Bundle Trust Board Meeting in Public Session 6 August 2019

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

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Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 2nd July 2019 for accuracy
Chair
Item 5 Public Board Minutes JULY 2019 v1 (002).docx

6 Matters arising from the previous meeting/action log
Chair
Item 6 Public Action log July 2019.docx

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

8 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 Assurance and Risk Report Quality Governance Committee
QGC Chair
Item 11.1 QGC Upward report July 2019.doc
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11.2 CQC Inspection Letter
Chief Executive
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11.3 Maternity CNST Safety Incentive Scheme
Divisional Head of Nursing and Midwifery - Penny Snowden
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12 Providing efficient and financially sustainable services SO2

12.1 Assurance and Risk Report Finance, Performance and Estates Committee
FPEC Chair
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13 Providing services by staff who demonstrate our values and behaviours SO3

13.1 Assurance and Risk Report Workforce and OD Committee
Workforce and OD Chair
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14 Providing seamless integrated care with our partners SO4

14.1 Healthy Conversations Campaign 2019 - Engagement report

Chief Executive

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15 Performance - Integrated Performance Report

Exec Directors

Item 15 Integrated Performance Report.pdf

16 Risk and Assurance

16.1 Audit Committee Upward Report

Liz Libiszewski for Audit Committee Chair

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16.2 Audit Committee Annual Report

Liz Libiszewski for Audit Chair

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16.3 Corporate Governance Manual

Trust Secretary

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Item 16.3 SOs updated v 300719.doc

Item 16.3 SFIs Updated v 300719.doc

16.4 NHSI Board Committee Observations

Chair

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16.5 Risk Management Report

Medical Director

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Item 16.5 Appendix III - Risk Scoring Guide - July 2019.pdf

16.6 BAF 2019/20

Trust Secretary

Item 16.6 BAF 2019-20 Front Sheet August 2019.docx

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17 Strategy and Policy

18 Board Forward Planner

Trust Secretary
For Information

Item 18 Public TB Board Forward Planner 2019 v 2.doc

18.1 Board Development Schedule

Trust Secretary

Item 18.1 ULHT Board Development Sessions 2019 v3.doc

19 ULH Innovation

Assistant Director Communications
For Information

Item 19 Innovation Report August - MIA (5).docx

20 Any Other Notified Items of Urgent Business

21 The next meeting will be held on Tuesday 3rd September, Boardroom, Lincoln County Hospital

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

Minutes of the Public Trust Board Meeting

Held on 2nd July, 2019

New Life Centre, Sleaford

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, Director of Finance and Procurement
Mr Andrew Morgan Chief Executive
Mr Kevin Turner, Deputy Chief Executive
Mrs Gill Ponder, Non-Executive Director

Non-Voting Members:
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
Mr Darren Tidmarsh, Deputy Director of HR&OD
Mrs Victoria Bagshaw, Deputy Chief Nurse

Apologies:
Mr Martin Rayson, Director of HR &OD
Mrs Michelle Rhodes, Director of Nursing

925/19 **Item 1 Introduction**

The Chair welcomed members of staff, public, NHS Improvement observers and the new Chief Executive to the meeting.

926/19 **Item 2 Public Questions**

Q1 from Jody Clark – At the Healthy Conversation Event in Grantham on 19th June, I raised the concern of Grantham residents not wanting to go to Lincoln or Pilgrim for urgent or emergency care due to poor patient experience and the poor reputation.
An EMAS representative corroborated this and said many are choosing Peterborough. He did clarify that they always recommend Lincoln for Heart Attacks and Strokes, but I did point out that those patients are not left in an A&E department.
On reading this months board papers, its disheartening to see ongoing issues at both of these locations in the CQC findings.

What assurances can you give us that improvements will be made in the near future?

The Chief Operating Officer responded:

The disappointment and frustration expressed by Ms Clark about the poor care delivered despite efforts of staff was shared by the Board. Previous discussions at the Board meetings had covered the demand and workforce challenges being faced, there continued to be an unprecedented level of demand that the Trust continued to try to meet. The Trust must overcome the challenges and improve As such a clear improvement plan remained in place

managed across all sites. As part of the improvement plan there would be delivery of month on month improvements and this had been seen in June.

Q2 from Liz Wilson – Please can the Board describe how the proposed GP led Urgent Treatment Centre at Grantham and District hospital differs from the current consultant-lead Accident and Emergency Department, and explain what the impact will be on patients?

The Medical Director responded:

The proposed model would not be a GP Led service but would be provided by Lincolnshire Community Health Services NHS Trust with Trust clinicians providing specialist advice where required. At present it appeared that the Trusts' consultants would be part of the skill mix. The model remains in the design phase. An engagement event had taken place on the 19th June to allow members of the public to contribute to ideas.

The proposal would see the opening times extended to 24 hours with overnight access via 111 suggested. The staff mix would be altered from consultant led as the integrated service becomes established.

The previous 5 years had seen restrictions on the types of conditions accepted at Grantham however the proposal would expand what could be accepted. The full impact of the service redesign would not be known until the model had been determined and this was led by the community services.

Whilst the range of conditions that would be handled in the urgent treatment centre would be different from a traditional Accident and Emergency the service would be available to residents 24 hours a day, 7 days a week.

927/19 **Ward Accreditation**

The Board presented a Ward Accreditation Certificate to Sharon Kelham, Ward Manager from Hatton Ward

928/19 **Item 3 Apologies for Absence**

Apologies were received from the Director of Human Resources and Organisational Development and the Director of Nursing

929/19 **Item 4 Declarations of Interest**

Mr Andrew Morgan the Chief Executive declared that he remained an employee of Lincolnshire Community Health Services NHS Trust whilst on secondment to the Trust and declared he is a Trustee with Linkage Community Trust

930/19 **Item 5 Minutes of the meeting held on 4th June 2019 for accuracy**

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

721/19 – Should read – This would remain an area of security risk to the Trust and moving forward options would be explored to resolve this.

729/19 – the word introduction to be replaced by the word withdrawal.

806/19 – Should read - Concern was also raised about the disproportionality of references within the pharmacy and medicines optimisation and the small amount of information in relation to other areas such as therapy services.

869/19 –Right to treatment should read Referral to treatment.

931/19 **Item 6 Matters arising from the previous meeting/action log**

642/19 – Asbestos and fire works report to Finance, Performance and Estates Committee – complete, included on the Committee work plan

684/19 – Committee review of KPIs – deferred to August 2019, work ongoing with Committees to review KPIs, Finance, Performance and Estates Committee trialling set of KPIs

721/19 – Response to Public Question– Complete, meeting scheduled

726/19 – Arrangements for fire asbestos work – Complete, Capital Revenue Investment Group reviewing

754/19 and 759/19 – Development of Nursing Associate – Complete, the Trust are clear about the theoretical number of 220 FTE Nursing Associates, currently there are over 100 in the Trust. Any changes to the skill mix would be considered through the Quality Impact Assessment process and workforce planning

772/19 – Descriptor of County Hospital Louth in 5 Year Strategy – Complete

806/19 – Amendments agreed at meeting to Clinical Strategy – Complete

809/19 – Assurance on delivery of Clinical Strategy agreed, reporting agreed - Complete

827/19 – Assurance on delivery of H&S actions report to FPEC – Expected completion and reporting to August Finance, Performance and Estates Committee. Additional design within the training system would allow training information to be reported through ESR

842/19 – How the Trust moves away from fax referrals – Complete, the Trust had moved away from fax referrals with ERS in place however a small number of referrals continue to be received on a weekly basis from opticians and dentists. Work continues to ensure providers refer via NHS.Net accounts

883/19 – Inaccuracies and out of date data in IPR – Complete, review of the IPR content undertaken and process refined. Work continues to develop the kite mark and audit work regarding the assurance of the kite mark is due to take place later in the year

886/19 – Review of KPIs in IPR across Committee – Complete

891/19 – Controls against the 5 high corporate risks not having desired effect on mitigation – review underway agenda item - Complete

893/19 – Cover report for risk register to be high level – Complete, agenda item

900/19 – BAF to take patient experience to QGC – Complete, discussions held at Quality Governance Committee, changes made to the BAF to strengthen patient experience and alignment to harm free care. Patient experience work plan to be included within the Quality Strategy

914/19 – Letter to be sent to consultant re service at County Hospital Louth – Complete, letter sent to consultant

919/19 – Review of 15 Steps – Complete, paper due to be considered by ET

920/19 – Board visibility – Complete, paper due to be considered by ET

The Deputy Chief Nurse joined the meeting.

932/19 **Item 7 Chief Executive Horizon Scan including STP**

The Chief Executive advised the Board that future written reports would be provided covering Trust and System wide updates.

933/19 The Chief Executive provided the Board with his background and set out his intentions during his time at the Trust. A well-motivated and inspired group of staff would always deliver a better outcome rather than a disheartened workforce. The focus for the Chief Executive would be on leadership, culture, behaviour, talent management, health and wellbeing and all things that help staff to deliver care. Values underpin the work undertaken in the Trust and need to be owned and embedded, the Chief Executive would ensure role modelling of values and behaviours.

934/19 The Chief Executive advised of the intention to be visible across the Trust to ensure staff were able to provide both positive and negative feedback to ensure success. The Chief Executives approach would be one of work on forgiveness not seeking of permission, when things go wrong these faults would be admitted and advice and support would be sought.

935/19 The Board and Chief Executives role was to ensure success of the organisation and support staff to deliver. Internal and external communications play a key part in the role of the Chief Executive and there would be the intention to ensure Trust visibility through various communication methods.

936/19 The key priorities for the Trust that had been discussed with the regional director for NHS Improvement were, quality and safety, services delivered need to be safe and of high quality so that the Trust can look to exit special measures quickly. Quality and safety affect the reputation of the Trust and the confidence that the public have regarding services.

937/19 The Board had signed off the 5-year strategy and it would be important that people understand the content and ensure ownership. The strategy had been aligned to the Sustainability and Transformation Plan and was underpinned by future alliances, there would be a need to support the delivery of the strategy.

938/19 The Trust must ensure that the licence to operate continues to be earnt through improvement of performance, specifically in relation to accident and emergency, cancer waits and 52-week waits. There would also be a need to ensure delivery of the Trust's financial plan.

939/19 The Trust must have an effective Executive Team to ensure leadership of the Trust is as good as possible. Although the role would be a secondment the job would be conducted fully and would involve focus on both long and short-term positions, not just a holding position. The Trust must ensure that it has the right intent, capacity and capability in order to ensure it can deliver.

940/19 The Chief Executive provided a horizon scan for the Board. The NHS long term plan implementation guidance had been published and supported how the Lincolnshire system

would deliver at least a 5 year plan. This would also pick up issues of the integrated care system, why it would be needed, how it would work and the benefit for patients.

941/19 The role of the Trust as a key partner in the system would be about the Trust looking outward and the Chief Executive taking seriously the responsibility in leading and guiding the direction of the Lincolnshire system. Compliance with the plan would be required however there would be a need to ensure that Lincolnshire would be able to deliver what is required locally. The guidance would allow for the Lincolnshire plan to be developed.

942/19 Primary care networks would be an important and different way for the system to become organised. There would be around 15 groups of GP practices working together, each with a Clinical Director. Partnership working would be required with the networks to ensure people were treated appropriately.

943/19 In addition to the Trust being required to meet the agreed control total there would be a requirement for Lincolnshire to also meet a control total. The original plan determined that £88m of savings would be required. There would be a significant challenge across the system in order to deliver and there would be a need to work together to realise the savings.

944/19 The Chief Executive advised the Board that he was chair of the System Executive Team and that there was a more focused agenda on self-care and prevention, this would involve the County Council in addition to public and NHS providers there had not yet been enough of a focus.

945/19 The Board were aware of the Acute Services Review work, in addition to this the Integrated Community Care review would be undertaken and focus on population health management in respect of keeping people safe and well and close to home. Individuals would need to take responsibility for their health and a multi-disciplinary approach would be taken. The Trust would intervene in care in an appropriate way at the appropriate time. The work was currently in formative stages but would be crucial to the future work of the Trust.

946/19 The Chief Executive advised that to work as a system across Lincolnshire there would be a need for assurance processes to be reflected by NHS Improvement/NHS England to enable more system wide discussions.

947/19 Dr Gibson identified that other rural areas in the UK had begun integration of healthcare services however this had not resulted in quality and safe services and questioned how Lincolnshire would ensure this would not become an issue.

948/19 The Chief Executive stated that there would need to be a choice about working differently and behaving in the correct manner, there would be considerable authority for the Trust to ensure this would happen. As Chief Executive and Chair of the System Executive Team the choice would be to make quality one of the non-negotiable areas for delivery. This would drive process for financial turnaround, quality impact assessments and equality.

949/19 The Chair identified that included within the strategic plan had been the additional objective of partnership working, Non-Executive and Lay members would be receiving a presentation regarding how quality would be delivered across the system along with responsibilities and assurance that would be delivered. This would support the system wide approach.

950/19 Mr Bains asked the Chief Executive how confident he was that integration with the NHS, Social Care and Public Health would be achieved.

951/19 The Chief Executive advised that the discussion held at the System Executive Team involved both health and social care representatives, this would assist with the progress to be made

however there was concern that it would still be considered as reconfiguration through an organisational lens rather than redesign of pathways and population health management. Merging of organisations does not ensure integration, services need to be redesigned and integrated for the benefit of patients. Staff would be the key to pathway redesign and the commencement of integration. The Trust need to be more outward focused working in partnership with councils, voluntary sector and other NHS providers to support delivery of integration.

952/19 The Chair thanked the Chief Executive for the update and for raising the expectations of the Trust.

The Trust Board:

- **Received the report**

953/19 **Item 8 Patient/Staff story**

Midwives Emma Upjohn, Helen Shepherd and Claire Green attended the Board to present the staff story from the Continuity of Carer offers Outstanding Support (COCO'S) team.

954/19 The Board heard that the development of the team had stemmed from the NHS 10 year plan for better births which focused on women being cared for by a small group of around 4-8 midwives based in the community.

955/19 The first team had been established in the Gainsborough area due to increased social deprivation, lower socio-economic background and high smoking in pregnancy rates.

956/19 The introduction of the team had seen reduced case load numbers for the midwives and the aim would be for around 30-35 cases, this was a reduction of halve on the case load allowing for the delivery of intrapartum care.

957/19 The team had achieved a home birth booking rate of 14% up from 2%, achieving above the national average, the Continuity of Carer allows for improved care delivery and the confidence of women in their midwives had resulted in the increase in home births.

958/19 The plan had been set out for delivery of 51% of Continuity of Carer by March 2021 without additional staff being appointed.

959/19 Midwife Shepherd informed the Board of the success achieved by the team including women being booked on to the pathway from February with the first lady due to give birth in October. Initial feedback received from the women and families had been extremely positive.

960/19 The morale of the midwives within the team had improved due to the flexibility of working hours, home birth pathway bookings had increased and women who were keen to home birth would be more likely to deliver at home if they knew their midwife. The team had developed social media platforms to support the families within their care.

961/19 The Trust submitted a target to NHS England of 5% achievement, this had been achieved and surpassed with actual performance of 7% the next stage would be to achieve 51% by 2021. The team had sought the opinions of the public and following this further expressions of interest would be sent out to develop a team in Sleaford followed by Skegness in October, Grantham and a Diabetic team.

962/19 The Chair thanked the staff for their attendance and congratulated them on the change made to the team and getting this off the ground despite barriers.

963/19 Mrs Dunnett asked if there had been anything learnt from the team and any patient feedback that would result in a different approach as this was rolled out in other areas. The team identified that additional staff engagement would be beneficial and that there had been a number of questions asked that could not be answered initially, these could now be responded to as the first team had been established.

964/19 Midwives had raised concerns about being on call for prolonged periods however the team had been able to demonstrate that this had not been an issue due to the rota of one night call followed by day calls. The reduced case load had been key to supporting the new way of working.

965/19 The Chief Operating Officer echoed the positive results at such an early stage and asked if the team felt equipped to go through the process or if further support could have been given by the Trust to achieve this.

966/19 Midwife Shepherd indicated that there had been a good level of support from the Local Maternity System however additional support regarding workforce to be able to ensure safe staffing on wards until the tipping point on the redesigned service is achieved would be beneficial. Until the tipping point can be achieved there would be 2 systems running. Consideration needs to be given to staffing the women and not the ward, the new model staffs the women and delivers a safer service. The team would be keen to repatriate women who have chosen to deliver out of area due to the increased level of support through the new model.

967/19 Midwife Green indicated that there had been a number of women choosing to deliver out of area due to Gainsborough being central, this had now started to change and women who had previously delivered out of area were delivering in Lincoln due to the new team.

968/19 Mrs Libiszewski asked how progress had been made with smoking cessation.

969/19 Midwife Shepherd advised that there had been a smoking rate of 23% which was high. Smoking cessation support had been made available on a weekly basis in Gainsborough however it had been difficult to get women to access the service. As the women are seen by the same midwife for appointments it had been possible to hold continuous conversations about smoking cessation. Progress would be audited in one year to determine the impact.

970/19 The Deputy Chief Executive raised the issue of the slow trajectory role out and asked how the team would deal with the demand from women who did not have COCO's in their area.

971/19 Midwife Upjohn advised that the roll out can only go at a pace that would be manageable, there had been a need to go where staff want to work in the new model as the journey needed to be progressed with the midwives.

972/19 The Deputy Chief Nurse asked how student midwives would be prepared for the new model and if any feedback had been received from students in relation to the model.

973/19 Midwife Upjohn advised that the University were on board with the model and it was being taught to students. The team were expecting 2 students to be allocated to the specific pathway from the University of Lincoln and they would join the pilot teams and would be a key part of the development. Newly qualified midwives were showing a keen interest in being taught about the new model.

974/19 The Chair and Chief Executive asked the team what support could be offered from the Board to assist them through the process.

975/19 Midwife Upjohn suggested that support with the establishment as the journey progresses would be beneficial as the teams were working within the current establishment. Support from both HR and Finance had been positive.

976/19 The Chair thanked the team for presenting their story to the Board.

The Trust Board:

- **Received the staff story**

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

977/19 **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 June meeting.

978/19 The Board were advised that the Committee had been observed by the Care Quality Commission and had previously been observed by NHS Improvement.

979/19 The Committee work programme had been aligned to the new Board Assurance Framework and delivery of objective 1a – Providing consistently safe, responsive, high quality care, split in to 2 indicators of harm free care and mortality. The agenda had been aligned to the indicators.

980/19 The report in relation to patient safety had indicated a slight increase in the number of incidents resulting in moderate harm and work had been undertaken to review this, there had been no patterns identified and a report would be received by the Committee once the work had completed.

981/19 The Quality Safety Improvement plan had identified that the interim Children's Lead Nurse had left the Trust and risks had been identified in relation to the vacancy, the Trust were actively recruiting to the post.

982/19 A request for a review of the work programme had been made in light of the latest Care Quality Commission visit and feedback received. The work programme would be refreshed and gradually move to an outcome focused reporting structure.

983/19 The Committee received a verbal report from the Quality, Safety Oversight Group.

984/19 The Quality Impact Assessment report detailed the rejection of schemes which had not provided enough detail for the Executive Team to make a decision. Those schemes rejected were predominantly linked to estates work. Work would be undertaken between the Director of Nursing and Director of Estates and Facilities.

985/19 The Committee received an update in relation to Maternity CNST detailing the work being undertaken to improve the Trusts compliance with the standards, due diligence had been completed on those areas that remained red.

986/19 The Committee received a reported detailing the Trusts current position against the National Safety Standards for Invasive Procedures which would continue to be updated, the Committee requested a further update and work would be completed in consideration of never events.

987/19 Patient experience had been considered by the Committee and it had been determined that this would form part of reporting in to harm free care.

988/19 The Committee had delegated responsibility from the Board for the delivery of the Quality Account and had received the latest version of the report. Finalisation of the work conducted by the external auditors remains outstanding. A number of issues had been referred back to the Audit Committee to consider and data findings referred to the Finance, Performance and Estates Committee to ensure the ongoing nature of reporting. This would identify if the issues raised had been a one off or continuous issue. The work had concluded on the production of the report.

989/19 Feedback had been received from NHS Improvement following their observation of the Committee and a full report including feedback from the observed reporting groups would be received by the Committee. The feedback would support the internal governance arrangement audit and additional actions would be included as necessary.

990/19 A significant debate had been held with regard to the high rated risk of aseptic pharmacy and the Committee received an update on a number of actions. The risk would be split in to 3 to ensure mitigations and controls were affective against each element of the risk. The Committee expect to receive an update at the July meeting.

991/19 The Chair questioned how there would be greater Board visibility of the Quality and Safety Improvement Programme in light of the recent CQC findings, this would need to be reflected back in to the plan and programme of activity.

992/19 The Chair noted that delivery of the audit of the Quality Account by PWC had felt very last minute and there would need to be a conversation with the auditors as to why there had been a delay in the process.

993/19 The Director of Finance and Procurement advised the Board that both the Trust accounts and Quality Account were in a better position than previous years. A debrief had been scheduled with the auditors.

The Trust Board:

- **Received the update**

994/19 **Item 11.2 Care Quality Commission Letter**

The Medical Director presented the letters (dated 14th and 20th June 2019) received from the Care Quality Commission (CQC) to the Board.

995/19 The CQC had undertaken 2 visits to the Trust inspecting Pharmacy, Urgent and Emergency Care, Maternity, Children's and Young People Services, Medicine and Critical Care at both Lincoln and Pilgrim.

996/19 Verbal feedback had been received by the Trust, prior to receipt of the letters, at the June Quality Governance Committee that had been observed by the CQC.

997/19 Positive feedback had been received with regard to maternity services at both sites, this had been an encouraging position for the Trust given the difficulty of the service over previous years. The largest contributor to the change in staff morale had been the change in the leadership of the service. Staff had been able to talk about the changes and improvements made.

998/19 Issues were identified due to the fragility of the Children's and Young People's service and the number of consultant staff, the Trust were aware of this issue and recruitment had already commenced for 3 consultant paediatricians. Concerns were raised regarding nurse staffing

levels that did not always meet planned levels. Comments were received on the lack of transition pathways from children's to adults services, the Trust were working to develop these pathways and recognised further work would be required.

999/19 Development of audit and monitoring system outcomes were identified as areas requiring improvement however the Trust had focused on maintaining services and developing pathways with a focus on outcomes being about incident and safety management, this would require further development. It had been noted that there was a lack of surgeon interaction with paediatric surgery, the Trust recognised the concern and development of this had commenced.

1000/19 There had been different views of Urgent and Emergency Care across the sites, the focus for the Board had been at Pilgrim due to difficulty in maintaining staffing and standards. The CQC commented that they had not seen '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'.

1001/19 The department size and reconfiguration had resulted in the ability to recover after being under adverse pressure and it was an interesting observation by the CQC that the department did not appear to be performing under pressure, the Trust were pleased that the department had functioned well during the inspection. Comments remained regarding staffing challenges.

1002/19 Feedback received for Lincoln had raised concerns about the culture and bullying, there had been a further change in leadership and these concerns would need to be addressed and support put in place.

1003/19 The CQC provided positive feedback in relation to critical care and medicines, particularly in relation to the care given to patients with learning difficulties. This had been viewed as innovative.

1004/19 The Deputy Director of Nursing raised the issue of specific concerns regarding sepsis and triage, particularly in relation to the Lincoln site and children, there had been clear action plans aligned to these. Consideration would need to be given to address the issues highlighted to ensure data alignment with the data presented to the Board.

ACTION – Director of Nursing, 6th August 2019

1005/19 The Chief Operating Officer noted that the Trust were aware of the required improvements in the children's area at Lincoln however constraints related to the estate. Work was underway to consider the options to improve, this would need to be considered against the availability of capital. The Trust recognised the challenge to provide a proper environment for younger people.

1006/19 Mrs Ponder expressed concern regarding the comment on children and young people not being transferred from Pilgrim given the previous assurances received at the Board that capacity would not be an issue. The Medical Director confirmed that patients on high flow oxygen had not been able to transfer over the winter, the decision to not transfer those patients had been based on patient safety. The issue identified by the CQC had been due to the way in which this had been communicated to the CQC by staff and not a capacity issue.

1007/19 Dr Gibson questioned if there had been specific actions put in place to address values and behaviours of staff and incident grading. The Medical Director confirmed that work was underway to ensure correct grading of incidents and that standard processes were followed. The culture would need to be addressed. Changes in leadership and fundamental issues with

large numbers of temporary staff had meant that the provision of consistent support had been difficult. Support would be provided to ensure the issues were resolved.

1008/19 Mr Bains asked if the culture and behaviour issues had been unexpected. Concerns had been expressed regarding relationships between the Emergency Department and Medical Emergency Assessment Unit due to workloads and difficult decision making. Individual behaviour issues had been addressed and additional senior support offered, this had not however been sufficient to resolve the concerns.

1009/19 The Deputy Director of Nursing confirmed that the letter received had been initial feedback with a subsequent data request, some issues had been resolved through the data requests. Discussions were ongoing regarding the areas the CQC wished to explore further through the Well Led inspection.

1010/19 Mr Hayward raised concern about the medicine and pharmacy feedback, specifically the comments about policies not being adhered to and the pressure on pharmacy to distribute medicines.

1011/19 The Medical Director confirmed that even though a number of agency staff were working within the department they undertake a clear induction and regular staff are required to adhere to and work in a way that is consistent with policy. Adherence to policy would be about culture and role modelling, serious issues would be escalated. Audits and ward accreditation would continue to help improve standards. The pressure on pharmacy was across sites and the Trust had commenced a transformation process to move to a new way of working.

1012/19 Mrs Libiszewski highlighted that the Quality and Safety Improvement Programme had not moved the Trust to the required position for medicine, a review had been requested by the Quality Governance Committee. There were a number of significant issues that would require resolution including medicine, sepsis and safeguarding. These areas would benefit from a review of the QSIP to enable delivery.

1013/19 The divisions and teams had been made aware of the concerns raised and were taking ownership of the issues. The QSIP plans were being refreshed with a view to streamlining, this would be discussed further with the Chief Executive.

1014/19 The Chair highlighted the improvements in maternity over the previous year should be celebrated however leadership continued to be an area requiring support. The critical care findings had been very positive in the most part and again would be something to celebrate.

1015/19 The feedback had been disappointing relating to Children's and Young People Service due to the level of scrutiny that had been given over the previous year to ensure the service continued to run safely and successfully. The narrative provided through the Well-Led inspection would support the process that had been conducted. Work was still required to ensure consistent level of care performance.

1016/19 The Board acknowledged that the QSIP programme had not had the desired impact and would require a review of the process to ensure assurances were received and an impact seen.

ACTION – Chief Executive, 6th August 2019

1017/19 The Board would have an opportunity through the Well Led inspection process to contribute some assurance to the CQC findings in the letters presented and to demonstrate that the Trust had effective leadership in place at both Board level and through the Assurance Committees.

The Trust Board:

- **Received the letter**

Item 12 Providing efficient and financially sustainable services SO2

1018/19 **Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee**

1019/19 The Chair of the Finance, Performance and Estates Committee, Mrs Ponder, provided the assurance received by the Committee at the June meeting.

1020/19 The key points highlighted by the Committee were the financial performance reporting in line with plan for month 2, however the pay bill had reached a record level with agency spend of £4m. The Trust had only achieved plan due to annual leave accrual being released. The Committee had concluded that urgent work would be required to gain grip and control of the pay bill. Discussions had taken place at the Financial Turnaround Group and Executive Team with the divisions and this would be managed through PRMs.

1021/19 Income had been reported as £371k adverse to plan and non-pay £800k favourable to plan. The Trust had agreed the 4 CQUINs with the commissioner and had been advised of the national requirement to reduce capital spend.

1022/19 The Committee were asked to support revenue borrowing of £7.925m and capital borrowing of £3.155m, the Committee supported the borrowing and escalated to the Board for approval.

1023/19 The Committee received the report from the Financial Turnaround Group and noted that whilst further Financial Efficiency Programme opportunities continued to be identified there was a requirement for pace and momentum to ensure delivery of these. A risk adjusted plan had been produced which had a value of £22.3m.

1024/19 It had been identified that there was a risk of non-delivery against the workforce schemes to reduce agency spend and recruit to substantive posts, as such a further £4-5m in plans would be identified to support the potential gap.

1025/19 The Trust had received an improvement notice from the Health and Safety Executive in relation to confined spaces, whilst the Health and Safety Executive acknowledged the progress since 2014 an update would be required in order to close the notice, ongoing management of the standards would be required.

1026/19 The Committee were advised that the Trust awaits confirmation of funding in relation to the LED lighting due to the national capital position, NHS Improvement had been advised by the Trust of the impact of the work not being funded.

1027/19 A further update was requested by the Committee in respect of comments made by the Health and Safety Executive regarding asbestos, a request was also made regarding manual handling to ensure specific actions had been take to reduce the risk and implement learning. Confirmation of the closure of the confined space notice would also be presented to the July Committee.

1028/19 The Committee received updates in relation to fire, water, electrics and asbestos. The key points noted by the Committee had been the progress on asbestos noted by the Health and Safety Executive. Extensions had been granted to the fire enforcement deadlines with an overall completion date of March 2021. The extension of the deadline had resolved the need to use waivers to procure the work required. A water action plan had been put in place to ensure issues would be addressed.

1029/19 The Urgent Care update received by the Committee highlighted some improvement in performance but the Trust remained below trajectory. Three improvement actions had been put in place to support delivery. The Committee requested further assurance that the improvement programme would have an impact on performance.

1030/19 The Cancer trajectory had been achieved in April however the Committee were advised of the risk to delivery of the trajectory in May due to a number of patients waiting over 62 days for treatment.

1031/19 The Committee were advised that there had been a growth in the size of waiting lists and that work had commenced to determine if outpatients being under plan had impacted on this growth.

1032/19 Further work would be required in relation to the Board Assurance Framework for objective 2b due to the baseline year with a request for further updates in respect of the % reductions in face to face contacts in outpatients by 5%.

1033/19 The Committee wished to escalate to the Board the requirement for urgent action to reduce spend on pay and the need for increased pace and momentum on delivery of Financial Efficiency Programmes. The Committee had referred issues of agency use and recruitment to the Workforce, Organisational Development and Transformation Committee.

1034/19 The risk register had been received and the Committee noted that there had been no material change however requested a deep dive in to risk 3688 to ensure the Committee had sight of all high level risks.

1035/19 Mr Hayward requested that work commence prior to the Workforce, Organisational Development and Transformation Committee on the referred matter to ensure a position could be reported at the July meeting.

1036/19 Mrs Libiszewski raised concerns regarding the extension to the fire work and asked if this would increase the risk across the organisation and if lock down can now occur.

1037/19 The Director of Estates and Facilities advised that the risk continued to reduce over time as work was undertaken, Lincolnshire Fire and Rescue had reflected that more had been achieved by the Trust than had been expected as this point in time. The lock down issue would be resolved as part of the ongoing works, it was anticipated that the works would be delivered in June/July and that a training programme would be put in place, the issue is expected to be resolved by the autumn.

1038/19 The Chief Executive commented on the update received and noted that there was an appearance of a loss of grip on the pay bill and that wider discussions would be required to resolve this. The financial plan had been predicated on spending money that the Trust did not have resulting in the need to borrow money. Consideration needs to be given to the possibility of a withdrawal of borrowing.

1039/19 The Chair summarised the report identifying the need to ensure more was done through the Financial Turnaround Group to impact on the Financial Efficiency Programme to improve the pay bill. Consideration should be given by the Executive Team prior to further time being spent as a Board.

ACTION - Director of Finance and Procurement and Director of Human Resources and Organisational Development, 6th August 2019

The Trust Board:

- **Received the update**

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

1040/19 **Item 13.1 People Strategy**

The Deputy Director of Human Resources and Organisational Development presented the People Strategy to the Board.

1041/19 The strategy had been presented to the Board for approval and had been refreshed reflecting the NHS People Plan and 10 year strategy. The refresh had taken account of the Trust's staff survey results and True North objectives whilst aligning with the Sustainability and Transformation Plan.

1042/19 The Deputy Director of Human Resources and Organisational Development confirmed that updates that had been included within the strategy and advised that there were 5 elements of the people plan that addressed most of the challenges discussed by the Board. These elements were making the NHS the best place to work, improving leadership, in particular leadership culture, addressing workforce shortages, vacancy rates within the Trust remain well above the national average, delivering 21st century care and developing an integrated care system (ICSs). The strategy also sets out the performance measures which should ensure delivery.

1043/19 Mrs Dunnett reflected on the discussions held regarding the Quality and Safety Improvement Programme and asked if the focus had been correct in the strategy. There would be a need to ensure a large difference was made in a short amount of time. The strategy contained a large number of actions and was consistent with national plans but questioned whether these had been prioritised in order to ensure an impact. There would need to be pace on the strategy and to also reflect the content of the clinical strategy. Discussions with divisional teams would need to take place to ensure ownership and capacity to deliver. Mrs Dunnett requested assurance on the focus, pace and delivery of the strategy.

1044/19 Mrs Ponder reiterated the comment of pace and raised concerns that the strategy, whilst hard to argue with, felt like the previous ones produced by the Trust, there was no clarity over how delivery of this strategy would be different to previous ones.

1045/19 Dr Gibson welcomed the longer term view however there had been no indication that the plan included sufficient information regarding transformation and skill mix.

1046/19 Mrs Libiszewski reiterated the view that the strategy felt like previous ones seen by the Board however the framing from the national plan gave emphasis on the actions to be taken. The strategy felt very finance dependent, this could give the view to staff that the strategy had been produced to focus on financial delivery and not staff. Mrs Libiszewski also commented on the number of strategies that Trust had in place. There was a need to consider the reduction of the number of strategies. Consideration for inclusion in the strategy should be given to recruitment and staff improvements. Plans would be needed to support the strategy and not a further set of strategies as had previously been produced, there was be a need to identify issues and frame them in a way that ensured resolution.

1047/19 Mr Hayward agreed with the comments of other members and identified that the strategy did not include an appropriate workforce plan moving forward. There had been no evidence of understanding the workforce gaps and the strategy plans included for the current year. There would need to be a data capture to ensure a link between finance and workforce.

1048/19 The Chair confirmed that page 5 of the plan had included the financial bridge of reduction however there was a lack of granulation in respect of the delivery and the document very much felt like a work in progress.

1049/19 The Director of Finance and Procurement identified that a number of Performance Management Reviews had been conducted recently for each division which had bound together the need to resolve both finances and workforce. Following the meetings the divisions had been tasked with working through the actions that would need to be taken.

1050/19 The Director of Finance and Procurement and Deputy Director of Human Resources and Organisational Development were working with the teams to ensure they would be able to exit 2019/20 with clear plans to transform services. The ability to develop a workforce plan sits across the system and as such there had been no specific date for delivery however work continued.

1051/19 The Chair advised that there did not appear to be plan that demonstrated the establishment and gaps.

1052/19 The Chief Executive stated that the point had already been made but central to the success of the organisation would be the staff, there would need to be a workforce plan however this must be system compliant. The strategy demonstrates that a lot of work had been done however there had not been clarity over what would be different or better for staff.

1053/19 The strategy demonstrated where the Trust hoped to be but did not show the impact and difference that needed to be made moving forward. There would be a need for more ambition and a step change in order to deliver, the target audience should be considered when writing the strategy.

1054/19 Mr Bains stated that an earlier comment made had been that there had been nothing in the strategy that anyone would disagree with, has there been this would have allowed for a debate to take place about the content and delivery.

1055/19 The Deputy Director of Human Resources and Organisational Development responded to the questions posed by the Board. The feedback would suggest a focus on the outcome rather than the activity would be required, since joining the Trust this challenge had been put to the team. Trusts are required to submit a workforce plan to NHS Improvement which incorporates all known information including business cases, transfers of staff, development and evolution of new roles. Some of the work around system intentions had also been included. An annual detailed plan had been produced however improvements could be made.

1056/19 A large piece of work was underway which would address the comments regarding pay and had been part of the work conducted by KPMG some time ago. Due to the restructure it had been difficult to revalidate, the costs of pay have been high and as such there would be an opportunity to reduce cost. Work with the divisions was underway to help identify the issues.

1057/19 To address the question of what had been different in the strategy it was identified that teams had been established to work collaboratively with the divisions, clarity had been provided about the autonomy however support would be required for information and partnering. HR Business Partners had been established and a new resourcing team set up to support substantive recruitment. The priority had been to focus on clinical vacancies as the Trust continued to run at a 20% vacancy rate.

1058/19 A temporary medical team had been established to gain control of the agency spend, in particular spend on medical staff. Local people plans had been created to support ownership and capacity within the divisions and the HR Business Partners continue to work with the

Triumvirates to further develop plans and feed down the work to be addressed at a divisional level.

1059/19 The Deputy Director of Human Resources and Organisational Development reflected that there were some high level ambitions within the strategy regarding culture and experience, it would be beneficial to be able to articulate what staff would say about working at the Trust. There had been some good work undertaken regarding the new workforce model, evidence had been collected in relation to workforce redesign however the scale and process of this had not been reflected. The Trust performs well when compared to other Trusts nationally.

1060/19 The Chief Operating Officer highlighted the point made about the local people plans and asked how independent strategies would be integrated to ensure delivery, this would need to be mapped with the divisions to ensure the correct workforce levels and delivery of quality patient care. There would be a need to simplify the process for staff and connect back to True North with a direction set that would be clear and deliverable.

1061/19 The Chair stated that there had been a set of expectations from True North that had set the direction, the divisions would be required to set plans in train based on the strategic direction set by the Board. The divisions would be required to take time to set the strategic direction.

1062/19 The Chair summarised that based on the Board discussions the strategy would not be approved. There had been an attraction to the ambitious outcomes in the strategy however this would require building up with colleagues within the divisions. Work would need to move at pace as it would be fundamental in making the changes required. A forward plan would be required for the remainder of the year with the strategy presented back to the Board when further developed.

ACTION –Director of Human Resources and Organisational Development, 6th August 2019

1063/19 Mrs Libiszewski questioned if there would be benefit of the Board reviewing the totality of the Trusts strategies in a workshop format to consider the overlap and duplications and the feed in to business planning processes for 2020/21. Consideration should also be given to the future use of the term strategy.

ACTION – Chief Executive/Trust Secretary, 6th August 2019

The Trust Board:

- **Received the report**

1064/19 **Item 13.2 Continuous Quality Improvement Strategy**

The Deputy Chief Executive presented the strategy to the Board on behalf of the Director of Human Resources and OD.

1065/19 The strategy had been separated from the People Strategy due to the fundamental aspects within True North and would empower staff to make improvements.

1066/19 The strategy linked to previous Board discussions regarding the FAB Academy however quality improvement would not be a training programme but a way in which the Trust operates. The approach to quality improvement was not new as the Trust had been delivering an in house programme, the strategy would build on the existing process in place and upscale involvement.

1067/19 Two members of staff had achieved qualified Associate status through the Quality, Service Improvement and Redesign Practitioner Programme (QSIR) resulting in the Trust achieving NHS Improvement and Advancing Change and Transformation (ACT) Academy Faculty status.

1068/19 Mrs Libiszewski considered if the work could be used to influence the Board stories as this would help to demonstration the connection. She also raised that the strategy did not feel as though medical staff were included fully and it had been difficult to see how those staff would be engaged and motivated to adopt this.

Action – Director of Human Resources and Organisational Development, 6th August 2019

1069/19 The Deputy Chief Executive agreed that there would be benefit of the strategy influencing the stories presented to the Board as the small improvements in the Trust usually go unnoticed. The strategy had not been designed to exclude medical staff and there had been engagement with the staff group. There had been an attempt to carry out this at the early stages of doctors careers. If the correct approach had been adopted then medical engagement would take place.

1070/19 The Medical Director confirmed that there had been a number of doctors who had completed the pilot programme and that junior doctors must undertake improvement programmes as part of their training.

1071/19 Mrs Ponder praised the consistent methodologies however highlighted concerns around the length of the document and the concern that too much resource had been dedicated to producing papers that few people would read.

1072/19 The Deputy Chief Executive responded identifying that the length of the document had been driven by the review of the strategy through the Board. There would need to be a view from the Board regarding the less is more approach and accepted the point made.

1073/19 Dr Gibson raised concerns about the ability to deliver the strategy due to the potential high level of demand. There would be a need to be able to release staff to learn the methodology to be able to deliver change.

1074/19 The Deputy Chief Executive confirmed that it would be positive to raise the demand and would be keen that it became embedded in the way the Trust works, by establishing the faculty and training others to deliver the training, it would be possible to embed in to day to day delivery.

1075/19 The Board were encouraged to see that patient inclusion had been an aspect of the strategy and that there would be a need to ensure coproduction, there would need to be flexibility in the methodology to enable it to work with other tools. It was confirmed that the programme had been designed to be inclusive and patients, volunteers and representative would be included.

1076/19 The Chair commented on the number of actions included within the strategy and advised that translation of these actions into outcomes and how the Board would be updated would need to be described.

Action – Director of HR and OD, 6th August 2019

1077/19 The Board agreed that there would be a need to ensure the methodology continued to drive improvements in the quality of care provided and that the approach would need to embed. There had been system interest in the methodology and there would be benefit of a system wide approach. There would be a need to feedback to the system to advise that the Trust are taking forward the methodology.

ACTION – Director of HR and OD, 6th August 2019

The Trust Board:

- **Received the report**

Item 14 Providing seamless integrated care with our partners SO4

1078/19 **Item 14.1 System Wide Data Sharing**

The Deputy Chief Executive presented the paper to the Board and sought approval and commitment to roll out and embed the new way of working within the organisation.

1079/19 The paper outlines the sharing of data for patients across organisations, there remains vulnerability about data sharing however legal advice had been sought and received.

1080/19 The paper detailed the discussion held at the June Board meeting relating to the care portal and the beginning of other organisations starting to contribute. The paper detailed how other organisations would be able to sign up to data sharing and the impact on the care provided to patients when patient data was shared.

The Trust Board:

- **Received the report**
- **Approved the paper**

Item 15 Performance

1081/19 **Item 15.1 Integrated Performance Report**

The Chair highlighted that there had been a number of performance challenges discussed as part of the upward reports from the Committees and as such a focus on the executive summary would be sufficient.

1082/19 The Director of Finance and Procurement highlighted that HSMR was at the lowest reported level for the Trust at 90.74%, this remained below the expected limit. SHMI was reported at 111.15 and the Trust remains in band 1 and outside of expected limits. The Trust had moved 6 places lower against the peer analysis which places the Trust in a positive position.

1083/19 Incident reporting remained consistent with levels from the previous year and the Trust sits in the lower half of incidents reported per 1000 bed days compared to other trusts. Analysis by NHS Improvement confirmed that there had been no evidence of under reporting.

1084/19 The Trust had reported 14 serious incidents in April along with 2 previously reported Never Events.

1085/19 The Trust had seen performance improvements in Urgent Care, ambulance handover and A&E 4 hour waits. Even though improvements had been seen for ambulance and A&E waits these remained behind planned trajectories. Referral to treatment waiting lists had grown by 3% and it was noted that there had been no single specialty area disproportionately contributing to this growth.

1086/19 Two patients had waited over 52 weeks in April for their treatment, this had occurred due to an administration error and work continues to ensure improvements in data quality. Whilst it

would be expected that no patients wait more than 52 week the Trust had seen a significant improvement against the previous year.

1087/19 There continued to be an improvement against 62 day cancer performance which placed the Trust slightly ahead of trajectory. 2 week wait breast symptomatic had also shown an improvement.

1088/19 The Director of Finance and Procurement highlighted the key points to note in relation to workforce had been the higher than expected pay costs and agency pay, there had been some adjustments to the overall establishment. Turnover had been re-calculated to ensure it remained reflective of how it worked in the Trust. Sickness rates had shown a slight increase to 4.8%.

1089/19 The Deputy Director of Nursing advised the Board of the positive position of C-Difficile and how even with the increased timespan of data collection the position remained good. There had been a continued improvement in tissue damage and pressure ulcers

1090/19 The Chief Executive identified that the Trust was challenged however the report demonstrated a number of areas where the Trust should be proud. The question was raised about the communication of the positive areas of work within the Trust and it was felt that there could be an improvement in communicating these messages.

1091/19 The Chair observed that since commencing in post there had always been a focus on the improvements that were needed and not the celebration of the good news stories. The Chief Executive was keen to ensure promotion of good news stories through social media platforms and provide information to the media in order to promote the Trust.

ACTION –Associate Director of Comms and Engagement, 6th August 2019

1092/19 Mrs Libiszewski acknowledge the change in the management of serious incidents and the good news story associated with this, the Quality Governance Committee were now in a position where the focus did not need to be so great.

1093/19 The Chief Operating Officer also shared the good news story of streaming implementation, this had gone to plan and the hybrid model of staff working with Lincolnshire Community Health Services NHS Trust had resulted in streaming of 25% following the commencement of the model.

The Trust Board:

- **Received the report**

Item 16 Risk and Assurance

1094/19 **Item 16.1 Risk Management Report**

The Medical Director presented the report to the Board.

1095/19 The report summarised the key risks with the main focus remaining the aseptic pharmacy risk, appropriate mitigations continue to be identified. The risk would be reviewed to divide this in to environment, service closure due to infrastructure and staffing.

1096/19 Confirmation was provided to the Board that the facility at Lincoln had been closed and the facility at Pilgrim was small and in a poor state, this had the potential for regulatory intervention. An audit had been undertaken and a letter received following the audit identifying that concerns remained due to staffing levels.

1097/19 Work was underway with the pharmacy team to identify the mitigating actions required to reduce the risk however it was noted that there remains a national issue with aseptic pharmacy, a plan would be developed to focus on both medium and long term solutions subject to funding available.

1098/19 The immediate risk of aseptic pharmacy remained the fragility of the service which would predominantly affect cancer patients, affective mitigations were in the process of being identified.

1099/19 Mr Hayward raised concern regarding the service, given the intention to retain the service within Lincolnshire there would need to be a clear strategic investment.

1100/19 The Medical Director stated that there was a requirement for a clean facility, it was identified that commercial companies are able to make drop in facilities however these are high cost and would be required to remain in situ in order to realise the investment. Consideration of the joint venture with the University of Lincoln would require the transfer of staff. Whilst the joint venture and facility was explored and developed the key risk to the service would be the time frame to implement. A business case would be presented to the Finance, Performance and Estates Committee and Quality Governance Committee would continue to monitor the safety risk.

1101/19 Mrs Dunnett acknowledged the amount of progress made over the past 12 months on the risk register however some risks and narrative remained out of date. Focus from the divisions should be encouraged to ensure a grip and understanding of the risks.

1102/19 The Medical Director advised that staffing issues within the team had resulted in a focus on clinical risks however new starters were due to join the Trust within the next 6 weeks which would allow for a wider focus of the risk register.

1103/19 The Chair requested a review of the control mechanisms in place for the risk register by the Audit Committee due to the lack of movement month on month to enable the support process to be improved.

ACTION – Audit Chair, 6th August 2019

The Trust Board:

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

1104/19 **Item 16.2 BAF 2019/20**

The Board considered the latest iteration of the Board Assurance Framework that had been updated by the Quality Governance Committee and Finance, Performance and Estates Committee. The Workforce, Organisational Development and Transformation Committee had not met in month to allow for update but the relevant areas had been considered by the Director of Human Resources and Organisational Development.

1105/19 The Trust Secretary highlighted the discussions held by the Quality Governance Committee in relation to the mapping of clinical audit to the framework, this would be linked through the quarterly clinical audit report. The assurance ratings had this month been completed by the Committee as further work had been completed to allow ratings to be given.

1106/19 The Chair stated that the document felt more dynamic and reflected the high risks discussed by the Board, the Committees had completed their business to review the framework.

1107/19 The Board considered each of the objectives within the framework and considered further updates.

1108/19 SO1a could be supported through the assurance from Quality Governance Committee, Integrated Performance Report, Risk Register and the CQC letters. The Board confirmed the amber assurance rating.

1109/19 SO1b had been identified as red rated due to the requirement for further work to be undertaken, the Board confirmed the red rating.

1110/19 SO2a required further development of reports and as such had been red rated, the Board confirmed the rating.

1111/19 SO2bi had been reported as amber however was an incorrect assurance rating based on the discussions held at the Finance, Performance and Estates Committee and would require amending to red.

ACTION – Trust Secretary, 6th August 2019

1112/19 SO2bii had not been rated and thought would need to be given as to how this would be managed due to the baseline year.

ACTION – Director of Finance and Procurement, 6th August 2019

1113/19 SO3 could be supported by the People Strategy, Integrated Performance Report, QSIR and Risk Register, these would need to be included within the next update.

1114/19 SO4 had been reported as red and reported were awaited from the system, further assurance would be required by the Board.

The Trust Board:

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

1115/19 **Item 16.3 2019/20 Priority Setting and Deployment update**

The Deputy Chief Executive updated the Board on the progress of the strategic and tactical priorities identifying that this would be developed in to a strategy deployment process.

1116/19 The report demonstrated how this had been embraced by the divisions, there had been a good level of buy in however some variability had been seen whilst staff become familiar with the priorities. The divisions had demonstrated a high degree of energy however there are a large number of priorities and as such there would need to be a grip to ensure this remained on track, priority setting and deployment would be progressed through the PRMs

1117/19 The Board would need to consider how much of the True North approach was adopted, currently the Trust had adopted a modified approach but other Trusts had fully adopted. Dialogue with KPMG had been undertaken about this and it would be presented back to the Board for approval although there would be some risk associated with this.

1118/19 Discussions were held regarding methodologies that had been implemented by other Trusts and how these might support the Trust to determine the level of adoption. The Board had adopted a modified approach and this had impacted on the development with the Board and divisions, this would need to be echoed across the organisation to ensure it became

embedded. Further conversations would be required about how this is carried out and what the model and framework would look like.

The Trust Board:

- **Received the report**

Item 17 Strategy and Policy

1119/19 **Item 17.1 Board Forward Planner**

For information

1120/19 It was noted that the Safeguarding Annual report had not been received and would be required at the August meeting

1121/19 **Item 17.2 ULH Innovation**

For information

1122/19 **Item 18 Any Other Notified Items of Urgent Business**

None

1123/19 The next meeting will be held on Tuesday 6 August 2019, Trust Boardroom, Lincoln County Hospital

Voting Members	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	4 June 2019	2 July 2019
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	A	A	X	X	X	X	X	X	X	X
Geoff Hayward	X	A	A	X	X	A	A	A	X	A	X	X
Gill Ponder	X	X	X	X	X	X	X	X	A	X	X	X
Jan Sobieraj	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	A	X								
Michelle Rhodes	A	X	X	X	X	A	X	X	A	X	X	A
Kevin Turner	A	X	X	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	A	X	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	A				
Paul Matthew					X	X	X	X	X	X	X	X
Andrew Morgan												X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Deadline	Completed
7 May 2019	642/19	Asbestos and Fire Works	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	Complete To be included on Finance, Performance and Estates Committee work plan and closed through this Committee
7 May 2019 4 June 2019	684/19 886/19	Committee KPIs	Committees to review the number of KPIs that are reported to them with a view to confirming they are required.	All Board members	4 June 2019	Considered by Committees at May meetings. QGC remains outstanding
4 June 2019	726/19	Arrangements for fire asbestos work	Discuss with DoN Check what needed for QIA	Boocock, Paul	02/07/2019	Complete
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	Complete
4 June 2019	759/19	Establish the levels of trainees organisation can manage	Following Nursing Associate staff story	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	Complete
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	Complete
4 June 2019	809/19	Assurance on delivery of Clinical Strategy through to Board	How will this be monitored	Hepburn, Neill	02/07/2019	Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

4 June 2019	827/19	Assurance in respect of H&S actions reported to FPEC	Clarity required in relation to training etc and metrics on actions following historic regulation/prosecution	Boocock, Paul	~~02/07/2019~~ 03/09/2019	
4 June 2019	842/19	To pick up outside meeting how Trust moves away from fax referrals		Brassington, Mark	02/07/2019	Complete
4 June 2019	883/19	Inaccuracies and out of date data in IPR		Matthew, Paul	02/07/2019	Complete
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	30/09/2019	
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	Work has started with Aseptic paper reported Quality Governance Committee
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	Complete
4 June 2019	900/19	BAF take patient exp to QGC		Rayson, Martin	02/07/2019	Complete
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	Complete
4 June 2019	919/19	Review of 15 steps	Consider at QGC	Rhodes, Michelle	02/07/2019	Paper for consideration by ET then QGC Complete
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 Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

2 July 2019	1004/19	Finding relating to sepsis within the CQC report	Consideration of what needs to change to address the issues highlighted and how this doesn't align to data that Board had previously seen	Rhodes, Michelle	06/08/2019	
2 July 2019	1016/19	CQC Feedback letters June 2019	QSIP not having the impact would have wanted. Need review of this and where we get assurances from. How we prevent these issues arising rather than responding to problems after the event	Morgan, Andrew	06/08/2019	
2 July 2019	1039/19	Pay and FEPs	Consider first at ET how we improve position. Then time at Board	Matthew, Paul/Rayson, Martin	06/08/2019	Board Development session scheduled for August
2 July 2019	1062/19	People Strategy	Develop some ambitious outcomes, built up with colleagues within the divisions. Through ET in first instance. Develop forward plan for rest of this year. Strategy back when ready	Rayson, Martin	06/08/2019	
2 July 2019	1063/19	Trust Strategies	A plan to consider all strategies in a Board workshop as a totality. Include review of overall number of documents called strategies	Warner, Jayne/Morgan, Andrew	06/08/2019	Board Development session scheduled for October
2 July 2019	1068/19	Continuous Quality Improvement Approach	Use to influence the patient/staff story received at Board	Rayson, Martin	06/08/2019	
2 July 2019	1076/19	Continuous Quality Improvement Approach	Actions to be translated to outcomes for inclusion within the strategy and reporting to Board to be determined	Rayson, Martin	06/08/2019	
2 July 2019	1077/19	Continuous Quality Improvement Approach	Feedback to the system that the Trust are taking forward the methodology	Rayson, Martin	06/08/2019	
2 July 2019	1091/19	Improved Performance	Publicise the good news stories in our performance. To refer to Communications	Richards, Anna	06/08/2019	

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

2 July 2019	1103/19	Risk Register	Some areas of the risk register still out of date. Audit Committee to consider at July meeting	Dunnett, Sarah	06/08/2019	Risk Register reviewed at July meeting.
2 July 2019	1111/19	BAF	SO2bi to be updated to red assurance rating	Warner, Jayne	06/08/2019	Complete
2 July 2019	1112/19	BAF	Consideration to be given to management of SO2bii due to baseline year	Matthew, Paul	06/08/2019	

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	6 August 2019

Title:	**Chief Executive's Report**

Author/ Responsible Director Andrew Morgan, Chief Executive

Purpose of the Report:

To provide an overview of key strategic and operational issues.

The Report is provided to the Board for:

Information	✓	Assurance	
Discussion	✓	Decision	

Summary/Key Points:

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

Recommendations:

The Trust Board are asked to

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

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

System Issues

1. At M3 the year- to -date financial position of the System is adverse to plan by circa £4m. Despite this year to date position, each organisation is still forecasting that they will deliver their Control Total for the year, resulting in the System delivering the combined year-end target of a deficit of £63.7m. The unidentified savings gap is now £21.5m on a combined savings plan of £88.4m. Both SET and the LCB are urgently reviewing the robustness of the financial plans and the actions that are in place to deliver the plans.
2. NHSE/I in the Midlands have now confirmed the regional aims and priorities for the region. This follows some engagement work with key stakeholders. The purpose has been to identify the areas where collective action should help to focus attention and delivery. The aims and priorities are intended to be compatible with the NHS Long Term Plan Implementation Framework. There are 3 Aims; Reducing health inequalities; reducing unwarranted variation in quality of care; clinical and financial sustainability. There are 4 priorities. Priority 1 is to reduce demand, unwarranted variation in quality of care and health inequalities by delivering radical changes in the following services- cancer, learning disabilities and autism, mental health, urgent and emergency care. Priority 2 is to have compelling plans agreed for reducing health inequalities across the Midlands region and for each STP/ICS. Priority 3 is to transform our collective approach to supporting and developing our people, with a particular focus on equality, diversity, inclusivity; leadership development; talent management; staff engagement, health and wellbeing. Priority 4 is actions to support clinical and financial sustainability. The key enablers for the aims and priorities are the NHS Long Term Plan, regional strategies and plans, and the shared operating framework. The next step involves task and finish groups translating the aims and priorities into tangible changes and benefits that can be reflected in local plans.
3. Following the publication of the NHS Long Term Plan Implementation Framework, work is underway to scope out the actions that are needed in order to produce the Lincolnshire 5-year plan. The draft needs to be submitted to NHSE/I by 27th September and the final plan by 15th November. This is a very challenging timetable if the plan is to be whole-system focused rather than just an NHS document.
4. One aspect of the Lincolnshire 5-year plan that needs to be developed is the transition towards being an Integrated Care System (ICS) by April 2021. In reality this will entail moving to shadow ICS status in April 2020, with action being taken now to make this a reality. As part of the preparatory work for this, a self-assessment was undertaken using the ICS Maturity Matrix. This looks at 5 domains around system leadership, partnerships, and change capability; system architecture and strong financial management and planning; integrated care models; track record of delivery; coherent and defined population. The outcome of this self-assessment is being used to inform the action that is now needed in order for Lincolnshire to become an ICS.
5. NHSE/I are now re-invigorating the assurance work around the potential for exiting the EU without a deal in place. This work was stood-down earlier this year. It will be important for contingency plans to be in place and for there to

be clear lines of accountability through SROs at both organisational and system level.

6. The Lincolnshire Clinical Cabinet is continuing to meet, with feedback provided to SET after every Cabinet meeting. The focus of the Cabinet over the coming months will be on unwarranted clinical variation in the system and ensuring there is a strong clinical voice contributing to the Lincolnshire 5-year plan.
7. The Healthy Conversation 2019 is continuing. The work done to date will be a key input into the Lincolnshire 5-year plan.

Trust Specific Issues

1. Having taken up the post of CEO on 1st July I am continuing to meet staff and visit sites and services to better orientate myself about the Trust. I have made a number of visits to all 4 sites and I have been meeting both clinical and support staff. I have been made very welcome and I have met fabulous people. My focus remains on the 6 priorities that I set out at my first Board meeting on 2nd July, namely; the quality and safety of services; people/OD; strategy; licence to operate; financial plan delivery; having an effective Executive Team.
2. At M3 the Trust reported a year to date deficit of £17m which is in line with plan. The year-to-date delivery of the Financial Efficiency Plan (FEP) is £3.4m which is also in line with plan. The M3 position has depended on the use of appropriate technical financial flexibilities. These flexibilities will not be available in future months and it is therefore essential that progress is made on reducing the run rate, particularly around staff costs. Without this control of the run rate, there is a risk that projecting forward, the Trust could end the year £11.6m adverse to the control total of a deficit of £70.3m. That is a deficit of £81.9m. This is before accounting for any PSF or FRF funding. Although a deficit of £81.9m is an improvement on the outturn for 2018/19 of a deficit of £88.2m, it must in no way be seen as an acceptable position. The Trust has committed to the delivery a plan of a deficit of £70.3m and this must be delivered. This was re-inforced at the recent financial special measures review meeting with NHSE/I on 24th July.
3. On 24th July an A&E performance escalation meeting was held with NHSE/I. This also included stakeholders from across the system. The meeting was held because of the performance against the 4 hour A&E standard. A range of follow-up actions were agreed, which will be captured in a letter from NHSE/I. This has yet to be received. The actions include the greater use of the Clinical Assessment Service (CAS); implementing the recently agreed High Impact performance improvement actions; reviewing the potential for the removal of the postcode ambulance divert at Pilgrim Hospital; improving ambulance handover times; improving streaming uptake at Lincoln County Hospital; reviewing bade capacity assumptions; and agreeing a common and consistent set of performance and activity figures for urgent and emergency care.
4. Action is underway to recruit a new Director of Nursing following Michelle Rhodes' resignation as a result of her securing a new role at University Hospitals North Midlands. An internal process is underway to appoint to the Acting Director role and an external recruitment process involving the NHS Leadership Academy will commence after the summer holidays. The Trust

will also be using the NHS Leadership Academy to appoint substantively to the Director of Finance role bearing in mind that Paul Matthew is currently filling the role on an Acting basis. This will also be advertised after the summer holidays.

5. The Trust's Deputy CEO Kevin Turner has announced that he will be retiring at the end of August after a long and distinguished career in the NHS. I would like to thank Kevin for his contribution to ULHT and also to the wider system. He is much respected in both the Trust and the System and he will be greatly missed. I wish him well in his retirement. I am currently working through the allocation of Director portfolios but do not intend to have a standalone post of Deputy CEO. The Deputy CEO role will become an additional responsibility of one of the Directors.

NHS
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Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23rd July 2019
Chairperson:	Elizabeth Libiszewski , Non Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives
	Assurance in respect of SO 1a Issue: Delivering harm free care <u>Source of Assurance: Quality and Safety Oversight Group –</u> Progress continues to be made by the group, the lack of Medical Division representation at the meetings would be escalated. The group had reviewed the Quality Account identifying the need for divisions to be informed of the priorities set by the Trust. A request by the divisions to review the BAF had been made and this would be included on the agenda of the meeting. Assurance was provided that as reporting to the group improved so would the upward reports to the Committee. <u>Source of Assurance: Infection Control Upward Report –</u> C-Difficile had reported positively even with new targets in place. Concerns were raised due to capacity issues within the CCGs to conduct investigations. Concerns were raised to the Committee regarding cleanliness audits using the MiC4C audit tool, there was an inability to reach 100% compliance against the hygiene code. Financial constraints resulting in the ceasing of window cleaning had led to an impact on hygiene audits. <u>Source of Assurance: Pressure Ulcer Annual Summary –</u> The Trust had seen a 14% decrease in pressure ulcers and with the introduction of new categorisation would be able to benchmark against other Trusts. There had been no grade 4 pressure ulcers reported for quarter 4 of 2018/19. The action plan in place would continue to ensure progress continues. The target for reduction in 2019/20 had yet to be agreed however the

	target would form part of the Quality Strategy. Source of Assurance: Medicines Optimisation Upward Report – Reporting of medicines incidents had been reported as higher than the national median, the Committee were assured that there had been a reduction in levels of harm irrespective of the increased reporting. The Committee discussed the Aseptic Pharmacy risk, the Clinical Support Services Division has agreed to fund additional posts which would result in increased compliance. A business case would be presented to the Board regarding the build of a new facility. Source of Assurance: Quality Impact Assessment - The Committee were advised that 84 QIAs had been completed since January and a proposed amendment to the QIA process was presented. This would allow schemes with a lower risk score to be managed locally with larger schemes coming through the Executive QIA process. The Committee approved the change to the process and requested that this be included within the refresh of the TOM governance documentation. The Pilgrim post implementation reconfiguration report was presented to the Committee and it was noted that there had been an improvement at the site. The QIA to support the Lincoln reconfiguration would be seen by the Committee. Source of Assurance: Children and Young Peoples Report – The Committee received the report and were advised that the service remains fragile in respect of the workforce. Further work would be completed to ensure ongoing development of the model and an update report presented to the Committee in October. Further detail is included at appendix 1. Source of Assurance: Maternity Report – The Committee received the maternity report detailing the increase in induction of labour. There had been a national increase due to the move to customised growth charts and the focus on late growth retardation. A working group had been established to review inductions to determine if these were appropriate. Source of Assurance: 15 Steps Report – The 15 Steps report was received by the Committee to provide assurance to the Board that a programme was in place. There had been concerns raised regarding the effectiveness of the visits and no clear reporting received by the Committee to understand if there had been any learning shared. Further support to the process would be required and consideration for engagement with staff, such as Matrons to support visits. Source of Assurance: CNST Report – The Committee received assurance

	on the position of the CNST report with all standards reported green, there was a minor exception with some staff requiring training however this would be completed by 6th August. CNST was being anticipated for the following year with a paper due to be presented to the Workforce, Organisational Development and Transformation Committee regarding support for ongoing training to be included within core mandatory training. Source of Assurance: Safeguarding Upward Report – The Committee were advised of the concern regarding 177 outstanding DBS checks for staff. Discussion had been held at ET regarding conducting 42 of the 177 due to the nature of the job roles. Sign off was required by ET to confirm the numbers to be DBS checked. It had been agreed that DBS checks would not be completed 3 yearly but only for new starters with a fit a proper person question included within all staff appraisals. Concern had been raised during the CQC inspection about the lack of supervision offered to the Trusts Safeguarding Lead due to capacity within the CCG. The Trust confirmed that local supervision was in place and that the staff member was happy with the arrangements. Additional supervision had been offered by LCHS. Source of Assurance: Patient Safety Incidents – The Committee received the report noting that there was a developing backlog of significant learning events. Meetings had been reinstated to address the backlog and confirmation was provided that none of the backlog were sever harm or death cases.
	Assurance in respect of other areas:- Integrated Performance Report – The report received by the Committee had improved however had not been fully populated. Discussion took place regarding the data reported and targets included within the report. The Committee agreed the revised set of metrics that had previously been circulated to Committee members and relevant work would be undertaken to set trajectories. The Committee would receive the dashboard at the August meeting. Patient Experience – The patient experience plan was presented to the Committee as part of the drafting process. The Committee acknowledged the difficulty in producing the plan in the absence of the Quality Strategy. Once the Quality Strategy had been produced clarity could be provided to support the development of the plan. Complaints Annual report – The Committee were advised that complaint figures and reasons remain static. There is still a requirement for improvement of the response quality and description of lessons learnt.

	The Committee requested that benchmarking be undertaken and also consider how complaint actions link in to the Quality Strategy CQC Feedback – The Committee received the CQC letters for information along with the response report that the Trust submit on a weekly to the CQC. The draft inspection report is expected to be received by the Trust by the end of August however work is underway to address both the section 31 and 29A notices. NHSi Feedback – The Committee received the feedback form the observations which had taken place by NHS Improvement. Following the completion of all observations that Committee would receive the final report identifying actions required. The feedback received had been largely positive, those areas identified for improvement had not been unexpected. Quality and Safety Improvement Plan – The Committee were advised that a paper had been presented to the Executive Team proposing how QSIP progresses. A close down report would be received by the Committee however some work would continue to be held corporately in order to ensure delivery. Ward Accreditation – The Committee received a suite of papers supporting the risk summit held due to the second red ward accreditation received by Carlton Coleby Ward. The Committee were assured that the accreditation process functions for both green and red accreditation as action plans had been put in place and support provided by the divisional team to drive forward improvement. Actions requested by the Committee: The Committee requested that data triangulation be completed in order to determine if there had been an increase in areas such as harm, complaints and incidents that may have alerted to the red award.
Issues where assurance remains outstanding for escalation to the Board	No items were identified for escalation
Items referred to other Committees for Assurance	No items were referred
Committee Review of corporate risk register	The Committee reviewed the risk register noting that there had been no major changes to the document.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed since the last meeting. The Committee rated the assurances which were the responsibility for the Committee 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	J
Elizabeth Libiszewski Non-Executive Director	X	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	A
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	X
Neill Hepburn Medical Director	D	X	X	D	X	X	X	X	X	X	D	X	X

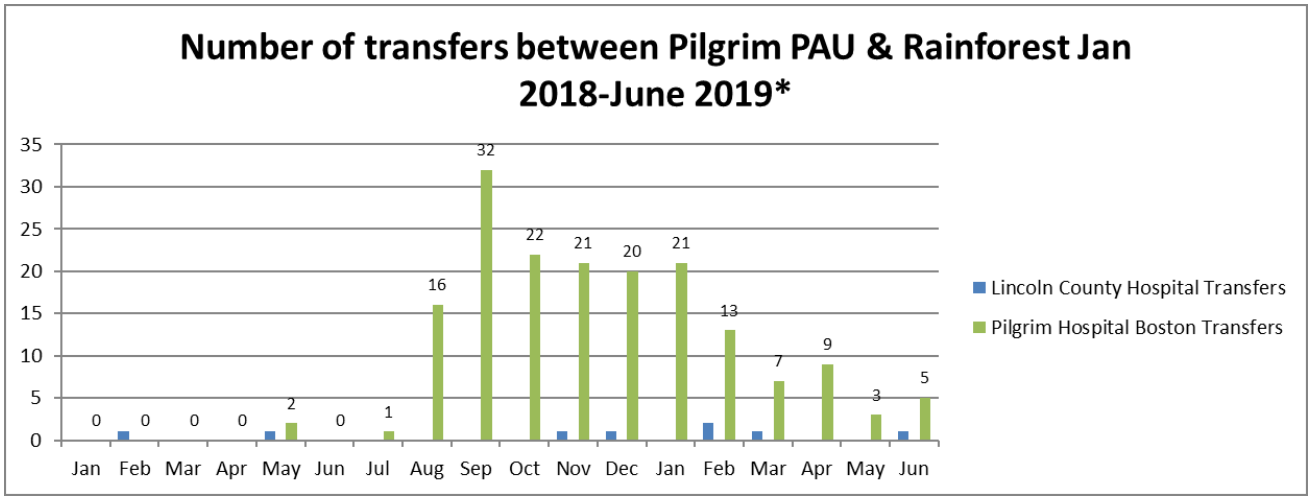
X in attendance A apologies given D deputy attended

Children and Young Persons' report – Paediatric update, July 2019

The Quality Governance Committee received the Paediatrics update report and a summary of key points are summarised below for the Trust Board. The Divisional Head of Nursing & Midwifery attended the Committee when the report was presented.

Key Points to note:

Transfers and Activity
Data available demonstrates that the number of transfers have reduced significantly since September 2018 following the introduction of the Paediatric Assessment Unit (PAU). This may, in part, reflect the continuing development of the service model with the PAU as an assessment unit. The majority of transfers are from the PAU to Rainforest Ward at Lincoln.



* Figures reflect transfers from one site to another and not transfers to one site from another.

Care Quality Commission (CQC) Letter
The Division working to understand the requirements of the CQC improvement letter received on 2nd July and will create a plan to address the issues raised.

Risks
The Children and Young Person's service currently has thirteen items on the risk register. The division are conducting a significant review of the identified risks to ensure that these are updated and truly reflective of the current risk level.

GIRFT
Paediatric surgery is part of the Trust's Getting It Right First Time (GIRFT) programme. The ambition of the programme is to identify examples of innovative, high quality and efficient service delivery by identifying areas of unwanted variation in clinical practice and/or divergence from the best evidence-based Paediatric Surgery care. To date a report and a set of recommendations aimed at improving the quality of care, optimising the volume of activity reducing expenditure, reducing complications, optimising procurement and stopping inappropriate treatments has been produced and the Divisional Team are working on plans to address these issues.

Staffing
The staffing of the model remains fragile with significant vacancies across the Trust however following advertising for 8 Whole Time Equivalent (WTE) Consultant Paediatric posts 3 appointments have been made.

A specialist recruitment company has been engaged to develop a specialised national recruitment campaign to attract registered children's nurses to Lincolnshire; this will include the recruitment of the Lead Nurse for Children.

Engagement
Public engagement in the process of developing the service remains a priority and several public meetings were held during 2018/19. Engagement and consultation will continue with service users, including specific events for Children and Young Persons' services in the 'Healthy Conversation 2019' in addition to the Trust's own regular paediatric listening events.

Engagement will also continue with staff and system stakeholders to ensure service development are optimal.

Service Model Description
The Division will undertake further work with hospital staff to ensure they can describe the service model, through guidelines and Standard Operating Procedures.

Royal College of Paediatrics and Child Health (RCPCH) action plan
The RCPCH, on invitation from the Trust, conducted a review into paediatric services at ULHT. As a result of the review a series of recommendations have been made to the Trust that combine short term enabling actions with a longer-term visions of the future of the serviced, to retain obstetric and paediatric services across both Lincolnshire sites. This is in line with the current plans that continue in development with system partners.

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Jayne Warner, Trust Secretary
Date:	6 August 2019

Title:	**CQC Post Review Feedback Letter**

Author/ Responsible Director Michelle Rhodes Director of Nursing

Purpose of the Report:
The CQC visited the Trust on the 16,17 & 18th of July to undertake the Well Led Review. The assessment over the 3 days consisted of focus groups with staff and the Divisional leadership teams and individual interviews with the Executive and members of the Trust Board, including the chair of Audit, FPEC, QGC and the Chair of the Trust.

The Report is provided to the Board for:

Information	✓	Assurance	✓
Discussion		Decision	

Summary/Key Points:
Prior to the CQC inspection the Trust Board, through Board development sessions, carried out a review against each of the Key Lines of Enquiry for Well Led. This exercise was extremely useful and allowed the Trust Board to consider the evidence against each criteria and form an opinion as to the Organisation's current position.

The self- assessment concluded that the Trust sat at the upper end of Requires Improvement in each of the 8 KLOEs, gaps in the evidence have been identified and actions to remedy the gaps have been agreed.

The feedback received from the CQC following the Well Led Inspection was encouraging across a number of the KLOEs, this supported the outcome of the self –assessment undertaken by the Board.

The CQC did however identify a number of area's where further work is required. The themes of these include; ongoing requirements to strengthen the skills and abilities of our leaders, ensuring individuals understand their role in delivering the vision and strategy, further work required to strengthen and embed our approach to inclusion, patient engagement in service change and senior leadership commitment to the continuous quality improvement programme.

A number of actions are already in place to ensure that these themes are being addressed, we will however, need to consider accelerating the work in a number of areas to ensure that the impact is felt quickly.

Recommendations: The Trust Board are asked to receive the report.	
Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (e.g. Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Requirement for further review?	

Care Quality Commission
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By Email: Andrew.Morgan@ULH.nhs.uk

Andrew Morgan
Chief Executive
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
LN2 5QY

Date: 19 July 2019

CQC Reference Number: INS2-5741841731

Dear Mr Morgan

Re: CQC inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Carolyn Jenkinson, Head of Hospital Inspection, Michelle Dunna and Julie Fraser, Inspection Managers on 18 July 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues 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 18 July 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:

W1 Leadership

- Not all of the leaders have all the skills, abilities, and commitment to provide high-quality services. Most leaders recognise the training needs of managers at all levels, including themselves, and work to provide development

opportunities for the future of the organisation. The outcome of the leadership development programmes has not yet realised.
- The trust leadership team have knowledge of current priorities and challenges, however, we found, whilst they were the right plans, they do not always get delivered due to capacity and capability.
- Improvements have been made to the divisional leadership structures which will better support financial improvement. However, leadership structures need a continued focus to ensure they embed across the organisation.
- The trust recognises the need to further build internal capability required to develop and implement improvement initiatives.

W2 Vision and Strategy

- The board and senior leadership team have set a vision and values.
- The trust strategy is directly linked to the vision and values of the trust. The trust involves clinicians, patients and groups from the local community in the development of the strategy.
- Staff do not always understand how their role contributes to achieving the strategy.

W3 Culture

- There are low levels of staff satisfaction in the trust and high numbers of staff feeling overworked.
- Most executive leaders told us that culture within the organisaion is one of their key priorities.
- We did not see enough evidence of how staff from a BAME background were being supported through their career development. The causes of workforce inequality have not been sufficiently addressed.

W4 Governance

- The arrangements for governance and performance have been recently reviewed and there appears to be a clear structure in place. It has not yet had the opportunity to be fully tested but staff seem enthusiastic about how it will work. The new Trust Operating Model has a structure for overseeing performance, quality and risk.
- Staff at all levels of the organisation are not always clear on their accountabilities.

W5 Management of risk, issues and performance

- The governance team are working hard to develop systems to identify learning from incidents, complaints and safeguarding alerts and make improvements. However, this needs to continue to embed across the whole organisation to ensure it is sustainable and not reliant on a central team.
- Recorded risks are aligned with what staff said were on their ‘worry list’.
- There has been a lot of progress to develop the BAF and make this a working and useful document.
- The challenge and risks to deliver the financial and quality improvement plans are understood and leadership is committed to addressing this. However, the Trust needs to work at pace to ensure mitigations are implemented to avoid a further deterioration in their financial and quality position this year.

W6 Information management

- The board reviews performance reports that include data about the services. The use of SPC charts was welcomed.
- Information used in reporting, performance management and delivering quality care is developing to ensure it is valid and reliable.
- There is scope to improve systems and information to support business decisions and financial improvements in the organisation.

W7 Engagement

- The trust has included and communicated with patients, staff, the public, and local organisations.
- The trust is actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.
- The trust seeks to actively engage with people who were living with a learning disability and patients with physical disabilities.

W8 Learning, continuous improvement and innovation

- There is an appetite for innovation amongst some leaders, however, due to constraints innovation is not always seen as a priority.
- The trust has a quality improvement programme in place which staff have received training on. We noted there was a lot of enthusiasm for the programme. However, senior leaders need to be fully committed to this programme to enable benefits to be realised.

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 Jeff Worrall and Vanessa Wort at NHS Improvement / NHS England.

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 of Trust
Vanessa Wort - NHSI/E
Jeff Worrall - NHSI/E
Louise Grifferty - CQC regional communications manager

NHS
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NHS Trust

To:	**Trust Board**
From:	Michelle Rhodes, Director of Nursing
Date:	6th August
Healthcare standard	Health and Social Act, Regulatory activities – Regulation 12, 18

Title:	**Maternity CNST Safety Incentive Scheme – final position**

Author/Responsible Director: Penny Snowden, Family Health Divisional Head of Midwifery/Nursing

Purpose of the Report:
This paper outline ULHT's compliance position against the ten safety actions outlined in the Maternity CNST Incentive Scheme in order that the Trust Board are fully informed to sign the Board Declaration Form needs to be submitted to NHS Digital by the 15th August 2019

The Report is provided to the Committee for:

Decision	x	Discussion	x
Assurance	X	Information	

Summary/Key Points:
This paper provides evidence and therefore assurance that ULHT Maternity Service is compliant against each 10 safety actions

Recommendations:
It is recommended that the Board discuss the paper to ascertain their level of assurance that Maternity Service has achieved full compliance. If assured, the Trust Board are therefore requested to formalise their decision for the CEO to sign the Board Declaration Form in readiness of the organisation's submission to NHS Resolution.

Strategic Risk Register	**Performance KPIs year to date:** n/a

Resource Implications (eg Financial, HR) Reduction in Maternity CNST premium of up to 10%

Assurance Implications Yes

Patient and Public Involvement (PPI) Implications Yes

Equality Impact Protected Characteristic - Pregnancy

Information exempt from Disclosure No

Requirement for further review? Not for Year 2 CNST but there will be for Year 3 CNST

Title of Paper: Maternity CNST Incentive Scheme Year Two- Final Position
Author: Penny Snowden, Divisional Head of Midwifery/ Nursing

Background

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those Maternity Providers who have taken action to improve maternity safety. Hence the Maternity CNST Incentive Scheme; which is now in year two with more stringent safety actions; outlines the requirements which maternity providers need to comply with in return for a 10% rebate on their CNST premium. The two main considerations for ULHT as a Maternity Provider is that; the service is driven to halve the stillbirth rates by 2025 as outlined in the National strategy and the 10% rebate is approximately £700,000.

In providing evidence of compliance; the scheme has outlined the need for regular Board/Sub Board Reports to ensure that the Trust Board is sighted on maternity and the associated risks. The paper refers to several of the metrics that sit within each action point providing more detailed information so that Trust Board can determine whether they are fully assured. There is a wealth of evidence that underpins each safety action which can be requested but is considered to be too large to include in a Trust Board paper.

A paper was presented to Quality Governance Committee in July 2019 supported by a verbal narrative that the Maternity Service would be able to evidence full compliance against each of the ten safety actions points by the Trust Board August Meeting.

If the Trust Board is full assured with the compliance evidence, the CEO is required to sign the Board Declaration Form. This alone will be submitted to NHS Resolution who will triangulate the Organisation's submission with other agencies or regulators. If full compliance is not deemed evident, then a full costed business case to how full compliance will be achieved is required to be submitted with the Board Declaration Form. Indicative decisions from NHS resolution are expected in September with the funds paid to organisations in November 2019.

The paper provides the final position for ULHT's Compliance against each standard

Summary Position against each Safety Action Point

Safety Action No.	Action Descriptor	Compliance Achieved (Green – achieved)
1	Utilisation of the National Perinatal Mortality Review Tool	
2	Submission of data to the Maternity Services Data Set (MSDS) to the required standard	
3	Evidence that the service has transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme	
4	Effective system of medical workforce planning to the required standard	
5	Effective system of midwifery workforce planning to the required standard?	
6	Compliance with all four elements of the Saving Babies' Lives care bundle V1	
7	Evidence that the service has a patient feedback mechanism for maternity services and that the service regularly acts on feedback	
8	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	
9	Evidence that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	
10	Has the servie reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme	

The next section of the report provides an overview of the evidence against each safety action point

Safety Action One: Are you using the National Perinatal Mortality Review Tool to review the report the perinatal deaths to the required standard

The metrics for this standard are outline below together with current compliance levels. Evidence has been collated against each metric.

No	Standard	Evidence
1	A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	PMRT Database reports Quarterly QGC/ TB Reports
2	At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	PMRT Database reports Quarterly QGC/ TB Reports
3	In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	PMRT Database reports Quarterly QGC/ TB Reports
4	Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	Quarterly reports submitted for whole monitoring period
5	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.	Quarterly reports submitted for whole monitoring period Action plan in place at thematic level and individual level
6	Data Cross reference/ accuracy check with MBRRACE-UK data	Quarterly Reports. Data cross check undertaken and matched

In the likelihood of the NHS resolution triangulating organisation's declaration with PMRT database, scrutiny will continue to ensure on-going compliance with the above metrics.

Maternity Safety Action Two: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard

The Trust was not able to comply with all aspects of this safety action point and in accordance with the CNST technical guidance, the issues were escalated to the NHS Digital. The response received was positive and subsequently the service is able to rate compliance.

However, the service will have on-going challenges meeting the MSDS version 2 due to Maternity Medway not complying with the full specification. The procurement of the software predates the current leadership team; however this was a missed opportunity. The anticipated issues the service will continue to face has been escalated through Financial Turnaround Group and to Women's and Children's STP via Better Births. The national maternity digital maturity working group is indicating two providers which are BadgerNet and K2 and it has been escalated to this group that further funding would be required for Organisations to move to either of these digital solutions.

The compliance position post escalation are outlined below

No	Standard	Evidence
1	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria	Scorecards Excel spreadsheets Escalated that can only meet 15 out of 19 criteria with manually adjusted data Escalation letters
2	One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019.	October data not submitted in December 2018 Scorecard Letters of escalation
3	One criterion relates to the submission of data for the first	Confirmation of

	month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.	submission
4	If a trust feels that there are exceptional circumstances, they should raise this with NHS Digital at an early stage. This might include evidence of a fall in birth rate, or of services covered in the assessment not being available at the trust.	Emails Letters of escalation and response

Maternity Safety Action Three: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

ULHT maternity service is able to not only demonstrate that appropriate processes are in place but that a reduction in terms admission to Neonatal Services has been achieved. The team identified this as an improvement project whilst on Wave 1 of the Maternity Neonatal Safety Collaborative Programme.

No	Standard	Achieved/ Included
1	Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. Sunday 3 February 2019	Policy was in place by 3rd February
2	A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version Sunday 3 February 2019	Badgernet captures data – data report
3	An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews Sunday10 March 2019	Action Plan LMS Minutes Board Minutes Deadline missed – escalated to NHS digital and extension given by 1 month
4	Progress with the agreed action plans has been shared with your Board and your LMS & ODN Sunday 19 May 2019	LMS Minutes QGC Paper

		Updated Action plan
5	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Pathways in place by 31/01/2019	Policy in place Policy reviewed June 2019 to bring several policies together so all points listed are in one policy on Transitional Care
6	Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS.	Example of data collected
7	An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews.	Completed ATAIN Proformas
8	Evidence of an action plan to address identified and modifiable factors for admission to transitional care.	Action plan in place - ATAIN
9	Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.	ATAIN Action plan LMS Agenda and Minutes emails

Maternity Safety Action Four: Can you demonstrate an effective system of medical workforce planning to the required standard

All evidence has been submitted to the RCOG as outlined in the CNST technical guidance

No	Standard/ Evidence	Achieved/ Included

1	Formal record of the proportion of obstetrics and gynaecol… 'disagreed/strongly disagreed' with the 2018 General Medical … question: *'In my current post, educational/training opportunities … rota.'* In addition, a plan produced by the trust to address lost edu… gaps. 2018 GMC National Training Survey (covers the period 20 Mar…	Medical Paper Action plan
2	An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6. Six month period between January 2019 and June 2019	Gap Analysis undertaken – no action plan required
3	Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk	Email to RCOG
4	Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.	In medical paper Gap Analysis for both sites

Maternity Safety Action Five: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

All aspects are in place with the Red Flag Improvement plan being monitored through the Trustwide Labour Ward Forum with exception reporting to Speciality Governance and Divisional Cabinet.

No	Standard/ Evidence	Achieved/ Included
1	A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	BR+ Report
2	The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service	In funded establishment and audited through the Birthrate Plus

		APP
3	Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)	Audit data. On new Maternity Dashboard
4	A bi-annual report that covers staffing/safety issues is submitted to the Board	Paper submitted to QGC in July and Workforce in July
5	A bi-annual report that includes evidence to support a-c being met. This should include:	Paper submitted to QGC in July and Workforce in July
6	A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.	Finance data
7	Details of planned versus actual midwifery staffing levels	Reports to TB each month.
8	An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.	No deficit – so no action plan required
9	Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any	Escalation policy Midwifery On- call

	shortfalls	system
10	Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).	Action plan developed following audit

Maternity Safety Action Six: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle

ULHT have interpreted this standard in a thorough way so not only evidencing system and processes but also auditing compliance levels to evidence implementation. The team agreed this the correct interpretation given that Maternity is primarily a safety initiative. ULHT submitted evidence to NHS England in February 2019 as part of a deep dive exercise on implementation of Saving Babies Lives. The case audits continue and the latest audit demonstrates significant improvement as outline below:

- Smoking status recorded at booking = 100%
- Referral to Smoking Cessation Service = 100% (36% declined the referral)
- 93% of staff trained in Symphysis Fundal Height Measurement, Fetal Weight Charts, Gap and Grow and Customised Growth Charts
- 100% of notes audited (40 cases) – Fetal Weight charts utilised (improvement from 88%)
- 100% compliance with customised growth charts (improvement from 68%)
- 100% fresh eyes stickers in pace – improvement from 85%
- 59% Small for Gestational Age detection rate which requires more improvement
- Reduced Fetal Movement checklist only utilised in 53% of notes; which is a 10% improvement but still requires further work.

No	Standard	Evidence
1	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services	TB Paper FTG Report QGC Paper
2	Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s). The scheme will take into account the position of trusts at end July 2019.	TB Paper Policies Learning Audit
3	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of	TB Minutes QGC Minutes

	each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).	Agenda's
4	Carbon monoxide (CO) testing of all pregnant women at antenatal booking appointment and referral, as appropriate, to a stop smoking service/specialist, based on an opt out system. Referral pathway must include feedback and follow up processes.	Policy Minutes of Meetings Audit evidence available
5	Recording of smoking status of each pregnant woman ii. Recording of CO reading for each pregnant woman iii. If this identifies exposure to smoke or a high CO reading, referral to stop smoking service or other action	Policy covers both points Audit data Data on high CO readings Maternity Dashboard
6	Number/rates of women smoking at booking Number/rates of women smoking at time of delivery (SATOD)	Dashboard System meeting
7	Use supplied algorithm to aid decision making on classification of risk, and corresponding surveillance of all pregnancies. (Some providers may wish instead to use the RCOG algorithm*) All relevant staff trained in use of algorithm ii. Proportion of pregnancies appropriately screened and monitored according to risk	In SGA policy Training data Missed audit data
8	For women at high risk of fetal growth restriction, fetal growth to be assessed using serial ultrasound scans as per algorithm (Appendix B). Estimated fetal weight derived from ultrasound measurements recorded on a chart** Estimated fetal weight derived from ultrasound biometry and used to plot every growth scan ii. All staff competent in use of estimated fetal weight charts, and audited within Trusts e.g. through midwifery supervision/trust based training and competence records	In SGA policy Gap and Grow Audit Training records

9	For low risk women, fetal growth to be assessed using antenatal symphysis fundal height charts** by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated. Symphysis fundal height charts used in each pregnancy ii. All fundal height measurements plotted on chart iii. Audit of representative sample of maternity to identify that: □ charts are being used □ charts are plotted correctly □ staff in need of further training are identified □ evidence of completion of re-training available	In AN guideline training data Audit of June's cases Audit Action Plan
10	Ongoing audit, reporting and publishing (on local dashboard or similar) of Small for Gestational Age (SGA) birth rate, antenatal detection rate, false positive rate and false negative rate.	Jan – March audit April to June Audit Missed audit data Stillbirth annual report
11	Ongoing case-note audit of selected cases not detected antenatally, to identify learning and improve future detection (Increase/decrease of antenatal detection rate of SGA babies at birth, including false positive and false negative rate ii. Rate of stillbirths with SGA with and without antenatal detection)	Case note audit undertaken baseline and follow up
12	Action plans based on missed case audit are implemented to drive improvement	Action plan in place

The improvement plan regarding the missed case audit will be overseen by the Maternity Safety Collaborative with lessons shared at Speciality Governance and learning lessons bulletins moving forward.

Maternity Safety Action Seven: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Below is a list of how we maternity service gains feedback. A couple of examples of how we have utilised feedback include:

- Social media survey on reduced fetal movements led to many myths being articulated by women. In response, ULHT Maternity Service and Lincolnshire Better Births developed a film accessible by YouTube https://www.youtube.com/watch?v=2gou2EMm67g – "Think BABY"

- ULHT maternity service held a three day staff and patient engagement event for continuity of carer and the feedback from women was the wish to have a team for those who had diabetes. This has now been included in our Continuity of Carer Plan.

No	Standard/ Evidence	Achieved/ Included
1	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.	• Report • Complaints/PALS • Include in PMRT reviews • CQC user survey improvement plan • FFT • Women's Stories at meetings • User Reps at LMS • Maternity Voices Partnership Minutes • Maternity 15 steps • Neonatal Voices Partnership Minutes • Social Media • Survey Reports • Engagement Events

Maternity Safety Action Eight: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

This standard has involved a considerable amount of staff training both in maternity but also theatre staff. Following the 2nd August 2019 training date all staff should be trained. This will be confirmed verbally as the submission date of this report is prior to the training date.

Lessons have been learnt from this safety action plan and a proposal to add PROMPT training to specified staff is made to the Core Learning Group so assist with monitoring compliance. Additionally, the administration of the PROMPT training is going to be reviewed to assist with future workforce planning which in turned should assist the service to sustain compliance levels above 90%

The table below shows progress against the other metrics in this standard

No	Standard	Evidence
1	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar. By the 15th August 2019	Have a plan in place to reach at least 90% for all groups by 2/08/2019
2	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.	Presentations, handbook
3	Training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.	Presentations
4	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety	Have a plan in place to reach at least 90% for all groups by 2/08/2019 Will provide verbal update at TB

	action.	

Maternity Safety Action Nine: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

There has been several changes to the safety champions and the evidence utilised and considered the work undertaken by all post holders

No	Standard	Evidence
1	The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	LLS minutes Member of the Maternity Safety Collaborative Meeting Previous post holder – chair of maternity safety committee
2	The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues (Must be implemented by Wednesday 27 February 2019)	Walk round dates Poster SD feedback and response from team to SD
3	The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff (Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis)	QGC Report July 2019 QI Posters Safety Champion posters PASCAL Survey Feedback
4	Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three	Safer Maternity Meetings
5	Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact	Safety Action Plan

	and outcomes with the quality improvement activities being undertaken locally	TB papers TB Patient Story Integrated performance dashboard
6	Evidence of attendance at one or more National Learning Set or the annual national learning event	No national event available so attended regional learning set July 2019 (Board Safety Champion)
7	Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns	QGC Report Board Safety Champion feedback
8	Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff	We See Boards
9	Evidence of engagement with relevant networks and the collaborative LLS	LLS minutes/ LMS
	All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27 January 2019	Conference, Safer Maternity Minutes

Maternity Safety Action Ten: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme

No	Standard/ Evidence	Achieved/ Included
1	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria. (1 April 2018 to 31 March 2019)	Data reports
2	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.	Quality Dashboard Governance Reports PRM packs

		SI reports HSIB referrals Coroner's Letters
3	NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.	Data Report
4	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.	Data Report

Recommendations

1. To consider evidence presented alongside verbal narrative.

2. If full assurance is determined, to sign the Board Declaration Form

3. If partial assurance is determined to request further evidence so that full assurance can be given followed by signing the Board Declaration Form – See attached document

Summary.

The paper provides information regarding ULHT Maternity Service's compliance against each of the ten safety action plans. Given the significant amount of evidence that underpins each of the action points and the capacity with Trust Board, regular reports and evidence have been submitted to the Quality Governance Committee. The final report was submitted in July supported by a verbal narrative by the Divisional Head of Midwifery/ Nursing outlining the expected position in August would be full compliance. The committee were assured that a position of full compliance would be achieved in August and that the level of evidence submitted to the Committee was adequate to assess assurance.

Maternity incentive scheme - Guidance

Trust Name: **United Lincolnshire Hospitals NHS Trust**
Trust Code: **T565**

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

Section A : Maternity safety actions - United Lincolnshire Hospitals NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Section B : Action plan details for United Lincolnshire Hospitals NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**United Lincolnshire Hospitals NHS Trust**
Trust code	**T565**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature	
For and on behalf of the board of	United Lincolnshire Hospitals NHS Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	25 July 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 were advised that at month 3 the Trust had delivered to plan with an £18k favourable variance, but this had been due to £1.5m of technical adjustments from the release of accruals(£1m) and the bringing forward of planned FEP (£0.5m). No further flexibilities were available to support achievement of the financial plan for the remainder of the year. Overall income was reported at £200k adverse to plan, excluding pass through activity. Non Lincolnshire CCG commissioned activity was £300k adverse to plan, which included £200k of fines, predominantly for cancer and breast symptomatic waits. These performance shortfalls were increasing the financial risks, as there was no provision for fines in the financial plan. Grip and control of spend on pay continued to be the main issue. A summit for the Medicine division was due to be held, as the majority of the spend on agency staff was in that division. Further meetings with Nursing and the new Medical staffing are also to be held understand the controls in place and available. The Committee requested assurance on the actions being taken to bring the Trust back on track for delivery of the financial plan of £70.3m and the planned outturn of £40.1m after receipt of MRET, FRF and PSF funding available if the Trust deliver its plan. The Committee also requested details of the evidence required to demonstrate achievement of the CQUIN targets that had been agreed.

	The Committee were asked to support revenue borrowing of £5.637m and £6.284m capital borrowing. The Committee gave support for the borrowing and recommended Board approval.
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception report from Financial Turnaround Group Source of assurance: The Committee were advised that due to technical adjustments the Trust had achieved the Financial Recovery Plan to date. The Trust continued to work on the assumption of full delivery however there were a number of areas that had significantly under delivered by the end of month 3. At month 3, the in year identified savings stood at circa £28m, which was above the FEP target of £25.6m. However, the risk adjusted value of the FEP plan was estimated at £21.8m, £3.8m short of the target. In response to feedback, changes had been made to the FEP (including QIA approval) process to make it quicker to move schemes from idea to delivery. Workforce and recruitment FEPs remained challenging with some gains being seen, but these plans were not delivering savings as planned. Job planning savings were also a concern, as completion timescales had slipped and minimal progress is being made. Action requested by the Committee: The Director of Human Resources and Organisational Development to be invited to the Committee meeting in August to provide assurance on the delivery of the 2019/20 FEP savings for both Job Planning and recruitment .
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Progress Housing Update Source of assurance: Occupancy had increased in May and June, which meant that no guarantee payments had to be made to Progress Housing. The paper set out a number of proposals to reduce the guarantee payments or get better value for money spent, which included an increase in general occupancy and upgrade of accommodation to 3*. Work was underway to further develop the proposals and consider costs versus benefits. Action requested by the Committee: The Committee asked for analysis to be done to understand why occupancy had increased in May and June, as this would enable the Trust to do more of the same to maintain

	occupancy levels and reduce future guarantee payments.
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception Report Health and Safety Group Source of assurance: The Committee received the upward report noting the appointment of a Manual Handling Advisor. Attendance at the group continued to be an issue and work was underway to propose a new model to enable better engagement and representation from the Divisions. The HSE had recently visited the Trust to review progress with the actions required on asbestos and to review violence and aggression towards staff and manual handling. The HSE had commented favourably on the training that had taken place since a recent legal case involving hoists, a number of which had been replaced. Actions requested by the Committee: The Committee asked to see the HSE report when it was received and requested a simple summary of the actions taken against each deficiency found in the legal case, so they could be assured that the learning had been put into practice to prevent a similar incident in future.
	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception Report Information Governance Source of assurance: The Committee were advised that the new Data Security and Protection Toolkit had been published which included 116 indicators, of which 75% were new. These had been amended without consultation resulting in a large volume of indicators to be reviewed. The group escalated to the Committee the fact that an approach to health care records destruction had not yet been agreed with the contracted health records storage supplier. The Committee were advised that the Trust were in a position to sign the contract with RESTORE which would include clauses on destruction of records no longer needed. Performance against FOI requests had been discussed at the group. Further work would be required to indicate the level of current performance against response targets. Concerns were raised by the Committee regarding the lack of assurance on IG incidents and the learning from them. Assurance was provided that the Trust have full knowledge of the incidents, but trends could not be obtained from Datix. Data Protection Impact Assessments had been completed and the Trust was GDPR compliant. Impact assessments were being carried out with

	suppliers to ensure that they were also compliant.
	Lack of Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception Report Digital Group Source of assurance: The Committee were advised that due to limited capital funds available for routine replacements of IT equipment, there had been an increase in associated risks. A risk based review meeting had taken place and priorities would be reconsidered by the Executive Team. The Committee would receive a report on the outcome of this review in August. Any increased risks from having insufficient capital to complete planned work to reduce the risks of cyber attacks would be reported to the Audit Committee and to the Board.
	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: ICT Assurance Report Source of assurance: Patching of GE servers was not progressing at the rate expected, which affected all Trusts in EMRAD. As the last cyber attack had started on those servers, there was an increased level of risk. but this was mitigated by the fact that the last attack had been unable to penetrate far into the network as other equipment was protected. The cyber security improvement plan had been impacted by the need to review available capital however this would be progressed in line with the risk based approach to the review of capital funds. The Trust had achieved a good rating in respect of the NHS Digital maturity self-assessment.
	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Assurance/Exception Report Emergency Planning Group Source of assurance: The Committee noted the substantial compliance that had been achieved however concerns were raised in relation to the later timescales for the installation and lock down testing of the new fire doors. The Committee were advised that the delay had been due to the manufacture process for the doors but the doors and testing of the lockdown process would be completed during the Autumn this year. This would enable full compliance to be reported against the required standards.

	Assurance in respect of SO2b, Providing Efficient and Sustainable Services Issue: Estates Update - Fire Source of assurance: The Committee received an update paper in respect of Fire Safety. The Committee deferred the confined spaces and PLACE reports to August. The HSE had been sent the information they requested to assure them that the necessary improvements had been made in working in confined spaces and their response was awaited. The Fire Safety Group had been tasked to conduct a review of the increase in fires and consider specific actions that may need to be undertaken in response to the increase. The Committee questioned the increase in the risk register score referred to in the paper, as this appeared inconsistent with the granting of an extension of the deadlines for the completion of enforcement notice work and they were advised that this had not been approved. The risk would be reviewed to see if it could be reduced from the current score due to the amount of improvement work that had been completed. The risk of arson was also being reviewed, following a recent fire.
	Lack of Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent and Emergency Care Improvement Programme Source of assurance: Whilst this had been the third month of improvement, with a performance of 72.44% the Trust had not met the performance trajectory. The improvement programme continued, as did dialogue with both the wider system and NHSI. Attendances and admissions were both above plan. Ambulance handover times continued to cause concern and a task and finish group had been set up to look at alternative protocols with EMAS. Further details on the agreed actions to improve would be given to the Committee in August. Action requested by the Committee: Further assurance was requested by the Committee on the impact and outcomes of the improvement programme workstreams and actions, to enable the Committee to gain assurance that the actions were delivering the benefits planned.
	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 5 out of the 9 standards had been achieved and improvements had been seen in 2 week waits. The largest success had been with regard to Breast

	Symptomatic where the Trust were now achieving 90% and it was expected that the next reporting period would see achievement of that standard. The 62 day wait standard had declined to 65.52% in May and analysis had shown that this had been due to the low number of patients treated in some specialities and a small number of breaches having a significant impact on performance percentages as a result. Performance was expected to recover back to trajectory in June. The 104 day wait had not been achieved as 15 patients had waited over 104 days. This would form part of future reports. Harm reviews had been carried out on 7 of the 15 patients and no harm had occurred. Reviews of the other 8 patients were underway. Action requested by the Committee: The Committee requested assurance showing the impact and outcomes achieved as a result of improvement plans and actions.
	Assurance in respect of SO1, Providing Consistently Safe, Responsive, High Quality Care Issue: Trauma and Orthopaedic trial Source of assurance: The Committee received the update report noting that the rate of improvement in waiting times and cancellations had slowed, but improvements already seen were being sustained. The patient criteria was due to be reviewed to see if it would be possible to operate on a wider range of patients. Plans were being made to start repatriating some activity as waiting times reduced further. Action requested by the Committee: The Committee requested assurance that the planned benefits from the trial were being achieved.
	<u>Assurance in respect of other areas:</u> <u>Dashboard:</u> The Committee received the draft dashboard for review and agreed that this would be trialled at the Committee subject to a number of amendments requested by the Committee and the inclusion of the Health & Safety items.
Issues where assurance remains outstanding for escalation to the Board	No items were identified for escalation
Items referred to other Committees for Assurance	No items were referred

Committee Review of corporate risk register	The Committee received the corporate risk register and noted that there had been no material change to the corporate risk profile or very high and high risks.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee received the Board Assurance Framework and requested changes made during updates by the Directors were highlighted to the Committee. The Committee reviewed the assurance ratings provided and determined these all remained red rated.
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	A	S	O	N	D	J	F	M	A	M	J	J
Gill Ponder Non Exec Director	X	X	X	A	X	X	X	X	X	X	X	X
Geoff Hayward Non Exec Director	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non Exec Director	X	A	X	X	X	X	X	X	A	X	X	A
Deputy Chief Executive	X	X	A	X	X	X	X	A	A	A	X	X
Director of Finance	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	X	X	A	X	D	X	X	X	X	D
Director of Estates and Facilities	X	X	X	X	D	X	D	A	X	D	X	X

Attendance Summary for rolling 12 month period

X in attendance A apologies given D deputy attended

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Workforce, OD and Transformation Committee Assurance Report to Board
Date of meeting:	11th July 2019
Chairperson:	Geoff Hayward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary
Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets bi monthly and takes scheduled reports according to an established work programme.
Assurances received by the Committee	**Assurance in regard to Workforce KPI Report** **Source of Assurance**: The Committee received the new suite of KPIs with data populated for April and May. There had been excessive agency spend for medical and nursing staff with an under delivery of the workforce FEP. The PRM's were not covering the items and as such the Executive Team were reviewing the sign off of agency use by the Divisions.
	Assurance in regard to Recruitment update **SO Ref: SO3a** **Source of Assurance:** The Committee received the recruitment update and noted the pipeline for international recruitment worked well however the process could take 6 months prior to commencement in post, the report demonstrated an improving position. The Committee noted the need for support to the process and resources for new international recruits to ensure retention of candidates, a review had commenced. Nursing continued to be of concern due to the difficulty to recruit however new trainees were due to commence in post in September. Targeted work would be undertaken with the divisions on hot spot areas Assurance had been provided that actions were in hand and it was expected that the KPIs would demonstrate the effectiveness of the actions to provide assurance regarding: • Return to practice • Rolling cohort recruitment programme • Earn, learn and return in partnership with HEE
	Lack of Assurance in regard to Job Planning update **SO Ref: SO3a** **Source of Assurance:** The Committee received the update however did not receive assurance that up to date job plans were in place. There had

	been delays in the process. The Committee was advised that job plans would be in place this year. The delay in job planning had affected the identified FEP which had been risk adjusted as the cost savings may not be realised.
	Assurance in regard to Audit of Medical Appraisal Summaries 2018/19 **SO Ref: SO3a** **Source of Assurance**: The report demonstrated a high level of compliance with appraisal completion along with improved quality and consistency. An improvement had also been seen with the completion of personal development plans however the quality had been variable with further improvement required.
	Assurance in regard to Development of the Medical Workforce **SO Ref: SO3a** **Source of Assurance**: The Committee received the report which detailed the outline of the development programme. The implementation plan required further development and resource to support the plan would need to be identified. It was anticipated that this would be complete within 2 months.
	Assurance in regard to Quality of the Medical Workforce **SO Ref: SO3a** **Source of Assurance:** The report identified Doctors with GMC conditions and evidenced that these Doctors posed a higher risk to the Trust. The Trust currently has approximately 100 consultants with a number of locums not on the specialist register, these staff mainly work in fragile areas. The aim of the Trust would be to ensure Doctors who are employed do not have GMC conditions. A draft implementation plan had been drawn up to improve the position over the next 2 years and the reintroduction of the associate specialist register to support is being considered.
	Assurance in regard to Update on the Morale Survey **SO Ref: SO3a** **Source of Assurance:** The Committee received an update on the survey that had been conducted with junior doctors. Analysis had been completed and challenges identified including rotas and supervision. Clear actions had been identified particularly in relation to rotas prior to commencement in post. Consideration is being given on the changes that require implementation.

	Assurance in regard to Medical Revalidation Report **SO Ref: SO3a** **Source of Assurance:** The Committee received the annual report that is submitted by the Trust to NHS England to demonstrate compliance with revalidation of doctors. The report provides assurance that 93.77% of appraisals have been completed, 6.04% missed and 0.19% not approved. The figures demonstrate that the Trust are working in accordance with NHS England/NHS Improvement guidance.
	Assurance in regard to Analysis of 2018/19 ER Activity **SO Ref: SO3a** **Source of Assurance:** The report presented to the Committee reviewed the trends in the number of disciplinaries and grievances across the Trust. The main driver for the Trust would be to use the 'Just Culture' approach to attempt to resolve issues prior to the entering of a formal process, unless appropriate to do so. Challenges had been identified through the report and actions would be identified as required. Consideration to utilising best practice from this across other areas was being considered.
	Assurance in regard to Learning lessons to improve our People Practices **SO Ref: SO3a** **Source of Assurance:** The Committee received a report outlining the results of a review of current processes and cases undertaken following the suicide of an NHS staff member involved in a disciplinary investigation. The Committee were advised there would need to be formal sanctions in place however improved ways of dealing with these would be implemented by the Trust. Consideration of replicating the medical process for nursing staff would be given.
	Assurance in regard to Assurance Report from Equality, Diversity and Inclusion Group **SO Ref: SO3b** **Source of Assurance:** The Committee received the assurance report from the group with assurance being provided that the Trust were meeting statutory and regulatory duties.
	Assurance in regard to Bullying and Harassment **SO Ref: SO3b** **Source of Assurance:** The Committee were presented with a report to detailing the reported bullying and harassment within the Trust from the staff survey. Initial work had been completed by the Trust and analysis completed following the results. Actions were in place to address the concerns.

	Actions requested by the Committee: Future reporting, evidence and regular reviews to be defined by the Director of Human Resources and Organisational Development
	Lack of Assurance in regard to Leadership Development **SO Ref: SO3b** **Source of Assurance:** The Committee were advised that a multi-module computer based leadership development programme is in place and has been utilised by over 1000 staff. No evidence of the effectiveness of the training programme had been presented to the Committee and statistical evidence was awaited. **Action requested by the Committee:** The Chair requested that consideration be given to the Leadership Training Programme becoming a set of core mandatory training for managers.
	Assurance in regard to Assurance Report from 2021 Programme Group **SO Ref: SO3b** **Source of Assurance:** There had been positive initial engagement of the Continuous Quality Improvement approach and rollout of the programme was progressing. Transition from the 2021 Programme Group had commenced with progress on the delivery of the 5 year strategy being presented to the Trust Management Group Strategy meeting.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	No areas identified
Committee Review of corporate risk register	The Committee noted the need for the Risk Register to be updated and agreed that this would be considered by the Medical Director
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Board Assurance Framework was presented to the Committee who agreed that the current assurance ratings remain

Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner
Date:	6 August 2019
Essential Standards:	

Title:	Freedom To Speak Up Quarterly Report Apr - June 2019

Author/Responsible Director: Jayne Warner – Freedom To Speak Up Guardian

Purpose of the Report:
The report provides an update on our Freedom To Speak Up activities and quarterly data collection submitted to the office of the national guardian.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Information	X

Summary/Key Points:

The Trust has a responsibility to listen to staff, to be open and responsive to concerns that are raised.

The report provides an update on the following

- Concerns raised with FTSU Guardian
- National Updates
- Actions taken
- Trend Analysis

Recommendations:
The Board are asked to note the latest freedom to speak up data.

Strategic Risk Register:	**Performance KPIs year to date**

Resource Implications (e.g. Financial, HR)

Assurance Implications:

Equality Impact

Information exempt from Disclosure
None

Requirement for further review?

Freedom to Speak Up Guardian

Update to Trust Board

National Guardian's Office

Data Collection
The National Guardian's Office are collecting and publishing quarterly data on FTSU. The most recent data collection is now due, requesting data from the quarter April 2019 to June 2019

Reporting Period	April 2019 – June 2019
Number of issues raised	3
Number of issues raised anonymously	0
Number of issues raised with element of Patient Safety	1
Number of issues raised with elements of Bullying/ harassment	2
Did reporter describe having suffered detriment from speaking up	0
Staff Groups referrals came from	2 A&C 1 Nursing
Feedback Obtained	0

Whistleblowing Notifications

During Quarter 1 of 2019/20 (April to June 2019) there have been
0 notifications of whistleblowing to Human Resources. However the CQC were contacted by staff who raised bullying during their well led inspection visits.

There have been no new reports to Local Counterfraud Service.

Issues highlighted Quarter 1
- Breakdown of relationship with line manager
- Ward practices in relation to staff in training

Freedom to Speak Up Guardian

The Guardian continues to have quarterly 1:1 meetings with the Chief Executive. The new Chief Executive will remain as the Executive Lead for Speaking Up.

The Trust launched a survey for staff asking what framework they would like to see for a new network of FTSU Champions. The results from the survey were shared at the Executive Team meeting and the majority of staff who had responded had requested that the network took the form of champions representative of each staff group with presence on all Trust sites. The Trust is

using a role description which was developed nationally and champions will do their champion role in addition to their normal duties. Staff are now being asked to volunteer or nominate others as Champions. Initial interest has been limited, so a further drive will be made to build on the 9 volunteers interested so far. The Guardian has worked with the E&D Lead to ensure that all of the staff networks were aware of the opportunity to become Champions.

The National Guardian has announced that October 2019 will be national FTSU Month so the aim will be to have the Champions Network in place and to work with the Communications team to create internal publicity in line with the national events which will be taking place.

The Guardian was interviewed by the CQC as part of the well led inspection and was able to describe how the Trust had continued to develop speaking up since the previous visit.

The role of the Guardian continues to be included in the induction day for all staff and has also been added as a presentation in person to the preceptorship programme for nurses.

Healthy Conversation 2019 campaign report- wave one

1. **Purpose:**

   This report provides a summary of the Healthy Conversation 2019 campaign to NHS provider boards, governing bodies, partners and stakeholders. It details the wave one activity-to-date, feedback and results, as well as the next steps in the campaign.

2. **Reporting period:**

   05/03/2019 to 31/05/2019

3. **Background:**

   On 5 March 2019, the NHS across Lincolnshire launched its Healthy Conversation 2019. It is an open engagement exercise which will shape how the NHS in Lincolnshire takes health care forward in the years ahead. It is a chance for everyone to learn more about the NHS's current thinking on the future of NHS services and is a way to get meaningful feedback from our patients, their representatives, the public, NHS partners and staff about what future services may look like. Healthy Conversation 2019 will continue throughout the year, with a wide range of engagement events and discussions across the county.

The core principles for the campaign are:

Core principle	Success criteria
Consistency is key	Successful delivery of plans
Provide the background	Feedback is in context
Facts first	Accurate reporting in the media
Transparency	Audit trail to demonstrate compliance
Patient-led	High levels of engagement evidenced in 'you said, we did'
Clinicians front and centre	Clinician support to champion the campaign in communications, at events and in media interviews

The key overarching Healthy Conversation 2019 campaign messages for this period have been:

- Lincolnshire's NHS needs to continue to transform to improve quality, attract staff and be fit for the future
- The way we all use the NHS needs to change too
- We need to make this change together – get involved

4. Activity undertaken and outcomes:

4.1 Campaign launch and stakeholder management

Lincolnshire NHS's Healthy Conversation 2019 campaign commenced on 5 March 2019. This first day involved:

- A series of internal and stakeholder briefing sessions
- Staff team briefing process – face to face
- Briefs to all communication points of access across NHS organisations to ensure public were dealt with effectively and quickly, first time, should they wish to contribute feedback
- Email briefs to lay members and non-executive directors, council of members, GPs, MPs, local councillors, health and care stakeholders and partners (all 'internal' audiences)
- A 'catch all' email to those unable to attend face to face briefings
- Briefings emails sent to all partners, stakeholders, and local 'influencers' (for example, education sector, large local businesses) (all 'external' audiences)
- A press call to brief the media, led by clinicians
- Lift of public embargo at 3pm
- Proactive social media and press bulletin schedule commenced for the
- following fortnight initially
- Days two to eight were dedicated to press office management and responding to public enquiries

4.2 Media relations

The initial press call was attended by seven key print press and broadcasters in the county:

- The Lincolnite
- Health Correspondent BBC East Midlands
- BBC East Midlands
- Grantham Journal
- Lincs FM
- BBC Radio Lincolnshire & Sunday Politics (Yorkshire & Lincolnshire)
- Lincolnshire Live

Quotes and interviews within the resulting articles were all delivered by senior clinicians.

The core themes that the press subsequently led with were:

1) Urgent and emergency care – headlines included 'A&E downgrade at Grantham'
2) Publicity of Healthy Conversation 2019 (county wide)

Examples of press coverage:

06/03/2019	Radio Lincolnshire	Dr Yvonne Owen & Dr Sunil Hindocha interview with Scott Dalton

06/03/2019	Look North	Dr David Baker interview with Peter Levy
08/03/2019	Lincolnshire Reporter	Matt Warman A concrete commitment to our NHS
13/03/2019	Lincs. FM News	Public feedback session in Boston on health changes
14/03/2019	Grantham Journal	Have your say on plans for Grantham Hospital in 'Healthy Conversation'
15/03/2019	Grantham Journal	Let's have a "healthy conversation" about Grantham Hospital - Dr Neill Hepburn
16/03/2019	Grantham Journal	Let's Have a healthy conversation about Grantham hospital
17/03/2019	Skegness Standard	Chance to have say on health service issues
19/03/2019	Lincolnshire Reporter	Jan Sobieraj - Let's start a healthy conversation
19/03/2019	Lincolnshire Free Press	Have your say on future of NHS
21/03/2019	Lincs FM	Interview with Kevin Turner about A&E services and funding at Pilgrim hospital, Boston

5. Campaign Activity

5.1 'Good News Stories'

No. uploaded to the website	No. of press releases issued	No. of press clippings
25	5	51 (20 positive, 17 neutral and 14 negative)

5.2 Social media

We are able to manage our reputation more effectively and reach more of our target audiences directly through our website and social media channels and this will increase as our following on these channels grows. In the last three months, our top-achieving post on Facebook (about the launch of Healthy Conversation 2019) had a reach of 5,510 (meaning it appeared on that many people's computer/tablet/phone screens), was shared 33 times, liked 54 times and commented on by five people, which led to 338 clicks to view the full post.

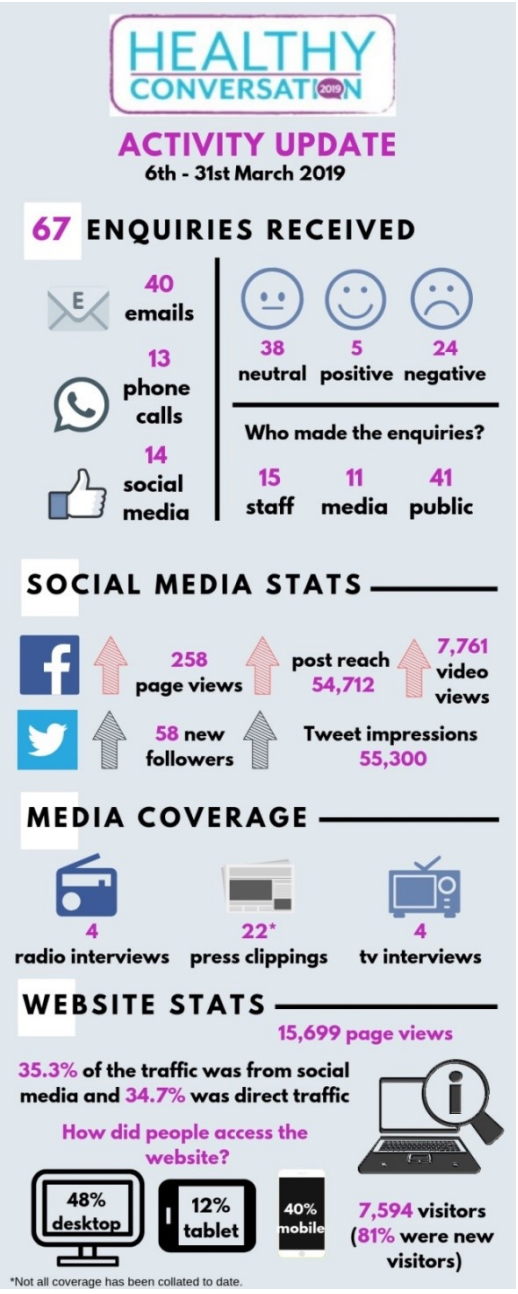
On Twitter, the top-achieving post over the last three months (about supporting Purple Day) had 8,955 impressions (the number of Twitter account timelines it appeared on) and 158 total engagements (made up of retweets, link clicks, likes, media engagements etc).

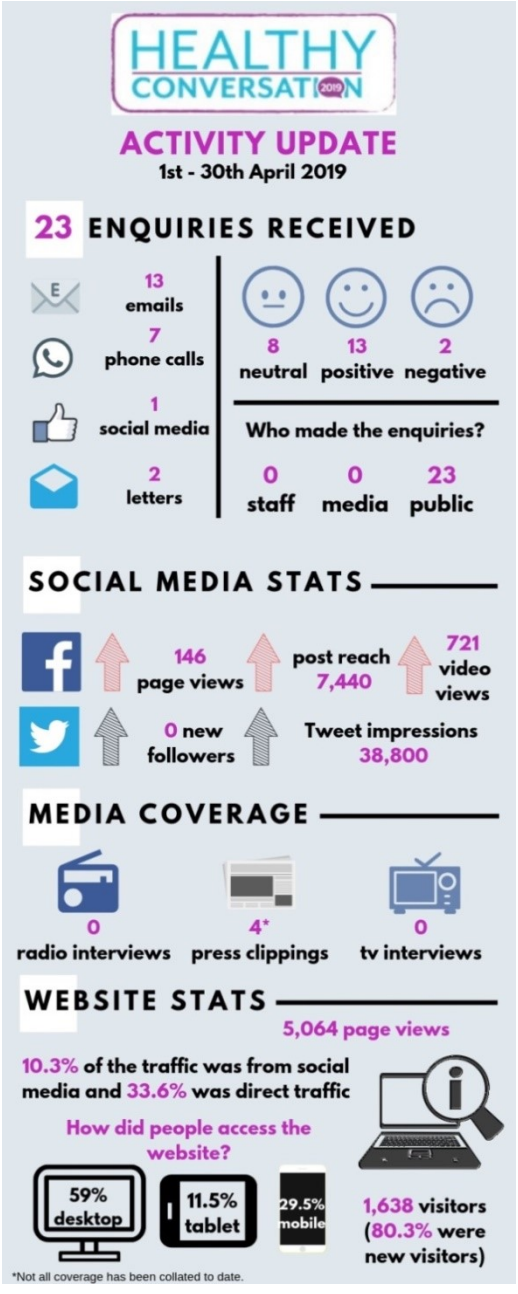
Summary of campaign activity:

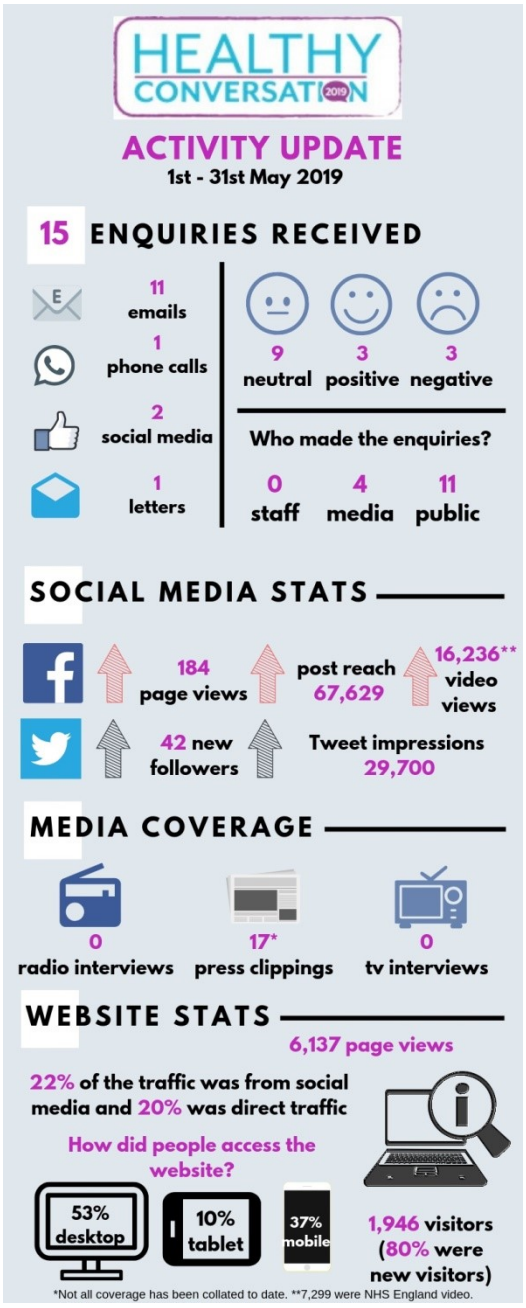
	March	April	May	Total
Total no. of enquiries	67	23	15	105
No. of website visitors **(percentage of new visitors)**	7,594 81%	1,638 80%	1,946 80%	11,178 80%
No. of pages viewed website	15,699	5,064	6,137	26,900

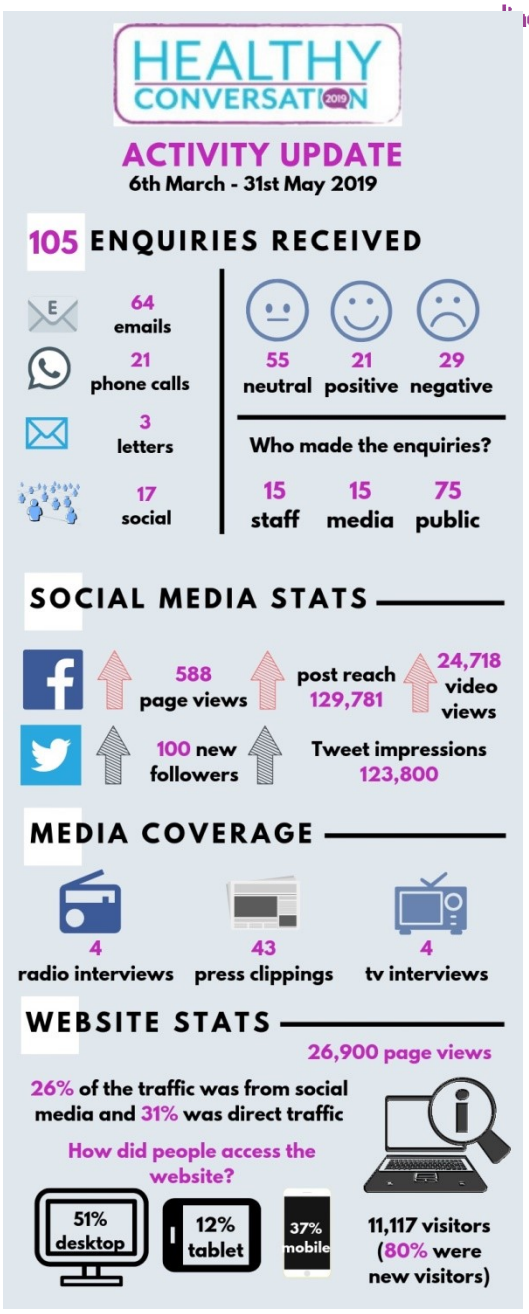
No. of press clippings	22	4	17	43
Facebook post reach	54,712	7,440	67,629	129,781
Twitter tweet impressions	55,300	38,800	29,700	123,800

Infographics summarise communications activity below. The first three infographics are for each of the months (March, April and May). The fourth infographic represents cumulative activity since the launch of Healthy Conversation 2019 to 31 May 2019:









6. Engagement activities

6.1 Public Engagement Events

The engagement events to date have been attended by 298 people. The core themes that were raised within feedback (through direct verbal feedback, written forms and the surveys analysed to date) were:

Date	Location	Key Locality Themes	No. of attendees
13/03	Boston	• Accessibility of stroke services in the future	67

		• Loss of services to Boston as a whole	
14/03	Louth	• Threat of hospital closure (this was an initial concern that alleviated once responded to)	17
19/03	Skegness	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	20
20/03	Grantham	• A&E downgrade perception • Urgent Treatment Centres and what they are	129
20/05	Sleaford	• Lack of GP access • Lack of coordination following discharge from hospital	25
21/05	Gainsborough	• Lack of GP access • Financial difficulties when having to travel to visit family	13
22/05	Lincoln	• Financial difficulties for family members having to travel to hospital • Professionals should be able see each other's notes to make it more streamlined for patient	30
12/06	Stamford	• Ensure links with North West Anglian NHS Trust for services in Stamford • Grantham A&E closure overnight	20
13/06	Spalding	• UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton	44

6.2 Surveys and feedback

As of the end of May, 518 surveys had been completed and submitted. Our updates on engagement activity are also published on the website for public viewing, as is a full overview of the key themes from public feedback in our 'you said, we did' section. Any individual who requested direct information or feedback since the

campaign began, has received a reply.

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family, particularly on behalf of those who may struggle
- NHS111 and its effectiveness
- East Midlands Ambulance Service and response times
- Issues of overburden on Lincoln County Hospital

Examples of feedback we heard and responses given to date include:

6.2.1.Travel & Transport

- ❖ Feedback from the public:

- Issue isn't the hospitals but travelling to them – poor road networks and lack of public transport
- Early appointments not achievable when using public transport
- Costly travelling across the county to hospitals further away
- Can't always rely on family and friends
- Community transport sometimes unreliable
- Unable to get back from hospitals if taken by ambulance

- ❖ Response:

The NHS is responsible for delivering medical and health care services. Local councils are responsible for public transport. However, we fully appreciate how crucial transport is so that patients can access NHS services, therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. We have worked to a principle of the most regular care requirements remaining close to home, such as routine screens in cancer care for example. It is when care needs become more complex and specialised that we introduce further travel; we have heard from Lincolnshire's public that the right care, first time is the priority, even if that means further travel. A large consideration for our clinicians as they review services is how to best spend NHS funding, including whether we divert some of our funds away from care in order to supplement patients' travel, and we would welcome your continued input into this consideration.

We are also working on digital solutions so where possible, we can prevent the need for travel and for example a face to face consultation could happen by the internet. See technology and information section.

6.2.2. Technology & Information Services

- ❖ Feedback from the public:

- Welcome e-consultations to avoid concerns regarding transport
- Refreshing to hear; innovative thinking, digital is the future
- E-consultations and telephone consultations are good ideas
- Many people do not have access to the internet and will need alternative options
- Areas of poor broadband and poor mobile phone signal
- Shouldn't need to keep re-telling your story/medical history

- ❖ Response:

In Lincolnshire we have developed the Lincolnshire Care Portal. This is a secure computer system that provides health and care staff with a selected view of a patient's personal information contained in different health and care systems. The Care Portal enables health and care staff to view an integrated care record for the patient. It brings together selected patient information from multiple organisations and systems in real time. We are in the process of connecting up systems across Lincolnshire organisations, this includes GP practice systems, hospitals along with community and mental health. We are also looking farther afield so when Lincolnshire patients travel to hospitals in other areas, such as Peterborough, Nottingham, Grimsby etc. staff in those organisations have the patient information they need from Lincolnshire organisations. For more information about the Lincolnshire care portal please visit https://www.lincolnshire.nhs.uk/together/care-portal

There are other digitals plans too. These include plans for remote patient monitoring so for example a blood sugar or blood pressure can be taken by the patient in their own home, using a wearable device, and electronically sent to the patient's clinician who can review and then agree the treatment directly with the patient.

6.2.3. GP Services

- ❖ Feedback from the public:

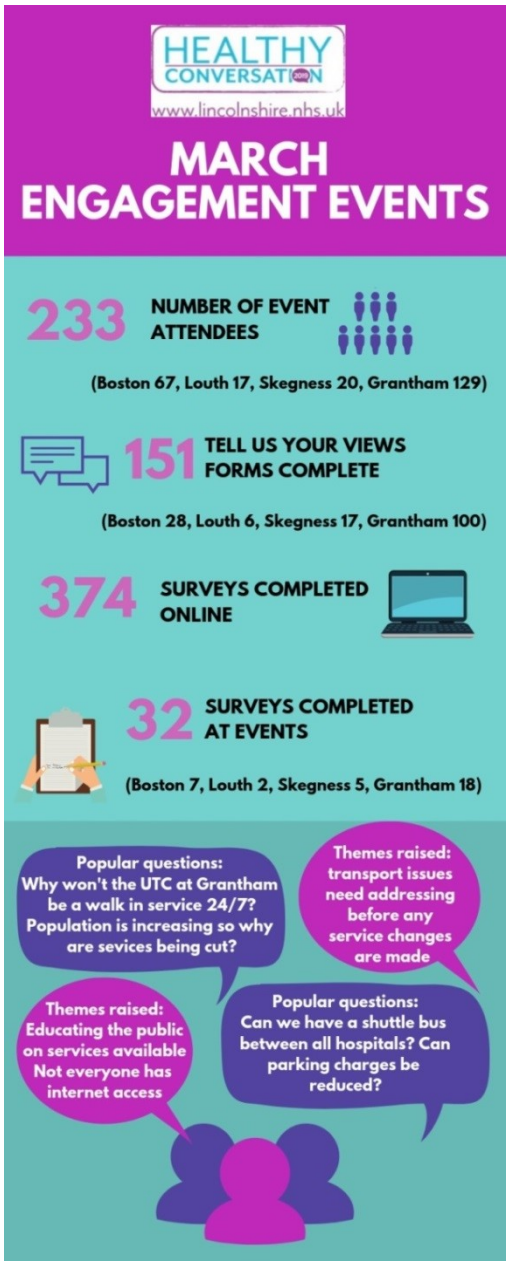
- Communicate all options for appointments and don't always need to see a GP
- Promote GP Out of Hours services, especially at Grantham Hospital

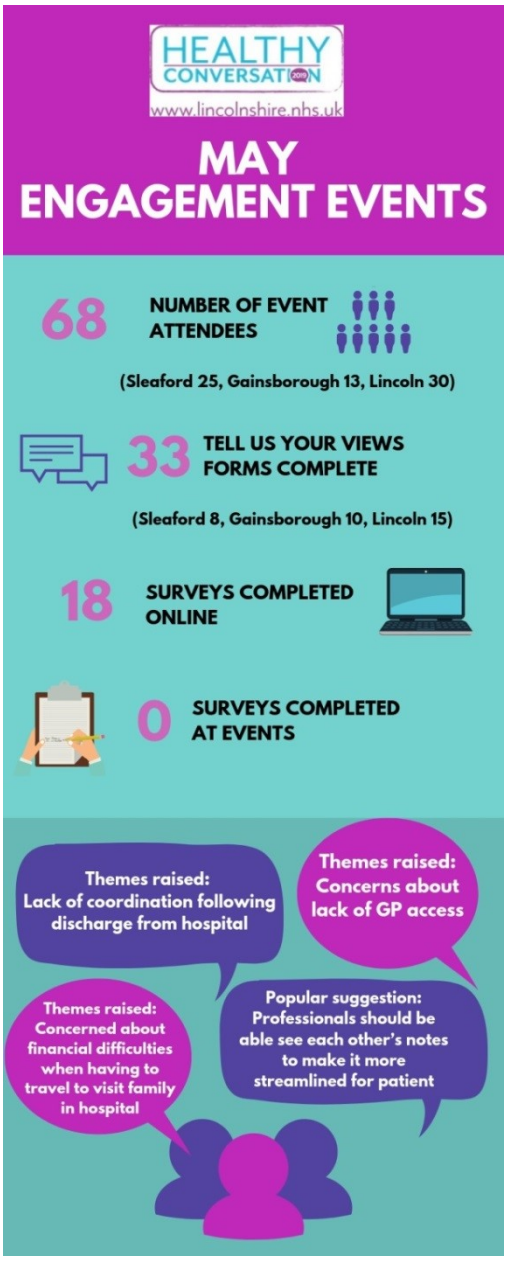
- ❖ Response:

We are working hard to communicate with the county that there are several options available to access health services which don't always involve seeing a GP. These include seeing the advanced clinical practitioners (such as nurses) we have recruited across the county.

ASAPLincs is a free app and website resource which was launched to help the public access the most appropriate heath care. It also features an up to date overview of all out of hours services and their availability and has been heavily promoted on bus sides, through local papers, on social media and in GP practices etc. We have also promoted GP Out of Hours services through literature in schools.

Infographics summarise engagement activity below for March and May:





7. Learnings from activity to date:

- The public welcomed these difficult conversations. Engaging them early and being honest about the choices we face yielded a far more mature and respectful conversation than we have previously held. The public fed back that conversations about "transformation" under the banner of the STP had been perceived as promoting an agenda of thinly disguised cuts.
- The public overwhelmingly supported the prevention and self-care agenda, and many shared frustration regarding the 'misuse' of the NHS (for example, unnecessary attendance at A&E, lack of self-care resulting in greater need for services etc). There was also significant public support was for joined up care in the local community, and services that were affordable and sustainable, with many commenting that the NHS should not be spending more money than it has.
- Many of the key concerns, such as travel and transport issues, and use of digital alternatives were expressed on behalf of others – 'felt responsibility'. For example, lots of people explained that they would personally be able to make longer journeys as car owners, but were concerned about those in the community who may not be in the same position.
- Branding – the STP has been perceived as a negative brand in some places nationally which has also been felt at a local level. Giving it a different local profile 'Lincolnshire's NHS' was instrumental/assisted in more positive engagement.
- Having a shared, dedicated and specialist resource to plan and deliver this communications and engagement activity was essential. We could not have done this by asking staff without the necessary skills and experience to do this on top of business as usual. We must not underestimate the time and resource it takes to run a programme of this type, not only for the dedicated communication and engagement team but also for the clinicians, managers and other staff involved.
- Many partners have been asking for increased public engagement for some time, creating a mistrust that had to be overcome. We must continue to work towards co-production and co-ownership of campaigns with these partners.
- Featuring partners and their work in our engagement creates a more seamless and understandable journey for public, helping them to understand the whole process.
- If the events are branded more creatively, promoted well and held in better positioned venues etc. you do get far greater and more representative attendance by our public than usual.
- Making more of the opportunity to spotlight positive activity happening across Lincolnshire's NHS, for example our Talent Academy, schools in-reach etc. meant patients and public are more able to trust the work that we are doing and the quality of it
- There was a consistent appetite for the sharing of good news stories and positive case-studies from partners, stakeholders and the public and patients in order to dispel the perception that it is all bad.
- Investing a small amount in paid social media advertising allowed us to reach a much broader and greater audience
- Response from public to clinicians being front and centre has been very positive. We must commit to future engagement being more clinician led.

8. Next steps:

A communication and engagement plan is in place as *Healthy Conversation 2019* progresses over the summer and into autumn and incorporates the learning to date.

8.1 Attendance at Partner and Stakeholder events

We will continue to attend partner and stakeholder events in order to promote and discuss *Healthy Conversation 2019*, as well as hosting our standard events throughout the county.

8.2 'You said, we did' communications

'You said, we did' communications are published on the website and are updated weekly following feedback and suggestions from the public. We will also continue to publish key themes and frequently asked questions on the website. To date we have responded to all enquiries (public, staff and media) in a timely fashion.

8.3 Next phases

- Locality roadshows – raising awareness of the campaign to reach a wider audience in local supermarkets, high streets and market places (Grantham 18th/19th June, Boston 26th/27th June). Further roadshows are being finalised in Lincoln and Skegness during September.
- Locality workshops – with members of the public attending to discuss key themes (ASR focused) in more detail with clinicians and staff, providing greater input to the continued work on the ASR and future considerations. Workshops have been held so far in Grantham on 19th June and Boston on 27th June. Further events are being arranged to continue the next level of discussions in these areas in September.
- Clinicians Q&As – members of the public unable to attend the workshops are invited to send in questions which clinicians will answer on camera and the resulting footage will be uploaded to the website. This exercise is ongoing.
- We are finalising our work with the Peoples' Partnership, focusing on engagement with those groups who would not ordinarily participate in the other public engagement activities produced to date. As soon as their reporting is complete, this will be published through our online and public meeting forums.
- Staff engagement sessions – staff will be briefed through team brief on the key themes emerging from Healthy Conversation 2019 and invited to share their feedback and comment in order to supplement the public information received. Staff engagement work has also been developed with internal communications messages regarding the campaign and its progression.
- Joint work with Healthwatch to contribute to their Long Term Plan report. We were linked with our local Healthwatch at the outset to ensure their engagement work would be useful for continued service review work. We have also provided wording to include in their reporting and are currently co-planning the public and media release of outcomes.

9. Conclusion

The Healthy Conversation 2019 campaign has delivered a recognisable and effective platform to enable our key stakeholder groups to share feedback with Lincolnshire's NHS.

This work will be used to inform our long term plan submission in the autumn, as well as our ongoing system wide transformation and improvement work.

To:	Trust Board
From:	Paul Matthew, Interim Director of Finance & Procurement
Date:	6th August 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for June 2019

Author/Responsible Director: Paul Matthew, Interim Director of Finance & Procurement

Purpose of the report:
To update the Board on the performance of the Trust for the period 30th June 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

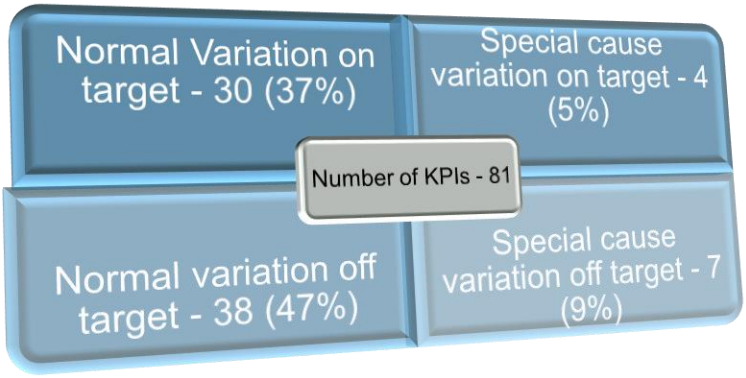
Information exempt from disclosure None

Requirement for further review? None

Integrated Performance Report

Trust Board
July 2019

EXECUTIVE SUMMARY



Quality

New Harm Free Care for May is above the national average at 98.7%.

HSMR (April 2018-March 2019) is 89.43 and is below expected limits, the lowest reported HSMR for the Trust. SHMI (January 2018-December 2018) is 109.92 and is in band 2 within expected limits.

The bespoke eDD dashboard was launched which enables clinicians to review their compliance and allow then to drill down to individual patients. Focus remains on clearing the backlog. The Bereavement Centre will ensure all deceased eDDs are completed. A video is being developed to highlight the importance of a quality and timely eDD.

VTE assessment remains above the 95% standard.

Overall incident reporting rates so far in 2019 remain consistent with levels reported in 2018 (no significant increase or reduction), with an average of 1158 patient incidents reported per month.

The Trust declared 10 Serious Incidents in May 2019, which is the lowest number in 2019 so far (compared with an average of 18 per month in 2018).

2 Never Events have been declared so far in 2018/19; 2 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).

There has been a significant reduction in the number of Pressure Ulcer Serious Incidents declared by the Trust in 2019 compared with 2018.

Duty of Candour (in person notification) compliance in May 2019 was 76%.

Operational Performance

Zero waiting indicators in urgent care services have seen some improvements in June although not recovery fully to trajectory levels. The A&E 4 hour standard has improved again in June now the third month of improvement however ambulance handovers waiting >59 minutes has remained static with no overall improvement and both of these against a context of fewer 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.

June saw the launch of the Lincoln Big Change reconfiguration scheme alongside the 5 other work streams covering all aspects of the urgent care pathway. As a system a high impact actions were agreed in late

June/early July that will feature in future iterations of the IPR and link the urgent care internal improvement programme to partnership activities with other providers and commissioners in the system.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have grown by 939 pathways (2.4%) from April to May 2019. No single specialty area disproportionately contributed to this growth in waiting list, although three specialties Neurology, Cardiology and Ophthalmology account for 75% of total growth in waiting lists.

Overall performance against the RTT incomplete 18 week standard has improved in May at 84.48% of patient pathways waiting less than 18 weeks for treatment. This represents the second month of above trajectory performance, and reflects the substantial work completed in previous months on validation of patient pathways.

In May one patient was 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 has started its improvement project on data quality and pathway management. This scheme will support the sustained performance of RTT 18 week standard, and will help alleviate errors in pathway management that contribute to 52 week wait patient pathways.

In May the Trust achieved five out of the nine cancer standards, nationally only three of the standards were met. This is an improvement from April where we only achieved four of the nine standards, and the first time since November 2018 that we have achieved five of the nine.

Zero waiting indicators in cancer services showed our 62 Day Cancer performance in May taking a significant drop away from the trajectory though the June forecast indicates the Trust is back on achieving the trajectory going forward.

The Trust continues to be in the top 20 of the largest providers of cancer treatments in the country with May putting us in 12th position.

Both 2ww standards (2ww Suspect and 2ww Breast Symptomatic) have continued to improve towards the standard.

Breast 2ww performance has particularly shown major improvement in both their Suspect and Symptomatic capacity with May finishing just below the national standard and June forecast to exceed it.

Finance

The Trust's control total and financial plan for 2019/20 (excluding PSF, FRF and MRET) is £70.3m. Delivery of the financial plan for 2019/20 facilitates the Trust accessing £28.9m of PSF, FRF and MRET funding resulting in a planned deficit of £41.4m.

Delivery of the planned deficit includes a Financial Efficiency Programme (FEP) of £25.6m.

The Month 3 position is as follows:

- The in-month position is a deficit of £5.8m, which is in line with the plan - the underlying in-month position was £329k adverse to plan, requiring release of £347k of technical flexibility to deliver the in-month reported position.

- The year to date position is a deficit of £11.2m, which is in line with plan - the underlying year to date position was £1,533k adverse to plan, requiring release of £1,551k of technical flexibility to deliver the year to date reported position.

The key movements year to date are as follows:

- Excluding the £0.7m adverse variance on Pass-through Income, Operating Income is overall £0.2m adverse to plan.
- Excluding the £1.0m benefit from the release of Pay provisions, the underlying Pay position is £2.0m adverse to plan.
- Excluding the £0.7m favourable variance on Pass-through Expenditure and £0.6m benefit from the release of technical Non Pay savings, Non Pay is £0.5m favourable to plan

The underlying year to date position at Month 3 position was £1,533k adverse to plan, and the year to date plan has been delivered by release of £1,551k of flexibility.

The underlying pay position is £2.0m adverse to plan and the adverse movement to plan is primarily driven by Agency Pay in general and Medical and Agency in particular the key concern – whilst Agency spend is of particular concern within the Division of Medicine, scrutiny of the temporary staffing usage across all staff groups and Divisions is required.

Supporting the adverse movement to plan in the underlying position has removed all pay flexibility that the Trust retained.

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.

Overall, whilst on plan at month 3, 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 continued higher than planned agency costs exceeding substantive staff savings. Total medical agency run rate for month three reduced with a significant (£400K) reduction in medical agency. A further increase in nursing agency costs was experienced this month which is being explored in greater detail.

The overall vacancy rate was broadly stable in June following revisions to the establishment model inclusive of planned investments in service delivery which have carried through from the prior year. A marginal improvement in medical vacancy rate was offset by a marginal reduction in nursing vacancy rate.

Sickness absence (rolling twelve months) remained stable at 4.8%.

Paul Matthew
Interim Director of Finance & Procurement
July 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostrum Difficile (post 3 days)	Safe	Our Patients	Michelle Rhodes	5	5	4	5	14	P		
	MRSA bacteraemia (post 3 days)	Safe	Our Patients	Michelle Rhodes	0	0	0	0	0	P		
	MSSA	Safe	Our Patients	Michelle Rhodes	2	1	2	0	3	P		
	ECOLI	Safe	Our Patients	Michelle Rhodes	8	2	7	4	13	P		
	Number of Never Events	Safe	Our Patients	Neil Hepburn	0	2	0	0	2	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	New Harm Free Care %	Safe	Our Patients	Michelle Rhodes	98%	98.60%	98.70%		98.65%	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Pressure Ulcers Category 4	Safe	Our Patients	Michelle Rhodes	0	0	0		0	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Stroke - Patients with 90% of stay in Stroke Unit	Caring	Our Patients	Michelle Rhodes	80%	86.40%	76.90%		81.65%	F		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Michelle Rhodes	80%	89.70%	64.60%		77.15%	F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Michelle Rhodes	50%	62.30%	51.90%		57.10%	P		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Michelle Rhodes	100%	100%	98.80%		99.40%	F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Michelle Rhodes	90%	76.80%	52.50%		64.65%	F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Michelle Rhodes	17%	10.60%	10.30%		10.45%	P		
	SHMI	Effective	Our Patients	Neill Hepburn	100	111.85	109.92		110.885	F		
	Hospital-level Mortality Indicator	Effective	Our Patients	Neill Hepburn	100	90.74	89.43		90.085	P	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis Bundle compliance in A&E	Caring	Our Patients	Michelle Rhodes	90%	83.30%	85.00%		84.15%	F		
	IVAB within 1 hour for sepsis in A&E	Caring	Our Patients	Michelle Rhodes	90%	95.20%	86.30%		90.75%	F		
	Sepsis screening compliance in inpatients	Caring	Our Patients	Michelle Rhodes	90%	85.00%	96.00%		90.50%	P	A	
	IVAB within 1 hour for sepsis in inpatients	Caring	Our Patients	Michelle Rhodes	90%	84.60%	57.00%		70.80%	F		
	Serious Incidents reported (unvalidated)	Safe	Our Patients	Neill Hepburn	0	12	10	12	34	F		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	Catheter & New UTIs	Safe	Our Patients	Michelle Rhodes	1	0	0		0	P		
	Falls (with Harm)	Safe	Our Patients	Michelle Rhodes		0.20	0.19		0.20	F		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	Medication errors	Safe	Our Patients	Neill Hepburn	0	195	193	218	606	F		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	Medication errors (mod, severe or death)	Safe	Our Patients	Neill Hepburn	0	20	19	16	55	F		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	VTE Risk Assessment	Safe	Our Patients	Michelle Rhodes	95%	96.15%	97.21%	96.87%	96.74%	P		
	Dementia Screening	Caring	Our Patients	Michelle Rhodes	90%	89.90%	96.9%		93.41%	P		
	Dementia risk assessment	Caring	Our Patients	Michelle Rhodes	90%	99.32%	98.95%		99.14%	P		
	Dementia referral for Specialist treatment	Caring	Our Patients	Michelle Rhodes	90%	92.86%	100%		96.43%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	92.62%	92.20%	92.67%	92.50%	F	H	
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	15.26%	15.21%	15.43%	15.30%	F		
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.71%	4.80%	4.81%	4.77%	F		
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	5.34%	12.45%	12.18%	9.99%	F		
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	72.99%	72.40%	72.74%	72.71%	F	B	
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-6009	-6112	-4019	-5126	-15257	P		
	Income	Well-Led	Our Services	Paul Matthew	36935	40221	41522	39838	121581	P		
	Expenditure	Well-Led	Our Services	Paul Matthew	-42944	-46332	-45297	-44964	-136593	F	B	
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	2838	510	1546	1342	3398	F	H	
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	4031	839	1958	2875	5672	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-1905	-3621	-4019	-3640	-11280	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	26.90%	31.51%		29.21%	P	H	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	96%	91.19%	90.19%		90.69%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	14%	20.09%	28.53%		24.31%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	79.71%	80.06%		79.89%	F		
	Friends & Family Test Maternity (Reponse Rate)	Caring	Our Patients	Martin Rayson	23%	11.29%	15.09%		13.19%	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%	8.14%	10.55%		9.35%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	93.17%	93.64%		93.41%	F		
	Mixed Sex Accommodation	Caring	Our Patients	Michelle Rhodes	0	0	1		1	F		Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	67	63		130	P		Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Martin Rayson		473	487		960	F		Timeliness, Completeness, Validation, Process
	eDD sent within 24 hours	Effective	Our Patients	Neill Hepburn	95%	87.86%	87.36%	94.00%	89.74%	F		
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	1.66%	2.20%	2.95%	2.27%	F		
	Duty of Candour compliance - Verbal	Responsive	Our Patients	Neill Hepburn	100%	100.00%	93.00%		83.47%	F	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Neill Hepburn	100%	100.00%	76.00%		71.29%	F	H	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	73.0%	66.36%	68.22%	72.44%	69.01%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	77%	84.20%	85.08%	78.96%	82.75%	P		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	2	1		3	F		
	18 week incompletes	Responsive	Our Services	Mark Brassington	84%	84.16%	84.48%		84.32%	P		
	Waiting List Size	Responsive	Our Services	Mark Brassington	36,718	38,956	39,895		39,895	F		
	62 day classic	Responsive	Our Services	Mark Brassington	75%	77.31%	65.52%		71.42%	F		
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	79.98%	81.84%		80.91%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	67.83%	91.67%		79.75%	F		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	97.90%	97.26%		97.58%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	96.88%	100.00%		98.44%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	94.29%	90.70%		92.50%	F		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	97.27%	95.05%		96.16%	P		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	100.00%	92.11%		96.06%	P		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target	Apr-19	May-19	Jun-19	YTD	Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	78.72%	89.21%		83.97%	P		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	99.0%	96.53%	95.56%	96.40%	96.16%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	0.8%	1.56%	1.84%	2.04%	1.81%	F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	16.30%	2.50%	1.71%	6.84%	P		
	#NOF 24	Responsive	Our Services	Mark Brassington	70%	75.00%	53.33%		64.17%	F		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	95%	94.74%	92.00%		93.37%	F		
	EMAS Conveyances to ULHT	Responsive	Our Services	Mark Brassington	4626	4920	4991	4823	4911	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	231	635	494	494	541	F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	11	15	20	46	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	2.80	2.49	2.34	2.54	P		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.44	4.39	4.40	4.41	P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	2.32%	2.68%		2.50%	P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	7540	8644	8565	8250	F		
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Mark Brassington	40.8%	34.5%	38.6%	34.6%	35.90%	F		
	% discharged within 24hrs of PDD	Effective	Our Services	Mark Brassington		54.5%	55.6%	57.3%	55.80%			

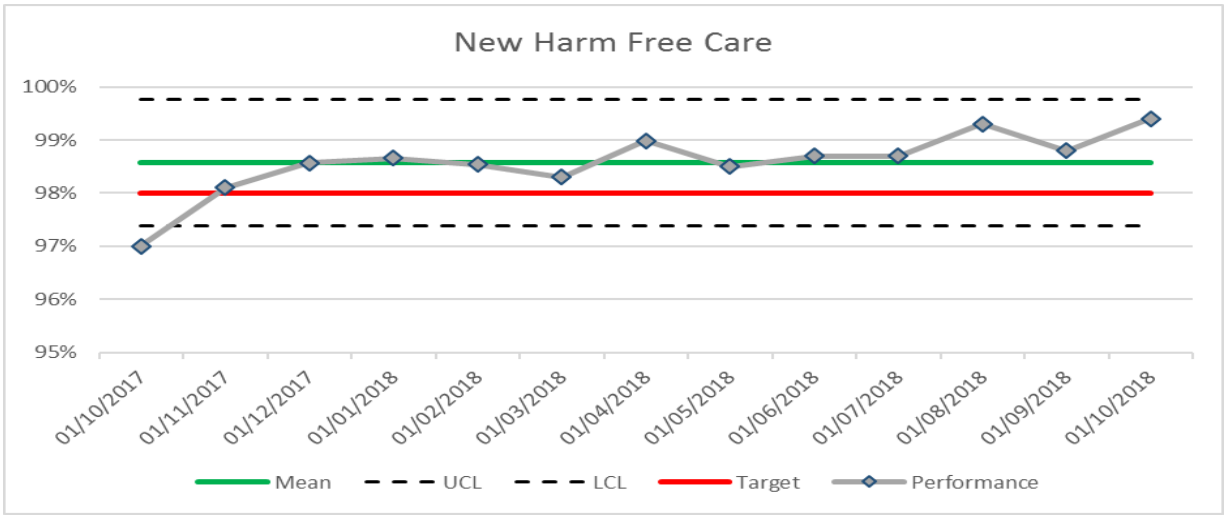
STATISTICAL PROCESS CONTROL CHARTS

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:



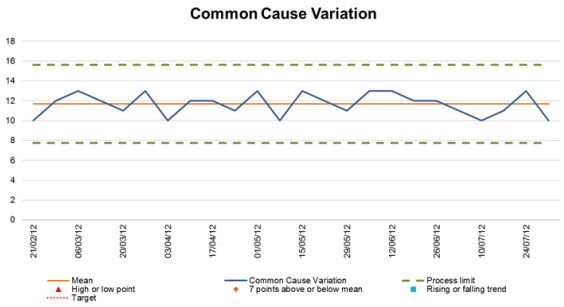
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

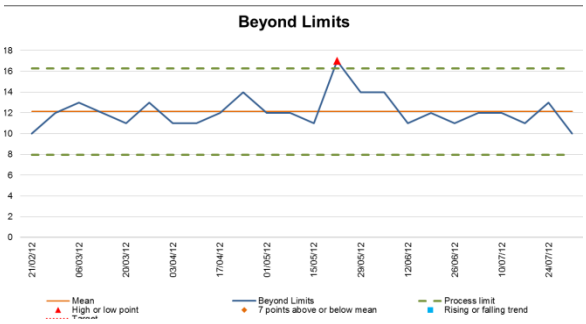
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

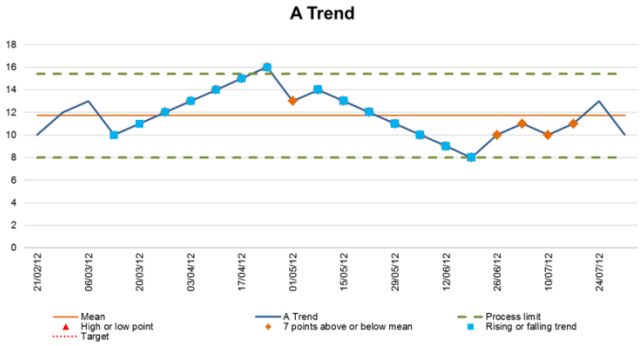


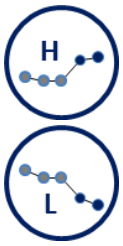
Extreme Values



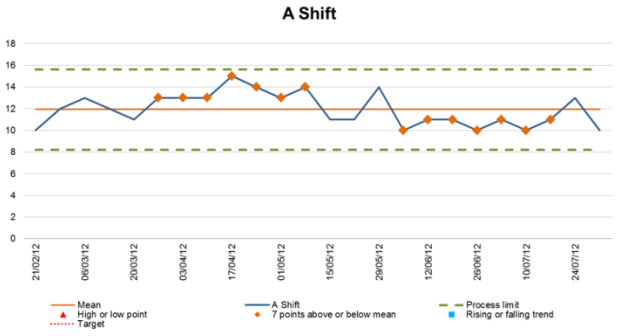
There is no Icon for this scenario.

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

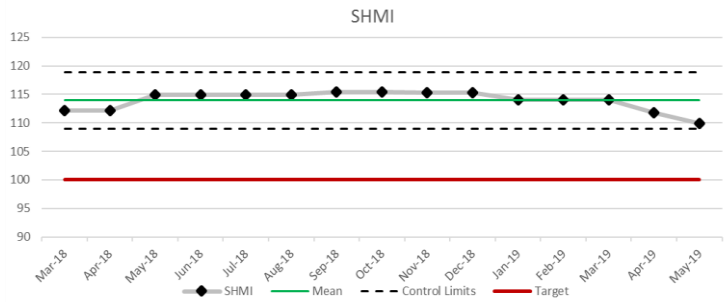
Executive Lead: Neill Hepburn

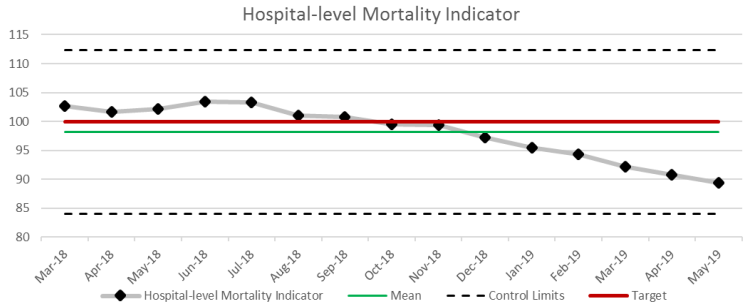
CQC Domain: Safe

2021 Objective: Our Patients

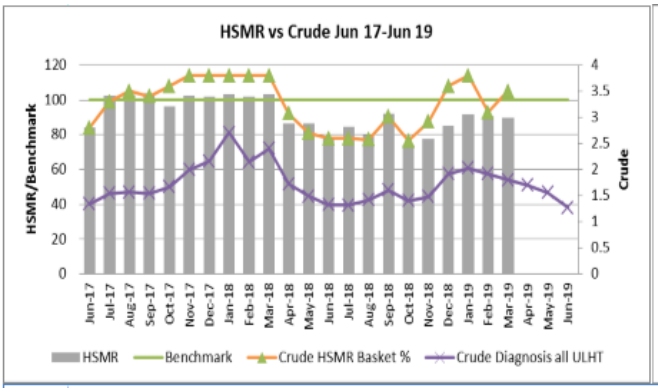
SHMI

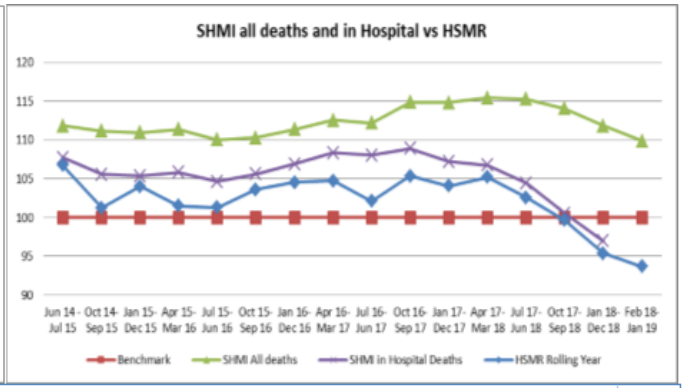
HSMR





Trust/ Site	ULHT HSMR Apr 18-Mar 19 12 month	ULHT HSMR Apr 18-Mar 19 FYTD	ULHT HSMR Mar 19	ULHT SHMI Feb 18-Jan 19	Trust Crude Mortality Internal source Jul 18-Jun 19
Trust	89.43	89.43	89.75	109.92	1.62%
LCH	100.57	100.57	103.87	111.50	1.71%
PHB	85.67	85.67	86.60	116.36	1.78%
GDH	50.20	50.20	32.40	77.89	0.66%





Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 89.43 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits. HSMR has now been reported by divisions, where HSMR is high but not alerting is due to small numbers and high confidence intervals. Attached is a timeline of mortality reduction actions taken over time that depicts against the HSMR.

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is a Quality and Safety Improvement Programme (QSIP) to address the improvements required. 'Other Perinatal Conditions' a paper has been produced and was presented at QSG and Trust Board in March 19. A meeting has been arranged with the Divisional Nurse to discuss the progress of the QSIP. Site alerts; COPD and Bronchiectasis is alerting for the Lincoln site for the third month. An in depth review will be requested.

Summary-level Hospital Mortality Index-SHMI

ULHT are in Band 2 within expected limits with a score of 109.92, 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 January 2019.

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:

- Surgical Division is currently an outlier, driven by Critical Care. Surgical Mortality reviews have not raised any significant concerns in care. The Trust has a low depth of coding for elective spells. An in-depth review is currently underway.
- In-depth Dr Foster reviews ongoing for Acute MI and Lower Respiratory Disease due to previous alerts.
- Other Liver disease review has been completed, report and action plan produced. Report is on the July Patient Safety Group Agenda.
- Presentations have been produced for the Safety Improvement Board and Trust Management Group to be presented in July 19.
- Pneumonia stickers have been launched for Community Acquired Pneumonia (a copy can be found in the left hand panel of this report).
- 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 there homes. Neighbourhood team have work streams in; advanced care planning in care homes, Complex Case Managers, Short term overnight carer intervention, practice Care Coordinator and Triage Practitioner. The Collaborative have asked the CCG if KPI's are being developed for these. It has been confirmed that the Mortality Summit will be reinstated.
- 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.
- Clinical Coding class - meeting is to be held on the 12th July to discuss the workshop going forward based upon the survey monkey feedback.

Crude Mortality

The crude mortality has decreased in June 19 to 1.27%. In rolling year July 18-June 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 April 19 to allow for 4 week deadline completion of initial mortality review.

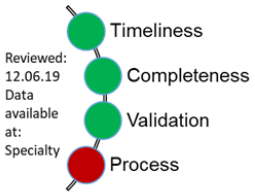
Measure	Description	Month Apr-19	YTD Apr-19	Narrative
Deaths in Scope	• Total Deaths in scope • Number inpatient deaths • Number of A&E Deaths	183 165 18	183 165 18	All deaths as reported, in Month and year to date.
ME Screening	• ME Deaths Screened • % of referrals to Specialty	83 12%	83 12%	Medical 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 Speciality. 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	72%/131 70 53% 32%	72%/131 70 53% 32%	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)	28 40% 54%/70	28 40% 54%/70	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/%)	23/82% 5/18% 0/0% 0/0% 0/0%	23/82% 5/18% 0/0% 0/0% 0/0%	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	1 4% 0%	1 4% 0%	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%	0 0 0%	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	1 1 100%	1 1 100%	Severe Mental Health Codes,/Diagnosis as advised by NHSI they advise to include schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

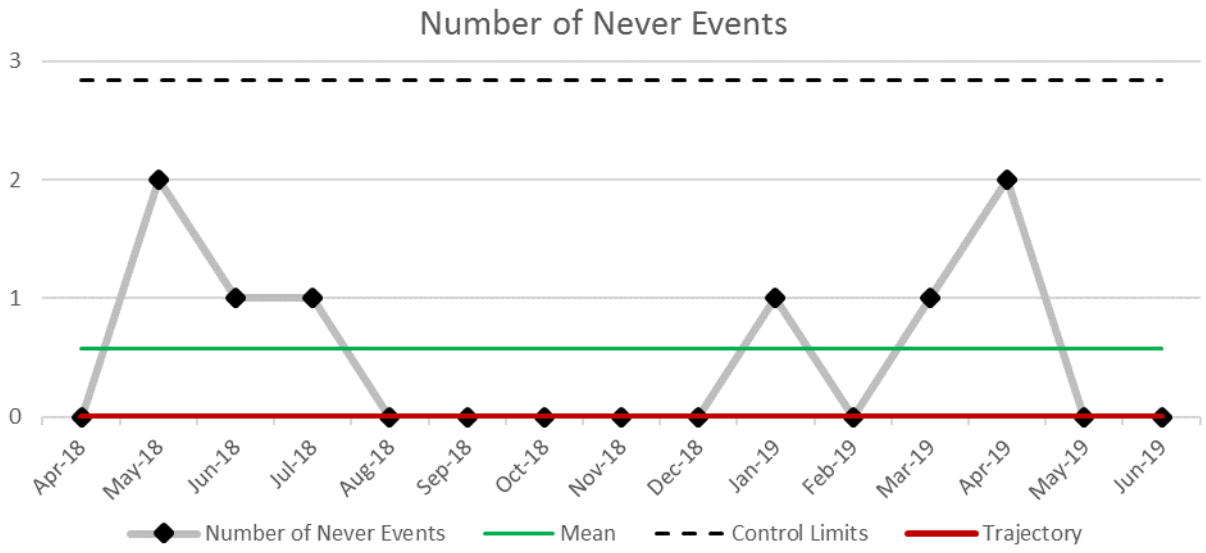
HARM FREE CARE – NEVER EVENTS

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 2019/20
- 0 Never Events were declared in June 2019
- A theme has been identified in relation to wrong site surgery incidents occurring primarily outside of the theatre environment

Actions being taken to address any issues:

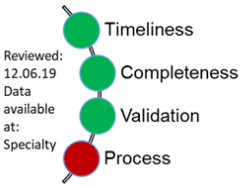
- Analysis is being undertaken of all wrong site surgery incidents reported in the last 2 years
- The application and monitoring of compliance with local safety standards for invasive procedures (LocSSIPs) is to be reviewed and strengthened
- A Never Event Summit with the CCGs is being set up for September 2019, to review learning and actions arising from recent incidents

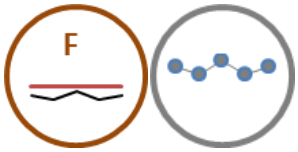
HARM FREE CARE – SERIOUS INCIDENTS

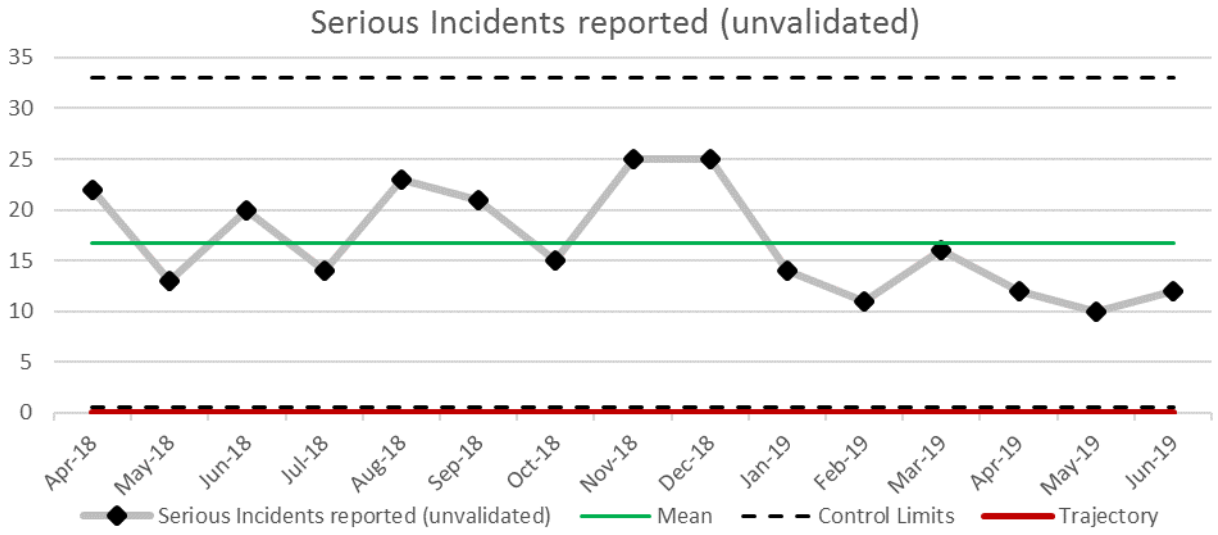
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes

- The Trust declared 12 patient Serious Incidents in June 2019
- This is 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 36% of the Serious Incidents declared by the Trust so far in 2019
- Patient accidents / falls have accounted for 23% of Serious Incidents in 2019; Pressure Ulcers 19% (compared with 40% in 2018)
- Accident & Emergency at Lincoln County Hospital have declared 15 Serious Incidents in 2019 so far (20% of the Trust total); no other location has declared more than 3

Actions in place to recover:

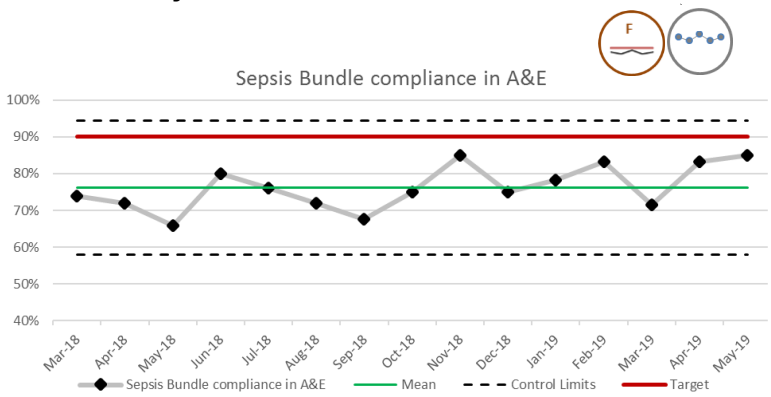
- The Patient Safety Group has commissioned a reviewed of incidents reported within A&E departments on all sites, to identify common themes and causes

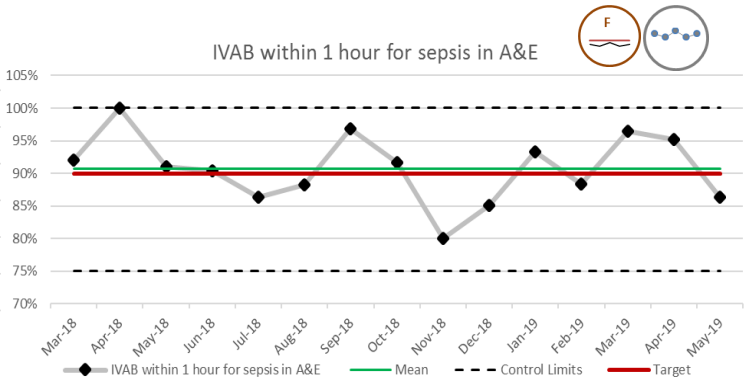
HARM FREE CARE - SEPSIS

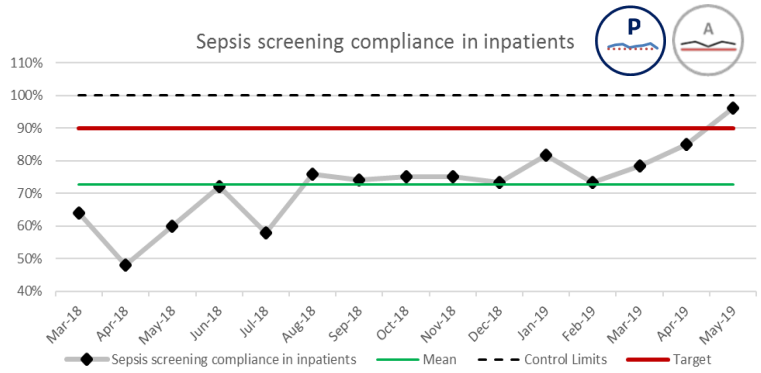
Executive Lead: Michelle Rhodes

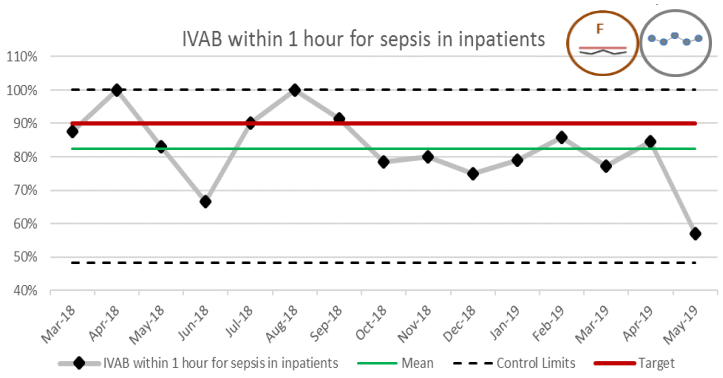
CQC Domain: Safe

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 consistently 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.

The focus for compliance screening has now switched to the ED departments where there was continued failure to reach the 90% standard. This has entailed daily reviews of missed screens with weekly reporting to include themes for missed screens and lessons learnt to feed into the departmental safety groups for dissemination.

Delivery of IV antibiotics within 60 minutes

The performance for this month for both A&E and inpatients showed a significant decline which is partly explained by the relatively small numbers used for analysis and would account for the percentages being labile in nature. From the beginning of July we have moved towards validating 100% of the data and this should stop the variances being so marked from month to month.

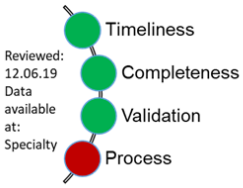
The policies for all aspects of sepsis are now out for agreement and it is hoped that this will strengthen the clinical pathways and support decision making particularly around paediatrics.

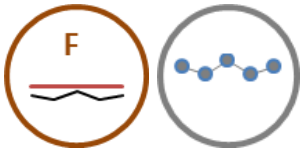
HARM FREE CARE – MEDICATION ERRORS

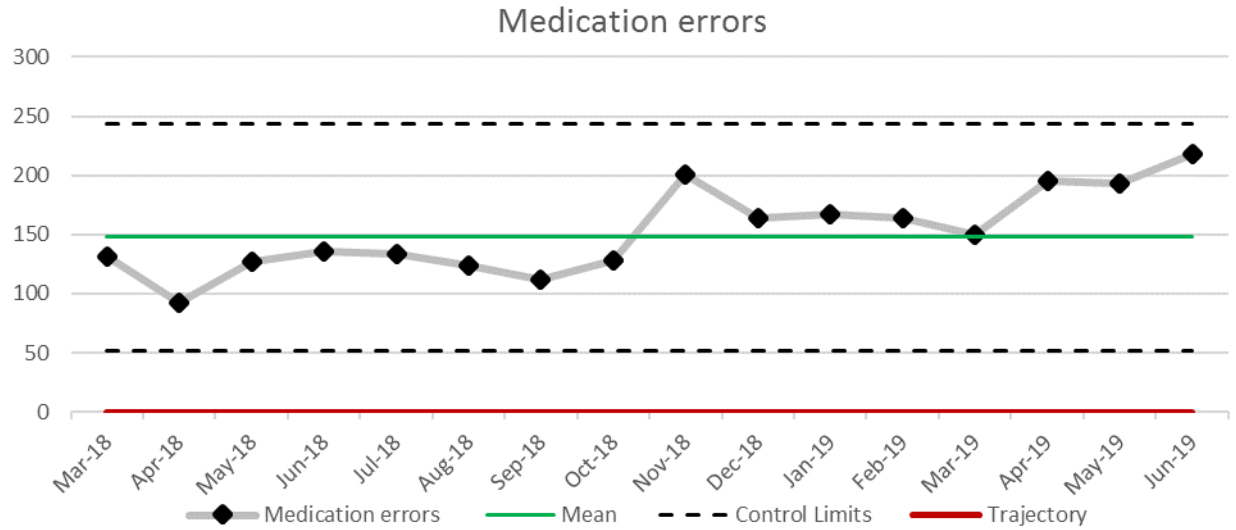
Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients







Challenges/Successes -

This data report is inclusive of all medication related incidents that were reported from 1st June 2019 to 30th June 2019. In June there were 218 medication related incidents reported via Datix.

For June the medication incident reporting rate for the Trust per 1000 bed days was 7.32. 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 218 medication incidents reported, 7.3% (calculated as medication incidents reported as causing harm or death/all medication errors x 100 – (16/218x100) 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.

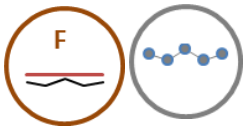
- Work is currently in progress with Rowlands Pharmacy to address the prescribing issues in the outpatient department. Individual prescribers are now being identified and are being informed directly about the error made.

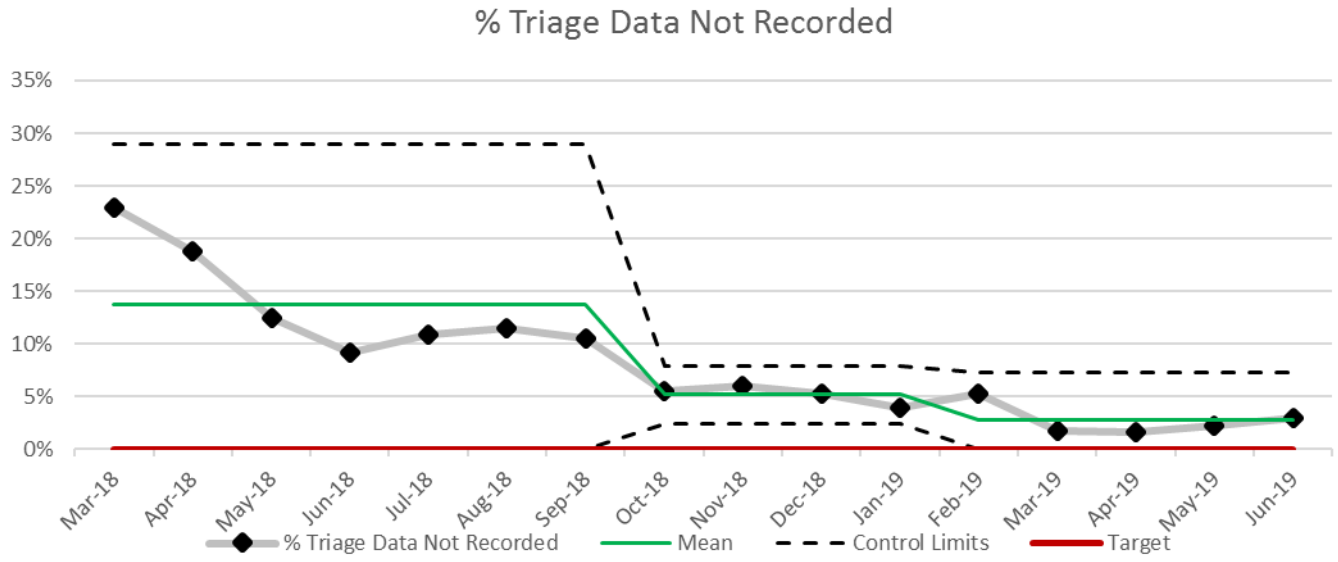
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Mark Brassington

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

More than 97% data accuracy has been sustained in June although there is a small deterioration month on month for 3 periods. Achievement against this metric is dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.

Actions in place to recover:

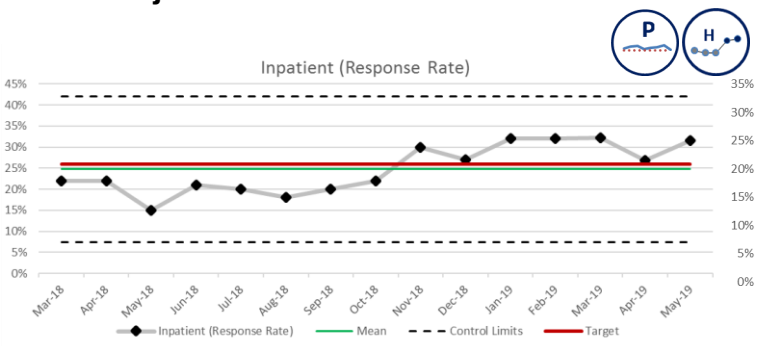
As part of the UEC Improvement Programme, analysis of individual performance and productivity is taking place over the next month to highlight individual compliance which will be addressed with staff members on an individual basis. Triage time continues to be monitored as a key performance metric within the UEC programme and on a daily basis operationally.

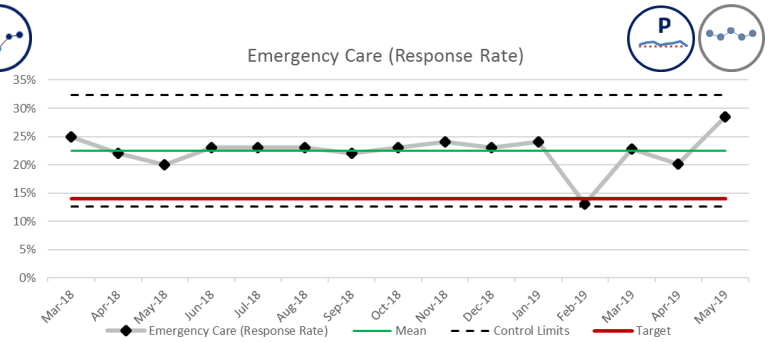
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

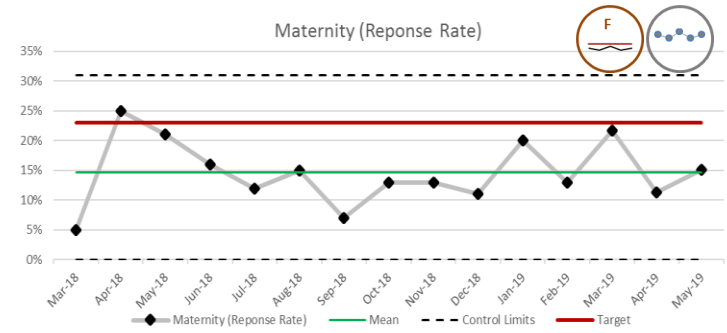
Executive Lead: Martin Rayson

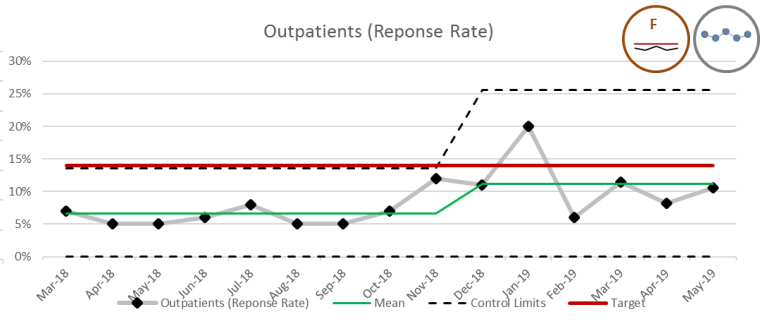
CQC Domain: Caring

2021 Objective: Our Patients









Actions in place to recover:

- Currently 63 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	21
MEDICINE	20
FAMILY HEALTH	11
SURGERY	10
CORPORATE	1

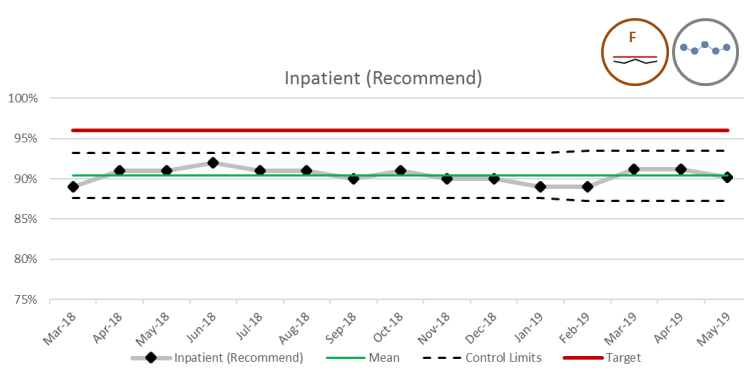
- The Patient and carer experience plan 2019 -2021is being written and will be presented for approval to the Patient Experience Group in July 2019

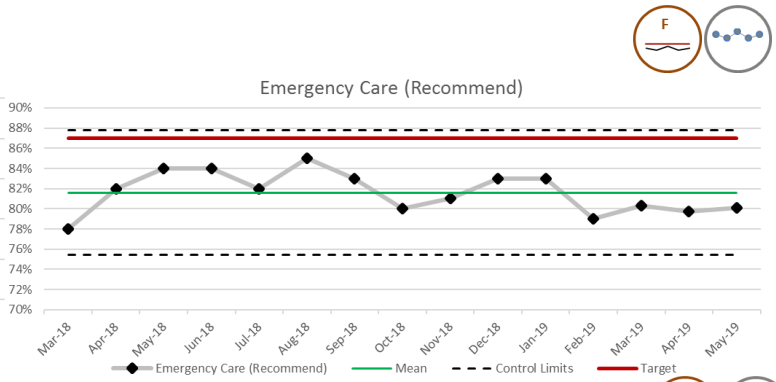
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

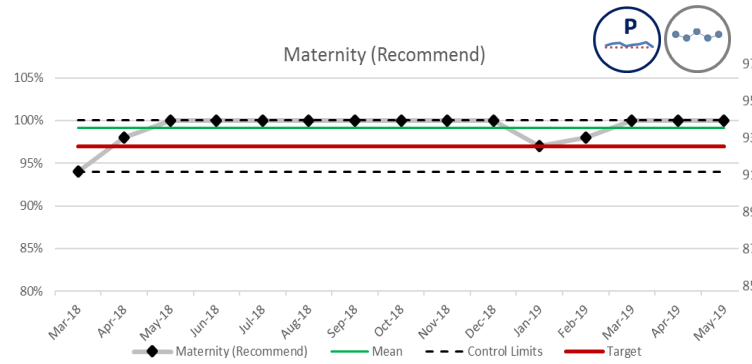
Executive Lead: Martin Rayson

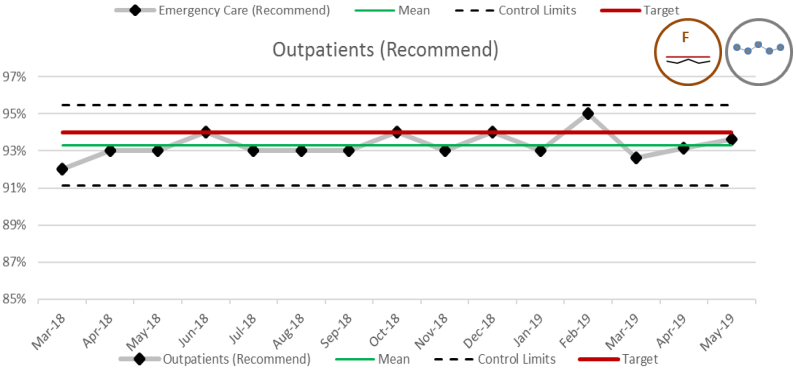
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Emergency care, inpatients and outpatients percentage FFT recommends stayed fairly consistent between April and May. 91% of patients would recommend which was a 1% improved from April. This was based on 9,626 ratings and 7,565 comments with 78% of comments received being positive, 5% neutral and 17% negative. Top 3 positive themes from FFT comments were Staff, Staff attitude and implementation of care.

Actions in place to recover:

- Currently 63 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	21
MEDICINE	20
FAMILY HEALTH	11
SURGERY	10
CORPORATE	1

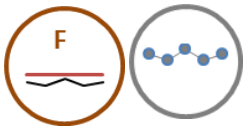
- The Patient and carer experience plan 2019 -2021is being written and will be presented for approval to the Patient Experience Group in July 2019

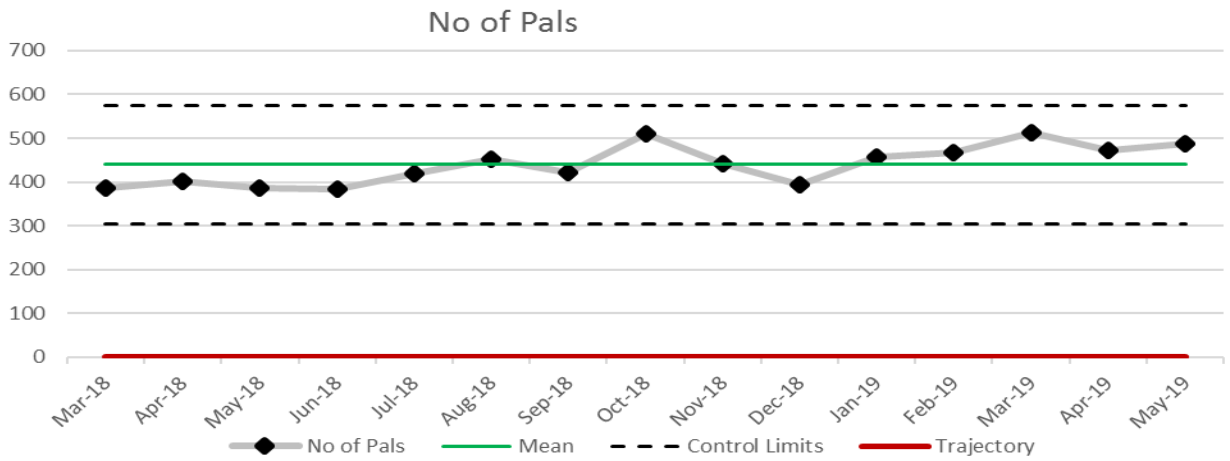
VALUING PATIENTS TIME – PALS

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients





Challenges/Successes

- The top 3 themes for PALS for May were: Communication with Patients, Appointment Cancellations and Car Parking
- 530 concerns were taken to PALS during May which was a 12% increase compared to April. 249 for Lincoln and Louth, 49 for Grantham, 209 for Pilgrim and the remainder for community hospitals. 5 PALS concerns were escalated to formal complaints
- We reached our 80,000th counting compliment within May.
- The divisional split for PALS concerns received were:
  - Clinical Support Services 124
  - Medicine 107
  - Surgery 89
  - Estates & Facilities 45
  - Family health 22
  - Corporate 7

- Counting Compliments against complaints ratio – 36:1

Actions in place to recover:

- Currently 63 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	21
MEDICINE	20
FAMILY HEALTH	11
SURGERY	10
CORPORATE	1

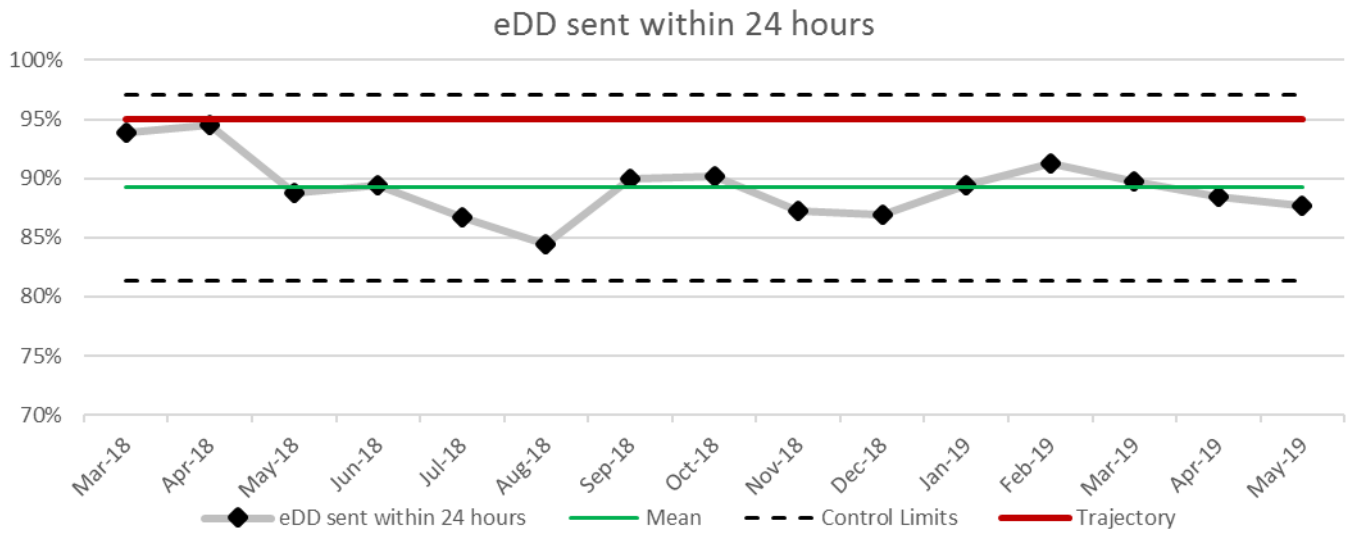
- The Patient and carer experience plan 2019 -2021is being written and will be presented for approval to the Patient Experience Group in July 2019

VALUING PATIENTS TIME – ELECTRONIC DISCHARGE DOCUMENTS

Executive Lead: Neil Hepburn

CQC Domain: Caring

2021 Objective: Our Patients



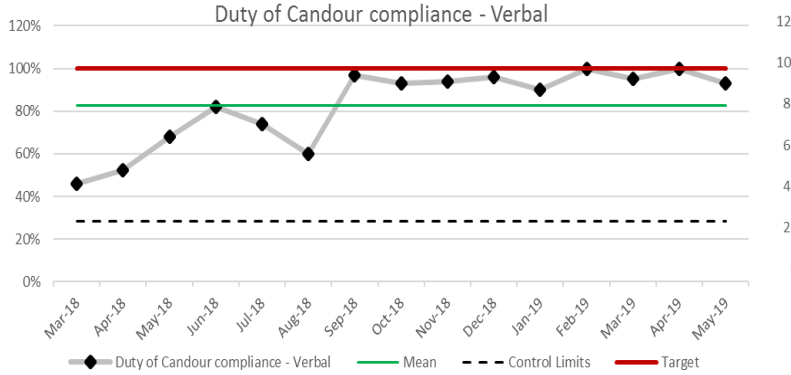
The bespoke eDD dashboard was launched which enables clinicians to review their compliance and allow then to drill down to individual patients. Focus remains on clearing the backlog. The Bereavement Centre will ensure all deceased eDDs are completed. A video is being developed to highlight the importance of a quality and timely eDD.

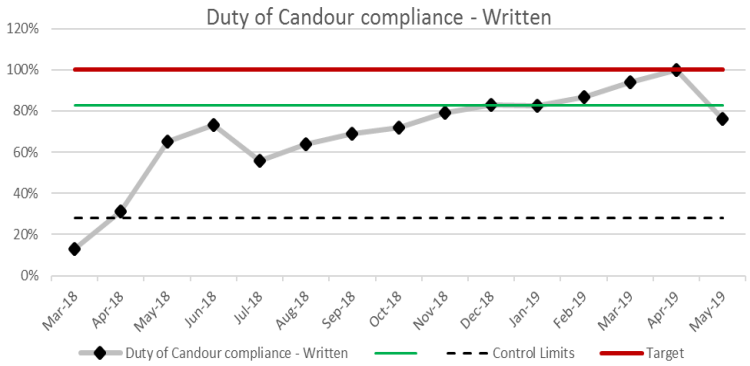
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





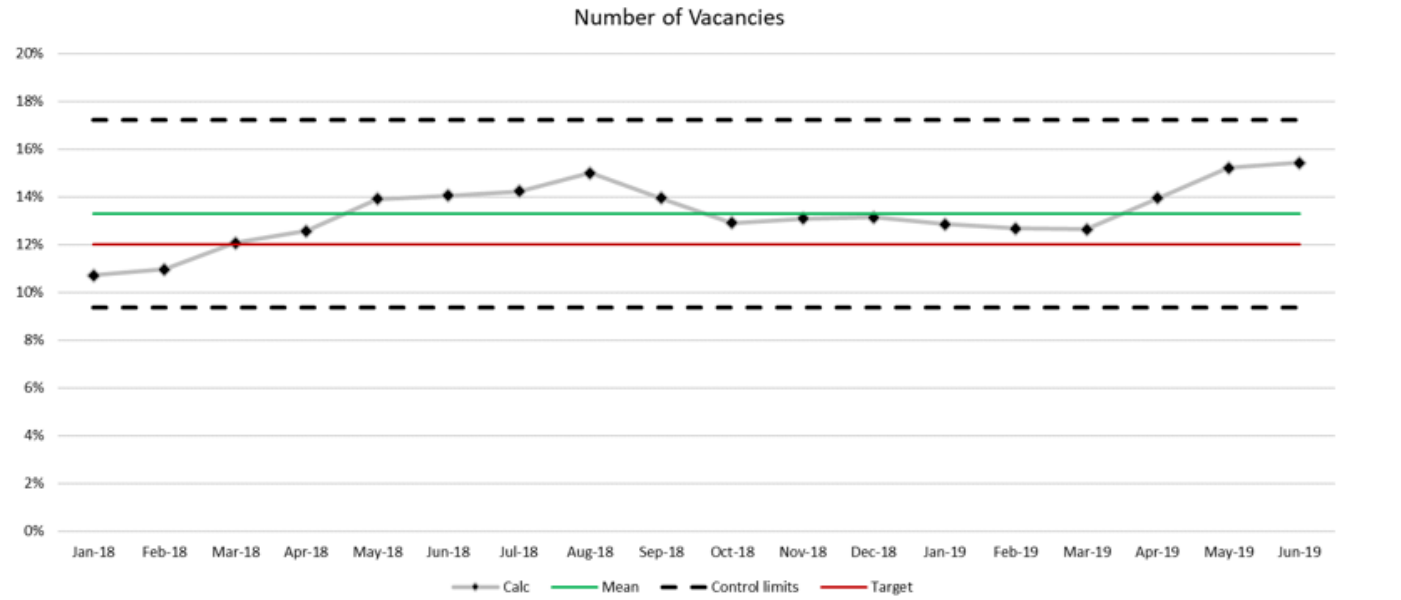
- Duty of Candour (in person notification) compliance in May 2019 was 93%
- This was the 9th month in a row with a compliance level of 90% or more
- Written follow-up compliance in May 2019 was 76%
- This indicates that whilst the processes for providing notification and apology in person are now well established, the practice of providing follow-up letters in a timely manner remains inconsistent
- Additional guidance is being added to the Datix system to support managers in accurately recording Duty of Candour compliance; these changes will go live by the end of July

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People



Challenges/Successes

The overall Trust Vacancy Rate increased slightly from 15.2% in May to 15.4% in June.

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 processed 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 this will start to inform some of our recruitment activity.

Medical Vacancy Rate
The vacancy rate continues to improve, June is 20.5%.

Plan for every post being used and further developed as a tool to deliver recruitment strategy and agency reduction. Recent Family Health AAC panel made 3 offers

Medicine division have seen a number of new starts, specifically in Lincoln Elderly Care IP who have recruited 4.2 FTE reducing their vacancy percentage to 42%.

Further detail of Medical Vacancy Rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Lincoln Radiology Consultants	8.9	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	10.2	42%
	A&E Attenders Lincoln	13.2	35%
	A&E Attenders Pilgrim	11.0	31%
	Lincoln Cardiology IP	3.0	14%
Surgery	Lincoln ENT IP	5.7	53%
	Lincoln Ophthalmology IP	4.6	33%

Nursing Vacancy Rate
This has increased slightly by 0.3% .Staff in post at the end of Jun decreased by 6.4 FTE against a planned reduction of 10 fte. 30.0% of the nursing vacancies are in the Medicine division. Historical understatement of attrition has been corrected. Reduction in fte resulting from retire and return is better understood. International registered nurses working as HCSW supported through OSCE.

Further detail of Nurse Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Clinical Support Pan Trust Mgmt	5.0	83%
	Ward 7A Chemo Suite	5.6	35%
Medicine	A&E Pilgrim	28.96	52%
	Pilgrim AMSS	19.6	56%
	A&E Lincoln	18.3	28%
	Lincoln EAU	17.7	36%
	Pilgrim Stroke Unit	14.6	51%
	Ward 7B	10.2	44%
	Ward 6A	10.2	44%
Surgery	Lincoln Main Theatres	16.0	24%
	Ward 5B	10.8	46%
	Bevan Ward	8.9	61%
	Ward 9A	9.3	43%
Family Health	Ward 4A	14.3	43%
	Rainforest Ward	13.5	42%

AHPs Vacancy Rate increased from 14.8% in May to 16.0% in June. Detail of notable AHP Vacancy rates are provided in the following table.

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	11.4	36%
	Pilgrim Occupational Therapy	8.1	39%

Actions in place to recover

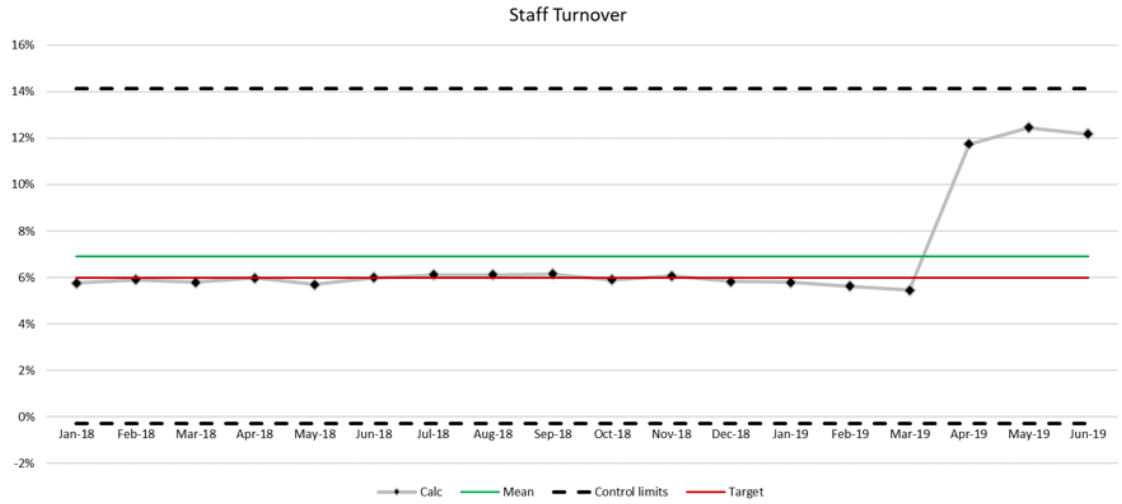
Medical and Dental – There have been 21 fte of new starts (Consultant and SAS) for the first quarter and 41 fte is forecast for the second quarter of 2019/20. Divisions are increasingly adopting the 'plan for ever post' approach to all vacant post and there is greater triangulation with associated agency costs. Two potential international strategic partners have been shortlisted with a final decision to be taken in July. Continued strong pipeline into Q3.

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Self-Rostering

We ran a self-rostering pilot (June '19) across 7 wards and 1 clinic. 3 of them have successfully completed the pilot. We now have a toolkit published on the intranet – a self-help document that wards can use to implement self-rostering on their own.

Retire and Return

We have created a process (April '19) to actively encourage, track and monitor staff who are potentially retiring to have conversations with their managers about retire and return. The intranet has been updated with lots of relevant information addressing questions that staff may have. We have run a communication campaign involving senior leaders encouraging staff to retire and return. As part of the campaign staff video case studies have also been published on the intranet.

Getting the data right

We have made changes to the exit interview process (Feb '19) and the questions to be answered as part of exit interviews. This will give us meaningful data that can lead of significant changes in the coming months.

Itchy Feet Conversations

Through the Itchy feet conversations initiative (April '19) we provide staff with an avenue to speak to senior leaders about issues that they face that in some instances almost force them to resign. This is yet another initiative to show staff that we care and that we are willing to invest in them and help them build a career with us.

Internal Movements

We have recently created an internal transfer policy for registered nurses. This will allow and encourage staff to explore internal opportunities before they consider external ones.

Pre-retirement workshop

The pre-retirement workshop is run once every two months across sites. It's a workshop that helps potential retirees plan their pensions. The OD team is re-designing the workshop to include other aspects such as information on support post retirement, retire and return options, volunteering opportunities at ULHT etc.

Legacy Nurse

Staff feedback showed that induction and engagement of Newly Qualified Nurses needed to be addressed. At the same time, we had experienced nurses, nearing retirement who had so much more to give to the Trust. This initiative will act as a link between the two staff groups – a buddy and mentor who can help the newly qualified nurse.

Actions in place to recover

Manager enablement / awareness

We are looking to roll out workshops to help managers with staff retention. The workshops will not only help enhance awareness about retention initiatives but also serve as a means of feedback for continuous improvement.

Communication and branding

As a way of bringing in all the initiatives under one umbrella of 'Engagement, Development and Retention' we are planning a big event in September. A promotional bus will be driven around the different ULHT sites giving staff an opportunity to access information about initiatives as well as time with leaders. A cross functional team is working on the initiative and we hope that through this we can demonstrate to staff that the 'Trust cares' and that 'their voice does matter'.

Nursing offer

Aspects of the nursing offer about to be launched, notably the Director of Nursing fellowships.

Shared governance

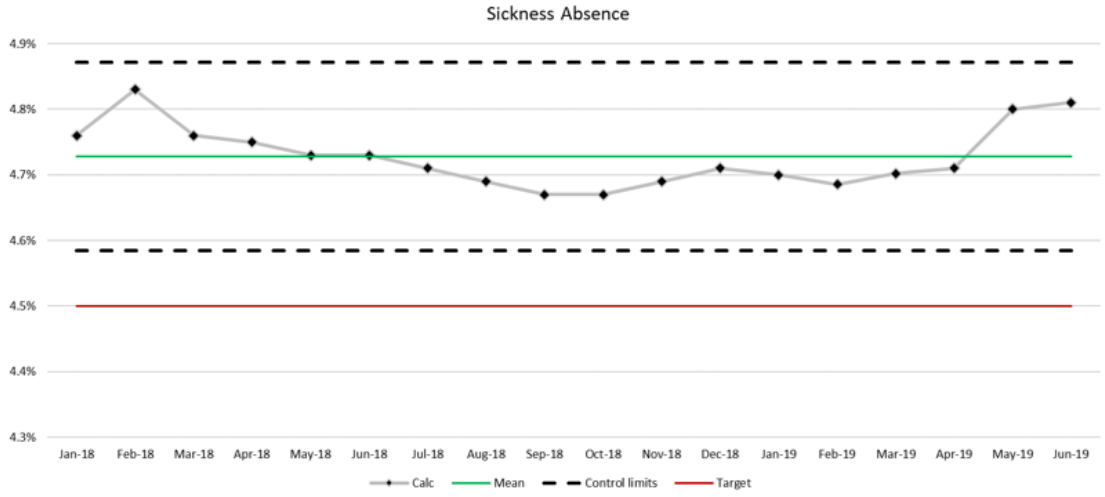
We are exploring the possibility of introducing shared governance as a tool to enhance engagement around improvement. This has been shown to have a positive impact on turnover at a number of other Trusts.

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 4.8% 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 ER Advisors are working with the Divisions and SHRBP's to work on trajectories for future sickness 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

Absence Reason	FTE Days Lost	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	23,845.45	£2,129,115.55	22.6
S98 Other known causes -not elsewhere classified	17,283.65	£1,461,690.37	16.4
S12 Other musculoskeletal problems	11,384.42	£980,160.97	10.8
S25 Gastrointestinal problems	8,773.12	£743,073.45	8.3
S11 Back Problems	7,531.87	£580,404.18	7.1

Actions in place to recover

The monthly 'Case Reviews' with input from Occupational Health reports are being created to highlight the longest sickness periods, the blockers and the most frequent number episodic absences, this will help to monitor performance of absence management within Divisions.

There are currently 6 cases that are looking at redeployment opportunities and he 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.

Targeted action plans are in place for Pilgrim theatres who have a high level of absence currently, which coincides with some further work that is being taken to tackle culture and behaviours.

Two departmental training sessions have been arranged to train and support the deputy sisters (ICU Lincoln and Theatres Grantham

The ER advisors are working on redeploying Long term sick staff to other areas prior to potential capability hearing

There has been a large reduction in long term sickness within CSS

2 project Managers have been assigned to manage the introduction and implementation of the new absence management system (Empactus), which will support managers to take the leading role in managing absence, supported by HR. this will assist the Trust to ensure a managed approach to the system across the Trust.

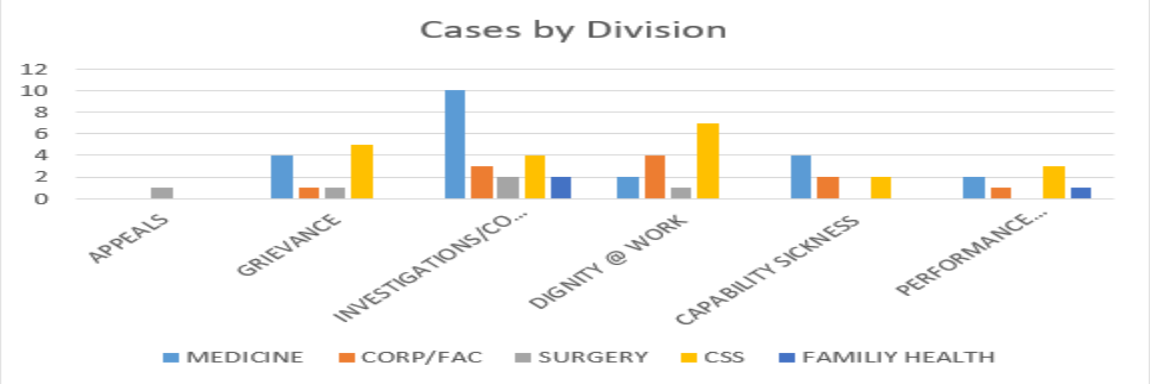
ER Team continues to work with Divisions on the percentage of return to work interviews and report into Divisions to highlight non- compliance.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

There are 62 open cases for June compared with 66 cases for May this is a 6% decrease. The majority of cases remain in the Medicine Division with 22 cases (which remains the same as last month with no movement) . Dignity @ Work has increased by 5 cases from last month, with a reduction in conduct cases by 8, this is due to a review of the cases that has recorded them differently.

Performance capability cases have remained the same again is lower than what would be expected for a challenging Trust with Circa 7,800 staff.
There are currently 7 cases proceeding to hearings.
We have no new cases this month, we are attempting to bring to closure one case prior to going to a hearing.
Two of the Employment tribunals have been in 'stay' for over a year.

We currently have the same 3 suspensions (none are medical staffing). HR strongly advise against suspensions and look at redeployment options in suspension cases and this has supported the numbers to remain the same.

There are currently 22 active cases logged through the Medial LDMG this remains the same as last month, 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 with the Head of HR Ops.

Actions in place to recover

The ER Managers have weekly case conferences with the ER Advisors to ensure and update cases and identify any problems with cases being completed.

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

There is currently assistance with training in Facilities for sessions on Trust Values and behaviours

A new divisional performance report on ER activities documents the number of cases being dealt with by each Division.

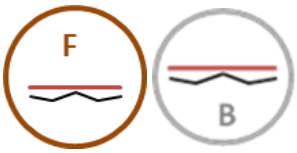
The ER team work with the HRBP's to feed into the Performance review meetings

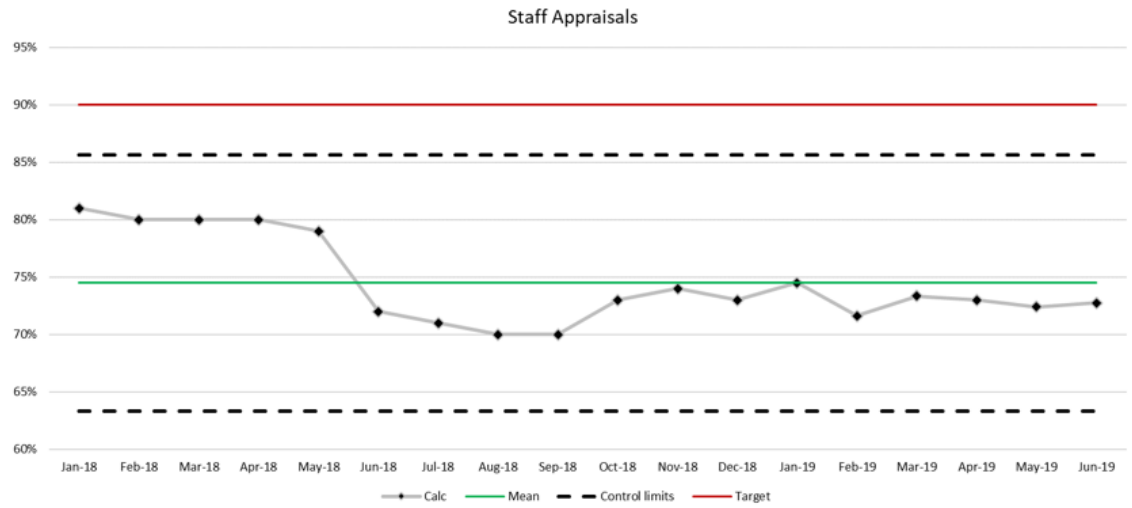
MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People





Challenges/Successes

Overall Trust performance continues to be well below the current target.

Performance is as follows:

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 TMG in July to agree the new approach and including the feedback from the appraisal quality survey that was launched in April 2019.

This will then be launched and promoted widely to all staff

SHRBPs are well acquainted with the position and working with their senior Divisional triumvirates to address the issues

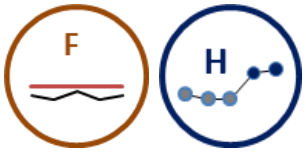
Some concerns have been raised about reporting which will be taken forward with the Workforce Intelligence team

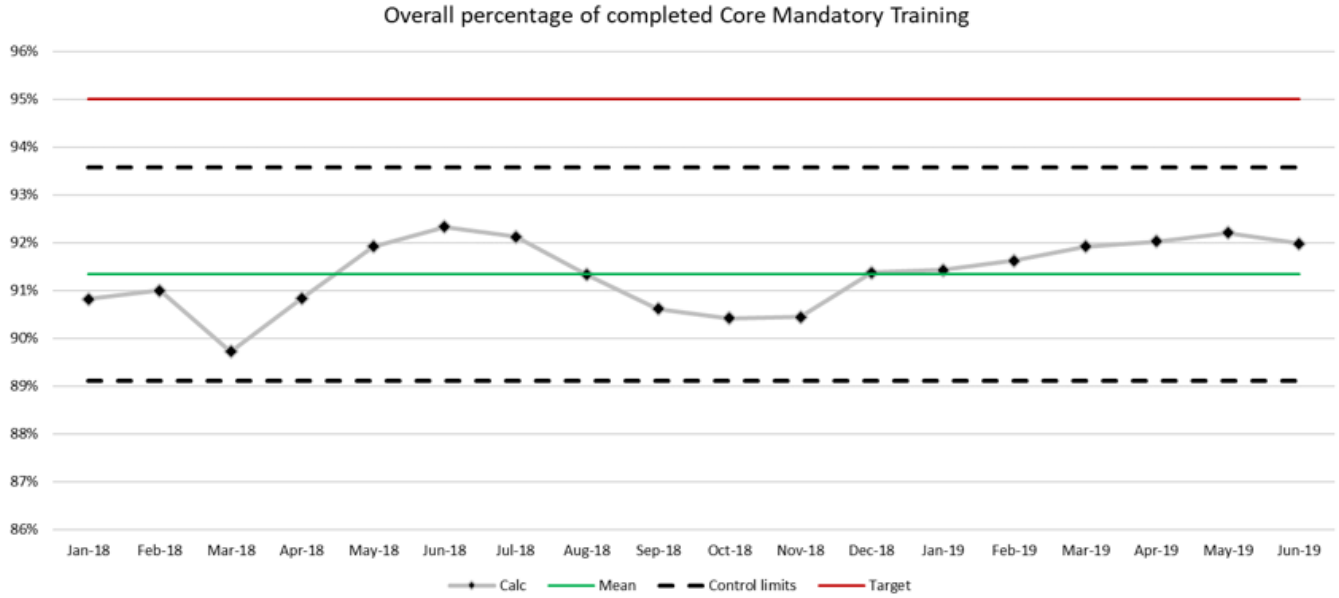
MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People





Challenges/Successes

After a gradual month on month increase, compliance as fallen slightly this month by 0.22% to 91.98%. This is now 0.34% below the highest percentage the Trust has achieved which was in the same period last year.

Looking at the individual topics, all have taken a fall apart from Local Fire Procedures and Fraud Awareness. It is concerning that the largest drop in compliance is once again Information Governance/Data Security with -1.17% after a -0.97% fall highlighted last month. This takes compliance down to 84.87% far below the Trust target of 95% set by the NHS Digital Data Security Toolkit. The table shows compliance for this by Division in ranking

Division	Information Governance - 1 Year
Family Health	89.60%
Clinical Support Services	89.35%
Corporate	88.71%
Surgery	85.77%
Medicine	80.20%
Director of Estates & Facil	75.19%

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.

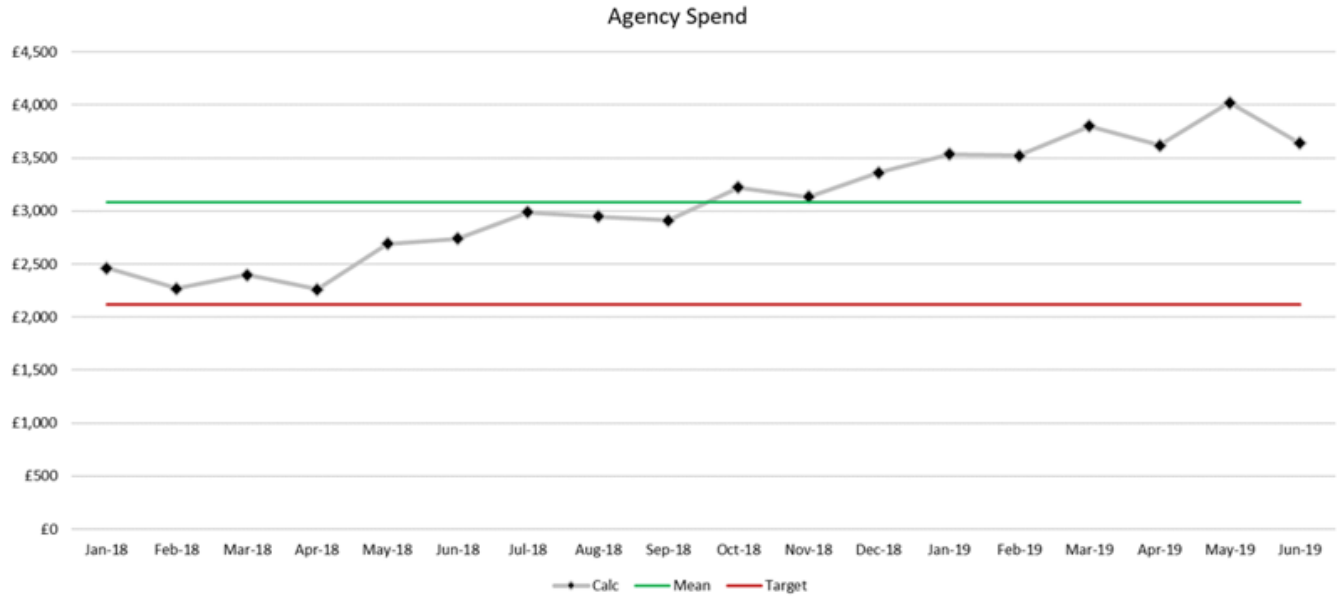
Core Learning Panel to consider use of external e-learning which is generally more problematic than in-house designed programs.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People

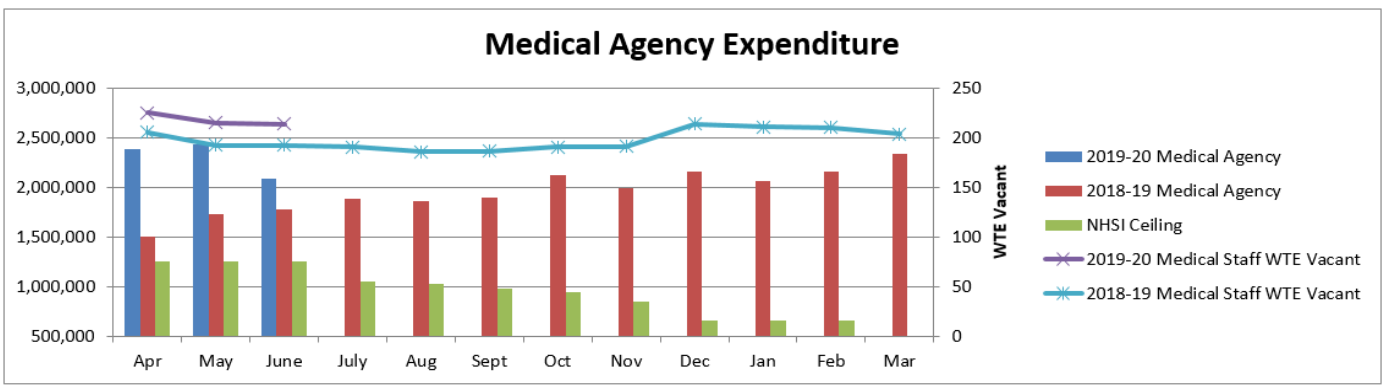


In June, Year to Date (YTD) planned pay costs improved slightly to 1.1% adverse [inclusive of £890K accrual release in May with an underlying position of 2% adverse to plan] and 73.5% of income, which is 1.4% higher than plan.

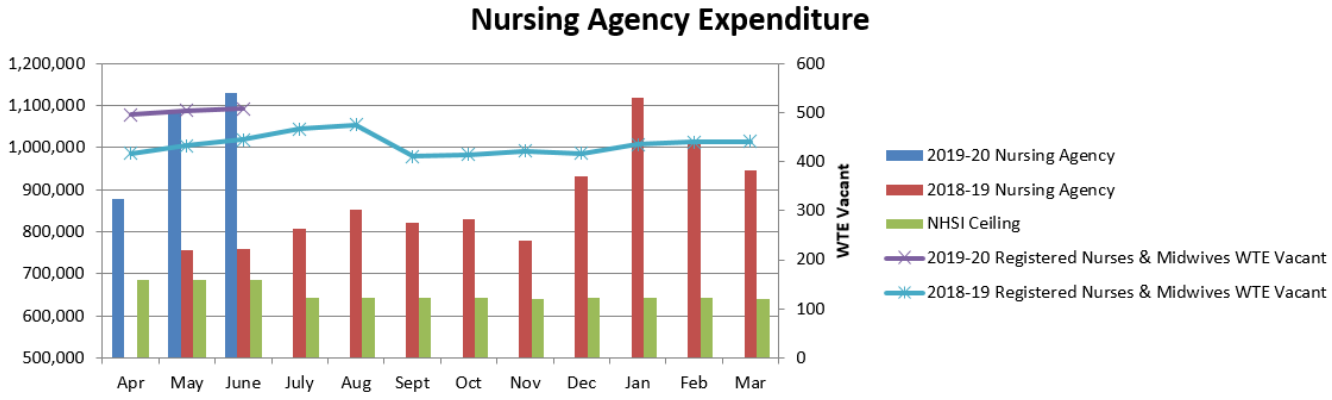
The adverse variance to plan remains driven by the higher premium cost of agency staffing and some under delivery of workforce FEP.

The monthly run rate for Agency spend decreased Month 2 to Month 3 but continues to exceed that planned.

First full month with Temporary Medical Staffing central team in post. Central approval of timesheets now in place. New medical temporary staffing SOP being rolled out and will be fully implemented by July 2019 with targeted action including removal of paid breaks for temporary medical staff, increased challenge on additional hours, introduction of revised non–residential on-call, study leave cover eliminated as far as possible and improved early divisional MI to support earlier intervention.



Medical agency costs reduced significantly in June with a marginal improvement in vacancy rate, £ per vacant fte reduced from £11,303 to £9,733 with both reduced volume per vacant fte and price per hour contributing to the improvement.



The agency costs of Nursing increased again in June with £ per vacant fte up from £1773 in April to £2223 in June19. Further analysis below (Lincoln and Pilgrim) shows that fill rates are broadly stable but the downward movement in the percentage of shifts filled by substantive staff at Lincoln is greater than the increase in vacancy rate and the gap continues to be effectively filled by Agency with the introduction of a new tier 3.5 to reduce tier 6 use.

	1	2	3	4	5	6
Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Contracted staff Percentage	76%	71%	71%	73%	72%	69%
Total temp percentage	20%	24%	23%	22%	22%	25%
Bank percentage	11%	13%	14%	12%	11%	12%
Agency percentage	9%	11%	9%	10%	11%	14%
Total bank requests	540	657	665	606	640	711
Percentage bank fill	80%	76%	73%	76%	73%	75%
Total percentage staffing against required	96%	95%	94%	95%	94%	94%
Total percentage staffing without agency	87%	84%	85%	85%	83%	81%
Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Contracted staff Percentage	58%	57%	59%	59%	58%	58%
Total temp percentage	38%	37%	38%	36%	38%	38%
Bank percentage	11%	11%	12%	12%	11%	10%
Agency percentage	27%	27%	26%	24%	27%	28%
Total bank requests	679	704	664	667	686	685
Percentage bank fill	83%	81%	88%	83%	85%	87%
Total percentage staffing against required	96%	95%	97%	96%	96%	97%
Total percentage staffing without agency	69%	68%	71%	71%	69%	68%

Other Agency costs remained broadly stable from May to June.

Actions in place to recover

The primary action to reduce agency costs is to still to reduce vacancy rates through substantive recruitment. We will undertaking a deep dive into the reasons for the Nursing agency cost increase in order to identify the further actions that may be necessary to bring levels of spend under control.

Enhanced nursing bank rate pilot, focused on high cost agency areas – August 19
Targeted removal of Medical Umbrella companies by September 2019.

Full review of rostering practice for Nursing including payments of breaks and management of annual leave – September 2019
Longer term temporary nursing staffing plans to be developed to avoid higher premiums of shorter lead time requests.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Current Month			Year to Date			Forecast		
	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k
Income	40,391	39,838	(553)	122,505	121,581	(924)	501,616	501,616	0
Expenditure	(44,403)	(43,888)	515	(134,120)	(133,349)	771	(520,722)	(520,854)	(132)
EBITDA	(4,012)	(4,050)	(38)	(11,615)	(11,768)	(153)	(19,106)	(19,238)	(132)
Depn/Interest	(1,810)	(1,772)	38	(5,378)	(5,262)	116	(22,306)	(22,174)	132
Surplus/(Deficit)	(5,822)	(5,822)	0	(16,993)	(17,030)	(37)	(41,412)	(41,412)	0
Technical adjustments	1	19	18	3	58	55	14	14	0
Surplus/(Deficit)	(5,821)	(5,803)	18	(16,990)	(16,972)	18	(41,398)	(41,398)	0
EBITDA % Income	-9.9%	-10.2%	-0.2%	-9.5%	-9.7%	-0.2%	-3.8%	-3.8%	0.0%
FEPs	1,180	1,342	162	3,393	3,398	5	25,610	25,610	0

The Forecast position contained in the table above is delivery of plan, or a £41,398k forecast outturn deficit.

Overall YTD financial performance is £16,972k deficit, or £18k favourable to the planned £16,990k deficit.

EBITDA for the year to date is £11,768k deficit (-9.7% of Income).

Income from Patient Care is £773k adverse to plan, with income overall is £924k adverse to plan YTD; the YTD income position assumes £4,705k in relation to PSF, FRF & MRET.

Expenditure is £771k favourable to plan YTD, but this includes an adverse Pay movement to plan of £1,005k.

The adverse movement to plan of £1,005k on Pay expenditure comprises of £1,772k lower than planned against substantive staffing and £2,796k higher than planned expenditure on temporary staffing; the adverse movement in temporary staffing includes an adverse movement to plan of £2,023k re Agency staffing and £773k re Bank Staffing.

FEP delivery of £1,342k in June is £162k favourable to plan: FEP delivery of £3,398k YTD is £5k favourable to plan.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20	Actual M1	Actual M2	Actual M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	In Month Plan M3	In Month Actuals M3	In Month Variance M3	Full Year Plan Full Year	Full Year Forecast Full Year	Full Year Variance Full Year	Year to date Plan M3	Year to date Actuals M3	Year to date Variance M3
Income																					
NHS Clinical Income	31,497	32,935	31,772	33,557	32,408	32,001	33,294	31,646	31,404	32,481	30,469	32,925	31,582	31,772	191	385,686	385,689	3	96,062	96,204	141
Non NHS Clinical Income	291	273	68	283	282	282	282	281	282	282	284	491	282	68	(214)	3,384	3,381	(3)	846	632	(214)
Pass through income	4,101	4,068	3,793	4,241	4,224	4,224	4,241	4,224	4,215	4,232	4,215	4,232	4,215	3,793	(423)	50,710	50,710	(0)	12,663	11,962	(700)
Total Patient related income	**35,889**	**37,276**	**35,633**	**38,081**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**37,648**	**36,079**	**35,633**	**(446)**	**439,780**	**439,780**	**(0)**	**109,571**	**108,798**	**(773)**
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	1,569	1,569	0	28,928	28,928	0	4,705	4,705	0
Other Income	2,764	2,678	2,636	2,743	2,742	2,741	2,745	2,743	2,741	2,744	2,742	2,889	2,743	2,636	(107)	32,908	32,908	0	8,229	8,078	(151)
Total Other operating income	**4,332**	**4,246**	**4,205**	**4,732**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,145**	**4,312**	**4,205**	**(107)**	**61,836**	**61,836**	**0**	**12,934**	**12,783**	**(151)**
Total Income	**40,221**	**41,522**	**39,838**	**42,813**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**43,793**	**40,391**	**39,838**	**(553)**	**501,616**	**501,616**	**(0)**	**122,505**	**121,581**	**(924)**
Expenditure																					
Pay	(30,868)	(29,254)	(29,808)	(28,757)	(28,697)	(28,607)	(28,444)	(28,253)	(27,859)	(27,847)	(27,848)	(26,378)	(29,338)	(29,808)	(470)	(342,620)	(342,620)	0	(88,925)	(89,930)	(1,005)
Pass through non pay	(4,101)	(4,068)	(3,793)	(4,241)	(4,224)	(4,224)	(4,241)	(4,224)	(4,215)	(4,232)	(4,215)	(4,232)	(4,215)	(3,793)	423	(50,710)	(50,710)	0	(12,663)	(11,962)	700
Other Non pay	(10,278)	(10,892)	(10,287)	(10,496)	(10,509)	(10,510)	(10,496)	(10,507)	(10,519)	(10,603)	(10,614)	(12,513)	(10,850)	(10,287)	562	(127,392)	(127,524)	(132)	(32,532)	(31,457)	1,076
Total Expenditure	**(45,247)**	**(44,214)**	**(43,888)**	**(43,494)**	**(43,430)**	**(43,341)**	**(43,181)**	**(42,984)**	**(42,593)**	**(42,682)**	**(42,677)**	**(43,123)**	**(44,403)**	**(43,888)**	**515**	**(520,722)**	**(520,854)**	**(132)**	**(134,120)**	**(133,349)**	**771**
Finance & Depreciation costs	(1,728)	(1,762)	(1,772)	(1,846)	(1,856)	(1,849)	(1,882)	(1,867)	(1,908)	(1,912)	(1,867)	(1,925)	(1,810)	(1,772)	38	(22,306)	(22,174)	132	(5,378)	(5,262)	116
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)**	**(5,822)**	**(5,822)**	**0**	**(41,412)**	**(41,412)**	**(0)**	**(16,993)**	**(17,030)**	**(37)**
Impairments/Revaluations Adjustment	0	0	0	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	19	1	1	2	1	1	1	1	2	(54)	1	19	18	14	14	0	3	58	55
Adjusted Surplus/(Deficit)	**(6,735)**	**(4,434)**	**(5,803)**	**(2,526)**	**(3,640)**	**(3,950)**	**(1,668)**	**(3,124)**	**(3,027)**	**(1,602)**	**(3,580)**	**(1,309)**	**(5,821)**	**(5,803)**	**18**	**(41,398)**	**(41,398)**	**(0)**	**(16,990)**	**(16,972)**	**18**
Adjustments to derive underlying deficit																					
FSM Loan Interest	643	704	710	746	756	749	782	767	808	812	767	841				9,106	9,106	0			
External Support	558	558	558	75	75	75	0	0	0	0	0	0				1,900	1,900	0			
Prior Year Income & Challenges	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Profit on Disposals	0	0	0	0	0	0	(250)	0	0	0	0	0				(250)	(250)	0			
Accruals Adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Income timing adjustment	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0			
Underlying Surplus/(Deficit)	**(5,534)**	**(3,172)**	**(4,535)**	**(1,705)**	**(2,809)**	**(3,126)**	**(1,136)**	**(2,357)**	**(2,219)**	**(790)**	**(2,813)**	**(468)**				**(30,642)**	**(30,642)**	**(0)**			

The Trust's financial plan is a deficit of £41.4m, and as at the end of June the Trust position is a deficit of £16,972k or £18k favourable to plan.

The run rate in future months is based upon plan and the table above shows that the planned run-rate in future months is markedly better than in April to June: the planned run rate from July to March averages £2,714k per month compared to an average of £5,657 per month in April to June. The improvement in the planned run-rate in future months reflects both an increase in the planned level of PSF and FRF funding and an increase in the planned level of FEP savings. Receipt of PSF and FRF funding is dependant upon delivery of the financial plan.

The Pay position in April includes payment of a planned one off cost of £920k in relation to the Agenda for Change pay award, while the May Pay position includes the benefit of the release of £912k of Pay accruals.

To achieve the planned deficit, the Trust requires to deliver Financial Efficiency savings of £25.6m; savings of £3,398k have been delivered YTD against planned savings of £3,393k i.e. FEP delivery is £5k favourable to plan.

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 3

	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		
	Jun Activity Actual	Jun Activity Plan	Jun Activity Actual	Jun Activity Variance	Jun £k Actual	Jun £k Plan	Jun £k Actual	Jun £k Variance	Jun Activity Actual	Jun Activity Plan	Jun Activity Actual	Jun Activity Variance	Jun £k Actual	Jun £k Plan	Jun £k Actual	Jun £k Variance
Activity:																
Accident & Emergency	12,696	11,801	12,019	218	1,830	2,006	2,054	48	37,890	35,798	36,748	950	5,454	6,084	6,260	176
Daycases	5,474	5,119	5,031	(88)	2,777	2,729	2,776	47	16,408	15,866	16,179	313	8,394	8,457	8,745	288
Elective Spells	860	735	726	(9)	2,019	2,029	2,034	5	2,380	2,278	2,214	(64)	5,868	6,285	6,276	(9)
Non Elective Spells	5,760	5,979	5,938	(41)	10,197	11,186	11,722	536	17,457	17,973	18,448	475	30,904	33,550	37,835	4,285
Elective Excess Bed Days	90	117	43	(74)	22	32	12	(19)	353	351	220	(131)	87	95	59	(37)
Non Elective Excess Bed Days	1,435	1,645	1,536	(109)	348	431	247	(184)	4,759	4,934	3,792	(1,142)	1,138	1,293	858	(435)
Outpatient Firsts	24,645	23,384	22,789	(594)	3,258	3,351	3,225	(126)	73,646	72,460	71,710	(751)	9,746	10,383	10,183	(199)
Outpatient Follow Ups	32,142	30,327	30,042	(285)	2,710	2,813	2,734	(79)	97,135	94,009	93,821	(188)	8,227	8,720	8,573	(147)
Outpatient Non Face To Face	2,138	2,057	2,065	8	47	135	136	0	6,451	6,237	7,440	1,203	140	409	473	65
Outpatient Advice & Guidance	0	279	279	0	0	8	8	0	0	837	1,089	252	0	25	29	3
Critical Care	1,572	1,630	1,591	(39)	1,129	1,551	1,514	(37)	4,657	4,891	4,383	(508)	3,516	4,654	4,062	(593)
Maternity	1,000	1,028	979	(49)	883	895	893	(2)	3,045	3,083	2,842	(240)	2,622	2,685	2,616	(69)
Non PbR		78,177			3,930	3,082	3,046	(36)					11,335	9,259	9,370	111
Block	0	0	0	0	0	237	237	0	0	0	0	0	0	712	712	0
Shadow Monitoring - recognising the impact of contracted activity levels and the marginal rates of payment aligned to them	0	1,395	1,395	(0)	0	0	(758)	(758)	0	4,185	4,219	34	0	0	(3,163)	(3,163)
Repatriation						467	467	0						1,417	1,417	0
Backlog						48	48	0						150	150	0
Work in Progress:						0	571	571						0	(41)	(41)
Sub total without passthrough					**29,151**	**31,001**	**31,725**	**724**					**87,431**	**94,179**	**97,578**	**3,399**
CQUIN					597	355	360	5					1,792	1,081	1,128	47
Fines						0	(87)	(87)						0	(262)	(262)
Fines Reinvested						0	36	36						0	107	107
								0								0
Prior Year						0		0						0		0
								0								0
Maternity Prepayment						0		0						0		0
								0								0
Total (Non Passthrough)						**31,356**	**31,275**	**(81)**						**95,260**	**95,388**	**128**
Passthrough					3,969	4,215.2	3,792.5	- 422.6					12,135	12,662.6	11,962	(700)
Total (Inc Passthrough)						**35,571.7**	**35,067.6**	**- 504.0**						**107,922.2**	**107,350**	**(572)**

Patient Care Income is £128k favourable to plan (all figures exclude passthrough which is c£700k unfavourable to plan)

For the income from patient care activities related to the APA (i.e. the Lincolnshire CCGs), Income is £0.4 favourable to plan; (this being in essence the marginal rate adjustment for Non Elective over performance – further detail below).

It should be noted that the Trust are shadowing monitoring the Lincolnshire CCGs on a PbR basis alongside the Lincolnshire CCGs contract (including APA). The actual income levels reported at month 3 are £1.6m below the value that would have been received if the Trust was on PbR contract for the Lincolnshire CCGs. Albeit open to contract challenges and fines from Lincs CCGs.

The primary driver for the additional £1.6m that would have been accessed through a PbR contract for the Lincolnshire CCGs is Non-Elective activity in the Medicine Division. Non Electives are £3.5m reduction to the reported income position. Non Elective activity year to date is 3% up against plan in relation to activity and 13% in relation to income - Further details are being shared with the Medicine Division. Key specialties within NEL are General Medicine (70%), Geriatric Medicine (16%), Cardiology (7%) and Gastroenterology (5%).

The backlog and repatriation assumptions included above are a key risk to the Trust. The Trust has established and now combined the Backlog and Repatriation working groups into a core group.

Critical Care income is c£600k adverse against plan. Liaison with the Division has clarified that there has been no reduction in capacity and no change in bed numbers. There has been a decreasing number of admissions after elective surgery alongside the usual variation in admission for this time period of the financial year (May to July is often quieter across the network).

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	Actual 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	12,019	12,197	12,197	11,801	12,197	11,801	12,197	12,197	11,405	11,359	144,096	144,096	-
Daycases	5,307	5,841	5,031	5,880	5,373	5,373	5,880	5,373	5,119	5,627	5,119	5,313	65,238	65,238	-
Elective Spells	681	807	726	843	771	771	843	771	735	807	735	871	9,362	9,362	-
Non Elective Spells	6,045	6,465	5,938	6,153	6,137	5,952	6,110	5,867	6,012	5,995	5,587	5,559	71,820	71,820	-
Elective Excess Bed Days	67	110	43	117	117	117	117	117	117	117	117	248	1,406	1,406	-
Non Elective Excess Bed Days	1,002	1,254	1,536	1,645	1,645	1,645	1,645	1,645	1,645	1,645	1,645	2,787	19,736	19,736	-
Outpatient Firsts	24,311	24,610	22,789	26,848	24,538	24,538	26,848	24,538	23,384	25,693	23,384	26,444	297,924	297,924	-
Outpatient Follow Ups	31,382	32,397	30,042	34,870	31,841	31,841	34,870	31,841	30,327	33,356	30,327	33,544	386,638	386,638	-
Outpatient Non Face To Face	2,726	2,649	2,065	2,156	2,090	2,090	2,156	2,090	2,057	2,123	2,057	920	25,179	25,179	-
Outpatient Advice & Guidance	373	437	279	279	279	279	279	279	279	279	279	27	3,349	3,349	-

Activity	18/19 YTD Actual M3	19/20 YTD Plan M3	19/20 YTD Actual M3	YTD Var M3	% Var M3
Accident & Emergency	37,890	35,798	36,748	950	2.7%
Daycases	16,408	15,866	16,179	313	2.0%
Elective Spells	2,380	2,278	2,214	- 64	-2.8%
Non Elective Spells	17,457	17,973	18,448	475	2.6%
Elective Excess Bed Days	353	351	220	- 131	-37.4%
Non Elective Excess Bed Days	4,759	4,934	3,792	- 1,142	-23.1%
Outpatient Firsts	73,646	72,460	71,710	- 751	-1.0%
Outpatient Follow Ups	97,135	94,009	93,821	- 188	-0.2%
Outpatient Non Face To Face	6,451	6,237	7,440	1,203	19.3%
Outpatient Advice & Guidance	-	837	1,089	252	30.1%

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

Whilst A&E activity is lower for the first three 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 3% up against plan YTD in relation to activity and 13% 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

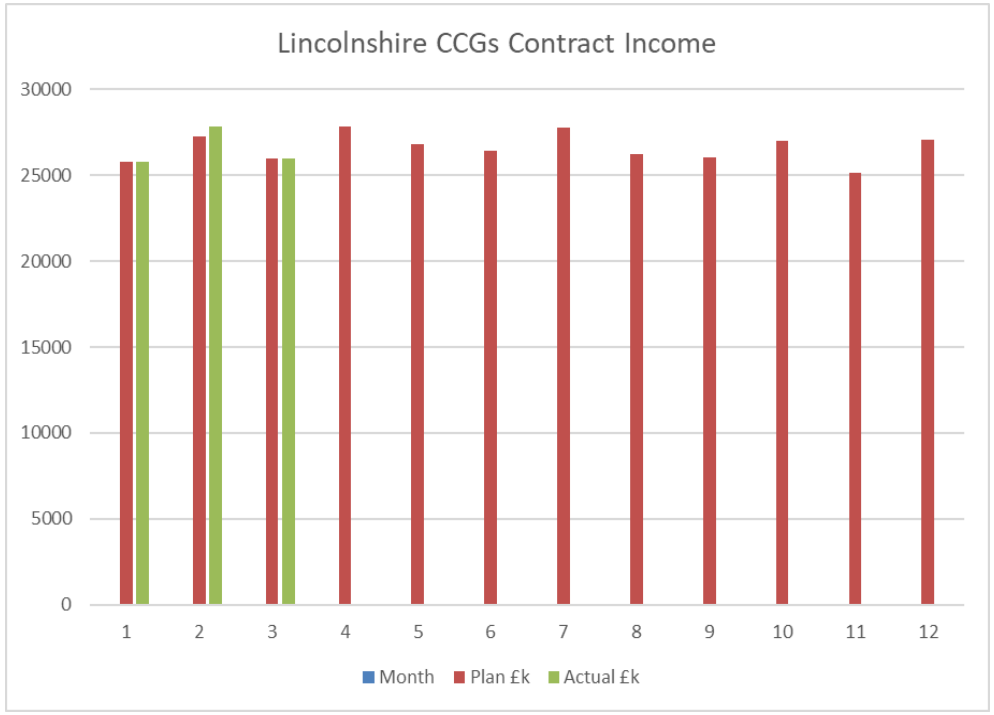
	Plan (£k)														
Income	Actual M1	Actual M2	Actual M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	Full Year Actual £	Full Year Plan	Variance
Accident & Emergency	2,039.2	2,167.2	2,053.6	2,072.9	2,072.9	2,005.6	2,072.9	2,005.6	2,072.9	2,072.9	1,938.3	1,905.4	24,479.6	24,479.6	0.0
Daycases	2,897.9	3,071.0	2,776.2	3,133.0	2,863.9	2,863.9	3,133.0	2,863.9	2,729.3	2,998.5	2,729.3	2,710.4	34,770.2	34,770.2	0.0
Elective Spells	1,963.1	2,278.5	2,034.2	2,326.1	2,128.1	2,128.1	2,326.1	2,128.1	2,029.0	2,227.1	2,029.0	2,236.3	25,833.7	25,833.7	0.0
Non Elective Spells	12,688.6	13,424.1	11,722.4	11,501.4	11,463.8	11,124.6	11,398.7	10,923.4	11,168.3	11,128.2	10,360.5	6,936.1	133,840.1	133,840.1	0.0
Elective Excess Bed Days	17.4	28.8	12.4	31.8	31.8	31.8	31.8	31.8	31.8	31.8	31.8	68.6	381.5	381.5	0.0
Non Elective Excess Bed Days	273.8	337.2	247.2	431.0	431.0	431.0	431.0	431.0	431.0	431.0	431.0	865.6	5,171.6	5,171.6	0.0
Outpatient Firsts	3,477.6	3,480.6	3,225.1	3,845.7	3,515.9	3,515.9	3,845.7	3,515.9	3,351.0	3,680.8	3,351.0	3,880.2	42,685.0	42,685.0	0.0
Outpatient Follow Ups	2,874.2	2,964.9	2,733.7	3,234.4	2,953.4	2,953.4	3,234.4	2,953.4	2,812.9	3,093.9	2,812.9	3,240.9	35,862.6	35,862.6	0.0
Outpatient Non Face To Face	172.1	165.7	135.6	139.5	136.6	136.6	139.5	136.6	135.2	138.1	135.2	73.2	1,644.0	1,644.0	0.0
Outpatient Advice & Guidance	9.5	10.8	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	5.2	102.0	102.0	0.0
Critical Care	1,380.6	1,166.6	1,514.4	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	1,551.5	2,144.2	18,617.6	18,617.6	0.0
Maternity	897.9	825.7	892.6	895.0	895.0	895.0	895.0	895.0	895.0	895.0	895.0	963.7	10,739.8	10,739.8	0.0
Non PbR	3,007.6	3,316.6	3,045.9	3,087.5	3,068.9	3,095.5	3,093.5	3,107.2	3,075.7	3,098.8	3,136.4	2,973.9	37,107.5	37,107.5	0.0
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	0.0
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	0.0
Backlog	47.8	54.1	47.8	54.1	54.1	47.8	54.1	47.8	54.1	54.1	41.5	54.1	611.1	611.1	0.0
Work in Progress	(219.6)	(391.6)	570.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.6	0.0	0.0	0.0
														0.0	0.0
Sub total without passthrough	32,232.4	33,620.4	31,724.8	33,032.5	31,895.4	31,493.7	32,935.8	31,304.2	31,066.2	32,130.2	30,140.8	28,818.4	380,394.7	380,394.7	0.0
															0.0
CQUIN	375.0	392.6	360.2	380.8	366.5	361.6	379.5	359.2	356.1	369.4	344.7	323.8	4,369.3	4,369.3	0.0
													0.0		0.0
Fines	(86.4)	(88.3)	(87.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	262.0	0.0	0.0	0.0
Fines Reinvested	35.2	36.4	35.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(107.4)	0.0	0.0	0.0
													0.0	0.0	0.0
Shadow Monitoring - recognising the impact of contracted activity levels and the marginal rates of payment aligned to them	(1,495.3)	(909.6)	(758.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3,163.2	0.0	0.0	0.0
													0.0	0.0	0.0
Total (Non Passthrough)	**31,060.9**	**33,051.6**	**31,275.1**	**33,413.3**	**32,262.0**	**31,855.3**	**33,315.3**	**31,663.4**	**31,422.3**	**32,499.6**	**30,485.5**	**32,459.9**	**384,764.1**	**384,764.1**	**0.0**
															0.0
Passthrough	4,101.2	4,068.4	3,792.5	4,240.9	4,223.7	4,223.7	4,240.9	4,223.7	4,215.2	4,232.3	4,215.2	4,932.8	50,710.5	50,710.5	0.0
Total (Inc Passthrough)	**35,162.1**	**37,120.0**	**35,067.6**	**37,654.1**	**36,485.7**	**36,079.0**	**37,556.2**	**35,887.1**	**35,637.5**	**36,731.8**	**34,700.7**	**37,392.7**	**435,474.6**	**435,474.5**	**0.0**

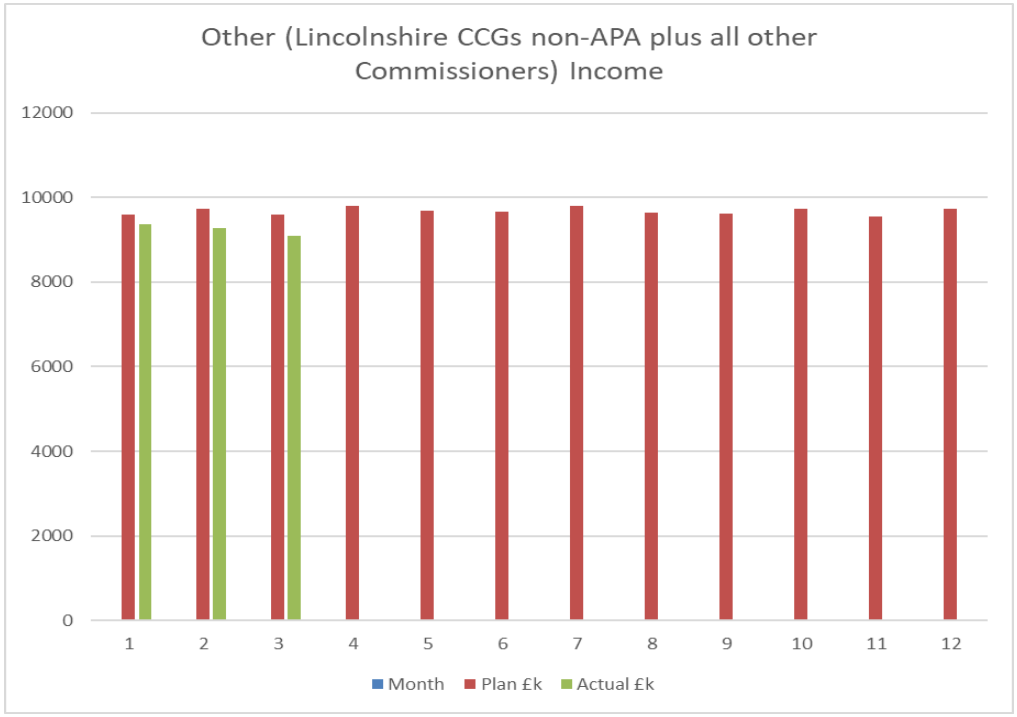
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





SUSTAINABLE SERVICES – INCOME SUMMARY AND RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Other Income Summary: YTD Month 3

Other Income	Other Income: In-Month				Other Income: Year-To-Date			
	2018/19 June £k Actual	2019/20 June £k Plan	2019/20 June £k Actual	2019/20 June £k Variance	2018/19 Apr - Jun £k Actual	2019/20 June £k Plan	2019/20 June £k Actual	2019/20 June £k Variance
NHS Patient Care Income main contract	30,007	31,357	31,117	(239)	87,556	95,259	95,378	118
NHS Patient care Pass through income	3,825	4,215	3,793	(423)	11,990	12,663	11,962	(700)
NHS Patient Care Income other	91	219	643	424	216	787	797	10
Non NHS other income	94	113	99	(14)	279	337	342	5
Non NHS Private Patients	18	18	13	(5)	51	54	62	8
Overseas Visitors	22	16	4	(12)	59	48	30	(18)
Injury Cost Recovery Scheme	40	141	(35)	(176)	93	423	227	(196)
Patient Care Income Total	**34,097**	**36,079**	**35,634**	**(445)**	**100,244**	**109,571**	**108,798**	**(773)**
Other Income								
Research & Development	94	99	101	2	287	299	345	46
Education & Training	1,337	1,387	1,309	(78)	3,973	4,165	4,134	(31)
Non patient services to other bodies	803	505	475	(30)	1,791	1,511	1,375	(136)
PSF, FRF and MRET funding	0	1,569	1,569	0	0	4,705	4,705	0
Other Income	619	752	753	1	1,929	2,254	2,224	(30)
Other Income Total	**2,853**	**4,312**	**4,207**	**(105)**	**7,980**	**12,934**	**12,783**	**(151)**
Total Income	**36,950**	**40,391**	**39,841**	**(550)**	**108,224**	**122,505**	**121,581**	**(924)**

Income of £121,581k has been achieved YTD compared to planned income of £122,505k resulting in the Income position being £924k (0.8%) adverse to plan.

The income position includes £4,705k YTD in relation to PSF, FRF & MRET. Receipt of PSF and FRF is dependent upon delivery of the financial position, and the level of PSF and FRF funding increases in future periods:

£4,705k in Q1

£5,968k in Q2

£8,495k in Q3

£9,760k in Q4

The majority of the adverse movement to plan relates to Patient Care Income. Income of £108,798k has been achieved YTD compared to planned income of £109,571k, which is £773k adverse to plan. This adverse movement to plan includes under performance of £700k in relation to pass-through income, for which there is an offset within Non Pay.

The adverse movement in Income also includes an adverse movement of £196k in relation to Injury Cost Recovery and an adverse movement of £151k in relation to Other Income, and these variances are being reviewed.

Excluding PSF, FRF and MRET, Income has averaged £38,959k per month from April to June, and to achieve plan in July-March will require achievement of Income of £39,535k per month.

2019/20 Other Income Run Rate

	Actual & Forecast £k														
	Actual M1	Actual M2	Actual M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	Full Year Plan	FOT £	Variance
NHS Patient Care Income	35,706	37,120	35,653	37,905	36,739	36,332	37,642	35,977	35,726	36,820	34,791	37,268	437,679	437,679	0
Non NHS Private Patients	31	18	13	17	18	18	18	17	18	18	18	9	213	213	0
Overseas Visitors	13	13	4	17	16	16	16	16	16	16	17	34	194	194	0
Injury Cost Recovery Scheme	139	123	(35)	142	141	141	141	141	141	141	142	337	1,694	1,694	0
Patient Care Income Total	**35,889**	**37,274**	**35,635**	**38,081**	**36,914**	**36,507**	**37,817**	**36,151**	**35,901**	**36,995**	**34,968**	**37,648**	**439,780**	**439,780**	**0**
Other Income															
Research & Development	121	123	101	100	100	99	100	100	99	100	100	52	1,195	1,195	0
Education & Training	1,368	1,457	1,309	1,389	1,389	1,387	1,389	1,389	1,388	1,389	1,389	1,418	16,661	16,661	0
Non patient services to other bodies	480	420	475	503	503	504	504	503	504	503	503	639	6,041	6,041	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	28,928	28,928	0
Other Income	875	678	671	751	750	751	752	751	750	752	750	780	9,011	9,011	
Other Income Total	**4,412**	**4,246**	**4,125**	**4,732**	**4,731**	**4,731**	**5,577**	**5,575**	**5,572**	**5,996**	**5,994**	**6,145**	**61,836**	**61,836**	**0**
Total Income	**40,301**	**41,520**	**39,760**	**42,813**	**41,645**	**41,238**	**43,394**	**41,726**	**41,473**	**42,991**	**40,962**	**43,793**	**501,616**	**501,616**	**0**

SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

2019/20 Pay Summary: YTD Month 3

	Pay: In-Month				Pay: Year-To-Date			
Staff Groups	**2018/19**	**2019/20**			**2018/19**	**2019/20**		
	Jun £k Actual	**Jun £k Plan**	**Jun £k Actual**	**Jun £k Variance**	**Apr - Jun £k Actual**	**Jun £k Plan**	**Jun £k Actual**	**Jun £k Variance**
Substantive:								
Registered Nursing, Midwifery and Health visiting staff	6,856	7,153	7,094	59	20,743	21,736	21,589	147
Health Care Scientists and Scientific, Therapeutic and Technical staff	2,499	2,597	2,712	(115)	7,475	7,894	8,251	(357)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	4,484	4,784	4,886	(102)	13,371	14,535	14,800	(265)
Medical and Dental Staff	6,608	6,835	6,566	269	19,670	20,763	19,093	1,670
Non-Medical - Non-Clinical Staff	2,505	2,911	2,713	198	7,508	8,833	8,256	577
Bank:								
Registered Nursing, Midwifery and Health visiting staff	442	473	520	(47)	1,474	1,415	1,523	(108)
Health Care Scientists and Scientific, Therapeutic and Technical staff	40	45	47	(2)	135	133	131	2
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	326	373	395	(22)	1,057	1,115	1,144	(29)
Medical and Dental Staff	806	797	880	(83)	2,471	2,391	2,846	(455)
Non-Medical - Non-Clinical Staff	123	177	256	(79)	498	531	715	(184)
Agency:								
Registered Nursing, Midwifery and Health visiting staff	751	934	1,127	(193)	1,999	2,802	3,086	(284)
Health Care Scientists and Scientific, Therapeutic and Technical staff	127	138	176	(38)	438	414	500	(86)
Qualified Ambulance Service staff	0	0	0	0	0	0	0	0
Support to clinical staff	7	10	2	8	9	30	6	24
Medical and Dental Staff	1,761	1,708	2,091	(383)	5,003	5,124	6,901	(1,777)
Non-Medical - Non-Clinical Staff	95	296	245	51	246	888	787	101
Apprentice levy	104	107	115	(8)	310	321	347	(26)
Capitalised staff	(51)	0	(17)	17	(63)	0	(45)	45
Total Pay	**27,483**	**29,338**	**29,807**	**(469)**	**82,344**	**88,925**	**89,930**	**(1,005)**

Pay year to date is £1,005k adverse to plan.

The adverse movement to plan in Pay includes two key movements: £1,772k favourable movement against substantive staffing and £2,796k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £1,772k favourable to plan, this includes £890k of one off benefit in relation to the release in May of £890k of Pay accruals. 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 almost flat over the three months: Substantive Pay has moved from £23,997k in April to £23,971k in June.

The above table shows that:

1) The adverse movement to plan on temporary staffing comprises of an adverse movement to plan of £773k on Bank Pay and £2,023k on Agency Pay.

2) Of the £773k adverse movement to plan on Bank Pay, £455k (59%) relates to Medical & Dental Staff and £105k (24%) relates to Non Clinical Staff groups.

3) Of the £2,023k adverse movement to plan on Agency Pay, £1,777k (88%) relates to Medical & Dental Staff.

Overall, of the £1,005k adverse movement to plan on Pay, £562k (56%) relates to Medical & Dental and £441k (44%) relates to Registered Nursing & Midwifery; a favourable movement of £494k in Non Clinical offsets the adverse movements of £270k in Support to Clinical Staff and £245k in Registered Nursing & Midwifery.

SUSTAINABLE SERVICES – PAY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

	Forecast (£k)														
Staff Groups	**Actual M1 £000s**	**Actual M2 £000s**	**Actual M3 £000s**	**Forecast M4 £000s**	**Forecast M5 £000s**	**Forecast M6 £000s**	**Forecast M7 £000s**	**Forecast M8 £000s**	**Forecast M9 £000s**	**Forecast M10 £000s**	**Forecast M11 £000s**	**Forecast M12 £000s**	**Full Year Plan £000s**	**Forecast £000s**	**Variance £000s**
Substantive:															
Registered Nursing, Midwifery and Health visiting staff	7,614	6,880	7,094	7,190	7,190	7,190	7,190	7,190	7,191	7,191	7,191	7,338	86,450	86,450	0
Health Care Scientists and Scientific, Therapeutic and	2,868	2,672	2,712	2,602	2,602	2,602	2,602	2,603	2,603	2,603	2,604	2,248	31,319	31,320	(1)
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	4,886	4,780	4,780	4,780	4,780	4,780	4,780	4,780	4,781	4,516	57,557	57,557	(0)
Medical and Dental Staff	6,435	6,092	6,566	6,798	6,793	6,784	6,777	6,760	6,724	6,723	6,723	8,352	81,527	81,527	(0)
Non-Medical - Non-Clinical Staff	2,872	2,671	2,713	2,911	2,911	2,911	2,911	2,911	2,911	2,911	2,911	3,667	35,032	35,211	(179)
Bank:															
Registered Nursing, Midwifery and Health visiting staff	508	495	520	471	471	473	471	471	473	471	471	363	5,658	5,658	(0)
Health Care Scientists and Scientific, Therapeutic and	39	44	47	44	44	47	44	44	45	44	44	49	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	395	371	371	373	371	371	372	371	371	344	4,459	4,459	0
Medical and Dental Staff	1,073	893	880	691	675	650	629	579	474	472	472	(105)	7,383	7,383	(0)
Non-Medical - Non-Clinical Staff	226	233	256	177	177	177	177	177	177	177	177	(10)	2,121	2,121	0
Agency:															
Registered Nursing, Midwifery and Health visiting staff	877	1,082	1,127	876	876	876	876	876	876	876	876	592	10,686	10,686	0
Health Care Scientists and Scientific, Therapeutic and	147	177	176	131	131	131	131	131	131	131	131	45	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	2	17	17	17	17	17	17	17	17	41	183	183	(0)
Medical and Dental Staff	2,379	2,431	2,091	1,445	1,406	1,344	1,290	1,165	907	902	902	(1,180)	15,082	15,082	(0)
Non-Medical - Non-Clinical Staff	216	327	245	146	146	146	71	71	71	71	71	172	1,752	1,752	(0)
Apprentice levy	119	113	115	107	107	106	107	107	107	107	106	81	1,282	1,282	0
Capitalised staff	(14)	(14)	(17)	0	0	0	0	0	0	0	0	(135)	0	(180)	180
Items included in Non pay:															
Operating expenses: research and development	(118)	(99)	(99)	(110)	(110)	(110)	(110)	(110)	(110)	(110)	(110)	(124)	(1,320)	(1,320)	0
Operating expenses: education and training	(158)	(149)	(166)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	17	(1,368)	(1,368)	0
Operating expenses: redundancy	0	0	0	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(20)	(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**	**29,807**	**28,757**	**28,697**	**28,607**	**28,444**	**28,253**	**27,859**	**27,847**	**27,848**	**26,378**	**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 3

	Non Pay: In-Month				Non Pay: Year-To-Date			
Non Pay	2018/19 June £k Actual	2019/20 June £k Plan	2019/20 June £k Actual	2019/20 June £k Variance	2018/19 Apr - Jun £k Actual	2019/20 June £k Plan	2019/20 June £k Actual	2019/20 June £k Variance
Ambulance Services	80	169	149	20	135	509	469	40
Clinical Supplies & Services	5,352	5,181	4,883	298	10,019	15,543	14,984	559
Drugs	649	449	247	201	1,090	1,330	913	418
Drugs Pass through	4,337	4,215	3,793	423	8,165	12,663	11,962	700
Establishment Expenditure	440	528	459	69	860	1,584	1,606	(22)
General Supplies & Services	1,272	822	977	(155)	1,875	2,466	2,841	(375)
Other	(191)	327	369	(42)	509	977	898	79
Premises & Fixed Plant	1,616	1,633	1,464	169	3,184	4,900	4,524	376
Clinical Negligence	1,775	1,741	1,741	0	3,549	5,223	5,222	1
Capital charges	981	1,100	1,076	24	1,962	3,300	3,244	56
Total Non Pay	**16,311**	**16,165**	**15,158**	**1,007**	**31,348**	**48,495**	**46,663**	**1,832**

	Actual m1 to m3 Forecast m4 to m12 £k														
Non Pay	Actual M1	Actual M2	Actual M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	FOT £	Plan	Variance
Ambulance Services	125	195	149	170	170	169	170	170	169	170	170	208	2,035	2,035	0
Clinical Supplies & Services	4,756	5,345	4,883	5,182	5,181	5,182	5,182	5,181	5,182	5,181	5,180	5,742	62,177	62,177	0
Drugs	275	392	246	477	495	483	477	483	503	485	481	472	5,269	5,269	0
Drugs Pass through	4,101	4,068	3,793	4,278	4,261	4,270	4,278	4,270	4,253	4,270	4,270	4,602	50,710	50,710	0
Establishment Expenditure	505	643	458	528	528	528	528	528	528	527	527	505	6,333	6,333	0
General Supplies & Services	1,047	817	977	489	489	489	489	489	489	589	589	215	7,168	7,168	0
Other	286	242	370	326	325	328	326	325	328	328	328	539	4,051	3,919	(132)
Premises & Fixed Plant	1,549	1,511	1,464	1,634	1,634	1,633	1,634	1,633	1,633	1,634	1,633	2,010	19,602	19,602	0
Clinical Negligence	1,741	1,741	1,740	1,741	1,741	1,741	1,741	1,741	1,741	1,740	1,740	1,741	20,889	20,889	0
Capital charges	1,085	1,083	1,076	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,156	13,200	13,200	0
Total Non Pay	**15,470**	**16,037**	**15,156**	**15,924**	**15,923**	**15,922**	**15,924**	**15,919**	**15,926**	**16,024**	**16,017**	**17,190**	**191,434**	**191,302**	**(132)**

Non Pay expenditure of £46,663k YTD is £1,832k favourable to planned expenditure of £48,495k.

The favourable movement also includes £0.7m in relation to passthrough drugs and Devices, which is directly offset by an equal and opposite reduction in income, and £0.2m lower than planned costs in relation to Turnaround which is a timing difference and as such the under spend accrued to date will reduce in future periods.

The YTD Non Pay position also includes £576k of Technical savings, of which £313k relates to June.

The Non Pay run-rate table below shows that Non Pay has averaged £15,554k per month from April to June compared to a forecast average of £16,086k per month from July to March in order to achieve the planned deficit. Whilst forecast expenditure is £532k higher in future months, it is noted that planned activity and income is also expected to be higher in future months.

SUSTAINABLE SERVICES – FINANCIAL EFFICIENCY PROGRAMME SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

M03

	In Month			YTD			
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	RAG
FEP	1,180	1,342	162	3,393	3,398	5	

Finance Position

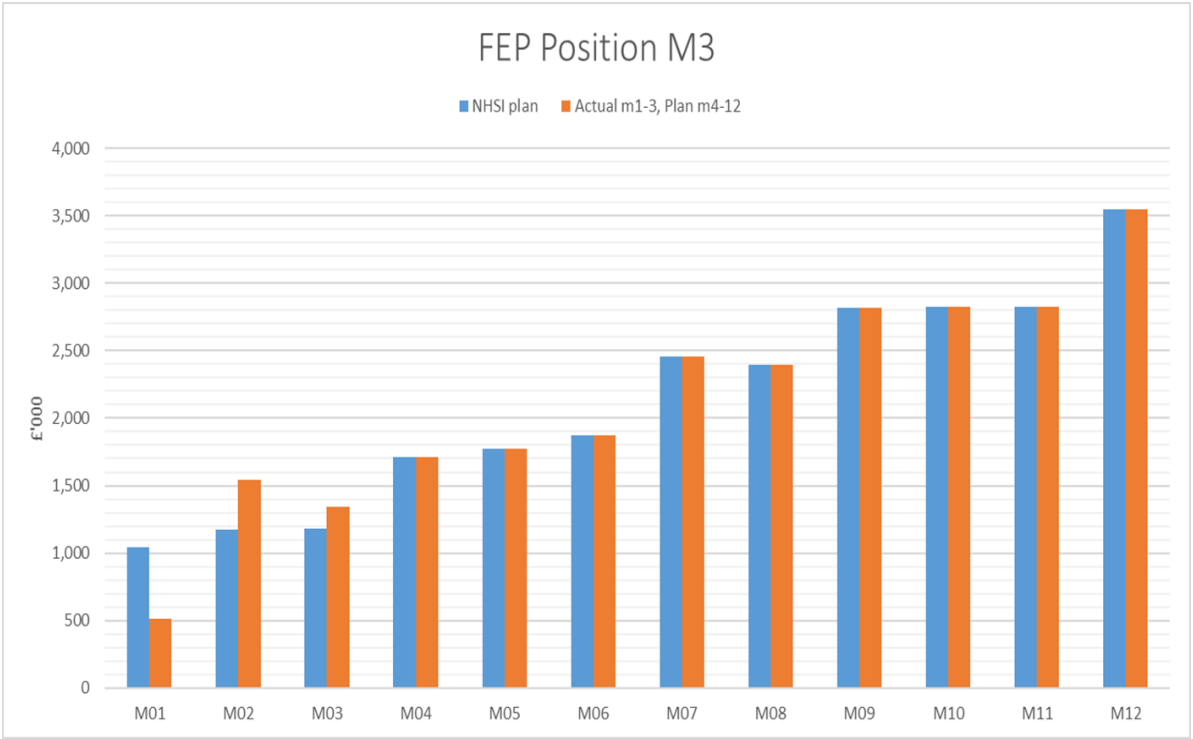
YTD ACTUAL	£k	FORECAST	£k
Recurrent	1,847	Recurrent	24,209
Non Recurrent	1,551	Non Recurrent	1,401
TOTAL	**3,398**	**TOTAL**	**25,610**

The financial plan for 2019/20 includes an efficiency programme to deliver £25.61m of savings; this includes £250k of planned non-recurrent savings in relation to the sale of the original front entrance of Grantham Hospital.

FEP savings delivery of £1,342k is reported in June; compared to planned FEP savings delivery of £1,180k, savings delivery in June is £162k favourable to plan.

YTD FEP savings delivery of £3,398k to the end of June is £5k favourable to planned FEP savings delivery of £3,393k.

However, whilst overall delivery is in line with plan, the YTD FEP position is supported by delivery of £1,551k of non-recurrent Technical FEP savings. This non-recurrent FEP savings delivery is comprises of £975k of Technical Savings in relation to Pay and £576k of Non Pay savings. The delivery of non-recurrent Technical FEP savings has offset the slippage in delivery in relation to a number of planned savings schemes, most notably the Theatres and Outpatient Productivity savings schemes and Workforce savings schemes.



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

	Year end		Year to date			Monthly Actual 2019/20			Forecast Outurn		
	31 March 2019		30 June 2019			30-Apr-19	31-May-19	30-Jun-19	31 March 2020		
	Actual Month 12	Plan	Actual	Plan	Variance	Actual Month 1	Actual Month 2	Actual Month 3	Actual	Plan	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets											
Intangible assets	6,341	5,488	5,907	5,019	888	6,195	6,048	5,907	4,639	4,637	2
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	27,654	22,495	27,550	27,258	292	27,619	27,585	27,550	27,238	26,954	284
Property, plant and equipment: other	181,095	213,599	184,058	205,551	(21,493)	181,031	182,083	184,058	201,948	224,849	(22,901)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,560	1,828	1,537	1,600	(63)	1,529	1,551	1,537	1,600	1,600	0
Total non-current assets	**216,650**	**243,410**	**219,052**	**239,428**	**(20,376)**	**216,374**	**217,267**	**219,052**	**235,425**	**258,040**	**(22,615)**
Current assets											
Inventories	7,440	6,799	7,317	7,350	(33)	7,593	7,521	7,317	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	15,203	17,664	16,170	21,790	(5,620)	15,563	18,820	16,170	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	6,833	4,848	15,803	7,978	7,825	11,306	12,479	15,803	7,912	7,912	0
Assets held for sale and assets in disposal groups	660	0	660	660	0	660	660	660	0	510	(510)
Cash and cash equivalents: GBS/NLF	7,376	6,143	1,206	990	216	3,251	2,248	1,206	4,214	4,214	0
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	0
Total current assets	**37,522**	**35,464**	**41,166**	**38,778**	**2,388**	**38,383**	**41,738**	**41,166**	**46,331**	**46,841**	**(510)**
Current liabilities											
Trade and other payables: capital	(10,791)	(4,723)	(7,990)	(1,637)	(6,353)	(8,748)	(7,764)	(7,990)	(2,538)	(4,466)	1,928
Trade and other payables: non-capital	(40,622)	(38,039)	(47,043)	(49,115)	2,072	(46,383)	(47,773)	(47,043)	(41,621)	(41,096)	(525)
Borrowings	(114,339)	(77,359)	(131,947)	(22,212)	(109,735)	(118,596)	(124,423)	(131,947)	(197,439)	(197,289)	(150)
Provisions	(608)	(735)	(608)	(565)	(43)	(608)	(608)	(608)	(565)	(565)	0
Other liabilities: deferred income	(2,869)	(2,707)	(1,110)	(1,200)	90	(1,106)	(1,088)	(1,110)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	0
Total current liabilities	**(169,732)**	**(124,066)**	**(189,201)**	**(75,232)**	**(113,969)**	**(175,944)**	**(182,159)**	**(189,201)**	**(243,866)**	**(245,119)**	**1,253**
Net Current liabilities	**(132,210)**	**(88,602)**	**(148,035)**	**(36,454)**	**(111,581)**	**(137,561)**	**(140,421)**	**(148,035)**	**(197,535)**	**(198,278)**	**743**
Total assets less current liabilities	**84,440**	**154,808**	**71,017**	**202,974**	**(131,957)**	**78,813**	**76,846**	**71,017**	**37,890**	**59,762**	**(21,872)**
Non-current liabilities											
Borrowings	(188,196)	(228,888)	(191,802)	(301,932)	110,130	(189,662)	(191,890)	(191,802)	(178,323)	(178,440)	117
Provisions	(2,863)	(2,911)	(2,989)	(2,982)	(7)	(2,865)	(2,865)	(2,989)	(2,825)	(2,782)	(43)
Other liabilities: other	(13,081)	(13,081)	(12,956)	(12,955)	(1)	(13,040)	(12,998)	(12,956)	(12,578)	(12,578)	0
Total non-current liabilities	**(204,140)**	**(244,880)**	**(207,747)**	**(317,869)**	**110,122**	**(205,567)**	**(207,753)**	**(207,747)**	**(193,726)**	**(193,800)**	**74**
Total net assets employed	**(119,700)**	**(90,072)**	**(136,730)**	**(114,895)**	**(21,835)**	**(126,754)**	**(130,907)**	**(136,730)**	**(155,836)**	**(134,038)**	**(21,798)**
Financed by											
Public dividend capital	260,042	257,563	260,042	260,042	0	260,042	260,042	260,042	265,318	265,318	0
Revaluation reserve	32,159	34,455	31,933	35,491	(3,558)	32,089	32,008	31,933	31,255	34,951	(3,696)
Other reserves	190	190	190	190	0	190	190	190	190	190	0
Income and expenditure reserve	(412,091)	(382,280)	(428,895)	(410,618)	(18,277)	(419,075)	(423,147)	(428,895)	(452,599)	(434,497)	(18,102)
Total taxpayers' and others' equity	**(119,700)**	**(90,072)**	**(136,730)**	**(114,895)**	**(21,835)**	**(126,754)**	**(130,907)**	**(136,730)**	**(155,836)**	**(134,038)**	**(21,798)**

BORROWINGS											
Current											
Borrowings: DHSC capital loans	1,889	2,429	2,155	2,562	(407)	1,828	1,828	2,155	**2,753**	2,636	117
Borrowings: DHSC working capital / revenue support loans	112,450	74,930	128,056	17,508	110,548	114,694	120,938	128,056	**191,520**	191,521	(1)
Accrued interest on DHSC loans		0	1,736	2,142	(406)	2,074	1,657	1,736	**2,703**	2,670	
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	**463**	462	1
Total current borrowings	**114,339**	**77,359**	**131,947**	**22,212**	**109,735**	**118,596**	**124,423**	**131,947**	**197,439**	**197,289**	**117**
Non-current											
Borrowings: DHSC capital loans	24,283	33,343	24,678	24,242	436	24,344	25,005	24,678	**32,629**	32,746	(117)
Borrowings: DHSC working capital / revenue support loans	163,913	195,545	167,124	277,690	(110,566)	165,318	166,885	167,124	**142,688**	142,687	1
Borrowings: other (non-DHSC)	0	0	0	0	0	0	0	0	**3,006**	3,007	(1)
Total non-current borrowings	**188,196**	**228,888**	**191,802**	**301,932**	**(110,130)**	**189,662**	**191,890**	**191,802**	**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 30 June 2019 was £1.2m. This includes revenue and capital cash loans drawn in April 2019 - June 2019 of £20.8m / £0.6m respectively.

The Trust has reduced the level of capital creditors from £10.8m to £8m.

The impact on the ability to pay suppliers has been limited as a result of the delays in the capital programme and the payment of the capital creditors.

Year to date	Plan	Actual	Variance
	£k	£k	£k
Cash balance	1,000	1,216	216

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Cash balance	4,224	4,224	0

Year to date	Plan	Actual	Variance
	£k	£k	£k
Operating Surplus	(14,373)	(15,012)	(639)
Depreciation	3,300	3,244	(56)
Other Non Cash I&E Items	(54)	0	54
Movement in Working Capital	(994)	(5,254)	(4,260)
Provisions	119	117	(2)
Cashflow from Operations	**(12,002)**	**(16,905)**	(4,903)
Interest received	9	39	30
Capital Expenditure	(12,719)	(8,472)	4,247
Cash receipt from asset sales	0	14	14
Cash from / (used in) investing activities	**(12,710)**	**(8,419)**	**4,291**
PDC Received	0	0	0
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and leases	(1,872)	(2,287)	(415)
Capital element of leases	0	0	0
Drawdown on debt - Revenue	21,759	20,780	(979)
Drawdown on debt - Capital	0	661	661
Repayment of debt	(328)	0	328
Cashflow from financing	**19,559**	**19,154**	**(405)**
Net Cash Inflow / (Outflow)	**(5,153)**	**(6,170)**	**(1,017)**
Opening cash balance	6,153	7,386	1,233
Closing Cash balance	**1,000**	**1,216**	**216**

Year End Forecast	Plan	Actual	Variance
	£k	£k	£k
Operating Surplus	(32,306)	(32,438)	(132)
Depreciation	13,200	13,200	0
Other Non Cash I&E Items	(214)	(214)	0
Movement in Working Capital	(13,680)	(13,845)	(165)
Provisions	(81)	(81)	0
Cashflow from Operations	**(33,081)**	**(33,378)**	(297)
Interest received	36	156	120
Capital Expenditure	(38,312)	(39,976)	(1,664)
Cash receipt from asset sales	150	674	524
Cash from / (used in) investing activities	**(38,126)**	**(39,146)**	**(1,020)**
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**

Total revenue and capital borrowings (excluding accrued interest) at 30 June were £322.0m. 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.

The cash balance of £1.2m at 30 June reflects a number of factors:

- the reduction in capital creditors from the year end high of £10.8m to £8.0m;

- 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 £21.4m have been drawn in the year to June 2019. This is against the backdrop of a cumulative I&E deficit to June of £17.0m.

Capital cash is supporting the overall cash position by circa £8.0m at June 2019.

The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £2.5m 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 £k	Actual £k	Variance £k
Capital Balance	**3,306**	**5,672**	**-2,366**

Year End Forecast	Plan £k	Actual £k	Variance £k
Capital Balance	**31,817**	**31,817**	**0**

Year to date	Plan £k	Actual £k	Variance £k
Medical Equipment replacement	191	66	**125**
Estates - Fire	2,600	5,149	**-2,549**
ICT	31	305	**-274**
Estates - Backlog	150	139	**11**
Service developments	334	13	**321**
Total	**3,306**	**5,672**	**-2,366**

Year End Forecast	Plan £k	Actual £k	Variance £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	10,984	10,984	**0**
Total	**31,817**	**31,817**	**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£9.0m - the discretionary capital available has been reduced due to the requirement to pay the fire loan. This leaves limited resources available to prioritise against Medical Device replacement, IT infrastructure and replacement, Estates Backlog and Service and Digital Developments.

The M3 spend incurred amounts to c£5.7m against a planned spend of c£3.3m, details below:

Facilities; Minimal spend in M3 of £139k. Majority of spend incurred links to Anti-barricading improvements (£119k) and 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 continues to progress at pace. Costs incurred at the end of June amounted to c£5.1m (spend in month was c£2.7m). Fire Works package 1 at LCH is £1.7m, package 2 is £1.2m, Emergency Lighting at LCH is £271k. Package 1 at Pilgrim amounts to £746k.

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 M3 along with £26k of PC replacement.

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 involved 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

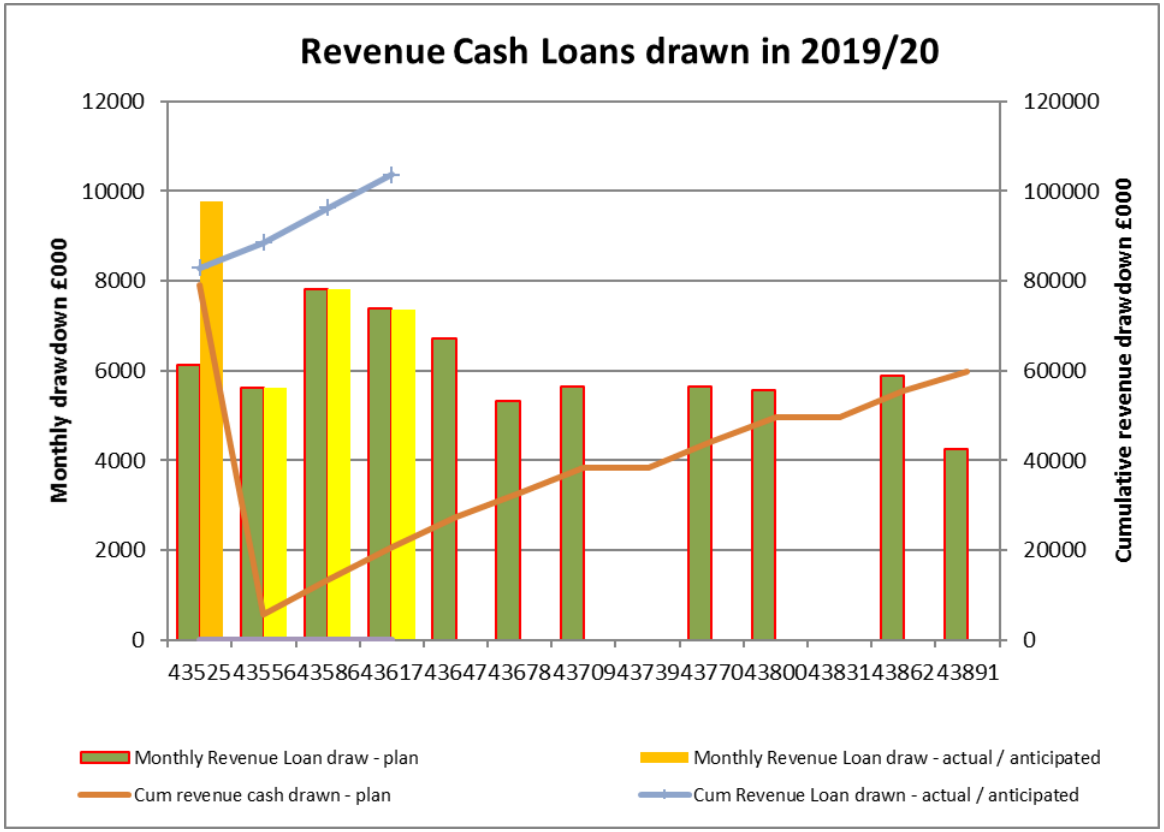
2021 Objective: Our Services

Revenue Borrowing

The Trust has drawn cash loans of £21.4m during the three months to June 2019, this is split £20.7m revenue support and £0.7m capital. This includes £7.4m 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



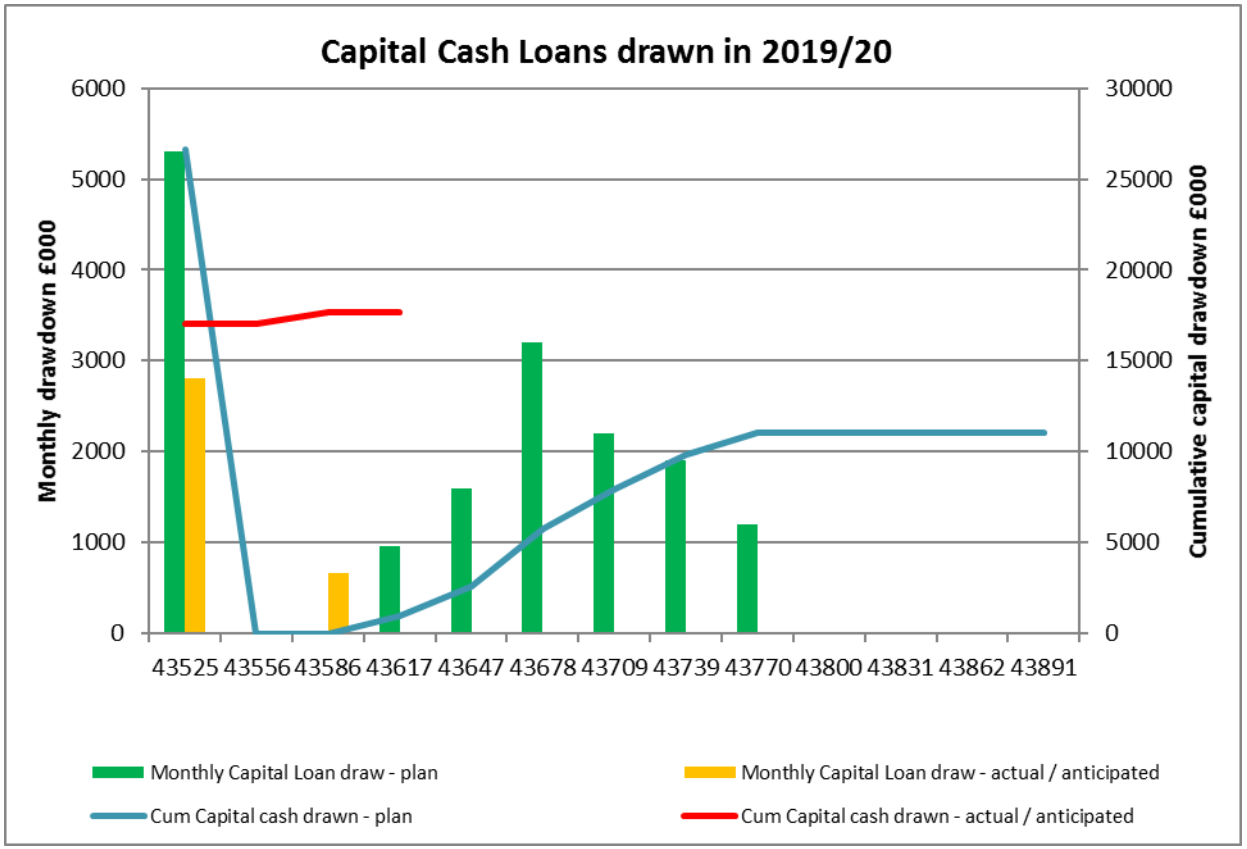
Capital Borrowing

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 the three months to June, there was a capital drawdown of £0.7m in June and the capital creditors reduced to £8.0m as at 30th June 2019.

The 31st March 2019 year end capital creditor was £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:	July 2019	Revenue £7.376m
		Capital £1.600m
	August 2019	Revenue: £7.925m
		Capital £3.155m

The board is requested to approve borrowing in September 2019 in line with the draft 2019/20 financial plan for revenue and the actual spend for capital.

Revenue £5.637m Capital £6.284m

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Borrowings and Interest

At 30 June 2019 total 'repayable' borrowings (excluding accrued interest) were £322m, capital (£26.8m) and revenue (£295.2m).

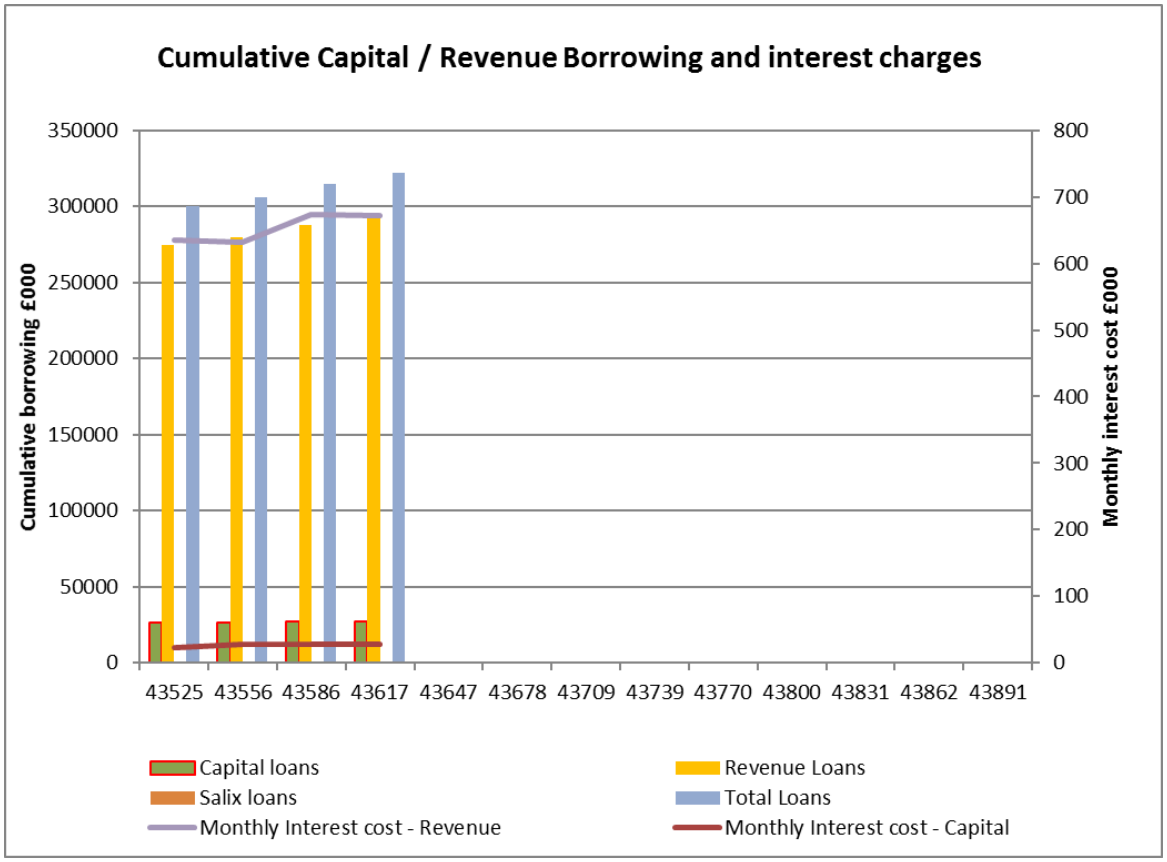
Existing loans are held at a variety of interest rates, Capital 1.1% (£9.2m) & 1.37% (£17.0m), Revenue 1.5% (£155.3m), 3.5% (£81.3m) & 6.0% (£43.4m).

(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 £9.1m (Revenue £8.7m / Capital £0.4m).

Changes in accounting standards in 2018/19 mean that any accrued interest June 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.

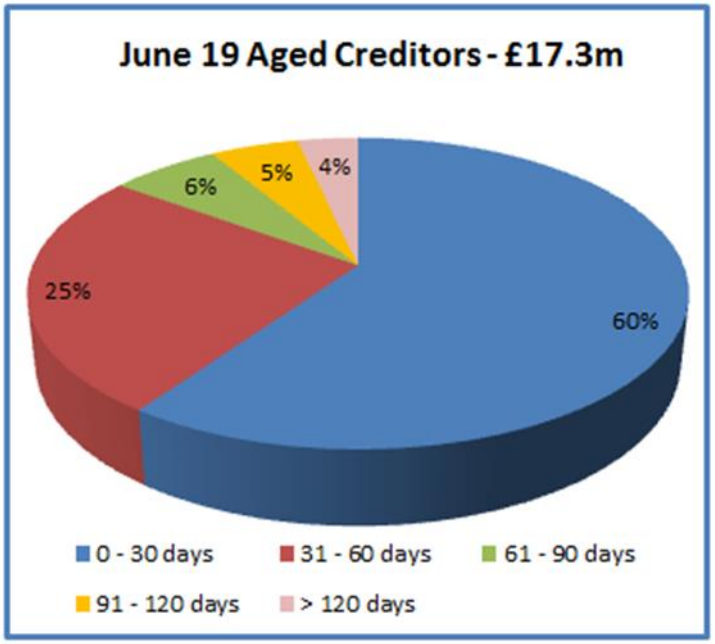
Type	Loan £m	Repayment		Loan £m	Repayment	Repayment Terms
Revenue	35.6	tbc		6.0	Feb-21	The terms of each loan state that there is to be a single one off repayment in full. It is anticipated however that some form of re-financing will take place. The means by which this might be transacted is uncertain at this stage.
	4.6	Nov-19		5.4	Mar-21	
	2.5	Dec-19		7.2	Apr-21	
	52.0	Jan-20		6.4	May-21	
	4.1	Jan-20		9.3	Jun-21	
	4.2	Feb-20		7.2	Jul-21	
	7.6	Mar-20		5.0	Aug-21	
	6.2	Apr-20		5.0	Sep-21	
	5.8	May-20		5.0	Oct-21	
	5.5	Jun-20		5.4	Nov-21	
	11.0	Jul-20		12.5	Dec-21	
	7.0	Aug-20		10.0	Jan-22	
	9.3	Sep-20		9.8	Mar-22	
	6.6	Oct-20		5.6	Apr-22	
	6.2	Nov-20		7.8	May-22	
	6.0	Dec-20		7.4	Jun-22	
	6.0	Jan-21				

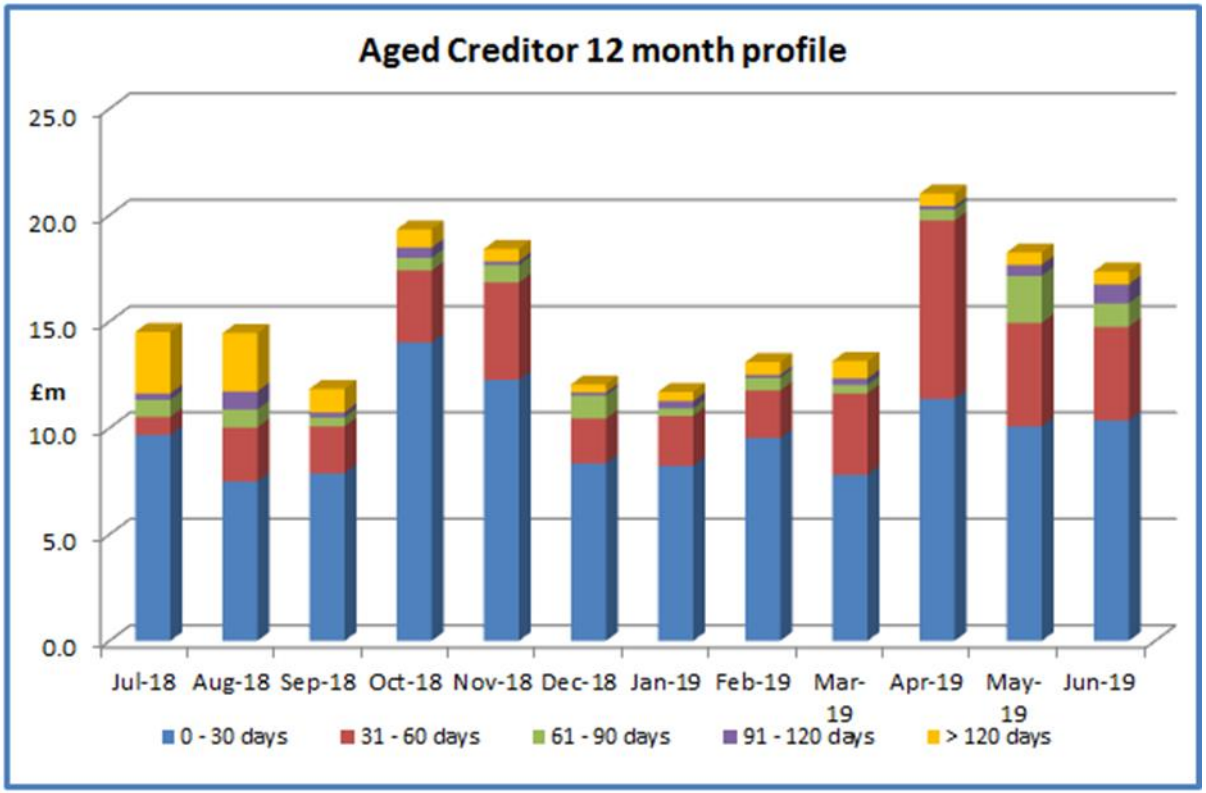
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors

Total Creditors were £17.3m at 30 June 2019, of which £7.0m were over 30 days (£1.5m > 90 days). Focusing further upon those invoices over 30 days £2.5m (67%) relates to just ten suppliers. The reasons for delays in payment to suppliers has been investigated and in each case the Trust is taking action where appropriate / working with the supplier and internal departments to resolve issues.

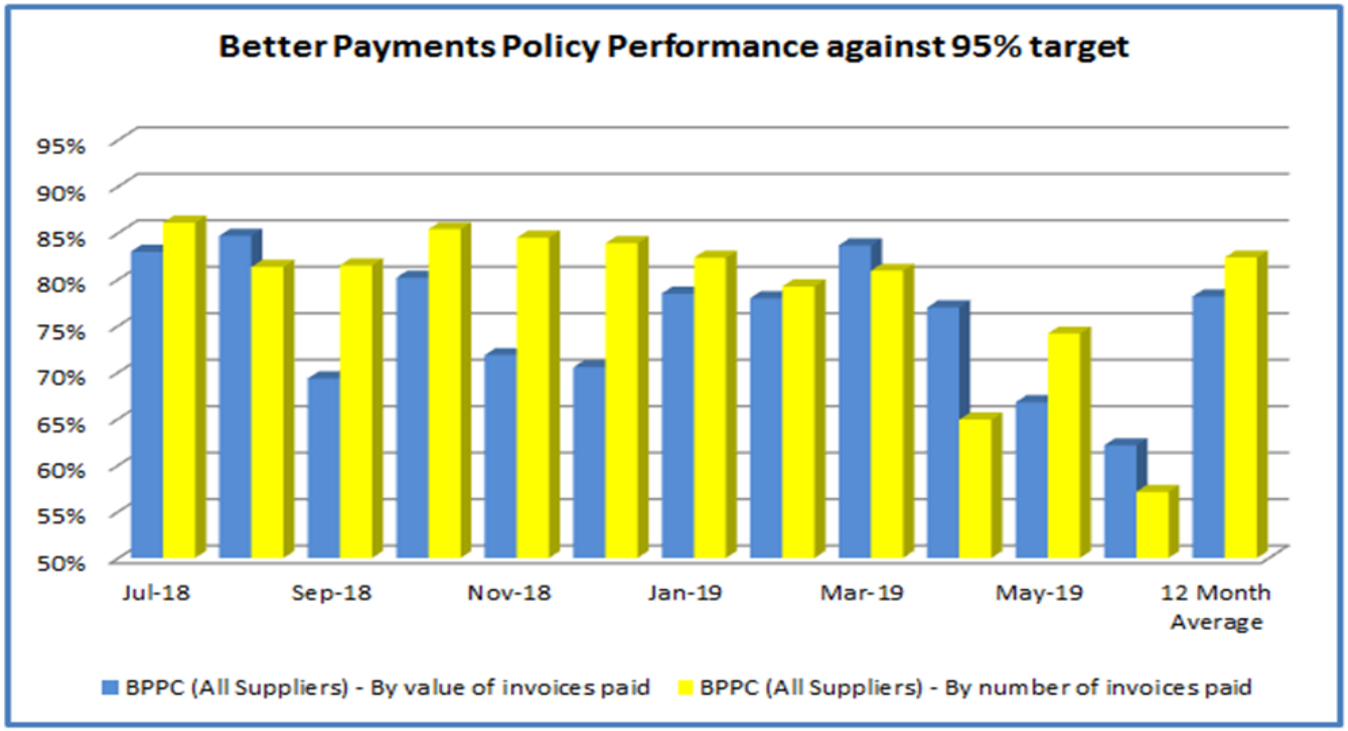
The Finance and Procurement Teams continue to enforce the policy of requiring suppliers to provide a purchase order before payment is made. At 30 June there were 371 separate invoices (£1.3m), over 90 days old spread across 91 suppliers where payment is delayed awaiting a purchase order.

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 June 2019 performance are shown in the following table

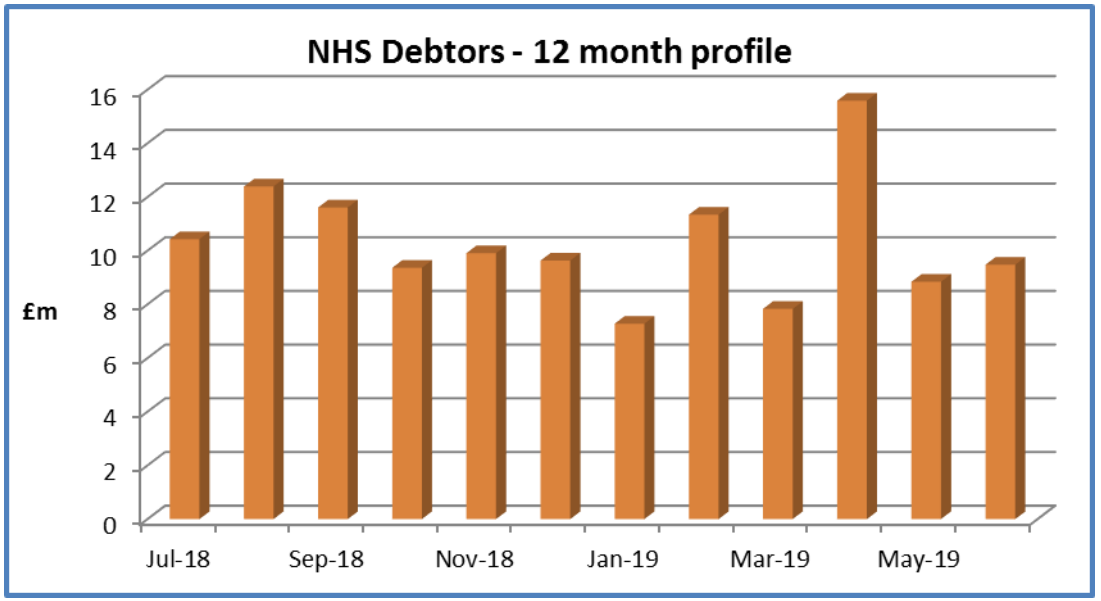
Year to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	418	10,446	29,413	46,481
Total bills paid within target	319	9,830	19,107	28,648
% of bills paid within target YTD	**76.32%**	**94.10%**	**64.96%**	**61.63%**
% of bills paid within May 2019	**94.44%**	**99.93%**	**57.06%**	**55.83%**

SUSTAINABLE SERVICES – NHS RECEIVABLES

Executive Lead: Paul Matthew

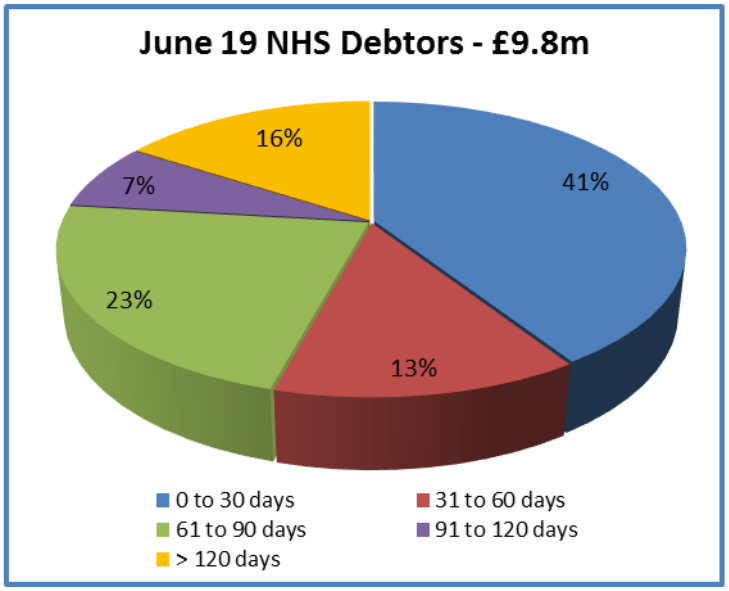
CQC Domain: Well-Led

2021 Objective: Our Services



The level of NHS debt over the last 12 months is shown in the table above, while the table left focuses upon the aged split at 30 June 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	2,167	651	134	54	178	3,184	232
CCGs - Other	443	306	85	36	160	1,030	196
Trusts - Lincolnshire	156	12	56	17	70	311	87
Trusts - Other	571	46	386	439	1,018	2,460	1,457
Other NHS	535	252	1,486	143	76	2,492	219
Total	**3,872**	**1,267**	**2,147**	**689**	**1,502**	**9,477**	**2,191**

The level of aged debt > 90 days has increased significantly from £1.5m in March 19 to £2.2m at 30 June.

The largest element currently over 90 days relates to NHS Trusts where queries are unresolved with Nottingham University.

In volume terms there are 298 invoices > 90 days at 30 June 2019.

SUSTAINABLE SERVICES – NON- NHS RECEIVABLES

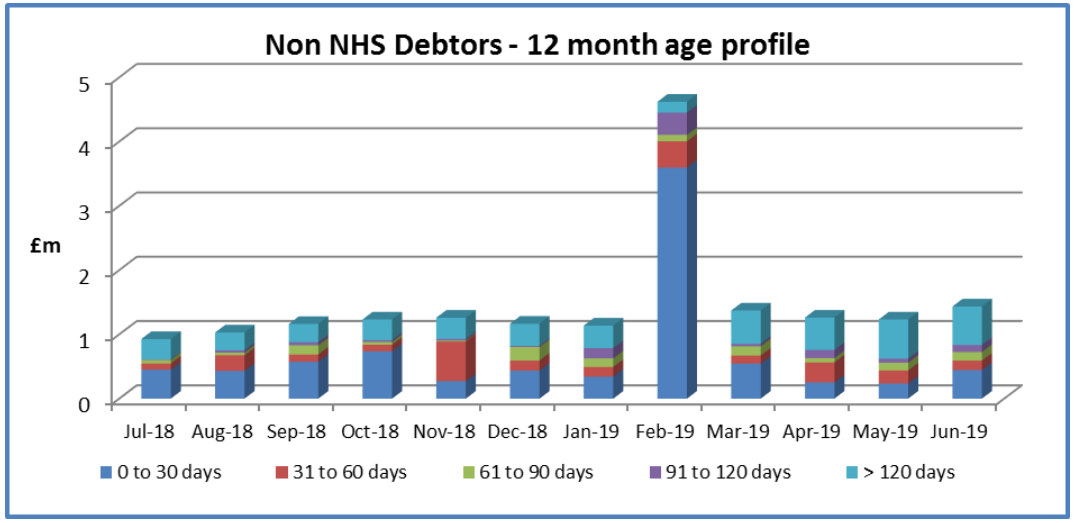
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

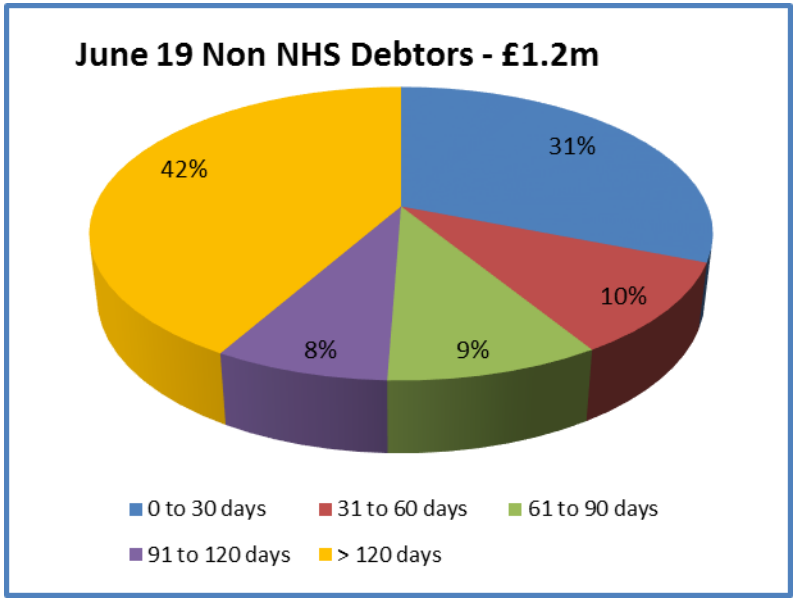
The level of Non-NHS debt over the last 12 months is shown in the table above, while the table left focuses upon the aged split at 30 June 2019.

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



Description	Totals outstanding debt £ 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

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	2,377	2,682	2,727	4,227	3,727	2,991	3,857	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	5,683	8,365	11,092	15,319	19,046	22,037	25,894	28,802	31,817
Operating Surplus/Deficit	-6,088	-9,803	-14,915	-16,696	-19,581	-22,784	-23,671	-26,029	-28,249	-29,040	-31,855	-32,306

In Month Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	41,522	39,838									
Operating Expenditure	-46,332	-45,297	-44,964									
Efficiency	510	1,546	1,342									
Agency	-3,621	-4,019	-3,640									
Capital	839	1,958	2,875									
Operating Surplus/Deficit	-6,111	-3,775	-5,126									

Cumulative Actual	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	40,221	81,743	121,581									
Operating Expenditure	-46,332	-91,629	-136,593									
Efficiency	510	2,056	3,398									
Agency	-3,621	-7,640	-11,280									
Capital	839	2,797	5,672									
Operating Surplus/Deficit	-6,111	-9,886	-15,012									

In Month Variance (-) adverse	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-264	-553									
Operating Expenditure	84	204	539									
Efficiency	-532	375	162									
Agency	-535	-933	-554									
Capital	-23	-641	-1,702									
Operating Surplus/Deficit	-23	-60	-14									

Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-107	-371	-924									
Operating Expenditure	84	288	827									
Efficiency	-532	-157	5									
Agency	-535	-1,468	-2,022									
Capital	-23	-664	-2,366									
Operating Surplus/Deficit	-23	-83	-97									

In Month Variance (-) adverse %	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.63%	-1.37%									
Operating Expenditure	0.18%	0.45%	1.18%									
Efficiency	-51.06%	32.02%	13.73%									
Agency	-17.34%	-30.23%	-17.96%									
Capital	-2.82%	-48.63%	-145.11%									
Operating Surplus/Deficit	-0.38%	-1.62%	-0.27%									

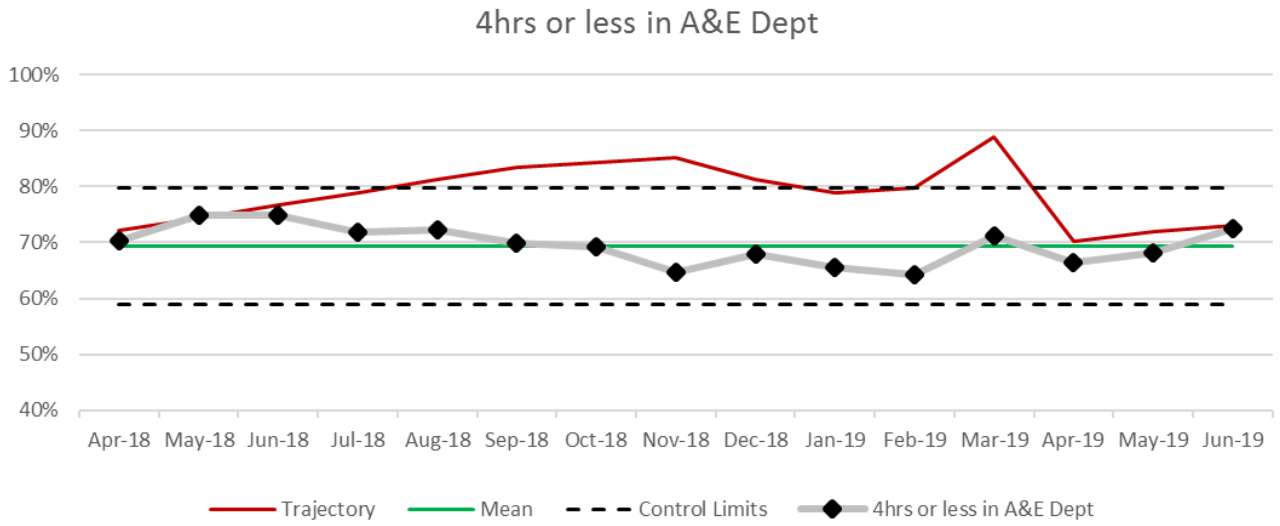
Cumulative Variance	April	May	June	July	August	September	October	November	December	January	February	March
Operating Income	-0.27%	-0.45%	-0.75%									
Operating Expenditure	0.18%	0.31%	0.60%									
Efficiency	-51.06%	-7.09%	0.15%									
Agency	-17.34%	-23.78%	-21.84%									
Capital	-2.82%	-31.11%	-71.55%									
Operating Surplus/Deficit	-0.38%	-0.85%	-0.65%									

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- June's performance was 72.44% which represented a 4.78% performance improvement from May.
- Primary Care Streaming remains one of the key high impact changes to improve 4 hour performance. System streaming targets for all ED attendances are 25% at PBH and 20%. For June, the percentage of patients streamed at PBH was 23.7% a 0.1% reduction (or 66 patients less) compared with May. LCH streamed 15.8% of patients, a 2.7% increase (or 133 patients more) than May. Staff absence has contributed to the slight dip in performance at PBH in June and a fortnightly operational meeting is in place to discuss and review performance.
- A&E attendances have been higher than expected and non-elective demand continues to exceed capacity.
- Nursing and Medical staffing levels for inpatient wards and the emergency department continue to be an area of concern. The fragility of medical staffing will improve towards the end of Q3 2019/20 beginning of Q4 2019/20 as we start to see newly appointed doctors come into post. Recruitment plans against start dates are monitored weekly by the division and are on target to deliver against timescale.
- For June, the average number of Super Stranded Patients in the Trust was 101 a reduction of 11 compared with May and 78 patients less than the trajectory of 179 reflecting the success of 'Long Stay Tuesday's and Wednesday's' at the LCH and PBH sites. DToC remains within normal variation.
- Total ULHT bed occupancy for June was 92.16%, above the target occupancy of 92%, with LCH and PBH carrying the greatest occupancy pressure; LCH 94.04% and PBH 96.08%.

Actions in place to recover:

The UEC Improvement Programme is implementing High Impact Changes (HIC) to improve performance that are monitored through the Improvement Programme Steering Group. The HIC include the following:

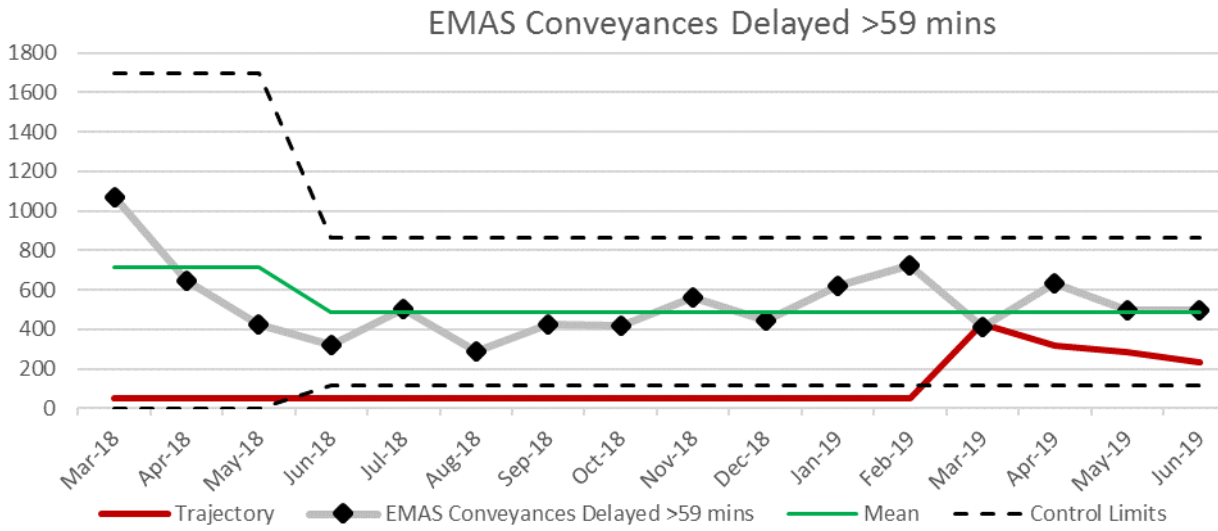
Reduction of ambulance conveyances through alternative pathways targeting out of area first; discharge within 24 hours of PDD; increasing the numbers of patients seen through primary care streaming; protecting the minors stream and focussing on delivering 4 hours through this stream; long stay Tuesday's and Wednesday's at LCH and PBH to further reduce stranded patient numbers; criteria led discharge; increasing the numbers of patients who are seen and treated through a Same Day Emergency Care (SDEC) pathway; standards for inpatient flow (SIF) eliminating unnecessary inpatient waits and medical and nursing recruitment. Progress on these areas are described in more detail in the separate Urgent Care performance paper.

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Handover delays >59 mins experienced in June were 494 compared with 494 in May missing the trajectory of 231 by 263. However, the improvement noted in May has been sustained through June.
- PBH continues to improve compliance against >59 minute handover improving June's performance (114) by 60 compared with May's performance (174).
- Almost correspondingly, the LCH position in June (377) has deteriorated compared with May (311) by 66.
- GDH have improved their position in June (3) by 6 compared with May (9).
- Same Day Emergency Care (SDEC) pathways have been implemented in AEC and SAU at LCH. Gains have not yet been realised in terms of ambulance handover times but are expected to have a positive impact on performance.

Actions in place to recover

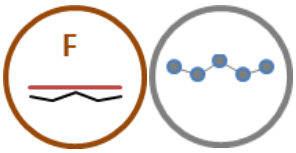
- New pathways at PHB rolled out to enable GP direct admissions bypassing ED and continues to work well in hours. OOH remains challenging.
- Rapid Access and Treatment (RAT) models are being reviewed at both LCH and PBH hospital sites in particular the staffing models for RAT, competency and processing of patients. An example of this would be at PBH where an additional HCA has been added to the team during July and early indications is that this is having a positive impact on turnaround times.
- Daily calls remain in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.

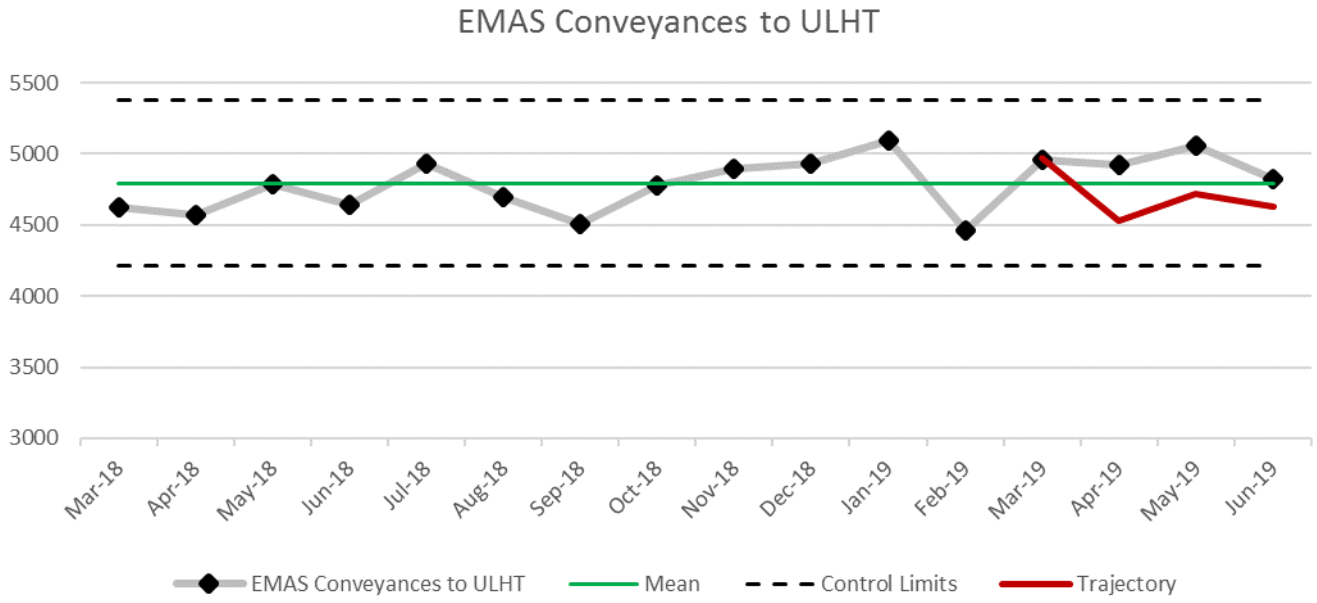
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- There was a slight improvement overall in ambulance conveyance through June (4823) with 94 ambulances fewer than in May (5062). This represents a 4.08% increase against plan (4626).
- At hospital site level LCH received 173 less conveyances in June (2535) than in May (2708); PBH received 70 less conveyances in June (1999) compared with May (2069) and GDH received 4 more conveyances in June (289) compared with May (285).
- Alternative pathways to avoid conveyance have still not been realised to deliver the percentage reduction anticipated.

Actions in place to recover

- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily.
- ULHT Representative and EMAS ROM / DOM control continue to apply a daily review of pressure on the departments, County profile against demand, destination of demand and attempts manage that demand. Daily intelligence is now shared routinely as to the forecast spikes in demand and this is being applied to the Emergency Department response capability.
- Conveyance numbers 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 Call.

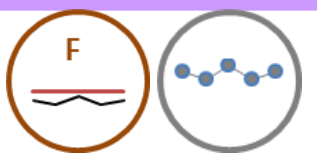
.

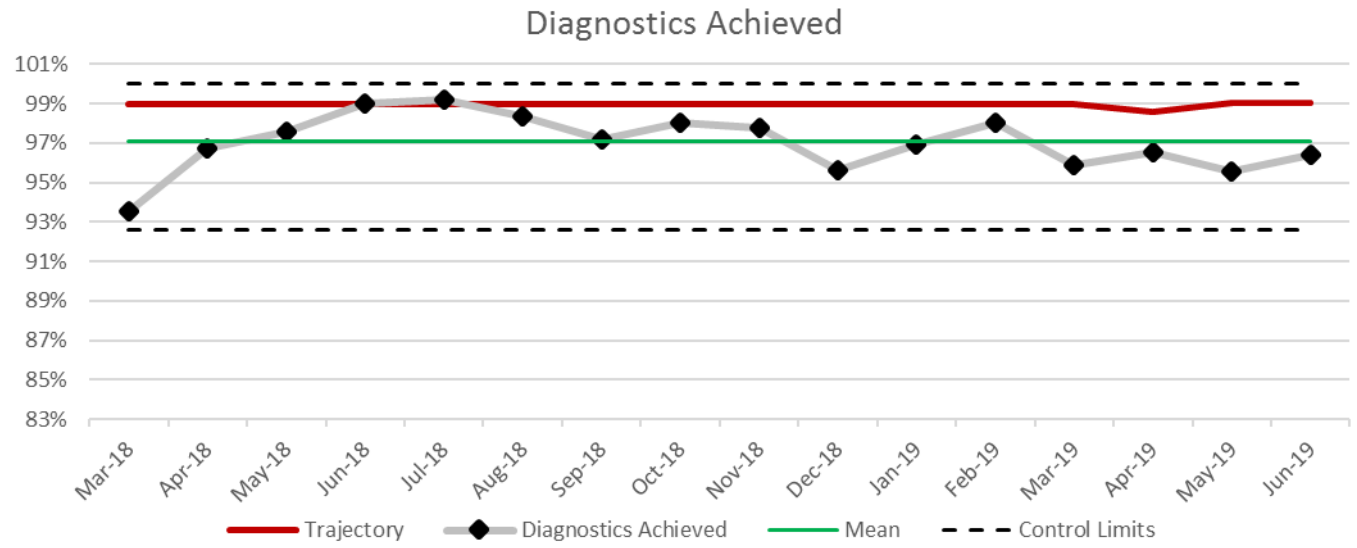
ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance is 96.4% for June which has improved from May 95.56%

Performance is challenged by staff retirement and sickness in Neurophysiology and Urodynamics where small teams have lost a large amount of capacity. Outsourcing teams have been brought in throughout July and should reduce the backlog .

Urodynamics is more of a challenge where service redesign and staff training are required to increase capacity, short term solutions are also being sought.

Increasing demand across all areas is proving to be challenging.

Actions in place to recover

Work is continuing to ensure that all staff understand the DM01 standards and apply best practice to delivery. (A new report is being devised with the support of the cancer team)

Urology is still working through their back log and are working through their recovery plans.

The Trust has committed to deliver sustained compliance with the standard (99%) in 2019/20.

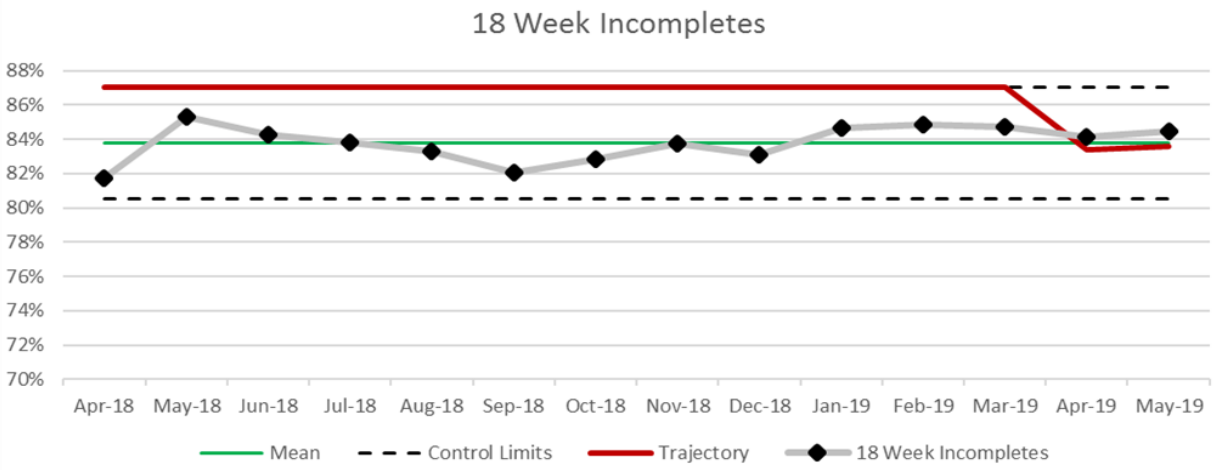
Still some late referrals are causing breaches even before we receive the request. We are working with referrers to improve the process and stop late referral.

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently above trajectory, however waiting list overall number growth suggests that improvements are required to further improve and sustain.

May saw RTT performance improve to 84.48% above trajectory for the second month of 2019/20. This improvement was 0.32% better than April

Overall waiting list size however deteriorated with May waiting list increasing by 939 to 39,895. (A 2.4% increase). The key drivers for this were:

- an increase in external referrals (657 more than April)
- an increase in internal referrals (129 more than April)
- less clock stops than clock starts including less patients added to waiting list than in May

The specialities with the lowest performance against the RTT standard continue to be; Neurology (42.72%), Nephrology (68.85%) and Maxillo-Facial Surgery (75.25%)

Specialties that have had the greatest increase in waiting list are Neurology (266 growth) Ophthalmology (235 Growth, Cardiology (197 growth)

Actions in place to recover:

Alignment with system elective improvement plans, currently being synthesised and with trajectories being mapped out.

Additional capacity created in ENT and performance shows improvement.

Continued delivery of the benefits in T&O from the reorganisation and establishment of Grantham as elective hub. Aspiring to achieve 18 weeks standard in 2019/20.

Validation software procured to ensure standardisation of process across Trust. A rollout plan to implement usage is being drafted for approval.

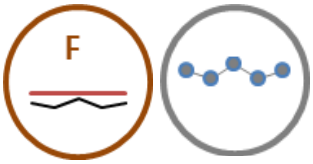
Targeted specialty specific recovery plans are being developed in Neurology. This is a significant shared priority with CCGs and likely to involve outsourcing/insourcing, revised pathways out of hospital and suspension of referral access (subject to regulatory approval). Neurology has approached an external provider to take a cohort of patients between 25 – 40 weeks waiting. Awaiting confirmation to proceed.

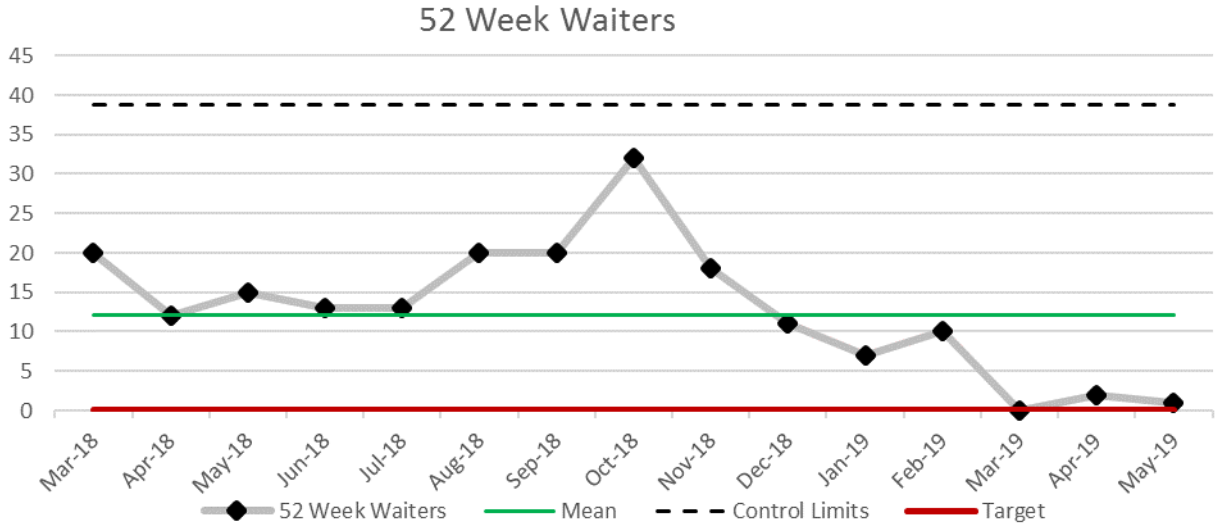
ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

May 52 week performance – 1 patient

- This is an improvement from April where there were 2 confirmed.
- The end of May position is reported as **one** incomplete 52 week waiter.

In order to prevent deterioration in 52 week wait patient numbers all patients are escalated at 40 weeks and above. This performance metric is being used as lead indicator for reducing 52 week wait risk

Validation and administrative error remains a key risk to the delivery of 52 week standard.

April to May showed a decrease of 4 patients waiting over 40 weeks. However, with the issues noted in Neurology and Maxillo-Facial, this is likely to increase in those specialties.

Actions in place to recover:

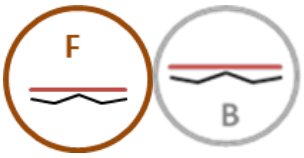
- Continued operation of weekly oversight via RTT PTL meeting and senior review of over 40 week patients.
- Recovery plans being developed in Neurology working with CCG. Although commencement dates have not been confirmed.
- OMF has backlogs in dental extractions and skin. Also a mid-grade doctor is leaving in July. The division will look at replacing this doctor. Plans are being discussed to transfer the backlog out if possible to NUH or private providers.
- Training and validation tracking software has been procured and will be rolled out with competency and compliance monitoring to ensure that administrative errors reduce.

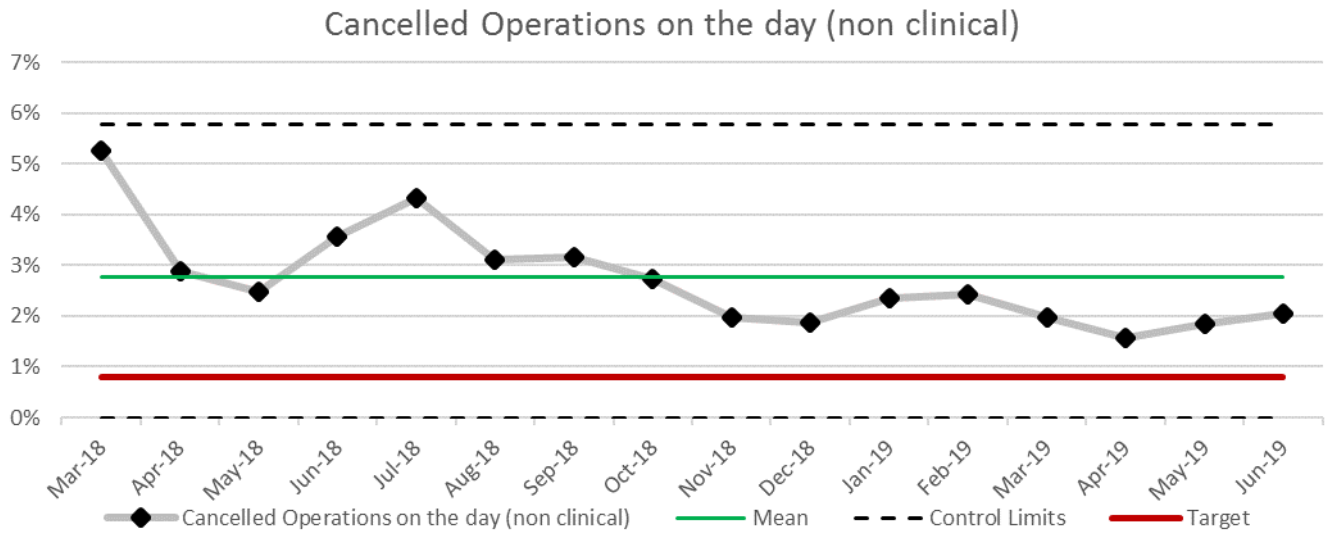
ZERO WAITING – CANCELLED OPS ON THE DAY (NON CLINICAL)

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:

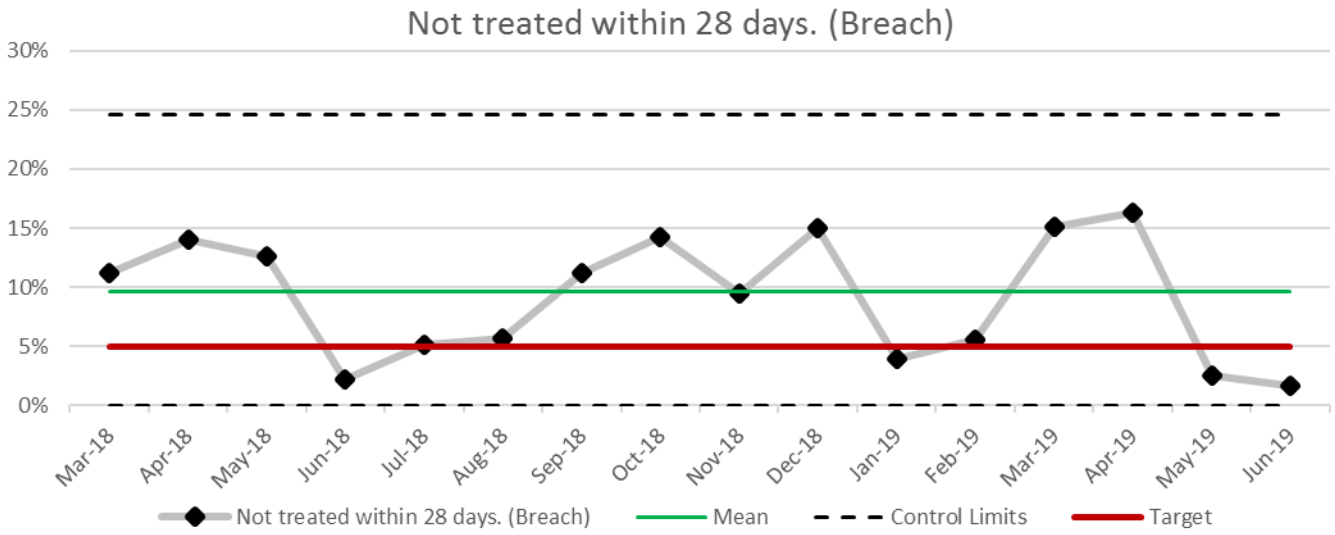
Improved processes for pre-assessment is having a positive impact.
Grip and control at the 6:4:2 meeting is also helping.

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.

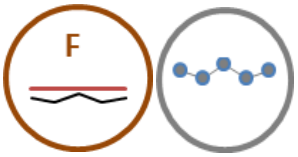
Centralisation of booking clerks project which will be completed by the end of June 2019 will help the process for tracking.

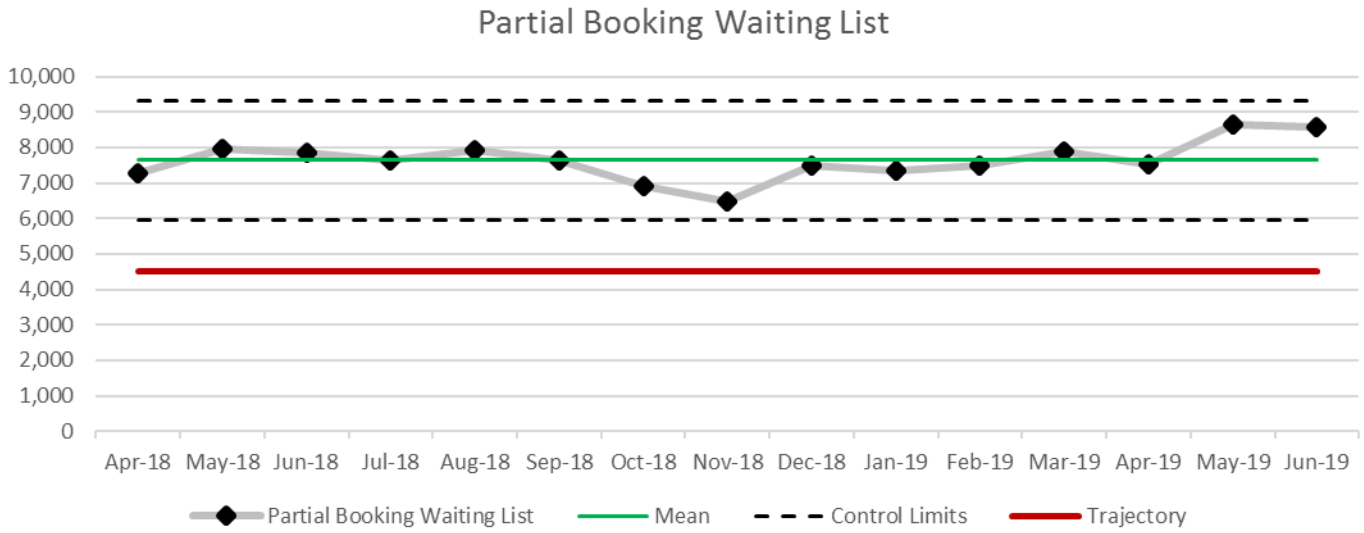
ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

With Neurology being a fragile service, use locums and outsourcing are already taking place.

The challenge for the majority of plans are :

- the availability of locums,
- the extra costs incurred,
- providing nursing and space for the extra capacity,
- balancing priorities.

Actions in place to recover:

All Divisions have been asked to provide backlog recovery plans with timescales, the majority have now been provided.

The Divisions will be accountable to the action plans, the main themes are

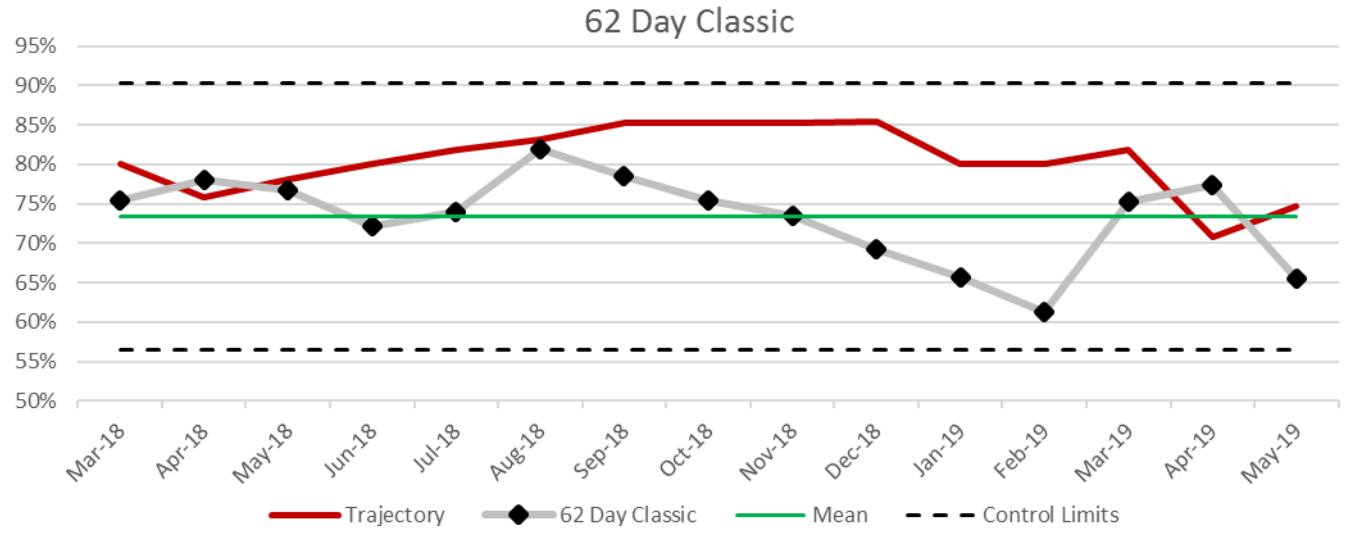
- Validation,
- Alternative patient pathways,
- Locums,
- Outsourcing.

ZERO WAITING – CANCER 62 DAY

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



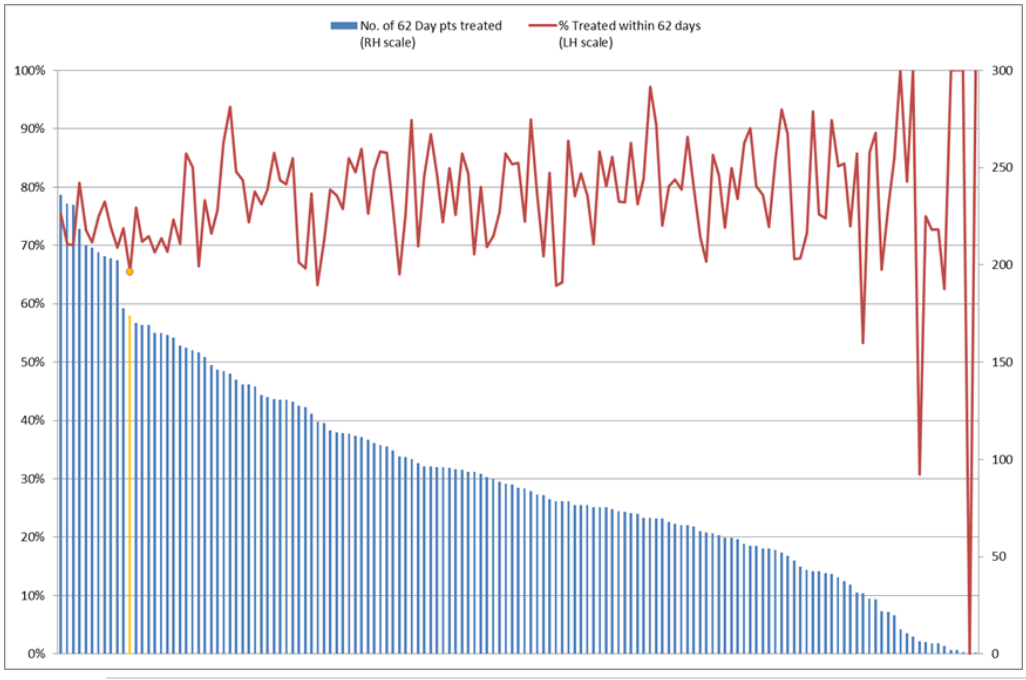
62 Day Classic and Backlog

The 62 Day Classic standard significantly under-performed against the trajectory of 74.8%, with Head & Neck, Sarcoma and Skin all over-performing against their agreed trajectories.

Early indications are that our June performance will be back on track by being either on (or very close to) our agreed trajectory of 78.4% and this improvement continuing into July. This demonstrates that the poor performance in May was restricted to that month.

(Cancer trusts in order of treating volumes – ULHT is yellow bar/dot)

ULHT was in 12th position for volume of patients treated



Key issues & actions against delivery for 2019/20

There are a number of service challenges common to all tumour sites, which will require Trust-wide actions to support the divisions:

• Faster Diagnosis Standard (FDS) +62 Day patients (diagnosed & undiagnosed) – ULHT continues to be challenged by the implementation of the FDS. The greatest challenge in collecting the data has been ensuring adequate recording suitable for audit (essentially in the patient notes or a letter to the patient) as well as gaining clinical engagement in completing and documenting to a satisfactory standard (clarity of letters stating cancer is no longer a concern).

Actions undertaken:

- Colorectal and Gynaecology have designed standard FDS letters templates.
- Colorectal, Urology, Lung, Skin and Head & Neck are utilising the Cancer Centre Co-ordinators supporting the Divisions via one-to-one meetings with clinicians.
- The Division of Medicine's General Manager is engaging directly with clinicians to ensure letters are completed and signed off in a timely manner.

Colorectal – Through April and May 2019, this tumour site has had difficulty in achieving their 62 Day performance. Colorectal did not meet their agreed trajectory in April and May for number of treatments or breaches contained within the treated volume.

Actions undertaken:

- working on earlier pathway activity;
- improving 7 and 14 day performance;
- reducing timescales for migration to a single trust wide MDT approach

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 did not meet their agreed trajectory in April for number of treatments or breaches contained within the treated volume and in May for number of breaches contained within the treated volume.

Actions undertaken:

- setting up a one-stop PMB clinic
- identified additional theatre list at Grantham to provide extra 2ww capacity
- working with Oncology on job plans of the Gynae-oncologists to provide additional clinics

Pathology – Path Links have been 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 – an input that should assist ULHT in better engaging NLAG. We routinely review cancer patient turn-around times for pathology.

Actions undertaken:

- locum cover arranged into the summer, pending accommodation provision
- substantive Breast pathologist commenced in post
- commencing joint Breast pathologist post with NUH

Tertiary Diagnostics and Treatments - A number of tumour sites are continuing to experience delays in securing timely diagnostics and/or treatments from the tertiary cancer centres (predominately Nottingham).

Actions undertaken:

- Cancer Alliance funding was secured to employ three fixed term Project Managers (Band 8A – joint appointments between ULHT and CCGs), two have commenced in post and the final one, who will be focusing on tertiary working, is due to commence in August.

Oncology – This service is continuing to have clinic capacity difficulties for numerous tumour sites and should be considered to have significant fragility. Recent recruitment success meant that the ULHT Oncology service would have been be staffed to establishment however another Oncologist is now due to leave and adds ongoing instability.

Actions undertaken:

- New Oncologist started 1st July
- 2 x overseas recruitment awaiting GMC registration completion
- Appointed 2 x ACP in new roles
- New Radiographer led clinics

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).

Actions undertaken:

- The Cancer Standard Operating Policy is under review as the first stage of the benchmarking
- The Cancer Centre has produced a Job Description/Terms of Reference for the Cancer Centre Co-ordinators supporting the Divisions, awaiting Managing Director sign-off

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.

Actions undertaken:

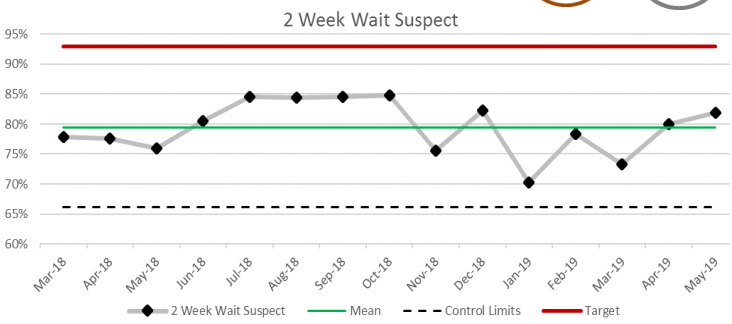
- Awaiting imminent guidance to be issued by an NHSE team who have been working on streamlining the MDT process and the introduction of ‘predetermined Standards of Care’ (SoCs)

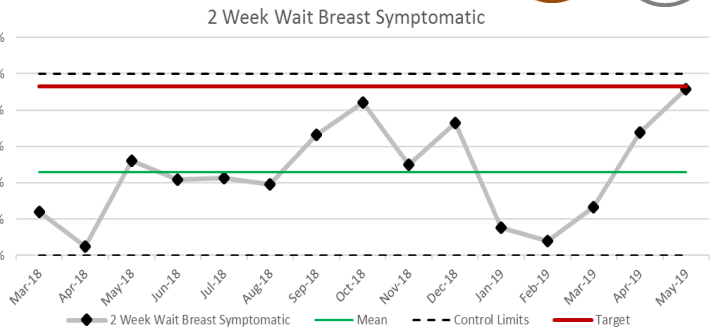
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Only three tumour sites met the 14 Day standard in May: Brain, Head & Neck and Lung. The Breast service continues to show a marked improvement from previous months and continues into June (expected performance for June to be 96%)

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. May's tumour site performance is as below:

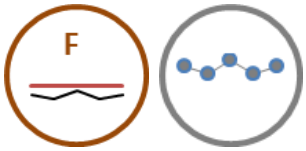
	Total	< 7 Day Prfrmnce %	< 14 Day Prfrmnce %
Brain/CNS	11	36.4	100.0
Breast	293	18.1	91.8
Breast Symptomatic	144	24.3	91.7
Colorectal	439	39.2	82.5
Gynaecology	194	11.9	49.5
Haematology	19	47.4	89.5
Head & Neck	235	32.3	93.2
Lung	67	77.6	98.5
Sarcoma	17	47.1	82.4
Skin	435	6.4	73.3
Upper GI	170	60.6	92.4
Urology	262	41.2	83.2

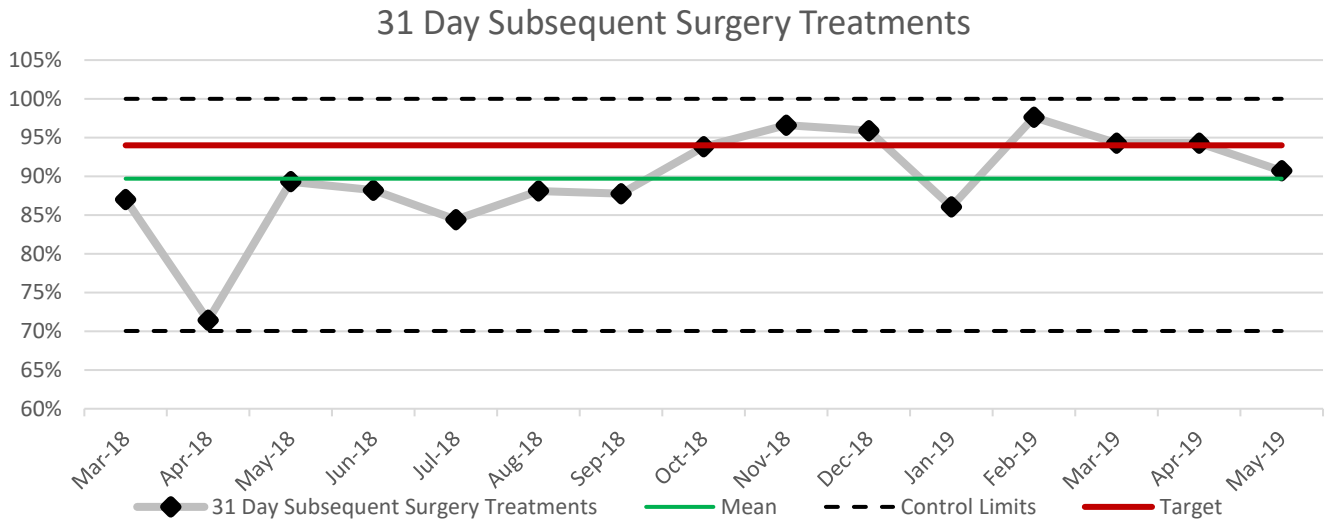
ZERO WAITING – 31 DAY WAIT

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 May. The Surgery Subsequent standard was missed due to two patient choice and two due to capacity.

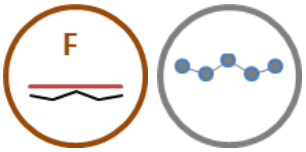
		Breaches								
31 day Subs (98/94/94% NATIONAL STANDARDS)	**Booked in target**	**32 - 38**	**39 - 48**	**49 - 62**	**63 - 76**	**77 - 90**	**91 - 104**	**104+**	**Total**	**Prfrmnce**
Drug	70								70	**100.0%**
Radiotherapy	96	**3**	**2**						101	**95.0%**
Surgery	39	**1**	**1**				**2**		43	***90.7%***

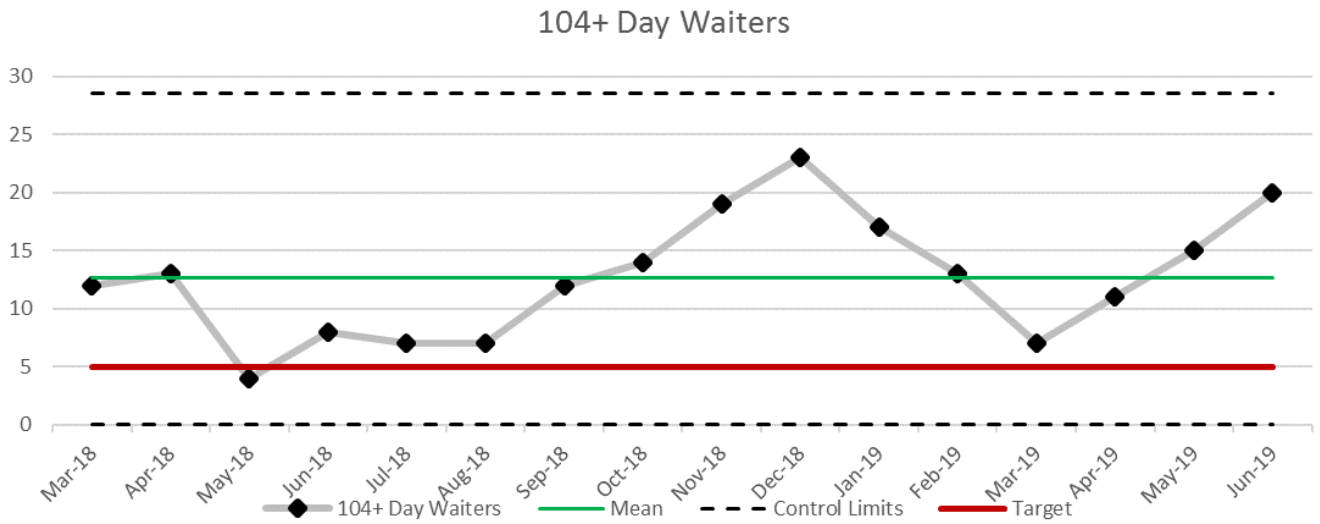
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





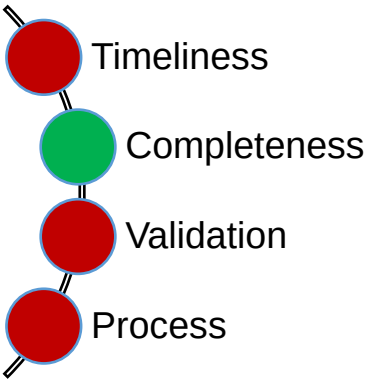
The number of Trust patients waiting over 104 days has been steadily increasing each week since early June with an increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).

The 104+ day waits in the Midlands region have increased significantly in 2018/19, over and above the overall increase in activity and backlog and this trend has continued into 2019/20.

NHSI/E are looking to support trusts in addressing both the quality and performance issues relating to 104+ day cancer waits.

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

Report to:	Trust Board
Title of report:	Audit Committee Report to Trust Board
Date of meeting:	15th July 2019
Status:	For Discussion
Chairperson:	Mrs Sarah Dunnett, Non-Executive Director
Author:	Mrs Jayne Warner, Trust Secretary

Purpose	To provide the Board of United Lincolnshire Hospitals NHS Trust with a formal report of the work of the Audit Committee since its last meeting, the assurances that have been received and validated, and those that are missing along with the actions to address them.
Background	This Committee meets at least quarterly and takes scheduled reports from the Trust's Internal and External Audit Providers, Counter Fraud Service, Finance Director and other parties in accordance with an established work programme.
Business undertaken	**Internal Audit** The Committee received and approved the revised draft Internal Audit Plan 2019/20 from the Trust's newly appointed Internal Audit providers Grant Thornton. The Plan had been updated following comments from the Committee. The Committee noted that the Internal Auditors whose appointment had only been made on 1 April 2019 were focussed on the challenge to deliver the plan in year. The Committee asked the Internal Auditors to determine a set of KPIs in relation to the Internal Audit contract and plan which could be used by the Committee to monitor delivery.
	Internal Audit Recommendation Tracker The Committee noted the significant efforts which had been made with addressing the outstanding overdue internal audit recommendations. There remained 29 overdue recommendations made by the previous internal audit service providers. It was agreed that these would be passed back to the Trust to manage and resolve allowing the new providers to establish a more robust system for managing recommendations going forward. The Committee received assurance that the latest list of recommendations had been highlighted to Executive Directors. Moving forward the Committee would expect the Trust to demonstrate improved responsiveness and considered actions the Committee may

	take if this was not the case. A target of clearance of the remaining 29 by the October Committee meeting was given.
	Counter Fraud The Committee received the LCFS progress report and the Counter Fraud Annual Report for 2018/19. The Committee agreed that the annual report was a true reflection of the counter fraud work in the Trust for the year and the quarterly reporting which they had received during the year.
	External Audit **Quality Account Report** The Committee received the final report which issued a limited assurance report in relation to the content of the Trust Quality Account. This had involved a review of the content of the Quality Account against the requirements of NHSI's published guidance, as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19' and reviewing the content of the Quality Account for consistency with the source documents specified by NHSI in the detailed guidance. The data issues which had been highlighted during the review had been referred to the Finance, Performance and Estates Committee to seek further assurances. The Chair of the Quality Governance Committee commented that the final report had been delayed and that this had created a challenge for the Committee in terms of sign off and publication. This would be picked up by the Trust with the External Audit providers in the debrief process. **ISA 260** The Committee received the final update letter on the ISA 260 report on their audit for the year ended 31 March 2019. **Annual Audit Letter** The Committee received the annual audit letter. The letter captured all recommendations made across the year end work completed by External Audit. This would be incorporated into an action plan and monitored through the Committee.
	Corporate Governance Manual - Standing Orders and Standing Financial Instructions

	The Committee considered the draft Standing Orders and Standing Financial Instructions. These had been modernised in line with best practice and required Committee recommendation to support their final sign off at Trust Board. Internal and External Audit were satisfied with the documents presented. The scheme of delegation remained in place whilst further work was completed to identify where the revised arrangements relating to the Trust Operating Model impacted. This would be considered by the Committee at its meeting in October. The Committee recommended the manual for approval at the Trust Board.
	Standards of Business Conduct The Committee reviewed a new Standards of Business Conduct Policy which brought the Trust arrangements in line with national guidance. The policy was approved and an appropriate communication strategy would be determined with the Communications Team.
	Policy Management The Committee received a position statement in relation to policies. The Committee were not assured that the Trust had an adequate process in place to manage, maintain and monitor policies. The Committee sought further assurances to be provided on progress against the actions planned at its meeting in October.
	NHS I Undertakings The Board had asked the Committee to review progress against the undertakings agreed by the Trust with NHSI. The Committee were not assured particularly in respect of the workforce plans and the Quality and Safety Improvement Plans. The Committee agreed to escalate to Trust Board the lack of assurance that the Trust had in place a workforce plan which would deliver in 2019/20.
	Audit Committee Annual Report 2018/19 The Committee approved its own annual report for submission to the Trust Board.
Issues where the Committee are seeking further assurance	Policy Management NHSI Undertakings Resources for Counterfraud Continued improvements in year end closedown audit arrangements Scheme of delegation Links on STP governance arrangements

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner Trust Secretary
Date:	6th August 2019
Essential Standards:	

Title:	Audit Committee Annual Report

Author/Responsible Director: Jayne Warner, Trust Secretary / Sarah Dunnett Audit Committee Chair

Purpose of the Report:

To present the 2018/19 Audit Committee Annual Report to Board.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	X

Summary/Key Points:

It is best practice to provide the Trust board with the Audit Committee's Annual report covering the work of the Committee for the financial year 2018/19.

The draft Audit Committee Annual Report is presented following its approval by the Audit Committee at their meeting on the 15th July 2019.

Recommendations:

The Board are asked to:

- Receive the Audit Committee Annual Report.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR) N/A

Assurance Implications

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review?

United Lincolnshire Hospitals NHS Trust

Draft Annual Report to the Trust Board from the Audit and Risk Committee 2018/19

1. INTRODUCTION

The Audit and Risk Committee's main purpose is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes. In order to discharge this function it is best practise for the Trust Board to receive a formal annual report from the Trust's Audit and Risk Committee (the Committee). This report summaries the work of the Committee for the financial year 2018/19. This report includes information provided by Internal and External Audit.

2. ROLE OF THE COMMITTEE

The role of the Committee is central to the governance of the Trust. The role has continued to develop to incorporate a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business.

2.1 Terms of Reference

During 2018/19, in line with all other Committees of the Board, the Committee's Terms of Reference were reviewed and amended and approved by the Trust Board at it's meeting on 26 October 2018. The terms of reference and membership of the Committee reflect the governance arrangements and the guidance requirements set out in the NHS Audit Committee Handbook. Under the agreed terms of reference the Committee was tasked as follows, to support the Board by scrutinising the robustness of and providing assurance that there is an effective system of governance and control for risk, the accounting policies and the accounts of the organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for the organisation.

2.2 Membership

The membership of the Committee is confined to Non-Executive Directors, not including the Chair of the Trust, and comprises four Non-Executive Directors. Three of these Non-Executive Directors chair one of the other Board Committees. A quorum shall be not less than three Non-Executive Directors. Any NED can deputise for a Committee member, with the exception of the Trust Chair, as delegated by the Trust Board. All meetings were quorate in 2018/19. The Committee has seen 93% attendance at its meetings across the year.

Details of the Committee's membership are set out below:

Voting Members:

Mrs Sarah Dunnett, Non-Executive Director – Audit and Risk Committee Chair
Mr Geoff Hayward, Non-Executive Director – W&OD Chair
Mrs Liz Libiszewski, Non-Executive Director – QGC Chair
Mrs Gill Ponder, Non-Executive Director – FPEC Chair

In Attendance:
Director of Finance and Procurement (Executive Lead)
Trust Secretary and FTSU Guardian
Internal Audit
External Audit
LCFS
Chief Executive (by invitation once a year)

2.3 Frequency

The Committee met on 6 occasions during the financial year and reported directly to the Trust Board. The Committee members also met in private with the Internal and External Auditors to obtain additional assurance. No matters of concern were raised.

2.4 Self-Assessment

The Committee conducted a self-assessment of its performance during the year. The assessment considered the Committee's establishment and role, membership experience, training, leadership, internal and external audit, procedures, meetings and communications. The Committee developed an action plan in response to the self-assessment to enhance its performance.

3. DELIVERY OF WORK PROGRAMME:

The Committee has reported its work to the Board through monthly upward assurance reports and is reporting progress against the delivery of the work plan, defined by the terms of reference through this annual report. The Audit Committee's indicative work programme for 2018/19 is set out as an appendix to this report.

4. INTERNAL CONTROLS & RISK MANAGEMENT

4.1 Assurance Framework

The Board Assurance Framework (BAF) is the key assurance document for the Trust. The Audit Committee has scrutinised the BAF at each of its meetings in 2018/19 and has considered the adequacy of the mechanisms and processes surrounding the BAF in place to support the Trust Board in seeking assurance in respect of the strategic objectives. The Trust Board has sought to develop the BAF during 2018/19 building on audit recommendations. The Committee received the Head of Internal Audit Opinion and acknowledged the opinion given in relation to the BAF. The Trust received a number of reports on the governance arrangements with limited assurance opinions. Through the Board Committees the Board has sought to implement the recommendations at pace. Work is still to be doen particularly on embedding the governance framework pan Trust.

4.2 Care Quality Commission (CQC) Regulation

The CQC visited the Trust and carried out a number of inspections during the year. These inspection reports were presented to the Quality Governance Committee along with the

action plans and progress against those plans. The Audit Committee received verbal assurance reports from the Quality Governance Committee.

In July 2018 the CQC published their report on the well led inspection of the Trust, which resulted in the Trust moving from Inadequate to a rating of Requires Improvement. The Trust implemented a comprehensive action plan to address areas for further improvement which was overseen by the Quality Governance Committee and the Board. The Audit Committee sought assurance on the progress via the reports from the Quality Governance Committee and by wider assessment of the controls against individual risks through the BAF.

The Trust continues to have CQC conditions in place in respect of its licence. These were reported in the Annual Governance Statement.

4.3 Self-Declaration / Self-Assessment Processes
The Trust is required to make a self-declaration of compliance against the Single Over-sight Framework (SOF) at the year end. A quarterly report of compliance against the themes set out in the SOF has been prepared and considered by the Audit Committee each quarter. The Committee have continued to develop this report through 2018/19.

4.4 Governance Arrangements
The Committee received quarterly reports on compliance with the Trust's governance arrangements. During the period no significant breaches of governance arrangements occurred. The Committee specifically reviews the detail of waivers, losses and compensations and declarations of hospitality. The Committee has continued to monitor closely the level of waivers performed and through the Director of Finance and Procurement worked to see these reduce. This has been a particular challenge due to urgent fire safety works. In addition there has been a review of overpayment of salaries, where by tighter controls have now been put in place. Work continues to strengthen the governance around how the Trust conducts its business with the development and roll out of a new standards of business conduct policy.

4.5 Annual Review of Governance Arrangements
The Committee reviewed as part of the annual update and in light of best practice, but most significantly as a result of the implementation of a new Trust Operating Model the proposed changes to the key corporate governance documents of the Trust:

- Standing Financial Instructions
- Scheme of Delegation
- Standing Orders

The Committee recommended amendments to these which are still in progress before presenting for approval at Trust Board. These will be kept under review throughout 2019/20.

4.6 NHS Counter Fraud Service
The Trust is required to monitor and ensure compliance with NHS Provider Standards for Fraud, Bribery and Corruption regarding its arrangements for counter fraud and corruption work. A key role for the Committee is to provide assurance to the Trust Board that these arrangements are robust.

During the year, the Committee:

- received and recommended to the Trust Board the LCFS Annual report 2017/18

- approved the Annual Counter Fraud Plan for 2018/19
- reviewed and approved the Trust's annual LCFS submission to NHS Protect
- monitored progress against the Plan at each meeting
- monitored reactive and proactive fraud work provided by the LCFS, and received reports on the volume of cases under investigation and subsequent actions taken by management to strengthen control, an area of additional reporting requested but the Committee
- received strategic updates from the NHS Counter Fraud Authority

The Trust continues to monitor the level of Counter Fraud recourses in light of the current level of reactive work.

4.7 Internal Audit

360 Assurance have been the Trust's Internal Audit service provider since 1 April 2015. During the year the Committee:

- Approved the Internal Audit Plan for 2018/19 to address areas of internal control where assurance was sought, to cover mandatory areas as required by NHS Internal Audit Standards and to meet the statutory responsibility to provide a Head of Internal Audit Opinion. All internal audits in the 2018/19 plan were successfully completed by May 2019, a significant achievement in comparison to prior years
- monitored progress against plan, including consideration of issues arising and high priority recommendations raised by 360 through receipt of regular progress reports
- received and considered the Head of Internal Audit's opinion for 2018/19 in April 2019
- focussed on overdue audit recommendations to bring the number down
- evaluated internal audit performance against agreed performance metrics
- received reports on, and monitored progress on, the re-procurement of the Internal Audit service pan Lincolnshire, which resulted in the new appointment of Grant Thornton.

The overall Head of Internal Audit opinion was limited which is consistent with last year and Committee expectations based on reports received throughout the year. The Committee were assured that significant work was being undertaken pan Trust to strengthen the overall control environment and whilst systems of financial control where satisfactory, in many other areas these were embryonic and required embedding.

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5. EXTERNAL AUDIT AND FINANCIAL REPORTING

The Trust's external auditor for 2018/19 was PWC. This was their second year of engagement following appointment in 2017/18.

The Audit Plan set out the work to be undertaken in relation to the 2018/19 accounts and was developed on the basis of a risk-based approach to audit planning. This was received and considered by the Committee. During 2018/19 the Trust was subject to additional NAO reporting requirements which resulted in additional fees payable to PWC. This was approved by the Committee.

There had been a number of problems encountered by the External Auditors during the 2017/18 year end audit, primarily with the production of the Trust's annual report and quality account. As a result, the Committee requested and received an improvement plan and timetable early in the new financial year. The Committee monitored this timetable and the delivery of the annual report and accounts for 2018/19 throughout the year. This included early sight of accounting policies, draft annual report and annual governance statement, together with regular progress update reports from PWC. The Committee, following review of the financial projections, assurances, delivery of revised plan and specialist advice for

2018/19, satisfied itself that the Trust's Annual Accounts for 2018/19 should be prepared on a "Going Concern" basis. Although significantly improved further enhancements will be sought in 2019/20.

The external auditors presented their Annual Opinion to the Committee prior to the Committee's review of the Annual Accounts in May 2019. The Committee considered and recommended the 2018/19 Annual Accounts and report to the Board at its meeting on 20 May 2019 whilst an unqualified opinion was issued they were not satisfied that the Trust had put in place arrangements to ensure economy, effectiveness and efficiency in its use of resources and issued an adverse opinion. This is consistent with the current and prior year financial challenges the trust is facing.

The Committee received a report from the external auditor on the Quality Report for 2018/19. This report noted the concerns about the issues encountered during the review with production of the report and also the data quality. During 2018/19 the Committee exercised greater oversight of the completion timetable which resulted in all deadlines being achieved. The Trust had delegated responsibility to the Quality Governance Committee for the Quality Report. The account was produced in a more timely and compliant basis.

6. SUMMARY

It has been 18 months of transition for the Trust and the Committee with changes in key personal, namely Director of Finance, increased regulatory scrutiny and support given the Trust's special measures status, change in external auditors and from 2019/20 a change in internal auditors. Alongside this there has been the introduction of a new Trust Operating Model which has seen the Trust streamline and consolidate form 15 divisions to four.

Against this backdrop this report demonstrates that the Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust. The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of controls in place and as necessary applied additional control measures in order to maintain, strengthen and develop systems of control that enable the Trust to be compliant with its legislative and statutory duties.

The focus for the new financial year 2019/20 will be on continuing to support and assure the Trust Board on reviewing and strengthening financial reporting, internal control, risk assurance and governance. The Committee itself will continue to ensure that it is itself improving with an increased focus on strengthening new arrangements developed throughout 2018/19, with an additional focus on the Trust's relationship with Lincolnshire's STP governance arrangements.

Agenda Item:

Audit and Risk Committee

Work Programme
(based on Audit Committee handbook requirements and checklist completion by members)

1. Governance	Jul	Oct	Jan	Mar	May
1.1. Review the board assurance framework	X	X	X	X	
1.2. Review the risk management system		X		X	
1.3. Note business of other committees and review inter-relationships	X	X	X	X	
1.4. Review draft Annual Governance Statement			X	X	X
1.5. Receive other sources of assurance	X	X	X	X	
1.6. Review the draft Annual Report			X	X	X
1.7 Review the Quality Account		Delegated to Quality Governance Committee for assurance			
1.8 Review whistle blowing arrangements		Delegated to Workforce and OD Committee for assurance			
1.9 Review other reports and policies as appropriate	X	X	X	X	
1.10 Review clinical audit		Delegated to Quality Governance Committee for assurance			

2. Financial Focus					
2.1. Agree annual accounts and annual report timetable and plans		X			
2.2. Review of annual report and accounts progress			X	X	
2.3. Review of Audited Annual Accounts and Financial Statements (including external audit opinion)					X
2.4. Review risks and controls around financial management		X			
2.5. Review changes to standing orders, standing financial instructions/ prime financial policies and changes to accounting policies	X				
2.6. Review losses and special payments	X	X	X	X	
2.7. Review waiving of standing orders	X	X	X	X	

3. Internal/External Audit					
3.1. Review and approve the annual internal audit plan				X	
3.2. Review and approve internal audit terms of reference				X	
3.3. Review the effectiveness of internal audit		X			
3.4. Receive internal audit progress reports	X	X	X	X	

3.5.	Receive Head of Internal Audit Opinion				X	X
3.6.	Agreement of external audit plans and fee				X	
3.7.	Review the effectiveness of external audit		X			
3.8.	Review external audit progress reports	X	X	X	X	
3.9.	Receive External Audit annual governance report					X
3.10.	Receive external auditors Annual Audit letter	X				

4. Counter fraud and security						
4.1.	Review annual reports on counter fraud activity	X				
4.2.	Review Annual Counter fraud work programmes				X	
4.3.	Receive Counter fraud progress reports	X	X	X	X	
4.4.	Review organisations self review against NHSCFA standards				X	
4.5.	Review effectiveness of those carrying out Counter fraud activity		X			

5. General						
5.1.	Review the terms of reference				X	
5.2.	Review the Committee effectiveness		X			
5.3.	Develop improvement plan based on review of effectiveness			X		
5.4.	Produce Annual Report for Trust Board	X				
5.5.	Private meeting with Internal /External Auditors				X	

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner, Trust Secretary
Date:	6 August 2019

Title:	**Corporate Governance Manual incorporating Standing Orders and Standing Financial Instructions**

Author: Jayne Warner, Trust Secretary/ Jonathan Young, Acting Deputy Director of Finance/ Barry Pogson, Associate Director of Procurement

Responsible Director Paul Matthew, Director of Finance and Procurement

Purpose of the Report:

To provide the revised and updated Corporate Governance Manual for approval by Trust Board.

The Report is provided to the Board for:

Information		Assurance	✓
Discussion		Decision	✓

Summary/Key Points:

The Corporate Governance Manual together with the following provide a comprehensive regulatory and business framework for the Trust.

- Standards of Business Conduct Policy and Declarations of Interest Policy
- Local Counter Fraud Bribery and Corruption Policy

The manual has been updated following consideration by the Audit Committee at both its April and July meetings in line with the latest best practice and to reflect the launch of the Trust Operating Model.

A revised scheme of delegation is not included within the document. This continues to be developed to provide a greater level of detail. The existing approved scheme of delegation, which currently deals only with the delegation of powers through Trust Board, Chief Executive and Executive Directors is being reviewed at the October Audit Committee

An overview of those areas which have been amended from previous versions are listed below. This does not include minor areas when there has been a more general tidying up of language or phrasing.

The Audit Committee considered the Corporate Governance manual and recommended for consideration and approval by the Trust Board.

Recommendations:

The Trust Board are asked to approve the documents for publication.

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

Significant changes to Standing Orders

Paragraph relating to joint directors simplified.

Ordering of paragraphs changed to give better flow. Some sections merged under one heading.

Number of sections relating to proposing motions, amending motions, withdrawing motions removed. To bring document up to date in line with modern practices and other Trusts.

Individual committee details this is within ToR and removes need for more frequent updates to SO's.

Declaration of Interests section updated to reference Standards of Business Conduct Policy. In line with current national guidance.

Significant changes to Standing Financial Instructions

Fraud Bribery and Corruption section was out of date and was amended with input of LCFS.

Largest change relates to the former tendering section which now relates to current procurement practices. Particularly the authorizing and awarding of contracts.

Payroll areas have been updated to reference IR35.

External borrowing section updated to include clarity on how Trust agrees loans.

Updated information in the advice referring to disposal and condemnations.

Amendments made at the request of the Audit Committee

Clarity around the numbers of Board members voting and non voting and maximum numbers allowed by statutory instrument.

United Lincolnshire Hospitals NHS Trust

CORPORATE GOVERNANCE MANUAL

Document Information

Trust Policy Number	:	ULH-CORPORATE-SO01
Version	:	2019 Draft v 3
Status	:	For approval by Board
Issued by	:	Trust Secretary
Issued date	:	2019 Draft
Approved by	:	Trust Board
Date of approval	:	
Date of review	:	

Change Control

Previous Versions	:	Version 1.2, 1.3, 2
Changes: Additions and revised Trust Operating Model	:	Reflection of updated corporate governance / committee structure
Modifications	:	
Deletions	:	
Date of Issue	:	
Review Date	:	
Referenced Documents	:	
Relevant Legislation		NHS Corporate Governance Framework / NHS Manual for Accounts
Relevant Standards	:	

FOREWORD

The Standing Orders including the Scheme of Delegation and Standing Financial Instructions provide a comprehensive regulatory and business framework for the Trust.

All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

Failure to comply with any part of standing orders is a disciplinary matter, which could result in dismissal. Non compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the Trust's local counter fraud specialist in accordance with the Counter Fraud Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The United Lincolnshire Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 20th April 2000 under The United Lincolnshire Hospitals NHS Trust (Establishment) Order 2000 No 410, (the Establishment Order) and The United Lincolnshire Hospitals NHS Trust (Establishment) Amendment Order 2001 No 154.

The principal places of business of the Trust are Lincoln County Hospital, Lincoln; Pilgrim Hospital, Boston; Grantham and District Hospital, Grantham and Louth Hospital, Louth.

NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust has a duty to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The Board must also comply with the standard for members of NHS Board and CCG Governing Bodies in England 2012.

The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care, NHS Improvement and NHS England, issues further directions and guidance. These are normally issued under cover of a circular or letter.

The NHS Code of Conduct & Accountability requires that, among other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior officers (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The NHS Code of Conduct & Accountability makes various requirements concerning possible conflicts of interest of Board Directors.

The Freedom of Information Act sets out the requirements for public access to information about the Trust's business.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in the Scheme of Delegation and Reservation and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4 NHS Board Governance

NHS Trust Boards must put in place and maintain good corporate governance arrangements, integrated across the organisation and all aspects of governance. This will encompass corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD

2.1 Corporate role of the Board

All business shall be conducted in the name of the Trust.

All funds received in trust shall be held in the name of the Trust as corporate trustee.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No.3.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations the composition of the Board shall be:

The Chair of the Trust (Appointed by NHS Improvement);

Up to 7 non- executive directors (appointed by NHS Improvement);

5 executive directors including:

- the Chief Executive;
- the Director of Finance and Procurement;
- the Director of Nursing
- the Medical Director
- The Deputy Chief Executive

The Trust currently operates with 5 Non-Executive Directors not the maximum of 7 allowed by the statutory instrument.

2.2 Appointment of Chair and Directors of the Trust

The Chair and Directors of the Trust - are appointed by NHSI on behalf of the Secretary of State. The appointment and tenure of office of the Chair and Directors are set out in the Membership and Procedure Regulations.

2.3 Terms of Office of the Chair and Directors

The regulations setting out the period of tenure of office of the Chair and directors and for the termination or suspension of office of the Chair and directors are contained in regulation 7 and regulations 8 and 9 of the Membership and Procedure Regulations, respectively.

2.4 Appointment and Powers of Vice-Chair

Subject to Standing Order 2.4 (2) below, the Chair and directors of the Trust may appoint one of their numbers, who is not also an executive director, to be Vice-Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

Any director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and directors may thereupon appoint another director as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Directors

Where more than one person is appointed jointly to a post mentioned in regulation 2 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

2.6 Role of Directors

The Board will function as a corporate decision-making body, executive and Non-executive directors will be full and equal directors. Their role as directors of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives and other such requirements as determined by NHS Improvement.

(3) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its directors and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as directors of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with NHS Improvement over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.10 Lead Roles for Board Directors

The Chair will ensure that the designation of lead roles or appointments of Board Directors as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Safeguarding etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Admission of public and the press

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

A body may by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings') wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applied. (Public Bodies (Admission to meetings) Act 1960.

The Chair shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and,

without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.2 Calling meetings

Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

The Chair of the Trust may call a meeting of the Board at any time.

One third or more directors of the Board may request a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a request being presented, the directors signing the request may forthwith call a meeting.

3.3 Notice of Meetings and the Business to be transacted

Before each meeting of the Board a notice specifying the business proposed to be transacted shall be delivered to every director, so as to be available to them at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf.

Want of service of such a notice on any director shall not affect the validity of a meeting.

In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.4 Chair of meeting

At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Board has appointed one), if present, shall preside.

If the Chair and Vice-Chair are absent, such director (who is not also an Executive Director of the Trust) as the directors present shall choose shall preside.

3.5 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.6 Quorum

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one director who is also an executive director of the and one non- executive director) is present.

An Officer in attendance for an Executive Director but without written acting up status may not count towards the quorum.

If the Chairman or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7 Voting

Every question at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.

All questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

If a director so requests, their vote shall be recorded by name.

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.8 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

3.9 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.10 Annual Public Meeting

The trust will publicise and hold an annual public meeting on or before 30th September in every year in accordance with the NHS Trusts (Public meeting) Regulations 1991 (SI 1991) 482.

3.11 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- that two thirds of the Board directors are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the Board are present (including at least one executive director of the Trust and one non-executive director) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and directors of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) Every decision to suspend standing orders shall be reported to the Audit Committee.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to regulation 17 and 18 of the Membership and Procedure Regulations, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

Regulation allows for the functions of NHS trusts to be carried out jointly with any other NHS body or other NHS trust, or any other third party.

4.2 Emergency Powers

The powers which the Board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-executive directors. The

exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Unavailability of Chair/ Vice Chair

In addition to the statutory power of the vice chair, if the chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the chair, then, if so requested by the Chief Executive, the vice chair shall be empowered to act in the chair's place and to exercise all the powers and duties of the chair until the chair is again available.

If the vice chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the vice chair, then if so requested by the chief executive in relation to any particular matter, any non-executive director shall be empowered to act in the vice chairs place and exercise all the powers and duties of the vice chair in relation to that matter.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board.
The powers of such committees shall be limited to those set out in their terms of reference.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

4.6 Non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and justification for non-compliance and the circumstances shall be reported to the next formal meeting of the Board for action or ratification. All directors of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive and Chair as soon as possible.

4. TRUST COMMITTEES

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and shall receive and consider reports from such committees.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish groups they may not delegate executive powers to the group unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Committees established by the Trust Board

The committees established by the Board are as follows:

- Remuneration Committee
- Audit and Risk Committee
- Quality Governance Committee

- Finance, Performance and Estates Committee
- Workforce, OD and Transformation Committee

5. RELATIONSHIP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for United Lincolnshire Hospitals NHS Trust staff;

- the staff Disciplinary and Appeals Procedures adopted by the Trust

- The Counter Fraud, Bribery and Corruption Policy

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with guidance and requirements issued by or on behalf of the Secretary of State for Health.

7. DUTIES AND OBLIGATIONS OF BOARD DIRECTORS AND UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

All Board members and staff of the Trust are required to comply with the Standards of Business Conduct and Conflicts of Interest Policy. If Board directors have any doubt about the relevance of an interest they should discuss it with the chair or the Trust Secretary.

7.2 Recording of Interests in Trust Board minutes

At the time Board directors' interests are declared, or updated, they should be recorded in the Trust Board minutes.

7.3 Publication of declared interests in Annual Report

Board directors' declarations of interests will be published in the Trust's annual report.

7.4 Conflicts of interest which arise during the course of a meeting

At the start of every Board meeting there will be an agenda item which invites Directors to declare whether they have any interests which might be relevant to any items of business on the agenda. Directors should declare all such interests whether or not they have already declared them for the register. If a conflict of interest is established, the Board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.5 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members.

The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.6 Exclusion of Chairman and Directors in proceedings of the Board

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of Schedule 5 of the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

This Standing Order applies to a committee as it applies to the Trust and applies to a member of any such committee (whether or not he/she is also a member of the Trust) as it applies to a director of the Trust.

7.7 Canvassing of and Recommendations by Directors in Relation to Appointments

Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.8 **Relatives of Directors or Officers**

Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

The Chairman and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of by the Chief Executive, and Chairman, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. The register shall be reported to the Audit Committee.

8.4 **Use of Seal – General guide**

The Seal shall be affixed in the following general circumstances;

- All contracts for the purchase/lease of land and/or building
- All contracts for capital works exceeding £250,000
- All lease agreements where the annual lease charge exceeds £30,000 per annum and the period of the lease exceeds beyond five years
- Any other lease agreement where the total payable under the lease exceed £250,000
- Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £250,000

This list is not exhaustive and further advice regarding the affixation of the Seal should be gained from the Trust Secretary or Director of Finance.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods and services relating to non-pay expenditure officers should refer to Standing Financial Instruction

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 The Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health under the provisions of Section 99 (3), 97 (A) (4) and (7) and 97 (AA) of the National Health Service Act 1977 for the regulation of the conduct of the Trust in relation to all financial matters. The Code of Accountability requires that the Trust shall give, and may vary or revoke Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code.

These Standing Financial Instructions together with the following provide a comprehensive regulatory and business framework for the Trust. They shall have effect as if incorporated in the Standing Orders (SOs):

- Standing Orders,
- Scheme of Delegation,
- Standards of Business Conduct Policy and Declarations of Interest Policy and
- and Local Counter Fraud, Bribery and Corruption Policy and Response Plan

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for

referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

10.2 Responsibilities and delegation

10.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out within Section C of the Corporate Governance Manual, 'Scheme of Reservation and Delegation of Powers: ['Decisions Reserved to the Board']. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 The Chief Executive and Director of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 The Director of Finance

The Director of Finance is responsible for:

(a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed.

(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(e) the provision of financial advice to other members of the Board and employees;

(f) the design, implementation and supervision of systems of internal financial control;

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and All Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For any and all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference (based on those contained in the latest NHS Audit Committee Handbook), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across

the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally the Director of Finance may be instructed to refer the matter to the Department of Health and Social Care. Matters pertaining to fraud, bribery and/or corruption must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan.

11.1.3 The Minutes of Audit Committee meetings shall be formally recorded and an upward report submitted to the Board.

11.2 Director of Finance

11.2.1 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided. The Audit Committee shall be advised of the selection process and appointment when / if an Internal Audit service provider is changed.

11.2.2 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors and LCFS are entitled (without necessarily giving prior notice) to require and receive:

(a) access to all records, documents and correspondence and data relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.2.3 The Trust's Chief Executive and Director of Finance are responsible for ensuring that access rights are given to NHS Counter Fraud Authority (NHSCFA) where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHSCFA Provider Standards.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

11.3.2 Whenever any matter arises which involves, or is thought to involve, fraud, bribery or corruption, the matter must be reported to the LCFS, in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan. All other irregularities, or suspected irregularities, concerning cash, stores, or other property of the Trust, or the exercise of any function of a pecuniary nature, must be notified to the Director of Finance immediately.

11.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

11.3.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.5 Internal Audit terms of reference shall have effect as if incorporated within these Standing Financial Instructions. The terms of reference cover the scope of internal

audit work, authority and independence, management responsibilities, co-ordination of assurance work, reporting and key outputs and the operational responsibilities.

11.4 External Audit

11.4.1 The External Auditor is appointed and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor.

11.5 Fraud Bribery and Corruption

11.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.

11.5.2 The Director of Finance is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

11.5.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority (NHSCFA) Counter Fraud Standards.

11.5.4 The LCFS shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud Authority (NHSCFA) in accordance with the NHS Counter Fraud Authority Counter Fraud Standards, the NHS Counter Fraud manual and the NHSCFA's Investigation Case File Toolkit.

11.5.6 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the Director of Finance to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHSCFA.

11.5.7 The LCFS will at least annually provide a written report to the Audit Committee on anti-fraud, bribery and corruption work within the Trust.

11.5.8 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the Director of Finance and outcomes fed back to the Audit Committee.

11.5.9 The Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption concerns and internally publicise this, together with the NHSCFA's national fraud and corruption reporting line and online referral form.

11.5.10 The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Director of Finance shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.
The Director of Finance shall sign-off qualitative assessments (in years when this assessment is required) and submit it to the relevant authority.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Estates and Facilities and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will prepare annually, a statement of strategic direction for approval by the Board of Directors.

13.1.2 The Chief Executive will submit to the Board of Directors an annual business plan (the "Annual Plan") which takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

In preparing the Annual Plan the Trust should ensure:

(a) financial performance measures have been defined and will be monitored;

(b) reasonable targets have been identified for these measures;

(c) a robust system is in place for managing performance against the targets;

(d) reporting lines are in place to ensure overall performance is managed;

(e) arrangements are in place to manage/respond to adverse performance.

13.1.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit a financial plan and associated income & expenditure budget to the Board for approval. The plan will contain:

(a) a statement of any significant assumptions on which the plan is based and an assessment as to whether they are realistic;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

The budget will:

(a) be in accordance with the aims and objectives set out in the Annual Plan and long term financial model;

(b) accord with activity and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income;

(e) identify potential risks.

13.1.4 The Director of Finance shall monitor financial performance against budget and Annual Plan, periodically review them, and report regularly to the Board.

13.1.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and financial performance against budgets to be monitored.

13.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.7 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage budgets successfully.

13.2 Budgetary Delegation

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This will be achieved through the approval by the Chief Executive of the Executive Devolution Policy setting out Delegation of authority and decision-making power to Corporate Directorates and Divisions, This policy will provide for differential levels of delegated authority dependent upon the Performance of the Directorate or Division.

13.2.2 Subject to any specific provisions arising from a particular set of circumstances, Budgets shall be delegated as far as possible to the lowest level consistent with effective operational management.

13.2.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

13.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

13.2.6 All Business Cases will be approved in accordance with the authority set out in Investment Appraisal Framework and Scheme of Reservation and Delegation of Powers to the Board.

13.3 Budgetary Control and Reporting

13.3.1 The Director of Finance will devise and maintain systems of budgetary control. All managers whom the Trust may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems.

The Director of Finance shall also be responsible for providing budgetary information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and issue to all relevant staff, rules and procedures governing the operation of Budgets.

13.3.2 The Director of Finance is responsible for presenting financial reports to the Board giving details of underlying performance, financial efficiency, liquidity and achievement of plan, as well as details of the overall financial risk ratings score.

(a) Monthly financial reports in a form approved by the Board will contain as a minimum:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) progress against the efficiency / savings programme
(iii) summary cash flow and balance sheet including a forecast year-end position;
(iv) details of new cash borrowings in month and cumulative debt levels
(v) movements in working capital;
(vi) External Financial Limit (EFL) target and performance against Capital Resource Limit (CRL)
(vii) capital project spend and projected outturn against plan;
(viii) explanations of any material variances from plan;
(ix) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance' view of whether such actions are sufficient to correct the situation;
(x) monitoring of management action to correct variances;
(xi) Performance against risk assurance metrics

13.3.3 The Director of Finance is responsible for the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

13.3.4 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of a member of the Executive Team;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

(d) No temporary employees are appointed which would lead to an overspend on the delegated budget without approval of the Chief Executive.

(e) The systems of budgetary control established by the Director of Finance are complied with fully.

(f) cost improvements, productivity, efficiency and income generation initiatives are identified and implemented in accordance with the requirements of the Annual Plan

13.3.5 The Chief Executive may delegate the responsibility for identifying and implementing cost improvements and income generation initiatives to Divisions and Directorates in accordance with the requirements of the Annual Plan and its delivery.

13.3.6 The Director of Finance shall devise and maintain adequate systems to ensure that the Trust can identify, implement and monitor opportunities for schemes to be included within cost improvement and income generating programmes.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in line with the agreed timescales.

13.6 Value for Money

13.6.1 The Chief Executive in conjunction with the Director of Finance shall be responsible for the efficient and effective use of the total financial resources available to the Trust and ensure that good value for money is achieved.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards;

(b) prepare and submit annual financial returns and accounts to the Department of Health and Social Care in accordance with the national timetable and published requirements;

14.2 The Trust's annual accounts must be audited by the Trust's external auditor as appointed by the Audit Panel and thereafter adopted by the Trust Board.

14.3 The Trust will publish an annual report, in accordance with the national timetable. The document will comply with the relevant Department of Health and Social Care guidance including that contained in the Department of Health Group Accounting Manual.

14.4 The Audited Annual Report and Accounts must be presented to a public meeting and made available to the public.

15. BANK ACCOUNTS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions and

best practice advice issued by the Department of Health and Social Care and Treasury. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

The Board of Directors shall approve the banking, working capital and investment arrangements including a review of the Trust's Treasury Management Policy on an annual basis.

15.2 Bank Accounts

15.2.1 The Director of Finance is responsible for:

(a) the operation Government Banking Service (GBS) and other bank accounts held by the Trust, Working Capital Facilities and the appropriate investment of the Trust's cash.

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken);

(e) ensuring the Board of Directors is notified of changes to the Trust's borrowing facilities; and

(f) monitoring compliance with Department of Health and Social Care or any other relevant guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Director of Finance will prepare detailed instructions on the operation of all Trust bank accounts, investments and borrowings which must include:

(a) the conditions under which each bank and GBS account is to be operated, including the limit to be applied to any overdraft

(b) a panel of officers with delegated authority to sign cheques or authorise payments drawn on the Trust's accounts and the number of signatories required on each authority to pay.

(c) those authorised to invest monies; and

(d) any records which must be maintained in respect of the above.

15.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.3.3 All funds shall be held in accounts in the name of the Trust. No members of staff other than those designated by the Chief Executive and the Director of Finance shall open any bank or building society account in the name of the Trust. Any employee aware of the existence of such an account shall report the matter to the Director of Finance.

15.3.4 Where an agreement is entered into with any other body for payment to be made on behalf of the Trust from bank accounts maintained in the name of the Trust or other body, or by Electronic Funds Transfer (BACS), the Director of Finance shall ensure

that satisfactory security regulations of the Trust/other body relating to bank accounts exist and are observed. This will be specified in an agreement with the appropriate body.

15.4 Investments

15.4.1 The Director of Finance is responsible for arrangements for the investment of surplus cash with the National Loans fund ensuring:

(a) a competitive rate of return within a minimal risk profile;
(b) the availability of cash to meet operational requirements;

15.4.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

15.4.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15.5 Tendering and Review

15.5.1 The Director of Finance will review any commercial banking arrangements of the Trust at five yearly intervals to ensure they reflect best practice and represent best value for money.

15.5.2 Competitive tenders shall be sought and the results reported to the Board. This review is not necessary for the operation of Government Banking Services accounts required by the Department of Health and Social Care.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

16.1.3

16.1.4 The Trust may carry on activities for the purpose of making additional income available in and/or to better carry out the Trust's principal purpose subject to any restrictions contained in the Regulatory Framework.

16.1.5 Disposal of materials and items surplus to requirements shall be dealt with in accordance with relevant financial procedure notes – see overlap with SFI 26.1.

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health and Social Care's advice in setting prices for NHS service agreements. The charges will be in line with National Tariff or locally agreed where tariff is not applicable.

16.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

Where sponsorship income is considered the guidance in theTrust's 'Standards of Business Conduct and Declarations of Interest Policy shall be followed.

16.2.3 All employees must inform the Director of Finance promptly of money due from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings, overseas patients and other transactions.

16.2.4 In relation to Income Generation Schemes, the Director of Finance shall ensure that all costs and revenues attributed to each scheme can be identified.

16.3 Debt Recovery

16.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts including detailed procedures for the issuing of credit notes and write-off of debts after all reasonable steps have been taken to secure payment.

16.3.2 Income not received should be dealt with in accordance with losses procedures and reported to the Audit Committee.

16.3.3 The Director of Finance is responsible for ensuring that systems are in place to prevent salary and other overpayments. Where overpayments occur, recovery should be initiated as per the Trust's debt recover procedure.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or for the granting of personal loans of any kind.

16.4.3 All cheques, postal orders, cash receipts shall be banked intact to the credit of the Trust's Main Account or, if appropriate, the Trust's Charitable fund bank account. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.4.5 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

16.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned shall be reported immediately to the Director of Finance and dealt with in accordance with the agreed procedure for reporting losses.

17. PROCUREMENT AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.14 Suspension of Standing Orders is applied).

17.2 EU Directives Governing Public Procurement

European Union Directives (including the current financial thresholds) on public sector purchasing promulgated by the UK Government https://www.gov.uk/guidance/transposing-eu-procurement-directives prescribing procedures for advertising and awarding all forms of contracts shall have effect as if incorporated in these SFIs. (EU thresholds are not per year but based on whole life costs of a contract).

17.3 Policy and Procedure

The Director of Finance is responsible for ensuring policies and procedures are in place for the control of all procurement activity carried out within the Trust.

17.4 Formal Competitive Procurement

17.4.1 General Applicability

(i) The Procurement and Contract Procedure is governed by 4 ranges of expenditure, explained below. Unless specifically exempted below the Board shall ensure that competitive offers are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens;
- disposals.

(ii) Through the online Procurement system purchase orders are automatically generated for catalogue items where pricing has been competitively contracted or benchmarked against approved suppliers to ensure best value.

(iii) For all goods and services Trust Standing Orders and EU legislation dictates the different purchasing thresholds and the process route of purchasing.

(iv) For spend below £5,000 (excluding VAT) no formal procurement exercise is required, but value for money must still be demonstrated. See SFI 17.7 (b)

(v) For non NHS Supply spend between £5,000 - £25,000 (excluding VAT) Procurement should be engaged on 3 possible routes :

a. Formal Procurement e.g. Tender or further competition under a compliant framework agreement – if there is a competitive market and /or the potential for future growth in spend

b. Three quotes – for a one-off purchase but in a competitive market. (In exceptional circumstances with the agreement of the Head of Procurement two quotes may be accepted) –see SFI 17.7.
c. Direct award – for a unique requirement but value for money must still be demonstrated.

See SFI 17.9 for further details.

(vi) For spend above £25,000 (excluding VAT) but below the current OJEU limit, Procurement must be engaged in a formal procurement i.e. competitive local tender or further competition / direct award under a compliant framework agreement

(vii) For spend above the current OJEU limit, Procurement must be engaged in a formal procurement i.e. competitive EU Tender or further competition / direct award under a compliant framework agreement.

Subject to a VFM assessment the Trust shall procure all building and estates capital schemes with an estimated value over £500,000 using the NHS Procure 22 Framework, unless there are valid and significant reasons for not doing so, as approved by the Director of Finance. The Trust will follow Department of Health and Social Care and Treasury guidelines for the procurement of all estates capital schemes. Procurement contracts and frameworks used to commission contractors shall be appropriate to the type and nature of capital scheme being procured and will be required to demonstrate value for money.

An appropriate record should be kept in the contract file where it has not been possible to invite a building or estates tender above OJEU limits through a framework.

(viii) All procurements must be undertaken in accordance with Procurement Standard Operating procedures.

17.4.2 **Healthcare Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the procurement and contracting procedure and need to be read in conjunction with SFI No. 18.

17.4.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures (i.e. local or OJEU) **need not be applied**:

(a) where the estimated expenditure or income does not, or is not reasonably expected to, exceed **£25,000**;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 26;

(d) where works or services connected to proposed works are to be commissioned from an approved Procure 22 Principal Supply Chain Partner (PSCP), as appointed formally to the Department of Health and Social Care framework agreement or its successor schemes; or

(e) where the supply is proposed under any external compliant contract / framework agreement to which the Trust has access. In such circumstances value for money and compliance to the agreement should be demonstrated.

Formal procurement procedures (i.e. local or OJEU tender / quotes or direct award) **may be waived** in the following circumstances:

(f) in very exceptional circumstances where formal procurement procedures would not be practicable.

(g) where the timescale genuinely precludes competitive procurement but failure to plan the work properly would not be regarded as a justification for a single tender;

(h) where specialist expertise is required and is available from only one source;

(i) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(j) there is a clear benefit to be gained from maintaining continuity with an earlier project or compatibility with existing equipment / service. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive procurement;

(k) for building and engineering construction works and maintenance where there is either a direct legal enforcement of safety the consequence of which would result in the closure of the Trusts services and/or prosecution of the Trust and it's officials or a specified National or Local Health economy imperative where failure to deliver could place patients safety at risk.

The waiving of procurement procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure unless specifically covered within the original agreement.

Where it is decided that competitive procurement is not applicable and should be waived, the fact of the waiver and the reasons should be documented reviewed by procurement, authorised by the Director of Finance and / or Chief Executive and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

17.4.4 **Fair and Adequate Competition**

Other than where the exceptions set out in SFI Nos. 17.1 and 17.4.1 and 17.4.3 apply, the Trust shall ensure that requests for procurement are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The deadline for returns must be considered reasonable.

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17.5 Tendering Procedure for Goods, Materials, Services and Disposals including non NHS provided health care.

17.5.1 **Invitation to tender**

(i) All invitations to tender shall be issued via the appropriate e procurement/sourcing portal in use within the Trust.

(ii) All invitations to tender shall state that no tender will be accepted unless it has been submitted via the appropriate e procurement/sourcing portal adhering to all the required terms of the invitation to tender but specifically the requested time and date of return.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions of Contract as are applicable. Any contract that is projected not to be under such terms must be referred to the Head of Procurement prior to any contractual agreement.

(iv) Every tender for building or engineering works not procured under the procure 22 framework with an approved Principal Supply Chain Partner (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract) Standard forms of contract or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.5.2 **Receipt and safe custody of tenders**

The Chief Executive or his/her nominated representative will be responsible for the electronic receipt, and safe custody of tenders received within the e-procurement system until the time appointed time for the electronic seal to be opened.

17.5.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic vault will be opened by senior nominated member of the procurement team.

(ii) Every tender received shall be marked with the date of opening automatically by the e-procurement software and will maintain a full auditable record of the opening process.

(iii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders should be dealt with in the same way as late tenders. (Standing Order No. 17.5.4 below).

(iv) Appropriately detailed electronic notes shall be kept in the contract file to detail any matters such as action taken in respect of late tenders, non-compliant bids or any other matters relevant to tender receipt and opening.

17.5.4 **Admissibility**

(i) Tenders submitted but not received until after the due time and date (at which point the electronic vault is locked), may be considered only if confirmation of submission is received from the e-sourcing portal. The Chief Executive or his/her nominated officer will decide whether there are exceptional

circumstances e.g. System failure on the part of the Portal having been uploaded in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

(iv) Where only one tender is sought and / or received, it must be demonstrated that the price to be paid is fair and reasonable and will ensure value for money for the Trust. This will be recorded in the appropriate documentation namely the contract award report.

17.5.5 **Acceptance of formal tenders (See overlap with SFI No. 17.6)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. All such questions must be raised and responded to via the e procurement system to maintain audit trails and transparency.

(i) Evaluation criteria will be based on either:

- the lowest price; or
- the most economically advantageous cost over the whole life of the Contract.

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project may include (without limitation):

(a) Qualitative elements of the bidders proposal;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be documented in the contract file, and the reason(s) for not accepting the lowest priced tender clearly stated.

Criteria taken into account in selecting a successful tenderer must be clearly recorded and documented in the invitation to tender/quote.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive or nominated officer

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; or

(b) that best value for money was achieved.

(v) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000 as amended, be treated as confidential and should be retained for:

(a) 6 years after contract completion - successful tenders
(b) 6 years after contract start - unsuccessful tenders.

(vi) All tenders should be assessed for embedded derivatives and embedded leases utilising a standard checklist. Any proposed tender award which indicates the existence of either should be notified to the Associate Director of Finance – Financial Services, prior to award.

17.6 Authorisation of Procurement Awards (Internal Trust Process)

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation for the awarding of a contract (internal Trust process) must be authorised by the following staff to the value of the contract as follows:

	Threshold Value (total requirement)	Operational Purchasing Manager	Head of Category Procurement Governance Manager	Deputy Director of Procurement	Director of Finance	Chief Executive	Trust Board
Aggregated Total Contract Value	< £5000	✔					
	< £25,000	✔	✔				
	< £100,000		✔	✔			
	< £250,000		✔	✔	✔		
	< £250,000 - £1m		✔	✔	✔	✔	
	£1m+		✔	✔	✔	✔	✔

For all contract awards requiring Trust Board approval, these must be submitted to FPEC for assurance.

These levels of authorisation may be varied or changed only with the express agreement of the Trust Board.

Formal authorisation to initiate any procurement process must be put in writing in the form of a Procurement Sponsorship Form for all procurement processes where the award value is expected to exceed £25,000..

17.7 Signing of Commercial Procurement Contracts (External Document)

17.7.1 The signing of the commercial procurement contracts must only be undertaken by the following Trust Staff and within the identified value limits

< £50,000 – Deputy Director of Procurement
> £50,000 – Director of Finance

17.8 Private Finance and leasing for capital procurement (see overlap with SFI No. 24)

17.8.1 When the Board proposes, or is required, to use finance provided by the private sector (PFI) the following should apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate department or agency for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.8.2 Where it is proposed that leasing be considered in preference to capital procurement then the following should apply:

(a) The selection of a contract / finance company shall be on the basis of a competitive process;

(b) All proposals to enter into a leasing agreement shall be referred to the Director of Finance before acceptance of any offer;

(c) The Director of Finance shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Director of Finance prior to acceptance of any offer to the lease.

In the case of property leases the relevant NHS guidance shall be followed.

17.9 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions issued by Treasury, the Department of Health or other Statutory Body.

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis of the Procurement.

(g)

17.10 Personnel and Agency or Temporary Staff Contracts (see overlap with SFI Nos. 20.6, 20.9, 21.2.3)

The Chief Executive shall nominate officers with delegated authority to design and operate a process for engaging with and enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.11 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006 as amended and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

17.12 Disposals (See overlap with SFI No. 26)

Competitive Procurement procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.13 In-house Services

17.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive procurement.

17.13.2 In all cases where the Board determines that in-house services should be subject to competitive procurement the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist/s.

(b) In-house bid group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a Procurement Officer and Director of Finance or nominated representative. For services having a likely annual expenditure exceeding £ 1,000,000, a non-officer member should be a member of the evaluation team.

17.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house bid group may participate in the evaluation.

17.13.4 The evaluation team shall make recommendations to the Board.

17.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.14 Applicability of SFIs to Procurement using funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased by the United Lincolnshire Hospitals Trust Charity.

17.15 Cancellation of Contracts

17.15.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

(a) the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust;

(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor);

(c) in relation to any contract with the Trust the contractor or any person employed by him or acting on his behalf shall have committed any offence under the extant Bribery Act and other appropriate legislation.

17.16 Determination of Contracts for Failure to Deliver Goods or Material

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

(a) such default, or
(b) in the event of the contract being wholly determined the goods or materials remaining to be delivered.

Further the amount by which the cost of purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

18. AGREEMENTS FOR PROVISION OF HEALTHCARE SERVICES (see overlap with SFI No. 17.13)

18.1 The Chief Executive, as the Accountable Officer of the Trust, supported by the Director of Finance and Deputy Chief Executive, is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with national guidance and the Annual Plan.

18.2 All agreements should aim to implement the agreed priorities contained within the NHS Operating Framework and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- existing agreements, to ensure where appropriate they build on existing partnership arrangements;
- the mandated performance indicators;
- existing Joint Investment Plans;
- the need to ensure agreements are based on integrated care pathways; and any model contracts issued by the Department of Health and Social Care.

In carrying out these functions, the Chief Executive should take account the advice of the Director of Finance regarding:

- the National Tariff Payment System and associated guidance (e.g. national activity recording and coding requirements, the National Grouper etc.) and the costing and pricing of services;
- payment terms and conditions;
- amendments to agreements and other NHS patient services arrangements.

All agreements should be underpinned by the NHS standard contract clauses.

18.3 Involving partners and jointly managing risk

The risks involved in joint working will be assessed and articulated within a legally binding contract. Such a contract will be informed by the view of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Director of Finance to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.4 Sub-contracting Provision of Services to Non-NHS Providers

Where the Trust makes arrangements for the provision of services by non-NHS providers, it is the Director of Finance, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities and ensure all sub-contracting is in accordance with the NHS Standard Contract. This is to ensure that the quality and performance measures reflect the Trust contract with their main commissioners.

18.5 The Director of Finance, on behalf of the Chief Executive, shall be responsible for drawing up and agreeing to the financial details and terms and conditions contained in the legally binding contract entered into by the Trust.

18.6 Agreements should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Agreement prices shall comply with the latest costing guidelines.

18.7 The Director of Finance shall be responsible for establishing arrangements for the identifying, gaining approval for and invoicing of other NHS patient services referrals.

18.8 Reports to Board on contracts

The Director of Finance will ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. Contract performance will be reported separately by the Deputy Chief Executive.

19. COMMISSIONING

Not applicable

20. HUMAN RESOURCES AND PAY

20.1 Remuneration and Terms of Service (see overlap with SO No. 4.8.2)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) receive assurance from appropriately qualified officers of the trust in regard to appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination

payments taking account of such national guidance as is appropriate;

(e) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments exceeding £50,000 taking account of such national guidance as is appropriate.

- For any payment less than £50,000 the Executive Team has authority to consider and approve.
- For any termination payment over £150,000 the payment must gain Board approval.

(f) Special severance payments (those outside normal statutory or contractual requirements) cannot be made without Treasury and Board approval

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 Funded Establishment

20.2.1 The Executive Devolution Policy provides for a degree of earned autonomy to be reflected in the delegation of powers to Directorates and Divisions in varying Establishment. Unless otherwise devolved, the following apply:

- The workforce plans incorporated within the annual budget will form the funded establishment.
- All new posts must be approved through the business planning process.
- The funded establishment of any department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Director of Finance or nominated deputy.

20.2.2 The authority to fill a funded post on the establishment with permanent or fixed term staff sits with the budget holder except when the Trust is operating under special measures when this authority may be rescinded.

20.2.5 The authority each budget manager is attributed in relation to all pay and non-pay decisions is set out within the Executive Devolution Policy (See SFI No. 13.3.1 and 21.2)

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) authorised to do so by the Chief Executive;

(b) within the limit of their approved budget and funded establishment or as set out within the Executive Devolution Policy.

20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

20.3.3 Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

20.4 Variation to existing job plans

20.4.1 Only the Clinical Director or Business Manager of the relevant Clinical Business Unit can authorise variations to existing job plans within the agreed budget.

20.5 Authorisation of overtime and additional sessions

20.5.1 The budget holder is responsible for authorising overtime and additional sessions.

20.5.2 Overtime and additional sessions must be authorised prior to being worked. In exceptional circumstances where documentation or electronic systems are not authorised prior to the work being undertaken, these must be completed as soon as possible.

20.6 Authority to engage bank and agency staff, Self-employed or Third Party Workers

20.6.1 Within delegated budget:

(a) The budget holder holds the responsibility to authorise the booking of bank and agency staff or self-employed or Third Party Workers

Outside of delegated budget:

(b) The booking of bank and agency personnel or self-employed or Third Party Workers outside of budget must be agreed in advance with the appropriate Executive Director in consultation with the Director of Finance.

20.6.2 All bookings of bank or agency staff must be made through the agreed process, variations to this can only be made with the express authority of the Director of Finance.

20.7 Leave Policy

20.7.1 The Director of Human Resources is responsible for agreement and publication of Leave Policy, to cover Annual, Maternity, Paternity and other Special Leave categories.

20.7.2 The Director of Human Resources is responsible for agreement and implementation of a Policy to support Career Breaks.

20.8 Redundancy

20.8.1 All staff redundancies must be authorised by the Director of Finance.

20.9 Engagement of Workers off Payroll – (see overlap with SFI No 21.2.3)

20.9.1 The Director of Finance shall issue detailed guidance setting out responsibilities and required actions for managers engaging workers 'off-payroll'.

20.9.2 Only in exceptional cases should a worker be engaged and not paid through the Trust payroll.

20.9.3 Prior to engagement, the tax status of the 'worker' must be determined. To facilitate this, the engaging manager must complete an online IR35 assessment which prior to engagement must be reviewed and agreed by a nominated officer within the Finance Directorate.

20.9.4

20.9.5 Appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

20.9.6 NHSI payment Caps may not be exceeded without the express agreement of the appropriate Executive Director;

20.10 Processing Payroll

20.10.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.10.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers;

(h) procedures for the recall of bank direct credits (including BACS) and stopping of cheques;

(i) Pay advances and their recovery;

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.10.3 The Budget Holder has delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances;

(c) completing time records and other notifications in accordance with the Director of Finance' instructions and in the form prescribed by the Director of Finance;

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

20.10.4 Individual employees are responsible for:

(a) Keeping accurate time records

(b) Submitting time records and claims for reimbursement of overtime, enhancements and extra duties to line management for authorisation each month or where required more frequently in accordance with published timetables

(c) Submitting claims for reimbursement of travel and other expenses within 3 months of being incurred. Claims outside this period must be authorised by the Director of Finance or nominated Deputy.

(d) Checking their pay each month and immediately notifying Payroll of any identified error for correction in the following pay period.

20.10.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.10.6 All timesheet, pay records and other pay notifications shall be certified and submitted in accordance with the instructions of the Director of Finance. A list of designated authorising Officers shall be maintained, detailing the limits of authorisation and shall contain specimen signatures.

20.10.7 The Director of Finance shall determine the dates on which the payment of salaries, wages, expenses, allowances, termination or compensation payments, and any other form of remuneration are to be made, having regard to the general rule that it is undesirable to make payments in advance, except in special circumstances.

20.10.8 The Director of Finance will publish a salary overpayments and advances policy detailing the Trust approach to and process for recovery of overpayments and circumstances under which an advance of salary may be made.

20.11 Contracts of Employment

20.11.1 It is the responsibility of the Director of Human Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders and Standing Financial Instructions

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

21.1.2 The Director of Finance will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(c) the maximum level of each requisition and the system for authorisation above that level.

The list of managers and limits of financial authority will be set out within the Trust authorisation matrix hierarchy. This defines the actions individuals have delegated authority to carry out on behalf of the Trust. The authority will be restricted in most cases to a limited range of budget areas for which the manager is responsible. The matrix incorporates delegated authority in relation to Human Resources (e.g. recruitment), Procurement / Invoice authorisation, Admin rights, budget amendments and Charitable Fund requests.

21.1.3 No contract in respect of the supply of revenue or capital goods and/or services may be authorised other than by approved budget managers in conjunction with advice from Procurement or Estates services or exceptionally by the Chief Executive. The approved manager shall not authorise a contract in respect of a budget for which they are not accountable.

21.1.4 The Director of Finance shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with SFI No. 17)

21.2.1 **Requisitioning**

The requisitioner in specifying the item to be supplied (or the service to be performed) shall always engage with Procurement Services to obtain the best value for money for the Trust.

21.2.2 It should be the duty of the Associate Director of Procurement to exercise general supervision over all purchases, except for drugs and pharmaceutical supplies. After making reasonable efforts to resolve conflicts, and having due regard to materiality,

he shall inform the Director of Finance of any requisition which appears to be in conflict with the Trust's Standing Orders and Standing Financial Instructions. In the case of drugs and pharmaceutical supplies this duty falls to the Chief Pharmacist.

21.2.3 Where services are required from an individual, consideration should be given to the nature of the role to be undertaken to ensure that the contract will be a contract FOR services (non-pay) and not a contract OF service (pay). It is the responsibility of the Budget Manager to ensure that when making an appointment or agreement for services that the individual is paid appropriately in accordance with the relevant tax regime. This also applies where services are offered by ex-employees or individuals supplying through their own personal service companies: it is the nature of the role which determines the appropriate pay or non-pay arrangement and advice of the Procurement team should be sought where necessary.
The relevant Finance Manager must be consulted when engaging with a PSC for the provision of personal services to ensure IR35 tax legislation is consistently applied. (see overlap with SFI 20.9)

21.2.4 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.5 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds for each route to procurement ; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions and guidance for governing the procurement of non-pay goods and services within agreed authorisation limits.

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures where appropriate) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.6 below.

21.2.6 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. The Director of Finance will provide a list of suppliers or services where payment in advance is permitted. Any situations not covered will require explicit authorisation from the Director of Finance. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.7 **Official orders**

All goods, services or works will unless otherwise exempted be ordered on an official order and contractors shall be notified that they should not accept orders unless in an official form. The only exceptions to raising an official order shall be for:

(a) cases of emergency or urgent necessity where a confirmation order number should be used.;
(b) those specific approved goods and services for which a non-stock requisition is not required (as advised by the Head of Procurement on the 'Official exemption list).
(c) those purchases made with a procurement card or by petty cash in accordance with the relevant approved procedure.

Official Orders must:

(a) be uniquely numbered;
(b) be in a form approved by the Director of Finance;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive.
(e) Confirmation order numbers shall be issued only by an Officer designated by the Chief Executive and used only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued as soon as possible and ideally the next working day. The order should be clearly marked "Confirmation Order".

Orders / requisitions shall only be raised (or electronically processed) by Officers so authorised by the Chief Executive.

Lists of authorised Officers shall be maintained detailing the limits of authorisation within the Trust authorisation matrix (SFI 21.1.2).

21.2.8 **Purchasing Cards**

(a) All purchase cards are issued subject to the appropriate budget holder completing a business case of need, and authorisation by the Associate Director of Procurement.
(b) The card must be utilised according to the procedures documented in the Purchase Card Manual.
(c) Purchase card transactions and relevant backing information will be subject to audit by finance to ensure it is appropriately completed and stored.
(d) Illicit use of the purchase card for inappropriate or personal spend will result in disciplinary action and referral to the local counter fraud specialist where applicable.

21.2.9 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with the Trust's "Standards of Business Conduct and Declarations of Interest Policy");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works (unless specifically exempted by the Director of Finance – SFI 21.2.7) are ordered on an official order;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase (indemnity forms should be completed for all trial/loan and free issue equipment); All trials or loans must be authorised in advance through the relevant governance structure.

(i) changes to the list of employees and officers authorised to commit resources and certify invoices are notified to the Director of Finance;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(k) petty cash records are maintained in a form as determined by the Director of Finance.

21.2.10 No Officer shall place a requisition, purchase from petty cash, by procurement card or require an official order to be raised with an individual to whom they are related or with any person or organisation with whom they hold a financial interest or from whom they are likely to receive any payment, gift or other consideration, without first making a disclosure. of the circumstances in writing to the Chief Executive and receiving his written authority to proceed. A copy of an authority so given must be lodged with the Director of Finance.
Related Party disclosure should be made in accordance with the Trust Standards of Business Conduct and Declarations of Interest policy.

21.2.11 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the high level principles described within Health Building Note 00-08. The evaluation of the efficiency and effectiveness of these contracts shall be the responsibility of the Director of Estates and Facilities.

22. EXTERNAL BORROWING

22.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Director of Finance shall be responsible for ensuring that the best value is obtained in securing loan finance and other sources of external funding and shall prepare detailed procedural instructions concerning applications for loans and overdrafts and on the form or records to be maintained.

22.1.3

22.1.4 Borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

22.1.6 All long term borrowings must be agreed by the Trust Board. Loan documentation must be authorised by the Chief Executive and Director of Finance.

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 Social Care and be approved by the Trust Board.

22.1.8 The Director of Finance is responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfill the requirement to maintain adequate cash balances. The Board of Directors will receive details of the Trust's performance from the Director of Finance.

23. FINANCIAL FRAMEWORK

23.1.1 The Director of Finance should ensure that members of the Board are aware of the NHS Financial Regime. The Director of Finance should also ensure that the direction and guidance issued as part of the NHS Financial Regime is followed by the Trust.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c) shall ensure that the capital investment is not undertaken without confirmation of Commissioner support (where appropriate) and the availability of resources to finance all revenue consequences, including VAT and capital charges.

24.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with current Department of Health and Social Care guidance and the Trusts Investment Appraisal Framework is produced setting out:

(i) an option appraisal of potential financial and non-financial benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

(c) that advice is taken and acted upon to minimise the VAT and other taxes payable;

24.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will issue procedures for their management.

24.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

24.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure. This as a minimum shall include reporting to the Board on:

(a) an individual scheme / project

(b) the source and level of funding, and

(c) the expenditure incurred against the annual plan profile

24.1.6 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health and Social Care guidance and the Trust's Standing Orders.

24.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

24.1.8 The Director of Finance shall issue procedures for the use of capital receipts from the sale of assets and will ensure that the Trust's financial plans incorporate any expected capital receipts.

24.1.9 The Board of Directors will approve details of the Capital Expenditure Programme as part of the Annual Plan.

24.1.10 The Board of Directors will approve the acquisition / disposal of land and property.

24.1.11

24.1.11 The classification and recording of capital expenditure should be in accordance with the requirements laid down in the Department of Health Group Accounting Manual.

24.2 Private Finance and leases (see overlap with SFI No. 17.10)

24.2.1 The Trust should consider market-testing against Private Finance Initiative Funding (PFI) and / or leasing agreements when considering a large capital procurement.

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis every two years.

24.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be sufficient to meet requirements set out within International Financial Reporting Standards and other requirements as stipulated in the Department of Health Group Accounting Manual.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and salary records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies and indexed / revalued annually as appropriate.

24.3.7 The Director of Finance shall calculate and make dividend payments in accordance with instructions issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of non-current assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments, and donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance who may also undertake such other independent checks as considered necessary.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust; it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security checks and practices in relation to Trust and NHS property as may reasonable or as otherwise specified by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses – see SFI 26.2.

24.4.6 Where practical, assets should be marked as Trust property.

24.4.7 Employees unless specifically authorised by the Chief Executive shall not use Trust assets for personal use.

24.4.8 The up-to-date maintenance and annual checking of asset records shall be the responsibility of designated departmental managers or Budget Holders for all items for which the initial purchase or replacement is within their delegated responsibilities.

24.4.9 Registers shall be maintained to record all controlled items issued to individuals, and where practicable, receipts shall be obtained.

24.4.10 Records shall also be maintained and receipts obtained for:

- equipment on loan to patients; and
- all contents of furnished lettings.

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stocks are those goods normally utilised in day-to-day activity but which, at any point in time, have not yet been consumed (excluding capital assets). They are usually held in controlled stores and within departments.

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum level commensurate with delivery and cost effective purchasing;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1

Subject to the requirements of the Director of Finance for the systems in use, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers The control of any Pharmaceutical stocks

shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel to a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

25.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
All stock records shall be in such form, and shall comply with such systems of control, as the Director of Finance shall approve.

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one Officer other than the storekeeper and his staff. The stocktaking records shall be numerically controlled and signed by the Officers undertaking the check. Any surplus or deficiencies revealed on stocktaking shall be reported to the Director of Finance immediately.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 26 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and report discrepancies to avoid overpayment where such discrepancies cannot be resolved via the Procurement Team.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine the estimated market value of the item, taking account of professional advice where appropriate. Advice should be sought from the Associate Director of Procurement as to the most appropriate disposal process (for example: auctions < £5,000 market value or quotation / tender > £5,000).
(see overlap with SFI 17.14)

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Director of Finance must prepare procedural instructions on the recording, approval of and accounting for losses, and special payments.

26.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance or confidentially inform an officer charged with responsibility for responding to concerns involving loss or potential fraud. This officer will then appropriately inform the Director of Finance.
The loss must be recorded by the Officer on Datix (risk management system) and a Datix reference number obtained.

26.2.3 Where a criminal offence is suspected, the Director of Finance must have in place provision to immediately inform the police.
In cases of theft or arson the Director of Finance must immediately inform the police.
In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS).

26.2.4 The Director of Finance must ensure arrangements are in place to notify the Audit committee of all suspected frauds.

26.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must ensure the following are notified:-

(a) the Board of Directors; and
(b) the External Auditor

26.2.6 The Audit Committee shall approve the writing-off of losses and special payments

26.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made.

26.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

26.2.10 All losses and special payments must be reported to the Audit Committee on a quarterly basis.

26.2.11 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations. This should include:

(a) when a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

(b) ensuring that any payments due by the Trust are made to the correct person.

(c) ensuring that any claim by the Trust is properly lodged with the correct party and without delay.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Director of Finance

27.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The Director of Finance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

27.2 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

27.3 Risk Assessment

The Deputy Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans and vulnerability to cyber-security attack.

27.4 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Deputy Chief Executive shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Integrated Digital Care Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

27.5 Acquisition and Disposal of Computer Systems
The Director of Finance will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Integrated Digital Care strategy.

27.6 The Director of Finance will ensure that separate control procedures are put in place for computer systems. This procedure will include:

- the acquisition and disposal of IT, systems and equipment;
- the decommissioning of systems containing confidential data; and in accordance with any guidance issued by the Information Commissioner and the Department of Health and Social Care.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of terminal or deceased patients in hospital.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records;
- the advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

28.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for health and Social Care for all Exchequer funds.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as applicable these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Director of Finance shall ensure that all staff are made aware of the Trust Standards of Business Conduct and Declarations of Interest policy. This policy deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts

32. RETENTION OF RECORDS

32.1 All NHS records are public records under the terms of the Public Records Act 1958 Section 3 (1) – (2). The Chief Executive and senior managers of the Trust are personally accountable for records management within the organisation.

32.2 The Trust will follow the latest guidance Records Management Code of Practice for Health and Social Care 2016") issued by NHS Digital. The Records Management Code sets out the minimum length of time for the retention of particular.

32.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Trust policy.
Records held in archives shall be capable of retrieval by authorised persons.

32.4 Records held in accordance with latest guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.
Day to day responsibility for decisions to destroy records following achievement of the retention date, and maintenance of the destruction register, is the responsibility of the Records Manager taking into account the provisions of the Records Management Code. The Records Manager is accountable to the SIRO and Chief Executive for decisions taken.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.
A Board Assurance Framework shall be in place to enable the monitoring of risk.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) decision on and a clear indication of which risks shall be insured through arrangements with either the Risk Pooling Schemes administered by NHS Resolution or commercial insurance. ;

g) arrangements to review the Risk Management programme.

a) appropriate levels of external accreditation.

These matters shall be defined in more detail in the Risk Management Strategy or Policy. The existence, integration and evaluation of the above elements will support statements and conclusions within the Annual Governance Statement (AGS).

33.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 The Trust may not enter into insurance arrangements with commercial insurers except:

(1) for the purpose of **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place, income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult NHS Resolution.

(4) for the purposes of insuring Directors and Officers against any liability arising in their appointment,

(5) where, in the opinion of the Board of Directors, the level of cover afforded through the NHS Resolution Scheme in the event of significant or total loss of a facility would be insufficient to enable the re-provision of a safe and appropriate level of care to service users.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'excess'). The Director of Finance

should ensure documented procedures also cover the management of claims and payments below ‘excess’ levels.

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Jayne Warner, Trust Secretary
Date:	6 August 2019

Title:	**Board Committee Observations by NHS Improvement**

Author/ Responsible Director Jayne Warner Trust Secretary

Purpose of the Report:

To inform the Board of the observations made by NHSI following their attendance at the Board assurance committees.

The Report is provided to the Board for:

Information		Assurance	✓
Discussion		Decision	

Summary/Key Points:

All recommendations made by NHSI in their feedback have been incorporated in to one document alongside a set of actions which the Trust will take to address the recommendations.

Recommendations:

The Trust Board are asked to note the recommendations and agree the suggested actions.

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

Finance, Performance and Estates Committee – Observed January 2019	Response/ Actions required
There was no workforce or clinical representative at the committee despite many of the finance and performance challenges being the result of workforce and clinical issues. Workforce and clinical attendance at the committee may enhance assurance on finance and performance which are reliant upon workforce improvements.	The Chair of the Committee felt that the balance of the Committee was satisfactory and that the other Committee Non Execs were able to reflect the discussions from their other committees (QGC and WOD). Executive attendance would be sought when specific FEP areas were being discussed rather than as routine.
There was significant overrun on the first agenda items relating to approval of the minutes and the action log. This meant that discussion time for finance and performance agenda items was reduced.	Work continues to ensure that responses to actions captured have been where possible provided ahead of the meeting to reduce length of discussion on action log.
The committee might consider removing closed actions from the 'live' action log to enable better focus on issues requiring progress.	Only the actions closed at the previous meeting remain on the log to provide an audit trail. These are always removed for the subsequent meeting.
Due dates for the completion of actions on the log might also be approved when actions are agreed.	Going forward committee chair would agree completion dates with committee when actions were determined.
When actions are agreed, committee members should ensure that the actions are understood and clearly captured on the action log to ensure common understanding about the agreed action. Timely distribution of the action log would help progress delivery of the actions	Noted and agreed. Greater detail to be provided in action log. Circulation with minutes 1 week after meeting.
Action update reports provided to the committee did not always provide the committee with the assurance that was being sought	Revision of front cover in progress along with guidance on report writing for those producing committee papers. Including guidance on assurances being sought.
Committee papers did not include an overall finance dashboard summarising key finance KPIs included in either the integrated performance report or individual papers	The dashboard was being developed and would be in place for July meeting, although would not be complete.
Discussions on finances focused on performance against the revised financial forecast outturn, rather than variance to plan. This led to discussions which described 'delivery of the plan' at M9 which is not correct	Revised plan had been agreed with NHSI. Committee monitoring against revised outturn referred to as the plan. Monitoring against financial recovery plan.
The committee papers and discussion did not cover the underlying / recurrent financial position of the Trust, the split between recurrent and non-recurrent actions, the assessment of longer-term financial trends or run-rates. This additional information is included in committee papers and discussed	The Chair responded that run rates were included in the IPR. The Committee were working on clearer reporting of underlying position. The reports needed to support the committee discussions of these areas more. The Committee noted that the divisions were in the midst of aligning reporting for TOM

as required in committee meetings. Furthermore, the financial information and discussion did not provide any information on divisional financial performance.	and this would appear in reporting from July onwards.
There was limited discussion on financial risks and no discussion on opportunities for improvement on the revised outturn, and how this might be delivered. The papers described the nature of risks and opportunities, but these were not clearly quantified and so the magnitude of the potential financial outturn range was not clear. The committee reflected the need to deliver the Trust's revised FOT of £84.9m, but there was limited assurance on the actions that would be taken to mitigate the risks.	The Chair reflected that the Board had considered risk to delivery when the plan was set. Committee paper would be revised from September meeting for risks, assumptions and opportunities. Agenda would be amended to highlight this.
Updates to the committee on performance and fire safety improvement works did not provide assurance on the completion of improvement actions previously described to the committee.	Updates to the committee on performance and fire safety improvement works did not provide assurance on the completion of improvement actions previously described to the committee.
There is room for improving the communication between committees as there was discussion in the meeting about the role of FPEC in relation to more than 1 item referred to it from other committees.	Further discussions needed about rationale for cross committee referrals.
Quality Governance Committee – Observed June 2019	
There was a significant agenda and although the chair managed the timings well, with reference to when running behind, the size of the agenda resulted in the committee significantly over running.	Agenda and workplan continue to be reviewed. Fully functioning QSOG should enable reduced agenda to be in place for QGC.
Given the length of the meeting a planned comfort break would aid concentration and effectiveness	Noted by Chair for future meetings.
Some of the documents supplied to NHSE/I could not be opened due to system issues. Papers came through individually rather than a bundle e.g. complete set in PDF, which made it difficult to review in a meaningful / logical way in electronic format.	This has been addressed by the introduction of a new electronic system which has allowed for a move away from paper-based packs.
Some of the responses given by the DMD in response to questions from the NED, when seeking assurance around	Briefing of deputies who are required to attend to be undertaken with Directors to ensure appropriate representation

the impact of respiratory issues on SHMI lacked sufficient detail and were vague in terms of providing assurance.	
Presentation of the medicine's optimisation item did not deliver full assurance to the committee in relation to clear focus on delivery of expected KPIs; actions taken to address were not delivering; where accountability for delivery sits; and how this will be managed. Of particular note was the lack of emphasis on how the wider MDT are engaged in delivery of required KPIs. Each action appeared to reference drilling down' to individual ward level, which is only one element of the approach that would be expected given the issues highlighted	Revision of front cover in progress along with guidance on report writing for those producing committee papers. Including guidance on assurances being sought. Briefing to be provided to report author by Director to ensure reports accurately reflect Committee requirements
The committee identified concerns regarding aseptic suite risk, which is currently highest rated risk on the Trust risk register, and the need to review this. Given the length of time this risk has been rated at this level, in the context of all the other risks the Trust is currently managing, this does require urgent attention to fully re-scope the level of risk and either reduce to appropriate level of risk rating, taking in to account mitigations the Trust has put in place, or put in place a set of actions to manage the risk down to an acceptable level	Action has already been taken in respect of Aseptic Risk. Risk has been reviewed and re-classified in three categories.
Quality and Safety Oversight Group Upward Report was a late report and as such not all members had sight of this prior to the meeting.	The tight timetabling between data availability and the QSOG and QGC meeting on occasion has resulted in the QSOG report being circulated later. The teams continue to work to ensure that this happens infrequently, but in some months this is unavoidable.
Later reports on the agenda were taken together/ not given sufficient time due to over run of committee.	See earlier comments re - Agenda and workplan continue to be reviewed. Fully functioning QSOG should enable reduced agenda to be in place for QGC.
There needs to be a more effective use of the subcommittee structure (i.e. a fully functioning QSOG) to ensure the agenda reaching the Quality Governance Committee is of manageable size and appropriate level of content. This would involve the	See comment above.

devolving of detail from QGC to sub committees, in particular QSOG.	
Whilst there was evidence committee members have a good understanding of assurance, this appeared variable for people in attendance to present items. Attention should be paid to ensure all presenters to the committee understand assurance requirements and how the items they are presenting need to effectively fulfil these expectations.	Revision of front cover in progress along with guidance on report writing for those producing committee papers. Including guidance on assurances being sought.
A point for consideration is how the trust has tested the connections between Sub-Board Committees i.e. exec and NED cross fertilisation between committees to ensure the dots are joined up between the respective committee responsibilities	Trust Board Committees have all recently reviewed their ToR. Meeting to be held with all chairs to ensure read across between committee responsibilities is maintained.
The committee needs to be clearly sighted upon its role in terms of policy sign off. It was unclear whether policies were being signed off or being presented for information/ oversight. The committee recognised the need to clarify this and were taking action to address.	Committee confirmed at subsequent meeting its role of approving policies.
A defined single performance dashboard has been cited as an ambition and the work on this requires clarity, grip and pace to supplement effective committee performance.	Dashboard in development.
As identified by the committee a review of out of theatre Never Events and development of Locsips is highly recommended as an action requiring attention	The Committee identified that the divisions would hold responsibility and that actions would be fed up through the Clinical Effectiveness Group to QSOG and then in to the Committee via a quarterly report.
Workforce and OD Committee – Observed	
The volume of papers was significant and varied in levels of detail and quality of report writing for expected audience. It was also not clear on all papers the purpose of coming to the committee.	Revision of front cover in progress along with guidance on report writing for those producing committee papers. Including guidance on assurances being sought.

The meeting start was delayed and disrupted due to technical issues with connecting videoconferencing between Lincoln and Grantham sites	VC system being replaced across all sites
Whilst there were introductions at the start of the meeting when new people joined the meeting it was not always clear who individuals were.	Noted by Chair for future meetings.
Nursing was only represented for part of the meeting with limited engagement, yet this is a key element of the workforce, which is a significant risk for the organisation.	The chair advised following the meeting the Deputy Chief Nurse is a member of the Committee and regular attendee, however at this particular meeting a diary clash had prevented attendance of all Senior nursing team.
The lack of clarity on TOR and associated workforce governance structure, within the context of the emerging trust TOM structure, was of concern.	The committee had a good discussion on how this could be resolved and agreed to work on it outside of the meeting, however, this does need addressing if the Trust is to be confident in its workforce assurance processes.
There is a risk the Trust/committee may end up with over complicated reporting and assurance processes, which have the potential to lead to gaps in Trust assurance processes or distract from the focus on required assurance in specific committees, for example: • Discussion re CNST and Board request for workforce plans to be overseen by this committee led to discussion regarding deconstruction of the 10 points and alignment to respective committees • Unclear expectations of reporting expectations from the 3 sub-groups sitting under this committee • Responsibilities for assurance re job planning due to FEP delivery expectations associated with this • Whether assurance on filling vacancies in TOM structures sits with operational or committee assurance	Trust Board Committees have all recently reviewed their ToR. Meeting to be held with all chairs to ensure read across between committee responsibilities is maintained. Reporting expectations of sub-groups to be clarified through production of Committee ToRs and subsequent refresh of sub-group ToRs to reflect required business to be conducted
Presentation of the revised approach to managing sickness absence paper lacked structure, however, there was good subsequent discussion by committee	Revision of front cover in progress along with guidance on report writing for those producing committee papers.

members which the presenter responded to appropriately	
The word assurance was used indiscriminately through the meeting which raised concern regarding committee members understanding of difference between assurance vs reassurance and what good assurance looks like	Chair to consider training/ development for committee members in respect of assurance.
The risk register was not reviewed as not available for this meeting.	The chair has confirmed the Risk register has been received at all other meetings it is considered alongside the BAF.
Several times during discussions there were closed questions asked of the committee. This is a small style thing however, it is important to set the tone for the committee to have good, rounded and inclusive discussions on the presented issues.	Noted by Chair for future meetings.
The Trust needs to address the issue of consistency of papers both in terms of content and format, including coversheets. Attention should be paid to the level of the committee ie Sub Committee of the Board and papers should therefore reflect appropriate level of detail and analysis to guide committee members to the pertinent points for information; discussion; or decision.	Revision of front cover in progress along with guidance on report writing for those producing committee papers.
It is essential that, as a priority, the Trust clarify the governance arrangements for workforce and agree a consistent approach to escalating and de-escalating workforce risks to this Sub Committee of the Board, within the context of operational management meetings and the new TOM structures	Trust Board Committees have all recently reviewed their ToR. Meeting to be held with all chairs to ensure read across between committee responsibilities is maintained.
Nursing attendance at the meeting was not sufficient and needs to be addressed given the level of risk associated with this particular staff group, that is fundamental to the delivery of safe and effective care for patients and is a key element of the Trusts financial recovery plan.	Conversations have already taken place, prior to receipt of this feedback, and in recognition of the importance of nursing workforce a request has been made and agreed that the Director of Nursing attend the Committee going forward
Further work is required to ensure there is a shared understanding by all committee members as to what good assurance looks like. The chair recognises the need for improvement and education of the committee and the Trust should support the committee to focus on the work it is doing to	Chair to consider training/ development for committee members in respect of assurance.

improve the understanding of good assurance.	
Technical issues are a feature of cross site meetings that have been observed in the Trust. It is encouraging to see the use of video-conferencing to ensure appropriate, yet efficient engagement across sites, however, processes need to be put in place to ensure those using the equipment either receive clear instructions or are supported to do so by a nominated person.	VC system being replaced across all sites

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	August 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, particularly in relation to financial sustainability; workforce capacity and capability; and the age and condition of parts of the estate
- Several significant risks are due for review, to reflect progress that has been made in putting additional mitigations in place; support for this process has been limited in recent months but additional investment has now been made within Clinical Governance

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required.

Strategic Risk Register Corporate risks that are considered to be of strategic significance are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risk in accordance with the Risk Management Policy is reported regularly to the Audit Committee.

Assurance Implications This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.
Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.
Information exempt from Disclosure – No
Requirement for further review? No

1. Purpose of the Report

1.1 The purpose of this report is to enable the Trust Board to:

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation..

4. Summary of Key Points

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, each individually described and assessed – potential harm to patients; infrastructure failure; and compliance with regulations
- The Patient Safety Group and Clinical Effectiveness Group are now regularly reviewing their elements of the Corporate Risk Register; as this review process matures the identification, assessment and treatment of risks will be more clearly articulated

- Further work is required on other areas of the Corporate Risk Register that are overseen by the Quality & Safety Oversight Group (QSOG) to review and update the level of risk and mitigation plans – Infection Prevention and Control; Medicines safety & management; Safeguarding; and Patient Experience
- 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; these require a focus on gaps in the control framework rather than the current emphasis on physical issues and hazards requiring attention
- Corporate demand management and workforce risks are due for review and update, to reflect progress that has been made with putting effective mitigations in place

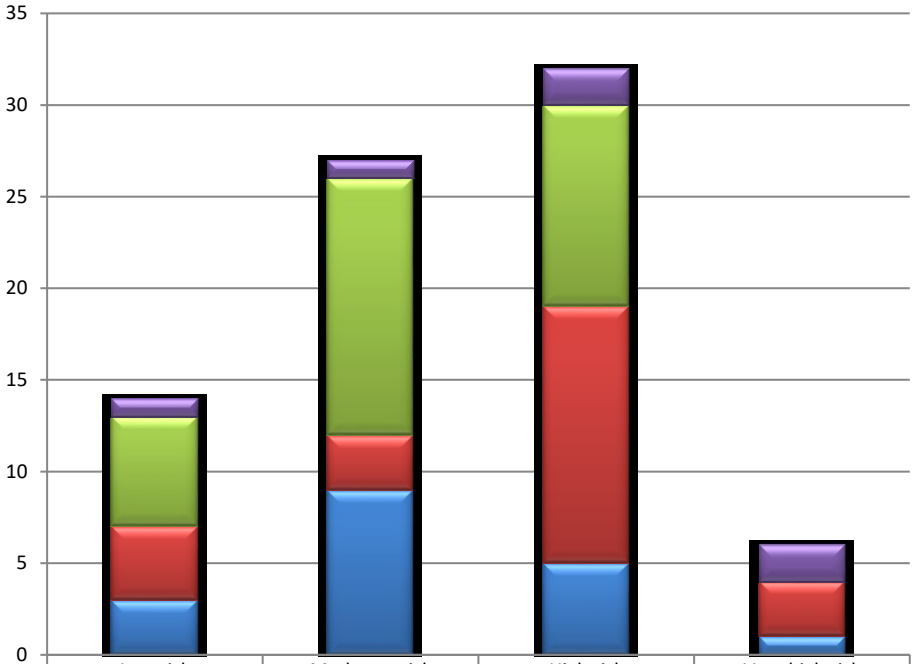
4.2 Each corporate risk has an Executive lead, with overall responsibility for its management; and a Risk lead responsible for reviewing and updating the risk register. The majority are also assigned to a lead management group for regular scrutiny. All are aligned with the appropriate assurance committee of the Trust Board.

4.3 Operational risk registers are also in place for every Clinical Business Unit (CBU) and corporate department. The provision of management information to divisional and business unit management teams is still being developed. Once in place this will facilitate more regular and routine review of operational risks and improve the level of analysis that can be done to identify areas of significant concern. Oversight of risk management at divisional level is already included with the Performance Review Meeting (PRM) process.

4.4 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

4.5 **Chart 1** shows the number of corporate risks by current (residual) risk rating:

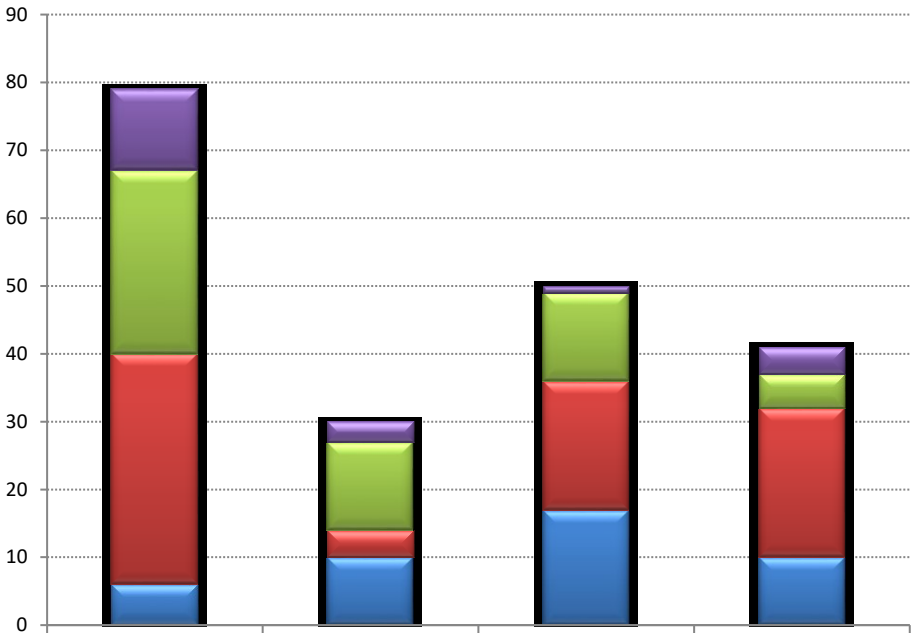


	Low risk	Moderate risk	High risk	Very high risk
Finances	1	1	2	2
Reputation / compliance	6	14	11	0
Service disruption	4	3	14	3
Harm (physical or psychological)	3	9	5	1

4.6 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**. A summary of those corporate risks with a current rating of Moderate or Low risk is included as **Appendix II**.

Operational Risk Profile

4.7 **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	3	1	4
Reputation / compliance	27	13	13	5
Service disruption	34	4	19	22
Harm (physical or psychological)	6	10	17	10

4.8 A copy of the Risk Scoring Guide, which is used to assess all risks recorded on the Trust's corporate an operational risk registers, is attached for reference as **Appendix III**.

TMG - Corporate Risk Report (August 20919)

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
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)	Financial Turnaround Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/08/2019	Deliverable FRP schemes do not cover the extent of savings required. Financial plan for 2018/19 includes an efficiency programme of £25m; as of the end of Q1 the FRP was approx. £0.5m adverse to plan.	Finance	New Turnaround Director to oversee all planned FRP schemes & implement changes to support increased pace of delivery.	Very high risk (20-25)	31/12/2018	
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)	Financial Turnaround Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/08/2019	Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost (at the end of Q1 pay expenditure was £0.8m adverse to plan).	Finance	Range of recruitment & retention initiatives as part of the People Strategy, to fill substantive posts and reduce reliance on temporary staff.	Very high risk (20-25)	31/03/2019	
										Trusts in Special Measures are charged a punitive interest rate of 6%. At the point the financial plan was submitted, NHSI had indicated that interest rates would be reduced to 3.5% if the Trust could achieve plan in three consecutive periods.	Finance	Financial plan to assume interest rates will reduce for both new and existing borrowing from August 2018.	Very high risk (20-25)	31/12/2018	
4405	**Critical infrastructure failure disrupting aseptic pharmacy services (corporate)** If there is a critical failure of the infrastructure that supports aseptic pharmacy services within the Trust; Caused by issues with the age and condition of the facilities and the impact of managing increasing levels of demand; It could result in unplanned suspension of services which would have a significant and prolonged impact on a large number of patients, services, and other service providers. Executive lead: Neill Hepburn Risk lead: Colin Costello	Service disruption	Very high risk (20)	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Estates & Facilities Planned Preventative Maintenance programme & responsive repairs process. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates). Business continuity plans for ASU require patients to be treated outside of the Trust in the event of service disruption.	Very high risk (20)	Medicines Optimisation & Safety Group	Quality Governance Committee	Low risk (4)	31/10/2019	The Pilgrim ASU facility is18 years old, is operating at capacity and the availability of external supplies is both erratic and inconsistent. In addition, cancer care in the Trust is increasing by 10% annually and demand for aseptic preparations is predicted to outstrip current levels of availability by the end of 2020.	Pharmacy	Development of a sustainable infrastructure plan for aseptic pharmacy services.	Very high risk (20-25)	31/12/2020	Full Business Case being prepared for Trust Board in October 2019, containing proposals for a new aseptic unit; preferred option is a joint venture partnership through the STP.
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)		Workforce and Organisational Development Committee	Moderate risk (8)	31/03/2019	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	Human Resources	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	Very high risk (20-25)	31/03/2019	
										High vacancy rates for consultants & middle grade doctors throughout the Trust.	Human Resources	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	Very high risk (20-25)	31/03/2019	
										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.	Human Resources	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.	High risk (12-16)	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.	Human Resources	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.	Moderate risk (8-10)	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.	Human Resources	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.	Very high risk (20-25)	21/03/2019	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.

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
										NHSI propose the introduction of 2 further measures to reduce agency spend in non-clinical areas: - a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts (to use of on-framework agencies only) - A restriction on the use of admin and estates agency workers to bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	Human Resources	Review of proposals and potential impact, to identify any required action.	High risk (12-16)	30/06/2019	
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)		Finance, Performance & Estates Committee	Moderate risk (8)	31/08/2019	• Comprehensive and effective triage • Improve time to RAT • Reduce ambulance handover delay • Improve time to 1st assessment • Effective GP Streaming • Improve non-admitted pathway compliance • Delivery of an ambulatory care model • Implementation of frailty model • Reconfiguration • Redesign the site management and bed meeting model • SAFER implementation • Effective discharge by 1000 • Reduce number of stranded and super stranded patients • Implementation of Red to Green • Implementation of Full Capacity Protocol (FCP) • Implementation of criteria led discharge	Operations	Urgent and Emergency Care Programme work streams: QS04 Pilgrim EC1A Lincoln EC1B Grantham EC2 Assessment Function EC3 Site Function EC4 Inpatient Ward Function EC5 Discharge and Partnerships	Very high risk (20-25)	30/09/2019	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.
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).	Very high risk (20)	Safeguarding Group	Quality Governance Committee	Low risk (4)	30/06/2019	Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration.	Safeguarding	Develop & roll out clinical holding training for identified staff Trust-wide. Introduce debrief process. Identify trends and themes through incidents reported on Datix. Monitor training compliance rates. Introduce audit of 5 security incidents per month from September 2018. Review of chemical sedation pathway.	Very high risk (20-25)	31/01/2019	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%. Further training dates arranged and circulated to areas identified. Compliance with attending training continues to monitored through QSIG plan. Chemical sedation policy and pathways under review.
										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.	Safeguarding	Develop on-call medical photography service through additional appointments onto the Bank. Quantify impact due to service availability issues.	Moderate risk (8-10)	31/03/2019	Staff have been reminded of requirement to complete incident report on Datix when service has been unavailable to enable impact to be assessed.
										The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.	Safeguarding	Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group to scope extent of issues and to progress pathway development.	High risk (12-16)	31/03/2019	Draft pathway developed and under consultation.
										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.	Safeguarding	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.	High risk (12-16)	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	Safeguarding	1. Liaise with training and development department to resubmit applications for core learning. 2. Liaise with clinical education department to determine numbers and reach of HEE funded programme. 3. Refresh training needs analysis to incorporate Autism developments. 4. Ensure reflected within MHLD&A Strategy and associated work-plan.	High risk (12-16)	30/09/2019	

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
										Children and young people (under 18) may be admitted to an adult inpatient ward, where there is a lack of specialist paediatric care and equipment available, such as paediatric resus trolleys. The current mechanism for real time alerting to safeguarding if staff fail to follow the current policy & do not complete the necessary risk assessment is not reliable (either ad hoc or retrospectively through incident reporting); this impairs the ability to respond in a timely manner to the needs of children & young people to ensure they receive appropriate care from appropriately trained staff in the right environment. Only areas that regularly care for children receive Level 3 child safeguarding training (others received L2). It is also not clear if an emergency call for a child on an adult ward would be responded to by paediatrics on-call. Paediatrics are not routinely involved in bed management meetings in order to be made aware of outliers.	Safeguarding	To review and update the existing policy for admission of 14-18 year olds to adult inpatient areas, so that anyone under 16 must be admitted to a paediatric ward (unless they strongly object, fully aware of the risks). Those aged 16-17 to be given the choice, once made fully aware of the risks. Risk assessment to be reviewed. Potential for enhancements to patient administration systems to be considered to reinforce policy. Engagement of paediatrics with bed management meetings to be introduced.	Very high risk (20-25)	31/03/2020	Action plan to be reassigned to appropriate lead once in post.
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.	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)	Patient Environment Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/08/2019	Due to lack of investment in the GDH site building fabric the windows, fascia and doors are in very poor state of repair, most of which are now beyond economic repair and require replacing. This causing drafts and water increase into buildings resulting in increased energy and maintenance costs.	Estates	Any dangerous windows and doors at GDH are replaced on individual basis. No identified funding.	Moderate risk (8-10)	31/12/2019	EPC contract awarded, some of these areas maybe picked up with this contract.
										Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	Estates	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	High risk (12-16)	31/12/2019	Funding and resource to be allocated.
										The air conditioning unit in Acute Care at Grantham Hospital has been condemned. Impact on patient and staff comfort.	Estates	Mobile Air Con units required for ACU at Grantham, Requested but not yet in place, no time frame and finance not agreed.	Moderate risk (8-10)	31/12/2019	Mobile heaters are in place. They are bulky and a health and safety risk, with regard to heat and trip hazard, and potential to overload electrical systems, as they are placed in large cages. They are also not very effective in a large space. they glow bright orange, lighting the unit up at night, this is effecting the sleep patterns of patients, which in turn has the potential to have a detrimental effect on their recovery.
										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. Over the last 5 years the pipework's under the floor have corroded and collapsed spilling out food waste into the soil underneath the floor. This has deteriorated over time and causes very bad smells and lots of drain flies. Environmental health aware and are monitoring with possible closure orders as per hygiene regulations.	Estates	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.	Very high risk (20-25)	31/12/2019	All drains have been removed. Potentially eliminated fly problem. Recommend sealing the floor.
										Floor Coverings across the Trust - Many areas are 45 years old, looks tired and is damaged in areas. Frequently fails environment and PLACE audits. Sub Floor is also damaged in some cases. High risk areas include Maternity at Lincoln, Tower Block at Grantham, Theatre Corridors at Pilgrim.	Estates	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	High risk (12-16)	31/12/2019	
										LCH & GDH: Lack of resources to carry out external decoration. High level areas in the East Wing are difficult and costly to access due to requirement to erect scaffolding. Deterioration of paint finish to wooden windows and door fascias and soffits leaving timber exposed to weather. Will lead to deterioration of timber window frames and their failure with associated costs. Physical appearance very poor. Fails annually on PLACE scores.	Estates	Repairs to external decoration at LCH & GDH undertaken based on available labour, accessibility. Monitor the situation and carry out ad hoc repairs where situation dictates. Funding required for a rolling programme of external decoration, window replacement and facias.	Moderate risk (8-10)	31/12/2019	
										LCH: East Wing ward/theatre block - gutters leaking causing disruption to service and damage to fabric.	Estates	Reactive maintenance carried out to LCH gutters as required. Some areas re-lined; Funding Required to re-line areas of guttering not already done.	High risk (12-16)	31/12/2019	
										LCH: Patient bed space curtain track systems within patient areas are obsolete; sufficient hooks to hang the curtains satisfactorily are not available; [redacted] inadequately hung curtains can affect patient dignity as reported on PLACE.	Estates	Existing curtain hooks at LCH are "spaced out" to increased distances to allow curtains to hang. Funding required to replace the obsolete curtain rail systems.	Moderate risk (8-10)	31/12/2019	
										LCH: Failed Double Glazed Units in Windows of South Facing Wards; Windows "mist up" causing complaints from patients and staff and poor patient environment. Increased energy usage. Mold growth in some frames.	Estates	LCH: Funding required to replace affected double glazed units of south facing wards; Estimated cost £40k+vat. Survey has been completed, need to identify funding to progress.	High risk (12-16)	31/12/2019	
										LCH: Building Fabric Repairs required - East Wing.	Estates	Ad hoc repairs to building fabric of the East Wing; Funding required for a rolling programme of repairs. Estimated cost £30K +vat	High risk (12-16)	31/12/2019	
										Maternity Wing at LCH, 5th Floor Comfort Cooling. Currently no cooling provision. Areas overheated during summer period, adverse effect on patients and staff, in particular in the operating theatres.	Estates	Appoint consultant engineer to carry out detailed design and install comfort cooling system for Maternity Wing at LCH. Part of refurbishment programme.	Moderate risk (8-10)	31/12/2019	

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										PLACE inspection June 2018 Trust scores reduced compared to 2017. Trust Ranking 146/152. Patient perception and concern that the environment reflects the level of care they may receive.	Estates	PLACE Inspection reported to ET in November 2018, see attached report. Requested to scope the work required to improve the environment to an acceptable standard.	High risk (12-16)	29/11/2019	
										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.	Estates	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'.	Very high risk (20-25)	31/12/2018	
										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.	Estates	To design a extension to the existing entrance that will prevent the wind funnelling into the main foyer at Pilgrim.	Very high risk (20-25)	31/12/2018	
										GDH Tower Block Facia Boards rotten and falling off.	Estates	No mitigation possible. Removal required asap.	Very high risk (20-25)	31/01/2019	
										Dishwasher machine Pilgrim Hospital CPU, that washing all patient and restaurant cutlery crockery, 15 years old and beyond economical repair and parts are obsolete.	Facilities	Tender process required for replacement machine. In an emergency hand dishwashing which will require additional staff.	Very high risk (20-25)	31/03/2019	
										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.	Catering (F)	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.	High risk (12-16)	31/12/2019	
										CPU - Building Fabric at Lincoln County Hospital. The general internal fabric is deteriorating and increasingly hard to maintain in a manner compliant with food safety legislation. Structurally, drainage and ceilings are particularly at risk from failure that would compromise the provision of service.	Catering (F)	Robust defect reporting system in place. Regular local authority Environmental Health Officers inspections. PPM regime in place on all plant and environmental cleaning. HACCP system in place (monitoring and temperature checks etc.). Funding required for building repairs estimated cost £30K+vat.	Moderate risk (8-10)	31/12/2019	
										Lack of appropriate religious space for staff of different faiths resulting in difficulties in staff recruitment and retention and therefore affecting staff morale and service resilience	Estates	Provision of additional multi faith areas at Lincoln	Very high risk (20-25)	31/05/2019	
4497	**Contamination of aseptic products (corporate)** If the products supplied by the Trust's aseptic pharmacy services were to become contaminated; Caused by issues with hygiene standards at the production facility, or user error; It could result in significant harm and potentially the death of multiple patients. Executive lead: Neill Hepburn Risk lead: Colin Costello	Harm (physical or psychological)	Very high risk (20)	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS) regulatory stndards. Aseptic pharmacy lead. QAAPS states that aseptic capacity should not exceed 80%. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (15)		Quality Governance Committee	Low risk (5)	31/10/2019	Due to the current state of the infrastructure in Lincoln, and the potential risk of contamination, the Lincoln Pharmacy ASU is not fit for purpose.	Pharmacy	Closure of the Lincoln Pharmacy ASU to avoid the risk.	High risk (12-16)	28/02/2018	Lincoln Pharmacy ASU has been closed.
										Most aseptic processes are operator dependant. This means that when overcapacity there is an increased risk of calculation errors or producing contaminated products. Whilst air pressure monitoring will highlight the risk of contamination it does not give information on the actual risk. Microbial plates take 2 weeks to provide results, therefore any potentially contaminated products cannot be identified until after they have been issued and administered to patients. This is because the aseptic unit operates under Section 10 exemption from the Medicines Act and is not licensed. There is therefore no batch manufacturing and no associated quality control of batch manufactured products which would otherwise enable microbiological and chemical stability testing to take place.	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a safe service and achieve capacity levels of under 80%. CSS Division to identify resources for additional staff required.	High risk (12-16)	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
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.	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)	Fire Safety Group	Finance, Performance & Estates Committee	Low risk (4)	31/01/2019	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards. The Maternity Wing has a partially compliant alarm system in need of upgrading to current standards (Any works to the Fire alarm system within the Maternity Wing are constrained by the presence of asbestos. This applies to maintenance works and any upgrade works). Detection Zones plans are also referenced as a reason for the inadequate Fire Detection System under Article 13(1) (a) & 13 (2) of the Fire Enforcement noticed served 14th June 2017.	Estates	The Fire Alarm System at LCH is maintained by a specialist contractor and directly employed labour force. The system in some areas has been upgraded as part of services developments e.g. HDU & ICU and as part of previously funded upgrade. Programme of refurbishment and re-provision on a phased basis to install a 'loop' for the site and linking in modern equipment is underway.	High risk (12-16)	31/12/2019	Phases 1, 2 and 3 complete. Phases 4 is underway and as part of these works; and to improve auditability and compliance with DDA, additional sounders and beakers are being installed. Phase 5 (Mat Wing) The Fire Alarm systems on 1st and 6th floor have been replaced, works are currently on-going to replace the Fire Alarm system within all lift lobby areas and within the 3rd floor ward area.
										Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection of patient and staff areas in accordance with statutory standards. See Fire Strategy surveys for areas affected. As referenced under article 8 in the Fire Enforcement Notices.	Estates	Fire Strategy Plans and surveys identify where compartmentation is required. Fire compartmentation works costs are detailed within the capital plan.	Very high risk (20-25)	30/06/2019	The work packages for the remedial works are taking place subject to availability of sufficient capital funding.

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
										Numerous sets of fire doors in poor condition due to wear and tear and damage where the fire resisting qualities have been reduced or negated. Under article 17(1).	Estates	Fire Doors will be addressed as part of the Fire Action Plan from the enforcement notices received for Lincoln and Pilgrim. Fire Doors requiring replacement to be replaced with new certified fire doors. PPM inspections and ad hoc repairs to fire doors in response to serious damage, etc.	Very high risk (20-25)	30/06/2019	Replacement programme in progress.
										There are some areas of the estate with insufficient provisions of emergency lighting. Testing of these units is required to ensure their continuing efficiency in the event of mains failure during fire incidents. Failure to comply with testing schedules could result in unit failure in service. Additional resources required to enable full compliance with Trust policy and applicable regulations.	Estates	Energy Performance Contract EPC being established to include full replacement of Emergency Lighting System Trust wide. EPC to be instructed to undertake replacement programme in accordance with Fire Enforcement Notice Timescales. Standby generator would come into operation to provide some essential emergency lighting.	Very high risk (20-25)	30/06/2019	Replacement programme in progress.
										Adherence to fire safety policy, procedures, strategic approach to active and passive fire safety measures and evacuation strategy. Adherence to Fire Safety training arrangements which include recording, analysis of training needs, personal development systems in place for all staff inclusive of permanent, temporary, agency and or bank staff. 1. Staff failing to attend Fire Safety Training in accordance with policy, procedures and Training needs analysis. 2. No testing of emergency procedures via evacuation drills. 3. Fire safety training to be provided in accordance with role, seniority or professional discipline within the fire emergency plan. 4. Undertaking and Recording of Personal Emergency Evacuation Plans for Less able bodied and disabled staff. 5. Staff being allowed to continue within role against HTM guidance that states: 'should not be permitted to continue their duties with a gap in their record of training longer than twice the interval identified in the training needs analysis' which is two years within ULH. 6. Non identification of staff by managers to attend core modules when undertaking annual PDR.	Estates	Specific actions in relation to fire safety training & evacuation: 1. staff identified and managers informed to ensure staff attend 2. Evacuation drills to be implemented and tested. 3. New Fire safety training packages being introduced. 4. persons requiring PEEP and procedures tested during evacuation drills. 5. discussions with HR to identify an appropriate procedure to identify and inform staff outside of compliance dates, with managers cc into correspondence to ensure urgent attendance. 6. Fire safety trainer to discuss with ESR team about information required for PDR and H & S team for reporting against core modules to ensure compliance.	Very high risk (20-25)	31/03/2019	New mandatory staff fire safety awareness module introduced.
3951	**Compliance with regulations & standards for aseptic pharmacy services (corporate)** If the Trust is found by a regulator to be systemically non-compliance with regulations & standards for aseptic pharmacy services; Caused by fundamental issues with the design or application of local policies and procedures, or the quality of the facility; It could result in regulatory intervention that forces immediate closure of the facility and suspension of services, impacting on a large number of patients, services and other service providers. Executive lead: Neill Hepburn Risk lead: Colin Costello	Reputation / compliance	Very high risk (20)	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (16)		Quality Governance Committee	Low risk (4)	31/10/2019	Pilgrim Hospital ASU does not comply with national and EU standards: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	Pharmacy	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	High risk (12-16)	31/12/2020	Business Case in development, to be presented to Trust Board in October 2019.
										Aseptic preparation services must have adequate resources to ensure compliance with the defined national standards as described in Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic preparation time has increased due to changes in aseptic services standards (addition of an extra disinfection stage and use of a sporicidal agent with an increased contact disinfection time).	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a service that complies with QAAPS standards. CSS Division to identify resources for additional staff required.	High risk (12-16)	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
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)	Financial Turnaround Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/03/2019	Clinical coding & data quality issues impacting on income.	Finance	Appointment of Grant Thornton to carry out short-term income review project.	High risk (12-16)	31/01/2019	
										Operational ownership of income at directorate level.	Finance	Complete an income improvement plan for each Directorate & incorporate within performance review process.	High risk (12-16)	31/01/2019	
										Commissioners have a combined shortfall to contract of c£5m. This could result in demand management schemes that the Trust cannot pull the costs out of at the same rate or aggressive in year fines and penalties.	Finance	Continued engagement with Commissioners throughout 2018/19 in the development & implementation of demand management schemes.	High risk (12-16)	31/03/2019	
3720	**Critical failure of the electrical infrastructure (corporate)** If the Trust experiences a critical failure of its electrical infrastructure;	Service disruption	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme.	High risk (16)	Electrical Safety Group	Finance, Performance & Estates Committee	Low risk (4)	31/01/2019	Street lighting and car park lighting cables at PHB are suffering from multiple faults due to their age.	Estates	Repairs to street lighting at PHB carried out when necessary. Need to re-wire street lighting circuits and replace light fittings. Funding dependant.	Moderate risk (8-10)	31/03/2019	

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
	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			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.						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.	Estates	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.	High risk (12-16)	31/01/2019	
										HV incoming switchgear at GDH is obsolete and requires replacement. Western Distribution have been to site to inspect their side of the switchgear. There is a possibility that in the near future they will be upgrading the incoming HV supply. This will result in the Trust having to replace our side of the switchgear.	Estates	Funding required to replace the switchgear at GDH in the event that Western Power decide to upgrade the incoming HV supply.	Moderate risk (8-10)	31/01/2019	
										Potential for failure of electrical distribution to large area of Pilgrim Hospital due to panel failure.	Estates	Complete review of the system. Accelerated replacement programme. Funding and resource required. Consider the use of thermal imaging camera.	Moderate risk (8-10)	31/12/2019	Funding and resource required. Infrastructure review carried out by DSSR across all sites. Apprx £50k cost
										Weakness of the distribution systems is the change over contactors which connect the electrical load to either the Mains or the standby generators. There are 60 around the LCH site and they cannot be maintained unless the supply is totally disconnected from the electrical supply. These emergency changeover contactors connect the emergency standby generation to the hospital electrical distribution system in the event of mains electrical supply failure. It is not possible to carry out maintenance on these without an interruption to the electrical supply to specific areas of the hospital.	Estates	Ad hoc defects addressed by Estates Team as required. Programme required for replacement of local distribution boards. Programme requirement for replacement of change over contactors with units which comprise a 'by pass' arrangement to enable maintenance to be carried out.	Moderate risk (8-10)	31/12/2019	Est cost £20k per unit. Total cost of appx £700-£800k.
										Potential for extended standby generator usage & disruption to services due to failure of obsolete LV switchgear at LCH. Switchgear is obsolete and spare parts unobtainable. Some 630A Federal Electric Fuse Switches have failed and spare parts are not available. If a failure of similar units occur large sections of the site would be on the standby generator for a considerable time, as a replacement unit is not readily available.	Estates	Old equipment is re-used where possible to maintain services. A portable 630 Switchfuse has been mounted on a frame with cables attached which could hopefully be used to temporarily replace a failed unit whilst a permanent replacement was arranged. Funding required for a replacement programme for switchgear.	Moderate risk (8-10)	31/12/2019	Estimated Cost to initially replace the Main Panel Boards: £300K+vat per unit. Appx 17-2o units in total. £3-£5m Trustwide.
										The majority of the high voltage switchgear and transformers on all three sites are oil filled. The majority of switchgear is over 40 years old and the majority of switchgear in the East Wing is over 25 years old. Generally in industry these are being replaced with vacuum and SF6 switchgear to reduce fire risks due to oil and maintenance costs.	Estates	All switchgear is regularly maintained by specialist high voltage contractor. Funding require for a programme of switchgear replacement.	Moderate risk (8-10)	31/12/2019	Estimated Cost £500k + vat. Pilgrim should be the first site to undertake.
										Potential for disruption to clinical services as a result of Electrical Supply Distribution - Maternity Wing. Switchgear on each floor and sub mains cabling are 45 years old and obsolete. Circuit protection requires upgrading.	Estates	Completely replaced on the 1st floor and 6th floor. Asbestos removals and ceiling replacement will enable access for remedial works to remaining floors. £250k to run electrical system.	Moderate risk (8-10)	31/12/2019	Funding is not in place for a programme of Inspection & Testing of electrical installations so condition of switchgear cannot be rigorously assessed
										Lightning protection inadequately protects the buildings at Lincoln County. This is caused by the age of the buildings and protection systems that do not comply with current standards (BS EN 62305 (2-2006), IEE Wiring Regs 17th). Would lead to an impact/effect on the ability of the buildings to withstand a lightning strike	Estates	Annual inspection carried out by specialist contractor. Funding required to install a compliant Lightning protection system to these buildings.	Moderate risk (8-10)	31/12/2019	Estimated Cost £20k+ VAT.
										Potential for Mechanical & Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	High risk (12-16)	31/12/2019	Estimated cost £50k +vat.
										Mechanical & electrical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	High risk (12-16)	31/12/2019	
										X Ray Department at GDH: Need to replace existing heater batteries and control panel with new. Controls are obsolete can no longer maintain. Heater batteries are old and starting to fail and need replacement	Estates	Maintain and inspect on a regular basis. Capital investment required.	High risk (12-16)	31/12/2019	Capital funding applied for.

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										Potential for failure of Electrical Infrastructure at GDH resulting in service interruption, fire and closure of clinical services. The site has an aging electrical infrastructure and some of the switchgear is obsolete and in need of replacing. It does not comply with current IET wiring regulations (BS7671). Area affected are:- Tower Block. Rayrole room. Main Switchgear fed from Transformer no 3 (back of Theatres). Main Switchroom outside of ward 6 including Ward 6 Distribution boards. Various Distribution are obsolete and we unable to obtain spare parts for. A&E Endoscopy X-ray Department Theatres Tower Block Out-Patients Medical Physic Pharmacy Rehabilitation	Estates	Capital investment required to upgrade electrical infrastructure at GDH.	High risk (12-16)	31/12/2019	Capital funding applied for.
										High Voltage Switchgear (Switching prohibition) EFN 2016 05 - GDH has a Log and Crawford GF£ High Voltage Fuse Switch that has a switching prohibition on it. which means we cannot operate it. No contingency if this unit fails other than emergency generator which supplies limited outlets.	Estates	Log and Crawford GF£ High Voltage Fuse Switch identified on capital programme for replacement.	High risk (12-16)	31/12/2019	
										Currently one generator provides backup power to ITU (and Endoscopy and Medical air plant) at Pilgrim Hospital during a power cut. Current generator was second hand when installed 4 years ago and has failed previously on start-up. There is the capability on other generators serving critical areas to switch in another generator onto the circuit should one fail but not in this case.	Estates	Option to hire a 2nd generator at approximately £750 per week until a permanent solution is found. A back up generator is required.	Moderate risk (8-10)	31/12/2019	A capital scheme needs to be drawn up to provide further generator back up.
										Generator 1 and 2 contactor panels and associated switchgear are 40 years old and obsolete. These panels switch the generator supply onto load during a power outage to 90% of all clinical areas including the Tower Block, Theatres and A&E. Open design of the electrical panels means it is unsafe to work in panel unless isolated should a failure occur.	Estates	Contactors tested during weekly generator tests. Replace electrical panel (design already provided during the changeover panel replacement carried out in 2015/16).	High risk (12-16)	31/12/2019	No parts available should breakdown occur. New electrical panel required but financial constraint prevents replacement.
										The majority of the electrical switchgear and distribution boards on the Pilgrim Hospital site are over 40 years old. This is in excess of the recommended replacement age found in HTM06-02. Some of the distribution boards are showing signs of overheating and many boards are full to capacity. Distribution boards do not meet any Form 4 manufacturing standards meaning maintenance is difficult without isolation. Equipment is obsolete.	Estates	Monitoring and inspection of distribution boards on PPM (staff numbers allowing). Carry out audit of switchgear and distribution boards. Replace failing and obsolete equipment.	Moderate risk (8-10)	31/12/2019	
										The LV network within blocks 0A, 0D, 0J, 0W, 0L, 0U, 0T, 0V, 0X and 0Y is full to capacity. The N+1 design capacity of the original installation no longer exists, meaning under HV fault conditions all the hospital load cannot be switched within the LV network to continue supply. There is no capacity for new schemes, etc without investing in extending the HV network and taking some of the load of the existing network and re-supply from extended HV network.	Estates	Smaller schemes requiring power can bring power in from other parts of the site, but the infrastructure cost to this is not insignificant. Increase HV network and load shed existing LV network onto new LV network fed from extended HV system.	Moderate risk (8-10)	31/12/2019	Financial constraints
										There is a risk that communications with ULHT elements at Louth will not work, because the Louth Switchboard (both equipment and cabling) is obsolete and deteriorating rapidly due to age. The impact of this is possible risk of no communication internal and externally between ULHT areas. Additionally, sound quality is poor raising a subordinate risk of errors in clinical care.	Estates	Gap analysis to be carried out, by system owner - Arden GEM. Completing risk assessments to justify cost. Business Continuity plan to be raised. Possible solution for all ULHT areas to buy a phone possible cost of £300 pounds per phone.	High risk (12-16)	31/12/2019	The maintainer (NG Bailey) is currently employing scavenging techniques to carry out repairs due to many of the parts being obsolete. ULHT have no contingency plan.
										Both CT scanners in the x-ray room at Lincoln Radiology are supplied by the same electrical switch and both cardiac rooms are supplied by another electrical switch. In order for any maintenance on these switches to occur or a failure in either switch would result in loss of power to either both CT scanners or both cardiac rooms at the same time.	Estates	To explore the possibility of changing the arrangement to the CT and Cardiac labs, so that 1 CT and 1 Cardiac lab are on one circuit and vice versa. This would provide some resilience to the trust.	Moderate risk (8-10)	31/12/2019	Engineers to carry out a feasibility study for these works.

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										Transformer No 3 is exhibiting signs of overloading -the oil has had to be changed twice in the last 5 years and stem seals split in October 2017 resulting in a power loss to the Boiler House and Estates, X-ray, Education Centre, critical water plant and part of Outpatients. This is partly caused by the CHP back-feeding excess power during periods of low demand overloading the transformer. The transformer is 50 years old and parts are obsolete. It is also inefficient compared to new transformers. Cannot monitor oil levels 24/7. If another fault develops then it is possible that the transformer cannot be repaired. 8 to 12 week wait for replacement transformer to be installed if required.	Estates	Monitor transformer with 6 monthly oil condition tests. Request run time of CHP to be stopped overnight to reduce overload during this period. Check transformer oil levels. Power supply can be resumed during a failure with switching routine and move load to transformer No.4 but only for a relatively short period of time. Replace transformer No.3.	Moderate risk (8-10)	31/12/2019	
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 Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/01/2019	Lift controls for lifts 9 & 10 at LCH are obsolete and the excessive heat in the motor room if affecting the ride quality of the lift. Risk to patients and visitors of malfunctioning lift.	Estates	Regular inspection and maintenance of lifts at LCH. Service contract in place. Price received to replace controllers: £30K + VAT.	Moderate risk (8-10)	31/03/2019	
										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.	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	High risk (12-16)	31/12/2019	
										Potential for Mechanical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure: estimated cost £50k +vat.	High risk (12-16)	31/12/2019	
										Potential for plant failure for Medical oxygen for all sites.	Estates	Consider provision of a further VIE at a separate location, which would provide site resilience in the event of plant failure to original medical oxygen unit. Regular PPM and reactive maintenance.	High risk (12-16)	31/12/2019	
										At Grantham Hospital, vital transportation of samples and other items around the site via the airtube system may not be possible due to the need to continue upgrading programmer to maintain the capacity of the system. Main controller is obsolete and requires replacement.	Estates	Monitoring and continuous repair. Partial replacement of air tube stations, as and only when funding becomes available. Replacement controller added to Capital / Backlog Maintenance List.	High risk (12-16)	31/12/2019	50% of stations have been replaced.
										Maternity Lifts at Pilgrim are in poor condition and in need of further refurbishment /replacement. Risk of failure whilst in use and unavailability.	Estates	Capital and revenue investment to refurbish Maternity lifts at Pilgrim. Safety checks in place supplementary inspections in place Comprehensive maintenance contract in place. Use of alternative lifts available.	High risk (12-16)	31/12/2019	
										Mechanical ventilation (Air Handling Units) within the Maternity Wing at LCH is 45 years old and should be considered for replacement. The ductwork systems within the building have not been internally cleaned since installation due to cost and logistical constraints.	Estates	Replacement programme required for air Handling Units across the LCH site. Ductwork cleaning programme required. Estimated Cost £100k+vat Ad hoc cleaning takes place when areas have be upgraded and access was possible. Planned Maintenance carried out on AHU's.	Moderate risk (8-10)	31/12/2019	
										Potential Loss of the medical air to ICU, HDU, Cath Lab 1&2, A&E, Interventional Suite X Ray, Oncology Unit, Cardiac Short Stay at LCH. The current plant does not meet HTM02-01 recommendations, the plant is 12 years old and the manufacturers recommend a service life of 10 to 15 years.	Estates	Recommend as a minimum to install an additional air compressor to upgrade the current plant at LCH to a triplex configuration (three compressors) cost circa £22k. Replace air plant with a new triplex (three compressor) plant as recommended by the current HTM02-01, cost circa £100k together with a large cylinder backup. Increase the necessary number of back up cylinders to maintain 4 hours recommendation as per HTM02-01. Ensure our cylinder supplier (BOC) has the resources to have the required backup cylinders on site if needed and within a timely timescale.	Moderate risk (8-10)	31/12/2019	We have been informed by BOC that they can deliver cylinders to site within 4 hours including out of hours working).
										Medical Gas alarms at Pilgrim are obsolete and cannot be upgraded.	Estates	Ensure all alarms are linked to BMS system. Consider duplex panel. Funding required.	Moderate risk (8-10)	31/12/2019	£20k + VAT identified on the capital programme.
										Potential for a severe leak of heating and hot water service due to the poor condition of plastic pipework at Pilgrim. Plastic Pipework in very poor condition. Severe water leak will cause loss of heating and hot water services. Several leaks have occurred in the past.	Estates	£50k + VAT identified in the capital plan to replace the plastic pipework at Pilgrim. Subway inspections and planned maintenance.	High risk (12-16)	31/12/2019	There will be some disruption to services to allow the work to go ahead.
										Mechanical Services Valves at GDH are all of varying ages and some are over 50 years old and are no longer serviceable and are beyond economic repair. Unable to satisfactorily isolate services for maintenance. Causes isolation of large areas, wastes water and causes disruption and inconvenience to wider areas of the hospital.	Estates	Year on year replacement programme is required. Use of pipeline freezing techniques if possible.	Moderate risk (8-10)	31/12/2019	

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										Existing gas main at LCH runs from maternity wing subway underground across the site under the corridor to clinic 9 was installed to feed additional areas and is grossly oversized. Risk of leaks due to age and possible condition and it is difficult to identify leaks due to limited use. It is also current guidance that natural gas pipes DO NOT pass beneath buildings.	Estates	Disconnect the gas pipeline at LCH at the valve which is located within the Maternity wing subway and install a local Propane manifold within the courtyard adjacent to the Dental Department. Estimated Costs £5K +vat.	High risk (12-16)	31/12/2019	
										Old maternity block at GDH houses 2 Wards and management offices and is serviced by 2 lifts. 1 lift has had a new motor fitted in 2015. The remaining lift is of the same age. If this lift fails then we will not be able to service 2 Wards(food, patient moves, patient admissions etc).	Estates	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.	High risk (12-16)	31/12/2019	
										Frost batteries located within the air handling units in plant rooms 3, 9 and 10 and heater batteries in plant room 13 at LCH do not have the capacity to cope with extremely low ambient temperatures as experienced during the winter of 2010/11.	Estates	Funding required to replace frost batteries located within the air handling units at LCH with units of larger output. Estimated Cost £40K +vat.	Moderate risk (8-10)	31/12/2019	
										Medical Vacuum Plant Located in Plant Room 1 at LCH. Supplies 10 East Wing Operating Theatres, 9 wards, OPD Clinics and 4 X-ray rooms. Plant is 25 years old. Does not conform to current HTM 02-01. Replacement parts increasingly difficult to obtain. If it failed this would cause major disruption to the areas outlined above.	Estates	Replace Medical Vacuum Plant Located in Plant Room 1 at LCH with unit compliant with HTM 02-01 . Estimated Cost £55k +vat	Moderate risk (8-10)	31/12/2019	
										Seized and Defective Isolation Valves on Mechanical Services at LCH. Risk of interruption to clinical services due to access to isolate services for maintenance.	Estates	Rolling programme required to replace Seized and Defective Isolation Valves on Mechanical Services at LCH. Use pipeline freezing techniques if possible.	Moderate risk (8-10)	31/12/2019	
										The theatres infrastructure on at least the Lincoln and Pilgrim sites needs to be reviewed in light of primary services: i.e. electrical supply / medical gases / air exchange. As new technology is introduced the loading on individual circuits is closing in on the circuit limits. Air exchange plant is running at its maximum. The provision of medical gases is stretched.	Estates	Clinical Strategy to be in place. Appoint design consultants. Map clinical requirements to functional space and engineering requirements. Produce strategy & design. Commission / construct new theatre installation.	Moderate risk (8-10)	31/12/2019	Establishing capacity within Theatres to enable design of fit for purpose infrastructure.
										Potential for failure of air conditioning plant which affects large parts of the Tower Block at Pilgrim.	Estates	Perform site survey. Allocate funding through the Facilities Capital allocations.	Moderate risk (8-10)	31/12/2019	Need to repair defective plant, (£5,000 committed to date).
										Obsolete controls to the Ventilation system within Maternity at Lincoln. The Heating and Ventilation system controls are obsolete and functionality limited. Not energy efficient and provide little or no control of temperature within Maternity Wing including Labour Ward Operating Theatre No. 1.	Estates	1. Survey of the ventilation system within Maternity at Lincoln needs to be carried out to determine the correct contract strategy. 2. Replacement programme implementation (The presence of Asbestos Containing Materials - ACM's would present difficulties). Funding required to replace existing defective and obsolete controls. Estimated Cost £30k + VAT.	Moderate risk (8-10)	31/12/2019	
										Ambulatory Care at LCH - Heating Calorifier. Only 1 unit installed. There is no means of heating the ward if this fails.	Estates	Funding required to install additional plate heat exchangers (duty and standby) for Ambulatory Care at LCH. Estimated cost £ 80k +vat.	High risk (12-16)	31/12/2019	
										Heating Pipework for Robey House at LCH is steel and is suffering from a build up of internal deposits which cause lack of circulation and therefore heating.	Estates	Replace heating system within Robey House at LCH, est £80k +vat.	Moderate risk (8-10)	31/12/2019	Some sections of ground floor pipework replaced as part of Trust Board move into this building.
										Physiotherapy Heating Calorifier at LCH is 40 years old, labour intensive to maintain and not energy efficient. Not duplex so service vulnerable if this one fails during period of very cold weather.	Estates	Funding required to install plate heat exchangers for Physiotherapy Heating Calorifier at LCH. Estimated costs £80k +vat	Moderate risk (8-10)	31/12/2019	
										Maternity Wing Drains at LCH are susceptible to blockages caused by the condition and capacity of the drains. The drainage system within the Maternity Wing is subject to higher frequencies of blockages due to capacity and condition of the drainage system. In addition users are placing inappropriate items down toilets and the presence of Asbestos Containing Materials (ACM's) present difficulties in accessing large sections of the drainage system.	Estates	Business Case to be developed for a drainage replacement programme for the Maternity Wing at LCH. Estimated Cost £200k + VAT	Moderate risk (8-10)	31/12/2019	1. Some sections have been replaced. 2. Sewage spillages are managed as they occur using agreed procedures. 3. Signs are placed adjacent to each toilet to request users not to place inappropriate items in them.
										The lifts at Lincoln County may not function correctly. This is caused by out of date components and inadequate control circuit configurations on lifts that are 20 - 25 years old this would lead to an impact/effect on Lift no. 1-6 and Lifts 9-11 in terms of overheating, fire risk and poor reliability.	Estates	Funding required for lifts at LCH. --Lifts 1-6 replace control panels at £8k each (total £48k) Replace car top controls at £900 each (total £5.4k). Replace door operator at £4.6k each (total £27.6k). Lifts 9-11 - replace control panels at £8k each (total £24k). Replace car top controls at £900 each (total £2.7k).	Moderate risk (8-10)	31/12/2019	Quotes received from Stannah Lifts.
										Contaminated Medical Vaccum Pipework resulting from upgrading and new plant fitted within the Maternity Unit	Estates	Remove the old plant and pipework from the Boiler house complex to the Maternity Wing Ground Floor. Quote obtained.	Moderate risk (8-10)	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	Service disruption	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Space Utilisation Policy. Capital investment planning process and programme	High risk (12)	Estates Strategy Group	Finance, Performance & Estates Committee	Moderate risk (8)	31/01/2019	Lack of health community clinical strategy to inform the development of the Trust's Estates Strategy. No identified resource to develop Estates Strategy.	Estates	Develop, review and implement an Estates Strategy (aligned to the capital investment programme) with reference to the STP, ERIC data & Lord Carter's recommendations.	Very high risk (20-25)	31/03/2019	

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	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			(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.						Lack of awareness of cost of space to the user / service and assumption that the Trust has space readily available and fit for purpose.	Estates	Continued development and implementation of Premises Assurance Model (NHS PAM).	Moderate risk (8-10)	31/03/2019	
										Availability of sufficient capital and revenue funds to enable delivery of projects within the Estates Strategy & support prioritisation to ensure compliance with statutory and HSE Regulatory Requirements.	Estates	Review of defined Capital Prioritisation Process used to effectively stratify statutory risks in conjunction with available capital to confirm it remains fit for purpose. EFM Directorate Financial Reporting and Capital progress reporting to Estates Environment Infrastructure Investment Committee	Moderate risk (8-10)	31/03/2019	
										Processes for escalation of significant issues through Trust formal governance systems.	Estates	Review of Risk Reporting through core programmes to Estates Investment & Environment Group, through Finance, Performance & Estates Committee and up to Trust Board to confirm that it remains fit for purpose.	Moderate risk (8-10)	31/03/2019	
										Review required to look at the estate as leases become due for renewal and decision made on whether the lease renewal is financially viable to comply with modern day standards in relation to 3rd party occupants.	Estates	Full review of all lease clauses with Trust Legal Advisors and tenant to agree responsibilities. Business Case to be submitted to support the review of all the leases including legal advice.	High risk (12-16)	31/03/2019	
										The Baverstock House building is in a poor state of repair leading to potential claims of not meeting the Landlord obligations. The building is not compliant with our current fire strategy in line with the fire enforcement notice. The electrical infrastructure is fully loaded with no capacity and running at maximum. This could result in an electrical fire, loss of building. The social club is used as a infrastructure passing point for the electric supply to another building (Baverstock House) if there was a loss of electricity to the social club or a fire this would lead to disruption to Baverstock House (a leased property) potentially leading to loss of revenue for the Trust for both buildings. The building is leased to a third party for use as a social club/bar which has several fire risk factors including cooking and storage of flammable products. The bar is open to the general public and licenced for functions.	Estates	A dilapidation survey has been undertaken to assess the Baverstock House building condition and estimate costs to undertaken repairs. A Fire Risk Assessment has been undertaken by the Trust's Fire Safety Advisor and is due for review. A paper has been drafted for the Executive Team to consider investment in repairs and the options for a new lease. 1. Review Fire Risk Assessment - Action FSA 2. Finalise dilapidation survey and report to include estimated repair costs. 3. Review of Landlord and tenant obligations and agree with tenant responsibilities in respect of repair and maintenance.	Very high risk (20-25)	31/12/2019	Undertaken a technical loading test which has a phase inbalance requiring further investigation. On the 1st March, one of the 32 amp MCB's in the fuse boards melted under the loading causing power disruption. Given the recent incident it is likely that until the electrical infrastructure is reviewed and additional capacity is installed there is a risk of further failures.
										Risk of non-compliance with obligations in lease to For Under Fives in respect of maintenance to the building. Key issues are poor electrical infrastructure and limited fire compartmentation. The nursery building is connected to Rheumatology and there is no fire stopping/compartmentation between the two departments. It is timber clad building which provides no fire resistance. Following the Grenfell Fire there is notice to reduce the risk posed by timber clad buildings. A fire in this building would result in a business continuity issue for the tenant who provide nursery care to children of employees on the hospital. Due to the nursery being adjacent to Rheumatology works to fire compartmentation is very difficult whilst the nursery is operation. To undertake the required fire improvement works the nursery would need to be temporarily relocated. The Trust Fire Safety Advisor is concerned about the lack of fire compartmentation in a nursery.	Estates	A Fire Risk Assessment has been undertaken in conjunction with the Nursery owner. A dilapidation survey/schedule of condition has been undertaken. A quote for repair works has been requested by contractors currently undertaking works on the Lincoln site to address the biggest dilapidation issues e.g. to make the brick part of the building adequately water tight, full electrical test and a heating flow and return test.. 1. Fire Risk Assessment to be reviewed - Action FSA 2. Dilapidation survey report to be reviewed and updated with cost of repairs 3.Quote for works to make the brick part of the building adequately water tight, full electrical test and a heating flow and return test. 4.Review options for temporary relocation whilst fire compartmentation works are undertaken.	High risk (12-16)	31/12/2019	
										To escalate to the Risk Register the lack of availability and prioritisation of meeting rooms or VC for Clinical leadership meetings.	Estates	To review the utilisation and governance for the use of rooms and maximisation of VC within these rooms. Need to prioritise speciality governance – meeting rhythm across the governance scheme –	Very high risk (20-25)	31/05/2019	
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	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	Asbestos Management Group	Finance, Performance & Estates Committee	Low risk	31/01/2019	Asbestos Policy is overdue for review.	Estates	Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.	High risk (12-16)	31/03/2019	
										Asbestos Management Plan still to be fully developed.	Estates	Complete development & begin implementation of Asbestos Management Plan.	Very high risk (20-25)	31/12/2018	
										Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	Estates	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	Very high risk (20-25)	31/12/2018	
										Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Estates	Agree Appointed Person & structure for Asbestos management.	Moderate risk (8-10)	31/03/2019	
										Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	Estates	Review of asbestos contractors appointment & verification of training.	High risk (12-16)	31/03/2019	
										No Access areas still to be surveyed for asbestos.	Estates	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	Moderate risk (8-10)	31/03/2019	
										Potentially inaccurate survey data due to restricted access to areas.	Estates	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	Moderate risk (8-10)	31/03/2019	

TMG - Corporate Risk Report (August 20919)

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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)	Water Safety Group	Finance, Performance & Estates Committee	Low risk (4)	31/01/2019	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Estates	Legionella monitoring carried out by direct labour as far as possible with competing priorities. Action required: appoint additional staff or contractor in lieu of staff to carry out work. Further actions required (subject to funding): water systems drawings are required for all sites (CAD); review and issue a Trustwide tender document for the monitoring work; to appoint a responsible person; to form a Trustwide Legionella group to consist of Facilities, Infection Prevention and Control Consultant and Nurses (sub group of Infection Prevention and Control Committee?)	Moderate risk (8-10)	31/12/2019	
										13 waste disposal units do not incorporate a 'Type A Air Gap' on the water supply inlet and therefore as they are classed as 'CAT 5 Fluid' they do not comply with the 'Water Regulations' which is a statutory regulation.	Estates	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'. The non-compliant units to be replaced with those which comply with the Water Regulations.	High risk (12-16)	31/12/2019	Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.
										Lack of compliance with ACOP L8 and HTM standards in respect of water schematics for the hot and cold water systems could impact on the Trust's ability to demonstrate compliance with statutory standards and potentially place service users at risk of poor water safety.	Estates	Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	High risk (12-16)	30/06/2019	Funding required for replacement TMVs, sinks and hand basins. Schematics produced by surveyors have not been quality assessed and have not been stitched into Estates and Facilities master CAD models. Some funding has been identified from Facilities CIP.
										Although routine checks are undertaken , the water tanks at LCH do not comply with the Water Regulations	Estates	Bid for Capital funding to replace non-compliant water tanks made May 2016.	Moderate risk (8-10)	31/12/2019	
										Trustwide Water Systems - Chlorine Dioxide Dosing System. Scotmas inform that some of the monitors are now obsolete and require replacing. BMS is now linked to Lincoln.	Estates	Specification has been out to tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	Moderate risk (8-10)	30/06/2019	In December 2017 Scotmas were the only supplier to bid on this tender.
										The Trust may not comply with drinking water guidelines and HTM04-01 at Pilgrim Hospital, because of Chlorine Dioxide dosing impurities due to lack of available maintenance.	Estates	Automatic monitors in place. It is being constantly monitored and completion of new water main which will be 2018/19. Capital investment required to mitigate this risk.	Moderate risk (8-10)	31/12/2019	Delayed completion of new water main which is required before we can gain access to complete the work required.
										The Water Safety Statutory Improvement Programme (directed by site risk assessments) may not complete on time; on going upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Estates	Stringent Water sampling and flushing programs in place. Funding required.	Moderate risk (8-10)	31/12/2019	
3722	**Energy performance and sustainability (corporate)** If the Trust is unable to deliver sustainable energy performance; Caused by issues with the maintenance and development of the energy management infrastructure; It could result in significant avoidable costs that impacts adversely on the delivery of the annual control total. Executive lead: Paul Boocock Risk lead: Chris Farrah	Finances	Very high risk (20)	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process (environmental legislation). BMS systems, Energy centre management contract (Lincoln & Pilgrim); some sub-metering in place. Oversight and management of Energy Performance Contract (EPC). Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk 12)	Energy & Sustainability Group	FSID	Moderate risk (8)	31/01/2019	LCH: Large areas of lagging damaged and/or missing; results in heat loss and inefficiency.	Estates	Bespoke capital investment programme to improve insulation standards at LCH and therefore improve energy performance standards. The exact requirement of which to be determined by site surveys.	Moderate risk (8-10)	31/03/2019	
										LCH: Windows in Block 27; Aluminium construction seals have perished and obsolete, single glazed, draughty and not energy efficient.	Estates	LCH: Windows in Block 27; Plastic sheets in place to control draughts. Funding required to replace windows.	Moderate risk (8-10)	31/03/2019	
										LCH: Maternity Wing Heating Calorifier is 45 years old, labour intensive to maintain and not energy efficient.	Estates	LCH: Materrnity Wing Heating Calorifier is on planned maintenance programme. Funding required to install plate heat exchangers. Consider as part of EPC.	Moderate risk (8-10)	31/03/2019	
										LCH: Over 20% of the heat lost through the building fabric escapes through the roof. All East Wing is currently insulated to depth of 100mm -the current guidance is for a minimum of 150mm. Insulation to areas of pipework within subways is damaged and not of adequate thickness. Insulation to areas of ventilation ductwork is damaged/not adequate.	Estates	LCH: Commence programme of upgrading the insulation levels within East Wing roof voids, pipework and ductwork.	Moderate risk (8-10)	31/03/2019	
										Boilerhouse Heating Calorifiers are 45 years old labour intensive to maintain and not energy efficient as were designed for the heating load of whole of the West Wing. Plant Room 1 Heating Calorifier is 30 years old, Plant Room 12 Heating Calorifier is 22 years old.	Estates	LCH: EPC Programme to replace Heating Calorifiers.	Moderate risk (8-10)	31/03/2019	
										LCH: Luminaires; many units over 25 years old and obsolete, resulting in poor lighting and energy performance. Obsolete & Defective Lighting Control System within County Restaurant and East Wing Corridor.	Estates	Replacement luminaires and lighting control systems are required to be installed.	Moderate risk (8-10)	31/03/2019	
										Emergency standby generator no. 3 is obsolete and major components are very difficult to source. The generator is 30 years old and supplies the Maternity Wing, West Wing and Pathology Block.	Estates	Emergency standby generator no. 3 is routinely checked and maintained by Estates and specialist contractors. Action required to obtain funding to carry out assessment of connected load. Supply and install generator, modify louvres, cabling and exhaust, test and commission.	Moderate risk (8-10)	31/03/2019	
										Poor performance and energy utilisation at Pilgrim caused by ineffective plant.	Estates	The Energy Performance Control will consider upgrading ineffective plant at Pilgrim. Appoint a preferred partner to carry out an Investment Grade Audit.	Moderate risk (8-10)	31/03/2019	

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										Potential for overheating of Medical/Industrial Air Plant at Pilgrim.	Estates	Carry out final stage of work to separate medical/industrial air at Pilgrim (compliance with HTM); Carry out additional ventilation to plant room to reduce overheating of equipment.	Moderate risk (8-10)	31/03/2019	
										Maternity building drain stacks at Grantham need to be replaced; they are no longer fit for purpose due to ward reconfiguration and increased use of pulp products. Presence of asbestos within the Tower Block prevents the removal of drain stacks.	Estates	Capital Funding Required to proceed with replacement of Maternity building drain stacks at Grantham. Awaiting asbestos removals works before continuing.	Moderate risk (8-10)	31/03/2019	
										OPD boilers are in need of major refurbishment in order to provide full service to a number of critical areas including OPD Rehabilitation Pathology and Ward 6.	Estates	Increased level of maintenance for OPD boilers which cannot fully prevent breakdown. Funding required.	Moderate risk (8-10)	31/03/2019	
										Lack of serviceable equipment due to obsolete BMS outstations, field controls and actuators in very poor state of repair and require replacement which would lead to an impact/effect on increased energy consumption & running costs.	Estates	Equipment replacement program (BMS outstations, field controls and actuators) needs to be developed and funded.	Moderate risk (8-10)	31/03/2019	
										Lack of automatic controls on corridor lighting at LCH resulting in excessive energy usage; lighting is virtually all controlled by manual switching.	Estates	Ad hoc lighting controls replacement & energy campaign. Staff encouraged to switch off lighting in unused areas. Programme is required to install automatic lighting controls in appropriate priority areas.	Moderate risk (8-10)	31/12/2019	
										There is an environment and maintenance overhead due to obsolete luminaires at GDH. We have an aging site which contains old and inefficient lighting and controls. These are wasting energy and resources in the increasing time it takes to maintain them.	Estates	Replacement programme required for luminaires at GDH.	Moderate risk (8-10)	31/12/2019	Capital funding applied for. EPC Contract Awarded these issues will be dealt as part of the contract.
										The CHP engine plant and equipment has an estimated 6 months life expectancy remaining. The current maintenance contract has been extended for 6 months but does not include the same coverage that is currently in place. The only contingency to maintain the sites heating if the CHP fell over is to procure generators to keep the buildings heated.	Estates	The replacement and upgrade of the CHP at LCH is part of the Trusts overall EPC but because of the inherent risks, weaknesses and gaps in control the replacement and upgrade of the CHP is now being prioritised as an individual action to address to TB and ET.	High risk (12-16)	31/03/2019	
4142	**Safe delivery of patient care (corporate)** If there are multiple patient incidents throughout the Trust; Caused by fundamental issues with the safe and consistent application of clinical policies, procedures, guidelines or pathways; It could result in significant harm caused to a large number of patients. Executive lead: Neill Hepburn Risk lead: Richard Andrews	Harm (physical or psychological)	Very high risk (20)	Clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG) & sub-groups: - Harm Reduction Group - Radiation Protection Group - Deteriorating Patient Group - Medical Devices Group - Hospital Transfusion Group - Nutrition Group Divisional Clinical Cabinets & CBU / specialty governance arrangements. Clinical staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes (including Safety Thermometer). Quality Matron team and specialist nurses (Tissue Viability; Frailty; Sepsis).	High risk (12)	Patient Safety Group	Quality Governance Committee	Low risk (4)	31/08/2019	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	Corporate Nursing	Design & introduce refined policies and processes for the identification of & response to deteriorating patients.	High risk (12-16)	30/09/2019	Regular progress reporting through Quality & Safety Implementation Group (QSIG).
										Inconsistent levels of compliance with the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs), particularly outside of the operating theatre environment, which increases the likelihood of a Never Event occurring.	Quality & Compliance	Conduct an initial review of compliance with LocSSIPs to identify areas for improvement.	Moderate risk (8-10)	31/10/2019	
										Issues within Emergency Departments including ambulance handovers; overcrowding; responding to deteriorating patients; delayed assessment / triage /streaming; discharge / flow decision-making; and reliance on agency / locum clinical staff; increase the risk of patient safety incidents resulting in harm.	Accident and Emergency	Initial review of patient safety incident data & reports to inform mitigating action.	High risk (12-16)	31/08/2019	Data under review; to be presented to PSG in August 2019.
										Development of the WebV system for handover has been delayed due to lack of dedicated project manager; potential adoption of the Nervecentre system is not possible until 2021. Presently there is no Trustwide handover IT system in place.	Information & Communications Technology	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	High risk (12-16)	31/03/2020	Associate Director of ICT to be invited to PSG in August to discuss project management options.
										Inconsistent application of clinical pathways and guidelines for pneumonia, leading to increased mortality risk.		Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	Moderate risk (8-10)	31/03/2020	Business case in development for audit function.
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)		Quality Governance Committee	Low risk (4)	31/08/2019	Staff engagement & ownership of patient experience feedback, staff morale and staff shortages; lack of pride or hope in working at ULHT translated as low energy and passion; communication features highly as a negative indicator within feedback; staff lacking awareness of the 'impact of self'; staff do not feel valued; workload and demand gives little time to provide the care to the standard aspired to leaving staff disappointed and dissatisfied.	Human Resources	Deliver against Patient Experience workplan; provide service and divisional level patient experience reports that are useful, timely and meaningful, secure a FAB Experience champion in every directorate; promote & spread Academy of FAB NHS Stuff to highlight FAB patient experience quality projects and achievements - spreading celebration and enthusiasm to rebuild motivation and hope and passion; determine links between staff and patient experience and drill down to team level to support improvements and interventions; provide data that delivers confidence that this is what staff and patients are saying about their experience within that service - and then support that service to design and deliver improvements.	High risk (12-16)	30/09/2019	

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ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
4082	**Workforce planning process (corporate)** If there is a fundamental failure in the Trust's workforce planning process; Caused by issues with the design or application of the process, the availability of accurate workforce information or the capability to utilise it; It could result in significant, prolonged disruption to multiple services across directorates and potential unplanned closure of one or more services. 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)		Workforce and Organisational Development Committee	Moderate risk (8)	30/11/2018	Capacity within the business to support the process and recognition of its priority is an inhibiting factor, which is less within the direct control of HR.	Human Resources	KPMG are providing additional capacity and capability. Created temporary team to take forward work aligned to CSR. Business partners to be appointed. Skill-building planned at STP level, where we also have continued support from WSP. Escalation to FRG if necessary.	Very high risk (20-25)	31/01/2019	
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)		Workforce and Organisational Development Committee	Low risk (4)	31/03/2019	Impact of the cost reduction programme & organisational change on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.	Human Resources	Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. The actions proposed provide the mitigation, but we have to recognise that this remains a tough environment in which to drive up morale. Staff survey predated launch of 2021, but there is a need to tackle vacancy gaps as well.	High risk (12-16)	31/03/2019	
										Relationships with staff side representatives are challenged by the scale of organisational change required and the extent to which staff side wish to protect the status quo. There are disagreements amongst staff side representatives and not all meetings have taken place as scheduled.	Human Resources	Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. It is based on the Sandwell model and seeks to ensure proper debate, without giving staff side the capacity to prevent us moving beyond the status quo. Intention is to write to staff side to propose a further partnership meeting. Formal consultation around the new recognition agreement will begin shortly.	Moderate risk (8-10)	31/01/2019	
4145	**Compliance with safeguarding regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties. Executive lead: Michelle Rhodes Risk lead: Victoria Bagshaw	Reputation / compliance	Very high risk (20)	Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	High risk (12)	Safeguarding Group	Quality Governance Committee	Low risk (4)	30/06/2019	Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.	Safeguarding	Increase visibility of the Safeguarding team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored.	High risk (12-16)	31/03/2019	
										Not yet consistently achieving 90% compliance with safeguarding training requirements.	Safeguarding	Confirm that safeguarding training completion continues to be included in performance framework with compliance reviewed and managers held to account through operational performance management reviews; individual accountability to be managed through appraisal process.	Moderate risk (8-10)	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.	Safeguarding	Areas for more efficient working to be identified and improvements implemented; progress work to develop an integrated Safeguarding model for Lincolnshire that will deliver optimum benefits for Safeguarding across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority.	High risk (12-16)	31/03/2019	Different models of working being explored.
										The Trust is not yet fully compliant with recommendations made following the Savile and Bradbury inquiries (e.g. Chaperone Policy and Safer Recruitment).	Safeguarding	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.	High risk (12-16)	31/03/2019	Chaperone Policy ratified and published, specific training to be developed DBS checks being explored by HR.

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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, with 6 NIV machines (4 installed 2009; 1 in 2011; 1 in 2018). Ward 7B (PHB) is established for 2 NIV beds, with 4 NIV machines (2 installed in 2007; 1 in 2017; 1 in 2018). Additional NIV machine available in Clinical Engineering if needed. Acute Care Unit at GDH is established for 3 NIV beds. Escalation process in place. Authorisation to increase staffing capacity through the use of Bank, overtime and agency. Oxygen saturation monitoring in place and cardiac monitoring can be accessed via the Outreach Team if any concerns re potential arrhythmia. Trust-wide staff competencies for NIV. Safecare Live system used to record patient acuity. 1x NIV-skilled nurse per shift in all areas where NIV is provided.	High risk (12)	Patient Safety Group	Quality Governance Committee	Low risk (4)	30/09/2019	1. Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. 2. NIV may be the ceiling of care which would deem a patient not suitable for admission to an ICU bed; if a patient were then admitted to ICU it may be unsuitable for the patient and would be in breach of Critical Care Network agreed policies. 3. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. 4. Recruitment of nurses with required skills to vacancies on Ward 7B (PHB). 5. Inconsistent adherence to the NIV Care Pathway.	Respiratory Medicine	1. SOP to be developed for commencement of NIV in Emergency Departments. 2. Escalation Process for Ward Based NIV Capacity developed. 3. Capacity & demand being reviewed with the aim of increasing established, trained staff levels. 4. On-going competency training in place for all nurses. 5. NIV to review audit results and agree appropriate action.	High risk (12-16)	31/03/2020	Action plan kept under regular review by he NIV Group, which meets quarterly. Next meeting September 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)	Medicines Optimisation & Safety Group	Quality Governance Committee	Low risk (4)	31/05/2019	The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.	Pharmacy	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	High risk (12-16)	31/03/2020	
										Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.	Pharmacy	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	High risk (12-16)	31/03/2019	
										The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.	Pharmacy	Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency - ward monitoring of temperatures & escalation of issues.	High risk (12-16)	31/12/2019	
										Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	Pharmacy	Temperatures of refrigerated medicinal products to be monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased.	Very high risk (20-25)	31/03/2019	
										Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Pharmacy	Risk regarding unsecure storage and stock accountability of medical gas cylinders at all sites to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	Moderate risk (8-10)	30/06/2019	
4157	**Compliance with medicines management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties. Executive lead: Neill Hepburn Risk lead: Colin Costello	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)	Medicines Optimisation & Safety Group	Quality Governance Committee	Low risk (4)	31/05/2019	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	Pharmacy	Planned introduction of an auditable electronic prescribing system across the Trust.	High risk (12-16)	31/03/2020	
										Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	Pharmacy	The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	High risk (12-16)	30/06/2019	
										Administration of medication by pharmacy technicians including oral, intravenous, NG and PEG - legislation, governance and training issues. The Medicines Regulations 2012 specified that parenteral products can be legally administered by persons acting under the instruction of a legally valid appropriate prescriber (as shown in Regulation 214). Pharmacy technicians could also adopt this role in clinical areas in the Trust. However, his practice has not been approved and accepted by the Trust and is not embedded into the Medicines Management policy.	Pharmacy	To define the process for administration of medicines by pharmacy technicians and their supervision and training. To embed the process in the Medicines Management Policy.	High risk (12-16)	30/09/2019	

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										There is not full assurance that the new pharmacy technician roles and practices are acceptable in terms of professionally registered practice and that professional codes of practice are being correctly adhered to.	Pharmacy	To establish the professional supervision and development of the new roles. To take advice from the General Pharmaceutical Council (GPhC) and NHSI to ensure the new roles are covered by the relevant professional codes of practice.	High risk (12-16)	30/09/2019	
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)	Patient Safety Group	Finance, Performance & Estates Committee	Low risk (4)	31/07/2019	Trust-wide issues with the availability of suitable equipment (e.g. beds / trolleys; wheelchairs; weighing scales; blood pressure cuffs) and appropriate policies, procedures & pathways supported by training for the safe care of bariatric patients.	Corporate Nursing	To review and update where necessary policies, procedures and relevant pathways to improve the safety of care for bariatric patients across existing policy areas, including: moving & handling policy; Theatres - procedures on trolleys / tables; observation policy (e.g. right size cuff to take blood pressure); A&E; outpatients.	High risk (12-16)	30/06/2019	Working group set up, involving corporate nursing, health & safety & risk, to identify required improvements.
										Lack of a centralised database for all medical devices; some records are held locally.	Clinical Engineering	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	High risk (12-16)	30/11/2019	MDSG has agreed on MEMS as the centralised medical equipment management database. Divisional engagement is underway.
										Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control.	Clinical Engineering	Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT.	High risk (12-16)	30/06/2019	BC developed and approved in principle by CRIG
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)	Financial Turnaround Group	Finance, Performance & Estates Committee	Low risk (4)	31/12/2018	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.	Finance	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.	Very high risk (20-25)	31/01/2019	Trust Board has approved a financial recovery plan for remainder of 2018/19 and 2019/20. Awaiting review by NHSI.
4179	**Major cyber security attack (corporate)** If the Trust is subject to a major cyber security attack that breaches its network defences; Caused by the exploitation of an existing vulnerability or the emergence of a new type of threat; It could result in loss prolonged, widespread loss of access to ICT systems throughout the Trust which disrupts multiple services and affects a large number of patients and staff. Executive lead: Kevin Turner Risk lead: Michael Humber	Service disruption	Very high risk (20)	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital (CareCerts) ICT hardware & software upgrade programme. NHS Data Security Protection Requirements (DSPR). Corporate and local business continuity plans for loss of access to ICT systems. Mandatory major incident training for all staff (part of Core Learning). Installation of Site based Firewalls with full Traffic inspection enabled.	High risk (12)	Information Governance Group	Finance, Performance & Estates Committee	Low risk (4)	10/10/2019	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Information & Communications Technology	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	Moderate risk (8-10)	12/09/2019	The DPST was updated nationally to include the requirements of Cyber Essentials and other national requirement's. The Trust is working towards meeting this for march 2020 return.
										Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.	Information & Communications Technology	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	High risk (12-16)	11/09/2019	For financial year 19/20 no Trust capital has currently been provided to any Business as Usual schemes. Affecting the ability to continue in delivery schemes Move forward with in plan schemes Delays will affect the strategy as attack vectors and methods are constantly evolving
										Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Information & Communications Technology	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	Moderate risk (8-10)	11/09/2019	The BCP and Disaster plan has been updated A test of the plan is scheduled for the 31st July 2019, to desktop test the current plan.
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)		Finance, Performance & Estates Committee	Low risk (4)	31/03/2019	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	Operations	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. 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).	High risk (12-16)	31/03/2019	

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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 Safety Group	Finance, Performance & Estates Committee	Low risk (4)	31/10/2018	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.	Estates	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.	Moderate risk (8-10)	31/03/2019	Quotations have been submitted to bring systems up to date.
										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.	Estates	Replacement of Fire Dampers required in Maternity Wing in accordance with developing Fire Strategy Plans.	High risk (12-16)	30/06/2019	Replacement programme in progress.
										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.	Estates	Compliance with Fire Enforcement Notice through Statutory Fire Safety Programme implementation. Early warning system due to automatic fire detection system.	Very high risk (20-25)	30/06/2019	As built façade scheme drawings indicate fire protection of structural elements to the perimeter of the building recently upgraded.
										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.	Estates	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.	High risk (12-16)	30/06/2019	Survey undertaken 2015/16 - identified remedial works required. to be considered for backlog maintenance. Refer to EFAN.
										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.	Estates	Going out to tender in new financial year replacing pipework and valve in the External Underground Fire Ringmain at Pilgrim.	High risk (12-16)	30/06/2019	Specific work on RPZ valve has been completed.
										Potential inability to evacuate Trust premises in the event of an emergency in the event of poor or non-existent fire training.	Estates	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.	Very high risk (20-25)	30/06/2019	Training in higher risk areas has commenced. Recent appointment of additional fire resource.
										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).	Estates	Multiple leaks repaired and patches placed on the pipework. Ensure Emergency repair kits are available onsite. Identify Capital Funding.	Moderate risk (8-10)	30/06/2019	Routine monitoring, repair as best we can when leaks occur.
										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.	Estates	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	High risk (12-16)	31/12/2019	
										Lack of clear policy for the prescription and management of oxygen; increased potential fire hazard, within hospital or at home.	Corporate Nursing	Review of existing policies & procedures for prescription and management of oxygen, taking account of identified good practice and involvement of the fire service and other local partner agencies.	High risk (12-16)	30/06/2019	Working group set up, involving Corporate Nursing, Health & safety and Risk to coordinate development of required policies & procedures.
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.	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.	High risk (12)	PRM	Finance, Performance & Estates Committee	Low risk (4)	01/04/2019	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients.	Operations	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	High risk (12-16)	31/03/2019	
										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.	Operations	Short term solution to offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes.	Moderate risk (8-10)	31/03/2019	

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
	Executive lead: Mark Brassington Risk lead: Yaves Lalloo			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).						Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	Operations	Clinical Directorates to provide trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans at speciality level. C&A manually drawing down referrals from ASI list.	High risk (12-16)	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.	Operations	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	Very high risk (20-25)	31/03/2019	
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)	Emergency Planning Group	Finance, Performance & Estates Committee	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.	Pharmacy	Planned introduction of an electronic prescribing system across the Trust.	High risk (12-16)	31/03/2020	
										Shortages of several brands of normal immunoglobulin. Gap in immunologist input for switching patients between brands.	Pharmacy	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.	High risk (12-16)	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.	Pharmacy	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.	High risk (12-16)	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.	Pharmacy	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.	Very high risk (20-25)	31/01/2019	
4421	**Delivery of the E-prescribing project (corporate)** If the Trust does not deliver the E-prescribing project to planned specification, cost & timescales; Caused by issues with the availability of sufficient funding, project planning, or project management; It could result in significant disruption to multiple services throughout the Trust and failure to realise the potential benefits in terms of efficiency and risk reduction that e-Prescribing is expected to bring. Executive lead: Neill Hepburn Risk lead: Colin Costello	Service disruption	Very high risk	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		Finance, Performance & Estates Committee	Low risk	31/05/2019	Funding not yet in place - requirement for successful application to NHSI. Initial application was rejected.	Pharmacy	Application to NHSI for funding to be re-submitted in early 2019.	High risk (12-16)	30/06/2019	
4467	**Impact of a 'no deal' EU Exit scenario (corporate)** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust. Executive lead: Kevin Turner Risk lead: Nick Leeming	Service disruption	Very high risk	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	High risk		Finance, Performance & Estates Committee	Low risk	30/09/2019	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.	Operations	To review existing business continuity plans and update where necessary, in line with national and local guidance. Trust response to be coordinated through re-establishment of an executive-led task & finish group.	Low risk (4-6)	30/09/2019	Currently awaiting further details from the Dept of Health regarding potential impacts and any required changes to existing business continuity plans.

TMG - Corporate Risk Report (August 20919)

ID	Title	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead management group	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Lead Specialty	Planned actions	Risk ratring	Due date	Progress
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	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		Finance, Performance & Estates Committee	Low risk	31/10/2018	The cold-water supply pipe work on all floors of the Maternity Wing at LCH is of varying sizes and manufactured from PVC. It has been in place since the construction of the building (approaching 45 years) Over time there have been a number of failures. This has been apparent at pipe work junctions and joints, and is probably as a result of adhesive degeneration. Similarly, with age, the pipe works ability to expand and contract has been reduced and the resulting 'brittleness' of the installation is increasing the risk of failure which could result in serious service interruption and contamination of other services and equipment, resulting in potential for injury and disruption to patient care.	Estates	Funding required for refurbishment of water systems throughout the Maternity Wing (estimated Cost £3M +Vat). A robust defect reporting system is in place.	Moderate risk (8-10)	31/12/2019	
										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.	Estates	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	High risk (12-16)	31/12/2019	Scheme of work and design currently being produced.
4476	**Compliance with clinical effectiveness regulations & standards (corporate)** If the Trust is found to be systemically non-compliance with regulations and standards for clinical effectiveness; Caused by fundamental issues with the systems and processes used for managing clinical audits, policies, guidelines and best practice; It could result in a significant loss of confidence amongst a large number of patients as well as commissioners, regulators and the general public which may lead to regulatory action and sanctions.	Reputation / compliance	Very high risk	Clinical governance arrangements in place at corporate level: Quality & Safety Oversight Group (QSOG) / Clinical Effectiveness Group. Clinical policies, guidelines and best practice management processes. National clinical audit programme management processes. Local clinical audit programme management processes.	High risk		Quality Governance Committee	Low risk	31/08/2019	Infrastructure is in place for divisional management of clinical policies; guidelines; best practice and clinical audit. Issues with time allocation within job plans for divisional leads to deliver against requirements.	Quality & Compliance	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	High risk (12-16)	31/03/2020	Report template in development.
										Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	Quality & Compliance	Integration of routine oversight of clinical effectiveness as part of the divisional Performance Review Meeting (PRM) process through the introduction of appropriate KPIs.	Moderate risk (8-10)	31/03/2020	
										Insufficient staffing resources within the established Clinical Effectiveness central support team.	Quality & Compliance	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	High risk (12-16)	31/12/2019	
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. Executive lead: Mark Brassington Risk lead: Suganthi Joachim	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)		Quality Governance Committee	Low risk (4)	30/06/2019	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	Paediatric Medicine	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	High risk (12-16)	30/03/2020	
										Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	Paediatric Medicine	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	High risk (12-16)	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).	Paediatric Medicine	Development of sustainable long-term model for paediatrics at PHB, through the STP.	High risk (12-16)	31/03/2020	
4423	**Working in partnership with the wider system (corporate)** If the Trust fails to work effectively in partnership with the wider system, including other healthcare providers and commissioners; Caused by issues with the planning process, the availability of sufficient resources or the effectiveness of partnership governance arrangements; It could result in significant disruption to the provision and sustainability of multiple services that has a long term impact on the experience and quality of care for a large number of patients. Executive lead: Kevin Turner Risk lead: Julie Pipes	Service disruption	Very high risk (20)	Sustainability & Transformation Partnership (STP), including ULHT; LCHS' LPFT; & others. STP partnership governance arrangements. STP planning & delivery mechanisms. Lincolnshire Coordinating Board (including chairs of each partner organisation).	High risk (12)		Finance, Performance & Estates Committee	Low risk (4)	31/08/2019	Failure to work effectively in partnership may result in some ULHT services having demand that exceeds capacity; failure to work with other providers and CCGs may also result in the viability of ULHT services being jeopardised. Failure to progress on taking forward the Acute Services Review may result in some existing fragile services failing, or some services becoming fragile.	Corporate Affairs	Continued engagement with the STP delivery process through established governance arrangements.	High risk (12-16)	31/03/2020	

Appendix II - Moderate Low corporate risks (August 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4496	Financial Risk due to removal from Windows 10 national licensing agreement	Corporate	Finances	9	Moderate risk
4401	Safety of the hospital environment (corporate)	Corporate	Harm (physical or psychological)	9	Moderate risk
4403	Compliance with electrical safety regulations & standards (corporate)	Corporate	Reputation / compliance	9	Moderate risk
4486	Clinical outcomes for patients (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4003	Major security incident (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4043	Compliance with patient safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4044	Compliance with information governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4469	Compliance with blood safety & quality regulations & standards (corporate)	Clinical Support Services	Reputation / compliance	8	Moderate risk
4479	Safe clinical staffing levels (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4481	Safe use of patient information (corporate)	Clinical Support Services	Harm (physical or psychological)	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4402	Compliance with regulations and standards for mechanical infrastructure (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4422	Delivery of the Electronic Patient Records project (corporate)	Corporate	Service disruption	8	Moderate risk
4424	Delivery of the Quality & Safety Improvement Plan (QSIP)	Corporate	Reputation / compliance	8	Moderate risk
4177	Critical ICT infrastructure failure (corporate)	Corporate	Service disruption	8	Moderate risk
4180	Reduction in data quality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4181	Significant breach of confidentiality (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards (corporate)	Corporate	Reputation / compliance	8	Moderate risk
4144	Uncontrolled outbreak of serious infectious disease (corporate)	Corporate	Service disruption	8	Moderate risk
4154	Participation in important clinical research projects (corporate)	Corporate	Harm (physical or psychological)	8	Moderate risk
4061	Financial loss due to fraud (corporate)	Corporate	Finances	4	Low risk

Appendix II - Moderate Low corporate risks (August 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4138	Patient mortality rates (corporate)	Corporate	Reputation / compliance	4	Low risk
4155	Safety of research project participants (corporate)	Corporate	Harm (physical or psychological)	4	Low risk
4363	Compliance with HR regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service (corporate)	Corporate	Service disruption	4	Low risk
4387	Critical supply chain failure (corporate)	Corporate	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4277	Adverse media or social media coverage (corporate)	Corporate	Reputation / compliance	4	Low risk
4438	Severe weather or climatic event (corporate)	Corporate	Service disruption	4	Low risk
4439	Industrial action (corporate)	Corporate	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards (corporate)	Corporate	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products (corporate)	Clinical Support Services	Harm (physical or psychological)	4	Low risk
4483	Safe use of radiation (corporate)	Clinical Support Services	Harm (physical or psychological)	4	Low risk

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Risk Management Policy Appendix I: Risk Scoring Guide

To be used when assessing risks that are recorded on the Trust risk register (Datix).

	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting a small number of patients, staff or visitors within a single location.	Low level of harm affecting a large number of patients, staff or visitors within a single location.	Significant but not permanent harm affecting multiple patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	6th August 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 all of the Board Committees during July. There were no material changes to the content of the framework and as such none of the assurance ratings have been amended by the Committees during their considerations in July.

The amber assurance rating direction of travel has reduced to reflect the corrected RAG rating for SO2bi to a red rating.

Direction of Travel of Assurance Ratings:

RAG Rating	June 2019	July 2019	Direction
Red	6	6	→
Amber	2	1	↓
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2019/20 - July 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 - HQIP ReSPECT Care Plan Quality Account Priority 3	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 for coding Organisational Development Patient Safety Committee Clinical Effectiveness Committee Drugs and therapeutic Committee 7 day Services Mortality review group Formal report from public health workshops to be requested ReSpect update and coding update requested within next mortality report July 2019	Quality Governance Committee	**A**
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy Patient Experience Plan Inclusion Strategy QSOG reports Quality Account priorities 1 ,2 & 4	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Quality Strategy not approved Metric not finalised Sharing and learning not at desired level	Bi weekly meetings Harm Free care Steering Group QSIP Programme Patient experience annual plan as part of Quality Strategy Meeting to finalise metrics	Integrated Performance Report Patient Experience Dashboard and codesign of pathways with patients Quality and Safety Improvement Plan Board Walkrounds Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain as gap for time being QSOG still in development New Trust Operating Model still embedding. Patient Experience and links to Quality Strategy and how articulated in BAF	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

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							Internal Audit: Data quality of KPIs - Q4 Compliance with legislation - Q2			Infection Prevention Control exception report Equality and Diversity Patient report Inclusion strategy				
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	Systems unable to capture and report data Unreliable, incomplete or inaccurate data Insufficient clinic capacity resulting in overbooking Inappropriate clinic configuration providing duplicate appointment times Patients arriving late for their clinic appointment Poor engagement	Corporate risk ID 4368 - Outpatient demand (High)	CQC Responsive	Specialty Governance Data Quality Group Outpatient Improvement Programme Delivering Productive Services Group Internal Audit: Data quality - Q1	Data Quality Group New reporting metric Insufficient outpatient capacity to meet current demand across a number of specialties Consistency of Specialty Governance process	Data Quality workstream Performance Review Meetings Outpatient improvement programme System approach to managing planned care demand Governance team supporting embed of specialty governance port TOM implementation	Monthly Delivering Productive Services report PRM FPEC	Data quality assurance IPR	Development of data quality process prior to reporting Report from system SRO	Finance, Performance and Estates Committee	R

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SO2	Providing efficient and financially sustainable services													
2a	Have 'zero waits' to access our services	% patients discharged within 24 hours of PDD	Chief Operating Officer	Systems unable to capture and report data Unreliable or inaccurate data Poor engagement with setting PDD Internal systems not efficient to support timely discharge	Corporate risk ID 4176 - Planned care demand (High)	CQC Effective	Urgent and Emergency Care Improvement Programme - workstream 4, Ward Processes and 5, Discharge and Partnerships Daily review and overview by operational services Delivering Productive Services Group	Specialty Governance Data Quality Issues New reporting metric	Data Quality workstream PRM Roll out of the TOM in line with the governance framework	Monthly Delivering Productive Services report Urgent and Emergency Care Improvement Programme update IPR	Reporting at speciality level unavailable		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	R
		% 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	

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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 Quality Account Priority 2 <u>Internal Audit:</u> Policy compliance - Q2 Mandatory training - Q2	Consistent quality of local leadership and management Staff engagement and belief in 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

United Lincolnshire Hospitals NHS Trust

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SO4	**Providing seamless integrated care with our partners**													
4a	Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration	% reduction in face to face contacts in Outpatients 5%	Deputy Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable 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

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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:

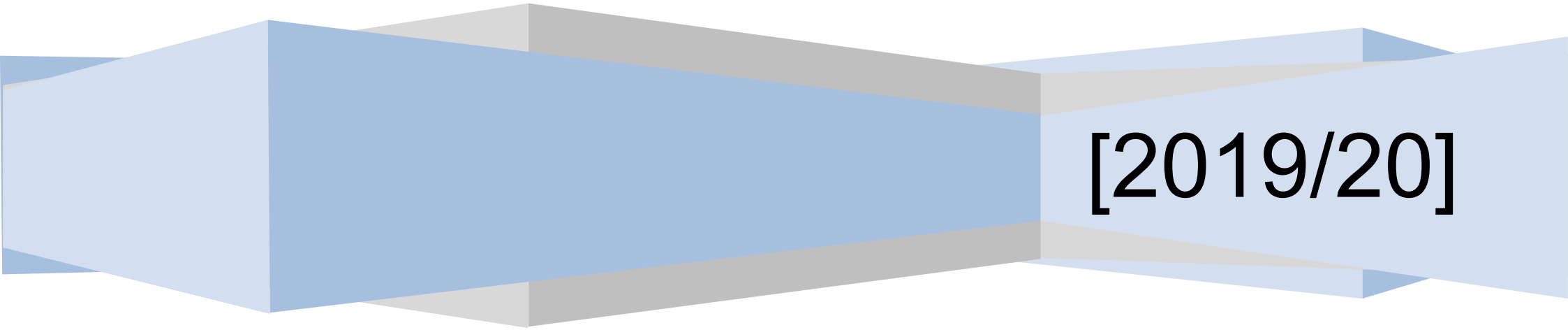
R — Effective controls may not be in place and/or appropriate assurances are not available to the Board

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

TRUST BOARD FORWARD PLANNER

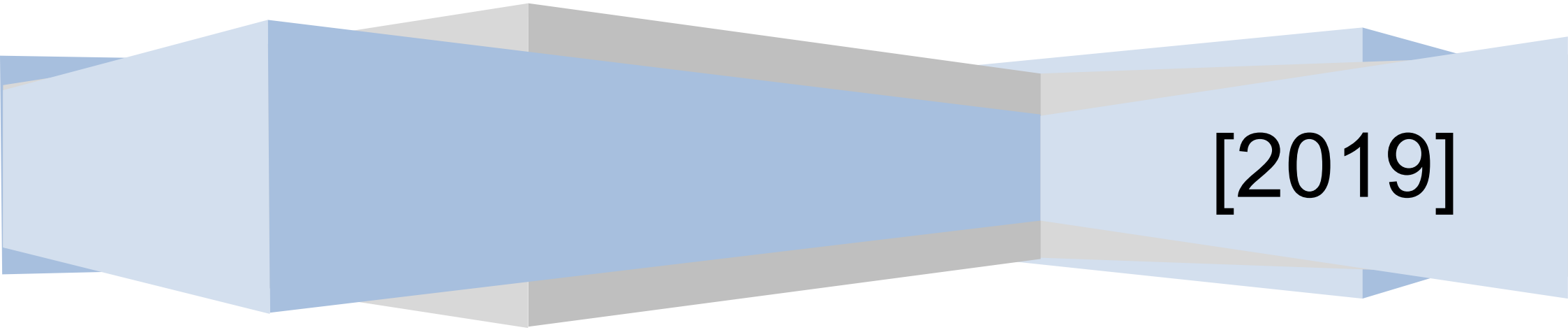


	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration 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											

United Lincolnshire Hospitals NHS Trust

BOARD DEVELOPMENT PROGRAMME



DATE	TIME	VENUE	THEME/ACTIVITY	Lead	Notes
22 Jan 2019	9.30am-1.30am	Lincoln	Strategic Planning Framework • Mission and values • True North Pillars, themes metrics • Strategic priorities • How to implement	External -KPMG	
19 Feb 2019	2pm – 4pm	Lincoln	Trust Operating Model Governance Revised IPR Format and KPIs	CEO DCEO/DoF	
19 Mar 2019	1.30pm-6.00pm	Lincoln	Contract Position Risk Appetite Workshop Well Led PIR Submission Improvement Plan Position	DoF External Good Governance Institute DoN DoN	
16 April 2019	2pm-6pm	Lincoln	Being Effective in a Distressed System	External Mark Withers	
17 May 2019	2pm-5pm	Lincoln	FAB Accreditation Board Well Led Self Assessment	Dir of HR Trust Secretary	
18 June 2019	2pm-5pm	Lincoln	Joint Board and Divisional Triumverate CQC Preparation	DoN	
20 Aug 2019	2pm-5pm	Lincoln	Workforce/Finance/Pay Deep Dive	DoF/DoHR	
17 Sept 2019	2pm-5pm	Lincoln	Health and Wellbeing Data/ Diagnostic Board Working -Mark Withers	NHSE External Mark Withers	
15 Oct 2019	2pm-5pm	Lincoln	Continuous Quality Improvement Workshop 5 Year Plan -Enabling Strategies Workshop	DoHR/ Head of Strategy DoHR	
19 Nov 2019	2pm-5pm	Lincoln	Risk Workshop	Med Director	
17 Dec 2019	2pm-5pm	Lincoln	Planning for 2020/2021	DoHR	

United Lincolnshire Hospitals is one of two Trusts in the country trialling artificial intelligence software to support breast cancer screening

United Lincolnshire Hospitals NHS Trust (ULHT) is one of only two Trusts in the country to take part in a groundbreaking new trial using artificial intelligence (AI) to support breast screening.

ULHT is part of the East Midlands Radiology Consortium (EMRAD), a partnership of seven NHS trusts, spread over 11 hospitals, looking after more than five million patients.

EMRAD launched in 2013 with the objective to create the foundations for stronger clinical collaboration, starting with the implementation of a new, common digital radiology system. This pioneering work saw the East Midlands become the first health community in the UK where NHS hospitals could quickly and easily share diagnostic images such as x-rays and scans. The image-sharing system has set the national benchmark for a new model of clinical collaboration within radiology services in the NHS.

Currently all images produced during breast screenings, known as mammograms, are reviewed by two members of the breast screening reading team. With a national shortage of radiologists and with almost a quarter planning to retire within the next five years, there is a clear need to investigate and look for potential alternatives.

Last year, the consortium formed a partnership with two UK-based AI companies, Faculty and Kheiron Medical, to help develop, test and ultimately deploy AI tools in the breast cancer screening programme in the East Midlands.

Faculty's 'Platform' software has the potential to help optimise clinic scheduling and staff resourcing, helping the service to be as efficient and effective as possible. The aim is to make the best possible use of scarce resources like radiologists' time and scanners, and to reduce stress on the clinical and administrative workforce delivering the programme.

Kheiron Medical's MIA (mammography intelligent assessment) tool uses an AI algorithm to try and diagnose breast cancer. The algorithm has been used on half a million scans from hospitals in Hungary, but it is new to the UK. The UK trial is using scans from ULHT and Nottingham University Hospitals NHS Trust.

The first phase is a retrospective trial where old images have been anonymised and used to see how accurate MIA is at diagnosing scans that need further investigation, compared to the results produced by the breast screening reading team. Already, it is performing better than most humans.

If the evidence shows that it is safe to do so, then the next stage will see the team use MIA to do the first read of all scans before they are then reviewed by a member

of the radiology team and the results compared. If there is any difference of opinion then the scan will automatically be sent for a third read.

ULHT Consultant Mammographer and the Trust's lead on the project, Bernadette Trzcinski, said: "I am really excited to be working on this trial, which may revolutionise how we read scans in the future.

"Across the country we desperately need something to help us with the current staff shortages, which are predicted to become increasingly challenging as the demand for imaging grows. The success of this project will transform the breast screening service, improving both quality and efficiency for our breast screening population.

"It is not about replacing radiologists. All scans at the Trust will continue to be read by at least one member of the breast screening reading team. However if MIA is successful, it has the potential to half the amount of time we spend reviewing scans, this is time we could be spending with our patients, improving their overall experience."