Bundle Trust Board Meeting in Public Session 2 July 2019

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

1	09:15 - Introduction, Welcome, Chair's Opening Remarks and Health and Safety *Chair*
2	Public Questions *Chair*
3	09:45 - Apologies for Absence *Chair*
4	Declarations of Interest *Chair*
5	09:50 - Minutes of the meeting held on 4th June 2019 *Chair* Item 5 Public Board Minutes JUNE 2019 v1.docx
6	Matters arising from the previous meeting/action log *Chair* Item 6 Public Action log June 2019.docx
7	10:00 - Chief Executive Horizon Scan Including STP *Chief Executive*
8	10:15 - Patient/Staff Story *Director of Human Resources and Organisational Development*
9	BREAK
10	Strategic Objectives
11	Providing consistently safe, responsive, high quality care SO1
11.1	10:50 - Assurance and Risk Report Quality Governance Committee *QGC Chair* *To consider* Item 11.1 QGC Upward report June 2019.doc
11.2	11:00 - CQC Letter *Director of Nursing* *To consider* Item 11.2 CQC Letter Front sheet.doc Item 11.2 CQC Letter 20190614 Post Inspection feedback ULHT Final for Trust.pdf Item 11.2 CQC Letter 20190620 Post Inspection feedback ULHT.docx
12	Providing efficient and financially sustainable services SO2
12.1	11:10 - Assurance and Risk Report FPE Committee *FPEC Chair* *To consider* Item 12.1 FPEC Upward Report June19 v1.doc
13	Providing services by staff who demonstrate our values and behaviours SO3
13.1	11:20 - People Strategy *Deputy Director of HR & OD* *To approve* Item 13.1 2019 People Strategy - Paper.doc Item 13.1 2019 People Strategy.docx Item 13.1 Appendix A - Interim People Plan.pptx
13.2	11:35 - Continuous Quality Improvement Strategy *Deputy Chief Executive*

Item 13.2 CQI Strategy for Trust Board.docx

Item 13.2 Final Continuous Improvement Strategy.pdf

Item 13.2 Executive Summary vs2.pdf

14 11:50 - Providing seamless integrated care with our partners SO4

14.1 12:00 - System Wide Data Sharing

Deputy Chief Executive

To approve

Item 14.1 Item STP System Wide Data Sharing - Front Cover Final.doc

Item 14.1 Item STP System Wide Data Sharing - Final2.pdf

Item 14.1 Item STP System Wide Data Sharing - Final.pptx

Item 14.1 STP System Wide Data Sharing - Consent Position Statement.docx

15 Performance

15.1 12:10 - Intergrated Performance Report

Exec Directors

To consider

Item 15.1 Integrated Performance Report - Trust Board.pdf

16 Risk and Assurance

16.1 12:25 - Risk Management Report

Medical Director

To approve

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

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

Item 16.1 Appendix II - High operational risk summary - June 2019.pdf

16.2 12:35 - BAF 2019/20

Trust Secretary

To approve

Item 16.2 BAF 2019-20 Front Sheet July 2019.pdf

BAF 19-20 v25.06.19.xlsx

16.3 12:50 - 2019/20 priority setting and deployment update

Deputy Chief Executive

Item 16.3 2019-20 Priorities.doc

Item 16.3 ULH priority deployment 3 July 19.pdf

17 Strategy and Policy

17.1 13:00 - Board Forward Planner

Trust Secretary
For Information

Item 17.1 Public TB Board Forward Planner 2019 v 2.doc

17.2 13:05 - ULH Innovation

Assistant Director Communications
For Information

Item 17.2 July innovation report v 2.docx

18 Any Other Notified Items of Urgent Business

19 The next meeting will be held on Tuesday 6 August 2019, New Life Centre, Sleaford

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

Agenda Item 5

Minutes of the Public Trust Board Meeting

Held on 4th June, 2019

Boardroom, Lincoln County Hospital

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 Geoff Hayward, Non-Executive Director

Non-Voting Members:
Mr Martin Rayson, Director of HR &OD
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)
Mr John Bains, Healthwatch

Apologies:

720/19 **Item 1 Introduction**

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

721/19 **Item 2 Public Questions**

Q1 Jody Clark – While looking through the annual accounts 2017/18, I came across this? Saying that the old entrance building to Grantham Hospital is being sold? Can you tell us, if its sold yet? Who has bought it? And what is it going to be?

The Director of Estates and Facilities responded:
The Trust had declared the building as "surplus to healthcare use" and included the detail within the Trust Annual Accounts however the building had not been sold. The Trust would be exploring options for the future use of entrance building and Healthy Conversation 2019 would allow for planning options to be considered and established. This would remain an area of risk to the Trust and moving forward options would be explored.

Q2 Sue McQuinn – In the last two weeks at least 22 people have been in contact because they have had issues with the system. Mostly they have received PCNs, predominantly they are Blue Badge holders or members of staff. Overwhelmingly, they have received these PCNs despite trying to use the system according to the rules. I imagine that as the number of people who know about my interest is relatively small, I am only hearing about the tip of a very large iceberg.

Can the board explain why they believe so many unwarranted PCNs are still being issued?
Can they also provide the following information:

1) How many PCNs have been issued since the ParkingEye system was introduced
2) How many appeals have been made
3) How many appeals have been rejected
4) How many PCNs have been taken to POPLA for adjudication
5) How many PCNs have been cancelled because of intervention by ULHT

As ULHT has the ultimate say over PCNs, I would expect this information to be readily available.

The Director of Estates and Facilities responded:
In response to the 22 people who have been in contact, development of the ANPR system is underway to ensure ease of use by staff and visitors. A preregistration system had been put in place for blue badge holders, this would enable them to register once and then benefit from the automated system utilising a barcode to receive a reduced rate.

13k people had registered on the system currently and the Trust would be happy to support staff, patients and visitors to use the system. Advances had been made since the introduction of the system and these are being rolled out nationally.

Regarding the questions related to the Penalty Charge Notices this information forms part of ParkingEye's operations and as such is not information held by the Trust.

The Trust would be in contact with Ms McQuinn to ensure the best resolution to the questions.

ACTION – Director of Estates and Facilities, 2 July 2019

Q3 Emma Wilcock – Having had my daughter under the care of Dr Gantasala in the Children & Young Persons Clinic at Pilgrim, I was deeply saddened to discover such a talented Doctor is leaving ULHT. Over the last 12 months my daughter has been experiencing some problematic symptoms but thanks to Dr Gantasala and the continuity of care between him and her GP, we finally got an answer to her symptoms earlier this year.

With such a promising and talented Doctor leaving ULHT and the recent issues the Trust have been having with recruitment and retention, was anything put in place or offered to Dr Gantasala to try and retain him at Pilgrim?

Several of my friends also see Dr Gantasala for their children's conditions and we've all voiced our sadness at his departure.

The Director of Human Resources and Organisational Development responded:
Detail cannot be provided on a specific employee however it was of course disappointing for the Trust when a talented individual leaves, this was however a normal part of organisational life. The Board were advised that the Trust hold conversations with staff when they indicate a wish to leave to try and determine if there are ways to support and retain them. The Trust will always experience turnover in services and the Trust ensure that a talent pipeline is in place, especially for fragile services. The Trust need to work to ensure that the organisation is somewhere staff wish to remain.

The Chair noted the words of appreciation for the work of Dr Gantasala and requested that a letter of thanks be sent to recognise his dedication and work with the patients.

ACTION – Trust Secretary, 2 July 2019

Q4 Alison Marriott – The following items from the public action log are now marked as complete, but there is no detail of the outcome:

438/19 - In summary where are paediatric patients coming from?
439/19 - amendments to exception reporting to ensure sufficient information re: Paediatrics is provided to the Board.

Could the detailed outcome of each be shared with the public please?

The Medical Director responded:
The six month review had been presented to the Board and reporting had moved to business as usual through the Quality Governance Committee with the next report due in July. Details of the report were being discussed to ensure this encompassed all required aspects.

In response to where the patients are coming from the location of domicile remains the same as it had been in March 2018 for March 2019. 308 patients at Pilgrim were from Lincolnshire in March 2019 compared to 159 in March 2018. The March 2018 figures are prior to the introduction of the new model and the 2019 figures are post implementation. The majority of patients at Lincoln are also from Lincolnshire and there had been an increase of 250 in March 2018 to 317 in March 2019, these figures represent Kingfisher Ward only.

The figures presented reflect the general activity within the service and demonstrate a service that is developing.

722/19 **Ward Accreditation**

The Board presented Ward Accreditation Certificates to representatives from Burton Ward, Branston Ward, Navenby Ward and the Stroke Unit.

723/19 **Item 3 Apologies for Absence**

There were no apologies for absence.

The Director of Nursing would join the meeting after opening a therapist conference

724/19 **Item 4 Declarations of Interest**

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

725/19 **Item 5 Minutes of the meeting held on 7th May 2019 for accuracy**

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

Mr Bains should be recorded as 'In attendance' not voting member.

637/19 – Should read – The Trust have £8.6m of discretionary capital and a risk based approach had been taken to assess the requirements and align to the available funding.

638/19 – Should read – The Interim Director of Finance and Procurement highlighted the spend of £2.2m in relation to proposed asbestos works being carried out

645/19 – Should read – External opportunities for capital would continue to be explored with NHS Improvement being approached regarding funding for fluoroscopy and other statutory estates schemes at Lincoln and Pilgrim

687/19 – Should read – CHPPD (Care Hours Per Patient Day)

726/19 **Item 6 Matters arising from the previous meeting/action log**

616/19 – Risk register update – complete included in papers.

642/19 – Fire and asbestos work to be conducted at the same time – discussions had been held and measures in place to minimise impact, further updates to be provided to Finance, Performance and Estates Committee. Action to be held open whilst further Quality Impact Assessment discussions take place between Director of Estates and Facilities and Director of Nursing.

ACTION – Director of Estates and Facilities, 2 July 2019

643/19 – Periodic reporting to Audit Committee of enforcement, regulatory health and safety and coroner notices – Incorporated within compliance report received quarterly at Committee Item complete.

727/19 **Item 7 Chief Executive Horizon Scan including STP**

The Chief Executive provided an update to the Board.

728/19 The Board were advised that the NHS People Plan had been published in draft and would be reviewed to understand how it impacts the Trust and Lincolnshire. An offer is laid out in the plan to make the NHS a more attractive employer and focuses on work life balance. The plan also details pension arrangements especially in relation to high earning staff and the wish to undertake additional duties and work additional hours. Negotiations would be required with the Treasury in relation to this aspect, a consultation will be conducted.

729/19 Management of workforce devolution had also been included which discussed bringing workforce planning closer to local planning and 5 year plans. There is a desire to increase nurse numbers with attempted recruitment of 40k nurses by September 2019. There had been an ongoing struggle to recruit since the introduction of bursaries.

730/19 The Trust will conduct a thorough review of the plan and incorporate the relevant aspects in to the Trusts People Strategy.

ACTION – Director of Human Resources and Organisational Development 2 July 2019

731/19 A recent Care Quality Commission report had reported on segregation of patients which had identified a number of concerns, the report highlighted that current arrangements were not fit for purpose, there is not yet an indication of how this would be resolved. Introduction of new legislation in respect of Mental Health and the Mental Capacity Act 2019 will be reviewed by the Trust when available.

732/19 Health Education England recently reported the effort to break down care pathways had not progressed as hoped and Nurse Associate recruitment had not been positive, this had a direct impact on the Trust due to the Nurse Associate roles within the organisation.

733/19 The number of vacancies within learning difficulties nursing had increased to circa 30%, this does not have a direct impact on the Trust.

734/19 The Chief Executive identified that the Lincolnshire Healthy Conversation 2019 events held recently had been positive and the level of both website page and video views remained positive.

735/19 The Sustainability and Transformation Programme had begun the process of forming programme Senior Responsible Officers that would cut across the organisations, there are 14 programmes and 5 themes across the system. The Senior Responsible Officers will have authority across the organisations based on the set terms of reference, staff would need to understand who leads which programme. Progress would be made prior to further updates being brought back to the Board for formal approval.

736/19 The Trust had agreed that the Clinical Commissioning Group Lead would be invited to a Senior Leadership Forum to present the information to staff. The Chair indicated her wish to invite the Chair of NHS Improvement to Lincolnshire to demonstrate the work being undertaken in the county.

737/19 Mr Bains highlighted a report in the news related to health inequalities and Sure Start Centres and asked if the effect of closing these would lead to an increase in A&E attendances. It was confirmed that there were Sure Start Centres in Lincolnshire however the Trust had not looked to correlate increased attendances to centre closures.

738/19 The Deputy Chief Executive had circulated a system architecture paper to the Board that contained the expectation of the System Executive Team roles and would help to form the basis of information to the Trust Board. Non-Executive lay members forums would benefit from sight of the paper and it was agreed that this paper would be presented that to ensure the same understanding across the system. A further paper would be presented to the Board to ensure clarity and line of accountability.

ACTION – Deputy Chief Executive, 6 August 2019

The Trust Board:

- **Received the report**

739/19 **Item 8 Patient/Staff story**

The Matron for Education and Workforce, Kerrie Linger, attended the Board to present the staff stories of Amanda Gill, Nursing Associate Waddington Ward and Louise MacNeil, Nursing Associate A&E Lincoln

740/19 The Board heard that Amanda was a Trainee Nursing Associate on the pilot programme and had registered as a Nursing Associate in January this year.

741/19 Originally the role was described as bridging the gap between nursing and HCSW's working under the supervision of nurses and the notion of doing such things as CDs and IVs was never factored in. At that point the nursing associates didn't even know if they were going to have a pin with the NMC.

742/19 Over the course of the 2 years of our foundation degree the nursing shortage crisis became more apparent and reflected in the amendments and enhancements to the course requirements. Feedback from other members of staff such as staff nurses was very mixed, some negative but mostly positive.

743/19 The daily routine on the ward for the Nursing Associate is much the same as a RN.

744/19 The biggest challenges came from a staffing perspective and the challenges faced daily with staffing, needing to have the confidence to speak out and raise any concerns or voice tasks not yet able to carry out.

745/19 The support and feedback I have had from the ward I'm based on has all been very positive Initially the biggest challenges faced were the transition of HCSW to Registered Nursing Associate and managing nurse orientated tasks and delegating to HCSWs tasks they could do.

746/19 The Board then heard that Louise, had been in ULHT for 5 years now, working in A&E as a HCSW. She wanted to be a registered nurse but due to financial circumstances was unable to do this. She qualified in January 2019.

747/19 Being a RNA Louise had to think and understand the rationale of their illness, their circumstances and of the patient themselves. Using a holistic approach and understanding the importance of this and delivering safe, effective care.

748/19 Working as a RNA had been challenging but had more rewards, working back in A&E, especially at such difficult times she saw how it benefited patient care.

749/19 Louise reported that the opportunity had given her the chance to challenge herself, develop assessing skills but also help develop others in their careers. Which I would like to continue to develop.

750/19 Dr Gibson thanked Matron Linger for the positive messages received and asked what other staff think about the role.

751/19 Matron Linger indicated that there had been a challenge as staff who had been in post for some time as they had perceived the role as the historic two tiered nursing role. Communications were sent to staff to aid their understanding of the role and it soon became apparent that the role would be there to help and allow other staff other staff to provide hands on care. The Nurses now look to have these roles in their departments as they can see the benefits. Further work would be required to develop the role and work is required in outpatients along with further education of patients to ensure they understand the role. Matron Linger expressed how proud she had been of the Trust for taking on the opportunity to support the role.

752/19 The Chair asked Matron Linger what the Board would do to support her with the development of the Nursing Associate.

753/19 Matron Linger identified that the next round of recruitment had begun in June for a 2 year programme and the staff who had now qualified were keen to develop to become registered nurses. Support would be required for the staff to undertake the 18 month supernumerary programme.

754/19 The Chair indicated that strategically in principle there would be benefit in carry out this further training and supporting staff as it had been made clear that they had grown within the role. Consideration would be given to supporting the development of the nursing associates.

ACTION – Director of Human Resources and Organisational Development, 2 July 2019

755/19 Mr Bains asked if there had been difficulty in recruiting to the role. Matron Linger confirmed that there had been no difficulty in recruitment and identified that for the intake in September there had been over 100 applications, the largest challenge had been where to place within the organisation due to the role requiring support, as a training role.

756/19 Mrs Libiszewski indicated that the intention within the People Strategy would be to recruit more nurses, there would need to be a radical shift in the classic view of placements, a move to a more coaching model and alternative methodology would be needed to support this.

757/19 Matron Linger stated that nurse monitoring and assessment would be changing from September and this would support with improved multidisciplinary working.

758/19 The Director of Human Resources and Organisational Development identified that the biggest issues faced in supporting the process was funding Investment funding for 2019/20 had been made for £20m however there would only be £5m available, this would be a difficult issue to resolve in the current climate but an answer would need to be found.

759/19 Mr Hayward asked if the organisation could establish the maximum number of staff at each level that could be supported and trained by the organisation. The Director of Human Resources and Organisational Development would consider how the Trust could establish the levels of trainees that the organisation could manage.

ACTION – Director of Human Resources and Organisational Development, 2 July 2019

760/19 The Chief Executive indicated that the new arrangements in place would help to increase capacity and that additional monies had recently helped to expand registered nurse training however there had been a lack of people interested in applying to the university. The University of Lincoln will expand places from 120 – 240 but these cannot be filled due to multiple issues.

The Director of Nursing arrived – 10.15am

761/19 Mrs Ponder indicated her interest in the comment regarding the number of applicants for places and questioned what happened with the good candidates who were unsuccessful.

762/19 Matron Linger identified that of the 15 places due to commence in September 4 had been filled by previous applicants being held back. Discussions would be held to consider other offers that could be made to un-appointed suitable candidates

763/19 The Director of Estates and Facilities questions the impact of the initiative on the quality, safety and experience of patients.

764/19 Matron Linger identified that she would expect all aspects to be improved however it would be lovely to hear patient stories at the Board with the Nursing Associate in attendance as well to hear directly the positive impact they had made.

765/19 Thanks were given to the staff who had provided their nursing associate story and they were wished continued success in their development within the organisation.

The Trust Board:

- **Received the staff story**

766/19 **Item 9 ULH Five Year Strategy**

The Director of Human Resources and Organisational Development presented the strategy to the Board for approval.
It was highlighted that consideration had been given to move from the 2021 branding to a 5 year strategy brand however this would need to be handled carefully in order to manage
767/19 understanding in the organisation.

768/19 The Chair thanked the Director of Human Resources and Organisational Development for the work that had gone in to the development of the strategy. The document had been produced in conjunction with the Board and had resulted in an easy to read, clear document. There had been a clear thread in relation to staff and quality of care throughout the document and it was hoped that staff would realise the intention of the long-term investment in staff that had been fully aligned to the Lincolnshire system.

769/19 The strategy included a statement of aspirations to achieve CQC ratings by services, Board members commented that these had not been agreed through Board consideration. It was confirmed this had been included as an aspiration statement and would be removed if the Board felt it was not required. The Board agreed that this would be more appropriate to be included within the Quality Strategy and there would be agreement about this through a Board Development session including the Divisions.

ACTION – Director of Human Resources and Organisational Development, 2 July 2019

770/19 Confirmation was provided in relation to the communications plan to move from 2021 to a 5 year strategy branding. There are 2 aspects of work underway including understanding ambitions of the Trust through visuals and utilising communications channels and the second is about translating to ward level through continued True North work with the Trusts objective and ambitions.

771/19 The Board were advised that work was underway through Communications to determine an improved method of sharing key messages and how Trust North progress can be presented in a way that Board to ward can focus on key priorities. The Strategy would be translated in to delivery plans that ensured ownership.

772/19 The Chair highlighted that the section regarding County Hospital Louth did not appear to match the Clinical Strategy due to be presented to the Board, this would require alignment.

ACTION – Director of Human Resources and Organisational Development, 2 July 2019

773/19 The Board passed on thanks for the work that had gone in to the completion of the strategy.

The Trust Board:

- **Received the 5 Year Strategy**
- **Approved the strategy subject to the changes discussed**

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

774/19 **Item 11.1 Assurance and Risk Report Quality Governance Committee**

The Chair of the Quality Governance Committee provided the assurance received by the Committee at the May meeting.

775/19 The revised approach to the risk register was discussed and accepted and would support staff to identify risk more appropriately. The Committee had identified that these discussions would be required at other Committees.

776/19 The report received in relation to incidents was much improved and the next step would be to see the development of learning from these. The stillbirth deep dive had confirmed that there were no specific actions required by the Trust.

777/19 The Quality Safety Improvement Plan latest report also included a dashboard which added to the debate and discussion question that the metrics are included as part of the performance report. There had been criticism regarding the number of metrics for the Committee would be reviewing these with a view to rationalising.

778/19 The first written report from the Quality Scrutiny Oversight Group had been received by the Committee, the Committee would continue to receive detailed reports including some of those presented to the group until it reached the place where all levels of reporting were embedded.

779/19 The Quality Improvement Assessments report presented more in-depth detail of the process and those QIAs that had taken place. Approximately half had been rejected due to the lack of detail, one of the largest gaps in the schemes were through estates and the Director of Estates and Facilities had agreed that further work would be undertaken to address this

780/19 Updates had been received through the Chief Operating Officer in relation to harm reviews. Harm reviews were being conducted however the last step in the process had not been followed. The Committee had asked for assurance that this was addressed.

781/19 Infection prevention and control levels had met trajectory for infections and significant work had taken place across the organisation. The annual report to the Board had been highly commended by the Committee.

782/19 In relation to medicines optimisation the Board had been sighted on the Aseptic issues and more work was to be done as part of the Quality and Safety Improvement Plan programme to ensure learning is embedded, particularly in relation to medicines issues that had taken place.

783/19 The Quality Account had been received by the Committee and feedback had been provided, the Board had delegated authority to the Committee to sign off the account.

784/19 The first draft of the Patient Experience Report had been received which would be discussed in the Private Board session.

785/19 The latest iteration of the Quality Strategy had been received and the Committee identified that the alignment to Trust North had sanitised the document too much. Further work would be undertaken to ensure that there was a clear direction of travel. As the strategy had not been completed it would not be presented to the Board today.

786/19 The external audit report on the Quality Account had identified issues relating to data quality and as such, the Committee had referred to the Finance, Performance and Estates Committee.

787/19 The Board Assurance Framework had been received by the Committee, the agenda had been structure around this. The assurance gaps were not populated and therefore the Committee had not rated assurance levels. It was deemed inappropriate to rate them until further work had been undertaken, this had been referenced in the Board Assurance Framework report.

788/19 The Committee Chair noted that the Committee had been observed by NHS Improvement and that a report would be provided. This would be presented to the Board following receipt.

789/19 Mrs Dunnett commented on the improved position of the Quality Account for the year with deadlines having been met and appropriate processes completed.

790/19 The Chair commented on the increased level of assurance that had been given by the Committee.

791/19 The Director of Nursing informed the Board that the initial verbal feedback from NHS Improvement had been that the meeting was very different to the previously observed meeting. The Committee Chair confirmed that this had been due to the quality of the reports allowing the Committee to be clearer about how and what should be discussed. The Trust Operating Model and Quality Impact Assessment process had allowed the Committee to focus more appropriately.

792/19 Mr Bains asked if the National Inpatient Survey resulted would be presented in a Public Board session, it was confirmed that once published they would be presented in public.

The Trust Board:

- **Received the update**

793/19 **Item 11.2 Clinical Strategy**

The Medical Director presented the refreshed Clinical Strategy.

794/19 The Clinical Strategy set out for staff and Trust partners where the Trust fits in to the wider system and had been written in the context of the NHS Long Term Plan and drivers. The strategy had been written in such a manner that anyone reading would be able to understand where the Trust were and what the aims of achievement were particularly in relation to sustainability of services. The strategy had been produced in the setting of the acute services review and included individual sites and clinical services described in as much detail as possible. The implementation of the strategy would need to sit in the setting of the acute services review.

795/19 Mrs Dunnett commented that the content regarding Pilgrim did not refer to rehabilitation, particularly in relation to Stroke services and step down, post hyper acute care. The Medical Director confirmed that work would be undertaken with Community Services, as this aspect of care would take place in the community. Hyper acute care takes place in hospital with the aim to move patients to community care soon after. Upskilling of staff in community services is required to support this and hyper acute 3-7 day care would be centralised to Lincoln.

796/19 The governance processes for the service were discussed and it was identified that there would be a further discussion to ensure the governance was conducted through the appropriate route and allow a clear line of sight to the Board.

797/19 Mr Hayward commented that a timeline would be required for the changes to ensure an understanding of the required resources to support. There was an expectation that this would be delivered through the Clinical Transformation Steering Group and the Medical Director would upward report to the appropriate committee where required.

798/19 The Chief Executive identified that a timeline had been included however a critical piece was missing in relation to the Estates Strategy. There would be a requirement for Trust wide modelling to see how activity sits across the sites. The first step would be the Estates Strategy reported to Board. As the People Strategy is progressed this would need to underpin where staff and skills are required including the number of staff required for specific projects.

799/19 Dr Gibson highlighted that this would be a large scale change management process that would require support for individuals through the change. He also asked if centralisation of the Stroke service would result in transport issues.

800/19 The Medical Director confirmed that there are some issues in relation to the service model however the modelling demonstrated that there would be little difference in relation to transport and patients arriving at the hyper acute unit.

801/19 Mr Gibson welcomed the section in relation to telemedicine but suggested that this appeared to be an add-on to the strategy. The Chair highlighted that the Digital Strategy would be the route to embed telemedicine however it was acknowledged that it would require strengthening in the Clinical Strategy.

802/19 The Medical Director identified that the telemedicine issue is in relation to the integration of care however there would be a large gain in reducing the movement of patients for consultations. The difference would be the fundamental changes to the way in which clinicians work to assess information at the same time as they hold a conversation with the patients. This would result in large savings in relation to patients time and travel however the technology is not quite available but would be the biggest change to the Trust.

803/19 The Deputy Chief Executive stated that this would require capital. The Trust had discussed the possibility of this being delivered capital light however this could not be achieved and the Trust are reliant on capital being available. Linked to this is the consideration of work that could be undertaken without the need for capital or consultation.

804/19 Mrs Libiszewski questioned how the clinical divisions and triumvirates had been sighted on the strategy. It was confirmed that this was variable. This process commenced in April 2019 so it had been reasonable for the triumvirate and divisions to concentrate on specific issues related to them, there is now a need for the wider issues to be considered.

805/19 Mrs Libiszewski requested that page 11 be amended to show that the Board not the Executive Team had reached a decision about the delivery of measures. Also that on page 43 in relation to the creation of a Delayed Transfer of Care (DTOC) ward the label of DTOC should be removed from patients. These changes would be made to the strategy.

806/19 Concern was also raised about the disproportionality of references within the Therapy Services section, there was only a small amount of information in relation to other areas such as pharmacy and medicines optimisation. Consideration was requested to ensure information presented was proportionate across the sections.

ACTION – Medical Director, 2 July 2019

807/19 The Chief Executive advised the Board that this had been the first time the timetable had been presented in a public domain and that this had been a positive step. The section that had focused on fragile services identified that the Trust have progressive services. There would be a need to continue to the review these to ensure that they are kept in mind when considering development of sites. Wider issues to also be considered would be staffing and equipment. Discussion regarding fragile services would be beneficial to be held in public in order to ensure transparency.

808/19 The Chair agreed that the strategy provided the Trusts overall direction of travel and whilst there would always be challenges with fragile services the strategy clearly gives the mechanism to enable these discussions.

809/19 The Chair thanked the Medical Director and colleagues for the work undertaken and identified the need for clarification regarding assurance of delivery.

ACTION – Medical Director, 2 July 2019

The Trust Board:

- **Received the Clinical Strategy**
- **Approved the strategy subject to the changes discussed**

Item 12 Providing efficient and financially sustainable services SO2

810/19 **Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee**

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

811/19 The key points highlighted by the Committee were that the Trust had reported a month 1 deficit of £6.7m, favourable by £16k against the planned deficit. There had however been significant variances and the finance team had been working on these to understand the reason.

812/19 The divisional budgets were being discussed through the Performance Review meetings, particularly agency spend which continued to be over budget.

813/19 The 4 proposed CQUINs for 2019/20 had not yet been agreed but would be delivered from Q2 onwards due to timing of the sign off.

814/19 The capital plan had been agreed with £500k of unallocated contingency. An application to Lincolnshire Fire and Rescue had been made for an extension to the enforcement notice deadline to ensure the Trust could complete the required work.

815/19 The Committee were asked to support revenue borrowing of £6.717m and capital borrowing of £1.6m in line with the plan, the Committee had supported and this and escalated to Board for approval.

816/19 The Financial Turnaround Group upward report had been received and the Committee noted the drive to deliver £25.6m of savings, this had been risk adjusted to £21.5m, and as such the Trust were £421k behind plan at month 1. Additional schemes would be required if the shortfall could not be made up.

817/19 Discussions had been held in relation to manual handling and managers fulfilling their legal responsibilities, mechanisms were being built in to the Electronic Staff Record (ESR) and the Committee had requested that the manual handling paper included additional context and scale in order the Committee could be assured.

818/19 Urgent and Emergency Care performance had been discussed and a detailed 4 hour improvement programme was in place with a trajectory that had been approved by NHS Improvement. The Committee were assured by the plans in place to achieve improvement.

819/19 Cancer performance had delivered at 75.2% which had been above trajectory and discussions had taken place regarding the scale of the service and delivery. The 2019/20 trajectory had been approved by NHS Improvement and plans had been developed to ensure improvement.

820/19 The Committee acknowledged the achievement of waiting lists in relation to planned care and that at the end of March there were zero waits over 52 weeks. The Trust were confident that this would be maintained.

821/19 The Committee reviewed the draft terms of reference and populated the Board Assurance Framework. The Committee requested that identified controls were aligned to primary, secondary and tertiary in order to respond to the three lines of defence. The framework had remained short of some metrics being available which may not be ready for the next meeting.

822/19 The Committee received a report from the Digital Board that highlighted the lack of capital affecting timescales, as a result e-prescribing would be rolled out initially to high risk areas.

The information governance report indicated non-compliance with 6 standards mainly in relation to contracting/procurement and training. The improvement plan had been agreed. Concerns had been raised regarding the destruction of health records policy and had been escalated to the Committee. A clause had not been included in the current contract regarding the destruction of records when the contracted company had been bought out.

823/19 The Committee received 5 internal audits reports and noted the assurance levels afforded to these.

824/19 The Chair raised concerns regarding the large financial variances, confirmation was provided that this had been reviewed through the Executive Team and would be reported to the divisions prior to submission to the Committee. The Financial Efficiency Plan gaps were being considered to ensure these could be closed, this work would be undertaken at pace.

825/19 The Board expressed concern in relation to health and safety, manual handling and training compliance but noted that the Committee had requested further assurance, further rigour would be required to ensure the organisation achieves compliance. Further information had been requested and consideration of additional resource would be considered to ensure metrics are developed, the same methodology as used for fire safety would be applied and visibility would be through the Committee.

826/19 Mrs Libiszewski felt that the issue discussed had been in relation to a specific case, confirmation was provided that the incident that had resulted in involvement from the Health and Safety Executive had been dealt with and these current concerns were in relation to further requirements to change how staff are trained. Investment had been made to the team to enable training to be provided and this was work in progress to improve the Trusts position.

827/19 As this had been a wider issue than just manual handling the Board agreed that the next report to the Finance, Estates and Performance Committee would need to provide clarity over the actions required and the current position, including those beyond manual handling.

ACTION – Director of Estates and Facilities, 2 July 2019

828/19 The Chair referred back to the information governance issue and medical records destruction asking what the risk was to the Trust if the necessary contractual clause was not in place.

829/19 The Deputy Chief Executive confirmed that there is no risk to patient care, this is regarding the storing of records. There is a need for a clear policy in relation to the destruction of records. There are two identified issues, one is the ongoing cost of storage, these costs would continue to rise and urgent access to notes could be delayed due to quantities.

830/19 General Data Protection Regulation (GDPR) had been the trigger for the issue, the contract was moved to a new supplier and there would be a cost involved in identifying a new provider, the contract had been identified as not GDPR compliant and the Trust are struggling to put a clause in to the contract to resolve this.

The Trust Board:

- **Received the update**

831/19 **Item 12.2 Digital Strategy**

The Deputy Chief Executive presented the Digital Strategy to the Board.

832/19 The strategy had been received at the Finance, Performance and Estates Committee prior to presentation to the Board. Changes had been made to the strategy in light of comments from the Committee.

833/19 The strategy attempts to narrate the vision, bringing systems together, reducing to a paper light organisation and utilisation of technology to allow access to services, this would also allow improved safety of the data the Trust holds. At the heart of the strategy is the electronic health record which the Trust had previously approved a business care for.

834/19 The Trust would be required to link to a clinical system that would ensure information could be shared both in and outside of the Trust with other organisations and clinicians who require access to the patient records. Digital images would need to be stored in one location to enable the single system to work across the seven East Midlands organisations. A complex evaluation of the systems available will be undertaken and this process sits with procurement.

835/19 Easier access to systems through digitisation would support clinical decision making due to access to the most up to date information on conditions, the evolution of artificial intelligence is also underway to support the workforce and ease bookings for patients.

836/19 The Board were advised that it was hoped that collaborative work could be undertaken to procure a single ICT service, the current barrier is the pace of movement due to available funds. The strategy detailed timescales however the start of the journey had been slow. The timeline for immediate priorities are the launch of e-prescribing in year, pharmacy robotics and the interoperability of systems, the introduction of e-health records and digital dictation.

837/19 Due to the nature of technology the Trust would continually update the strategy to ensure it remains current. There were limitations to the implementation of the policy due to the current financial position. The governance for the strategy sits with the Finance, Performance and Estates Committee and upward reporting to Board would be through this route.

838/19 Mrs Dunnett asked if consideration had been given to a single system strategy to alleviate the capacity challenges. The Deputy Chief Executive confirmed that a conscious decision had been made not to develop a single model as these had not been successful elsewhere however consideration was being given to a system wide Chief Clinical Information Officer to support the system to develop the digital strategy.

839/19 Mr Bains identified that there had been concerns raised recently in relation to the care portal and the buy in from all providers and how soon there would be a system that enabled all providers to share information.

840/19 The Deputy Chief Executive confirmed that it was hoped this would be in place in the next 4-5 months however this would not be a full system. This was due to the supplies of GP systems and some reluctance to engage in a system that allowed information sharing through a portal.

841/19 Dr Gibson highlighted the point made in the strategy regarding the possible deficit in clinical and non-clinical informaticists and asked if this had been included in the Trusts people plan. Confirmation was provided that this had not been included due to the difficulty in sustaining the posts, if a single informatics service was pursued in Lincolnshire this would offer better recruitment and retention possibilities.

842/19 Mrs Libiszewski raised an issue identified through an external audit report in relation to fax referrals being received by the Trust and asked how this would be stopped going forward. The Board were advised that the Trust only accept fax referrals for cancer 2 week waits and considerations needed to be given as to how this would be phased out. Further work would be undertaken to determine how the Trust moved away from fax referrals.

ACTION – Chief Operating Officer, 2 July 2019

The Trust Board:

- **Approved the Digital Strategy**

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

843/19 **Item 13.1 Guardian of Safe Working Report**

The Medical Director presented the report to the Board.

844/19 As background, the Board were advised that the Guardian of Safe Working post was usually held by a doctor and was independent from the Trust management structure, this had been introduced as part of the junior doctor contract. The aim was to ensure that trainee doctors work in a safe manner, are complaint with working hours receiving adequate rest and support.

845/19 The Trust had appointed a guardian but this had not worked in the intended manner, the report demonstrates that a minimal impact had been made, the data included did not contain detailed analysis, as such an alternative model for the guardian had been considered.

846/19 The Trust had proposed a structure that would include a Guardian and a coordinator that would support the administration of the process and provide a more resilient system.

847/19 Mr Hayward commented that the Workforce and Organisational Development Committee had received assurance on the progress being made in relation to structure however there had been no assurance in relation to data. Mr Hayward offered support to the new model but was not aware when the Board would be advised that statutory requirements could be met.

848/19 The Medical Director reiterated the plan to have a coordinator and guardian role in place and that this had been approved by the Executive Team, this would be submitted to the Quality Improvement Board for sign off then implementation. The coordinator role had been banded and awaited consistency check prior to recruitment being undertaken

849/19 Mrs Dunnett stated that there may be benefit in the Guardian presenting the annual report to the Public Board to provide assurance in future. Page 45 of the report detailed patient safety issues that had been raised regarding consultant care in outliers, Mrs Dunnett questioned if this had been picked up through an assurance route.

850/19 The Medical Director confirmed that the care of outliers had been discussed through a variety of forums and the report confirmed information that had already been known to the Trust. The outliers are supported by dedicated physicians and the Trust continually alter the way in which physicians work to ensure improvements. The main concern regarding outliers had been the time of day the review would be conducted, this did not take place early enough for the timing of the end of shifts for Junior Doctors.

851/19 The Chief Operating Officer identified this had been an issue predominantly at Lincoln, significant improvements had been made at Pilgrim. The Trust were reviewing and rebasing a number of specialty beds to ensure an alignment of staff to support the medical outliers.

852/19 Mrs Libiszewski identified that the Workforce and Organisational Development Committee had referred the issue to the Quality Governance Committee and that the Medical Director had responded by detailing the current process in place.

853/19 The Director of Nursing indicated that the Trust are keen to move this forward to ensure implementation as intended. Once in place consideration could be given for other professions to receive support in a similar manner.

854/19 The Medical Director indicated the need to understand the totality of the workforce of Junior Doctors as it is acknowledged that staff hold a wider portfolio than that of Trust work.

855/19 The Chair questioned if there would still be a dependence on educational supervisors once the new model had been put in place.

856/19 The Medical Director confirmed that there would remain a dependence on educational supervisors however management action had been take to engage with individuals due to this being an area of weakness. Introduction of the coordinator role would result in improvements due to implementation of routine reporting.

The Trust Board:

- **Received the report**

857/19 **Item 13.2 Assurance and Risk Report Workforce and Organisational Development Committee**

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

858/19 Mr Hayward noted that the Guardian of Safe Working report had been received and escalated to Board and proceeded to identify the other key points to note.

859/19 The Committee wished to advise the Board of outstanding issues in relation to leadership training and general training due to a lack of take up from differing levels of staff. In order to aspire and achieve leadership there would be a need to encourage all managers to take part in leadership training and then offer training to all staff.

860/19 The vacancies remaining in the Trust Operating Model had raised concerns for the Committee and the possibility of a negative impact on the delivery of expected benefits.

861/19 The Quality Service Improvement and Redesign (QSIR) programme requires full leadership backing to allow staff to be trained and disseminate skills in to the organisation to fully realise the benefits. The Committee could not be assured that the necessary level of support was in place to progress this.

862/19 The Chair questioned what plan would be in place to address leadership as it was felt that the organisation had programmes in place.

863/19 The Director of Human Resources and Organisational Development advised that an exercise to review the programmes had been undertaken and the issue identified had been regarding access. The organisation needed to be committed to supporting the development of staff and allowing access to this, the issue would require further exploration however it is recognised as a fundamental challenge for a pressured organisation.

864/19 The Quality Service Improvement and Redesign programme was in the early stages for the Trust and the programmes would require embedding, the strategy would be presented to the July Board meeting and a Board Development Session had been planned. The Committee acknowledged the early stages of the process and reflected the concern going forward was the need to ensure backing for success.

865/19 The Chair confirmed that the Board fully supported the process however there would need to be an impetus to support this.

866/19 The Trust Secretary advised that the Committee had been observed by NHS Improvement and written feedback had been received and would be shared.

The Trust Board:

- **Received the report**

867/19 **Item 14 Providing seamless integrated care with our partners SO4**

No items

Item 15 Performance

868/19 **Item 15.1 Integrated Performance Report**

The Interim Director of Finance and Procurement presented the report to the Board indicating that the report had been further developed and a new in depth executive summary would be available from next month.

869/19 The key points noted from the executive summary included the improvement of Duty of Candour and HSMR, this had now reduced for 9 consecutive months. Right to treatment remains flat and cancer 62 day performance had declined to 61.3%.

870/19 Whilst the Trust submitted a plan for the year 2018/19 of £70.3m deficit, NHS England had sufficient funds to level out the system from financial deficit at the end of 2018/19. However there would continue to be a significant national gap for 2019/20, the Lincolnshire system had a number of small adjustments to make and the provider organisations had been asked to make adjustments of £200k in activity.

871/19 There had been over commitment by NHS England in respect of capital funds and the Trust had been requested to make adjustments and resubmit the capital fund request. The £1.7m loan in relation to fire works had been removed and the expectation would be for the Director of Estates and Facilities to work with the Finance team, this had been discussed through the Finance, Performance and Estates Committee.

872/19 Workforce vacancy rates had increased to 12.7% with a slight improvement seen in medical vacancies, the nursing efficiency plan is in place with the expected change seen, a reduction would be realised later in the year.

873/19 The Director of Nursing noted that the figure in relation to pressure ulcers was down from 40% last year to 23.1% currently. There is recognition of the work to be done in relation to serious incidents at Lincoln in order to realise a reduction. Children's sepsis had been broken down with 100% at Lincoln and 75% in inpatient areas at Pilgrim, work would be undertaken to make improvements.

874/19 The Chair highlighted the sustained improvement of harm free care and that this was something that should be celebrated by the Trust.

875/19 The Medical Director highlighted key points to note in relation to hospital mortality reporting better than the national average however the Trust continued to remain an outlier for SHMI. In order to ensure improvements are made better relationships would be required with community providers to develop integrated care working.

876/19 Work would be required in relation to care within treatment rooms and clinics to reduce errors. Awareness raising with staff regarding risk in less controlled environments would be required, the Trust had reflected on the incidents that had been reported.

877/19 The Chief Operating Officer indicated that the Referral To Treatment (RTT) trajectory for the year would take the Trust to around 84%. There was confidence regarding 52 week waiters around capacity however there remained a risk in relation to data quality. April data indicated 2 breaches of 52 week waits due to data quality issues, work would be undertaken to ensure improvements were made in data quality.

878/19 The Board were advised that if the cancer trajectory was delivered each month for the year the Trust would achieve performance of 81% against a target of 85%, there had been a number of challenges last year including an increased number of patients treated however performance did not improve. The report demonstrated deterioration however this had been due to change in how patients on the cancer pathway were notified of diagnosis. The issue was due to a backlog in the administration of letter production, this is not an isolated issue for the Trust.

879/19 In relation to urgent care there had been 4 areas of improvement last year. The Trust had seen 5% more ambulance attendance and despite the growth there had be a reduction in the length of wait for ambulance handover by 7%, further work was required to continue to reduce.

880/19 The Trust had received a section 31 notice in relation to triage, this position had now improved with 20% more patients seen within 15 minutes and the Trust were reporting in the top quartile nationally in March. 30% streaming at Pilgrim in quarter 4 had been achieved, further work would be required at Lincoln, this related to the skills uplift from Pilgrim being reflected at Lincoln.

881/19 The Trust remains in the upper quartile for length of stay and a paper would be presented to the Quality Governance Committee, based on the Pilgrim reconfiguration. The length of stay had reduced by 8.5%, this had been as a result of patients being managed appropriately.

882/19 Work had been undertaken to focus on streaming at Lincoln to ensure improvements would be realised by the end of June. A kick start to same day emergency care had been planned through the national accelerated programme. Recruitment remained on track to employ 20 additional doctors by September. The Trust would aim to have the first stage of the reconfiguration at Lincoln in place by the end of June or early July to ensure pressure would be reduced. Data sets would be developed for inclusion in the IPR.

883/19 The timeliness of the data being discussed was questioned given that March data had been discussed in June. Confirmation had been provided that this was due to the data being disused at the April Committee meetings prior to reporting to Board. Data reporting dates determine when data is available to be presented. Questions were also raised in relation to data quality due to some targets being set at zero, this was due to the process being under development.

ACTION – Interim Director of Finance and Procurement, 2 July 2019

884/19 The Chief Executive highlighted that urgent care statistics would change and that this would be going through a consultation. A report would be due back around September the Trusts metrics would need to be shifted towards the national metrics.

ACTION – Chief Operating Office, 30 September 2019

885/19 The Deputy Chief Executive stated that the Committee Chairs had been requested to review the suite of KPIs included within the report and requested confirmation of the position to finalise these.

886/19 The Chairs confirmed that this was still outstanding and confirmation was given that the intended action had been a reduction of KPIs to refine reporting. Work would be required to review the KPIs.

ACTION – Committee Chairs, 2 July 2019

The Trust Board:

- **Received the report**

Item 16 Risk and Assurance

887/19 **Item 16.1 Risk Management Report**

The Medical Director presented the report to the Board.

888/19 The risk register had been reformulated to include unmitigated, residual and target risk ratings. The changes would require embedding through the divisions to the clinical teams and would provide an easier way for staff to understand how risk works. A key point to note had been that the change to the register would ensure it is easier to modify practice and make improvements.

889/19 The Board acknowledged the changes to the register and the Chair requested confirmation that members were satisfied that the top 5 stated risks to the organisation in the report were a true reflection.

890/19 Dr Gibson noted that there had been challenge at Quality Governance Committee in relation to the aseptic pharmacy risk and the potential for this to be reduced due to recruitment within the service. The Committee had requested that the Risk Manager carries out a review of the risk.

891/19 Mrs Libiszewski commented on the need to review the risk register actions to ensure the focus by the Committees to determine if the correct actions had been identified to aid the mitigation. If the control does not have the desired impact then the question should be raised as to why the action had been carried out, further narrative would then be required.

ACTION – Medical Director, 2 July 2019

892/19 The Chief Executive confirmed that an external report had been commissioned on the aseptic pharmacy and would be sent to Quality Governance Committee to review.

893/19 Mrs Dunnett enquired as to whether the Committees could continue to review the detail of the risk register and the Board conduct a cross check of the information. The Chair confirmed that the Board own the risks within the organisation and as such must continue to receive the register however the Board would benefit from improved narrative in relation to the movement of risk.

ACTION – Medical Director, 2 July 2019

894/19 The Director of Nursing raised the incorporation of risk to funding given to business cases, the expectation would be that funding would ultimately reduce the impact on the risk due to mitigating actions being carried out. Consideration would need to be given as to how business cases would have a positive impact on the risk.

The Trust Board:

- **Received the report**
- **Accepted the top risks within the register further to discussions at the Committee meetings**

895/19 **Item 16.2 BAF 2019/20**

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

896/19 The framework had been through the Committees and the report identified the issue raised from Quality Governance Committee in relation to being unable to provide assurance ratings. Additional work would be undertaken to support completion by the Committee.

897/19 There had been 2 areas raised for the Boards attention, these were in relation to objective 1a and the clarity of patient experience and objective 2b, the metric identified had not been set and would be utilised as a baseline for 2019/20.

898/19 Work continues to develop the framework including links to the risk register and internal audit plan as agreed by the Audit Committee, next steps would be to include audits from the clinical audit programme.

899/19 The Chair noted that the Board continued to see the development of the framework in the new format and that it had not been rated by all assurance committees due to further work being required. Quality Governance Committee would be in a position to complete the assurance ratings at the next Committee meeting in July. The issues regarding patient experience would require consideration, given the reports due to be presented to the Private Board session this would require inclusion within the framework.

900/19 The Board discussed the reporting route for patient experience acknowledging that patient experience is a quality issue. The Board were clear that patient experience required reporting through the Quality Governance Committee however further discussions would be required in relation to Executive leadership and reporting.

ACTION – Director of Human Resources and Organisational Development, 2 July 2019

901/19 The Board discussed the developing metrics and agreed that colleagues would be held to account for delivery at end of June to allow the Committee to provide assurance.

902/19 The Board Assurance Framework would now move to the Executives to update on a monthly basis to then be received by the Committees for further comment and update. The Board would receive an updated framework on a monthly basis, this is a developing process and progress would be maintained.

903/19 Committee agendas had been aligned to the framework as fully as possibly however some gaps remain which had resulted in them not being fully aligned, work would continue.

904/19 The Chair commented on the significant improvements that had been made and identified that this reflected back to the Board Development Sessions regarding the objectives of the organisation. The framework appears to be correctly aligned with the right narrative, the next step would be to ensure the necessary level of assurance.

The Trust Board:

- **Received the Board Assurance Framework**

- **Noted the progress**

905/19 **Item 16.3 Audit Committee Report**

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

906/19 Key points noted were that the Committee focus had been primarily on the receipt of the annual accounts, annual report and governance statement which had previously been discussed at the Extraordinary Board meeting on 23rd May.

907/19 The Committee approved the Internal Audit Plan which had been the first plan from the new auditors Grant Thornton. This had been through a robust process and there had been a small number of minor follow ups to be completed. Work had commenced on quarter 1 audits.

The Trust Board:

- **Received the report**

908/19 **Item 16.4 Annual Self Certification NHS Provider Licence Conditions**

The Trust Secretary presented the annual self-certification declaration.

909/19 NHS Improvement require all NHS Trusts to complete an annual self-certification that they meet the obligations set out in the NHS provider licence and show that they have complied with governance requirements. NHS Trusts are exempt from meeting the provider licence however directions from the Secretary of State require NHS Improvement to ensure that Trusts comply with conditions equivalent to the license as it deems appropriate.

910/19 The Board were requested to sign the declaration for condition FT4, *The provider has complied with required governance arrangements,* as 'not confirmed'. The Trust had been able to confirm against section 2 and 3 which demonstrates the improvements made in governance processes however sections 1, 4, 5 and 6 remain not confirmed.

The Trust Board:

- **Approved the self-certification for condition FT4**

Item 17 Strategy and Policy

911/19 **Item 17.1 Healthy Conversation 2019**

The Deputy Chief Executive presented the item and identified that the update had been covered in the Chief Executives update and the report presented had been produced by the STP office. The Sustainability and Transformation Programme had been satisfied by the impact of the events and an infographic on page 4 provided an indication of engagement.

The Trust Board:

- **Received the report**

912/19 **Item 17.2 Board Forward Planner**

For information

913/19 **Item 17.3 ULH Innovation**

For information

914/19 The Chair noted the good work that was being undertaken at County Hospital Louth in relation to partial knee replacements. The Board agreed that a letter of thanks would be sent to the consultant.

ACTION – Chief Executive, 2 July 2019

915/19 **Item 17.4 Board Visibility**

The Chief Executive presented the new report to the Board which details the visibility of the Board members throughout the organisation.

916/19 The report had been produced to demonstrate the work being undertaken by the Board including 15 Steps visits. Discussions were held regarding the benefit of such a report and it was identified that this would provide the opportunity to regularly demonstrate Board visibility.

917/19 The Board were requested to decide if they wished to continue reporting in this format. It had been identified that the 15 steps visit information reports formally on a quarterly basis to Quality Governance Committee and that the report presented would be required to capture more informal visibility that the Board conducted.

918/19 Mrs Libiszewski commented that the Quality Governance Committee were not assured in terms of the robustness of the 15 Steps programme, it does not help the Non-Executive Directors to contribute well and it had been noted that the output had been limited. This had been fed back within the organisation. The methodology of 15 Steps is correct however better facilitation would be beneficial. Mrs Libiszewski identified that the Non-Executive Directors would benefit from administrative support to provide the information for the Board Visibility report and also the 15 Steps programme, this would allow the opportunity to write letters of thanks to staff.

919/19 The Chair advised that 15 Steps is used by the Trust for quality assurance and is reported to Quality Governance Committee, given comments made a review of the process would be required.

ACTION – Director of Nursing, 2 July 2019

920/19 Work would be undertaken to ensure capture of Board Visibility and reporting of the information.

ACTION – Trust Secretary, 2 July 2019

The Trust Board:

- **Received the report**

921/19 **Item 18 Any Other Notified Items of Urgent Business**

The Chair formally acknowledged that this had been the final meeting for the Chief Executive due to his retirement and passed on thanks for the hard work, dedication and contribution to health care both at the Trust and in the county that had been made.

922/19 On behalf of the Board the Chair thanked Mr Sobieraj for his personal commitment and leadership to the Trust.

923/19 The Chief Executive responded to thank the chair for her kind words and stated that he wanted to ensure that upon leaving there would be hope and a bright future for the Trust.

924/19 The next meeting will be held on Tuesday 2 July 2019, New Life Centre, Sleaford

Voting Members	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	5 June 2019
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	A	X	A	A	X	X	X	X	X	X	X
Geoff Hayward	X	X	A	A	X	X	A	A	A	X	A	X
Gill Ponder	X	X	X	X	X	X	X	X	X	A	X	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	A	X							
Michelle Rhodes	X	A	X	X	X	X	A	X	X	A	X	X
Kevin Turner	A	A	X	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	A	X	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	X

Agenda item: 6

PUBLIC TRUST BOARD ACTION LOG

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Deadline	Completed
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	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
2 April 2019	398/19		Healthy Conversation consultation summary to be presented to the Board	Chief Executive	4 June 2019	Complete
2 April 2019	507/19		Guardians of safe working report to be presented to Board	Medical Director	7 May 2019	Complete
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	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	Complete
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	Further update to Finance, Performance and Estates Committee, to be included on Committee workplan

PUBLIC TRUST BOARD ACTION LOG

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	Complete Included in compliance quarterly report to Audit Committee
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 internal audit plans to the BAF.	Trust Secretary	4 June 2019	IA Plan – complete QGC agreed process for alinginng clinical audit at June meeting - complete
4 June 2019	721/19	Public question Sue McQuinn	Pick up car parking questions directly with Sue McQuinn.	Boocock, Paul	02/07/2019	Trust has been in contact with Sue McQuinn Complete
4 June 2019	721/19	Dr Gantasala departure	Thanks from Board for work here. Note the praise given at Board.	Warner, Jayne	02/07/2019	Letter sent Complete
4 June 2019	726/19	Arrangements for fire asbestos work	Discuss with DoN Check what needed for QIA	Boocock, Paul	02/07/2019	
4 June 2019	730/19	NHS People Plan	DoHR bring back people strategy to Board capturing the issues from NHS People Plan	Rayson, Martin	02/07/2019	Agenda item Complete
4 June 2019	738/19	Paper for Board on governance around SROs/SET	To allow Board understanding. Also to NEDs Lay Members Group	Turner, Kevin	02/07/2019	Circulated outside of meeting Complete

PUBLIC TRUST BOARD ACTION LOG

4 June 2019	754/19	Development of Nursing Associates	Consideration of Nursing Associate's to develop their careers. Take through W&OD Committee?	Rayson, Martin	02/07/2019	
4 June 2019	759/19	Establish the levels of trainees organisation can manage	Following Nursing Associate staff story	Rayson, Martin	02/07/2019	
4 June 2019	769/19	Wording on p40 around CQC aspiration of 5 year strategy	Needs removing. Should feature in Quality strategy not here.	Rayson, Martin	02/07/2019	Complete
4 June 2019	772/19	Descriptor of County Hospital Louth in 5 year strategy	Needs to match up with clinical strategy. Orthopaedics missing	Rayson, Martin	02/07/2019	
4 June 2019	806/19	Amend Clinical Strategy doc	Pg11 amend reference to ET to Board Pg43 Don't use DTOC. Too much info on pharmacy/ proportionality and balance	Hepburn, Neill	02/07/2019	
4 June 2019	809/19	Assurance on delivery of Clinical Strategy through to Board	How will this be monitored	Hepburn, Neill	02/07/2019	
4 June 2019	827/19	Assurance in respect of H&S actions reported to FPEC	Clarity required in relation to training etc and metrics on actions following historic regulation/prosecution	Boocock, Paul	02/07/2019	
4 June 2019	842/19	To pick up outside meeting how Trust moves away from fax referrals		Brassington, Mark	02/07/2019	
4 June 2019	883/19	Inaccuracies and out of date data in IPR		Matthew, Paul	02/07/2019	
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	30/09/2019	
4 June 2019	886/19	Review of KPIs in IPR across committees	Aiming to reduce number	Committee Chairs and	04/06/2019	

Agenda item: 6

PUBLIC TRUST BOARD ACTION LOG

				Executive Directors		
4 June 2019	891/19	If controls against the 5 high corporate risks aren't having desired effect on mitigating then should be reviewed		Hepburn, Neill	02/07/2019	
4 June 2019	893/19	Cover report for risk register needs to be high level	Summarise discussion from committee reports. Summary of movement in risks	Hepburn, Neill	02/07/2019	
4 June 2019	900/19	BAF take patient exp to QGC		Rayson, Martin	02/07/2019	
4 June 2019	914/19	Letter to consultant re service at County Hospital Louth	Letter of thanks to be sent for work in relation to partial knee replacements at County Hospital Louth	Sobieraj, Jan	02/07/2019	
4 June 2019	919/19	Review of 15 steps	Consider at QGC	Rhodes, Michelle	02/07/2019	Paper for consideration by ET then QGC
4 June 2019	920/19	Board visibility	Look at how we gather this data. How it is reported at Board	Warner, Jayne	02/07/2019	Paper for consideration by ET then QGC

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21st June 2019
Chairperson:	Elizabeth Libiszewski , Non Executive Director
Author:	Jayne Warner, Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives
	Assurance in respect of SO 1a Issue: Delivering harm free care <u>Source of assurance: Patient Safety Incidents –</u> The Committee were advised that the Trust were investigating incident data for incidents resulting in moderate harm and above following an increase in numbers reported. Significant harm incidents reported in May were also being considered at the Quality and Safety Oversight Group and no patterns had been identified. <u>Actions Requested by the Committee:</u> The Committee would receive the results of the investigative work once complete. <u>Source of Assurance: Quality and Safety Improvement Plan –</u> The Trust remains amber across the 12 programmes. The Committee noted the risks highlighted relating to the failure to appoint to the post of children's lead nurse and the continued support to the data quality project. The Committee were advised that the feedback which was being received from the current CQC visits would be reviewed and aligned with the programme. <u>Actions Requested by the Committee:</u> The Committee asked for a refresh of the programme which provided assurance on how the areas being closed down would move to business as usual. The refresh should also allow the programme to move from task to outcome focussed. <u>Source of assurance: CQC unannounced inspections –</u> The Committee received a verbal update on the areas which had been visited by the CQC during June. The letters received as a result of this would be shared with public board.

	Source of Assurance: Quality and Safety Oversight Group – Progress continued to be made in the development of this group. The Committee were advised that there had been a review of the divisions and the consistency of reporting. Divisional attendance remained limited but this was being addressed. Actions Requested by the Committee: The Committee would continue to receive additional reporting whilst reporting to the group became further embedded. Source of Assurance: QIA – The Committee were assured that the QIA process was now in place and had improved due to QIAs being rejected if not appropriate. The Committee would continue to review. Source of Assurance: CNST Maternity Standards The Committee received the position statement against the standards. The Trust remained RED rated against standards 6 and 8. Actions Requested by the Committee: The Committee would continue to receive monthly monitoring reports on behalf of the Board.
	Assurance in respect of SO 1a Issue: Mortality Source of Assurance: Mortality – The Committee noted that mortality remained below expected levels for the Trust. The Committee noted that ReSPECT had been rolled out across the Trust. Actions Requested by the Committee: The Committee requested an update on ReSPECT and also coding quality in the next mortality report. These areas were identified as assurance gaps within the Board assurance framework. Source of Assurance: National Safety Standards for Invasive Procedures (NatSSIPs) Forward Plan – The Committee received a report detailing the Trust current position against the standards and the proposals to improve compliance going forward. The Committee noted the link between the standards and reductions in the occurrence of surgical never events. Source of Assurance: Duty of Candour – The Committee noted the continued improvement in compliance with Duty of Candour.
	Assurance in respect of other areas:- Patient Experience – The Committee reiterated the concern that it remained unclear within the Trust objectives about how assurance on patient experience would be achieved. The Committee received the quarter four patient experience report and noted the publication of the national inpatient survey which had been considered at Trust Board in

	June. The Committee noted patient experience feedback where patients attending the MIU were reverting back into the emergency department. Actions Requested by the Committee: The Committee asked that the Chief Operating Officer review the data. Quality Account – The Committee received the final version Quality account. The external statements had been received from Healthwatch, CCGs and Community partners. The external audit had highlighted issues with A&E 4hr data and cancer patient fax referrals which had required further fieldwork. The Trust were not in receipt of the final external audit report but had received assurances that the remaining work would not result in a change to the limited assurance opinion. The Committee approved the quality account on behalf of the Board as a balanced view of the Trust position. Actions requested by the Committee: Delays in receipt of final audit report to be raised with Audit Committee. The final report to be shared with FPEC to allow further consideration of the work on data validity. Further work would now be required to allow measures for priorities to be developed by leads with regular updates to the Committee. Policies for approval: IRMER - The Committee approved the policy
Issues where assurance remains outstanding for escalation to the Board	The Committee had received feedback following the May meeting when it had been observed by NHSI. This would be shared with the Board along with actions when feedback was received from all committee and reporting group observations. The Committee would highlight in private Trust Board the details of a high risk case.
Items referred to other Committees for Assurance	The Committed wish to raise delays in receipt of final audit report in relation to the Quality Account to be raised with the Audit Committee. The final report from External Audit to be shared with FPEC to allow further consideration of the work on data validity. Further work would now be required to allow measures for priorities to be developed by leads with regular updates to the Committee.
Committee Review of corporate risk register	The Committee had received a Quality Governance Corporate Risk Register. The Committee were updated on the ongoing review of the aseptic pharmacy risk. This work was being led by the divisional clinical lead. The Committee had previously raised concern that mitigating actions had not resulted in a lower risk score. The risk was now being considered in relation to patient safety, infrastructure and compliance. The Committee were advised that there were no reported incidents of harm. NHSI had offered to conduct an external risk review. The Committee had asked for a review of risk 4041 relating to NIV. This was being considered at the patient safety group.

Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed and updated since the last meeting. The Committee rated the assurances which were the responsibility for the Committee which would be escalated through the Board Assurance Framework
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives. The Committee were not assured in respect of any of the strategic risk areas which aligned to it.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

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

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Director of Nursing
Date:	2nd July 2019
Healthcare standard	

Title:	CQC Inspection Feedback

Author/Responsible Director: Michelle Rhodes, Director of Nursing

Purpose of the Report: To provide Trust Board with the feedback received from the CQC following their visits on 13th June 2019 and 20th June 2019

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	√

Summary/Key Points:

The feedback covered
Pharmacy
Lincoln

- Urgent and Emergency Care
- Maternity
- Children's and Young People Services
- Medicine
- Critical Care

Pilgrim Hospital, Boston

- Urgent and Emergency Care
- Maternity
- Children's and Young People Services
- Medicine
- Critical Care

Verbal feedback was provided to the Quality Governance Committee at their meeting in June which was also observed by the CQC.

Recommendations: For Trust Board to note the feedback and findings of the inspections.	
Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

By email

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 66161
Fax: 03000 616171

www.cqc.org.uk

Our reference: INS2-5741841731

Mr Jan Sobieraj
Chief Executive
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
LN2 5QY

Date: 14 June 2019

Dear Mr Sobieraj

Re: CQC inspection of United Lincolnshire Hospitals NHS Trust – Lincoln County Hospital and Pilgrim Hospital.

Following your feedback meeting with Simon Brown, Inspection Manager and Anna Kerrigan, Inspector on 13 June 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to your colleagues Michelle Rhodes, Victoria Bagshaw, Claire Pacey, Paul Matthews, Louise Hobson and Mark Brassington at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 13 June 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Lincoln County Hospital

Urgent and Emergency Care

- We were concerned about the triage process, sometimes it was recorded as visual triage and sometimes it was clinical.
- There was a lack of oversight of patients in the waiting area for long periods despite conditions at triage indicating they should be a priority.
- We found the department not compliant with RCPH standards for children.
- We were concerned about the management of the deteriorating patient, some patients were not treated in the correct areas for example majors or minors and we found examples where patients had not been screened for sepsis in a timely way and did not always receive a timely sespis six. There were delays in patients recieveing antibiotics.
- There were challenges around both medical and nursing staffing numbers.
- We found the RAT process was not always effective at reducing ambulance handover delays.
- We found you were not meeting the 4 hour standard and there had been a number of patients in the department over 12 hours during our inspection.
- We were concerned about the culture. We spoke with several staff who told us they percieved there was bullying among their colleagues.
- We were concerned about the incident grading, we saw a number of incidents graded as low or moderate harm which could have actually been severe.
- We found a lack of governance processes around safegaurding, for example following up on concerns.
- We saw some good management of sick patients once they were moved to resus.
- We saw some good examples of compassionate care, however there were times when care was being delivered which was not in line with the trust values.

Maternity

- Staffing levels on the ward were in line with best practice and established guidelines. There were effective systems to safeguard vulnerable women and children. Staff knew how to report incidents and learning was disseminated to staff.
- There was good record keeping and staff completed comprehensive risk assessments for women in line with national guidance.
- Staff provided a caring, kind and compassionate service, which involved wome in their care and we received numerous positive comments from women.
- Women had access to a range of specialist midwives.
- Staff were positive about good local leadership on the unit and informed us their managers were visible and approachable. Staff at various levels said they liked working on the unit and felt other staff were friendly.
- Staff told us of an improved culture following changes to the leadership team.

Children and Young People Services

- We found improvement in the management of sepsis.

- We found good risk assessment processes.
- We were concerned about the lack of safeguarding supervision for the named safeguarding childrens nurse. We are also concerned that there is no named doctor at present.
- Consultant staffing is not in line with the RCPH standards.
- Nursing staffing levels were not always meeting planned levels particularly overnight. We were concenred that further risk was added to this if staff were asked to attend A&E overnight.
- There was a lack of transition pathways for some conditions.
- We are concerned around the use of audit and monitoring of patient outcomes.
- We are concerned around the lack of surgeon engagement in the children and young people steering committee.
- There appeared to be a lack of robust governance process, but know that the new leadership team are new in post and have plans to address.
- We saw compassionate care being delivered to children.
- We found good local leadership.

Pilgrim Hospital, Boston

Urgent and Emergency Care

- We didn't see the department performing under adverse pressure as we had previously, therefore it was difficult to corroborate some of the improvements we had been told about.
- We saw additional resources given to triage, but this did not always reduce triage delays.
- There were still periods of over crowding in the department as a result of exit block and increase demand on the service.
- There were concerns amongst staff around the level of managerial support.
- We found some processes to expedite patients going to the ward may have introduced other risk. E.g. Patients going to the IAC in pain and no Drs available to prescribe.
- The department was still challenged by the nursing and medical workforce levels.
- We found there had been progress with addressing the skills issues for nursing staffing and that there had been environment changes to benefit children.
- There was a mixed morale amongst staff within the department, some were more positive than others.

Maternity

- Staffing levels on the ward were in line with best practice and established guidelines. There were effective systems to safeguard vulnerable women and

children. Staff knew how to report incidents and learnings were disseminated to staff.
- There was good record keeping and staff completed comprehensive risk assessments for women in line with national guidance.
- Staff provided a caring, kind and compassionate service, which involved women in their care and we received numerous positive comments from women.
- Women had access to a range of specialist midwives midwives.
- Staff were positive about good local leadership on the unit and informed us their managers were visible and approachable. Staff at various levels said they liked working on the unit and felt other staff were friendly.
- Staff told us of an improved culture following changes to the leadership team.

Children and Young People Services

- We wereconcerned around the lack of M&M meetings for children.
- We were concerned children with high dependency needs are kept on PAU due to the inability to transfer them using the private ambulance service.
- We found some out of date guidelines. We found a lack of consistency when consulting other trust's guidelines.
- We found competent nursing staff with good level of training for nurses.
- We found good local leadership.
- There was a lack of systems for identifying children with additional needs.
- We found patients stayed longer than 12 hours on PAU.
- We were concerned about the fragility of the service in relation to medical staffing.
- Governance systems were not well established.
- We had someconcerns about a disconnect between management and clinicians.
- We found staff delivering compassionate patient care.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater, Jeff Worrall and Vanessa Wort at NHSE/I.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate

Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Carolyn Jenkinson

Head of Hospitals Inspection

c.c. Elaine Bayliss - Chair

Dale Bywater, Jeff Worrall and Vanessa Wort NHSE/I

Louise Grifferty CQC regional communications manager

By email

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Our reference: INS2-5741841731

Mr Jan Sobieraj
Chief Executive
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
LN2 5QY

Date: 24 June 2019

Dear Mr Sobieraj

Re: CQC inspection of United Lincolnshire Hospitals NHS Trust – Lincoln County Hospital and Pilgrim Hospital.

Following your feedback meeting with Simon Brown, Inspection Manager and Frances Lewis, Assistant inspector on 20 June 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to your colleagues Michelle Rhodes, Neill Hepburn, Louise Hobson, Victoria Bagshaw, Claire Pacey, Jan Potts, David Cleave, Dermot O'Donaugh and Mark Brassington at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 20 June 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Pharmacy / Medicine inspectors' feedback

- The self-administration of medicines policy did not appear properly implemented on wards, we found no evidence of patient assessment in accordance with policy.
- Pharmacy staff are very stretched we were concerned re staff covering too many wards to be effective for example we saw evidence of patient medicine not being reviewed such that they were prescribed a drug at a dose outside of trust guidance for nine days before pharmacy identified the error.
- We found the storage of medicines better than previous inspection.
- We found fewer omissions than at our previous but still some areas of concern and limited evidence of review of these on the wards.
- There is a lack of clarity of ward oversight on who is authorised to use PGDs – no current signature sheets on wards in any area looked at that.
- Mixed morale amongst pharmacy staff, most described an increased workload and poor levels of support.

Pilgrim Hospital, Boston

Medicine

- The culture /morale amongst staff appears to have deteriorated generally and we've found staff teams to be fractured in places.
- We've observed some episodes of care that fell short of the trust values and observed some issues around behavior and respect on the wards, between staff and from staff towards patients. We also heard how the focus on A&E at pilgrim had resulted in a lack of focus on other areas within the trust
- We were particularly concerned around the reliance on locum and agency nurse and doctors on AMSS and found generally poor co-ordination of care.
- We found low morale amongst the stroke team who described no support from senior leaders.
- We were concerned about the pressure on OT and Physios particularly the chest physios who described an increased workload which they were unable to always manage.
- We were impressed by the level of patient and staff engagement strategies on ward 6b and saw how some changes had improved the local morale amongst staff.
- We saw some impressive work by the Physio and OT team in relation to falls prevention.

Critical Care

- Patients received full assessments and high-quality care whilst in the unit. There was excellent MDT working and communication to enable joined up individualised care for patients.
- Speech and Language Therapy staff for the hospital were stretched and were often not available to attend the critical care unit to assess patients. This sometimes caused a delay to moving to oral feeding for patients. Tracheostomy patients required SALT swallowing assessment before oral weaning could be commenced.

- There was a high-level risk register for theatres, Anesthetics and Critical care (TACC) but there were only three risks on the register for Pilgrim Hospital Critical Care Unit of new beds, delayed discharge and pharmacy cover. There was no lower level more detailed risk register of risks owned by the unit.
- We had some concerns around the pharmacy provision for example the service did not have pharmacy cover of an 8a specialist clinical pharmacist as per the national guidelines and a pharmacist was not always present for the MDT ward round.
- The service had been responsive when issues had been identified through audits. For example, incidents of pressure ulcers and staff recording of oral care for patients. Managers worked with staff to improve through communication, training and further audits to check progress.
- The service offered a follow up programme for patients, offering individual multidisciplinary appointments to review their care records during their stay in the unit.
- Staff were caring and supportive with patients and their loved ones. Patients loved ones gave very positive feedback about their experiences.

Lincoln County Hospital

Medicine

- We were particularly impressed with the actions taken by the trust in relation to care of of patients living with learning disabilities and those with mental health conditions, this included individualised care plans, risk assessments and environmental changes.
- We are concerned around the reliance on bank and agency staff on some wards.
- Medical and nursing notes were not always stored securely, notes were often seen on nurses' stations.
- There was poor communication on MEAU around specialist consultant reviews consultants did not proactively ring or visit the MEAU to help with the transfer process.
- All nursing risk assessments are completed appropriately and updated appropriate equipment put in place such as pressure reliving equipment.
- We observed some excellent MDT working on Ashby ward and we attended a meeting where patients additional needs on discharge were considered.
- Good continuous monitoring of NEWS and staff were aware of the escalation process.
- Most staff felt that they were well supported by their managers and that managers were visible and approachable. Staff on Lancaster and MEAU felt that managers were not visible and lacked an understanding of the pressures faced on the ward.
- Staff on discharge lounge report that they have no direct manager and have not received an appraisal.
- All staff were seen to treat patients with kindness, dignity and respect. Patients and their relatives felt they were involved in their care.

Critical Care

- We were particularly impressed by the use of bespoke mental health risk assessments developed by staff on ICU.
- We found good implementation and use of LocSSIPs.
- We had some concerns around the pharmacy provision for example the service did not have pharmacy cover of an 8a specialist clinical pharmacist for the required time as per the national guidelines and there was no designated dietitian assigned to the unit.
- We found exceptional MDT working.
- We were particularly impressed with the ACCP who were FICM members.
- We found local leaders (band 7 & 8a) had good oversight of the unit.
- The new middle management team coupled with new divisional team structure meant that oversight of critical care at this level was not currently robust.
- There were pockets of low staff morale across nursing staff as a result of staff movement to other areas.
- We found consistently positive feedback from patients and relatives and we were particularly impressed with the level of emotional support staff afforded patient.
- We found innovative practice with regards to use of new equipment and development of care bundles.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater, Jeff Worrall and Vanessa Wort at NHSE/I.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

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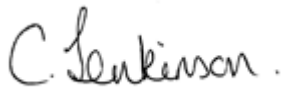
Yours sincerely



Carolyn Jenkinson

Head of Hospitals Inspection

c.c. Elaine Bayliss - Chair

Dale Bywater, Jeff Worrall and Vanessa Wort NHSE/I

Louise Grifferty CQC regional communications manager

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 June 2019
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme.
Assurances received by the Committee	Lack of Assurance in respect of 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 in line with plan for month 2. However, the pay bill was at a record level with £4m spend on agency, up from £2.5m in the same period last year. The Trust had only achieved plan due to the release of the annual leave accrual and accruals from year end that had not been required. This had removed contingencies that could have been used later in the year. The position had been managed but there was an urgent need for action to gain grip and control on the pay bill. A clear control process in relation to agency and bank would be required that works with the TOM and strikes a balance with empowering the divisions. Discussions had taken place at ET and FTG and work was being undertaken by the Finance Team with the Divisions to bring spend back on plan. This would be monitored through PRMs. The substantive pay bill remained broadly flat. Income was reported as £371k adverse to plan however the income from Lincolnshire CCGs contracts remained in line with plan. Non-pay was reported as £800k favourable to plan, but £500k of that related to pass-through activity. The Trust had agreed 4 CQUINS for 2019/20 and assurance against delivery would be presented to the Committee from July. The Committee required sight of backlog activity that had a financial value

	and would support the Trust coming back on plan, including patients waiting over 26 weeks and repatriation opportunities to use spare capacity. This would be included in the income report from July. Nationally there had been capital plans submitted 20-25% over available funds, with Trusts being asked to reduce capital requests. If the Trust's capital spend was reduced, it would have a negative impact on compliance and delivery of the FEP. The Committee were asked to support revenue borrowing of £7.925m and £3.155m capital borrowing. The Committee gave support to the borrowing and recommended Board approval. Action requested by the Committee: Assurance on increased grip and control on pay costs.
	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 that whilst further FEP opportunities were being identified, pace and momentum were needed to bring the ideas through to delivery. A risk adjusted plan had been produced, which had a value of £22.3m. A session had been held with NHSI in respect of process, governance and reporting with a focus on workforce issues. A follow up session would take place due the acknowledgment of the challenging plan the Trust had in place. Feedback received had been positive, but pace and momentum would be required to deliver the plan. . There was an identified risk of non-delivery against workforce schemes to reduce agency spend by recruiting to substantive posts. Further FEP schemes of £4-5m were being identified to mitigate this risk. Action requested by the Committee: Assurance on delivery of FEP's.
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception Report Estates, Infrastructure and Environment Group Source of assurance: The Committee received an update from the Estates, Infrastructure and Environment Group including a set of performance dials. The Committee noted that the dials were useful to demonstrate the current risk position in each area, however an additional line to show the movement from the previous report would be beneficial. The report from the group did not provide assurance to the Committee,

	particularly in respect of the improvement notice in relation to confined spaces issued by the Health and safety Executive during their recent audit. The HSE had acknowledged the significant progress that the Trust had made since 2014. An update would be provided to the HSE by 1st July, which should result in the closure of the confined space notice. Ongoing management to those standards would then be required. LED lighting funding had been awarded, but due to the national capital position, this is subject to NHSI confirmation of funding. The Trust had written to NHSI to explain the impact on the planned FEP savings and how the LED lights would reduce the risk of fires due to old lights overheating. The Committee requested a further update on the comments made by the HSE in respect of asbestos within the Trust. This would be included in the next report. The Committee raised concerns regarding outstanding invoices for leases and licences, but were assured that the issues had been resolved. Escalations from the group to the Committee included: • Theatre Housekeeping – the risk had been mitigated through Estates to ensure that there was no impact on infection control • Johnson update – sessional space booked was previously invoiced but NHSPS now require credit card booking. ULHT had a spend of £0.25m and are insisting on invoicing to avoid credit card fees impacting on NHS funds • Manual Handling – the Committee requested further assurance on the specific actions taken to reduce the risk and to implement the learning from a recent legal case, confirmation was provided that this would be presented to the July Committee Action requested by the Committee: The Committee requested assurance that the confined spaces improvement notice had been closed at the next meeting, information on the HSE response to the Trust's progress against the asbestos notice and assurance on outstanding manual handling items.
	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Focused Assurance reports for Fire, Water, Asbestos and Electrical Safety Source of assurance: The Committee received a suite of papers in respect of Fire, Water, Asbestos and Electrical Safety. The key points noted were: <u>Asbestos:</u> • Asbestos works had been linked to the fire safety programme. The HSE had indicated that progress being made was acceptable. • The risk score had been increased to 12, due to the need for amendments to be made to the Asbestos Management Plan to incorporate existing procedures for the management of water

	leaks in contaminated locations. The plan was due to be completed within the next month, after which the risk score would be reduced again. <u>Fire:</u> • The Committee noted the percentage of completed fire doors installed was 38% (1,909 door leafs) against total plan. • Assurance was provided that there were no ongoing issues, as the early part of the programme focused more on manufacturing the doors ready for installation. • Applications had been made to Lincolnshire Fire and Rescue for extensions to the enforcement notice deadlines, which had been successful. A 2 year extension had been agreed for Lincoln and an 18 month extension for Boston. Overall completion was due by March 2021. • Due to short deadlines required by the Enforcement Notices, there had been a requirement to use waivers within the Standing Financial Instructions procedures due to the urgency of the works. Future plans would aim to make sure that sufficient time for full tender procurement process is factored into future works reducing or eliminating the need for this urgent requirement. <u>Water:</u> • The Committee were advised of underutilised spaces within the Trust presenting a higher risk and the management of those. • Each issue had an action plan in place • There was reduced representation at the Water Safety Group from nursing or housekeeping. The Committee requested that this be considered for inclusion on the risk register, including mitigating actions. Actions requested by the Committee: Assurance that the water action plan was being delivered to mitigate the increased risk
	Lack of Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent and Emergency Care Improvement Programme Source of assurance: The Chief Operating Officer provided the headline data to the Committee: • May 4 hour performance was 68.13%. This had improved from April but remained below trajectory • Attendance had been above plan but was similar to the previous year. There had been a 7% increase in admissions • Ambulance conveyances had increased by 5% • Bed occupancy rates remained above plan as a result 3 improvement actions had been put in place to support delivery: • Streaming at Lincoln would commence 24th June which would replicate Pilgrim • Ambulatory care trials supported by ECIST for same day emergency care

	• Accelerating Lincoln reconfiguration programme to replicate Pilgrim. The model would be redesigned with staff Action requested by the Committee: Assurance that improvement plans were having an impact on performance trajectory.
	Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Cancer Improvement Plan Source of assurance: The Committee received the update and noted that the trajectory had been delivered in April. However, there was a risk to delivery of trajectory in May due to the number of over 62 day patients treated. The Committee were not assured with regard to the Pathology Improvement paper presented, but had seen the improvement plan in May. Action requested by the Committee: An update to the cancer improvement plan and inclusion of the 28 day faster diagnosis requirements was requested next month.
	Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Planned Care Source of Assurance: The Committee were advised of a growth in waiting lists. Investigations were underway to determine if outpatients being under plan had impacted on this growth. 2 52 week breaches were experienced in April due to data quality issues, due to human error. The patients had received treatment and had suffered no harm. The Committee were advised that training would be undertaken with staff to improve data quality. No breaches had occurred in May and none were expected in June, as the Trust were aiming to eliminate waits over 40 weeks.
	<u>Assurance in respect of other areas:</u> <u>Board Assurance Framework:</u> The Committee received the Board Assurance Framework and requested alignment of actions to support the read across of the document. Further work would be undertaken in relation to objective 4a and the baseline year. Further updates were requested against the % reductions in face to face contacts in outpatients by 5%. <u>Policies for approval:</u>

	The Committee approved the following polices: • Business Continuity Policy • Hospital Command, Control and Coordination Policy • VIP Policy
Issues where assurance remains outstanding for escalation to the Board	The Committee wish to raise with the Board the following points: • The need for urgent action to reduce spend on pay • The need for increased pace and momentum on delivery of FEPs
Items referred to other Committees for Assurance	The Committee wish to request from the Workforce and Organisational Development Committee a review of: • Control of agency use • Recruitment pipeline against substantive workforce numbers and the impact on agency and bank numbers • Time to hire – review of TRAC
Committee Review of corporate risk register	The Committee received the corporate risk register and noted that there had been no material change to the corporate risk profile or very high and high risks. . The Committee requested a deep dive in to risk 3688 be undertaken and reported to the July meeting. The Committee noted the risk in relation to the EU exit remained static at a 12 but recognised that this may increase due to the changing political landscape.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	As above.
Areas identified to visit in dept walk rounds	None

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

Attendance Summary for rolling 12 month period

Agenda Item 12.1

X in attendance A apologies given D deputy attended

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To:	**Trust Board**
From:	Director of HR and OD
Date:	2nd July 2019
Healthcare standard	Staffing

Title:	Refreshed 2019 People Strategy

Author: Martin Rayson (Director of HR and OD)
Responsible Director: Martin Rayson (Director of HR and OD)

Purpose of the report: To present to the Board for agreement the refreshed People Strategy for 2019. The Strategy retains its structure, but has been amended to reflect the latest evidence from the 2018 staff survey, our work on True North, the Workforce Financial Recovery Plan and the National People Plan (draft).

The Strategy is a key element of the Board Assurance Framework in relation to the True North objectives of:

- Having a modern and progressive workforce
- Working as one team

The Strategy has been discussed and agreed at the Workforce & Transformation Committee.

The report is provided to the Board for:

Decision	X	Discussion	
Assurance	X	Information	

Summary/key points:

The three year People Strategy is refreshed each year to take account of changes in the context and the latest evidence on the gap between our ambitions and the current reality. It sets out what we need to do to deliver our ambitions for our people and ensure ULHT is a place people want to work, to enable excellent patient care and the delivery of the Trust 5-Year Strategy

and in particular, the new Clinical Strategy.

The Strategy has been amended to reflect the NHS Draft People Plan and the response we need to make to the core issues evident in the results from the 2018 National Staff Survey.

The structure of the Strategy has been adapted to demonstrate how we will deliver the two True North objectives of "Modern and Progressive Workforce" and "One Team", but it also reflects the ambition to embed a continuous improvement methodology, improve patient experience and be more inclusive as a Trust.

To deliver those objectives and to manage the main workforce risks, we have identified a number of "areas of focus" and these are set out in the Strategy and in paragraphs 4.1 and 4.2 below. The actions planned for 2019/20 under each area are also included in the Strategy.

The Strategy links to other supporting strategies – Quality, Continuous Improvement, Patient Experience, Inclusion and the Education and Learning Strategy, which is in development.

Recommendations:
To agree the 2019 People Strategy

Strategic risk register	**Performance KPIs year to date**
Addresses risks on workforce numbers and engagement	In report

Resource implications (eg Financial, HR) – Actions to be delivered within resources available. Additional bids may be made to CRIG following completion of reviews

Assurance implications
The Strategy is an important element in managing the control gaps in the BAF around our two workforce objectives in the BAF

Patient and Public Involvement (PPI) implications
There is a strong link between levels of staff engagement and patient experience

Equality impact
An Equality Impact Assessment was undertaken on the People Strategy in 2018. This remains valid for this refreshed Strategy. There are no equality implications as the Strategy is underpinned by a commitment to allow equal access to our initiatives. Our workforce policies are individually assessed from a quality perspective. Areas of concern from an equality perspective are addressed through the Strategy

Information exempt from disclosure
None

Requirement for further review?
The Workforce & Transformation Committee will review progress through the KPIs at each of its meetings

1. Introduction

1.1 The updated People Strategy for 2019 is attached at Annex A. The Strategy has been created with input from key stakeholders, managers, staff and staffside representatives.

1.2 The Strategy seeks to deliver our ambitions for our people, which in itself will enable the achievement of our broader 5-year strategy and the recently agreed Clinical Strategy. It aligns closely with the workforce objectives agreed for the STP.

2. Response To National Staff Survey

2.1 In particular the Strategy is a response to the issues evident from the results of the 2018 National Staff Survey. In our analysis of the survey results previously presented, we identified the following as key priorities for the Trust, as a consequence of the survey results:

- Addressing the permanent/temporary workforce mix.
- Being clear around our strategic narrative as a means to give hope to the organisation, ensuring our future is seen to be as part of the Lincolnshire system and emphasising that patients (and not finance) are our top priority at all times.
- Re-establishing a connection between the Trust and its leaders and the people who work for it.
- A revised leadership strategy, building on the work undertaken to date, Creating a sense that the organisation really cares about its staff (looking at the health and well-being issue more broadly)
- Building that sense of the Trust being an organisation with a consistent focus on safety and learning.
- Identifying and managing talent, so that people can build their careers with us
- Understanding and tackling the concerns around bullying and harassment.

3. National Interim People Plan

3.1 A presentation on the People Plan is attached at Annex 2. The NHS Interim People Plan has been developed with involvement from NHS Employers and a wide range of other stakeholders to set out an initial approach to tackling the range of workforce challenges.

3.2 The substantive People Plan will be published following the Spending Review. Key financial commitments will be decided as part of the Spending Review. NHS organisations will be expected to undertake

initial actions and further action following the publication of the final People Plan.

3.3 The key messages from the interim plan are set out below:

Workforce supply is acknowledged as the biggest challenge facing the NHS but the plan is clear that the quality of staff experience must be improved or those extra people will not stay, or come at all.

NHS organisations will be asked to develop their approach to making their organisation the best place to work.

- *creating a healthy inclusive and compassionate culture (including ensuring equality and diversity, tackling bullying and reducing violence)*

- *enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers)*

- *ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working).*

4. People Strategy As A Response

4.1 To deliver the "Modern & Progressive Workforce" objective we will therefore:

- Redefine the workforce we need through effective workforce planning & seek to reduce overall workforce cost, whilst delivering high quality services to patients (linking to changes in clinical pathways and the STP)

- Understand more about the workforce we have, their skills and where there are gaps in our skill sets

- Increase workforce supply, using the Talent Academy to create new supply pathways that reflect our future workforce shape

- Improve recruitment and retention success rates, so that we alter the workforce balance between permanent and temporary staff and thereby reduce the cost of temporary staff

- Involving our staff in improving what we do, encouraging innovation and continuous improvement (as a learning organisation) and empowering people to deliver change

- Improving the learning opportunities for trainees and staff at ULHT, demonstrating how people can build a portfolio of skills and careers in this organisation (talent management. Ensure our staff have access to

the development opportunities they need to provide consistently excellent services and thereby improve retention rates

- Maximise productivity and performance, by getting back to basics in the way we manage our workforce.

4.2 To deliver the "One Team" objective we will therefore:

- Engage our staff around a positive future vision of ULHT in the Lincolnshire system, giving them a greater sense of "hope" and belief the Trust can be successful in the future

- Develop and define an offer for our staff that ensures they feel valued and believe that we are concerned about their well-being

- Ensure that the experience our patients receive reflects our ambitions as a Trust to put patients and safety first

- Demonstrate compassionate, inclusive leadership at all levels and consistently across ULHT, developing leaders who have a system, as well as a ULHT focus.

- Give confidence to our staff that their voice will be heard and their concerns listened to

- Celebrate and recognise those who are delivering in line with our values and ensure that people at all levels are held account for behaviours that reflect the ULHT values

- Be equitable and fair in the way that we treat all our people, promoting the value of diversity**.**

4.3 The planned actions to deliver against these key areas are included in section 6 of the Strategy.

4.4 The table below shows how they relate to the main themes of the Interim People Plan:

Interim People Plan Theme	People Strategy Actions
Improving workforce supply	• Employment brand work (for ULHT and Lincolnshire Healthcare) • Recruitment strategy • Talent Academy activity on apprentices and other pipelines • Retention initiatives (NHSI 90 day retention work)
Creating a healthy, inclusive and compassionate culture (including ensuring equality and diversity, tackling	• Leadership development programme • Bullying and harassment project

bullying and reducing violence)	• Actions in Inclusion Strategy around workforce
Enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers)	• Links to Education and Learning Strategy • Improving the trainee experience • Development pathways work • Nursing offer • Medical engagement work
Ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working).	• Key part of approach to engagement • Marketing campaign around Trust Strategy • Devolution approach to TOM management • Engagement of staff in QSIR • Approach to health and well-being – stress • Flexible working within retention project • Review of Freedom To Speak Up Guardian Role

This is not a comprehensive list, but illustrates that through the implementation of the People Strategy, alongside other linked strategies, the Trust can demonstrate that it is already addressing the key themes of the national plan. What we know of course is that we have yet to see the impact in terms of substantive workforce numbers and staff survey scores, that we are perceived as the best place to work.

Recommendation

The Board are asked to agree the 2019 People Strategy.

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Our journey to excellence

2019 People Strategy

June 2019

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

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1. Purpose

1.1 The ULHT People Strategy is a rolling three year Strategy linked to our overall Trust Strategy. It is refreshed every year to reflect changes in the ULHT operating environment and the evidence of the workforce challenges ULHT faces, the gap between its ambitions and the current reality. This strategy therefore covers the period 2019/20 through to 2021/22. It contains a delivery plan for the first year of the strategy also for the 2019/20 financial year.

1.2 Organisations development Workforce or People Strategies to ensure they have the *"Right number of people, in the right places, with the right skill mix, attitude and behaviours, motivated and managed to perform at their best"*

When we talk about "our people" at ULHT we mean:

- Our permanent workforce
- Our temporary workforce
- Our Volunteers + Carers

1.3 The ULHT People Strategy fits within the overall framework of the STP and the ULHT 5-year strategy. It is fundamentally about managing our people through their life at ULHT to ensure they are able to deliver the best service they can to patients. The elements of what constitutes what is termed the "employee lifecycle" is shown on the front-cover. We must pay attention to all elements of that lifecycle, but at any one time elements may have greater priority depending upon the context and the particular challenges faced. This is why this People Strategy is refreshed each year.

2. Changes In Context

2.1 There have been some changes to the context which frames the ULHT People Strategy.

NHS Long-Term Plan

2.2 At a national level, the long term plan has been published and the accompanying People Plan produced in interim form. The key ambitions of the national people plan, published in June 2019, are as follows:

- Making the NHS the best place to work – retention and attraction of staff
- Improving the leadership culture – good leadership is essential
- Tackling the nursing challenge – recognizing that this is not the only, but is the most urgent area of shortage
- Delivering 21st Century Care – developing a multi-professional and integrated workforce
- A new operating model for the workforce – improved workforce planning, focused at a system level

There is significant alignment between the narrative in the national People Plan and the areas of focus in this People Strategy. We will take advantage of the opportunities to participate in national pilots and programmes, where they fit with the priorities of the Trust. Fundamentally we want ULHT to be "the best place to work", but recognize there are some challenges to achieving this.

Lincolnshire Sustainability and Transformation Plan (STP)

2.3 The national people plan emphasizes the importance of "system" going forward, particularly in identifying workforce needs. System means the overall health and care system in a geographical area. The STP has refreshed its own workforce strategy and the strategy on a page from that document is set out below.

2.4 The objectives of that strategy align with our own People Strategy, but there needs to be an increasing emphasis on supporting change within the system, particular around workforce shape and leadership within the system, as well as within the organization.

Financial Recovery Plan

2.5 The Trust has agreed with NHSI a recovery plan which seeks to deliver over £25m of savings in the 2019/20 financial year. The Trust is also finalising a longer term "path to zero" to demonstrate its ability to get back to financial balance, as part of the STP. Staff costs represent 66% of total costs and therefore as a contribution to the plans for 2019/20 we are planning to deliver £15.6m of workforce savings.

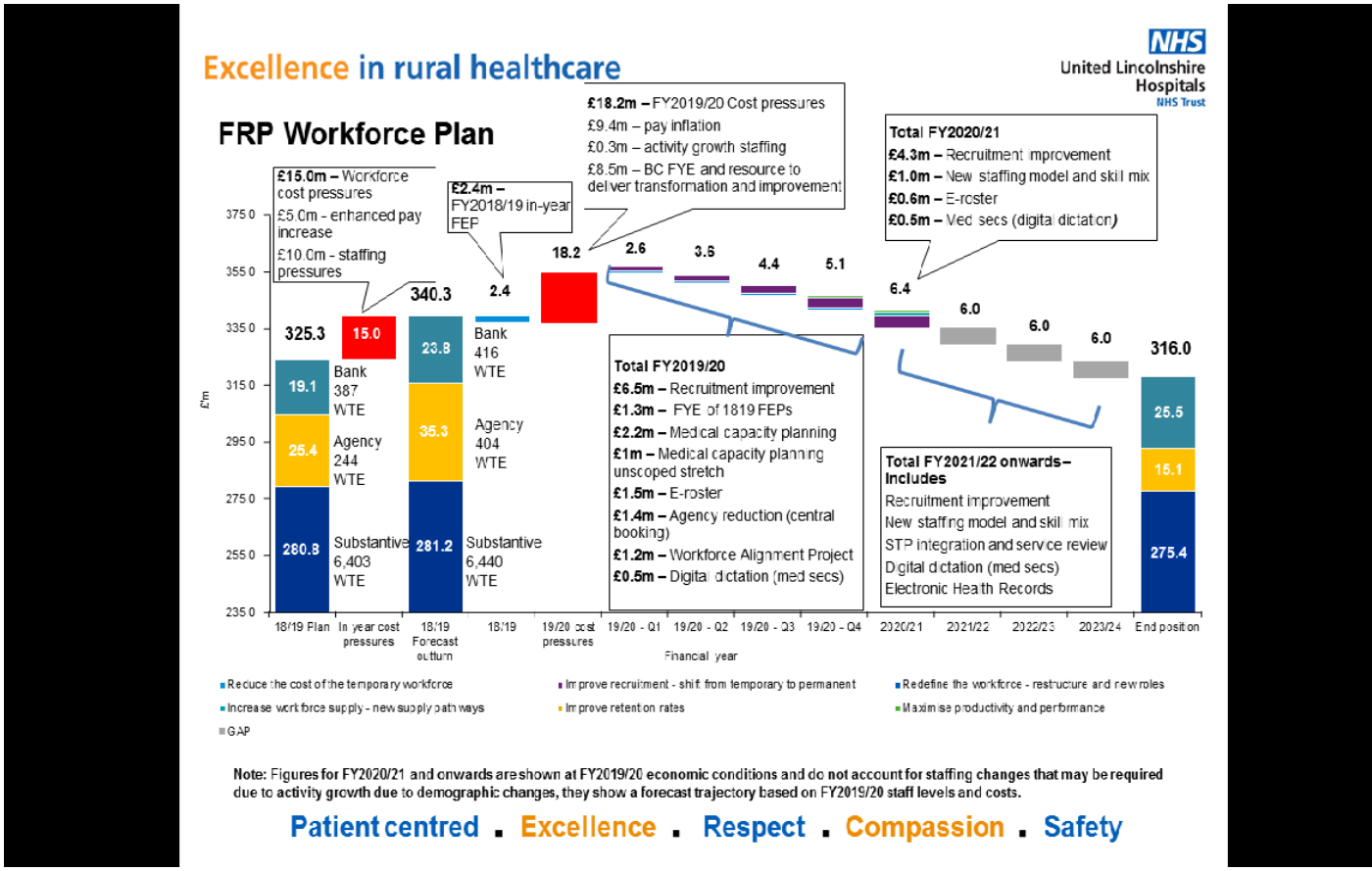
2.6 The Trust of course also remains in quality special measures. Whilst the actions being taken around workforce in the financial plan are designed to deliver savings, this is not to the detriment of patient care. Indeed, they will strengthen our ability to meet patient expectations and deliver quality care.

2.7 The financial bridge below shows how those savings will be delivered. The four main projects in 2019/20 are:

- Improved recruitment success rates (£4.5m)
- Medical capacity and activity planning (£4.7m)

- Agency cost reduction (£1.5m)
- Workforce realignment – non-clinical workforce (£1.2m)

2.8 In the following financial years there is much greater emphasis on re-shaping the workforce around new clinical pathways.



Quality Improvement (QI) and Quality, Service Improvement and Redesign (QSIR)

2.9 The Trust has recognized the need to revamp and embed more fully its approach to continuous quality improvement. The Trust has adopted an LiA approach in the past. During the course of 2018/19 we took the steps necessary to establish the NHSI sponsored QSIR framework in ULHT.

2.10 A dual approach to leadership and quality improvement, which engages with staff, features strongly in the draft national people plan. ULHT will focus on embedding continuous quality improvement during the course of the 2019/20 financial year.

Learning Organisation

2.11 The Trust has stated its ambition to be known as a learning organisation and potentially to become a “teaching trust”. This aligns with the employment brand we have been promoting (as a means to recruit and retain), but we know we must do more to put education at the core of our business, improve the training experience and ensure access to learning for all our staff. The opening of the Lincoln Medical School provides a great opportunity to reinvigorate learning and development in the Trust.

2.12 The current issues and risks around the workforce, which of course provide a context for this strategy are set out in section 4.

3. What Are We Trying To Achieve – Our Workforce Ambitions

3.1 The People Strategy is essentially constructed by undertaking a gap-analysis. We define our ambitions in terms of ULHT's people, use the evidence available to determine where we are as an organisation against our ambitions and then identify the actions necessary to close the gap between the two.

3.2 Our workforce ambitions are defined as part of our Trust overall strategic plan. As part of our planning process for 2019/20 we have undertaken an exercise called True North, through which we can be clear on and align around our priorities. The Board have agreed new vision and mission statements, as follows:

Our Vision:

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 Mission:

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

3.3 We have added to our previous three strategic ambitions, including one on Our People, a fourth relating to the healthcare system in which we operate and our need to work in partnership within this system. This reflects the fact that our future is as part of a Lincolnshire Integrated Care System. Our ambitions therefore are:

- *Our Patients – providing consistently safe, responsive, high quality care*
- *Our Services – providing efficient 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*

3.4 We have an agreed set of organisational values, which underpin what we do and bind us together as one team. They are:

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Supporting our values is our Staff Charter, which defines what we expect of our staff against each of the values and what we offer to our staff in return.

3.5 As indicated above, the Board has been using a tool called True North to confirm our strategic priorities/objectives. These are shown in the diagram below:

2021 – Strategic Planning Framework

		True North Objectives	Strategic Priorities (2019-2021)	Tactical Priorities (2019)	
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 Patients** Providing compassionate, safe, responsive, high quality care	• Harm Free Care • Valuing Patients Time	• **Learning and Safety Culture**	• **Learning from Experience** • Patient Experience	**Inclusion**
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	**Our services** Providing efficient, effective and financially sustainable services	• Zero waiting • Sustainable Services	• Estates • Financial Recovery Plan • Digitisation	• GIRFT • Theatres • Urgent & Emergency Care (A&E) • 62 Day Cancer • Data Quality • Immediate Fragile Services Plans	
Values • Patient centred • Excellence • Respect • Safety • Compassion	**Our People** Providing services by staff who demonstrate our values and behaviours	• **Modern and progressive workforce** • **One team**	• **Future Workforce** • **One Team** **QI Programme**	• **TOM** • **Recruitment**	
	Our System / Partners Providing seamless integrated care with our partners	• Service Integration	• Partnership Working (ICP) – Governance and Strategy Definition in line with STP/LTP	• Pathway Redesign (3 STP and 6 community commitments)	

3.6 Workforce issues figure significantly in the True North objectives/priorities. There are two which explicitly underpin this People Strategy, “Modern and Progressive

Workforce" and "One Team". However other priorities have significant workforce implications which are reflected in this People Strategy, such as the desire to embed the Quality Improvement methodology in the way that we do things, the aim to build a learning culture, which ensures patient safety and in the focus on the patient experience (and we understand the correlation between staff and patient experience).

3.7 It is through delivery of this People Strategy that we outline how we will meet those objectives and, through the Workforce and Transformation Committee, assurance will be provided to the Board on delivery progress and risk mitigation.

What Does A "Modern & Progressive Workforce" Mean?

3.8 To help shape this strategy, we have taken "modern" to mean:

- Embracing new roles
- With the right skill sets to enable delivery of up-to-date healthcare e.g. digital skills
- Adaptable and flexible in the way we work

We have taken "progressive" to mean:

- Seeking to learn and enhance skill sets
- Innovative/challenging
- Outward looking

What Does "One Team" Mean?

3.9 We have defined "one team" as meaning:

- One team around the patient
- Sense of pride in who we work for
- Values at the heart of what we do
- Engaged with the Trust vision
- Focused on service, not site
- Delivering consistently high standards

By focusing on these two True North objectives, we will make ULHT a great place to work, thereby enhancing quality of service and improving the financial position.

Consistency With Previous People Strategy

3.10 The priorities identified by the True North exercise do reflect the themes in previous iterations of the People Strategy:

- Workforce skills and numbers – having an establishment we can afford, with the right skill mix around the patient and filled with permanent employees

- Engagement through change – staff who are proud to work for ULHT and are motivated to perform at their best.

Alignment With Other Strategies

3.11 There is a need for a close alignment between this People Strategy and the other strategies that underpin our overall 5-year Strategy (previously referred to as 2021). All

our strategies are inter-related and we are working to align them more closely. The Clinical Services Strategy has the largest impact on our people, as it sets out the vision for clinical services and for our hospital sites over the next five years. This is aligned with the broader plans for the Lincolnshire Health and Care Community (on which we are engaging in a "healthy conversation, so they may change).

3.12 The clinical strategy is based on 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 Clinical Strategy recognises the challenges around recruitment and retention and we must ensure that our People Strategy supports the achievement of our ambitions for healthcare in the County and our hospitals.

4. Our Current Reality

4.1 We have drawn together an evidence base to assess how ULHT currently matches up against its new ambitions.

Workforce Costs

4.2 Pay costs have grown significantly in the last year. The overall size of the establishment has grown by around 200 posts, as we seek to address quality and performance issues. The number of substantive staff in post has stayed broadly similar, but the vacancy rates for medical and nursing have increased by 5% since January 2018. Whilst AHP rates were improving during 2018/19, they have now slipped back again. The evidence shows that the gap (both vacancy gap and growth in establishment) has been covered through premium pay rates, either in the form of bank or overtime payments to our existing staff or agency staff. This must be reversed.

4.3 Turnover is a significant issue, for nursing and AHPs in particular. The age profile of the workforce (30% of nursing staff are over 51) means that there is the potential for turnover to increase and we need a strong focus on flexibility in employment practice, the encouragement of talent and the provision of development opportunities for all, if we are to sustain engagement and support retention.

4.4 Sickness rates have stayed fairly stable at around 4.7% (rolling 12 month average), which given the pressures in the organisation, is an achievement. However sickness is around 0.4% higher than the average for Acute Trusts and we need to take further action to build on the success we have had to establish core processes and return the sickness rate to the average level.

4.5 We have struggled to see improvement in core learning and appraisal rates for non-medical staff (appraisal rates at c75% against a target of 90%). These are core elements of the framework for managing staff and ensuring a culture of safety and learning and must continue to be a focus for us.

Engagement/Morale

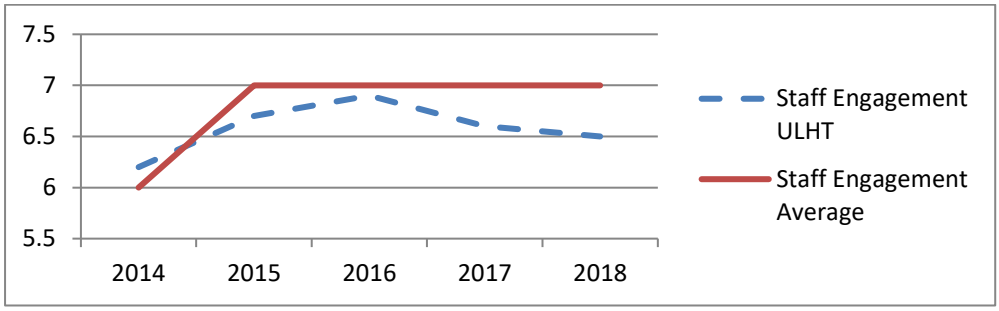
4.6 The 2018 staff survey results are disappointing and do not show improvement in most areas from 2017. Where we have particularly focused attention in 2018/19 there has been some small improvement, in areas such as:

- The profile of the values
- Access to learning and development
- Willingness to raise concerns/safety culture
- Recognition

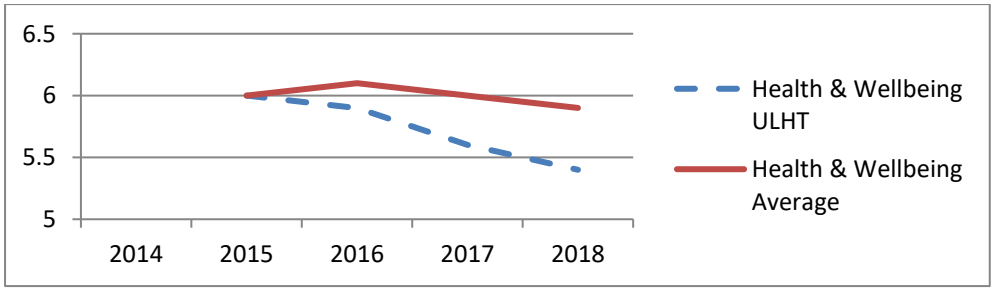
There has been a significant drop in staff feeling that the organisation cares about their health and well-being. Other key indicators have dropped between 1 and 3% demonstrating a decline and certainly no improvement in overall morale.

4.7 The graphs below show the ULHT scores since 2014, or in some instances 2015, against key indicators. The average line refers to the national average in the staff survey.

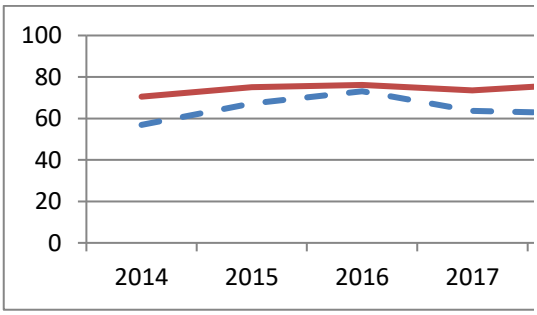
Staff Engagement Index



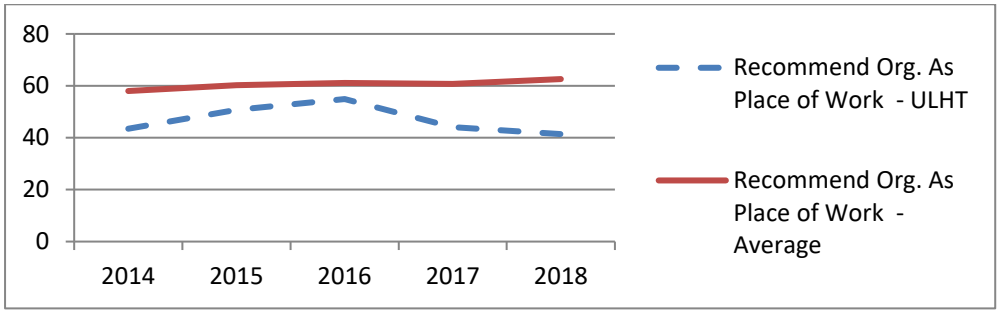
Health & Wellbeing Index



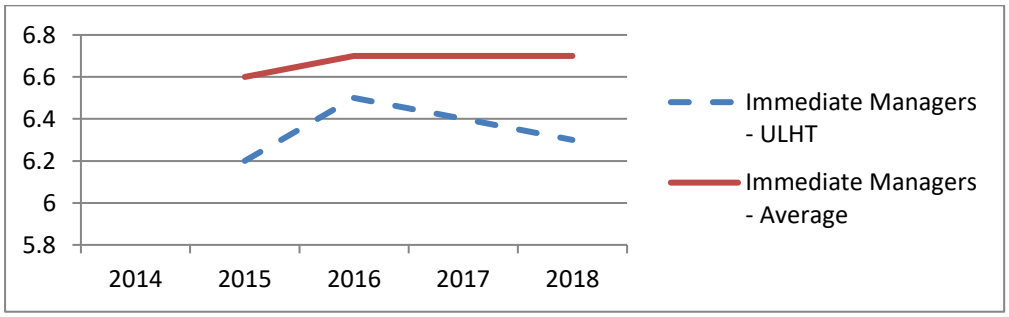
Care of Patients is Top Priority Score



Recommend Organisation as Place to Work Score



Immediate Managers Score



4.8 What this does show is that from the onset of quality and financial special measures there has been a dramatic reduction in morale and at the same time a significant rise in vacancy rates. The themes from the free-text elements of the national staff survey are:

- Car parking
- The focus on the uniform policy to the detriment of the real issues
- The focus on finance rather than the patient
- The impact of staffing levels on the ability to deliver the care they aspire to
- Too many managers
- Focus on targets rather than the patient (and this leads to bullying behaviours by managers)
- The quality of middle management
- Quality of communication
- Involvement in decision-making
- Favouritism in recruitment process
- Lack of opportunity to access training and to progress

- Flexible working.
- Senior managers not visible enough and understanding of the issues staff face

4.9 Looking at the actions agreed in response to the 2017 survey, we have delivered on the majority of them. What this reinforces is that there are some deep-rooted factors impacting on morale and there is a disconnect between the Trust and its staff which inhibits the impact of the actions we take). Re-establishing the connection between the core ambitions of our people (to deliver great care) and the Trust is key. We are unlikely to achieve this unless we can change the current narrative around the staffing position. Alongside this, we will demonstrate that we have listened to the concerns of our staff.

4.10 Actions in this People Strategy seek to address staffing shortages, improve the consistent quality of leadership and management, be clear about development opportunities and offer more flexibility around work. Through our new management structure, we want to strengthen the voice of our employees and have a debate about some of the “wicked issues”, such as car parking.

5. How We Will Deliver Our Ambitions

Overall

5.1 In shaping the ULHT response to the challenges faced, we look at best practice from other organisations (Morecambe Bay, Frimley Park and HEY) and national frameworks, such as 'Developing People – Improving Care', but we use evidence from ULHT to ensure best practice is adapted to the specific needs of ULHT (e.g. the history of ULHT, the "one Trust, three sites challenge" and the age profile, showing high levels of potential retirements).

5.2 We also know that those organisations who have exited special measures have focused on the following:

- Culture
- Leadership
- Staff Engagement
- Governance
- Quality Improvement
- Effective Communications

5.3 The strategy is structured around the two True North objectives, but the reality is that there is significant overlap between the two and the interventions proposed. Indeed the People Strategy must be a coherent whole, if the challenges the Trust faces are to be addressed. Additionally good governance and effective communications underpin the delivery of this strategy and we are working to develop a real engaging marketing campaign for our five year strategy, embracing all key stakeholders.

Modern & Progressive Workforce

5.4 To achieve our ambitions around a modern and progressive workforce we must focus on getting in the right people, ensuring they have opportunities to develop and creating the right environment where they are managed well and striving to continuously improve. Through this strategy and the actions planned, we will therefore:

- Redefine the workforce we need through effective workforce planning and seek to reduce overall workforce cost, whilst delivering high quality services to patients (linking to changes in clinical pathways and the STP)

- Understand more about the workforce we have, their skills and where there are gaps in our skill sets

- Increase workforce supply, using the Talent Academy to create new supply pathways that reflect our future workforce shape

- Improve recruitment and retention success rates, so that we alter the workforce balance between permanent and temporary staff and thereby reduce the cost of temporary staff. We will do this by being clearer about our brand, have strategies for projecting that brand into different market places and having a efficient processes that enables us to recruit candidates to plan.

- Involve our staff in improving what we do, encourage innovation and continuous improvement (as a learning organisation) and empower people to deliver change

- Improve the learning opportunities for trainees and staff at ULHT, demonstrating how people can build a portfolio of skills and careers in this organisation (talent management). Ensure our staff have access to the development opportunities they need to provide consistently excellent services and thereby improve retention rates

- Maximise productivity and performance, by getting back to basics in the way we manage our workforce.

<u>One Team</u>

5.5 To establish a sense of "One Team" at the Trust, we want to embed a culture focused around our values. We place a particular emphasis on establishing a learning and safety culture, as this is the heart of being patient focused. We know that there are a broad range of "cultural issues" in ULHT. We want to quickly change "the way we do things around here" and have therefore adopted as a framework, the System 1 (systems & processes) / System 2 (hearts and minds) approach. This approach did enable Morecambe Bay NHS Trust to make rapid improvement.

5.6 We know that to make rapid progress we must embed good systems whilst we build staff engagement around the vision & values. Leadership that can both inspire staff and hold them to account, is hugely important in the delivery of change, as is our QSIR programme, which provides opportunities for staff to engage in change at a practical level. We must demonstrate a commitment to addressing the issues that cause our staff not to be feel cared for.

5.7 Through this strategy and the actions planned, we will therefore:

- Engage our staff around a positive future vision of ULHT in the Lincolnshire system, giving them a greater sense of "hope" and belief the Trust can be successful in the future

- Develop and define an offer for our staff that ensures they feel valued and believe that we are concerned about their well-being

- Ensure that the experience our patients receive reflects our ambitions as a Trust to put patients and safety first

- Demonstrate compassionate, inclusive leadership at all levels and consistently across ULHT, developing leaders who have a system, as well as a ULHT focus.

- Give confidence to our staff that their voice will be heard and their concerns listened to

- Celebrate and recognise those who are delivering in line with our values and ensure that people at all levels are held account for behaviours that reflect the ULHT values

- Be equitable and fair in the way that we treat all our people, promoting the value of diversity.

5.8 In the sections below we have set out in more detail our approach in a number of key areas:

- Staff Engagement
- Leadership
- Continuous Quality Improvement
- Health and Well-Being
- Education & Learning

ULHT Approach To Staff Engagement

5.9 Ensuring strong staff engagement with the ULHT vision ("Excellence in rural healthcare") and our values (compassion, respect, safety, excellence, patient-centred) is crucial to delivering excellent services and having a consistent safety culture.

5.10 To improve engagement we have focussed on the four key drivers of engagement:

1. **Strategic narrative** – having a clear story about the future of ULHT and one that our staff believe in. At present our staff lack hope and a real belief that after a number of false starts over several years, the Trust can be a better place. Our five year strategy, linked to healthy conversations and the clinical strategy provide that narrative. Involving staff in shaping the future is fundamental to its success. We will in the 2019/20 re-launch our strategy with a strong marketing campaign to create a momentum around change.

2. **Employee voice** – ensuring our staff believe they are listened to and can help shape their own and the organisation's future. We are inviting staff to play a key role in shaping our strategy through our "big conversations" and "reference groups" associated with each work programme.

   Staff have already had a role in shaping our ambitions and the Staff Charter. They have submitted over 500 improvement ideas. We need to be better at explaining what we are doing to tackle the big issues that concern them. We have a Staff Engagement Group, chaired by the Chief Executive and comprising staff, TU reps and managers to oversee our engagement work.

   We want the employee voice to translate into engaged action through our QSIR programme.

3. **Organisational integrity** – the organisation feeling is it consistently lives by its values. We have relaunched the values and Staff Charter as part of our 5-year strategy. We need to embed the Charter in how we recruit and manage people.

   The last two national staff surveys suggests staff think we are concerned more about money than patients and we need to demonstrate that the patient is at the centre of what we do.

4. **Quality of leadership and management** – this is at the heart of the day-to-day experience of staff of the Trust.

5.11 Whilst at ULHT we want to focus on having one workforce around the patient, we know that we continue to have a particular issue around medical engagement. We need to consider the issues that have created a sense of detachment and work to overcome them.

5.12 We do know that engagement and overall staff morale is impacted by factors such as staffing and the overall assessment of the Trust as "inadequate". We must work on these alongside the focus on engagement

ULHT Approach To Developing Leadership

5.13 We recognise that compassionate, inclusive leadership is key to ULHT achieving sustained improvement. Our approach to ensuring we have consistent leadership across ULHT is based around our simple mantra:

- Set out clearly our expectations
- Listen to understand the challenges in meeting those expectations
- Equip people with the skills and knowledge they need
- Empower people within a clear control framework
- Hold people to account

5.14 The CQC identified inconsistent leadership as one of the issues impacting on quality and safety at ULHT. To address this we have developed a modular leadership programme and have engaged with 1600 people in that programme. We have continued to sponsor individuals to attend national programmes where appropriate and have been at the forefront of developing system leadership programmes, recognising the particular challenges of leading in the STP. The results of the 2018 staff survey suggest there is more to do.

5.15 Evidence from Northumbria indicates though that leadership is fundamental to sustained improvement. Whilst we have had good participation levels in the programmes established, we need to invest further to ensure the reach of our programmes is appropriate and they develop the future skills we need at all levels. The 2018 staff survey results demonstrate that there is neither consistent leadership at middle manager level.

5.16 We are therefore reviewing our approach to leadership to ensure it has the right emphasis and priorities. We need to focus in particular on:

- A change in leadership style by the Board to reflect the need to coach and empower, as well as hold to account
- Investment in leadership through the new Trust Operating Model structure
- A more systematic approach to assessing leadership through the use of 360 appraisal at all levels
- The integration of our QSIR approach into leadership development.

ULHT Approach To Continuous Quality Improvement

5.17 The Five Year Forward View reinforces the importance of creating a culture of change and improvement across the health service. Within ULHT that focus on improvement, centred on the patient, is at the heart of our values. The QI and QSIR Practitioner Programmes are designed to equip ULHT and its staff with a framework to drive patient-focused improvement, both in terms our large scale change programmes within our five-year strategy, but also locally, enabling our staff to drive local improvement, thereby helping them to feel engaged with the ULHT journey.

5.18 Specifically, the aims of QI and QSIR are to:

- Provide the Trust with a systematic and recognised approach to quality improvement through the application of improvement science tools and techniques, which will support our vision, ambitions and objectives to be delivered through our business planning processes.

- Support all the existing and planned programmes, projects and initiatives in the Trust, by ensuring that individuals and teams go through either the in-house Quality Improvement Programme, or the QSIR Practitioner Programme that will be delivered by our Associates, whilst they are delivering or preparing to deliver their piece of work.

- Ensure that the current 2021 Improvement Programmes, the Financial Efficiency Programmes (FEP) and improvements identified within our key enabling strategies to deliver our vision go through the QSIR Programme.

- Provide opportunities for individuals at all levels to be able to be supported to achieve an improvement and be developed to be Ambassadors.

5.19 The Trust has adopted improvement methodologies before, but our aim is that this approach should truly be part of "the way we do things around here". We want it to deliver sustained change at all levels and to impact on engagement by bringing our strategy for improvement and quality to life for our staff. It embraces the work we do as part of the Academy of Fabulous Things and the FAB brand remains as an embodiment of local action and a willingness to share and learn.

5.20 Our QI and QSIR approaches touch on many of the other actions proposed in the People Strategy, notably the changes we are making to the way we develop leaders. Our approach is set out in more detail in the Continuous Improvement Strategy.

ULHT Approach To Health & Well-Being

5.22 The Trust is aware of its very low score against the national staff survey health and well-being index. We have benchmarked our approach to health and well-being against Northumbria Healthcare Trust and cannot see any significant gaps in our approach.

5.23 We are focused on supporting people who have health and well-being issues and ensure they can remain at work or return to work as quickly as possible. We have agreed a policy which will enable ULHT staff to get early access to treatment where appropriate. Our focus primarily though is on keeping people healthy. We have appointed a health and well-being co-ordinator to raise the profile of health and well-being issues and the actions we are taking, ensuring that there is awareness of what is available amongst all our staff, as this is one of our weaknesses.

5.24 We have a particular focus on stress, with programmes on mental health first-aid and mindfulness and efforts to equip managers to create resilient workplaces. Whilst we are always keen to adapt and extend our offer, our scores around health and well-being reflect more deep-rooted issues in the organisation around the stress and pressure created by staffing gaps and being in double special measures and so it is through the broader impact of this People Strategy that improvements in perceptions of health and well-being will be achieved.

ULHT Approach To Education & Learning

5.25 The Trust wishes to differentiate itself as an organisation by being focused on education and development. We have an ambition to become a "teaching trust" and have developed an Education and Learning Strategy which sets out our roadmap to get there. Our approach is based on ensuring that:

- All trainees have a positive experience with us
- There are no unnecessary impediments to staff accessing development opportunities
- We are clear on our specific offer to different groups of staff and development pathways are defined to show how people can both progress and extend their skill-sets in role
- We have a co-ordinated approach, linked into the STP, which ensures maximum impact from the investment we make

6. Priority Actions

6.1 The actions planned for 2019/20 are set out against what are termed our "areas of focus" under each True North Priority:

MODERN & PROGRESSIVE WORKFORCE		
Areas of Focus	**2019/20 Targets (18/19 Actuals)**	**Planned Actions For 2019/20**
Redefine the workforce we need through effective workforce planning & seek to reduce overall workforce cost, whilst delivering high quality services to patients (linking to changes in clinical pathways and the STP)	*Workforce planning process to be in place for 20/21 financial year – targets to be set thereafter*	• Development of a workforce planning process that will deliver the re-shaping of the workforce we need in a planned way, linked to changes within the STP pathways. Every specialty will have a plan for the 2020/21 year. • Workforce alignment project delivery. Review of non-clinical workforce. Model non-clinical workforce structure agreed for Surgery, to be rolled out wider in 2020/21.
Understand more about the workforce we have, their skills and where there are gaps in our skill sets	*No specific targets in 19/20* *Core learning rate – 95% compliance (x)*	• Assess against our values within recruitment, explore potential of a probationary period, or use capability policy to ensure, once in the Trust, people are able to work according to our values • Explore options for undertaking a skills gap analysis for our staff
Increase workforce supply, using the Talent Academy to create new supply pathways that reflect our future workforce shape	*Targets to be set for new roles for 20/21* *Apprenticeship starts – 236 (public sector target = 2.3% of the workforce)*	• Participate in Widening Access To Specialised Training (WAST) pilot • Agree new Talent Academy objectives, specifically relating to apprenticeships, new roles (including new staff structure for the Academy) • Continue to support a collaborative system wide approach to apprentices, to maximise the use of the levy across the system • Continue to increase the number of volunteers and integrate them into the way the NHS works to maximise their support to patients
Improve recruitment and retention success rates, so that we alter the workforce balance between permanent and temporary staff and	*Overall vacancy rate at 12% by year end (currently 14.2%)* *Registered Nursing – 12% (16.4%)* *Medical – 12% (20.2%)*	• Actions as set out in the workforce element of the FRP – agency reduction, job planning, e-rostering

thereby reduce the cost of temporary staff-shape	*10% improvement in av. time to recruit (65 days non-medical, 110 days medical)* *2% improvement in retention (12.3%)*	• Actions as set out in the workforce element of the FRP around recruitment – from decision to recruit through to on-boarding • Engage with national programmes around the recruitment of international nurses, increasing nurse placements and national programme boards looking at medical shortages in specialties and rural areas • Continue projects in retention programme: - Exit interviews - Development pathways - Itchy feet interviews - Flexible working - Focus on medical engagement through development opportunities - Self –rostering on ward pilots - Retire and return scheme - Internal transfer scheme
Involving our staff in improving what we do, encouraging innovation and continuous improvement (as a learning organisation) and empowering people to deliver change	*200 staff trained in improvement tools and techniques* *% staff able to contribute to improvements 70% (65%)* *% of staff able to make improvements happen in their area of work – 55% (48%)*	• Embedding of QSIR Programme & QI tools • ULHT as first FAB Trust – develop and embed place of FAB within continuous improvement brand (sharing & learning element)
Improving the learning opportunities for trainees and staff at ULHT, demonstrating how people can build a portfolio of skills and careers in this organisation (talent management). Ensure our staff have access to the development opportunities they need to provide consistently excellent services and thereby improve retention rates	*% staff who have had training, learning & development in last 12 months 72% (68%)*	• Adopt a structured and transparent approach to talent management and succession planning – Take part in NHSE pilot programme + explore potential of system approach • Improve junior doctor experience – including effective supervision of doctors in training + embracing the fatigue and facilities charter. Implement the new Guardian of Safe Working arrangements • Develop and agree Learning and Education Strategy – incorporate a focus on equipping people with the skills they need for the digital age – actions to be agreed in Strategy • Promote current development opportunities for staff, so that awareness levels increase

Maximise productivity and performance, by getting back to basics in the way we manage our workforce.	*No of disciplinaries – Monitor, no target set (43)* *No. of grievances – Monitor, no target set (35)* *% non-medical appraisal rate 90% (73.5%)* *Sickness rate – 4.5% (4.7%)*	• Complete "staff moves" project • First day sickness reporting – introduce new system to support it • Improved provision of management information to managers • Workforce policy reviews – STP work on common policies • Complete review of TU recognition agreement • Share best practice through the HR Newsletter • Support the agile working project • Increase appraisal participation (by reviewing current process) & review core learning
ONE TEAM		
Areas of Focus	**2019/20 Targets (18/19 Actuals)**	**Planned Actions For 2019/20**
Engage our staff around a positive future vision of ULHT in the Lincolnshire system, giving them a greater sense of "hope" and belief the Trust can be successful in the future	*% staff who feel senior managers involve them in decisions – 35% (25%)* *% staff recommending ULHT as a place to work to increase by 10 points – 46% (41%)* *% staff saying care of patient is our top priority – 69% (64%)*	• Re-launch of our strategy with staff – marketing campaign to build engagement
Develop and define an offer for our staff that ensures they feel valued and believe that we are concerned about their well-being	*% staff believing immediate manager takes a positive interest in health and well-being – 65% (62%)* *Health and well-being index increases by 10%* *Recognition and value of staff by managers – 3.35 (3.30)*	• Complete TMP brand work – marketing campaign will follow – link to NHS offer "best place to work" • Further development of health and well-being approach – staff rapid access to treatment, taking health and wellbeing to staff, health and wellbeing champions (continuing to promote mental health wellbeing and mindfulness) • Financial well-being offer • Introduction of Schwarz rounds • Empowerment work through TOM

		implementation • "Back to the floor" sessions for senior leaders + support staff • Support creation of the Workforce Wellbeing Guardian at Board level
Ensure that the experience our patients receive reflects our ambitions as a Trust to put patients and safety first	*If friend or relative needed treatment, % staff who would recommend – 53% (47%)*	• Revised Patient Experience Plan (strengthening the links to People Strategy). Actions to address top priorities: - Valuing patient time - Communication and empathy • Access to real-time patient experience data for all staff
Demonstrate compassionate, inclusive leadership at all levels and consistently across ULHT, developing leaders who have a system, as well as a ULHT focus. .	*% staff believing immediate manager takes positive interest in health and wellbeing – 65% (62%)* *% staff satisfied with recognition they get for good work - 50% (46%)* *Staff feeling supported by their line manager – 3.67 (3.62)* *10% increase in ULHT staff completing system leadership programmes* *10% increase in participation in ULHT leadership modules*	• Embedding existing leadership programmes – ensuring managers can do the basics – effective meetings, problem solving • Defining leadership competencies to reflect what we need – link to the "NHS Leadership Compact" • Developing an approach to strategic leadership (compassionate, but distributed leadership) – linking to STP system leadership work • Consistently use coaching and coaching conversations as a means of performance improvement and development • Adopt a consistent and robust approach to values based recruitment and selection for all senior posts building on the TOM Assessment Centre model • Schedule Mary Seacole Local programmes to run throughout 19/20 and measure impact • Evaluate impact of first 3 cohorts of LinCS and use to inform new programme funded through NHSE £85k for system leadership and transformation to be co-designed with STP Clinical

		Cabinet • Roll out additional cohorts of "Developing an Outward Mindset" • Work with SLF to develop role as leadership community • Explore the potential of a middle manager forum, so that we can engage more effectively with this key layer in the Trust
Giving confidence to our staff that their voice will be heard and their concerns listened to	*Staff confident and secure in reporting unsafe clinical practice – 3.65 (3.50) Increase in referrals to Freedom To Speak UP Guardian*	• Review of Freedom to Speak Out Guardian role • Review of Guardians of Safe Working Practice • Embed processes around SIs etc. • Review 2021 communication processes
Celebrate and recognise those who are delivering in line with our values and ensure that people at all levels are held account for behaviours that reflect the ULHT values	*Increase in number of Certificates in Excellence issued – 2000 by end March 2020 (currently 1010)*	• Work with staff networks to understand issues behind staff survey bullying and discrimination scores and agree actions to address.
Be equitable and fair in the way that we treat all our people, promoting the value of diversity.	*% staff who report never experiencing bullying, harassment or abuse at work by their manager – 86% (84%)*	• Explore the "Just and Learning Culture" approach of Merseycare as a way of addressing our issues (links across to learning culture and productivity themes) • Engage in the NHSI Gender and Behaviour Insights project, exploring gender issues in CEAs • Set targets for BME representation within the ULHT workforce

7. Measuring Progress

7.1 There are a number metrics agreed as part of the True North work related to our identified priorities, as follows:

- Future Workforce – Vacancy Rate
- One Team – Friends and Family Test – recommend ULHT as place to work
- Learning and Safety Culture – improvement in relevant staff survey indicators

7.2 We have developed a new workforce indicator report for the Workforce Oversight Board and the Workforce and Transformation Committee. This is linked to our themes and priorities in this Strategy. There are additional metrics in this Strategy linked to priorities, but these are largely drawn from the national staff survey, which can be reported on annually. We will take account of the additional workforce metrics in the NHS Oversight Framework, once it is agreed, to ensure there is alignment between internal and external scrutiny.

8. Risks & Dependencies

8.1 The two key workforce strategic risks have been outlined above and this strategy is a response to them. In terms of the risks associated with delivery of this strategy, the most significant relates to capacity to deliver. Additional resources have been added centrally to recognise the significance of workforce issues to the Trust. There is a strong dependency on working with Divisions in the new TOM to deliver the strategy. We must manage that dependency through engaging regularly with the Trust Management Board and through the HR Business Partners who are aligned with Divisions.

8.2 We seek to work in partnership with Staff Side. There have been challenges in that partnership during 2018/19. We are seeking to address those challenges, but they may remain. They will make more difficult, but will not prevent delivery of this strategy.

9. Equality, Diversity & Inclusion

9.1 ULHT is committed to equality and diversity in the workplace. The Trust has developed its first Inclusion Strategy that includes the following vision for our staff:

- Feel valued and fairly treated in an organisation that really cares
- Know the Trust as an organisation that people want to come and work for, stay with and thrive in, because of its commitment to equality, diversity and inclusion
- Are proud to work in an open and inclusive organisation.

9.2 We agree a number of equality objectives each year, recognising that at present we fall short of achieving that inclusivity vision for our staff. We seek to integrate the actions we believe we need to take as a consequence of our EDS2 review and our work on the WRES into the Inclusion Strategy, so that we have one set of objectives to which we are working.

9.3 We need to embed diversity and inclusion into the way we do business in the Trust. It must be at the heart of the way that we manage our people, through the whole employee lifecycle. All the areas of focus in this strategy have a diversity and inclusion impact. For our key actions we will undertake equality impact assessments, so that we

can ensure they are supportive of our ambitions as an organisation and those set out for our staff in the Inclusion Strategy.

9.4 Specifically within this strategy we are seeking to address the following:

- There is concern about the number of people who perceive there is bullying in the organisation, and the staff survey percentage who report this is higher among BAME groups. Inclusive leadership is embedded within our whole approach to leadership development. We will use our staff charter workshops as a means to promote inclusivity and the behaviours that underpin our values.

- There is also a concern around fairness and equity and discrimination evident in the staff survey results. We will be reviewing our key processes to ensure that they are fair and equitable and will be exploring the "just culture" approach to seek to resolve issues at an earlier stage. We will ensure our leaders are equipped to manage within our policies in a way that is fair and equitable.

10 Review

10.1 The People Strategy will be reviewed and refreshed at the end of the 2019/20 year to reflect progress and the evidence available as to the extent we are achieving our ambitions.

NHS Interim People Plan

Briefing for board members

Introduction

The Interim People Plan for the NHS has been developed over the last few months and sets an agenda to tackle the range of workforce challenges in the NHS with a particular focus on the actions for this year.

Baroness Harding has described the interim plan as follows:

“This interim People Plan doesn’t answer all the questions we know need answering, nor does it set out a detailed 5 -10 year roadmap.

“It does, however, set out our vision for our people and the urgent actions we all need to take this year, both to make immediate improvements but also to build a plan for our people that is fully integrated with those for financial and operational delivery.”

Background

- Workforce supply is acknowledged as the biggest challenge facing the NHS but the plan is clear that the quality of staff experience must be improved or those extra people will not stay, or come at all.
- The NHS Interim People Plan has been developed with involvement from NHS Employers and a wide range of other stakeholders to set out an initial approach to tackling the range of workforce challenges.
- The substantive People Plan will be published following the Spending Review. Key financial commitments will be decided as part of the Spending Review.
- NHS organisations will be expected to undertake initial actions and further action following the publication of the final People Plan.

Key themes

- Making the NHS the best place to work
- Improving NHS leadership culture
- Addressing workforce shortages
- Delivering 21st century care
- Developing a new operating model for workforce.

Making the NHS the best place to work

- The plan acknowledges that people working in the NHS report 'growing pressure, frustration…, and rising levels of bullying and harassment'.
- BME staff report the poorest workplace experiences.
- Sickness absence runs 2 percentage points higher than the rest of the economy.
- 1 in 11 staff leave the NHS permanently each year.

Making the NHS the best place to work

- NHS organisations will be asked to develop their approach to making their organisation the best place to work.
- They will also be asked to contribute ideas to the development of a new offer for staff setting out the support they can expect from the NHS as a modern employer.
- There will be a summer of conversation led by the new chief people officer to develop this offer to staff.

Making the NHS the best place to work

This offer would cover:

- creating a healthy inclusive and compassionate culture (including ensuring equality and diversity, tackling bullying and reducing violence)
- enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers)
- ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working).

A balanced scorecard will be developed to assess organisations in these areas via the NHS Oversight Framework and the CQC Inspection Framework (Well Led Assessment).

Pensions

- As part of the theme of making NHS the best place to work, there is an acknowledgement of the impact of the current pension taxation policy on staff retention, particularly in relation to senior clinicians.
- Accordingly, the government is bringing forward a consultation on a proposal for new pension flexibility for senior clinicians.
- The proposal would give senior clinicians the option to halve the rate at which their NHS pension grows, in exchange for halving their contributions to the scheme.
- This consultation is expected to take place over the summer, and it may lead to changes from April 2020.

Improving leadership and culture

The plan says NHS leaders should have:

- 'a compassionate inclusive culture' including senior leaders, clinical and non-clinical roles and the 'vital middle manager layer.'
- It should have a greater focus on collaborative talent management and a range of measures for greater board assurance.

NHS England/Improvement will work to develop an agreed set of competencies for senior leadership roles and will engage widely on options for assuring leadership (which will enable a response to the Kerr and Kark reviews).

They will agree a new compact setting out the 'gives and gets' to shape the development of senior leaders.

Leadership priority areas

- System leadership
- Quality improvement
- Talent management
- Inclusion and diversity.

These leadership challenges apply just as much to the national NHS arms-length bodies, which have an equally important role to play in fostering a new leadership culture.

Addressing workforce shortages

The plan includes measures to improve workforce supply and retention across the NHS clinical workforce. There will be a focus on nursing in terms of immediate actions which include:

- NHS England/Improvement expanding its retention support programme with a focus on the most challenged areas
- increasing clinical placements by 25% to 5,000 by September 2019
- developing a new return to practice scheme in conjunction with Mumsnet
- better coordination of international recruitment with a national procurement framework for lead agencies.

Addressing workforce shortages

The final People Plan, which is scheduled for release later this year, will cover:

- entry routes into the profession building on the nurse apprenticeship and nurse associate routes
- the development of a 'blended learning nursing degree' programme working with higher education providers
- greater focus on primary and community nursing.

Subject to resources being allocated within the spending review, the aim would be to achieve a phased restoration of previous CPD funding levels over five years.

Delivering 21st century care

In order to deliver the vision of care set out in the NHS Long Term Plan, the report calls for a reshaping of the NHS workforce. It specifically calls for:

- a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working

- the scaling up of new roles via multi-professional credentialing and more effective use of the apprenticeship levy.

There will be further detailed planning work across all major NHS workforce care groups and discussion with the service over future needs before the final plan.

Delivering 21st century care

On nursing, the plan calls for further expansion of the nursing associate role to reach 7,500 nursing associates by the end of 2019.

On medical workforce, it pledges an expansion of doctors in primary care by 5,000, further roll out of medical credentialing and support for shortage areas and for the development of more generalist roles.

There will also be action to expand AHP, scientific and other roles as well further develop multi-professional team working starting in primary care networks.

A new programme entitled *Releasing Time to Care,* which has a focus on using technology to support better deployment of staff time and increase productivity, will be launched.

A new operating model for workforce

The interim plan accepts that the workforce planning model in the NHS needs to change.

It argues that functions should be undertaken at the best level to meet the needs of the services. It commits to devolution of responsibility to the Integrated Care Systems (ICSs) as over time they will 'take on greater responsibility for people planning and transformation activities, in line with their developing maturity.'

A newly developed ICS workforce ‘maturity framework’ will be used to assess the readiness of ICS to take on responsibilities including workforce planning.

Developing the final People Plan

This interim plan will be followed by work over the summer with a range of stakeholders to help develop a fully-costed final plan.

The aim is to publish a full, five-year plan later this year, following the Spending Review and the development of five-year STP/ICS plans.

The final plan will include:

- measures to embed culture change and develop leadership capability
- more detail on changes to professional education and on investment in CPD
- more detail on additional staff needed.

Developing the final People Plan

- The final plan will be developed via National People Board (to be chaired by the CPO, Prerana Issar) and an advisory board (to be chaired by Baroness Harding).
- The way of working will reflect that established in the last phase with working groups chaired by senior leaders including chief executives drawn from the service (Navina Evans, Rob Webster, Julian Hartley).
- The plan will seek investment from the CSR, but is clear that there must be a focus on the things that are in the control of the NHS.

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To:	**Trust Board**
From:	Martin Rayson, Director of HR and OD
Date:	2nd July 2019

Title:	**Continuous Quality Improvement (CQI) Strategy**

Author: Karen Sleigh, Head of 2021 Programme

Purpose of the Report:

The purpose of this report is to introduce the Continuous Quality Improvement Strategy to the Trust Board for approval.

The Report is provided to the Board for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- Background
- Implementing our Continuous Quality Improvement Strategy
- Communications and Engagement Plan

Recommendations

- That the Trust Board approves the Continuous Quality Improvement Strategy.

Strategic Risk Register The Trust Board has set Quality Improvement as a strategic priority within the Five-Year Strategy. This is to enable the Trust to deliver its vision, ambitions and objectives.	**Performance KPIs year to date** There are performance monitoring targets set for the delivery of the Continuous Quality Improvement Strategy.

Assurance Implications
This paper forms part of the governance assurance of the Trust for the implementation of Continuous Quality Improvement Strategy.

Patient and Public Involvement (PPI) Implications
There will be further communication and engagement with our patients and public to keep them updated on the delivery of our improvements, but also to canvass their support in delivery improvements and becoming members of the programmes.

Equality Impact
There will be an Equality Impact Assessment conducted as part of the delivery of improvements.

Information exempt from Disclosure – No

Requirement for further review? Yes

1. Purpose of the Report

1.1 The purpose of this report is to introduce our first Continuous Quality Improvement (CQI) Strategy to the Trust Board.

1.2 We want to promote an opportunity for the Trust to demonstrate its commitment to improvement through the systematic application of improvement science that we will support individuals and teams through the delivery of Quality Improvement Programmes.

1.3 The proposal is to support everyone in the Trust to be able to deliver improvements that we can celebrate and share learning, building confidence and empowering our staff with a range of science of improvement tools and techniques to identify opportunities, measure and sustain the implementation of those improvements.

1.4 We want to wrap our current Quality Improvement approaches around our new and existing programmes, projects and initiatives across the Trust. These include our in-house introductory Quality Improvement (QI) Programme and also our new Quality, Service Improvement and Redesign Practitioner Programme (QSIR) accredited by NHS Improvement. This will maximise the existing capacity for individuals and teams and build capabilities through tailored practical application of improvement science tools and techniques.

1.5 We have been delivering our in-house QI Programme since January 2018. We have just started the delivery of our first QSIR Practitioner Programme from the 13th June, which we have achieved NHS Improvement and Advancing Change and Transformation (ACT) Academy Faculty status, through two newly qualified Associates for the Trust, Karen Sleigh, the Head of the 2021 Change Programme and Maria Wilde, Programme Delivery Manager.

1.6 We want to be able to support individuals and teams to problem solve, implement and sustain improvements that will enable us to achieve our Trust's vision and ambitions together. The 2021 Programme Hub will be driving a Continuous Quality Improvement Faculty status forward for the Trust.

2. Recommendations

2.1 It is recommended that the Trust Board approves the implementation of the Continuous Quality Improvement Strategy.

3. Summary of Key Points

Background

3.1 There has been ongoing work to develop a Continuous Quality Improvement (CQI) Strategy, which sets out how we will be delivering our quality improvement offer for the Trust. The Executive Summary is attached as **Appendix A** and the Strategy is attached as **Appendix B.**

3.2 The Trust has identified the need for a Quality Improvement Programme as a strategic priority to enable us to achieve our Five-Year Strategy's vision, ambitions, objectives,

strategic and tactical priorities. There will also be alignment to the delivery of key actions for our enabling strategies.

3.3 The CQI Strategy aims to outline the **intended journey** to embrace and **embed CQI** as part of delivering our Trust's vision. The Strategy sets out the following aim:

"To support and empower our staff to deliver improvements to achieve high-quality care, share and celebrate learning through the use of improvement science tools and techniques."

3.4 This CQI Strategy supports the new Trust Operating Model (TOM) to deliver transformational change. We will align our improvements to our Trust's vision and ambitions, providing a 'trans-theoretical' approach through various programmes of improvement across the Trust, together with supporting all levels of the organisation to deliver improvements in their areas of work that will improve our patient care.

Our in-house Quality Improvement Programme

3.5 The approach has been developed from the successful implementation of the HEE funded Quality Improvement (QI) Programme, which ran from January to March of 2018, with sharing events in April and May. Since then, we have successfully developed and delivered our own in-house Quality Improvement Programme. We have had more than 200 of our staff and volunteers go through the programme and deliver an improvement project / initiative, celebrating their improvements at Sharing Events, and promoting their continuing improvements through our communication channels.

3.6 Our QI Programme, is an introductory level programme to support individuals apply improvement science tools and techniques to successfully deliver their improvement piece of work. It has been and still is open to all of our staff and volunteers.

3.7 **How does it work?** The programme consists of 3 half-day workshops, with one workshop a month, where candidates are encouraged to bring an improvement piece of work to be supported through to delivery. These workshops are supported by one-to-one coaching in-between the workshops to provide further support for individuals.

3.8 At the end of the QI Programme we hold sharing events, where candidates are awarded their certificates and have an opportunity to share their improvement project with all their cohort, their managers and the Executive Team, together with previous cohorts being invited. All of the information is captured for sharing across the Trust through our QI Programme Catalogues and year-books.

3.9 We have been monitoring and sharing the success of these programmes and linking to other networks such as the FAB Academy, QI networks and the NHS Improvement Quality, Service Improvement and Redesign (QSIR) networks to promote the good work that our staff have been doing.

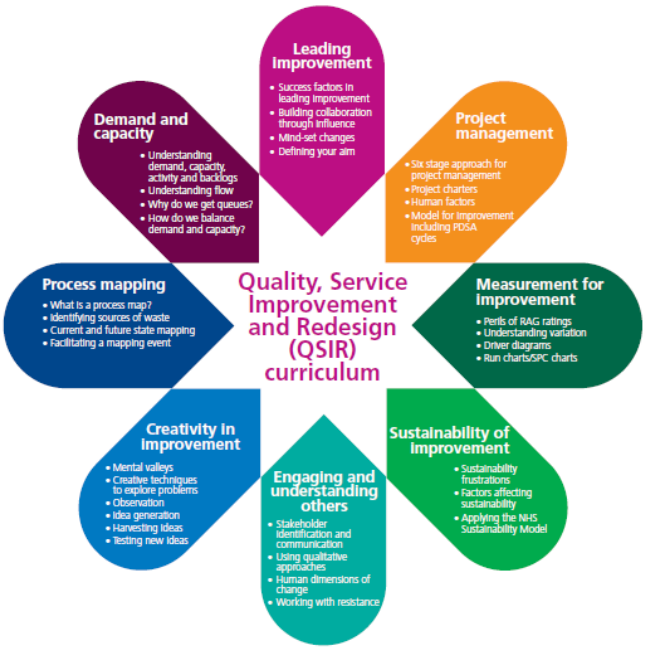
3.10 We monitor feedback from the programme to ensure that we are continuously improving the programme. We have had a consistent 100% response to enjoying and would recommend the programme to others.

3.11 We have been inviting some of our stakeholders and partners to undertake the programme, where they have then taken the programme back to their organisations to look at delivering.

Our Quality, Service Improvement and Redesign (QSIR) Practitioner Programme

3.12 We have also signed up to the NHS Improvements QSIR Practitioner Programme, where 5 members of the 2021 Programme Hub Team have completed the Programme in 2018. We have 2 members of this cohort who have successfully completed their Associate level examinations and assessments with the ACT Academy, who are now be able to deliver the QSIR Practitioner Programme within the Trust, with another member to complete assessments in October.

3.13 We are now classed as a QSIR Faculty by the NHS Improvement ACT Academy. We have started delivering our first QSIR Practitioner Programme from the 13th June, which consists of 5 full day workshops, one a month covering 8 modules outlined in the diagram.



3.14 This is an advanced programme, with the workshops covering 8 modules, which will be supported by additional coaching and improvement clinics where necessary.

3.15 The educational content of the QSIR Practitioner programme is accredited by the Royal College of Nursing (RCN) Centre for Professional Accreditation, together with The Institute of Healthcare Management (IHM) endorsing all of the education programmes delivered by the ACT Academy.

3.16 We want to provide the opportunity for all of our Senior Leadership Forum to go through our QSIR Practitioner Programme. We would also encourage existing programme and project individuals and teams across the Trust to be supported by gaining accreditation through going through the Practitioner Programme.

3.17 All of the improvement programmes, projects and initiatives will be supported with access to NHS Improvement materials for delivery through our Associates within the 2021 Programme Hub, who will be the Continuous Quality Improvement Faculty. We will continue to provide support through our in-house QI Programme and coaching together with providing specialist programme and project management support to improvement programmes and projects throughout the Trust to delivery our Five-Year Strategy's Five Improvement Programmes.

3.18 We would like to encourage registration onto the programme, where we can work with individuals or teams to attend to tackle bigger programmes or initiatives.

3.19 We would also like to support those individuals who would like to progress to become QSIR Associates. This requires the completion of our in-house QSIR Practitioner Programme and demonstration of an improvement, followed by attending the ACT

Academy exam and assessment process, which the 2021 Programme Hub will provide support.

3.20 Becoming a QSIR Associate, will lead to being accredited to our QSIR Faculty, and individuals will be able to deliver the QSIR Practitioner Programme with us and within teams across the Trust.

3.21 We have invited stakeholders and partners onto our first QSIR cohort. There are currently 62 NHS Organisations that have adopted QSIR, we are one of 90 expected by the end of 2019, and there are currently 8 ICS and STPs.

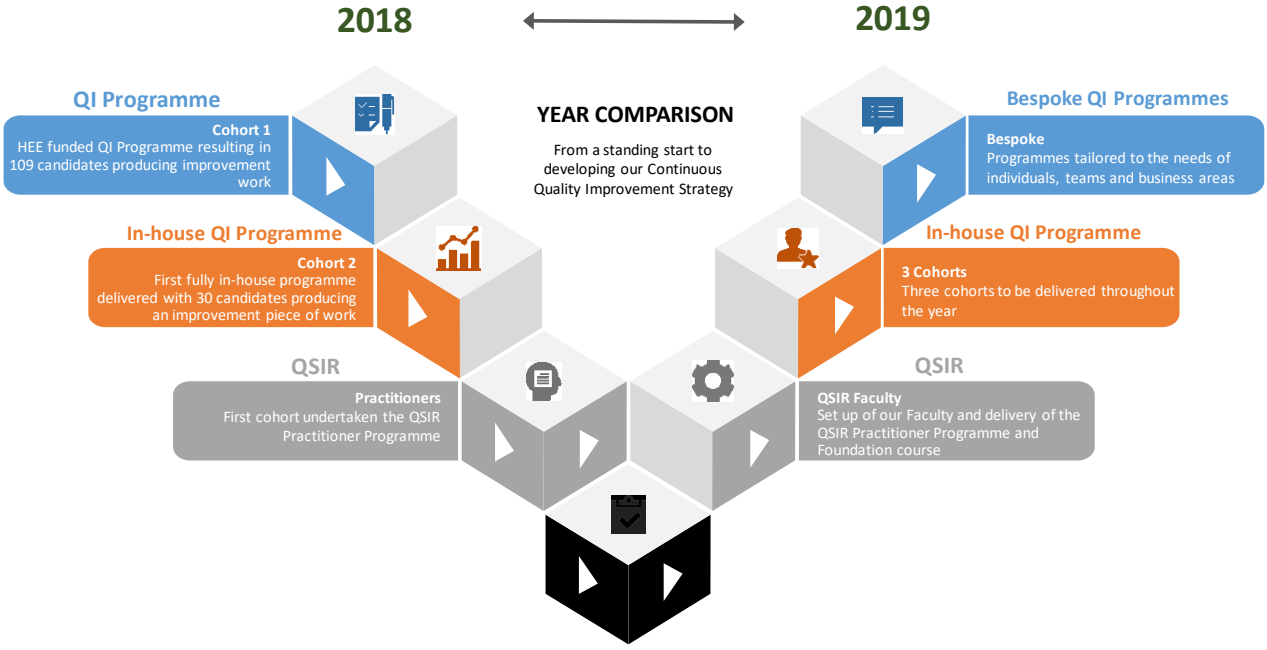
3.22 We would be in a much more inclusive place if we work towards encouraging some of our volunteers and patient representatives to also go through the programme. There has only been two patient representatives nationally that have gone through the programme so far.

3.23 We will be also be planning to deliver a one-day QSIR Fundamentals programme.

3.24 Being part of this Faculty provides national and international networking through the QSIR NHS I and ACT Academy networks, which will enable us to keep up to date with the latest things and provide a platform to celebrate our successes to delivering our vision and ambitions.

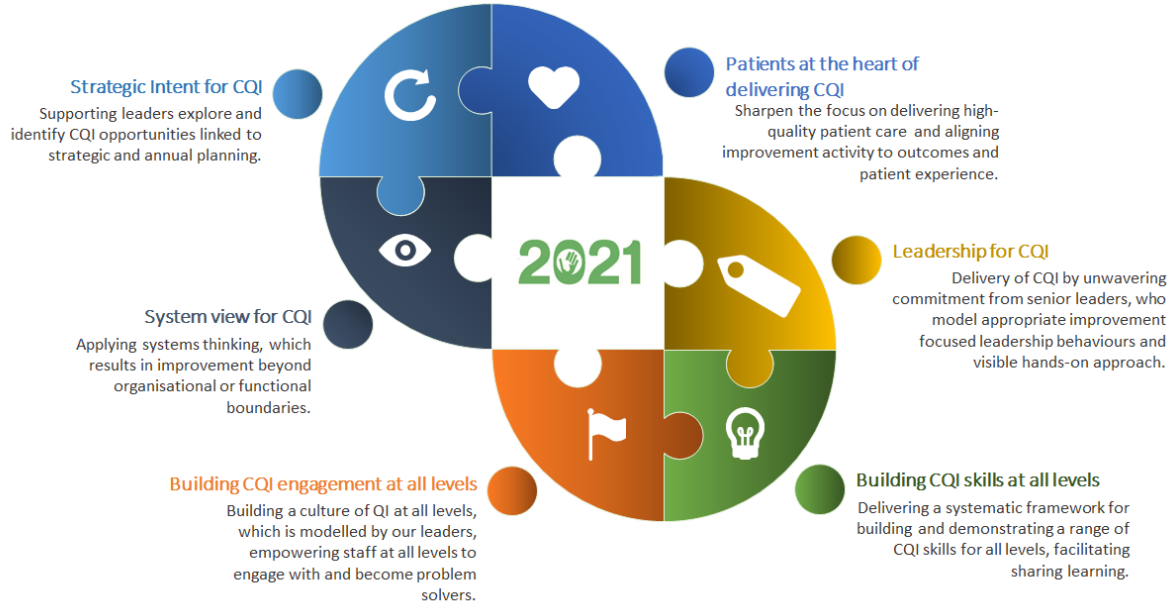
Progress of Implementing our Continuous Quality Improvement Strategy

3.25 We have been developing our CQI Strategy from the success of our in-house QI Programme, which has demonstrated that we can apply a systematic approach to implementing quality improvement. We recognise that we are on a quality improvement journey, which is a “marathon not a sprint”. The following diagram outlines our journey from last year to this year:



Six Elements for successful delivery of continuous improvement

3.26 The Strategy outlines the approach to the systematic use of science for improvement, and is built on 6 best practice key elements, identified in the following diagram:



3.27 The 6 elements and our objectives of our CQI Strategy are:

1. **Strategic intent for CQI:** Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.

    - This will enable us to demonstrate that our CQI approach supports the delivery of our programmes, projects and initiatives through our business planning and alignment to our strategic vision and ambitions.

2. **Patients at the heart of delivering CQI:** Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.

    - This will enable us to demonstrate that we have a patient focused co-design approach to improving our services to our patients, through the inclusion of our patients or patient data where ever we are doing an improvement piece of work.

3. **Leadership for CQI:** Delivering CQI by unwavering commitment from senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.

    - We will be able to support all of our leaders to be part of our QSIR Practitioner Programme and to support their staff to be part of either the QSIR Practitioner Programme or our in-house QI Programme to deliver a new or existing improvements. We would want to promote the opportunity for our leaders to become future accredited QSIR Associates once they have done the QSIR Practitioner Programme to promote QSIR in their areas and be part of a wider NHS Improvement and ACT Academy network.

4. **Building CQI skills at all levels:** Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning.

    - We will be able to support individuals through a range of opportunities to develop their CQI skills through the practical application of tools and techniques to new and existing programmes, projects and initiatives, utilising a 'dosing' model approach to provide the most appropriate level of support.

5. **Building CQI engagement at all levels:** Building a culture of QI at all levels, which is modelled by our leaders empowering staff at all levels to engage with and become problem solvers.

    - We will be striving for:

        - Engaging, encouraging and inspiring our staff
        - Developing improvement skills
        - Embedding improvement into a day to day activities
        - All of our programmes and projects are supported through the QI and QSIR Practitioner Programmes

6. **System view for CQI:** Applying systems thinking which results in improvement beyond organisational or functional boundaries.

    - We will be able to demonstrate that we have a systems approach to our improvements, cutting across boundaries and improving system changes within our services and with our health and care partners.

Key Success Factors

3.28 The key success factors of this approach will be to:

- Provide the Trust with a systematic and recognised approach to quality improvement through the application of science for improvement tools and techniques, which will support our vision, ambitions and objectives to be delivered through our annual planning processes.

- Support all the existing and planned programmes, projects and initiatives in the Trust, by ensuring that individuals and teams go through either our in-house QI Programme, or the QSIR Practitioner Programme, whilst they are delivering or preparing to deliver their piece of work either individually or as a team.

- Ensure that the current Improvement Programmes, the Financial Efficiency Programmes (FEP) and improvements identified within our key enabling strategies to deliver our vision go through the QSIR Programme.

- Provide opportunities for individuals at all levels to be able to be supported to achieve an improvement and be developed to be Ambassadors.

- To provide bespoke opportunities programmes for teams to deliver improvements.

- To grow our own expertise in improvements, which will include the training through the supportive in-house QI Programme and the NHS Improvement accredited QSIR Practitioner Programme, where we will be developing Associates to be able to

deliver the future Programmes, being champions in their areas and developing their expertise further to build sustainability across the Trust.

- To ensure that the CQI Strategy supports all of our Organisational Development priorities to deliver the improvements, which will include leadership programmes, medical, nursing graduate and undergraduate programmes.

- Monitoring the successful delivery of our programmes and sharing learning across the Trust linking with relevant networks to continuous build skills and the latest approaches to improvement into the Trust, together with celebrating success through networks such as the FAB Academy and Q networks.

What have we achieved so far this year?

3.29 So far this year:

- We have delivered one in-house QI Programme cohort and we are on the second one, where we will be holding a joint Sharing Event in September to celebrate their achievements.

- We have included in this these programmes, our partners who are completing the programme with a view to learning the materials and being able to deliver the approach in their own organisations.

- Developed bespoke Quality Improvement Programmes, which have included:

    - Quality Matrons – supporting the implementation of learning from Northumbria
    - Nurse Preceptees – over 100 individuals completing a 1 day programme in February 2019
    - Delivering introduction to our approach to 237 undergraduates at the University of Lincoln
    - Building a bespoke programme for our new Nurse Fellows
    - 21 Maternity Matrons going through a bespoke QI Programme
    - A&E nurses at Pilgrim programme being designed
    - Drafting a CQI approach to Managing Equipment Services programme

- Grown our own Associates to set up our QSIR Faculty. The programme covers the theory of change and the Science of Improvement (SOI) through the application of trans-theoretical quality improvement tools and techniques.

- Linking to key networks, which includes: FAB Academy, QI East Midlands, QI Life and QSIR Networks.

- Promotion of our refreshed ‘Staff Suggestion Scheme’, identifying improvement opportunities which will be included in either set programmes or bespoke programmes.

3.30 This approach includes working collaboratively with our staff, volunteers and patients, together with key stakeholders and partners, through sharing the programmes and enrolling them onto the programmes.

Assurance

3.31 There has also been a self-assessment conducted, based on the CQC Brief guide: assessing quality improvement in a healthcare to assess the maturity of our quality improvement approach and ensure that we can evidence our journey for future CQC Well-Led Inspections.

3.32 We will be able to demonstrate **improving maturity** through our CQI Ambassadors, delivery of our programmes, monitoring of benefits, but more importantly, the biggest test of maturity will be through our staff and patient feedback on the improvements we have made.

3.33 We are able to demonstrate that we are a recognised QSIR Faculty, accredited through NHS Improvement and the ACT Academy. Delivery of the five-day / 8-module QSIR programme to a minimum of five cohorts are expected to be undertaken within the period June 2019 to November 2020. In addition, we are planning to deliver the QSIR Fundamentals 1-day programme.

3.34 We will need to present our delivery plans and evidence of delivery to the ACT Academy Award Board as demonstration of our continuing accreditation.

3.35 There is a supporting Communication and Engagement Plan, which will ensure that we promote the good work that our staff are doing from our improvement programmes.

3.36 Our QSIR cohorts will form part of the sharing events we currently run for our in-house QI Programme.

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Delivering Excellence

Continuous Quality Improvement Strategy and Delivery Plan

2019-2021 and beyond

Directorate of Human Resources and Organisational Development

Head of 2021 Programme
Karen Sleigh

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Foreword

Martin Rayson
Director of Human Resources and
Organisational Development

I am delighted to introduce United Lincolnshire NHS Hospital Trust's (ULHT) first Continuous Quality Improvement Strategy, which sets out our aspirations and approach for improving the quality of care we provide to our patients through a more consistent and joined-up approach to quality improvement.

Our Quality Improvement Programme is a strategic priority, which demonstrates the Trusts commitment to supporting and empowering our staff, volunteers, patients, careers and partners to make improvements to how we deliver services, now and for the future. All of these improvements will enable us to demonstrate achieving our 2021 vision and ambitions together.

I recognise that we are on a journey, to join up our areas of excellent practice and share learning across the Trust. This Strategy will play an important part in bringing together our learning potential, through providing support on the use of and practical application of improvement science tools and techniques.

As a Trust, we want to develop all of our staff and volunteers with the skills to deliver improvements that matter to them and their patients. We will celebrate and share our improvements and their learning across the Trust, showing that we can and are doing outstanding jobs that make a real difference to our patient's experiences of their care.

However, we recognise that we have some key challenges to overcome, we want to ensure that we integrate this Strategy into our existing business planning frameworks to demonstrate that improvement is a vital contributor to improving care flow processes and performance, making things run more smoothly and effectively. This all contributes to us providing services that we should quite rightly be proud of.

I would encourage you to read through this Strategy, as it is not just a programme of training and development, it sets out how we will be inclusive and work together to build the improvement skills we need, provide support to deliver improvements and encourage Ambassadors to develop across the Trust who can lead and develop local programmes of improvement. There will be something for everyone to be able to get involved and adapt to their areas of work. Remember, no improvement is too big or too small for us to apply our improvement approach.

We all have a role to play in challenging and improving the way they do things in our every-day roles, and we want to join up all of our efforts to achieving and celebrating how we can demonstrate that we are delivering excellence, supported by our drive and motivation to make improvements.

1. About our Trust

At ULHT, we want to ensure that everyone who works at the Trust is encouraged to strive for excellence in all that they do by working together to deliver high quality patient care. We have made a great start on introducing quality improvement, we now want to ensure a clearly understood and recognised joined up and consistent methodology.

Introduction

This Continuous Quality Improvement (CQI) Strategy aims to set out our intended journey to embrace and embed quality improvement as part of delivering our Five-year Strategy. We will achieve this by building both individual, team and therefore our organisational capacity and capability, through a systematic approach to using improvement science tools and techniques, which we will term our Continuous Quality Improvement (CQI) approach.

We will be developing different levels of improvement expertise tailored for individuals, teams and focused pieces of work, through supporting the practical application of CQI to deliver local improvements, together with our bigger transformational strategic improvements. We want to encourage strong local leadership through developing CQI Ambassadors, who can deliver our quality improvement training within their own teams, teams across the Trust, together with teams across our health and social care system networks. We will celebrate and share our successes, learning, experience and knowledge, through the development of our CQI Knowledge Hub as part of our CQI Faculty.

Simply by training alone, will not achieve the impact of our CQI intent, we need to see that it is part of all of our roles to help transform our organisation to achieve our 2021 vision. We want to demonstrate that CQI is the way we do things here, where our staff feel confident and empowered to challenge, problem solve and innovate to improve our patients care, illuminate waste and reduce variation which will improve patients experiences of our services.

Our vison and values

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.

The Trust has set out its ambitions to strive for excellence in the Five-year Strategy, supported by our priority setting methodology to identify our strategic and annual priorities. Our ambitions are:

- Our Patients

- Our Services
- Our People
- Our System / Partners

Quality improvement is one of our strategic priorities within Our People ambition. To complement the delivery of our ambitions are our values, underpinned by our Staff Charter that sets out the expected behaviours from each other. These values will be embedded throughout our CQI approach:

- Patient-centred
- Safety
- Compassionate
- Respect
- Excellent

Our Continuous Quality Improvement aim

The key outcomes for our CQI approach is improved patient safety and experience. There is no single definition of quality improvement. The Care Quality Commission (CQC) Report on the learning from trusts on a journey of quality improvement describe it as:

> *'Quality improvement is an approach to improving service quality, efficiency and morale simultaneously: this is done by systematically enabling staff and leaders in the continuous study of improvement of their work, anchored in methodologies and tools from improvement science'.* [1]

Critically, quality improvement requires staff, operational managers and senior leaders to work together, with problem solving and decision-making happening as close to the issues being experienced as possible. An important ingredient in successful and sustained improvement is the way in which the change is introduced and implemented.[2]

There is also the reference to the Science of improvement (SOI), which is used by a wide range of people and professionals to mean different things, but an article by Pela et al (2013) provides an historical review of SOI and its application in healthcare settings. This describes it as the integration of ideas, concepts and models between scientific disciplines to develop robust improvement models, tools and techniques with a focus on practical application and problem solving.

The aim of this strategy is:

[1] CQC Report on Quality Improvement in Trusts. Sharing Learning from trusts on a journey of QI September 2018

[2] Øvretveit J. *Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers.* London: Health Foundation, 2009.

> "To support and empower our staff to deliver improvements to achieve high-quality care, share and celebrate learning through the use of improvement science tools and techniques."

The objectives for this Strategy have been shaped around the key elements of success from the national best practice, identified in the CQC[3] Report, together with building on our learning and the learning from NHS Improvement Quality, Service Improvement and Redesign approach across the system:

1. **Strategic intent for CQI:** Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.

2. **Patients at the heart of delivering CQI:** Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.

3. **Leadership for CQI:** Delivering CQI by unwavering commitment from senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.

4. **Building CQI skills at all levels:** Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning.

5. **Building CQI engagement at all levels:** Building a culture of QI at all levels, which is modelled by our leaders empowering staff at all levels to engage with and become problem solvers.

6. **System view for CQI:** Applying systems thinking which results in improvement beyond organisational or functional boundaries.

Embedding CQI is not just delivering programmes of training, it is a way of working, and can be measured through many traditional performance frameworks. A key indicator of success will be from measuring improving patient experience and staff satisfaction surveys. The focus will be on the delivery of programmes with individuals and teams to support and guide, build skills and capability to deliver improvements.

This approach will build confidence in generating ideas for improvement, together with fostering a more collaborative approach to involving our staff, patients, carers and key stakeholders in delivering the improvements.

This is not an easy quick fix; it is a challenging endeavour to change behaviour in complex organisations and developing an effective leadership and organisational approach to continuous improvement. We can achieve this together through engaging and empowering our staff, harnessing our creativity to solve problems and innovate as part of our daily roles.

[3] CQC Report on Quality Improvement in Trusts. Sharing Learning from trusts on a journey of QI September 2018

It is not a sprint it is a marathon, and this strategy and delivery plan clearly sets out pace and direction, whilst building solid foundations for our continuous quality improvement journey together.

Success factors will include:

- Staff who are passionate about the delivery of improving high-quality care for our patients.
- Staff and leaders at all levels who are engaged, confident and committed to making improvements.
- Collaborative ways of working with patients and key stakeholders in driving system improvements.
- Clear links from local improvements to our vision, ambitions and priorities.
- Integrated improvement planning with our strategic, business and performance management planning.
- Clear governance for improvement ownership, trust and confidence that problems will be dealt with swiftly.
- Sharing opportunities with peers and internal networks to build skills and knowledge transfer.

2. Our Current Position

Whilst the demand for our services increases year-on-year, we need to find new and innovative ways to deliver the way we work. In outstanding rated trusts, there is a clear focus on developing a culture of continuous quality improvement, embedded throughout the organisation.[4] A key factor is successfully embedding improvement through a consistent methodology. We need to recognise that we are on a journey, our Staff Survey identifies that we have to improve the pride and confidence in promoting our Trust as a good place to work that we are proud of.

Defining our approach

The key is to have a defined and systematic approach to improving safety, service quality, efficiency and morale, not just as a mechanism to problem solve in failing parts of the organisation, but as a way of expanding improvement beyond organisational functional boundaries.

This type of approach has, at its heart, a focus on providing better patient outcomes through systems thinking and training on the application of improvement science tools and techniques. The application of quality improvement, can demonstrate improved operational, organisational and financial performance. We need to support curiosity and experiential learning, supported by our leaders.

- We will be building on the success of our in-house Quality Improvement Programme.

- We will be launching our NHS Improvement Quality, Service Improvement and Redesign (QSIR) Faculty and embed the QSIR Practitioner programme approach at all levels across the Trust. We will be classed as an organisation participating in the QSIR College programme, which uses an organisational / system approach to building improvement capacity and capability.

- We will be applying system thinking, bespoke programmes and specialist spin off support, which will include more in-depth applications of methods, including; measurement for improvement, conventional and lean process improvement, Agile and Prince Project Management, and Managing Successful Programmes.

- We will be linking with networks and making collaborations across the Quality Improvement networks.

We will integrate improvement planning within existing strategic, annual business and performance planning to identify opportunities for improvement. This identification of improvement supported by specialist programmes of training and

[4] CQC Report on Quality Improvement in Trusts. Sharing Learning from trusts on a journey of QI September 2018

support from the 2021 Programme Hub. We will be facilitating the widening of skills and understanding of running initiatives, projects and programmes to sustainably deliver short and long-term targets for improvement. We will also support the development of staff ideas and recommendation on who to take these forward supported by our CQI approach.

2018
Quality Improvement Programme

At the beginning of 2018, the Trust was supported by HEE to kick-start a Quality Improvement Programme. This programme was delivered by an external company providing an introduction to the use of improvement tools and techniques to an improvement idea, which enabled over a 130 of our staff and volunteers to start and deliver an improvement project. This has been further developed into our in-house delivered programme, which has led to another 30 of our staff and volunteers delivering an improvement project across our sites and multiple services.

Quality, Service Improvement and Redesign (QSIR)

A cohort of 5 staff have undertaken the NHS Improvement QSIR Practitioner Programme, with 3 individuals progressing to the NHS Improvement ACT Academy Associate level to be able to deliver the NHS Improvement QSIR Practitioner Programmes and set up our QSIR Faculty.

2019
Quality Improvement Programme

We have started our 2019 programme of delivery, which comprises of x3 half day workshops with coaching to support the delivery of an improvement piece of work. We have a target of 3 cohorts of 30 or more staff on each programme across our sites.

We have also developed this programme into bespoke programmes for key specialist areas and projects, which has included:

- Over 100 of our Nurse Preceptees going through a 1 day programme in February, generating improvement ideas for our Quality Fellows to follow up with a bespoke programme
- Lectures to University of Lincoln undergraduate students
- Focus on A&E nursing improvements at Pilgrim Improvement programme
- Maternity Nursing programme
- Applying the QI and QSIR approach to key programmes under the 2021 Improvement programmes
- Working with some of our partners to train up and deliver our QI Programme bespoke to their organisation

Quality, Service Improvement and Redesign (QSIR)

There will be a cohort of 3 QSIR Associates. We will be launching our QSIR Faculty and rolling programme of delivery of the NHS Improvement QSIR Practitioner Programme in the Trust in May. We will be providing a clear set of tools and techniques to access via the Intranet and a promotion of the integration of CQI into our day jobs, to become part of new ways of working through our new Trust Operating Model.

Model for Improvement

We are currently trying to gain more traction in the use of a standard set of improvement tools and techniques that will be available to all of our staff tailored to their needs and experience.

We want to support staff at all levels to lead and deliver measurable change with the 'model of improvement'[5] (Plan, Do, Study, Act) at its core. This approach will demonstrate embedding our values, promoting openness and transparency towards tackling things when they go wrong, apply quality improvement approaches and share learning to improve our patient care. Each member of our staff has a key role to play in creating and delivering improvements for our patients and staff.

No improvement is too small, and of course not every improvement needs to go through our CQI programmes, but we would like to capture them and promote them through our Knowledge Hub. They will be further celebrated though sharing with the FAB Academy.

Through the development of this CQI Strategy, we have taken a realistic view of where we are in the challenges we face, the progress to date on what we have managed to achieve, and set out a clear ambition to be an organisation that is committed to delivering high-quality care through embedding a systematic and effective approach to CQI.

[5] Institute of for Healthcare Improvement "model for improvement"

3. Our Challenges

We recognise that we have quite a challenge ahead of us and that we have to address many issues. This CQI Strategy will form part of those approaches that when we look back, we will recognise how important it was to invest in empowering our staff to deliver improvements which improve our services that our patients will benefit from.

Identifying our opportunities

Whilst we recognise that the Trust faces a range of challenges, if we apply our CQI approach they become opportunities:

- We will be relaunching our vision to achieve excellence through our Five-year Strategy, to reflect the work to set out our vision, ambitions, objectives, strategic and tactical priorities.

- The Trust is in double special measures for Quality and Safety and Finance and we have challenging performance results, but we have an ambition to strive for excellence.

- We have implemented a new Trust Operating Model (TOM), which has included the structural changes from 15 Directorates to 4 Divisions, supported by 13 Clinical Business Units and 40 Clinical services / specialities.

- The TOM is not just about an organisational restructure, it is about shaping our Divisions to be able to focus more on delivering our vision and ambitions, which will be supported through 'new ways of working', covering clear governance and meeting structures and devolution of powers to encourage decision-making to be made closer to the operational issues.

- Implementing the wider Sustainability and Transformation Partnership (STP) plans across the health and social care system to reduce the demand on our hospitals.

- This all ties in closely with our organisational 2021 transformational Improvement Programmes.

- Continuing need to widen our stakeholder and patient communication, consultation and engagement identified through our staff and patient surveys.

- Encouraging staff pride and engagement remains a key issue, whilst some areas score highly in our staff surveys, to drive consistently high scores across the Trust we need to promote energy, enthusiasm and pride in the importance and quality of our work.

- Need to tackle the root causes of our staff survey results for why our staff are not feeling proud to work for ULHT and would not recommend us as a place to work.

- As a Trust across multiple sites, we have a diverse range of businesses and ways of working. We can learn from this diversity, using excellence in delivery to inform how we deliver improved patient care, and building a 'one team' approach.

- Clear ambitions to set up centres of excellence for key services across the Trust, which will lead to improved sharing and improving knowledge of improvement.

We want to be an organisation that can demonstrate that we can identify and work together on the opportunities that will shape the future vision of our Trust.

4. Continuous Quality Improvement (CQI) Maturity

The Trust has started on its journey of quality improvement. However, we recognise that we are at the early stages of adopting a systematic approach to CQI tools and techniques. Where there are good examples of progress there is not yet a mature infrastructure to promote and support the adoption of CQI, this Strategy will help accelerate how we can celebrate our sharing of learning, supported by the launch of our Quality, Service Improvement and Redesign (QSIR) Faculty.

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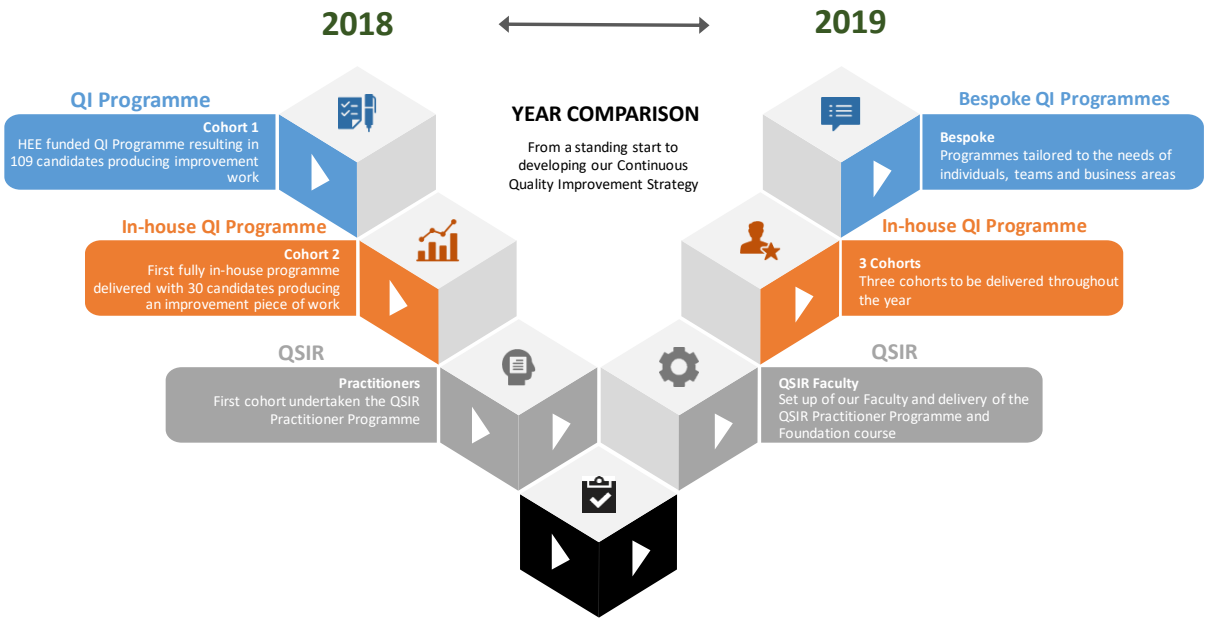
Recognising our journey

The following diagram outlines the comparison from starting our journey in 2018, identifying what we have achieved and what we have planned for this year:



We recognise the benefits that CQI can bring and the importance of moving over time to a consistent but flexible approach, that supports the diversity of our organisation, at all levels. We want to be recognised for promoting our good work.

We want to ensure that we can support new and existing programmes, projects and initiatives through our CQI approach which will focus on delivery and sharing learning.

5. Long-Term Vision

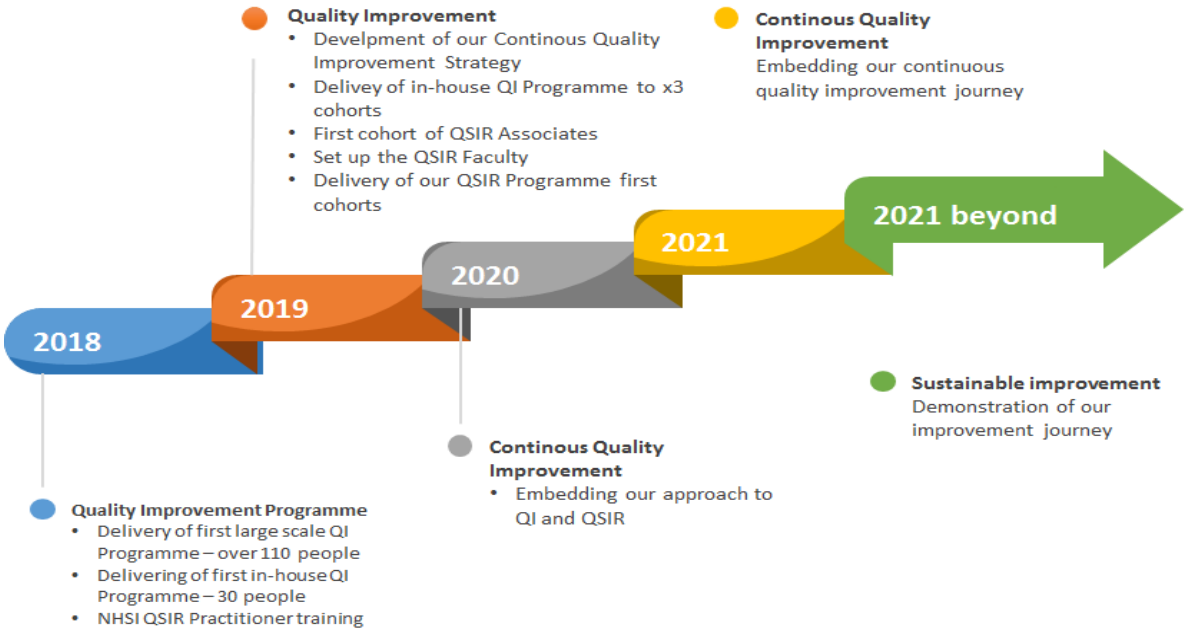
This CQI Strategy will support the Trust to achieve sustainable improvements in line with the transformational changes required by the Trust's vision and ambitions, which are aligned to the wider STP health and care system, together with supporting and embedding TOM and new ways of working.

Our improvement vision

We want to develop a process for identifying opportunities from existing ways of working, together with linking to quicker life-cycles of improvement through supported CQI programmes. We want to build a confident and vibrant response to change and improvement, where CQI is an integral part of the way we think and act.

Together with tackling and identifying improvement opportunities, we want to grow the level of expertise throughout the Trust. We want to encourage our leaders to understand and own CQI to drive their business improvement opportunities in their own areas. This will help develop the capability and capacity at local levels, and help demonstrate improving the use of resources and delivering value for money, from a motivated and empowered workforce, who put the patient at the heart of everything they do. This will provide us with a sustainable approach to improvement, which we can do for ourselves, benefiting our patients.

The following timeline sets out our planning intention to reach CQI maturity:



The launch of our QSIR Faculty will be a legacy to the staff, volunteers and patients who have contributed to energising our improvement journey.

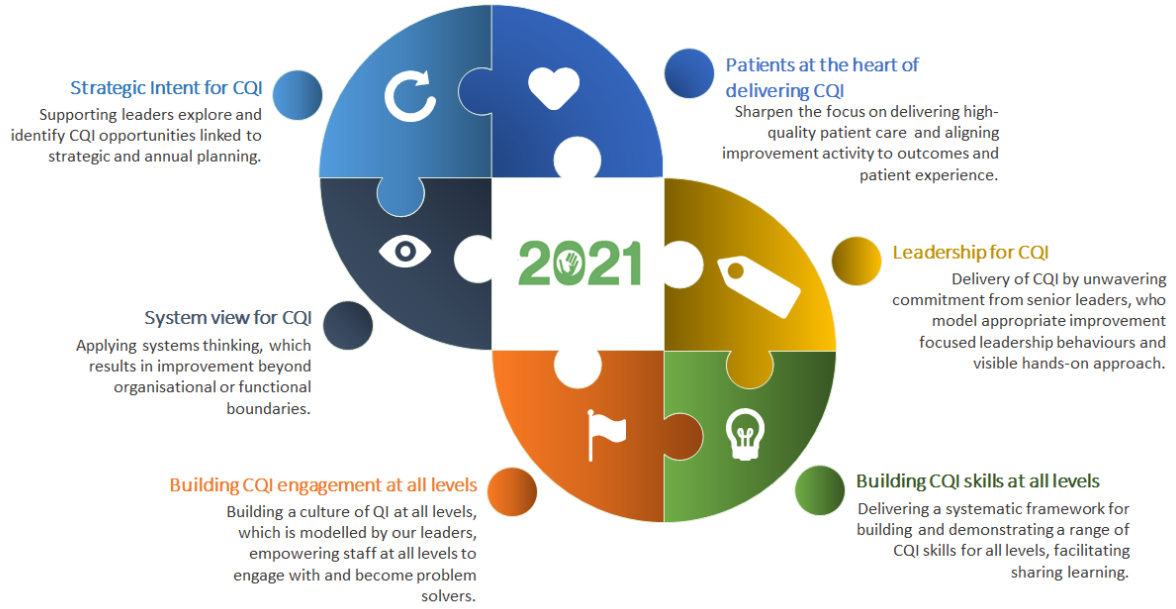
6. Six Elements of this CQI Strategy

Our CQI Strategy has six elements, which are the building blocks to achieve improvement maturity. We are currently achieving the delivery of these elements in varying degrees. Our aspiration is to build on what is working well, and create the conditions to support the development of our CQI approaches that meet the diverse needs and delivery models across the Trust. This will provide a platform to share learning, expertise and best practice.

Factors for successful delivery

Delivering our new TOM and supporting new ways of working will drive standardisation of transactional corporate activity, whilst improving opportunities for transformation change and being more innovative. This will be supported by the application of CQI, which will be applied to smaller improvements that matter to us, together with larger re-engineering of current systems and processes. We will be building skills and capability to deliver improvements that we achieve sustainable change.

The experience of successful organisations who have achieved 'excellent' in CQC ratings show that CQI techniques can be applied successfully across all parts of an organisation. The following diagram outlines our CQI Strategy elements:



We want to make our CQI approach accessible to all levels of the Trust. There will be clear communication on our improvement programmes, how they work together and will be supported by Leadership Modules and access to improvement tools and techniques on our Intranet. There will be an inclusive approach to our engagement.

7. CQI Implementation Plan

There will be an Annual CQI Implementation Plan produced as part of our Improvement Planning cycle, which will form part of our integrated strategic and business planning process. Through these planning processes, we will be able to identify existing, new and emerging opportunities for improvement aligned to the Trust's vision, ambitions, improvement programmes, strategic and tactical priorities.

Delivering our CQI Strategy

The CQI Implementation Plan, will form part of the Trust's governance, and published as part of the Trust's Operational and Divisional Business Plans. The Plan will be reported to the Trust Management Group, providing assurance of delivery and escalating issues and risks.

The key success will be integration of CQI into the existing strategic and annual planning processes, and being delivered through to Divisional Operational Plans. There will be support from the 2021 Programme Hub to develop the opportunities for improvement.

The Annual CQI Implementation Plan will be signed off as part of the Trust's Annual Operational Plan. There will be monthly reports provided to the Trust Management Group, Trust Committees and Trust Board.

The development of the CQI Implementation Plan will be built up through the following six elements:

- Strategic intent for CQI
- Patients at the heart of delivering CQI
- Leadership for CQI
- Building CQI skills at all levels
- Building CQI engagement at all levels
- System view for CQI

Element 1: Strategic intent for CQI

Objective 1: Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.

The QI Programme is a strategic priority to deliver our Trust's vision. This CQI Strategy sets out the framework for embedding our approach throughout the organisation. Our CQI journey involves the systematic application of improvement science tools and techniques. This will support the new TOM ways of working and intention to deliver operational transformational change.

Why is this element important?

This element sets out the Trust's strategic intent for CQI, and demonstrates how the Trust Board and our senior leaders will identify and agree improvements that will deliver our vision and ambitions.

Our strategic intent for CQI builds on the good work that has already been achieved. It starts with identifying and prioritising our improvement activities in line with our strategic and annual planning processes. It is not just a training programme, it is about setting out a clear and sustainable approach to identifying opportunities for improvement and sustaining change that they will deliver, with tailored support where needed.

What is our vision?

That there is a clear CQI planning approach, which identifies our improvements aligned to our vision, ambitions and priorities. If our approach is not integrated into existing systems and processes, it will be seen as and feel like a bolt on "nice to have", rather than a fundamental part of the way of a way of working to strive for excellence.

The CQI Implementation Plan, should outline the priorities for delivery of our Quality Improvement Programme. We will build on our existing strategic and business planning processes, through identifying, registering and grading improvement projects through our 2021 Programme Hub and translating into improvement forward plans. These forward plans will align and prioritise our improvement activities to our vision, ambitions and priorities.

Once agree by the Trust, the forward plans will be translated into the CQI Implementation Plan and programme managed through the Trusts Governance Framework to demonstrate delivery of our Five-year Strategy.

We want to be recognised as a learning organisation, where all of our staff feel empowered and are supported to deliver sustainable improvements that will deliver the changes needed to achieve excellence in patient care. No improvement is too small.

This will be achieved though empowering our staff to make the small improvements that will make their day-to-day jobs better, together with approaching our strategic transformational changes with rigour and support. This will help the Trust develop its story of continuous improvement and strive towards excellence for our patients and our communities of Lincolnshire.

How will this be achieved?

- Provide the Trust with a systematic and recognised approach to quality improvement through the application of science for improvement tools and techniques.

- Support all the existing and planned programmes, projects and initiatives by ensuring that individuals and teams go through either the in-house Quality Improvement Programme, or the QSIR Practitioner Programme whilst they are delivering or preparing the delivery their piece of work.

- To ensure that the current 2021 Improvement Programmes, the Financial Efficiency Programmes (FEP) and improvements identified within driving our key enabling strategies to deliver our vision go through the QSIR Programme.

- Embedding this CQI Strategy, reporting through to the Trust Management Group and providing updates to the Trust's Governance meetings, Committees and Board.

- Integrating our CQI Implementation Planning cycle into the Trust's strategic and annual planning cycle.

- Producing our Annual CQI Plan, which sets out the CQI Programme of delivery aligned to our vision, aims and priorities.

- Developing and delivering our CQI Implementation Plan though the strategic and annual planning process, identifying strategic and tactical improvement opportunities aligned to the vision and ambitions.

- Working with Divisions to identify improvement opportunities through their annual planning, forming part of their future planned delivery and celebrating successes of actual improvement plans delivered.

- Registering, recording and grading the improvements through the 2021 Change Programme pipeline process, which will lead to the generation of quarterly CQI Forward Plans, to be managed and monitored through the Trust Management Group and developed into the CQI Implementation Plan to be programme managed.

- Clarify the benefits realised through the CQI Implementation Plan and reporting through monthly and quarterly performance reports in line with the Trust Governance framework.

- Support the strategic and Divisional approach to national and local horizon scanning for identifying improvement opportunities from new and emerging information and issues.

- The CQI Implementation Plan to be programme managed alongside annual planning and support our enabling strategies.

- Identifying improvements as part of the TOM Transition Plan to implement the new ways of working into the Trust.

- Work with key stakeholders, our staff and volunteers to identify improvements that can form part of the horizon scanning approach to identifying opportunities for improvement utilising existing systems and processes where possible.

- Publish and promote the Communications and Engagement Plan to support the embedding of the CQI Strategy.

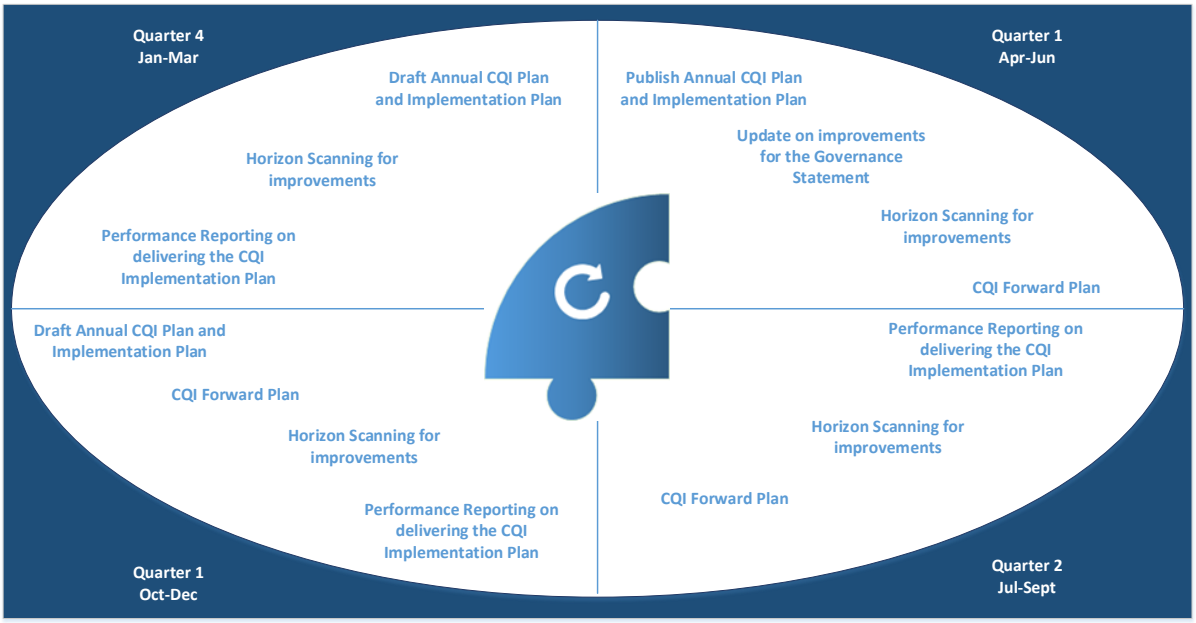
- Share the learning from the improvements, promoting individuals and teams demonstrating new ways of working to outline how we are a modern progressive workforce.

- Provide information of learning from the QI Programme to the Chief Executive's Annual Governance Statements.

- Adopting an approach, which covers concepts, tools, techniques and methodologies that will be practical and supported to deliver improvements.

The following diagram outlines the cycle for developing and delivering our CQI Implementation Plan.

Developing and delivering our CQI Plan



Key actions

- Embedding our CQI Strategy through integrated strategic and business planning.
- Programme managing the development and delivery of our CQI Implementation Plan.
- Embedding performance reporting on the delivery of the identified improvements to demonstrate delivery of our Trust's vision and ambitions.
- Celebrating success and share learning.

Element 2: Patients at the heart of delivering our CQI Plan

Objective 2: Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.

To demonstrate this we will be working to ensure that patients will be treated as true and equal partners as part of improvement opportunities that will impact on patient care.

Why is this element important?

Our Five-year Strategy sets out that our patients are at the heart of our vision, with the Patients ambition "providing consistently safe responsive, high quality care".

This simply means that we will ensure that our patients and service users are central to the delivery of improvements to our services. We will strive to include our patients as active stakeholders and equal partners in our CQI initiatives, involving them in our journey in a demonstrably meaningful way through co-production, involving them in decision-making and actively seeking their feedback in the design, management and delivery of our CQI Forward Plans. This will require all improvement opportunities to consider patients as stakeholders from the outset.

Patient involvement links to good leadership, which includes listening to the views of our patients using our services, and actively acting on their feedback to improve the way we provide our services, which is recognised through our patient and staff surveys.

What is our vision?

We need to ensure that we reflect our patient's voices in designing our systems and processes, the way we work, to harness patient experience in redesigning around their needs, which will demonstrate valuing their time.

We want to ensure that we utilise existing information to identify opportunities for improvement for providing harm free care, together with demonstrating a learning and safety culture. There are many different stakeholders we can work with to include in the CQI Implementation Plan, which will demonstrate a collaborative approach that will be recognised as shaping our services around our patient's needs.

How will this be achieved?

- Ensure that our patients are a key stakeholder in our Communications and Engagement Planning for CQI.

- Ensure that throughout the planning and identification of improvements we utilise existing mechanisms for data and information gathering from our patient's experience, which will provide opportunities for a patient improvement focus to our improvements.

- When using patient feedback information we will focus on how we have responded to improve our care, and celebrate where we are doing things right, promoting good news stories and raising the profile that we are living our value of patient-centred care.

- Each Clinical Business Unit has an opportunity to review their Patient Feedback to identify localised opportunities for improvements.

- There are further opportunities for improvement from our Clinical Governance mechanisms, which will support our Quality and Safety Improvement Programme and Health and Safety Strategy aims through sharing of learning across the Trust:

    - One of the key areas that will inform CQI opportunities will be our Incident Management data in Datix and our responses to Duty of Candour and Health and Safety. This is a rich picture of information, which could be interrogated to determine 'hot spots' of patient harm, to focus CQI opportunities, leading to intelligence-led improvements.

    - This will demonstrate that we can identify and respond to services when things go wrong and applying CQI to look at new ways of working, which will provide opportunities for learning and sharing lessons to reduce harm and improve patient care.

- To ensure that we can identify, respond and include our patients in our service redesign CQI opportunities is an important part of our journey, however, this has to be complemented with demonstrating that we are sharing our learning to improve our quality and safety culture.

- Ensure that we can identify and respond to those groups that are often 'hard to hear' coming through our services, and demonstrating their improvements.

- We will ensure that we are inclusive in our approaches, promoting our learning and sharing our successes, which will build trust and confidence with our patients and our staff.

- Throughout the CQI Implementation, we will be collating information and sharing learning to celebrate success across the programmes of improvement and all other available channels.

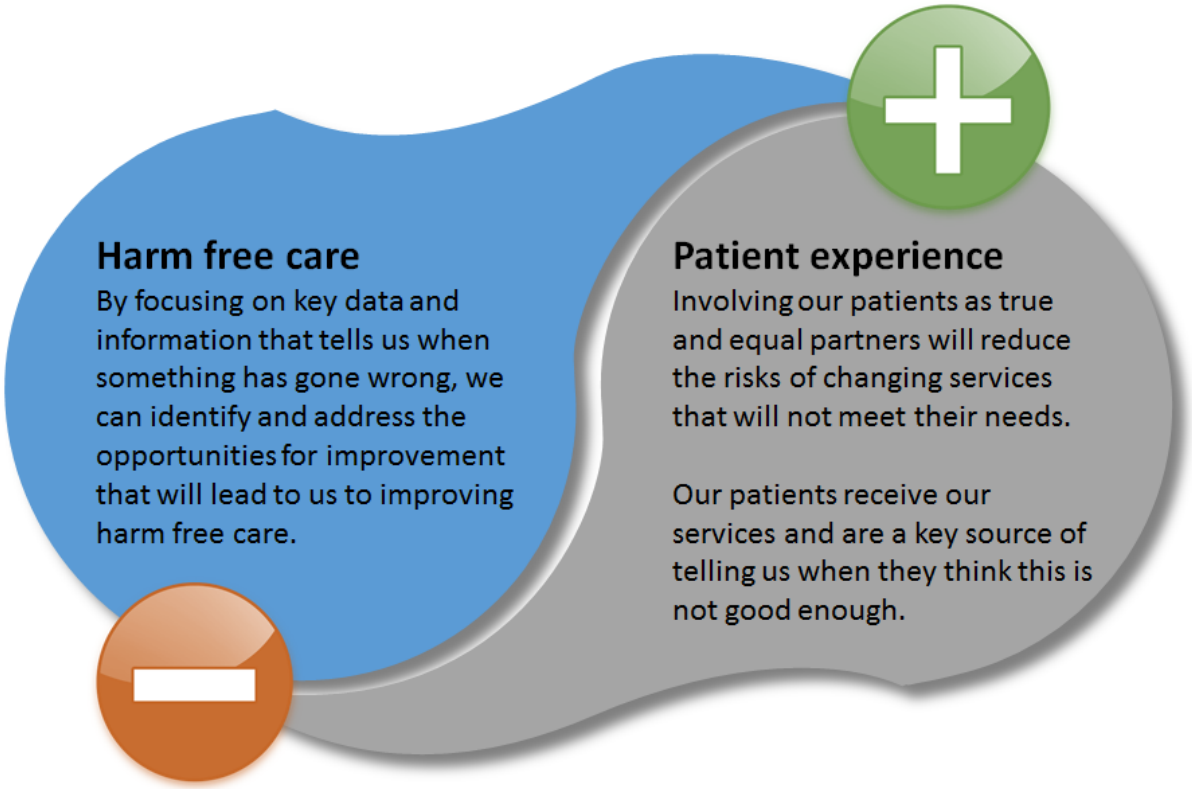
- There will be regular ‘Sharing Events’ for those who have embarked on a CQI programme, together with us developing a central library (knowledge hub) of improvements and sharing across networks such as the FAB Academy, our Quality Improvement Networks and NHS Improvement QSIR Network.

- We will support all CQI improvements with the opportunity to engage with our patients and existing stakeholder networks.

- By focusing our efforts on the patient and their outcome will also help to engage our staff. Everything we do should always contribute to improving our patient’s experience, which is at the centre of our Five-year Strategy.

- Promoting a co-production and co-design way of working on improvements will improve trust and confidence in our service improvements.

Our patients provide a substantive wealth of experience that they can contribute to developing our improvements to achieve our vision. The following diagram outlines that by involving our patients in the improvements we make will ensure that we can reduce harm free care and improve patient experience.



Key actions

- Ensuring patients are key stakeholders as part of our CQI Implementation Plan.
- Embedding a Communication and Engagement Plan that promotes the outcomes of CQI and patient input.
- Patient related data to be considered by all CQI initiatives as part of measuring improvement success.
- Ensuring patient feedback is considered throughout the life-cycle of improvement initiatives.

Element 3: Leadership for CQI

Objective 3: To provide clear leadership for delivering quality improvements.

One of the most important factors in setting out and determining the quality of care in the NHS is leadership. To support our leaders explore and clarify their approach for CQI we will provide a variety of options to identify opportunities, together with supporting them through delivering improvements whilst building skills. We want to demonstrate kind, compassionate and inclusive leadership to drive improvements.

Why is this element important?

The 'Developing People, Improving Care Framework' (NHSI 2017) explores how curiosity, persistence, courageous, humility behaviours will support the creation of an improvement orientated team culture.[6] The report identifies that the impact of such leadership behaviours within a team are that staff feel valued, empowered and feel able to propose service improvement ideas.

There is a need to set out for our leaders the clarity of what CQI can deliver for them. It should be integrated into the local business and performance management frameworks, for identifying opportunities for quick wins and longer-term opportunities for improvement, together with harnessing staff ideas and enthusiasm for improvement.

What is our vision?

We want to support all of our Senior Leaders to go through our QSIR Practitioner Programme and to encourage those who want to become QSIR Associates to deliver the programme. We also want to encourage our leaders to support their staff to bring their improvement ideas to life, which align to the Trust's vision, ambitions and priorities. This will be supported by the 2021 Programme Hub to deliver, and provide a range of CQI approaches to meet their needs.

The improvement initiatives identified will increase learning from the Quality Improvement programmes, but also the experience of delivering an improvement, working with colleagues across organisational boundaries creates a 'one team' approach to problem solving and sharing learning. The proof will be demonstrated through positive staff and patient experience feedback. We will be more transparent in sharing our feedback and celebrating what we have achieved.

[6] NHS Improvement, Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services, December 2016

How will this be achieved?

- We want to support the adoption of our CQI approach to deliver improvements supported by unwavering commitment from our senior leaders, who model appropriate improvement-focused leadership behaviours and a visible hands-on approach to CQI.

- It is vitally important that our leaders embrace and act as role models for improvement, promoting behaviours that support change and improvement.

- There will be an investment in CQI skills for our leaders, from an introduction to our approach through to participating and delivering our Quality Improvement Programmes.

- We want to encourage all of our leaders in the Trust to go through an introductory CQI programme, outlining how it works, and how it could benefit their Teams.

- We want to target our Senior Leadership Forum to become QSIR Practitioners, which is NHS Improvement accredited.

- We will promote the attendees on the QSIR Practitioner Programme to become Associates, where they will be able to deliver the programme.

- We want our leaders to promote their staff attending our in-house introductory programme for Quality Improvement, which requires manager sponsorship and celebrate their learning.

- We want our leaders to promote those who have attended our in-house Quality Improvement Programme to go onto the QSIR Practitioner Programme.

- We will provide wrap around bespoke CQI programmes to target specific improvement areas.

- We will utilise current and new opportunities to engage with our staff at all levels on the importance of their ideas and being supported to deliver them.

- Facilitate the new Divisions to embed this CQI journey into their daily activities so that staff feel confident in suggesting improvement ideas, know the local mechanisms to do this, and to be assured their ideas will be heard, and where feasible acted upon.

- Support leadership behaviours that effectively build organisation-wide commitment to CQI, which is supported by the Developing People, Improving Care Framework.[7]

[7] NHS Improvement, Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services, December 2016

- Supporting a culture of improvement efforts focused on adding patient value, which will demonstrate a good use of resources.

- Supporting leaders to engage and develop true involvement with wider stakeholders and embrace the people who use their services, staff and external partners to be involved in quality improvements and processes of redesigning systems.

- Whilst our CQI approach will support the delivery of our Trust's vision, we will also be developing and supporting specialist skill sets, which will support key areas of Trust improvement for Data Quality and performance, such as measurement for improvement, statistical analysis, interpretation and reporting improvement opportunities through Statistical Process Control (SPC) Charts, which will improve intelligence led improvement.

- The CQI approach will support the TOM through providing organisational development for the Divisions to access CQI Programmes.

- By demonstrating that we have a learning culture that embraces change, we will lift morale, supporting our staff to make the changes that will make a difference to their day jobs, together with raising confidence or larger redesign improvements.

- By demonstrating that the organisation is embracing change and improvement, it will become a more attractive option for future staff, together with being a place that current staff feel proud to be a part of.

- Embracing CQI will help support the freeing up of capacity for Divisions to do more improvements and transformational change, leading to more celebration of success and being recognised as an employer of choice.

- Ensure that CQI is developed as a Leadership Model, and core learning module, together with forming part of our Trust Induction and linked to our Appraisal process.

- We will develop key 'spin off' specialist modules with will include measurement for improvement, together with programme and project management, agile project management, conventional and lean process mapping.

The 'Developing People, Improving Care Framework' (NHSI 2017) is outlined below:

Developing our leaders to champion their staff to make improvements will provide a change in culture, where staff will feel empowered and proud to deliver the changes that they know will make a difference to their patients.

Key actions

- Trust Board Development sessions to take place to equip the Executive Team and the Non-Executives with core CQI skills, which will facilitate them role modelling CQI leadership.
- To ensure that the CQI approach supports the introduction of new reporting documentation for performance, embracing the techniques for 'measurement for improvement'.
- CQI to be established as a core leadership element in the development of our managers and future leaders.
- Divisions to embed CQI into their business plans and through their Performance Review Meetings to identify opportunities for improvement where staff could go through Quality Improvement programmes or be supported to go through programmes to deliver improvements aligned to local priorities.
- Continued emphasis on organisational engagement through the refresh of the 'Staff Suggestion Scheme' to allow staff to submit ideas for improvement and where possible get sponsored to deliver improvements.
- Divisions to embed CQI into their daily activities, which will lead to more confidence in suggesting ideas and embarking on potential team based ideas to be supported to go through CQI training programmes.

Element 4: Building CQI skills at all levels

Objective 4: To demonstrate an accessible approach to providing CQI to every level of the Trust.

There are many methodologies available; however, it is not the choice of the methodology that is important, but the commitment to a coherent, systematic improvement methodology, which is anchored in improvement science. This can then be adapted over time to fit with the organisations business context.

Why is this element important?

The Trust is at the beginning of its journey of embracing CQI. Whilst there has been a history of small-scale implementation of improvement techniques, we have made significant progress through the delivery of our in-house QI programme in 2018 and continuing into 2019.

We will be managing the ideas and requests for improvement and support for attending programmes, or tailoring programmes to individuals team's needs, together with our staff ideas through the 2021 Programme Hub. We will apply a robust programme management approach.

All requests for additional support, outside the set delivery programmes will be collated as part of the CQI Improvement Planning, being registered and graded as part of the Forward Plan each quarter, before being agreed to go into the CQI Implementation Plan, which will be managed and reported to the Trust Management Group.

What is our vision?

A high priority for this CQI Strategy is collaboration with our staff, volunteers and key partners. We want to become a Centre of Excellence with the launch of our QSIR Faculty.

We will be able to demonstrate increasing consistency over time, avoiding duplication and 'reinventing the wheel', learn from excellence across our Trust, improve a 'one team', CQI family approach, which will be coordinated through the 2021 Programme Hub.

How will this be achieved?

- We want to build a model that empowers our leaders and staff to identify opportunities for improvement.

- We want to support our staff at all levels to benefit from having contact with our improvement intentions.

- Deliver training to meet individual and team needs, covering introductory sessions, interactive workshops, specialist programmes and bespoke programmes for clinical and non-clinical employees.

- We want to build quality improvement capacity and capability across the Trust, ensuring that our model is not for the few, but for everyone at every level.

- To celebrate success and promote learning from improvements through key networks such as the FAB Academy.

- To provide expertise in service improvement methods and facilitate improvement activities.

- Develop and maintain a library of improvements together with easy to use tools and techniques available on our website.

- To promote frontline leadership and ownership of improvements through engagement, communication and a project management approach.

- To ensure key stakeholders are engaged with and supported by clear communication on what improvements have been achieved.

- To provide specialist support teams to deliver improvements with teams to aid the spread of new ways of working, which will be monitored and reported on through our performance frameworks.

Our in-house Quality Improvement Programme

- Embedding a rolling delivery programme of cohorts throughout the year, who take an improvement initiative supported by their manager through 3 workshops, supported by coaching to delivery their improvement.

- To promote our leaders to nominate staff for the QI Programme, which will support local improvements, this includes individuals and teams.

- The learning will be shared at scheduled events, and promoted throughout the Trust to celebrate improvements and learning.

- We will design and deliver bespoke programmes in-line with our requests from strategic and business planning, performance planning and reporting together with horizon scanning and adhoc requests.

- Leaders to support individuals who attend to progress to being CQI Ambassadors and continue their development and spread of improvement.

Our in-house programme is set out in the following diagram:

Our Quality Service Improvement and Redesign Faculty

- We are setting up preparations for our QSIR Faculty launch, where we will be able to deliver the NHS Improvement QSIR Practitioner Programme.

- The QSIR Practitioner Programme will be delivered by our Trust QSIR Associates, who will work in collaboration with NHS Improvement and the Academy for Change and Transformation (ACT).

- This programme will be targeted at our senior leaders who can nominate themselves and key team members to take an improvement initiative through the programme, which will provide training and application of trans theoretical tools and techniques.

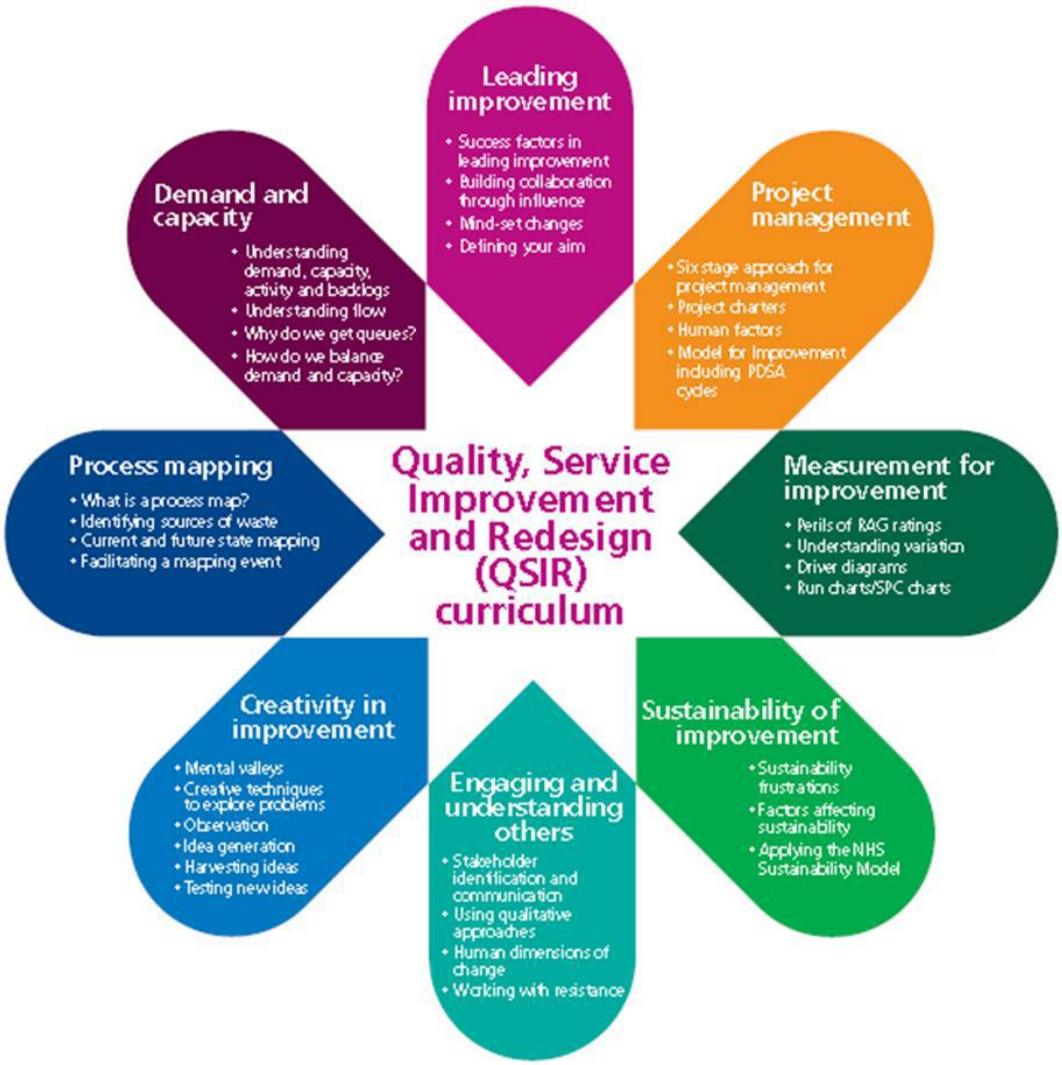
- Individuals who undertake the QSIR Practitioner Programme will be encouraged to deliver our in-house QI programme, together with being supported to graduate to QSIR Associate level, to form part of the QSIR Faculty, and deliver the QSIR Programmes, becoming champions in their own areas and spreading the learning.

- Promote the opportunities for staff and volunteers to get involved and develop expertise across the organisation to sustainably deliver improvements, which will include the NHS Improvement QSIR Practitioner programme and the ACT Associates programme.

- The 2021 Programme Hub will provide the infrastructure to support the delivery of improvements, providing an exchange of information and learning

hub, encouraging flexibility, efficiency and the capture of benefits for clear reporting processes. There will be a focus to grow our skills across the Trust to build continuous confidence to deliver and sustain a culture of improvement.

The NHS Improvement QSIR Practitioner Programme covers the following modules, with the Model for Improvement being at its heart:



Developing our 'dosing model'

The NHS Improvement, Building capacity and capability for improvement: embedding quality improvement skills in NHS providers[8], outlines that a focus of developing people and improving care should be based on experiential learning and the application of the concepts, tools and methods to daily work. Both classroom and virtual learning. It also outlines the 'dosing' approach to embedding quality improvement skills, first developed by Dr Robert Lloyd, derived from the principles

[8] NHS Improvement, Building capacity and capability for improvement: embedding quality improvement skills in NHS providers, Institute for Healthcare Improvement

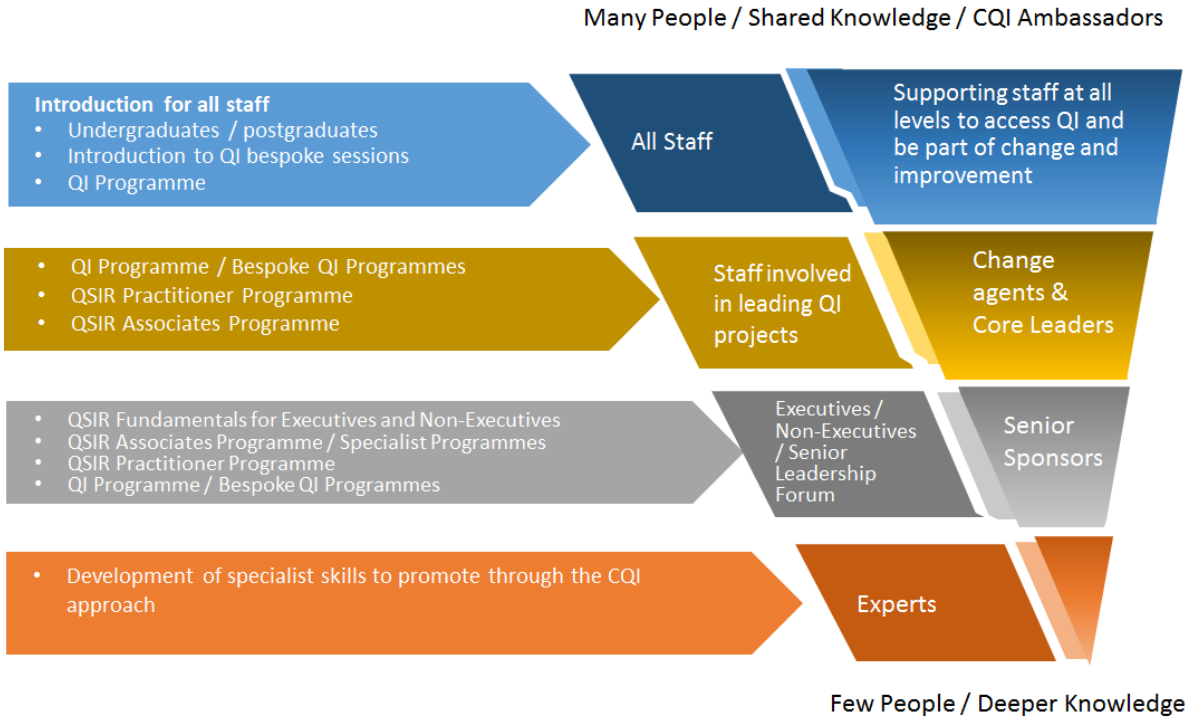
used to establish the appropriate dose of a medicine. The approach helps us outline the scale of training and development required to embed quality improvement into the fabric of the organisation.

- We want to identify and harness specialist skills to take part in and graduate through the available programmes for quality improvement.

- We want to build the professionalism around improvement science through developing our staff at all levels to undertaken our quality improvement programmes, but also to promote recognised practitioners in clinical services and corporate services across the Trust.

- We want to recognise the investment that individuals and teams make to undertaking improvement activities supported by our quality improvement programmes, this will be reflected in the following model:

The following diagram outlines our 'dosing model':



Key actions

- Promote QI and QSIR programmes and delivery schedules.
- Develop a CQI brochure to promote the choices of access.
- Develop a CQI Knowledge Hub and promote access for learning.
- Communicate and promote the training and support offer.
- Develop and promote as a tool for Appraisals and identification of CQI Ambassadors.
- Promote coaching skills for CQI.

Element 5: Building CQI engagement all levels

Objective 5: We want to be more inclusive in our approaches, ensuring everyone has a voice in making improvements, which will be supported by the introduction of CQI Ambassadors.

We want to be an organisation that is recognised for being confident and inclusive in the delivery of quality improvement activities and applying improvement tools and techniques into day-to-day working.

Why is this important?

CQI puts our patients at the heart of our thinking and improving processes, efficiency and effectiveness of the delivery of our services, achieved through a more collaborative engagement, involvement and empowerment of our staff to develop new and innovative ways of working.

We will engage with all levels of the organisation and key stakeholders to raise awareness of the CQI Strategy and the benefits to improved patient care. We are striving for individuals and teams to take part and to seek assistance from the planned and bespoke quality improvement programmes. We will work together to harness our expertise to enable greater awareness across the Trust and provide opportunities to share information and transfer skills. We will develop our CQI Ambassadors to help promote and lead improvement awareness across all corners of the Trust.

We will build upon our existing good practices, providing an opportunity to network our existing skills and expertise, together with working with external specialists to shape our improvement profile to maximise learning, sharing of learning and celebrating our successes through our new CQI Knowledge Hub which will link to our CQI networks.

What is our vision?

- We want to be recognised as an organisation that is confident and successful in delivering quality improvement activities and applying improvement tools and techniques into day-to-day working, which will improve our patient care.

- We want to ensure that all of our staff recognise the quality improvement opportunities that are available to them and have multiple access choices to gain knowledge, insight and opportunities for getting involved with and supported by quality improvement programmes.

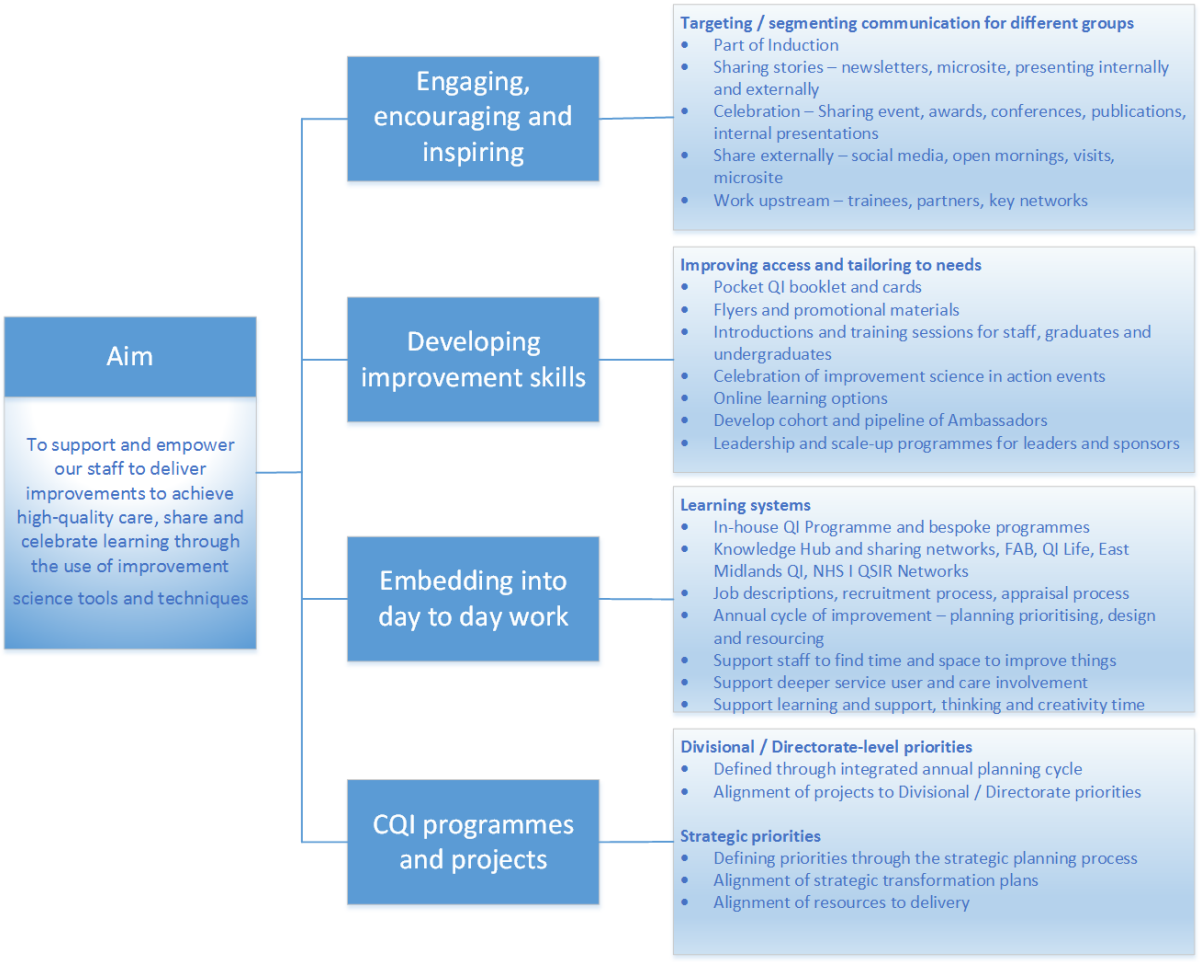
- We will be sharing our learning through the development of our CQI Knowledge Hub, together with ensuring that we promote and link with existing networks such as our FAB Ambassadors and the FAB Academy.

- There will be programme materials and a supporting toolkits provided on the Intranet.

- We want to encourage individuals and teams to deliver an improvement initiative, supported by our quality improvement programmes.

- We want to create a sustainable approach to quality improvement through empowering all of our staff to take part in and/or be part of owning and delivering improvement initiatives.

- We want to have a renewable CQI infrastructure, not just one-off training sessions; we want to build capacity and capability, building energy and enthusiasm for continually improving the way we do things. To help with this we will develop our Engagement and Inclusion Plan, which will promote all the opportunities for getting involved, the following diagram provides a high level outline of this:



- We want to encourage and recognise the investment of time and commitment to improvement by developing CQI Ambassadors. The development levels for the Ambassadors are:

    - **Bronze QI Practitioner:**
      This level will be awarded to those individuals who have undertaken an improvement activity through our in-house Quality Improvement Programme. There will be opportunities for these individuals to graduate up to the Silver QSIR Practitioner level, together with having the opportunity to be part of the delivery of future in-house programmes.

    - **Silver QSIR Practitioner:**
      This level will be awarded to those individuals who have undertaken an improvement activity through the QSIR Practitioner Programme. There will be opportunities for these individuals to graduate up to the Gold QSIR Associate level, together with having the opportunity to be part of the delivery of future in-house programmes and bespoke programmes.

    - **Gold QSIR Associate:**
      This level will be awarded to those individuals who have successfully completed the QSIR Practitioner Programme, together with undertaking the ACT Academy examinations to become part of the QSIR Faculty. As part of the Faculty and to maintain accreditation by NHS Improvement, there will be a requirement to be part of the delivery of the Trust's QSIR Practitioner Programme, together with opportunities to be part of the QSIR Network and deliver the programme across wider NHS health and care system partnership. These individuals will also have an opportunity to deliver future in-house programmes and bespoke programmes.

    - **Platinum QSIR Associate Specialist:**
      This level will be awarded to those individuals who have successfully completed the Gold QSIR Associate level, and can demonstrate that they have developed and delivered specialist improvement modules for the Trust. There will be opportunities to deliver across all the in-house and QSIR Practitioner Programmes, together with providing specialist development of their spin off improvement modules.

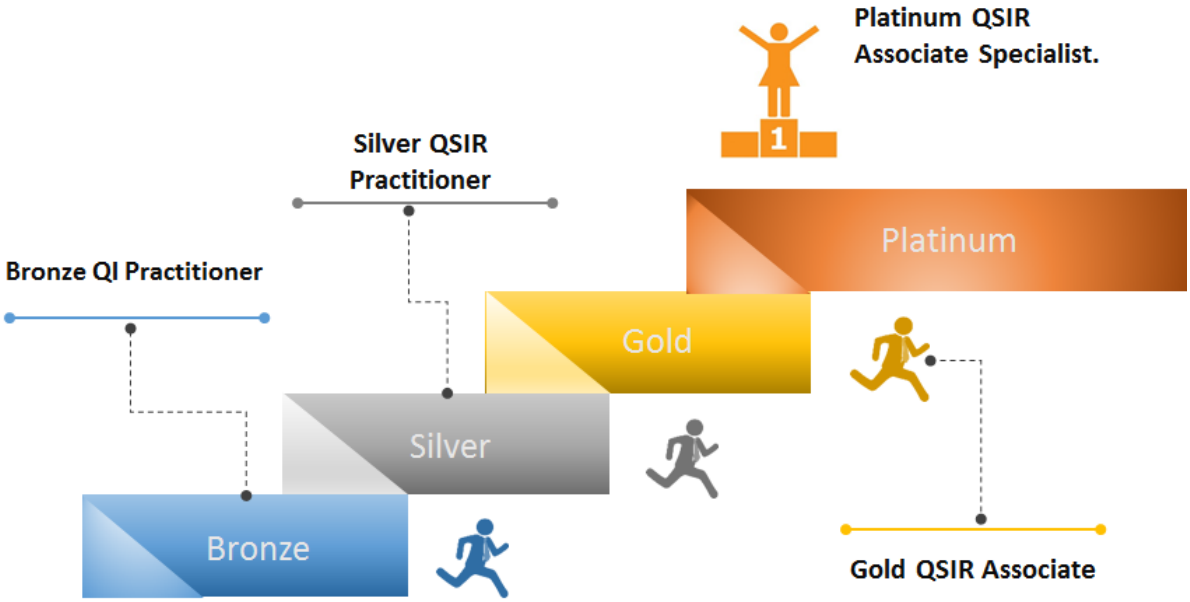
- We will be celebrating the graduation through these levels as part of the Sharing Events after each cohort of the quality improvement programmes.

- We want to build these levels into the recognition mechanisms of the Trust.

- We want to encourage the identification of individuals to progress through the CQI Ambassador levels through staff appraisals.

- We also want to support the wider NHS Improvement Network and provide support to our wider system health and care partners to deliver the QSIR Programme.

The following diagram outlines the CQI Ambassador levels.



Key actions

- Develop our Engagement and Inclusion Plan.
- Develop a detailed guide and recognition requirements for the CQI Ambassador Levels.
- Develop a knowledge Hub to share information linking to existing networks such as the FAB Academy.
- Develop a suite of materials for training delivery and supporting tools and techniques.
- Develop CQI facilitation skills.

Element 6: System view for CQI

Objective 6: Working as one team to deliver improvements that we can share and celebrate.

True improvement comes when CQI is anchored in an understanding of how systems work. It will be maximised where staff and leaders work together to align the component parts of the system, to achieve high-quality patient care across end-to-end system.

Why is this element important?

Many of the current challenges in a complex organisation are relating the relationships between multiple parts and streamlining links through working together. Our approach to CQI methods will ensure that we can help leaders and teams lead systematic improvement. We will be moving beyond organisational and functional boundaries and traditional hierarchies, which requires systems thinking.

Clarity on the purpose of CQI focuses our improvement activities on delivering high-quality patient care, which will contribute to improving our patient experience and journey.

What is our vision?

- We want to ensure that as we embed our CQI approach in the Trust, that we can develop individual and teams experiences, which will build confidence in tackling really difficult and 'wicked' problems, which will include working across teams, functions, and specialities, wider into our health and care systems.

- We want to link our approach through our Improvement Programmes with the wider Sustainability Transformation Planning partners, where we can develop true collaborative working across systems.

- We want to build on our current collaborations to offer our training to partners across the system, widening to honorary CQI Ambassadors.

- As our approach matures, we will be able to demonstrate our adaptability, experimental and opportunistic ways of tackling problems together, where CQI becomes the 'ways things are done around here'.

- In the Beyond Barriers[9] report, it identified that local and national leaders need to work together to share approaches.

- We want to support the TOM through the change in leadership roles, from the new ways of working devolved decision-making, which will enable improvements to be aligned to local priorities, with leaders being able to apply systematic rigour to unblock constraints and boundaries which hold back their service areas potential.

- The use of improvement science to deliver a systematic approach to provide rigorous evaluation and sharing of learning across the organisation and wider into our health system, will lead to new and innovative ways of working, which will increase the enthusiasm that this is a an attractive learning organisation.

- We need to support and encourage our leaders to have a shift in thinking, a shift in approach, and a perspective on where the value lies, beyond traditional boundaries for collaboratively working on improvement initiatives.

Building collaborations and networks

- We will be continuing to develop collaborations and networks to build our CQI expertise. We will develop specialist modules and additional specialist skills in specific tools and techniques that can be utilised to enhance continuous improvement programmes.

- We want to ensure that we encourage the generation of ideas that will be funnelled through the 2021 Programme Hub to grade and populate the Forward Plan.

Key actions

- Ensure that the ideas for improvement are generated throughout the organisation are harnessed, funnelled and graded through the 2021 Programme Hub.
- Identified partnership working improvement programmes.
- Identify collaborative opportunities with key local partners.

[9] CQC, Beyond barriers: how older people move between health and care in England, July 2018

8. Measuring Progress and Benefits

Implementing this CQI Strategy, represents a significant opportunity for change together with supporting our staff, volunteers, patients and key stakeholders to not just be a part of the changes that matter to them, but to own and steer them. The ultimate goal is to improve our patient care.

Measuring our success

We have made a significant start on our journey, which will be more of an adventure when we all have a story to tell how we have brought this strategy alive.

Our success will be measured by all the improvements that we make, not just the numbers of people being trained or introduced to the tools and techniques. We will ensure that we can collate the benefits from everyone who undertakes an improvement activity, to enable us to include it in our CQI Knowledge Hub and play back all the improvements we have made, provide a hub of learning to be shared.

- We will monitor the feedback from individuals to ensure that we are providing what benefits them.
- We will be able to demonstrate our improvement activities through our strategic and annual plans.
- We will be able to identify our improvement opportunities from our approach to implementing the new performance framework and use of SPC charts to identify variation and process redesign opportunities.
- We will be able to identify opportunities for improvement from core quality metrics, such as our Datix reporting and our patient feedback data.
- We will promote our learning across the organisation and link to key quality improvement networks.
- We will be monitoring the impact of embedding our CQI Strategy through staff and patient surveys.

We will be providing regular updates on the progress of delivery of this Strategy and the supporting actions to demonstrate that we are achieving improved patient care through our Governance mechanisms. There will be dashboards made available on the Intranet and through our performance meetings, together with celebrations of the successes promoted throughout the Trust and with our patients and key stakeholders.

9. Reviewing Progress

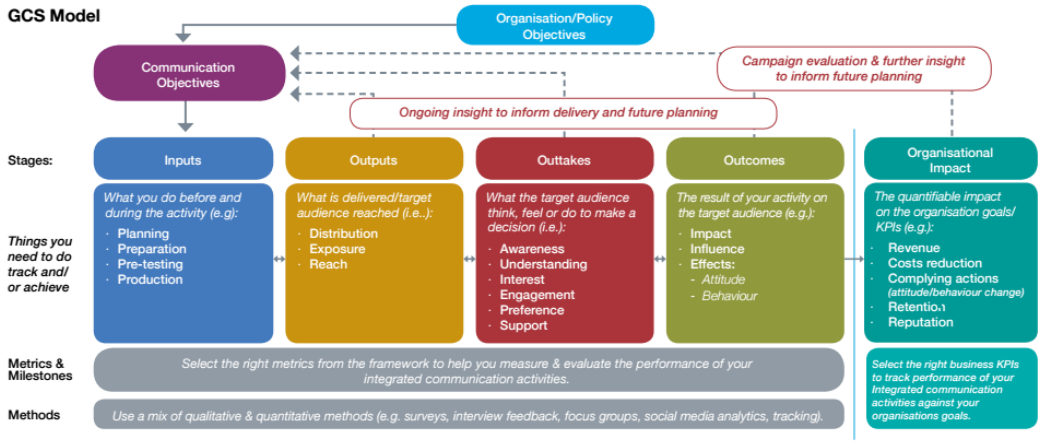
This Strategy will be managed, monitored and refreshed each year to ensure that we remain focused on our strategic priorities and making adjustment as we mature in our quality improvement approaches.

Communication and engagement

Together with reporting on the benefits realised through the delivery of this Strategy, we will continually review feedback of the programme and from our Inclusion Plan. We will see a continual improvement approach to this Strategy, looking to ensure that everyone has an opportunity to challenge and check that what we said we would do is happening and change the things that are not working, together with building in opportunities for our CQI Ambassadors to take ownership of the future direction of this Strategy.

All of this feedback and progress against our Delivery Plan will be reported through our governance mechanisms with regular updates to the Performance Review Meetings, Trust Management Group, Committees and the Trust Board. We will also provide regular updates to the ACT Academy and the NHS Improvement QSIR Network, together with promoting learning through our FAB Academy.

Evaluation of our communication and engagement is essential to assess what has worked and what was achieved to ensure resources have been focused in the appropriate areas. An evaluation dashboard will be developed based on the Government Communications Service Evaluation Framework.[10]



[10] Government Communications Service, 2016

10. Assessing our Maturity

An early priority in our CQI Strategy implementation will be to adopt a CQI maturity model aligned to our self-assessment with the CQC.

Continuous self-assessment

We have adapted the CQC, Quality Improvement maturity model, where we have been conducting a continuous self-assessment as part of our maturity monitoring. This forms part of the Well-led criteria for our CQC assessments, and through our engagement and monitoring.

- We will ensure that we can demonstrate our evidence of maturity against this criteria.

- We will be able to demonstrate improving maturity through our CQI Ambassadors and delivery of our programmes and monitoring of benefits, but more importantly, the biggest test of maturity will be through our staff and patient feedback.

- We will be able to demonstrate that we are an organisation participating in the QSIR College programme, which uses an organisational / system approach to building improvement capacity and capability. As accredited QSIR College graduates, we will be committed to undertake delivery of the five-day / 8-module QSIR Practitioner programme to a minimum of five cohorts. This can be delivered across our QSIR networks. The ACT Academy will provide workbooks and other materials to support our local QSIR programme delivery.

- Delivery of the five-day / 8-module QSIR programme to a minimum of five cohorts is expected to be undertaken within the period May 2019 to November 2020. In addition, we are planning to undertake the QSIR Fundamentals 1-day programme.

- We will need to present our delivery plans and evidence of delivery to the ACT Academy Award Board as demonstration of our continuing accreditation.

11. Aligning to our Key Enabling Strategies

We will ensure that we align to, and complement our Trust key enabling strategies. This will be important to deliver our ambitions.

Our enabling strategies

The following outlines the CQI Strategy alignment to our Five-year Strategy's key enabling strategies:

- **Quality Strategy:** This strategy sets out the intention to strive towards a quality and safety culture supported by quality improvements and the support of our CQI approach.

- **Inclusion Strategy**: this strategy sets out our intention to improve patient care and standards by addressing equality and diversity. Our CQI Strategy outlines that we want to be inclusive in our application of CQI across the Trust.

- **Clinical Strategy:** There will be opportunities to align our CQI approach to our clinical redesign programmes and projects.

- **People Strategy:** The approach to quality improvement will support our People Strategy and development of our Leadership Programme.

- **Finance Strategy:** There are many benefits to be realised through the application of CQI, which will generate more efficient and effective ways of working.

- **Digital Care Strategy:** There will be opportunities to apply CQI to the implementation of digital projects, together with providing opportunities for new and emerging digital improvements to be identified through our CQI approaches.

- **Estates Strategy:** The CQI approach will support the delivery of the Estates Improvement Programme through being applied to the projects.

- **Research Strategy:** There are opportunities to apply CQI through our research projects.

The application of CQI throughout the organisation will generate wider opportunities for learning and sharing learning.

Appendix 1: CQI Strategy Delivery Plan

Element 1: Strategic Intent for CQI					
Objective 1: Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.					
Ref	**Key Actions**	**Detailed actions**	**SRO**	**Responsible**	**Target Date**
1.1	Embedding our CQI Strategy through integrated strategic and business planning.	• Align to the business planning cycle • Include CQI in the Planning documentation for TOM • Include CQI in the Annual Operating Plan	Martin Rayson	Karen Sleigh	Mar 20
1.2	Programme managing the development and delivery of our CQI Implementation Plan.	• Outline Programme Plan • Benefits realisation plan	Martin Rayson	Karen Sleigh	Apr 19
1.3	Embedding performance reporting on the delivery of the identified improvements to demonstrate delivery of our Trust's vision and ambitions.	• Performance measures identified for the performance framework. • Performance manage delivery of improvements aligned to benefits realisation	Martin Rayson	Karen Sleigh	Apr 20
1.4	Celebrating success and share learning.	• QSIR Faculty • Sharing Events • ULHT Media celebrations • Communications Plan	Martin Rayson	Karen Sleigh	Apr 20

Element 2: Patients at the heart of delivering CQI					
Objective 2: Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.					
Ref	**Key Actions**	**Detailed actions**	**SRO**	**Responsible**	**Target Date**
2.1	Ensuring patients are key stakeholders as part of our	• Stakeholder Analysis	Karen Sleigh	Maria Wilde	Apr 20

	CQI Implementation Plan.	• Improvement initiatives			
2.2	Embedding a Communication and Engagement Plan that promotes the outcomes of CQI and patient input.	• Communications Plan • Promoting lessons learned	Martin Rayson	Karen Sleigh	Jun19
2.3	Patient related data to be considered by all CQI initiatives as part of measuring improvement success.	• Patients data reporting • Application of data analytics / measurement for improvement	Karen Sleigh	Maria Wilde / Jennie Negus	Dec 19
2.4	Ensuring patient feedback is considered throughout the life-cycle of improvement initiatives.	• Data analytics for patient safety • Improvement initiatives performance measures	Karen Sleigh	Maria Wilde / Jennie Negus	Dec 19

Element 3: Leadership for CQI					
Objective 3: Delivering CQI by unwavering commitment from senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.					
Ref	**Key Actions**	**Detailed actions**	**SRO**	**Responsible**	**Target Date**
3.1	Trust Board Development sessions to take place to equip the Executive Team and the Non-Executives with core CQI skills, which will facilitate them role modelling CQI leadership.	• QI sessions • NHS I QSIR session for Executives	Martin Rayson	Karen Sleigh	Apr 20
3.2	To ensure that the CQI approach supports the introduction of new reporting documentation for performance, embracing the techniques for 'measurement for improvement'.	• Intelligence led approach to data through CQI projects – utilising SPC • Measurement for improvement spin off modules – support the application of specialist approaches to measurement – linking to Leadership modules	Karen Sleigh	Maria Wilde / Sabrina Vinter / Sharon Hurrell	Apr 20
3.3	CQI to be established as a core leadership element in the development of our managers and future leaders.	• QI Leadership module development • Core learning module development	Karen Sleigh	Maria Wilde / Sharon Hurrell	Apr 20
3.4	Divisions to embed CQI into their business plans and through their Performance Review Meetings to identify opportunities for improvement where staff could go	• Part of business planning • Supporting the identification of new and emerging issues	Karen Sleigh	Maria Wilde	Apr 20

	through Quality Improvement programmes or be supported to go through programmes to deliver improvements aligned to local priorities.	• Advice and guidance on the application of QI approaches			
3.5	Continued emphasis on organisational engagement through the refresh of the 'staff suggestion scheme' to allow staff to submit ideas for improvement and where possible get sponsored to deliver improvements.	• Refresh the Staff Suggestion Scheme • Relaunch the Staff Suggestion Scheme • Monitor and review impact and alignment to the CQI initiatives	Karen Sleigh	Maria Wilde / Sabrina Vinter / Sharon Hurrelll	Apr 20
3.7	Divisions to embed CQI into their daily activities, which will lead to more confidence in suggesting ideas and embarking on potential team based ideas to be supported to go through CQI training programmes.	• Divisional and corporate awareness sessions • Divisional and corporate training sessions	Karen Sleigh	Maria Wilde	Apr 20

Element 4: Building CQI skills at all levels					
Objective 4: Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning.					
Ref	**Key Actions**	**Detailed actions**	**SRO**	**Responsible**	**Target Date**
4.1	Promote QI and QSIR programmes and delivery schedules.	• Communication Plan • Marketing pack • Attendees and efficacy of delivery • Reaccreditation of QSIR Associates	Karen Sleigh	Maria Wilde / Sabrina Vinter / Sharon Hurrell	Nov 20
4.2	Develop a CQI brochure to promote choice and access.	• Outline brochure – the programmes offer • Supporting communications materials to be developed as part of the Communications Plan	Karen Sleigh	Maria Wilde / Sabrina Vinter / Sharon Hurrell	Dec 19
4.3	Develop a CQI Knowledge Hub to promote and share	• Design micro site	Karen Sleigh	Maria Wilde /	Dec 19

	learning.	• Outline materials • Include in Communications Plan		Sabrina Vinter / Sharon Hurrell	
4.4	Communicate and promote the training and support offer.	• Training schedules • Communications Plan • Bespoke programmes and spin off modules such as: Agile, Process Mapping (Conventional and Lean)	Karen Sleigh	Maria Wilde / Sabrina Vinter / Sharon Hurrell	Dec 19
4.5	Develop and promote as a tool for Appraisals and identification of CQI Ambassadors.	• Development / leadership plan	Karen Sleigh	Maria Wilde / Sabrina Vinter/ Sharon Hurrell	Mar 20
4.6	Promote coaching skills for CQI.	• Methodology – Grow • Schedules	Karen Sleigh	Sharon Hurrell	May 19

Element 5: Building CQI engagement at all levels

Objective 5: Building a culture of QI at all levels, which is modelled by our leaders empowering staff at all levels to engage with and become problem solvers.

Ref	Actions	Detailed actions	SRO	Responsible	Target Date
5.1	Develop our Engagement and Inclusion Plan.	• Inclusion Plan	Karen Sleigh	Maria Wilde	Jun 19
5.2	Develop a detailed guide and recognition requirements for the CQI Ambassador Levels.	• Levels methodology • Promotion and recognition materials • Supporting products	Karen Sleigh	Maria Wilde / Sabrina Vinter	Apr 20
5.3	Develop a knowledge Hub to share information linking to existing networks such as the FAB Academy.	• Alignment of the Knowledge Hub with the FAB Academy utilising InPhase • Case studies bank and sharing through the Communication Plan	Karen Sleigh	Maria Wilde / Sabrina Vinter / Jennie Negus	Dec 19

5.4	Develop a suite of materials for training delivery and supporting tools and techniques.	• Training tools pack • Access to the Intranet • Alignment to collaborative sites – NHS Improvement QSIR tools • Bespoke and expertise tools – spin off modules	Karen Sleigh	Maria Wilde / Louise Hobson / Steph Dockerty	Apr 20
5.5	Develop CQI Facilitator training.	• Training pack for facilitators • Delivery schedule for facilitators • NHS I Facilitator training	Karen Sleigh	Maria Wilde	Apr 20

Element 6: System view for CQI

Objective 6: Applying systems thinking which results in improvement beyond organisational or functional boundaries.

Ref	Actions	Detailed actions	SRO	Responsible	Target Date
6.1	Ensure that the ideas for improvement are generated throughout the organisation are harnessed, funnelled and graded through the 2021 Programme Hub.	• Programme pipeline	Karen Sleigh	Maria Wilde	Apr 20
6.2	Identified partnership working improvement programmes	• Work with partners to deliver and share the in-house QI programme • Invite partners onto the QSIR Practitioner Programme	Karen Sleigh	Maria Wilde	Apr 20
6.3	Identify collaborative opportunities with key local partners.	• Support the University of Lincoln undergraduates improvement projects • Provide specialist improvement science insight modules for undergraduates and post graduates	Karen Sleigh	Maria Wilde	Apr 20

NHS
United Lincolnshire Hospitals
NHS Trust

Continuous Quality Improvement Strategy and Delivery Plan: Executive Summary

This Continuous Quality Improvement (CQI) Strategy aims to set out our intended journey to embrace and embed quality improvement as part of delivering our 2021 Strategy and beyond.

At ULHT, we want to ensure that everyone who works at the Trust is encouraged to strive for excellence in all that they do, by working together to deliver high quality patient care. We have made a great start on introducing quality improvement, we now want to ensure a clearly understood and recognised joined up and consistent methodology. We will achieve this by building both individual, team and therefore our organisational capacity and capability, through a systematic approach to using improvement science tools and techniques, which we will term our Continuous Quality Improvement (CQI) approach.

Quality improvement is one of our strategic priorities within Our People ambition. To complement the delivery of our ambitions are our values, underpinned by our Staff Charter that sets out the expected behaviours from each other. These values will be embedded throughout our CQI approach:

- Patient-centred
- Safety
- Compassionate
- Respect
- Excellent

The aim of this strategy is:

> "To support and empower our staff to deliver improvements to achieve high-quality care, share and celebrate learning through the use of improvement science tools and techniques."

The objectives for this Strategy have been shaped around the key elements of success from the national best practice, identified in the CQC[1] Report, together with building on our learning and the learning from NHS Improvement Quality, Service Improvement and Redesign approach across the system, which are outlined in the following diagram:

[1] CQC Report on Quality Improvement in Trusts. Sharing Learning from trusts on a journey of QI September 2018

Our Continuous Quality Improvement Strategy

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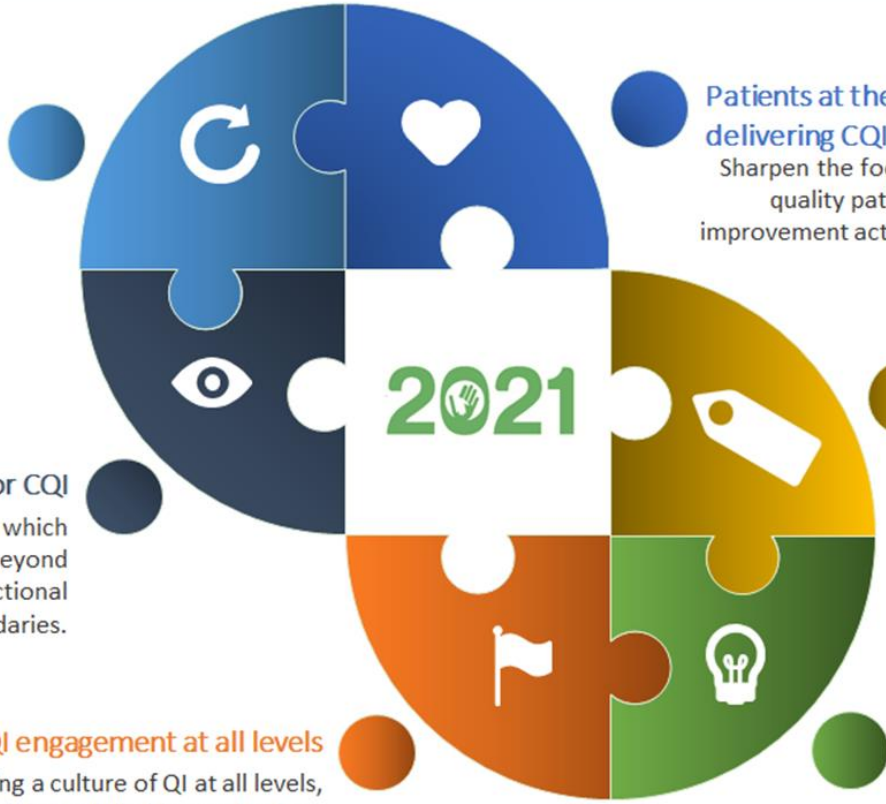
We have aligned the development of our Continuous Quality Improvement Strategy with our longer term strategic and business planning processes. Our CQI Strategy will help demonstrate that we are a learning organisation, being innovative and embracing change at all levels to achieve the 2021 vision and ambitions. The aim of this strategy is: **"To support and empower our staff to deliver improvements to achieve high-quality care, share and celebrate learning through the use of improvement science tools and techniques."**
We have set the following objectives to support the delivery of each of our elements:



Strategic Intent for CQI

Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.

Patients at the heart of delivering CQI

Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.

Leadership for CQI

Delivery of CQI by unwavering commitment from senior leaders, who model appropriate improvement focused leadership behaviours and visible hands-on approach.

System view for CQI

Applying systems thinking, which results in improvement beyond organisational or functional boundaries.

Building CQI engagement at all levels

Building a culture of QI at all levels, which is modelled by our leaders, empowering staff at all levels to engage with and become problem solvers.

Building CQI skills at all levels

Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning.

The 6 elements and our objectives of our CQI Strategy are:

1. **Strategic intent for CQI:** Supporting leaders explore and identify CQI opportunities linked to strategic and annual planning.

    - This will enable us to demonstrate that our CQI approach supports the delivery of our programmes, projects and initiatives through our business planning and alignment to our strategic vision and ambitions.

2. **Patients at the heart of delivering CQI:** Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience.

    - This will enable us to demonstrate that we have a patient focused co-design approach to improving our services to our patients, through the inclusion of our patients or patient data where ever we are doing an improvement piece of work.

3. **Leadership for CQI:** Delivering CQI by unwavering commitment from senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.

    - We will be able to support all of our leaders to be part of our QSIR Practitioner Programme and to support their staff to be part of either the QSIR Practitioner Programme or our in-house QI Programme to deliver a new or existing improvement. We would want to promote the opportunity for our leaders to become future accredited QSIR Associates once they have done the QSIR Practitioner Programme to promote QSIR in their areas and be part of a wider NHS Improvement and ACT Academy network.

4. **Building CQI skills at all levels:** Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning.

    - We will be able to support individuals through a range of opportunities to develop their CQI skills through the practical application of tools and techniques to new and existing programmes, projects and initiatives, utilising a 'dosing' model approach to provide the most appropriate level of support.

5. **Building CQI engagement at all levels:** Building a culture of QI at all levels, which is modelled by our leaders empowering staff at all levels to engage with and become problem solvers.

    - We will be striving for:

        - Engaging, encouraging and inspiring our staff
        - Developing improvement skills
        - Embedding improvement into a day to day activities
        - All of our programmes and projects are supported through the QI and QSIR Practitioner Programmes

6. **System view for CQI:** Applying systems thinking which results in improvement beyond organisational or functional boundaries.

    - We will be able to demonstrate that we have a systems approach to our improvements, cutting across boundaries and improving system changes within our services and with our health and care partners.

Key Success Factors

The key success factors of this approach will be to:

- Provide the Trust with a systematic and recognised approach to quality improvement through the application of science for improvement tools and techniques, which will support our 2021 vision, ambitions and objectives to be delivered through our business planning processes.

- Support all the existing and planned programmes, projects and initiatives in the Trust, by ensuring that individuals and teams go through either the in-house Quality Improvement Programme, or the QSIR Programme whilst they are delivering or preparing to deliver their piece of work.

- Ensure that the current 2021 Improvement Programmes, the Financial Efficiency Programmes (FEP) and improvements identified within our key enabling strategies to deliver our Trust's vision go through the QSIR Programme.

- Provide opportunities for individuals at all levels to be able to be supported to achieve an improvement and be developed to be Ambassadors.

- To grow our own expertise in improvements, which will include the training through the supportive in-house QI Programme and the NHS Improvement accredited QSIR Practitioner Programme, where we will be developing Associates to be able to deliver the future Programmes, being champions in their areas and developing their expertise further to build sustainability across the Trust.

- To ensure that the CQI Strategy supports all of our training and developing staff to deliver the improvements, which will include medical, nursing graduate and undergraduates.

Embedding CQI is not just delivering programmes of training, it is a way of working, and can be measured through many traditional performance frameworks. A key indicator of success will be from measuring improving patient experience and staff satisfaction surveys. The focus will be on the delivery of programmes with individuals and teams to support and guide, build skills and capability to deliver improvements.

This approach will build confidence in generating ideas for improvement, together with fostering a more collaborative approach to involving our staff, patients, carers and key stakeholders in delivering the improvements.

We will ensure that we align to, and complement our Trust key enabling strategies.

Achieving our Trust's vision through our Continuous Quality Improvement Strategy

NHS
United Lincolnshire Hospitals
NHS Trust

Our Five-year Strategy

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.

Our Ambitions:

- Our Patients
- Our Services
- Our People
- Our System / Partners

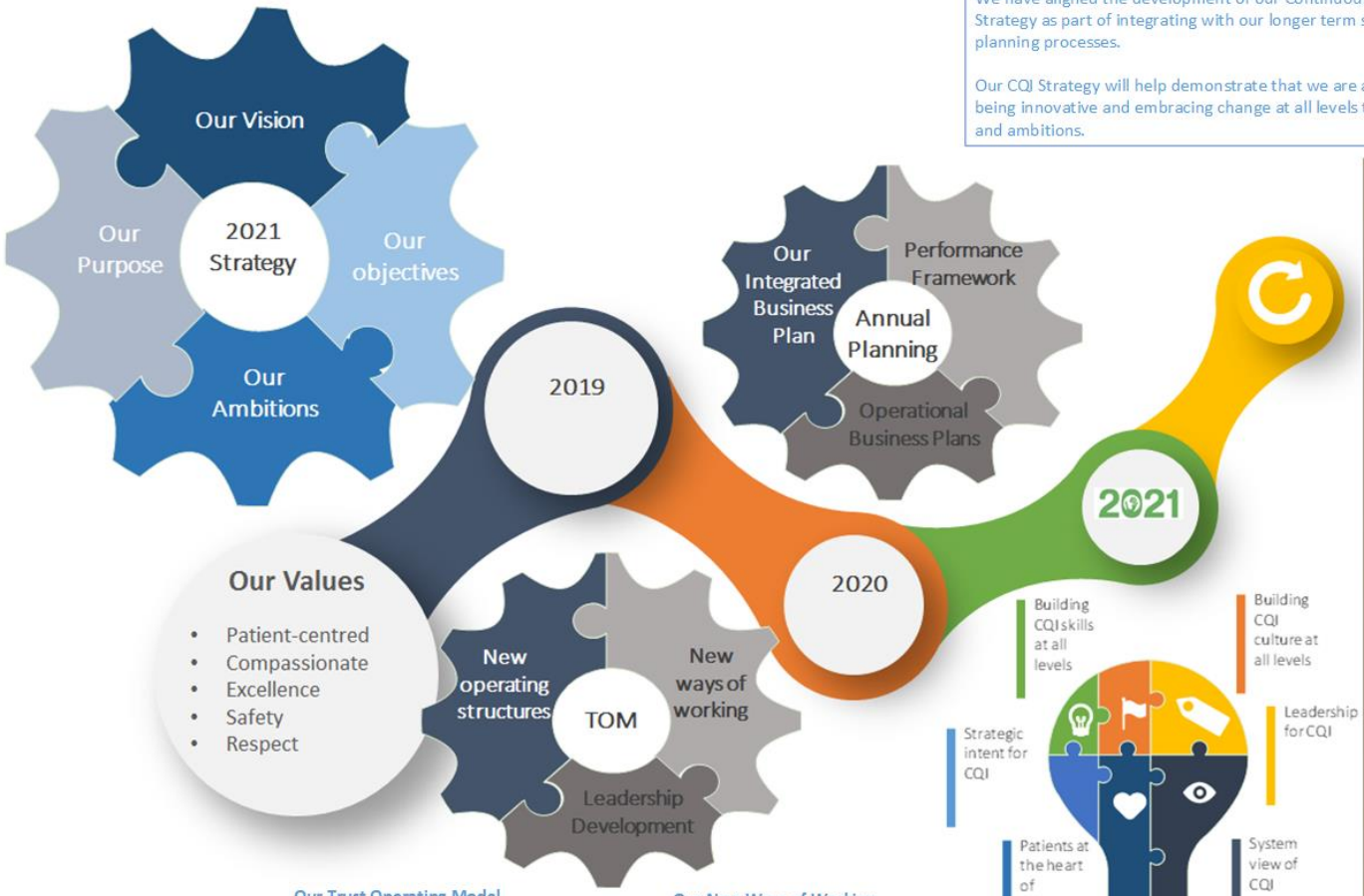
Our Objectives:

- Harm free care
- Valuing patients time
- Zero waiting
- Sustainable services
- Modern and progressive workforce
- One Team
- Service Integration

Developing our Continuous Quality Improvement Strategy:

We have aligned the development of our Continuous Quality Improvement Strategy as part of integrating with our longer term strategic and business planning processes.

Our CQI Strategy will help demonstrate that we are a learning organisation, being innovative and embracing change at all levels to achieve the 2021 vision and ambitions.



Our Trust Operating Model

- Consists of 4 Divisions
- 13 Clinical Business Units
- 40 Clinical Services

Our New Ways of Working

- Governance Guide
- Meetings overview
- Devolution Policy
- Performance Framework
- Organisational Development Plan
- Corporate Offers

Our Key Enabling Strategies

Quality Strategy
To create a culture of safety through quality improvements

Clinical Strategy
To lead the development of integrated care

People Strategy
To respond to changing needs and service models

Inclusion Strategy
To support the delivery of improved standards through equality and inclusion

Financial Strategy
To achieve sustainable financial position

Digital Care Strategy
To facilitate care through technology

Estates & Environment Strategy
To secure a sustainable estates plan across all sites

Research Strategy
To make the most of research for continuous improvement

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Deputy CEO
Date:	2 July 2019
Healthcare standard	

Title:	System Wide Sharing of Information for the Purpose of Providing Direct Patient Care

Author/Responsible Director: Kevin Turner, Deputy Chief Executive

Purpose of the Report:

The purpose of this report is to share with the Trust Board a critical piece of work which has been undertaken on behalf of the Lincolnshire NHS senior system leaders from across all commissioning and provider organisations.

The STP Information Management & Technology Enabling Group (IMTEG) has developed a legally compliant protocol to enable system wide sharing of information for the purpose of providing improved direct patient care.

This paper requests the Trust Board to:

1. Review its contents.
2. Seeks Trust Board approval and commitment to roll out and embed this new way of working within the organisation.
3. If the Trust Board feels unable to approve, please provide specific details as to why so that they can be addressed.

The Report is provided to Trust Board for:

Decision	X	Discussion	X
Assurance		Information	

Summary/Key Points:

The STP IMTEG at the request of System Executive Directors across the 7 organisations have developed a system data sharing protocol. It was developed by our local Information Governance experts and has had external

legal scrutiny to ensure it is fit for purpose and meets legislation requirements in order that we can radically improve data sharing across the Lincolnshire STP system. It has been developed and supported by Caldicott Guardians across the system and has Lincolnshire Medical Council support.

At present sharing data processes vary, with many inconsistencies and a culture bias towards a reluctance to share. This protocol provides legal clarity on the matter to support behavioural change and will enable clinicians significantly improved access to patients records in a timely manner in order to deliver better patient outcomes.

Once approved by each organisation, we will then commence a communications and training plan roll out across the system as part of our IMTEG Delivery Plan for 2019/20.

Patient consent is not required for the sharing of personal data between Lincolnshire Providers (including GPs) for the purpose of providing health and social care. This is because the sharing of such data is already lawful under the UK data protection legislation – Data Protection Act 2018 (DPA 2018) and the General Data Protection Regulation (GDPR).

There is often confusion around the legal basis for the sharing of personal data for the purpose of providing health and social care. It is often assumed that explicit patient consent is required.

The DPA 2018 and GDPR requires that you must have a lawful basis in order to process personal data. There are six lawful bases for processing and the most appropriate to use will depend on your purpose and relationship with the individual.

Consent is one of the lawful bases available to legitimise the processing of personal data. However, it should only be used when no other lawful basis can reasonably be applied and only when the individual is being offered genuine choice and control over how you use their personal data. Consent cannot be relied upon to process personal data in the provision of care as it cannot be conditional. Furthermore, if you make consent a precondition of a service, it is unlikely to be the most appropriate lawful basis .

Ensuring the correct legal basis is relied upon supports the lawful sharing of personal data, supports the delivery of care, and enhances patient confidence in the way we handle their data.

Under DPA 2018 and GDPR, where it is necessary to share personal data for the purpose of providing care, it is not appropriate to rely on consent as a legal basis. Instead it is the view, consistent with advice provided by the Information Commissioners Office, that alternative legal basis can be relied upon.

As long as STP Partners follow UK data protection legislation requirements there is a lawful basis for sharing personal data for the provision of health and

social care.

This position is supported by:

Dr Gurdip Samra, Associate Medical Director and Caldicott Guardian, ULHT
Dr Yvonne Owen, Medical Director and Caldicott Guardian, LCHS
Dr Ananta Dave, Medical Director and Caldicott Guardian, LPFT
Dr Kieran Sharrock, Medical Director, Lincolnshire LMC Limited
Michael Humber, Associate Director ICT / CIO, ULHT
Ian Baldam, Deputy Director of Informatics, LPFT
Dan Dring, Head of Information Management and Technology, LCHS
Steve Quint, Deputy CFO and IG lead, Lincolnshire East CCG
Maria Tute, IG Compliance Manager & DPO, ULHT
Kaz Scott, IG Lead and DPO, LCHS
Kathryn Scully, Team Leader IG, Records & Privacy, LPFT
David Ingham, Information Assurance Manager, LCC
Liz Jones, Project Manager – IMT, STP.

Recommendations:

1. All NHS organisations sign up to the data sharing protocol.
2. That IMTEG in partnership with our system IG leads will develop and implement a comprehensive communication plan to support the roll out and training requirements.
3. That IMTEG will continue to develop IG practices in order to further support and improve Direct Patient Care and improved Patient Outcomes, including developing and refining existing protocols for third party and voluntary sector organisations where appropriate as well as the sharing of patient information for analytical purposes.

Strategy Impact **Agreed as a key strategic priority for the Lincolnshire STP system**	**Performance KPIs year to date** **The protocol will radically improve data sharing across the Lincolnshire STP system**

Resource Implications (e.g. Financial, HR): Will be managed and provided through STP IMTEG

Assurance Implications: To be reviewed by FPEC

Patient and Public Involvement (PPI) Implications – Significant PPI required when implementing patient facing aspects of the protocol – to be managed though STP IMTEG

Equality Impact: To be considered during implementation of the protocol

Information exempt from Disclosure: None

Requirement for further review? No

STP Information Management and Technology Executive Group (IMTEG)
February 2019

SYSTEM WIDE SHARING OF INFORMATION FOR THE PURPOSE OF PROVIDING CARE

IMTEG Leads Michael Humber, Associate Director ICT / CIO, ULHT
Ian Baldam, Deputy Director of Informatics, LPFT
Dan Dring, Head of Information Management and Technology, LCHS
Steve Quint, Deputy CFO and IG lead, Lincolnshire East CCG
Dr Peter Holmes, GP, LEGP

Authors Michael Humber, Associate Director ICT / CIO, ULHT
Maria Tute, IG Compliance Manager & DPO, ULHT
Kaz Scott, IG Lead and DPO, LCHS

Contributors Kathryn Scully, Team Leader IG, Records & Privacy, LPFT
David Ingham, Information Assurance Manager, LCC
Liz Jones, Project Manager – IMT, STP

1. Purpose of this report

This paper is intended to provide IMTEG with the clarified and agreed common position from the Data Security and Protection Group (DSPG)[1] over the sharing of personal data across STP partners for the purpose of providing care to patients.

The position is that under the General Data Protection Regulation (GDPR) and the Data Protection Act (2018), where it is necessary to share personal data for the purpose of providing care, it is not appropriate to rely on consent as a legal basis. Instead it is the view, consistent with advice provided by the Information Commissioners Office[2], that alternative legal basis' can be relied upon.

Furthermore to ensure transparent processing of personal data it is necessary to provide patients with clear and consistent information about how their data is being processed. This will include who we share information with and why and this should be made clear within Privacy Notices.

IMTEG are asked to review this paper and supporting information.

[1] DSPG members include EMAS, St Barnabas, Lincolnshire County Council, ULHT, LCHS, LPFT, Lincolnshire STP, AGEM, Lincolnshire East CCG, OPTUM.
[2] https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/consent/when-is-consent-appropriate/

2. Appropriate legal basis

As NHS care providers we operate within a statutory environment that requires partners to provide health and social care. To meet these requirements it is necessary, in some instances, to share personal data for this purpose.

Therefore, under the GDPR our legal basis for processing personal data can be drawn from:

- Article 6(1) (c) processing is necessary for compliance with a legal obligation to which the controller is subject.

- Article 6(1) (e) the performance of a task carried out in the public interest or in the exercise of the controller's official functions, and the task or function has a clear basis in law.

For special categories of personal data (those that are more sensitive and so attract additional safeguards[3]) our legal basis in addition to those above can be drawn from:

- Article 9(2) (g) processing is necessary for reasons of substantial public interest.

- Article 9(2) (h) the provision of health or social care or treatment or the management of health or social care systems and services.

Consent should only be considered as a relevant lawful basis where no other lawful basis can reasonably be applied and only where the individual is being offered a genuine choice and control over how their personal data is processed. Consent cannot be relied upon to process personal data in the provision of care as it cannot be conditional.

Ensuring the correct legal basis is relied upon supports the lawful sharing of personal data, supports the delivery of care, and enhances patient confidence in the way we handle their data.

3. Principles of lawfulness, fairness and transparency

The wider principles of the DPA 2018 legislation must also be considered. The principles of lawfulness, fairness and transparency, means that we must ensure patients are well informed about how their data will be used and

[3] Special category data is personal data which the GDPR says is more sensitive, and so needs more protection, for example information about an individual's: race, ethnic origin, politics, religion, trade union membership, genetics, biometrics (where used for ID purposes), health, sex life, or sexual orientation.

shared. As such, we need to ensure that our Privacy Notices included relevant information on who we share information with and why.

4. The Care Portal

As a specific example, the Care Portal is a platform that enables care providers to share patient information in order to provide health and social care. As such, under GDPR we have a legal basis for processing patient information in this way and under the Data Protection Act (2018) we can adhere to the legislation by ensuring the processing of patient information on the Care Portal is included in all Privacy Notices. Further, the Department of Health and Social Care's 'Code of Conduct for Data-Driven Health and Care Technology' positively encourages such systems and data sharing by outlining "10 key principles for safe and effective digital innovations, and 5 commitments from the government to ensure that the health and care system is ready and able to adopt new and innovative technology at scale … When collected and used properly, data relevant to people's health and care has the potential to be transformative. Sharing data offers immense promise for improving the NHS and the social care system[4]".

5. Summary

Given the discussions above and as long as we follow the guidance there are no legal reasons to prevent us from sharing patient data and information between STP partners for the purpose of providing health and social care.

6. Reference / contacts

For further information, please contact Michael Humber, Associate Director ICT / CIO, Lincoln County Hospital.

[4] https://www.gov.uk/government/publications/code-of-conduct-for-data-driven-health-and-care-technology

NHS
Lincolnshire Sustainability and Transformation Partnership

STP IMTEG seeking support for its position on:

System Wide Sharing of Information for the Purpose of Providing Direct Patient Care

STP IMTEG SRO: Marie Fosh

Background

- Requested by System Executive Directors across the 7 organisations to developed a system data sharing protocol
- Required so we can radically improve data sharing across the Lincolnshire STP system
- Developed by our local Information Governance experts
- Has had external legal scrutiny to ensure it is fit for purpose and meets legislation requirements
- Developed and supported by Caldicott Guardians across the system and has Lincolnshire Medical Council support

Problem and Rationale

- At present sharing data processes vary, with many inconsistencies and a culture bias towards a reluctant to share
- This protocol provides legal clarity on the matter to support behavioural change and will enable clinicians significantly improved access to patients records in a timely manner in order to deliver better patient outcomes

Position Statement

- Put simply, as long as STP Partners follow UK data protection legislation requirements there is a lawful basis for sharing personal data for the provision of health and social care
- Therefore, where consent as a legal basis is being relied on to deliver health and social care we request that organisations, along with their Data Protection Officer, consider the contents of the position statement

What Next?

- Once approved by each organisation, IMTEG will commence a communication and training plan roll out across the system as part of their Delivery Plan for 2019/20
- IMTEG will also continue to work through the more difficult and complex sharing relationships between organisations such as neighbourhood teams and the sharing of patient information for analytical purposes and will update the position statement as appropriate

Agenda Item 14.1

IMTEG POSITION STATEMENT

Relying on consent as a lawful basis to process personal data

This position statement sets out the view of IMTEG and aims to provide clarity around the use of consent to legitimise the processing of personal data.

It also aims to facilitate the lawful sharing of personal data with third parties and give partners the confidence to share information in the best interests of their patients and service users.

Data protection legislation (the Data Protection Act 2018 (DPA 2018), and the General Data Protection Regulation (GDPR) as it applies in the UK) requires that you must have a lawful basis in order to process personal data. There are six lawful bases[1] for processing and the most appropriate to use will depend on your purpose and relationship with the individual.

Consent is one of the lawful bases available to legitimise the processing of personal data. However, it should only be used when no other lawful basis can reasonably be applied and only when the individual is being offered genuine choice and control over how you use their personal data. Furthermore, if you make consent a precondition of a service, it is unlikely to be the most appropriate lawful basis[2].

Delivery of health and social care services is much more likely to engage an alternative legal basis to consent particularly because you will be in a position of power over the individual(s) concerned and therefore cannot offer genuine choice and control over how the individual (s) data is processed. Instead processing is generally dictated by the statutory environment in which this processing activity is conducted.

As such, IMTEG considers that reliance on consent in these circumstances would in fact be inherently unfair on the individual(s) and inconsistent with your data protection obligations.

It is our view that the following lawful bases are more likely to be engaged when processing personal data necessary for the delivery of health and social care services:

- **Legal Obligation[3]:** Health and social care professionals deliver services in order to meet their own legal obligations and it will be necessary to process personal data in order to comply with those obligations. The National Health Service and Local Authorities are governed by a multitude of legislation and statutory instruments.

- **Public Task [4]:** Legislation may not always provide you with an obligation to provide certain services but instead provides you with a power to do so. Where you are processing personal data in order to deliver services that are

[1] https://gdpr-info.eu/art-6-gdpr/
[2] https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/consent/
[3] General Data Protection Regulation Article 6(1)(c)
[4] General Data Protection Regulation Article 6(1)(e)

discretionary rather than obligatory you are acting with official authority. This lawful basis also legitimises processing that is necessary to deliver a public task that is in the public interest

The following lawful bases are most likely to be engaged when processing special category data[5] necessary for the delivery of health and social care services:

- **Health or Social Care Purposes[6]:** Processing special category data is permitted when it is necessary for the purposes of the provision of health or social care treatment or the management of health or social care systems and services on the basis that the services are required by UK law.

- **Substantial Public Interest[7]:** Processing special category data is lawful where it is necessary in order to deliver health services that are part of your official function or task and it is necessary for reasons of substantial public interest, e.g. safeguarding of children and of individuals at risk.

If the processing of personal data and/or special category data aligns with the lawful bases identified above, consent for data protection purposes is not required.

It should be noted that receiving consent to engage with, or deliver a service to, an individual is often conflated with consent to process personal data. The two are, in fact, separate and it is important that they remain so. For example, in many circumstances you are required to obtain consent from a patient to administer treatment, but that does not equate to requiring consent to process the data necessary in order to deliver that treatment.

Information Sharing

The issue of consent commonly arises in the context of information sharing e.g. consent is sought before sharing. However, the lawful bases described above remain relevant.

For example, a request is made for the disclosure of information necessary to determine the level of service or care an individual needs. Sharing of personal data in this context can be considered lawful as it is necessary to the delivery of a public task that is in the public interest, and in the case of special category data, this will be necessary for the provision of health and social care. Consequently, consent would not be required.

Common law duty of confidentiality

In the context of information sharing there is often confusion as to whether consent is required for the purpose of data protection legislation or whether it is required as a means of sharing information without breaching the common law duty of confidentiality.

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[5] https://gdpr-info.eu/art-9-gdpr/
[6] General Data Protection Regulation Article 9(2)(h), Data Protection Act 2018 Schedule 1, Para 2
[7] General Data Protection Regulation Article 9(2)(g), Data Protection Act 2018 Schedule 1, Part 2, Paras 5 to 28

The common law duty of confidentiality allows for the sharing of information without breaching that duty in the following circumstance:

- With the consent of the individual concerned; or
- Where sharing the information is necessary to meet a statutory obligation; or
- Where sharing the information is in the substantial public interest.

As has been set out above, it will often be the case that processing personal data in the delivery of health and social care services will be necessary to meet a statutory obligation or to perform a task that is in the substantial public interest. Where information is shared for these purposes, even in the absence of consent, it will not breach the duty of confidentiality that health and social care professionals owe to their patients.

Fairness and Transparency

Processing of personal data must be achieved in a clear, open and honest manner. Managing expectations is vital in ensuring that data protection obligations are met, and individuals are informed. All health and social care services must provide adequate privacy information to ensure individuals understand how the data they provide will be used, what legal bases are being relied upon, where it may be obtained from, and who it is shared with.

Finally, IMTEG recognises the challenges for those partners who may use consent as the default lawful basis when processing an individual's personal data for health and social care purposes. We also acknowledge that in some circumstance's health and social care applications, rather than legal obligations, drive behaviour.

It is however necessary to ensure that personal data is used in a way that is fair, and not unexpected or misleading to the individuals concerned.

We therefore request that where consent as a legal basis is being relied on to deliver health and social care you, along with your Data Protection Officer, consider the contents of this position statement.

If you would like to discuss this in more detail please do contact [insert details]

Yours [faithfully/sincerely]

To:	Trust Board
From:	Paul Matthew, Interim Director of Finance & Procurement
Date:	2nd July 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for May 2019

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

Purpose of the report:
To update the Board on the performance of the Trust for the period 31st May 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

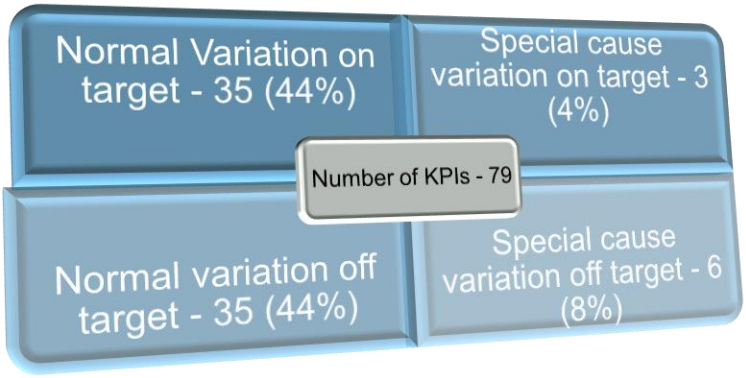
Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
June 2019

EXECUTIVE SUMMARY



Quality

New Harm Free Care is above the national average at 98.6%.

HSMR (March 2018-February 2019) is 90.74 and is below expected limits, the lowest reported HSMR for the Trust.

SHMI (January 2018-December 2018) is 111.85 and is in band 1 and outside of expected limits. Within the peer analysis the Trust has moved 6 places lower and holds a lower SHMI than some Trust's within band 2. The Trust's confidence intervals has meant the Trust re-mains within Band 1. SHMI methodology has changed and will now be published on a monthly basis but will still remain 6 months in arrears.

VTE assessment remains above the 95% standard

The number of complaints remains between 65 – 75 per month. The complaints team are working with the Divisions to ensure timely and quality responses are sent to the complainants and lessons are being learnt.

Overall incident reporting rates for far in 2019 are consistent with levels reported in 2018. Compared with other acute hospital trusts, ULHT is in the lower half in terms of incidents reported per 1,000 bed days but analysis by NHSI (for incidents reported between April and September 2018) indicates there is no evidence of under-reporting. The number of significant harm incidents (those resulting in moderate harm; Severe harm; or Death) reported in April 2019 (16) was noticeably lower than in either of the previous 2 months. Analysis has been requested to identify possible themes in relation to incidents occurring within Accident & Emergency departments on each site.

The Trust declared 14 patient Serious Incidents in April 2019, which was consistent with the monthly average in 2019 so far (compared with an average of 18 per month in 2018); one organisational SI was also declared in April

2 Never Events have been declared so far this financial year; both of these were declared in April 2019 (a wrong site surgery in Maxillofacial Surgery Outpatients / Dermatology; and a retained foreign object post-procedure in Theatres / Gynaecology; both were at Lincoln County Hospital).

Operational Performance

Zero waiting indicators in urgent care services have seen improvements in May. The A&E 4 hour standard and ambulance handovers waiting >59 minutes have both improved against a context of increasing numbers of ambulance conveyances. The improvements are not to the levels planned for in trajectories but do show early signs of the impact Urgent Care Improvement programme.

Planned actions to recover performance to trajectory reflect significant actions with substantial resources and effort allocated. Scheme such as the Lincoln Big Change reconfigurations scheme amongst 5 other work streams are planned in future months to continue the improvement journey.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have grown by 1194 pathways (3%) from March to April 2019. No single specialty area disproportionately contributed to this growth in waiting list.

Overall performance against the RTT incomplete 18 week standard however has improved in April with 84.16% of patient pathways waiting less than 18 weeks for treatment. This represents the first month of above trajectory performance, and reflects the substantial work completed in previous months on validation of patient pathways.

In April two patients were waiting for more than 52 weeks for their treatment, which occurred as a result of administrative error in managing the patient pathway. This is above the 0 tolerance trajectory but does reflect a substantial improvement from previous months in 2018/19.

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

Zero waiting indicators in cancer services showed our 62 Day Cancer performance to be continuing to improve back to pre-winter levels and above trajectory.
The Trust continues to be the 5th largest provider of cancer treatments in the country. Both 2ww standards (2ww suspect and 2ww Breast Symptomatic) have improved although are below the standard expected.
2ww Breast Symptomatic has shown a very significant improvement showing the overall progress in breast services and is expected to continue to improve again reflecting progress made.
31 day Drug Treatments, 62 day consultant update and 104 day waiting standards have all deteriorated and are below trajectories however all other 31 day standards were met.

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 in-month financial position is a deficit of £4.4m and in line with the planned deficit of £4.4m. The year to date position is a deficit of £11.2m and in line with the planned deficit of £11.2m.

The key movements year to date are as follows: Income is £371k adverse to plan, Employee expenses and other operating expenses are overall £288k favourable to plan, this comprises of an adverse Pay variance to plan of £535k and a favourable Non Pay variance to plan of £823k.

The underlying Month 2 position was £890k adverse to plan. The plan to date has been delivered due to the release of £890k of flexibility. This is inclusive of 2 elements; the early release to the position of the annual leave FEP and an accrual made at year-end in respect of pay that has been released as now identified as not required. This has removed all pay flexibility that the Trust retained. The underlying pay position in Month 2 is £811k adverse to plan. The impact of the £890k release of flexibility resulted in an improved pay position of £79k favourable to the in-month plan. The adverse year to date pay position is driven by temporary staffing spend of £2.0m greater than the planned levels, with £1.5m of this on agency primarily driven by Medical staff with Medicine being the key area of concern, although scrutiny of the temporary staffing usage across all staff groups and Divisions is required.

The income position is inclusive of significant over performance on Non-Elective activity in the Medicine Division, however this has not adversely affected Elective performance to date. As the Trust implements

plans to deliver backlog reductions and work with commissioners to undertake repatriation of activity the pressure on beds and resources will increase, so current Elective performance is a risk.

Whilst Non-Pay year to date is £0.8m favourable to plan, £0.5m is in relation to pass-through activity which is directly offset by an equal and opposite reduction in income. The favourable variance to plan also includes £0.2m lower than planned costs in relation to Turnaround; this movement is a timing difference and as such the under spend accrued to date will reduce in future periods.

Overall whilst on plan at month 2 the underlying position driven by pay usage and the risks in respect of income are a concern.

Workforce

Pay costs are higher than planned year to date driven by further increase in agency staffing costs. A significant increase in nursing agency costs was experienced this month.

The overall vacancy rate improved marginally in May having risen in March and April due to significant establishment increase and despite increased staff in post numbers.

Turnover has been re-calculated from this month to more accurately reflect the total number of staff leaving the Trust.

Sickness absence (rolling twelve months) increased slightly to 4.8% with this month's level higher than the same month last year.

Paul Matthew
Interim Director of Finance & Procurement
June 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostrum Difficile (post 3 days)	Safe	Our Patients	Michelle Rhodes	5	5	5	4	9	P		
	MRSA bacteraemia (post 3 days)	Safe	Our Patients	Michelle Rhodes	0	1	0	0	0	P		
	MSSA	Safe	Our Patients	Michelle Rhodes	2	0	1	2	3	P		
	ECOLI	Safe	Our Patients	Michelle Rhodes	8	0	2	7	9	P		
	Number of Never Events	Safe	Our Patients	Neill Hepburn	0	1	2	0	2	P		Timeliness Completeness Validation Process
	New Harm Free Care %	Safe	Our Patients	Michelle Rhodes	98%	99.20%	98.60%		98.60%	P		Timeliness Completeness Validation Process
	Pressure Ulcers Category 4	Safe	Our Patients	Michelle Rhodes	0	0	0	0	0	P		Timeliness Completeness Validation Process
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Michelle Rhodes	80%	88.00%	86.40%		86.40%	P		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Michelle Rhodes	80%	79.50%	89.70%		89.70%	P		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Michelle Rhodes	50%	58.60%	62.30%		62.30%	P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Michelle Rhodes	100%	98.90%	100%		100.00%	P		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Michelle Rhodes	90%	69.00%	76.80%		76.80%	F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Michelle Rhodes	17%	8.40%	10.60%		10.60%	P		
	SHMI	Effective	Our Patients	Neill Hepburn	100	114.05	111.85		111.85	F		
	Hospital-level Mortality Indicator	Effective	Our Patients	Neill Hepburn	100	92	90.74		90.74	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis Bundle compliance in A&E	Caring	Our Patients	Michelle Rhodes	90%	71.60%	83.30%		83.30%	F		
	IVAB within 1 hour for sepsis in A&E	Caring	Our Patients	Michelle Rhodes	90%	96.40%	95.20%		95.20%	P		
	Sepsis screening compliance in inpatients	Caring	Our Patients	Michelle Rhodes	90%	78.30%	85.00%		85.00%	F	A	
	IVAB within 1 hour for sepsis in inpatients	Caring	Our Patients	Michelle Rhodes	90%	77.20%	84.60%		84.60%	F		
	Serious Incidents reported (unvalidated)	Safe	Our Patients	Neill Hepburn	0	16	12	10	22	F		Timeliness, Completeness, Validation, Process
	Catheter & New UTIs	Safe	Our Patients	Michelle Rhodes	1	1	0		0	P		
	Falls (Moderate or above) per 1000 OBD	Safe	Our Patients	Michelle Rhodes		0.16	0.20	0.19	0.20			Timeliness, Completeness, Validation, Process
	Medication errors	Safe	Our Patients	Neill Hepburn	0	150	195	193	388	F		Timeliness, Completeness, Validation, Process
	Medication errors (mod, severe or death)	Safe	Our Patients	Neill Hepburn	0	23	20	19	39	F		Timeliness, Completeness, Validation, Process
	VTE Risk Assessment	Safe	Our Patients	Michelle Rhodes	95%	96.46%	96.15%	97.21%	96.68%	P		
	Dementia Screening	Caring	Our Patients	Michelle Rhodes	90%	93.10%	89.90%		89.90%	F		
	Dementia risk assessment	Caring	Our Patients	Michelle Rhodes	90%	98.60%	99.32%		99.32%	P		
	Dementia referral for Specialist treatment	Caring	Our Patients	Michelle Rhodes	90%	100.0%	92.86%		92.86%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	92.52%	92.62%	92.20%	92.41%	F		
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	13.83%	15.26%	15.21%	15.24%	F		
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.70%	4.71%	4.80%	4.76%	F		
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	5.45%	5.34%	12.45%	8.90%	F		
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	73.35%	72.99%	72.40%	72.70%	F		
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-6009	-23202	-6112	-4019	-10131	P		
	Income	Well-Led	Our Services	Paul Matthew	36935	41313	40221	41522	81743	P		
	Expenditure	Well-Led	Our Services	Paul Matthew	-42944	-64515	-46332	-45297	-91629	F	B	
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	2838	2480	510	1546	2056	F	H	
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	4031	11159	839	1958	2797	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-1905	-3802	-3621	-4019	-7640	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	32.16%	26.90%		26.90%	P	H	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	96%	91.20%	91.19%		91.19%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	14%	22.77%	20.09%		20.09%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	21.72%	79.71%		79.71%	F		
	Friends & Family Test Maternity (Reponse Rate)	Caring	Our Patients	Martin Rayson	23%	21.72%	11.29%		11.29%	F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Martin Rayson	97%	100.0%	100.0%		100.0%	P		
	Friends & Family Test Outpatients (Reponse Rate)	Caring	Our Patients	Martin Rayson	14%	11.44%	8.14%		8.14%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	92.62%	93.17%		93.17%	F		
	Mixed Sex Accommodation	Caring	Our Patients	Michelle Rhodes	0	0	0		0	P		Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	70	67		67	P		Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Martin Rayson		229	473		473	F		Timeliness, Completeness, Validation, Process
	eDD	Effective	Our Patients	Neill Hepburn	95%	89.72%	88.50%		88.50%	F		
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	2.20%	1.66%	2.20%	1.93%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	72.0%	68.55%	66.36%	68.31%	67.33%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	1	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	76%	84.54%	84.20%	85.08%	84.64%	P		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	0	2		2	F		
	18 week incompletes	Responsive	Our Services	Mark Brassington	83%	84.73%	84.16%		84.16%	P		
	Waiting List Size	Responsive	Our Services	Mark Brassington	36718	36718	38956		38956	F		
	62 day classic	Responsive	Our Services	Mark Brassington	71%	75.24%	77.31%		77.31%	P		
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	73.29%	79.98%		79.98%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	26.51%	67.83%		67.83%	F		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	96.96%	97.90%		97.90%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	97.30%	96.88%		96.88%	F		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	94.29%	94.29%		94.29%	P		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	90.48%	97.27%		97.27%	P		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	95.00%	100.00%		100.00%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Mar-19	Apr-19	May-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	84.75%	78.72%		78.72%	F		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	99.0%	95.86%	96.53%	95.56%	96.05%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	0.8%	1.96%	1.56%	1.84%	1.70%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	15.13%	16.30%	2.50%	9.40%	P		
	#NOF 24	Responsive	Our Services	Mark Brassington	70%	62.90%	75.00%		75.00%	P		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	95%	95.16%	94.74%		94.74%	F		
	EMAS Conveyances to ULHT	Responsive	Our Services	Mark Brassington	4720	4720	4920	4991	4956	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	283	410	635	494	564.5	F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	7	11	15	26	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	2.62	2.80	2.49	2.645	P		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.66	4.44	4.39	4.415	P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	3.45%	2.32%		2.32%	P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	7872	7540	8644	8092	F		

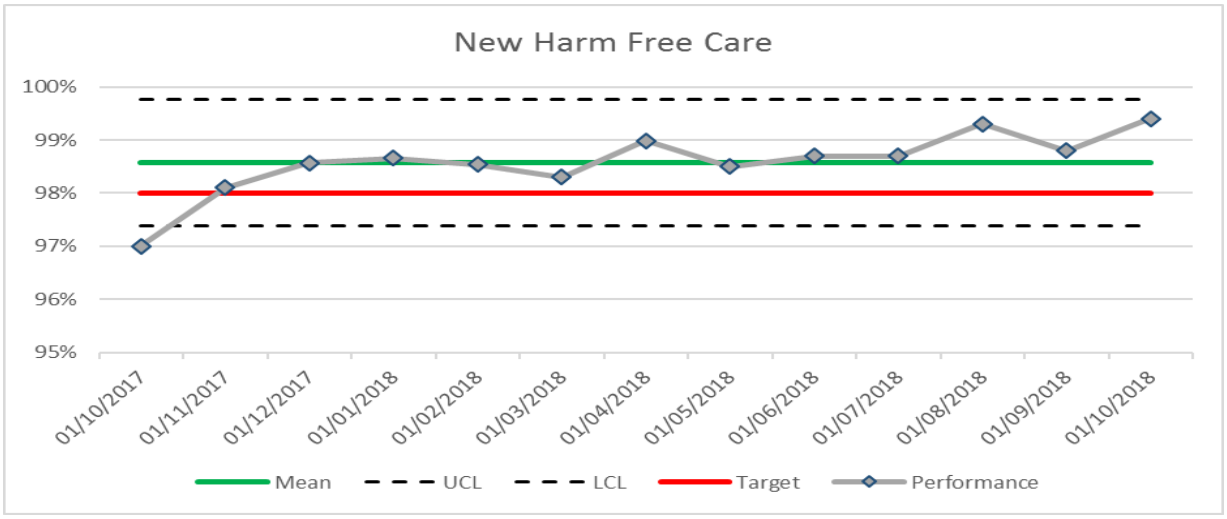
STATISTICAL PROCESS CONTROL CHARTS

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:



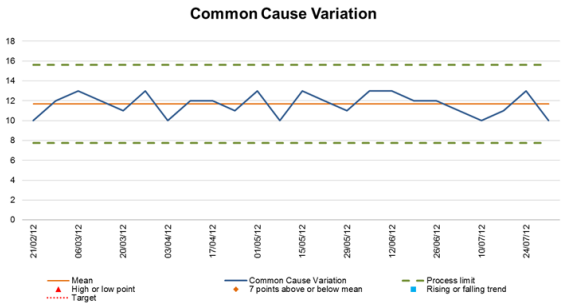
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

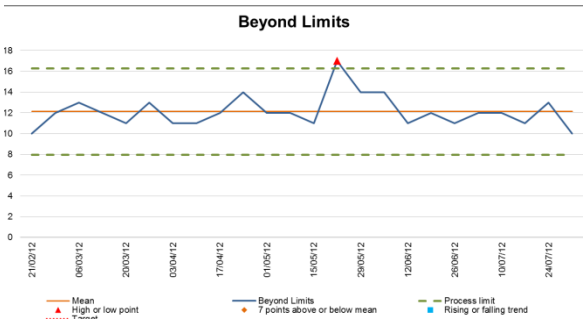
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

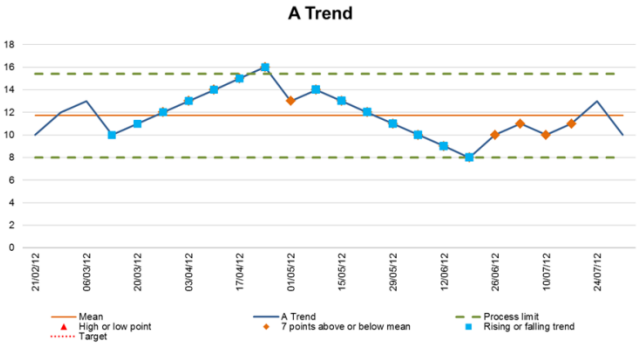


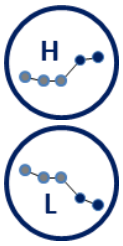
Extreme Values



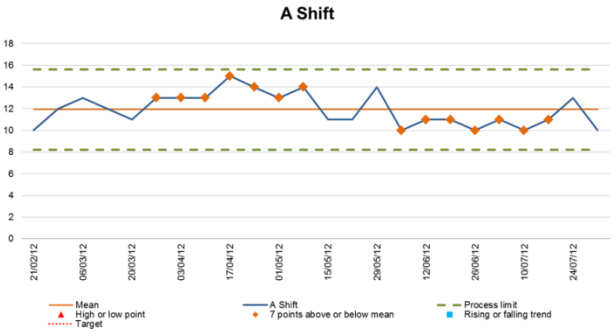
There is no Icon for this scenario.

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

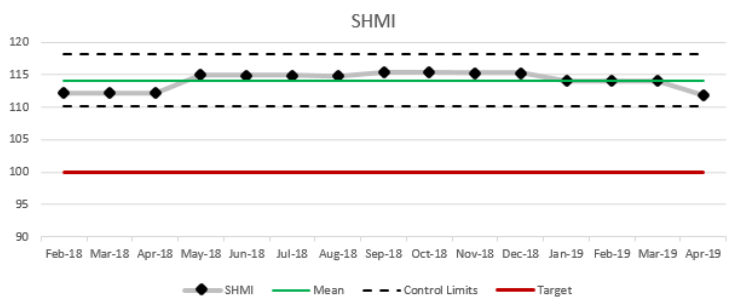
Executive Lead: Neill Hepburn

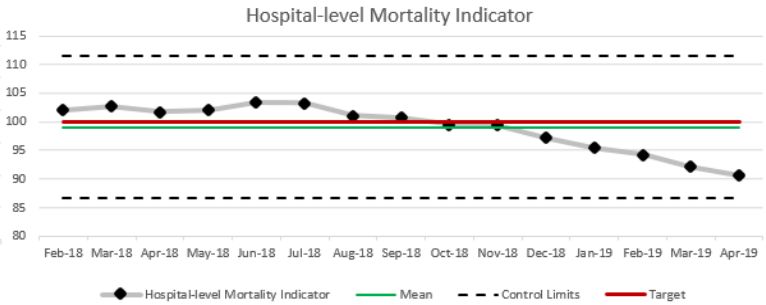
CQC Domain: Safe

2021 Objective: Our Patients

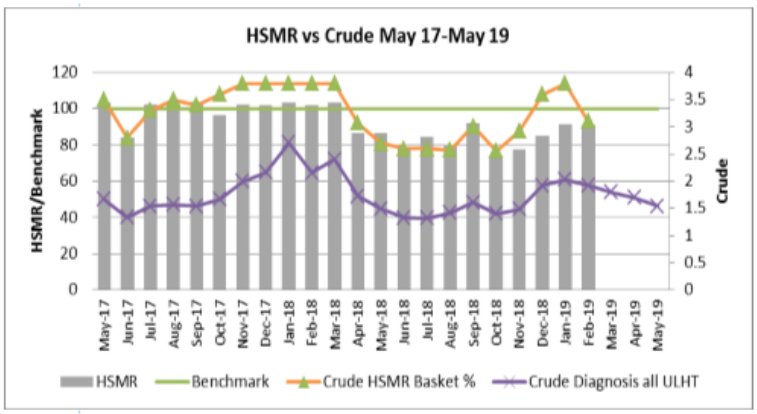
SHMI

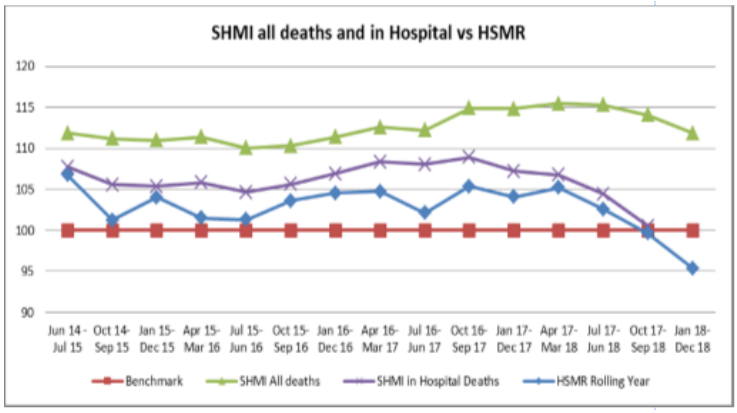
HSMR





Trust/ Site	ULHT HSMR Mar 18-Feb 19 12 month	ULHT HSMR Apr 18-Feb 19 FYTD	ULHT HSMR Feb 19	ULHT SHMI Jan 18-Dec 18	Trust Crude Mortality Intemal source Jun 18-May 19
Trust	90.74	88.35	83.70	111.85	1.62%
LCH	101.11	98.90	95.14	114.65	1.70%
PHB	87.56	84.78	76.84	116.63	1.81%
GDH	52.53	51.38	56.44	80.45	0.62%





Performance Overview

Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 90.74 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits. HSMR has now been reported by divisions (attached), where HSMR is high but not alerting is due to small numbers and high confidence intervals.

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is a Quality and Safety Improvement Programme (QSIP) to address the improvements required. Site alerts; Pilgrim site is driving the 'Other Perinatal Conditions' a paper has been produced and was presented at QSG and Trust Board in March 19. A meeting has been arranged with the Divisional Nurse to discuss the progress of the QSIP. 'Other Lower Respiratory Disease' was alerting for the site at Pilgrim however this is no longer alerting but a review is currently underway. 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 111.85, 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. The data is reflective up to December 2018.

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

Mortality Strategy Reduction Key Actions:

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

- Divisional Mortality Dr Foster Outcome reports (attached) are being produced and will also form part of the Mortality Overview presented at Trust Management Group. Surgical Division is currently an outlier, Surgical Mortality reviews have not raised any concerns. The Trust has a low depth of coding for elective spells.
- In-depth Dr Foster reviews ongoing for Acute MI, Liver Disease and Lower Respiratory Disease due to previous alerts.
- The Community have various work streams they are undertaking to ensure out of hospital patients receive appropriate end of life care which include; End of life audits in care homes, end of life training, multidisciplinary approach to advance care planning and anticipatory prescribing, Project Echo and roll out of the ReSPECT tool kit.
- Lincolnshire health and care community have launched; Home First Prioritisation. An initiative aimed to focus on frail and over 75's out of hospital and close to 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. It has been confirmed that the Mortality Summit will be reinstated.
- In-depth reviews for Biliary Tract Disease external review has concluded. A preliminary report has been sent to CQC and the external reviewer has yet submitted a full report this has been chased as the deadline for this report was the 12th May 2019. 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 to discuss ongoing arrangements of this workshop.

Crude Mortality

The crude mortality has decreased in May 19 to 1.56%. In rolling year June 18-May 19 crude has remained at 1.62%. A reduction in crude and an increase in Dr Foster expected mortality is the driving force behind the reduction in HSMR and hopefully this reduction will be replicated in SHMI.

Mortality Reviews– Deaths in Scope

Deaths reported to Mar-19 to allow for 4 week deadline completion of initial mortality review.

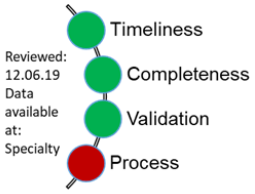
Measure	Description	Month Mar 19	YTD Apr 18-Mar 19	Narrative
Deaths in Scope	• Total Deaths in scope • Number inpatient deaths • Number of A&E Deaths	184 152 32	2201 1896 305	All deaths as reported, in Month and year to date.
ME Screening	• ME Deaths Screened • % of referrals to Specialty	60 12%	260 12%	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 5 months of that reported.
Await Completion	• To be reviewed by Specialty • Total allocated Specialty • % of total with Specialty • % of total awaiting allocation	71%/131 86 47% 41%	90%/1971 667 30% 19%	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)	19 15% 43%/79	1070 54% 60%/1330	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/%)	10/53% 1/5% 0/0% 0/0% 8/42%	863/81% 75/7% 25/2% 0/% 107/10%	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	6 32% 0%	135 13% 24%	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	0 0 0%	22 22 100%	These include all Learning Disability deaths as identified by the information support team using code RB19 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	2 0 0%	25 16 64%	Severe Mental Health Codes,/Diagnosis as advised by NHSI they advise to include schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

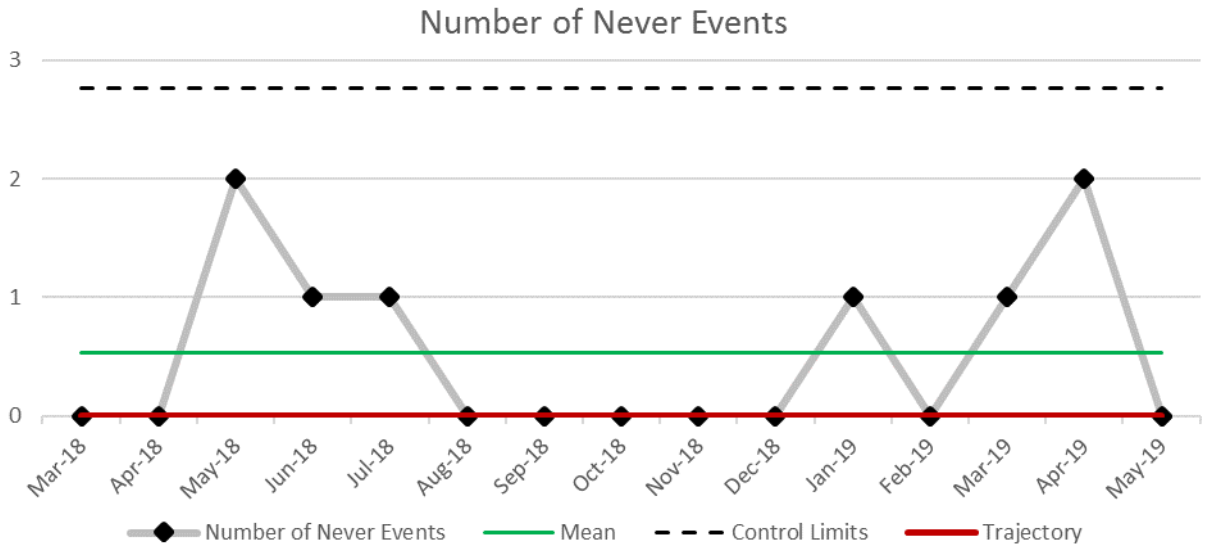
HARM FREE CARE – NEVER EVENTS

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- 2 Never Events have been declared by the Trust so far in 19/20
- 0 Never Events were declared in May 2019
- A theme is emerging in relation to wrong site surgery incidents occurring primarily outside of the theatre environment

Actions in place to recover:

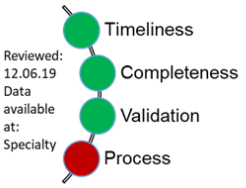
- Analysis is being undertaken of all wrong site surgery incidents reported in the last 2 years
- The application and monitoring of compliance with local safety standards for invasive procedures (LocSSIPs) is to be reviewed and strengthened
- A Never Event Summit with the CCGs is being set up for September 2019, to review learning and actions arising from recent incidents

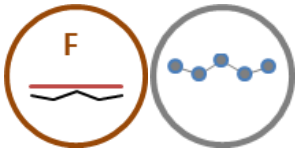
HARM FREE CARE – SERIOUS INCIDENTS

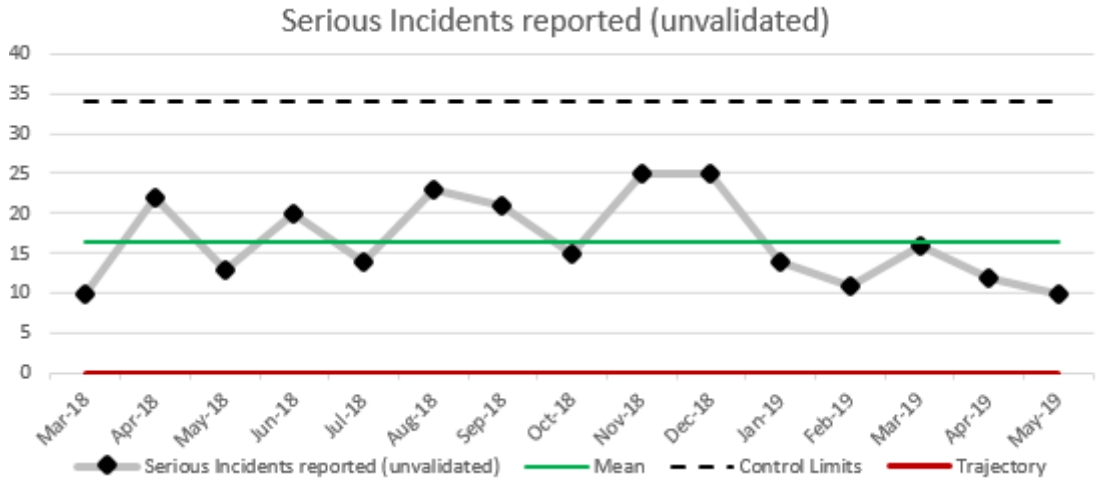
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes

- The Trust declared 10 patient Serious Incidents in May 2019
- This is the lowest number of Serious Incidents declared for any month in 2019 so far, and significantly lower than the average of 18 per month in 2018 and 24 per month in 2017
- Taken together, diagnostic & therapeutic process incidents have accounted for 37% of the Serious Incidents declared by the Trust so far in 2019
- There has been a significant reduction in the number of Pressure Ulcer Serious Incidents declared by the Trust in 2019 compared with 2018
- Accident & Emergency at Lincoln County Hospital have declared 12 Serious Incidents in 2019 so far; no other location in the Trust has declared more than 3
- Ward 6a at Pilgrim Hospital declared 3 Serious Incidents in May (none previously in 2019)

Actions in place to recover:

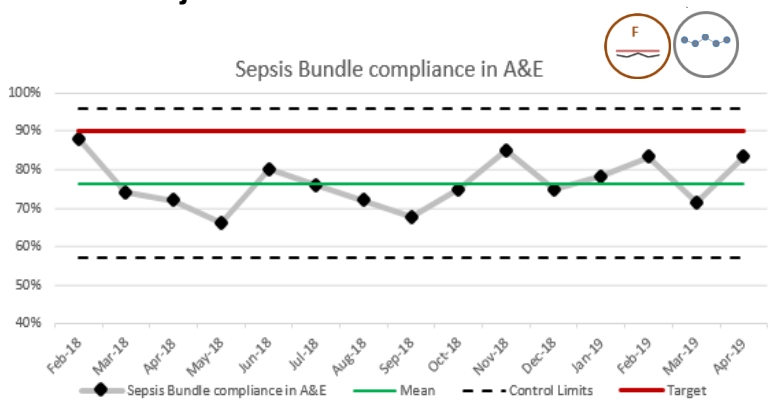
- The Patient Safety Group has commissioned a reviewed of incidents reported within A&E departments on all sites, to identify common themes and causes
- There are processes in place to ensure timely completion of effective Serious Incident investigations; there were 37 Serious Incident investigations open at the end of May 2019; none of these were overdue their deadline date

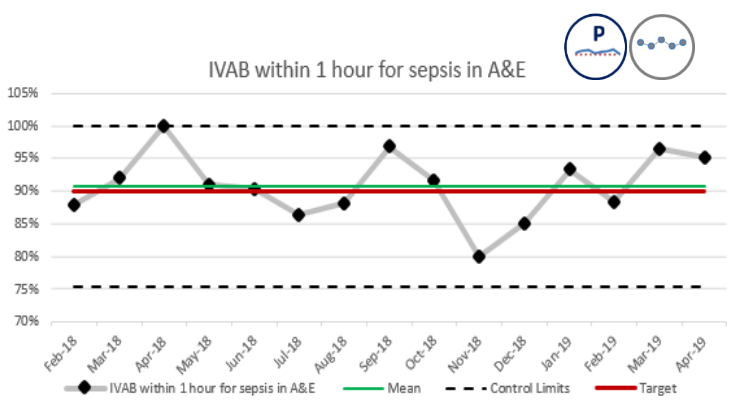
HARM FREE CARE - SEPSIS

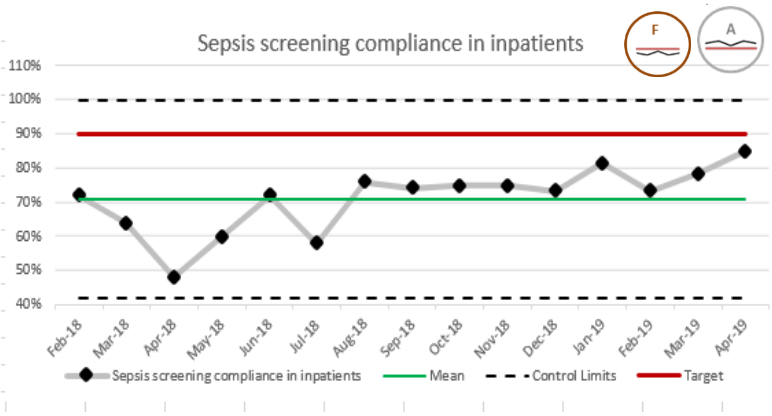
Executive Lead: Michelle Rhodes

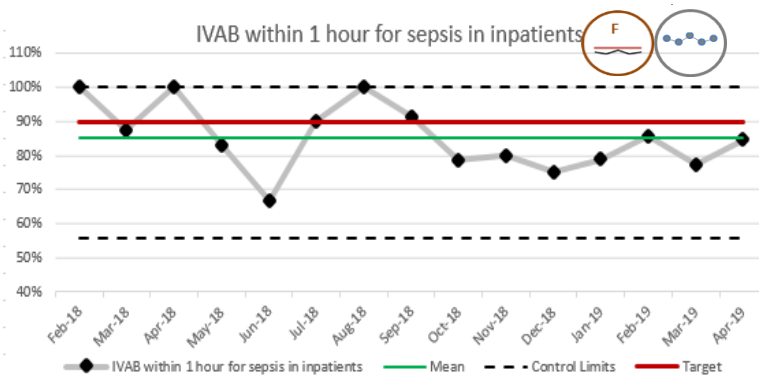
CQC Domain: Safe

2021 Objective: Our Patients









Sepsis screening

The compliance for both A&E and inpatients has demonstrated an improvement on the previous month and an overall upward trajectory although we are still not meeting the 90% standard. The themes that have been seen are similar to other months in that the nursing staff are still not selecting the non- infection option to show that the screen has considered the cause of the raised NEWS score.
An investigation into the cases where agency nurses have nor completed the screen has identified that the Agency nurses have not received the preparatory material and relevant induction in all cases and a report is being prepared to collate this information and will be available for discussion at the next Harm Free Care meeting.

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.

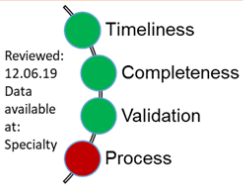
The Sepsis Practitioners are attending the clinical governance meetings and engagement with medical staff has improved. Paediatrics are a current focus and the policy is being written with their support and will include an unsure option allowing for a period of observation and harvesting of results before the antibiotics are given.

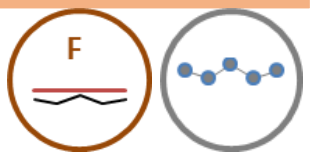
HARM FREE CARE – MEDICATION ERRORS

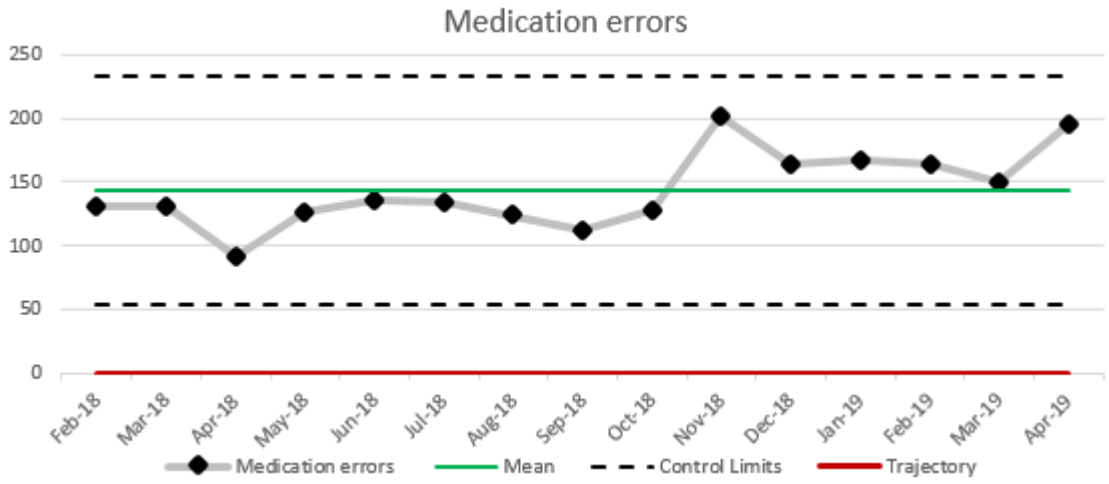
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes -

For May the medication incident reporting rate for the Trust per 1000 bed days was 6.19. 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. There were no severe harm events relating to medication incidents reported during the reporting period.

Of the 193 medication incidents reported, 9.8% (calculated as medication incidents reported as causing harm or death/all medication errors x 100 – (19/193x100) 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.

Action plan to reduce harm and reduce omitted and delayed medicines

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

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

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

1. Develop a monthly data report demonstrating the medication incident trends

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

2. Review of medication incident investigation and review process and develop SOP

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

3. Staff to do a written reflection of any medication incidence they are involved in and with their line manager agree lessons learnt and training needs.

- With the Heads of Nursing and the quality matrons we will develop a pathway to support staff and identify any training needs.

4. Define high risk/critical medication and develop SOP for obtaining medication in and out of hours

- The Guideline for Reducing Harm from Omitted and Delayed Medicines will be reviewed and updated will include a comprehensive guide to obtaining medicines in and out of hours.

5. Raise awareness of site duty manager and on-call pharmacist

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

6. Educate staff that there is more than one prescription chart in use and prescription chart should move with patient if transferred

- A piece of work needs to be done alongside the nursing teams to educate staff around the potential numbers of inpatient chart and the different types of specialist charts we have within the organisation.

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

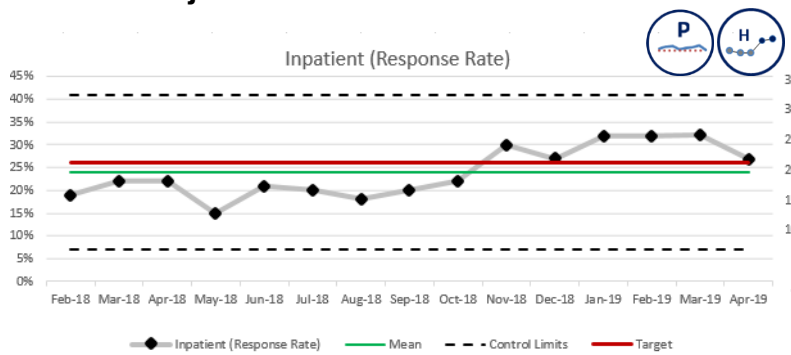
- In addition to these actions within the Quality and Safety Improvement Plan we have updated the Prescribing and Medicines Optimisation and Safety webpages and made them more engaging and user friendly. Within the new design we have a page dedicated to sharing learning from medication incidents and informing staff of themes and trends. There are also strategies to help combat medication related incidents.
- We have created a Facebook account to link in with the ULHT Together account and share information via that forum. This will then help to us to capture as many of ULHT staff as possible and ensure that learning reaches as far as possible.
- A specialist forum is to be set up. This forum will give opportunity to discuss medication incidents, look at the themes and trends, and allow staff to share good practice and ideas from different areas. Medicine Management Link Nurse and junior grade doctors will be given the opportunity to attend.

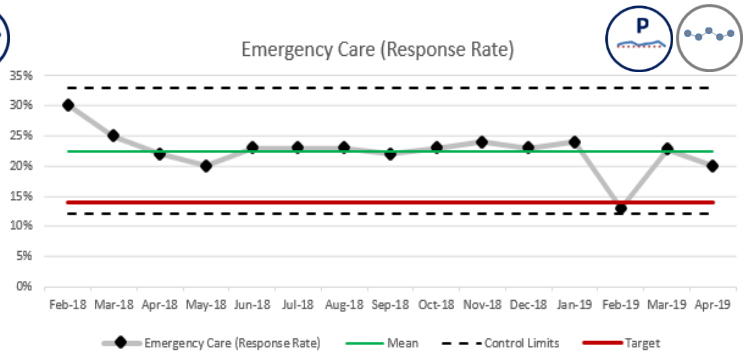
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

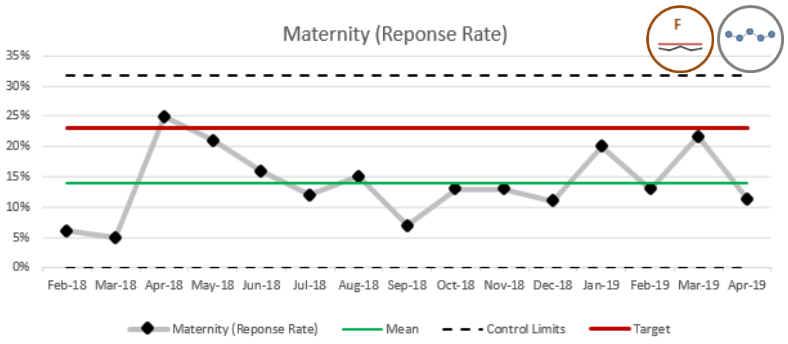
Executive Lead: Martin Rayson

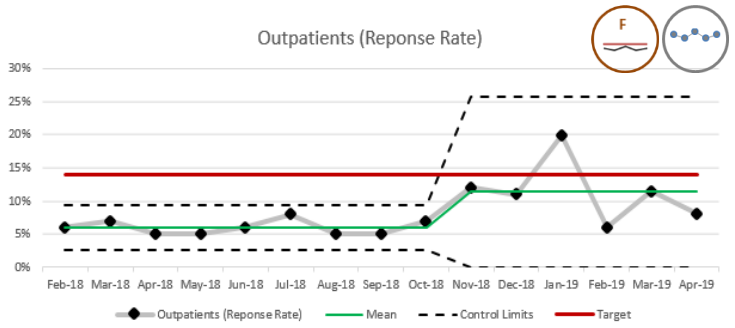
CQC Domain: Caring

2021 Objective: Our Patients









Actions in place to recover:

- Patient Experience paper to be presented to Trust Management Group in June regarding performance management, engagement and ownership of all patient experience metrics and initiatives by the divisions.
- Currently 40 FAB Experience Champions have been signed up across the divisions. The first round of drop in sessions will be set up in May 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.

    - CLINICAL SUPPORT SERVICES 14
    - CORPORATE 1
    - FAMILY HEALTH 9
    - MEDICINE 11
    - SURGERY 5

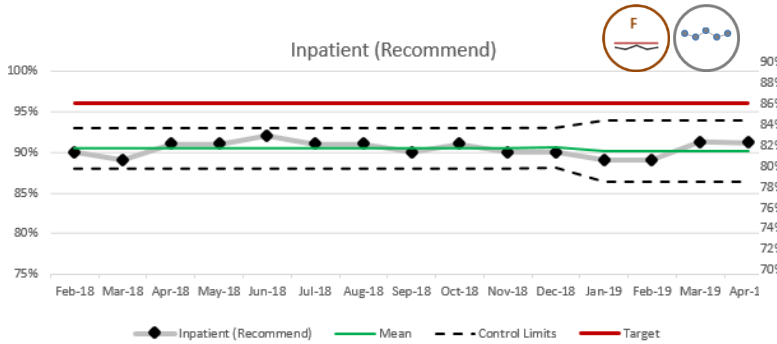
- The SUPERB dashboard went live in March and has been well received. Many different teams, departments and areas have begun to make good use of it. Further training sessions will be developed to encourage all teams to routinely interrogate their data using the dashboard.

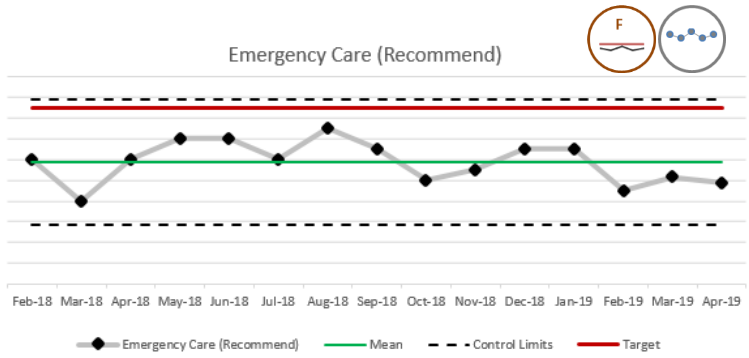
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

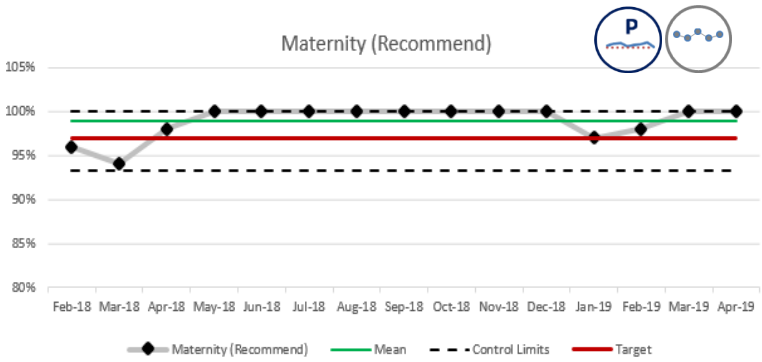
Executive Lead: Martin Rayson

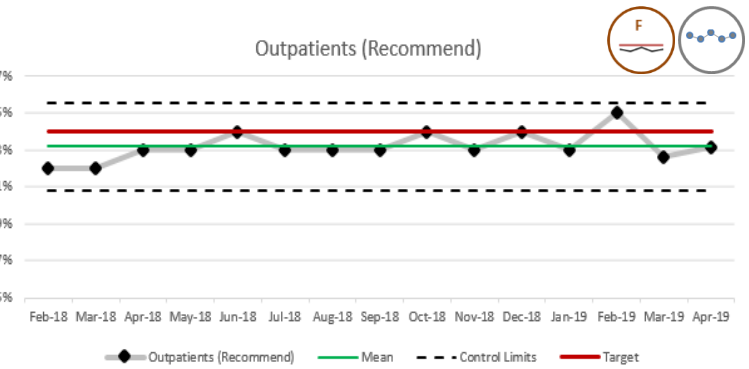
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Emergency care, inpatients and outpatients percentage FFT recommends stayed fairly consistent between March and April. 90% of patients would recommend which remained static against data for March too.

Actions in place to recover:

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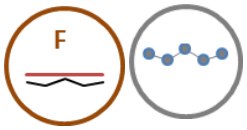
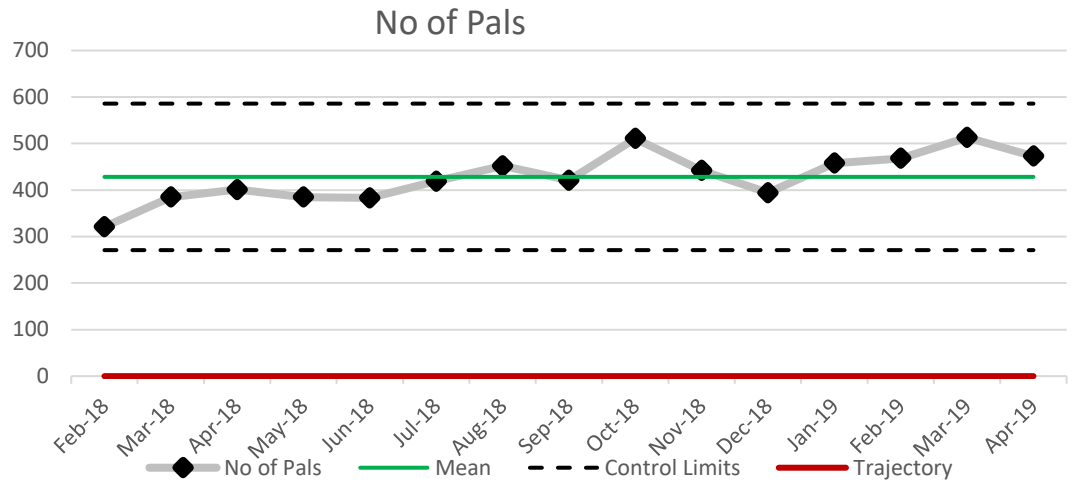
VALUING PATIENTS TIME – PALS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients





Challenges/Successes

- The top 3 themes for PALS for April were: Communication with Patients, Appointment Cancellations and Car Parking
- 473 concerns were taken to PALS during April. 270 for Lincoln and Louth, 41 for Grantham, 162 for Pilgrim and the remainder for community hospitals.
- Expectations are that we'll reach our 80,000th Compliment within May.
- Using SUPERB dashboard, the divisional split for PALS concerns received were:
    - Clinical Support Services 144
    - Medicine 90
    - Surgery 84
    - Estates & Facilities 41
    - Family health 23
    - Corporate 3
- Counting Compliments against complaints ratio – 35:1

Care Opinion, 45 stories were posted with 67% being positive

Actions in place to recover:

- Patient Experience paper to be presented to Trust Management Group in June regarding performance management, engagement and ownership of all patient experience metrics and initiatives by the divisions.
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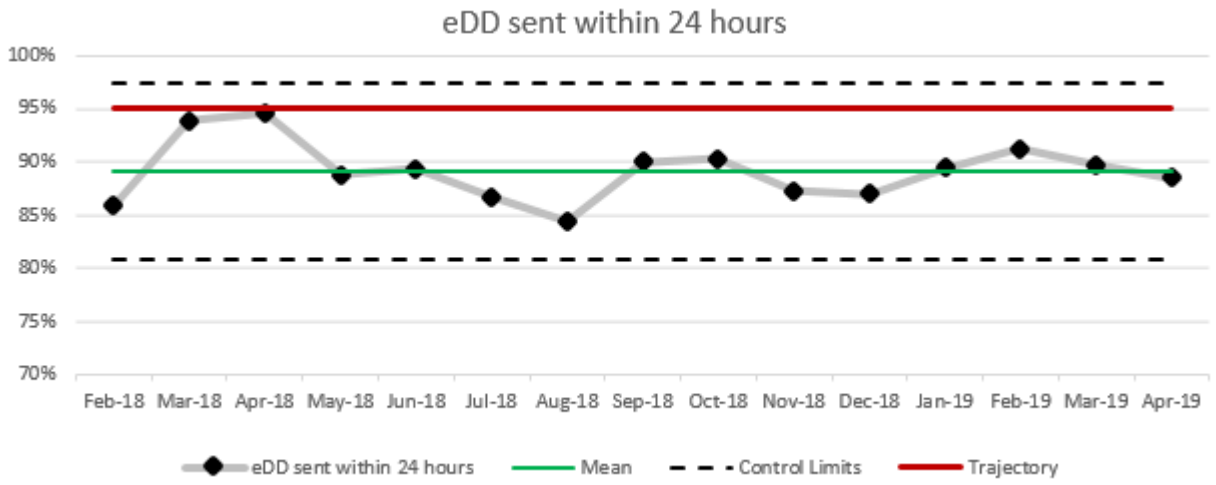
VALUING PATIENTS TIME – ELECTRONIC DISCHARGE DOCUMENTS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients



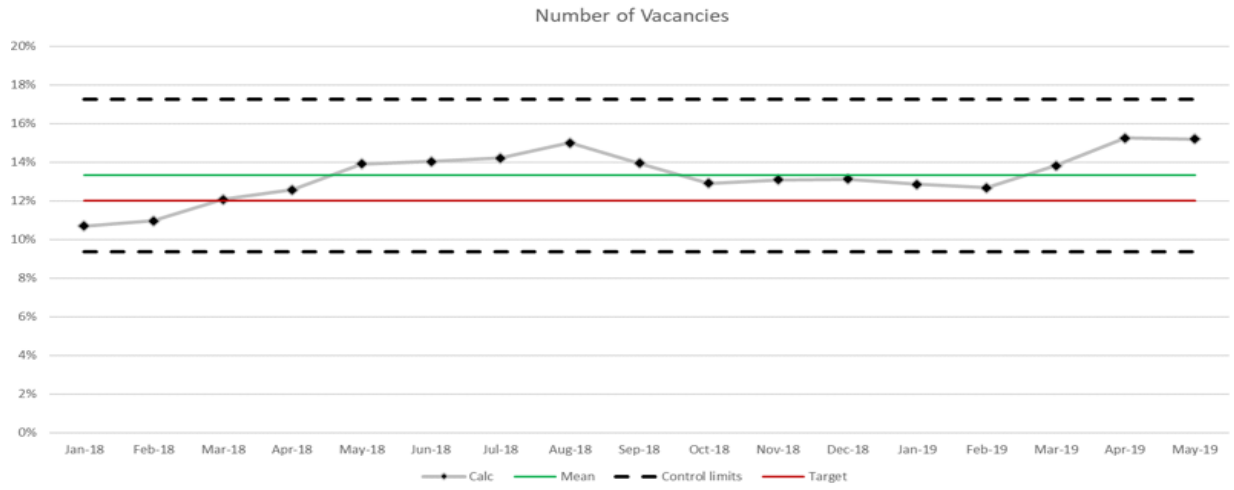
The Trust is not achieving the standard of all eDDs being sent within 24 hours. A bespoke eDD dashboard has been developed to enable clinicians and managers to review compliance of their eDDs. This will be launched in June 2019. Maternity and day case wards will be added when the data have been validated. Focus is on removing the backlog and timely eDDs being sent.

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People



.Challenges/Successes

The overall Trust Vacancy Rate decreased slightly from 15.3% in April to 15.2% in May having risen markedly from February to Aril due to increased establishment.

The Finance Team has itemised the increases as follows:

The 101.95 fte increase to March 19

- 60 fte in relation to the Capacity & Delivery business case
- 10 fte in relation to the expansion of the staff bank and creation of a medical agency and bank team
- 12 fte in relation to the clinical coding business case
- 6 fte in relation to the expansion of pharmacy aseptic staffing phase 1
- Plus other business cases e.g. clinical holding BC, NOUS AQP BC, CQUIN Alcohol & Tobacco BC, Clinical Strategy restructure.

The 87 fte increase in March to April was for the establishment of unfunded posts and creation of an endoscopy reserve.

Medical Vacancy Rate reduced in May to 20.8% having risen in March and April due to increased establishments. Staff in post increased by 5.4 WTE in May. Further detail of Medical Vacancy Rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Lincoln Radiology Consultants	8.7	53%
	Lincoln Clinical Haematology IP	3.1	33%
Family Health	Lincoln Paediatrics IP	8.7	30%
	Pilgrim Paediatrics IP	3.7	19%
Medicine	Lincoln Elderly Care IP	14.4	59%
	A&E Attenders Lincoln	14.2	37%
	A&E Attenders Pilgrim	12.0	34%
	Lincoln Cardiology IP	5.0	23%
Surgery	Lincoln Anaesthetics Medical Staff	9.4	18%
	Lincoln ENT IP	5.7	53%

Of particular note is A&E Attenders at Pilgrim with the Vacancy fte reducing from 18.00 fte to 12.00 fte.

Nursing Vacancy Rate remains at 20.2% following a sharp rise to April 19. Staff in post at the end of May decreased by 8.9 fte, broadly in-line with the Trusts workforce and FEP plans. Further detail of Nurse Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Medicine	A&E Pilgrim	32.8	54%
	Pilgrim AMSS	19	56%
	A&E Lincoln	18.4	28%
	Lincoln EAU	17.1	35%
	Pilgrim Stroke Unit	13.8	48%
	Ward 7B	13.0	56%
	Ward 6A	21.8	48%
Surgery	Lincoln Main Theatres	16.0	24%
	Ward 5B	10.8	47%
	Bevan Ward	9.5	65%
	Ward 9A	9.3	42%
Family Health	Rainforest Ward	14.5	45%
	Ward 4A	13.5	41%

AHPs Vacancy Rate remained at 14.8%. Detail of notable AHP Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	10.4	32%
	Pilgrim Occupational Therapy	8.1	39%

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. HRBPs are working with division to ensure EF3s are process in a more timely way to enable early commencement of recruitment.

TMP have completed the first two phases of their work around employer brand development and will start to inform some of our recruitment activity. It is planned for initial creative work to be tested with staff focus groups.

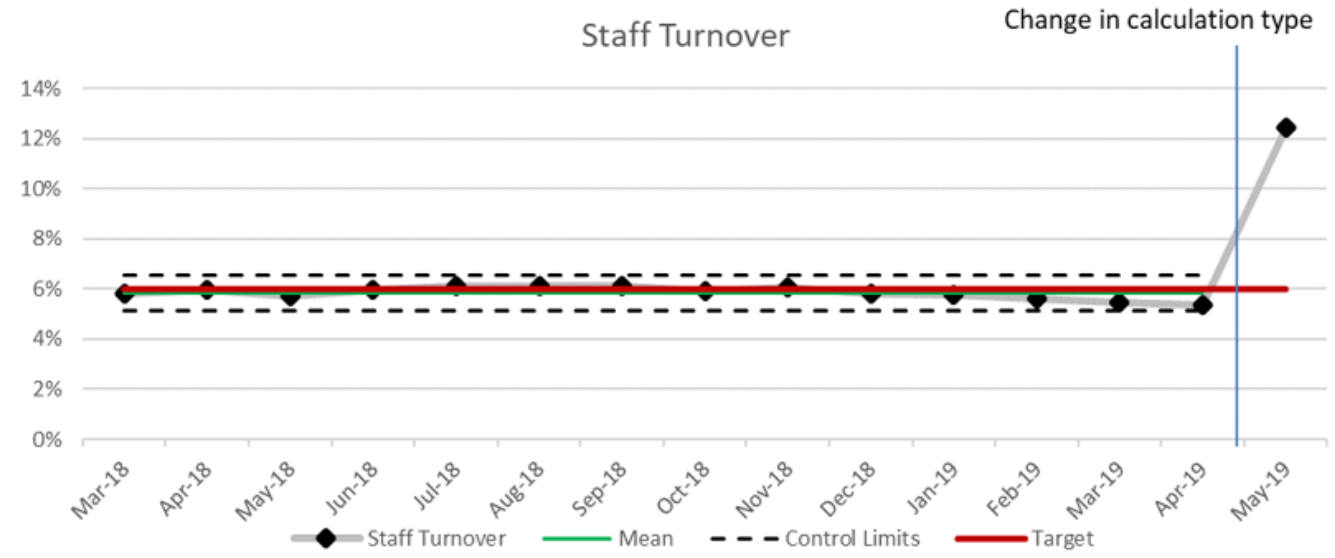
Medical and Dental – There have been 23 fte of new starts (Consultant and SAS) for the first quarter and 37 fte is forecast for the second quarter of 2019/20. Divisions are increasingly adopting the 'plan for ever post' approach to all vacant post and there is greater triangulation with associated agency costs. Two potential international strategic partners have been shortlisted with a final decision to be taken at June TMG. External on-boarding support is being piloted.

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



From May 2019 the calculation of turnover has changed to include all staff who have retired and those who have left their substantive role and remained on the Staff Bank to more accurately reflect the level of staff leaving the trust (This excludes DiT rotation movements). Previously we reported staff retiring separately in the IPR and did not include staff moving from permanent to bank contracts. However, for the purposes of fully understanding the staffing position, we have changed the basis of reporting. The breakdown is 544.79 FTE who have completely left the trust and 223.21 FTE who have left the trust and remained on the bank.

Actions in place to recover

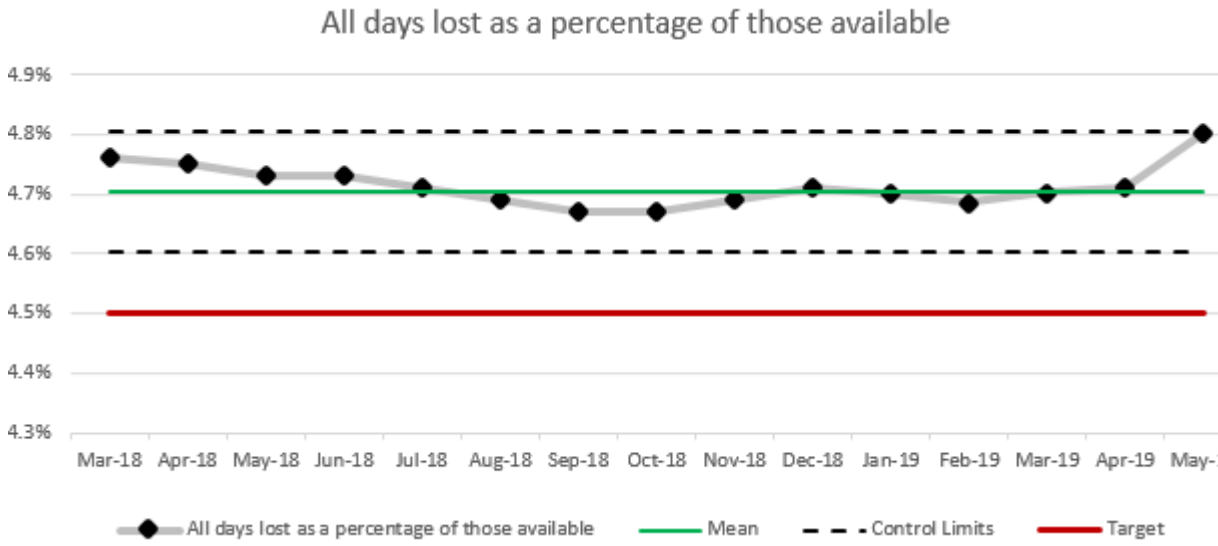
Self-rostering pilot in progress.
Process for Retire and Return designed and implemented.
Pre-retirement workshops being re-designed to include more information on Retire and Return.
Legacy Nurse role currently under discussion.
Videos being developed on different flexible working options and the current policy also being re-worded.
Internal transfer policy created and taken to EPF.
Itchy Feet conversations launched. Communication plan being designed to ensure staff are aware about this scheme.
Launched career pathways campaign.
Analysis of exit data to be completed by end June.
Week-long event being designed for mid- September to showcase all retention opportunities across the Trust.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



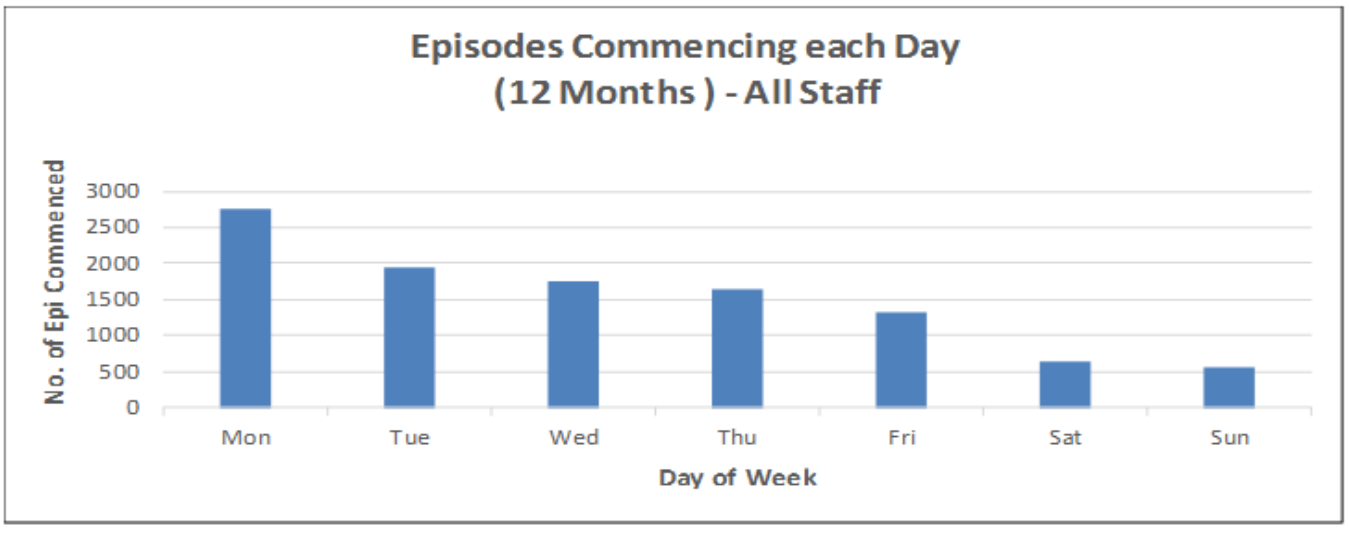
Challenges/Successes

The overall sickness rate for the Trust (12 month rolling average) has been stable at around 4.7% to 4.8% since October 2018.

ULHT is 0.3% above our target of 4.5%. According to the last available 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). There is variation between Divisions and evidence that a focus on sickness issues can have an impact.

The HRBPs and ER Team are working together to focus on hotspot areas.

There is also a focus on patterns of sickness. The table below shows episodes per day of the week.



Monday shows the highest reporting of absence, the ER team are working with Divisions to investigate this further. 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.

Absence Reason	FTE Days Lost	Abs Estimated Cost	%
Anxiety/stress/depression/other psychiatric illnesses	25,730.53	£2,318,719.52	22.74
Other known causes - not elsewhere classified	18,247.31	£1,530,215.05	16.13
Other musculoskeletal problems	12,537.66	£1,066,612.76	11.08
Gastrointestinal problems	9,481.74	£803,695.95	8.38
Back Problems	8,208.73	£631,187.36	7.25

Stress/ Anxiety and depression is the major cause of absence. Other known cause is the next largest reason followed by MSK.

Actions in place to recover

The monthly ‘Case Reviews’ with input from Occupational Health in ‘difficult to manage’ continue to be undertaken.

The Employee Relations Team (ER) are supporting managers to arrange immediate follow-up meetings following OH appointments to review reports, with greater emphasis on ensuring timely case reviews. There are currently 6 cases that are looking at redeployment opportunities and
the ER team continue to support managers to look at opportunities to support staff to enable them to return to work as soon as practicable in some capacity.

A new divisional performance report on ER activities documents the number of cases being dealt with by each Division.

ER Team continues to work with Divisions on the percentage of return to work interviews and report into Divisions to highlight non- compliance.

The ER team work with the HRBP’s to feed into the Performance review meetings.

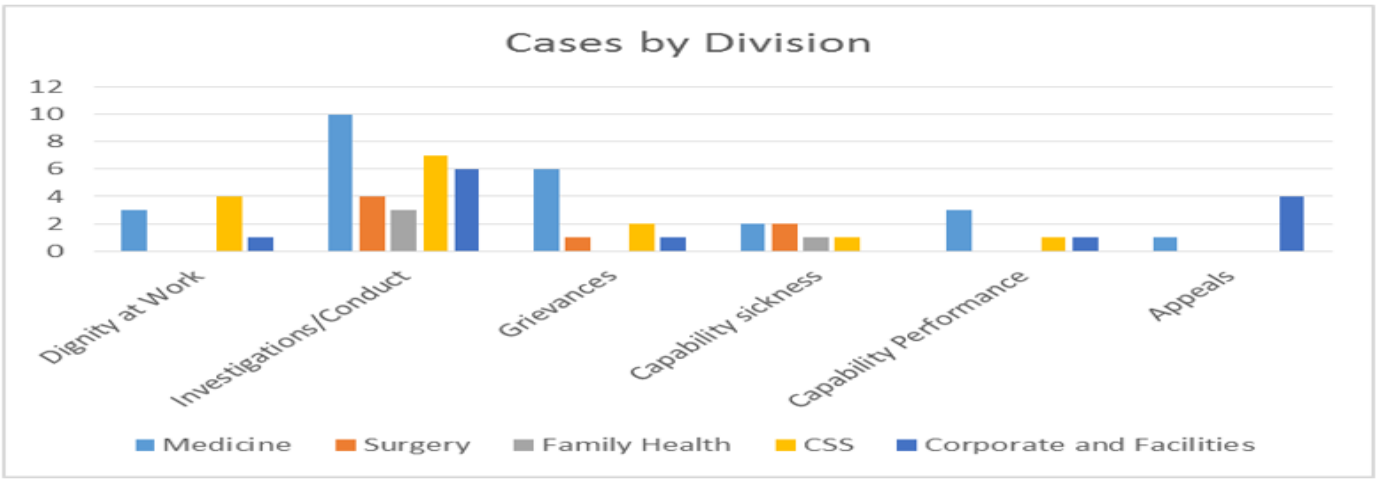
We have, with NHSI support, purchased a new absence management system (Empactus), which will support managers to take the leading role in managing absence, supported by HR. The system has delivered benefits at sites where it has been introduced. It will also systemize the process we have tried to establish of reporting absence to OH, who can arrange early access to treatment and give advice on potential return to work. We expect to implement in the Autumn.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

There are 66 open cases for May compared with 62 cases for April, this is a 6% increase and a 29% increase in activity from March. The majority of cases are in the Medicine Division with 22 cases (reduction of 2 from last month. The Division has seen a significant increase for April by 8 additional cases, this is a 32% increase in activity.

Whilst there is still a significant drift in the amount of Performance capability cases, compared to what would be expected for a challenging Trust with Circa 7,800 staff, there has been an increase of 2 since last month. There are currently 26 cases that are proceeding to hearings, where panels are being established.

We have one new case this month for alleged race discrimination. Two of the Employment tribunals have been in 'stay' for over a year. One of the claims for pay should be settled out of court prior to the hearing.

We currently have 3 suspensions (non are medical staffing). HR strongly advise against suspensions and look at redeployment options in suspensions and this has supported the numbers to remain the same.

There are currently 22 active cases logged through the Medial LDMG this is an increase of 5 cases, all these cases are not necessarily being managed through MHPS process but are actively monitored through the medical LDMG whom meet on a weekly basis.

Actions in place to recover

The ER Managers continue to have weekly case conferences with the ER Advisors to ensure and update cases and identify any problems with cases being completed.

Divisional performance reports have been created to advise divisions of performance and current ER status.

ER Team continues to challenge managers on appropriate management and actions on issues and cases

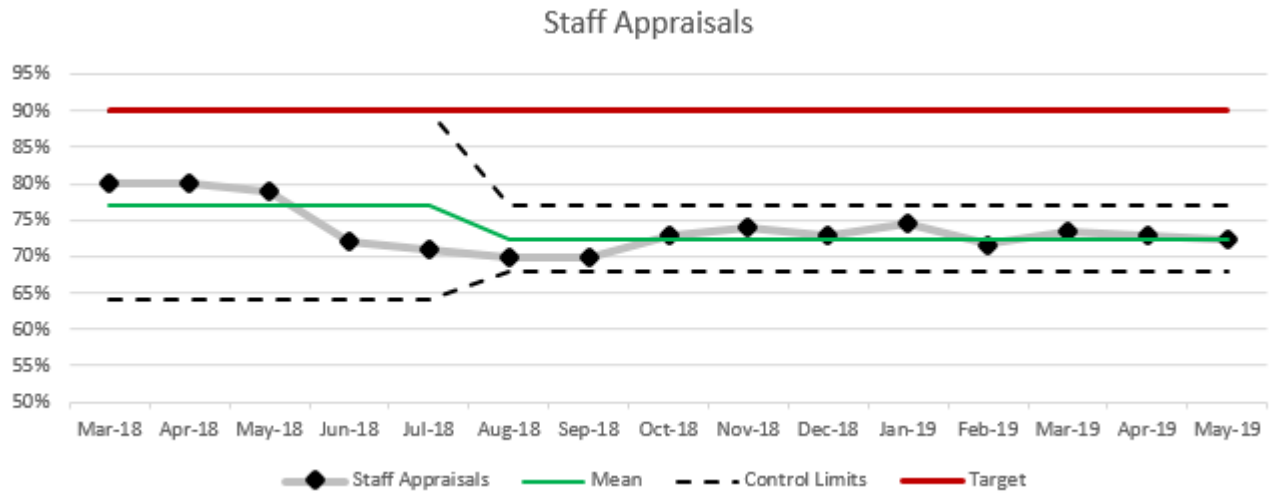
Head of HR Ops meets with HRBP's monthly and shares ER activity, so that Divisional and Directorate management teams can be sited on the overall position

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 –

- Chief Operating Officer 25.58%
- Medicine Division Management 20.69%
- Surgery Division Management 25.00%

Actions in place to recover

Positive feedback has been received to date on the updated appraisal paperwork, which has been widely circulated including staff side colleagues.

A paper will be taken to ET late June to agree the new approach and including the feedback from the appraisal quality survey that was launched in April 2019.

Appraisee training has been taking place during April and May. 86 staff have attended to date. A further 22 sessions are scheduled for 19/20 with 440 places available. These are being revised to cover information for both appraisees and appraisers.

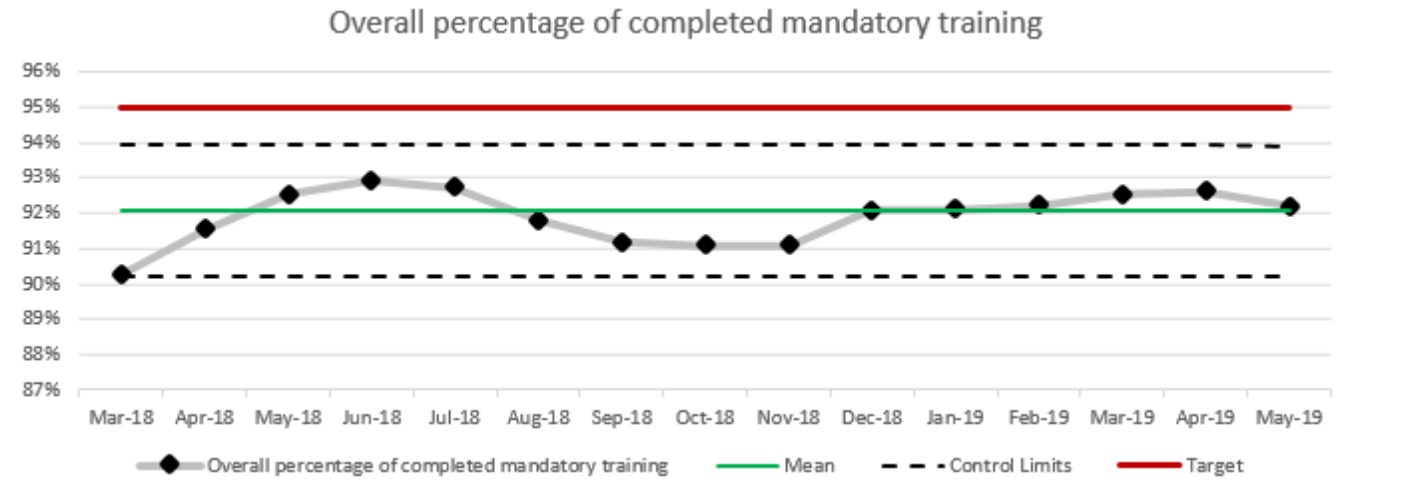
There has to be a focus through PRMs for holding people to account for holding appraisals.

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Overall compliance has continued to increase again this month by 0.18% to 92.2%. This is now only 0.12% below the highest percentage the Trust has achieved which was in June 18 and 0.28% higher than this month last year.

Looking at the individual topics, all apart from Basic Life Support and Information Governance show an increase. Information Governance/Data Security has fallen the greatest by 0.97% with an overall compliance of 86.04% which is far lower than the 95% target the Trust is required to achieve for NHS Digital Data Security Toolkit. The Trust did not meet it's target at the end of March 2019 submission (although it was higher than last year) and is therefore required to report back again in August. The table shows compliance for this by Division.

Division	Information Governance - 1 Year
Clinical Support Services	88.59%
Corporate	89.37%
Director of Estates & Facil	78.43%
Family Health	90.81%
Medicine	81.86%
Surgery	87.89%

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.

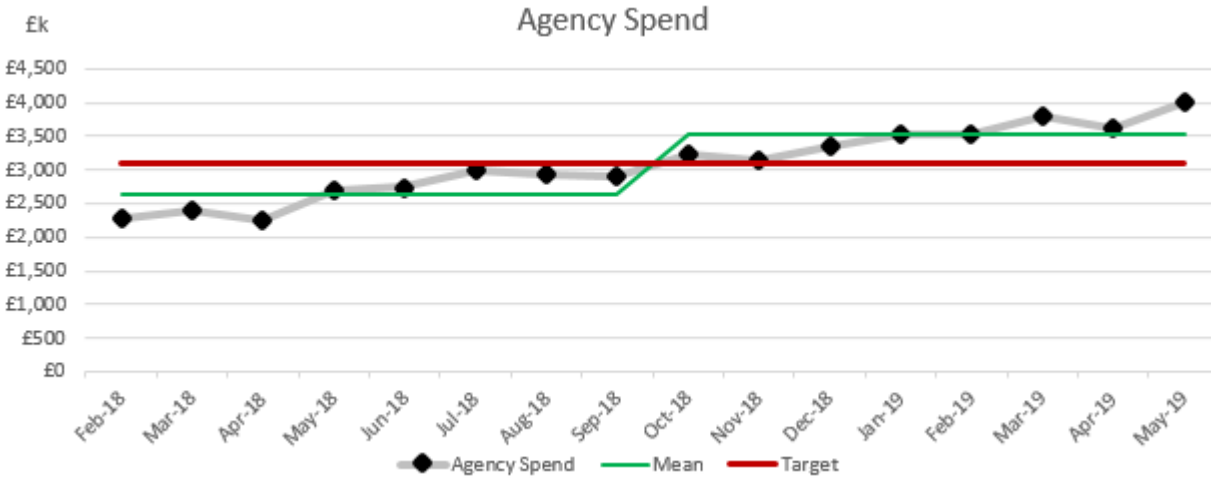
Core Learning Panel to consider use of external e-learning which is generally more problematic than in-house designed programs.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

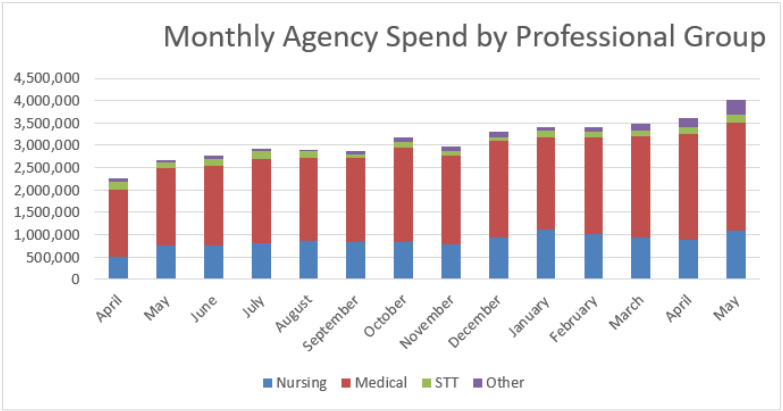
2021 Objective: Our People



In May, Year to Date (YTD) actual pay costs were 0.9% adverse to plan and 73.6% of income (or 1.0% higher than plan).

The adverse variance to plan is being driven by the higher premium cost of temporary staffing which is £535k greater than the substantive underspend.

The monthly run rate for Agency spend continued to increase in Month 2 and significantly exceeds that planned despite the rate aspects of the Agency cost reduction and some improvement in substantive staff in post fte. The table below shows agency spend at M2 and the graph the last 12 months by month and by professional group.



As at end May 19	Nursing	Medical	STT	Other	Total
Profile £	1,370	2,499	205	160	4,233
Actual £	1,963	4,811	324	542	7,640
Variance £	-593	-2,312	-120	-382	-3,407
Variance %	-43.32%	-92.55%	-58.44%	-238.64%	-80.50%

In M2 agency costs for nursing increased significantly from April (by an additional £207K) and had been on a downward trend from a 12 month high in January 19. The increase was driven both by additional demand for temporary nurse staffing (see vacancy rate section) and the proportion of this demand being provided by Tier 6 agencies. The month of May had two bank holidays and a half-term resulting in higher annual leave of substantive staff and an increase in the level of bank staff cancelled availability. There was also an increase in sickness absence for this staff group during the period of the half-term.

Whilst high, Medical agency costs for May increased marginally by £52k from £2.38M in April 19 to £2.43M in May 19, despite an anticipated reduction in run rate. Requested medical shifts were up from 4,047 in April to

4,224 in May 19. Fill rate remained static at 98.5%. Family Health saw the greatest increase in demand from April to May. Just over 23% of activity was through the internal medical Bank. Work to fully understand vacancy and other cover versus Extra Duty Payments to substantive and fixed term locums is being undertaken.

Other Agency costs increased significantly in May, £327K from £217 in April and have been increasing since February 19.

The Central Temporary Medical Staffing team is now in place and is making good progress, and actions in May mitigated the overall increase in Agency spend. Direct Engagement of AHPs now in place and with have FYE in 19/20. New reduced collaborative medical rates have been effective from 1st March 19. New medical temporary staffing SOP developed with divisional engagement, this is being trialled in ED at Lincoln. Central timesheets approval now in place.

Actions in place to recover

The primary action to reduce agency costs is to still to reduce vacancy rates through substantive recruitment.

New medical temporary staffing SOP to be fully implemented by July 2019.

Targeted removal of Umbrella companies by September 2019

Further removal of paid breaks for temporary medical staff.

Introduction of revised non–residential on-call payments in Surgery Division.

Study leave cover to be eliminated as far as possible.

Central agency team working with HOLT to provide divisions with improved early MI to support earlier intervention (w/c 17th June 2019)

SHRBP's to link with divisions providing professional challenge and scrutiny to ensure the divisions are engaging appropriately with the central resourcing and agency teams.

Full review of rostering practice for Nursing including payments of breaks and management of annual leave

Longer term temporary nursing staffing plans to be developed to avoid higher premiums of shorter lead time requests.

We will undertaking a deep dive into the reasons for the agency cost increase in April and May in order to identify the further actions that may be necessary to bring levels of spend under control.

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	41,786	41,522	(264)	82,114	81,743	(371)	501,616	501,616	0
Expenditure	(44,401)	(44,214)	187	(89,717)	(89,461)	256	(520,722)	(520,722)	0
EBITDA	(2,615)	(2,692)	(77)	(7,603)	(7,718)	(115)	(19,106)	(19,106)	0
Depn/Interest	(1,804)	(1,728)	76	(3,568)	(3,490)	78	(22,306)	(22,306)	0
Surplus/(Deficit)	(4,419)	(4,420)	(1)	(11,171)	(11,208)	(37)	(41,412)	(41,412)	0
Technical adjustments	1	20	19	2	39	37	14	14	0
Surplus/(Deficit)	(4,418)	(4,400)	18	(11,169)	(11,169)	0	(41,398)	(41,398)	0
EBITDA % Income	-6.3%	-6.5%	-0.2%	-9.3%	-9.4%	-0.2%	-3.8%	-3.8%	0.0%
FEPs	1,171	1,546	375	2,213	2,056	(157)	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 £11.169m deficit, or in line with the planned £11.169m deficit.

EBITDA for the year to date is £7.718m deficit (-9.4% of Income).

Income overall is £371k adverse to plan YTD; the income position assumes £3.136m in relation to PSF, FRF & MRET.

Expenditure is £256k favourable to plan YTD, but this comprises of an adverse Pay movement to plan of £535k and a favourable Non Pay movement to plan of £791k.

Pay expenditure is £1,473k favourable to plan against substantive staffing and £2,009k adverse to plan on temporary staffing; the adverse movement in temporary staffing includes an adverse movement to plan of £1,468k in relation to expenditure on Agency staffing and £540k.

Against a YTD FEP savings target of £2,213k, actual FEP savings delivery of £621k was reported in April has now been restated to £510k, and FEP savings delivery of £1,546k is reported in May. The YTD FEP position is therefore savings delivery of £2,056k or an adverse movement to plan of £157k.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	In Month Plan M1	In Month Actuals M1	In Month Variance M1	Full Year Plan Full Year	Full Year Forecast Full Year	Full Year Variance Full Year
Income																		
NHS Clinical Income	31,724	33,679	31,702	33,686	32,537	32,121	33,423	31,766	31,532	32,609	30,580	32,818	33,089	33,679	590	387,176	387,176	0
Non NHS Clinical Income	506	229	282	283	282	282	282	281	282	282	284	280	282	229	(53)	3,384	3,384	0
Pass through income	3,659	3,368	4,095	4,112	4,095	4,104	4,112	4,104	4,087	4,104	4,104	4,104	4,104	3,368	(736)	49,220	49,220	0
Total Patient related income	**35,889**	**37,276**	**36,079**	**38,081**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**37,202**	**37,475**	**37,276**	**(199)**	**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	2,678	2,743	2,743	2,742	2,741	2,745	2,743	2,741	2,744	2,742	2,782	2,743	2,678	(65)	32,908	32,908	0
Total Other operating income	**4,332**	**4,246**	**4,312**	**4,732**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,038**	**4,311**	**4,246**	**(65)**	**61,836**	**61,836**	**0**
Total Income	**40,221**	**41,522**	**40,391**	**42,813**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**43,240**	**41,786**	**41,522**	**(264)**	**501,616**	**501,616**	**0**
Expenditure																		
Pay	(30,868)	(29,254)	(29,338)	(28,757)	(28,697)	(28,607)	(28,444)	(28,253)	(27,859)	(27,847)	(27,848)	(26,848)	(29,333)	(29,254)	79	(342,620)	(342,620)	0
Pass through non pay	(3,659)	(3,368)	(4,095)	(4,112)	(4,095)	(4,104)	(4,112)	(4,104)	(4,087)	(4,104)	(4,104)	(4,104)	(4,104)	(3,368)	736	(49,220)	(49,220)	0
Other Non pay	(10,720)	(11,592)	(10,970)	(10,625)	(10,638)	(10,630)	(10,625)	(10,627)	(10,647)	(10,731)	(10,725)	(11,534)	(10,964)	(11,592)	(628)	(128,882)	(128,882)	0
Total Expenditure	**(45,247)**	**(44,214)**	**(44,403)**	**(43,494)**	**(43,430)**	**(43,341)**	**(43,181)**	**(42,984)**	**(42,593)**	**(42,682)**	**(42,677)**	**(42,486)**	**(44,401)**	**(44,214)**	**187**	**(520,722)**	**(520,722)**	**0**
Finance & Depreciation costs	(1,728)	(1,762)	(1,810)	(1,846)	(1,856)	(1,849)	(1,882)	(1,867)	(1,908)	(1,912)	(1,867)	(2,009)	(1,804)	(1,762)	42	(22,306)	(22,306)	0
I&E - Deficit	**(6,754)**	**(4,454)**	**(5,822)**	**(2,527)**	**(3,641)**	**(3,952)**	**(1,669)**	**(3,125)**	**(3,028)**	**(1,603)**	**(3,582)**	**(1,255)**	**(4,419)**	**(4,454)**	**(35)**	**(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	20	1	1	1	2	1	1	1	1	2	(24)	1	20	19	14	14	0
Adjusted Surplus/(Deficit)	**(6,735)**	**(4,434)**	**(5,821)**	**(2,526)**	**(3,640)**	**(3,950)**	**(1,668)**	**(3,124)**	**(3,027)**	**(1,602)**	**(3,580)**	**(1,279)**	**(4,418)**	**(4,434)**	**(16)**	**(41,398)**	**(41,398)**	**0**
Adjustments to derive underlying deficit																		
FSM Loan Interest	643	689	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	(890)	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)**	**(4,077)**	**(4,553)**	**(1,705)**	**(2,809)**	**(3,126)**	**(1,136)**	**(2,357)**	**(2,219)**	**(790)**	**(2,813)**	**(438)**				**(30,642)**	**(30,642)**	**0**

The Trust's financial plan is a deficit of £41.4m, and as at the end of May the Trust position is a deficit of £11.169m or in line with 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 year to date - the planned run rate from June to March averages £3.0m 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. However, the underlying Pay run rate remains higher than planned; whilst in April this was offset by lower than planned Non Pay, in May this has been supported by the release of £890k of Pay provisions.

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 2	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20			2018/19	2019/20			2018/19	2019/20		
	May Activity Actual	May Activity Plan	May Activity Actual	May Activity Variance	May £k Actual	May £k Plan	May £k Actual	May £k Variance	May Activity Actual	May Activity Plan	May Activity Actual	May Activity Variance	May £k Actual	May £k Plan	May £k Actual	May £k Variance
Activity:																
Accident & Emergency	12,963	11,585	12,740	1,155	1,881.8	2,073.1	2,168.0	94.9	25,194	22,794	24,729	1,935	3,623.5	4,078.9	4,207.0	128.1
Daycases	5,512	5,582	5,617	35	2,859.2	2,961.3	3,039.5	78.1	10,934	10,656	10,920	264	5,616.6	5,653.4	5,905.0	251.6
Elective Spells	793	791	851	60	1,988.4	2,179.5	2,366.1	186.7	1,520	1,510	1,544	34	3,849.2	4,160.9	4,329.5	168.6
Non Elective Spells	6,019	6,100	6,441	341	10,587.4	11,376.2	12,809.4	1,433.2	11,697	11,994	12,488	494	20,707.5	22,363.9	25,228.8	2,865.0
Elective Excess Bed Days	184	117	46	- 71	42.5	31.8	11.6	- 20.2	263	234	114	- 120	65.2	63.6	29.3	- 34.3
Non Elective Excess Bed Days	1,647	1,645	1,625	- 20	398.7	431.0	263.1	- 167.8	3,324	3,289	2,672	- 617	790.0	861.9	547.3	- 314.7
Outpatient Firsts	25,649	25,402	23,579	- 1,823	3,397.9	3,627.8	3,333.0	- 294.9	49,001	48,495	47,809	- 686	6,488.0	6,925.9	6,795.0	- 130.8
Outpatient Follow Ups	33,260	33,321	32,881	- 440	2,827.2	3,090.9	2,939.8	- 151.1	64,993	63,613	64,606	993	5,516.7	5,900.8	5,831.1	- 69.6
Outpatient Non Face To Face	2,294	2,123	2,164	41	49.6	138.1	126.3	- 11.8	4,313	4,180	6,466	2,286	92.6	273.3	409.4	136.1
Outpatient Advice & Guidance	-	279	279	-	-	8.5	8.5	-	-	558	655	97	-	17.0	18.0	1.0
Critical Care	1,395	1,630	1,482	- 148	1,055.0	1,551.5	1,311.3	- 240.2	3,085	3,261	3,050	- 210	2,387.0	3,102.9	2,727.7	- 375.2
Maternity	1,013	1,028	979	- 49	893.4	895.0	892.6	- 2.4	2,045	2,055	1,888	- 167	1,738.5	1,790.0	1,784.3	- 5.7
Non PbR					3,648.0	3,083.7	3,109.4	25.8					7,404.7	6,176.1	6,281.3	105.2
Block	-	-	-	-	-	237.4	237.4	-	-	-	-	-	-	474.7	474.7	-
Shadow Monitoring	-	1,395	1,395	-	-	-	-	-	-	2,790	2,877	87	-	-	-	-
Repatriation						482.8	482.8	-						950.0	950.0	-
Backlog						194.8	194.8	-						383.3	383.3	-
Work in Progress:						-	- 391.6	- 391.6						-	- 611.2	- 611.2
Sub total without passthrough					**29,629.1**	**32,363.2**	**32,902.1**	**538.9**					**58,279.5**	**63,176.5**	**65,290.7**	**2,114.2**
CQUIN					605.7	372.9	384.7	11.8					1,194.7	726.5	759.3	32.8
Fines						-	- 90.7	- 90.7						-	- 181.4	- 181.4
Fines Reinvested						-	30.7	30.7						-	61.4	61.4
								-								-
Bring Lincolnshire CCG Contract to Plan						-	- 746.4	- 746.4						-	- 2,358.2	- 2,358.2
APA (calculated at quarterly billing)						-	484.0	484.0						-	484.0	484.0
								-								-
Prior Year						-		-						-		-
								-								-
Maternity Prepayment						-		-						-		-
								-								-
Total (Non Passthrough)						**32,736.1**	**32,964.3**	**228.2**						**63,903.0**	**64,055.8**	**152.8**
Passthrough					4,339.2	4,232.3	3,929.8	- 302.5					8,166.4	8,447.5	7,957.5	- 490.0
Total (Inc Passthrough)						**36,968.4**	**36,894.2**	**- 74.2**						**72,350.5**	**72,013.3**	**- 337.2**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Activity Units														
Activity	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Forecast Activity	Full Year Plan	Variance
Accident & Emergency	11,989	12,740	11,209	11,585	11,585	11,209	11,585	11,209	11,585	11,585	10,832	9,650	136,763	136,763	-
Daycases	5,303	5,617	5,074	5,835	5,328	5,328	5,835	5,328	5,074	5,582	5,074	5,317	64,695	64,695	-
Elective Spells	693	851	719	827	755	755	827	755	719	791	719	756	9,166	9,166	-
Non Elective Spells	6,047	6,441	5,979	6,153	6,137	5,952	6,110	5,867	6,012	5,995	5,587	5,540	71,820	71,820	-
Elective Excess Bed Days	68	46	117	117	117	117	117	117	117	117	117	237	1,406	1,406	-
Non Elective Excess Bed Days	1,047	1,625	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	2,262	19,736	19,736	-
Outpatient Firsts	24,230	23,579	23,093	26,557	24,247	24,247	26,557	24,247	23,093	25,402	23,093	26,088	294,433	294,433	-
Outpatient Follow Ups	31,725	32,881	30,292	34,836	31,806	31,806	34,836	31,806	30,292	33,321	30,292	32,328	386,221	386,221	-
Outpatient Non Face To Face	4,302	2,164	2,057	2,156	2,090	2,090	2,156	2,090	2,057	2,123	2,057	- 163	25,179	25,179	-
Outpatient Advice & Guidance	376	279	279	279	279	279	279	279	279	279	279	182	3,349	3,349	-

Activity	19/20 YTD Actual M2	19/20 YTD Plan M2	19/20 YTD Actual M2	YTD Var M2	% Var M2
Accident & Emergency	25,194	22,794	24,729	1,935	8.5%
Daycases	10,934	10,656	10,920	264	2.5%
Elective Spells	1,520	1,510	1,544	34	2.3%
Non Elective Spells	11,697	11,994	12,488	494	4.1%
Elective Excess Bed Days	263	234	114	- 120	-51.3%
Non Elective Excess Bed Days	3,324	3,289	2,672	- 617	-18.8%
Outpatient Firsts	49,001	48,495	47,809	- 686	-1.4%
Outpatient Follow Ups	64,993	63,613	64,606	993	1.6%
Outpatient Non Face To Face	4,313	4,180	6,466	2,286	54.7%
Outpatient Advice & Guidance	-	558	655	97	17.4%

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

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

A&E and Non-Elective activity levels are being raised formally with Lincolnshire CCGs given their impact upon the Trust's ability to manage flow and bed resources and their overall impact on the Trust's financial position.

Non Elective activity is 4% up against plan YTD in relation to activity and 14% in relation to income. This Non Elective over performance is mainly within the Medicine Division and further details are being shared with the Division.

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

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Plan (£k)														
Income	Actual M1	Actual M2	Forecast M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	Full Year Actual £	Full Year Plan	Variance
Accident & Emergency	2,039.0	2,168.0	2,005.8	2,073.1	2,073.1	2,005.8	2,073.1	2,005.8	2,073.1	2,073.1	1,938.5	1,945.0	24,473.5	24,473.5	-
Daycases	2,865.6	3,039.5	2,692.1	3,095.9	2,826.7	2,826.7	3,095.9	2,826.7	2,692.1	2,961.3	2,692.1	2,709.7	34,324.4	34,324.4	-
Elective Spells	1,963.4	2,366.1	1,981.4	2,278.5	2,080.4	2,080.4	2,278.5	2,080.4	1,981.4	2,179.5	1,981.4	2,010.8	25,262.2	25,262.2	-
Non Elective Spells	12,419.4	12,809.4	11,186.4	11,501.4	11,463.8	11,124.6	11,398.7	10,923.4	11,168.3	11,128.2	10,360.5	8,355.9	133,840.1	133,840.1	-
Elective Excess Bed Days	17.7	11.6	31.8	31.8	31.8	31.8	31.8	31.8	31.8	31.8	31.8	66.1	381.5	381.5	-
Non Elective Excess Bed Days	284.1	263.1	431.0	431.0	431.0	431.0	431.0	431.0	431.0	431.0	431.0	745.6	5,171.6	5,171.6	-
Outpatient Firsts	3,462.1	3,333.0	3,298.0	3,792.7	3,462.9	3,462.9	3,792.7	3,462.9	3,298.0	3,627.8	3,298.0	3,758.7	42,050.0	42,050.0	-
Outpatient Follow Ups	2,891.3	2,939.8	2,809.9	3,231.4	2,950.4	2,950.4	3,231.4	2,950.4	2,809.9	3,090.9	2,809.9	3,160.5	35,826.0	35,826.0	-
Outpatient Non Face To Face	283.1	126.3	135.2	139.5	136.6	136.6	139.5	136.6	135.2	138.1	135.2	1.9	1,644.0	1,644.0	-
Outpatient Advice & Guidance	9.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	7.5	102.0	102.0	-
Critical Care	1,416.4	1,311.3	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,926.7	18,617.6	18,617.6	-
Maternity	891.7	892.6	895.0	895.0	895.0	895.0	895.0	895.0	895.0	895.0	895.0	900.7	10,739.8	10,739.8	-
Non PbR	3,171.8	3,109.4	3,080.9	3,086.8	3,068.2	3,094.8	3,092.7	3,106.5	3,075.0	3,098.1	3,135.7	2,987.5	37,107.5	37,107.5	-
Block	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	237.4	2,848.4	2,848.4	-
Repatriation	467.2	482.8	467.2	482.8	482.8	467.2	482.8	467.2	482.8	482.8	451.6	482.8	5,700.0	5,700.0	-
Backlog	188.5	194.8	188.5	194.8	194.8	188.5	194.8	188.5	194.8	194.8	182.2	194.8	2,300.0	2,300.0	-
Work in Progress	- 219.6	- 391.6	-	-	-	-	-	-	-	-	-	611.2	0.0	-	0.0
														-	-
Sub total without passthrough	32,388.6	32,902.1	31,000.5	33,032.0	31,894.9	31,493.1	32,935.3	31,303.6	31,065.7	32,129.7	30,140.3	30,102.7	380,388.6	380,388.6	0.0
															-
CQUIN	374.6	384.7	356.0	381.3	367.1	362.1	380.0	359.7	356.6	369.9	345.2	338.2	4,375.5	4,375.5	-
													-		-
Fines	- 90.7	- 90.7	-	-	-	-	-	-	-	-	-	181.4	-	-	-
Fines Reinvested	30.7	30.7	-	-	-	-	-	-	-	-	-	- 61.4	-	-	-
													-	-	-
Bring Lincolnshire CCG Contract to Plan	- 1,611.8	- 746.4	-	-	-	-	-	-	-	-	-	2,358.2	-	-	-
APA (calculated at quarterly billing)	-	484.0										- 484.0	-	-	-
													-	-	-
Prior Year													-	-	-
													-		-
Maternity Prepayment													-	-	-
													-		-
Total (Non Passthrough)	**31,091.5**	**32,964.4**	**31,356.5**	**33,413.3**	**32,262.0**	**31,855.3**	**33,315.3**	**31,663.3**	**31,422.3**	**32,499.6**	**30,485.5**	**32,435.2**	**384,764.1**	**384,764.1**	**0.0**
															-
Passthrough	4,027.7	3,929.8	4,215.2	4,240.9	4,223.7	4,223.7	4,240.9	4,223.7	4,215.2	4,232.3	4,215.2	4,722.3	50,710.5	50,710.5	-
Total (Inc Passthrough)	**35,119.1**	**36,894.2**	**35,571.7**	**37,654.1**	**36,485.7**	**36,079.0**	**37,556.2**	**35,887.1**	**35,637.5**	**36,731.9**	**34,700.6**	**37,157.4**	**435,474.6**	**435,474.5**	**0.0**

SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Pay Summary: YTD Month 2	Pay: In-Month				Pay: Year-To-Date			
Staff Groups	2018/19 May £k Actual	2019/20 May £k Plan	2019/20 May £k Actual	2019/20 May £k Variance	2018/19 Apr - May £k Actual	2019/20 May £k Plan	2019/20 May £k Actual	2019/20 May £k Variance
Substantive:								
Registered Nursing, Midwifery and Health visiting staff	6,895	7,153	6,880	273	13,886	14,583	14,494	89
Health Care Scientists and Scientific, Therapeutic and Technical staff	2,499	2,597	2,672	(75)	4,976	5,297	5,539	(242)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	4,428	4,784	4,787	(3)	8,887	9,751	9,914	(163)
Medical and Dental Staff	6,620	6,835	6,092	743	13,062	13,928	12,527	1,401
Non-Medical - Non-Clinical Staff	2,445	2,911	2,671	240	5,002	5,922	5,543	379
Bank:								
Registered Nursing, Midwifery and Health visiting staff	450	471	495	(24)	1,033	942	1,003	(61)
Health Care Scientists and Scientific, Therapeutic and Technical staff	39	44	44	(0)	95	88	83	5
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	324	371	371	0	731	742	749	(7)
Medical and Dental Staff	759	797	893	(96)	1,666	1,594	1,966	(372)
Non-Medical - Non-Clinical Staff	156	177	233	(56)	375	354	459	(105)
Agency:								
Registered Nursing, Midwifery and Health visiting staff	755	934	1,082	(148)	1,248	1,868	1,959	(91)
Health Care Scientists and Scientific, Therapeutic and Technical staff	118	138	177	(39)	311	276	324	(48)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	1	10	3	7	2	20	4	16
Medical and Dental Staff	1,736	1,708	2,431	(723)	3,241	3,416	4,811	(1,395)
Non-Medical - Non-Clinical Staff	82	296	327	(31)	151	592	542	50
Apprentice levy	103	107	113	(6)	206	214	232	(18)
Capitalised staff	(12)	0	(14)	14	(12)	0	(28)	28
Total Pay	**27,398**	**29,333**	**29,256**	**77**	**54,861**	**59,587**	**60,123**	**(536)**

Pay year to date is £0.5m adverse to plan.

The adverse movement to plan in Pay includes two key movements: £1,463k favourable movement against substantive staffing and £2,009k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £1,463k favourable to plan, this includes £890k of one off benefit in relation to the release in May of £890k of Pay provisions. Excluding the impact the one off cost of £920k in April of the Agenda for Change pay award and the one off benefit of £890k in May from the release of provisions, Substantive Pay in May is £11k lower than in April i.e. there has been no material movement in the underlying Substantive Pay cost of the Trust.

The above table shows that:

1) The adverse movement to plan on temporary staffing comprises of an adverse movement to plan of £540k on Bank Pay and £1,458k on Agency Pay.

2) Of the £540k adverse movement to plan on Bank Pay, £372k (69%) relates to Medical & Dental Staff and £105k (19%) relates to Non Clinical Staff groups.

3) Of the 1,458k adverse movement to plan on Agency Pay, £1,395k (95%) relates to Medical & Dental Staff.

Overall, of the £536k adverse movement to plan on Pay, £365k (68%) relates to Medical & Dental and £64k (12%) relates to Registered Nursing & Midwifery.

The Financial Efficiency Programme (FEP) assumes that savings of £885k would be delivered in April and May.

SUSTAINABLE SERVICES – PAY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	(£k)														
Staff Groups	**Actual M1 £000s**	**Actual 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	6,880	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	2,672	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	4,787	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	6,092	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	2,671	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	495	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	893	797	691	675	650	629	579	474	472	472	350	7,383	7,383	0
Non-Medical - Non-Clinical Staff	226	233	177	177	177	177	177	177	177	177	177	174	2,121	2,121	0
Agency:															
Registered Nursing, Midwifery and Health visiting staff	877	1,082	934	876	876	876	876	876	876	876	876	876	10,686	10,686	0
Health Care Scientists and Scientific, Therapeutic and	147	177	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	3	10	17	17	17	17	17	17	17	17	17	183	183	0
Medical and Dental Staff	2,379	2,431	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	327	296	146	146	146	71	71	71	71	71	71	1,752	1,752	0
Apprentice levy	119	113	107	107	107	106	107	107	107	107	106	107	1,282	1,282	0
Capitalised staff	0	(14)	0	0	0	0	0	0	0	0	0	0	0	0	0
Items included in Non pay:															
Operating expenses: research and development	(118)	(99)	110	110	110	110	110	110	110	110	110	110	1,320	1,320	0
Operating expenses: education and training	(158)	(149)	114	114	114	114	114	114	114	114	114	114	1,368	1,368	0
Operating expenses: redundancy	0	0	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**	**29,256**	**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 2

Non Pay	Non Pay: In-Month				Non Pay: Year-To-Date			
	2018/19	2019/20			2018/19	2019/20		
	May £k Actual	May £k Plan	May £k Actual	May £k Variance	Apr-May £k Actual	May £k Plan	May £k Actual	May £k Variance
Ambulance Services	80	170	195	(25)	135	340	320	20
Clinical Supplies & Services	5,352	5,182	5,345	(163)	10,019	10,362	10,101	261
Drugs	649	562	1,093	(531)	1,090	1,130	1,809	(679)
Drugs Pass through	4,337	4,104	3,368	736	8,165	8,199	7,027	1,172
Establishment Expenditure	440	528	643	(115)	860	1,056	1,148	(92)
General Supplies & Services	1,272	822	818	4	1,875	1,644	1,864	(220)
Other	(191)	325	244	81	509	650	528	122
Premises & Fixed Plant	1,616	1,634	1,512	122	3,184	3,267	3,060	207
Clinical Negligence	1,775	1,741	1,741	0	3,549	3,482	3,482	0
Capital charges	981	1,100	1,084	16	1,962	2,200	2,168	32
Total Non Pay	**16,311**	**16,168**	**16,043**	**125**	**31,348**	**32,330**	**31,507**	**823**

Non Pay Run Rate 2019/20

Non Pay	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Forecast	Plan	Variance
	Actual m1-2 & Plan m3-12 (£k)														
Ambulance Services	125	195	169	170	170	169	170	170	169	170	170	188	2,035	2,035	0
Clinical Supplies & Services	4,756	5,345	5,181	5,182	5,181	5,182	5,182	5,181	5,182	5,181	5,180	5,444	62,177	62,177	0
Drugs	717	1,092	569	555	570	560	555	560	577	562	558	1,056	6,759	6,759	0
Drugs Pass through	3,659	3,368	4,095	4,112	4,095	4,104	4,112	4,104	4,087	4,104	4,104	4,104	49,220	49,220	0
Establishment Expenditure	505	643	528	528	528	528	528	528	528	527	527	435	6,333	6,333	0
General Supplies & Services	1,047	817	822	489	489	489	489	489	489	589	589	(925)	7,168	7,168	0
Other	286	242	327	326	325	328	326	325	328	328	328	1,755	3,919	3,919	0
Premises & Fixed Plant	1,549	1,511	1,633	1,634	1,634	1,633	1,634	1,633	1,633	1,634	1,633	1,841	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	1,083	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,132	13,200	13,200	0
Total Non Pay	**15,470**	**16,037**	**16,165**	**15,837**	**15,833**	**15,834**	**15,837**	**15,831**	**15,834**	**15,935**	**15,929**	**16,770**	**191,302**	**191,302**	**0**

In April, Non Pay was £15,470k or £692k favourable to planned expenditure of £16,162k.

In May, Non Pay was £16,043k or £125k favourable to planned expenditure of £16,168k, resulting in YTD expenditure of £31,507k or £823k favourable to plan.

The favourable movement includes £0.2m lower than planned costs in relation to Turnaround; this movement is a timing difference and as such the under spend accrued to date will reduce in future periods. The favourable movement also includes £0.5m in relation to passthrough drugs and Devices which is directly offset by an equal and opposite reduction in income.

The Financial Efficiency Programme (FEP) for 2019/20 assumed Non Pay savings of £491k would be delivered in April and May.

SUSTAINABLE SERVICES – FINANCIAL EFFICIENCY PROGRAMME SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

M02

	In Month			YTD			
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	RAG
FEP	1,171	1,546	375	2,213	2,056	(157)	RAG

Finance Position

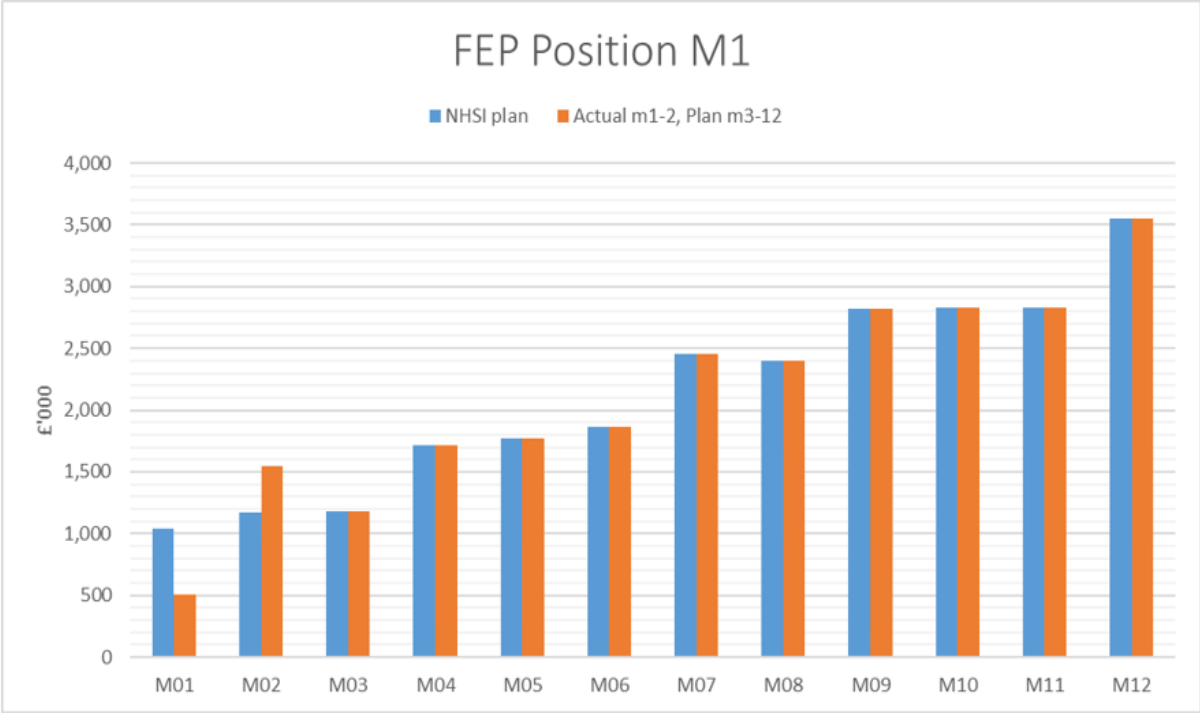
YTD ACTUAL	£k	FORECAST	£k
Recurrent	1,166	Recurrent	25,360
Non Recurrent	890	Non Recurrent	250
TOTAL	**2,056**	**TOTAL**	**25,610**

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

Reported FEP savings delivery of £621k in April was £421k adverse to planned savings of £1,042k; the key areas of underperformance were the Recruitment and Medical Capacity (job planning) workforce schemes and the Theatres Productivity scheme as a result of lower than targetted activity in April. Savings delivery for April has been restated in May to remove the £111k of savings delivery reported in April in relation to Theatre Productivity.

FEP savings delivery of £1,546k in May was £375k favourable to planned savings of £1,171k; this includes £890k of one off technical FEP savings in May.

Year to date, FEP savings of £2,056k have been delivered against a FEP target of £2,213k; the £157k adverse movement to plan includes the underperformance in relation to Theatre Productivity and the continued underperformance in relation to workforce schemes, which have been largely mitigated by one off technical savings.



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

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Statement of Financial Position May 2019

	Year end		Year to date			Monthly Actual		Forecast Outurn		
	31 March 2019		31 May 2019			30-Apr-19	31-May-19	31 March 2020		
	Actual £'000	Plan £'000	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Actual £'000	Actual £'000	Plan £'000	Variance £'000
Non-current assets										
Intangible assets	6,341	5,488	6,048	5,147	901	6,195	6,048	4,648	4,637	11
Property, plant and equipment: on-SoFP IFRIC 12 assets	27,654	22,495	27,585	27,292	293	27,619	27,585	27,238	26,954	284
Property, plant and equipment: other	181,095	213,599	182,083	205,306	(23,223)	181,031	182,083	201,946	224,849	(22,903)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,560	1,828	1,551	1,600	(49)	1,529	1,551	1,600	1,600	0
Total non-current assets	**216,650**	**243,410**	**217,267**	**239,345**	**(22,078)**	**216,374**	**217,267**	**235,432**	**258,040**	**(22,608)**
Current assets										
Inventories	7,440	6,799	7,521	7,350	171	7,593	7,521	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	15,203	17,664	18,820	20,526	(1,706)	15,563	18,820	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	6,833	4,848	12,479	7,986	4,493	11,306	12,479	7,912	7,912	0
Assets held for sale and assets in disposal groups	660	0	660	660	0	660	660	0	510	(510)
Cash and cash equivalents: GBS/NLF	7,376	6,143	2,248	990	1,258	3,251	2,248	4,214	4,214	0
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	0
Total current assets	**37,522**	**35,464**	**41,738**	**37,522**	**4,216**	**38,383**	**41,738**	**46,331**	**46,841**	**(510)**
Current liabilities										
Trade and other payables: capital	(10,791)	(4,723)	(7,764)	(1,319)	(6,445)	(8,748)	(7,764)	(3,436)	(4,466)	1,030
Trade and other payables: non-capital	(40,622)	(38,039)	(47,773)	(50,645)	2,872	(46,383)	(47,773)	(40,730)	(41,096)	366
Borrowings	(114,339)	(77,359)	(124,423)	(16,672)	(107,751)	(118,596)	(124,423)	(197,439)	(197,289)	(150)
Provisions	(608)	(735)	(608)	(565)	(43)	(608)	(608)	(565)	(565)	0
Other liabilities: deferred income	(2,869)	(2,707)	(1,088)	(1,200)	112	(1,106)	(1,088)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	0
Total current liabilities	**(169,732)**	**(124,066)**	**(182,159)**	**(70,904)**	**(111,255)**	**(175,944)**	**(182,159)**	**(243,873)**	**(245,119)**	**1,246**
Net Current liabilities	**(132,210)**	**(88,602)**	**(140,421)**	**(33,382)**	**(107,039)**	**(137,561)**	**(140,421)**	**(197,542)**	**(198,278)**	**736**
Total assets less current liabilities	**84,440**	**154,808**	**76,846**	**205,963**	**(129,117)**	**78,813**	**76,846**	**37,890**	**59,762**	**(21,872)**
Non-current liabilities										
Borrowings	(188,196)	(228,888)	(191,890)	(299,057)	107,167	(189,662)	(191,890)	(178,323)	(178,440)	117
Provisions	(2,863)	(2,911)	(2,865)	(2,982)	117	(2,865)	(2,865)	(2,825)	(2,782)	(43)
Other liabilities: other	(13,081)	(13,081)	(12,998)	(12,997)	(1)	(13,040)	(12,998)	(12,578)	(12,578)	0
Total non-current liabilities	**(204,140)**	**(244,880)**	**(207,753)**	**(315,036)**	**107,283**	**(205,567)**	**(207,753)**	**(193,726)**	**(193,800)**	**74**
Total net assets employed	**(119,700)**	**(90,072)**	**(130,907)**	**(109,073)**	**(21,834)**	**(126,754)**	**(130,907)**	**(155,836)**	**(134,038)**	**(21,798)**
Financed by										
Public dividend capital	260,042	257,563	260,042	260,042	0	260,042	260,042	265,318	265,318	0
Revaluation reserve	32,159	34,455	32,008	35,551	(3,543)	32,089	32,008	31,255	34,951	(3,696)
Other reserves	190	190	190	190	0	190	190	190	190	0
Income and expenditure reserve	(412,091)	(382,280)	(423,147)	(404,856)	(18,291)	(419,075)	(423,147)	(452,599)	(434,497)	(18,102)
Total taxpayers' and others' equity	**(119,700)**	**(90,072)**	**(130,907)**	**(109,073)**	**(21,834)**	**(126,754)**	**(130,907)**	**(155,836)**	**(134,038)**	**(21,798)**

BORROWINGS										
Current										
Borrowings: DHSC capital loans	1,889	2,429	1,828	2,562	(734)	1,828	1,828	2,753	2,636	117
Borrowings: DHSC working capital / revenue support loans	112,450	74,930	120,938	12,047	108,891	114,694	120,938	191,520	191,521	(1)
Accrued interest on DHSC loans		0	1,657	2,063	(406)	2,074	1,657	2,703	2,670	33
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	463	462	1
Total current borrowings	**114,339**	**77,359**	**124,423**	**16,672**	**107,751**	**118,596**	**124,423**	**197,439**	**197,289**	**150**
Non-current										
Borrowings: DHSC capital loans	24,283	33,343	25,005	23,282	1,723	24,344	25,005	32,629	32,746	(117)
Borrowings: DHSC working capital / revenue support loans	163,913	195,545	166,885	275,775	(108,890)	165,318	166,885	142,688	142,687	1
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	3,006	3,007	(1)
Total non-current borrowings	**188,196**	**228,888**	**191,890**	**299,057**	**(107,167)**	**189,662**	**191,890**	**178,323**	**178,440**	**(117)**

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

The cash balance at 31 May 2019 was £2.3m. This includes revenue and capital cash loans drawn in April 2019 - May 2019 of £13.4m / £0.6m respectively.

The Trust has reduced the level of capital creditors from £10.8m to £7.5m. The capital creditors have only reduced this figure by £3.3m 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 creditorsTotal revenue and capital borrowings (excluding accrued interest) at 31 May were £314.7m. As a consequence of this borrowing costs are anticipated to be £9.1m in I&E terms , and in cash terms £8.4m.

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

Year to date	Plan £k	Actual £k	Variance £k
Operating Surplus	(9,261)	(9,886)	(625)
Depreciation	2,200	2,168	(32)
Other Non Cash I&E Items	(36)	0	36
Movement in Working Capital	1,839	(4,047)	(5,886)
Provisions	119	2	(117)
Cashflow from Operations	**(5,139)**	**(11,763)**	(6,624)
Interest received	6	28	22
Capital Expenditure	(11,864)	(5,823)	6,041
Cash receipt from asset sales	0	12	12
Cash from / (used in) investing activities	**(11,858)**	**(5,783)**	**6,075**
PDC Received	0	0	0
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(1,251)	(1,666)	(415)
Capital element of leases	0	0	0
Drawdown on debt - Revenue	0	13,423	13,423
Drawdown on debt - Capital	0	661	661
Repayment of debt	(328)	0	328
Cashflow from financing	**(1,579)**	**12,418**	**13,997**
Net Cash Inflow / (Outflow)	**(18,576)**	**(5,128)**	**13,448**
Opening cash balance	6,153	7,386	1,233
Closing Cash balance	**(12,423)**	**2,258**	**14,681**

Year End Plan	Plan £k	Actual £k	Variance £k
Operating Surplus	(32,306)	(32,316)	(10)
Depreciation	13,200	13,200	0
Other Non Cash I&E Items	(214)	(214)	0
Movement in Working Capital	(13,680)	(14,736)	(1,056)
Provisions	(81)	(81)	0
Cashflow from Operations	**(33,081)**	**(34,147)**	(1,066)
Interest received	36	36	0
Capital Expenditure	(38,312)	(39,085)	(773)
Cash receipt from asset sales	150	672	522
Cash from / (used in) investing activities	**(38,126)**	**(38,377)**	**(251)**
PDC Received	5,276	5,276	0
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(8,486)	(8,402)	84
Capital element of leases	0	0	0
Drawdown on debt - Revenue	59,809	59,809	0
Drawdown on debt - Capital	15,400	15,400	0
Repayment of debt	(2,721)	(2,721)	0
Cashflow from financing	**69,278**	**69,362**	**84**
Net Cash Inflow / (Outflow)	**(1,929)**	**(3,162)**	**(1,233)**
Opening cash balance	6,153	7,386	1,233
Closing Cash balance	**4,224**	**4,224**	**0**

The cash balance of £2.3m at 31 May reflects a number of factors:
- the reduction in capital creditors from the year end high of £10.8m to £7.5m;
- delays in the 2019/20 capital programme.

These in turn have impacted upon the level of capital cash expenditure (plan £11.9m : actual £5.8m).
The Trust has submitted and had approved a requests to NHSI / DHSC to carry forward £9.6m into 2019/20, in relation to the Fire Safety, capital loans in respect of this totalling £0.6m were received in May 2019.
Revenue loans totalling of £13.4m have been drawn in the year to May 2019. This is against the backdrop of a cumulative I&E deficit to May of £11.2m.
Capital cash is supporting the overall cash position by circa £7.9m at May 2019.

The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £3.4m in March 2020

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

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	2,133	2,797	-664

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Capital Balance	31,815	31,815	0

Year to date	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	166	66	100
Estates - Fire	1,700	2,428	-728
ICT	0	279	-279
Estates - Backlog	100	19	81
Service developments	167	5	162
Total	2,133	2,797	-664

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Medical Equipment replacement	936	936	0
Estates - Fire	13,700	13,700	0
ICT	2,408	2,408	0
Estates - Backlog	3,789	3,789	0
Service developments	10,982	10,982	0
Total	31,815	31,815	0

Funding available 2019/20

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

The M2 spend incurred amounts to c£2.8m against a planned spend of c£2.1m, details below:

Facilities; Minimal spend in M2 of £19k. Majority of spend incurred links to Lincoln Heating where CQC had raised an issue following an incident with a patient (£12k). Added to this spend are starting costs of £2k and £3k for Water Access/Water Tanks and Mental Health respectively.

Fire; Expenditure on fire related schemes is progressing at pace. Costs incurred at the end of May amounted to c£2.4m (spend in month was c£1.8m). Fire Works package 1 at LCH is £862k, package 2 is £401k, Emergency Lighting at LCH is £169k. Package 1 at Pilgrim amounts to £432k.

Medical Devices; Radiology Ultrasound machine purchase of £66k.

IT; E-Health-record costs of £207k together with Wifi spend linked to HSLI deferred monies amounting to £63k has been incurred at the end of M2.

Updated Phased Plan profile

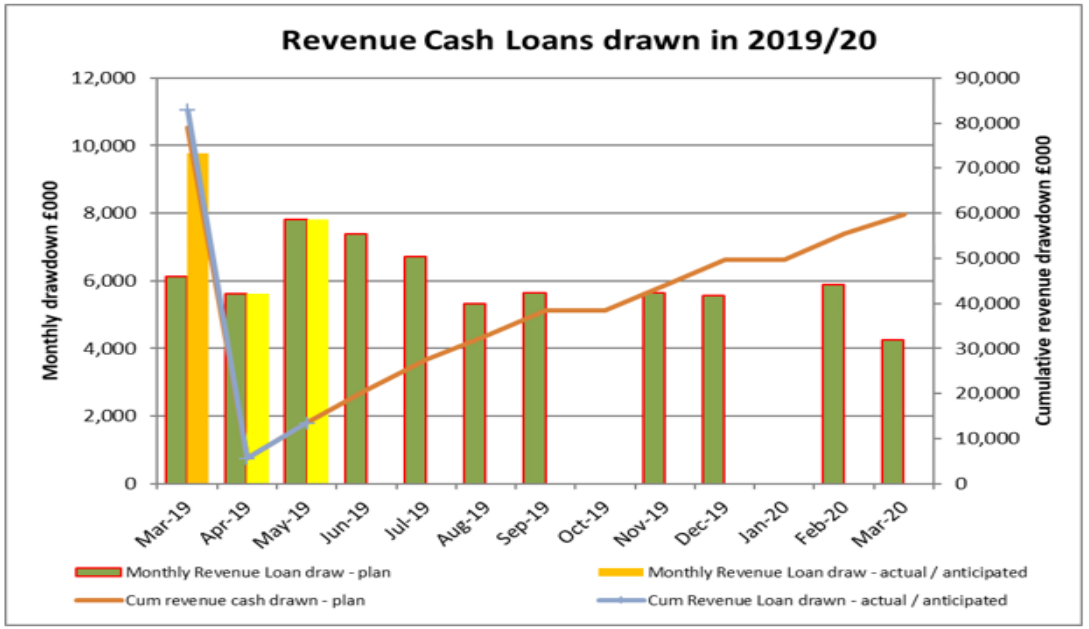
There has been significant progress made in profiling spend across 2019/20 together with a revision of costs to be incurred. Colleagues from all 'groups' alongside Procurement and Finance have been involced in these discussions so that assurance can be provided on forecast spend against each scheme together with identifying early where there is potential slippage that can be reallocated to other prioritised schemes within the Trust.

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 £14.1m during the two months to May 2019, this is split £13.4m revenue support and £0.7m capital. This includes £0m deficit support relating to 2018/19.

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

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

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

Capital Borrowing

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

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

The planned capital loan drawdown in 2019/20 is £11.7m as a result of this. In May there were a capital drawdowns of £0.7m and the capital creditors reduced to £7.5m.

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.

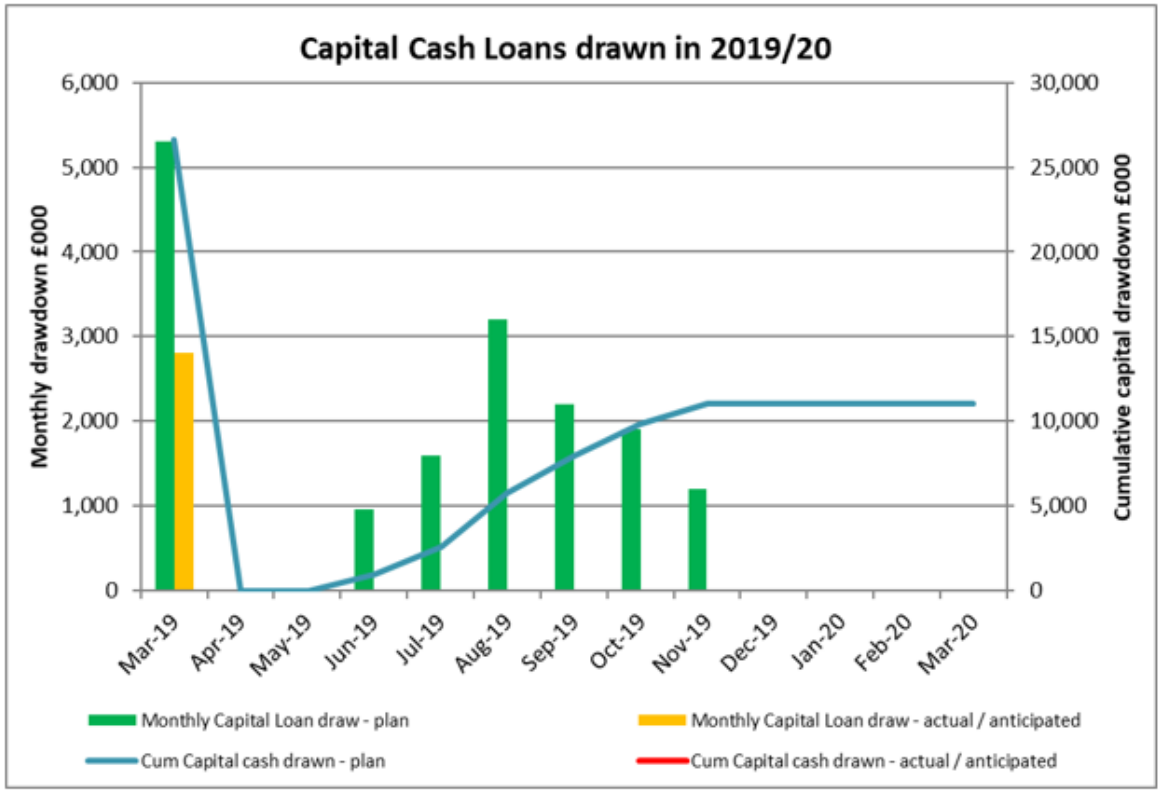
The Board has previously approved borrowing for:

June 2019: Revenue £7.376m

Capital £0m

July 2019: Revenue: £7.376m

Capital £1.600m



The board is requested to approve borrowing in June 2019 for August drawdown

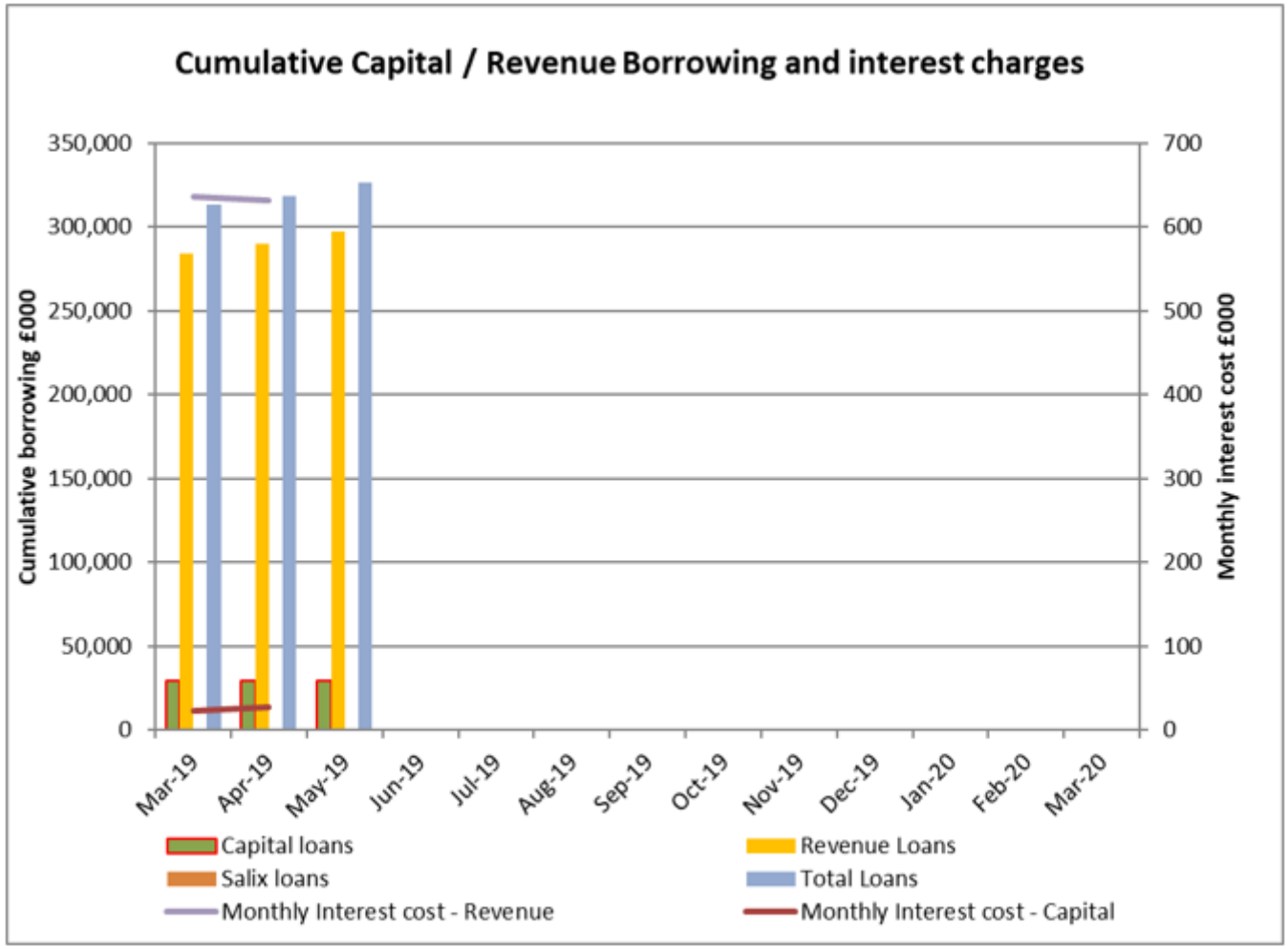
Revenue £7.925m and Capital £3.155m

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowings and Interest

At 31 May 2019 total 'repayable' borrowings (excluding accrued interest) were £314.7m, capital (£26.8m) and revenue (£287.9m).

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 May 19 - £1.7m) 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.

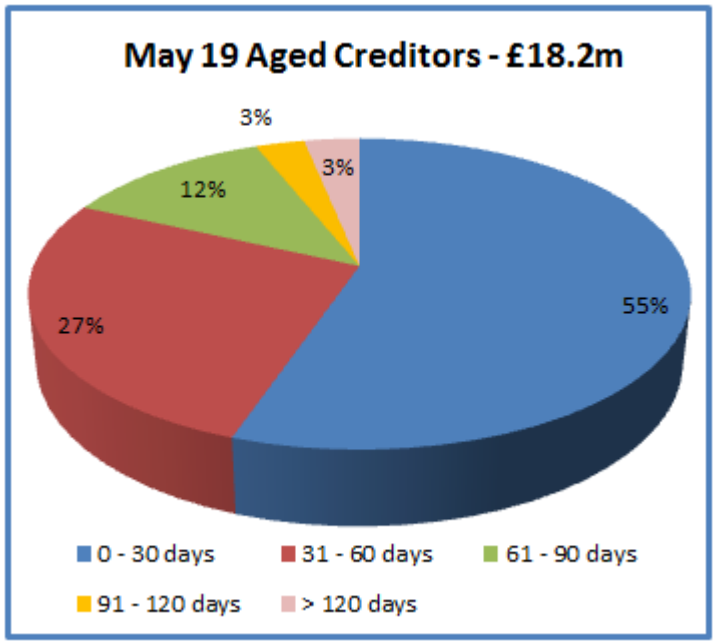
Type	Loan £m	Repayment		Loan £m	Repayment	Repayment Terms
Revenue	35.6	tbc		6.0	Jan-21	The terms of each loan state that there is to be a single one off repayment in full. It is anticipated however that some form of re-financing will take place. The means by which this might be transacted is uncertain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

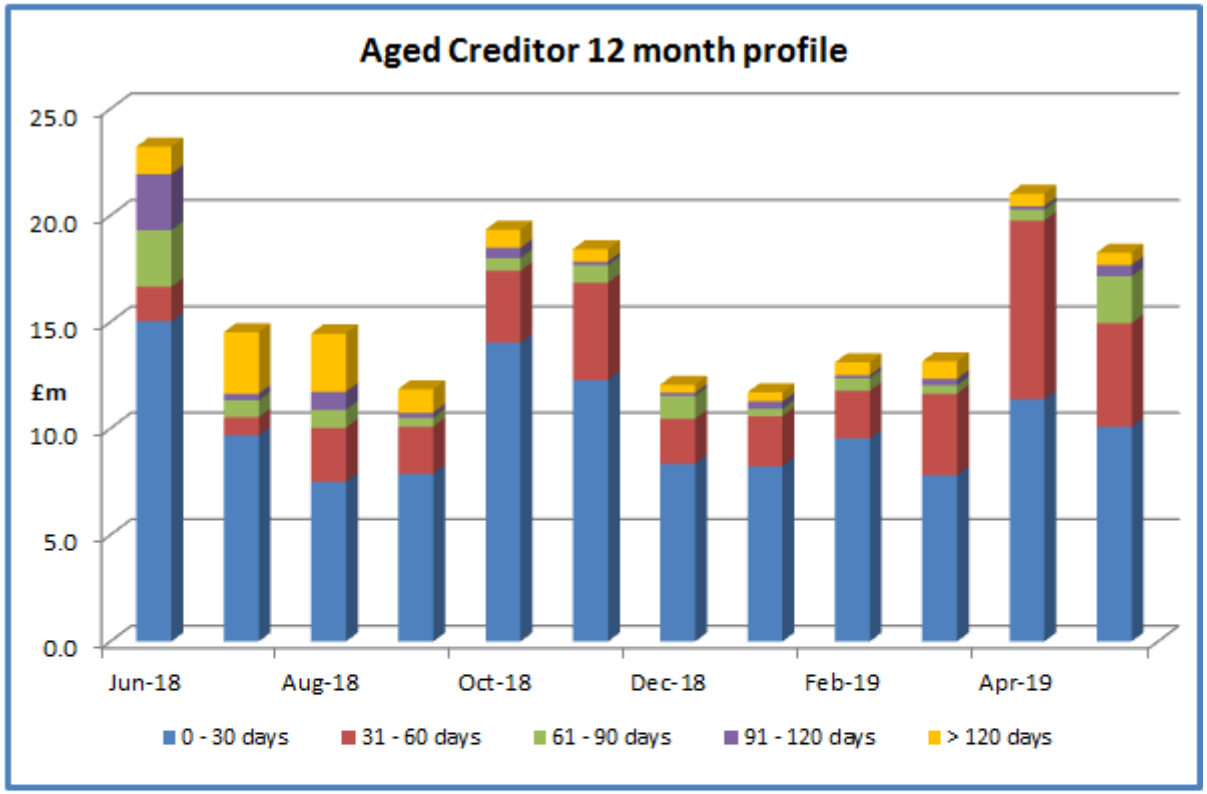
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors

Total Creditors were £18.2m at 31 May 2019, of which £8.1m were over 30 days (£1.1m > 90 days).
Focusing further upon those invoices over 30 days £0.8m (70%) 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.

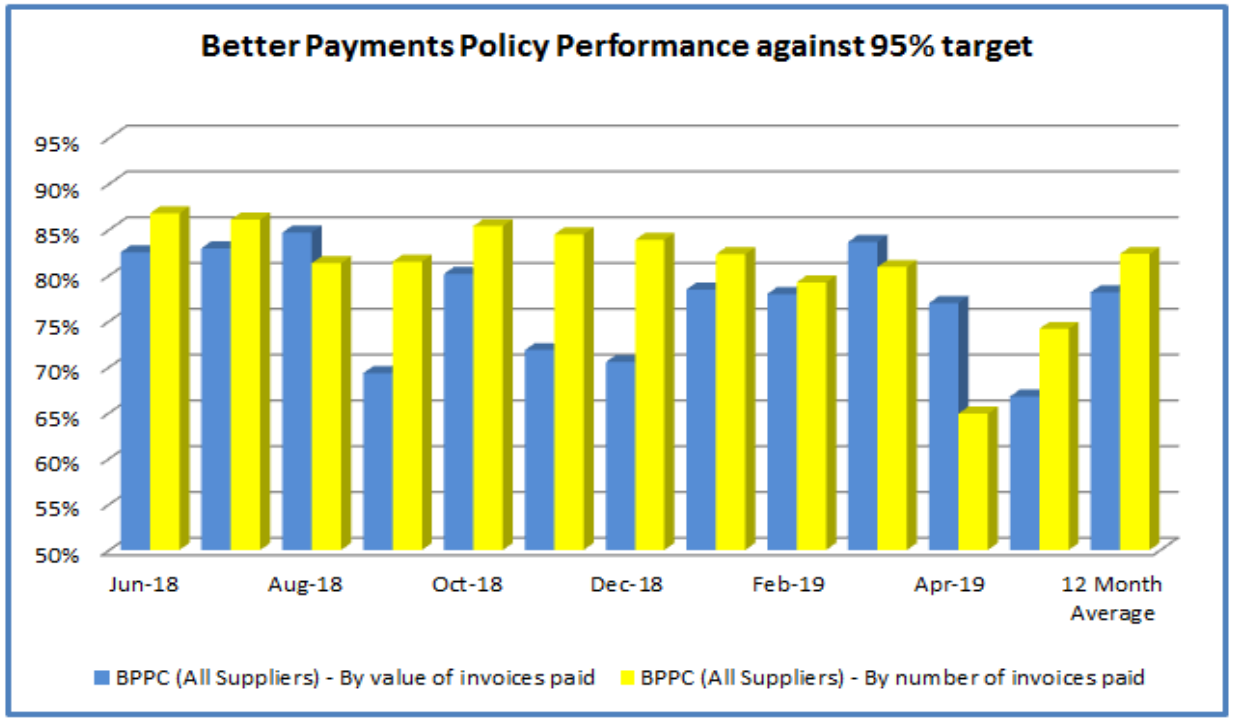
The Finance and Procurement Teams continue to enforce the policy of requiring suppliers to provide a purchase order before payment is made. At 31 May there were 244 separate invoices (£0.4m), over 90 days old spread across 91 suppliers where payment is delayed awaiting a purchase order.

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

Year to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	400	7,479	17,966	28,649
Total bills paid within target	302	6,865	12,575	18,693
% of bills paid within target YTD	**75.50%**	**91.79%**	**69.99%**	**65.25%**
% of bills paid within May 2019	**78.61%**	**95.58%**	**74.07%**	**56.80%**

SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Paul Matthew

CQC Domain: Well-Led

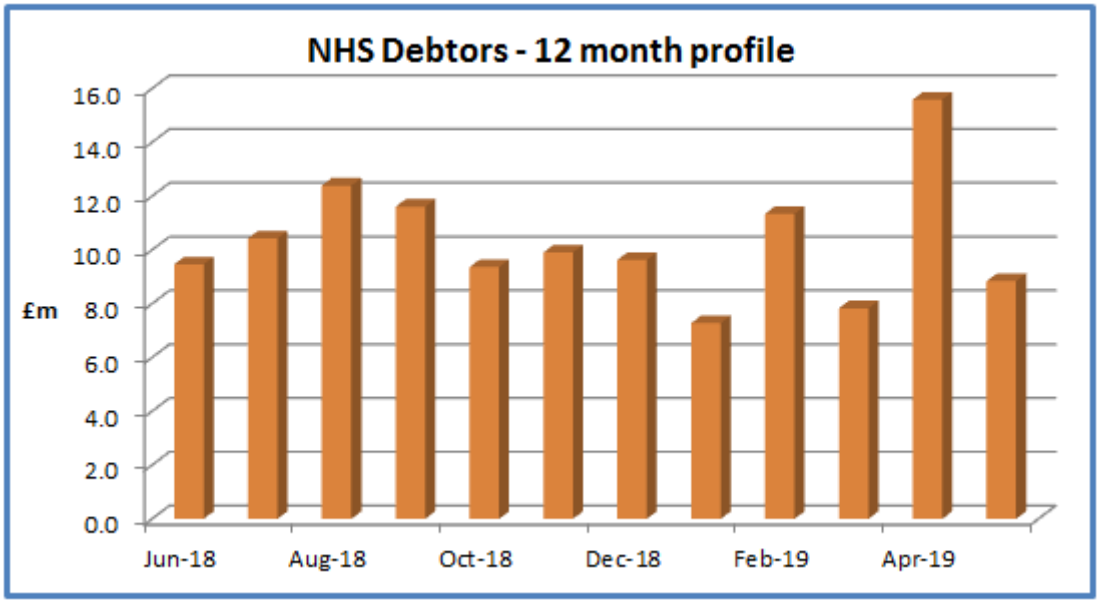
2021 Objective: Our Services

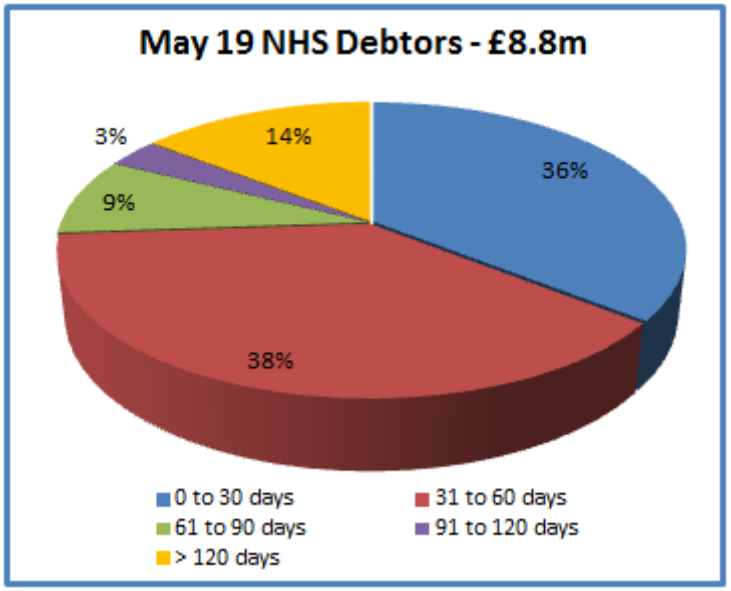
The level of NHS debt over the last 12 months is shown in the table to the right, while the table bottom right focuses upon the aged split at 31 May 2019.

The level of aged debt >90 days has reduced significantly from £4.7m in October to £1.5m at 31 May. 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.

In volume terms tehre are 246 invoices> 90 days at 31 May 2019.

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





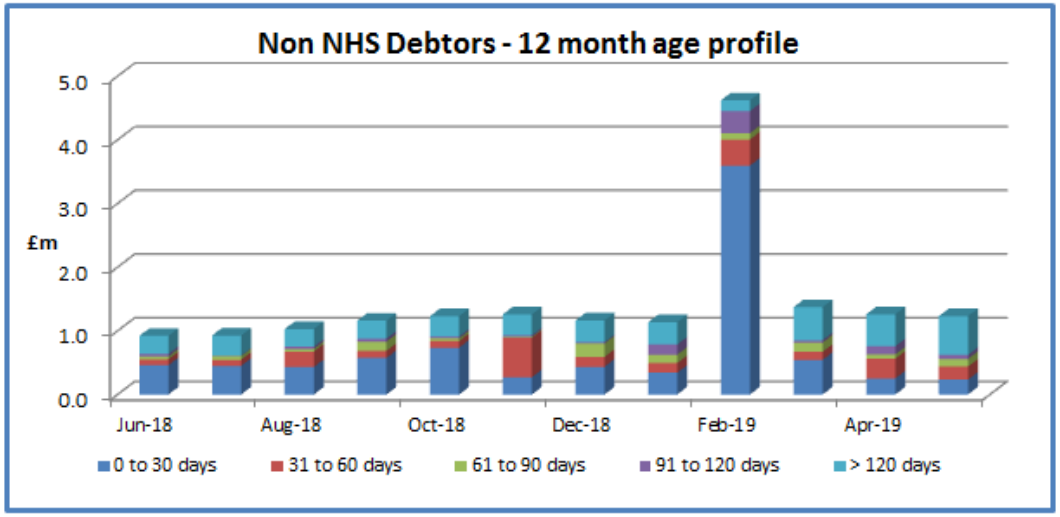
Totals shown in £000	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	1,862	284	90	0	208	2,444	208
CCGs - Other	423	181	53	86	94	837	180
Trusts - Lincolnshire	209	71	17	46	29	372	75
Trusts - Other	135	617	439	144	876	2,211	1,020
Other NHS	522	2,226	150	6	71	2,975	77
Total	**3,151**	**3,379**	**749**	**282**	**1,278**	**8,839**	**1,560**

SUSTAINABLE SERVICES – NON- NHS RECEIVABLES

Executive Lead: Paul Matthew

CQC Domain: Well-Led

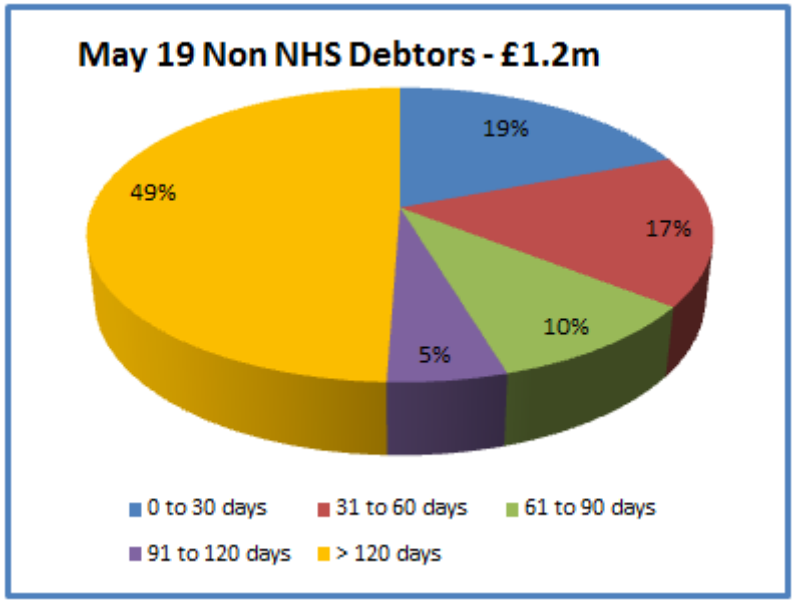
2021 Objective: Our Services



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 31 May 2019.

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

	Totals outstanding debt £						
Description	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
Overseas Visitors	8,914	13,608	20,821	22,166	122,773	188,282	144,939
Debt Collection - Overseas	0	0	0	233	130,891	131,124	131,124
NHS Non English	7,818	2,314	6,100	6,584	5,340	28,156	11,924
Misc	217,927	187,838	89,137	32,478	226,470	753,850	258,948
Salary Overpayments	0	54	2,923	2,904	73,286	79,167	76,190
Private Patients	0	0	0	0	11,463	11,463	11,463
Debt Collection - General	0	0	0	0	26,042	26,042	26,042
Agreed Installment Plans	0	0	1,209	0	12,933	14,142	12,933
Grand Total	234,659	203,814	120,190	64,365	609,198	1,232,226	673,563



The balance over 90 days (£0.7m) comprises relatively high volume (235) 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	September	October	November	December	January	February	March
Operating Income	40,328	41,786	40,391	42,813	41,645	41,238	43,394	41,726	41,473	42,991	40,962	42,869
Operating Expenditure	-46,416	-45,501	-45,503	-44,594	-44,530	-44,441	-44,281	-44,084	-43,693	-43,782	-43,777	-43,320
Efficiency	1,042	1,171	1,180	1,711	1,770	1,869	2,453	2,398	2,816	2,827	2,827	3,546
Agency	-3,086	-3,086	-3,086	-2,615	-2,576	-2,514	-2,385	-2,260	-2,002	-1,997	-1,997	-1,692
Capital	816	1,317	1,173	2,375	2,682	2,727	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	September	October	November	December	January	February	March
Operating Income	40,328	82,114	122,505	165,318	206,963	248,201	291,595	333,321	374,794	417,785	458,747	501,616
Operating Expenditure	-46,416	-91,917	-137,420	-182,014	-226,544	-270,985	-315,266	-359,350	-403,043	-446,825	-490,602	-533,922
Efficiency	1,042	2,213	3,393	5,104	6,874	8,743	11,196	13,594	16,410	19,237	22,064	25,610
Agency	-3,086	-6,172	-9,258	-11,873	-14,449	-16,963	-19,348	-21,608	-23,610	-25,607	-27,604	-29,296
Capital	816	2,133	3,306	5,681	8,363	11,090	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	September	October	November	December	January	February	March
Operating Income	40,221	41,522										
Operating Expenditure	-46,332	-45,297										
Efficiency	510	1,546										
Agency	-3,621	-4,019										
Capital	839	1,958										
Operating Surplus/Deficit	-6,111	-3,775										

Cumulative Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	81,743										
Operating Expenditure	-46,332	-91,629										
Efficiency	510	2,056										
Agency	-3,621	-7,640										
Capital	839	2,797										
Operating Surplus/Deficit	-6,111	-9,886										

In Month Variance (-) adverse	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-264										
Operating Expenditure	84	204										
Efficiency	-532	375										
Agency	-535	-933										
Capital	-23	-641										
Operating Surplus/Deficit	-23	-60										

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-371										
Operating Expenditure	84	288										
Efficiency	-532	-157										
Agency	-535	-1,468										
Capital	-23	-664										
Operating Surplus/Deficit	-23	-83										

In Month Variance (-) adverse %	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.63%										
Operating Expenditure	0.18%	0.45%										
Efficiency	-51.06%	32.02%										
Agency	-17.34%	-30.23%										
Capital	-2.82%	-48.63%										
Operating Surplus/Deficit	-0.38%	-1.62%										

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.45%										
Operating Expenditure	0.18%	0.31%										
Efficiency	-51.06%	-7.09%										
Agency	-17.34%	-23.78%										
Capital	-2.82%	-31.11%										
Operating Surplus/Deficit	-0.38%	-0.85%										

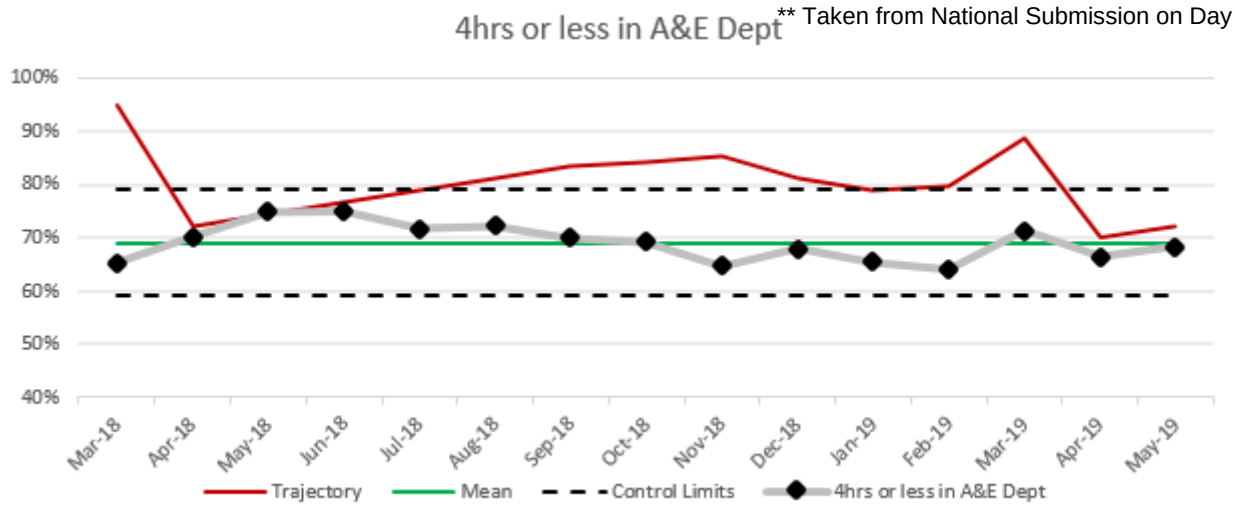
ZERO WAITING – A&E 4 HOUR WAIT

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 - The system set targets of 25% of all ED attendances at PHB and 20% at LCH to be streamed. For May the total % of patients streamed was 23.83% which is an improvement of 1.06% from April. However, the impact of streaming at Pilgrim as demonstrated a downward trend overall since February (31.3%). Some of this downward trend can be attributed to minor injury skilled staff absence. Lincoln experienced a decrease at 13.08% in May compared to 16.54% in April (3.51%).
- 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. This is on target to deliver as planned.
- At the end of May, the average number of Super Stranded Patients in the Trust was 112 against an ambition of 94. There has been variable improvement at Pilgrim and Lincoln. DToC remains within normal variation. 4 specific points of intervention were enacted in May to reduce the number of >21 day LoS. The impact of these interventions were positive and an overall reduction was demonstrated.
- This has resulted in length of stay and bed occupancy being above assumed levels and thus affecting flow. Bed occupancy remains above the target occupancy of 92% at Lincoln and Pilgrim. 93.77% and 96.34% respectively**.**

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 has been reviewed across all sites and new ways of working introduced as well a system review of frailty service provision. Awaiting outcome of the latter.

Support continues to be 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. Stocktake meeting took place on 17th May 2019 – formal outcome awaited.

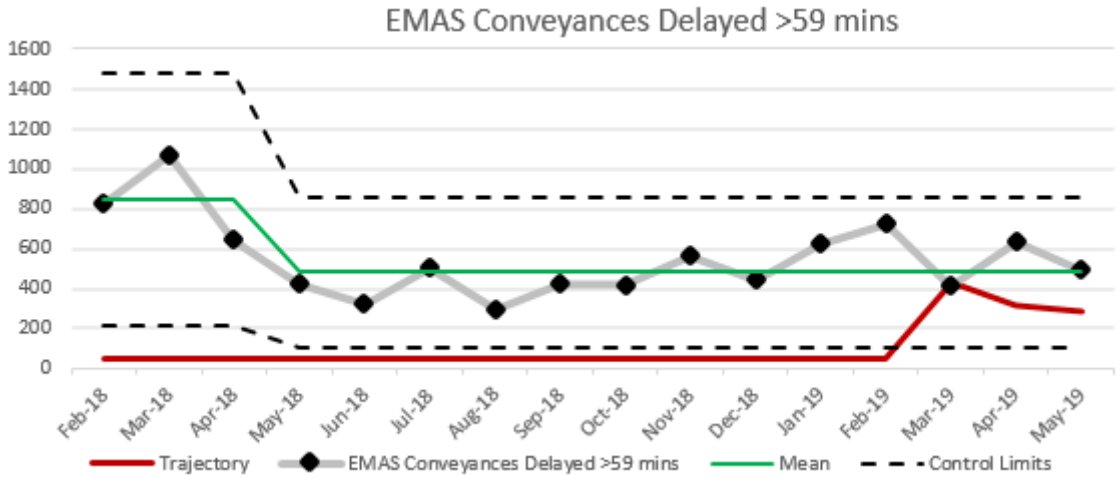
New approach in managing medically fit patients started in April led by LCHS with an internal project looking at improving the discharge pathway and associated pathway. Progress to date is being evaluated. A paper is being produced for Urgent and Emergency Care Delivery Board to be presented in June.

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- System wide pressure continued throughout May. This is demonstrated when comparing actual conveyance in May (5062) against plan (4720). This equates to a 6.76% increase against plan (342 additional conveyances than expected). This is slightly less than the increase experienced in April (8.4%).
- An increasing trend against EMAS demand/conveyances continue to be apparent at LCH (2708 in May v 2557 in April. Grantham experienced an increase of 21 conveyances compared to April (285 May v 261 April). Pilgrim experienced a reduction of 33 conveyances compared to April (2069 May v 2102 April)
- 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.
- Handover delays exceeding 59 mins experienced in May was 494 compared to 635 in April (9.75% of total conveyances in May v 12.8% of total conveyances in April). A marked improvement has been noted in May and acknowledged by EMAS.

Actions in place to recover

New pathways at PHB rolled out to enable direct GP admissions bypassing ED and continues to work well in hours. OOH remains challenging.

Further pathways to both AEC and SAU at Lincoln were rolled out however, areas were still regularly being used for escalation. This position was 'reset on Friday 7th May and both areas remain de-escalaed and business as usual.

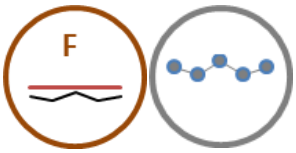
Daily calls remain in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.

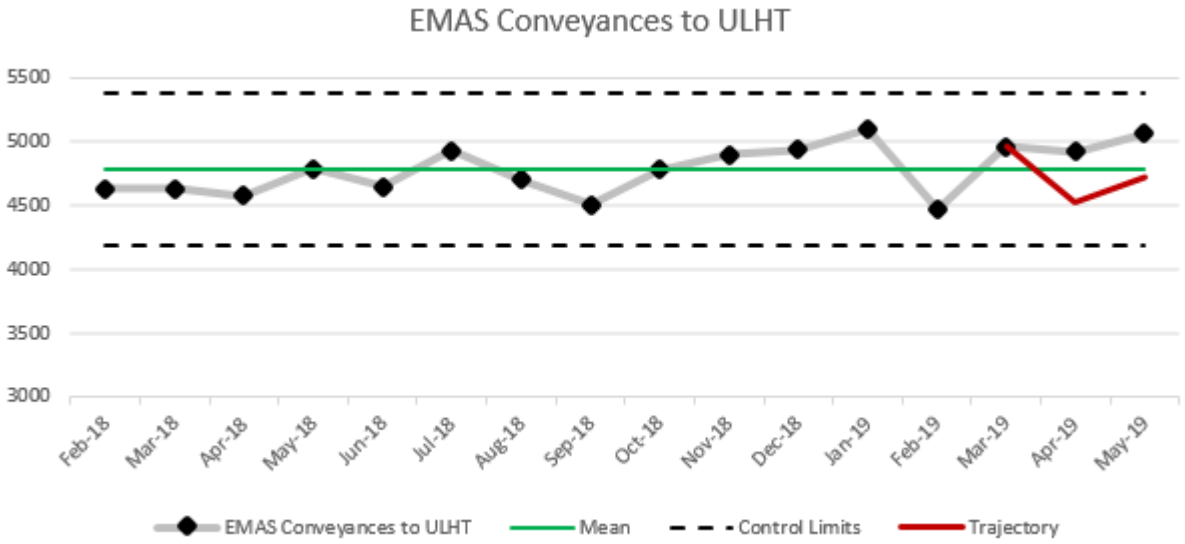
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

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- Handover delays exceeding 59 mins experienced in May was 494 compared to 635 in April (9.75% of total conveyances in May v 12.8% of total conveyances in April). A marked improvement has been noted in May and acknowledged by EMAS.
- Alternative pathways to avoid conveyance have still not matured and delivered the % reduction expected.

Actions in place to recover

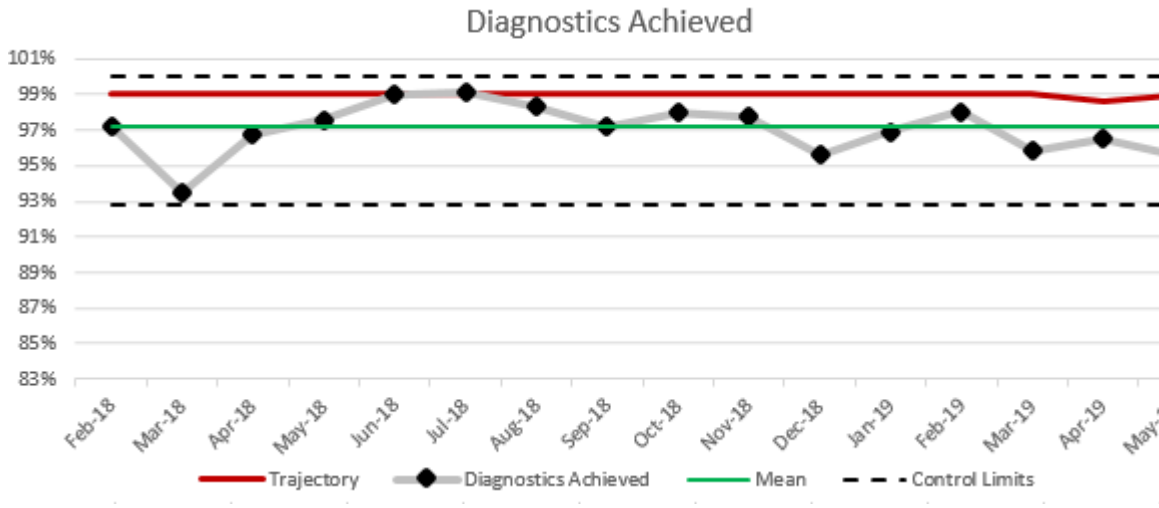
- Work remains ongoing with the System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily.
- ULHT Representative and EMAS ROM / DOM control continue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

ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Performance is 95.56% for May which has deteriorated from April 96.53%

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

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

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

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

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

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.

Trajectory to Recover

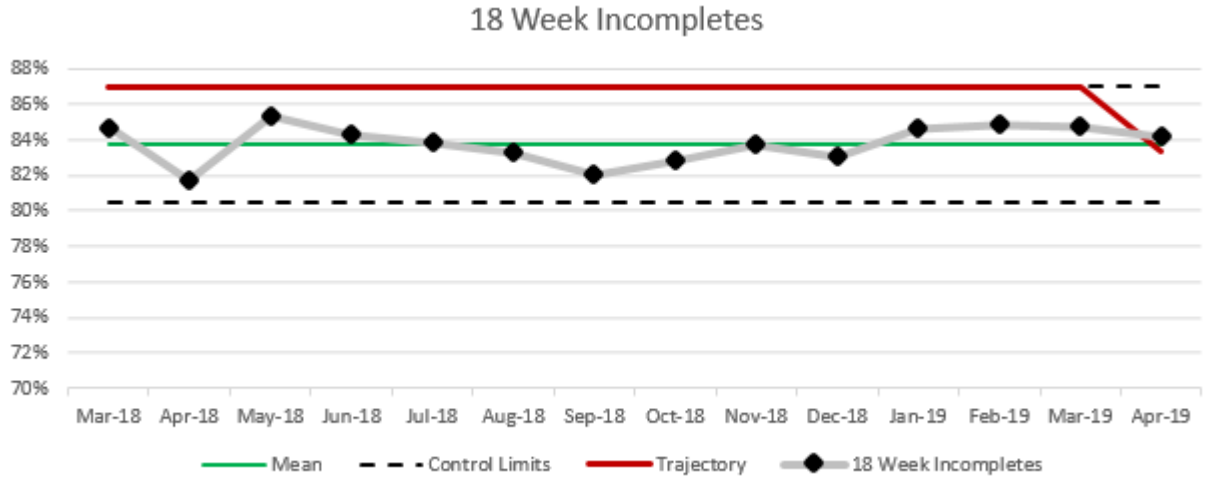
Month	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trajectory	97.15%	97.77%	98.38%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

April increased the total Incompletes Pathways by 1194 from 37762 to 38956. This represents a 3.16% increase.

Overall 18+ week backlog shows a mixed response across the specialities with small increases and decreases in many specialities. Neurology is showing the largest increase of 275 (52.18%). Maxillo Facial has the second largest increase of 81 (13.09%) with smaller increases in Cardiology, Dermatology, Respiratory Medicine, Rheumatology and Gynaecology.

ENT has shown the biggest decrease of 89 which is a 9.57% decrease. April also saw improved RTT performance in Vascular Surgery (4.85%) and T&O (1.01%).

Actions in place to recover:

External validation team have presented their findings from the validation programme. The lessons learnt has been presented to the relevant team members. Project plan b is being developed to implement learnings.

Maxillo-facial has commenced skin patients within their pathway. Work has commenced to review the pathway and assess capacity against demand.

Neurology- Discussion is ongoing with regards to additional support from neighbouring hospital and private sector.

A locum Consultant has been appointed and starts in mid-June and additional sessions are taking place on Saturdays in June and July.

The medical specialities of Cardiology, Dermatology and Rheumatology are developing plans to reduce backlog. Capacity remains a challenge in Gynaecology due to consultant vacancy.

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

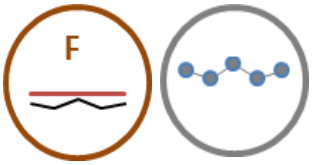
Maintain 84% during 2019/2020 due to commissioned activity

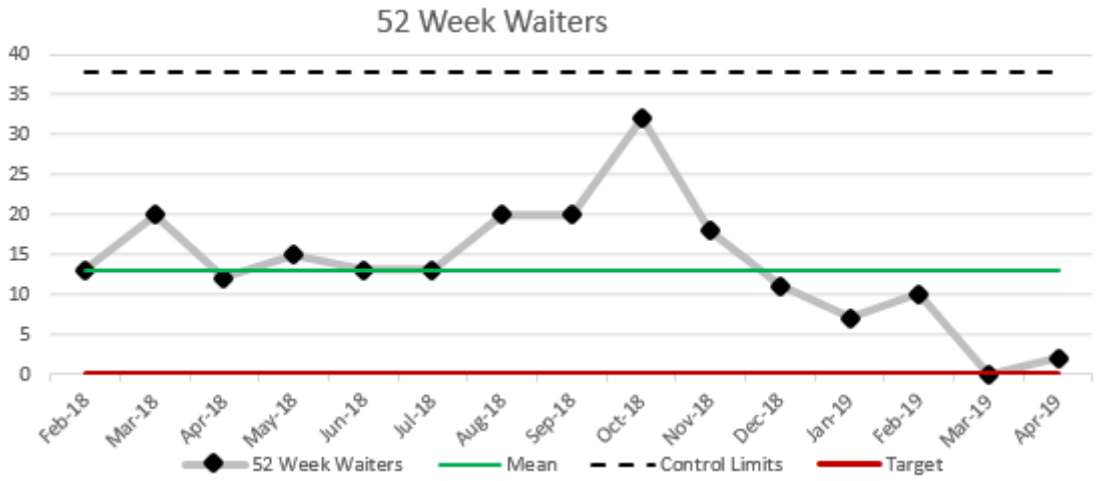
ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

At the end of April we are unfortunately reporting two over 52 week breaches.

One Maxillo Facial and one Urology, both are caused by incorrect data entry.

Actions in place to recover:

Weekly meetings continue with Divisions to review plans for patients above 30 weeks. A further meeting is held once a week to discuss in detail any patient at 45 weeks and above.

An RTT recovery meeting is held fortnightly with senior managers to go through RTT recovery plans.

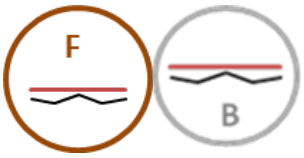
At risk specialties continue to validate long waiters and ensure correct action is mobilised.

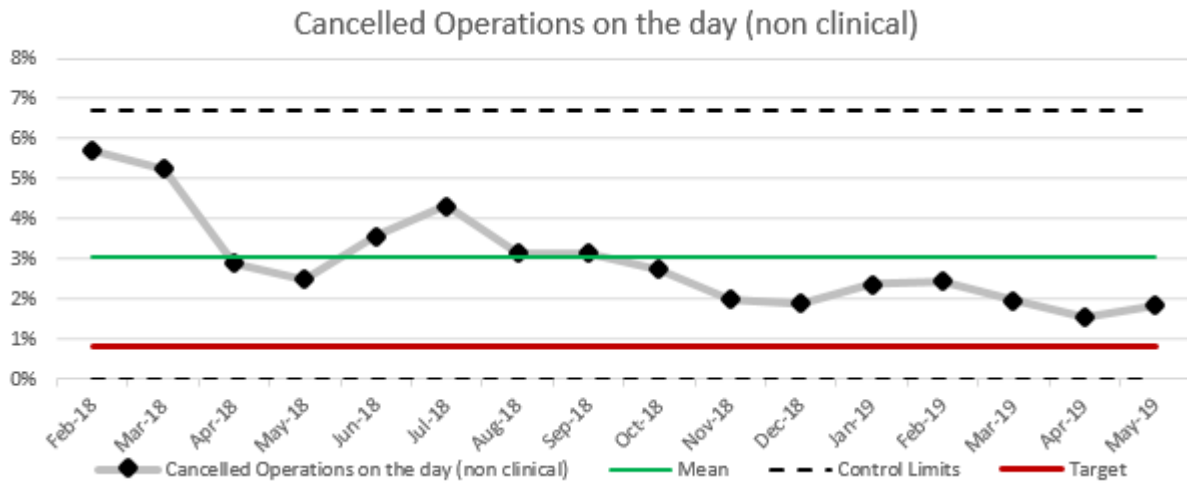
ZERO WAITING – CANCELLED OPS ON THE DAY (NON CLINICAL)

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Cancelled Operations on the day continues to show a trend below the mean.

Actions in place to recover:

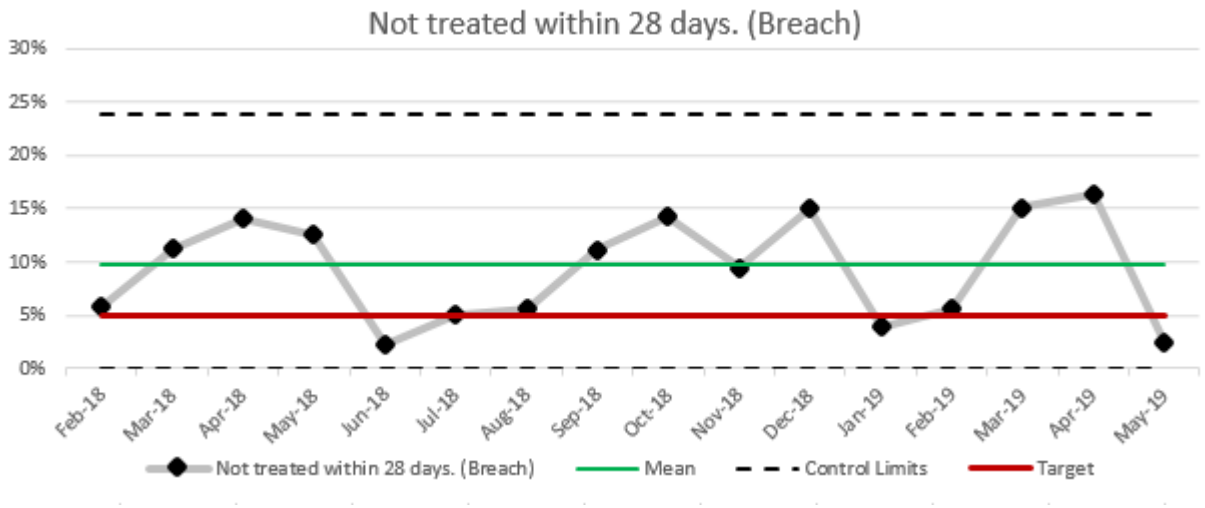
Improved processes for pre-assessment is having a positive impact.
Grip and control at the 6:4:2 meeting is also helping.

ZERO WAITING – CANCELLED OPS 28 DAYS BREACH

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Due to increasing emergency demand and bed pressures it has been challenging to rebook cancelled operations within 28 days but May has shown signifcant improvement.

Actions in place to recover:

Review the systems and process at speciality level to ensure timely booking. Weekly tracking within the divisions to ensure capacity is prioritised for cancelled operations within 28days.

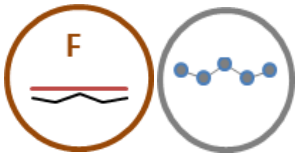
Centralisation of booking clerks project which will be completed by the end of June 2019 will help the process for tracking.

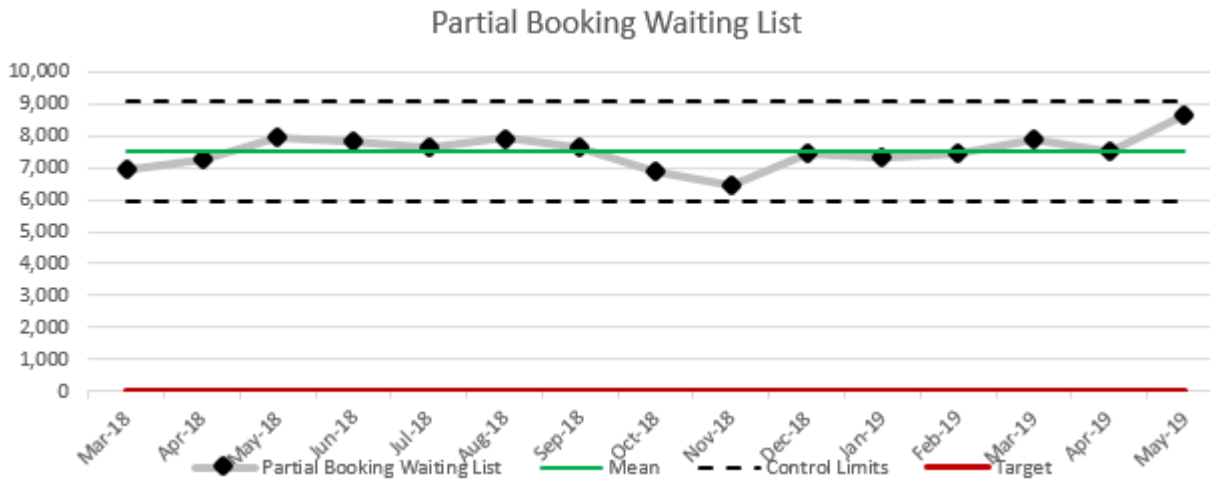
ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- No Time Critical patients are overdue on the PBWL
- The Trust has a Harm Review SOP/policy to review long waiters
- Each CBU needs to create their own backlog recovery plans
- The size of the PBWL has been on an upward trend
- The Trust is focusing on the NHS long term plan to reduce Outpatient arrendances by a third

Actions in place to recover:

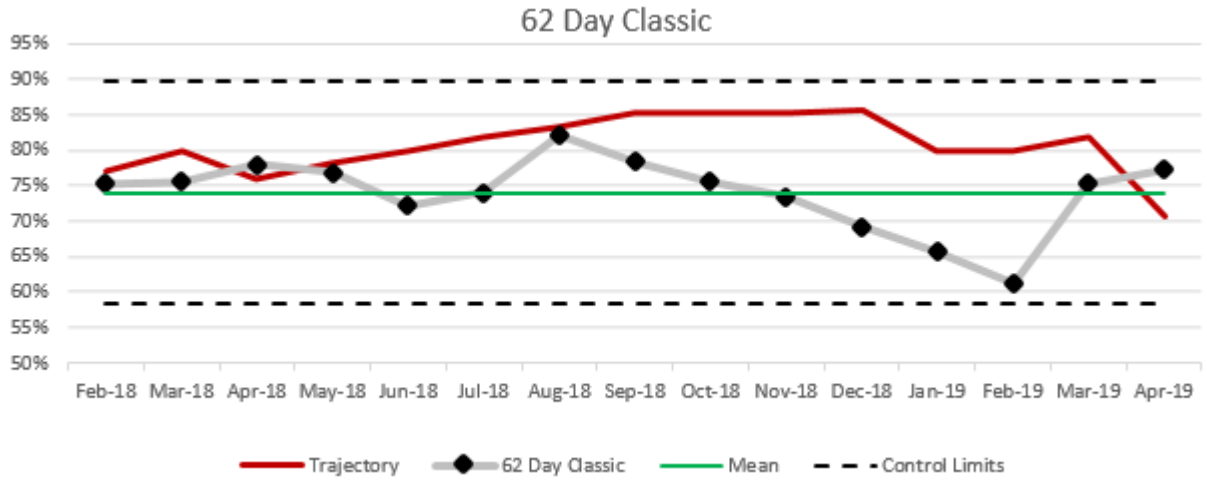
- Validation of patients on the PBWL
- Backlog recovery included in the new contract and a lead has been appointed to co-ordinate the CBU individual plans
- Each speciality has been requested to provide a recovery plan
- The Trust is developing new ways for patient pathways ie Patient Initiated Follow Ups, to reduce the number of patients on the PBWL

ZERO WAITING – CANCER 62 DAY

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services

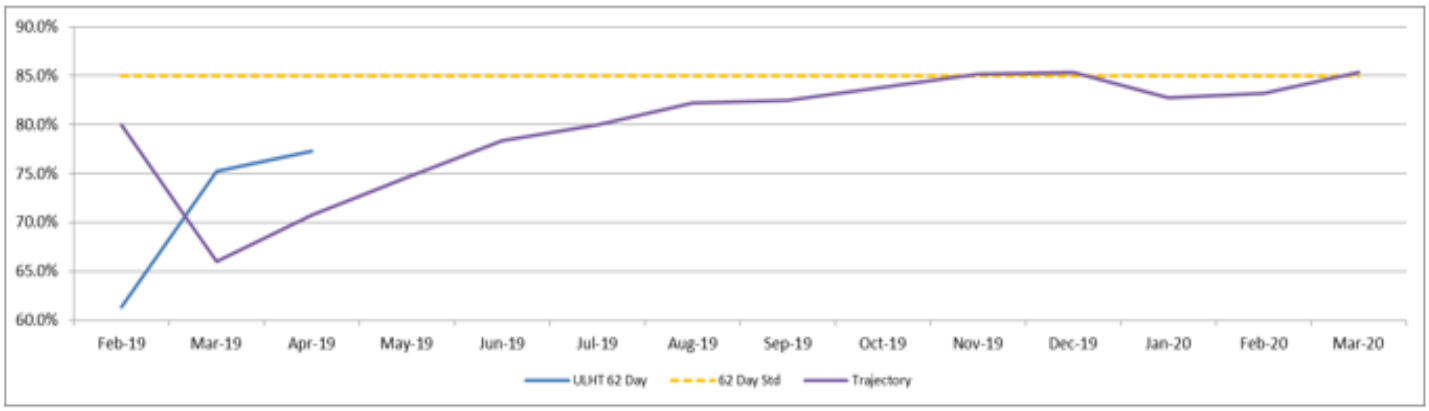


62 Day Classic and Backlog

The 62 Day Classic standard significantly over-performed against the trajectory of 70.8%, with Head & Neck, Lung, Skin and Urology all over-performing against their agreed trajectories.

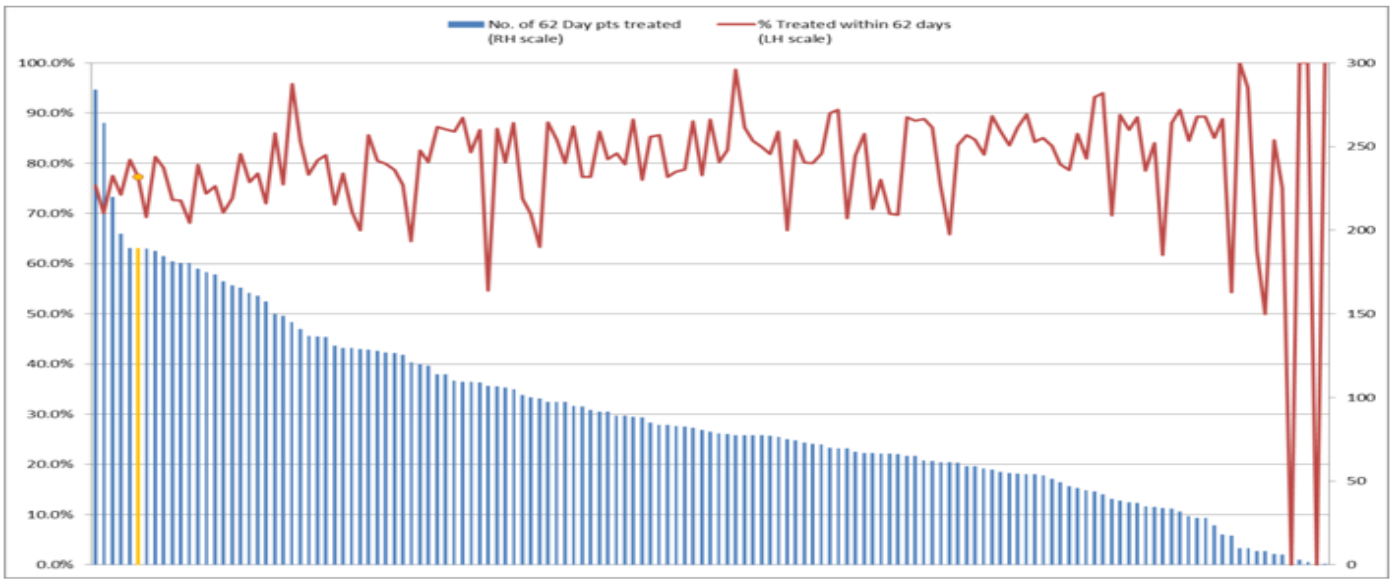
It shows as a pass as we are monitoring against our trajectory, however this is fragile and will deteriorate in the next reporting period.

(ULHT 62 Day Classic performance against national standard and 2019/20 recovery trajectory)



The new national monitoring of the IPT breach reallocation came into effect from April 2019 and the Trust performed less well in this month, mainly due to late referral of patients to tertiary trusts, predominantly Upper GI to NUH.

(Cancer trusts in order of treating volumes – ULHT is yellow bar/dot)



62+ Day Backlog –
Position as at: 09:00am 13 June 2019

Cancer Site	Backlog Target	Diagnosed	Undiagnosed	Grand Total
Brain	0		9	9
Breast	1	1	1	2
Colorectal	16	2	34	36
Gynaecology	1		21	21
Haematology	0	4	1	5
Head and Neck	1	2	10	12
Lung	4	2	5	7
Sarcoma	0		4	4
Skin	1		3	3
Upper GI	4	2	16	18
Urology	12	5	13	18
Grand Total		**18**	**117**	**135**

There are a number of service challenges common to all tumour sites, which will require Trust-wide actions to support the divisions:

• Faster Diagnosis Standard (FDS) – In line with many other trusts regionally and nationally, ULHT has been significantly challenged by the implementation of the FDS. However through concerted engagement from all tumour sites as of 4th June 2019 this position has improved significantly from mid-60s in early May 2019

Cancer Site	FDS
Brain	6
Colorectal	14
Gynaecology	2
Haematology	1
Head and Neck	1
Sarcoma	2
Upper GI	6
Urology	3

- Colorectal – Due to Divisional restructuring there have been significant challenges in identifying sufficient support to assist the clinicians in focusing on the most relevant patients on their cancer PTL to ensure that cancer admin was completed in a timely manner to minimise any delays to the patient's diagnosis. This admin issue was also evident in the ongoing Faster Diagnosis Standard work where the majority of these delays were around gaining sufficient evidence that the patient had been informed they did not have cancer.

- Gynaecology – Through April and May 2019, this tumour site has had difficulty in achieving the 14 Day standard with these delays at the start of the pathway impacting on their 62 Day performance as well. Gynaecology have not met their agreed trajectory for number of treatments or kept within the number of breaches contained within it.

- Pathology – Path Links are unable to recruit sufficient staff to cover their core service demand. Through late December, January and February they have sought to deliver service with only 9 of their 15 consultant posts covered by substantive staff. This period also saw them unable to attract locum consultants and resulted in significant delays for results – despite their attempts at prioritising cancer samples (where identified). Local operational relations with the Path Links team are positive but the organisational relationships are less so and impacted by the absence of a signed contract, with clear KPIs, escalation and penalties. Path Links are hosted by NLAG and ULHT representatives are seeking active contract negotiations. NHSI are also to engage in discussions about regional provision of pathology services, including the Path Links service, and are planning to meet key partners before the end of March – an input that should assist ULHT in better engaging NLAG. We routinely review cancer patient turn-around times for pathology and as of w/c 6 May 2019 it is clearly evident that Path Links continue struggle to deliver a 14 day standard, albeit the recommendation being a 7 day turn-around time (this will be a fundamental requirement for 2021 due to the introduction of the 28 Day Faster Diagnosis Standard (FDS).

- 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). Individual specialities are trying to influence the tertiary service responsiveness (e.g. head and neck general manager meeting NUH counterparts on a monthly basis). The ULHT Cancer Manager escalates delays with the NUH cancer manager. Cancer Alliance funding has been secured to employ three fixed term Project Managers (Band 8A – joint appointments between ULHT and CCGs)

- Oncology – The service is included in this section to reflect the reliance of most tumour sites on the oncology service, and to acknowledge the significant capacity difficulties that have existed in the service through November-January and ongoing in Upper GI. Recruitment success means that the ULHT Oncology service will be staffed to establishment within the next three months and the early phases of the recruitment will bring additional Upper-GI sub-speciality capacity into the organisation. There does, however, continue to be significant fragility due to sick leave, the split between clinical and medical oncology recruitment, in addition to tumour site coverage during the interim period of increasing establishment.

- 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. This includes adopting recommended monitoring processes, terms of reference, role clarity within the Cancer Centre and the Divisions to reduce duplication of work and to embed joint working to deliver a patient pathway that cuts across Divisions (including CSS).

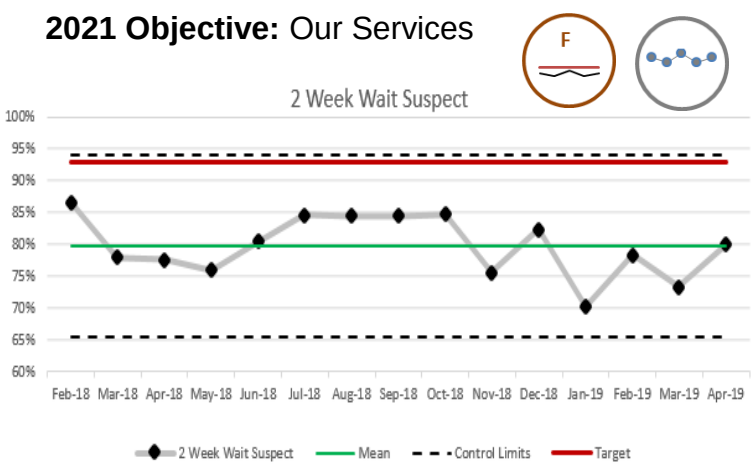
- MDT Organisation – There are a number of tumour sites which are operating hospital site specific MDTs. The rationale for the continuation of such arrangements needs to be reviewed in the context of national guidance for MDTs, the ULHT commitment to Trust-wide working and the pressures in supporting services to attend or support MDTs (particular pressures in pathology and oncology). Recognising the commitment in MDTs to site working, the direction of wider reviews is likely to need direction from the Medical Director/Trust Cancer Lead.

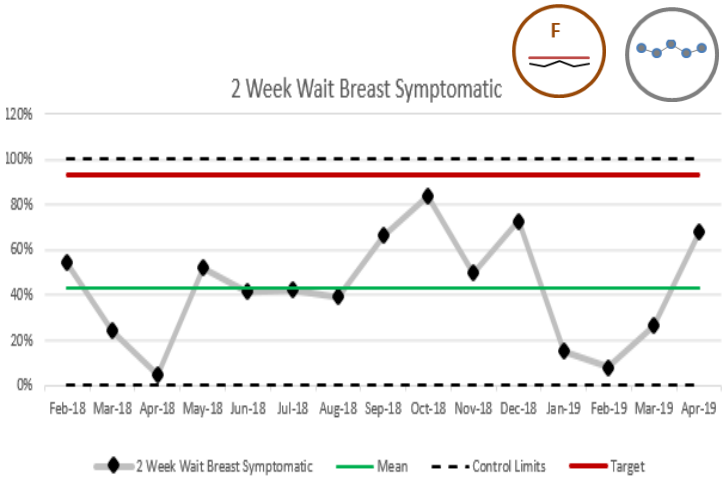
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Only three tumour sites have met the 14 Day standard: Haematology, Lung and Upper GI. The Breast service has shown a marked improvement from previous months and continues into May 2019 (expected performance of approx. 93%)

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

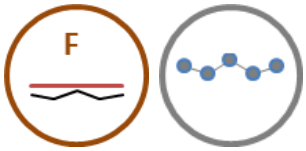
14 Day (93% NATIONAL STANDARD)	**Total**	**< 7 Day Prfrmnce %**	**< 14 Day Prfrmnce %**
Brain/CNS	13	**15.4**	**84.6**
Breast	330	**7.6**	**73.6**
Breast Symptomatic	143	**3.5**	**67.8**
Colorectal	453	**38.6**	**90.3**
Gynaecology	179	**13.4**	**70.4**
Haematology	9	**44.4**	**100.0**
Head & Neck	253	**18.2**	**87.4**
Lung	69	63.8	**98.6**
Sarcoma	11	**54.6**	**63.6**
Skin	343	**5.3**	**69.7**
Upper GI	145	**55.2**	**93.8**
Urology	274	**31.4**	**69.3**
Totals (excl Breast Sympto)	2080	**24.5**	***79.7%***
14 Suspect Total excl Breast	1750		***80.9%***

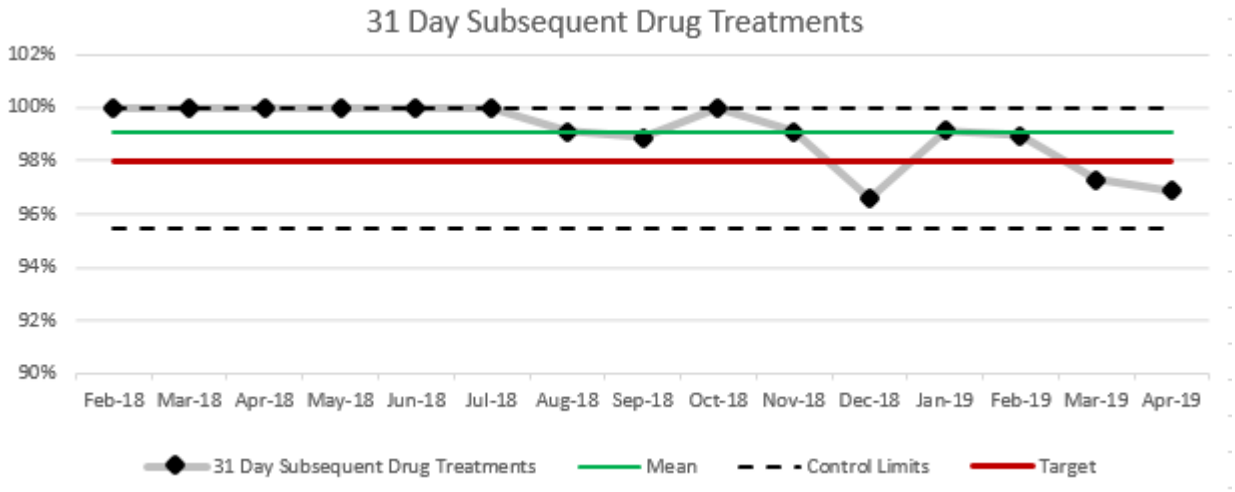
ZERO WAITING – 31 DAY WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





31 Day standards – The Trust achieved three of the four 31 Day standards in April. The Chemo Subsequent standard was missed due to one patient choice, one patient fitness and one due to capacity.

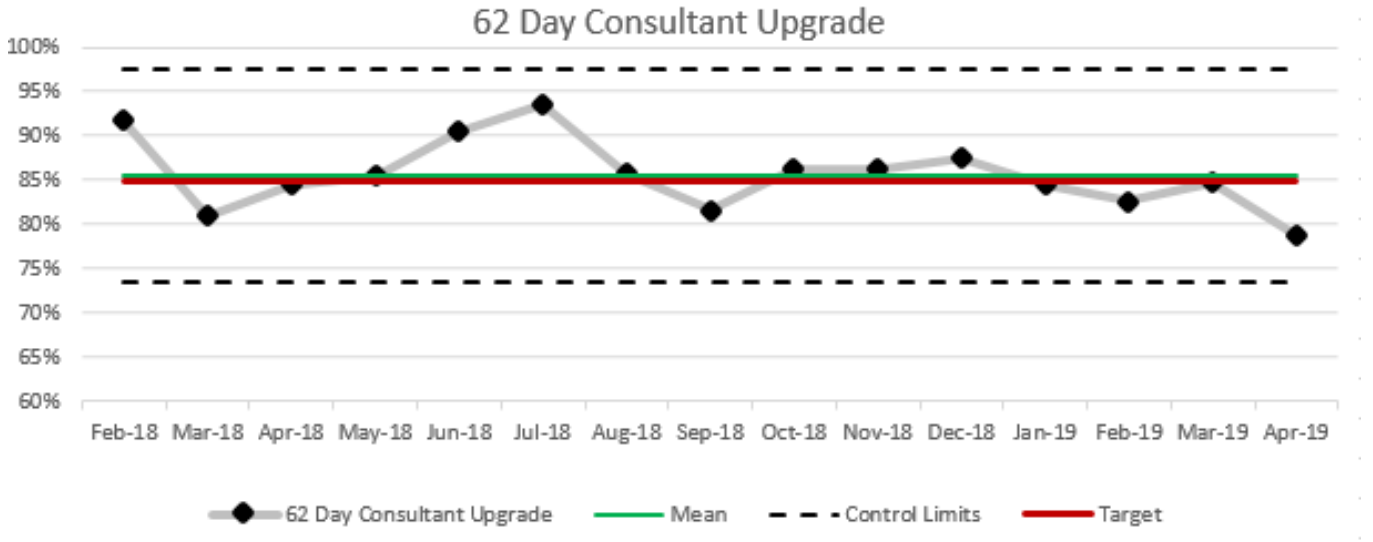
31 day Subs (98/94/94% NATIONAL STANDARDS)	Booked in target	Breaches							Total	Performance
		32 - 38	39 - 48	49 - 62	63 - 76	77 - 90	91 - 104	104+		
Drug	93	2		1					96	96.9%
Radiotherapy	107		3						110	97.3%
Surgery	33	1	1						35	94.3%

ZERO WAITING – 62 DAY CONSULTANT UPGRADE

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



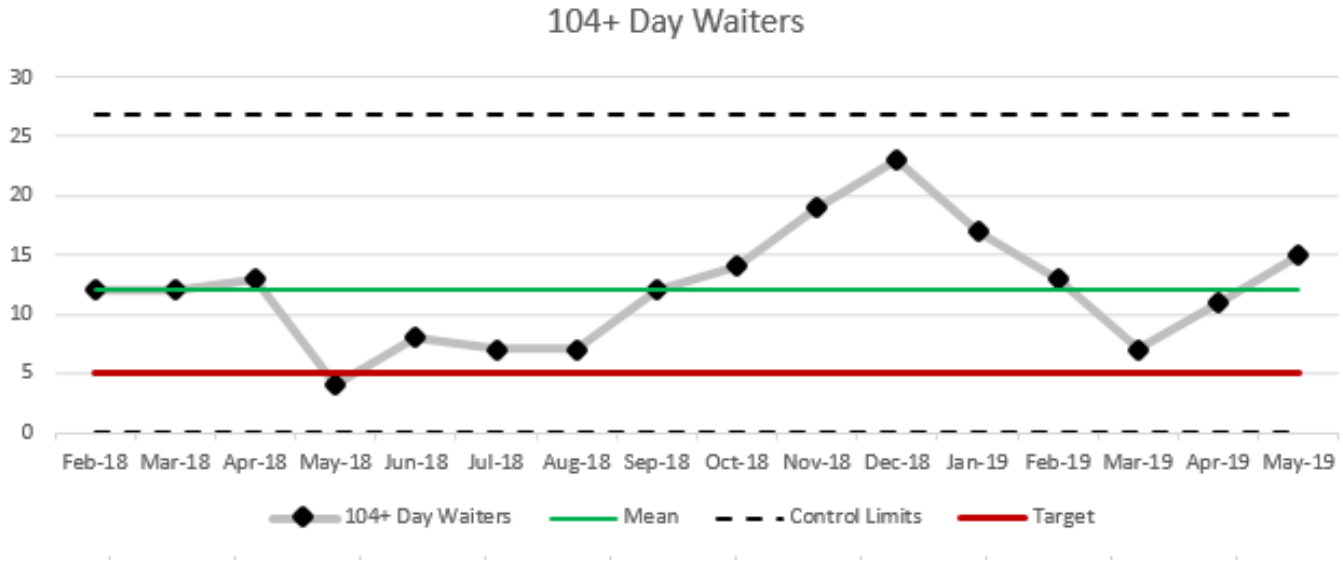
The 62 Day Upgrade was not achieved. Effort continues to be applied to achieve this standard despite it not being the national focus. In April the Trust reports 70.5 patients treated under this standard, which puts the Trust in the top 10 nationally for number of upgrades treated.

ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Mark Brassington

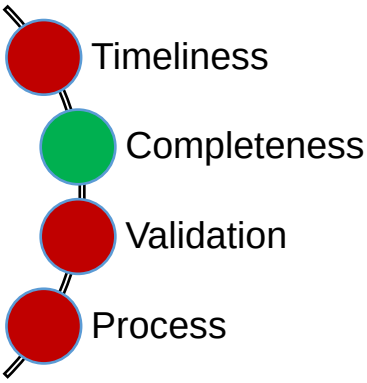
CQC Domain: Responsive

2021 Objective: Our Services



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:	July 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
- There have been no material changes the risk rating of any High or Very high risks since the last report
- Several significant operational and workforce risks are due for review and update, to reflect current risk treatment strategies and plans

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.

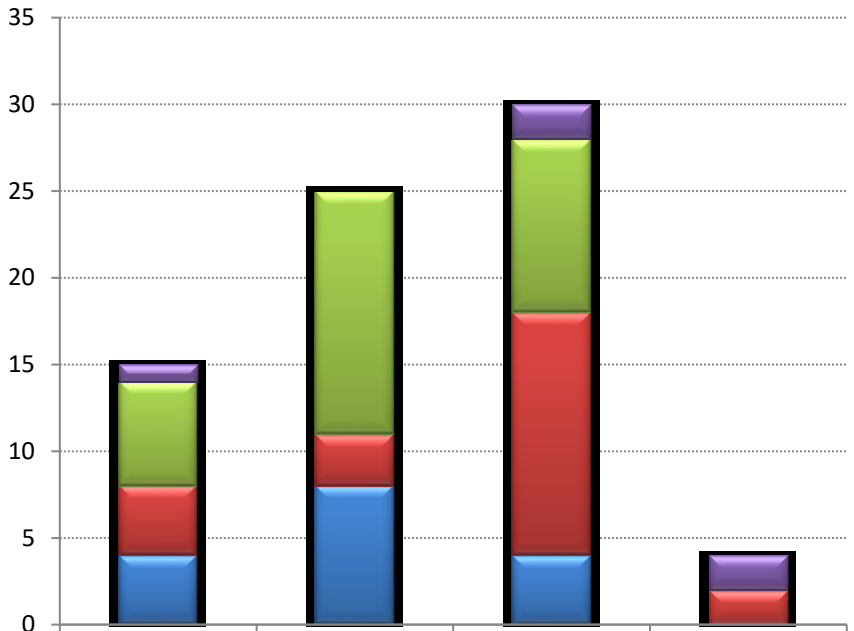
4. Summary of Key Points

4.1 The Trust Board is advised of the following specific points:

- The corporate risks associated with the Trust's aseptic pharmacy service are in the process of being reviewed by the Chief Pharmacist, supported by the Risk Management Lead and Clinical Support Services Division triumvirate; there are 3 distinct areas of risk that will be clearly articulated and individually assessed in future reports, a summary of which is provided below:
  - Potential for significant harm to a large number of patients if aseptic products (including chemotherapy medication) are contaminated due to hygiene issues at the facility or human error as a result of workload and training issues – this priority risk is being closely managed by the Trust lead for aseptic pharmacy and monitored the Chief Pharmacist; some additional staffing resource is currently going through the recruitment process, however this will only provide 6 posts of the 13 requested through a business case
  - Potential for extended service closure of the Pilgrim Hospital facility, which would impact on a large number of patients and other service providers, if there is a critical failure of the existing infrastructure (including air handling units, water pipes and isolator cabinets) much of which requires frequent maintenance and repair to enable service continuity; contingency plans are in place to outsource the supply of some aseptic products if necessary, however this only applies to around 60% of current requirements
  - Potential for regulatory intervention which forces closure of the Pilgrim Hospital facility, if the required professional standards are not maintained; a formal letter has been received from regional auditors highlighting their concerns; the Lincoln facility has already been closed by the Chief Pharmacist due to significant issues with its condition, which has increased the risk of infrastructure failure at Pilgrim
- All corporate financial risks have been reviewed and updated for the new financial year by the Director of Finance
- All corporate Estates & Facilities risk are in process of being reviewed and updated with the Director of Estates & Facilities
- There are several significant operational and workforce risks which also require a review and update with the lead directorates; this will enable clear identification of areas where additional attention is required to manage those risks more effectively
- The availability of resources to support corporate risk management processes has been limited in recent months and continues to be so; however, additional investment has been made within Clinical Governance and recruitment has taken place, which will enable greater support to be provided to corporate and divisional leads from September 2019 onwards

Corporate Risk Profile

4.2 **Chart 1** shows the number of corporate risks by current (residual) risk rating:

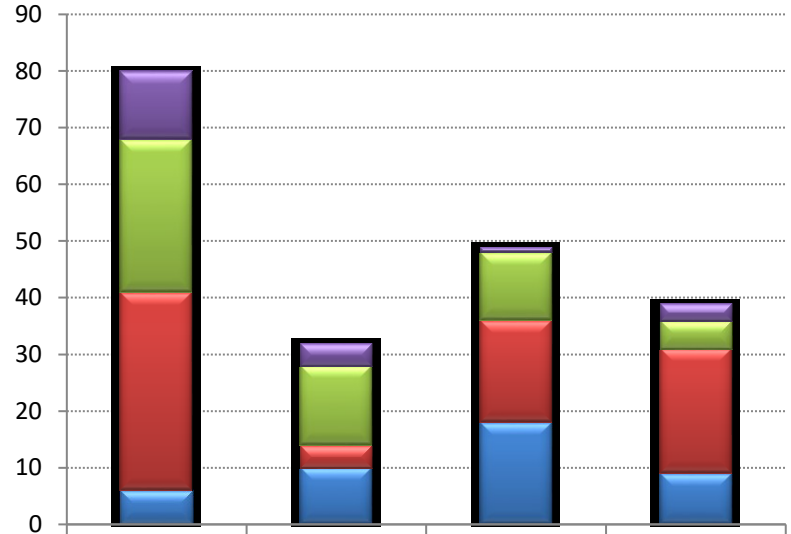


	Low risk	Moderate risk	High risk	Very high risk
Finances	1	0	2	2
Reputation / compliance	6	14	10	0
Service disruption	4	3	14	2
Harm (physical or psychological)	4	8	4	0

4.3 A report showing details of all corporate risks recorded on the Corporate Risk Register with a current (residual) risk rating of High or Very high (a score of 12 or more), along with planned mitigating actions is included as **Appendix I**.

Operational Risk Profile

4.4 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk
Finances	12	4	1	3
Reputation / compliance	27	14	12	5
Service disruption	35	4	18	22
Harm (physical or psychological)	6	10	18	9

4.5 A summary of all operational risks with a current rating of High is attached as **Appendix II**.

4.6 A copy of the Risk Scoring Guide, which is used to assess all risks recorded on the Trust's risk registers, is attached for reference as **Appendix III**.

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
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		
						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 bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	Review of proposals and potential impact, to identify any required action.	2. High priority risk mitigation	Rayson, Martin		30/06/2019		

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
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		
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		
						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		

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
						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 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)	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance (PPM) / testing. Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processes.	High risk (16)	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
						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		

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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
						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		
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

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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 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	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 arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.	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
						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		
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		
						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		

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						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 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	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. Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.	High risk (12)	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
						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		

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	~~and financial penalties.~~ Executive lead: Neill Hepburn Risk lead: Colin Costello					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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						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		
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. Executive lead: Paul Boocock Risk lead: Chris Farrah	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). Planned Preventative Maintenance PPM (Testing). Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processees.	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
						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		

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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
						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		
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

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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
						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		
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. Executive lead: Neill Hepburn Risk lead: Colin Costello	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		
						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		

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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 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	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. Business continuity / contingency plans for reduced availability of devices & equipment. CAS Alerts processes for managing device safety issues. Datix incident reporting & management processes for incidents.	High risk (12)	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		
						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.	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		

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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: Kevin Turner Risk lead: Nigel Gay					Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	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
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		

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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		
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; How likely is it to result in prolonged, widespread disruption to the health and social care sector to such asn extent that it 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)	The date of the UK's exit from the EU has been moved to 31st October 2019. Existing contingency plans may or may not be sufficient to mitigate potential impacts on the workforce; supply of medicines and medical devices; and the availability of information.	To review existing business continuity plans and update where necessary, in line with national and local guidance. Trust response to be coordinated through re-establishment of an executive-led task & finish group.	4. Lower priority risk mitigation	Leeming, Nick	Currently awaiting further details from the Dept of Health regarding potential impacts and any required changes to existing business continuity plans.	30/09/2019	Low risk (4)	30/09/2019

Appendix II - High operational risk summary (June 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	16	High risk
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	16	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	16	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	16	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	16	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4330	Workforce capacity & capability (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	15	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	15	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	15	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	15	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	15	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	15	High risk
4190	Safety & effectiveness of patient care (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4191	Availability of essential equipment (Surgery CBU)	Surgery	Service disruption	12	High risk
4195	Delayed patient discharge or transfer of care (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4214	Workforce capacity & capability (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4262	Availability of essential equipment & supplies (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4115	Workforce capacity & capability (TACC & Pain CBU)	Surgery	Service disruption	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4329	Safety & effectiveness of patient care (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4373	Availability of essential information (Outpatient Services)	Clinical Support Services	Service disruption	12	High risk
4408	Safety & effectiveness of patient care (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4409	Health, safety & security of staff, patients and visitors (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4410	Compliance with regulations & standards (Children & Young Persons CBU)	Family Health	Reputation / compliance	12	High risk

Appendix II - High operational risk summary (June 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk

Agenda Item 16.2

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	2nd July 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 June, with the exception of the Workforce, Transformation and Organisational Development Committee, which meets bi-monthly, and subsequently updated to reflect discussions held.

The Director of HR and OD has reviewed the framework and advised that there are no updates required at this time. Further discussions are still required by the Director of HR and OD to address Patient Experience being better represented within the document.

The Quality Governance Committee discussed the mapping of clinical audit to the framework due to the volume of audits. A decision was taken that the quarterly summary report on clinical audit received at the Quality Governance Committee would be referenced within the framework.

The metrics from objective 1a have been rated by the Quality Governance Committee resulting in an increase in the overall number of assurance ratings provided within the framework. 8 out of 9 assurance ratings have been provided.

The remaining assurance rating is in relation to objective 2b, metric % of services rated as 'delivering', this is due to the metric being identified as the baseline year and as such the Finance, Performance and Estates Committee do not have sufficient information to provide an assurance rating.

In order to support the continued population of the framework the Board are requested to consider identification of reports to be presented to the Board or Committees that would support with the closure of identified assurance gaps. Identification of further reports would allow for a more informed judgement of assurance ratings to be provided.

Direction of Travel of Assurance Ratings:

RAG Rating	May 2019	June 2019	Direction
Red	5	6	↑
Amber	1	2	↑
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2019/20 - June 2019

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Unreliable or inaccurate data Steps not delivered within the Trust Mortality Reduction Strategy Partnership working across health care system Coding incomplete	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 National Audit Data - HQUIP ReSPECT Care Plan	Speciality governance process Partnership working across health care system ReSPECT care plans not adhered to or in place No established process for cross system reviews	Trust Operating Model role out Performance review mechanisms of staff	Speciality assurance against governance guide National audit reports Audit of speciality governance Mortality Reduction Plan Quality review of medical workforce Quality review of nursing workforce Regular reporting on learning from deaths. Updates on coroner cases and preventing future deaths	System wide partnership reports - variable community buy in ReSPECT roll out not clear	Masterclass and Organisational Development Patient Safety Committee Clinical Effectiveness Committee Drugs and therapeutic Committee 7 day Services Mortality review group Fomal report from public health workshops to be requested ReSpect update and coding update requested within next mortality report July 2019	Quality Governance Committee	A
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy QSOG reports Quality Account priorities <u>Internal Audit:</u> Data quality of KPIs - Q4 Compliance with legislation - Q2	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Not complete Metric not finalised Sharing and learning not at desired level	Bi weekly meetings Harm Free care Steering Group QSIP Programme Meeting to finalise metrics	Integrated Performance Report Patient Experience Dashboard Quality and Safety Improvement Plan Board Walkrounds Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention Control exception report	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain oas gap for time being QSOG still in development New Trust Operating Model still embedding. Patient Experience and links to Quality Startegy and how articulated in BAF	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	Systems unable to capture and report data Unreliable or inaccurate data Insufficient clinic capacity resulting in overbooking Inappropriate clinic configuration providing duplicate appointment times Patients arriving late for their clinic appointment Poor engagement	Corporate risk ID 4368 - Outpatient demand (High)	CQC Responsive	Specialty Governance Data Quality Group Outpatient Improvement Programme Delivering Productive Services Group <u>Internal Audit:</u> Data quality - Q1	Data Quality Group New reporting metric Insufficient outpatient capacity to meet current demand across a number of specialties Consistency of Specialty Governance process	Data Quality workstream Performance Review Meetings Outpatient improvement programme System approach to managing planned care demand Governance team supporting embed of specialty governance port TOM implementation	Monthly Delivering Productive Services report PRM FPEC	Report not available Data quality assurance IPR	Interim report being tested and reviewed Development of data quality process 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 Delivering Productive Services	Specialty Governance Data Quality Issues New reporting metric	Data Quality workstream PRM Roll out of the TOM in line with the governance framework	Monthly Delivering Productive Services report Urgent and Emergency Care Improvement Programme update IPR	Reporting 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 backlog and repatriation schemes and inability to remove cost Activity exceeds contracted levels over and above repatriation and fails to secure all income due from commissioners	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very high)	CQC Well Led CQC Use of Resources	Financial Turnaround Group (FTG) oversight of FRP Vacancy control process Centralised agency team Financial Strategy and Annual Financial Plan Performance Management Framework Delivery of output of Clinical Service Review programme System 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 Improved reporting in to divisions 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' *Note: 2019/20 is baseline year. % not in place, working through baseline in draft, scrutiny and road testing criteria and application, scheme of delivery and devolution* *Baseline analysis of how to manage classification of service performance - 3 levels*	Director of Finance and Procurement	Lack of capacity to establish a robust programme of work Lack of focus and attention - not nationally required, externally driven - alternative pressures	None	CQC Use of Resources	TOM Operational Group TMG Delivery Proposal taken and agreed at TMG to set baseline 6 month shadow running <u>Internal Audit:</u> TOM Governance - Q4	Aligned to revision to national standards 20/21 Report on milestone plan Triumvirate Plan Signed off proposal at TMG	Tracking national developments Developing shadow running of national standards as they become clear Trust Operating Model Operational Group Debate on metrics across the CBUs/Divisions Project management plan with milestones being met	FPEC Updates TMG Updates	Process not in place currently, no plan and milestones	TOM Implementation to develop and agree service rating scheme for formal agreement at TMG	Finance, Performance and Estates Committee	

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 engagem ent (High)		Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: -Engagement of staff in 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**													

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
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 Poor system working No single system plan	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive CQC Well Led	1st line Activity monitoring Activity plan Contract Improvement project System plan delivery STP/SET/LCB infrastructure ASR Single system plan ICC development programme 2nd line: ICS Development 3rd line: NHS ICS Maturity Index Internal Audit: STP Governance - Q2	ASR - capital limitation Lack of system wide performance framework System delivery method not yet mature	ASR being refreshed for resubmission STP performance framework in development System wide SROs appointed and delivery framework being established	LCB Oversight SET CEO Updates at Board Healthy Conversation	No system delivery report	Being developed for going live in July 2019	Finance, Performance and Estates Committee	R

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

The BAF management process

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

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

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

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

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

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

To:	**Trust Board**
From:	Deputy Chief Executive
Date:	2 July 2019
Strategic objectives	All

Title:	Update on 2019/20 priority setting and deployment.

Author/Responsible Director: Kevin Turner, Deputy Chief Executive

Purpose of the Report: To brief the Board on the deployment of the agreed priorities for 2019/20

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	√

Summary/Key Points:

Since March 2019 the Trust has defined and refined the 2019/20 strategic and tactical priorities for 2019/20 in line with the agreed Strategic Planning Framework, itself aligned to the five year strategy 'Our Journey to Excellence'.

This has included:

- Scoping the strategic and tactical priorities that will be delivered to meet the trust's five year strategy and ambitions
- Communicating these priorities to the Clinical Divisions (Strategic Deployment)
- Agreeing the alignment of each Division's initiatives to the strategic and tactical priorities *('catchball'* at joint Board/TMG on 16 May 2019)
- Further discussion, challenge and agreement at TMG on 6 June 2019
- Presenting the final framework to Trust Board on 2 July 2019.

Throughout this process the priorities agreed by the Board earlier in the year have not changed.

The next steps will be to embed monitoring of progress into monthly PRMs and continue to monitor through the BAF.

Recommendations: The Trust Board is asked to note the deployment of the agreed priorities to Executives and Clinical Directors.	
Risk Register Identified risks noted on the BAF	**Performance KPIs year to date**
Resource Implications (eg Financial, HR) Included within the operational plan	
Assurance Implications Board assurance through the BAF	
Patient and Public Involvement (PPI) Implications Not considered	
Equality Impact Not considered	
Information exempt from Disclosure No	
Requirement for further review? ongoing	

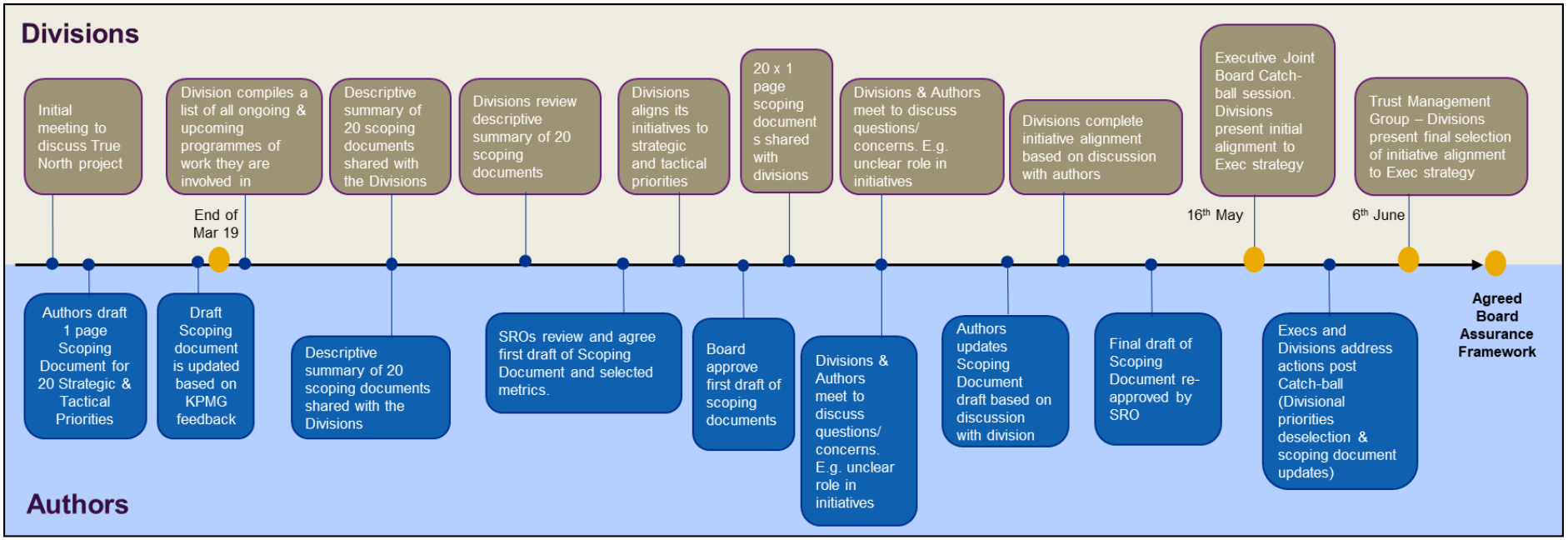
Update on 2019/20 priority setting and deployment.

2 July 2019/20

Background

- Since March 2019 the Trust has defined and refined the 2019/20 strategic and tactical priorities for 2019/20 in line with the agreed Strategic Planning Framework, itself aligned to the five year strategy 'Our Journey to Excellence'.

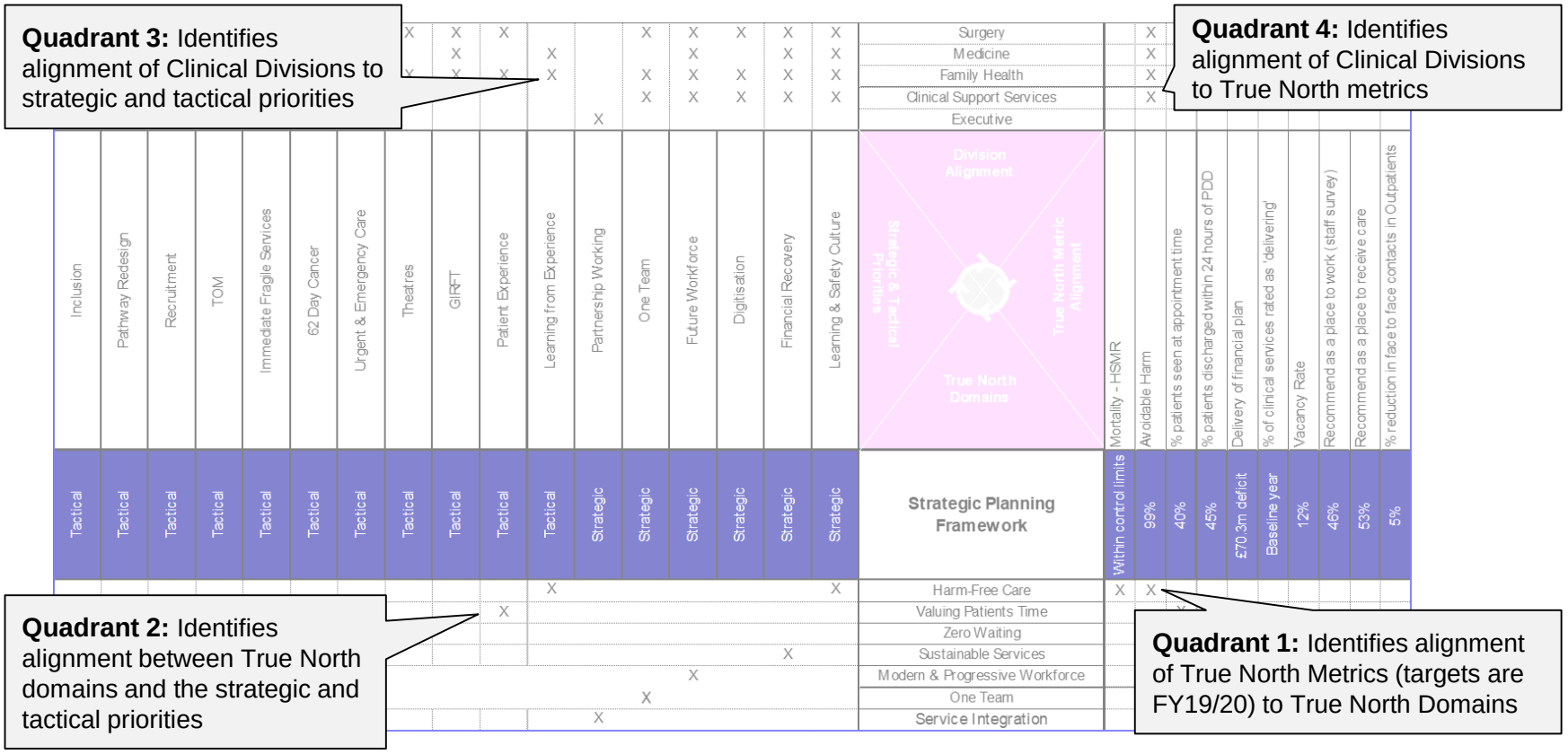
- This has included:
- Scoping the strategic and tactical priorities that will be delivered to meet the trust's five year strategy and ambitions
- Communicating these priorities to the Clinical Divisions (Strategic Deployment)
- Agreeing the alignment of each Division's initiatives to the strategic and tactical priorities *('catchball'* at joint Board/TMG on 16 May 2019)
- Further discussion, challenge and agreement at TMG on 6 June 2019



ULH Strategy Deployment
How to navigate the X-Matrix

A summary of the cascade of Strategic and Tactical priorities to the clinical Divisions has been depicted via the below Strategy Deployment X-Matrix.

The graphic below demonstrates how to navigate the X-Matrix.



ULH Strategy Deployment X-Matrix

Inclusion	Pathway Redesign	Recruitment	TOM	Immediate Fragile Services	62 Day Cancer	Urgent & Emergency Care	Theatres	GIRFT	Patient Experience	Learning from Experience	Partnership Working	One Team	Future Workforce	Digitisation	Financial Recovery	Learning & Safety Culture												
	X		X	X	X		X	X	X			X	X	X	X	X	Surgery		X	X		X	X		X		
						X		X		X			X		X	X	Medicine		X		X	X	X	X			
	X		X	X	X	X	X	X	X	X		X	X	X	X	X	Family Health		X			X	X	X		X	
	X			X	X	X						X	X	X	X	X	Clinical Support Services		X			X	X		X	X	X
X											X						Executive										
Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Tactical	Strategic	Strategic	Strategic	Strategic	Strategic	Strategic	**Strategic Planning Framework**	Within control limits	99%	40%	45%	£70.3m deficit	Baseline year	12%	46%	53%	5%
										X						X	Harm-Free Care	X	X								
									X								Valuing Patients Time			X							
					X	X	X										Zero Waiting				X						
				X											X		Sustainable Services					X	X				
		X	X										X				Modern & Progressive Workforce							X			
X												X					One Team								X	X	
	X										X						Service Integration										X

Division Alignment

Strategic & Tactical Priorities

True North Metric Alignment

True North Domains

Alignment Outcomes

Quadrant 1:
True North Metric alignment to True North domains

- Each True North domain has at least 1 metric identified, with targets set for the next 2 years

Quadrant 2:
Strategic and Tactical priorities alignment to True North domains

- Each True North domain has a strategic or tactical priority aligned to it
- Valuing Patients Time and Zero Waiting True North domains have no strategic priority aligned to them, only tactical priorities
- Modern and Progressive Workforce and Zero Waiting True North domains have the most number of strategic and tactical priorities aligned to them (3 in total)

Quadrant 3:
Clinical Divisions alignment to Strategic and Tactical priorities

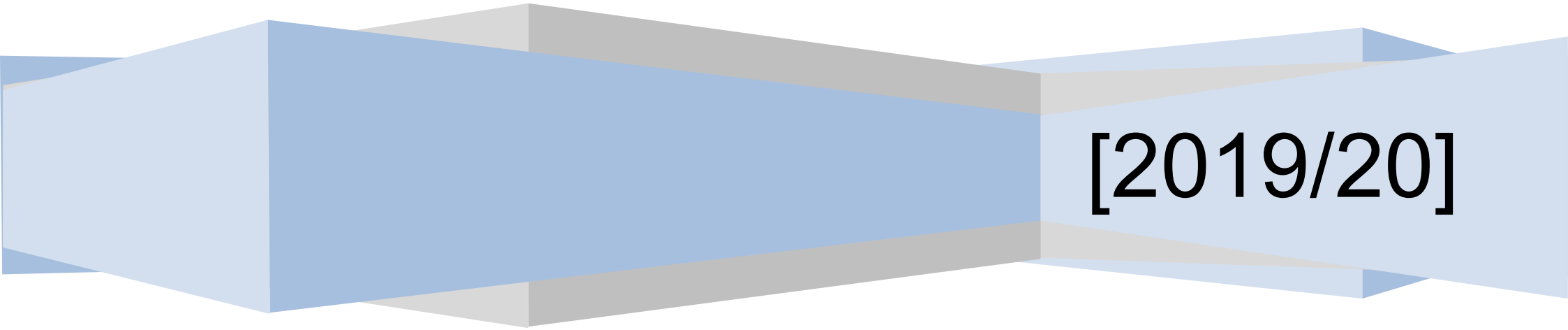
- Apart from the Partnership Working strategic priority and Inclusion tactical priority, all other strategic and tactical priorities are supported by more than 1 Division
- There are no gaps in ownership of strategic and tactical priorities
- Partnership Working is only being driven by Executives, there is no clinical Division alignment

Quadrant 4:
Clinical Divisions alignment to True North metrics

- All True North metrics are supported by at least 1 Divisional Team
- % seen within appointment time is only being driven by Surgery
- % patients discharged within 24 hours of PDD is only being driven by Medicine
- % reduction in face to face contact in Outpatients is only being driven by CSS

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER



	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020									X		
BAF Sign off for 2019/20	X									X	
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											
Finance, Performance and Estates Committee	X	X	X	X	X	X	X	X	X	X	X

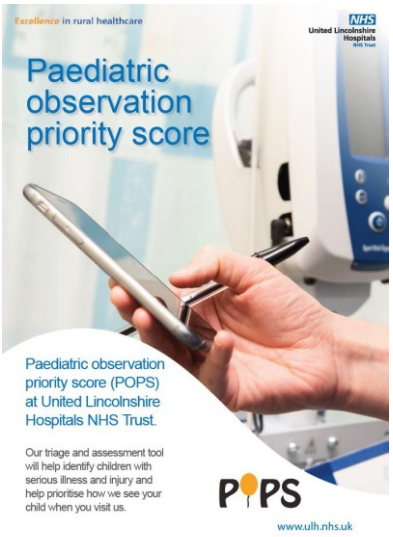
Assurance and Risk Report											
Financial Plan and Budgets										X	
Clinical Strategy Update										X	
Operational Plan Update					X		X		X		
Emergency Planning Annual Self Assessment						X					
SO 3 Providing Services by Staff Who Demonstrate our Values and Behaviours											
Workforce, 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											

Introducing a new way of assessing children and young people in hospital emergency departments

United Lincolnshire Hospitals NHS Trust (ULHT) have introduced a new, innovative way of triaging and assessing children and young people in emergency departments, to ensure consistency across all hospital sites and provide safe care to all of our patients.

POPS, the Paediatric Observation Priority Score, is a physiological and observational scoring system designed for use by health care professionals of varying clinical experience.

It has been introduced across all of our hospital emergency departments, to standardise the way staff identify ill and injured children, to improve standards of care, encourage improved communication both within and outside of the department and assist in the early recognition of clinical deterioration in ill children.



The introduction of this required us to make changes to include specific documentation, assessment tools designed for the needs of children and young people, and to ensure all staff assess serious illness in a consistent manner.

Jamie Crew, Health Education England fellow said, “Health Education England (HEE) fellows have been working with colleagues across the Trust to address training needs for care of children and young people and the feedback so far has been overwhelmingly positive.”

Victoria Bagshaw, Deputy Chief Nurse said, “All staff have been extremely enthusiastic to learn about POPS and the engagement has been fantastic. There is a raised level of skills and knowledge to ensure staff are confident in recognising sick children when they arrive at our hospitals.”

The new full assessment includes assigning children a score so staff will identify and see our most unwell children first.

All of our emergency department staff have now received training and communication around full assessment and POPS, so they feel confident and skilled to assess and plan care for children and young people at ULHT. We have adopted the train the trainer technique to address sustainability of standards and the teaching new staff.

This is a particularly exciting innovation at ULHT, and mirrors the standards outlined in the Facing the Future document that sets out standards for the care of children and young people visiting emergency departments. POPS is one of only a few validated tools to assess children in emergency care settings in the UK. The team are delighted that we have launched this at ULHT, which is also used by Lincolnshire Community Health Service NHS Trust (LCHS) and East Midlands Ambulance Service (EMAS).