904
Specialised Rehab	258,708	258,708	258,708	258,708	258,708	258,708	258,708	258,708	258,708	258,708	258,708	258,708	3,104,501
Specialised Rehab WIP	0	0	0	0	0	0	0	0	0	0	0	0	0
Therapies	210,699	231,769	210,699	242,304	221,234	221,234	242,304	221,234	210,699	231,769	210,699	231,769	2,686,417
Other - non PbR etc	333,789	338,610	333,789	341,021	336,200	336,200	341,021	336,200	333,789	338,610	333,789	338,610	4,041,628
Activity sub total	**30,663,091**	**32,247,625**	**30,861,772**	**32,937,218**	**31,770,905**	**31,364,371**	**32,834,538**	**31,163,185**	**30,911,014**	**31,999,691**	**29,968,553**	**32,092,353**	**378,814,316**
Readmissions	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(304,058)	(3,648,699)
MRET	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(305,017)	(3,660,205)
System Resilience	199,018	199,018	199,018	199,018	199,018	199,018	199,018	199,018	199,018	199,018	199,018	199,018	2,388,222
CQUIN	353,608	372,895	356,011	381,286	367,078	362,141	380,044	359,708	356,627	369,897	345,189	371,018	4,375,502
Fines	0	0	0	0	0	0	0	0	0	0	0	0	0
Fines Reinvested	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	560,294	525,631	548,758	504,845	534,057	538,829	510,806	550,510	564,731	540,026	581,787	534,646	6,494,920
Maternity Prepayment	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Cost/Volume PODs (Non Passthrough)	**31,166,936**	**32,736,094**	**31,356,484**	**33,413,292**	**32,261,983**	**31,855,284**	**33,315,332**	**31,663,347**	**31,422,315**	**32,499,557**	**30,485,472**	**32,587,960**	**384,764,056**
Passthrough	4,215,176	4,232,293	4,215,176	4,240,852	4,223,735	4,223,735	4,240,852	4,223,735	4,215,176	4,232,293	4,215,176	4,232,293	50,710,490
Board Report Position	**35,382,112**	**36,968,387**	**35,571,660**	**37,654,143**	**36,485,718**	**36,079,019**	**37,556,184**	**35,887,081**	**35,637,491**	**36,731,850**	**34,700,648**	**36,820,253**	**435,474,546**

SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Pay Summary: YTD Month 1

Staff Groups	Pay: In-Month				Pay: Year-To-Date			
	2018/19 Apr £k Actual	2018/19 Apr £k Plan	2018/19 Apr £k Actual	2018/19 Apr £k Variance	2018/19 Apr - Apr £k Actual	2018/19 Apr £k Plan	2018/19 Apr £k Actual	2018/19 Apr £k Variance
Substantive:								
Registered Nursing, Midwifery and Health visiting staff	7,127	7,430	7,614	(184)	7,127	7,430	7,614	(184)
Health Care Scientists and Scientific, Therapeutic and Technical staff	2,614	2,700	2,868	(168)	2,614	2,700	2,868	(168)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	4,808	4,967	5,127	(160)	4,808	4,967	5,127	(160)
Medical and Dental Staff	6,769	7,093	6,435	658	6,769	7,093	6,435	658
Non-Medical - Non-Clinical Staff	2,637	3,011	2,858	153	2,637	3,011	2,858	153
Bank:								
Registered Nursing, Midwifery and Health visiting staff	585	471	508	(37)	585	471	508	(37)
Health Care Scientists and Scientific, Therapeutic and Technical staff	63	44	39	5	63	44	39	5
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	431	371	379	(8)	431	371	379	(8)
Medical and Dental Staff	884	797	1,073	(276)	884	797	1,073	(276)
Non-Medical - Non-Clinical Staff	349	177	226	(49)	349	177	226	(49)
Agency:								
Registered Nursing, Midwifery and Health visiting staff	946	934	877	57	946	934	877	57
Health Care Scientists and Scientific, Therapeutic and Technical staff	167	138	147	(9)	167	138	147	(9)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	1	10	1	9	1	10	1	9
Medical and Dental Staff	2,338	1,708	2,379	(671)	2,338	1,708	2,379	(671)
Non-Medical - Non-Clinical Staff	351	296	216	80	351	296	216	80
Apprentice levy	113	107	119	(12)	113	107	119	(12)
Capitalised staff	(66)	0	0	0	(66)	0	0	0
Total Pay	**30,116**	**30,254**	**30,867**	**(613)**	**30,116**	**30,254**	**30,867**	**(613)**

Pay year to date is £0.6m adverse to plan.

The adverse movement to plan in Pay comprises of £286k lower than planned expenditure against substantive staffing and Apprenticeship Levy and £899k higher than planned expenditure on temporary staffing; the adverse movement in temporary staffing includes an adverse movement to plan of £535k in relation to expenditure on Agency staffing.

The above table shows that:

1) Substantive Pay is £298k lower than plan. Within the Substantive Pay position, Medical & Dental Staff and Non Clinical Staff groups have a combined under spend to plan of £810k which has been mitigated in part by a combined over spend to plan of £512k on the other three staff categories.

2) Bank Pay is £365k higher than planned. The majority of this over spend to plan is within the Medical & Dental Staff and Non Clinical Staff groups (which have a combined over spend to plan of £325k).

3) Agency Pay is £531k higher than planned. The Agency Pay position includes an over spend to plan of £671k on Medical & Dental Staff, which is mitigated in part by an under spend to plan of £57k in relation to Registered Nursing, Midwifery and Health visiting staff and an under spend of £80k in relation to Non-Medical/Non-Clinical staff.

Overall, Medical & Dental accounts for £289k of the £613k adverse movement to plan on Pay.

The Financial Efficiency Programme (FEP) assumes that savings of £k would be delivered in April; actual FEP savings delivery in April is being validated.

SUSTAINABLE SERVICES – PAY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	(£k)														
Staff Groups	**Actual M1 £000s**	**Plan M2 £000s**	**Plan M3 £000s**	**Plan M4 £000s**	**Plan M5 £000s**	**Plan M6 £000s**	**Plan M7 £000s**	**Plan M8 £000s**	**Plan M9 £000s**	**Plan M10 £000s**	**Plan M11 £000s**	**Plan M12 £000s**	**Full Year Plan £000s**	**Forecast £000s**	**Variance £000s**
Substantive:															
Registered Nursing, Midwifery and Health visiting staff	7,614	7,153	7,153	7,190	7,190	7,190	7,190	7,190	7,191	7,191	7,191	7,191	86,450	86,450	0
Health Care Scientists and Scientific, Therapeutic and	2,868	2,597	2,597	2,602	2,602	2,602	2,602	2,603	2,603	2,603	2,604	2,604	31,319	31,319	0
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	5,127	4,784	4,784	4,780	4,780	4,780	4,780	4,780	4,780	4,780	4,781	4,781	57,557	57,557	0
Medical and Dental Staff	6,435	6,835	6,835	6,798	6,793	6,784	6,777	6,760	6,724	6,723	6,723	6,682	81,527	81,527	0
Non-Medical - Non-Clinical Staff	2,858	2,911	2,911	2,911	2,911	2,911	2,911	2,911	2,911	2,911	2,911	2,911	35,032	35,032	0
Bank:															
Registered Nursing, Midwifery and Health visiting staff	508	471	473	471	471	473	471	471	473	471	471	471	5,658	5,658	0
Health Care Scientists and Scientific, Therapeutic and	39	44	45	44	44	47	44	44	45	44	44	47	536	536	0
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	379	371	373	371	371	373	371	371	372	371	371	373	4,459	4,459	0
Medical and Dental Staff	1,073	797	797	691	675	650	629	579	474	472	472	350	7,383	7,383	0
Non-Medical - Non-Clinical Staff	226	177	177	177	177	177	177	177	177	177	177	174	2,121	2,121	0
Agency:															
Registered Nursing, Midwifery and Health visiting staff	877	934	934	876	876	876	876	876	876	876	876	876	10,686	10,686	0
Health Care Scientists and Scientific, Therapeutic and	147	138	138	131	131	131	131	131	131	131	131	131	1,593	1,593	0
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	1	10	10	17	17	17	17	17	17	17	17	17	183	183	0
Medical and Dental Staff	2,379	1,708	1,708	1,445	1,406	1,344	1,290	1,165	907	902	902	597	15,082	15,082	0
Non-Medical - Non-Clinical Staff	216	296	296	146	146	146	71	71	71	71	71	71	1,752	1,752	0
Apprentice levy	119	107	107	107	107	106	107	107	107	107	106	107	1,282	1,282	0
Capitalised staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Items included in Non pay:															
Operating expenses: research and development	(118)	110	110	110	110	110	110	110	110	110	110	110	1,320	1,320	0
Operating expenses: education and training	(158)	114	114	114	114	114	114	114	114	114	114	114	1,368	1,368	0
Operating expenses: redundancy	0	5	5	5	5	5	5	5	5	5	5	5	60	60	0
Operating expenses: Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Cost £	**30,867**	**29,333**	**29,338**	**28,757**	**28,697**	**28,607**	**28,444**	**28,253**	**27,859**	**27,847**	**27,848**	**27,383**	**342,620**	**342,620**	**0**

SUSTAINABLE SERVICES – NON PAY SUMMARY & RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Non Pay Summary: YTD Month 1

Non Pay	Non Pay: In-Month				Non Pay: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20		
	Apr £k Actual	Apr £k Plan	Apr £k Actual	Apr £k Variance	Apr £k Actual	Apr £k Plan	Apr £k Actual	Apr £k Variance
Ambulance Services	55	170	125	45	55	170	125	45
Clinical Supplies & Services	4,667	5,180	4,756	424	4,667	5,180	4,756	424
Drugs	442	448	161	287	442	448	161	287
Pass through	3,827	4,215	4,215	(0)	3,827	4,215	4,215	(0)
Establishment Expenditure	420	528	505	23	420	528	505	23
General Supplies & Services	603	822	1,047	(225)	603	822	1,047	(225)
Other	700	325	286	39	700	325	286	39
Premises & Fixed Plant	1,568	1,633	1,549	84	1,568	1,633	1,549	84
Clinical Negligence	1,774	1,741	1,741	0	1,774	1,741	1,741	0
Capital charges	981	1,100	1,085	15	981	1,100	1,085	15
Total Non Pay	**15,037**	**16,162**	**15,470**	**692**	**15,037**	**16,162**	**15,470**	**692**

Non Pay Run Rate 2019/20

	Actual m1 & Plan m2 to m12 £k														
Non Pay	Actual M1	Plan M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Forecast	Plan	Variance
Ambulance Services	125	170	169	170	170	169	170	170	169	170	170	213	2,035	2,035	0
Clinical Supplies & Services	4,756	5,182	5,181	5,182	5,181	5,182	5,182	5,181	5,182	5,181	5,180	5,607	62,177	62,177	0
Drugs	161	434	449	426	441	440	426	440	449	434	447	722	5,269	5,269	0
Drugs Pass through	4,215	4,232	4,215	4,241	4,224	4,224	4,241	4,224	4,215	4,232	4,215	4,232	50,710	50,710	0
Establishment Expenditure	505	528	528	528	528	528	528	528	528	527	527	550	6,333	6,333	0
General Supplies & Services	1,047	822	822	489	489	489	489	489	489	589	589	365	7,168	7,168	0
Other	286	325	327	326	325	328	326	325	328	328	328	367	3,919	3,919	0
Premises & Fixed Plant	1,549	1,634	1,633	1,634	1,634	1,633	1,634	1,633	1,633	1,634	1,633	1,718	19,602	19,602	0
Clinical Negligence	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,740	1,740	1,740	20,889	20,889	0
Capital charges	1,085	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,115	13,200	13,200	0
Total Non Pay	**15,470**	**16,168**	**16,165**	**15,837**	**15,833**	**15,834**	**15,837**	**15,831**	**15,834**	**15,935**	**15,929**	**16,629**	**191,302**	**191,302**	**0**

Non Pay expenditure was £15,470k in April or £692k favourable to planned expenditure of £16,162k.

The under spend to plan can be attibuted to lower than planned expenditure in relation to clinical non-pay; the under spend to plan being mainly in relation to Ambulance Services, Clinical Supplies and Services and Drugs.

However, whilst the overall financial position in April assumes that NHS Patient Care income from the main contract to plan, lower than planned expenditure on non pay may indicate lower than planned activity levels or higher than planned Non Pay savings have been delivered. It is noted, though, that the under spend to plan in Non Pay is offset by an equivalent over spend in Pay in April. Actual savings delivery in April is being validated.

The reason for lower than planned Non Pay expenditure is being investigated.

The Financial Efficiency Programme (FEP) for 2019/20 assumed savings of £3.928m in relation to Non Pay schemes. The plan assumed delivery of £283k of FEP savings from Non Pay related savings schemes in April. Actual savings delivery in April is being validated.

SUSTAINABLE SERVICES – FINANCIAL EFFICIENCY PROGRAMME SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

M01

	In Month			YTD			
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	RAG
FEP	1,042	1,042	0	1,042	1,042	0	G

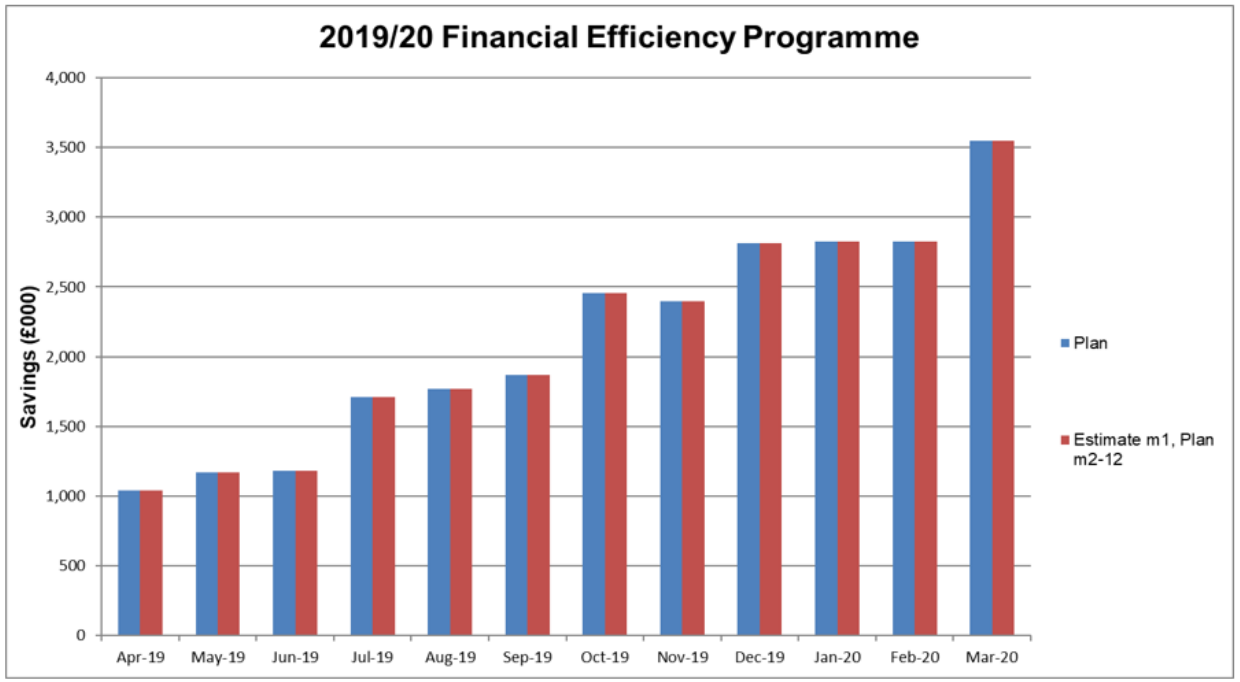
Finance Position

YTD ACTUAL	£k	FORECAST	£k
Recurrent	1,042	Recurrent	25,360
Non Recurrent	0	Non Recurrent	250
TOTAL	**1,042**	**TOTAL**	**25,610**

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

In addition to the profit on disposal of the original front entrance of Grantham Hospital, the Financial Efficiency Programme (FEP) includes savings of £7.682m in relation to income related schemes, £3.678m in relation to Non Pay schemes, and £14.0m in relation to workforce savings.

The table assumes that FEP Savings delivery is in line with plan and that savings of £1.042m have been delivered in April; savings delivery in April is being validated.



SUSTAINABLE SERVICES – STATEMENT OF COMPREHENSIVE INCOME

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

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

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Year end		Year to date			Monthly	Forecast Outurn		
	31 March 2019		30 April 2019			30-Apr-19	31 March 2020		
	Actual £'000	Plan £'000	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Actual £'000	Plan £'000	Variance £'000
Non-current assets									
Intangible assets	6,341	5,488	6,195	5,275	920	6,195	5,575	4,637	938
Property, plant and equipment: on-SoFP IFRIC 12 assets	27,654	22,495	27,619	27,326	293	27,619	27,248	26,954	294
Property, plant and equipment: other	181,095	213,599	181,031	205,306	(24,275)	181,031	201,216	224,849	(23,633)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,560	1,828	1,529	1,600	(71)	1,529	1,600	1,600	0
Total non-current assets	**216,650**	**243,410**	**216,374**	**239,507**	**(23,133)**	**216,374**	**235,639**	**258,040**	**(22,401)**
Current assets									
Inventories	7,440	6,799	7,593	7,350	243	7,593	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	15,203	17,664	15,563	18,653	(3,090)	15,563	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	6,833	4,848	11,304	7,993	3,311	11,304	7,912	7,912	0
Assets held for sale and assets in disposal groups	660	0	660	660	0	660	510	510	0
Cash and cash equivalents: GBS/NLF	7,376	6,143	3,251	990	2,261	3,251	4,214	4,214	0
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	0
Total current assets	**37,522**	**35,464**	**38,381**	**35,656**	**2,725**	**38,381**	**46,841**	**46,841**	**0**
Current liabilities									
Trade and other payables: capital	(10,791)	(4,723)	(8,748)	(6,361)	(2,387)	(8,748)	(2,198)	(4,466)	2,268
Trade and other payables: non-capital	(40,622)	(38,039)	(46,381)	(46,919)	538	(46,381)	(40,749)	(41,096)	347
Borrowings	(114,339)	(77,359)	(118,596)	(10,847)	(107,749)	(118,596)	(197,439)	(197,289)	(150)
Provisions	(608)	(735)	(608)	(565)	(43)	(608)	(565)	(565)	0
Other liabilities: deferred income	(2,869)	(2,707)	(1,106)	(1,200)	94	(1,106)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	0
Total current liabilities	**(169,732)**	**(124,066)**	**(175,942)**	**(66,395)**	**(109,547)**	**(175,942)**	**(242,654)**	**(245,119)**	**2,465**
Net Current liabilities	**(132,210)**	**(88,602)**	**(137,561)**	**(30,739)**	**(106,822)**	**(137,561)**	**(195,813)**	**(198,278)**	**2,465**
Total assets less current liabilities	**84,440**	**154,808**	**78,813**	**208,768**	**(129,955)**	**78,813**	**39,826**	**59,762**	**(19,936)**
Non-current liabilities									
Borrowings	(188,196)	(228,888)	(189,662)	(297,401)	107,739	(189,662)	(181,235)	(178,440)	(2,795)
Provisions	(2,863)	(2,911)	(2,865)	(2,982)	117	(2,865)	(2,825)	(2,782)	(43)
Other liabilities: other	(13,081)	(13,081)	(13,040)	(13,039)	(1)	(13,040)	(12,578)	(12,578)	0
Total non-current liabilities	**(204,140)**	**(244,880)**	**(205,567)**	**(313,422)**	**107,855**	**(205,567)**	**(196,638)**	**(193,800)**	**(2,838)**
Total net assets employed	**(119,700)**	**(90,072)**	**(126,754)**	**(104,654)**	**(22,100)**	**(126,754)**	**(156,812)**	**(134,038)**	**(22,774)**
Financed by									
Public dividend capital	260,042	257,563	260,041	260,042	(1)	260,041	264,342	265,318	(976)
Revaluation reserve	32,159	34,455	32,089	35,611	(3,522)	32,089	31,439	34,951	(3,512)
Other reserves	190	190	190	190	0	190	190	190	0
Income and expenditure reserve	(412,091)	(382,280)	(419,074)	(400,497)	(18,577)	(419,074)	(452,783)	(434,497)	(18,286)
Total taxpayers' and others' equity	**(119,700)**	**(90,072)**	**(126,754)**	**(104,654)**	**(22,100)**	**(126,754)**	**(156,812)**	**(134,038)**	**(22,774)**

BORROWINGS									
Current									
Borrowings: DHSC capital loans	1,889	2,429	1,828	2,562	(734)	1,828	(2,753)	2,636	(5,389)
Borrowings: DHSC working capital / revenue support loans	112,450	74,930	114,694	6,220	108,474	114,694	(194,223)	191,521	(385,744)
Accrued interest on DHSC loans		0	2,074	2,065	9	2,074		2,670	
Total current borrowings	**114,339**	**77,359**	**118,596**	**10,847**	**107,749**	**118,596**	**(196,976)**	**197,289**	**(391,595)**
Non-current									
Borrowings: DHSC capital loans	24,283	33,343	24,344	23,610	734	(24,344)	(34,329)	32,746	(67,075)
Borrowings: DHSC working capital / revenue support loans	163,913	195,545	165,318	273,791	(108,473)	(165,318)	(143,900)	142,687	(286,587)
Total non-current borrowings	**188,196**	**228,888**	**189,662**	**297,401**	**(107,739)**	**(189,662)**	**(178,229)**	**178,440**	**(356,669)**

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

The cash balance at 30 April 2019 was £3.3m. This includes revenue and capital cash loans drawn in April 2019 - April 2019 of £5.6m / £0m respectively.
The Trust has reduced the level of capital creditors from £10.8m to £8.7m. The capital creditors have only reduced this figure by £2.1m over the year.
The impact on the ability to pay suppliers has been limited as a result of the delays in the capital programme and the payment of the capital creditors.
Total revenue and capital borrowings (excluding accrued interest) at 30 April were £306.9m. As a consequence of this borrowing costs are anticipated to be £9.1m in I&E terms , and in cash terms £8.5m.

Year to date	Plan £k	Actual £k	Variance £k
Cash balance	(4,612)	3,260	7,872

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

Year to date	Plan £k	Actual £k	Variance £k
Operating Surplus	(5,546)	(6,412)	(866)
Depreciation	1,100	1,085	(15)
Other Non Cash I&E Items	(18)	0	18
Movement in Working Capital	20	(996)	(1,016)
Provisions	119	2	(117)
Cashflow from Operations	**(4,325)**	**(6,321)**	(1,996)
Interest received	3	16	13
Capital Expenditure	(5,894)	(2,883)	3,011
Cash receipt from asset sales	0	0	0
Cash from / (used in) investing act	**(5,891)**	**(2,867)**	**3,024**
PDC Received	0	(1)	(1)
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(549)	(548)	1
Capital element of leases	0	0	0
Drawdown on debt - Revenue	0	5,612	5,612
Drawdown on debt - Capital	0	0	0
Repayment of debt	0	0	0
Cashflow from financing	**(549)**	**5,063**	**5,612**
Net Cash Inflow / (Outflow)	**(10,765)**	**(4,125)**	**6,640**
Opening cash balance	6,153	7,385	1,232
Closing Cash balance	**(4,612)**	**3,260**	**7,872**

Year End Plan	Plan £k	Actual £k	Variance £k
Operating Surplus	(32,306)	(32,306)	0
Depreciation	13,200	13,200	0
Other Non Cash I&E Items	(214)	(214)	0
Movement in Working Capital	(13,680)	(14,716)	(1,036)
Provisions	(81)	(81)	0
Cashflow from Operations	**(33,081)**	**(34,117)**	(1,036)
Interest received	36	36	0
Capital Expenditure	(38,312)	(40,528)	(2,216)
Cash receipt from asset sales	150	150	0
Cash from / (used in) investing act	**(38,126)**	**(40,342)**	**(2,216)**
PDC Received	5,276	4,300	(976)
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(8,486)	(8,402)	84
Capital element of leases	0	0	0
Drawdown on debt - Revenue	59,809	61,021	1,212
Drawdown on debt - Capital	15,400	17,100	1,700
Repayment of debt	(2,721)	(2,721)	0
Cashflow from financing	**69,278**	**71,298**	**2,020**
Net Cash Inflow / (Outflow)	**(1,929)**	**(3,161)**	**(1,232)**
Opening cash balance	6,153	7,385	1,232
Closing Cash balance	**4,224**	**4,224**	**0**

The cash balance of £3.3m at 30 April reflects a number of factors:
- the reduction in capital creditors from the year end high of £10.8m to £8.7m;
- delays in the capital programme.

These in turn have impacted upon the level of capital cash expenditure (plan £5.9m : actual £2.9m).
The Trust has submitted and had approved a requests to NHSI / DHSC to carry forward £9.6m into 2019/20, in relation to the Fire Safety, no capital loans in respect of this were received in April 2019.
Revenue loans of £5.6m have been drawn in the April 2019. This is against the backdrop of an I&E deficit in April of £6.8m.

The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £1.8m in March 2020

The cash forecast assumes capital borrowing of £11.7m and revenue borrowing in 2019/20 at £59.8m.

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Current Status

Trust Board were presented with the proposed capital programme on 7th May following the FPEC telephone call on 30th April to finalise the 19/20 capital programme ahead of Trust Board. Trust Board have signed off the plan submitted in principle. There is work to be completed around the revised phasing profiles and this is currently being compiled by the leads for each area. Once complete, this will be shared with the relevant forums.

Year to date	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	816	839	-23

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	31,155	31,155	0

Year to date	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	66	66	0
Estates - Fire	700	669	31
ICT	0	89	-89
Estates - Backlog	50	12	38
Service developments	0	3	-3
Total	816	839	-23

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	1,873	1,873	0
Estates - Fire	13,700	13,700	0
ICT	2,335	2,335	0
Estates - Backlog	4,089	4,089	0
Service developments	9,158	9,158	0
Total	31,155	31,155	0

Funding available 2019/20

The Trust has capital resources of c£31m 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£8.6m - 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.

Facilities; Minimal spend in M1 of £12k. Nurse Call (£8k) plus starting costs of £2k and £3k for Water Access/Water Tanks and Mental Health respectively.

Fire; Expenditure incurred at the end of April amounted to £669k. Fire Works package 1 at LCH is £212k, package 2 is £140k. Package 1 at Pilgrim amounts to £201k.

Medical Devices; Radiology Ultrasound machine purchase of £66k.

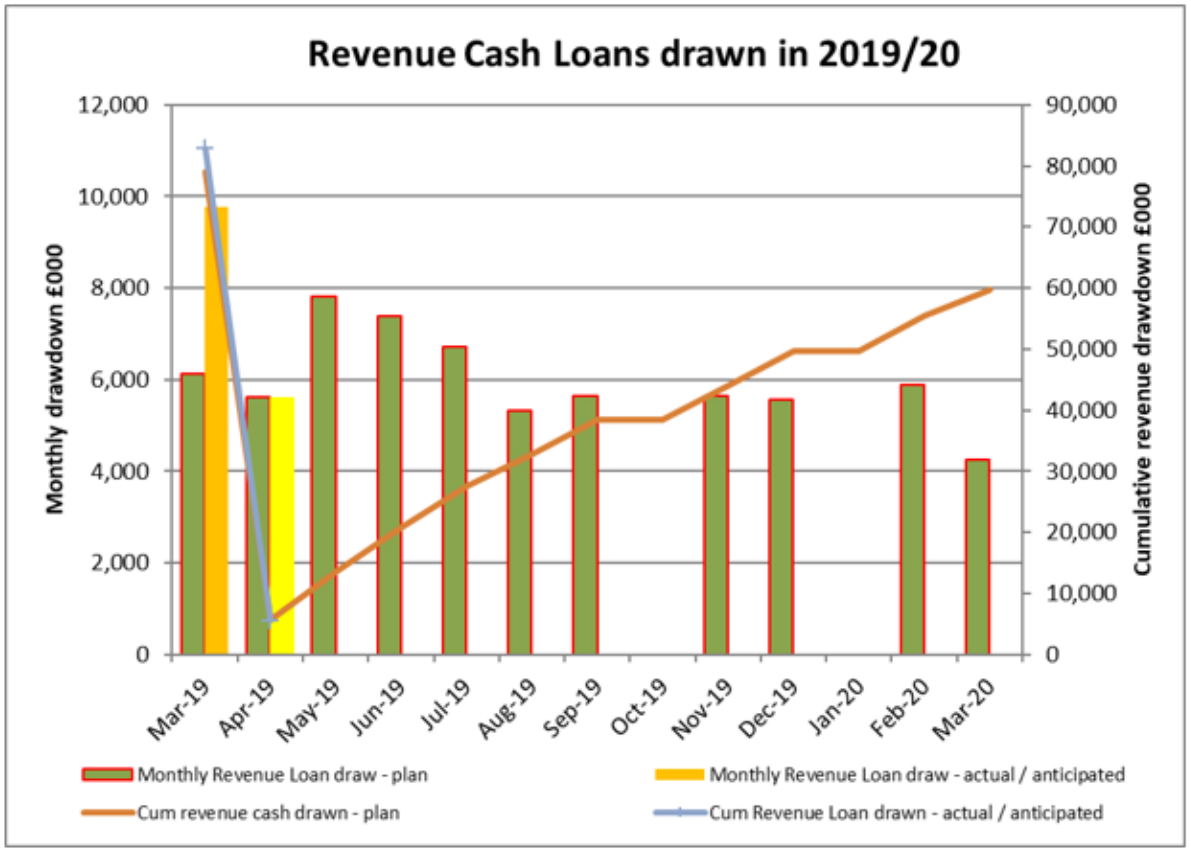
IT; Wifi spend linked to HSLI deferred monies has been incurred in M1 amounting to £79k

SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Revenue Borrowing

The Trust has drawn cash loans of £5.6m during the month to April 2019.

The forecast deficit for 2019-20 is £41.4m as submitted in the plan.

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

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

Capital Borrowing

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

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

The revised capital loan drawdown in 2018/19 is £17.0m as a result of this. In April there were no further capital drawdowns and the capital creditors reduced to £8.7m.

The year end capital creditor is £10.8m.

Process and approval of new borrowing:

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

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

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

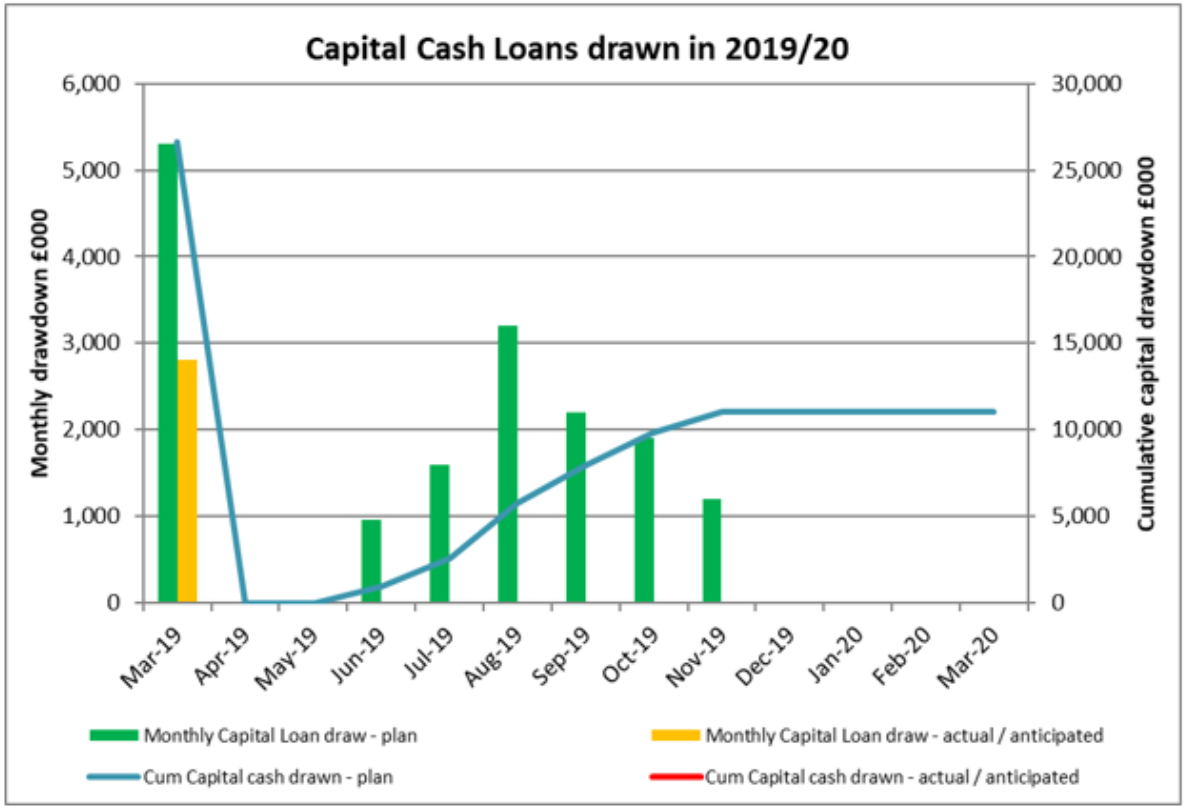
- a daily cashflow covering the next 3 months

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

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

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

The Board has previously approved borrowing for:



	April 2019	May 2019	June 2019
Revenue	£5.612m	£5.612m	£7.376m
Capital	£0m	£0.661m	£0.0m

The board is requested to approve borrowing in July 2019 in line with the draft 2019/20 financial plan.

Revenue £6.717m

Capital £1.600m

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

<u>Borrowings and Interest</u>

At 31 March 2019 total 'repayable' borrowings (excluding accrued interest) were £306.1m, capital (£26.2m) and revenue (£280.0m).

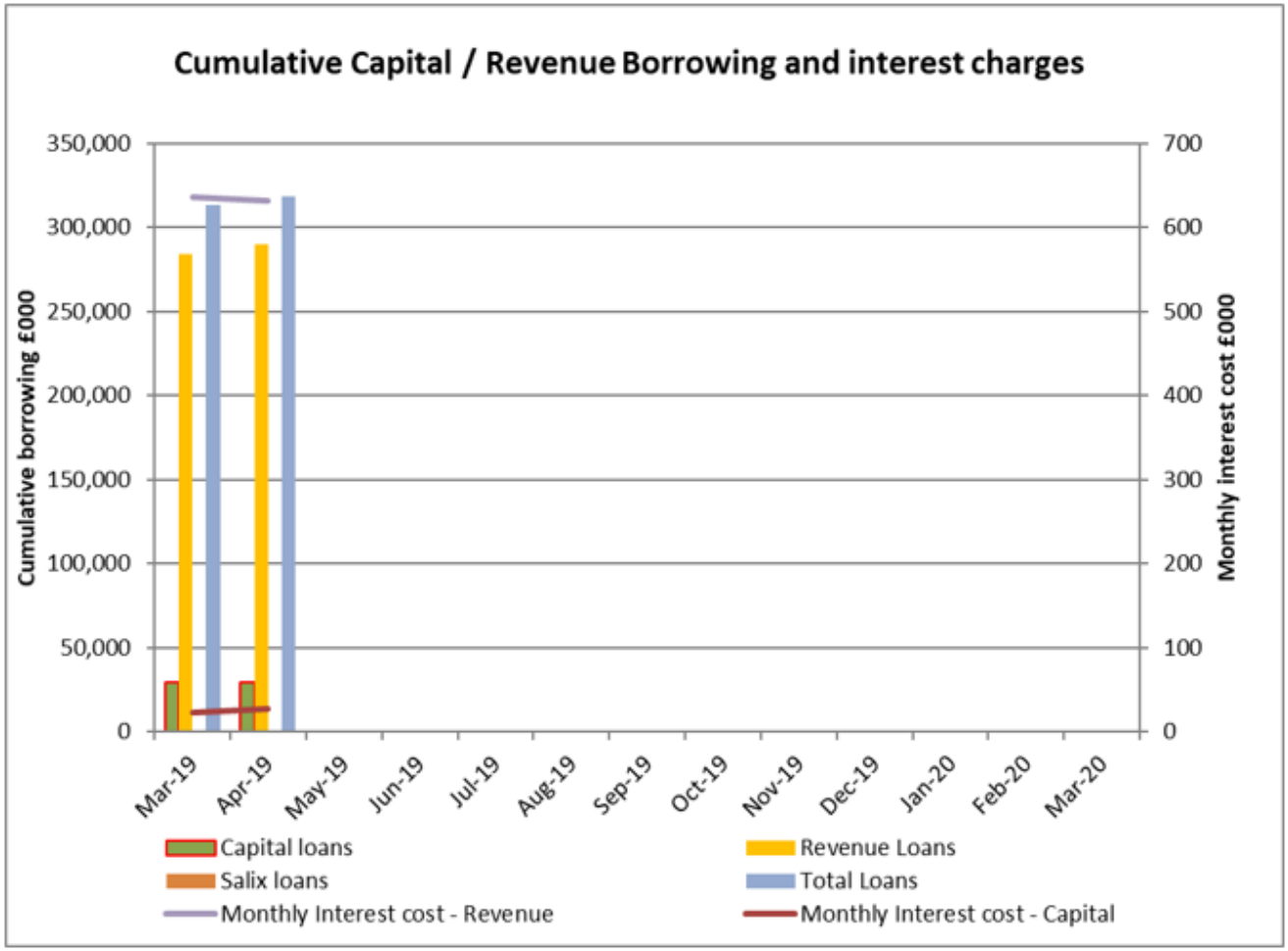
Existing loans are held at a variety of interest rates, Capital 1.1% (£9.2m) & 1.37% (£17.0m), Revenue 1.5% (£155.3m), 3.5% (£81.3m) & 6.0% (£43.4m).

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

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

Associated interest costs for 2019/20 are £6.3m (Revenue £0.63m / Capital £0.03m).

Changes in accounting standards in 2018/19 mean that any accrued interest Apr 19 - £2.0m) is now reported as part of overall borrowings on the Statement of Financial Position.



Repayments

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

Type	Loan £m	Final repayment		Repayment Terms
Capital	9.5	Nov-32		Repayments commencing Nov 2018 thereafter every 6 months. Annual repayment £0.7m. (Current balance £9.2m)
Capital	16.7	Nov-33		Repayments commencing Aug 2019 thereafter every 6 months. Annual repayment £0.4m.

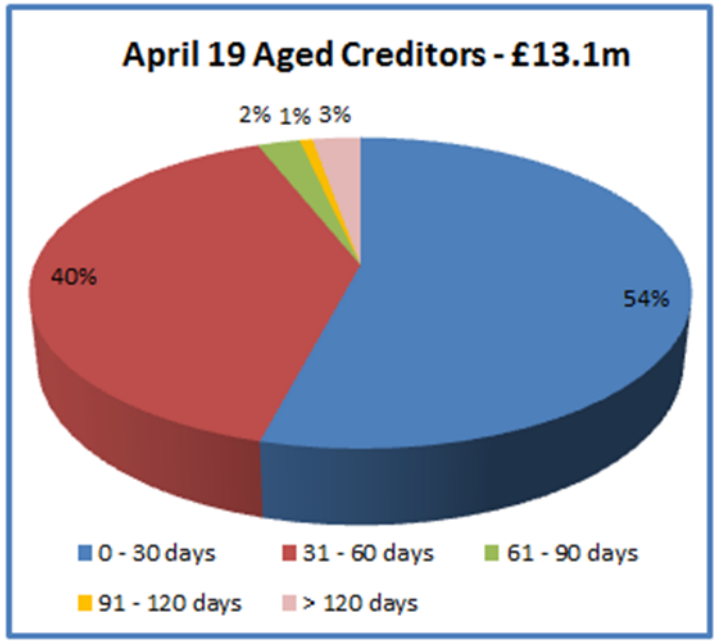
Type	Loan £m	Repayment		Loan £m	Repayment	Repayment Terms
Revenue	35.6	tbc		6.0	Dec-20	The terms of each loan state that there is to be a single one off repayment in full. It is anticipated however that some form of re-financing will take place. The means by which this might be transacted is uncertain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

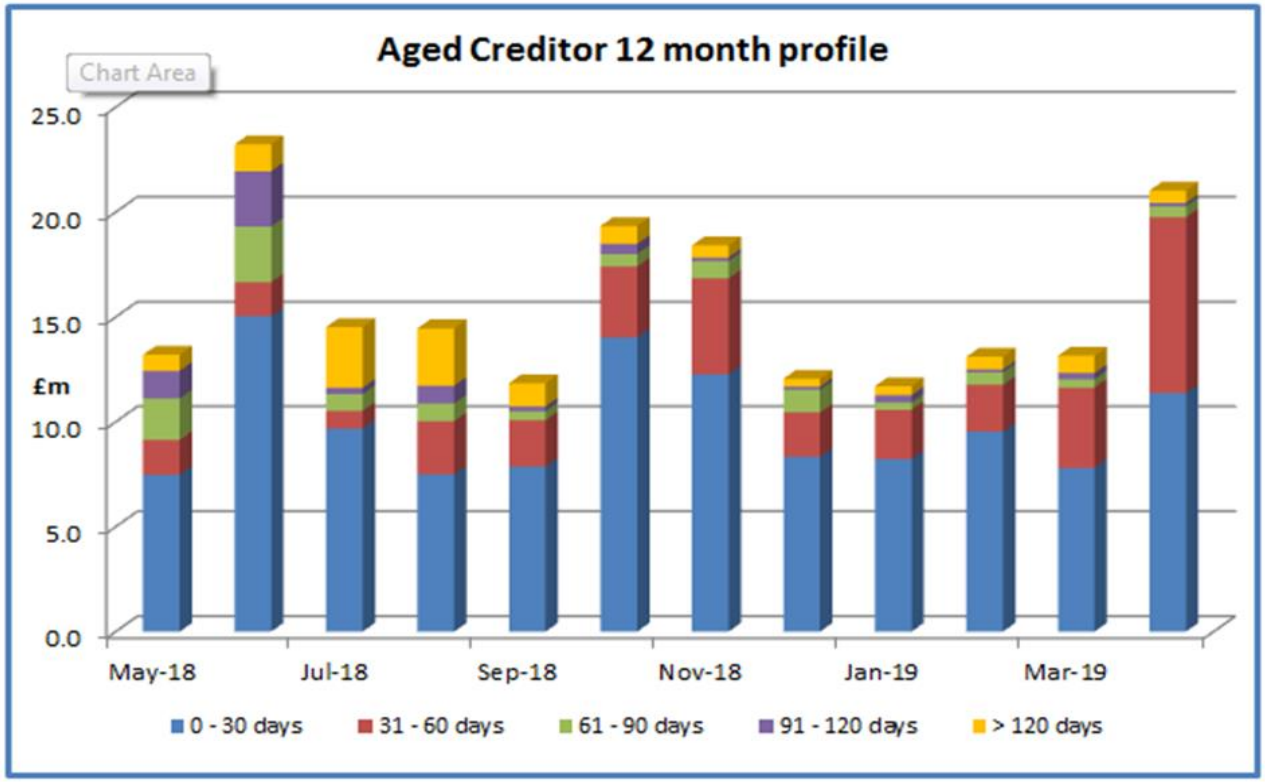
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors

Total Creditors were £21.0m at 30 April 2019, of which £9.6m were over 30 days (£0.7m > 90 days).
Focusing further upon those invoices over 30 days £5.4m (75%) relates to just ten suppliers.
The reasons for delays in payment to suppliers has been investigated and in each case the Trust is taking action where appropriate / working with the supplier and internal departments to resolve issues.

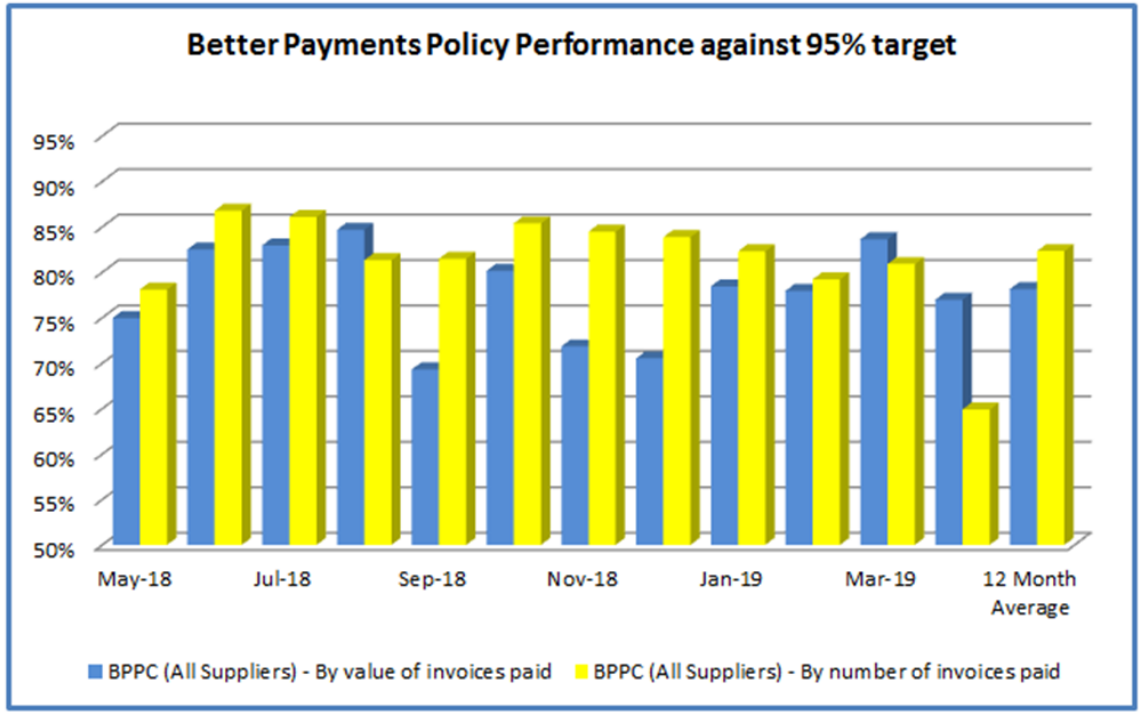
The Finance and Procurement Teams continue to enforce the policy of requiring suppliers to provide a purchase order before payment is made. At 30 April there were 186 separate invoices (£0.2m) spread across 105 suppliers where payment is delayed awaiting a purchase order.

SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



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

Rolling 12 months to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	2366	41,344	128,879	202,026
Total bills paid within target	1525	34,112	105,345	154,618
% of bills paid within target YTD	**64.45%**	**82.51%**	**81.74%**	**76.53%**
% of bills paid within February 2019	**73.13%**	**80.01%**	**64.65%**	**76.51%**

SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Paul Matthew

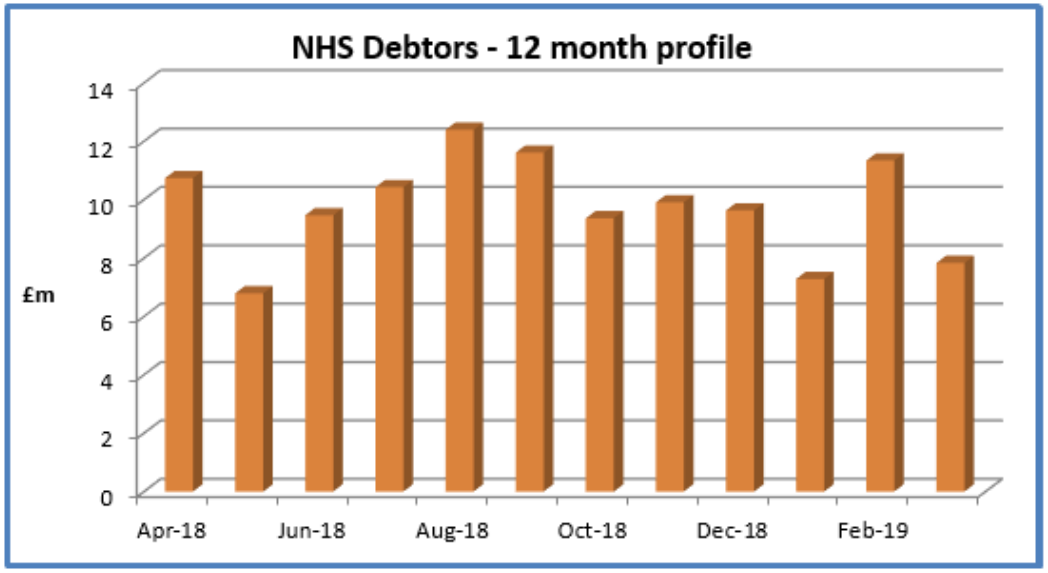
CQC Domain: Well-Led

2021 Objective: Our Services

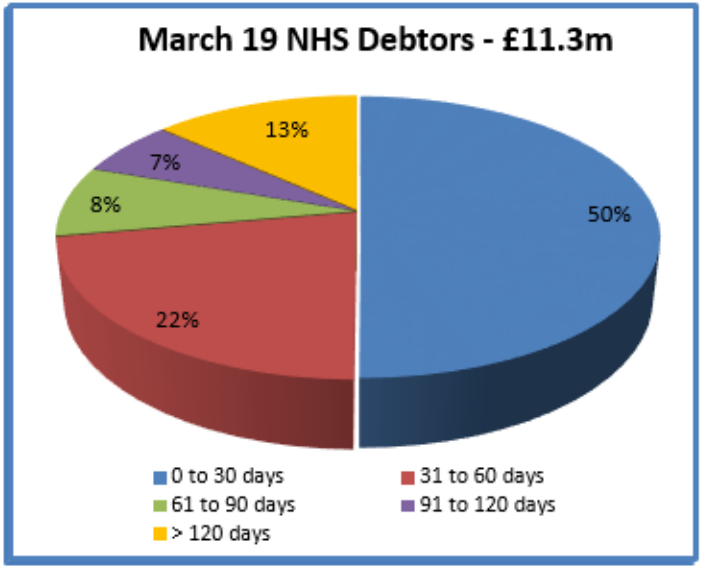
The level of NHS debt over the last 12 months is shown in the table to the right, while the table bottom right focuses upon the aged split at 30 April 2019.

The level of aged debt >90 days has reduced significantly from £4.7m in October to £1.5m at 30 April. This is as a result of the Lincolnshire CCGs clearing the majority of prior year reconcililation invoices. The largest element currently over 90 days relates to NHS Trusts where queries are unresolved with Nottingham and Leicester.

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



Totals shown in £000	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	714	1,245	220	74	407	2,660	481
CCGs - Other	164	99	42	34	92	431	126
Trusts - Lincolnshire	492	75	153	16	56	792	72
Trusts - Other	614	177	184	290	419	1,684	709
Other NHS	1,940	135	33	87	70	2,265	157
Total	**3,924**	**1,731**	**632**	**501**	**1,044**	**7,832**	**1,545**

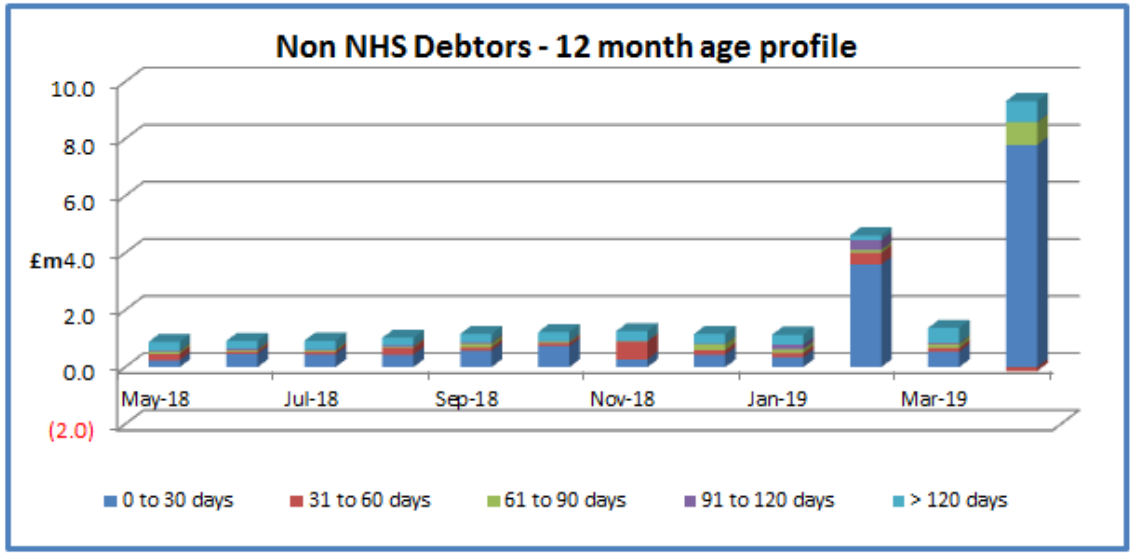


SUSTAINABLE SERVICES – NON- NHS RECEIVABLES

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



The level of Non-NHS debt over the last 12 months is shown in the table to the right, while the table bottom right focuses upon the aged split at 30 April 2019.

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

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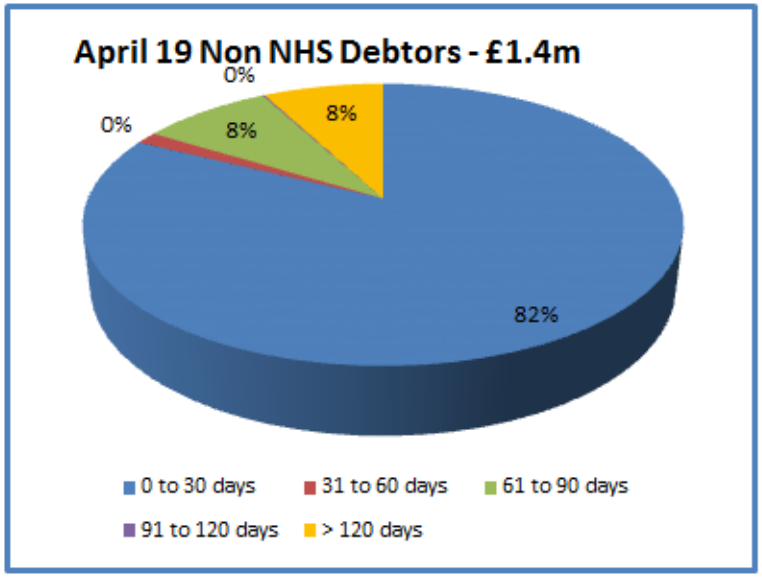
	Totals outstanding debt £						
Description	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
Overseas Visitors	18,413	21,061	22,932	(2,372)	219,257	279,291	216,885
Debt Collection - Overseas	0	0	0	0	39,944	39,944	39,944
NHS Non English	352	5,806	8,839	(70)	6,416	21,343	6,346
Misc	317,038	319,701	117,824	53,418	137,975	945,956	191,393
Salary Overpayments	54	6,373	38,221	0	48,597	93,245	48,597
Private Patients	0	0	0	0	13,166	13,166	13,166
Debt Collection - General	0	0	908	0	25,454	26,362	25,454
Agreed Installment Plans	0	1,554	866	0	13,342	15,762	13,342
Grand Total	335,857	354,495	189,590	50,976	504,151	1,435,069	555,127



The balance over 90 days (£0.5m) comprises relatively high volume (166) low value invoices.

Of this total £0.1m is being actively managed by the Trust Debt collection agency.

SUSTAINABLE SERVICES – FINANCIAL DASHBOARD

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Trust Dashboard Financial Performance

In Month Plan	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	40,328	41,786	40,391	42,813	41,645	41,238	43,394	41,726	41,473	42,991	40,962	42,869
Operating Expenditure	-46,416	-45,501	-45,503	-44,594	-44,530	-44,441	-44,281	-44,084	-43,693	-43,782	-43,777	-43,320
Efficiency	1,042	1,171	1,180	1,711	1,770	1,869	2,453	2,398	2,816	2,827	2,827	3,546
Agency	-3,086	-3,086	-3,086	-2,615	-2,576	-2,514	-2,385	-2,260	-2,002	-1,997	-1,997	-1,692
Capital	816	1,317	1,173	2,375	2,682	2,727	3,717	3,727	2,991	3,707	2,908	3,015
Operating Surplus/Deficit	-6,088	-3,715	-5,112	-1,781	-2,885	-3,203	-887	-2,358	-2,220	-791	-2,815	-451

Cumulative Plan	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	40,328	82,114	122,505	165,318	206,963	248,201	291,595	333,321	374,794	417,785	458,747	501,616
Operating Expenditure	-46,416	-91,917	-137,420	-182,014	-226,544	-270,985	-315,266	-359,350	-403,043	-446,825	-490,602	-533,922
Efficiency	1,042	2,213	3,393	5,104	6,874	8,743	11,196	13,594	16,410	19,237	22,064	25,610
Agency	-3,086	-6,172	-9,258	-11,873	-14,449	-16,963	-19,348	-21,608	-23,610	-25,607	-27,604	-29,296
Capital	816	2,133	3,306	5,681	8,363	11,090	14,807	18,534	21,525	25,232	28,140	31,155
Operating Surplus/Deficit	-6,088	-9,803	-14,915	-16,696	-19,581	-22,784	-23,671	-26,029	-28,249	-29,040	-31,855	-32,306

In Month Actual	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	40,221											
Operating Expenditure	-46,333											
Efficiency	1,042											
Agency	-3,621											
Capital	839											
Operating Surplus/Deficit	-6,112											

Cumulative Actual	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	40,221											
Operating Expenditure	-46,333											
Efficiency	1,042											
Agency	-3,621											
Capital	839											
Operating Surplus/Deficit	-6,112											

In Month Variance (-) ad	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	-107											
Operating Expenditure	83											
Efficiency	0											
Agency	-535											
Capital	-23											
Operating Surplus/Deficit	-24											

Cumulative Variance	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	-107											
Operating Expenditure	83											
Efficiency	0											
Agency	-535											
Capital	-23											
Operating Surplus/Deficit	-24											

In Month Variance (-) ad	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	-0.27%											
Operating Expenditure	0.18%											
Efficiency	0.00%											
Agency	-17.34%											
Capital	-2.82%											
Operating Surplus/Deficit	-0.39%											

Cumulative Variance	April	May	June	July	August	ptember	October	ovember	ecember	January	February	March
Operating Income	-0.27%											
Operating Expenditure	0.18%											
Efficiency	0.00%											
Agency	-17.34%											
Capital	-2.82%											
Operating Surplus/Deficit	-0.39%											

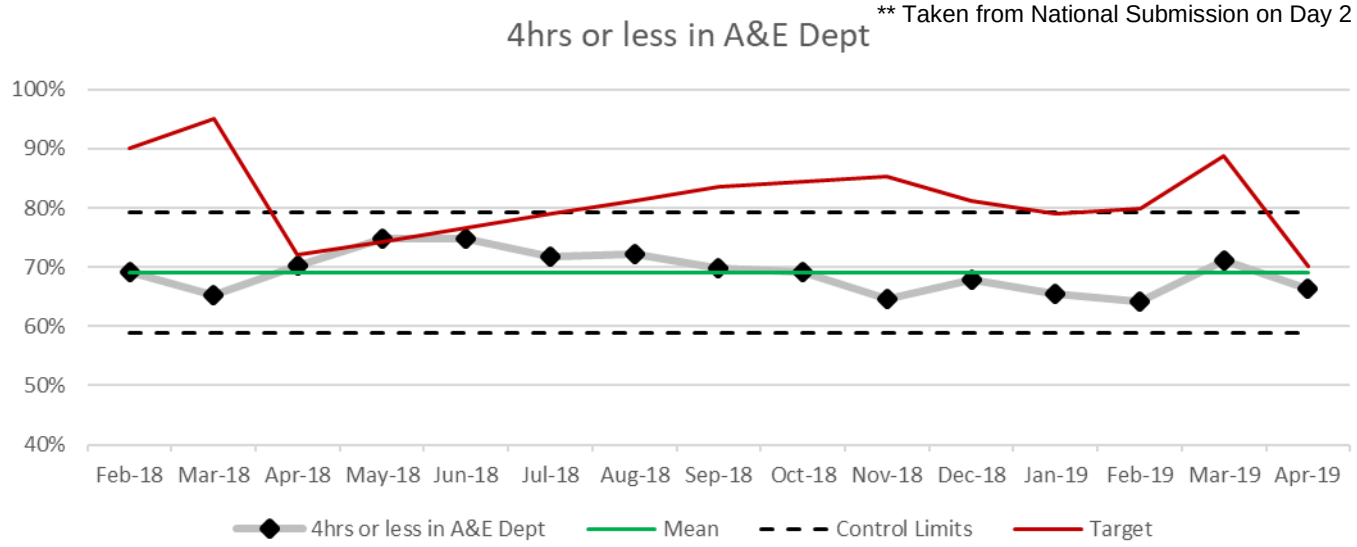
ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services

** Taken from National Submission on Day 2



Challenges/Successes

This data has been taken from the national submission on day 2.

Primary Care Streaming continues to improve on both sites with Lincoln demonstrating significant improvement. PHB recorded 22.73% for April compared to 30.4% for March demonstrating a 7.67% reduction. LCH recorded 16.55% for April compared 14.9% for March demonstrating a 1.65% increase.

A&E and non-elective admissions demand exceeded capacity.

Staffing levels within nursing and medical teams in both inpatient and ED continue to be of concern. Fragility of staffing will continue during Q1 and Q2 in 2019/20 whilst the recruitment plans are delivered.

At the end of March, the number of Super Stranded Patients in the Trust was 101 against a trajectory of 94. There has been a significant improvement at Pilgrim and Lincoln. DToC remains within normal variation at 4.26%.

This has culminated in length of stay and bed occupancy being above assumed levels affecting flow. Current occupancy is 92.78% but both Pilgrim and Lincoln remain above 94%

Actions in place to recover:

Full actions are embedded and monitored in the urgent care improvement plan. Key actions include;

Recruitment plan for Emergency Care Middle Grade and Consultants on track to deliver as planned.

Frailty pathway is being reviewed across all sites and new ways of working introduced as well a system review of frailty service provision.

Support is being provided by the Emergency Care Intensive Support Team at both Lincoln and Pilgrim to support with reduction in long LoS, SAFER and Red 2 Green. A stocktake meeting is planned for 17th May 2019.

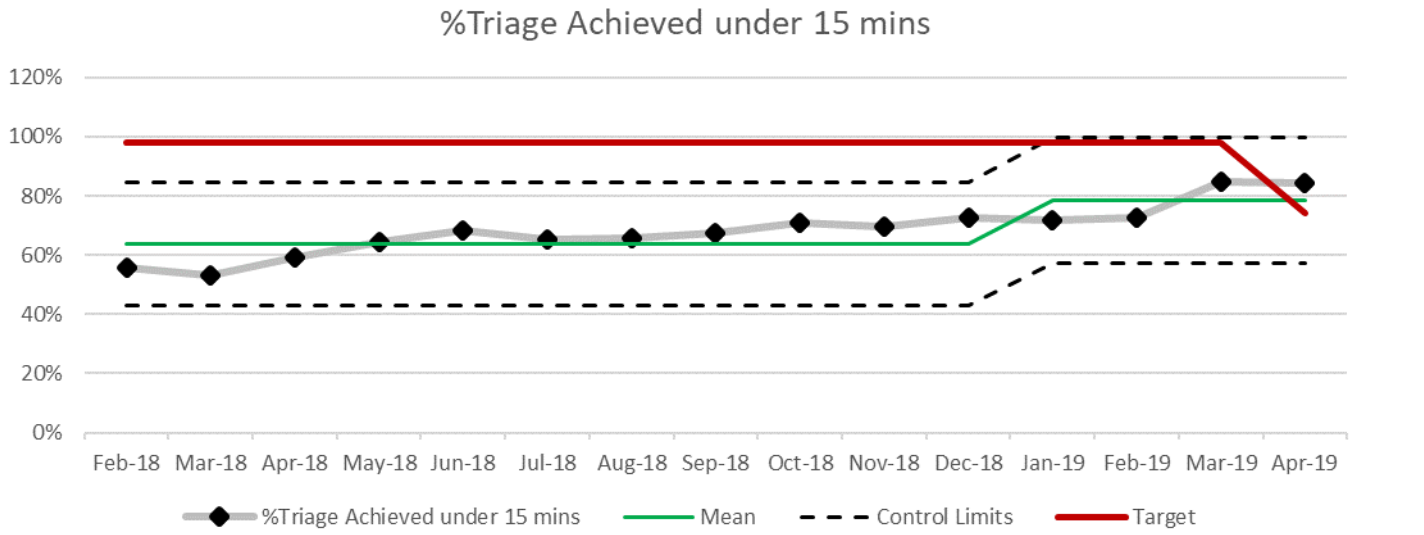
New approach to managing medically fit patients started in April led by LCHS with an internal project looking at improving the discharge pathway and associated pathway. Progress to date is being evaluated. A paper is being produced for Urgent and Emergency Care Delivery Board.

ZERO WAITING – TRIAGE UNDER 15 MINUTES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Performance and compliance against the standard has demonstrated a slight reduction in compliance in April at 80.46% against 84.54% for March. Lincoln has seen the most improvement at 93.33%

All Registered Nurses in Pilgrim ED have received triage training and have been signed off as competent.

Sustained improvement with Documentation

Actions in place to recover

All new appointees receive triage training.

Triage times are monitored every hour.

Weekly reports are generated to monitor compliance overall.

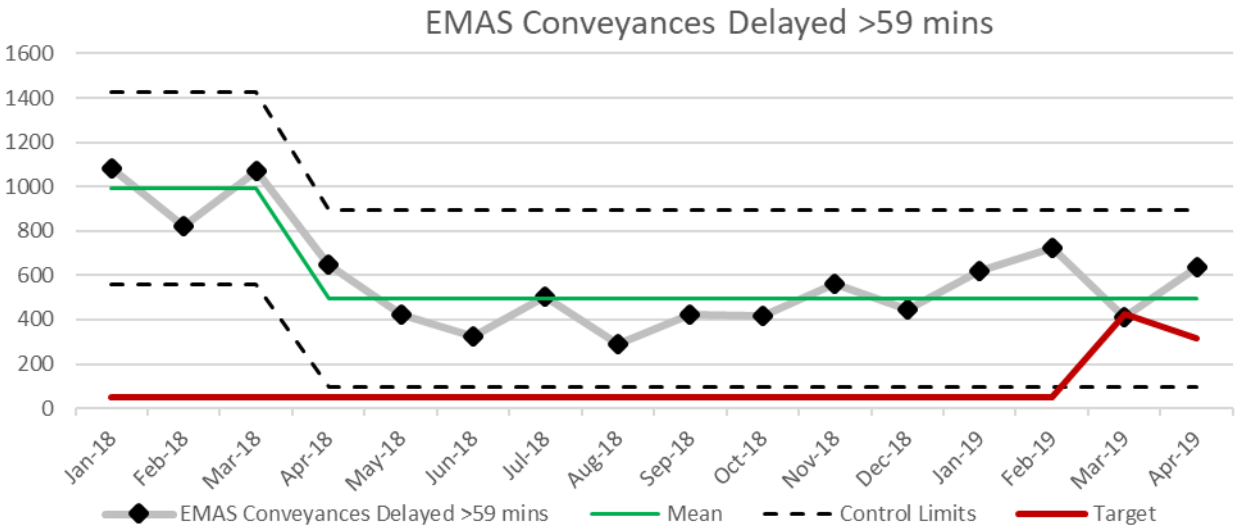
New key metrics dashboard reports monthly performance.

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

System wide pressure continued throughout April. An increasing trend against EMAS demand/conveyances continue to be apparent at LCH. This can demonstrated when comparing actual conveyance (4945) against 19/20 plan (4530).

Handover delays exceeding 59 mins increased in April to 635 (12.8% of total conveyances) compared to 410 in March (8.2% of total conveyance.

Handover delay < 59 minutes are improving.

Actions in place to recover

New pathways at PHB rolled out to enable direct GP admissions bypassing ED and is working well. A follow up review has been completed

Further pathways to the surgical assessment unit at Lincoln were rolled out however, area is still regularly being used for escalation.

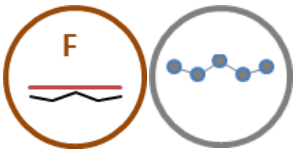
Daily calls in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.

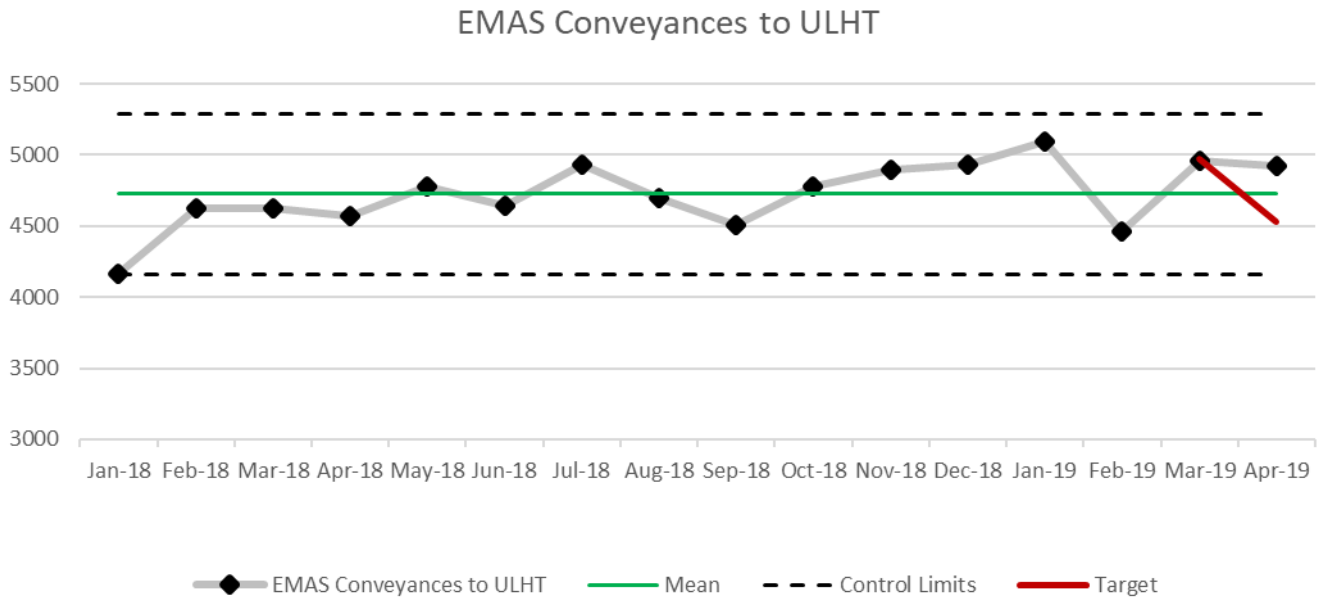
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Whilst April saw a reduction in conveyance in comparison to March, April conveyances are above plan.

Conveyance in April saw an increase of 415 against plan (8.4%). LCH received 2557 conveyances, PHB received 2102 conveyances and GDH received 261 conveyances.

Alternative pathways to avoid conveyance have not matured and delivered the % reduction expected.

Actions in place to recover

EMAS and ULHT are working more collaboratively to ensure intelligent conveyance is optimised

Reducing conveyance is included in the Urgent Care Improvement Programme and EMAS are active partners.

Conveyances numbers are now monitored through the Ambulance Handover Group which is chaired by NHSi

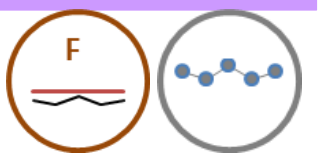
Appropriate conveyance monitoring is now in place within EMAS

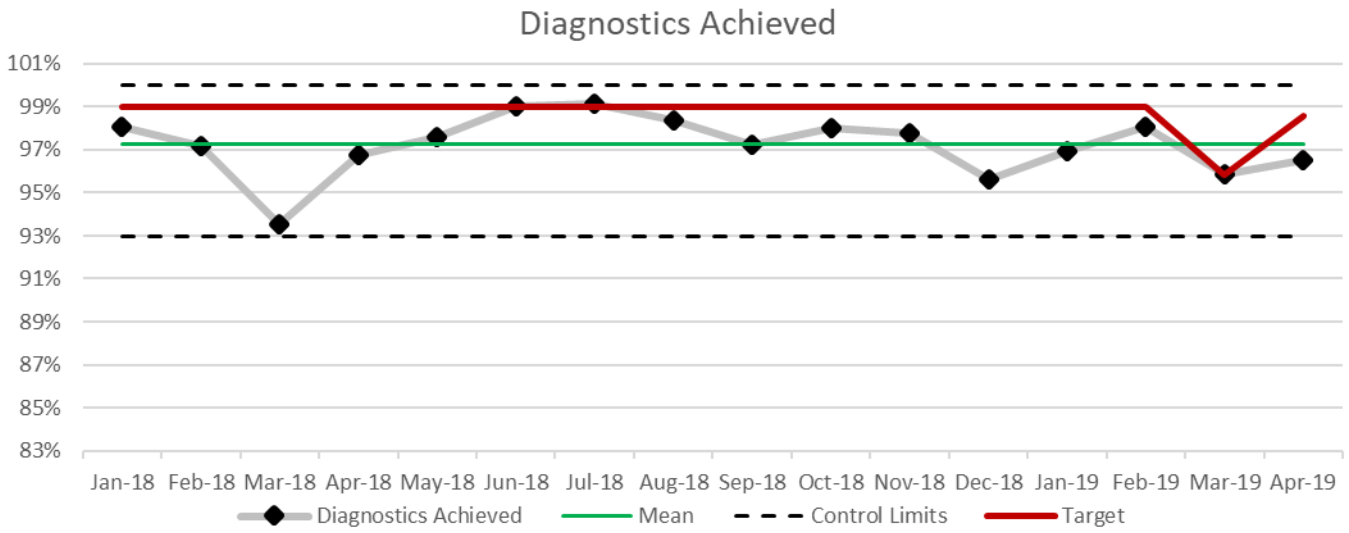
ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance is 96.53% for April which is an improvement from March 95.86%

Performance is challenged by continued issues with endoscope washers at Louth and process issues in cardiology and urology and capacity issues with neurophysiology. CT Cardiac capacity is challenged and additional capacity is being sought.

Increasing demand across all areas is proving to be challenging, with increase demand for complex MRI GA cases causing its own challenges.

Actions in place to recover

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

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

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

Some late referrals are causing breaches even before we receive the request. Work is underway to reduce this happening in the future.

Trajectory to Recover

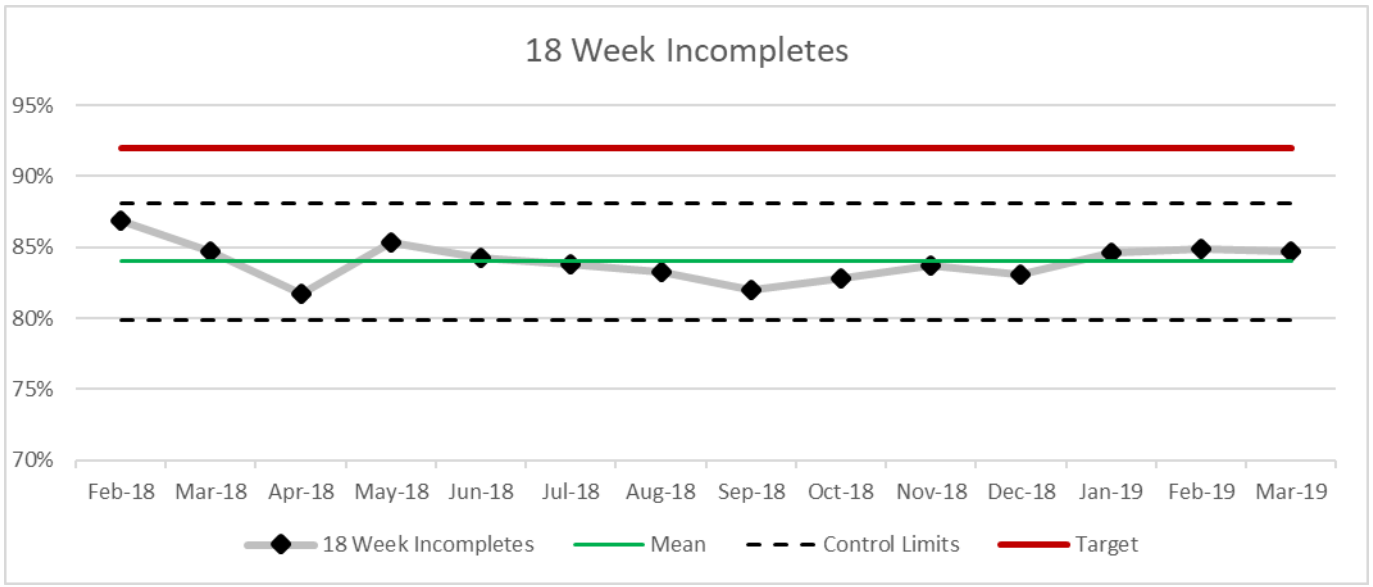
June 2019

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

March increased the total Incompletes Pathways by 1044 from 36718 to 37762. This represents a 2.84% increase.

Overall 18+ week backlog shows a mixed response across the specialities with small increases in many specialities. Maxillo-facial surgery is showing the largest increase of 49 (7.9%). Nephrology and Neurology continue to show increases as well.

ENT has shown the biggest decrease of 125 which is a 13.44% decrease. March also saw improved RTT performance in Gastroenterology.(3.89%) and paediatric T&O (2.68%).

Actions in place to recover:

Maxillo-facial has commenced skin patients within their pathway. Work has commenced to review the pathway and assess capacity against demand.

Nephology has plans to increase capacity from beginning of June which should have a positive impact on the performance.

Neurology- escalation meetings have commenced with CCG. Agreement has been reached to stop acceptance of out of area referrals. Discussion is ongoing with regards to additional support from neighbouring hospital and private sector.

All specialities are concentrating on plans to recover the capacity lost due to banks holiday. Discussion has commenced with regards to C2C referral and reinforcement of the guidelines.

Admitted pathway- continue to maximise theatre utilisation by robust scheduling process and greater focus to reduce same day cancellation.

Trajectory for Recovery

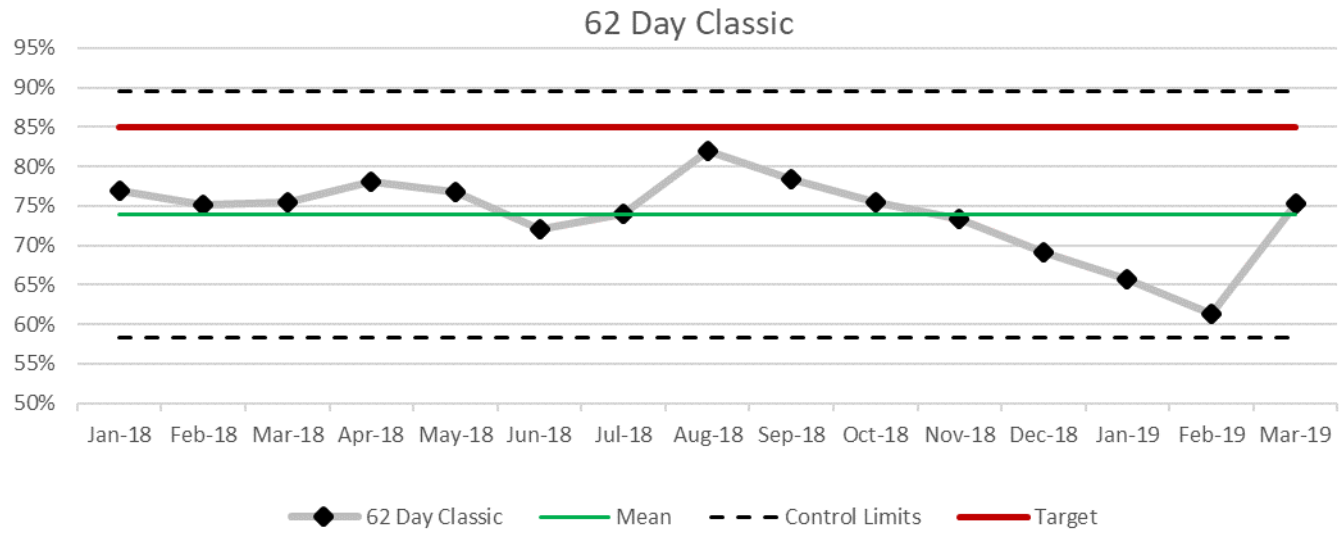
Maintain 84% during 2019/2020 due to commissioned activity

ZERO WAITING – CANCER 62 DAY

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services

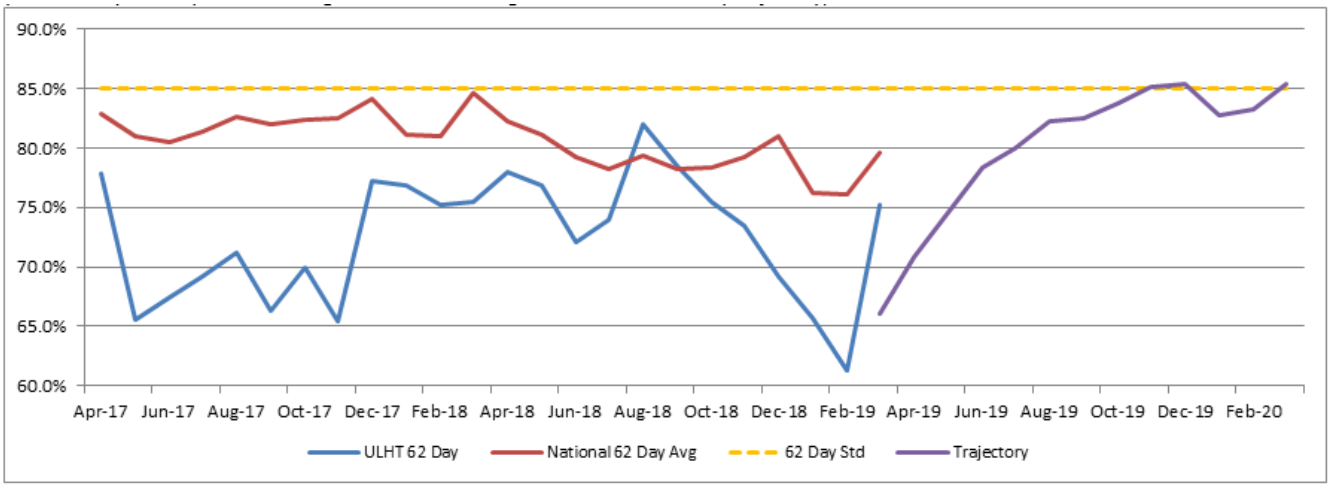


62 Day Classic and Backlog

Our 62 Day Classic performance declined rapidly over the winter months with February performance being a low point at 61.3%.

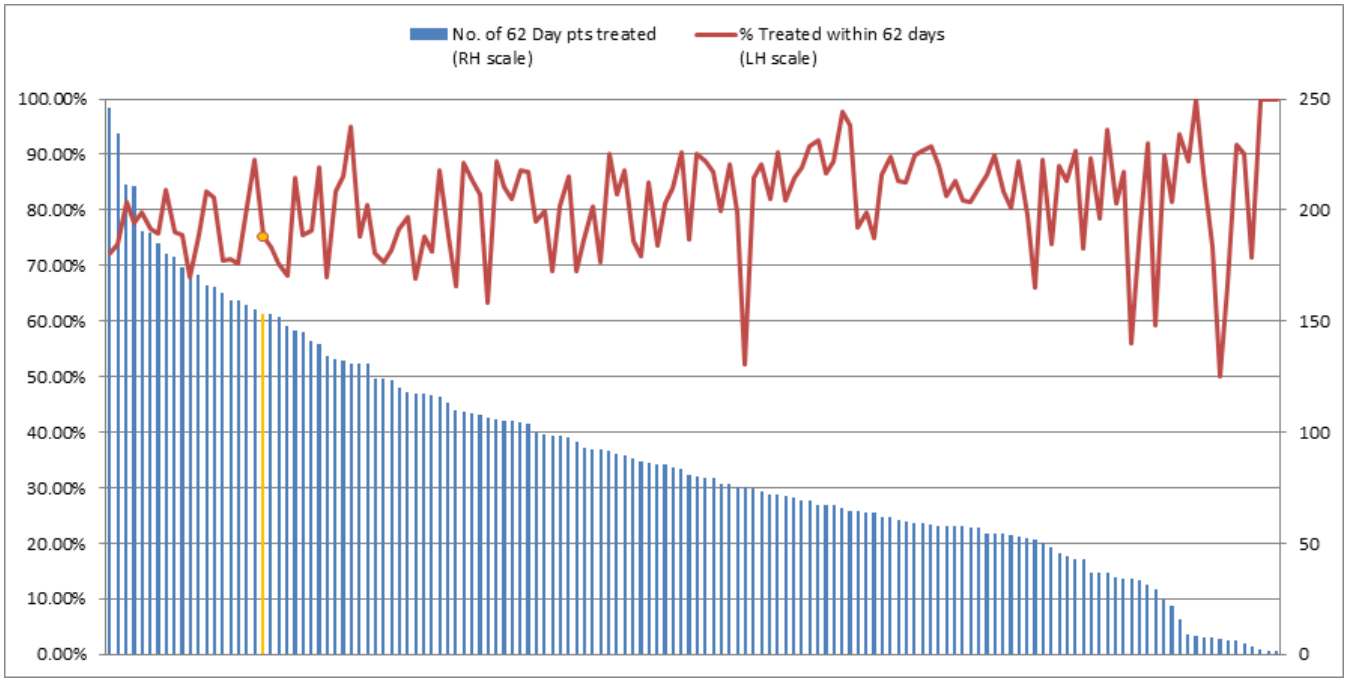
March has shown a significant recovery at 75.2% and put us back on track for our recovery trajectory, with early indications for April figures to maintain a similar level to March.

(ULHT 62 Day Classic performance against national average and 2019/20 recovery trajectory)



Though we had an improved performance in March our 62 Day activity level was only 153 treated patients, which saw us just inside the top 20 nationally for number of cancer patients in month.

(Cancer trusts in order of treating volumes – ULHT is yellow bar/dot)



The 62+ day backlog remains one of our biggest challenges with a continuous deterioration since March, particularly for Colorectal, Urology and Gynaecology

Position as at: 8:30am 10 May 2019

Cancer Site	Backlog Target	Diagnosed	Undiagnosed	Grand Total
Brain	0		5	5
Breast	0	1		1
Colorectal	16	2	46	48
Gynaecology	1	1	18	19
Haematology	0	2		2
Head and Neck	1	2	11	13
Lung	4	4	1	5
Sarcoma	0		3	3
Skin	1		2	2
Upper GI	4	3	11	14
Urology	12	15	23	38
Grand Total		**30**	**120**	**150**

(118)

Of these 150 open breach pathways 32 are awaiting letters to the patient so they can be removed from the pathway

For the 62 Day pathways there are a number of service challenges common to all tumour sites, which will require Trust-wide actions to support the divisions:

- Pathology – Path Links are unable to recruit sufficient staff to cover their core service demand.
- Sample Marking – To ensure priority for cancer samples, the Trust has a system of pacing a blue label on pathology samples for patients on a cancer pathway but not being utilised consistently.
- Tertiary Diagnostics and Treatments - A number of tumour sites experience delays in securing timely diagnostics and/or treatments from the tertiary cancer centres (predominately Nottingham).
- Implementation of shadow monitoring of the new, national 28 Day Faster Diagnosis Standard (FDS) – This has posed some challenge to all Divisions (reflected across the region), the new standard requires confirmation that the patient has been informed of a diagnosis, positive or negative, within 28 days of referral.
- Oncology – The significant capacity difficulties that have existed in the service through November-January and ongoing in Upper GI demonstrates the reliance of most tumour sites on the oncology service.
- Implementation of NHSI Elective Care Essentials – Cancer guidance – This is benchmarking ULHT against the NHSI best practice for Cancer Centres and the corporate management of the cancer standards.
- Patient Tracking – Centralised tumour site patient trackers are employed by the Trust. Following the successful pilot of Divisional trackers in Colorectal & Urology, the Cancer Alliance has pump-primed three additional posts for one year to supplement the tracking team with local administrative staff to handle the direct conversations with clinical teams around tracking issues within Urology, Colorectal and Lung/Head & Neck/Skin pathways.
- MDT Organisation – There are a number of tumour sites which are operating hospital site specific MDTs. The rationale for the continuation of such arrangements needs to be reviewed in the context of national guidance for MDTs, the ULHT commitment to Trust-wide working and the pressures in supporting services to attend or support MDTs (particular pressures in pathology and oncology).

Actions being undertaken:

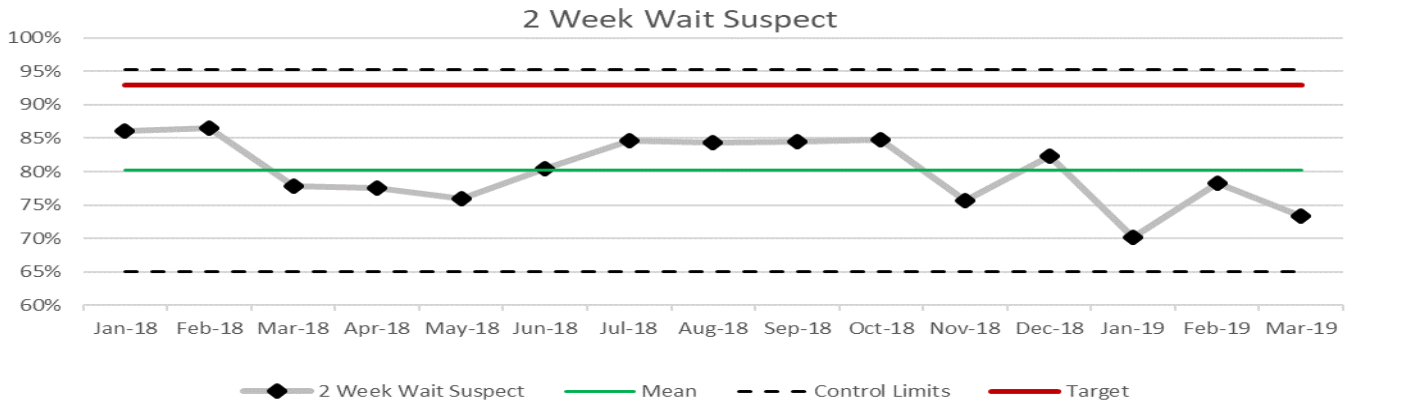
- ABC & Cancer Centre working collaboratively to provide Divisional reporting through SPC Charts for 2ww demand , booked and un-booked and capacity to maintain 7 Day Horizon booking
- The National Lung Optimal Pathway pilot is commencing at Lincoln and Pilgrim, where GP requests chest X-ray and patients are upgraded on to the 2ww pathway automatically on reporting of the X-ray reducing the front end by up to 7 days
- Introduction of Dermatology Rapid 2ww Clinics within ULHT to support the increase in demand from GPs due to seasonal variation
- Urology Governance signed off prostate pathway to allow for negative TRUS biopsies to be safely removed earlier from the suspect cancer pathway
- Conversion of one consultant post in Head & Neck to ACP to increase capacity in management earlier in the pathway
- Business Case under development for Breast Service 6 day working
- One Stop PMB clinics within Gynaecology currently being scoped to shorten diagnostic phase in patients pathway

ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



The ongoing poor performance against the 14 Day standards is underscored by lack of suitable capacity in nearly all Specialties as demonstrated below.

14 Day (93% NATIONAL STANDARD)	Mar-19 Total	Mar-19 < 7 Day Prfrmnce %	Mar-19 < 14 Day Prfrmnce %	Apr-19 Total	Apr-19 < 7 Day Prfrmnce %	Apr-19 < 14 Day Prfrmnce %
Brain/CNS	22	4.55	63.64	13	15.38	76.92
Breast	382	4.19	24.87	313	7.03	73.16
Breast Symptomatic	251	4.78	26.29	139	3.6	68.35
Colorectal	474	45.99	89.45	494	45.34	90.08
Gynaecology	168	27.98	86.31	177	13.56	71.19
Haematology	27	33.33	92.59	9	44.44	100
Head & Neck	207	20.77	87.92	255	18.43	87.45
Lung	53	67.92	98.11	65	50.77	96.92
Sarcoma	8	25	75	10	60	70
Skin	349	13.75	85.39	340	2.35	68.82
Upper GI	189	70.9	94.18	145	55.17	93.1
Urology	262	33.59	57.25	291	32.99	69.76
Totals (excl Breast Sympto)	2141	29.99	73.28	2112	25.85	79.73
14 Suspect Total excl Breast	1759		83.8%	1799		80.9%

Actions being undertaken:

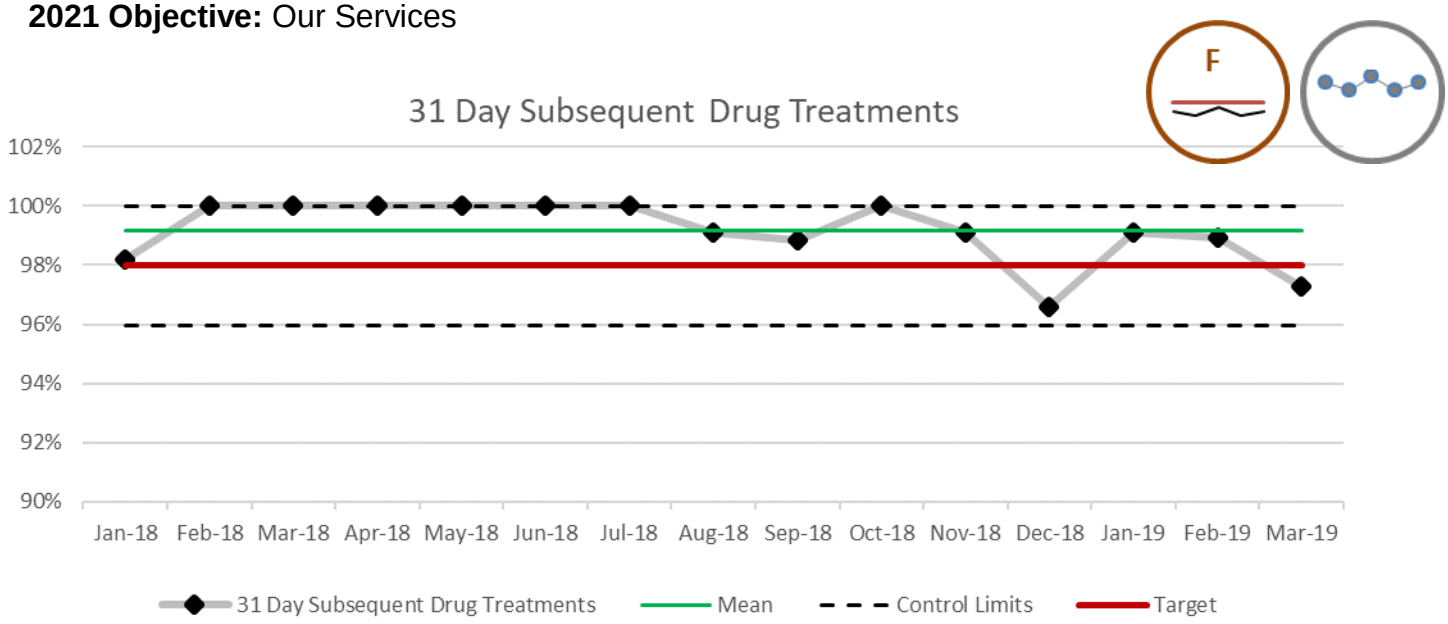
- ABC & Cancer Centre working collaboratively to provide Divisional reporting through SPC Charts for 2ww demand , booked and un-booked and capacity to maintain 7 Day Horizon booking
- The National Lung Optimal Pathway pilot is commencing at Lincoln and Pilgrim, where GP requests chest X-ray and patients are upgraded on to the 2ww pathway automatically on reporting of the X-ray reducing the front end by up to 7 days
- Introduction of Dermatology Rapid 2ww Clinics within ULHT to support the increase in demand from GPs due to seasonal variation
- Urology Governance signed off prostate pathway to allow for negative TRUS biopsies to be safely removed earlier from the suspect cancer pathway
- Conversion of one consultant post in Head & Neck to ACP to increase capacity in management earlier in the pathway
- Business Case under development for Breast Service 6 day working
- One Stop PMB clinics within Gynaecology currently being scoped to shorten diagnostic phase in patients pathway

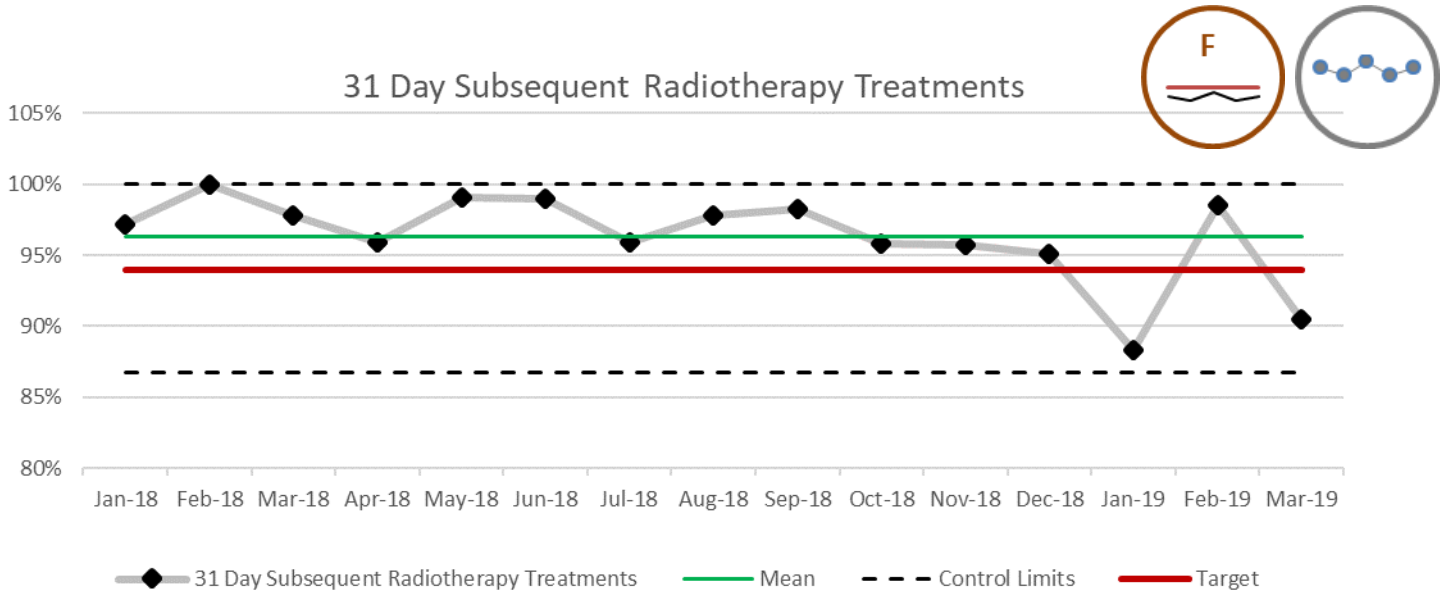
ZERO WAITING – 31 DAY WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





31 Day Subsequent Drug was below standard due to 2 breaches (standard can accommodate one), reasons being patient fitness and patient choice

31 Day Subsequent Radiotherapy was below standard due to a higher number than normal of patients needing a specialist iodine treatment and as a result the supply of the relevant iodine

Actions being undertaken:

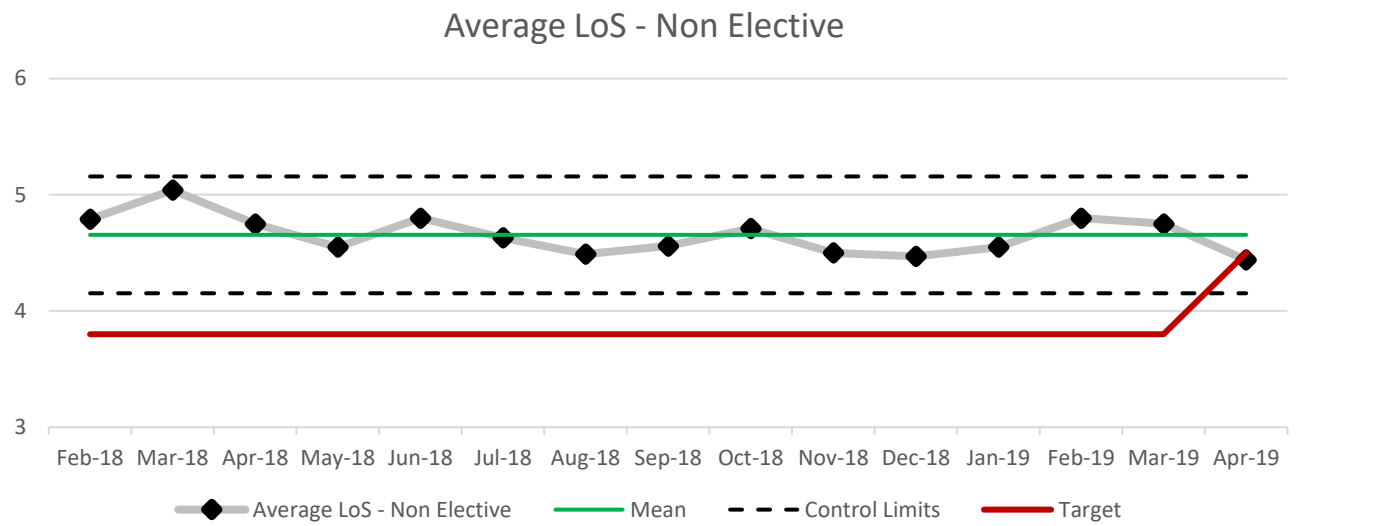
- Both standards underperformed due to exceptional circumstances outside the Trust's control

ZERO WAITING – AVERAGE LOS – NON-ELECTIVE

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Length of Stay across the organisation is at 4.53 days for April. This remains top quartile performance, although the ambition target is set is 3.8 days overall.

Length of stay increased in February but has reduced consecutively for March and April

>21 day LoS weekly reviews are yielding success and reductions are being realised. Week commencing 24th April saw 93 patients with a .21 day LoS which is below the trajectory

AEC and SAU have been escalated for the last 4 weeks effecting the Ambulatory Care pathways

Achievement of the ambition of 3.8 days is reliant upon increased throughput via the ambulatory pathways and units and the successful implementation of SDEC (Same Day Emergency Care)

Actions in place to recover

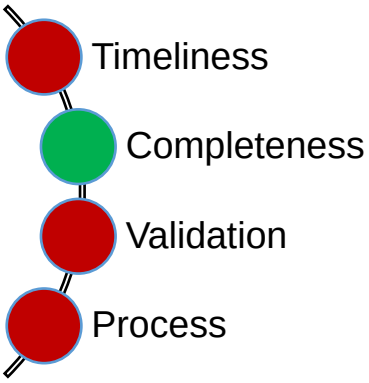
Long Stay reviews held weekly with Senior Clinical staff

Plans in place to de-escalate AEC and SAU and broaden the Ambulatory pathways to avoid admissions into the deeper bed base.

UHLT has been successful in becoming an accelerator site for SDEC which will support a reduction in overall LoS supported by NHSi.

APPENDIX A – KITEMARK

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



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

United Lincolnshire Hospitals NHS Trust

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

Title:	**Corporate Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Manager

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

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

The Report is provided to the Committee for:

Decision		Discussion	
Assurance	✓	Information	

Summary/Key Points:

- The current corporate risk profile shows that the Trust is exposed to a significant amount of risk at present, in excess of its risk appetite
- Progress continue to be made to incorporate the regular review of risks and scrutiny of mitigating action plans within corporate and divisional governance arrangements

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required to improve the management of risk within the Trust.

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 the Board 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 to improve the management of quality and safety risk within the Trust.

3. Reasons for Recommendations

3.1 The Trust Board has ultimate responsibility for the management of risk within the Trust.

4. Summary of Key Points

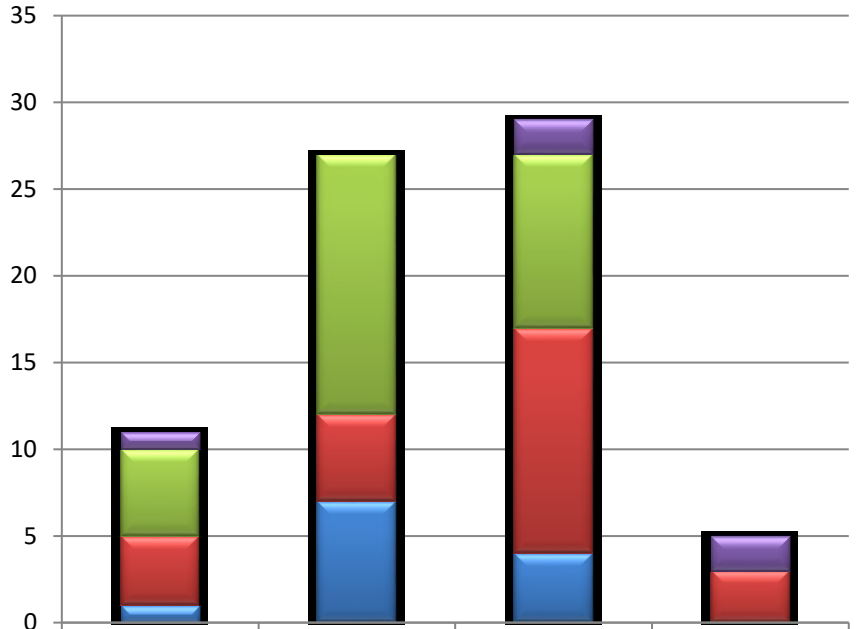
4.1 The Trust Board is advised of the following developments since the last report:

- The format used to report on the risk register has been reviewed in light of the new Risk Management Strategy & Trust Operating Model (TOM)
- The report now clearly shows inherent (unmitigated), current (residual) & acceptable (target) risk ratings
- The categorisation of 'emergent' risks that was previously used has been removed & all such risks will now be considered as corporate risks
- The process is underway to improve the identification of significant gaps in controls and the scrutiny of mitigating action plans, by way of regular risk reviews by specialist groups and divisions
- All corporate financial risks have been reviewed and updated for 2019/20 by the Director of Finance
- All High and Very high estates risks have been reviewed and updated by the Estates & Facilities governance group
- The Patient Safety Group has this month agreed to expand the patient safety risk register to differentiate more clearly between causes: e.g. workforce; demand management; health records; clinical governance
- The Medical Device Safety Group has this month agreed to include a new compliance risk within its risk register
- The Trust's risk reporting structure can be summarised as follows:
    - Wards & departments identify gaps in control and escalate through specialty governance arrangements
    - CBUs review their risk registers, taking account of any escalations
    - Divisions maintain oversight of CBU risk registers
    - CBU (operational) risks with a current rating of High are reported to lead management groups (where applicable)
    - Lead management groups review all corporate risks within their scope, along with High operational risks
    - Lead assurance committees receive reports on all corporate risks within their scope, along with High operational risks
    - Trust Board receives a report on High corporate and operational risks
- It is intended that the Trust Management Group (TMG) will in future receive a regular report on the Corporate Risk Register and High operational risks

4.2 This approach has been reported to the assurance committees of the Trust Board in order to identify any potential governance gaps that need to be addressed.

Corporate Risk Profile

4.3 **Chart 1** shows the number of corporate risks by current (residual) risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	0	2	2
Reputation / compliance	5	15	10	0
Service disruption	4	5	13	3
Harm (physical or psychological)	1	7	4	0

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**.

Appendix I - High Very high corporate risks (June 2019)

ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
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. Executive lead: Mark Brassington Risk lead: Michelle Harris	Service disruption	Very high risk (20)	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)	• 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	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	1. Critical priority risk mitigation	Harris, Michelle	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.	30/09/2019	Moderate risk (8)	31/05/2019
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. Executive lead: Paul Matthew Risk lead: Paul Matthew	Finances	Very high risk (20)	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 Director appointed. Financial Turnaround Group (FTG) oversight. Programme Management Office & dedicated Programme Manager.	Very high risk (20)	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 PMO team working with divisions to manage planned schemes and identify mitigating schemes. Additional external resource to be brought in to support delivery.	1. Critical priority risk mitigation	Matthew, Paul		31/03/2020	Moderate risk (8)	31/07/2019
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. Executive lead: Paul Matthew Risk lead: Paul Matthew	Finances	Very high risk (20)	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)	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.	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	1. Critical priority risk mitigation	Rayson, Martin		31/03/2020	Moderate risk (8)	31/07/2019
						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).	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.	1. Critical priority risk mitigation	Matthew, Paul		31/03/2020		
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. Executive lead: Martin Rayson Risk lead: Darren Tidmarsh	Service disruption	Very high risk (20)	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)	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	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.	1. Critical priority risk mitigation	Bates, Debrah		31/03/2019	Moderate risk (8)	31/03/2019
						High vacancy rates for consultants & middle grade doctors throughout the Trust.	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	1. Critical priority risk mitigation	Samra, Dr Gurdip		31/03/2019		
						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.	Workforce plans are identifying 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 in 2018/19. Target date for completion is September 2018.	2. High priority risk mitigation	Rayson, Martin		31/01/2019		

Appendix I - High Very high corporate risks (June 2019)

ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
						The Trust continues to employ a significant number of staff from the European Union, who may be affected by Brexit; at present there is not systematic communication and engagement with these employees, due to capacity issues.	Communication with EU staff and their managers, to ensure that they are aware of the position in respect of their employment rights and we are aware of their concerns and the actions we can take to reassure them and keep them at ULHT.	3. Medium priority risk mitigation	Rayson, Martin		31/03/2019		
						The Trust is dependent on Deanery positions to cover staffing gaps with medical trainees; there have been issues also with the effectiveness of the Guardians of Safe Working Practice; shortages in the medical recruitment team will impact on the next rotation if not resolved.	The Education Director has developed an action plan in relation to the issues raised.; two HEE fellows are currently looking at issues relating to engagement with the juniors; issues with the effectiveness of the Guardians to be addressed by the Medical Director.	1. Critical priority risk mitigation	Hepburn, Dr Neill	Guardians trained, met and expectations clarified Given template reports New software to facilitate reporting Guardian Review on 17 Jan 2019. Paper presented at Workforce and OD 15 Jan 2019. To develop new model for Guardian Role. Current Guardians to stop in 12 weeks.	21/03/2019		
						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 book or substantive / fixed	Review of proposals and potential impact, to identify any required action.	2. High priority risk mitigation	Rayson, Martin		30/06/2019		
4405	**Continuity of aseptic pharmacy services (corporate)** If there is a critical failure in the provision of aseptic pharmacy services within the Trust; Caused by issues with the condition of the facilities or the staffing capacity and capability required to maintain the service to the required standards; It could result in significant disruption to multiple services which impacts on the care and treatment of a large number of patients. 11.10.18- contamination of isolators (increased microbiological contamination of critical plates in isolators). Probable cause- increased workload and capacity. Consequence- product's contamination and patient safety. Executive lead: Neill Hepburn Risk lead: Colin Costello	Service disruption	Very high risk (20)	Aseptic pharmacy services facility at LCH and PHB. Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Pharmacy compliance monitoring / auditing. 11.10.18-regular review of microbiological plates but there will be a delay from plates exposure, products administration and plates results so products will had been administered when the plates results are back.	Very high risk (20)	Concerns about the reliability, sustainability and contingency of the current service. In-house aseptic capacity increasing due to lack of manufacturing capacity from outsourcing suppliers. With Lincoln facility currently closed due to its condition and risk of contamination, Pilgrim aseptic unit is unable to produce sufficient supplies of aseptic products to meet the current demand of the population. Pilgrim aseptic unit is also in need of refurbishment and is not likely to be fit for purpose in the medium to long term. No business continuity plans exist. Any failure of Pilgrim ASU would result in the Trust inability to provide treatments and patients will need to be treated out of county.	Plan for the future of aseptic services and additional resources to cope with the increasing capacity required. Options appraisal of all the aseptic service(s) options in progress. Full business case to be written for preferred option.	2. High priority risk mitigation	Marin, Francisca	All aseptic production is now taking place at PHB under Section 10 exemption from the Medicines Act. The Aseptic Capacity Plan produced by the Trust's Aseptic Accountable Pharmacist is now signed off and accepted at Board level (as per QAAPS5). A business case is being developed for a new aseptic unit to comply with national GMP and QAAPS standards to mitigate risks to business continuity. This business case has been considered at CRIB in November 2018 and will be considered again early in 2019.	31/03/2020	Low risk (4)	31/05/2019
						No provision for aseptic services out of hours (evening, weekends or bank holidays), Pharmacy on-call services do not include supply of aseptic products (including chemotherapy) & on-call pharmacists do not have required training. Lack of robust skill mix. Inability to provide robust cover when sickness and leave.	Exploration of options for out of hours aseptic service provision (including on call service; partnership with another Trust) along with purchasing of ready made chemotherapy and development of a policy & procedure for out of hours referral. Contingency: A voluntary list is maintained of staff who may be contacted but are not required to be available.	2. High priority risk mitigation	Marin, Francisca		31/03/2020		
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. Executive lead: Paul Matthew Risk lead: Paul Matthew	Finances	Very high risk (20)	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)	Clinical coding & data quality issues impacting on income.	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	1. Critical priority risk mitigation	Caig, Shaun		31/03/2020	Moderate risk (8)	31/07/2019
						Operational ownership of activity and income at specialty level.	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	1. Critical priority risk mitigation	Matthew, Paul		30/06/2019		
						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.	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.	1. Critical priority risk mitigation	Matthew, Paul		31/03/2020		
						Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	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.	1. Critical priority risk mitigation	Brassington, Mark		31/03/2020		

Appendix I - High Very high corporate risks (June 2019)

ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
						Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	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.	2. High priority risk mitigation	Matthew, Paul		31/03/2019		
3721	**Critical failure of the mechanical infrastructure (corporate)** If the Trust experiences a critical failure of its mechanical infrastructure (including ventilation, steam, cold water, heating, medical gas pipeline systems and lifts); Caused by issues with the age and condition of the infrastructure and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients. Executive lead: Paul Boocock Risk lead: Chris Farrah	Service disruption	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (16)	Mechanical Infrastructure at Lincoln County 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.	Work required to identify critical infrastructure risks at LCH & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019	Moderate risk (8)	31/07/2019
						Mechanical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity.	Work required to identify critical infrastructure risks at PHB & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019		
						Mechanical Infrastructure at Grantham District 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.	Work required to identify critical infrastructure risks at GDH & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019		
						Old maternity block at GDH houses 2 Wards and management offices and is serviced by 2 lifts. 1 lift has had a new motor fitted in 2015. The remaining lift is of the same age. If this lift fails then we will not be able to service 2 Wards(food, patient moves, patient admissions etc).	Prioritisation of capital for refurbishment of lifts in old maternity block at GDH. Fully comprehensive service/maintenance contract. Defects reported on Micad and a trapped person procedure. Lift failsafe system.	1. Critical priority risk mitigation	Farrah, Chris		31/12/2019		
3688	**Quality of the hospital environment (corporate)** If the Trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the Trust and may lead to commissioner or regulatory intervention. Executive lead: Paul Boocock Risk lead: Ian Hayden	Reputation / compliance	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Patient Experience Committee. NHS Premises Assurance Model (PAM) Patient-led Assessment of the Care Environment (PLACE) survey & response plans. Robust defect reporting system which prioritises critical issues within available resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.	High risk (16)	Issues with the quality and condition of the hospital environment identified through PLACE annual inspection.	Paper to be prepared for ET to identify scale of work required and costs to address issues identified in the PLACE annual inspection.	2. High priority risk mitigation	Farrah, Chris		31/05/2019	Moderate risk (8)	31/07/2019
						The drains under the 'wash up floor' at Pilgrim Hospital are failing, leading to a build up of stagnant water and food waste that attract fruit flies, mosquitos and give off a pungent odour.	Excavate parts of the 'wash up floor' at Pilgrim Hospital, seal rainwater drains, remove sludge and fill the void under the main wash up area. The floor then needs to be sealed to stop any water going underneath.	1. Critical priority risk mitigation	Farrah, Chris		30/06/2019		
						Outpatient main reception inadequate for both staff, desk not ergonomically designed, no privacy screens for PCs therefore no patient privacy and inadequate security for staff. Noise levels from the adjoining catering outlet means confidential discussions are more difficult to undertake.	Refurbishment work to the main outpatient desk to address staff operational issues, noise and patient confidentiality. Also to relocate the ambulance desk next to this facility to deliver a 'one stop shop'.	1. Critical priority risk mitigation	Farrah, Chris		30/06/2019		
						During winter months with the Main Entrance being East facing, any significant cold winds are funnelled into the main entrance foyer through the door lobby. Previous actions by fitting automatic doors have failed to improve the situation. Numerous staff and patient complaints.	To design a extension to the existing entrance that will prevent the wind funnelling into the main foyer at Pilgrim.	1. Critical priority risk mitigation	Farrah, Chris		31/03/2020		
						Tower Block Facia Boards rotten and falling off.	No mitigation possible. Removal required asap.	1. Critical priority risk mitigation	Farrah, Chris		31/07/2019		
						Infrastructure and doors in freezer units at Pilgrim catering, the fridge walls were installed in 1984. According to the refrigeration contractor the walls are deteriorating and losing the thermal properties to keep the cold. The doors have gaps where the seal has gone. The locks do not work, causing security issues and non compliance to keep locked for security and possible unknown contamination. The Shelter on the roof above is metal and keeps heat that causes the compressors to over work and cut out. This drastically reduces the temperature control and space for frozen stock.	Replace the insulated walls, new correct fitting doors with locks, fit meshing instead of doors on the roof to allow air flow for the compressors to function properly.	2. High priority risk mitigation	McIntosh, Wayne		31/03/2020		
3520	**Compliance with fire safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with fire safety regulations and	Reputation / compliance	Very high risk (20)	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process	High risk (16)	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards.	Complete upgrade of LCH fire alarm system.	2. High priority risk mitigation	Farrah, Chris		31/12/2021	Low risk (4)	31/07/2019

Appendix I - High Very high corporate risks (June 2019)

ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
	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. Executive lead: Paul Boocock Risk lead: Chris Farrah			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.		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.	Complete improvements to Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham.	1. Critical priority risk mitigation	Farrah, Chris		30/06/2021		
						There are some areas of the estate with insufficient provisions of emergency lighting. Additional resources required to enable full compliance with Trust policy and applicable regulations.	Emergency lighting replacement programme in accordance with Fire Enforcement Notice Timescales.	1. Critical priority risk mitigation	Farrah, Chris		31/07/2019		
						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.	New mandatory staff fire safety awareness moduleto be introduced; regular reminders to new divisional management indicating staff compliance.	1. Critical priority risk mitigation	Farrah, Chris		31/10/2019		
3720	**Critical failure of the electrical infrastructure (corporate)** If the Trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients. Executive lead: Paul Boocock Risk lead: Chris Farrah	Service disruption	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (16)	Electrical Infrastructure at Lincoln County 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.	Work required to identify critical infrastructure risks at LCH & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019	Low risk (4)	31/07/2019
						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.	Work required to identify critical infrastructure risks at PHB & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019		
						Electrical Infrastructure at Grantham District 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.	Work required to identify critical infrastructure risks at GDH & plan improvements, from backlog maintenance survey.	2. High priority risk mitigation	Farrah, Chris		31/07/2019		
						GDH: Main LV Electrical Switch Gear (Back of Theatres) connected to Transformer Number 3 requires upgrading. Switchgear is fully loaded with no room for future expansion to the southern part of the site.	Action Plan to be developed to upgrade main LV electrical switch gear at GDH. Any additional development to the southern half of the site will need to incorporate the replacement / upgrade of this switchgear.	2. High priority risk mitigation	Farrah, Chris		31/03/2020		
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. Executive lead: Martin Rayson Risk lead: Jennie Negus	Reputation / compliance	Very high risk (20)	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)	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.	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.	2. High priority risk mitigation	Negus, Jennie		30/09/2019	Low risk (4)	28/02/2019
3503	**Sustainable paediatric services at Pilgrim Hospital, Boston (Children & YP CBU)** If the Trust is unable to maintain the full range of paediatric services at Pilgrim Hospital, Boston; Caused by issues with the recruitment or	Service disruption	Very high risk (20)	Workforce planning systems & processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing	High risk (12)	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	2. High priority risk mitigation	Bolton, Mrs Beverley		30/03/2020	Low risk (4)	30/06/2019

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	retention of sufficient numbers of staff with the required skills and experience; it could result in extended, unplanned closure of the service or significant elements of it, impacting on the care and experience of a large number of patients and on the provision of interdependent services across the region. Divisional lead: Suganthi Joachim Risk lead: Beverley Bolton			arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.		Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	2. High priority risk mitigation	Bolton, Mrs Beverley		31/03/2020		
						Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown).	Development of sustainable long-term model for paediatrics at PHB, through the STP.	2. High priority risk mitigation	Bolton, Mrs Beverley		31/03/2020		
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. Executive lead: Martin Rayson Risk lead: Darren Tidmarsh	Service disruption	Very high risk (20)	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)	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.	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.	1. Critical priority risk mitigation	Rayson, Martin		31/01/2019	Moderate risk (8)	30/11/2018
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. Executive lead: Martin Rayson Risk lead: Darren Tidmarsh	Reputation / compliance	Very high risk (20)	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.	High risk (12)	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.	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.	2. High priority risk mitigation	Rayson, Martin		31/03/2019	Low risk (4)	31/03/2019
						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.	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.	3. Medium priority risk mitigation	Rayson, Martin		31/01/2019		
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. Executive lead: Michelle Rhodes Risk lead: Victoria Bagshaw	Reputation / compliance	Very high risk (20)	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 Committee & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	High risk (12)	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.	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.	2. High priority risk mitigation	Todd, Elaine		31/03/2019	Low risk (4)	28/02/2019
						Not yet consistently achieving 90% compliance with safeguarding training requirements.	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.	3. Medium priority risk mitigation	Todd, Elaine		31/03/2019		

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						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.	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.	2. High priority risk mitigation	Bagshaw, Victoria		31/03/2019		
						The Trust is not yet fully compliant with recommendations made following the Savile and Bradbury inquiries (e.g. Chaperone Policy and Safer Recruitment).	Complete outstanding actions from Savile & Bradbury incorporated into Safeguarding QSIP plan as priorities for 2018/19; Task and finish group to review chaperone policy; Existing chaperone posters to be displayed in clinical areas; Risk assessments for areas unable to comply with policy; More information to be made available for patients about availability of chaperones; 3 yearly DBS checks to be implemented – process being explored by HR.	2. High priority risk mitigation	Todd, Elaine		31/03/2019		
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. Executive lead: Neill Hepburn Risk lead: Colin Costello	Harm (physical or psychological)	Very high risk (20)	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)	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.	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	2. High priority risk mitigation	Fahimi, Nabil		31/03/2020	Low risk (4)	31/05/2019
						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.	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	2. High priority risk mitigation	Sheanon, Danielle		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.	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.	2. High priority risk mitigation	Sheanon, Danielle		31/12/2019		
						Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	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.	1. Critical priority risk mitigation	Sheanon, Danielle		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.	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.	3. Medium priority risk mitigation	Sheanon, Danielle		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	Reputation / compliance	Very high risk (20)	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.	High risk (12)	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	Planned introduction of an auditable electronic prescribing system across the Trust.	2. High priority risk mitigation	Fahimi, Nabil		31/03/2020	Low risk (4)	31/05/2019

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	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. Executive lead: Neill Hepburn Risk lead: Colin Costello			Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.		Significant areas of non-compliance with national standards for aseptic preparation of injectable medicines have been identified. Key issues are the inadequacy of current staffing resources & skills mix and the condition of the facilities.	Replacement of isolator cabinets at PHB and LCH. Closure of LCH facility until building works are complete.	1. Critical priority risk mitigation	Marin, Francisca	Isolator cabinets replaced at PHB; LCH facility remains closed whilst awaiting necessary building works (not currently possible to reopen due to potential for contamination).	31/05/2019		
						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.	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.	2. High priority risk mitigation	Rice, Sarah		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.	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.	2. High priority risk mitigation	Gilbert, Liz		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.	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.	2. High priority risk mitigation	Marin, Francisca		30/09/2019		
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. Executive lead: Michelle Rhodes Risk lead: Victoria Bagshaw	Harm (physical or psychological)	Very high risk (20)	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)	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.	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.	1. Critical priority risk mitigation	Negus, Jennie	Clinical Holding training has now been running for 12 months. A training needs analysis was developed in conjunction with operational teams and 93 individual staff identified as requiring to attend the Level 4 2-day training. These staff are those who would potentially respond to a call for urgent assistance and as such be required to lead the response to the situation. As of February 2019 compliance with the training is at just 32%. Level 3 training is a one day course designed to provide skills and experience to staff working in identified 'hot spot' or high risk areas such as ED, admissions units, dependency withdrawal wards and elderly care. The training needs analysis resulted in 120 places being made available across these clinical areas. As of February 2019 compliance is at 48%.	31/01/2019	Low risk (4)	31/05/2019
						The Trust employs a part time medical photographer which covers 2 days per week and also provides an on-call service; there is currently no cover for absence, which may result in inability to provide evidence to police & social care in support of legal / criminal proceedings.	Develop on-call medical photography service through additional appointments onto the Bank. Quantify impact due to service availability issues.	3. Medium priority risk mitigation	Todd, Elaine	Staff have been reminded of requirement to complete incident report on Datix when service has been unavailable to enable impact to be assessed.	31/03/2019		

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						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.	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.	2. High priority risk mitigation	Todd, Elaine		31/03/2019		
						Commissioning gap – National shortage of specialist learning disability / mental health beds for children and young people with challenging behaviours, which can result in inappropriate admissions and increased length of stay.	Work being led by the CCG to address the shortage of specialist learning disability / mental health beds for children and young people with challenging behaviours; external support being sourced as required for 1:1 supervision etc.; Additional support offered by safeguarding team; Development of log to evidence issues.	2. High priority risk mitigation	Todd, Elaine		31/03/2019		
						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	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.	2. High priority risk mitigation	Negus, Jennie		30/09/2019		
						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	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.	1. Critical priority risk mitigation	Todd, Elaine	Action plan to be reassigned to appropriate lead once in post.	31/03/2020		
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. Executive lead: Michelle Rhodes Risk lead: David Cleave	Harm (physical or psychological)	Very high risk (20)	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. Ward 7B (PHB) is established for 2 NIV beds. Acute Care Unit at GDH is established for 3 NIV beds. Escalation process in place. Increasing staffing capacity through the use of Bank, overtime and agency. Decreasing bed numbers; and transfer of patients for escalation to ICU. Oxygen saturation monitoring in place and cardiac monitoring can be accessed via the Outreach Team if any concerns re potential arrhythmia	High risk (12)	Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. There may be no patients suitable for escalation to ICU as NIV is ceiling of care and admitting COPD patients who have a ceiling of care of NIV alone to a level 2/3 critical care/ICU bed is against the Critical Care Network agreed admission and operational policies. Many patients do not meet the criteria for escalation to a level2/3 bed. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. High level of RN vacancies on the ward. Potential for delays in identifying deterioration in NIV patients as continuous ECG monitoring is not available on Carlton-Coleby Ward and the service is not in line with BTS/NCEPOD recommendations that NIV should only be provided in clinical areas where this is available to support monitoring of tachycaria, dysrhythmia or possible cardiomyopathy. High vacancy rate at pilgrim Hospital	1. Escalation Process for Ward Based NIV Capacity developed. 2. Requirements for ability to commence NIV in EDs being scoped, SOP will be required. 3. 24 hour band 6 recruitment in place. 4. On-going competency training in place for new Nurses 5. On-going recruitment 5. Cardiac monitoring available from Out Reach as required.	2. High priority risk mitigation	Cleave, Mr David		30/09/2019	Low risk (4)	31/07/2019

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				arrhythmia.		Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. There may be no patients suitable for escalation to ICU as NIV is ceiling of care and admitting COPD patients who have a ceiling of care of NIV alone to a level 2/3 critical care/ICU bed is against the Critical Care Network agreed admission and operational policies. Many patients do not meet the criteria for escalation to a level2/3 bed. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. High level of RN vacancies on the ward. Age of the 4 NIV machines on Ward 7b (15 years+).	1. Escalation Process for Ward Based NIV Capacity developed. 2. Requirements for ability to commence NIV in EDs being scoped, SOP will be required. 3. Capacity & demend being reviewed. 4. Cohort recruitment for medical specialities being planned. 5. Review of ward establishment when SafeCare data available. 6. Additional NIV machine available in Clinical Engineering if needed.	2. High priority risk mitigation	Wall, Mrs Tracey		30/09/2019		
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. Executive lead: Paul Matthew Risk lead: Paul Matthew	Reputation / compliance	Very high risk (20)	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)	Actual forecast outturn for 2018/19 varies from the approved plan by c£15m. This forecast is not approved by NHSI, therefore there is no guarantee the Trust will be able to draw the additional cash required to meet its payment obligations.	Development of a financial recovery plan for 2018/19 and 2019/20, subject to NHSI approval, which would secure access to the required level of cash for 2018/19. Development of a contingency plan - to identify clinical service priorities with required staff and essential supplier / utility costs and a strategy for operational implementation. To agree with the CCGs to continue to fund these services.	1. Critical priority risk mitigation	Matthew, Paul	Trust Board has approved a financial recovery plan for remainder of 2018/19 and 2019/20. Awaiting review by NHSI.	31/01/2019	Low risk (4)	31/07/2019
4399	**Compliance with health & safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with health & 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. Executive lead: Paul Boocock Risk lead: Philippa Fitzmaurice	Reputation / compliance	Very high risk (20)	Health & Safety Committee. Site-based H&S committees. Health & Safety Policy & related guidance. Health & safety training (Induction & Core Learning). Medical device & equipment training. Manual handling training. Planned Preventative Maintenance (PPM) / testing. Incident reporting & investigation processes & system (Datix). Occupational health services. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (12)	Quality Governance Committee raised issues with the effectiveness of the Trust Health & Safety Committee (only meets quarterly; disparity in engagement between sites; reporting assurance gaps raised concerns that full range of responsibilities are not being discharged).	Assurance issues identified by the Quality Governance Committee to be raised with the chair of the Health & Safety Committee. Future reports to cover all aspects of H&S management.	1. Critical priority risk mitigation	Fitzmaurice, Philippa	Health & Safety Strategic Plan / action plan (working in progress plan) has been developed to demonstrate the activities of work set from 2019 - 2024 in line with the British Safety Councils recommendations. Documents inserted to demonstrate the work being completed by the Health & Safety Team working in partnership with relevant key stakeholders. The risk rating of 12 reflects the current residual risk allocated to the documents not being approved and therefore not published.	29/03/2019	Low risk (4)	31/07/2019
						The Trust does not currently have in place a sustainable programme of manual handling training for staff.	Proposals to be developed for resourcing of a sustainable manual handling training programme.	1. Critical priority risk mitigation	Fitzmaurice, Philippa	Business case approved for the recruitment of x1 Strategic Lead for Manual Handling Band 7 and x2 Band 5 Manual Handling Health & Safety Trainers. The Band 7 has been submitted for Job Match panel and of this date awaiting confirmation prior to commencing recruitment of these posts. Documents related to training have been added to the update to demonstrate the communication of information to the Trust Health & Safety Group meeting January 2019.	29/03/2019		
4404	**Major fire safety incident (corporate)** If the Trust experiences a major fire safety incident; Caused by the uncontrolled spread of a substantial fire; It could result in multiple incidents of significant harm or death affecting patients, visitors and members of staff.	Harm (physical or psychological)	Very high risk (20)	Fire Policy. Fire Safety Group. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix).	High risk (12)	Fire alarm systems in the Catering Dept and 1st floor theatre block (Block OJ) are conventional systems which were connected to the newly installed system 20 years ago. Trinity the maintenance contractor have highlighted the need to replace the systems due to the age of the devices and lack of support for the old alarm panels.	Replacement of detection devices & panels in the Catering Dept and 1st floor theatre block (Block OJ). Regular maintenance carried out as per recommendations of BS 5839-1:2013 and HTM 05-03 Part B.	3. Medium priority risk mitigation	Royales, Fred	Quotations have been submitted to bring systems up to date.	31/03/2019	Low risk (4)	31/07/2019

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ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
	Executive lead: Paul Boocock Risk lead: Chris Farrah			Planned Preventative Maintenance PPM (Testing). Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processees.		The Fire Dampers located within the ventilation system in Maternity at LCH may not operate correctly in a Fire situation. The fire dampers should be inspected and tested annually but this is not possible within the Maternity Wing as they are located within the ventilation duct work in the ceiling voids and risers. Access is restricted due the presence of ACM's. Effective operation of the fire dampers is essential to prevent the spread of fire and smoke in the event of a fire. Failure to implement the recommended schedule of testing could result in an increased risk of in-service failure of these units.	Replacement of Fire Dampers required in Maternity Wing in accordance with developing Fire Strategy Plans.	2. High priority risk mitigation	Graham, Mr Mark	Replacement programme in progress.	30/06/2019		
						Pilgrim Hospital does not have adequate 1hr fire integrity. This is caused by the age of the structure, leading to an impact/effect on the structural integrity of the building under fire conditions potentially placing patients, staff and service users at risk of harm in the case of a major fire.	Compliance with Fire Enforcement Notice through Statutory Fire Safety Programme implementation. Early warning system due to automatic fire detection system.	1. Critical priority risk mitigation	Davey, Keiron	As built façade scheme drawings indicate fire protection of structural elements to the perimeter of the building recently upgraded.	30/06/2019		
						Fire Dampers within the East Wing of LCH are located within ventilation system ductwork to prevent the spread of smoke and fire. A number of the dampers are connected to the fire alarm system and activate when the alarm system operates. Other dampers are controlled by a "fusible link". No regular testing regime is currently in place. This is an issue for all sites.	Specialist contractor to carryout a survey to establish operational status and provide report of any remedial works required. Initiate remedial work programme. Implement regular testing regime.	2. High priority risk mitigation	Graham, Mr Mark	Survey undertaken 2015/16 - identified remedial works required. to be considered for backlog maintenance. Refer to EFAN.	30/06/2019		
						Some pipework & fittings in the External Underground Fire Ringmain at Pilgrim in poor condition. Water leaks could affect Fire fighting capability. RPZ valve faulty, requires repair/replacement.	Going out to tender in new financial year replacing pipework and valve in the External Underground Fire Ringmain at Pilgrim.	2. High priority risk mitigation	Royales, Fred	Specific work on RPZ valve has been completed.	30/06/2019		
						Potential inability to evacuate Trust premises in the event of an emergency in the event of poor or non-existent fire training.	Volunteer Fire Safety Advisor. Free up Fire Safety Advisors to facilitate bespoke training. Need to substantially officially appoint additional Fire Safety Advisor. TNA (Training Needs Analysis) in place and being managed. Formal training programme to be implemented.	1. Critical priority risk mitigation	Davey, Keiron	Training in higher risk areas has commenced. Recent appointment of additional fire resource.	30/06/2019		
						Potential for water leaks causing a fire if replacement of heating, hot and cold water services in main duct is not done (under EAU corridor, GDH).	Multiple leaks repaired and patches placed on the pipework. Ensure Emergency repair kits are available onsite. Identify Capital Funding.	3. Medium priority risk mitigation	Harrison, Nick	Routine monitoring, repair as best we can when leaks occur.	30/06/2019		
						Risk of Fire to wooden clad building (AF and AG/ AE). Rheumatology is delivered from a timber clad two storey building, there is minimal fire compartmentation in the building. The building is poor state of repair. The fire doors are poorly maintained. The windows are rotten and likely to fall out. There is a risk that a fire will spread rapidly through the building horizontally and vertically. Works are planned in 2019, the condition is a cause for concern from a fire perspective and needs escalation of fire improvement works. Requires decant to allow works to take place.	A Fire Risk Assessment is in place for the wooden clad building (AF and AG/ AE). Evacuation is staff led. A basic review of the building condition has been undertaken as a result of the issues raised in the adjacent nursery premises. Fire works are planned in this area Phase 4, package 3 - due 2019. 1. Fire Risk Assessment to be reviewed - action FSA 2. Escalate need for fire improvement works - actions FSA	2. High priority risk mitigation	Davey, Keiron		31/12/2019		
4406	**Critical failure of the medicines supply chain (corporate)** If the Trust experiences a critical failure in its medicines supply chain; Caused by issues with the business continuity arrangements of one or more major suppliers and a lack of resilience within the system; It could result in significant disruption to services throughout the Trust, impacting on productivity and the care and treatment of a large number of patients	Service disruption	Very high risk (20)	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Medicines stock management arrangements. Medicines supplier business continuity arrangements.	High risk (12)	Potential impact of Brexit on medicine supplies to the UK (particularly in the event of a 'no deal' scenario as of March 2019), which may restrict the availability of some medicines.	National preparations directed by the Dept of Health & Social Care to ensure at least 6 weeks supply of medicines in case imports to the UK are affected.	3. Medium priority risk mitigation	Fahimi, Nabil		31/03/2019	Low risk (4)	31/05/2019
						The Trust currently uses a manual prescribing process across all sites, which is inefficient and increases the potential for medication not being ordered when needed.	Planned introduction of an electronic prescribing system across the Trust.	2. High priority risk mitigation	Fahimi, Nabil		31/03/2020		

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ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
	large number of patients. Executive lead: Neill Hepburn Risk lead: Colin Costello					Shortages of several brands of normal immunoglobulin. Gap in immunologist input for switching patients between brands.	Senior pharmacist and medical staff to manage switch between immunoglobulin brands with advice from the responsible consultant. Where patients are not looked after by any consultant following retirement of consultant Immunologist, the patients will remain on existing brand until Immunology cover is available.	2. High priority risk mitigation	Sheanon, Danielle		31/03/2019		
						Frequency and duration of medication shortages are presenting an increasing problem, with associated risks to patient care. May mean increasing reliance on unlicensed import products. Management of shortages often involves procurement of more expensive alternatives. Identification of shortages is often at the point at which stocks are depleted – a more robust system would be desirable whereby we anticipate shortages.	Shortages of contract lines are reported centrally; shortages of non-contract lines rely on identification by Trust pharmacy staff. Where shortages are identified, aim to put in place an appropriate management plan, after liaison with relevant members of pharmacy staff or specialist clinicians.	2. High priority risk mitigation	Sheanon, Danielle		31/03/2019		
						Due to a significant shortage of Varicella zoster immunoglobulin (VZIg), Public Health England (PHE) has centralised stock holding of this product within their unit at Collindale. Ordinarily the Trust holds stock of this product on site to facilitate timely, appropriate treatment of patients. Pregnant patients in the first 20 weeks of pregnancy, with negative VZ antibody, who are eligible for treatment may experience a delay – this may be a risk if they are presenting towards the end of the treatment window as the product needs to be given within 10 days of exposure.	Information regarding the restrictions to use of VZIg and also the process for obtaining stock have been shared with all pharmacy staff. Stock will routinely be supplied on the next working day to the pharmacy or GP surgery. Clarification has been sought from PHE regarding out of hours emergency access.	1. Critical priority risk mitigation	Sheanon, Danielle		31/01/2019		
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. Executive lead: Paul Boocock Risk lead: Chris Farrah	Service disruption	Very high risk (20)	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)	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.	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	2. High priority risk mitigation	Farrah, Chris	Water main installed; to be connected.	31/07/2019	Low risk (4)	31/07/2019
						Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	2. High priority risk mitigation	Cook, Steven	Scheme of work and design currently being produced.	31/12/2019		
4421	**Delivery of the E-prescribing project (corporate)** If the Trust does not deliver the E-prescribing project to planned specification, cost & timescales; Caused by issues with the availability of sufficient funding, project planning, or project management; It could result in significant disruption to multiple services throughout the Trust and failure to realise the potential benefits in terms of efficiency and risk reduction that e-Prescribing is expected to bring. Executive lead: Neill Hepburn Risk lead: Colin Costello	Service disruption	Very high risk (20)	Business case development process. Funding application and approval process (Trust & NHSI). Project management resources & support. Project governance arrangements. CRIB / FSID review of Business Case. Clinical Management Board (CMB) engagement. Digital Strategy Board. NHS Digital maturity assessment.	High risk (12)	Funding not yet in place - requirement for successful application to NHSI. Initial application was rejected.	Application to NHSI for funding to be re-submitted in early 2019.	2. High priority risk mitigation	Fahimi, Nabil		30/06/2019	Low risk (4)	31/05/2019
4300	**Availability of medical devices & equipment (corporate)** If the Trust's is unable to maintain the availability of essential medical devices and equipment; Caused by issues with capital and / or revenue planning, procurement and delivery processes or the availability of sufficient funding and	Service disruption	Very high risk (20)	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.	High risk (12)	Gaps in service history recorded on central equipment inventory.	Departments to be given system access to update central equipment inventory.	3. Medium priority risk mitigation	Hacking, Chris		31/03/2019	Low risk (4)	30/05/2019
						Resource constraints (insufficient funds available to deliver against identified equipment requirements).	Prioritisation by Medical Device Group through Capital & Revenue Investment Board throughout 2018/19.	2. High priority risk mitigation	Samra, Dr Gurdip		31/03/2019		

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	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. Executive lead: Neill Hepburn Risk lead: Gurdip Samra			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.		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.	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.	2. High priority risk mitigation	Hacking, Chris		30/06/2019		
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. Executive lead: Mark Brassington Risk lead: Yaves Lalloo	Service disruption	Very high risk (20)	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)	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.	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	2. High priority risk mitigation	Lalloo, Yavenuscha		31/03/2019	Low risk (4)	31/05/2019
						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.	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.	3. Medium priority risk mitigation	Lalloo, Yavenuscha		31/03/2019		
						Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	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.	2. High priority risk mitigation	Lalloo, Yavenuscha		31/03/2019		
						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.	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	1. Critical priority risk mitigation	Lalloo, Yavenuscha		31/03/2019		
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. Executive lead: Kevin Turner Risk lead: Nigel Gay	Service disruption	Very high risk (20)	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital. ICT hardware & software upgrade programme. NHS 17/18 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).	High risk (12)	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	The Trust is working towards compliance with the Cyber Essential Plus framework and EU Network Security Directive.	3. Medium priority risk mitigation	Gay, Nigel		31/03/2019	Low risk (4)	31/07/2019
						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.	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	2. High priority risk mitigation	Gay, Nigel		31/03/2019		
						Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	2. High priority risk mitigation	Gay, Nigel			31/03/2019		
4176	**Management of demand for planned care (corporate)** If demand for planned care (elective, outpatient and diagnostic services) significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards. Executive lead: Mark Brassington Risk lead: Andrew Prydderch	Service disruption	Very high risk (20)	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)	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).	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. Strategic direction to be outlined in fragile services paper to Trust Board. Capital plan for estate development, space utilisation and medical equipment. Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP).	2. High priority risk mitigation	Prydderch, Andrew		31/03/2019	Low risk (4)	31/05/2019

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3687	**Delivery of an Estates Strategy aligned to clinical services (corporate)** If the Trust is not able to deliver an Estates Strategy that is aligned to clinical service strategies and development plans; Caused by issues with the design or implementation of the strategic planning or service transformation process, or insufficient capital funding available; It could result in a significant impact on the efficient utilisation of the estate which adversely affects the performance, quality and sustainability of multiple services. Executive lead: Paul Boocock Risk lead: Chris Farrah	Service disruption	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Space Utilisation Policy. Capital investment planning process and programme (prioritisation to support compliance with statutory and HSE Regulatory Requirements and manage critical infrastructure risk). Identification of age and condition of estate enabling planned investment and dis-investment. Implementation of premises assurance model (NHS PAM). Leases and Property Management (SLA's) LHAC, One public estate and Trust clinical strategy relationship.	High risk (12)	Lack of health community clinical strategy to inform the development of the Trust's Estates Strategy. No identified resource to develop Estates Strategy.	Develop, review and implement an Estates Strategy (aligned to the capital investment programme) with reference to the STP, ERIC data & Lord Carter's recommendations.	1. Critical priority risk mitigation	Farrah, Chris	Draft strategy to be presented to August Trust Board.	31/09/2019	Moderate risk (8)	31/07/2019
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. Executive lead: Paul Boocock Risk lead: Chris Farrah	Reputation / compliance	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Trust Asbestos Core Working Group. Asbestos Awareness training for managers and operatives (Estates staff and contractors). Specialist contractor appointed to advise Trust on specific Asbestos management issues across sites. Site Survey data available on Micad. Third Party Contractor induction for both capital schemes and day to day maintenance. Annual Facefit training for specialist PPE equipment. Occupational Health reviews, lung function test. Specialist surveys prior to making any physical change to built-in environment. Air monitoring of specific areas to give assurance that controls in place are adequate. Risk Prioritised Estates Capital Programme. Restricted access where known asbestos containing materials (ACMs) exist (permit to work system).	High risk (12)	Asbestos Management Plan still to be fully developed.	Complete development & begin implementation of Asbestos Management Plan.	2. High priority risk mitigation	Estates	To be reviewed at next Asbestos Group	30/06/2019	Low risk (4)	31/07/2019
						Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	Contract review control meeting to take place.	3. Medium priority	Estates		30/06/2019		
3690	**Compliance with water safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with water safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services. Executive lead: Paul Boocock Risk lead: Chris Farrah	Reputation / compliance	Very high risk (20)	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)	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.	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'. The non-compliant units to be replaced with those which comply with the Water Regulations.	2. High priority risk mitigation	Estates	Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.	31/12/2019	Low risk (4)	31/01/2019
						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.	Funding required for replacement TMVs, sinks and hand basins.	2. High priority risk mitigation	Estates	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. Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	30/03/2020		

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ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
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. Executive lead: Kevin Turner Risk lead: Nick Leeming	Service disruption	Very high risk (20)	Dep Ch Exec appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables - medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT Brexit 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)	Existing arrangements for risk assessment & business continuity may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Completion of all required actions in respect of risk assessment & business continuity, as detailed in the national EU Exit guidance.	4. Lower priority risk mitigation	Leeming, Nick	Annual leave - at present, no change to existing arrangements. Confirmation required that no departments are at risk. On-call arrangements to be reinforced by additional Gold / Silver on standby. Specific action cards prepared to supplement existing BC plans & enable escalation to national Brexit team if required. Local BC plans reviewed against Brexit risks. National & local BC plans in place for threats including: workforce shortage; fuel shortage; supply chain disruption. Alignment with LHRP contingency plans (weekly teleconference). All areas assessing national scenario guidance that are relevant to their speciality and assigning level of risk to each.	31/03/2019	Low risk (4)	30/04/2019
						The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	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.	2. High priority risk mitigation	Costello, Colin	As a rural Trust, normal stock levels equate to 30 days which will continue as normal. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. Options to manage the impact of the current recruitment freeze on staffing capacity in Pharmacy procurement to be considered.	31/03/2019		
						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.	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	3. Medium priority risk mitigation	Pogson, Barry	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.	31/03/2019		
						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.	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.	4. Lower priority risk mitigation	Pogson, Barry	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.	31/03/2019		
						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.	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	3. Medium priority risk mitigation	Tidmarsh, Darren	General message regarding settlement scheme & registration sent out. Approx 300 affected staff; 40% have confirmed status already. Awaiting further guidance regarding professional registration. Agencies may also be reliant on EU workforce - risk assessment requested from Holt. HR to liaise with agencies providing medical staff to assess any risks throughout the Brexit period. To consider the possibility of cancelling annual leave during the Brexit period if planned staffing levels are not sufficiently robust.	31/03/2019		
						Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	4. Lower priority risk mitigation	Hills, Mr Colin	Need to understand the scale of risk, to ascertain how many patients would suddenly have to pay if reciprocal arrangements cease and who would not qualify; to pull together resource plan to meet the requirements to charge EU citizens from 29 March 2019.	31/03/2019		

Appendix I - High Very high corporate risks (June 2019)

ID	Title & leads	Risk Type	Risk level (unmitigated)	Controls in place	Risk level (current)	Weakness/Gap in Control	Planned mitigating actions	Priority	Action lead	Progress	Action due date	Risk level (acceptable)	Next risk review due date
						Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	4. Lower priority risk mitigation	Leeming, Nick	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.	31/03/2019		
						Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	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.	3. Medium priority risk mitigation	Tute, Mrs Maria	Local risk assessment carried out did not identify any significant data sharing implications. Latest guidance to be reviewed and potential impact re-assessed.	31/03/2019		
						Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	4. Lower priority risk mitigation	Hills, Mr Colin	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time). Consideration to be given to the potential that prices for some goods (e.g. food) may increase post-Brexit.	31/03/2019		
						Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	3. Medium priority risk mitigation	Leeming, Nick	Communication of common message regarding clinicians not writing longer prescriptions and patients' storage of medicines at home. Communications plan in progress to inform affected staff of settlement scheme and professional registration requirements. Use of traditional and social media channels, in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).	31/03/2019		

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	4th June 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 May and subsequently updated to reflect discussions held.

The Quality Governance Committee had discussed in detail the assurances which they had received at their meeting but requested further work be done on the gaps in controls and assurance before the Committee would be in a position to determine a rating. This work would be completed for consideration at the meeting in June and was detailed in their assurance report to the Board.

The BAF has been updated to include links to the risk register, assurance gaps, mitigation and assurance ratings. Further work will be undertaken to ensure assurances provided through the clinical audit plan are reflected within the BAF and reported to the Board from July.

Consideration is requested by the Trust Board to:-

Objective 1a –Value our patients time – The Quality Governance Committee had asked that the Board consider how patient experience was considered as a feature

of this objective and whether this would be covered with the assurances received at the Finance, Performance and Estates Committee.

Objective 2a, metric - % of services rated a 'delivering', discussions held at the Finance, Performance and Estates Committee identified that the metric is in development and as such due to be setting a baseline during 2019/20 and therefore cannot be updated to function as part of the BAF. The BAF should be providing the Board with a current view of the Trust achievements to objectives, as such the development of a baseline metric is unlikely to contribute to the delivery of a strategic objective.

Future reports of the BAF to the Trust Board will include a direction of travel for the assurance ratings to demonstrate where movement of the assurance ratings has taken place. This will enable the Trust Board to keep a direct line of sight on the progress of the Trusts strategic objectives.

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 progress made on populating the 2019/20 Board Assurance Framework

The Trust Board are asked to consider the metric of objective 2b - % of services rated as 'delivering', to determine if it is appropriate to report a baseline metric within the BAF

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 - May 2019

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Unreliable or inaccurate data Steps not delivered within the Trust Mortality Reduction Strategy Partnership working	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Speciality Governance Integrated Performance Report National surveys and audit - secondary control Dr Foster - investigations into Dr Foster alerts SHMI and HSMR National Benchmarking Reports Model Hospital Data National Audit Data - HQUIP ReSPECT Care Plan	Speciality governance process Partnership working ReSPECT care plans not adhered to or in place No established process for cross system reviews	Trust Operating Model role out Performance review mechanisms of staff	Speciality assurance against governance guide Audit of speciality governance Mortality Reduction Plan Quality review of medical workforce Quality review of nursing workforce Regular reporting on learning from deaths. Updates on coroner cases and preventing future deaths	System wide partnership reports	Masterclass and Organisational Development Patient Safety Committee Clinical Effectiveness Committee Drugs and therapeutic Committee 7 day Services Mortality review group	Quality Governance Committee	
		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 Divisons.	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 Intergrated Performance Report Quality Strategy Subject matter expert group reports QSOG reports Quality Account priorities <u>Internal Audit:</u> Data quality of KPIs - Q4 Compliance with legislation - Q2	Divisional governance still in development.	Standardised Terms of Reference issued Governance guide issued.	Integrated Performance Report Patient Experience Dashboard Quality and Safety Improvement Plan Board Walkrounds Clinical Audit Programme Ward Accreditation Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention Control exception report	Quality Strategy not approved Harm Review QSOG still in development New Trust Operating Model still embedding.	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
1b	Value our patients' time	% patients seen at appointment time	Chief Operating Officer	Systems unable to capture and report data Unreliable 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	Data Quality Group Activity Plan Outpatient Improvement Programme <u>Internal Audit:</u> Data quality - Q1	Data Quality Issues New reporting metric Insufficient outpatient capacity to meet current demand across a number of specialties Referral demand across a number of specialties in excess of capacity Specialty Governance	Data Quality workstream Performance Review Meetings Outpatient productivity programme Contract Meetings System approach to managing planned care demand FTG exception report	Monthly Delivery Productive Services report PRM QSOG	Report not available Data quality assurance IPR	Outpatient improvement programme Development of data quality prior to reporting Report from system SRO	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
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	Specialty Governance Data Quality Issues New reporting metric	Roll out of the TOM in line with the governance framework	Monthly Delivery Productive Services report Urgent and Emergency Care Improvement Programme update IPR	Reporting at speciality level unavailable Metric under development	Development of report, due end June 2019 Development of metric, available June 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 Procurement	Efficiency schemes do not cover extent of savings required - £25.6m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure or financial penalties Failure to secure all income linked to coding or data quality issues Failure to secure contract income through repatriation schemes and inability to remove cost Activity exceeds contracted levels over and above repatriation and fails to secure all income due from commissioners	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very high)	CQC Well Led	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 planned care programme <u>Internal Audit:</u> Finance efficiency programme - Q2 Performance Management and reporting - Q3 Education Funding - Q1	Reliance on temporary staff to maintain services, at increased cost Operational ownership 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 Review back office functions Performance review process refresh through new operating model	Monthly Finance Report to Trust Board including capital and contracting FSM meetings with NHSI Scrutiny and challenge through Finance, Performance and Estates Committee Internal Performance Review Meetings Monthly NHSI Performance Review Meetings Internal Audit work reports IPR	FSM meeting review letter NHSI Performance meeting review letter	FSM letter to be reported to FPEC NHSI letter to be appended to PRM reports	Finance, Performance and Estates Committee	A
		% of services rated as 'delivering'	Chief Executive	Lack of capacity to establish a robust programme of work	None	CQC Caring CQC Responsive CQC Safe CQC Well Led CQC Effective	TOM Operational Group <u>Internal Audit:</u> TOM Governance - Q4	Aligned to revision to national standards 20/21 Report on milestone plan Triumvirate Plan	Tracking national developments Developing shadow running of national standards as they become clear Trust Operating Model Operational Group				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
SO3	**Providing services by staff who demonstrate our values and behaviours**													
3a	Have a modern and progressive workforce	Vacancy fill rate	Director of HR&OD	Inability to recruit and retain a suitably skilled workforce to meet demand resulting in unplanned and indefinite closure of multiple services across the Trust Failing to reduce high vacancy rates of consultants and doctors Reliance on deanery positions to cover staffing gaps Significant proportion of workforce approaching retirement age Inadequate workforce planning process	Corporate risk ID 4362 - Workforce capacity & capability (Very high) Corporate risk ID 4082 - Workforce planning (High)		People Strategy and Annual Workforce Plan Recruitment and retention strategies People management policies & procedures Vacancy controls Agency cost reduction plan Access to workforce business intelligence Core learning & leadership development programmes <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; exploration of new staffing models Review approach to recruitment to deliver at greater pace and scale Communication & engagement with EU staff & their managers Recruitment programme Development of sustainable service model -Talent Academy NHSI Retention Project Review of age profile & People Strategy to mitigate impact	People Strategy Additional resourcing support Staff survey results Data on effective application of people management policies Absence management arrangements in Trust GMC Surveys Data quality work	Medical capacity planning Delivery of People Strategy Workforce planning	Reviewing progress with Trust Management Group Completion of more detailed action plans Agreed approval of workforce planning	Workforce, OD and Transformation Committee	**R**
3b	Work as one team	Recommend as a place to work in staff survey 46% (↑ of 5%) Recommend as a place to receive care in staff survey 53% (↑ of 5%)	Director of HR&OD	A fundamental loss of workforce engagement which could result in a culture of low morale and motivation that impacts on the quality & safety of services throughout the Trust and permanently damages its reputation	Corporate risk ID 4083 - Workforce engagement (High)		Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: -Engagement of staff in 2021 programme -Opportunities for staff voice to be heard -Work on staff charter and values -Leadership and management development Staff charter and vision and values People management policies, systems, processes & training Management of organisational change policies & procedures Inclusion strategy <u>Internal Audit:</u> Policy compliance - Q2 Mandatory training - Q2	Consistent quality of local leadership and management Staff engagement and belief in 2021 as means of bringing improvement 2018 Staff Survey suggest gap between individuals and Trust around belief that patient care is most important	Localised divisional action plans in response to staff survey results Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose Leadership and management development programmes Revamp of 2021 communications Trust-wide response to staff survey results to inform revised People Strategy	CQC report Workforce Committee KPIs including vacancy rates, appraisals, turnover, core learning, agency usage Pulse survey Staff Survey Quarterly FTSU Guardian report to Board Staffside representative feedback Report on application of people policies - Sickness absence, disciplines, grievances TB FTSU Self Assessment IA Review Public Sector Equality Duty	Guardians of Safe Working Divisional management teams, completing engagement work with staff	Development of alternative to deliver Guardians of Safe Working responsibilities Review Divisional management teams through PRMs	Workforce, OD and Transformation Committee	**R**
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%	Deputy Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive	Activity monitoring Activity plan Contract Improvement project System plan delivery <u>Internal Audit:</u> STP Governance - Q2	Lack of system wide performance framework Lack of system delivery method	SET/LCB Hundred Day O/P implementation plans Planned care group	IPR Performance report Contract system reporting	No system report No delivery plan	ICC Programme Board being set up	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:

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

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

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

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Audit Committee Report to Trust Board
Date of meeting:	20th May 2019
Status:	For Discussion
Chairperson:	Mrs Sarah Dunnett, Non-Executive Director
Author:	Mrs Jayne Warner, Trust Secretary

Purpose	To provide the Board of United Lincolnshire Hospitals NHS Trust with a formal report of the work of the Audit Committee since its last meeting, the assurances that have been received and validated, and those that are missing along with the actions to address them.
Background	This committee meets at least quarterly and takes scheduled reports from the Trust's Internal and External Audit Providers, Counter Fraud Service, Finance Director and other parties in accordance with an established work programme.
Business undertaken	**Internal Audit** The Committee received the draft Internal Audit Plan 2019/20 from the Trust's newly appointed Internal Audit providers Grant Thornton. The plan was the culmination of risk assessment work and a session with the Executive Team. The Committee challenged some of the proposed content particularly with respect to the workforce areas. This would be reviewed by the Interim Director of Finance and Procurement and Grant Thornton. The Committee agreed initial work on Q1 of the plan could commence. The Committee agreed that in future it would also be useful to seek input from the Chairs of the Board Committees in the production of the plan.
	Head of Internal Audit Opinion 2018/19 The Committee had previously received this in draft and noted the provision of a limited opinion.
	Annual Governance Statement 2018/19 The Committee received the latest version of the Annual Governance Statement acknowledging that this had been seen twice previously by the Committee in draft form. Comments from Committee members and External Audit had been incorporated in to the version presented. The Committee agreed the Annual Governance Statement for inclusion in the annual report for

	submission to the Board subject to any final comments received from External Audit.
	ISA 260 PWC presented the ISA 260 report on their audit for the year ended 31 March 2019. The Committee were advised that the Trust had been advised that the historic methodology used for calculating useful economic lives of property, plant and equipment was incorrect and would require a prior period adjustment if the balance was material. This had been recorded in the accounts as an error, however, there would not be an adjustment. NHSI were supportive of this approach and the Trust was one of a number affected by the same issue. The External Auditors stated that whilst there were still a number of minor disclosures which would need to be resolved before submission the process had gone well and they expected to issue an unqualified opinion.
	Approval of the Trust Annual Accounts for 2018/19 The Committee considered the final accounts, noting that these had been considered in detail by the Committee both informally and formally. The Committee were happy to recommend the accounts for approval by the Trust Board at their extraordinary meeting on the 23 May subject to the resolution of the final disclosure matters with the external auditors.
	Approval of the Trust Annual Report 2018/19 The Committee noted the final version of the annual report and the comments made by external audit confirming that the report was compliant with requirements for NHS Trusts.
Issues where the Committee are seeking further assurance	None

Agenda Item

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Jayne Warner Trust Secretary
Date:	4 June 2019
Essential Standards:	

Title:	Annual Self Certification for NHS Trusts under NHS Provider Licence

Author/Responsible Director: Trust Secretary

Purpose of the Report: To ask the Board to sign off the self-declaration required by NHS Improvement.

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Information	

Summary/Key Points:

The Trust Board are required to provide an annual self-certification that they can meet the obligations set out in the NHS provider licence and show that they have complied with governance requirements.

Whilst NHS Trusts are exempt from meeting the provider licence, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.

The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and condition FT4) and must self-certify under these licence provisions. The CoS conditions do not apply to NHS trusts, so they are not required to self certify under CoS7 condition.

This means that the Trust needs to self-certify for the following conditions after the financial year end.
Condition G6 The provider has taken all precautions necessary to comply with the licence, NHS Acts and Constitution.
Condition FT4 The provider has complied with required governance arrangements.

Providers are able to determine their own process to be assured that they are compliant. NHSI have provided templates for boards to use.

Condition G6 must be signed off by the Board no later than 31 May 2019 and be made public no later than one month following this.

Condition FT4 must be signed off by the board no later than 30 June 2019.

Providers must select confirmed or not confirmed for each declaration. Explanations must be provided for declarations not confirmed.

Recommendations:

To ask the Board to sign the declaration for Condition FT4 as "not confirmed" acknowledging the position of the Trust being rated as requires improvement by the CQC and remaining in special measures for quality and finance.

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

United Lincolnshire Hospitals NHS Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2018/19 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Not Confirmed	The Trust has been subject to conditions placed on its licence by the CQC. The Trust has continued to make progress against addressing the actions which form part of its Quality and Safety Improvement Plan which was established to address the required improvements. The Trust is in financial special measures and has a put in place a financial recovery plan alongside additional support from NHS Improvement. The Trust continue to manage and consider work to improve quality and finance through its Board and Committee meeting upward reporting framework.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board reviews and takes account of all guidance issued by NHS Improvement.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has conducted a review of its committee structures and terms of reference and ensured that committee responsibilities are aligned to a revised BAF. The Board has engaged external support in a review of management structures and implemented a new Trust Operating Model. Responsibilities are clearly defined in a Trust Governance Manual.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not Confirmed	The Trust remains in special measures for Finance and Quality. The Trust has established a financial turnaround group and quality, safety improvement programme to monitor the action plans put in place to address the issues highlighted. Upward reporting on progress has been made through these groups to Board and Committees and then Trust Board. The Board has challenged data quality and required actions to address this. A new Integrated Performance Report has been developed which the Board and particularly committee chairs were involved in developing. The Trust has reviewed its BAF and Risk Register in year and these are considered at the monthly Board meetings. Risks to compliance are considered in a quarterly report to the Audit Committee. Progress reports on delivery of plans have been presented to committees and Board.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Not Confirmed	The Board have recently conducted a well led self assessment and through the completion of a gap analysis identified those areas where actions are required. The Board have initiated a review of the Board Assurance Framework to support its business. The new framework was in place for the latter half of the financial year. The Board has challenged data quality and required actions to address this. A new Integrated Performance Report has been developed which the Board and particularly committee chairs were involved in developing. The Board receive regular information on patient experience, quality and safety. Quality issues are escalated through Directorate Governance structures through Quality Governance Committee to the Trust Board.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Not Confirmed	Permanent recruitment has now been made to the Chair and Non Executive Board positions. The Trust has an Interim Director of Finance and has agreed a secondment arrangement for its Chief Executive Officer following an unsuccessful recruitment process. The Trust continues to work to address the ongoing medical and nursing recruitment issues.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Jan Sobieraj

Signature _____ **Name** Elaine Baylis

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A	The senior management team have taken steps to establish a stronger framework for the Trust to operate within. Specifically action has been taken to strengthen focus on areas of governance and risk management. This represents some of the fundamental control arrangements required if the Trust is to establish a strong position from which to achieve its strategic objectives. Progress is starting to show through in improved implementation rate of audit actions at follow up. However, although the Trust is establishing a sound base to set a positive path to improvement and had people in place to take this forward, this has yet to become embedded and achieve improved outcomes.	OK

Worksheet "Training of governors"

Financial Year to which self-certification relates Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Deputy CEO
Date:	3 June 2019
Healthcare standard	

Title:	Healthy Conversation 2019

Author/Responsible Director: Kevin Turner, Deputy Chief Executive

Purpose of the Report: To provide the Trust Board with a summary of the Health Conversation 2019 campaign, detailing the activity to date, feedback and results and the next steps.

The Report is provided to Trust Board for:

Decision		Discussion	
Assurance		Information	X

Summary/Key Points:

The healthy conversation 2019 campaign has delivered a recognisable and effective platform to enable key stakeholder groups to share feedback with Lincolnshire's NHS. The activity to date includes Internal and stakeholder briefings, Media briefings, public engagement events and working with the Peoples Partnership to hear the views of Lincolnshire's communities who aren't readily represented.

Recommendations:

For Trust Board to note the updates on the actions taken so far and the next steps.

Strategy Impact	**Performance KPIs year to date**

Resource Implications (e.g. Financial, HR) –	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications	
Equality Impact:	
Information exempt from Disclosure:	
Requirement for further review?	

Agenda Item 17.1

Report to: Trust Board
Date: 28 May 2019
Subject: Lincolnshire NHS *Healthy Conversation 2019* – General Update

Summary: This report provides a summary of the Healthy Conversation 2019 campaign, detailing the activity-to-date, feedback and results, and next steps in the campaign.

Actions Required: To note the progress on the delivery of the Healthy Conversation 2019 campaign.

1. Introduction

Objective

The ongoing need for modernisation in how the county's health care is provided must be informed by our patients, public, their representatives, our partners and of course, our staff's views. After engaging with, and seeking the advice of wider stakeholders, the health care system in Lincolnshire agreed that to allow the gathering and understanding of these groups' views, a county wide campaign that offered a consistent and recognisable point of contact would be appropriate.

2. Activity to date

Lincolnshire NHS's *Healthy Conversation 2019* campaign went live on 5 March 2019. This first day involved:

- A series of internal and stakeholder briefing sessions
  - Staff team briefing process – face to face
  - Briefs to all communication points of access across NHS organisations to ensure public were dealt with effectively and quickly, first time, should they wish to contribute feedback.
  - Email briefs to lay members and non-executive directors, council of members, GPs, MPs, local councillors, health and care stakeholders and partners (all 'internal' audiences)
  - A catch all email to those unable to attend face to face briefings
  - Briefings emails sent to all partners, stakeholders, and local 'influencers' (for example, education sector, large local businesses) (all 'external' audiences)
- A press call to brief the media, led by clinicians
- Lift of public embargo at 3pm

- Proactive social media and press bulletin schedule commenced for the following fortnight initially

Days two to eight were dedicated to press office management and responding to public enquiries.

13 March was our first public engagement event. The initial events delivered in this series were:

13 March - Boston
14 March - Louth
19 March - Skegness
20 March – Grantham

Followed by a second round of events after purdah:

20 May – Sleaford
21 May – Gainsborough
22 May – Lincoln
12 June – Stamford
13 June- Spalding

Each event was a consistent format, with a series of information and listening stands, supported by expert clinicians and support staff. The route through the event stands was:

- Integrated Community Care – self-care, primary care, diabetes, Integrated Neighbourhood Working
- Mental Health
- Acute Services
- Urgent Treatment Centres (at Grantham)
- Information Management & Technology
- Healthwatch long term plan
- Travel and transport

At each event, attendees were able to talk directly to staff who captured their feedback, as well as complete feedback forms and the more formal survey. The survey has been requested in numerous languages (Romanian, Polish, Russian, Latvian, Lithuanian, and Portuguese), and has been translated to all. These feedback forms and survey are also on our website and available in paper format on request as well the public being able to email and phone directly to the team. A freepost address has been set up for those that require one.

In addition to the public events to date, we have also been working alongside our partner, The People's Partnership, in order to hear the views of Lincolnshire's communities with protected characteristics and those who would otherwise not be readily represented. These findings will inform this work, as well as our Equality Impact Assessments.

3. Outcomes

Press Relations

The initial press call was attended by seven key print press and broadcasters in the county:

- The Lincolnite
- Health Correspondent BBC East Midlands
- BBC East Midlands
- Grantham Journal
- Lincs FM
- BBC Radio Lincolnshire & Sunday Politics (Yorkshire & Lincolnshire)
- Lincolnshire Live

Quotes and interviews within the resulting articles were all delivered by senior clinicians.

The core themes that the press subsequently led with were:

1) Urgent and emergency care – headlines included 'A&E downgrade at Grantham'
2) Publicity of *Healthy Conversation 2019* (county wide)

Overall the balance of media reports was neutral, with the negative articles being concentrated in the urgent and emergency care theme. A full list of the first day's media coverage was as follows: -

05/03/2019	Lincolnshire Reporter	Grantham A&E to be downgraded to Urgent Treatment Centre
05/03/2019	Lincolnshire Reporter	Disappointment as A&E fears come true for Grantham and Louth campaigners
05/03/2019	Boston Standard	Healthy Conversation proposals for Lincolnshire's health service
05/03/2019	Sleaford Standard	Healthy Conversation proposals for Lincolnshire's health service
05/03/2019	Louth Leader	Healthy Conversation proposals for Lincolnshire's health service
05/03/2019	Grantham Journal	Public consultation on future of healthcare service in Lincolnshire to begin
05/03/2019	Grantham Journal	Breaking news: Downgrade of Grantham A&E formally announced
05/03/2019	Market Rasen Mail	Healthy Conversation proposals for Lincolnshire's health service

After the first ten days, press activity dropped significantly. It increased again when the engagement events took place (13 March – Boston; 14 March – Louth; 19 March – Skegness; and 20 March – Grantham). In this period, the balance of coverage

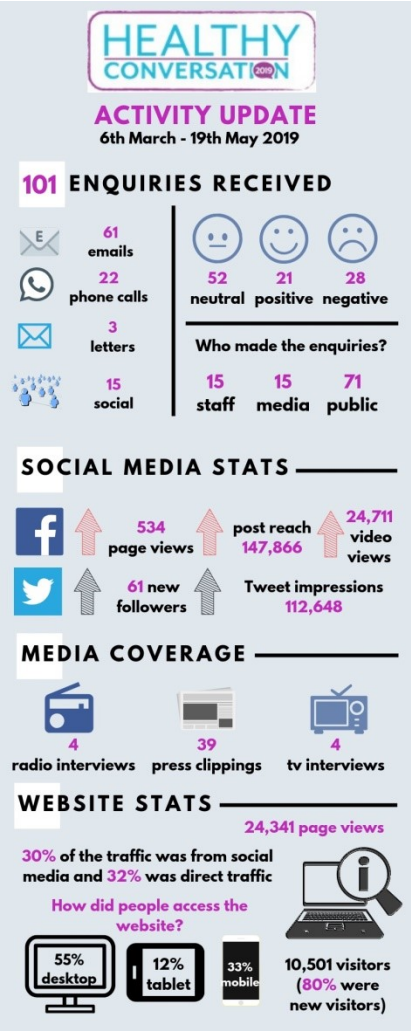
was much more positive. When the events started again after purdah press activity was quiet in comparison to the first round – probably due to the fact there are no contentious issues in the locations covered.

The core themes of coverage during this period were:
1) Publicity of *Healthy Conversation 2019* (county wide)
2) Urgent and emergency care – headlines included 'A&E downgrade at Grantham'
3) Future stability of Pilgrim Hospital (Boston)

The focus became increasingly on the *Healthy Conversation 2019* campaign coverage, opposed to the themes, as the events continued.

A full list of subsequent media coverage can be found at Appendix A.

This infographic captures the volume of activity up to 19/05/2019 managed by our press and public relations office. A monthly version is published on the website for public viewing.



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Public Engagement Events

The engagement events to date have been attended by 301 people (excluding the final two events in Stamford and Spalding). The core themes that were raised within feedback (through direct verbal feedback, formal forms and the surveys analysed to date) were:

Boston:
- Accessibility of stroke services in the future
- Loss of services to Boston as a whole

Louth:
- Threat of hospital closure (this was an initial concern that alleviated once responded to)

Skegness:
- Accessibility of stroke services in the future
- Loss of services to Boston as a whole

Grantham:
- A&E downgrade perception
- Urgent Treatment Centres and what they are

Sleaford:
- Lack of GP access
- Lack of coordination following discharge from hospital

Gainsborough:
- Lack of GP access
- Financial difficulties when having to travel to visit family

Lincoln:
- Financial difficulties for family members having to travel to hospital
- Professionals should be able see each other's notes to make it more streamlined for patient

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family
- NHS111 and its effectiveness
- East Midlands Ambulance Service and response times
- Issues of overburden on Lincoln County Hospital

As of the end of May, 518 surveys had been completed and submitted. Our updates on engagement activity is also published on the website for public viewing, as is a full overview of the key themes from public feedback in the 'you said, we did' section. Any individual who requested direct information or feedback since the campaign began, has received a reply.

Examples of feedback we heard and responses given to date include:

Travel & Transport feedback:

- Issue isn't the hospitals but travelling to them – poor road networks and lack of public transport
- Early appointments not achievable when using public transport
- Costly travelling across the county to hospitals further away
- Can't always rely on family and friends
- Community transport sometimes unreliable
- Unable to get back from hospitals if taken by ambulance

Travel & Transport response:

The NHS is responsible for delivering medical and health care services. Local councils are responsible for public transport. However, we fully appreciate how crucial transport is so that patients can access NHS services, therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. We have worked to a principle of the most regular care requirements remaining close to home, such as routine screens in cancer care for example. It is when care needs become more complex and specialised that we introduce further travel; we have heard from Lincolnshire's public that the right care, first time is the priority, even if that means further travel. A large consideration for our clinicians as they review services is how to best spend NHS funding, including whether we divert some of our funds away from care in order to supplement patients' travel, and we would welcome your continued input into this consideration.

We are also working on digital solutions so where possible, we can prevent the need for travel and for example a face to face consultation could happen by the internet. See technology and information section.

Technology & Information Services feedback:

- Welcome e-consultations to avoid concerns regarding transport
- Refreshing to hear; innovative thinking, digital is the future
- E-consultations and telephone consultations are good ideas
- Many people do not have access to the internet and will need alternative options
- Areas of poor broadband and poor mobile phone signal
- Shouldn't need to keep re-telling your story/medical history

Technology & Information Services response:

In Lincolnshire we have developed the Lincolnshire Care Portal. This is a secure computer system that provides health and care staff with a selected view of a patient's personal information contained in different health and care systems. The Care Portal enables health and care staff to view an integrated care record for the

patient. It brings together selected patient information from multiple organisations and systems in real time. We are in the process of connecting up systems across Lincolnshire organisations, this includes GP practice systems, hospitals along with community and mental health. We are also looking farther afield so when Lincolnshire patients travel to hospitals in other areas, such as Peterborough, Nottingham, Grimsby etc. staff in those organisations have the patient information they need from Lincolnshire organisations. For more information about the Lincolnshire care portal please visit https://www.lincolnshire.nhs.uk/together/care-portal

There are other digitals plans too. These include plans for remote patient monitoring so for example a blood sugar or blood pressure can be taken by the patient in their own home, using a wearable device, and electronically sent to the patient's clinician who can review and then agree the treatment directly with the patient.

GP Services feedback:

- Communicate all options for appointments and don't always need to see a GP
- Promote GP Out of Hours services, especially at Grantham Hospital

GP Services response:

We are working hard to communicate with the county that there are several options available to access health services which don't always involve seeing a GP. These include seeing the advanced clinical practitioners (such as nurses) we have recruited across the county.

ASAPLincs is a free app and website resource which was launched to help the public access the most appropriate heath care. It also features an up to date overview of all out of hours services and their availability and has been heavily promoted on bus sides, through local papers, on social media and in GP practices etc. We have also promoted GP Out of Hours services through literature in schools.

4. Next Steps

A communication and engagement plan is in place as *Healthy Conversation 2019* progresses over the summer and into autumn.

This incorporates key learnings from our first stage of activity, including:
- Featuring more partners and their work in our engagement events, such as EMAS
- Making more of the opportunity to spotlight positive activity happening across Lincolnshire's NHS upon recruitment, for example our Talent Academy, schools in-reach etc
- Continuing to develop and promote our 'good news stories' and case studies, and focusing more upon the patient point of view within these

Completion of first wave engagement events is to the following schedule:

- Wednesday 12 June – Stamford Theatre Lounge
- Thursday 13 June – Spalding United Reformed Church

In conjunction with these events, we will continue to attend partner and stakeholder events in order to promote and discuss *Healthy Conversation 2019*, as well as hosting our standard events throughout the county.

Our 'you said, we did' communications will continue; publication of the key themes, requests and responses captured throughout these listening events in order to demonstrate the commitment made to the public.

Continuation of proactive and positive public and stakeholder engagement will develop into more detailed discussions around themes identified across the system and more visibility of the campaign and its content across the county.

5. Conclusion

The Healthy Conversation 2019 campaign has delivered a recognisable and effective platform to enable our key stakeholder groups to share feedback with Lincolnshire's NHS.

Priorities now are:

- To ensure we highlight the importance of prevention and self-care, community care, and mental health throughout the remainder of the campaign
- To engage with a broader and deeper section of Lincolnshire's public, delivering a fully representative engagement piece
- Providing evidence regarding the impact of public feedback upon continued transformation planning

6. Appendices

Appendix A Media Coverage in the Days following the Press Call

7. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.
This report was written by Charley Blyth, Director of communications and engagement, who can be contacted on 01522 307315 or charley.blyth@lincschs.nhs.uk.

Appendix A
Media Coverage in the Days following the Press Call

06/03/2019	Horncastle News	health campaigners for Boston-s-Pilgrim-Hospital-vow-to-keep-fighting-
06/03/2019	Sleaford Standard	Campaigners for Boston's Pilgrim Hospital vow to keep fighting in

		face of latest proposals by health bosses
06/03/2019	Sleaford Standard	Grantham Campaigners react to news of downgrade plans
06/03/2019	Radio Lincolnshire	changes to NHS .2:11.58-2:18.16 interview transcribed
08/03/2019	Lincolnshire Reporter	Matt Warman A concrete commitment to our NHS
08/03/2019	Grantham Journal	Residents react in fury over plans to downgrade Grantham Hospital
08/03/2019	Lincolnshire Reporter	Local Democracy Weekly Diagnosis downgrade for county's hospitals
13/03/2019	Louth Leader	https://www.louthleader.co.uk/news/have-your-say-at-the-healthy-conversation-2019-engagement-events-1-8847056
13/03/2019	Horncastle News	Have-your-say-at-the-healthy-conversation-2019-engagement-events
13/03/2019	Lincs. FM News	Public feedback session in Boston on health changes
14/03/2019	Lincs. FM News	Interview with Tracy P at noon
14/03/2019	NKDC	Healthy Conversation
14/03/2019	Grantham Journal	Have your say on plans forGrantham Hospital in 'Healthy Conversation'
15/03/2019	Grantham Journal	We've waited so lomg - now we have our say Martin Hill page 36
15/03/2019	Grantham Journal	Let's have a "healthy conversation" about Grantham Hospital Dr Neill Hepburn page 36
15/03/2019	Grantham Journal	Chance to have your say on hospital services at Drop-in session page 7
16/03/2019	Grantham Journal	We have waited so long - now we have our say
16/03/2019	Grantham Journal	Let's Have a healthy conversation about Grantham hospital
17/03/2019	Skegness Standard	Chance to have say on health service issues
19/03/2019	Lincolnshire Reporter	Jan Sobieraj Let's start a healthy conversation
19/03/2019	Lincolnshire Free Press	Have your say on future of NHS page 5
20/03/2019	Calendar News	Plug for Healthy Conversation session on Grantham today
21/03/2019	Lincs FM	Interview with Kevin Turner about A&E services and funding at Pilgrim hospital, Boston
22/03/2019	Grantham Journal	People make voices heard on hospital page 5
22/03/2019	Grantham Journal	Grantham people make their voices heard at NHS engagement event
26/03/2019	County News	Have your say on health page 5
02/04/2019	Grantham Journal	Number of signatures on petition is disappointing
08/04/2019	Spalding Today	The wonder that is the NHS
12/04/2019	Lincolnshirelive	Revealed the number of times A&E patients at Lincolnshire hospitals return within a week
18/04/2019	Boston Standard	ULHT trustchiefexecutiveconfirmsdeparturedate
19/04/2019	Grantham Journal	Local healthcare 'will change for the better,' says Grantham GP
29/04/2019	Grantham Journal	We need a new hospital to serve town and county
02/05/2019	Grantham Matters	Have your say at the Healthy Conversation 2019 engagement events
02/05/2019	Voluntary Centre Services	Healthy Conversations 2019
04/05/2019	Grantham Journal	Grantham resident unhappy with answers to his questions on Grantham Hospital and parking
07/05/2019	Lincolnshire Reporter	Campaigners mark 1,000 days of A&E night closure
08/05/2019	Sleaford Standard	Join in the Healthy Conversation page6
08/05/2019	Sleaford Standard	Join in the conversation in Sleaford public meeting on future of local health services
09/05/2019	Lincolnshire Echo	Take part in the conversation to help the NHS serve you better

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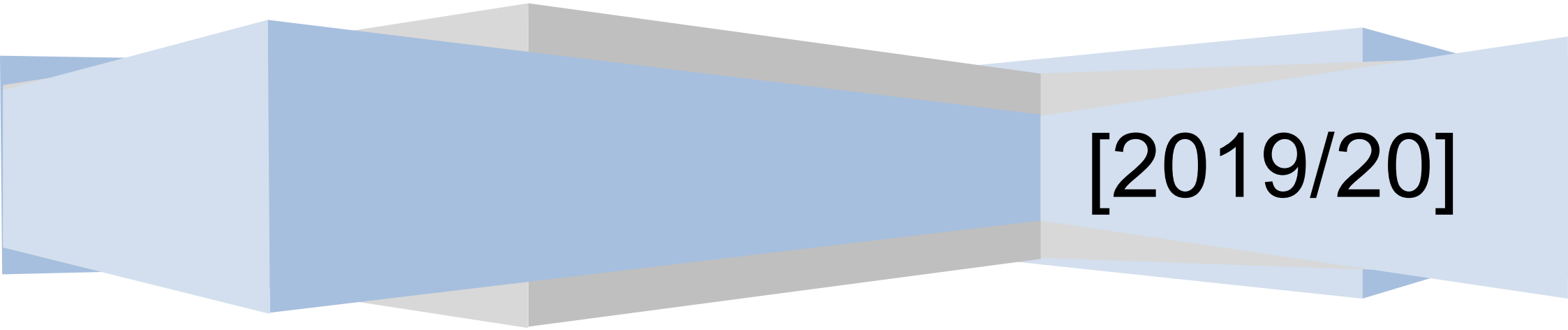
10/05/2019	Stamford Mercury	Take part in Healthy Conversation page 17 (LPFT)
10/05/2019	Grantham Journal	Cake marks 1,000 days of overnight A&E closure page 4
15/05/2019	Lincolnshire Reporter	STP hopes to tackle behind closed doors perception
15/05/2019	SpaldingVoice	Upgrade on the cards for hospital?
16/05/2019	Mollys Guide	Double page spread
17/05/2019	Lincs. FM	Gainsborough - Healthy Conversation Event
17/05/2019	Grantham Journal	Future for breast care Emerald Suite bleak page 1
17/05/2019	Grantham Journal	We fear for the future of breast care service at Grantham page 3
20/05/2019	Grantham Journal	We fear for the future of breast care service at Grantham
21/05/2019	Lincs. Free Press	We need a UTC page 16 Letters to the Editor

*Not all press clippings have been collated to date.

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER



	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Jan 20	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020										X	
BAF Sign off for 2019/20	X										X
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											
Finance, Performance and Estates Committee	X	X	X	X	X	X	X	X	X	X	X

Assurance and Risk Report											
Financial Plan and Budgets										X	
Clinical Strategy Update										X	
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									
2021 Strategy	X			X			X		X		X
SO 4 Providing Seamless Integrated Care with our Partners											

Transforming the experience for patients needing partial knee replacements

Patients in Lincolnshire are getting back on their feet sooner following partial knee replacements.

A team of consultants (Mr Kulandaivel Sakthivel and Mr Prasad Antapur) along with anaesthetists, physiotherapists, ward and theatre staff have been working together using an innovative approach so that those in need of the procedure, known as a unicompartmental knee replacement, can return home on the same day.

The teams have also improved how they share information with patients as returning home on the same day following this procedure means they need additional pain relief, support and advice than they would have previously required.

Mr Sakthivel, Consultant Orthopaedic Surgeon and Clinical Lead for Trauma and Orthopaedics at ULHT, said: “This is a positive change for patients who can benefit from this type of partial knee replacement. We all know patients recover better and quicker in their own familiar environment and hopefully we will be able to see patient experience continuing to improve. We are extremely happy that we are able to provide this kind of innovative and patient-centred care for the people of Lincolnshire."

County Hospital, Louth is the only place across the county this procedure is being carried out as a day case. This new approach has recently been made possible as a result of the trauma and orthopaedic pilot within the Trust which includes all of United Lincolnshire Hospitals NHS Trust (ULHT) sites in Lincoln, Boston and Grantham working together with Louth hospital, each one focusing on different elements of care.

The pilot is being led by Getting It Right First Time, a national programme created to improve the care of patients. It recommends having ‘hot’ (emergency/unplanned care) and ‘cold’ (elective/planned care) sites. Since the trial started in August 2018, the vast majority of elective orthopaedic patients who require an overnight stay have been seen at Grantham hospital, and those who are able to return home on the same day have been seen at Louth hospital. This enables the Lincoln and Pilgrim hospital theatres to focus on more complex elective care and emergency orthopaedic care.

This redesign of the service has many benefits for orthopaedic patients seen across the Trust, but for those needing partial knee replacements it is a completely new approach which has seen excellent results. Previously, patients would spend around two days in hospital following this procedure, whereas now they are able to return home on the same day. Not only is this more comfortable for the patients themselves, but means a shorter hospital stay and recovery period – a much better experience offered by the Trust. The aftercare, support and follow-up appointments remain the same to make sure patients continue to be safe and well at home.

Other benefits of this approach include a cost saving for the Trust as patients are not staying overnight, which can often cost around £300 per night. It’s also helping to increase the elective orthopaedic activity at Grantham as it frees up theatre and bed space on that site which can be utilised by other patients.

Although it is early days working in this new way, the advantages have already begun to show and the three patients who’ve had this procedure as a day case so far have had very positive feedback for the team. It is expected that around 60 patients per year could qualify for this type of surgery, a majority of whom would benefit from having this procedure as day case at Louth hospital.

Roger, 80, from Welton, had the procedure at Louth hospital in mid-May. He said: “The entire experience was very straightforward. I got to the hospital early in the day, everything was explained clearly to me and before I knew it I’d had the surgery and was awake again. It all went well and I returned home the same day - I didn’t mind travelling to have it done.

“I’m very active, I walk a lot and play golf three times a week so it’s great that I was back at home and on my feet so quickly. The recovery was a lot better than I expected and I’m pleased that the surgery will get rid of the pain I had.

“The follow-up has been superb. I was called the very next day to see how I was doing – which I thought was a nice touch.”

Agenda Item 17.4

United Lincolnshire Hospitals NHS Trust

Board to ward visibility update

The executive team and non executive directors of United Lincolnshire Hospitals NHS Trust regularly visit wards and departments, as part of their role in both representing the Trust at Board level and also linking that to the work that takes place 'on the ground'.

This is done in a variety of ways, from structured patient safety walkrounds using the established 15 Steps methodology to more informal visits to wards and departments, job shadowing and fact-finding exercises.

Patient safety walkrounds

Patient safety walkrounds have been shown to be extremely valuable leadership tools, and at ULHT have been used in various formats for some time. Such visits have been in place for many years and since Autumn 2018 members of the Trust Board have carried out monthly visits, based on the 15 Steps improvement model alongside some core human factors principles.

Since this process began, 12 areas have been visited during November and December 2018 and January 2019:

- Louth x 2
- Grantham x 2
- Lincoln x 2
- Pilgrim x 5

Each visit had an executive lead partnered with a non-executive, during which they visited two areas as well as having a de-brief afterwards to consider their findings.

During each visit, the Board members consider the following:

- Was the area welcoming?
- Was the area safe?
- Were staff caring and involving patients?
- Was the area well organised and clean?
- Any events that may have meant someone stayed in hospital longer than planned?
- Any near misses?
- Any patient harms?
- Any environmental factors that could cause harm?
- Anything we can do to prevent an incident?
- What can we as leaders do to make the work we do safer?
- What do you think patients are saying about your service?

The process also encourages staff and patients to tell their story.

All feedback from the visits are shared with the departments concerned, to celebrate areas of success and identify areas for improvement.

Themes from the feedback following these visits include:

- Feedback about areas needing environmental improvements.
- Overwhelming praise for staff who are overall organised, calm, warm, friendly and welcoming and display good team work.
- Concern about the level of participation and engagement of staff in change initiatives.

- Poor staff morale in some areas.
- Identification of some clutter in corridors, e.g. wheelchairs, stores trolley etc
- Examples of poor response from the main transport provider, TASL.
- Need to review information available for visitors- consider displaying SQD data, quality and safety information, patient information and welcome signs.
- Overall great patient feedback.

Staff in areas across the Trust have reported that they appreciated a senior visit of this nature. It was good to see staff confidence in flagging issues and sharing concerns indicating executives were approachable and encouraged the conversations. It was also good to see that these issues were acknowledged and recommendations made to support resolution.

Other visits

Members of the Trust Board frequently carry out ad-hoc visits to wards and departments, which can include working shifts alongside the teams in the wards, insight visits and meets with staff.

Over the last few months, such visits have been carried out as below:

- Non Executive Director Liz Libiszewski worked a shift on Greetwell Ward, Lincoln County Hospital, and visited Hatton Ward earlier this year alongside Director of HR, Martin Rayson.
- Medical Director Dr Neill Hepburn worked a half shift with nurses on Carlton/Coleby Ward, Lincoln County Hospital and has visited radiology, research and Scampton Ward, Lincoln County Hospital. He has also done visits to outpatient clinics and skin surgery.
- Non Executive Director Gill Ponder visited wards 8A and 1B with Deputy Chief Executive, Kevin Turner, as well as the operations centre, discharge lounge and theatres at Pilgrim Hospital, Boston. Gill also visited radiology and endoscopy with Chief Executive Jan Sobieraj at Lincoln County Hospital.